PART TWO

Selected Aspects of Disability Decision Making

EXPLANATION OF MATERIALS

The Board recognizes that significant background information is necessary in order to understand the complexities of the disability programs, including how they have developed and how they are administered. We hope that the following materials will be helpful in this regard. They are not intended to be comprehensive, but merely to provide information on specific aspects that we believe will be most useful to the readers of this document and of the Board's January 2001 report, *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change.*

The materials provide a description of how disability determinations are made, reviewing in some detail the complex process of how adjudicators are required to apply Social Security's definition of disability, using the agency's rules for sequential evaluation of an individual's impairment.

Other materials describe the multiple steps that claimants must follow in applying for DI and SSI benefits and appealing their cases through the administrative and judicial appeals structure.

There is a description of the major initiatives that the Social Security Administration has undertaken since 1994 to improve the disability decision making process. These include the agency's 1996 process unification rulings, the 10-State prototype initiative begun in October 1999, and the Hearings Process Improvement Initiative that was implemented in 2000.

Additional background information includes a summary listing of major disability legislation, a chronology of major court cases that have affected the way disability determinations are made, a description of the components within the Social Security Administration that have responsibilities in the disability process, a bibliography of materials related to disability, and a glossary to explain the terms that are used in the Board's disability reports.

The intent of these materials is not to provide a comprehensive handbook, but simply to make available a selection of materials that describe some of the major aspects of the disability programs.

I. HOW DISABILITY DETERMINATIONS ARE MADE

The Definition of Disability

The Social Security Act defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.[1]

There is no universally accepted statutory definition of disability. There are hundreds of Federal, State, and private disability insurance programs, each with its own specific and different definition of disability. The majority of these programs stress the degree of illness or injury as the primary qualifying criterion. The Social Security definition of disability differs, however, in that the primary eligibility requirement is the inability to work (engage in substantial gainful activity) with the proviso that the inability to work must be due to a medically determinable physical or mental impairment.

The Sequential Evaluation

As a result of Social Security's unique definition of disability, adjudicators must routinely deal with the interplay of complex medical, legal, and vocational concepts. The five-step sequential evaluation process that SSA requires all adjudicators to follow is a deceivingly simple schematic for a process that, because of the diverse impact of impairments on individual human beings, is extraordinarily complex.

Each step of the sequential process requires adjudicators to obtain and consider more and different types of evidence. At the first step only the amount of earnings is needed. At step five, on the other hand, non-medical evidence of eligibility, medical evidence, and vocational evidence are required. Each step of the sequential process requires increasingly complex judgments by adjudicators and requires progressively difficult assessments of increasingly subjective factors.

Although not a formal step in the sequential evaluation process, the 12-month duration requirement is considered at every step of the sequential evaluation process except the first step. With the exception of SSI statutorily blind individuals, any severe or disabling impairments preventing an individual from working must have lasted or be expected to last for at least 12 continuous months or the impairment must be expected to result in death.

The five sequential evaluation steps are followed in the sequence shown below.

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[1] The Social Security Act definition of disability is the same for adults in both the Disability Insurance program and the Supplemental Security Income (SSI) program. However, disabled children are eligible for benefits under the SSI program. To be eligible, individuals under the age of 18 must have a medically determinable physical or mental impairment (or combination of impairments) that causes marked and severe functional limitations and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

1. Is the individual engaging in substantial gainful activity (SGA)?

If the individual is working and earning an average of $700 or more a month (or performing substantial services if self-employed), the claim is denied without considering medical factors. The amount of earnings used to determine if an individual is engaging in substantial gainful activity is established by regulation.[2]

Since according to SSA's work oriented definition of disability an impairment is significant only to the extent that it prevents work, by engaging in SGA, an individual with an otherwise severe medical condition has demonstrated that he or she is not disabled.

2. Does the individual have a severe impairment?

Once the claimant has established that he or she is not presently engaging in SGA, the next step in the process is to establish the existence of a severe medical condition. Fundamental to the disability determination process is the statutory requirement that to be found disabled, an individual must have a medically determinable impairment "of such severity" that it prevents him or her from working.

If an impairment is such that it results in no more than a minimal effect on the individual's physical or mental ability to perform basic work activities, it is considered to be not severe. If the adjudicator determines that an impairment is not severe, a finding is made that the individual is not disabled irrespective of age, education, or previous work history.

If it is determined that the individual has a severe impairment, however, benefits are not awarded summarily. Instead, the claim progresses to the next step in the sequential evaluation.

3. Does the individual have an impairment that meets or equals (i.e., is equivalent to) an impairment described in SSA's Listing of Impairments?

According to Robert M. Ball, Commissioner of Social Security from 1962 to 1973, "The key administrative decision, which was made in the early days of the disability program, and which has governed disability determinations since, was to adopt what may be called a 'screening strategy.' The idea was to screen quickly the large majority of cases that could be allowed on reasonably objective medical tests and then deal individually with the troublesome cases that didn't pass the screen. What is wanted from a physician is not his opinion as to whether someone is 'disabled' or whether he 'can work,' but objective evidence about a condition."[3]

The listing step of the sequential process requires the most exacting and objective level of proof. Like step 2, the listing step is a screening step. It is also the only step where benefits may be awarded solely on the basis of medical factors. If an individual is not working and his

[2] SSA is proposing a change in its current regulations so that each year, based on any increases in the national average wage index, the average monthly earnings guidelines used to determine whether work is substantial gainful activity will be automatically adjusted. *Federal Register*: August 11, 2000 (Volume 65, number 156).

[3] *Social Security Today and Tomorrow*, Columbia University Press, 1978, pp. 157-158.

or her impairment is one of the listed impairments, or an impairment of equal severity, a finding of disability is justified without consideration of the individual's age, education, or previous work history.

The Listing of Impairments is a medical reference base for the determination of those degrees of physical or mental impairment that ordinarily would be expected to prevent an individual from working. The listings serve several important purposes. They are an effective screening device for those impairments that are obviously disabling, they provide public awareness of the criteria for disability, they serve as a benchmark of severity for adjudicators, and they promote national uniformity and consistency at all adjudicative levels.

The Listing of Impairments is organized according to disorders of 14 body systems: musculoskeletal; special senses and speech; respiratory; cardiovascular; digestive; genito-urinary; hemic and lymphatic; endocrine; multiple body; neurological; mental; neoplastic diseases, malignant; and the immune system. Each section has a general introduction with definitions of key concepts. Evaluation criteria provided for impairment categories are selected to establish findings that would confirm the presence and severity of the impairment, yet not exclude the consideration of varying individual reaction to illness and injury. In some disorders the findings that establish diagnosis are considered to be sufficient to concede the presence of a disabling impairment. In others, specific findings with discrete values must accompany diagnostic findings before the same conclusion can be drawn.

By comparing the clinical signs, symptoms, and laboratory findings from the evidence of record with those in a listing, the adjudicator can usually readily determine whether the listing is met. On the other hand, determining whether an impairment or combination of impairments is *equal* in severity to a listed impairment requires medical expertise as well as skill in applying difficult program concepts. An equivalence decision is justifiable under the following circumstances:

- When one or more of the specific medical findings for a listed impairment is missing from the evidence, but the evidence includes other medical findings of equal or greater *clinical* significance relating to the same impairment.

- When an impairment does not appear in the listings, but the medical findings and severity of the unlisted impairment are comparable in severity to a listed impairment.

- When there are multiple impairments, none of which meet or equal a listed impairment, but the combined severity of the multiple impairments is equal in severity to a listed impairment.

In deciding the medical equivalence, regulations require that adjudicators consider the opinion of program physicians or psychologists. Since 1975, decisions made on the basis of equivalency have declined from nearly 43 percent to less than 10 percent of all allowance decisions.

Residual Functional Capacity

Failing to establish that the individual's impairment meets or equals the listings does not mean that a claim will be denied. Benefits may still be awarded if it is found that the reason an individual is not working is because of a severe impairment. Since the severity of the impairment must be the primary basis for a finding of disability, an assessment of the individual's medically

based functional limitations and capacities must be completed before a decision can be rendered at step 4 or step 5 of the sequential evaluation process.

Residual Functional Capacity (RFC) is an administrative assessment requiring a thorough analysis of the medical and other evidence by the adjudicator. The purpose of the RFC is to determine the extent to which any impairment reduces the individual's ability to engage in specific work-related physical and/or mental functions. Although operating instructions (the Program Operations Manual System, or POMS) encourage disability examiner input into the assessment of RFC at the initial and reconsideration levels, regulations provide that program physicians or psychologists are responsible for completion of the RFC. In assessing RFC, the adjudicator must consider limitations and restrictions imposed by all of the individual's impairments including any that are considered to be "not severe." While a "not severe" impairment, by itself, would not have more than a minimal impact on work-related function, when considered in combination with other severe impairments, it could reduce the range of work an individual could do or prevent an individual from performing past work.

Adjudicator conclusions about an individual's functional ability (RFC represents the *most* that an individual can do given his or her limitations) must be supported by specific medical facts. But statements from the individual or others about functioning must also be considered. Any inconsistencies must be resolved or explained. The RFC assessment must include a discussion of why any symptoms, such as pain, that result in limitations can or cannot reasonably be accepted as consistent with the medical evidence. In addition, the RFC assessment must consider any medical source opinions, but particular importance must be given to any opinion expressed by the individual's treating source. When a treating source gives an opinion that discusses the consequences or the implications of an individual's impairment and the opinion is supported by the medical evidence, it must be given controlling weight by the adjudicator.

The adjudicator must arrive at a conclusion that expresses the individual's physical capacity for such activities as walking, standing, lifting and carrying. In cases involving mental impairments, adjudicators have to consider such capabilities as the individual's ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures.

4. Can the individual, despite any functional limitations imposed by a severe impairment, perform work that he or she did in the past?

Once the RFC assessment is completed, a determination must be made as to whether, considering the impairment-induced functional loss, the individual retains the capability to perform any work that he or she has done in the past 15 years. At this step, the vocational issues are narrow and do not consider the effect of age or educational level. If the adjudicator determines that the individual is able to meet the physical and mental demands of any prior work, a finding will be made that the individual is not disabled irrespective of age or education.

If it is determined that the individual does not have the functional capacity to perform any past work, the adjudicator moves to the fifth and final step of the process.

5. Can the individual do any other type of work?

In order to determine an individual's ability to do other work, the adjudicator must first consult the Medical-Vocational Guidelines – commonly known as the Vocational Grids. The Vocational Grids were developed to provide a framework for analyzing the effect of the claimant's RFC in

combination with his or her vocational factors (age, education, and work experience). The grids were developed by SSA in 1979 using vocational data supported by major government publications, such as the U.S. Department of Labor's *Dictionary of Occupational Titles.*

The Vocational Grids direct a conclusion as to whether or not an individual is disabled when the findings of fact concerning RFC (generally strength capabilities) and vocational factors coincide with the particular criteria of a rule. For example, according to Vocational Rule 201.03, a claimant who is limited to sedentary work because of physical impairments, is of advanced age (55 or older), and has a limited education (11th grade or less) will be found not disabled provided the previous work was skilled or semi-skilled and those skills are transferable to a new job setting. A grid rule will direct a finding of disabled or not disabled only when all of the applicable criteria of a specific rule are met.

The Medical-Vocational Guidelines provide only advisory weight in evaluating the relevant vocational factors when the determination of disability involves consideration of a severe non-exertional impairment. The Guidlines are based solely on the capacity for physical exertion. If a claimant's impairment is non-exertional (e.g., postural, manipulative, or environmental restrictions; mental impairment) or if he or she has a combination of exertional and non-exertional limitations, the claim will not be decided under the Guidelines at all. Instead, the existence of a severe non-exertional impairment forces the decision into an adjudicatory gray area.

At step five of the sequential evaluation process, the burden of proof shifts to the Social Security Administration to prove that the claimant can perform other work available in significant numbers in the national economy. In developing the grids, SSA was able to calculate the number of unskilled jobs that exist in the national economy at the various functional levels (sedentary, light, medium, heavy, and very heavy). Non-exertional limitations impact on the number of jobs (range of work) that an individual is able to do at the various functional levels.

In the example cited above, the grids direct a finding of not disabled for the claimant with exertional limitations restricting him or her to sedentary work. If, however, the same claimant also has significant limitations of fingering and feeling (a non-exertional limitation), the decision outcome may change. Since fingering is needed to perform most unskilled sedentary jobs and to perform certain skilled and semiskilled jobs at all exertional levels, the adjudicator will have to determine whether there are jobs "in significant numbers" that the claimant can do.

In claims reaching this stage of the sequential process, vocational issues are the most complicated. Adjudicators in the disability determination services may request assistance from a Vocational Specialist in a particularly difficult case. At the hearing level, the administrative law judge may request the testimony of a Vocational Expert in cases involving complicated vocational issues.

Under a new ruling issued by SSA in December 2000, before relying on any evidence from the Vocational Specialist or Vocational Expert to support the decision, the adjudicator must identify and explain any conflicts between the vocational evidence and the occupational information contained in such publications as the *Dictionary of Occupational Titles*. In addition, the adjudicator must assure that the vocational evidence is not in conflict with SSA policy.[4]

[4] Social Security Ruling 00-4p. Published 12/04/00.

The percentage of DI claims awarded on the basis of vocational factors has more than doubled, increasing from 18 percent of all awards in 1983 to nearly 42 percent in 2000. Denials based on the claimant's ability to perform usual work have increased from 19 percent in 1981 to 32 percent in 2000. Denials for ability to perform other work have increased from 11 percent in 1981 to 35 percent in 2000.

II. STEPS IN THE SOCIAL SECURITY DISABILITY APPLICATION AND APPEALS PROCESSES

Initial Application

Field Office Role

A claimant files an application for Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) disability benefits in one of SSA's 1,300 field offices. The application asks for information that will enable SSA staff to determine whether the claimant meets the nondisability requirements for eligibility. For DI cases, these requirements include such factors as whether the claimant is insured and the claimant's relationship to the wage earner. In SSI cases, individuals must provide proof of citizenship status, and document their income and resource status.

The field office is also responsible for obtaining information from the claimant about the disability and how it affects him or her, about past work and education, and about medical records, tests, and medications. The accuracy and completeness of the information on this "Disability Report" can influence whether the claimant's application is ultimately approved or denied and whether the decision is made in a timely way.

Claimants generally rely on field office staff to advise them or their representatives on what types of evidence to submit to support their claims. Because of limited staff resources, field offices increasingly rely on the claimant or his or her representative to complete the Disability Report with little or no assistance from the SSA interviewer, and in a high percentage of claims, SSA secures the information by telephone and never sees the claimant.

DDS Role

After securing the Disability Report, the SSA field office sends it to a Disability Determination Services (DDS), a State-run agency that makes disability determinations using SSA's regulations and procedures. There, a team consisting of a disability evaluation specialist and a physician (or psychologist) considers the facts in the case and determines whether the claimant is disabled under the Social Security law. These State agencies are not under SSA's direct administrative control, and they establish their own personnel policies, recruit examiners and medical consultants, and provide most of the training.

The claimant is required to prove that he or she is disabled by providing medical and other evidence of disability. However, the DDS is responsible for making every reasonable effort to help the claimant get medical reports from the claimant's physicians and hospitals, clinics, or institutions where the person has been treated. The government pays a fee (set by each State) for any medical reports that it needs and requests.

If additional medical information is needed before a case can be decided, the claimant may be asked to take a special examination called a "consultative examination," paid for by SSA. This examination is particularly important in the case of applicants who may not have a current medical provider or who use public hospitals and clinics and have little or no medical evidence that they can provide.

In making a decision in the case, the DDS conducts the process in an informal, nonadversarial manner. During each step, the claimant may present any information he or she feels is helpful to

the case. Generally, any information the claimant presents as well as all the information that SSA and the State agency obtain from medical and other sources will be considered. The individual may present the information him or herself, or it may be presented by the claimant's representative.

Once a decision is rendered, the claimant receives a written notice. The reasons for the initial determination and the effect of the initial determination are stated in the notice. The notice also informs the claimant of the right to appeal. If the claim is approved, the notice shows the amount of the benefit and when payments start. If it is not approved, the notice explains why.

Administrative Appeals

Individuals who receive an unfavorable initial disability decision have the right to appeal. There are four levels of appeal: (1) reconsideration by the State agency; (2) hearing by an administrative law judge (ALJ); (3) review by the Appeals Council; and (4) Federal court review. At each level of appeal, claimants or their appointed representative must file the appeal request in writing within 60 days from the date the notice of unfavorable decision is received. If the claimant does not take the next step within the stated time period, he or she loses the right to further administrative review and the right to judicial review, unless good cause can be shown for failure to make a timely request.

In recent years the number of appeals has been very large and resources have been limited, causing significant backlogs and delays in rendering decisions. SSA has recently implemented a number of administrative changes that it hopes will bring the appeals workload under control and shorten the time it takes for a claimant to get a decision.

Reconsideration

Generally, the reconsideration is the first step in the administrative review process that SSA provides. The reconsideration process is a case review and is similar to the initial determination process except that it is assigned to a different disability examiner and physician/psychologist team at the DDS. Claimants are given the opportunity to present additional evidence, and it is considered along with the evidence that was submitted when the original decision was made.

If the reconsideration team concurs with the initial denial of benefits, the individual may then request a formal hearing before an ALJ in the Office of Hearings and Appeals.

Administrative Law Judge Hearing

Administrative law judges (ALJs) are based in the 138 hearing offices located throughout the nation. At the hearing, claimants and their representatives may appear in person, submit new evidence, examine the evidence used in making the determination or decision under review, and present and question witnesses. The ALJ may request medical and vocational experts to testify at the hearing, and may require the claimant to undergo a consultative medical examination. The ALJ issues a decision based on the hearing record, and in cases where the claimant waives the right to appear at the hearing, the ALJ makes a decision based on the evidence that is in the file and any new evidence that is submitted for consideration.

DDSs and ALJs approach the decision making process differently, and sometimes do not consider the same evidence. DDSs conduct a paper review of a claimant's medical and vocational evidence, while ALJs hold face-to-face hearings and have the opportunity to observe the claimants

firsthand. And, since the case record is not closed after the reconsideration, ALJs often receive information not previously considered. Many experts contend that these are some of the differences in the decision making process that contribute to the high number of DDS decisions that ALJs reverse at the hearing level.

Appeals Council Review

The final administrative appeals step is at the Appeals Council. If the claimant is dissatisfied with the hearing decision, he or she may request that the Appeals Council review the case. The Council, made up of administrative appeals judges, may also, on its own motion, review a decision within 60 days of the ALJ's decision.

The Appeals Council considers the evidence of record, any allowable additional evidence submitted by the claimant, and the ALJ's findings and conclusions. The Council may grant, deny, or dismiss a request for review. If it agrees to review the case, the Council may uphold, modify, or reverse the ALJ's action, or it may remand it to the ALJ so that he or she may hold another hearing and issue a new decision. The Appeals Council may also remand a case in which additional evidence is needed or additional action by the ALJ is required.

The Appeals Council's decision, or the decision of the ALJ if the request for Appeals Council review is denied, is binding unless the claimant files an action in Federal district court.

Judicial Appeals

Federal District Court

Claimants may file an action in a Federal district court within 60 days after the date they receive notice of the Appeals Council's action. In fiscal year 2000, 14,363 cases, or approximately 16 percent of Appeals Council denials, were appealed to the courts.

There are many issues surrounding the appeal of Social Security cases to the Federal courts. Social Security appeals represent a large workload for the Federal courts. Appeals are not uniformly distributed among the judicial districts. In fiscal year 2000, it took an average of about 18 months for courts to render decisions on Social Security appeals.

Circuit Court; Supreme Court

If the U.S. District Court reviews the case record and does not find in favor of the claimant, the claimant can continue with the legal appeals process to the U.S. Circuit Court of Appeals and ultimately to the Supreme Court of the United States.

III. SSA's DISABILITY INITIATIVES

Disability Redesign Objectives and Expectations

In September 1994, in response to increasing claims for disability benefits (between fiscal years 1991 and 1993 disability claims increased from 3 million to 3.9 million) and a shrinking agency workforce, the Social Security Administration developed a plan to redesign the process for making disability determinations.[1] The original redesign plan included 83 initiatives to be completed over 6 years. The primary objectives of the redesigned process were:

- making the process "user friendly" for claimants and those who assist them;
- making the right decision the first time;
- making the decision as quickly as possible;
- making the process efficient; and
- making the work satisfying for employees.

Implementation of the redesign plan began October 1, 1994, and was to extend to September 30, 2000. It was anticipated that the full benefits from the redesigned process would be achieved by September 30, 2001.

According to the redesign plan, the new disability determination process would result in a reduction of the average processing time from about 150 days to pay an initial disability claim to 60 days. Because the definition of disability remained unchanged, it was concluded that program costs would be neutral. Finally, it was estimated that the administrative cost savings during the implementation period would be $704 million through fiscal year 2001 and $305 million annually, thereafter.[2]

Reassessment of the Redesign Initiatives; Testing of the Full Process Model

SSA tested numerous redesign initiatives between 1994 and 1997. However, progress was slow and uneven due, in part, to the complexity of the redesign initiatives. In February 1997, SSA reassessed its approach to redesign and made the decision to focus on a much smaller number of redesign initiatives. Central to the plan was an integrated test of several redesign features called the Full Process Model.

The Full Process Model consisted of several significant changes to the initial disability determination process. These included:

- single decision maker – a new position that would give the disability examiner authority to determine eligibility without requiring physician input;
- pre-decision interview – offered the claimant an opportunity to talk with the decision maker to assure that all relevant sources of information were identified and contacted prior to denying benefits;

[1] *Plan for a New Disability Claim Process*, Social Security Administration, September 1994.
[2] *Ibid.*

- elimination of the reconsideration step;
- adjudication officer – a new position designed to facilitate the appeals process.

According to SSA, the Full Process Model test showed that a higher percentage of individuals were appropriately allowed benefits at the initial level and the documentation of initial denial decisions improved. Results also showed that claimants who appealed their initial decision had access to the hearing process earlier, largely due to the elimination of the reconsideration step.

Implementation of the Prototype Process

SSA decided to take what was learned from the Full Process Model test and combine those changes with improvements at the hearing level. SSA made the decision to begin a "prototype" model in 10 States representing about 20 percent of the national workload. The idea was to study the impact of the redesign changes on a larger scale. Implementation of the prototype process began on October 1, 1999, in Alabama, Alaska, Colorado, Louisiana, Michigan, Missouri, New Hampshire, Pennsylvania, and in parts of California and New York.

The prototype process includes the same redesign elements as the Full Process Model except that the pre-decision interview has been renamed the claimant conference and the adjudication officer position has been eliminated. Additionally, there are two important modifications to the process that were not previously tested. The modifications include the requirement that the DDS provide enhanced process unification decision explanations and implementation of the Hearings Process Improvement plan (HPI) by the Office of Hearings and Appeals.

SSA has been conducting an ongoing evaluation of the prototype process to enable the agency to observe process changes in an operational environment on a scale large enough to prepare for national rollout, but small enough to monitor closely. The purpose is to allow potential areas of risk to be identified and addressed quickly. It also provides for the collection of impact assessment data required for budget and regulation development.

The agency contracted with The Lewin Group, Inc. to assess its prototype process evaluation criteria. In general, Lewin found that SSA's evaluation of the prototype will answer many important questions about the process.[3] The contractor pointed out in the report that the environment in which the test is being conducted would influence the findings of the evaluation, and noted that SSA recognizes these limitations and has made extensive efforts to address them.

In addition, Lewin pointed out that while the evaluation's basic approach to program cost analysis seems reasonable, important details need to be developed as the evaluation proceeds. Problems with projecting national impacts on final allowance rates in non-prototype States will be considerable if variation in impact estimates across the prototype States turns out to be substantial. To obtain cost impacts, it will be necessary to go beyond projection of the impact on the allowance rate to project impacts on the future stream of allowances and benefits.

Lewin identified two significant issues that need to be addressed as the evaluation proceeds. The first issue surfaced when Lewin became aware during its site visits that the 10 States had implemented process unification (see below for a description of process unification) in varying degrees prior to the start of the prototype. Process unification is likely to have an impact on DDS

[3] *Assessment of the Evaluation Plan for the Disability Process Redesign Prototype*. The Lewin Group, Inc., September 18, 2000.

allowances, processing time, and productivity in the prototype States. Likewise, other States, including the States being used for comparison purposes for the evaluation, are at varying stages in the implementation of process unification. Unless attention is paid to this issue, the estimated impacts of the prototype could be confounded with the impacts of process unification, which would limit their usefulness for projecting any national rollout.

The second issue involves the implementation of the Hearings Process Improvement plan (HPI) by the Office of Hearings and Appeals. Although not part of the prototype, HPI is being implemented in conjunction with the prototype and will have some degree of impact on the process. SSA is conducting a limited evaluation of HPI and a separate and independent evaluation of HPI is simultaneously being conducted by OHA. Lewin suggests that the two evaluation efforts need to be carefully coordinated so that SSA will be able to obtain the information it needs to evaluate the impact of HPI on the prototype process.

Although it is early in the evaluation process, SSA has learned that national rollout of the prototype will require extensive planning and training. SSA is planning to phase in the national rollout by dividing the remaining States into three groups and implementing the new process, one group at a time, in intervals of nine months and over the course of three years.

Process Unification

Before developing its redesign plan, SSA held a series of focus groups throughout the country. SSA heard from claimants and their representatives that they believed that their chances for a favorable decision improved if they appealed their claim to an ALJ. This was supported by the agency's own data showing that reversals of DDS decision by ALJ's grew from 58 percent in 1985 to nearly 72 percent in 1995.

SSA concluded that higher allowance rates at the hearing level led to the perception that different standards apply at the initial and appeals levels. Therefore, the redesign plan established process unification as one of the essential elements for improving the disability decision making process. Process unification is an attempt to bridge the gap between the initial and the appellate decision making process.

In order to achieve process unification, the agency developed a series of nine rulings to provide guidance to adjudicators in dealing with the most difficult and complex cases. The rulings concern the evaluation of the most subjective adjudicative concepts (e.g., how to assess pain and other symptoms, how to assess claimant credibility, weighing treating source opinion) when the objective medical evidence, in and of itself, does not result in a favorable decision. SSA conducted national training on the application of the rulings for all adjudicators in 1996 and 1997. For purposes of quality assurance measurement, SSA is enforcing the rulings only in the 10 prototype States. As the result of class action settlement agreements, the rulings are also being implemented in Iowa, Nebraska, and Oregon. Other States have also taken steps to implement them.

Hearings Process Improvement Initiative

The Office of Hearings and Appeals has introduced a new initiative to improve the hearings process that is aimed at significantly reducing the time between a request for a hearing and a

final decision.[4] The purpose of the Hearings Process Improvement plan (HPI) is to provide a new work flow model that will result in fewer handoffs and speedier case handling. HPI establishes processing time benchmarks for the overall hearing process and for certain tasks within the hearing process.

The plan makes significant changes in the hearing office organizational structure by creating processing teams that will be held accountable for improved workflow. Cases are assigned to a team including a supervisor, several administrative law judges, a legal advisor, attorney and paralegal analysts, case technicians and other support staff. The team is self-contained and is responsible for all aspects of case adjudication. Cases are initially reviewed by an attorney or legal advisor and either dismissed, allowed on the record (with ALJ approval), or referred to a case technician for in-depth development. After development and collection of evidence is completed, cases are assigned to an administrative law judge member of the team. The ALJ may either request additional development or schedule a hearing.

The Hearings Process Improvement plan has been implemented in three phases. The first phase began in January 2000, and included 37 hearing offices that are located in the 10 prototype States. Phase II began in October 2000, and included 52 additional hearing offices. Phase III, which was implemented in November 2000, included the final 49 hearing offices.

The Office of Hearings and Appeals, through an Implementation Monitoring Plan, is evaluating implementation of the new process. The monitoring plan is intended to monitor HPI changes in an operational setting. In conjunction with the prototype evaluation, the monitoring plan is intended to provide the agency with an understanding of how the new process affects performance, workload, and workforce effectiveness indicators.

Disability Claims Manager

SSA is testing another feature of the redesign plan, the disability claims manager position, in both Federal and State sites. The disability claims manager position, as envisioned in the redesign plan, is an individual who will have responsibility for the complete processing – from initial application and interview to final decision and issuance of a denial notice or processing the claim to payment – of an initial disability claim. The disability claims manager serves as the claimant's point of contact throughout the initial process.

The test was scheduled to last for three years and was to be conducted in two phases. The first phase, a proof of concept phase, was completed in the fall of 1999. The results of the first phase showed that the DDS and SSA field office employees who were working as disability claims managers were able, with appropriate preparation and support, to successfully combine the duties of a disability examiner and a claims representative that were assigned under this test. Moreover, both State and Federal employees involved in the test had a high level of job satisfaction and claimants had a positive response to the increased level of service provided by the disability claims manager.

The disability claims manager position has been a controversial aspect of the redesign plan because many question whether it is possible to implement it on a nationwide scale. There are also concerns that combining the two positions results in diminished productivity. The second phase of the test, which will extend until June 2001, will examine the performance of the disability claims

[4] For an assessment of the first phase of the implementation of HPI, see SSA's report, *Implementing a New Hearings Process in OHA, Hearings Process Improvement, Phase 1 Implementation Report* (October 2000).

manager without the level of support that was provided in phase one. SSA anticipates that the evaluation of the second phase of the disability claims manager test will be completed in the spring of 2001. Because the Social Security Act requires that disability determinations be made by State agencies, implementation of the claims manager position by an individual who does not work for a State agency would require a change in the statute.

IV. MAJOR DISABILITY LEGISLATION [1]

Aid to Permanently and Totally Disabled, 1950 (P.L. 734, 81st Congress)

The Social Security Amendments of 1950 provided for Federal financial assistance to States for programs of "aid to the permanently and totally disabled." Aid in this case meant "money payments to, or medical care in behalf of, or any type of remedial care recognized under State law" for needy disabled adults. The conference committee report noted that it was assumed that States would assure that "every individual for whom vocational rehabilitation is feasible will have an opportunity to be rehabilitated."

Disability "Freeze," 1954 (P.L. 761, 83rd Congress)

The Social Security Amendments of 1954 included a provision designed to prevent the erosion of retirement and survivors benefits as a result of a worker having a period of disability. This "disability freeze" excluded from benefit computations any quarter in which the worker was disabled. For purposes of the freeze, disability was to mean "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or be of long-continued and indefinite duration" or blindness.

This legislation did not create a program of disability benefits. The law specified that the determinations of disability would be made by State agencies under agreements with the Social Security Administration.

Social Security Disability Program, 1956 (P.L. 880, 84th Congress)

In its report on the 1956 Amendments, the House Ways and Means Committee said, "…the covered worker forced into retirement after age 50 and prior to age 65 should not be required to become virtually destitute before he is eligible for benefits….there is as great a need to protect the resources, the self-reliance, the dignity and the self-respect of disabled workers as of any other group."

The 1956 Amendments provided for Social Security Disability Insurance (DI) benefits for workers between the ages of 50 and 65 who were determined to be unable to engage in substantial gainful activity due to a medically determinable physical or mental impairment which is expected to result in death or which is of long-continued and indefinite duration.

Benefits for the dependents of disabled workers were added in 1958 (P.L. 85-840), and benefits were extended to workers under age 50 in 1960 (P.L. 86-778).

Changes in the Definition of Disability, 1965 (P.L. 89-97)

The Social Security Amendments of 1965 changed the duration of disability required for benefits from "long-continued and indefinite duration" to "has lasted or can be expected to last for a continuous period of not less than 12 months."

These amendments also changed the definition of disability for the blind over age 55 by specifying that they would be eligible if unable to engage in work requiring skills comparable to those of past occupations.

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[1] For more detail on the provisions of Social Security legislation see the Congressional Research Service Report 94-36 EPW, "Summary of Major Changes in the Social Security Cash Benefits Program: 1935-1996," December 20, 1996.

Clarification of Definition, 1967 (P.L. 90-248)

In response to a series of court decisions, the Social Security Amendments of 1967 clarified the definition of disability by specifying that a person must not only be unable to do his or her previous work but also be unable, considering age, education and work experience, to do any work that exists in the national economy, whether or not a vacancy exists or the person would be hired to fill such a job. The amendments also specified that the disability had to result from "anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."

Federal SSI Program, 1972 (P.L. 92-603)

The joint Federal/State programs of aid to the aged, blind and disabled were made wholly Federal in the Supplemental Security Income program to be administered by the Social Security Administration. Disability benefits were also provided for children with impairments of comparable severity to those of adults.

Social Security Disability Reforms of 1980 (P.L. 96-265)

The Disability Insurance and the SSI disability programs experienced rapid and unanticipated growth in the 1970s. The Social Security Disability reforms of 1980 included provisions that limited the amount of benefits under the DI program and made a number of changes in the way the programs were administered.

A major provision of the amendments limited total DI benefits to the lesser of 85 percent of the Average Indexed Monthly Earnings or 150 percent of the Primary Insurance Amount. The amendments required SSA to review a specified percentage of State DDS allowances on a pre-effectuation basis; provided for the agency partially or completely to take over from a State DDS the function of making disability determinations if the DDS fails to follow Federal regulations and guidelines or if the State no longer wishes to make the determinations; required the agency to make own-motion reviews of ALJ decisions; and required continuing disability reviews of DI benefits for non-permanently disabled beneficiaries at least every three years.

The amendments also contained a number of provisions designed to encourage DI and SSI disability beneficiaries to return to work, including continuation of benefits while the beneficiary is in vocational rehabilitation, the disregard of certain work-related expenses, and facilitated re-entitlement to benefits.

Procedural Amendments of 1983 (P.L. 97-455)

These amendments required that beneficiaries be given the opportunity for an evidentiary hearing before the termination of benefits and the continued payment of benefits during an appeal of a termination to the ALJ level.

The Disability Benefits Reform Act of 1984 (P.L. 98-460)

The report of the Senate Finance Committee noted that "the review process mandated under the 1980 amendments has resulted in some significant problems and dislocations which were not anticipated and which contributed to an unprecedented degree of confusion in the operation of the program."

The Disability Benefits Reform Act of 1984 made a number of changes in the program. Included in the changes was the establishment of a medical improvement standard for terminating benefits in most cases. This act also wrote into the law for a temporary period SSA's criteria for evaluating pain and required the consideration of the cumulative effect of multiple disabilities. The

Secretary of HHS, in conjunction with the National Academy of Sciences, was required to conduct a study of the use of subjective evidence of pain and of the state of the art of preventing, reducing or coping with pain. The Secretary was also required to establish uniform standards for determining disability to apply at all levels of determination, review, and adjudication.

Another provision required the publication of revised mental impairment criteria and the suspension of periodic reviews of mental impairment cases pending that publication. Other provisions related to the disability determination and review processes, including requiring pre-termination notices and continuation of payments during appeal.

Procedural Amendment of 1990 (P.L. 101-508)

The Omnibus Budget Reconciliation Act of 1990 changed the percentage of favorable State-agency decisions that must be reviewed by SSA from 65 percent to 50 percent and also stated that a sufficient number of other determinations should be reviewed to ensure a high degree of accuracy.

Restricted in 1994 (P.L. 103-296) and Eliminated in 1996 (P.L. 104-121) Benefits for Drug Addicts and Alcoholics

Following wide-spread allegations that the DI and SSI disability programs were being used by drug addicts and alcoholics to support their substance abuse, Congress ordered the General Accounting Office to study the issue. The GAO report said the number of substance abusers on the rolls had increased significantly and that SSA had not adequately enforced the requirement that they receive treatment for the addiction.[2] Congress consequently placed restrictions on benefit eligibility for addicts and alcoholics in 1994. These restrictions included: required appointment of a representative payee for all addicts and alcoholics, mandatory treatment for the addiction or alcoholism, suspension of benefits for refusing available treatment, and termination of benefits after 36 months of benefits for SSI beneficiaries and 36 months of treatment for DI beneficiaries.

In 1996, the Contract With America Advancement Act provided that individuals could not be found disabled for purposes of DI or SSI if drug addiction or alcoholism was a "contributing factor material to the determination of disability." Drug addicts and alcoholics who were disabled as a result of other causes would still be eligible.

Restrictions on SSI Childhood Disability, 1996 (P.L. 104-193)

In the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform), the definition of eligibility for childhood disabled benefits was changed to having "a medically determinable physical or mental impairment which results in marked and severe functional limitations." Individual functional assessments were eliminated, as was reference in the listings to "maladaptive behavior."

Ticket to Work, 1999 (P.L. 106-170)

The Ticket to Work and Work Incentives Improvement Act of 1999 created a program under which Social Security and SSI disability beneficiaries could receive a ticket with which to purchase vocational rehabilitation and other employment support services from providers of their choice.

The act provided for expedited re-entitlement to benefits for persons who were terminated due to work activity and extended the period during which a disabled beneficiary could continue receiving Medicare benefits while working. It also provided for several demonstration projects including a benefit reduction of $1 for each $2 of earnings for DI beneficiaries.

[2] United States General Accounting Office. *Social Security: Major Changes Needed for Disability Benefits for Addicts."* HEHS-94-128. May 1994.

V. CHRONOLOGY OF MAJOR COURT CASES THAT HAVE AFFECTED THE WAY DISABILITY DETERMINATIONS ARE MADE

Following is a chronology of major court cases that have affected the way disability determinations are made. The chronology also includes agency and Congressional responses to those cases. The cases listed here represent only a very small fraction of the litigation related to DI and SSI disability benefits. In 2000, Federal courts issued more than 12,000 decisions on disability cases.[1]

1960 In *Kerner v. Flemming*, the Second Circuit Court of Appeals held that when a claimant had shown that he could not do his past work, the burden of proof shifted to the government to show what the claimant could do and what employment opportunities there were for someone who can do only what the applicant can do. The change in the burden of proof gradually crept into all levels of disability adjudication over the next five years.

1963 The Fifth Circuit Court of Appeals required the consideration of pain even though the cause of the pain cannot be demonstrated by objective clinical and laboratory findings. By 1967, four other circuit courts of appeals had issued similar holdings.

1965 Appeals courts in two circuits required the government to show that jobs are available in the claimant's area when denying a claim on the basis of ability to do other work.

1967 The Congress responded to court decisions on pain by defining an impairment for DI purposes as one "that results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic findings." It also stated that disability included inability to "engage in any kind of substantial gainful work which exists in the national economy," regardless of whether such work was available locally. Judicial reversals of SSA decisions dropped from about 59 percent in 1967 to about 30 percent in 1973.

The Fourth Circuit in *Leftwich v. Gardner* held that a claimant was under a disability despite the fact that his work activity under regulations constituted "substantial gainful activity." Congress enacted specific regulatory authority to override this holding.

1970 In *Goldberg v. Kelly*, the Supreme Court held that due process required that public assistance recipients have an opportunity for an evidentiary hearing before termination of their benefits.

1971 In *Richardson v. Perales*, the Supreme Court held that a written report of a consultative physician could constitute substantive evidence to support a decision adverse to an applicant for disability benefits.

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[1] There are external factors that may affect the amount and type of litigation. For example, the Legal Services Corporation, which once was responsible for numerous class action suits, was in 1996 restricted from undertaking class actions. Another example is the Equal Access to Justice Act (EAJA) of 1980, which provides for government payment of a claimant's attorney fees if it is found that the government's position is not substantially justified or that it litigated in bad faith. In practice, in a large portion of district court cases that are lost by the agency, a fee petition under EAJA is filed and settled.

1975 In *Cardinale v. Mathews,* the district court in the District of Columbia decided that SSA's procedures for reducing or terminating SSI benefits did not properly apply the principles of the *Goldberg* decision of 1970. The SSI procedures did not require advance notice and an offer of a hearing when a reduction of benefits resulted from a change in Federal law, a clerical or mechanical error, or facts supplied by the beneficiary. The court found that all those exceptions violated the constitutional requirement for due process.

1976 In *Mathews v. Eldridge,* the Supreme Court stated that *Goldberg* standards did not apply to DI benefits.

1980 The reports of the Ways and Means and Finance Committees on the 1980 amendments stated that the courts should follow the statutory "substantial evidence rule" in giving deference to administrative agency evaluations of the evidence. Congress was also concerned about the large number of court remands and enacted a requirement that there must be a showing that there was new and material evidence and that there was good cause for failure to incorporate it into the record previously.

1981 The Ninth Circuit Court of Appeals in *Finnegan v. Mathews* restricted SSA's ability to terminate SSI payments to beneficiaries who had been grandfathered into the SSI program from the former State-run program. SSA issued a non-acquiescence ruling, a statement that it would not apply the decision beyond the case at hand, on the grounds that the court's standard would be impossible to administer.

1982 The Ninth Circuit Court of Appeals in *Patti v. Schweiker* ruled that SSA could not terminate benefits to an SSI disability beneficiary unless it showed that the beneficiary's condition had improved. SSA issued a non-acquiescence ruling.

1983 Congress provided for a due process hearing before termination of benefits of disability beneficiaries.

The Supreme Court in *Heckler v. Campbell* upheld SSA's use of its Vocational Grid. The Second Circuit had earlier held its use invalid. SSA had published in 1979 regulations designed to aid in more objective assessment of applicants' residual functional capacity and vocational factors (age, education, and work experience) in determining ability to work. The regulations provided a vocational "grid" as a way of meeting the burden of showing that there are jobs in the national economy that a claimant can perform.

1984 In the *Hyatt* class action the District Court for the Western District of North Carolina found SSA's policy on pain contrary to the Fourth Circuit law and enjoined the agency from refusing to follow the law of the circuit.

By the end of this year, every circuit court had held that SSA should apply a medical improvement standard before terminating disability benefits. The Ninth Circuit enjoined SSA to follow its rulings in *Finnegan* and *Patti.* District courts received 28,000 disability appeals (compared to 5,000 in 1975), many of them appeals of benefit terminations. The rate of reversals and remands increased to 62 percent (compared to 19 percent in 1975).

The Disability Benefits Reform Act of 1984 required substantial evidence of improvement and ability to work as grounds to terminate benefits. The Act also incorporated into the statute an amendment that was based on SSA's policies on the evaluation of pain. The

amendment, which was to apply to decisions made through 1987, required medical signs or findings showing the existence of an impairment that could be expected to produce the pain alleged. The Act also provided for a Commission on Pain to study the question, with the expectation that it would recommend the extension or replacement of the temporary amendment on pain.

1985 In *Stieberger v. Heckler*, the District Court for the Southern District of New York ruled in a class action suit that SSA had violated the rights of claimants by not following circuit court law on the weight to give to evidence from the claimant's treating physician. The court issued an injunction against denying or terminating benefits under policies that did not conform to circuit court law. The *Stieberger* class action was finally settled in 1992.

SSA began its policy of issuing Acquiescence Rulings explaining how it would apply the decisions of courts of appeals that it determined contained a holding that conflicted with its national rules for adjudicating claims.

1986 In *Schisler v. Heckler*, the Second Circuit Court of Appeals stated that a treating physician's opinion on the subject of medical disability is binding unless contradicted by substantial evidence.

The Supreme Court in *Bowen v. Yuckert* upheld SSA's use of a minimum threshold of medical disability in denying benefits based on a non-severe impairment at step two of the sequential evaluation process.

The Commission on Pain recommended additional research to obtain more reliable data and to develop methods to assess pain. It also recommended that the policy embodied in the 1984 temporary amendment on pain be continued until after that research was completed.

1988 SSA issued a new ruling on pain which restated the existing policy in the 1984 amendments and provided guidance on how to develop evidence of pain and how to apply the policy at each step of the sequential evaluation process.

1989 Reviewing the *Hyatt* class action case on remand, the District Court for the Western District of North Carolina found that SSA's published policies and instructions on pain, including its 1988 ruling, did not conform to circuit law. The district court ordered those policies and instructions to be cancelled and drafted a new ruling on pain to be distributed to North Carolina adjudicators.

1990 The Supreme Court's *Sullivan v. Zebley* decision ruled that SSA's policy regarding disability determinations for children erroneously held children to a stricter definition of disability than adults. As a result of the *Zebley* decision, SSA issued regulations requiring an individualized functional assessment for children who did not meet or equal the medical listings to determine the severity of their impairments and the associated limitations.

SSA issued regulations explaining how it would implement the acquiescence policy it adopted in 1985 and also applied it to the State agencies.

The provision of law that required that widow(er)s had to meet the medical listings had been overruled by several circuit courts. The Congress in the 1990 Reconciliation Act settled the matter by providing that they would have the same eligibility requirements as workers, and thus would not have to meet the listings in order to qualify for benefits.

1991 SSA issued new regulations on the evaluation of pain and other symptoms and on the evaluation of opinions of claimants' treating physicians. The pain regulation restated existing policy and included guidance on how this policy would be applied during the sequential evaluation process. The regulation on treating source opinion said the agency would give controlling weight to such opinions when they were well supported by medically acceptable clinical and laboratory diagnostic techniques and were not inconsistent with other substantial evidence in the case record.

1992-1997 Four Statewide class action suits were filed against State DDSs and/or SSA alleging that improper policies and procedures were employed in making disability determinations. The States involved were Iowa, Nebraska, Oregon, and Utah. The issues included development and consideration of treating source medical evidence and opinion; evaluation of subjective symptoms, including pain; evaluation of credibility; appropriate use of vocational resources and evaluation of vocational evidence; and Federal oversight of the DDSs. All cases were settled with agreements which included redeterminations of certain previously denied claims and ongoing communications with plaintiffs' representatives to discuss concerns related to the disability determination process.

1993 The Second Circuit Court of Appeals in *Schisler v. Sullivan* found that SSA's 1991 regulations on the opinions of treating physicians, while they departed in some ways from the court's earlier opinion, were a valid use of the agency's regulatory power.

1994 A settlement was reached in the *Hyatt* class action case, under which 80,000 cases would be re-adjudicated by the agency under the 1991 regulations. Litigation still continues on disagreements as to the details of the settlement and attorneys' fees under the Equal Access to Justice Act.

1996 SSA issued a set of nine Social Security rulings commonly called process unification rulings and provided training on the rulings for all disability adjudicators. The subjects of the rulings included the weight to be given to treating source opinions and other medical opinions, the evaluation of pain and other symptoms, the assessment of credibility and residual functional capacity, and the application of Federal court decisions.

VI. COMPONENTS WITHIN THE SOCIAL SECURITY ADMINISTRATION WITH RESPONSIBILITIES IN THE DISABILITY PROCESS

Nearly every staff component of the Social Security Administration has a role in administering the Social Security disability program. SSA employees are involved in many facets of the process, from writing informational pamphlets to holding administrative hearings. Outlined below is a list of SSA staff components and their responsibilities in the disability process. The numbers of staff shown are totals; not all work on disability issues. (An organizational chart for the agency is shown on p. 123.)

Office of Operations (47,264 employees)

- With input from other SSA components, the Office of Operations oversees the operation of SSA's field and regional offices.
- The Office of Operations is SSA's front-line to the public: field office staffs take disability claims, provide information to claimants and potential claimants, and meet with the public to provide information about the disability programs.
- Regional office staffs answer field office and Disability Determination Services (DDS) questions concerning disability policy.
- Regional offices have oversight responsibilities of the DDSs in their regions. They are the front-line liaisons between SSA and the DDSs. Some of their duties include: addressing DDS workload issues (working with DDSs to prioritize their workloads); addressing DDS technology support issues; and monitoring DDS activity.

Office of Disability (244 employees)

- This office, which is within the Office of Disability and Income Security Programs, serves as primary liaison between SSA and the DDSs on all budgetary, policy, and systems issues.
- The Office of Disability writes and interprets disability policy for the agency.
- The office works with the Office of Legislation and Congressional Affairs and provides policy expertise in writing legislative proposals.
- It answers questions from regional offices and field offices about disability policy.
- The office submits budget proposals to SSA's Office of Budget for disability programs, initiatives and mandates. It also submits budgets for DDS operations, based on input from the DDSs.
- It handles DDS policy and budget issues. It conducts fiscal reviews of the DDSs.
- The office works with the DDSs and the Office of Systems on technology issues, such as standardizing technology used by the DDSs.
- It has responsibility for training adjudicators on disability issues.

Office of Hearings and Appeals (7,381 employees)

- This office, which is within the Office of Disability and Income Security Programs, manages the hearing offices and the Appeals Council, where administrative law judges and administrative appeals judges render disability decisions.
- With the Office of Disability and often the Litigation Staff, OHA writes and interprets disability policy for the agency (particularly for the hearing offices and the Appeals Council).
- The office keeps statistics on hearing office decisions, most of which relate to disability claims.
- It maintains the hearings and appeals procedural manual.

- OHA works with the Office of General Counsel on responding to court cases, and preparing SSA's defense of court cases.

Litigation Staff (65 employees)

- This component, which is within the Office of Disability and Income Security Programs, works with the Office of General Counsel on responding to court cases, and preparing SSA's defense of court cases.
- With the Office of Disability and the Office of Hearings and Appeals, it assists in developing policies and procedures to comply with court decisions.

Office of Policy (including the Office of Research, Evaluation, and Statistics) (142 employees)

- The Office of Policy studies "big picture" disability issues (e.g., the effects of raising the retirement age on the Disability Insurance program) and works with other SSA components, Congress, advocates, and other government agencies to develop policy alternatives.
- It collects data related to Social Security disability programs, such as the number of people receiving benefits, and their demographic breakouts. It evaluates data for planning and other informational purposes.
- The office plans, coordinates, conducts, and contracts out studies of the disability program for planning and evaluation purposes.
- It is responsible for the National Study of Health and Activity.

Office of the Commissioner (68 employees)

- The Office of Strategic Management coordinates with all SSA components to write and manage SSA's Strategic Plan, including all disability initiatives.
- The 2010 Vision Team coordinates with all SSA components to write and manage SSA's 2010 Vision plan, including all disability initiatives.
- The Office of Customer Service Integration coordinates with all SSA components on the agency's customer service activities, including ones involving the disability programs and disability applicants.
- The Disability Process Redesign Team is responsible for Disability Process Redesign. This entails establishing the work plan and strategies for the various initiatives and working with all affected SSA components (Office of Operations, Office of Disability, DDSs etc.) to carry them out.

Office of the General Counsel (451 employees)

- This office defends SSA in disability cases before the courts.
- It works with other SSA components to write and interpret disability policy for the agency, based on court decisions, Congressional mandates, and agency initiatives.

Office of Legislation and Congressional Affairs (59 employees)

- With input from other SSA components, this office develops legislative proposals regarding the disability programs.
- It analyzes Congressional and other proposals for changes in the disability programs.
- The office responds to Congressional inquiries concerning disability issues.

- It meets with Congressional staffs to inform them of SSA's proposals and respond to questions raised about the disability programs.
- The office answers questions from other SSA components regarding disability legislation.
- It responds to other government organizations (e.g., the White House) about disability issues.

Office of Communications (179 employees)

- The Office of Communications produces pamphlets, booklets, fact sheets, videos, and information kits about disability benefits.
- It responds to public inquiries about disability benefits and claims.
- The office is the primary liaison with disability advocates.
- It acts as a liaison to other government and non-governmental agencies regarding SSA activities.
- It works with the press to address disability issues.
- The office writes speeches for SSA staff to use when addressing the public.

Office of the Chief Actuary (49 employees)

- This office prepares long- and short-range estimates regarding prevalence of disability, numbers of disability applicants, beneficiaries, etc.
- It prepares long- and short-range estimates of the disability trust fund.
- It prepares cost estimates for legislative proposals.
- The office provides program and other statistics to other SSA components for use in conducting studies, audits, and writing policy.

Office of Finance, Assessment, and Management (2,256 employees)

- The Office of Budget prepares budgets and full-time equivalent allocations for the Offices of Operations, Disability, and Hearings and Appeals, as well as the DDSs.
- The Office of Quality Assurance and Performance Assessment, through Disability Quality Branches, performs quality assurance reviews, including preeffectuation reviews, for the DDSs, and a preeffectuation review of administrative law judge decisions.
- The Office of Quality Assurance and Performance Assessment also performs other, more global reviews of SSA programs, such as looking at discrepancies of disability allowance and disallowance rates throughout the claims process and among different regions; and analyzes the effects of Disability Redesign initiatives.
- With input from other SSA components, the Office of Acquistion and Grants prepares and manages contracts and grants for research projects, etc. that relate to disability.
- The Office of Finance, Assessment and Management manages office space (Baltimore and Washington, D.C.) where people performing disability-related work are housed. It also works with regional office and field office staff in securing and managing office space.

Office of the Inspector General (557 employees)

- This office conducts audits of disability programs to ensure program integrity and program directives are met.
- It conducts fraud investigations of disability-related cases and issues.

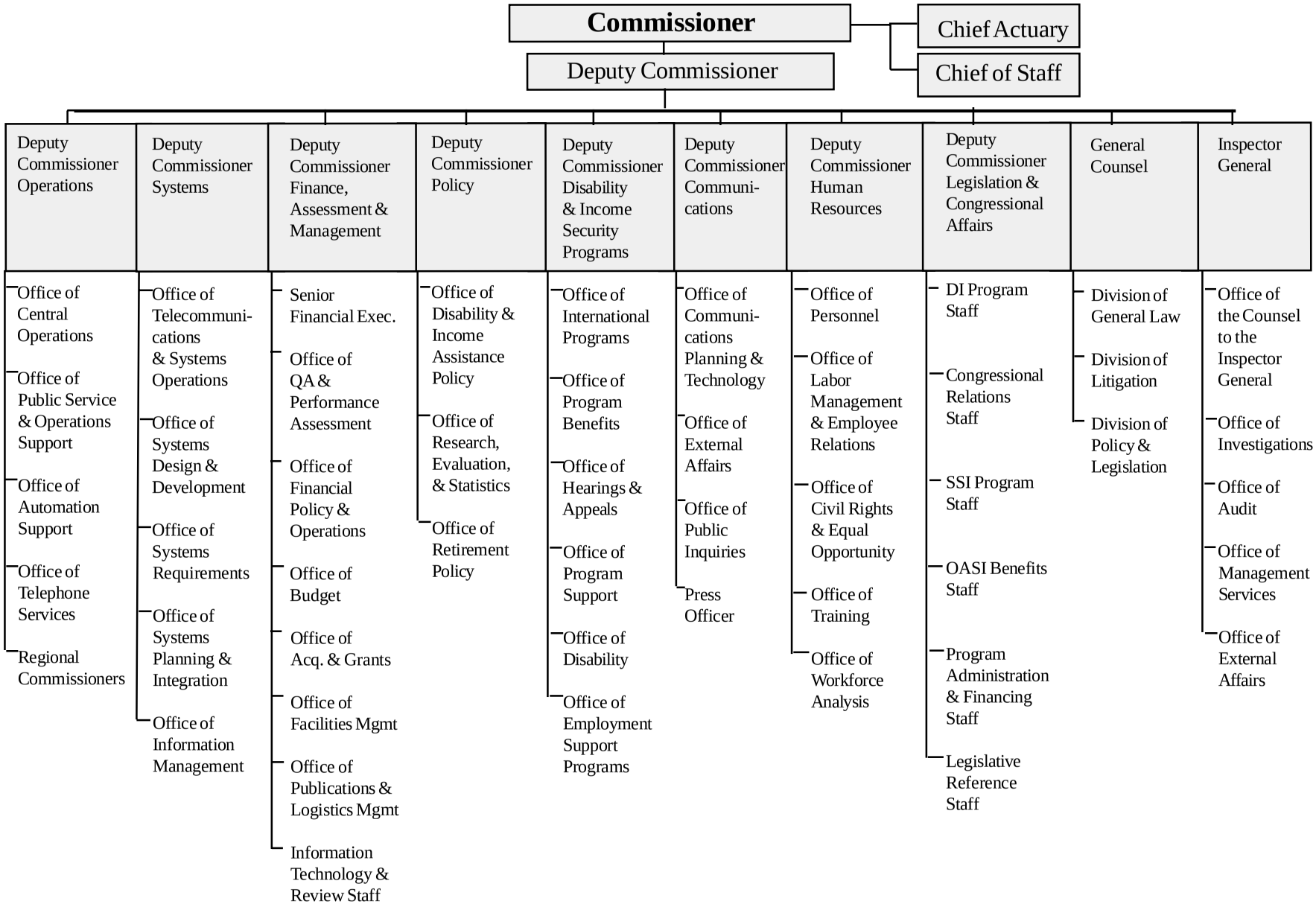
Office of Systems (2,859 employees)

- The Office of Systems coordinates planning and implementation of SSA's computer infrastructure. Most claims—disability claims included—are taken on the computer.
- It is responsible for development of a unified computer system for field offices, DDSs, and the Office of Hearings and Appeals, with a goal of eliminating paper processing.
- It transmits communications (e.g., emergency instructions, Commissioner's broadcasts, and administrative messages) to all SSA and DDS offices.

Office of Human Resources (449 employees)

- This office is responsible for personnel services for the components that handle disability issues.
- It plans and produces training on disability and non-disability issues.

SOCIAL SECURITY ADMINISTRATION ORGANIZATION CHART, 2000



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GLOSSARY

Adjudicative climate: The perceptions of individual disability adjudicators, based on the prevailing national attitudes regarding disability, that may affect how they apply existing formal policy in instances where some judgment is required within the specified evaluation procedures.

Administrative law judge: Administrative law judges in SSA's Office of Hearings and Appeals conduct hearings and make decisions on cases appealed by claimants.

Administrative review process: The procedures followed in determining eligibility for, and entitlement to, benefits. The administrative review process consists of several steps, which usually must be requested within certain periods and in the following order:
1) The initial determination: the DDS makes the initial decision on disability, and an SSA field office makes the initial decision on non-disability factors such as insured status, income, and resources.
2) Reconsideration: when an individual disagrees with the initial determination, the individual may ask SSA to reconsider it.
3) Hearing before an administrative law judge (ALJ): when an individual disagrees with the reconsidered determination, he or she may request a hearing before an ALJ.
4) Appeals Council review: when an individual disagrees with the decision or dismissal of the ALJ, he or she may request that the Appeals Council review that decision. The Appeals Council may deny or dismiss the request for review, or it may grant the request and either issue a decision or remand (return) the case to an ALJ. The Appeals Council may also review any ALJ action on its own motion within 60 days after the ALJ's action. The Appeals Council's decision or the hearing decision if the Council denies the request for review, represents SSA's final decision in the administrative review process. Individuals who disagree with that decision may pursue their appeals in a Federal district court, a circuit court of appeals, and the Supreme Court.

ALJ: See administrative law judge.

Allowance rate: The percentage of claims allowed in a given time period. At the hearing level, allowance rates are computed either as a percentage of dispositions (including dismissals) or as a percentage of decisions (excluding dismissals).

Appeals Council: The organization within SSA's Office of Hearings and Appeals that makes the final decision in the administrative review process. When an individual disagrees with the decision or dismissal of the ALJ, he or she may, within 60 days of receiving the hearing decision, request that the Appeals Council review that decision. The Appeals Council may deny or dismiss the request for review, or it may grant the request and either issue a decision or remand (return) the case to an ALJ. The Appeals Council may also review any ALJ action on its own motion within 60 days after the ALJ's action.

Attrition rate: The number of full-time separations during a fiscal year divided by the average full-time staff level for the year.

Average: Values shown as averages in this chartbook are arithmetic means, calculated by dividing the sum of all of the values of a variable by the number of cases.

Award: An action adding an individual to the Social Security benefit rolls.

Beneficiary: An individual on the Social Security benefit rolls.

Claimant: An individual who has applied for benefits and whose claim is still pending.

Concurrent claim: A claim for both Title II (OASDI) and Title XVI (SSI) benefits.

Continuing disability review: An evaluation of a disabled beneficiary's impairments to determine if the person is still disabled within the meaning of the law.

Conversion: The simultaneous cessation of payment of a specific type of benefit and entitlement of the beneficiary to another type of benefit. Title II disabled worker beneficiaries are converted to retirement benefits when they attain normal retirement age.

Cost per case: Total funding obligated by a DDS divided by the total number of cases processed by the DDS.

DDS: See Disability Determination Services.

Decisional accuracy: SSA measures the accuracy of DDS initial decisions through a Quality Assurance Review (QAR). The QAR randomly samples DDS decisions to capture 70 initial allowances and 70 initial denials per quarter for each DDS. The accuracy rate is the percentage of cases sampled free of either a decisional deficiency with sufficient documentation to support an opposite decision or a documentation deficiency where medical documentation is not sufficient to support any disability decision.

DI: Disability Insurance under Title II of the Social Security Act.

Disability: For purposes of Title II (OASDI) benefits and Title XVI (SSI) benefits for adults, disability is the inability to engage in any substantial gainful activity by reason of any medically determinable impairment which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months. A person must not only be unable to do his or her previous work but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy. It is immaterial whether such work exists in the immediate area, or whether a specific job vacancy exists, or whether the worker would be hired if he or she applied for work. For SSI disabled child benefits, a child under age 18 is considered disabled if he or she has any medically determinable physical or mental impairment(s) which result(s) in marked and severe functional limitations, and which can be expected to last for a continuous period of not less than 12 months.

Disability Determination Services (DDS): The State agency that makes the initial and reconsideration determination of whether a claimant is disabled or a beneficiary continues to be disabled within the meaning of the law.

Disability examiner: An employee of a State Disability Determination Services who collects medical evidence and, usually in conjunction with a physician, makes a determination on a claimant's disability.

Duration: A factor in the determination of disability. To be eligible for benefits, a claimant must have a disability that has lasted, or is expected to last, 12 months or to end in death. (See sequential evaluation process.)

Equals listing: A step in the sequential evaluation process. Regulations issued by SSA include a Listing of Impairments which describes, for each major body system, impairments that are considered severe enough to prevent a person from doing any substantial gainful activity. A determination that an impairment is equal in severity to the criteria in the listings is sufficient to establish that an individual who is not working is disabled within the meaning of the law. (See sequential evaluation process.)

Hearing: The level following reconsideration in the administrative review process. The hearing is a *de novo* procedure at which the claimant and/or his representative may appear in person, submit new evidence, examine the evidence used in making the determination under review, give testimony, and present and question witnesses. The hearing is on the record but is informal and non-adversarial.

Hearing Office: One of the 138 locations of SSA's Office of Hearings and Appeals at which hearings are held.

Hearings Process Improvement initiative: A plan which SSA is implementing with the goal of reducing processing time and increasing productivity in the hearings process through process improvements, group-based accountability, and automation.

Incidence rate: The number of persons awarded benefits in a specified period of time, per 1,000 of a specified population. For DI benefits, the incidence rate is the number of awards per 1,000 persons insured for disability benefits.

ME: See medical expert.

Medical expert (ME): A physician or mental health professional that provides impartial expert opinion at the hearing level of the SSA disability claims process. MEs either testify at hearings or provide written responses to interrogatories.

Medical listings: A common term for the Listing of Impairments issued by SSA as part of the regulations on determining disability. The listings describe, for each major body system, impairments that are considered severe enough to prevent a person from doing any substantial gainful activity. An impairment that meets or equals the criteria in the listings is sufficient to establish that an individual who is not working is disabled within the meaning of the law.

Meets listing: A step in the sequential evaluation process. Regulations issued by SSA include a Listing of Impairments which describes, for each major body system, impairments that are considered severe enough to prevent a person from doing any substantial gainful activity. An impairment that meets the criteria in the listings is sufficient to establish that an individual who is not working is disabled within the meaning of the law. (See sequential evaluation process.)

Non-severe impairment: An impairment that does not significantly limit a person's physical or mental ability to perform basic work activities. (See sequential evaluation process.)

Other work: Work that exists in the national economy, other than the work a person has done previously. (See sequential evaluation process.)

Prevalence: The percentage of a population receiving benefits at a specified time. For DI benefits, prevalence is expressed as a percentage of the population insured for disability.

Process unification: An SSA initiative with the objective to foster similar results on similar cases at all stages of the administrative review process by the consistent applications of laws, regulations and rulings. Process unification activities include development of a single presentation of policy, training, and enhancing documentation and explanations at the DDS level.

Productivity per work year: Total number of cases processed in a DDS divided by the number of workyears funded for the DDS.

Prototype: The implementation of elements of a redesigned disability process in 10 States known as "prototype States" in preparation for national implementation. This prototype began in October 1999. The elements of the prototype are: elimination of reconsideration; an expanded role for disability examiners to make decisions without approval of medical consultant; the opportunity for a conference with an adjudicator for claimants whose claims would receive an unfavorable decision; and enhanced rationales for decisions.

Reconsideration: An independent reexamination by the DDS of all evidence on record related to a case. It is based on the evidence submitted for the initial determination plus any further evidence and information that the claimant or his or her representative may submit in connection with the reconsideration. A reconsideration is made by a different disability examiner and physician/psychologist from the ones that made the original determination. (See administrative review process.)

Sequential evaluation process: The five-step process used in determining whether an individual meets the definition of disability in the law. A determination at any step that an individual is disabled or not disabled ends the process. The steps are:
1) Substantial gainful activity — If the claimant is, in fact, continuing to work and that work is found to be substantial gainful activity the process calls for a finding that he or she is not disabled.
2) Not severe — If it is determined that the claimant's medical impairments are not severe, i.e., do not significantly limit the ability to perform basic work activities, he or she is not disabled.
3) Listing of Impairments — If the claimant meets the criteria for an impairment listed in the regulations, or has an impairment or combination of impairments that is medically equivalent, he or she is found to be disabled.
4) Relevant past work — If a claimant's impairments do not prevent performance of relevant work he or she has done in the past, he or she is not disabled.
5) Other work — At this step, if a claimant, considering age, education, and work experience, cannot do other work which exists in the national economy, he or she is found disabled.

SSI: Supplemental Security Income, Title XVI of the Social Security Act, a program which provides benefits to low-income aged, blind, and disabled individuals who meet income and resource requirements.

State agency: A common term for Disability Determination Services, the State agency which makes the initial and reconsideration determinations of whether a claimant is disabled or a beneficiary continues to be disabled within the meaning of the law.

Substantial gainful activity (SGA): Remunerative work that is substantial, as determined from consideration of the amount of money earned, and/or the number of hours worked, and the nature of the work. The dollar amount is established by the Commissioner in regulations.

Termination: The ending of entitlement to a type of benefit. Disabled workers' benefits are most commonly terminated because of death, conversion to a retirement benefit at age 65, or recovery from their disabling condition.

Usual work: A claimant's past relevant work. (See sequential evaluation process.)

VE: See vocational expert.

Vocational considerations: Age, education, and work experience, considered at the final step of the sequential evaluation process.

Vocational expert (VE): Professionals who provide factual information and expert opinion relevant to particular vocational questions which may be raised at the hearing level of the SSA disability claims process.

Zebley: A 1990 Supreme Court decision (*Sullivan v. Zebley*) that ruled that SSA's policy regarding disability determinations for children erroneously held children to a stricter definition of disability than adults. As a result of the *Zebley* decision, SSA issued regulations requiring an individualized functional assessment for children who did not meet or equal the medical listings to determine the severity of their impairments and the associated limitations.

THE SOCIAL SECURITY ADVISORY BOARD

Establishment of the Board

In 1994, when the Congress passed legislation establishing the Social Security Administration as an independent agency, it also created a 7-member bipartisan Advisory Board to advise the President, the Congress, and the Commissioner of Social Security on matters relating to the Social Security and Supplemental Security Income (SSI) programs. The conference report on this legislation passed both Houses of Congress without opposition. President Clinton signed the Social Security Independence and Program Improvements Act of 1994 into law on August 15, 1994 (P.L. 103-296).

Advisory Board members are appointed to 6-year terms, made up as follows: 3 appointed by the President (no more than 2 from the same political party); and 2 each (no more than one from the same political party) by the Speaker of the House (in consultation with the Chairman and Ranking Minority Member of the Committee on Ways and Means) and by the President pro tempore of the Senate (in consultation with the Chairman and Ranking Minority member of the Committee on Finance). Presidential appointees are subject to Senate confirmation. Board members serve staggered terms.

The Chairman of the Board is appointed by the President for a 4-year term, coincident with the term of the President, or until the designation of a successor.

Members of the Board

Stanford G. Ross, Chairman

Stanford Ross is a partner in the law firm of Arnold & Porter, Washington, D.C. He has dealt extensively with public policy issues while serving in the Treasury Department, on the White House domestic policy staff, as Commissioner of Social Security, and as Public Trustee of the Social Security and Medicare Trust Funds. He is a Founding Member and a former Director and President of the National Academy of Social Insurance. He has provided technical assistance on Social Security and tax issues under the auspices of the International Monetary Fund, World Bank, and U.S. Treasury Department to various foreign countries. He has taught at the law schools of Georgetown University, Harvard University, New York University, and the University of Virginia, and has been a Visiting Fellow at the Hoover Institution, Stanford University. He is the author of many papers on Social Security and Federal taxation subjects. Term of office: October 1997 to September 2002.

Jo Anne Barnhart

Jo Anne Barnhart is a political consultant and public policy consultant to State and local governments on welfare and social services program design, policy, implementation, evaluation, and legislation. From 1990 to 1993 she served as Assistant Secretary for Children and Families, Department of Health and Human Services, overseeing more than 65 programs, including Aid to Families with Dependent Children, the Job Opportunities and Basic Skills Training program, Child Support Enforcement, and various child care programs. Previously, she was Minority Staff Director for the U.S. Senate Committee on Governmental Affairs, and legislative assistant for domestic policy issues for Senator William V. Roth. Ms. Barnhart served as Political Director for the National Republican Senatorial Committee. First term of office: March 1997 to September 1998; current term of office: October 1998 to September 2004.

Martha Keys

Martha Keys served as a U.S. Representative in the 94th and 95th Congresses. She was a member of the House Ways and Means Committee and its Subcommittees on Health and Public Assistance and Unemployment Compensation. Ms. Keys also served on the Select Committee on Welfare Reform. She served in the executive branch as Special Advisor to the Secretary of Health, Education, and Welfare and as Assistant Secretary of Education. She was a member of the 1983 National Commission (Greenspan) on Social Security Reform. Martha Keys is currently consulting on public policy issues. She has held executive positions in the non-profit sector, lectured widely on public policy in universities, and served on the National Council on Aging and other Boards. Ms. Keys is the author of *Planning for Retirement: Everywoman's Legal Guide*. First term of office: November 1994 to September 1999; current term of office: October 1999 to September 2005.

David Podoff

David Podoff is visiting Associate Professor at the Department of Economics and Finance at the Baruch College of the City University of New York. Previously he was Minority Staff Director and Chief Economist for the Senate Committee on Finance. He also served as the Committee's Minority Chief Health and Social Security Counselor and Chief Economist. In these positions on the Committee he was involved in major legislative debates with respect to the long-term solvency of Social Security, health care reform, the constitutional amendment to balance the budget, the debt ceiling, plans to balance the budget, and the accuracy of inflation measures and other government statistics. Prior to serving with the Finance Committee he was a Senior Economist with the Joint Economic Committee and directed various research units in the Social Security Administration's Office of Research and Statistics. He has taught economics at the University of Massachusetts and the University of California in Santa Barbara. He received his Ph.D. in economics from the Massachusetts Institute of Technology and a B.B.A. from the City University of New York. Term of office: October 2000 to September 2006.

Sylvester J. Schieber

Sylvester Schieber is Director of the Research and Information Center at Watson Wyatt Worldwide, where he specializes in analysis of public and private retirement policy issues and the development of special surveys and data files. From 1981 to 1983, Mr. Schieber was the Director of Research at the Employee Benefit Research Institute. Earlier, he worked for the Social Security Administration as an economic analyst and as Deputy Director at the Office of Policy Analysis. Mr. Schieber is the author of numerous journal articles, policy analysis papers, and several books including: *Retirement Income Opportunities in An Aging America: Coverage and Benefit Entitlement; Social Security: Perspectives on Preserving the System;* and *The Real Deal: The History and Future of Social Security*. He served on the 1994-1996 Advisory Council on Social Security. He received his Ph.D. from the University of Notre Dame. Term of office: January 1998 to September 2003.

Gerald M. Shea

Gerald M. Shea is currently assistant to the president for Government Affairs at the AFL-CIO. He previously held several positions within the AFL-CIO, serving as the director of the policy office with responsibility for health care and pensions, and also in various executive staff positions. Before joining the AFL-CIO, Mr. Shea spent 21 years with the Service Employees International Union as an organizer and local union official in Massachusetts and later on the national union's staff. He was a member of the 1994-1996 Advisory Council on Social Security. Mr. Shea serves as a public representative on the Joint Commission on the Accreditation of Health Care Organizations, is a founding Board member of the Foundation for Accountability, Chair of the RxHealth Value Project, and is on the Board of the Forum for Health Care Quality and Measurement. He is a graduate of Boston College. First term of office: January 1996 to September 1997; current term of office: October 2000 to September 2004.

Mark A. Weinberger

Mark A. Weinberger is currently the Director of the U.S. National Tax Practice for Ernst & Young LLP. Mr. Weinberger has previously served as Chief of Staff and Counsel to the President's 1994 Bipartisan Commission on Entitlement and Tax Reform (the Kerrey-Danforth Commission). He also is a former Commissioner of the National Commission on Retirement Policy.
Mr. Weinberger served as Chief Tax and Budget Counsel to Senator John Danforth, and also as a tax advisor to the National Commission on Economic Growth and Tax Reform (the Kemp Commission), which studied fundamental tax reform. Mr. Weinberger has written and lectured extensively on tax, budget, political and retirement security issues. He graduated from Emory University; holds a Masters degree in Business Administration and a law degree from Case Western Reserve University; and has an L.L.M. from Georgetown University Law Center. Term of office: October 2000 to September 2006.

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