

# SOCIAL SECURITY DISABILITY FRAUD SCHEME IN NEW YORK

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## HEARING

BEFORE THE  
SUBCOMMITTEE ON SOCIAL SECURITY  
OF THE  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED THIRTEENTH CONGRESS  
SECOND SESSION

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**SOCIAL SECURITY DISABILITY FRAUD  
SCHEME IN NEW YORK**

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**THURSDAY, JANUARY 16, 2014**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
SUBCOMMITTEE ON SOCIAL SECURITY,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 9:00 a.m., in Room B-318, Rayburn House Office Building, the Honorable Sam Johnson [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

# HEARING ADVISORY

## Chairman Johnson Announces Hearing on Social Security Disability Fraud Scheme in New York

Washington, Jan 9, 2014

U.S. Congressman Sam Johnson (R-TX), Chairman of the House Committee on Ways and Means Subcommittee on Social Security, today announced a hearing on a massive Social Security Disability Insurance fraud scheme in New York that could cost taxpayers hundreds of millions of dollars. **The hearing will take place on Thursday, January 16, 2014 in B-318 Rayburn House Office Building, beginning at 9:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

### BACKGROUND:

On January 7, 2014, the New York County District Attorney's Office announced the indictment of 106 defendants for their alleged involvement in a criminal conspiracy to defraud taxpayers. The defendants, who include many retirees of the New York Police and Fire Departments, are accused of massive fraud against the Social Security Disability Insurance (SSDI) program. The 102 beneficiaries, along with four facilitators who assisted them, are accused of collecting approximately \$22 million in fraudulent benefits.

According to the District Attorney, from approximately January 1988 to December 2013, the four principal defendants in the case coached applicants on how to falsely demonstrate symptoms of mental disorders in order to obtain disability benefits in exchange for a cash payment of up to \$50,000. The remaining 102 defendants are charged with lying about their mental health and ability to work in order to receive SSDI benefits to which they were not entitled. Each claimant collected an average of \$210,000 in total fraudulent SSDI payments, though for some the total amount obtained was close to \$500,000. Many defendants falsely claimed to suffer from post-traumatic stress disorder and other mental illnesses as a result of their experience with the September 11, 2001 terrorist attacks.

According to the Social Security Administration (SSA) Office of Inspector General (OIG), the investigation dates back to 2008, when New York Disability Determination Service employees noticed that many applications had the same handwriting and contained identical descriptions of their ailments. These claims were referred to the SSA OIG's New York Cooperative Disability Investigations unit. In 2011, the SSA OIG and the New York County District Attorney's Office launched an undercover operation that led to the indictments.

The announcement of these indictments follows revelations of similar abuse in August 2013, when authorities arrested more than 70 individuals involved in a disability fraud conspiracy in Puerto Rico. Also, in October of 2013, the Senate Homeland Security and Governmental Affairs Committee released the results of their bipartisan investigation detailing inappropriate conduct and collusion between a West Virginia law firm, a Social Security Administrative Law Judge and some local doctors in approving benefits while outlining the ineffective oversight by the SSA.

With the 2013 Social Security Trustees report projecting that the SSDI program will only be able to pay 80 percent of benefits beginning in 2016, losses to the system from fraud is an issue of increasing concern. According to the SSA, 11 million beneficiaries received \$139.4 billion in SSDI benefits in Fiscal Year 2013.

In announcing the hearing, Social Security Subcommittee Chairman Sam Johnson (R-TX) said, **"The widespread disability fraud uncovered in Puerto Rico and most recently in New York is deeply troubling and unacceptable. Scandal after scandal proves the Social Security Administration is failing to protect precious taxpayer dollars and undermines Americans' confidence in this vital program. With the Disability Insurance program unable to pay full benefits as early as 2016, my number one priority has been to keep this pro-**

**gram strong for those who truly need it and protect taxpayer dollars. It's time for Social Security to make it their number one priority as well. On behalf of hardworking American taxpayers, I am committed to getting answers and rooting out waste, fraud and abuse. Social Security must be held accountable for failing the American taxpayer and work to restore their trust."**

**FOCUS OF THE HEARING:**

The hearing will focus on the details of the New York investigation, how the fraud scheme was carried out, the estimated cost to taxpayers, and what the SSA is doing to crack down on disability fraud in the wake of this and other scandals in Puerto Rico and West Virginia.

**DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

**Please Note:** Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, January 30, 2014**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721 or (202) 225-3625.

**FORMATTING REQUIREMENTS:**

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and **MUST NOT** exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days' notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

Chairman JOHNSON. The meeting will come to order. Let me begin by saying to all my colleagues on this Subcommittee that it is with deep regret that we had to call this hearing today.

Last week we were greeted with shocking headlines. The New York Times led with, "Charges for 106 in a Huge Fraud Over Disability." And ABC News led with the "New York cops, firefighters, in massive 9/11 fraud, the indictment says." I am outraged. But, more importantly, the American people are outraged. Law-abiding Americans woke up to learn that the taxes they paid to Social Security had been stolen.

Today's hearing follows September's hearing on the scandal in Puerto Rico, which, according to the Inspector General, who is with us today, was at that time the largest fraud in the history of Social Security. Now, less than six months later, we have another even more shocking scandal in New York, where 106 people have been arrested. Not only the size of the fraud that is shocking, but those who committed it: former policemen, firemen, and a former FBI employee.

Worse, some of the defendants falsely claim that their disability was caused as a result of the 9/11 terrorist attacks, while many had never even worked at Ground Zero. It is truly a sad day in America when people who once held positions of public trust betray the public confidence. These individuals are accused of stealing from a vital program that serves those who can no longer work, due to disability.

In Fiscal Year 2013, Social Security paid out \$139 billion in disability benefits to 11 million beneficiaries. Also in that same year, Social Security paid out retirement benefits to 57 million beneficiaries. This Subcommittee has held 11 hearings on the disability program, and three of them focused specifically on disability fraud because preventing fraud is essential to maintaining public confidence in the program.

The public is fast losing faith in Social Security, and I don't blame them, because we all are. While I fully recognize there will always be bad apples, what is going on these days is very different. This is a program plagued by fraud conspiracy.

First, there was West Virginia. In October of 2013, the Senate Homeland Security and Governmental Affairs Committee released the results of their bipartisan investigation detailing collusion between a West Virginia law firm, a Social Security administrator, Administrative Law Judge, and some local doctors in approving benefits. Then there was Puerto Rico. And now, New York.

The initial cost to the system in New York is \$22 million initial cost. In Puerto Rico, the scandal initially alleged to cost taxpayers \$2.1 million. Amounts resulting from the corruption in West Virginia are still under investigation. Moreover, a total 181 individuals have been arrested in the New York and Puerto Rico scandals.

I know that crooks don't care about the people who really need their benefits, but I do. According to the Trustees, it is only two years before Social Security can only pay reduced benefits, unless Congress acts. The program can't afford more fraud. It is only a matter of time when Congress may be asked to bail out this program with the retirement side having to come to the rescue. And,



if that is the case, then all taxpayers and beneficiaries will shoulder the burden of a crime wave.

What is more troubling is that the cases are just the ones we know about so far. As we will hear from the Inspector General today, other similar investigations are underway. Like organized crime, these recent scandals reveal fraud committed by a network of professional crooks made up of doctors, lawyers, and judges. It is the new get-rich-quick scheme worth tens of thousands of dollars for every person who illegally gets on the rolls. It is appalling. And in New York, it went on for 25 years, starting in 1988.

With the shocking news of the disability scandal in New York, Puerto Rico, and West Virginia, Americans and this Subcommittee deserve answers, and we need them now. On behalf of my colleagues and the taxpayers, I am asking how can this happen time after time after time. Why is Social Security failing to prevent these fraud conspiracies in the first place?

But it is more than answers that are needed. To restore trust in the disability program, Social Security must be held fully accountable for failing to prevent widespread fraud. Accountability must be accompanied by action to prevent this from happening ever again. I think the time for excuses is over.

Let me make myself clear. I expect accountability at Social Security for these crimes. It is time for real leadership. It has been nearly a year to the day since Social Security had a Commissioner. With the greatest respect to Mrs. Colvin, she has been appointed on a temporary basis. These scandals send a clear warning to the President that we need a Social Security commissioner who will make it his or her six-year mission to fight fraud and restore to the public confidence in this program.

Further, not once has any Commissioner personally asked for our help to fight fraud. The next Commissioner must set a bold, new course, and be unafraid to reach out to us here in the Congress.

Mr. O'Carroll, I am demanding a full investigation by your office of Social Security's entire management and their failure to prevent fraud and conspiracy. And it must be a full, top-to-bottom investigation of Social Security. Leave no stone unturned. Find out how this could happen, and what Social Security can do to stop it in the future. You must make this investigation your top priority. I want the investigation with recommendations quickly. The rip-off of taxpayers by professional fraudsters has to end, and it needs to end now.

I also would like a full report from you, Acting Commissioner Colvin, telling Congress the immediate actions you are taking to prevent these crimes from occurring again and again, as well as any recommendations for legislation that might help you. I want this report within 30 days.

Lastly, preventing fraud should not be and is not a partisan issue. Ranking Member Becerra, I would like to work with you on whatever legislative is needed.

Today we will hear from Acting Commissioner Carolyn Colvin and the Social Security Inspector General Pat O'Carroll. Don't just tell us about the facts of the scandal; we can read that in the news. And don't just tell us about what you did; it is clearly not enough. And don't just say you need more money, when the fact is Social

Security has utterly failed to protect taxpayer dollars in the first place. Social Security must first regain the trust of the American taxpayer before it can credibly argue for more money.

Hard-working taxpayers want, need, and deserve answers and action now to restore their confidence in Social Security. I thank you all for being here today.

Chairman JOHNSON. I now recognize the Ranking Member, Mr. Becerra, for his opening statement.

Mr. BECERRA. Mr. Chairman, thank you very much. And let me join with you in saying that we must ask Social Security to do everything possible, and certainly the Inspector General, to give us the best sense of how to go about going after that conspiracy, that fraud that does occur.

But let me differ a bit, Mr. Chairman, from the way you have described it. The conspiracies in Puerto Rico, New York, were not uncovered by some intrepid consumer or some truth-seeking American or some law enforcement officer outside of Social Security. It was uncovered by front-line Social Security staff. And they are working day in and day out. In fact, they have units, some fraud-busting units, that are doing exactly what we want them to do.

So, it is more a matter of how do we work with the people there busting fraud today within Social Security, whether in the inspector general's office, or just the front-line staff of Social Security, that we must work with. Because when you have former police officers, former firefighters, when you have doctors who are colluding, these are all people of trust.

And so, when a front-line Social Security representative sees a report from a doctor, and sees in front of her or him a former police officer who may have been involved in 9/11, or a former firefighter who had saved people's lives saying, "I am disabled, and here is my documentation from a doctor saying I deserve now to receive the disability insurance benefits that I pay for," you could only do so much, unless you are going to say we are not going to not trust people like former firefighters, former police officers, and our doctors who care for us every day.

And so, this is deep, because the collusion was heavy and the conspiracy was dark. And so we have to get to the bottom of this. But to say that this is the fault of Social Security is to blame the wrong people who are working every day, and whose trust we have put in for decades to make sure that Social Security serves those who paid for it.

Remember, American workers pay for Social Security and Social Security Disability Insurance. Over its lifetime of some 78 years, Social Security has received from American workers some \$14.5 trillion in taxes, Social Security contributions. Because we haven't used that all up, and because some of that money has earned interest by being stored away in bonds, we now have more than \$2.5 trillion in the Social Security trust fund available for Americans who have paid for Social Security and Social Security Disability Insurance.

Social Security Administration workers have diligently, day in and day out, worked to protect Americans' Social Security. And I believe we see that in the conspiracy that was uncovered in Puerto Rico and in New York. Social Security provides a lifeline to 58 mil-

lion Americans each month, 58 million Americans each month. Yet it has an overpayment rate of less than one-half percent. Let me repeat that: less than half-a-percent overpayment, meaning whether it was due to fraud or due to error overpayment.

In fact, that error rate, if you compare it to the private sector, is quite low. Private sector payrolls, which calculate the paychecks that millions of Americans get every day, that—the rate of error for the private sector payroll offices in these companies, is probably about four times higher than Social Security’s. One out of every five consumers has an error in their credit report that could keep them from getting a loan, or force them to pay higher rates in interest than they should.

Do I need to talk about Target and the recent privacy-hacking there, or Neiman Marcus, or you name it? It happens, because there are some bad people out there, and they are after our money. And it shouldn’t surprise people that they are after Social Security’s money, as well. So we have to work very hard, Mr. Chairman. And I want to join you in calling forth this investigation. But let’s make sure we aim our fire at the bad guys, not the front-line workers who are detecting the fraud, not the front-line workers who are working so diligently to try to protect Americans’ money.

One of the most powerful fraud-busting teams that SSA has is the cooperative disability investigations unit. It is—it links with the inspector general, with local law enforcement, and front-line SSA staff. They are highly effective. In 2012 alone, these fraud busters prevented \$340 million in fraudulent Social Security payments. Most importantly, fraud prevention is built in to Social Security’s day-to-day operations.

As I said—I ask again. Who was it that uncovered the fraud conspiracy in New York? SSA front-line staff. Who was it that uncovered the conspiracy in Puerto Rico? SSA front-line staff. Day in, day out, Social Security workers are standing guard.

The recent fraud cases were sophisticated conspiracies, involved recruiters who sought out individuals to willingly falsify applications for benefits, colluding doctors willing to provide fraudulent medical evidence. Defrauding the disability insurance program, as in these conspiracies, requires criminal collusion, criminal collusion from doctors and other persons in positions of trust.

The New York City conspiracy, if you can believe it, again, required former police officers who recruited others to lie, an attorney willing to submit false claims, doctors willing to provide fake evidence, and applicants willing to undergo fake treatment for a year to make it look like they were genuinely disabled.

Social Security’s front-line employees are trained to spot and prevent fraud. Every employee, from the newest hire to the long-term veteran, attends fraud referral training every year, and is alerted to potential fraud tip-offs via a monthly bulletin. The vast majority of disability insurance beneficiaries, let’s remember, are honest, hard-working Americans who earned their benefits through hard work, and now they need them to live on.

To put it in perspective, last year, about 11 million people received Social Security disability insurance, and about 1.8 million applied for disability benefits. That same year, Social Security Administration front-line staff made over 22,500 referrals for sus-

pected disability fraud. The IG opened formal investigations on 5,300 cases, and referred 100 to the attorney—a U.S. Attorney’s office for prosecution. As you can see from these statistics, the vast majority, 99.9 percent of disability beneficiaries, are hard-working Americans who earned their benefits.

So, Mr. Chairman, let me begin to close by saying this. We know that the number of disability insurance recipients has increased. But everyone who has looked at this has told us it is not so much because of fraud, it is because the Baby Boomers, we are retiring, and we are beginning to use our Social Security or our Social Security disability benefits. Women, over the last decades, have begun to join the workforce, and now they are becoming Social Security recipients or disability insurance recipients. So the chief actuary has told us that you don’t even calculate, in the reason for the growth in the disability insurance population, the issue of fraud.

So, let’s go full steam ahead to investigate fraud, but let’s not say that that is what is driving the fact that honest, hard-working Americans are now using their disability benefits. Let’s go after the frauds, let’s go after those who are willing to take away the taxpayer dollar. But let’s not deprive those who have earned it, and now should receive it.

And finally, Mr. Chairman, as we go about deciding how to go out there and detect this fraud before it can ever happen, let’s not under-staff the very people at the front lines who detect it first. Let’s not tie the hands of Social Security to find the fraud by continuing to cut their budget over \$1 billion in the last year or two. That New York City office that detected the fraud, today they have fewer people on the front lines working than they did back in 2008, when they detected the fraud.

If we don’t want to see fraud, we can’t take the fraud busters off the front line. And so, let us work together to detect the fraud, but give Social Security the resources and personnel it needs to continue to be the defenders of a good working program for all Americans.

Mr. BECERRA. And, with that, Mr. Chairman, I yield back.

Chairman JOHNSON. Thank you, Mr. Becerra. As is customary, any Member is welcome to submit a statement for the hearing record. And, before we move on to our testimony today, I want to remind our witnesses to please limit your oral statements to five minutes. However, without objection, all of the written testimony will be made part of the hearing record.

And before I introduce our witnesses, I want to recognize two important people who are in our audience today from the Manhattan District Attorney’s office: Cyrus Vance, Jr., a District Attorney; and David Szuchman, Executive Assistant, District Attorney, and Chief of the Investigation. Thank you all for being here.

On behalf of all Americans, I want to thank you and your staffs, along with the federal agents from the Social Security Inspector General’s staff, the detectives from the New York Police Department, the New York State Attorney General’s office, other state and local law enforcement agencies that have assisted in the arrests, and the employees of the New York State Disability Determination Services, and the Social Security Administration. Thank you for your tireless work in bringing these defendants to justice.

We will now return to our hearing. And I am suspending our usual witness order protocol by asking the Honorable Patrick O'Carroll, Jr., Inspector General, Social Security Administration, to testify first, given the hearing's focus on the New York fraud scheme, and the primary role of the Inspector General and federal agents in this investigation. Mr. O'Carroll is accompanied by Edward Ryan, Special Agent in Charge, New York field division, Office of the Inspector General, Social Security Administration. And next is—next to him is Honorable Carolyn Colvin, Acting Commissioner of Social Security Administration.

Mr. O'Carroll, welcome, and thanks for being here again. Please go ahead.

**STATEMENT OF PATRICK P. O'CARROLL, JR., INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY EDWARD RYAN, SPECIAL AGENT-IN-CHARGE, NEW YORK FIELD DIVISION, OFFICE OF THE INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION**

Mr. O'CARROLL. Good morning, Chairman Johnson, Ranking Member Becerra, and Members of the Committee. Thank you for the invitation to testify today. I am joined by Special Agent in Charge Edward Ryan from our New York field division. I am also joined here today with the district attorney for Manhattan, Cyrus Vance, Jr., without whom this case may never fully have come to light.

The man you see on the TV screen is Louis Hurtado. Mr. Hurtado was an NYPD officer until 1988, when he left the force on a disability pension. In 1990, he applied for Social Security disability benefits, using a man named Raymond Lavallee as his attorney. In 1991, he was awarded benefits, including a lump sum retroactive payment of almost \$19,000. He continued to receive as much as \$1,700 in benefits every month, until they were suspended this week. In all, he received about \$475,000 from SSA. For much of this time, he owned and operated the VIP Black Belt Champions Training Center. He taught and performed martial arts, and you can see him in his activities in this video.

While we have more evidence than this clip, I am sure you will agree that running a business like this is inconsistent with his claim that he can't perform any work in the national economy. He is just one of 102 disability beneficiaries in this case. You will see pictures of some of them appear as I talk, who were recently indicted for fraud, and all but one has been arrested.

It is alleged that these 102 beneficiaries, most of them retired New York City public safety officials, were able to fraudulently obtain disability with the help of four men: Raymond Lavallee, an attorney; Thomas Hale, a disability consultant; Joseph Esposito and John Minerva, who are retired NYPD officers who acted as facilitators and recruiters.

The alleged scheme worked like this. A public employee on disability pension would contact Esposito or Minerva, who explained what the applicant needed to do to get SSDI for mental impairment, including coaching them on dealing with doctors, and then referred them to Hale. Hale further coached the applicant on how to appear mentally disabled, how to act, and what to say. About

half of the applicants alleged stress from their work on 9/11, which caused the impairment, then referred them one of the two doctors and to Lavallee.

After a year of mental health treatment, Lavallee would submit the disability application, and the person would be awarded SSDI, including a large lump-sum check for the year they were undergoing the treatment. Although the law generally limits attorneys to a fee of no more than \$6,000, Lavallee and the other conspirators charged a fee equal to 14 months' worth of benefits, often more than \$40,000, and accepted only cash as a payment. Esposito would instruct the clients to withdraw cash from their banks in amounts under \$10,000 to avoid IRS detection, and then have them bring the cash to him. He would then split the cash with his partners.

It was a lucrative business. When we executed search warrants on these four men, we found large amounts of cash in their homes and in their safety deposit boxes. For example, one safety box alone—safety deposit box alone held \$650,000. Another one held \$42,000 in cash, 28 gold coins, and 5 silver platinum bars.

We began this investigation in 2008, after our New York CDI unit received a number of allegations from the New York DDS. It was a complex and lengthy investigation, but after a successful undercover operation, court-ordered wire taps, search warrants that I mentioned earlier, and working closely with the NYPD and the Manhattan district attorney's office, we were able to obtain all 106 indictments. This investigation is ongoing and very active; there will be likely more arrests to come.

The SSDI program relies to some extent on honesty and integrity of the applicant. When that fails, it relies on the integrity of attorneys and doctors. When all those fails, fraud becomes a real possibility. Luckily, there are lines of defense, including the talented employees of SSA and the DDSs, anti-fraud measures like the CDI program, which led to this investigation, and law enforcement agents like the ones who put countless—hundreds of hours into this investigation.

I can't say enough about them or the unflagging cooperation and support of the Manhattan DA's office and the NYPD. It was gratifying to sit in the courtroom in Lower Manhattan last week and see those who defrauded SSA brought before a judge in the first step of the judicial process. This is obviously a very short version of a long and successful story.

SAC Ryan and I are happy to answer any questions that you have. I thank you for this hearing.

[The prepared statement of Mr. O'Carroll follows:]

Good morning, Chairman Johnson, Ranking Member Becerra, and members of the Subcommittee. Thank you for inviting me to discuss our investigation of a vast New York City-based Social Security Disability Insurance (SSDI) fraud scheme, and the vulnerability of Social Security programs to similar criminal enterprises.

### **Introduction**

On January 7, 2014, my office, in coordination with the Manhattan District Attorney's Office and the New York City Police Department (NYPD), began making arrests of 106 indicted individuals for their alleged involvement in a vast, longstanding scheme to defraud the Social Security Administration (SSA) out of millions of dollars.

The 106 people indicted include 102 disability beneficiaries and four middlemen, or facilitators—two 'recruiters,' an attorney, and a disability consultant. To date, 105 beneficiaries have been arrested, including the four facilitators. All have been charged with varying degrees of grand larceny. Additional indictments and arrests are expected in the coming months as we continue this investigation.

Through December, the total amount of fraudulent disability benefits allegedly taken from SSA by the 102 beneficiaries named in the January 7 indictments exceeds \$23 million; the total loss to SSA as a result of this conspiracy, however, is expected to be much more. As I said, our investigation continues.

The SSDI program necessarily relies to some extent on the integrity of applicants. Honesty, self-reporting, and forthrightness only go so far, however, so that reliance is then checked by the expectation of integrity on the part of attorneys and claimant representatives. Even when that expectation fails, the integrity of medical professionals serves as the next line of defense. When all of these fail, however, the vulnerability of the system can be exploited, as we saw in Puerto Rico, and now allegedly in New York.

As we also saw in both Puerto Rico and New York, however, there is another critical line of defense—the employees of the State Disability Determination Services (DDS) and of SSA, who bring to the attention of the Office of the Inspector General (OIG) suspicious applicants, applications, and beneficiaries. Both investigations began because these dedicated professionals saw something, and said something.

Before I describe the New York conspiracy and how it was ultimately exposed, I have to note that as disturbing as the Puerto Rico scheme was—or any scheme in which applicants, doctors, attorneys, and in other cases, even judges or SSA employees, deceive and manipulate—it is all the more upsetting when the applicants are former guardians of the public trust, such as law enforcement officers and other public servants who constitute the majority of the New York defendants. Moreover, the exploitation by many of the defendants in this case of the tragic events of September 11, 2001 is nothing short of infuriating. To do so makes a mockery of the lives lost that day and the heroism and integrity of the NYPD and Fire Department of New York City (FDNY) personnel who were there during and after the attacks. Our own agents were at Ground Zero that day, working on the rescue operation alongside the NYPD and FDNY, and our New York Cooperative Disability Investigations (CDI) unit, located at 22 Cortlandt Street—adjacent to the World Trade Center site—was severely damaged in the attack. Our

respect for the NYPD and FDNY is in no way diminished by these indictments, nor should their reputations be besmirched by the actions of these defendants.

Finally, while this investigation and arrest operation is another example of the fine work of our investigators and our cooperative efforts with SSA and other law enforcement agencies, the revelation of the scheme is also a stark reminder of the vulnerability of Social Security's disability programs, when both applicants and facilitators are willing to steal from the taxpayers and from the beneficiaries who actually need and deserve these critical benefits.

I'm joined today by Special Agent-in-Charge Edward J. Ryan, from our New York Field Division, to discuss with you the investigation and actions that we, SSA, and the Subcommittee can take to protect taxpayer funds from large-scale fraud and abuse such as this.

### **The Investigation**

The investigation of this conspiracy dates back to 2008, after New York State DDS employees had noticed similarities in several questionable disability applications from retired NYPD officers, FDNY, and others. Dating back a number of years, the DDS had referred several cases to the CDI unit involving NYPD and FDNY employees on disability retirement for a physical disability, now applying for SSDI for a mental disability. Some of the applicants had the same legal representation, the applications had the same handwriting, and they contained nearly identical descriptions of mental ailments. While the CDI unit investigated several of these allegations independently, there was not enough evidence to provide a compelling case for a conspiracy.

Moreover, while the CDI unit suspected that a common scheme might be involved, the referrals were of applications (which meant that no government money had been lost), so both Federal and State prosecutors declined to pursue criminal prosecutions.

After considering a number of approaches for expanding the scope of their review to identify more applicants and, more importantly, beneficiaries, who might be involved in a common scheme, the CDI unit decided to focus on the fact that they were dealing with retired NYPD officers. Knowing that a majority of retired police officers seek permits to carry concealed weapons, and also knowing that a permit holder must certify to the NYPD that they have no mental impairments (while an applicant for SSDI for a mental disability would obviously be swearing to the opposite), the CDI unit submitted the names of three individuals to the NYPD licensing division (LD). Mindful of privacy rules, they told the LD only that they had reason to believe that these three individuals might be unqualified to hold a gun permit. The NYPD informed us that all three were permit holders. Only then did we share with NYPD the fact that they were receiving benefits for a mental disability and were under investigation—and now under a joint OIG/NYPD investigation.

Between 2008 and 2011, we went on to check some 51 suspicious mental disability cases with the NYPD's licensing division. Forty-one had concealed carry permits and were receiving benefits for a mental disability; all had remarkably similar ailments and applications. As the permits were suspended and some licensees fought the suspension, more and more details of the potential Social Security conspiracy came to light.



We contacted the U.S. Attorney for the Southern District of New York in 2009, and while they agreed initially to prosecute, they later decided not to pursue the case. At about the same time, in 2010, the Manhattan District Attorney's Office (MDAO) was investigating one of our disability fraud subjects in a separate matter. After we briefed them on our growing conspiracy case, the MDAO agreed to prosecute.

While the evidence we'd gathered through the administrative appeals before the NYPD LD gave us a good idea of the nature of the conspiracy, we needed more to proceed to indictment, or even to obtain search warrants. For this, we knew we would need someone on the inside. After considerable difficulty identifying a viable undercover operative (since the facilitators would be mistrustful of anyone outside of their limited pool of potential clients), we launched an undercover operation in 2011 in conjunction with the NYPD Internal Affairs Bureau.

This filled in still more gaps in the conspiracy, and provided evidence sufficient to obtain court orders for telephone intercepts. That additional evidence, combined with hundreds of surveillances and the review of thousands upon thousands of pages of SSA records, brought the case close to prosecution.

Search warrants were obtained and executed in 2013, providing the physical evidence—including records, cash, and property—that was needed to support prosecution. At that point, the evidence was presented to a Grand Jury, indictments were returned, and last week, the arrests began.

#### **The Facilitators**

Our investigation revealed that these four individuals allegedly led this widespread fraud scheme:

- Raymond Lavallee, 83, of Massapequa, New York, is a self-employed attorney and a registered claimant representative with SSA. He previously served as an FBI agent in the 1950s, and later as an Assistant District Attorney and Chief of the Rackets Division of the Nassau County District Attorney's Office.
- Thomas Hale, 89, of Bellmore, New York, is the chairman and president of TJH, Inc., a disability consultancy firm based out of his residence. Lavallee registered the firm for Hale with the State of New York in 1985.
- Joseph Esposito, 70, of Valley Stream, New York, was employed with the NYPD from 1973 to 1990. SSA records show Esposito filed for SSDI based on "mood disorders" in October 1991, and he has received almost \$300,000 in benefits for himself, an additional \$114,000 for his three children, and an additional \$13,000 for his wife.
- John Minerva, 61, of Malverne, New York, was employed with the NYPD from 1973 to 1984. He currently serves as a disability consultant for New York's Detectives' Endowment Association, a union representing New York City police.

#### **The Scheme**

The details of the alleged scheme are as follows:

Upon retiring from the NYPD or FDNY (a few of the defendants are other public employees), retirees would contact Esposito or Minerva, who were known within the New York City law enforcement community as men who could assist individuals in obtaining disability or retirement benefits. Esposito and Minerva were the recruiters, and generally instructed the potential applicants that, in order to obtain SSDI, their claim needed to include a psychiatric illness; and that they could create a convincing version of such an illness based on events that occurred while they were working, such as the September 11, 2001 terrorist attacks.

Once they had a new client reeled in, Esposito and Minerva would connect applicants with Hale, a disability consultant who would schedule the applicant with a psychiatrist or psychologist. Since a qualifying disability must be expected to last for a year or more (or result in death), these applicants would generally undergo treatment for a full year before applying. This medical evidence would be included in the applicant's SSDI claim, which would be completed and filed by Hale and by Lavallee, who would be the applicant's attorney of record.

Esposito instructed applicants to exhibit symptoms of depression, anxiety, and related disorders during doctor visits. He coached them on how to act at an SSA consultative examination: how to dress, how to behave, and how to fail a concentration test. Finally, he coached them on specific claims to make, such as that they couldn't concentrate or sleep, didn't go out, and even that they were afraid of planes and large buildings, if they were claiming to be disabled based on their participation in the events following the 9/11 terrorist attacks.

As the case expanded to encompass more and more claimants, we found that all of their benefit applications followed a distinctive and common pattern in style, content, and phrasing, as well as the same handwriting. Even after applicants were awarded benefits, they were coached on how to report their conditions and to continue receiving treatment from the same New York doctors, even if they relocated away from the New York City area, to demonstrate that their conditions never improved and they could not be gainfully employed.

Because they were treated for a year before even applying for benefits, their ultimate SSDI award included a lump sum retroactive benefit payment from the alleged disability onset date. These lump sum initial payments were between \$10,000 and \$50,000.

The law currently limits a representative's fee to \$6,000 of an applicant's lump-sum retroactive benefit, and with Lavallee listed as the attorney of record, he would generally receive a payment of \$6,000 directly from SSA. However, the agreed-upon "fee" paid to the facilitators by these fraudulent beneficiaries was generally 14 months' worth of benefits, as much as \$45,000.

To make these payoffs, Esposito instructed applicants to withdraw cash from their banks in small amounts so as not to trigger IRS reporting requirements or any suspicions on the part of their financial institutions. The applicants would then make cash deliveries to Esposito and/or Minerva of an amount equal to 14 months' worth of benefits, less the \$6,000 Lavallee had already received from SSA. Esposito and Minerva would then split the cash with their co-conspirators.

As for the fraudulent beneficiaries themselves, they would continue to keep all of their monthly benefits for years to come. The investigation and evidence revealed that the applicants often engaged in lifestyles and activities that did not match representations made on their SSDI applications. They held jobs, managed finances, traveled, socialized with friends, and (to their ultimate detriment) were not shy about sharing descriptions, videos, and photos of many of these activities online.

Some of the beneficiaries indicted last week received benefits over time in excess of \$400,000.

As I've said several times, this investigation is very much ongoing and active. We are limited to some extent by applicable statutes of limitations, and by the fact that some of the indicted individuals were placed on benefits at a time when claim folders were still entirely paper records. But we continue to investigate, and even if some escape criminal prosecution, SSA will be reviewing every possible application connected with this scheme, and ill-gotten gains will be pursued and recouped to the greatest extent possible.

#### **OIG Integrity Efforts**

Our auditors have examined, and continue to examine, many aspects of the disability claims process, seeking to identify areas of weakness and vulnerability so that we can make high-impact, valuable, and feasible recommendations to SSA for changes that will improve the process and prevent fraud. That said, it is impossible to claim that any one recommendation or audit report holds the key to preventing this type of large-scale, organized fraud against a program with complex rules and regulations as well as multiple agencies and personnel involved in decision-making. Nevertheless, we continue to believe that of all SSA integrity activities, its continuing disability reviews (CDR)—and its efforts to complete as scheduled all such reviews that come due—offer the best way to ensure that only those who are eligible for SSDI benefits continue to receive them; and potentially to identify those who were *never* eligible for them.

In our report, *Full Medical Continuing Disability Reviews*, we recommended that SSA work with the Congress to secure funding to eliminate the CDR backlog. SSA agreed with our recommendation; however, the CDR backlog continues to grow. SSA's goal based on its FY2013 budget request was to conduct 650,000 full medical CDRs, but given the actual funding it received, the Agency has reported that it conducted 428,568. SSA expected a backlog of 1.3 million full medical CDRs to remain at the end of FY2013.

Also, we are currently assessing SSA's adherence to the medical improvement review standard (MIRS), and its impact on the beneficiary rolls. During a CDR, SSA follows MIRS – mandated by the Social Security Disability Amendments of 1984 – to determine if a beneficiary's impairment has *improved* since his/her most recent favorable determination and can perform work activities. However, if SSA mistakenly placed the individual on disability in the first place—if they were not disabled when the favorable determination was made—MIRS makes it difficult for SSA to take the person *off* disability, because under current law, there is *no medical improvement*. Based on our sample, it appears that some individuals would not be disabled under SSA's rules were MIRS not in place. Our report is still ongoing; we expect to issue it later this year.

On the investigative side, we have always placed a high priority on allegations of disability fraud committed by participants in the claims process, including administrative law judges, other SSA employees, and third-party facilitators such as attorneys, physicians, and others. However, in light of our recent investigations exposing large-scale schemes, we have added even more emphasis, using existing as well as new initiatives. First, this Subcommittee is well aware of the success of our CDI program over the past 15 years. It remains our most effective tool for preventing improper payments, but this case reveals the true potential of the CDI program.

The traditional CDI case involves an individual application referred by the DDS as suspicious, and a CDI investigation that finds evidence of fraud and helps DDS or SSA personnel make an accurate decision on the disability claim. Without in any way denigrating that process, which saves taxpayers millions of dollars a year, CDI units are also in a unique position to investigate and dismantle schemes and conspiracies such as this one, just as DDS analysts are in a unique position to question the suspect applications as they are processed.

The CDI program's potential is limited only by available resources, and we continue to advocate expansion of the program to all 50 states, just as we have done for well over a decade. While increased and dedicated appropriations are certainly one way to expand CDI, we have also long supported the creation of an integrity fund so that CDI can fund itself, using a portion of savings realized by CDI to fund more CDI units.

Operating as an extension of our CDI program, our new Disability Fraud Pilot seeks to identify high-dollar, high-impact cases involving third-party facilitators conspiring with claimants to defraud SSA. The pilot team is evaluating allegations received, and exploring ways to compile and analyze data that could give us insight as to how to proactively identify disability claims that might be fraudulent or might involve a corrupt facilitator or even an employee. We will evaluate the Pilot at the end of this fiscal year and potentially expand its staffing and scope at that time.

Unfortunately, our ability to detect schemes like the New York and Puerto Rico conspiracies is hampered by the ongoing lack of an exemption from the outdated requirements of the *Computer Matching and Privacy Protection Act* (CMPPA) and the *Paperwork Reduction Act*. While legislation granting an exemption has been introduced in the last several sessions of Congress, none has passed—although the OIG for the Department of Health and Human Services (HHS) has obtained its own CMPPA exemption. Without our having the ability to search and compare readily available databases to detect large-scale fraud, conspiracies such as this one will continue in many cases to be profitable endeavors. If, for example, we were to try to extend what we learned in this case to other public-sector pension programs across the country, we would be stopped cold by the requirements of the CMPPA, which would either delay the project while we attempted to execute dozens of matching agreements; or would fail if the agreement could not be obtained. Technology gives us the potential to save untold millions of dollars and dramatically reduce fraud in SSA programs; current law takes away that potential.

The CMPPA exemption would also take two very good OIG initiatives—our Disability Fraud Pilot, which I just described, and our Electronic Intelligence Center—and radically expand their potential. Both rely heavily on the ability to obtain and analyze electronic information, yet the law prohibits us

from comparing one set of data to another. The time has come to exempt the OIG from 26-year-old requirements that were outdated more than a decade ago.

Similarly, the *Paperwork Reduction Act* makes it virtually impossible for us to conduct certain audits in a timely and effective fashion. Unable to ask a group of beneficiaries multiple questions without clearing time-consuming bureaucratic hurdles, we are often forced to abandon audits that could result in millions of dollars in savings.

Finally, we were fortunate in this case to have the unflagging support not only of the NYPD, but also of the MDAO. Criminal prosecution, however, is not always a feasible option, whether due to monetary thresholds that we cannot meet, or the many intangible variables inherent in the process by which prosecutors decide which cases to accept. When we can't prosecute a case, the OIG's Civil Monetary Penalty program provides a valuable means of punishment, deterrence, and recovery of lost funds. Unfortunately, the penalty amount—\$5,000—has not increased in the nearly two decades since the legislation creating these penalties was enacted. While other civil monetary penalties are tied to consumer indexes to take inflation into account, ours have remained stagnant. We would suggest that the time has come to tie these penalties to inflation indexes, and to consider higher penalties for third-party fraud facilitators such as doctors and lawyers than for beneficiaries.

In the interim, we will of course continue to work—hard—with the resources we have. I've already mentioned CDI, our Disability Fraud Pilot, and our Electronic Intelligence Center. We have also launched a joint project of our Offices of Investigations and Audit to examine trends among claimant representatives and disability application allowances to confirm that representatives with success rates that deviate significantly from the norm are just good at their jobs, rather than something more sinister.

#### **Conclusion**

The arrest operation in New York is the culmination of a lengthy and complex investigation into a widespread disability fraud scheme among a group of facilitators and numerous beneficiaries, and is evidence of the OIG's continuing and even increasing focus on large-scale, facilitator-based fraud.

The scope of this fraud scheme is vast and disturbing to me and my office, and we will likely see more arrests of beneficiaries involved in this conspiracy, as well as other cases arising from the work of the Disability Fraud Pilot and the CDI program.

We are committed to identifying and pursuing all forms of disability fraud, as this and other recent large-scale investigations demonstrate. We will continue to do everything we can, as resources allow, to identify these schemes and pursue prosecution of all individuals who abuse government programs and waste taxpayer funds, while simultaneously conducting audits and evaluations of SSA's disability program to reduce its vulnerability to fraud.

Thank you again for the opportunity to testify today, and I'd be happy to answer any questions.

Chairman JOHNSON. Thank you. We appreciate your testimony. Commissioner Colvin, I appreciate you being here. And I didn't introduce your associate, Bea Disman; thank you for being here, as well. You are recognized.

**STATEMENT OF CAROLYN COLVIN, ACTING COMMISSIONER, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY BEATRICE M. DISMAN, REGIONAL COMMISSIONER, NEW YORK REGION, SOCIAL SECURITY ADMINISTRATION**

Ms. COLVIN. Chairman Johnson, Ranking Member Becerra, Members of the Subcommittee, thank you so much for this opportunity to discuss our front-line employees' role in uncovering the disability fraud conspiracy in New York. My name is Carolyn Colvin, and I am Social Security's Acting Commissioner. I have served in this position since February of 2013. I am joined by Beatrice Disman, our Regional Commissioner for the New York Region. Ms. Disman is available to answer questions you may have about the case.

Like you, I am offended whenever anyone attempts to defraud the government. I am especially outraged by the details of the fraud conspiracy in New York. In this case, an attorney and several others fabricated medical history to defraud the government of millions of dollars in disability benefits. Most of the false claims involved former firefighters and police officers. Some even alleged disabilities that they said arose from the tragic events of 9/11. Frankly, I am disgusted by this betrayal of the public trust, and I applaud the Chairman for shining a light on our work to root out fraud.

On behalf of every employee at SSA, I am putting the criminals on notice. We will find you, we will prosecute you, we will seek the maximum punishment allowable under the law, and we will fight to recover the money that you have stolen.

Social Security has zero tolerance for fraud. Moreover, this case in New York touches a very special nerve. As you can imagine, criminals invoking the memory of 9/11 to masquerade as disabled is deeply personal for our employees in the New York Region. Not only are the New York Regional Office and the New York DDS located within blocks of Ground Zero, but many of our employees were working at the time of the attack, and were fortunate to escape with their lives. Many of those same employees also returned to work in emergency outposts throughout the city to accept survivor claims from the families of the deceased.

As the investigation unfolds, I could not be prouder of our employees at SSA, the New York DDS, and the office of Inspector General. They worked cooperatively to flag the fraudulent cases, connect them to a criminal conspiracy, and build the cases for prosecution. Partnership with state and federal law enforcement has likewise been essential. We owe a special debt of gratitude to the diligent employees of the New York DDS, who are funded and trained by SSA to make disability determinations and to identify fraud.

These employees originally referred fraudulent cases involved in the conspiracy to the OIG. Over time, the OIG began to notice patterns in the referrals. The New York Cooperative Disability Inves-

tigation unit, one of the original five CDI units established in 1998, was critical to connecting the individual cases to a criminal conspiracy. To date, the Manhattan District Attorney has indicted 106 individuals for their crimes.

According to our estimates, the fraudulent payments totaled \$23.2 million to 102 disability beneficiaries and their auxiliaries. We have already suspended these individuals' benefits, and we will move aggressively to recover any overpayments.

While our data show that the level of fraud in the disability program is less than one percent, even one case of fraud is too many. The best way to ensure we continue stopping fraud is to invest in our employees. Last year, they made over 22,500 disability fraud referrals to OIG. Regrettably, Congress has not fully funded our employees' good work. In fact, since Fiscal Year 2012, Congress has appropriated \$421 million less for program integrity reviews than what it authorized for us in the Budget Control Act.

Recent news that Congress may fully fund our program integrity budget in 2014 is a step in the right direction. These resources would help to ensure that only those persons eligible for benefits receive them. However, I must caution that eliminating the CDR backlog and reversing the negative effects of past years of underfunding require a multi-year commitment. The net effect of budget cuts over the past three years has been the loss of about 11,000 employees. That means drastically fewer people standing watch for the next attempted theft, and drastically fewer people available to serve those who truly need us. Fewer people to handle mounting workloads also jeopardizes our exceptionally high payment accuracy, which is 99 percent or better in the Social Security disability program.

We are proud of these results, and we will continue delivering them with your support. Thank you. Ms. Disman and I will do our best to answer any questions you have, with the understanding that the fraud case is an active investigation.

[The prepared statement of Ms. Colvin follows:]

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee:

Thank you for this opportunity to discuss our partnership with the Office of the Inspector General (OIG) to root out disability fraud wherever it may occur.

My name is Carolyn Colvin, and I have served as the Acting Commissioner of the Social Security Administration (SSA) since February 2013. Prior to assuming my current position, I served as the agency's principal Deputy Commissioner. I also worked in several other positions, both inside and outside Government, in which I managed programs that help people with their healthcare and financial needs.

Throughout my career, I have met people from all walks of life who struggle to cope with severe disabilities. Whether their impairments are mental or physical, by birth or circumstance, these individuals face extraordinary challenges in providing for themselves and their loved ones. Little, if any, publicity documents the quiet struggle in the day-to-day lives of these remarkable individuals, but we must never forget them. They are the true face of disability in this country.

Unfortunately, the criminal mind knows no shame. While I am outraged whenever anyone attempts to commit fraud against the Social Security disability program, I am especially disgusted by the criminal conspiracy that our employees uncovered in New York. In this case, an attorney and several others fabricated medical history to defraud the U.S. Government of millions of dollars in disability benefits. Most of the false claims for benefits involved former fire fighters and police officers who claimed to be disabled in the line of duty, including disabilities claimed to arise from the tragic events of September 11, 2001.

As you can imagine, criminals invoking the memory of 9/11 to masquerade as disabled is deeply personal for our employees, especially those in the New York Region. Not only are the New York Regional Office and the New York Disability Determination Services (DDS) located within blocks of Ground Zero, but many of our employees were working at the time of the attack and were fortunate to escape with their lives. Soon thereafter, many of those same employees returned to work in emergency outposts throughout the city to accept survivor claims from the families of the deceased. One of those employees was Beatrice Disman, our Regional Commissioner for the New York Region. Bea led our agency's response to the aftermath of 9/11 and personally accepted a claim from a widow at Police Plaza. There, Bea met the father, a retired New York City fire fighter, and widows of two brothers who died in the attack—one a firefighter, the other a police officer. Bea joins me today to answer any questions you may have about our cooperation with the fraud investigation, which remains active and ongoing.

As the investigation unfolds and the perpetrators are brought to justice, I could not be prouder of our employees at SSA, the New York DDS, and the OIG. They worked cooperatively to flag the fraudulent cases, connect them to a criminal conspiracy, and build the cases for prosecution. Partnership with State and Federal law enforcement has also been essential.

Without question, we owe a special debt of gratitude to the diligent employees of the New York DDS, who are funded and trained by SSA to make disability determinations. These employees



referred fraudulent cases involved in the conspiracy to the OIG as far back as 1999.<sup>1</sup> After 9/11, the volume of the fraudulent claims increased significantly. Over time, the OIG began to notice patterns in the referrals. In 2008, as a result of a number of investigations stemming from referrals by the alert DDS employees, the New York Cooperative Disability Investigations (CDI) unit identified a potential conspiracy involving third-party facilitators and claimants submitting similar medical documentation that appeared to fabricate or exaggerate disabling conditions. As the CDI investigators and analysts, together with SSA's New York Region staff, began digging deeper, it became apparent that this was a vast and longstanding criminal conspiracy.

To date, the Manhattan District Attorney has indicted 106 individuals for their crimes. According to our estimates, the fraudulent payments total \$23.2 million dollars to 102 disability beneficiaries and their auxiliaries, and we have already suspended these individuals' benefits. To provide some context on the scale of the fraud, over 1 million Social Security disability beneficiaries in the New York Region receive over \$1 billion in monthly benefits. Nationwide, about 11 million Social Security disability beneficiaries receive about \$12 billion in monthly benefits.

We will move aggressively to recover any overpayments we assess after re-determining the entitlement of those involved in the New York fraud case, using tools such as court-ordered restitution, wage garnishment, and the diversion of any future federal income tax refunds. In addition, SSA and the OIG have established a special toll-free fraud hotline where individuals can report additional information connected with this indictment or other fraud situations. That toll-free number is 1-877-441-6012. Reports of fraud also may be sent to the OIG using the link <http://oig.ssa.gov/report>.

If we are to keep the incidence of fraud in the disability program low, we need support from both the public and Congress. The continued success of the fraud detection and referral process that Congress established between SSA and the OIG requires constant vigilance and input from all of our stakeholders. Working with the OIG, we must continually enhance our processes to stay a step ahead of the criminals.

Continued success also requires a sustained commitment of resources to ensure the integrity of the disability program. Over the past 2 years, Congress has appropriated \$421 million less for program integrity reviews than what it authorized for us in the Budget Control Act of 2011 (BCA). Over the past 3 years, we received an average of nearly a billion dollars less than what the President requested for our administrative budget. The net effect has been the loss of nearly 11,000 employees at Social Security—that means drastically fewer people standing watch for the next attempted theft and drastically fewer people available to serve those who truly need us. However, we are very pleased that the draft omnibus bill currently includes full funding of the fiscal year (FY) 2014 BCA level for SSA's program integrity reviews, which would allow us to significantly increase our continuing disability reviews (CDR), helping us save billions of taxpayers' dollars.

<sup>1</sup> Under the Inspector General Act of 1978, the SSA OIG is tasked with preventing fraud, waste, and abuse in SSA's programs and operations.

Fewer people at SSA to handle mounting workloads puts our record of exceptionally high payment accuracy at risk. In FY 2012, approximately 99.0 percent of all Social Security Disability Insurance payments were free of an overpayment, and approximately 99.8 percent were free of an underpayment. That same year, we also achieved high levels of payment accuracy in the Supplemental Security Income (SSI) program despite the inherent complexities in calculating monthly payments due to income and resource fluctuations and changes in living arrangements. We are proud of these results, and a sustained investment of resources in our workforce is essential for us to continue delivering them.

#### **Anti-Fraud Initiatives**

Because the investigation in New York is ongoing, my ability to discuss any more specifics of the case today is very limited. To the extent that providing more details would not jeopardize the investigation, both Ms. Disman and I will do our best to be responsive. I would also like to highlight for you the multiple anti-fraud activities that we have in place across the country.

As the dismantling of the fraud ring in New York has shown, our dedicated employees across the country are the first line of defense when it comes to combating fraud. They are highly trained professionals in the administration of the disability program, and they are in the best position to identify fraud, and refer any instances to our partners in law enforcement.

In fact, all of our front-line employees, including claims representatives in our field offices and disability examiners in the State DDSs, receive instruction in detecting potential fraud during their initial training program. Furthermore, all employees receive continuing training in the form of mandatory annual security reminders, programs and policy issuances, videos on demand, and office visits by executives from SSA and the OIG.

When our field office and DDS employees uncover potential fraud while performing daily responsibilities, we instruct them to report all (non-SSA employee) fraud allegations to the OIG Office of Investigations Field Division using the online electronic referral form, e8551. We provide periodic reminders to employees on how to complete the e8551, and maintain policy to instruct employees on its use.

Additionally, each region hosts a Regional Anti-Fraud Committee that meets to discuss and promote ongoing anti-fraud initiatives. The Committee sessions provide an opportunity to review the nature of the fraud referrals from SSA components and discuss techniques to encourage referrals and streamline our processes. Also, the Committees share ideas regarding areas that have potentially fraudulent activity that the OIG should examine.

On the back end, we support our employees' work with a series of anti-fraud initiatives that target the investigation and prosecution of fraud. Foremost among those initiatives are CDI units. Currently, there are 25 CDI units that investigate individual disability applications to identify beneficiaries and third-party facilitators who commit fraud. Each unit includes personnel from the OIG, SSA, DDSs, and local law enforcement. The value of these units is clear. If not for the New York CDI unit, which was among the first five units established in 1998, it may have been much more difficult to connect the individual fraud referrals from the

New York DDS to a criminal conspiracy. Moreover, according to the OIG, CDI units have produced SSA savings of more than \$860 million over the last 3 years. With this record of results, expanding the successful CDI program, if adequate and sustained resources are provided, offers substantial benefits in the fight against fraud.

In addition, in cases where Federal prosecutors do not take action on fraud cases presented by the OIG, our Office of the General Council agency attorneys may prosecute these cases instead. These attorneys serve as Special Assistant United States Attorneys in our 10 regional offices and at headquarters. From FYs 2003 through 2012, our attorneys secured over \$52.3 million in restitution orders and 921 convictions or guilty pleas. In FY 2013, they secured over \$8.9 million in restitution and obtained 139 convictions. There are currently 12 attorneys assigned to these cases.

Another anti-fraud tool we recently developed addresses the growing problem posed by identity theft and direct deposit fraud. Beneficiaries can request a block to prevent changes to their records to optimize security and prevent criminals from re-directing payments to a fraudulent account. From November 2012 through September 2013, nearly 7,000 beneficiaries had taken advantage of this option. We will continue to devise ways to prevent fraud and collaborate with the OIG to protect our customers' payments and identities.

Simultaneously, we continue to ramp up our program integrity reviews, as well as our quality assurance (QA) and overpayment recovery activities, which can help us to detect fraud and remediate its effects. All of our efforts have resulted in a very low incidence of fraud in the Social Security disability program. In fact, in FY 2013, over 22,500 disability fraud referrals were made to the OIG, of which the OIG opened about 5,300 cases and to date has referred over 100 to the United States Attorney's Office for criminal prosecution. That compares with, in FY 2013, over 1.8 million people who applied for Social Security disability, and, as referenced earlier, about 11 million people who received benefits.

#### **Increasing Program Integrity Reviews and Decisional Quality**

We are committed to protecting program dollars from waste, fraud, and abuse. The recent arrests in New York demonstrate how seriously we take our responsibility to maintain the public's trust by effective stewardship of program dollars and administrative resources. While we recognize that not all improper payments result from fraud, we work diligently to correct them and pursue them wherever they may lead.

An important part of our program integrity activities are periodic medical re-evaluations, called CDRs, which we use to determine if beneficiaries continue to be disabled over time.

The FY 2014 President's Budget included a special legislative proposal that would provide a dependable source of mandatory funding to significantly ramp up our program integrity work. These mandatory funds would replace the discretionary cap adjustments authorized by the BCA. These funds would be reflected in a new account, the Program Integrity Administrative Expenses account, which would be separate, and in addition to, our Limitation on Administrative Expenses

account. The funds would have been available for 2 years, providing us with the flexibility to aggressively hire and train staff to support the processing of more program integrity work.

Over the past several years, the annual appropriations process has not provided us with the resources necessary to conduct all of our scheduled CDRs. We estimate that the money spent on CDRs saves, on average, \$9 for every dollar invested, including savings accruing to Medicare and Medicaid, yet we have a backlog of 1.3 million CDRs due to budgetary shortfalls.

The draft FY 2014 omnibus bill, which was released earlier this week, would provide SSA with \$11.697 billion for our Limitation on Administrative Expenses account, including \$1.197 billion for program integrity work. The \$1.197 billion for program integrity is the same level authorized by the BCA. If we receive this funding, we will be able to complete more CDRs, allowing us to save billions of taxpayer dollars, and set the stage to complete even more CDRs in FY 2015.

This funding level also would allow us to replace some of the staffing losses we incurred over the last 3 years. From FYs 2011 through 2013 we lost nearly 11,000 employees. We would have more staff for both our important service and stewardship work.

In addition to program integrity reviews, strict adherence to our program rules improves our adjudicators' ability to identify fraud and reduces the potential for an improper payment. Accordingly, we provide training and take steps, such as multiple layers of quality review, to ensure that all of our employees apply our program rules uniformly and correctly. This fiscal year, we established a new review process called the Continuous Quality Area Director Review Process. This review will help ensure the accuracy of work completed by field office technicians. One of the areas reviewed will be front-end disability accuracy in field offices, with a concentration on the accuracy of how we determine the applicant's disability onset date. We intend to use the results of these focused reviews to identify systemic issues; recommend training, policy, and systems enhancements; and provide direct feedback to employees regarding their compliance with existing policy.

Having a scrupulous QA operation is critical to ensuring programmatic compliance. We require all of the DDSs to have an internal QA function. In addition, our employees conduct QA reviews of samples of the initial, reconsideration, and CDR determinations of the DDSs. Between FYs 2008 and 2013, QA reviews showed that the DDSs improved their accuracy across the board. The DDSs increased their initial claims decisional accuracy from approximately 94.4 percent to 96.0 percent. They increased their reconsideration decisional accuracy from approximately 92.1 percent to 95.3 percent. Moreover, they increased their CDR decisional accuracy from approximately 96.8 percent to 97.2 percent.<sup>7</sup>

As required by the Social Security Act, we also perform a pre-effectuation review of at least 50 percent of all DDS initial and reconsideration allowances for Social Security and SSI disability for adults. We also review a sufficient number of DDS CDR determinations that

<sup>7</sup> The percent is based upon a statistically valid sample of cases reviewed. It reflects the percent of cases reviewed where we agree with the decision made by the DDS.

continue benefits. These pre-effectuation reviews, which are separate from the reviews mentioned above, allow us to correct errors we find before we issue a final decision. In 2011, they resulted in an estimated \$751 million in lifetime program savings, including savings accruing to Social Security benefit payments, Medicare, federal SSI payments, and Medicaid. Based on our most recent data, the return on investment is roughly, on average, \$13 for every \$1 of the total cost of the reviews.<sup>3</sup>

To improve the consistency and quality of DDS decisions, we established the Request for Program Consultation (RPC) process. The RPC process allows DDSs and our quality reviewers to resolve differences of opinion they have on cases that we cite as deficient. In general, DDSs use the process to resolve the most complex cases. Our policy experts in headquarters thoroughly review these cases. We post all RPC resolutions and related data on our Intranet site, accessible to every disability examiner, medical consultant, and QA and supervisory staff. The process serves several key functions. It provides real-life examples of proper policy application, identifies issues and areas for improved disability policy, and provides our Regional Offices and DDSs information to assess local quality issues. Since 2008, we have reviewed over 6,200 cases and posted their resolutions online. Further, the RPC team has worked directly with policy components to develop policy clarifications, training, and other resources that I believe will further improve the consistency and quality of disability determinations at all adjudicative levels.

At the hearings level, we have also taken aggressive steps to institute a more balanced quality review. Our first effort in this area was to develop rigorous data collection and management information for the Office of Disability Adjudication and Review. We then revived development of an electronic policy-compliance system for the Appeals Council (AC). Because the Office of Appellate Operations (OAO) handles the final level of administrative review, it has a unique vantage point to give feedback to decision and policy makers. OAO developed a technological approach to harness the wealth of information the AC collects, turning it into actionable data. These new tools permitted the OAO to capture a significant amount of structured data concerning the application of agency policy in hearing decisions.

Using these data, we provide feedback on decisional quality, giving adjudicators real-time access to their remand data. We are creating better tools to provide individual feedback for our adjudicators. One such feedback tool is "How MI Doing?" This resource not only gives administrative law judges (ALJ) information about their AC remands, including the reasons for remand, but also information on their performance in relation to other ALJs in their office, their region, and the nation. We develop and deliver specific training that focuses on the most error-prone issues that our judges must address in their decisions. This kind of data-driven feedback guides business process changes that reduce inconsistencies and inefficiencies, and simplifies rules.

In FY 2010, OAO created the Division of Quality (DQ) in OAO to focus specifically on improving the quality of our disability process. While AC remands provide a quality measure on

<sup>3</sup> Details can be found in the Annual Report on Social Security Pre-effectuation Reviews of Favorable State Disability Determinations at <http://ssa.gov/legislation/PEER%20fy11.pdf>.

ALJ denials, prior to the creation of DQ, we did not have the resources to examine ALJ allowances. Since FY 2011, DQ has been conducting pre-effectuation reviews on a random sample of ALJ allowances. Federal regulations require that pre-effectuation reviews of ALJ decisions be selected at random or, if selective sampling is used, may not be based on the identity of any specific adjudicator or hearing office. Currently, DQ reviews a statistically valid sample of un-appealed favorable ALJ hearing decisions.

DQ also performs post-effectuation focused reviews looking at specific issues. Subjects of a focused review may be hearing offices, ALJs, representatives, doctors, and other participants in the hearing process. The same regulatory requirements regarding random and selective sampling do not apply to post-effectuation focused reviews. Because these reviews occur after the 60-day period a claimant has to appeal the ALJ decision, they do not result in a change to the decision.

Working alongside DQ is our Office of Quality Review (OQR), which provides another check on the quality of hearing decisions. OQR conducts an ongoing assessment of a national random sample of post-adjudication favorable and unfavorable decisions to determine and report on the accuracy of hearings at a national level. The findings from these OQR reviews provide additional data points to consider in improving the hearings operation.

Collaboration across all adjudicative levels is key to making high-quality disability decisions. The data collected from all of the quality initiatives that I have just described identify for us the most error-prone provisions of law and regulation. We use this information to adjust payments, strengthen business processes, improve training, spot trends, and clarify policy.

#### **Overpayment Recovery**

A major enforcement asset supporting our program integrity and QA activities is our debt collection program. It provides us many different avenues to make the taxpayer whole when a beneficiary is overpaid.

We collected \$3.46 billion in Social Security and SSI benefit overpayments in FY 2013 at an administrative cost of \$.07 for every dollar collected, and \$16.12 billion over a 5-year period (FYs 2009-2013). To recover overpayments, we use internal debt collection techniques (e.g., payment withholding, billing, and follow-up), as well as the external collection techniques authorized by the Debt Collection Improvement Act of 1996 for Social Security debts and the Foster Care Independence Act of 1999 for SSI debts.

Since 2004, our cumulative recoveries are \$27.66 billion for Social Security and SSI benefit overpayments. We suspend or terminate collection activity in accordance with the authority granted by the United States Code and the Federal Claims Collection Standards. Generally, when the debtor cannot repay, we are unable to locate the debtor, or the cost of collection is likely to be more than the amount recovered, we terminate or suspend collection action. Even though we terminate collection action by stopping our internal efforts, we continue to use our external collection techniques. Termination of collection action is a temporary or conditional write-off in that the debt remains on the person's record. If the debtor becomes re-entitled to benefits in the future, we will collect the debt by appropriate and available methods.

From inception in 1992 through September 2013, our external collection techniques have yielded \$4.713 billion in benefits recovered through a combination of overpayment recovery and prevention improvements. We developed a system to handle the Department of the Treasury's (Treasury) Treasury Offset Program (TOP), credit bureau reporting, and Administrative Wage Garnishment. Because the system includes more than TOP and is the basis for any future collection interfaces with agencies or entities outside our agency, we call it the External Collection Operation (ECO) system.

In September 2013, we enhanced ECO to collect delinquent debts through Treasury's State Reciprocal Program (SRP). Treasury's SRP allows States to enter into reciprocal agreements with Treasury to collect unpaid State debt by offset of Federal non-tax payments. In return, the agreements allow the Federal Government to collect delinquent non-tax debt by offset of State payments. In May 2012, we enhanced ECO to collect delinquent debts through TOP beyond the current 10-year statute of limitations, as authorized by Public Law 110-246. Through FY 2013, we notified 310,000 former beneficiaries with debts 10 years or more delinquent of our ability to collect their delinquent debt through TOP. Continued improvement in our debt collection program is also underway. As resources permit, we will expand the Non-Entitled Debtors program, and implement the remaining debt collection tools authorized by the Debt Collection Improvement Act of 1996. These tools include charging administrative fees, penalties, and interest or indexing of debt to reflect its current value. In addition, we will assess the use of private collection agencies in debt collection.

We are in the process of developing a notice of proposed rulemaking that would propose increasing the Social Security monthly minimum repayment amount from \$10.00 to 10 percent of the debtor's monthly benefit payment. This change would allow us to recover overpayments more effectively and better fulfill our stewardship obligations to the Disability Insurance Trust Fund. In addition, we will continue to expand our use of TOP by: 1) completing notification to all debtors with debts delinquent 10 years or more; and 2) continuing to notify debtors on a monthly basis of our ability to offset eligible State payments through Treasury's SRP to collect delinquent debt.

### **Conclusion**

My testimony has laid out the uncompromising efforts and rigorous processes that we are employing daily to detect and prevent fraud against the disability program and maintain the integrity of the programs we administer. Unfortunately, as the deplorable situation we uncovered in New York shows, there are despicable people who will chase a dollar at any cost—whether illegal or immoral. To those people, my message is clear: We will find you; we will prosecute you; we will seek the maximum punishment allowable under the law; and we will fight to restore the money you've stolen to the American people.

Our highest priority at SSA is ensuring that benefits are paid only to the right person, in the right amount, and at the right time. This guiding principle is ingrained in our agency culture and repeatedly emphasized in training sessions and alerts to the field. Without question, our highly trained employees remain vigilant for the next attempted theft from the taxpayer.

The Congress can take steps to support our employees' efforts in keeping the incidence of disability fraud low. This includes providing a sustained commitment of resources to ensure the effective operation of the disability program and fully funding program integrity. We need the Congress' support in order to ensure that the disability program continues to well serve the American public in need of its benefits, while protecting the program from those who would attempt to defraud and weaken it.



Chairman JOHNSON. Thank you for your testimony. We will turn to questions now. And I have one for Mr. O'Carroll.

The New York case is the latest of three disability fraud cases in less than two years. Can the American people expect more like this? Yes or no?

Mr. O'CARROLL. Chairman Johnson, we have got a number of investigations going on now involving—

Chairman JOHNSON. The reason I ask is can we expect more like this to surface, yes or no?

Mr. O'CARROLL. Probably.

Chairman JOHNSON. Okay. You are refusing to give me a yes or—

Mr. O'CARROLL. If you want a yes on it, yes. We have other investigations of—

Chairman JOHNSON. Okay.

Mr. O'CARROLL [continuing]. Magnitude.

Chairman JOHNSON. Thank you. Ms. Colvin, has anyone at your agency been held accountable for fraud conspiracy in West Virginia, Puerto Rico, or New York cases?

Ms. COLVIN. All of those cases are still open and active.

Chairman JOHNSON. You didn't answer my question, either. Are you holding anybody in your agency accountable, yes or no?

Ms. COLVIN. I think that my answer has to be that those are still open cases. We can certainly—

Chairman JOHNSON. So the answer is no. Has anyone been fired or disciplined for these fraud schemes?

Ms. COLVIN. There have been significant organizational changes in our West Virginia office. But, as I said before, those—

Chairman JOHNSON. Well, you got West Virginia, Puerto Rico, and New York now. Are you taking care of those areas, as well?

Ms. COLVIN. I think we need to let the investigation continue.

Chairman JOHNSON. You are not making any changes in the Administration. Is that true or false?

Ms. COLVIN. We are not making any changes in the Administration at all. There is no suggestion in my understanding that we need to do that at this time. I would prefer to see the investigation concluded, and we will make our decisions at that point.

Chairman JOHNSON. Well, you know it has been a long time coming. Those investigations have been going on for many years. It is not just something brand new.

Ms. COLVIN. We make the referral, Mr. Chairman. We don't determine the fraud or do the investigation. We simply make the referrals. And we make considerable referrals each year.

Chairman JOHNSON. Yes, but you are running the agency right now. And you note on page two of your testimony, "The continued success" of the fraud detection and referral process—you call success three scandals in two years, with the last two within six months of the same region?

Ms. COLVIN. Yes, I would call it success, because I think that anti-fraud activities have been very successful. Remember that it was our staff who uncovered those cases, and it was the Inspector General who was able to note patterns in those individual referrals that suggested conspiracy.

I still contend that the first line of defense are our well-trained employees, the DDS as well as the field office. They are trained to identify potential fraud, and they are doing just that. And, clearly, the reduction in the number of staff we have to watch the alert to potential fraud is a concern for us, because the numbers have substantially decreased.

Chairman JOHNSON. Well, it seems like it took an awful long time to uncover this last one.

On page two you state you will move to recover any overpayments from the New York fraudsters. You call these overpayments, but aren't they illegal payments? Yes or no?

Ms. COLVIN. I am sorry, you—

Chairman JOHNSON. The payments you made to those people in New York during all this, you call them overpayments. Weren't they illegal payments?

Ms. COLVIN. Bea.

Ms. DISMAN. Chairman, as in Puerto Rico, we can't make that determination now. I am actually waiting to get a release from the Manhattan District Attorney to start the re-review on the cases. As a result of the re-review, we will be able to make that determination. As I told you in Puerto Rico, in some of the cases that were involved, there is other medical evidence and other disabilities.

So, yes, we will be taking the same process as Puerto Rico. But right now you have the indictments and we have not been able to do that re-review of the cases.

Chairman JOHNSON. But it has been going on for years. It seems to me you should have been more aware of it.

Mr. O'Carroll, according to your testimony, U.S. Attorney for the southern district of New York ultimately declined to pursue the case. Thankfully, Manhattan's District Attorney agreed to take it. Why aren't federal prosecutors going after these crime rings?

Mr. O'CARROLL. Well, Chairman Johnson, we have taken a review of presentations on our investigations to U.S. Attorney's office. And I would say more than half of the time that we present to them, they do accept. Many times, the U.S. Attorney's offices have thresholds for the amount of fraud that is involved before they will authorize on a prosecution. And often times, with our cases, especially in the infancy of a case, it isn't that much, in terms of the dollar amount, to attract the prosecution of it.

And also, too, is that, with a lot of these things, it is cooperation. In terms of if we are using undercover agents or using other agencies to help us on an investigation, we will then have somewhat of an obligation to stay with the organization. In this case, here, it was a partnership with the district attorney's office. They were working in one direction, we were working another. We partnered, and we came up with a result. And we did keep the southern district of New York informed on it as we went along.

Chairman JOHNSON. Well, I appreciate that, and I thank you all for helping us in those instances.

Why don't federal prosecutors want to go after these kinds of crime rings?

Mr. O'CARROLL. Well, in terms of the—it is usually—it is a long, involved, complex investigation, would be the example of these, and—

Chairman JOHNSON. Too small a—

Mr. O'CARROLL. And the small ones, they are not interested in—usually, on it. What they will do is, if we can package them together, and make a presentation with a half-a-dozen or a dozen of these investigations, they will go. But—and often times, I guess when they are making a determination on, you know, charging someone with bank robbery or a disability fraud, it goes in—you know, they have their priorities.

And we—but I got to also tell you, Chairman Johnson, I go out personally and interview or meet with U.S. Attorneys across the country, discuss with them investigations that we have, explain to them the advantage of—the deterrent factor of doing it. And often times, it is just by talking to them we end up with prosecutions. So I am personally out there, talking to U.S. Attorneys, trying to get our prosecutions.

Chairman JOHNSON. Well, thank you for that. I think if we don't go after these crime rings, you know, the federal prosecutors are sending a message to professional crooks and the phony disabled that committing fraud pays off. Thank you for your testimony. I think we need to change that.

Mr. BECERRA, do you have questions?

Mr. BECERRA. Thank you, Mr. Chairman. And thank you all for your testimony. And may I just say congratulations on the work you have done to uncover this fraud, the conspiracies? And especially, Ms. Disman, to you, can you please express to all your front-line workers a sincere thank-you for stopping what had been a conspiracy that had run for quite some time? Very much appreciated. Very much appreciative of the fact that they are the ones, your staff are the ones that discovered this. They are the ones that moved forward.

And, Mr. O'Carroll, to the inspector general, I say thank you to you and your folks, working with New York City's district attorney and the local law enforcement authorities there in New York, for doing everything possible to follow up on the detection of the fraud, and now go after these folks. And, as the commissioner just said, now to go out and get back the money that taxpayers paid. That is very, very important.

I want to clarify something, as well. Ms. Disman, when the chairman asked you questions about have you taken back the money that some of these corrupt individuals got, and you are saying that is under investigation, I think you are essentially saying what we all know, is that, in America, you are presumed innocent until proven guilty. And not that we want any of these despicable people who held a position of trust, having been former police officers or former firefighters, that we want them to keep the money they don't deserve, it is just that, like any other American, before you can say, "You are a bad guy," we have got to prove it in court.

Ms. DISMAN. I absolutely agree with you in two respects. Number one, let me assure all of you, this is even more despicable to me, because of my role in September 11th. Let me also assure you that my people started to identify these cases right after we set up the continuing disability investigations unit in 1998. So, we were identifying individual cases in 1999, and referring them to the Office of the Inspector General. That is how they were able to put to-

gether the trail and the patterns that actually came together in 2008.

But having said that, we have—are abided by due process, we intend to do it. But make no mistake. As in Puerto Rico, we will get the money back. Once we review and determine the amount of the overpayment—and I also hope that, with the Manhattan District Attorney present, that part of sentencing after the trial will be to recover the money.

Mr. BECERRA. Yes, so—

Ms. DISMAN. So I think we have a dual approach to recover the money.

Mr. BECERRA. So I want to make sure that, on the record, it doesn't look like you are giving a bureaucratic response when you say, "The investigation is underway." It is just that you can't go out there and say publicly, as a government official, "Yes, these corrupt guys are guilty, and we're going to get the money." You are judging them before they have had their day in court. And we want them to be judged, and we want the judgment to be severe if they are found guilty. But, until then, we don't have a right to say you're guilty before we prove it.

Ms. COLVIN. Mr. Becerra, we also are taking some actions in the cases that Chairman Johnson raised. We would be happy to brief you privately, but we don't want to say anything publicly that is going to compromise the investigation, and that is why I kept stressing that it is an open investigation.

Mr. BECERRA. I appreciate that.

Ms. COLVIN. But there have been some actions taken.

Mr. BECERRA. I appreciate that. Maybe the chairman will let us take advantage of that.

Ms. Disman, again, you are in charge back there in New York. So, tell me, how many of the—of your Social Security employees were involved in the conspiracy that was discovered?

Ms. DISMAN. None. Unlike Puerto Rico, where you had a former Social Security employee, the extensive investigation and extensive analysis—and, let me just stress, my people worked directly with the Office of the Inspector General over the years. We helped do all the analytical work on the cases.

And let me reassure you on this New York case. It is a lot different than Puerto Rico. This is an affinity group of people that were involved in, most of them, New York City pensions that actually committed this awful conspiracy.

Mr. BECERRA. So, Mr. O'Carroll, let me get this straight. In New York City, not one Social Security employee was involved in this conspiracy of what you found?

Mr. O'CARROLL. Correct, Mr. Becerra. It was facilitators in this case, not SSA employees.

Mr. BECERRA. Not SSA employees. And in Puerto Rico, there weren't any Social Security employees involved, or at least not current. It was a former employee. But those that are on the line, on the job, getting paid by the taxpayers, were not involved in the conspiracies in New York or Puerto Rico.

Mr. O'CARROLL. Correct.

Mr. BECERRA. Okay. They are the ones that detected it. They weren't involved in it.

Mr. O'CARROLL. Yes.

Mr. BECERRA. Okay. Let's be clear on that. I think all of you know that this congress has continued to cut your funding over the last several years. And, Ms. Colvin, you mentioned that, as well. You mentioned \$421 million less that you have received to do the fraud busting that we are talking about today.

Ms. COLVIN. We are very pleased that it appears that our Fiscal Year 2014 appropriation may be approved. It has been approved in the House.

I would just say that we are very aggressively involved in anti-fraud activities. That is one of the reasons that we first established the CDI units back in 1998. At that time I was in charge of operations for all of the field offices. And we have seen that the CDI units are effective. These cases are very complex, so you need the cooperation of the DDSs and SSA, the Inspector General, and local law enforcement. And that is what we have under the CDI, we have those formal arrangements.

But because of the lack of resources, we only have 25 CDI units. With the program integrity money, if we get it, one of the things I want to do is expand some of those units, because we only have 25 states right now that have a CDI unit.

Mr. BECERRA. So let me conclude with this, because I know my time has expired. So, Mr. Chairman, let me just ask one quick question that I hope Mr. O'Carroll and Ms. Disman can both answer.

First, do you have enough of those fraud busters, these CDI units, where you need them? And secondly, how many of the staffers that you had in 2008, when you detected the conspiracy, the fraudulent conspiracy in New York, how many do you have now?

Ms. DISMAN. Well, if you are talking about how many people are in the New York DDS now, I can just tell you, compared to 2010, that staff is down 22 percent. And so, when you look at that, there are certainly less people on the line to do this work, and to report the detection. But they are really focused on fraud.

I will tell you this case and the Puerto Rico case made our employees even more aware. And what is important is not only will you report it, it will be investigated, but what the Manhattan DA did and the U.S. Attorney in Puerto Rico allows us to do more referrals, because they see results as a result of their referrals.

Mr. BECERRA. Inspector General?

Mr. O'CARROLL. The CDI units, I have got to say, with the support of you, the chairman, and every—the members of this Committee, this is probably one of our best tools in terms of fighting fraud. The best part of it, it gets the money and identifies the money before it goes out the door. It is pre-effectuation.

With the support of this Committee, we are anticipating expanding them. We are adding people to the CDI units that we have now, with just the purpose of identifying fraudulent doctors, lawyers, and facilitators. And I think we have a pretty good story. And, moving forward, that is going to be one of our, you know, priorities, with any resources that we have.

Mr. BECERRA. Thank you. Thank you, Mr. Chairman—

Mr. O'CARROLL. And we would like to be in all 50 states, is what we would like to do.

Mr. BECERRA. Thanks, Chairman.

Chairman JOHNSON. Thank you. Mr. Griffin, you are recognized.

Mr. GRIFFIN. Thank you, Mr. Chairman. I want to talk a little bit about this 99 percent accuracy, 1 percent inaccurate payment of overpayments and underpayments. You hear that general talking point or that factoid, whatever you want to call it, and you think, well, hey, everything is cool. It sounds like it is all great.

But correct me if I am wrong, Mr. O'Carroll. Until we learned about the folks that you showed upon the screen, we thought those were legitimate, correct?

Mr. O'CARROLL. Correct.

Mr. GRIFFIN. So how can anyone tell me what they don't know? I mean the people that we saw on the screen were part of your accuracy. Sure, you can guess. You can estimate. But you have no idea what you don't know. That is the nature of fraud. If you knew what the fraud was, the next question would be, "Why are we allowing it to happen?"

So, the idea that we can sit here and say, "Well, it is only one percent," you have no idea what it is, it could be 5 percent, it could be 10 percent, unless you have got a crystal ball that I am not familiar with. So, I know that makes for a good sound bite to say, well, it was only one percent, you know, let's go to the House.

But it is just not true. You don't know. You don't know. I don't know. And I am sure you would say, if you had more money, you would know more. I have never heard a federal agency say they need less money, ever. It will never happen, I guess. So, I just want to get that point out there.

I know there is a lot of hard-working people doing a good job. And you are a great guy, and I have worked with you on some stuff. But I just wanted to clarify that. That really—that entire talking point just needs to be erased. I am sure it won't be. But it just makes no sense.

The second thing I would say is—and I cannot speak for the Chairman—he does a great job on his own—but getting to the other cases of fraud, West Virginia and New York, and—the Chairman asked about employees. I certainly understand innocent until proven guilty in a court of law with regard to these guys' jet skis, and all this nonsense. Gymnast? I mean, you know.

But when you are talking about employees, civil servants who may or may not have been involved—and only you all know the details, you know, there is a lot of stuff you can't probably talk about here—we all know that, in order to fire someone, they do not have to be innocent until proven guilty in a court of law applying a beyond-a-reasonable-doubt standard. That is not the standard to fire people.

So, a lot of times, when things are discovered in an agency—IRS, for example, elsewhere—people are fired long before the case has made its way through the system fully, because you get enough, as an employer, to say, "Hey, this person shouldn't be working for me."

Now, I understand it takes a whole lot of bad action in the Federal Government under the civil service rules to get rid of somebody. I mean I have worked in those agencies, and sometimes you

think, short of a murder, we just got to move them around to some other desk, right? I mean let's all—we are all laughing, because we know it is true. If there are people identified as potentially bad actors, what do we do with them? We don't have to wait for courts to act to take action on that. I will wait on an answer on that.

One more thing I want to mention. And, you know, there is always a danger with anecdotal evidence. But anecdotal evidence is important for Members of Congress, because we go back home and we hear stories, right? And I can tell you. I don't know if the rules that we have that a lot of people comply with make it easy to commit fraud, I don't know exactly. But I could tell you that almost every time I go home—and I am thinking right now about the Christmas holidays.

There is a guy that I know, and I have talked with some folks about him, and he is a former professional. He rides a motorcycle, he is very active, he does all sorts of things. And he is on full disability, Social Security disability. And I don't think it is fraud like this. I think he went right through the system. And I think they said, "You know what? There is nothing in the world that you can do. You must just get a check. Now go ride your motorcycle." You know, there is a lot of that that goes on. And I know that is not in your 1 percent, 99 percent calculus.

So, I am out of time. But, Mr. O'Carroll, if you could, just speak to the issue of employees that might need to be fired, even though they are not guilty in a court of law.

Mr. O'CARROLL. Mr. Griffin, I will try to get both of them, real quick.

First one, on the employees one, it is—you—just as this thing—you know, it is important when an SSA employee goes bad, we watch very closely on it. I must tell you. I get a report every day about every one of our employee investigations that we are having.

And amongst them, kind of along your lines, I have two columns. I have—one column is what has happened to that employee now, meaning are they still working at SSA or are they, you know, on—if they are not at SSA, are they on leave with pay, or are they on leave without pay? And what we try to do is put them immediately on leave without pay while we are doing any of their criminal activities. Sometimes we will leave them in place, because that is the only way we are going to be able to catch any co-conspirators on it.

But I must assure you. First and foremost of all of our priorities is employee fraud. And I must say that it is a small percentage, as we talked before. But any percentage, when you are talking about fraud, is unacceptable.

And on the other one, for the person who is riding the motorcycle and looking very healthy, that is the reason why we have the CDI units, that is why we bring the videos in, to show you that we go out when there is a suspicion like that and do it. We get 140,000 allegations a year in our hotline, and we try to run out as many as we can.

Chairman JOHNSON. Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman, and I want to thank all of the witnesses with their testimony.

You know, when I got here this morning and I heard the Chairman's opening remarks, you know, I agree 100 percent. He used words "shocking," "outrageous." And when I heard the Ranking Member's remarks, I almost thought, well, there is no problem. We ought to just go leave and—it is the bad guys, those bad guys out there.

And, the truth of it is, there are bad guys. And we do have a lot of good employees. The issue, though, isn't just the bad guys, because there are always going to be bad guys, and we are always going to have to deal with bad people. The issue, really, is what are we doing to make sure we protect taxpayer dollars?

You know, when I was mayor of my community, I didn't start every Monday morning meeting by saying, "We got bad guys out there, we better be careful." What I started out every meeting was, "The number one goal of every one of us in this Administration is to make sure we protect the taxpayers' dollars." So, when I go home, I have to listen to my constituents who aren't going to say, "You guys are okay, it's the bad guys." They are going to say, "What are you doing to fix the problem?"

So, when you hear some of these fraud cases, and you see some of the pictures, yes, there are bad guys out there. But the question is, what are we doing to fix the problem? So I am going to go back to I know one question that the Chairman asked. I have got a couple as follow-ups.

You know, we have some issues. And, of course, there are some employees who were involved, because somebody approved a disability payment. So, at that point in time—and I am not saying that was fraudulent, I am not saying it was wrong. But somebody had to approve a bad payment. So there is an employee somewhere that was involved. I am not saying that is a bad employee; that could be a good employee. The question is, do we review our staff? And have we made any changes in staff since Puerto Rico or, now, with New York? Any changes in staff because of these fraudulent activities? Yes or no?

Ms. COLVIN. I am going to let Bea speak specifically to New York. But I don't see a reason to change our staff. There is nothing that has come to my attention that suggests that our staff has done anything wrong.

Mr. RENACCI. I am not saying they did.

Ms. COLVIN. Remember that the cases were identified by our staff. The medical information was fabricated, so there is no way that staff would have known that it was not—

Mr. RENACCI. Okay, let's move past that. Let's hold on. Any changes in policy, then? Let's move—we have great staff. Let's—

Ms. COLVIN. All right.

Mr. RENACCI. We've got that one. Now, any changes in policy?

Ms. COLVIN. We are looking at a number of policy areas. We are working with the Institute of Medicine to—

Mr. RENACCI. How long ago was the Puerto Rico issue?

Ms. COLVIN. How many?

Ms. DISMAN. The Puerto Rico issue was investigated over a period of years. And it actually came to fruition, as you know, in August of this past year.



Mr. RENACCI. Okay. Any changes in policy since August, because of the Puerto Rico incident?

Ms. DISMAN. Well, there has been a number of initiatives. As we looked at Puerto Rico, over the years—

Mr. RENACCI. Any changes in policy—

Ms. DISMAN. Well, I am going to tell you. There has been—our policy staff has been in touch with the Administrative Conference of the United States, and the Institute of Medicine—

Mr. RENACCI. You are not answering the question.

Ms. COLVIN. Mr. Renacci, we have to have data and research to make—

Mr. RENACCI. I am just asking a simple yes-or-no question. Have there been any changes in policies?

Ms. COLVIN. You don't make changes that quickly.

Mr. RENACCI. Okay.

Ms. COLVIN. You have to have time to—

Mr. RENACCI. All right. We will move to the next one. Any changes in procedures?

Mr. BECERRA. You have to let them answer.

Mr. RENACCI. I am asking yes or no questions. I am trying to move on. I have five minutes.

Mr. BECERRA. They are answering—

Mr. RENACCI. Any changes in procedures?

Ms. COLVIN. I am sorry. If you are looking for yes-or-no questions—answers, I can't give them to you.

Mr. RENACCI. You can't answer whether there has been any changes in policies and procedures, or—since the Puerto Rico issue?

Ms. COLVIN. [No response.]

Mr. RENACCI. All right. Let me give you a policy, then, and just see what your thoughts are on it. Because, clearly, we are not getting anywhere.

And I got to tell you. The people back in my district, they are concerned about this. They are concerned and they want to see action, that is why I am saying, I am not saying this is bad people, and I am not saying we are bad employees. I think you probably have a lot of great employees. And I think you are working as hard as you can. But I do think we have to move when we have dollars being lost, taxpayer dollars.

You know, the Medicare program, doctors convicted of defrauding Medicare are banned from serving Medicare beneficiaries. Can you tell me if doctors that are kicked out of the Medicare program for previous fraud convictions are allowed to give medical advice in these situations, and are we accepting medical advice?

Ms. COLVIN. They are not. We have a list of doctors that have been barred, and we check against that now. For information that is coming in from individual providers, we are not able to determine that. But for anyone that we hire or engage, they are not allowed to do that.

Mr. RENACCI. Well, that is good. That is—

Ms. COLVIN. And the local states and governments are very careful in checking those people who have been disbarred, if their attorneys have lost their medical license or been disciplined.

Mr. RENACCI. Well, I just ran—

Ms. DISMAN. If I could add to that, all the DDSs have professional relations people whose job it is to look at the licensing, and to also be alert to all of this. So they basically take them off any consultative panels and the medical evidence.

Mr. RENACCI. I am out of time. But I know that I heard Mr. O'Carroll say that there are additional cases coming down the line.

I would just ask you one thing, if you could get to my office. I would like to hear what policies and procedures you are going to change and have changed, hopefully within the next three to six months. I would like to hear some of those things and get some ideas. Policies and procedures, that is all I am asking for.

Ms. COLVIN. We would be very happy to do that. That is why I said it couldn't be a yes-or-no answer, but there are a number of things in the works that I would be very happy to discuss.

We are also looking at more data and analytics, so that we can look at the patterns. Because we knew these individual cases would not stand up alone, but when you see the pattern, the language pattern or whatever, and that is why the CDI units have been so effective, because we are able to work together and see those patterns.

Mr. RENACCI. Thank you.

Chairman JOHNSON. Thank you for your comments. Mr. Rangel, you are recognized.

Mr. RANGEL. Thank you, Mr. Chairman. And let me thank you for—I really came down to congratulate you for this fantastic investigation. I had hoped that—an example of these terrible frauds that are being committed at the expense of men and women that put up their lives every day, and probably find it more difficult to get the type of assistance they need.

The tone of the questions, I hope you understand, is because we do have a Democratic president, and sometimes anything that is done by the Administration is not appreciated. But in this particular case, I think, more than just the fact that you have indicted 100 people, you have sent a message to every policeman, every fireman, that the government does not intend to allow these things to happen.

My question would be, did this information—was it received by the southern district of New York, United States Attorney's office, before it was turned over to District Attorney Vance?

Mr. O'CARROLL. Yes. What happened in the early stages of this investigation was our investigators went to the southern district in New York and presented on it. And, in fact, I will have—let Mr. Ryan here, who—our agent in charge, he can kind of walk you through the two approaches, or the several attempts that we did, or several discussions that we had with southern district.

Mr. RANGEL. Well, before we get involved in that, did they reject the evidence that was given to them as—whether or not they would prosecute?

Mr. O'CARROLL. Yes. Early on in 2009, December of 2009, the case coordinators went over to the southern district of New York.

Mr. RANGEL. And then you presented it to the—

Mr. O'CARROLL. We presented it. They initially accepted it. Nine months later, we went back. Nine months later—I believe it was in September of 2010 we went back to them, explained what

happened in that 9-month period. They decided at that point in time to decline the investigation, because they needed additional evidence to prove more than making false statements.

Mr. RANGEL. Okay. I can't think of a program that has done more to take people out of poverty and to bring a sense of self-esteem and make such a tremendous contribution to our great nation than Social Security.

You did turn it over to one of the greatest district attorney's offices that we have in the country. But as a former assistant U.S. Attorney it bothers me that, with the type of evidence that you presented to the New York County DA, that the U.S. Attorney's office did not see fit to follow through on this.

In any event, I want to personally thank Ms. Disman for the cooperation that you have given with the difficult cases I have had in my congressional district. And I want to thank all of you for recognizing that it is rough being on that side of the table. But when you know that you are right, when you know that you have done the right thing, when you know that you have made a contribution to stop corruption, and when you can see 100 people have been indicted, I think this should serve as an example for all of our federal agencies and Department as to what can happen when the front-line troops are looking for this.

No U.S. Attorney's office, no district attorney's office can prosecute anything unless the evidence is presented to them in a way that is probable cause that they did violate the law. So I want you to know that it is appreciated. But these things happen politically, and all of you are mature enough to understand it. I do. And thank you so much for coming before this Subcommittee.

And thank you so much, Mr. Chairman, for having this very interesting hearing.

Chairman JOHNSON. Thank you. Mr. Kelly, you are recognized.

Mr. KELLY. Thank you, Chairman. First of all, I appreciate you all being here. And, as you know, Mr. Renacci was talking about, you know, when I go back home—and it doesn't matter where I go—people come up to me and say, "You know what? We know this is going on. And why aren't you guys doing something about it?" They don't say to me, "Listen, you need to get with the SSA people and find out who is not doing a good job." They say, "You need to do something about this."

And all of us in this room today, both you testifying and us up here, we all work for the American people. You don't work for SSA and I don't work for the Republican Party. In fact, this is not a Republican or Democrat issue, this is an American issue. Because, as you know—and, Ms. Colvin, you can probably state it better than anybody else—how is Social Security funded?

Ms. COLVIN. Taxpayer dollars. We are funded through—

Mr. KELLY. Wage taxes.

Ms. COLVIN [continuing]. FICA taxes.

Mr. KELLY. Yes, wage taxes.

Ms. COLVIN. Absolutely.

Mr. KELLY. Wage taxes are paid by people who are working, and their employer: 6.2 percent from the employer, 6.2 percent from the associate. There is 12.4 percent of everybody's payroll going into a fund to take care of Social Security recipients. So when

we talk about these things, it really isn't Republican versus Democrat, us versus you, it is about us, as a group, representing the American people. They sent us here to do a job. Our job in Congress is oversight, investigate and expose when we think there is something wrong.

Ms. Colvin, I was looking at your bio. You have an incredible bio. And if you don't mind, I am just going to go through it, because I don't know if people understand everything that you do. Now, this is since 1995. You are a Regional Commission. You have direct authority over Social Security Administrations in New York, New Jersey, Puerto Rico—

Ms. COLVIN. Ms. Disman.

Mr. KELLY. Ms. Disman. But this is all in your region, right?

Ms. COLVIN. I am the Acting Commissioner for the entire country.

Mr. KELLY. Okay.

Ms. COLVIN. Ms. Disman—

Mr. KELLY. Ms. Disman.

Ms. COLVIN [continuing]. Has the New York Region.

Mr. KELLY. Okay, I am sorry. Ms. Disman, right. You are doing all of these different things.

In addition to that—now, that is an administrative budget of about \$400 million. You have 3,900 employees, 113 field offices, 4 teleservice centers, 4 Social Security card centers, the northeast program service center, and the regional office administrative staff. Throughout the region, more than 7 million beneficiaries receive more than \$88 billion—that is billion—in Social Security and supplemental Social Security income benefits, annually.

Now, you are also—you were asked by the Commissioner of the Social Security to chair the Agency's Medicare planning and implementation task force. Right? You are responsible for implementing the responsibilities given to Social Security in the Medicare Modernization Act of 2003, the Medicare Improvement Acts—for Patients and Providers Act of 2008, and the Affordable Care Act of 2010.

I am looking at all the different hats you wear. Right now—and correct me if I am wrong on this, because I don't know how you do these things—the reason you are here today is about this crime ring in New York. All right? You were here before because of Puerto Rico. But you are also the executive in charge of implementing the Affordable Care Act on behalf of the Social Security Administration. I understand that Social Security Administration must confirm the Social Security number of everyone who signs up for Obamacare.

So, as you come here today, is your concern—has to be split. Of all these different things—really? You can do all these things? You are amazing.

Ms. COLVIN. Excellent staff.

Mr. KELLY. You are amazing.

Ms. DISMAN. I also—it is more than just me. I have to credit it with all the employees that work for me, my executive team, and certainly all my years of analytical and experience, institutional knowledge.

Mr. KELLY. Okay, all right. How many people we talking about getting Social Security numbers for, verifying?

Ms. DISMAN. Well, we are talking about—are you talking about for the Affordable Care Act?

Mr. KELLY. Yes, ma'am.

Ms. DISMAN. Well, for the Affordable Care Act at this point in time, we wait for the CMS hub to send us—

Mr. KELLY. Just ballpark it. I am not—listen, this is not a gotcha, I am just trying to figure out how many people you are trying—

Ms. DISMAN. Yes. We are basically over 30 million right now.

Mr. KELLY. Thirty million?

Ms. DISMAN. Right.

Mr. KELLY. Okay. And you have all this fraud going on, too.

Ms. DISMAN. Well, this situation has not—has nothing to do—

Mr. KELLY. You are a remarkable lady, then, for what you are doing. A remarkable person—I will take the gender specificity out of it. You are a remarkable person to be able to do all of this.

Ms. Colvin, you said that you are underfunded, as an agency.

Ms. COLVIN. That is correct.

Mr. KELLY. Okay. How do you define “underfunded”? What do you base that on?

Ms. COLVIN. We are able to identify in our budget what we can do with the amount of dollars that you give us.

Mr. KELLY. Okay.

Ms. COLVIN. As a result of—

Mr. KELLY. If I were to give you, from the United States taxpayers, \$11.5 billion, would that be considered a sizeable amount?

Ms. COLVIN. Our budget is—

Mr. KELLY. No, no. Is that a sizeable amount? Because, you know, as Mr. Griffin said, there is never enough money for any of the agencies. Do you know this year it is \$11.5 billion, and we are underfunding you?

Ms. COLVIN. Well, if you give us—

Mr. KELLY. And not “we.” I am talking about American taxpayers.

Ms. COLVIN. If we receive the 2014 budget, we will certainly be able to—

Mr. KELLY. Okay, all right. All right.

Ms. COLVIN [continuing]. Focus on that program—

Mr. KELLY. No, I just wanted to make sure that we are talking the right way here, because sometimes we get confused about who we are actually working for. I work for the people of America, that is who I work for. Taxpayers is who I work for. I got to tell you. What you are doing is fine. The work is noble. I am not criticizing your work. And I know that the number is absolutely incredible, the overpayments.

Now, Mr. Becerra said it is only a half-a-percent.

Ms. COLVIN. Well, as we said—

Mr. KELLY. A half-a-percent is—well, wait a minute, wait—is \$1.29 billion. Let's not minimize it by saying it is a half-percent. You know the debt owed from these overpayments has gone from

\$5.4 billion in 2010 to \$6.1 billion in 2012? So I don't want to identify it as "only a half-a-percent."

These are huge dollars. And what I don't want to do, I don't want to minimize what we are talking about by reducing it down to a percentage. A percentage, a small percentage of a very large number is a very large number to the people I represent in Western Pennsylvania. These are hard-working American taxpayers that are funding Social Security. They are putting 6.2 percent of every time they get paid, and their employer is matching it. This is not government money. This is taxpayer money.

And I really get aggravated. I have only been here for three years. This is not Republicans versus Democrats. This is Republicans and Democrats working together to serve the American people. I get so damn mad when it becomes political, but this is not a political issue. This is an issue we are defrauding the American people. We are not defrauding Social Security. And we better start to understand who we represent here. I did not get elected by all Republicans or all Democrats.

But, damn it, I will tell you what. I watch this—this is not a criticism of you. We have raised a group of people that look at a program and say, "I think I can game this. I think I can crawl under the wire here. I think I can do this and take advantage of the government." No, no, no, no, no. You took advantage of every woman and man who gets out of bed in the morning, puts their feet on the floor, and goes to a job, and every time they get paid, contributes 6.2 percent of their paycheck, matched by their employer 6.2 percent, to fund this. And if we think it is about defrauding the government, we are really way off the line on this. We better wake up and smell the coffee. No wonder the American people have such a low opinion of us. We are not protecting them.

I don't want you to take the blame for anything. Listen. You have a much higher approval rating than I do. But you know what? I get blamed for anything that happens in this government, because we didn't step up to do it. So the purpose of us being here isn't to go after you, it is to make sure that we protect the integrity of this system for the American taxpayers.

Listen, I thank you all for being here. Mr. O'Carroll, I know you have a great, great tour of duty. All you, I thank you for what you do. It is not about you. It never will be about you. It is about us, working with you, to get to where we need to be. I just have a hard time, Ms. Colvin, when I look at \$11.5 billion and think, my God, we are underfunding? That is a lot of money.

Chairman JOHNSON. The time of the gentleman has expired. Thank you.

Mr. KELLY. I have expired.

[Laughter.]

Mr. KELLY. Thank you, Chairman. Thanks for bringing it up.

Chairman JOHNSON. Yes, sir. Thank you for your comments.

Mr. Tiberi.

Mr. TIBERI. Do I have to go next?

[Laughter.]

Mr. TIBERI. Wow.

Chairman JOHNSON. Only if you will talk for five minutes.

Mr. TIBERI. Well, thank you all. I think Mr. Kelly's tone expresses the frustration that we have, and it is not personal and it is not political. It is a frustration that we hear from our constituents. And I know, particularly the three of you that work for Social Security, share this concern that I am going to raise, and that is any time there is fraud, it hurts the integrity of the program. It hurts the integrity of the truly disabled. The whole program gets a black eye.

And I would say that—to Mr. Griffin's point, when I go back home, there is not a whole lot of confidence in the program when they read stories like the New York story, because they don't think that is the one percent. They think it is the one that got caught. And so, while Mr. Rangel is correct—thank you for helping identify this—a constituent of mine might ask Mr. Ryan, “Well, it is great that you caught it, but why did it take 20 years to catch?”

Mr. Ryan, is it true that this goes back to 1988? And if that is true, what took so long to allow these criminals to operate for 20 years without getting caught?

Mr. RYAN. Well, there is a long, drawn-out answer to that. But I will try to break it down—

Mr. TIBERI. Okay.

Mr. RYAN [continuing]. In segments. Number one, in 1998 it was identified through the diligence of SSA and the DDS in referring individual cases, individual referral, stating either this person was an NYPD or FDNY, or they had Lavallee as an attorney. Individual cases. We worked those individual CDI cases, and returned it back with our report mechanism, video surveillance, interviews, whatever. Went back to DDS. DDS, in 95 percent of the time, denied them at the application stage.

Subsequent to the application stage, there is the ODAR, which is the administrative law judges. Some of those, regardless of what was in the file, was placed on the rolls, based on the definitions—

Mr. TIBERI. Outrageous.

Mr. RYAN [continuing]. Of mental disability, based on the medical evidence in that file.

The second part of the question is that total number was minuscule, and was not detected as a conspiracy, criminal conspiracy case, until 2008. And there was a lot of reasons for it. Automation. We were able to get in through the diligent efforts of Social Security, into the individual files electronically, and print that data, the analytics that Ms. Disman mentioned. We were able to get that, and we were able to identify the patterns then—Lavallee, et cetera—in this New York case.

So, it is difficult to go back from 2008 to 1998, but in 2008 we went full boat with the investigation. We knew what we had. It took us where we wanted to go with the prosecution, and get that money back. And it now rests with the Manhattan district attorney's office to get that money back to the American taxpayers.

Mr. TIBERI. It does go back to 1988, though, right? With the four facilitators?

Mr. RYAN. There was individual allegations.

Mr. TIBERI. Okay. Back to 1988.

Mr. RYAN. 1988.

Mr. TIBERI. Okay, thank you.

Mr. RYAN. And that was before—that was pension fraud. It was before when OIG was even in existence, and it was before CDI units were created—

Mr. TIBERI. And Ronald Reagan was president, so we can blame him, too, right? Hey, but no one is trying to blame anybody. The point is that this—

Mr. CROWLEY. I was in the other hearing room.

Mr. TIBERI. It was a joke. Ronald Reagan. You weren't here when Mr. Rangel talked about the President.

So, you know, this is real in American people's minds. And this is great that we caught this. But how much more of this is going on? I mean that is a question that people ask me all the time.

And so, I got a question, Ms. Colvin. Last year your agency conducted 1.6 million continuing disability reviews.

Ms. COLVIN. Yes.

Mr. TIBERI. Three-quarters of which were completed through self-reported questionnaires, my understanding—

Ms. COLVIN. Yes.

Mr. TIBERI [continuing]. Correct me if I am wrong—called mailers. Were the reviews of these defendants in the New York case, were they completed via mailers, or full medical reviews, do you know?

Ms. COLVIN. Which ones?

Mr. TIBERI. The defendants in this particular case, the New York case, with the 100 defendants.

Ms. DISMAN. Yes, these were not CDRs when they were reported. These were initial claims. But in my just doing some analysis on the 102, looking at it—remember, I can't look at the files right now—

Mr. TIBERI. Yes, yes.

Ms. DISMAN [continuing]. There were a number that had CDRs conducted on it. They were medical CDRs. As a matter of fact, we used that also as part of the investigation.

So—but remember one thing. If you worked with your facilitators and your coaching, you would have the continuance, based on what the medical reports were.

Mr. TIBERI. Does it—last question, because my time has expired. With respect to these mailers, if you are a criminal and you have got this disability benefit illegally, three-quarters of the recipients are getting mailers. How many—it doesn't give me much comfort that if you are a criminal, that you are going to answer a mailer honestly. Is that a concern going back to the procedures that we have talked about earlier that might be under review because of this? Because why would a criminal answer a mailer?

Ms. DISMAN. If I could just address the mailing system, because I was involved in disability, helping years ago. It is a profiling system. And that is to be smart with the budget that Congressman Kelly says, that you really want to identify those that are more likely to have medical improvement, and more likely to change.

So, in doing the mailers, those are the high-risk people that are identified through a system, through analytics. And a number of the mailers are also reviewed and become medical CDRs, as well.

Mr. TIBERI. Okay. I look forward to those procedures that Mr. Renacci talked about. I yield back.



Chairman JOHNSON. Thank you. I am not sure that answer answered your question.

Mr. Crowley, you are recognized.

Mr. CROWLEY. Thank you, Mr. Chairman. I apologize I was not here for Mr. Rangel's statement, nor did I get the joke. Apparently, no one else got the joke, either. So I apologize, Mr. Tiberi, for that.

Thank you, Mr. Chairman. I have tremendous respect for you, and so I do appreciate your holding this hearing today. We all know that we are people who will always try to—there are always people who will try to game the system in all walks of life. We see it throughout—it is throughout our society. What we need to do as policy-makers is to hamper their abilities to corrupt the system by putting into place systems to detect, catch, and bring those who violate the law to justice.

From the standpoint of that test, what we are looking at today is proof positive that we have put in place those resources, both technical and human, to weed out, detect, apprehend people trying to defraud the Social Security disability program. We should commend the actions of the Social Security Administration.

This hearing has been turned upside down on its head. This panel before us should be lauded for the work that they have done to uncover the fraud and corruption, and for bringing these cases to light. We here in Congress must also ensure our actions do not hinder their ability to continue these anti-fraud programs.

Listened very closely to the chairman's opening statement. I akin it to blaming the homeowner when their house is broken into. The homeowner, in this case, cried foul, got the cops on the beat, and brought those who invaded their home to justice. And we ought to be lauding that.

I also want to laud the fact—in reference to the 1988 number, those cases, as I understand it, Mr. Ryan, go back to 1988 because they involved New York NYPD pension fraud. Is that not correct?

Mr. RYAN. You are correct.

Mr. CROWLEY. In essence, people who are police officers—my dad was a police officer, my grandfather before him—individuals who are on the job, and then apply for what is known as three-quarter pay, is that correct, for disability?

Mr. RYAN. That is correct, three-quarters.

Mr. CROWLEY. And they get that in perpetuity, isn't that correct?

Mr. RYAN. Correct.

Mr. CROWLEY. And these are individuals who actually could work that you have helped to uncover. That not only saves the Social Security Administration dollars, but helps to save in conjunction with Mr. Vance's work, the district attorney of Manhattan, his work, millions and millions of dollars in New York City's pensions. Is that correct?

Mr. RYAN. That is correct.

Mr. CROWLEY. I thank you, once again, for that work, as well.

Let me be clear. The people accused of perpetrating fraud on the American public under the guise of the worst terror attacks in American history are an outlier among the brave first responders in New York City. I come from a family of both police and firefighters, so I defend the reputation of both those departments and

the men and women who serve in those departments, and do not defend in any way, shape, or form those outliers who would abuse the system.

But there are far too many brave firefighters and police officers who are suffering today from real illnesses and real disabilities as a result of their service on what was known as The Pile, cleaning up Ground Zero after the horrific attack upon our nation. Let's remember it was the Federal Government that declared the air at Ground Zero safe and toxic free. But that wasn't the case. And the air and the elements that they were working in were not safe. Yet we allowed thousands of first responders to search without the proper protective gear for the remains of almost 3,000 victims. We did so to bring some relief and closure to those victims' families.

We allowed thousands to work without protective gear to extinguish the fire, a fire, by the way, that burned for three months after the attack. We allowed those first responders to run into harm's way when the rest of us ran away. As a result, many of these heroes suffered and continue to suffer the after-effects of this service. These men and women are legitimate recipients of a federal Social Security disability insurance program, and we should not and cannot let the few human nature, the few, to ruin a necessary program for the many.

One of my proudest moments in Congress came when, under a Democratic majority, we passed the 9/11 First Responders Health Act. It came after years of obstruction and partisan delays, delays that never should have occurred.

So, let me be clear. If any Member of Congress tries to use the fraudulent activities to taint the sick and wounded first responders of 9/11, they will have to deal with me directly. Congress has oversight and responsibilities and obligations. But we also have to make sure we don't actually hamper the ability of federal investigators to do their job of fraud detection. Some in Congress have tried to cut off the very federal resources that stop fraud through budget cuts, furloughs, and downsizing, taking the very cops off the beat who are looking out for fraud and abuse in these programs. Ultimately, this lack of resources encourages more, and not less, fraud.

Thank you all again, each of you, for being here today. And, Mr. Chairman, thank you for holding the hearing. I do appreciate it. But I don't appreciate the tone of turning it upside its head and blaming the victims in this case for the work that they did to uncover this fraud and this abuse. There is always more to be done.

I have news. There will be fraud for the rest of the existence of the United States and the world, as long as human beings exist on this planet. We are an inherently flawed people, and we have to get used to that. Let's get beyond this.

Let's find—if we have—if there is an agenda of amendments that can reduce fraud and abuse, I ask the Majority to hold a hearing on your proposals. Bring them forward. If there is a way we can mitigate and stop waste, fraud, and abuse in this system, I am all for it. And, Mr. Chairman, I await your agenda, and let me know when the meeting notice will be. I will be here with bells on. I yield back the balance of my time.

Chairman JOHNSON. Thank you. Ms. Black, you are recognized.

Ms. BLACK. Thank you, Mr. Chairman. And, Mr. Chairman, thank you for allowing me to sit in on this Committee, although I am not a member of this hearing.

However, I was a member of the Subcommittee for the first two years that I was here. And this issue has become one that I have delved into pretty deeply. And I have also, as a result of that, spent time when I was back in my district going through the entire system, from my local office to the determination unit to meeting with the ALJ's and also meeting with those who are on the Social Security Advisory Board. So, this is an issue that I feel like I have really spent a lot of time in trying to understand.

As Mr. Renacci has said, how do we fix the problem? I thank you all for what you do. It is not an easy place to be. And, having gone through the entire system, I know that the determinations are not easy to make. There are a lot of things that we can fix, however, and I want to go to one of those.

Mr. O'Carroll, more than half of the defendants in the New York case faked mental disabilities. Is that correct?

Mr. O'CARROLL. Yes, Ms. Black, that is correct.

Ms. BLACK. Okay. And then, following up on that, I am also looking back at the defendants in the Puerto Rico case—also faked mental disabilities. Is that correct?

Mr. O'CARROLL. Yes.

Ms. BLACK. Okay. Would you say that mental disabilities are easier to fake than other conditions?

Mr. O'CARROLL. Yes. And the reason for it is, is that it is so subjective. As you well know, from being in the medical community, there aren't x-rays that will determine it, there aren't CAT Scans that do it. There is no test. So it is pretty much you are relying on the voracity of the patient, and then you are relying on the voracity of the doctor. And that is where our problem in Puerto Rico and New York was, is that they—it was collusion.

Ms. BLACK. Okay. And so, let's go just another step further, because we have discussed this in hearings previously, that the criteria for awarding these benefits or medical disabilities or mental illnesses has not been updated. The last update was 1985.

So, if we talk about how do we fix the problem so that we have better tools—not necessarily more money, but just better tools, Ms. Colvin, can you help me with why we haven't updated this? Is there a plan to update it? Are we working on that? Because this is 30 years now since it has been updated.

Ms. COLVIN. That is an excellent question. Yes, we are. We are working with the Institute of Medicine, and they are reviewing more objective instruments that might be out there to test—

Ms. BLACK. When do you expect something from this? I mean, again, 30 years' worth, I think I would like to have some kind of idea about what the plan is. You know, give us the timeline of when you would expect that there is going to be an actual update of looking at mental illnesses.

Ms. COLVIN. We have just given the task order to the Institute of Medicine, so I don't have a date of when we will get their report. I will be very happy, once I talk with staff, to see what the timeline is there.

But we also have been updating our medical listings. As you know, many of them had not been updated for many years. We have gotten——

Ms. BLACK. You mean the grid? Are you talking about the grid?

Ms. COLVIN. No, no, the listings, the medical listings that we use——

Ms. BLACK. Oh, the listings, okay.

Ms. COLVIN. And, in fact, I think right now we have updated 10 of 15. The others are in the process of being updated. Our goal is to have all of them updated and then have them reviewed every three years.

Ms. BLACK. Okay. I am sorry, I am going to reclaim my time, because I don't have very much time and I want to get to a couple of other things—but this updating is something that I have seen continuously throughout all of the departments that I have walked through. We have not updated this, and we can't wait for the medical community to say, "Oh, we got to do another five years of research." I want to hear a plan of getting this done and getting it through.

Grids are another thing. And looking at updating what currently jobs are available, we haven't updated that in years. So my own disability determination unit tells me that their hands are tied because there is not even computer skills that are out there now to say that you can be retooled to work with a computer skill if your knees are gone, or something where you have to have a job where you are sitting, that has not even been done. And it has been suggested for over 15 years now, so that one needs to happen, as well.

So, when we talk about what can we do to fix the problem, there are tools out there that would help you to be able to do a better job, so that perhaps people wouldn't get on disability that don't need to be on disability. And that is what I want to hear back from you all, is when that is going to happen.

Now, I want to go to Mr. O'Carroll again about using the Internet. So, Mr. O'Carroll, your agents were able to determine many of the defendants were working. And how were you able to do that? Did you use any of these more up-to-date kinds of tools that you could possibly use?

Mr. O'CARROLL. Yes. We have been using social media. In fact, that was some of the video that we showed at the beginning on it. Normally, what we do with our CDI units is, as soon as we get an allegation that somebody is riding a motorcycle or doing something that is outside of the normal way they portrayed their disability, first thing we do is we start taking a look at probably public service type—not public—public information, taking a look at licenses, see that type of information on it.

Next step that we go to is we go to social media. And, often times, these people that are claiming that they can't go out in public, that they are afraid of crowds and things like that, will show on their social media that they are, you know, leading tours through rock concerts and things like that.

Ms. BLACK. Certainly. So——

Mr. O'CARROLL. So we use that, and we think it is a very good lead, and it is something that should be considered when people make an application.

Ms. BLACK. So, if I could just complete this, Mr. Chairman—I know my time has run out, but going back to the decision-makers, I understand the decision-makers are prohibited from using these kinds of resources. Is that correct, Ms. Colvin?

Ms. COLVIN. That is correct.

Ms. BLACK. And is there a reason for that?

Ms. COLVIN. Well, there are a number of reasons for it. We believe that using those media, one, it opens up to having PII data exposed. We also believe that it is an appropriate thing for the investigators to use, not for the adjudicators to use.

Ms. BLACK. Well, I am going to suggest it is another tool. When we say how can we fix this problem to give those who are the decision-makers as much information as they possibly can, why not use things that are right at their fingertips, to be sure that they are getting all of the information, as well-rounded a picture as they can?

And I will tell you that the disability determination unit told me they would like to have the ability to be able to use things at their fingertips, but they are prohibited from doing so. I think this is something we should look into as a subcommittee, in giving them the opportunity, and maybe the ability to be able to use those.

Thank you again, Mr. Chairman, for allowing me to sit on this Committee, and I yield back.

Chairman JOHNSON. Thank you, Ms. Black. And I want to thank our witnesses for your testimony today, and thank the Members that were here and are still here. And I, along with my colleagues, are beyond outraged at this, and for good reason. So it is up to you, Commissioner, or Acting Commissioner—I will call you Commissioner—to take the actions you need to restore Americans' trust.

And, with that, I thank you all for being here. The committee stands adjourned.

[Whereupon, at 10:34 a.m., the subcommittee was adjourned.]

[Questions for the record follow:]



March 21, 2014

The Honorable Sam Johnson  
Chairman, Subcommittee on  
Social Security  
Committee on Ways and Means  
United States House of Representatives  
Washington, DC 20515

Attention: Kim Hildred

Dear Mr. Chairman:

This is in response to your questions for the record, further to my testimony on January 16, 2014 before the Subcommittee on Social Security, Committee on Ways and Means, at a hearing on a Social Security disability fraud scheme in New York City. I appreciate the opportunity to provide additional information to the Subcommittee. Below are responses to your specific questions.

**1. What recommendations have you made to the Social Security Administration (SSA) to help identify individuals faking mental illness before they are awarded benefits?**

Though not a formal audit recommendation, we have encouraged SSA to evaluate the economic costs and benefits of purchasing and using symptom validity tests (SVT), which can determine whether an individual is exhibiting signs of malingering. In a September 2013 [Congressional Response Report](#), *The Social Security Administration's Policy on Symptom Validity Tests in Determining Disability Claims*, we (1) reviewed SSA's policy that prohibits the purchase of SVTs; (2) assessed the medical community's opinion on the usefulness of SVTs; and (3) determined that other Federal agencies and private disability insurance providers allow the use of SVTs.

While SSA—like other Federal agencies, and private disability insurance providers—considers all relevant evidence in the case record before making a disability determination, the Agency does not allow the use of SVTs. SSA stated that these tests have limited value in proving malingering. However, medical literature and national neuropsychological organizations assert that SVTs are relevant in disability determinations. Moreover, other Federal agencies, such as the Department of Veterans Affairs and the Railroad Retirement Board, allow the purchase and use of SVTs in their disability determination processes. In addition, the three private disability insurance providers we contacted also support the use of SVTs in making claims decisions.

During our review, SSA told us that it was developing a proposal to award a contract for evaluating its SVT policy and the usefulness of SVTs in determining disability. In our final

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report, we encouraged SSA to (1) evaluate the economic costs and benefits of purchasing and using SVTs in its disability determination process; and (2) move forward with its plans already in progress in this area. We understand that in September 2013, SSA awarded a contract for studying SVTs. The contractor will: (1) perform a comprehensive review of psychological testing, including SVT; (2) determine the relevance of psychological testing, including SVT, to disability determinations in claims involving physical or mental disorders; and (3) provide guidance to help adjudicators interpret the results of psychological testing, including SVT.

**2. What recommendations has your office made regarding preventing fraud in the Continuing Disability Reviews (CDR) mailer process?**

Our office has not made any recommendations specifically targeted to fraud in the CDR mailer process. In past years, SSA performed quality reviews of samples of beneficiary responses to CDR mailers, and we are not aware of any concerns those reviews identified relating to fraud. With regard to CDRs in general, OIG audits and recommendations have focused on those processes and practices where we believe fraud, waste, and abuse are more likely to occur. Specifically, we have made numerous recommendations to improve SSA's processes related to work CDRs and full medical CDRs. We would be happy to provide those specific recommendations should you so desire.

**3. If the SSA performed CDRs in a timely manner, would fraud conspiracies like those in New York and Puerto Rico have been detected more quickly? How can the SSA use the CDR process to better protect this important program from fraudsters?**

We cannot state with any certainty whether conducting CDRs in a timely manner would help us identify fraud conspiracies more quickly, but we believe CDRs are critical to maintaining the overall integrity of SSA programs. Conducting CDRs in a timely manner not only ensures that individual claimants continue to meet eligibility requirements, but it also gives SSA the opportunity to review the entire claims folder and potentially recognize suspicious or unusual factors or trends that could lead to identifying and preventing fraud schemes. Insofar as CDRs can possibly result in the identification of these factors, it is reasonable to state that conducting CDRs timely could possibly identify such factors sooner.

We understand that SSA is undertaking a special initiative to expand its use of data analytics to enhance its ability to detect and prevent disability fraud. Specifically, SSA will apply analytical tools that can determine common characteristics and patterns based on data from past allegations and known cases of fraud. With these tools, SSA expects to prevent more fraudulent claims from being approved. However, SSA could also use these tools to identify individuals who are fraudulently receiving benefits—those who applied under false pretenses as well as those who were at one time legitimately disabled, but whose circumstances changed, causing them to become ineligible. SSA uses a number of characteristics to profile individuals receiving benefits and determine the likelihood of medical improvement. To use the CDR process to better detect fraud, SSA could use analytics to expand on these characteristics and profile individuals who are likely to have improved medically but continue to receive benefits fraudulently.

**4. Has your office made recommendations to prevent doctor, facilitator, or claimant representative fraud? Has SSA implemented any of your recommendations thus far?**

In *Hearing Office Case Rotation Among Administrative Law Judges*, we recommended that SSA (1) continue monitoring seven hearing offices with rotation issues to ensure the proper resolution of rotation issues; and (2) remind hearing office managers that ALJ coverage of remote sites should be consistent with rotation policy and involve all ALJs to the extent possible. SSA agreed with both recommendations and said it will continue monitoring the hearing offices and communicate information on the rotation policy.

In *The Role of National Hearing Centers in Reducing the Pending Hearings Backlog*, we recommended that SSA ensure steps are taken to prevent claimants from choosing the ALJ hearing their case, such as removing the ALJ's name from all hearing notices and reminding schedulers not to reveal the name of the ALJ when asked by a claimant representative. SSA agreed, and removed the ALJ signature on hearing notices in August 2012. However, subsequent pressure from the claimant representative community led to a reversal of this decision. All hearing notices now include the ALJ's name.

In *Claimant Representatives Barred from Practicing before the Social Security Administration*, we recommended that SSA (1) collect additional claimant representative data that can assist with verification of "good standing"; and (2) develop a pilot to verify whether representatives have been disbarred, suspended, or disqualified against lists maintained by other entities, to determine the costs and benefits of such controls. These entities could include State bars and/or other entities that collect and maintain similar disciplinary data.

SSA agreed with our recommendations and noted it was planning to collect additional electronic information in FY2008 and develop a pilot in FY2009, with this pilot being contingent on available staff resources. Our recommendations tracking system indicates the Agency later took steps to require additional certification by claimant representatives on submitted forms, but it appears the Agency did not create an automated system to verify such information against outside data sources.

**5. What is the current status of the Puerto Rico investigation? How has the hotline assisted in the ongoing investigation?**

The August 2013 arrest operation in Puerto Rico was the result of a lengthy and complex investigation into widespread disability fraud among doctors, a non-attorney claimant, and numerous beneficiaries. Our joint investigation with the FBI and the Puerto Rico Police Department continues. Of the 75 subjects charged in this case, 34 have entered guilty pleas, and three defendants are awaiting trials slated to begin in April, 2014. Of our three primary targets, one has agreed to plead guilty and the other two are in various stages of guilty plea negotiations with the U.S. Attorney's Office.

To date, the San Juan (Puerto Rico) CDI Unit has received 337 calls to the hotline number established by SSA specifically for individuals to report disability fraud allegations in Puerto Rico. Several callers provided information to us regarding the original doctors and subjects already under investigation; and some calls have also identified additional medical providers and



others who may be engaged in similar schemes. We are thoroughly evaluating this information for further investigation.

**6. The New York Cooperative Disability Investigation (CDI) is one of your oldest units, and was essential in identifying this conspiracy. Would you have been able to catch a similar fraudulent scheme in a state that has no access to a CDI Unit?**

Yes. We have identified similar fraudulent schemes in areas that did not have a CDI unit; for example, the ongoing Puerto Rico investigation was initiated before the San Juan CDI Unit was established. The CDI initiative, in fact, was a response to several large-scale disability fraud schemes we identified in Georgia and Washington State in the mid-1990s. However, in our experience, DDSs that have access to CDI units are far more likely to identify and refer potential fraudulent schemes to the OIG. For this reason, we strongly support CDI expansion as a critical integrity tool for SSA and the OIG, and we are encouraged by the Acting Commissioner's approval of seven locations for potential CDI expansion by FY2015.

CDI units contribute to identifying organized disability fraud due, in part, to the productive relationships they establish with DDS leadership and personnel. State DDS examiners and analysts are in the best position to identify potential third-party facilitator fraud because they review applications and reports written and submitted by doctors and attorneys. Their positions allow the opportunity to identify suspicious patterns (e.g., identical language in medical reports). It is likely that DDSs with access to a CDI unit have established working relationships with that CDI unit, and are more likely to refer suspicious activity to the OIG than a DDS with no CDI unit in their area. Further, CDI units conduct formal and informal training in their respective DDS agencies, so those DDS personnel are likely to be more mindful of the potential for fraud.

**7. In her testimony, the Acting Commissioner indicated that in FY 2013, over 22,500 disability fraud referrals were made to the OIG, of which the OIG opened about 5,300 cases and to date has referred over 100 to the United States Attorney's Office for prosecution. Why is the number of cases opened by the OIG so small? Does the SSA need to train better on the referrals they should be making? What is the number of cases referred for prosecution when you add in State and local prosecutors?**

The numbers presented by the Acting Commissioner focused on FY2013 allegations, and what became of them *during* FY2013. An allegation that proceeds all the way to a criminal prosecution takes months to travel that path; indeed, complex cases can take years. So while the Acting Commissioner was correct in stating that over 100 cases *stemming from disability allegations received from SSA in FY2013* were also presented to Federal prosecutors in FY2013, this should by no means be interpreted to suggest that the story ends there.

In FY2013, we received more than 141,000 allegations, opened over 8,000 cases, and closed more than 7,900 cases (many of these cases stemming from allegations received in prior fiscal years). Our casework resulted in 1,323 criminal convictions in FY2013—of which about half were based upon referrals from non-SSA sources—and 623 involved disability fraud. In addition, we achieved 326 civil actions or civil monetary penalty actions, a quarter of which

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were the result of referrals from sources other than SSA. But investigations and prosecutions do not abide by a fiscal calendar.

Even restricting ourselves to FY2013 allegations and following them as they worked their way through triage, investigation, and prosecution, the Acting Commissioner's numbers are unintentionally misleading. We received 141,000 total allegations in FY2013; among these are the 22,500 disability fraud referrals from SSA—constituting one-third of all disability fraud referrals. These 22,500 included 6,200 CDI allegations that do not anticipate criminal prosecution, as there is no loss to the government. Of the remaining 16,300 allegations, we closed 15,500 for a variety of reasons (statutes of limitations, unsubstantiated fraud, etc.). The 5,300 disability fraud investigations to which the Acting Commissioner refers include non-prosecutable CDI cases; in fact, we opened 888 non-CDI disability fraud investigations, which represents 5 percent of non-CDI allegations, a standard case-opening rate across all allegation sources.


While not all cases opened in FY2013 could possibly reach a conclusion during the same fiscal year, over 600 of the 888 cases have been presented to Federal or State prosecutors to date, and 186 were accepted (69 of these have *already* resulted in convictions or civil judgments or settlements, and the others remain in process). Another 28 of the 888 are awaiting a prosecutorial decision. And while 380 were declined by Federal prosecutors, they may yet be presented to State prosecutors or referred for civil monetary penalties or administrative sanctions.

Less than six months into FY2014, we are pleased with the progress made on SSA's FY2013 referrals, and with the fact that as many as 630 of those 888 investigations may see some form of criminal, civil, or administrative action. Many other allegations from fiscal years prior to 2013, and even some from the current fiscal year, will also result in prosecution and other judicial action as FY2014 continues to unfold.

Finally, while we would not discourage additional training for SSA employees on identifying and referring potential fraud, we do not link the quality of fraud referrals we receive with the rate at which we open investigations from those referrals. We have always and continue to encourage SSA employees to refer any and all potential fraud, waste, and abuse to the OIG, for further evaluation and development by OIG personnel trained to identify prosecutable fraud.

Thank you for the opportunity to elaborate on my testimony before the Subcommittee. I trust that I have been responsive to your request. Should you have further questions, please feel free to contact me, or your staff may contact Special Agent Kristin Klima, OIG Congressional and Intragovernmental Liaison, at (202) 358-6319.

Sincerely,



Patrick P. O'Carroll, Jr.  
Inspector General

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*Questions for the Record  
from the January 16, 2014 Hearing  
on the Disability Fraud Scheme in New York*

- 1. Given that the President has signed into law the Consolidated Appropriations Act, 2014, (P.L. 113-76), which provides the full authorized amount of \$1.2 billion for Continuing Disability Reviews (CDRs) will you reinstate the requirement that the Social Security Administration (SSA) review disability claims every three years beginning in fiscal year (FY) 2014, after waiving the requirement in FY 2012 and 2013?**

No. While the money Congress provided for our program integrity activities in FY 2014 is a substantial investment—one without precedent in recent history—it is not enough to eliminate the backlog of CDRs and complete all of the cases coming due this fiscal year.

To provide some context, we expect to complete about 510,000 full medical CDRs this fiscal year, which is nearly a 20 percent increase from the FY 2013 level, but still well short of the 1.3 million cases currently backlogged.

With a multi-year commitment of adequate funding from the Congress, we believe we can eliminate the CDR backlog. Unfortunately, receiving nearly an average of a billion dollars less than what the President requested for our administrative budget over the past 3 years has resulted in the loss of nearly 11,000 employees. For this reason, FY 2014 is a transitional year in which we will rebuild our personnel capacity to complete increasingly higher levels of CDRs in future years to be able to ultimately eliminate the backlog. We anticipate having to defer cases until the year in which we are funded to become current with this workload.

- 2. Given that the recently appropriated \$1.2 billion are temporary funds, intended to eliminate the current backlog of CDRs and Supplemental Security Income redeterminations, please separately provide us with your specific plan for how these funds will be spent.**

On March 4, 2014, we submitted to the Congress our FY 2014 Operating Plan (Plan), as required by section 516 of the Consolidated Appropriations Act, 2014 (Public Law 113-76). The Plan includes details on our program integrity spending plans, and it is publicly accessible on our website at <http://www.ssa.gov/budget/FY14Files/2014OP.pdf>.

- 3. In 2011 the SSA had a medical CDR backlog of 1.4 million. In response to a question for the record you stated that with full funding for program integrity as authorized in the Budget Control Act (BCA) the SSA could catch up on Title II medical CDRs by 2016. For FY 2014 the SSA has now received the fully authorized amount. What is your plan now to complete and stay current on medical CDRs for Title II beneficiaries? Please give us detailed numbers of CDRs (mailers and medical reviews), planned hiring, costs of doing these reviews, and any updated ratios of program savings.**

Based on current estimates, we project that we will be able to eliminate our current backlog of Title II medical CDRs by the end of FY 2015, assuming the Budget Control Act of 2011

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level of funding for program integrity in FY 2015. Current estimates suggest that, in the event funding were made available for the agency to become up to date on Title II medical CDRs, staying current (for both Title II and Title XVI) would require us to complete about 800,000 full medical CDRs per year.

In FY 2014, we plan to complete a total of 900,000 mailers and 510,000 full medical CDRs on both Title II and Title XVI beneficiaries, at a cost of about \$600 million. In FY 2015, with full funding of the President's Budget, we plan to complete a total of 1.1 million mailers and 888,000 full medical CDRs, at a cost of about \$1 billion. We are hiring staff in the State Disability Determination Services (DDS) this year to help us ramp up our cost-effective CDR efforts. We anticipate hiring a total of approximately 2,600 DDS employees in FY 2014, of which about 1,400 hires will be above replacement level for FY 2014 losses. We estimate that our FY 2015 program integrity fund will yield on average \$9 in net program savings over the next 10 years per dollar spent on medical CDRs, including Medicare and Medicaid program savings.

**4. When a facilitator or claimant representative is formally accused of committing fraud, what are the procedures for quickly identifying other cases involving these fraudulent actors? How does the agency determine how far back case review will occur?**

Section 205(u) of the Social Security Act (Act) requires the Commissioner to redetermine the entitlement of individuals if there is reason to believe that fraud or similar fault was involved in the individuals' applications. An exception may be made in cases in which a U.S. Attorney, or equivalent State prosecutor, with jurisdiction over the case certifies in writing that such action would jeopardize the criminal prosecution. When redetermining entitlement or making an initial determination of entitlement, the Commissioner must disregard the tainted evidence. If the Commissioner determines that there is insufficient evidence to support entitlement, the Commissioner may terminate entitlement and treat benefits paid on the basis of such insufficient evidence as overpayments. The Commissioner determines how far back the case review will occur based on reliable evidence of the scope and duration of the fraudulent activity. Data mining can help to uncover reliable evidence of the scope and duration of the fraudulent activity by identifying cases potentially related to the fraud for further investigation.

**5. When a person, facilitator, claimant, or other individual, is suspected of committing fraud, is there an alert system to identify other cases these suspects may be involved in for review?**

When there is suspicious activity related to a claim, our best and first lines of defense are DDS examiners, claims representatives, and other frontline employees. These employees are highly trained in the administration of the disability program rules and are dedicated to protecting the program from abuse. We train staff to be alert to indications of potential fraud, including contradictory statements, suspicious documents, and tips from members of the community. When such indicators are present, employees will attempt to verify information by requesting additional documentation, communicating with third parties, interviewing the sources of information, or any combination of these. Employees then refer cases of potential

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fraud to our Office of the Inspector General (OIG). In FY 2013, our frontline employees made approximately 22,500 referrals of potential fraud to OIG, of which OIG opened about 5,300 cases. Of the approximately 5,300 cases opened, OIG referred over 100 to the U.S. Attorney's Office for criminal prosecution. In many States, Cooperative Disability Investigations (CDI) units (led by an OIG Special Agent) are available to investigate individual disability cases to identify applicants or beneficiaries who commit fraud and attorneys, doctors, translators, and other third parties who facilitate fraud.

We are able to support fraud investigations by using our electronic systems to identify cases potentially related to the suspected fraud, and we work with our Office of the General Counsel regarding specific action to take given the facts. We alert employees about representatives who have been suspended or disqualified, and we maintain a website of sanctioned representatives. We also publish instructions about specific situations through our administrative and emergency message process.

**6. What have been the results of the reviews by Ms. Disman's staff of other cases from Puerto Rico that involved the same doctor, claimant representative or facilitator arrested in the investigation?**

We are still in the process of conducting redeterminations under section 205(u) of the Act but do expect to complete the initial redetermination of those cases not decided by an administrative law judge soon. Due to the ongoing criminal investigation, we would be happy to provide you the results in a private briefing.

**7. What would the cost be to make Cooperative Disability Investigation units available in every State?**

There are currently 29 States without CDI units. Based on current estimates, the average one-time cost to open a new facility is approximately \$300,000 per CDI unit, so it would cost nearly \$9 million to fund the new infrastructure needed for 29 new units.

Based on actual experience, ongoing annual operating costs to staff and support CDI operations are approximately \$800,000 per CDI unit – which includes both SSA- and OIG-funded costs. These ongoing operational costs include law enforcement contracts, vehicles, IT equipment, supplies, facilities, and SSA and OIG staff salaries. Therefore, if we were to add 29 additional CDI units, the ongoing annual cost alone would be approximately \$24 million.

As mentioned in the anti-fraud report we submitted to the Subcommittee on February 14, 2014, we plan to expand the number of CDI units from 25 to 32 by the end of FY 2015. With sustained, adequate funding, we will be able to continue to increase the number of units in future years.

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**8. What is the cost of placing a Social Security attorney in a U.S. Attorney's office to help prosecute fraud?**

We estimate that it would cost us roughly \$150,000 to place one of our attorneys in a U.S. Attorney's office as a fraud prosecutor. We currently have 12 attorneys serving as fraud prosecutors and plan to double that number.

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[Submissions for the record follow:]



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

**Statement for the Record**

**Hearing on the Social Security Disability  
Fraud Scheme in New York**

**Subcommittee on Social Security  
House Committee on Ways and Means**

**January 16, 2014**

**Submitted on behalf of the Co-Chairs of the Consortium for Citizens with Disabilities  
Social Security Task Force:**

Jeanne Morin, National Association of Disability Representatives  
TJ Sutcliffe, The Arc of the United States  
Rebecca Vallas, National Organization of Social Security Claimants' Representatives  
Ethel Zelenske, National Organization of Social Security Claimants' Representatives

\* \* \* \*

The Consortium for Citizens with Disabilities (CCD) is a working coalition of national organizations working together to advocate for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of the 54 million children and adults with disabilities in all aspects of society. The CCD Social Security Task Force focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program.

The Co-Chairs of the CCD Social Security Task Force submit this Statement for the Record of the January 16, 2014, House Ways and Means Social Security Subcommittee hearing on the Social Security Disability Fraud Scheme in New York.

Approximately 100 former police officers, firefighters and others were recently indicted in New York City for allegedly fraudulently obtaining Social Security Disability Insurance benefits. The allegations are extremely troubling, and if true, these individuals' actions are nothing short of deplorable.

We condemn any misuse of the Social Security disability programs. Any individual who seeks to abuse vital programs like Social Security does so at the expense of the millions of disabled workers for whom benefits provide essential economic security -- and must be brought to justice.

We encourage anyone who suspects abuse of the Social Security disability programs to report it via Social Security's hotline 1-800-269-0271 or online at [www.oig.ssa.gov](http://www.oig.ssa.gov).

At the same time, we must take care not to paint Social Security's disability programs with the brush of the few who aim to defraud it, without putting them in the context of the millions of individuals who receive benefits appropriately and for whom Social Security is a vital lifeline.

Social Security's disability programs are a core component of our nation's Social Security system, which keeps millions of hardworking Americans and their families out of poverty. Extremely strict eligibility requirements mean that fewer than four in ten applicants are approved for disability benefits, even after all stages of appeal. Demonstrating eligibility requires extensive medical evidence, and many individuals are denied benefits despite significant disabilities and chronic illnesses. Benefits are modest but vital -- averaging just over \$500 per month for Supplemental Security Income and approximately \$1,130 per month for Social Security Disability Insurance (SSDI). For many, disability benefits make it possible to secure stable housing and purchase food, life-sustaining medications, and other basic necessities. Disability benefits can be the difference between life and death for many Americans.

The SSDI program provides vital and much-needed economic security and access to health care for individuals whose impairments are so severe that they preclude substantial work. We recognize the importance of ensuring that Social Security disability payments are only made to people who are entitled to receive them and that the amount of the payments are accurate. The Social Security Administration (SSA) does a good job of ensuring that payments are accurate. Acting Commissioner Colvin pointed out in her testimony at the January 16, 2014, Subcommittee hearing that SSA has one of the lowest error rates in the government, with a less than 1% rate of inaccurate payments for the SSDI program. Although this low error rate is good compared to other government agencies and programs, the undersigned organizations of the CCD Social Security Task Force believe that more needs to be done to prevent overpayments and are concerned that recent appropriations decisions will undermine these efforts.

#### **SSA Requires Adequate Resources for Program Integrity**

SSA must have sufficient resources to meet the service needs of the public and ensure program integrity. SSA's administrative budget is only about 1.4 percent of benefits paid out each year. With the baby boomers entering retirement and their disability prone years, SSA is experiencing dramatic workload increases at a time of diminished funding and staff. For the two years prior to fiscal year (FY) 2014, Congress appropriated \$421 million less for SSA's program integrity efforts (such as medical and work continuing disability reviews and Title XVI redeterminations) than the Budget Control Act of 2011 (BCA) authorized. Over the three years prior to FY 2014, SSA received nearly \$1 billion less for its Limitation on



Administrative Expenses (LAE) than the President's request, and lost over 11,000 employees since FY 2011.

We are encouraged that the recently enacted budget bill for FY 2014 includes full funding of the FY 2014 BCA level for SSA's program integrity reviews. This will allow SSA to significantly increase continuing disability reviews (CDRs).

Adequate LAE is essential to preventing service degradation and ensuring that SSA can provide timely and accurate payments and perform necessary program integrity work, including:

- **Disability claims processing.** Adequate resources support claims processing and disability determinations at the initial levels so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Inadequate staffing at field offices and state Disability Determination Services (DDS) leads to increased workload at the hearing level. Disability claims may be less thoroughly developed, leading to incorrect denials of benefits and more appeals. Additionally, the significant progress made in recent years at the hearing level in reducing average wait times until hearings and shrinking the disability claims backlog has eroded due to the lack of needed resources.

- **Pre-effectuation and continuance reviews<sup>1</sup> of DDS determinations.** As required by the Social Security Act, SSA conducts pre-effectuation reviews of at least half of all DDS initial and reconsideration allowances for Title II (Social Security) and Title XVI (Supplemental Security Income) adult disability benefits. SSA also reviews a number of DDS Title II CDR determinations that result in continuation of benefits. For every dollar spent in FY 2011 on these reviews SSA estimates a lifetime savings of about \$11 in Title II and Title XVI benefits.<sup>2</sup>

- **Disability Determination Services quality review.** SSA has implemented multiple levels of quality review at the DDS level. For example, SSA requires all DDSs to have an internal quality assurance function, and also operates an Office of Quality Performance (OQP) which conducts quality assurance reviews of samples of initial and reconsideration determinations of the DDSs.

- **Review of Administrative Law Judge (ALJ) decisions in a manner consistent with law.** While ALJs have qualified decisional independence, they are required to follow SSA laws, regulations and policies. SSA has implemented a quality review process for ALJ decisions. In FY 2011, the SSA Office of Disability Adjudication and Review (ODAR) established a new Quality Review (QR) initiative and opened four new Branches in the Office of Appellate Operations. The QR Branches review a computer-generated sample of unappealed favorable ALJ decisions (over 7,000 in FY 2012), pre-effectuation, and then refer cases to the Appeals Council for possible review. If the Appeals Council accepts review, it can remand or issue "corrective" decisions, which may involve changing the favorable ALJ decision to a "partially" favorable decision or to an unfavorable decision. There is also some post-

<sup>1</sup> "Pre-effectuation" refers to reviews conducted before benefits are authorized to be paid. Accordingly, "continuance reviews" and "post-effectuation reviews" are conducted after benefit authorization.

<sup>2</sup> Social Security Administration, June 27, 2013, Annual Report on Social Security Pre-Effectuation Reviews of Favorable State Disability Determinations, Fiscal Year 2011.

effectuation review of ALJ decisions. While these ALJ decisions cannot be changed, post-effectuation review enables targeted examination of compliance with agency policies and policy guidance and additional training as needed to ensure high quality decision-making.

- **CDRs and redeterminations.** SSA is required by law to conduct CDRs in all cases where the beneficiary's condition is expected to improve, or where improvement is considered possible, to ensure that benefits are paid only as long as the individual remains eligible. SSA estimates that every \$1 spent on medical CDRs saves the federal government \$9, but reports a current backlog of 1.3 million CDRs. We are hopeful that the additional resources in the FY 2014 budget will allow SSA to significantly increase the number of medical and work CDRs and SSI redeterminations it is able to conduct. Work CDRs are discussed in more detail below.

- **Cooperative Disability Investigations (CDI).** SSA and the Office of the Inspector General (OIG) jointly established the CDI Program in 1998. Twenty-five CDI units across the U.S. investigate individual disability applicants and beneficiaries, as well as potential third parties who facilitate disability fraud. SSA or DDS personnel make referrals to a CDI unit for investigation, and CDI units also accept reports from the public via a toll-free telephone hotline and an online web form. Investigations uncovering fraud or attempted fraud can result in a denial, suspension, or termination of benefits, civil or criminal prosecution, and/or imposition of civil monetary penalties, and/or sanctions on claimant representatives for violation of SSA's ethical standards. Since the program's inception in FY 1998, CDI efforts have resulted in \$2.2 billion in projected savings to SSA's disability programs, with more than \$860 million just over the last three years, as Acting Commissioner Colvin noted in her testimony for this hearing.

**Delay in Processing Work CDRs Due to Inadequate Staffing Results in Significant Overpayments and Hurts People with Disabilities**

An SSDI beneficiary who goes to work is required to report his or her earnings to SSA so that a work CDR can be performed and benefits can be adjusted when appropriate. If the earnings report is processed in a timely manner, the benefits are adjusted and no overpayment results. However, if SSA lacks the staff to process earnings reports in a timely manner, the beneficiary is likely to receive an overpayment. The longer the delay in processing, the larger the overpayment will be. According to January 2012 testimony by Acting Commissioner Colvin before this Subcommittee,<sup>3</sup> SSA has allocated additional resources to work CDRs, targeting cases with the oldest earnings reports – those more than a year old. During the hearing, she stated that it takes more than 270 days on average for SSA to complete a work CDR. Every month that passes from the time that a beneficiary reports earnings before a work CDR is completed increases the likelihood of a large overpayment.

This delay in processing of earnings reports often has a very detrimental impact on people with disabilities. When beneficiaries faithfully notify SSA of earnings or other changes that may reduce their benefit payment amounts, as noted above, it may be months or years before SSA sends an overpayment notice to the beneficiary, demanding repayment of sometimes tens of thousands of dollars of accrued overpayments. It is shocking to beneficiaries to

<sup>3</sup> "Securing the Future of the Social Security Disability Insurance Program: Combating Waste, Fraud, and Abuse," Subcommittee on Social Security, House Committee on Ways and Means, January 24, 2012.

receive these notices, when they reasonably assumed that SSA had processed the information they submitted, and it is challenging, if not impossible, for someone subsisting on benefits alone to repay the overpayments. Many individuals with disabilities are wary of attempting a return to work out of fear that this may give rise to an overpayment, resulting in a loss of economic stability and health care coverage upon which they rely.

SSA needs to develop a better reporting and recording system and promptly adjust benefit payments –thus preventing these overpayments. It is important to note that, in and of themselves, **overpayments do not indicate fraud or abuse as beneficiaries are encouraged to work if they are able.** The problems arise when reported earnings are not properly recorded and monthly overpayments are not properly adjusted. SSA must have adequate resources and staffing to allow the agency to reduce both the backlog and processing time of earnings reports.

\* \* \*

### **Conclusion**

The Social Security Administration works hard to ensure program integrity, but it requires adequate resources to do so. It has been deprived of adequate administrative resources to conduct necessary program integrity work for several years. We look forward to working with Congress to enable the Social Security Administration to ensure that benefits are paid to the right person, in the right amount, and at the right time — and to implement the array of critical safeguards that exist in current law.



**Letter of Elsibeth Brandee McCoy**

Elsibeth Brandee McCoy  
mccoybrandee@hotmail.com  
Sarah Carver  
Sarah\_paralegal@yahoo.com

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January 17, 2014

Chairman Johnson  
Committee on Ways and Means Committee

Re: SSA/ODAR Huntington, W.Va. - The Agency has promoted and rewarded managers for engaging in reprisal and has paid an employee \$31,000 in what appears to be hush money for her participation in scheme to "take out" a whistleblower

Chairman Johnson,

Thank you for asking Commissioner Colvin if she is going to hold managers in West Virginia responsible on January 16, 2014 in the hearing before the Committee on Ways and Means. I regret to hear she reported that, "We're not making any changes in the administration at all. There is no suggestion, in my understanding, that we need to do that at this time."

**Background**

We are employees in Huntington, WV that reported to Senator Coburn's investigative staff that a whistleblower, Sarah Carver, was followed by a private detective. I, Brandee McCoy, found out after my Hearing Office Director Stephen Hayes and an employee Sandra Dyer admitted that they conspired to stalk Carver in an effort to ruin her credibility before the United States Senate Committee on Homeland Security and Governmental Affairs and then have her fired. Dyer also implicated Chief Judge ALJ Sherri Laba. With the release of the staff report released by the United States Senate Committee on Homeland Security and Governmental Affairs; *How Some Legal, Medical and Judicial Professionals Abused Social Security Disability Programs for the Country's Most Vulnerable: A Case Study of the Conn Law Firm* on October 7, 2013 we discovered that Chief ALJ Charlie P. Andrus and Eric C. Conn also participated in the scheme. Some of these facts have also been confirmed by the Office of General Counsel and Office of Inspector General for the Agency.

Stephen Hayes and Sherri Laba were promoted and Sandra Dyer has been placed on administrative leave and paid \$31,000 allegedly in consideration, "to keep her mouth shut." Charlie Andrus has been allowed to retire on the taxpayer's dime. Sadly, managers John Patterson and Carrie Roland knew that Sarah was stalked long before I made disclosures in

the spring of 2012. Specifically they received a fabricated video tape from Eric C. Conn, an attorney accused of case fixing. Through the discovery process it has come to employee's attention that managers including, Bobby Bentley, seek guidance from **Deputy Commissioner's Glen Sklar's** office on how to silence and break employees who speak out about the prohibited personnel practices in this office. Since we have made disclosures, we have weathered storms of reprisal. Others who speak out are on the fast track of removal. There would be more but employees live and work in fear of losing a "good job."

#### **Proposed Solution**

With all due respect, we are asking the Committee to place a bite in the NO FEAR ACT and recommend to the agency that these managers be removed from their positions and barred from federal service. Instead, many have been promoted or have been giving training opportunities in New York (during holiday season on the taxpayers dime). Managers who have engaged in the reprisal lack the necessary legal knowledge and moral compass to spot and weed out corruption. With the tools they have available to them managers have financially handicapped, bullied and ostracized employees in Huntington and New York for speaking out or cooperating in investigations. Finally, managers have cost the agency and taxpayers a considerable amount of time, money and resources by forcing employees to file grievances with the Union, EEO, OSC, MSPB and their elected representatives to seek redress due to the reprisal.

#### **West Virginia's Connection to New York**

Please be advised that there may be a link between Huntington and New York, NY. During the course of the 2011 congressional and criminal probe into the Huntington ODAR hearing office, the agency may have rid the office of all NY files. Last week, I asked the Chief of Police to report the FBI in New York, NY that the Huntington ODAR office completed 8,000 cases from New York from the years of 2003-2005. Sarah Carver reported the information to investigators from the Committee on Homeland Security and Governmental Affairs. We both called prosecutors in New York and given the lead.

Sincerely,

McCoy/Carver



**Statement of Larry Butler**

The opinions and positions stated in this submission for the record are personal and do not represent the opinions and positions of any other person or organization. This statement submitted for the record should be attributed only to:

**NAME:** LARRY J. BUTLER  
**ADMINISTRATIVE LAW JUDGE**  
**ADDRESS:** SOCIAL SECURITY ADMINISTRATION  
OFFICE OF DISABILITY ADJUDICATION & REVIEW  
3650 COLONIAL BOULEVARD, SUITE 210  
FORT MYERS, FL 33966-1157  
**TELEPHONE:** 888-462-1109 X 15500  
**CONTACT E-MAIL ADDRESS:** Larry.J.Butler@ssa.gov  
**TITLE OF HEARING:** HEARING ON THE SOCIAL SECURITY DISABILITY FRAUD  
SCHEME IN NEW YORK  
**DATE OF HEARING:** JANUARY 16, 2014  
  
**DATE OF SUBMISSION:** JANUARY 26, 2014

Dear Chairman Johnson, Ranking Member Becerra and Subcommittee Members,

Please review the copy below of an E-mail dated October 9, 2013 directed to Acting Commissioner of Social Security (COSS) Carolyn W. Colvin. A copy of the October 9, 2013 E-mail was simultaneously forwarded to numerous other Office of Disability Adjudication & Review (ODAR) managers.

No acknowledgement of receipt or response to my October 9, 2013 E-mail was ever received from Acting COSS Colvin or any other ODAR manager.

My October 9, 2013 E-mail recommends that fees remitted directly by the Social Security Administration (SSA) to representatives (both attorney and non-attorney) be posted on-line. At the present time, SSA withholds approximate \$2 billion per year in retroactive claimant Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits which is paid directly to representatives for fees.

Why is SSA involved in collecting fees for representatives? Are the amounts of fees that representatives are currently authorized to charge for claimant representation in the disability determination and adjudication process excessive and unjustifiable?

Thank you.

**From:** Butler, Larry J.  
**Sent:** Wednesday, October 09, 2013 12:04 PM  
**To:** Colvin, Carolyn  
**Cc:** Sklar, Glenn; Borland, Jim; Bice, Debra HQ ODAR; Garmon, Ollie; D'Alessio, Rossana; Evans, M. Dwight; Evans, George L.; Pearce, Charles C. ODAR Hattiesburg HO; Strauss, Hazel C.; Rodriguez, David; Snook, Thomas; McLaughlin, Patrick F.; Gilbert, Michael; Willy, Donald J.; 'Wenzel William (wawenz@gmail.com) (wawenz@gmail.com)'; Eppler, Rita S.; Gold, Joe; Davenport, G. William; Auslander, Charles; 'Frye, D. Randall'; Zahm, Marilyn; Glendening, Dale; Brown, Mark A. ODAR St. Louis HO; Valentino, Peter; Filion, Cheri L.; Clark, William; Martinelli, Peter; Sotolongo, Ariel; Stagno, Linda A.; Thompson, Edward L.; Loucas, Penny; Wolfe, Jeffrey ODAR Tulsa HO; Gaffaney, George; Benagh, Christine (Christine.Benagh@ssa.gov); Round, Edmund; Fier, Seymour; Hoppenfeld, Marilyn; Nisnewitz, David; Cofresi, Michael D.; Reeves, Martha R.; Weaver, Cynthia; Burgess, John R.; 'j.e.sullivan@dot.gov'; Ray, Thomas Mercer; Ayer, Francis; 'Swank.Drew.A - OALJ'; Armstrong, Paul R.; Gatewood, Tela L.; Deramus, Osly F.; Sifford, Bobbi; Daniels, Thomas; Northington, Maria; 'kdonahue@osc.gov'; 'dcash@osc.gov'; O'Carroll, Pat  
**Subject:** REQUEST TO PUBLISH ON-LINE AMOUNTS OF FEES PAID BY SSA DIRECTLY TO REPRESENTATIVES (ATTORNEY & NON-ATTORNEY) IN THE SSDI & SSI PROGRAMS (FY 2008 - FY 2012)

Dear Acting COSS Colvin,

**Please consider this a request for the Social Security Administration (SSA) to post on-line information related to the direct payments of fees by SSA to Social Security Disability Insurance (SSDI) and Supplement Security Income (SSI) representatives—both attorney and non-attorney--for Fiscal Years (FY) 2008 through 2012.**

If the following specific information is available regarding the direct payment of representative fees FY 2008 through FY 2012, please state:

- (1) What percentage of total fees paid directly by SSA to representatives was solely for representation at the State Disability Determination Services (DDS) level (this is, DDS awarded disability benefits to the claimant),
- (2) What Office of Disability Adjudication & Review (ODAR) Hearing Office or DDS field office was involved in making the disability decision resulting in payment of claimant benefits and representative fees,
- (3) What percentage of SSA's direct payment of fees to representatives was based upon:
  - (a) Fee Agreements (25% of retroactive benefits awarded up to \$6,000 maximum), and
  - (b) Fee Petitions (25% of retroactive benefits awarded with no maximum).

It should be noted that the retroactive benefit calculation includes all collateral benefits awarded to the claimant's spouse and children--not merely the claimant's retroactive benefits.

- (4) What amount of "reasonable attorney fees" did SSA pay attorneys from FY 2008 through FY 2012 based upon the *Equal Access to Justice Act (EAJA) (28 USC 2412)* when SSA voluntarily agreed to remand cases from federal district court for further administrative proceedings?

Attorneys receive an award of reasonable attorney fees at the federal district court level when SSA agrees to remand a case for further proceedings. The award of reasonable attorney fees is based upon the *Equal Access to Justice Act (EAJA) (28 USC 2412)*. 50% of appeals filed in federal district court are remanded for further proceedings by agreement with SSA--rather than SSA defending a decision in federal court denying benefits that typically has been reviewed twice at the DDS level, once by an administrative law judge (ALJ) after a hearing and finally by the Appeals Council (AC) which affirmed the ALJ decision and the DDS denial of benefits.

- (5) How much has SSA paid to reimburse representative travel expenses incurred to attend hearings from FY 2008 through FY 2012? Representative travel expense reimbursement is based upon *41 CFR Chapter 301; 20 CFR 404.999a - 999d; 20 CFR 404.938; 416.1438*.

On December 30, 2008, the Portland Oregonian first published administrative law judge (ALJ) statistical data on-line that the newspaper had obtained from SSA for the period 2005 to 2008. The Portland Oregonian pursued its Freedom of Information Act (FOIA) request for ALJ statistical data as a result of its attempt to determine the identity of a "billion dollar judge" the newspaper had heard rumors of. Since 2009, ALJ statistical data has been published on-line: [http://mwww.ba.ssa.gov/appeals/DataSets/03\\_ALJ\\_Disposition\\_Data.html](http://mwww.ba.ssa.gov/appeals/DataSets/03_ALJ_Disposition_Data.html). The Portland Oregonian publication of ALJ statistical data on December 30, 2008 was the first time that the general public (and ALJs in general) became aware of the existence of "billion dollar judges" operating within the SSDI and SSI disability insurance programs.

The amounts of direct payment of fees by SSA to representatives from withheld retroactive claimant benefits, the amounts paid by SSA for *EAJA* awards and the amounts paid by SSA to reimburse representative travel expenses all involve expenditure of taxpayer funds. The general public is entitled to know this information. This is information that can be obtained pursuant to the *FOIA*. The rationale and reasons for releasing this information to the public would be the same as the rationale and reasons applied when SSA decided to release ALJ statistical data on-line.

**Could you please have a member of your staff inform me whether SSA intends to post representative fee information on-line in the near future?**



**If SSA does not intend to do so, could a member of your staff please inform me of the rationale and reasons for SSA's decision not to do so.**

Thank you.

LARRY J. BUTLER, ALJ  
ODAR SATELLITE OFFICE  
3650 COLONIAL BOULEVARD, SUITE 210  
FORT MYERS, FL 33966-1157

TEL: 888-462-1109 X 15500  
FAX: 239-278-0684 (OFFICE)  
E-MAIL: [Larry.J.Butler@ssa.gov](mailto:Larry.J.Butler@ssa.gov)

## Statement of Michael Gilbert

These materials are for the House Committees on Ways and Means Subcommittee on Social Security/Oversight and Government Reform Subcommittee on Energy Policy, Health Care, and Entitlements [SOCIAL SECURITY DISABILITY PROGRAM REFORM]:

### 25 Theses in Social Security Disability Case Processing

REGARDING THE SOCIAL SECURITY DISABILITY ADJUDICATION PROGRAM [ODAR]

#### PART I: UNVALIDATED AGENCY ALJ PROCESSING QUOTAS LEAD TO BILLIONS OF DOLLARS IN UNWARRANTED ENTITLEMENT OBLIGATIONS

DID YOU KNOW?

1. Average case sizes in some regions require judges [ALJs] to read at a minimum, over a 400,000 pages of evidence per year just to meet the minimum disposition requirements of SSA? (This is the equivalent of more than 1333 novels per year).
2. Consequently, the data available strongly suggests that judges are not reading (and cannot possibly read) all the evidence? Many assume the decision drafting attorney-writer will.
3. The decision drafting attorney-writers DO NOT read all the evidence? They assume the judge did.
4. That SSA has never validated the workplace duties of ALJs with any objective metrics?
5. That SSA has never tested any ALJ to ensure that any given ALJ knows the regulations in this specialized area of law AND can apply those rules to a given set of facts?
6. These disconnects amount to billions of dollars in entitlement obligations based upon failure to read, let alone properly evaluate claims?

Metrics provided upon request.

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#### PART II: ADJUDICATION AND EVIDENCE DEVELOPMENT RESTRICTIONS IMPOSED ON ALJS

DID YOU KNOW?

SSA Judges are expressly PROHIBITED from:

1. Ordering an \$89 malingering test [MMPI]? This is true even though:
  - a. The medical evidence contains significant evidence of malingering and the testing is expressly requested by the:
    - i. Medical expert;
    - ii. Consultative examiner;
    - iii. Treating source doctor, or the representative.
  - b. It can save \$300, 000 in lifetime benefits, and *is expressly provided for* in our regulations.
  - c. Experts note over 50% of adult Disability Determination Service (DDS) claimants fail some form of Symptom Validity Testing in every jurisdiction studied. Over 40% of adult DDS claimants are found to meet conservative guidelines for symptom *invalidity*. See, American Academy of Clinical Neuropsychology Response to Notice of Proposed Rulemaking for the Revised Medical Criteria for Evaluating Medical Disorders. November 2010.

These materials are for the House Committees on Ways and Means Subcommittee on Social Security/Oversight and Government Reform Subcommittee on Energy Policy, Health Care, and Entitlements [SOCIAL SECURITY DISABILITY PROGRAM REFORM]:

2. Ordering an \$18 dollar, criminal history record on a claimant, but must rely upon the claimant's veracity about their criminal history? This is true even though their impairments may be expressly barred by regulation when they arise as part of the commission of a felony.
3. Accessing public websites such as local court databases to access the claimant's criminal history or public SOCIAL MEDIA websites [FACEBOOK, MYSPACE] of claimants?
4. Ordering a physical capacities exam, or PCE, even when expressly requested by a doctor, and even though it is the gold standard of evaluating an ability to perform work-like functions?
5. Providing more than 40 pages from the medical file (that may be over 1000 pages) when ordering a consultative exam?
6. Reporting attorney misconduct to the local bar no matter how egregious?
7. Applying a sanction for any act or omission made during the hearing process – either against the claimant or their attorney?
8. Drawing an adverse inference when claimants and representatives ignore specifically requested information requests?
9. Reporting criminal activity of claimants, discovered during the hearing process to local authorities or other federal agencies – tax fraud, VA disability fraud, failure to carry mandatory auto insurance?
10. Crosschecking third party witnesses' statements with the statements made by this same witness contained within their own pending application for disability benefits?
11. Crosschecking a claimant's statements with a statement they made in the third party witness's pending disability claim? [Claimants often "cross-vouch" for each other in their respective pending applications].
12. Ordering production of documents, timely discovery or request for admissions from the claimant – the person requesting disability?
13. Directing the claimant take a drug test, even when the doctor recommends it, the claimant agrees, and even when the prominent feature in the case is substance abuse?
14. Setting a deadline for submission of evidence in order to close the record of the proceeding?

PART III: LACK OF STANDARDIZED PROCEDURAL SAFEGUARDS AND UNWARRANTED COSTS

DID YOU KNOW?

1. There are no real procedural rules in place to properly administer the adjudicatory hearing process?
2. SSA PAYS for attorney representatives to travel to the hearing regardless of whether the claimant is disabled or not?
3. SSA PAYS to buy the claimant's medical records even when the claimant has an attorney AND even when the claimant is not indigent?

These materials are for the House Committees on Ways and Means Subcommittee on Social Security/Oversight and Government Reform Subcommittee on Energy Policy, Health Care, and Entitlements [SOCIAL SECURITY DISABILITY PROGRAM REFORM]:

4. It is not uncommon for representatives to withdraw at the 11<sup>th</sup> hour, triggering: delay, expense of experts (who are entitled to being paid, given the late notice), and mandatory continuances?
5. Medical experts get a flat fee of \$160. They are paid this fee to review the voluminous file AND to testify at the hearing. Considering the size of these files, it is very likely that many of these medical experts simply skim the record.

PART IV: SOLUTION:

Please exercise oversight responsibilities to restore/establish the integrity of these vital programs. The following solutions create the foundation for meaningful goals, permanent core competencies of ALJs, procedural accountability of representatives/claimants with timely processing, and significantly improve the likelihood that vital entitlement resources are directed to those who truly meet the criteria:

1. Amend the Act<sup>1</sup> to expressly direct the OPM and the SSA to conduct an objective validation study of the ALJ workplace procedures, including metrics  **tied to case size and applying the applicable regulations/rules**. (ALJ's must read the entire record whenever a case cannot be approved based solely upon the objective medical evidence. See, SSR 96-7p). Validation is essential to establish a baseline production goal applicable across the country – as case size varies, (the volume of evidence to consider), so does the goal. The SSA has been setting policy and providing sworn testimony about case production based solely upon unvalidated anecdotal models – this is sophistry. The SSA keeps myriad metrics, but does not keep a single metric on average case size; this is a critical and fundamental flaw that undermines any attempt to reform the system. An annual quota of 500-700 cases per year *without any notion of individual disability case size* resolves to *reductio ad absurdum* in the face of even meager metrics demonstrating that actual case size in any given office is greater than about 180-200 pages. However, detailed metrics of the last 850+ cases demonstrate that the average case file is *four times this amount*.
2. Amend the Act to expressly direct the OPM and the SSA to begin objective testing of all ALJs to ensure they are competent to hold hearings and issue decisions. (Assuming a case value of \$300,000 and an individual ALJ SSA quota of 500 cases per year means a single ALJ has the potential to obligate 150 million dollars per year in entitlement obligations). The American people have a right to know that their ALJs are performing their jobs with competency. There is significant objective evidence that in many cases, competency is not the norm. See, "Math for ALJs." See, the Senator Coburn study. The Administrative Procedure Act does not prevent testing core competencies, only performance appraisals. Congress should direct through

<sup>1</sup> SSA is an executive agency. While Congress can provide oversight – that oversight has been ineffectual as these matters represent long-term dysfunction in the disability adjudicatory model. The most effective way to correct the root of these matters is through amending the Act. Both of the undersigned ALJs have significant leadership and litigation experience, but each has less than 5 years' experience with the SSA. Their outside experiences (military) and elsewhere bring fresh eyes to these matters and represent a view distinct from SSA management, the ALJ union, and academic commentators.

These materials are for the House Committees on Ways and Means Subcommittee on Social Security/Oversight and Government Reform Subcommittee on Energy Policy, Health Care, and Entitlements [SOCIAL SECURITY DISABILITY PROGRAM REFORM]:

- amendment that the passing of objective testing be a condition of employment. The testing should be based upon the work place validation above.
3. Amend the Act to expressly direct the SSA to provide for a cohesive and enforceable set of procedural rules.
  4. Amend the Act to expressly direct the SSA to provide for the ordering of tests and evidence that enhance credibility analysis, and crosscheck statements contained in other disability files.

**These suggestions are not discussed or raised by SSA management because** the agency is not interested in objective validation because the true size of these cases will demonstrate that 500-700 cases per year is impossible in the vast majority of jurisdictions. **The ALJ union will not support** validation, as it will lead to objective measures by which ALJs can be held accountable – through objective testing and certification. Objective certification is not the same as performance evaluations; therefore, it would not violate the APA. Similar to security clearances, *objective certification can be a condition of employment.*

Validation is routinely done in the employment context;<sup>2</sup> OPM has the capacity to perform it with outside assistance. The military judicial model does have objective testing before certifying officers as competent to handle criminal trials. This model ensures that those ALJ unable to handle the validated core requirements of the job are no longer employed. This model certifies *objectively*, what is necessary to properly adjudication a case in accordance with the regulations, AND ensures that ALJs who hold hearings, 1) know the law; and 2) can apply the law and procedures to reach just outcomes in disability hearings. These two steps, validation and certification, will drastically correct the unsustainable disparity between pay and deny rates of the ALJ corps. It will bring accountability. The individual ALJ must demonstrate (*objectively*) core competencies before holding hearings and committing taxpayers dollars. The agency is accountable in that the validation of the adjudicatory model will demonstrate that the various regulations, SSRs and policies, when applied against the volume of evidence, require significantly more than the suggested “2.75 hours per case” to properly adjudicate.

Procedural rules are essential to the functioning of any adjudicatory model. The failure to have binding procedural rules is the deepest failure of agency leadership. This is not a new program. Moreover, ALJs’ ability to ferret out credibility concerns continues to be more restricted, despite the overwhelming empirical evidence that shows that validity testing is essential. The ability to test credibility is essential to evaluating any case involving subjective statements of limitations.

These matters provided under 5 USC 7211. These are not unsubstantiated anecdotal allegations, citation to regulation and agency policy can be provided upon request, as can specific examples and metrics.

Although the undersigned are both ALJs in the SSA Tacoma WA office, these are made in the personal capacity, and do not represent the opinions of SSA or any other organization.

s/s Michael Gilbert;

s/s Scott Morris

<sup>2</sup> Judge Gilbert holds an LLM in Labor and Employment law, cum laude.

**NATIONAL ORGANIZATION OF  
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES  
(NOSSCR)**

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*Executive Director*  
Barbara Silverstone

**Written Statement for the Record  
on behalf of the  
National Organization of Social Security Claimants' Representatives**

**Hearing on the Social Security Disability  
Fraud Scheme in New York**

**Subcommittee on Social Security  
House Committee on Ways and Means**

**January 16, 2014**

**Submitted by:**  
Barbara Silverstone, Executive Director

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These comments are submitted on behalf of the National Organization of Social Security Claimants' Representatives (NOSSCR) as a Statement for the Record of the January 16, 2014, House Ways and Means Social Security Subcommittee hearing on the Social Security Disability Fraud Scheme in New York.

Founded in 1979, NOSSCR is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability or Supplemental Security Income ("SSI") benefits. NOSSCR members represent these individuals in legal proceedings before the Social Security Administration and in federal court. NOSSCR is a national organization with a current membership of more than 4,000 members from the private and public sectors and is committed to the highest quality legal representation for claimants.

In January 2014, a group of approximately 100 former police officers, firefighters and others were indicted in New York City for allegations of fraudulently obtaining Social Security Disability Insurance benefits, as part of what is being described in news reports as a concerted action over a long period of time. The allegations are extremely troubling and deserve close scrutiny by the Social Security Administration and law enforcement.

NOSSCR condemns any misuse of the Social Security disability programs. If true, the allegations are beyond reprehensible. Any individual who seeks to abuse the Social Security disability programs does so at the expense of the millions of Americans with significant disabilities and severe illnesses who receive benefits appropriately, and for whom benefits are a vital lifeline – and should be brought to justice.

As an organization that fights for the economic security of American workers with disabilities and their families, we cannot allow the bad behavior of a few bad apples jeopardize the crucial benefits of the disabled workers who receive benefits appropriately, whom our members see in their work single every day.

The Social Security Administration (SSA) works hard to ensure program integrity, and thankfully fraud is extremely rare – but even one instance of abuse is unacceptable. SSA has been deprived of the administrative resources it requires to conduct necessary program integrity work for several years. Congress must provide SSA with sufficient administrative resources to ensure that benefits are paid to the right person, in the right amount, and at the right time – and to implement the array of critical safeguards that exist in current law.

In addition to these comments, NOSSCR supports the Statement for the Record submitted by the Co-Chairs of the Consortium for Citizens with Disabilities Social Security Task Force.

**Letter of Veronica Mayer**

January 19, 2014

The Honorable Sam Johnson  
United States House of Representatives  
Chairman on the Subcommittee on Social Security  
Ways and Means Committee Office  
1102 Longworth House Office Building  
Washington D.C. 20515

Dear Representative Johnson:

My name is Veronica Mayer, a resident of Arlington Texas, a person with disabilities, and social justice advocate. In 2005 and 2007, I was diagnosed with Multiple Sclerosis. I was determined to be disabled in May 2008 and have been receiving SSDI since April 2009. And I have been under medical review since December 2012.

I am writing to you regarding the hearings related to Social Security Disability Insurance Benefits. What are the proposed measures to detect fraud but protect those with legitimate claims?

As I review the various press releases and media articles, I do not see any quotes from citizens like me. It seems as if citizens who are educated (I have two Master's degrees) and earned 'high pay' (\$40k+) are penalized if we need to work part-time. And we're still paying federal income tax, state income tax, Medicare, and Social Security. My perception is we're paying into a system we cannot utilize.

At no time have I ever had any malice intention to defraud the system that I have paid into for 20 years. My plan was to return to financial self-sufficiency by 2013. I have determined, in order to repay the proposed overpayments, I would have to earn \$2700 per month. And I would have to earn \$3300 to include my student loan debt. Unfortunately, an increase in hours worsen my symptoms.

One of the biggest obstacles to having a diagnosis like Multiple Sclerosis is getting the public and Social Security Administration to understand it. The symptoms are tailor-made to each person, arbitrarily, with no way to know when it's coming or how long it will last. So 'very flexible' part-time opportunities are the only other means of income. A lot of us have medical expenses that are about 33% of our SSDIB. On a daily basis, we have to make decisions between basic necessities and medical care expenses.

I commend the Honorable Carolyn Colvin, Social Security Administration Acting Commissioner, the Honorable Patrick P. O'Carroll Jr., Social Security Administration Inspector General, and the House Ways and Means Subcommittee on Social Security on trying to make the system better. I hope it's not to the detriment of citizens like me. And I appreciate your time and hope for the best.

Respectfully  
Veronica Mayer  
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