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Social Security Advisory Board

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DISABILITY DECISION MAKING:

Data and Materials

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I. INTRODUCTION

Background

In January 2001, the Social Security Advisory Board issued the first edition of *Disability Decision Making: Data and Materials*. At that time the Board had spent over 3 years studying the question of how the Social Security Administration (SSA) could improve its service to the public. During the course of that study it became clear that the administration of the agency's disability programs was at the heart of SSA's service delivery problems. In 2006 we find that many of these problems continue to exist.

Over the past 5 years we have closely tracked the progress that the Social Security Administration has made as it has worked to improve its disability determination processes. While strides have been made and SSA continues to diligently pursue high-quality service, much work remains to be done. SSA is now implementing major changes. These include converting the disability program from a largely paper-based operation to a completely electronic environment and a significant restructuring of the adjudicatory processes. As the changes are implemented, the Board believes it will be useful to have available this compilation of data concerning the state of the disability programs.

The Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) programs provide essential income support (approximately $120 billion annually) to approximately 11.6 million people with disabilities and their dependents. Administration of the disability programs accounts for nearly two-thirds of the agency's administrative budget, or about $6 billion. In terms of executive management time and attention, the disability programs consume even more of the agency's resources than these numbers suggest. By comparison, the payment of retirement and survivors benefits, the issuance of Social Security numbers, and other basic functions run smoothly. While these other functions are core business processes of the Social Security Administration, they do not present the enormous management challenges that are presented by the SSDI and SSI disability programs.

The Social Security Advisory Board continued to look at the disability program and issued a second report in January 2001, *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change*. The purpose of that report was to provide the then new administration and Congress with a framework for considering the fundamental changes that we believed were needed. We again called for a look at whether or not disability decisions were consistent and fair and if disability policy was being developed in a coherent fashion. The report also asked: is Social Security's definition of disability appropriately aligned with the Nation's disability policy? Another report, *The Social Security Definition of Disability*, released in October 2003, chronicled the background of the program, how it had changed, and the various attempts to build in work incentives. The Board concluded that the time has come for the Nation to address the contradictions created by the existing definition of disability.

Because we believe that more work must be done to improve the disability process and the adjudicative standards, we have updated this document, *Disability Decision Making: Data and Materials*. It is intended to provide background information to help policymakers and the public gain a fuller understanding of how SSA's disability programs are being administered and of the major problems that are inherent in the current process.

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The data in this report raise significant questions, including issues about consistency and equity in decision making. SSA has, over the years, attempted a series of major initiatives that focused on streamlining the disability decision making process. In 1994, SSA developed *A Plan for a New Disability Claim Process* – better known as "Disability Redesign." This plan was to be implemented over a 6-year time span. Most of the projects ended in late 2001; however, some of the more promising changes were implemented in 10 States as a "prototype" for possible later implementation on a nationwide basis. In 2000, the Hearings Process Improvement (HPI) initiative was implemented, and later modified in March 2001. Aspects of HPI remain in place in SSA. However, even under this modified structure, there is still a general perception that HPI's net result did not improve the process.

The Long-Standing Concern: Consistency and Equity in Decision Making

Concern about consistency and equity in decision making goes back to the early days of the Disability Insurance program. In the fall of 1959, only 3 years after the program was enacted, the Ways and Means Subcommittee on the Administration of the Social Security Program (the Harrison Subcommittee) held a series of hearings that focused in part on variation in decision making among the States. During these hearings, the Social Security Administration's Deputy Commissioner, George Wyman, told the Subcommittee that the objective of achieving reasonable consistency represented "a real challenge." However, as explained by former Commissioner of Social Security Robert Ball, who at that time was Deputy Director of the Bureau of Old-Age and Survivors Insurance, the agency had developed a set of medical guidelines for use in adjudication. These guides were developed for the express purpose of achieving "as high degree of equity in the application of this law across the country as possible."

Yet, the program rules continued to grow in complexity and the number of decisions being made at the appeals levels has increased. In the mid-1970s the House Ways and Means and the Senate Finance Committees conducted an in-depth examination of the administration of the DI and SSI disability programs. The concern of the Committees was heightened by the issuance of a GAO report in 1976 that raised serious questions about consistency in disability decision making by the State agencies.

In their reports on proposed legislation (which ultimately was enacted as the *Social Security Disability Amendments of 1980*) both Committees expressed concerns. The Ways and Means Committee stated that "significant improvements in Federal management and control over State performance are necessary to ensure uniform treatment of all claimants and to improve the quality of decision making under the Nation's largest Federal disability program." The Finance Committee report expressed unease about "State-to-State, ALJ-to-ALJ variations and about the high rate of reversal of denials which occurs at various stages of adjudication, for it indicates that possibly different standards and rules for disability determinations are being used at the different locations and stages of adjudication."

The 1980 legislation incorporated several amendments aimed at addressing these concerns, including (1) giving SSA authority to establish performance standards and administrative requirements and procedures for State Disability Determination Services (DDSs), with the option of taking over the work of a DDS if the Commissioner finds that the State is substantially failing to make determinations in a manner consistent with regulations and other written guidelines; (2) requiring the agency to review a percentage of DDS decisions before payment begins; and (3) requiring the Commissioner to implement a program of own motion review of disability decisions made by administrative law judges (ALJs).

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In the *Social Security Disability Benefits Reform Act of 1984* the Congress again sought to improve consistency between the DDSs and the ALJs. The Act required the Commissioner to establish uniform regulatory standards to be applied at all levels of determination, review, and adjudication.

Legislation enacted in 1986 required the appointment of a special Disability Advisory Council to study and make recommendations with respect to the DI and SSI disability programs. One of the primary concerns expressed by the Advisory Council in its 1988 report was the lack of uniformity in the determination of disability. The Advisory Council recommended a number of measures to address this including:

- more effective use by the agency of its authority, through pre-effectuation review of decisions, to ensure the accuracy and uniformity of DDS decisions;
- establishment by the agency of more precise standards and criteria for determining eligibility;
- exercise by the agency of its full authority and obligation under the law to ensure that the States faithfully perform their administrative role on behalf of the Federal government;
- alteration of SSA's quality assurance system to ensure that reviews are not conducted by the same region in which the cases originate;
- efforts to determine why State agency decisions differ if for reasons that cannot be explained by differences in applicant pools or court orders;
- expedited promulgation of regulations so as to promote the use of a standard set of criteria by the DDS and the ALJ;
- action by the Congress to require the Department of Justice to prepare a study of possible alternatives to the current method of court review of disability cases. This included a recommendation that an evaluation of other types of courts and alternative placement of court review in the appeals process should be undertaken to determine potential impacts on timeliness, accuracy and nationwide uniformity of decisions; and
- study by SSA of the Medical Improvement Review Standard to assess whether or not the standard is the best way to measure someone's ability to work.

In response to the Advisory Council's report, staff in SSA's Office of Program and Integrity Reviews undertook a statistical analysis of State agency data. The major finding of this internal study, which was never published, was that "in general, more than half the differences in filing and allowance rates among States are associated with different characteristics of State populations." The study observed that differing filing and allowance rates were therefore appropriate and reflected expected variation among the States. It was noted, however, that there were several States where the actual allowance rate varied significantly from the "expected" rate and, with respect to those States, more intensive analysis was warranted.

Although they did not specifically address the issue of consistency among States or between levels of decision making, other studies undertaken by SSA in the 1990s analyzed the reasons for fluctuations in the growth of the Disability Insurance program. In 1992, the Department of Health and Human Services issued the "709 Report," a report prompted by the forecasts of the impending exhaustion of the DI Trust Fund following the sharp increase in awards in the late

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1980s and early 1990s.[1] The report speculated on the reasons for program growth, but could not quantify the extent to which various factors – economic, demographic, and program policy – contributed to the increased DI rolls. Follow-on studies were conducted and SSA issued the February 1996 *Report on Rising Cost of Social Security Disability Insurance Benefits*. This report, drawing on earlier findings of a study conducted by Lewin-VHI, Inc. under contract with the Department of HHS,[2] provided additional explanation for the growth in program rolls. The report also outlined SSA's plan to fundamentally redesign the disability program in order to improve overall disability program management and achieve more uniform, efficient, and timely disability decisions.

The 1990s saw several examinations of the disability program that focused on the inconsistency in decision making. In 1995 and 1997, the Social Security Subcommittee of the House Ways and Means Committee conducted hearings on the issue, and the Congressional Research Service and GAO both issued reports. Today, the GAO continues to focus on the disability programs. Since 2001, GAO has issued 22 reports that address various aspects of the programs, with most of them discussing recommendations for steps to achieve greater consistency across the program and for strengthening management oversight.

Disability Redesign and Process Unification

In September 1994, in response to a growing disability claims workload and a shrinking agency workforce, the Social Security Administration developed a plan to redesign the disability determination process. The original redesign plan included 83 initiatives to be implemented over a 6 year period. According to the plan, the new disability determination process would result in a reduction of the average processing time for an initial claim from about 150 days to somewhere around 60 days. Because the definition of disability remained unchanged, program costs were expected to remain neutral. In addition, it was expected that administrative costs would decline over the implementation period and that those savings would be reinvested in the program.[3]

By 1997, it was clear that the redesign initiative was far too complicated, and progress was slow. In February 1997, SSA reassessed its approach and decided to focus on a much smaller number of integrated projects. Most of the projects were terminated by late 2001, but a number of States continued to implement certain aspects of the redesign, including the elimination of the reconsideration step of the appeals process and the "single decision maker" approach of allowing disability examiners to adjudicate most cases without a mandatory concurrence by a doctor. It was expected that these procedures in the 10 prototype States would eventually be implemented nationwide. However, these changes are now planned to be eliminated in favor of a new initiative described later in this report.

The redesign activity included a "process unification" plan as one of the key changes for improving consistency within the decision making process. SSA proposed to develop a single

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[1]Section 709 of the *Social Security Act* requires that the Board of Trustees report to Congress on recommendations for statutory changes for alleviating financing inadequacy whenever it projects that any of the Social Security or Medicare Trust Funds will drop below 20 percent of a year's benefits.
[2]The results of this study are discussed in *Growth in Disability Benefits: Explanations and Policy Implications*, edited by Kalman Rupp and David C. Stapleton (W.E. Upjohn Institute for Employment Research, 1998).
[3]*Plan for a New Disability Claim Process,* Social Security Administration, September 1994.

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presentation of all substantive policies used in the determination process that would be binding on all decision makers. In 1996, the agency issued a series of 9 Social Security Rulings (SSRs) that addressed the areas that the agency had identified as being responsible for major differences in decision making between the State agencies and the ALJs. Nationwide, over 14,000 SSA and DDS employees were trained on the rulings. This was intended to be the model for an ongoing process of joint training between the DDS adjudicators and the ALJs. Since then, SSA has continued to use SSRs as a key policy interpretation tool; however, no coordinated, cross-component nationwide training initiative has been implemented.

SSA has struggled with balancing productivity with the cost and level of effort that is needed to fully document claims and clearly explain how these "process unification rulings" were considered during the disability decision making process. DDS instructions tell adjudicators to incorporate within the case analysis a detailed explanation of how they evaluated key elements of the rulings. Yet, we have heard repeatedly over the years that the DDSs are not funded adequately to permit proper implementation of this rationale process. GAO noted the same finding in a July 2004 report.[4]

Attempts at Improving and Streamlining the Appellate Process

Improving the hearings process has been a long-standing, but thus far unachievable, goal for SSA. Claimants wait far too long for a hearing before an administrative law judge. At the close of fiscal year 2005, the average processing time at the hearing level was 415 days, and there were 708,164 cases waiting for a decision. Prior efforts at process unification had started to narrow the gap in allowance rates between the DDSs and the ALJs, and allowance rates at the hearing level fell during the period 1996-1998. However, they have been on the increase since then. As the pending caseload has grown from 264,978 at the end of 1999 to 708,164 at the end of 2005, the allowance rate has climbed from 63 percent to 72 percent.

In January 1992, the Strategic Priority Workgroup – a team of SSA executives and staff tasked with studying SSA's hearings and appeals process – issued a report entitled *Improve the Appeals Process*. This was the 37th report on how to improve the appeals process. The workgroup noted that the appeals workload was growing and would continue to do so. It found that the appeals process took too long, with the average processing time in fiscal year 1991 being 229 days. The workgroup noted that the allowance rate at the ALJ level had risen to 63 percent.

The Strategic Priority Workgroup laid out the following goals: by the year 2005, all reconsideration claims would be processed in 60 days; all hearing requests would be processed in 120 days; manual processes would be streamlined; documentation of evidence and decision justifications would be improved; and the appeals system would be modernized through enhanced automation. Since the report, a few of the workgroup's recommendations have been implemented in some form; e.g., ALJ peer review, the use of personal computers, and deciding some cases without a formal hearing. Others, such as a "one hat" role for the ALJ (that is, narrowing the

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[4] *More Effort Needed to Assess Consistency of Disability Decisions*; GAO 04 656, July 2004.

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responsibilities of the ALJ to be a decision maker only), and ensuring that SSA is using all legally acceptable methods for managing the work of the ALJs, are issues with which the agency still struggles.

Between 1990 and 1993, hearing receipts grew by 64 percent, yet dispositions increased by only 26 percent. Pending workloads increased by 95 percent from 1991 to1993, and 34 percent from 1993 to 1994. By 1994, SSA began to develop plans for the Short Term Disability Project under which the entire agency joined to assist in addressing the growing backlog of hearings.

By 1998 productivity was up, ALJ staffing was at its peak and the backlog had declined by over 163,000 cases. Yet, average processing time had not declined. In August 1999, the Hearings Process Improvement (HPI) initiative was unveiled. HPI was intended to reduce hand-offs, streamline processes, and improve accountability and service delivery. Phase I of HPI, consisting of 37 offices, was implemented in January 2000 and rollout to all offices was originally scheduled to be completed by November 2000.

HPI implementation did not go well and roll out was slowed down. Despite modifications to the plan, there was widespread discontent, confusion over roles and responsibilities, and a strong feeling that the restructuring had created significant anxiety for the employees. As a result hearing office performance was adversely affected. Most aspects of the initiative were effectively abandoned by 2002.

The Definition of Disability and SSA's Administrative Structure Make Consistency and Equity Difficult to Achieve

It is important to point out that both the definition of disability and the administrative structure of SSA's disability program make consistent and fair decisions difficult to achieve. The statute requires a determination not only that the claimant has a severe medical impairment but also that, in combination with his or her individual vocational and educational circumstances, it precludes engaging in substantial gainful activity. Although the agency has issued extensive regulations to guide decision makers, determining whether that standard is met requires substantial judgment and analysis, particularly with regard to the nature and sufficiency of evidence that is needed to document the case and render a determination. Most adjudicators agree that there are a sizeable number of difficult cases in which the same evidence may lead different decision makers to different conclusions.

The administrative structure for determining disability involves different levels of government and different processes, depending upon the stage of an individual's claim. Although SSA is responsible for the program, the law requires that initial determinations of disability be made by agencies administered by the 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands. This State-based administrative mechanism was established by the Congress in 1954 on the theory that the arrangement would provide coordination with existing State vocational rehabilitation agencies and was necessary in order to secure the cooperation of the medical profession, which already had a working relationship with the rehabilitation agencies. In fact, although most State disability agencies are still part of their State departments of rehabilitation, the close coordination of the disability determination process and the delivery of vocational rehabilitation services that was originally envisioned has not been achieved.

In addition, the relationship of the State agencies with the medical profession has changed over the

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years as more health care is delivered through group providers and less through personal physicians. Direct access to practicing physicians to discuss a claimant's condition happens less and less and more of the "conversation" is carried on through securing records from medical librarians and office staff. The increasing use of electronic medical evidence has changed the dynamic as well.

Although the State agencies are required to follow the policy guidance of the Social Security Administration and are fully funded by the Federal government, there are few Federal requirements relating to their administrative practices. The agencies follow State established personnel policies with respect to salaries, benefits and educational requirements; and they do their own hiring, provide most of the training for adjudicators, and establish their own internal quality assurance procedures. Also, reimbursement rates for purchasing medical evidence and diagnostic tests vary from State to State.

By regulation, an individual whose claim is denied by the State agency may ask the agency to reconsider the decision and may present new evidence. After the reconsideration decision (or, after the initial decision, in those States where there is no reconsideration step[5]), the statute gives individuals who are dissatisfied with the agency decision the right to request a hearing. Hearings are conducted by the agency's corps of administrative law judges. New evidence is frequently introduced at this stage, and since an ALJ hearing is a *de novo* proceeding, it is essentially a complete readjudication of the case. Currently, about a quarter of all case allowances are made at this level. Although ALJs must follow the agency's regulations and rulings, they exercise decisional independence to ensure a fair hearing.

Individuals whose claims are denied at the ALJ level may appeal their cases to the Appeals Council, which is the final step in the administrative appeals process. At this stage, claimants may continue to introduce new evidence and raise new issues. In addition, the Appeals Council may exercise its "own motion" authority and review a case within 60 days of the date of the ALJ's decision. All of the case reviews conducted by the Appeals Council are done on a pre-effectuation basis. As part of this "own motion" authority, a sample of ALJ allowances are selected for review, based on a profile of error-prone cases. In fiscal year 2003, 7,255 ALJ allowances were found to meet the error profile criteria and underwent this review. These particular cases are first reviewed by SSA's Office of Quality Assurance (OQA), which forwards to the Appeals Council those cases in which it disagrees with the ALJ decision. If, after review, the Appeals Council agrees with OQA's assessment, it can reverse the decision or remand the case to the ALJ.

SSA has published regulations making several changes to the administrative adjudication process. These regulations first become effective on August 1, 2006 but will be gradually implemented over a period of years. They are described in more detail in Part Two of this report.

Many Factors Have Been Identified as Affecting the Dynamics and the Consistency of Decision Making

Over the years policy makers and administrators have identified many factors, in addition to the inherent subjectivity of the statutory definition of disability, that may affect the consistency of disability

[5]The reconsideration step has been eliminated in the 10 "prototype" States. These States are operating under a set of changes introduced by SSA in October 1999 that are aimed at improving the disability determination process. These testing regulations are due to expire on September 30, 2006.

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decision making. These include:

- economic differences among the States;
- demographic differences among the States;
- differences in health status and access to care;
- State public policy actions (e.g., eliminating general assistance programs; requiring individuals to file for SSA's disability programs as a condition of eligibility for State benefits);
- differences in assessing the accuracy of State decision making among SSA's regional Offices of Quality Assurance;
- differences in quality assurance procedures applied to ALJs and State agencies;
- hearing office differences in administrative practices (e.g., variation in use of and training of vocational and medical experts at ALJ hearings);
- differences in the training given to ALJs and State adjudicators;
- differences in State agency training practices;
- the fact that most claimants are never seen by an adjudicator until they have an ALJ hearing;
- involvement of attorneys and other claimant representatives at the ALJ hearing;
- changes in the adjudicative climate (the "message" sent by SSA, the Congress, or others to those who adjudicate claims);
- rules that allow claimants to introduce new evidence and allegations at each stage of the appeals process;
- lack of clear and unified policy guidance from SSA;
- insufficient funding and staffing for the State agencies and hearing offices; and
- SSA pressures on State agencies and on ALJs to meet productivity goals.

Court Cases – Influence on Program Policy

The 1980s and much of the 1990s were somewhat turbulent for SSA, from a program policy perspective, as a result of a high volume of landmark court decisions. These court decisions have affected the way SSA makes decisions and have shaped subsequent policy development. They have increased differences in decision making among different regions of the country as well as differences in decision making between DDSs and ALJs. The 1985 decision by the Second Circuit in *Stieberger v. Heckler* (615 F. Supp. 1315) overturned SSA's prior practice of not following the policy underlying decisions in circuit court cases when it adjudicated other cases within the same circuit. After this decision, SSA adopted its current policy of acquiescence. When there is a circuit court decision that the agency is unwilling to implement nationwide, it issues an acquiescence ruling stating that the agency will comply with the decision only within the issuing circuit. Initially these acquiescence rulings applied only to the ALJ level, but a regulation in 1990 extended them to State agencies.

In response to various court decisions and changing perceptions of how disability should be determined, SSA has implemented a number of policies that have introduced increased levels of judgment into the disability determination process.[6] The 1996 "process unification rulings" require all adjudicators to assess such subjective factors as the weight that should be given to the

[6]Court cases include *Schisler v. Bowen*, 787 F. Supp. 76 (2nd Cir. 1986), which dealt with treating source opinion and *Hyatt v. Heckler*, 579 F. Supp. 985 (4th Cir. 1986), which dealt with assessment of pain.

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opinion of a treating source and the credibility of statements made with respect to allegations of pain and other symptoms. These rulings are intended to improve consistency in decision making between the DDSs and hearing offices. However, the operational implementation of the rulings has proven to be labor intensive and costly. As a result, implementation of the rulings is uneven across the country.

There have also been court decisions upholding agency policy. In 2002, SSA withstood a challenge to its interpretation of the statutory definition of disability. In *Barnhart v. Walton*, the Supreme Court agreed that the statute requires that not only must a claimant's impairment meet the duration requirement but also the claimant's inability to work because of that impairment must last, or be expected to last, for 12 months. 2003 saw another Supreme Court challenge to SSA's rules for determining disability. The Court ruled in *Barnhart v. Thomas* that the agency's denial of benefits to a claimant who was still able to do her previous work was in accord with the law and did not require a determination by the agency of whether or not that type of work continued to be available in the national economy.

Critical Data for an Ongoing, In-Depth Assessment of the Disability Determination Process

Although there have been attempts in the past to shed light on aspects of the disability programs, those attempts have often been hampered in their analysis because there is little data available to help those outside of the agency understand in even a rudimentary way how the disability programs are operating. It is in response to this lack of information that the Social Security Advisory Board has assembled and updated this compendium of basic historical data. The Board considers these data to be essential to its continuing efforts to help Congress, the President, SSA, and the public to understand and address important issues of policy and public service.

The charts that are included in this document reflect the information that we have been able to assemble at this time. All of the charts are the work of the Board's staff. The data that were used in preparing them were provided by the Social Security Administration at the request of the Board or have appeared in SSA publications. Presentation of the charts generally follows the sequence of the disability determination process, from initial application through the administrative and judicial appeals processes. In summary, the charts show:

- variations in applications over time;
- variations in awards and allowance rates;
- variations in benefit termination rates over time;
- changes in the number of beneficiaries and variations in prevalence of disability;
- trends in continuing disability reviews;
- changes in the characteristics of beneficiaries;
- variations in DDS decision making;
- variations in State administrative arrangements;
- trends in characteristics of hearings;
- trends in Appeals Council actions; and
- trends in Federal court actions.

Although the data used in the charts were originally collected for the use of the Board itself,

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we believe it is important to share them widely with individuals who are engaged in the

administration of the disability programs, policy makers, and the public. We recognize that far more data than collected here are required to present a full picture of how the disability programs are operating. However, we believe the charts that are included in this document raise fundamental questions for which there are no clear answers. These questions are important not only for understanding the past, but also for thinking about whether there is a need for policy or administrative changes in order to improve disability decision making for claimants in the future. The questions include:

- What have been the reasons for the wide variations in the number of applications for DI and SSI disability over the years?
- What explains the variations in State agency and ALJ allowance rates?
- What are the reasons for the large number of State agency decisions that are reversed at the ALJ level?
- Why is the allowance rate among States as wide-ranging as it is?
- How effective is the Listing of Impairments? What accounts for the significant decline over the years in the percentage of DDS awards that are based on medical listings and the significant increase in awards on the basis of vocational factors?
- How have differences in State administrative arrangements and practices affected the quality of decision making?
- How has the increased presence of attorneys as claimant representatives affected the appeals process?
- How does the increasing use of outside vocational experts at the ALJ level affect decision making and what are the implications of increasing the presence of vocational specialists in the DDSs?
- What has been the impact of various Federal court decisions as well as the agency's acquiescence ruling policy?
- Is it reasonable to expect greater consistency in decision making than the statistics in these charts seem to show currently exists?

These questions are particularly critical now that SSA has, once again, announced changes to its adjudicative process that are intended to streamline decision making, and as it also plans to implement a more comprehensive quality assurance system to mitigate the variability in decisional outcomes.

The high degree of variability in outcomes that has persisted for many years seems to be inconsistent with a program that is intended to operate uniformly throughout the U.S., and with one that is based on a Federal statutory definition of disability that has not changed in over 30 years. As noted earlier in this section, there are many reasons that can be put forward as explanations for the differences among States and between the DDSs and the ALJs. But perhaps more importantly, how much variability is acceptable and expected, given demographic patterns, employment opportunities, and access to health care?

The disability rolls are projected to grow over the coming decades as baby boomers reach an age of increased likelihood of becoming disabled. These growing workloads will make it increasingly important for the agency to have clear and workable policies, as well as sound administrative rules and guidelines. This will require a better understanding than now exists of

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the factors that influence the dynamics of the disability rolls.

The agency currently has no effective mechanism in place to provide consistent and reliable information on the extent to which the variation may also represent a failure to apply program policies and procedures in a uniform way across the country and throughout the disability system. Clarifying the issue of horizontal equity, i.e., whether or not similarly situated individuals are receiving similar treatment, is essential to evaluating the fairness and effectiveness of the administrative structure of the disability program. It is also essential to evaluating the program from the standpoint of the contributors and taxpayers who pay the costs of the program. It is not justifiable for programs that cost nearly $120 billion in fiscal year 2005 to lack such basic information.

We believe that SSA urgently needs a new quality assurance management system that will routinely produce the information the agency needs to guide disability policy and procedures and to ensure accuracy and consistency in decision making. Such a system is essential to provide ongoing evaluation of agency initiatives such as the Commissioner's recently promulgated regulations for changes to the administrative review process for adjudicating initial disability claims. The system should incorporate all stages of the decision making process and should produce data that will enhance SSA's ability to analyze specific problems and help the agency to develop appropriate solutions. The information should be made available to all those who are concerned with the disability programs – both inside and outside of SSA.

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PART ONE

Data Relating to Disability Program Operations

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I. Applications

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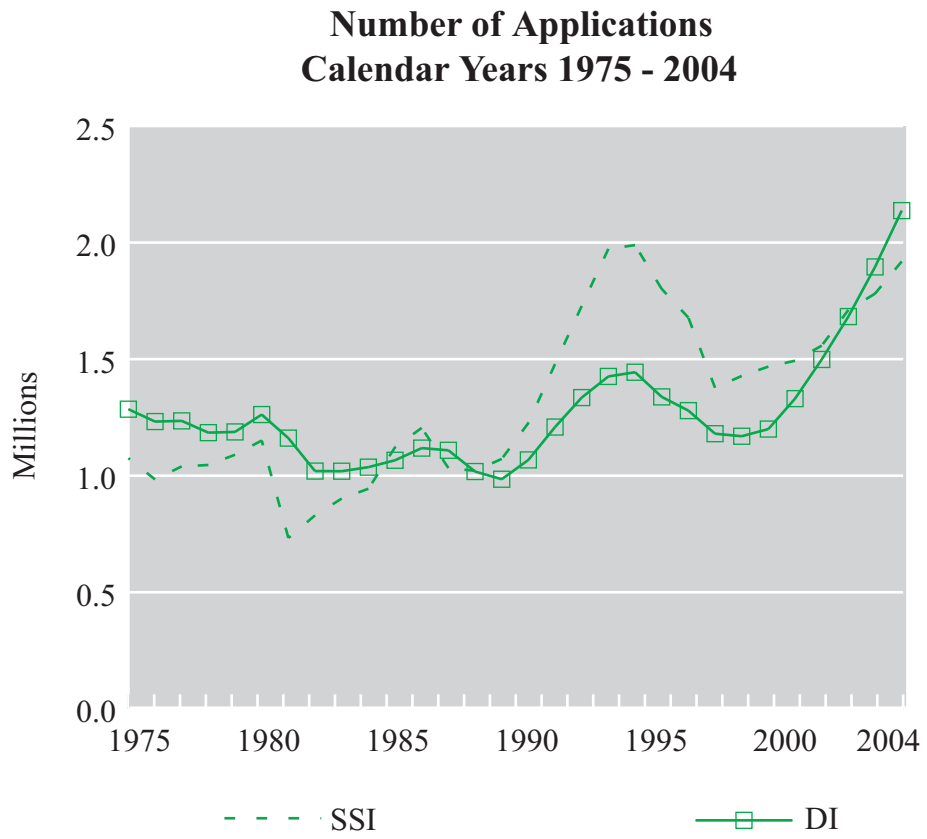
Chart 1



The number of applications for DI and SSI disability benefits has varied greatly over the years, although the overall trend has been upward since 1989. The numbers of DI applications increased sharply in the early 1990s and fell between 1995 and 1998. Since 2001, DI applications have been higher than their earlier peak in 1994.

SSI applications increased even more rapidly in the early 1990s. Much of that rapid growth was due to the Supreme Court's *Zebley* decision, which loosened the criteria for determining disability for children. Legislation in 1996 modified the impact of the *Zebley* decision and made other changes. SSI applications declined sharply from 1995 to 1997.

Past studies have shown some relationship between applications and unemployment, particularly for DI. Observers of the program also cite other factors affecting applications, including, for example, increases in the number of workers insured for Disability Insurance, efforts by State and local governments to shift welfare caseloads and spending to the Federal government, court decisions, changes in regulations, and adjudicative climate.

Numbers for DI and SSI are not additive because some applicants apply for benefits under both programs.

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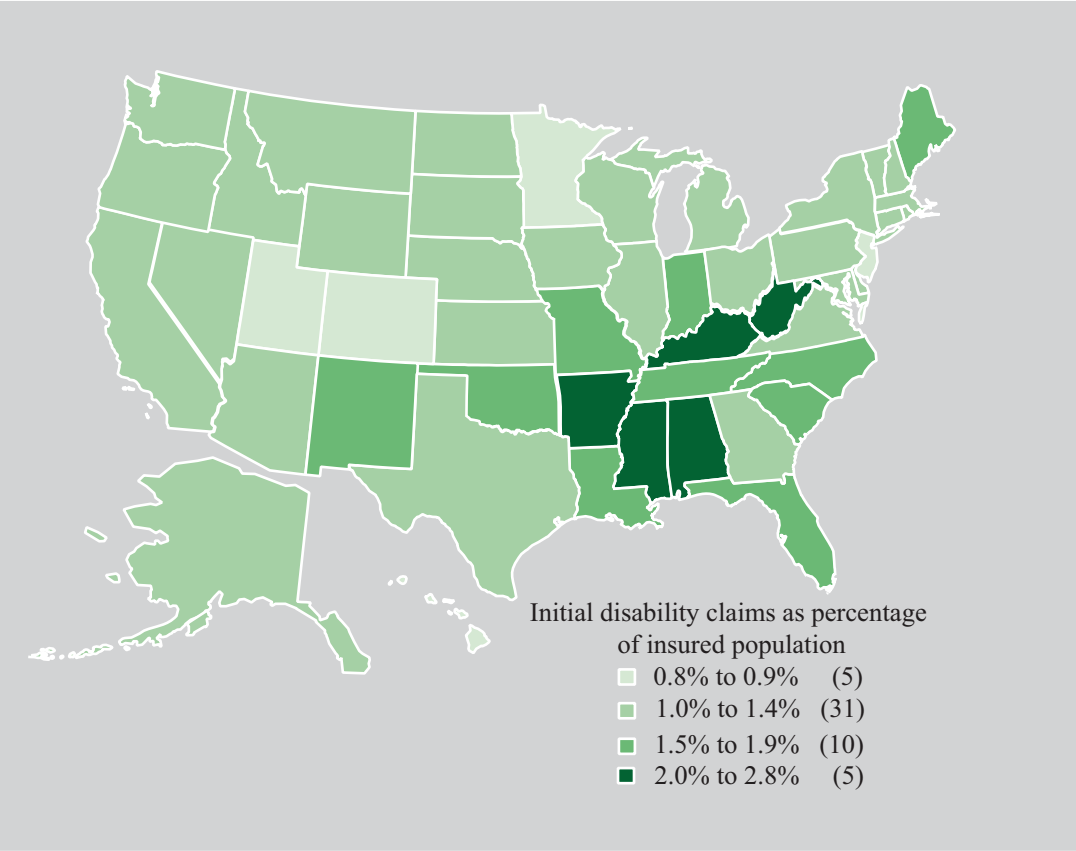
Chart 2

Disability Insurance Application Rates
Fiscal Year 2003



Application rates (benefit applications received as a percentage of the population insured for disability benefits) ranged from 0.8 percent in Hawaii to 2.8 percent in Mississippi. The highest DI application rates are generally in the Southeast.

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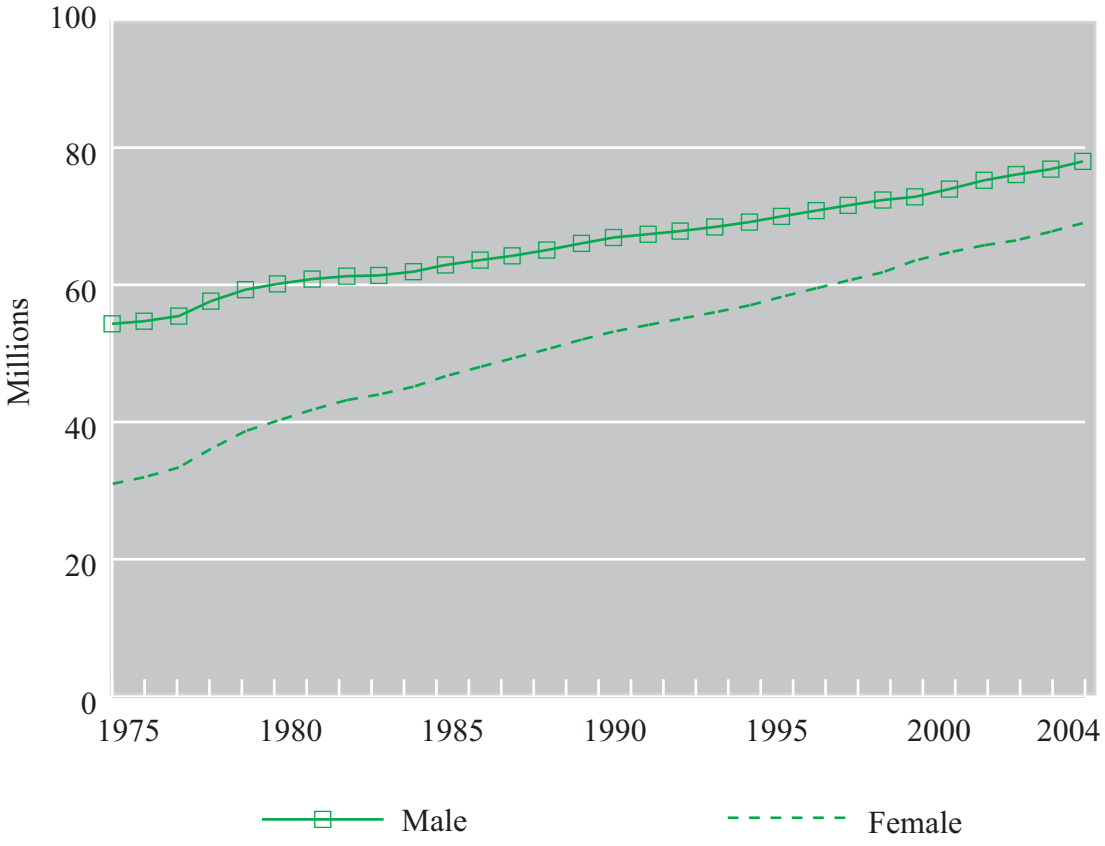
Chart 3

Workers Insured for Disability Benefits by Gender
Calendar Years 1975 - 2004



The number of workers insured for disability benefits increased by 72 percent between 1975 and 2004. The number of insured men grew by 43 percent, while the number of insured women grew by 123 percent. Women were 36 percent of the insured population in 1975, 47 percent in 2004.

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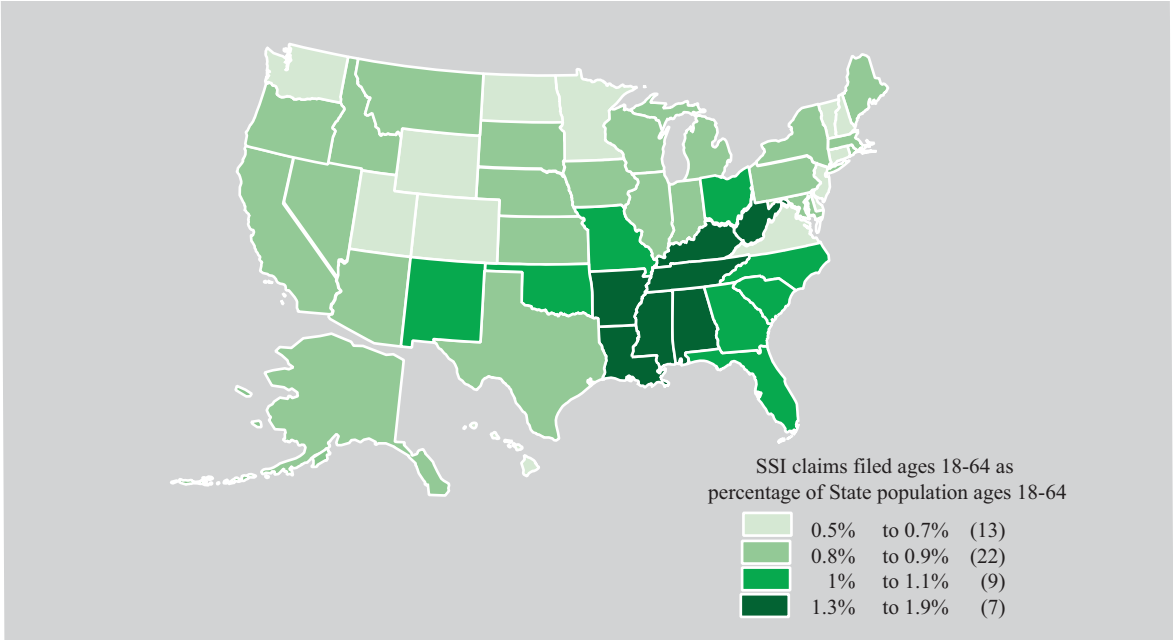
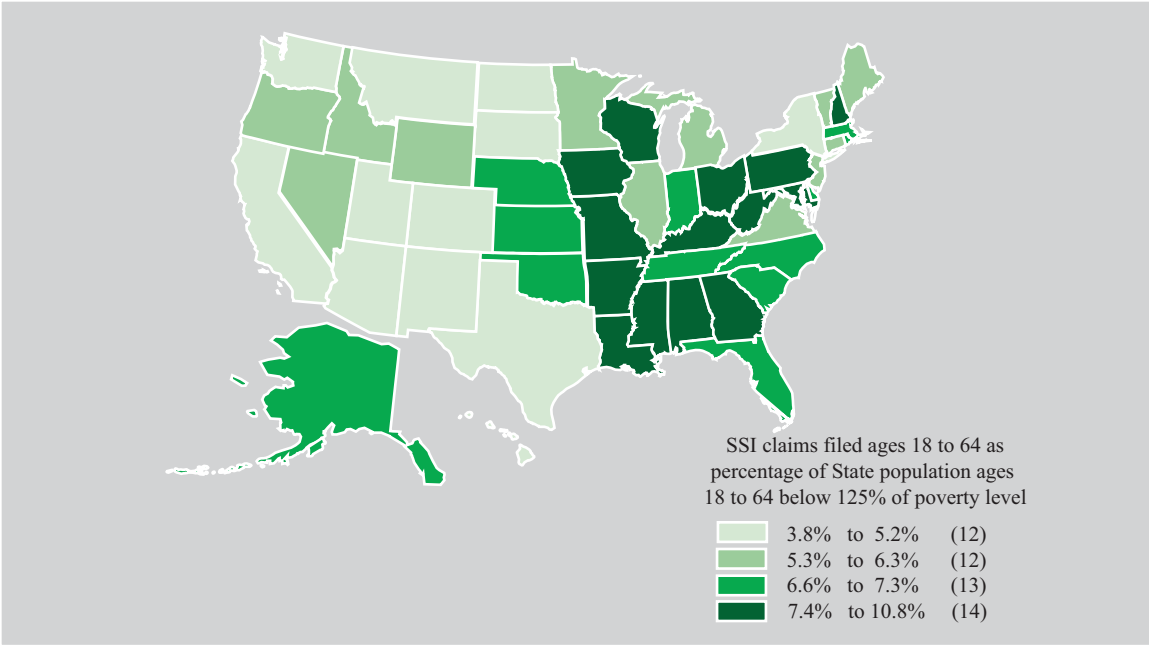
Chart 4

SSI Adult Disability Application Rates by State
Calendar Year 2003



SSI adult application rates as a percentage of the population ages 18 to 64 show a similar pattern to DI application rates. Application rates, ranging from 0.5 percent to 1.9 percent, are higher than our last report on this subject in 1999, when they ranged from 0.3 percent to 1.5 percent.



Viewed as a percentage of the population ages 18 to 64 living in households with income below 125 percent of the poverty level, application rates still cover a wide range, from 3.8 percent to 10.8 percent. This is also higher than in 1999, when the range was from 2.7 percent to 7.6 percent.

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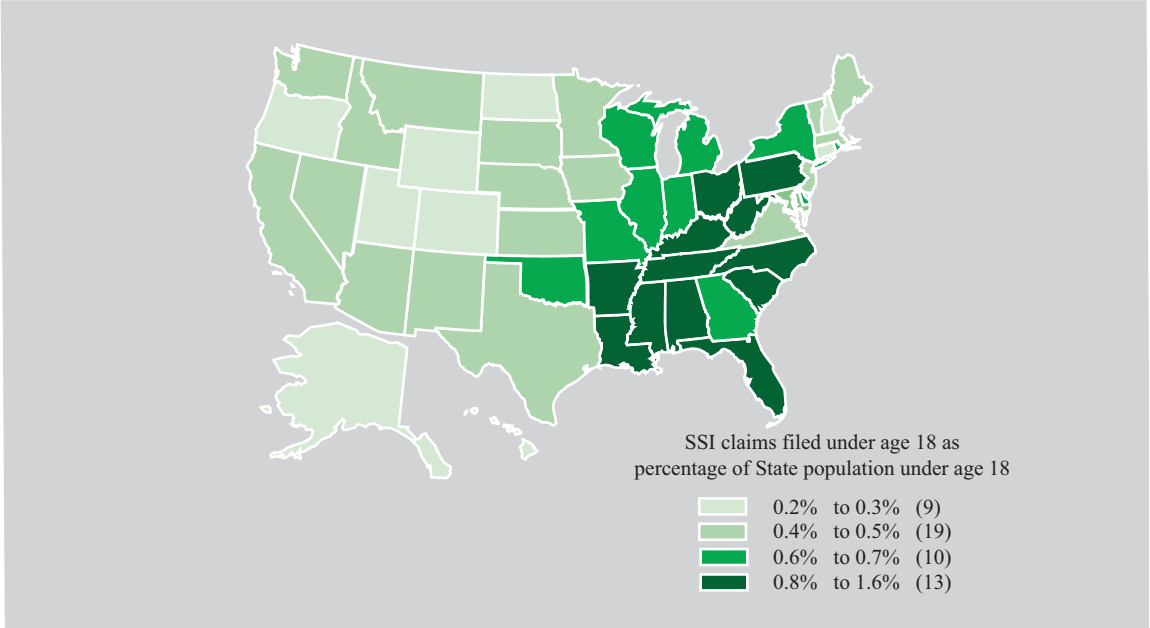
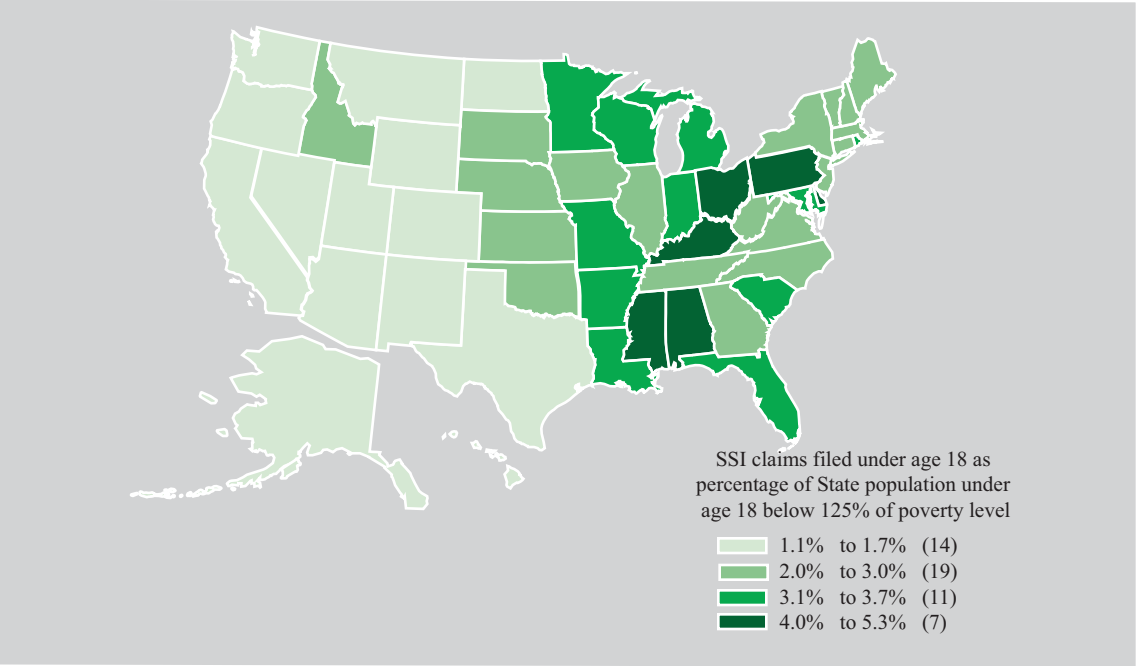
Chart 5

SSI Child Disability Application Rates by State
Calendar Year 2003



Disability application rates for SSI children as a percentage of the population are highest in the Southeast but are also high in States such as Pennsylvania and Ohio. The range of application rates, 0.2 percent to 1.6 percent, is narrower than in 1999, when it was 0.2 percent to 1.8 percent.



Expressed as a percentage of the population under 18 living in households with income below 125 percent of the poverty level in 2003, SSI child disability application rates range from 1.1 percent to 5.3 percent, higher overall than in 1999, when they ranged from 0.7 percent to 4.1 percent.

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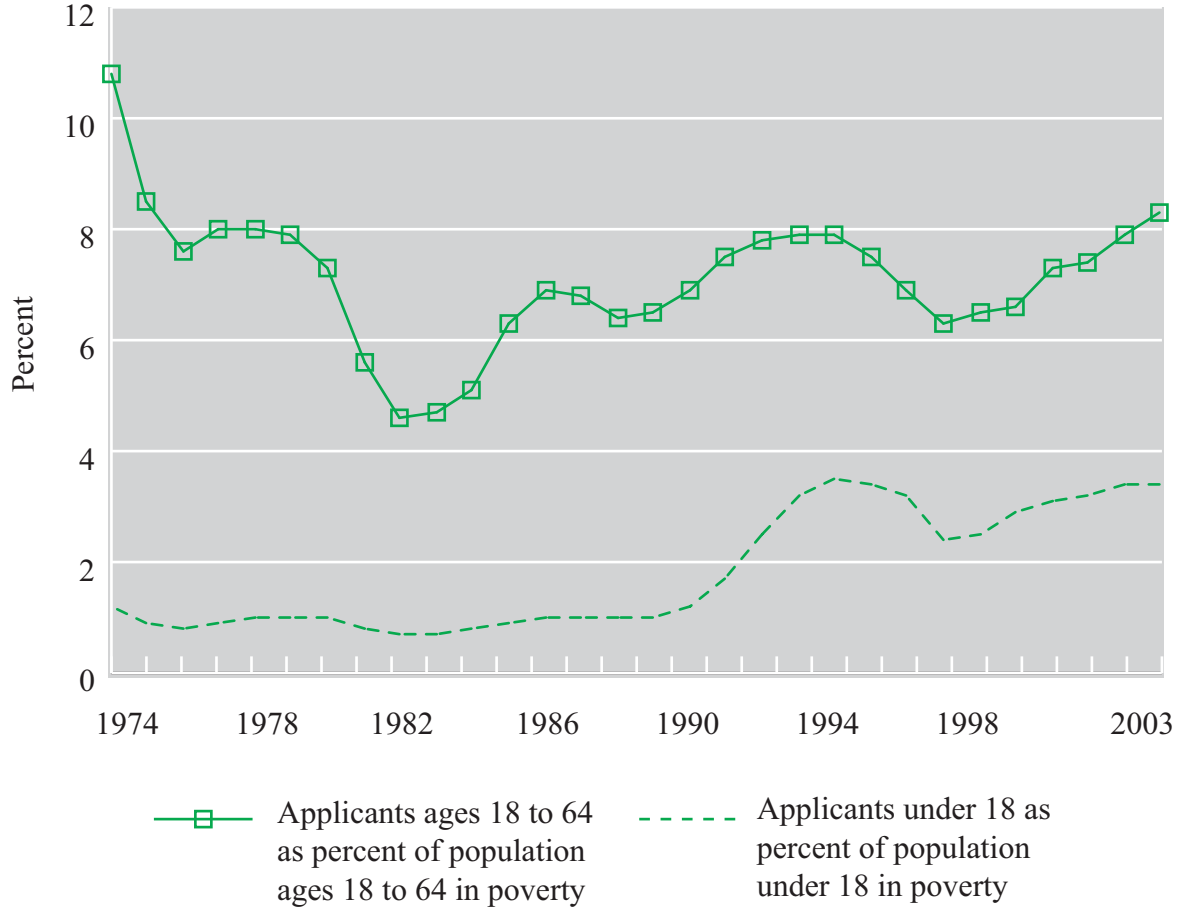
Chart 6

SSI Applicants by Age Group as Percentage of Population in Poverty Calendar Years 1974 - 2003



From 1975 through 1989, the number of children applying for SSI equaled 1 percent or less of children in poverty. That percentage began a sharp increase in 1990, the year of the *Zebley* decision, reaching 3.5 percent in 1994 before beginning to decline. It did not decline to its pre-1990 levels, however, falling only to 2.4 percent in 1997 before beginning to rise again. In 2002 and 2003 it stood at 3.4 percent, nearly the level it reached in 1994.

The number of adults ages 18 to 64 applying for SSI as a percentage of adults in poverty fell from an initial high of 10.8 percent in 1974 to 4.6 percent in 1982 before beginning to rise again. Between 1985 and 2002 it was in the 6 to 8 percent range. In 2003 it rose to 8.3 percent.

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II. Allowances

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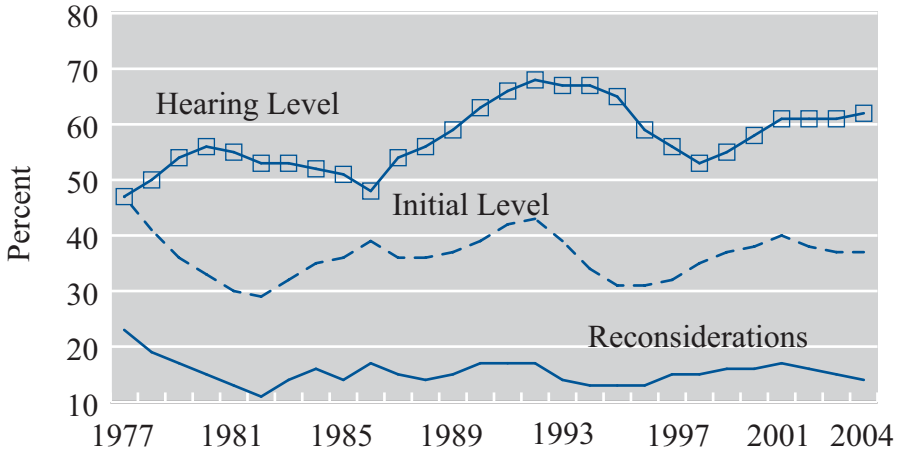
Chart 7

Allowance Rates at Each Level of Decision Making, DI and SSI Combined Fiscal Years 1977 - 2004



In the last 25 years, the percentage of claims adjudicated at the ALJ level that are allowed has been considerably higher than the percentage allowed by the DDSs at the initial level. The allowance rates for both levels have shown large variations, sometimes moving in tandem, sometimes not.

A revised process was introduced in 10 States at the beginning of FY 2000, under which initial denials could be appealed directly to the hearing level without a reconsideration.

The hearing level allowance rate shown here is the percentage of dispositions, which included dismissals. (Dismissals are cases disposed of without a hearing, usually because the claimant's request for a hearing was not timely or the claimant does not appear for the hearing. Dismissal rates have been fairly steady at 10 to 15 percent of dispositions.) The allowance rate includes all forms of Social Security and SSI cases reaching the hearing level, but the vast majority involve disability issues. In 2004, only 0.4 percent of hearing decisions dealt with retirement or survivors claims.

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Chart 8

State Agency Allowance Rates for Initial Claims
Fiscal Years 1990 - 2004

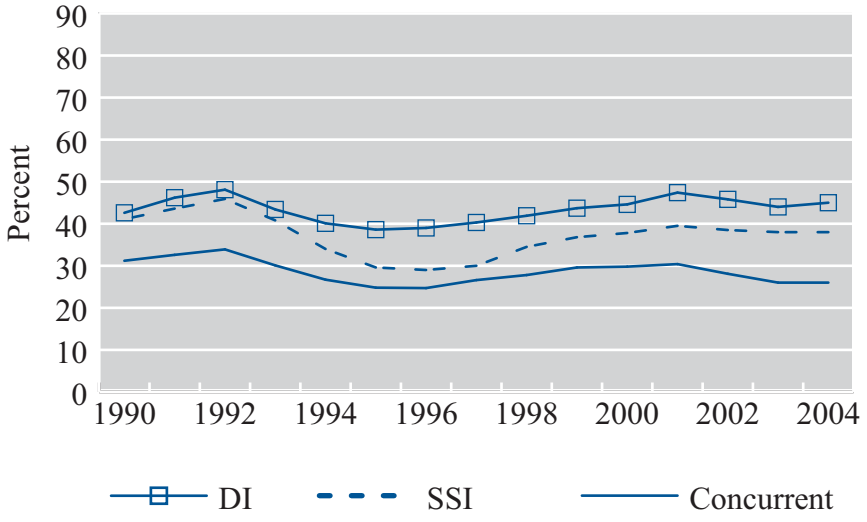
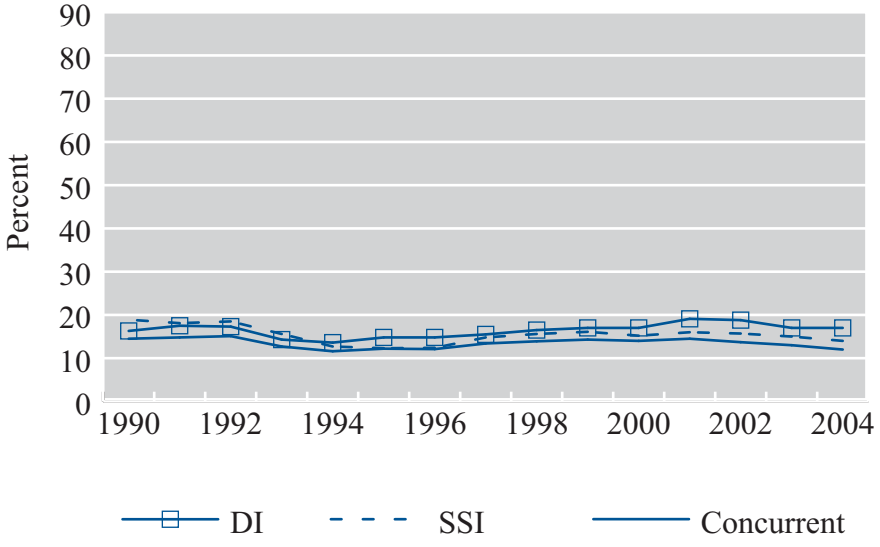


Chart 9

State Agency Allowance Rates for Reconsiderations
Fiscal Years 1990 - 2004



The percentage of DI, SSI, and concurrent applications allowed by State agencies at the initial level grew between 1996 and 2001 and fell in the 2 following years. Growth in State agency allowance rates can be attributed to a variety of factors, including the impact of the 1996 process unification rulings as well as a change in the adjudicative climate.

A revised process was introduced in FY 2000 in 10 States, under which initial denials could be appealed directly to the hearing level without a reconsideration.

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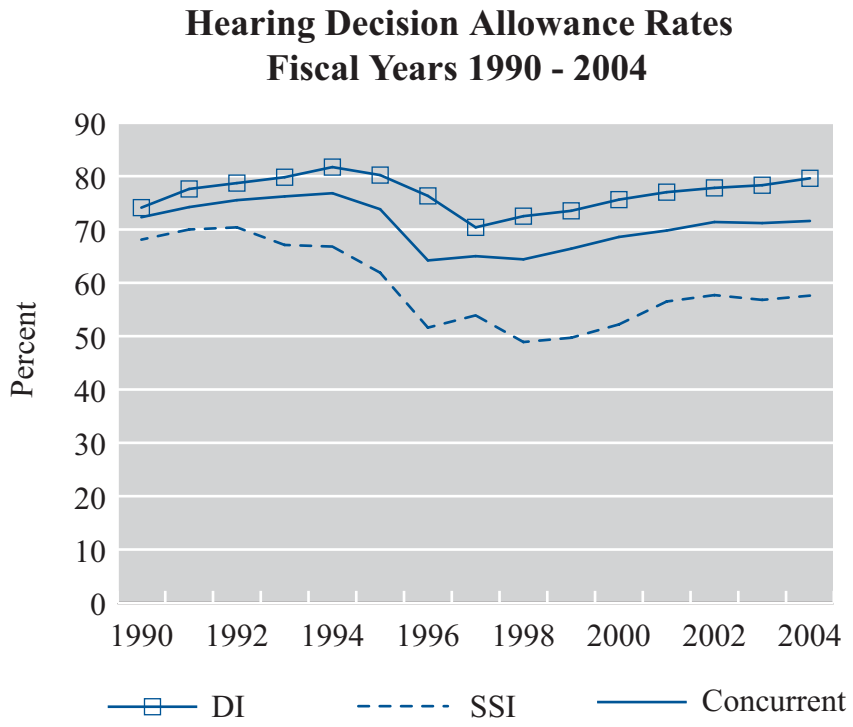
Chart 10



ALJ hearing decision allowance rates fell in the period 1995 to 1997, but they have risen since then. Note that allowance rates for SSI claimants are considerably lower than for DI. The rates shown here are the percentage of hearing decisions, excluding dismissals.

A revised process was introduced in FY 2000 in 10 States, under which initial denials could be appealed directly to the hearing level without a reconsideration.

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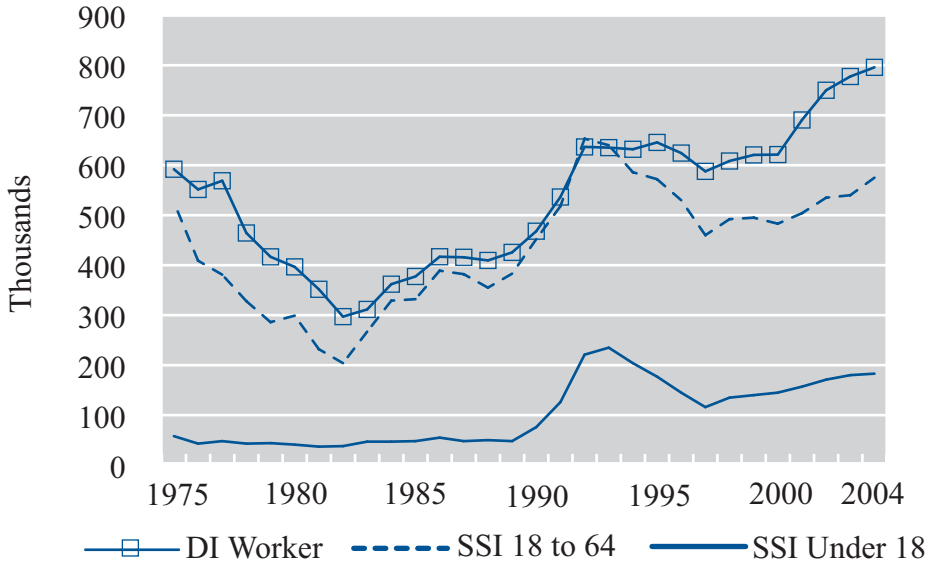
Chart 11

Disability Awards
Calendar Years 1975 - 2004



The number of DI worker and SSI disability awards has increased greatly since 1982. Awards declined slightly in the mid-1990s but have risen since then.

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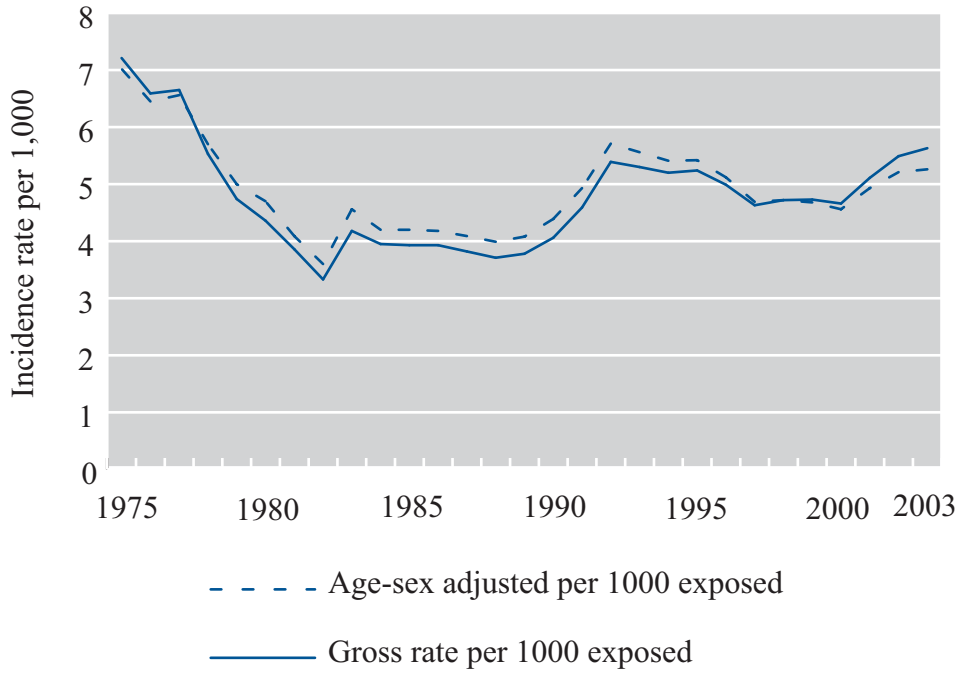
Chart 12

Incidence Rates for DI Worker Benefits
Calendar Years 1975 - 2003



The DI gross incidence rate (the ratio of annual awards to the population insured for disability benefits) has varied widely. It stood at 7.2 per thousand in 1975 and fell to a low of 3.3 per thousand in 1982. It rose again to 5.4 per thousand in 1992 and fell to 4.6 in 1997. Since 2000, it has risen from 4.7 to 5.6.

The incidence rate is a common indicator of the status of the disability system. This chart shows for DI benefits both the gross incidence rate and the age-sex adjusted rate. The adjusted rate factors out the effects of the changes in the population in terms of both age and sex. It shows what the incidence rate would have been assuming that the age and sex distribution of the population in each year was the same as in 1998.

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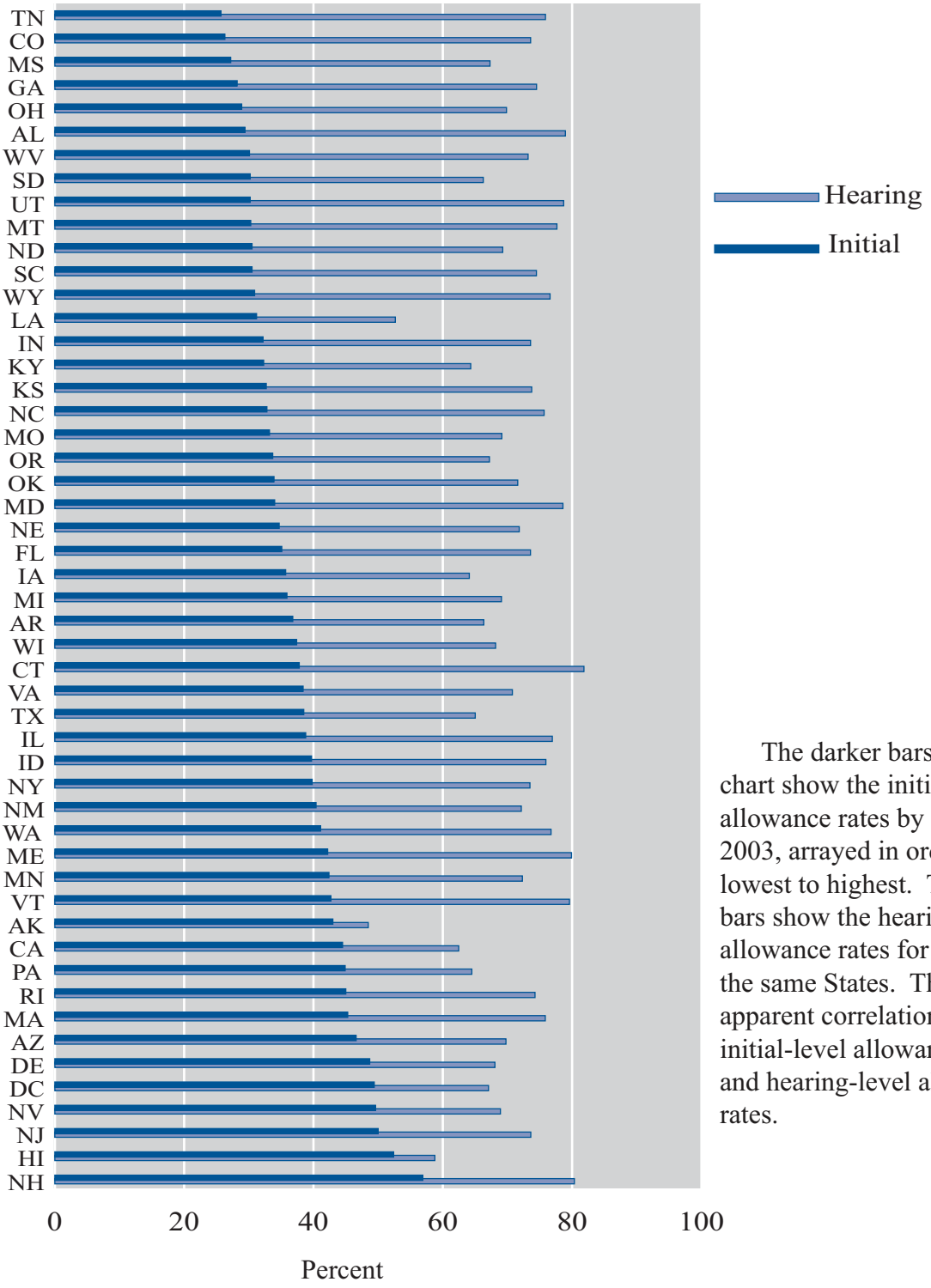
Chart 13

Allowance Rates at Initial (Fiscal Year 2003) and Hearing Levels (Fiscal Year 2004) by State



The darker bars on this chart show the initial-level allowance rates by State for 2003, arrayed in order from lowest to highest. The lighter bars show the hearing-level allowance rates for 2004 for the same States. There is no apparent correlation between initial-level allowance rates and hearing-level allowance rates.

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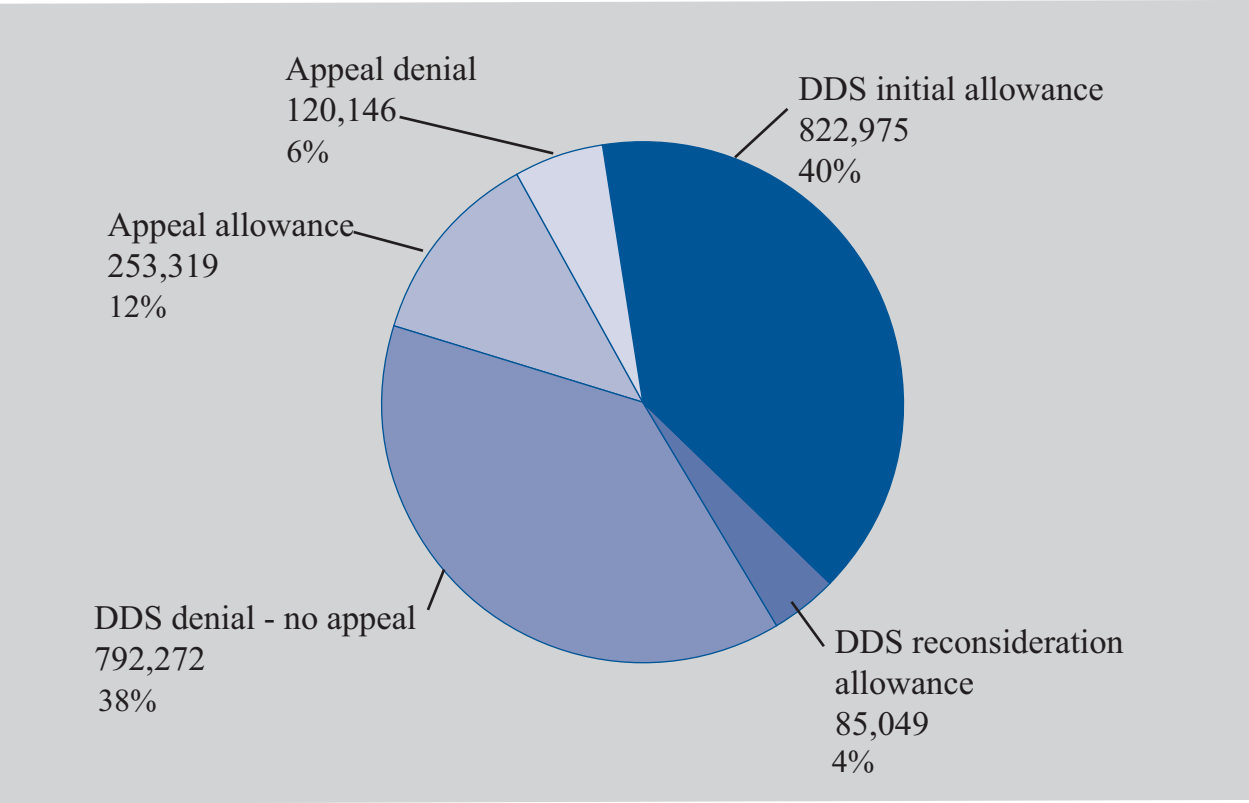
Chart 14

Disposition of DI and SSI Applications Filed in Calendar Year 2000



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III. Continuing Disability Reviews

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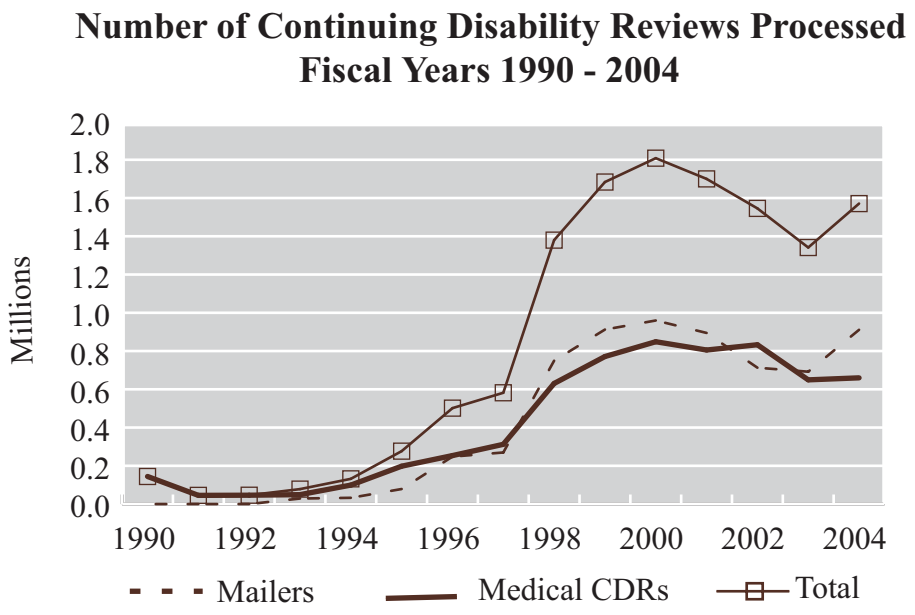
Chart 15



CDRs are conducted for beneficiaries of both DI and SSI. SSA uses statistical profiling to identify beneficiaries' probability of medical improvement. Those with higher probability are scheduled for medical CDRs. Field offices contact these beneficiaries and ask them to provide updated information on their conditions and their treatment sources. The field offices then send the cases to a State agency for decision. Beneficiaries with a lower probability of medical improvement are sent mailers with questions designed to raise issues of medical improvement. Beneficiaries send their responses to the mailer to a data operations center where they are reviewed. If the answers to a mailer indicate that medical improvement may have occurred, the beneficiary is scheduled for a full medical CDR.

SSA received additional funding, outside its discretionary spending cap, for processing the backlog of CDRs. The funding, which was received from FY 1996 to FY 2002, ensured that the agency was fully funded to enable it to carry out its 7-year plan to become current with this workload. In 2003, carryover funding of $39 million allowed the agency to process about 100 thousand more CDRs than it would have been able to do otherwise.

In FY 2004 SSA spent $543 million to process 1.6 million CDRs. SSA's appropriation for 2004 enabled it to remain current with its DI CDRs, but it was not able to process all the SSI CDRs that came due.

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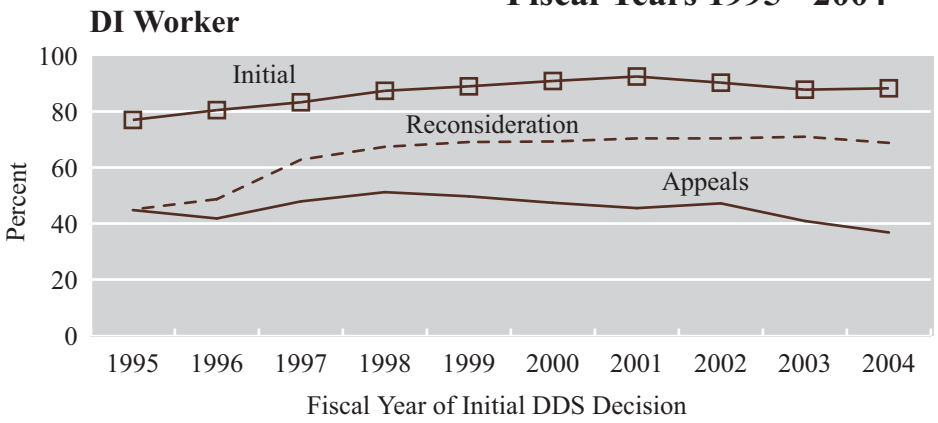
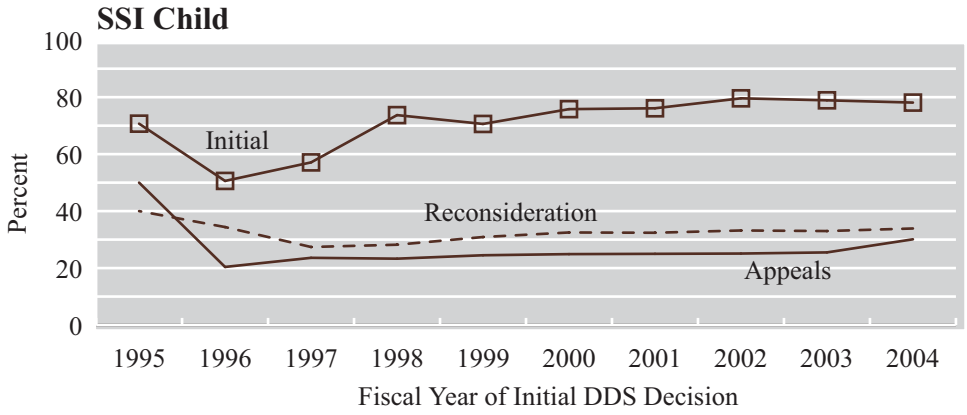
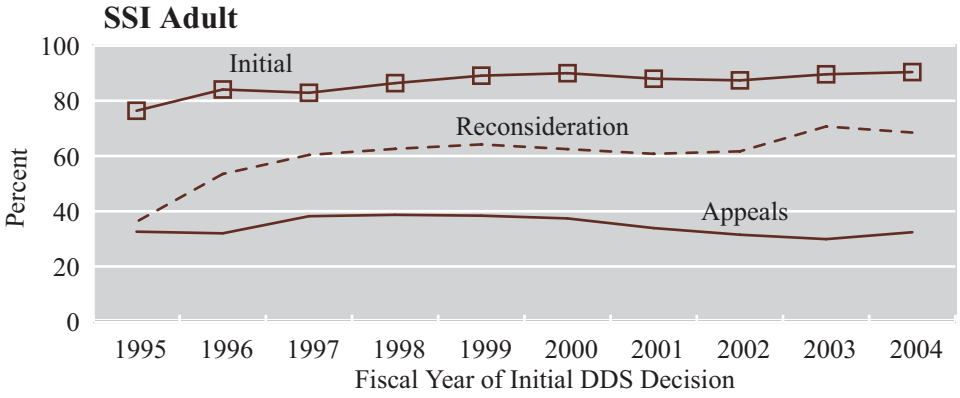
Chart 16

Medical CDR Continuation Rates by Decision Level, Fiscal Years 1995 - 2004







Continuation rates for medical CDRs vary somewhat by program, but the continuance rate at the initial level is high. Beneficiaries who receive an unfavorable decision at the initial level may request a reconsideration. The decision at this level is made by a hearing officer at the State agency. Favorable decision rates by hearing officers are much higher than for initial claim reconsiderations. Beneficiaries who receive an unfavorable decision from a hearing officer may request a hearing before an administrative law judge and have recourse to an agency-level appeal after the hearing and can take their case to court after an agency-level appeal.

Data on the charts reflect results as of January 2005 and are subject to change until all appeals are final.

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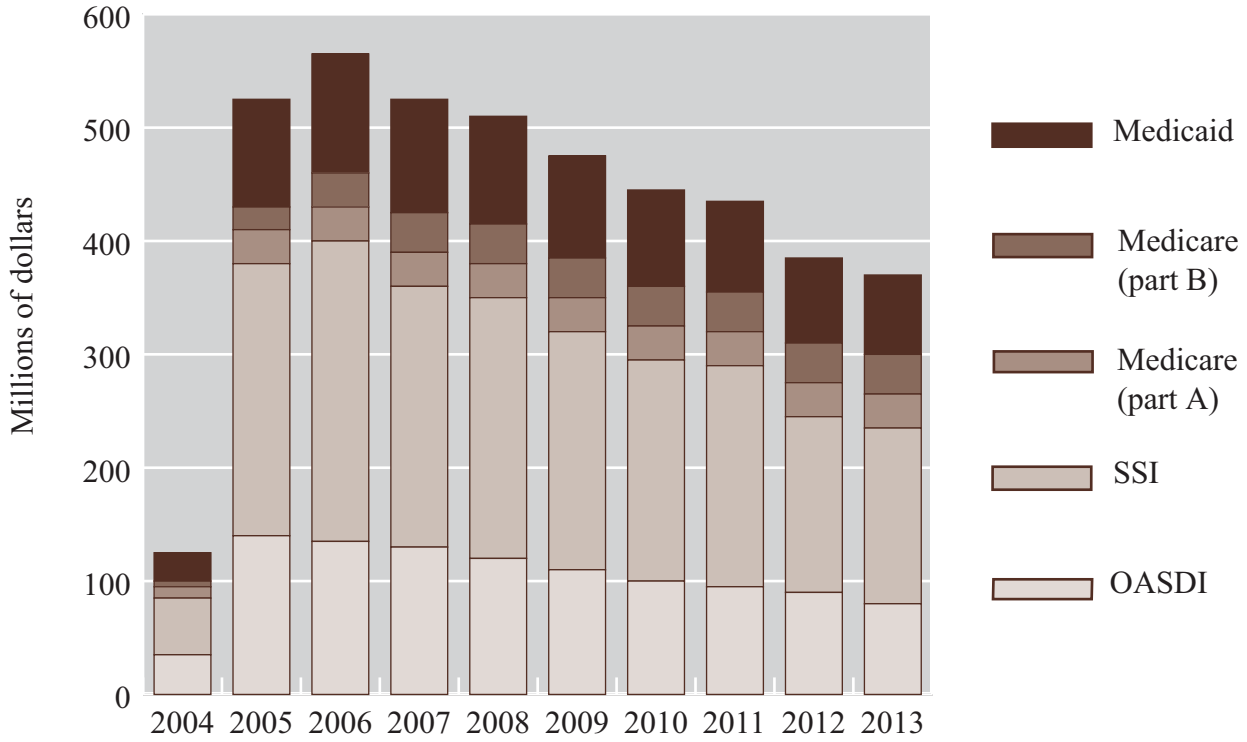
Chart 17

Ten-Year Estimated Federal Savings from CDR Cessations in Fiscal Year 2004 by Program



This chart shows the estimated reduction in benefit payments over a ten-year period resulting from initial CDR cessations in fiscal year 2004. The estimated reduction is based on a projected total of 65,100 ultimate cessations after all appeals. The CDR workload in 2003 had a great majority of SSI cases. Of the ultimate cessations, 51,200 are expected to be SSI and 13,900 OASDI. Although most CDRs do not result in cessation, SSA's CDR process has been yielding a favorable ratio of savings to costs. For fiscal year 2004, SSA estimates the ratio of savings to administrative costs at $10.5 to $1. This is calculated by dividing the estimated present value of total life time benefits saved with respect to CDR cessations ($5.7 billion) by the $543 million spent on periodic CDRs in FY 2004.

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IV. Terminations

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Chart 18

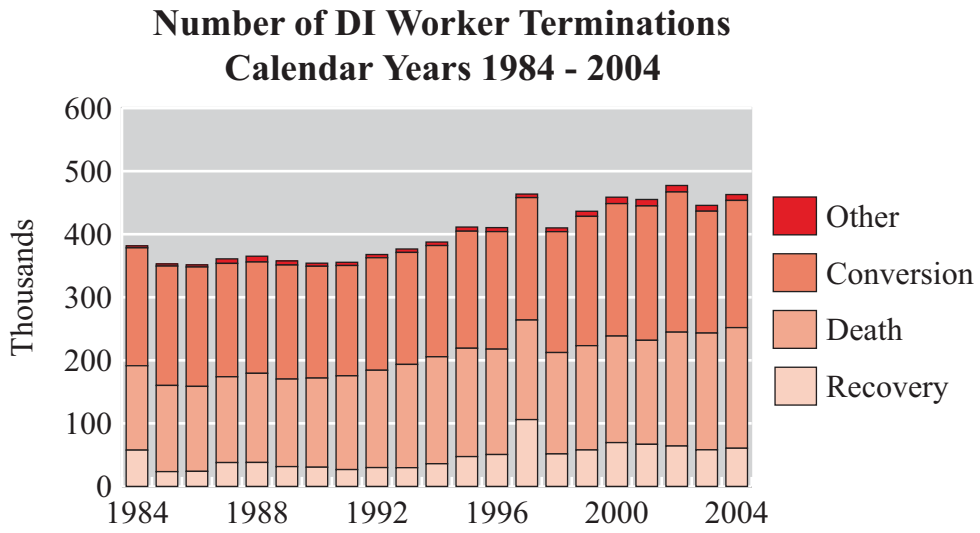
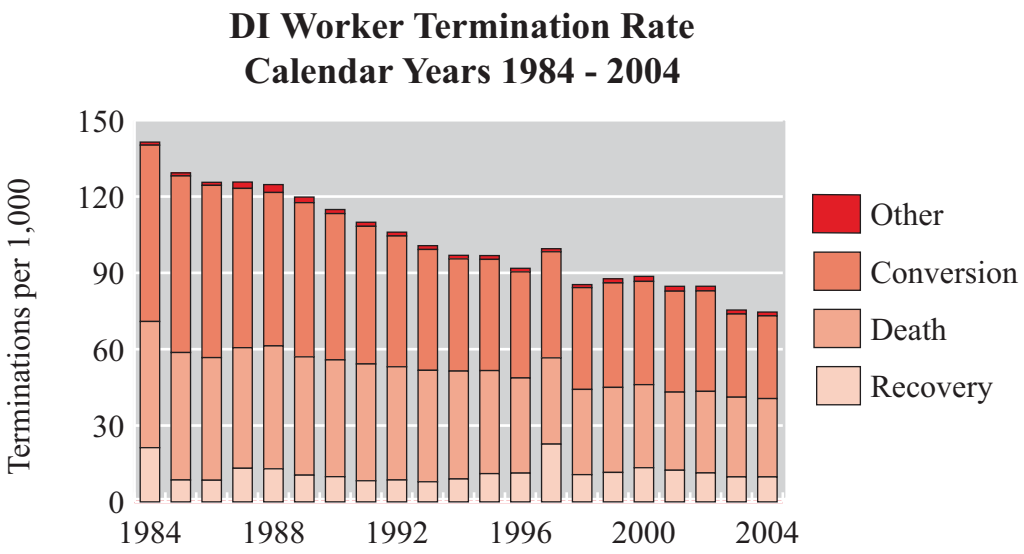


Chart 19



DI benefits for disabled workers can be terminated for reasons that are grouped into 4 categories: death; recovery (either medical recovery or return to work); conversion to retirement benefits at full retirement age; and other (switching to retirement benefits prior to full retirement age, withdrawal of application, or erroneous entitlement).

While there has been a general upward trend in the number of terminations of disabled worker benefits since 1990, the termination rate (the number of terminations per 1,000 beneficiaries) has generally declined. These trends in terminations and termination rates reflect the overall growth in the number of DI beneficiaries as well as the increasing proportion of younger beneficiaries. The spike in recoveries in 1997 is a result of legislation to eliminate drug addicts and alcoholics from the DI rolls.

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V. Beneficiaries

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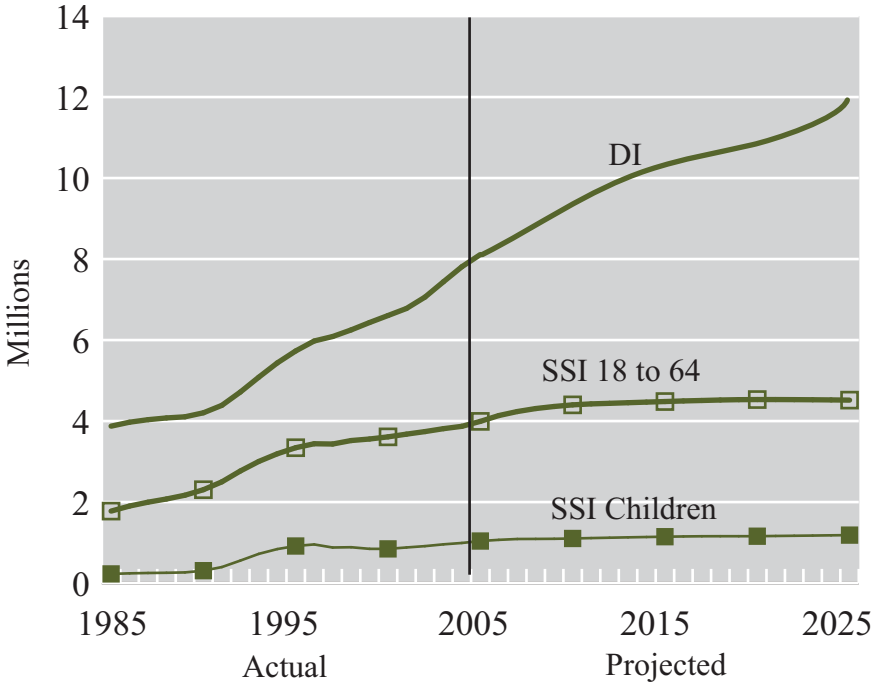
Chart 20

DI and SSI Beneficiaries
Calendar Years 1985 - 2025 (Projected)



The number of DI beneficiaries more than doubled between 1985 and 2004. In the same period, the number of SSI beneficiaries under 18 increased fourfold, and the number of SSI beneficiaries aged 18 to 64 more than doubled.

Some beneficiaries receive both DI and SSI benefits. Currently, about 1.4 million disabled beneficiaries receive both Social Security and SSI benefits.

The DI figures on this chart include dependents. There are now about 6.3 million DI worker beneficiaries and about 1.8 million spouses and children receiving benefits.

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Chart 21

Disabled Worker Beneficiaries as Percentage of Population Insured for Disability by Gender Calendar Years 1975 - 2004

This chart shows the prevalence rate for DI worker benefits. Since 1989 there has been a steady increase in the percentage of the population insured for disability that is receiving disability benefits. Prevalence rates among the male and female populations have drawn closer together.

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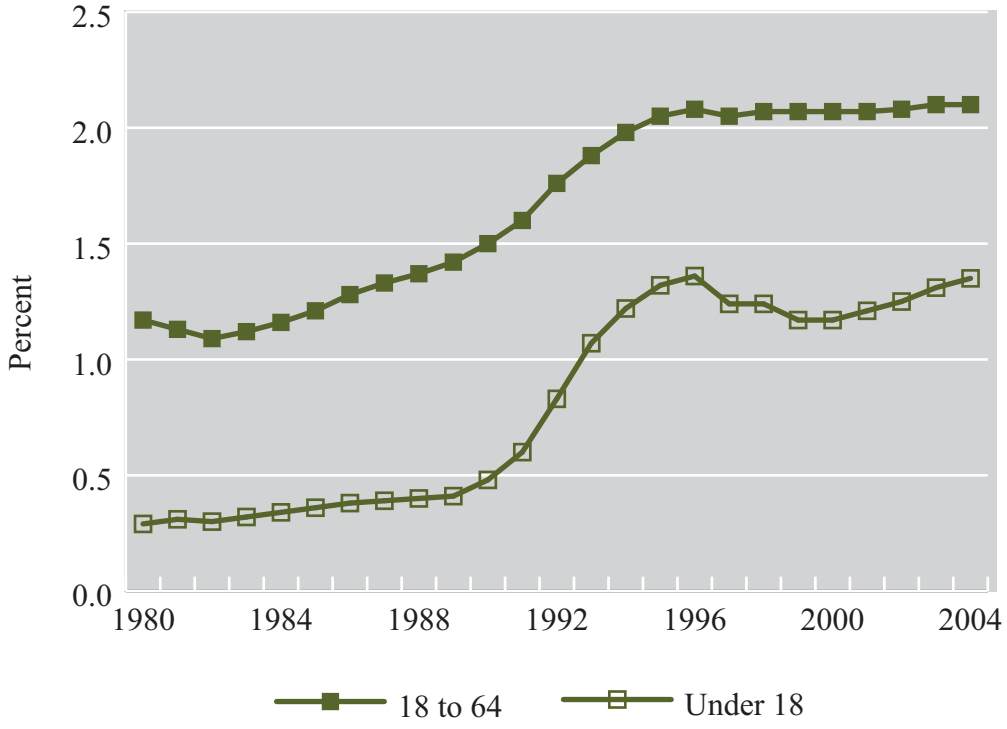
Chart 22

SSI Beneficiaries as Percentage of Population by Age Group Calendar Years 1980 - 2004



Since 1980, the percentage of the adult population receiving SSI disability benefits has nearly doubled, and the percentage of children receiving SSI benefits has increased more than fourfold. For both groups, growth was most rapid in the early 1990s. For adults, there has been slight change since 1995. The percentage of children receiving benefits began to decline in 1997 then rose again in 2001.

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Chart 23

Disabled Worker Beneficiaries as of December 2003 as Percentage of State Population Ages 18 to 64

DI worker beneficiaries as a percentage of State population ages 18 to 64 range from 1.8 percent in Utah to 6.3 percent in West Virginia.

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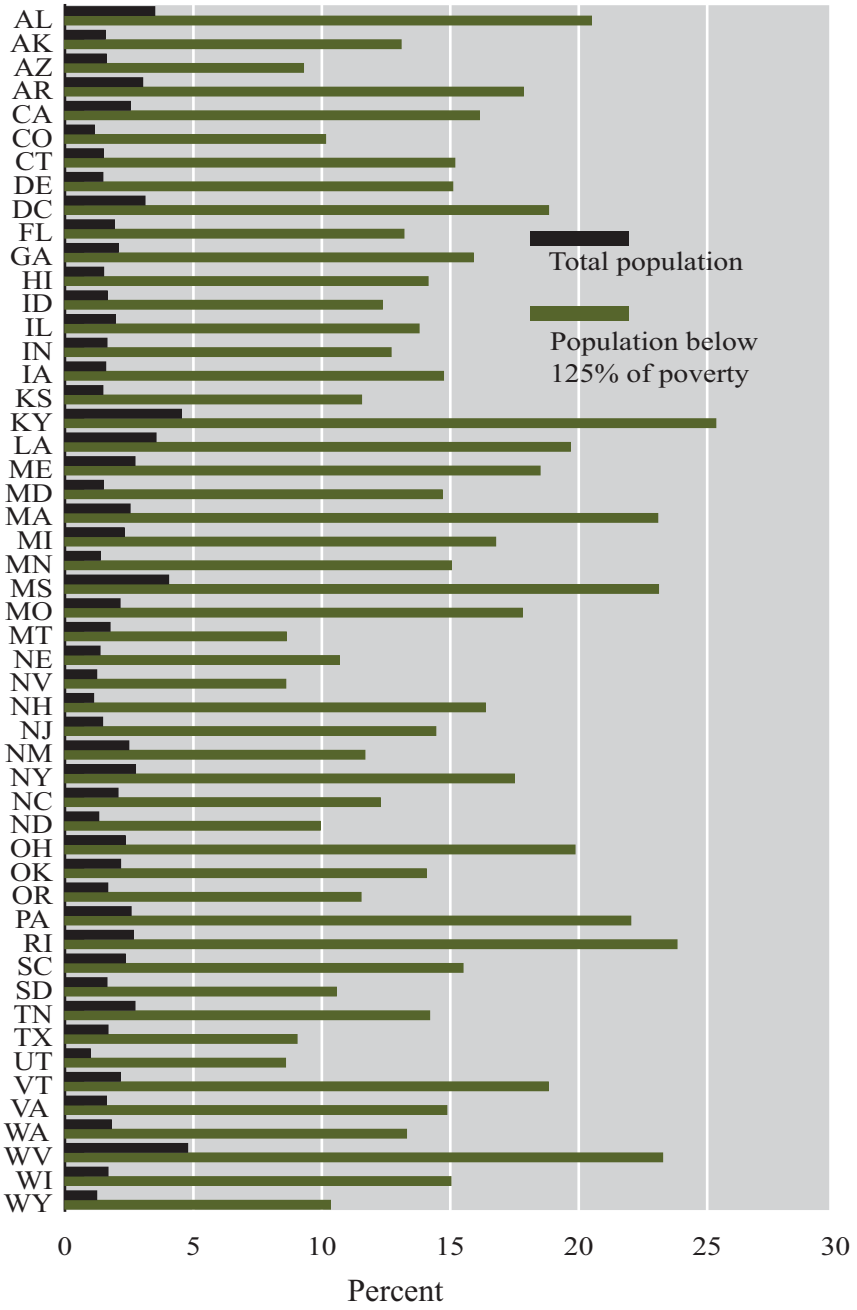
Chart 24

SSI Disabled Adults as of December 2003 as Percentage of State Population 18 to 64 and of Population 18 to 64 Below 125% of Poverty Level



The percentage of State population ages 18 to 64 receiving SSI benefits in 2003 ranged from 1 percent in Utah to 4.8 percent in West Virginia. The median for all States was 1.8 percent. The 5 lowest States were 1.2 percent or less. The 5 highest States were 3.5 percent or more.

Considering only population 18 to 64 in households below 125 percent of the poverty level, rates in 2003 ranged from 8.6 percent in Utah to 25.3 percent in Kentucky. In 27 States, the rate was less than 15 percent. In 7 it was 20 percent or higher. The median for all States was 14.7 percent. The 5 lowest States were at 9.3 percent or less. The 5 highest States were at 23.1 percent or more.

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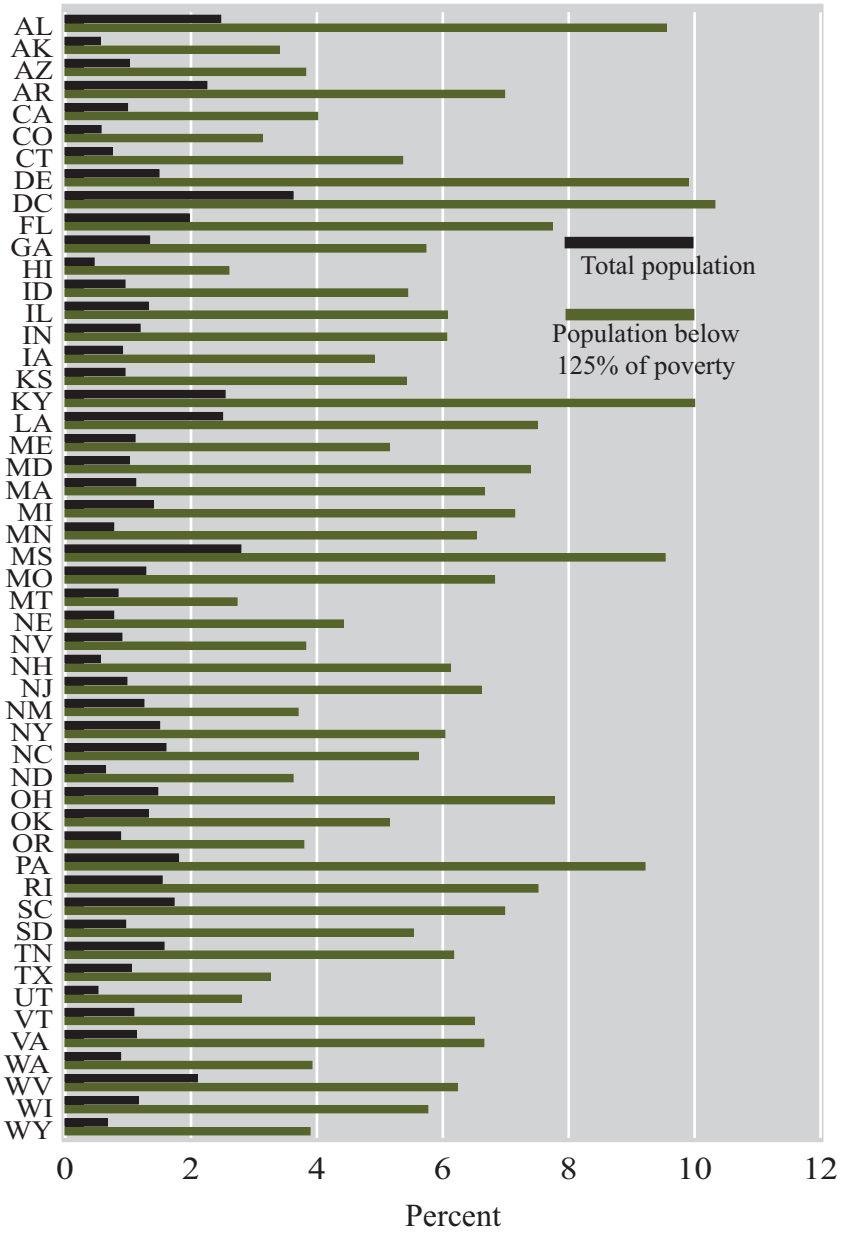
Chart 25

SSI Disabled Children as of December 2003 as Percentage of State Population Under 18 and of Population Under 18 Below 125% of Poverty Level



There was a wide variation among States in the percentage of the population under 18 receiving SSI disability benefits in 2003. The median was 1.1 percent. The 5 lowest States were at 0.6 percent or less. The 5 highest States were at 2.5 percent or more.

Looking just at the population under 18 living in households with income below 125 percent of the poverty level, the median was 6.0 percent. The 5 lowest States were at 3.3 percent or less. The 5 highest States were at 9.5 percent or more.

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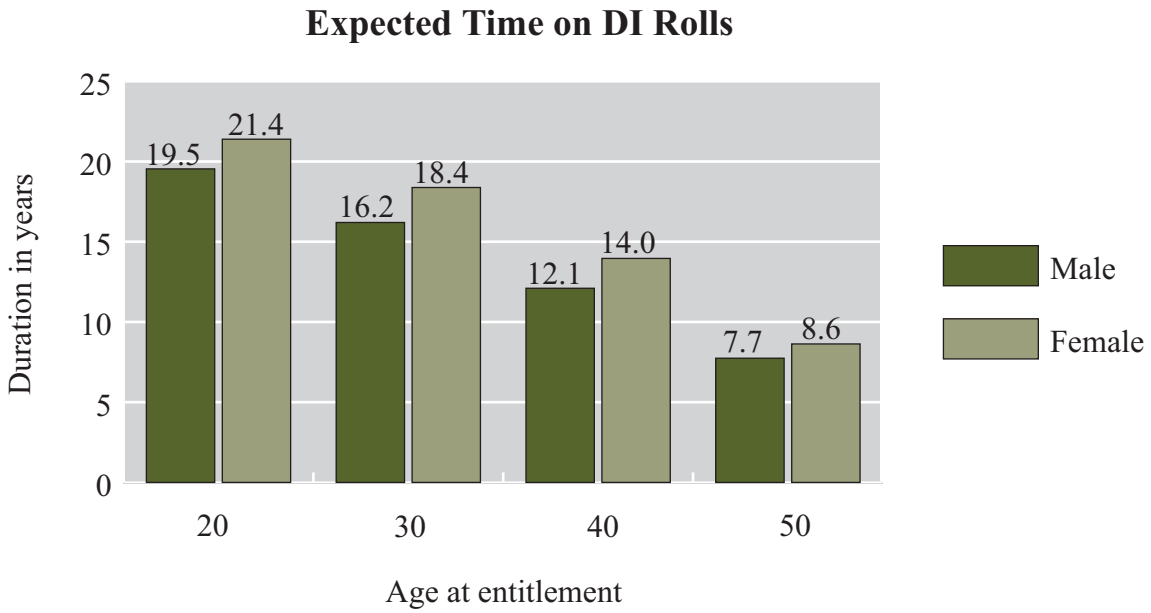
Chart 26



This chart shows the average duration on DI worker benefits prior to termination due to death, recovery, or attainment of age 65, based on disability experience between 1996 and 2000.

Technically, the chart shows length of entitlement, which is defined as meeting all requirements for the receipt of benefits, including the filing of an application. It is not equivalent to receipt of benefits, since benefits may be suspended during a period of entitlement for a number of reasons. Some examples of reasons for suspension are refusal of a disabled person to accept rehabilitation services or inability to locate the beneficiary.

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VI. Beneficiary Characteristics

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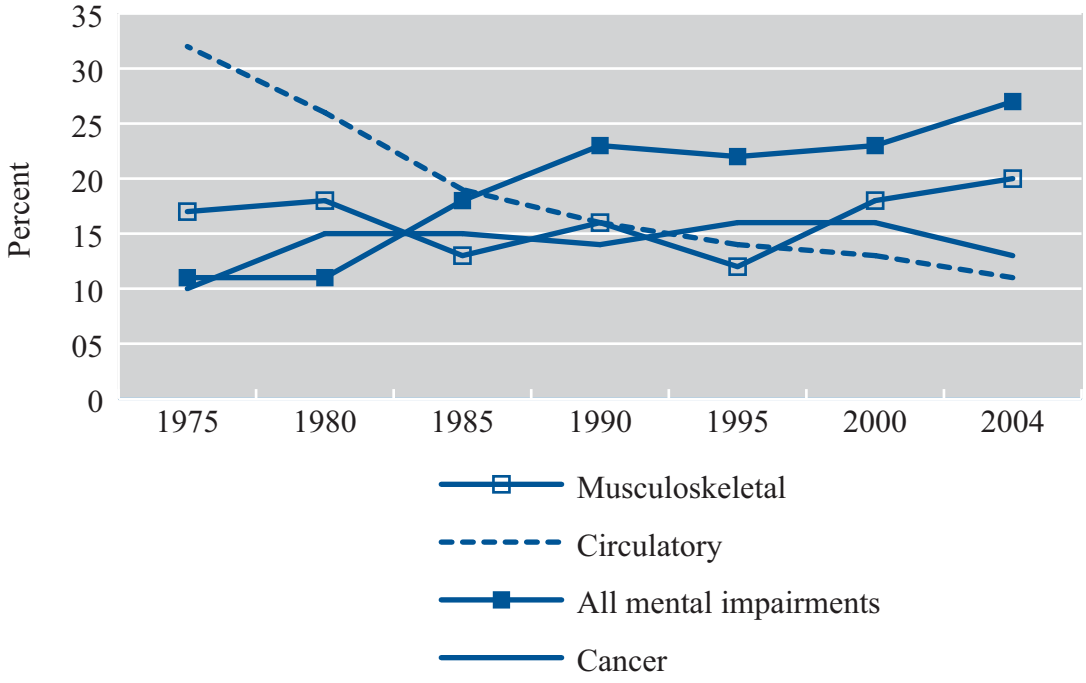
Chart 27

Trends in State Agency Initial DI Worker Awards by Major Cause of Disability Calendar Years 1975 - 2004



Mental impairment has become the largest single reason for State agency disability awards. Other major causes are cancer, impairments of the musculoskeletal system, and impairments of the circulatory system. The percentage of cases awarded on the basis of circulatory impairments, however, has declined substantially over the years.

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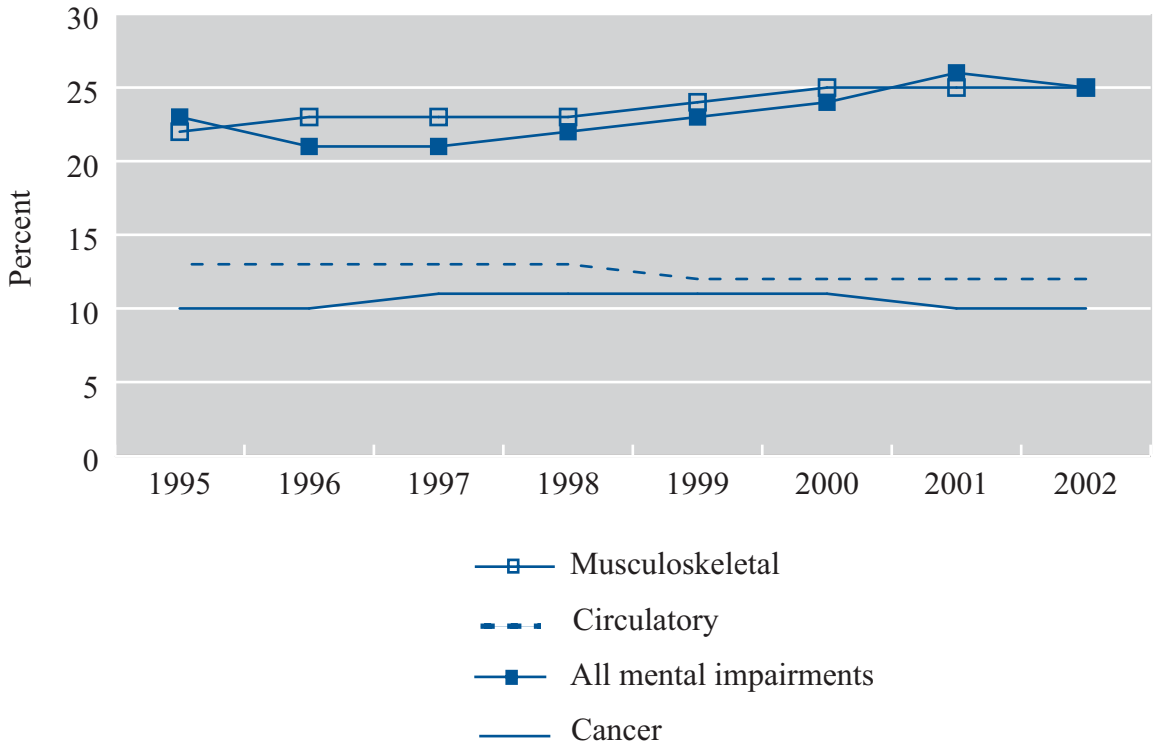
Chart 28
DI Worker Awards After All Appeals
by Major Cause of Disability
Calendar Years 1995 - 2002



Unlike at the State agency level, musculoskeletal cases are equal to mental impairments in the share of DI worker awards after all appeals. Comparable data are not available before 1995.

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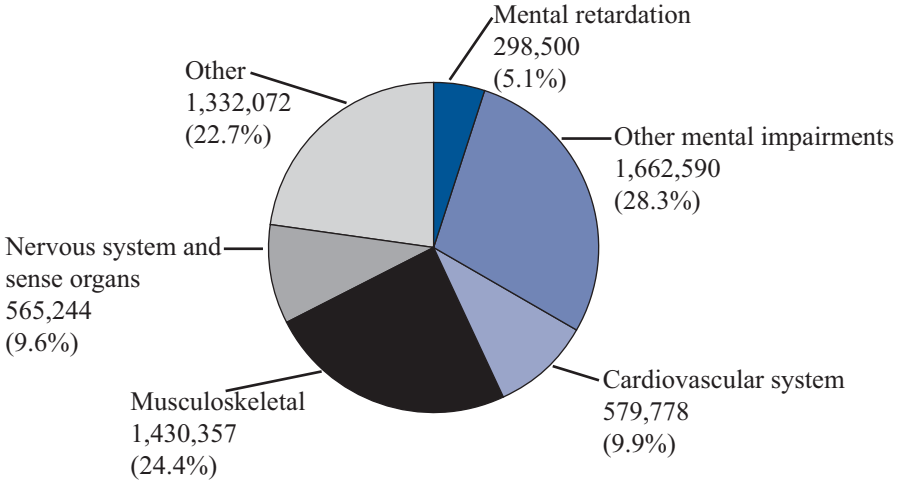
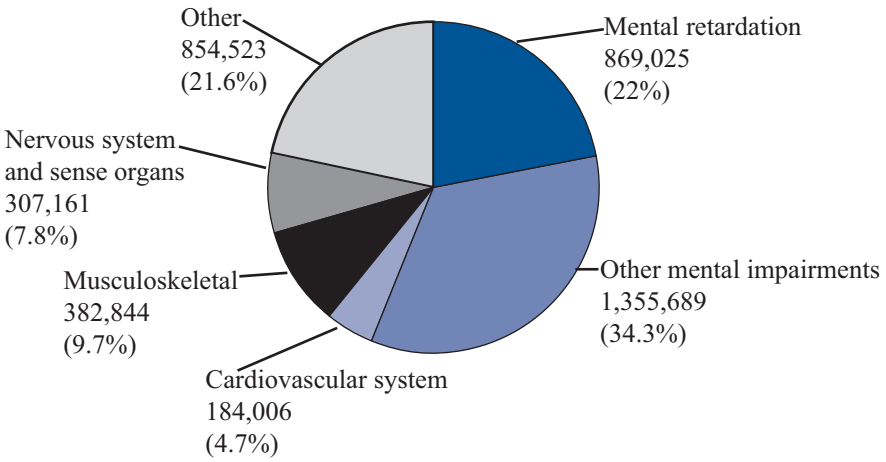
Chart 29

Number (and Percentage) of Beneficiaries by Type of Impairment, December 2002

DI Worker Beneficiaries



SSI Beneficiaries Ages 18 to 64



SSI Beneficiaries Under Age 18

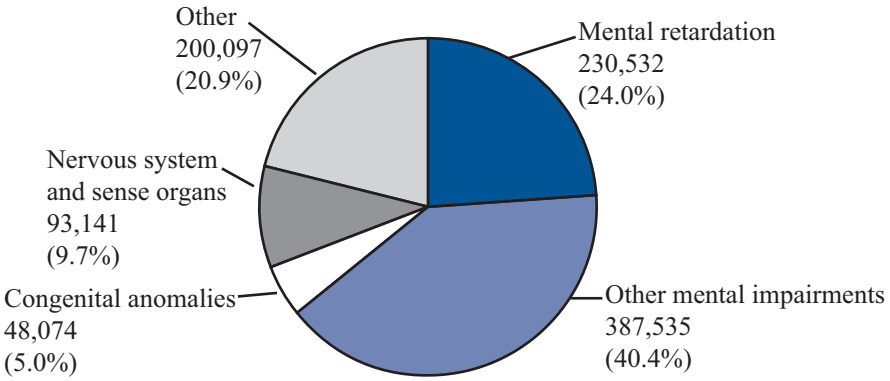


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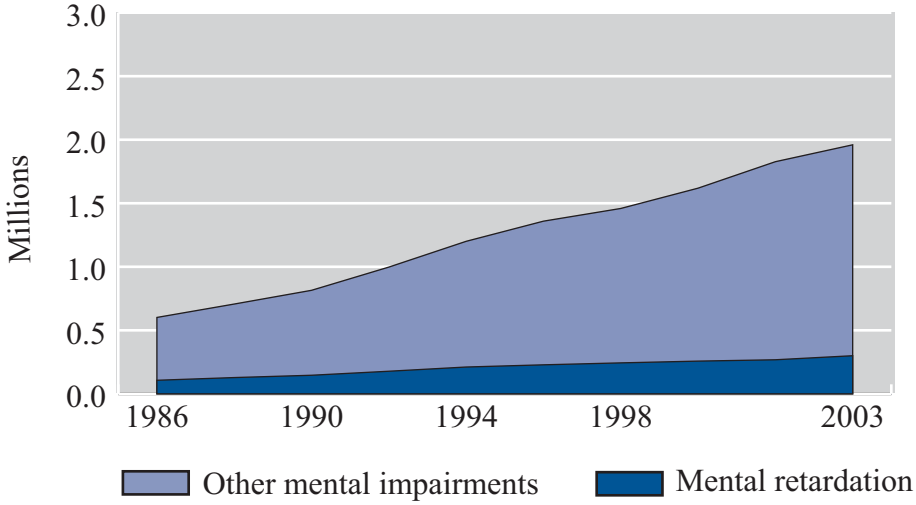
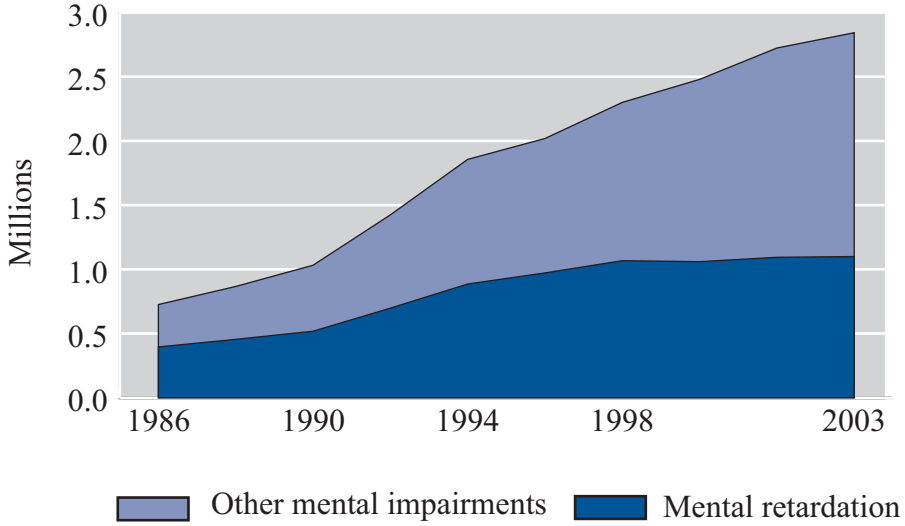
Chart 30

DI Beneficiaries with Diagnosis of Mental Impairment Calendar Years 1986 - 2003



SSI Beneficiaries with Diagnosis of Mental Impairment Calendar Years 1986 - 2003



The 1980s saw significant changes in legislation, regulation, and adjudicative standards for mental disabilities. Since the mid-1980s, the number of beneficiaries with a diagnosis of mental impairment (either retardation or other) has grown significantly in both the DI and SSI programs. The growth in the SSI program has been particularly pronounced.

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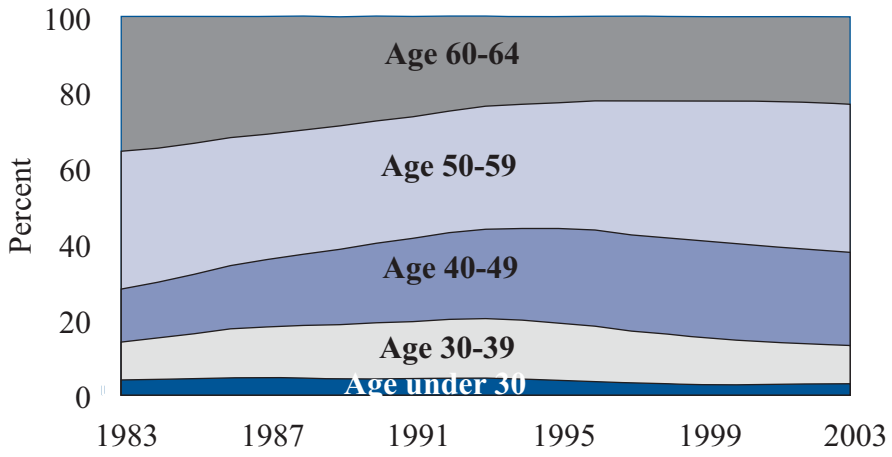
Chart 31

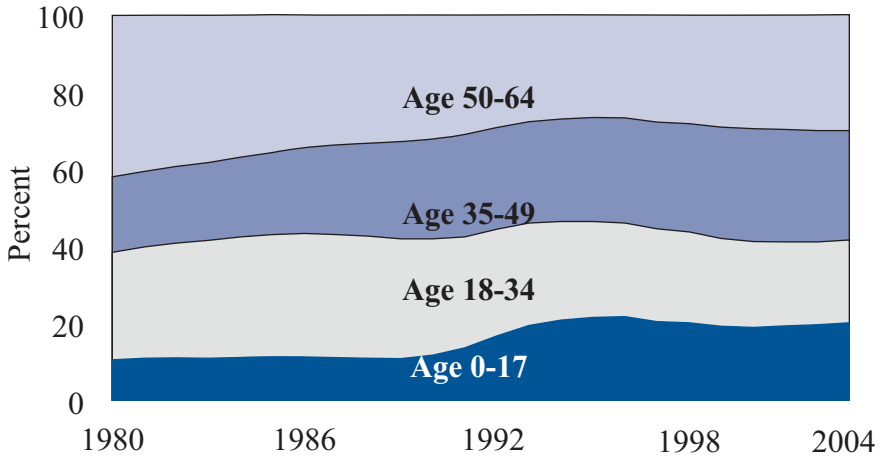
Share of DI Worker Beneficiaries by Age Group
Calendar Years 1983 - 2003



Between 1983 and 2003, the 40 to 49 age group of DI beneficiaries grew to 25 percent from 14 percent of the total, while the 60 to 64 age group fell to 23 percent from 36 percent of the total. DI beneficiaries are converted to retirement benefits at the age at which they can receive unreduced retirement benefits.

Chart 32

Share of SSI Disabled Beneficiaries under Age 65 by Age Group
Calendar Years 1980 - 2004



While the number of beneficiaries in every age group of SSI disability beneficiaries has grown, some age groups have grown more rapidly than others. Beneficiaries under age 18 were 11 percent of the total beneficiary population in 1980 and had grown to 20 percent of the population by 2004. Beneficiaries in the 35-to-49 age group were 20 percent of the beneficiary population in 1980 and had grown to 28 percent by 2004.

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Chart 33

Average Age of Newly Awarded DI Beneficiaries by Gender Calendar Years 1960 - 2004

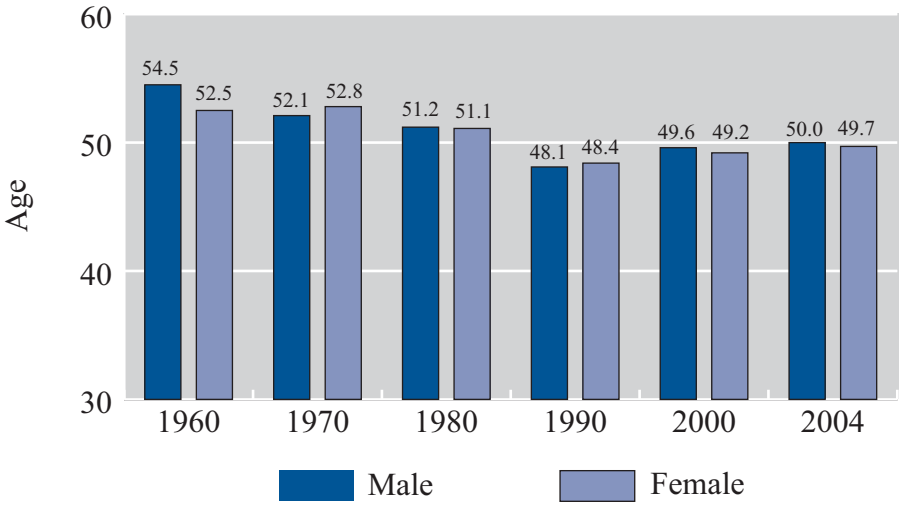
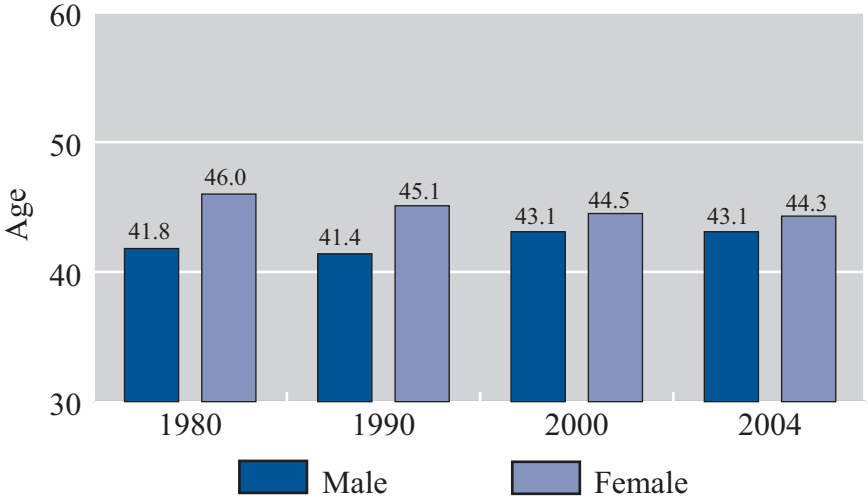


Chart 34

Average Age of Newly Awarded SSI Disabled Adult Beneficiaries by Gender Calendar Years 1980 - 2004



Until recently, there was a marked downward trend in the age of newly awarded DI beneficiaries. The average age of newly awarded adult SSI beneficiaries has been consistently lower than that of new DI beneficiaries.

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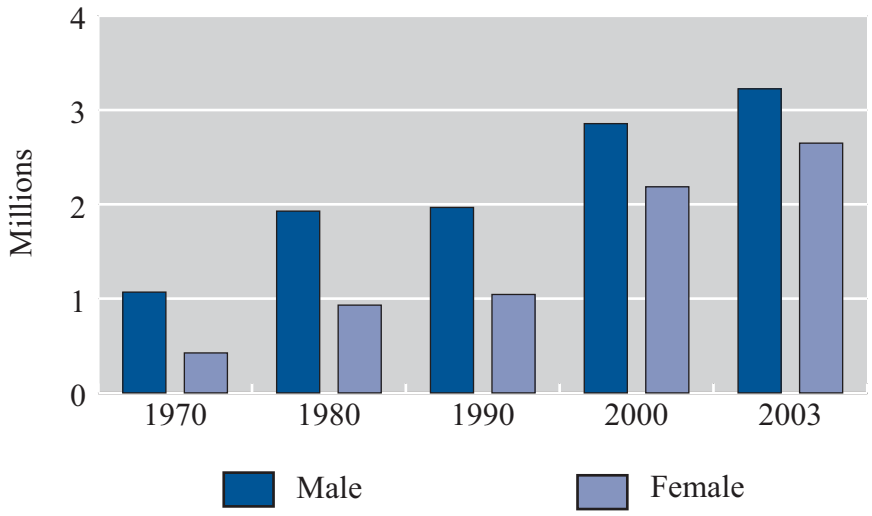
Chart 35

Number of DI Worker Beneficiaries by Gender
Calendar Years 1970 - 2003



Females comprise an increasingly large proportion of DI worker beneficiaries. In 1970, they were 28 percent of DI worker beneficiaries (and 33 percent of the insured population). In 2003 they were 45 percent of the beneficiaries (and 47 percent of the insured population).

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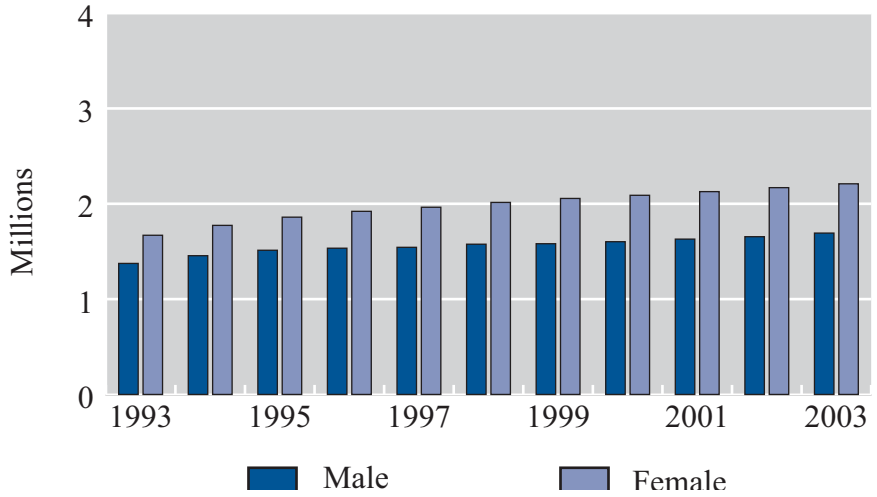
Chart 36

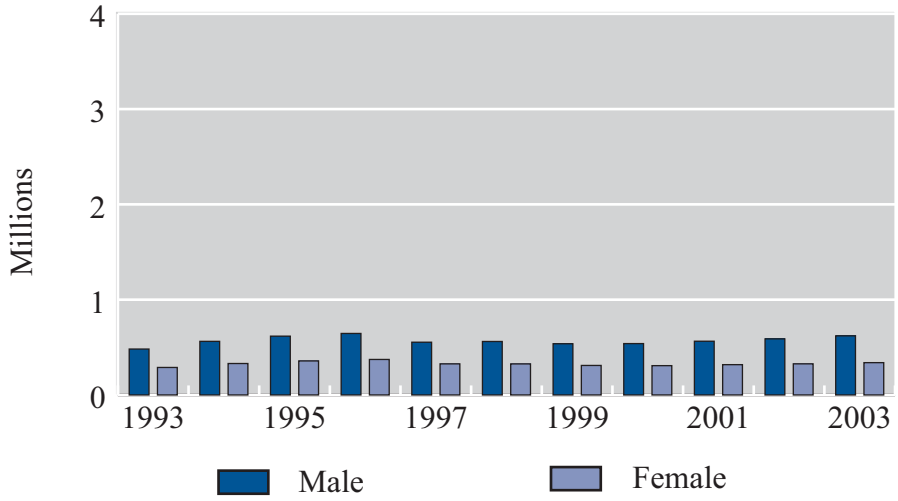
Number of SSI Disabled Beneficiaries
Age 18-64 by Gender
Calendar Years 1993 - 2003



Females are a majority of SSI disabled beneficiaries between ages 18 and 64. In the years shown, they have increased from 55 percent to 57 percent of this age group of beneficiaries, compared to 50 to 51 percent of this age group in the entire population.

Chart 37

SSI Disabled Child
Beneficiaries by Gender
Calendar Years 1993 - 2003



For beneficiaries under age 18, on the other hand, males are in the majority, with 63 to 65 percent of the total in each of the years shown. By comparison, males were 51 percent of the age group in the entire population.

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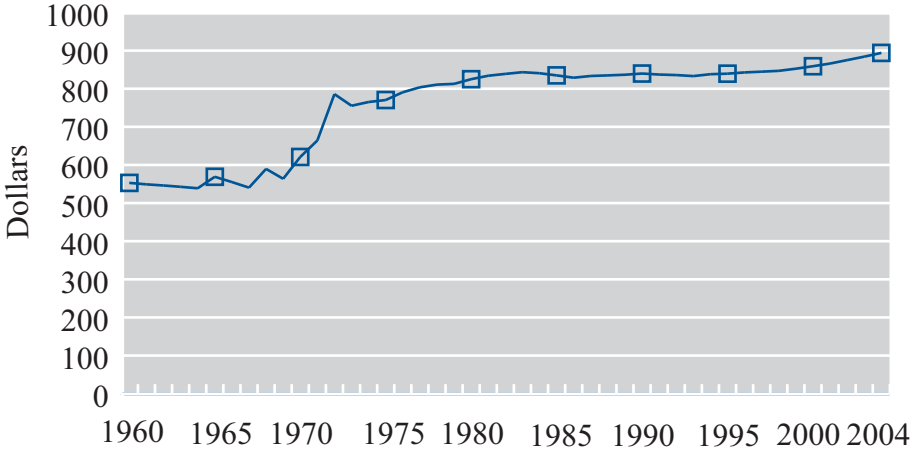
Chart 38

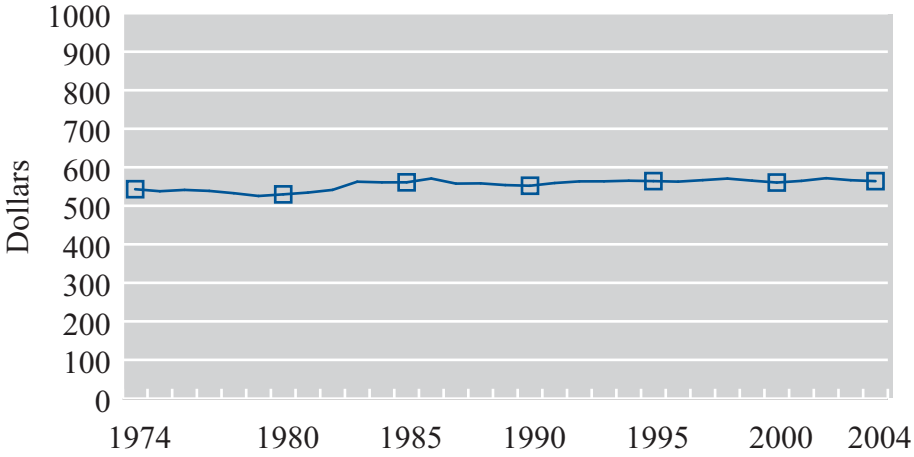
Average Monthly DI Worker Benefit
Calendar Years 1960 - 2004
(Constant 2004 Dollars)



Expressed in 2004 dollars, the average benefit increased from $553 in 1960 to $755 in 1973, reflecting in part several ad hoc benefit increases in the late 1960s and early 1970s. The subsequent increase has been gradual.

Chart 39

Monthly SSI Individual
Federal Benefit Rate
Calendar Years 1974 -2004
(Constant 2004 Dollars)



Expressed in constant dollars, the SSI Federal benefit rate has been fairly flat since the program began.

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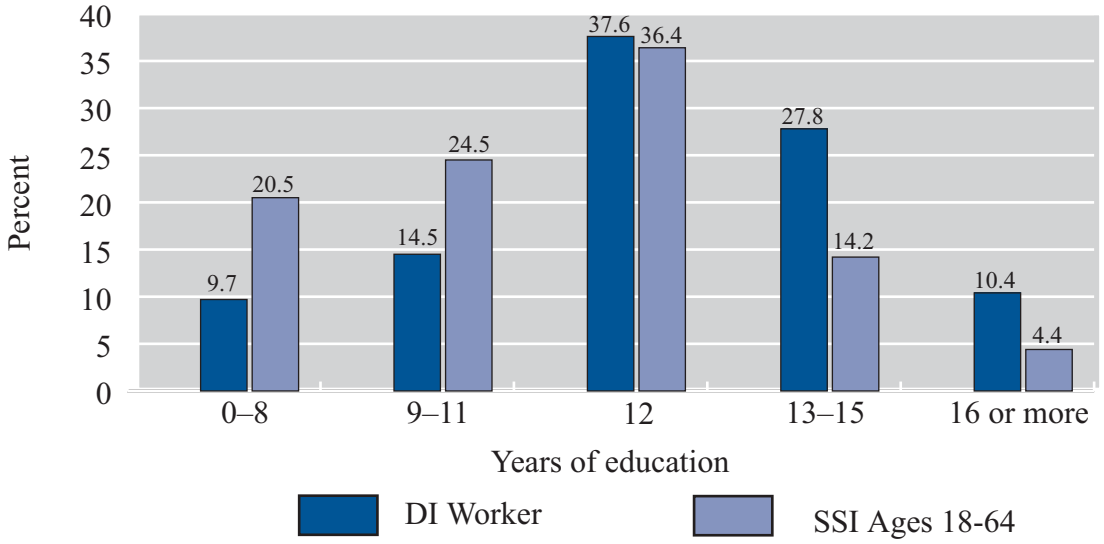
Chart 40

DI Worker and SSI Beneficiaries Ages 18 to 64 by Years of Education 2001



SSI disability beneficiaries have less education than DI worker beneficiaries. While slightly more than one third of both groups have 12 years of education, a larger percentage of SSI beneficiaries have less than that, and one fifth have eight years or less.

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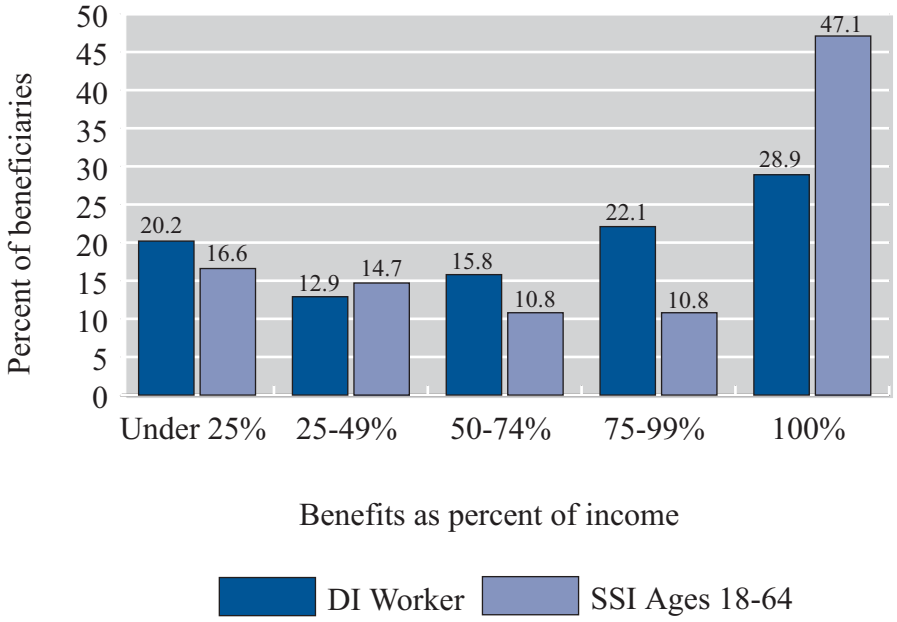
Chart 41

Percentage of Beneficiaries by Percent of Personal Income Received as Benefits 2001



Disability benefits are a large part of beneficiaries' total personal income. For half of DI worker beneficiaries, disability benefits were 75 percent or more of total personal income in 2001. For almost half of SSI beneficiaries, they are the only source of personal income.

For families with disabled worker beneficiaries, Social Security benefits comprised 45 percent of family income. For families with an SSI beneficiary ages 18 to 64, SSI benefits were 49 percent of family income.

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VII. Variations in State Agency Decision Making

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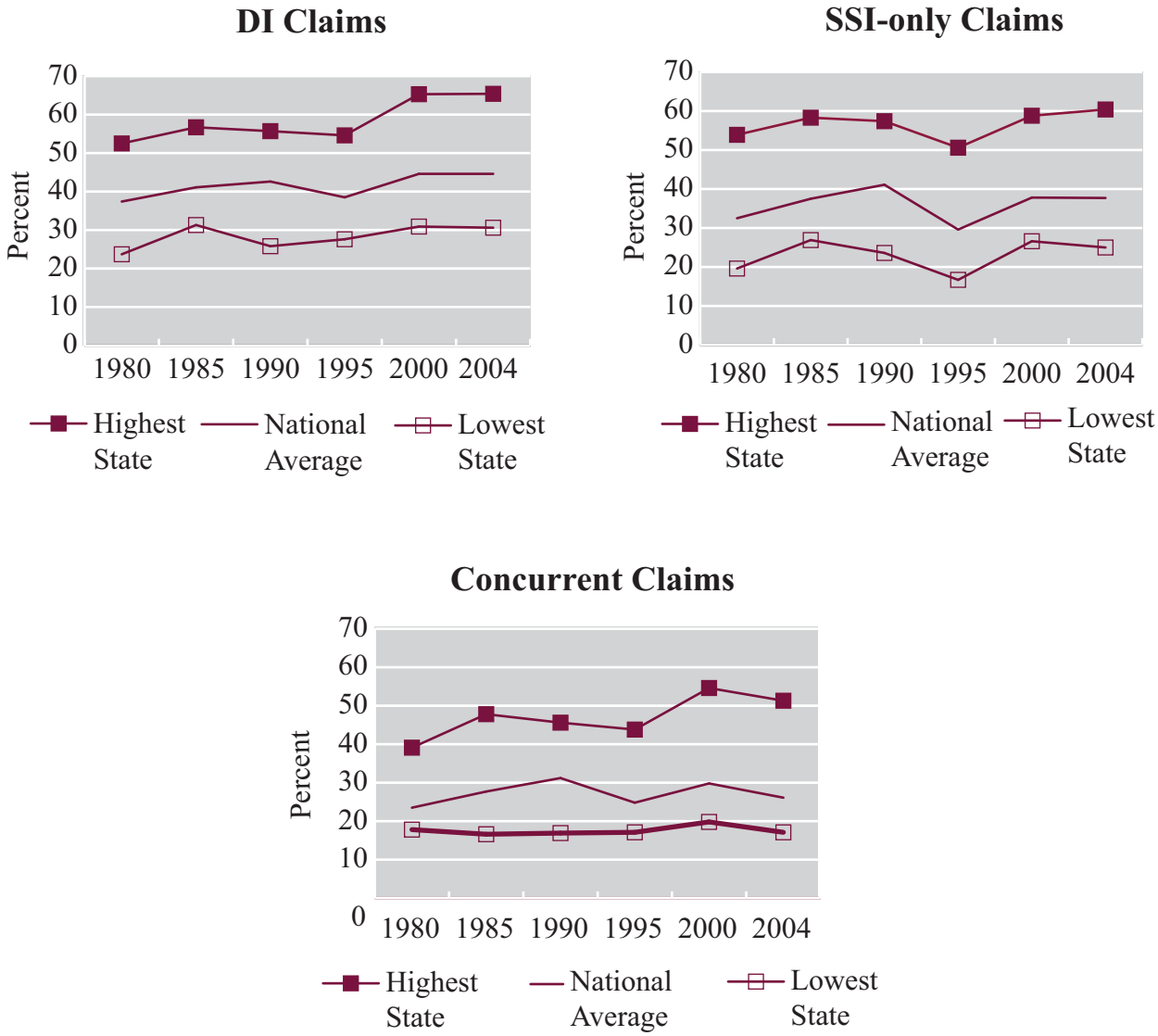
Chart 42
State Agency Initial Allowance Rates
Fiscal Years 1980 - 2004



State agency allowance and denial rates vary widely from State to State. For example, in 2004, allowance rates for DI-only applicants ranged from a high of over 65 percent in New Hampshire to a low of 31 percent in Tennessee. For SSI-only disability claims in 2004, allowance rates ranged from 60 percent in New Hampshire to 25 percent in Mississippi. And for concurrent DI-SSI claims, allowance rates ranged from 51 percent in New Hampshire to 17 percent in Colorado.

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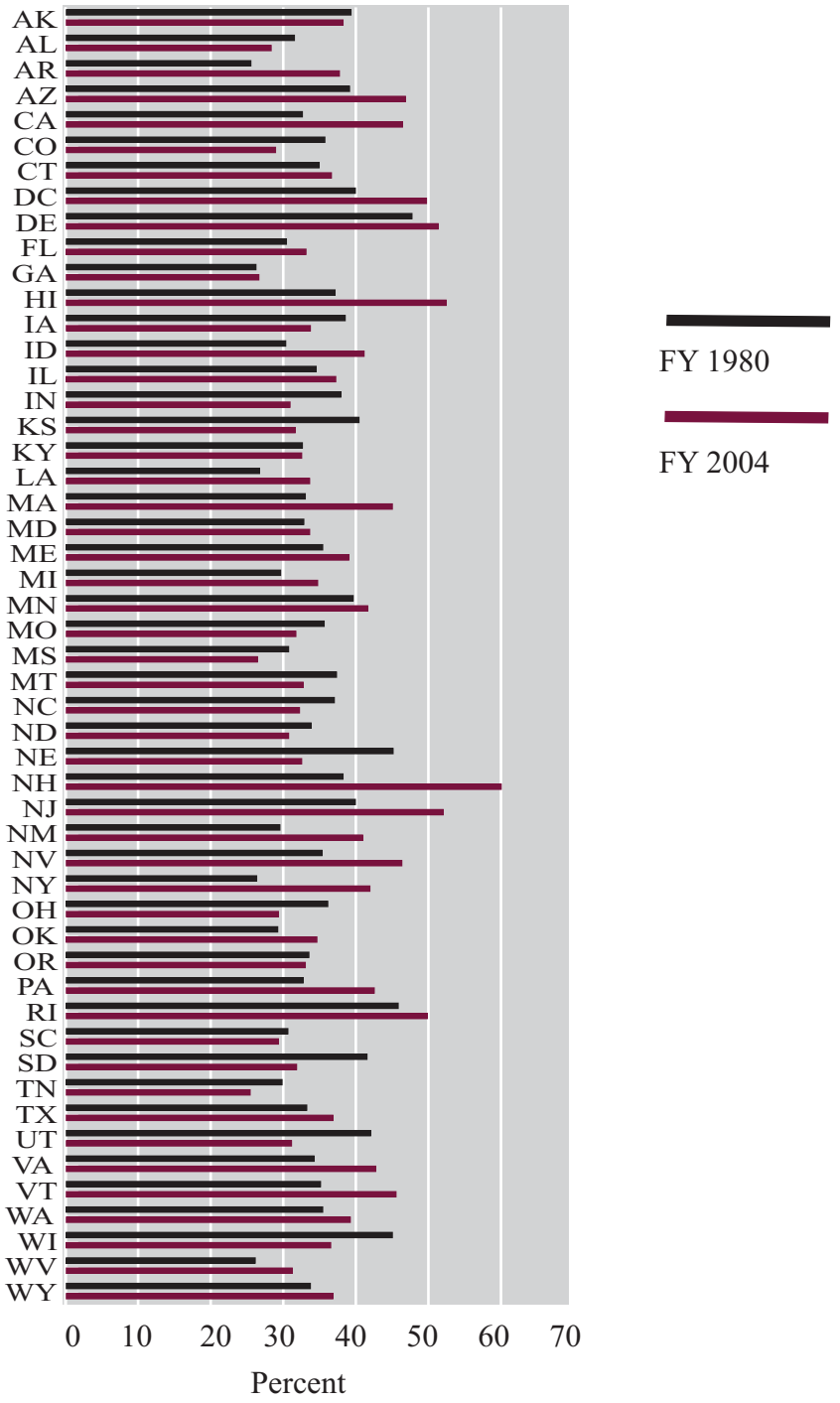
Chart 43

State Agency Initial Allowance Rates for DI and SSI by State Fiscal Years 1980 and 2004



State agency initial allowance rates have also varied over time. For example, Nebraska went from having one of the highest allowance rates in 1980 to a somewhat below average allowance rate in 2004. Over that same period, New Hampshire's allowance rate increased by 22 percentage points. Between 1980 and 2004, allowance rates increased by 20 percent or more in 17 States and decreased by 20 percent or more in 4 States.

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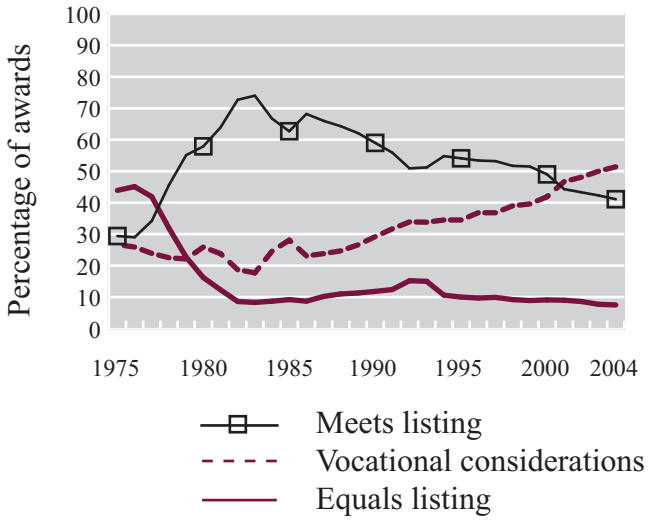
Chart 44

Percentage of State Agency DI Awards by Basis for Decision Fiscal Years 1975 - 2004



Since 1983, the percentage of initial-level DI cases awarded on the basis of meeting or equaling the medical listings has declined from 82 percent to 49 percent. The percentage based on vocational (or functional) evaluation has nearly tripled, from 18 percent of all initial DI awards in 1983 to 51 percent in 2004.

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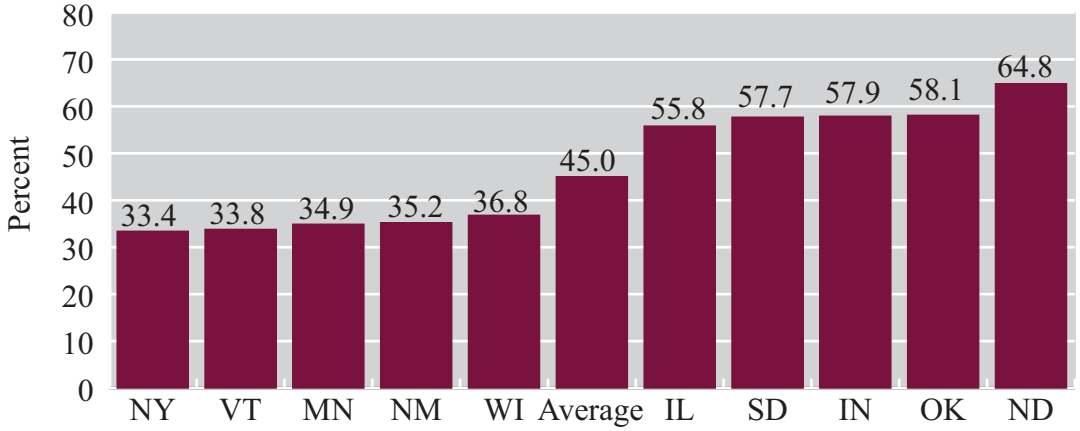
Chart 45

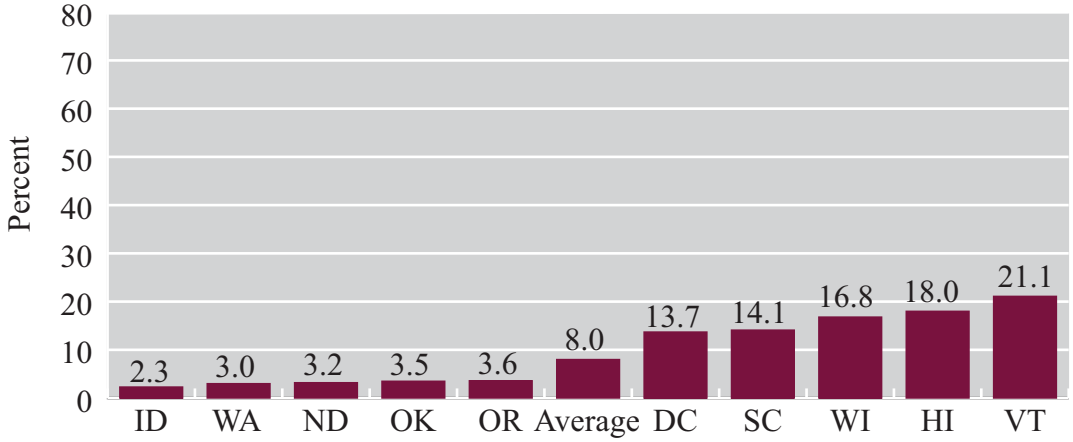
Variation in Basis for Initial Awards

Fiscal Year 2003

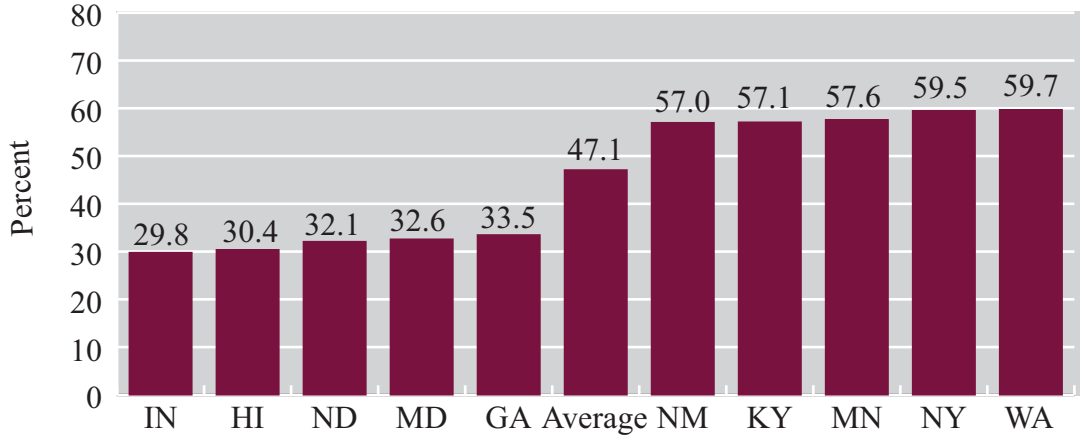
Meets the Medical Listings



Equals the Medical Listings



Vocational Considerations



These charts show the variation among State agencies in the basis for awarding benefits. For example, in 2003, North Dakota made 65 percent of its initial DI awards on the basis that the claimant met the medical listings, while New York awarded only 33 percent of its claims on that basis. New York and Washington made 60 percent of their DI awards based on vocational factors, while Indiana and Hawaii made only 30 percent of their awards on that basis.

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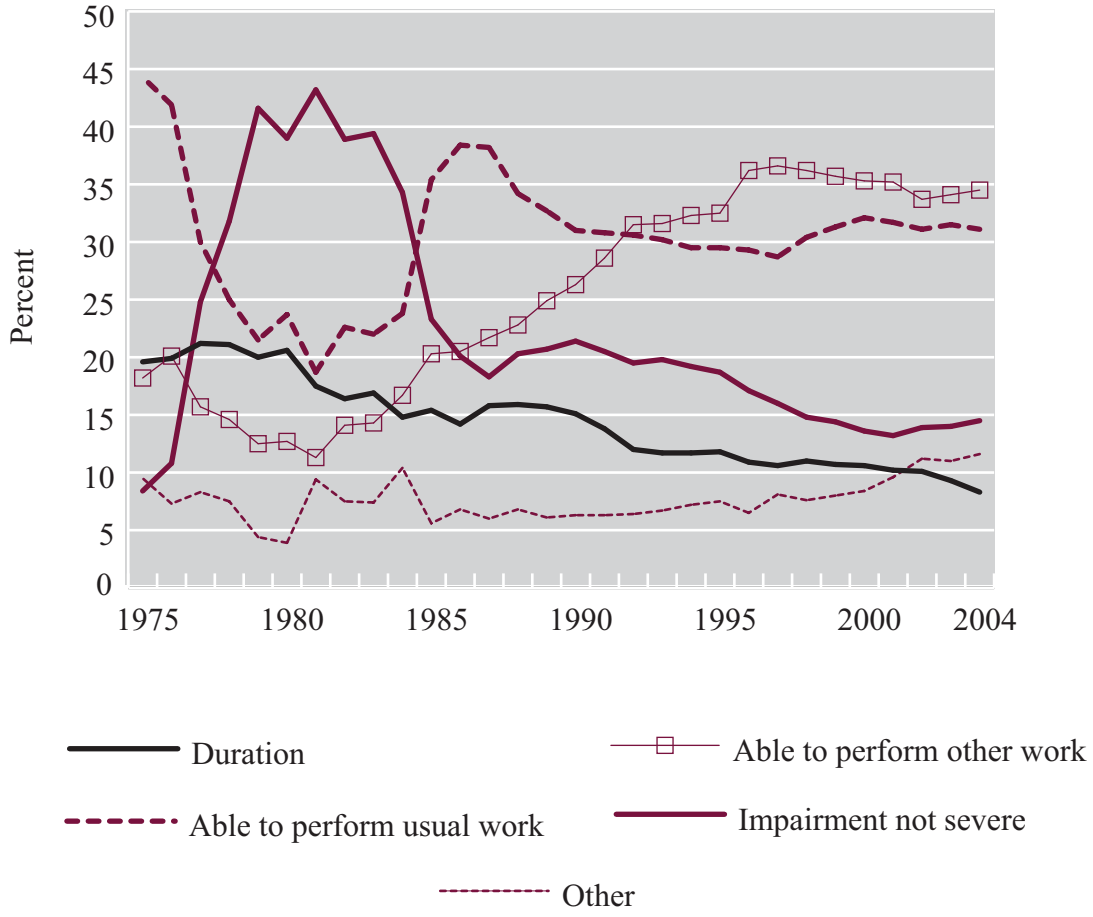
Chart 46

Percentage of State Agency Denials by Basis for Decision Fiscal Years 1975 - 2004



The reasons for denials by State agencies have varied widely over the years. Denials for non-severe impairments went from 8 percent of denials in 1975 to 43 percent in 1981 to 15 percent in 2004. Denials for ability to perform the claimant's usual work went from 44 percent of denials in 1975 to 19 percent in 1981 to 31 percent in 2004. Denials for ability to perform other work – the most complex and judgmental denials – went from 18 percent in 1975 to 11 percent in 1981 to 35 percent in 2004.

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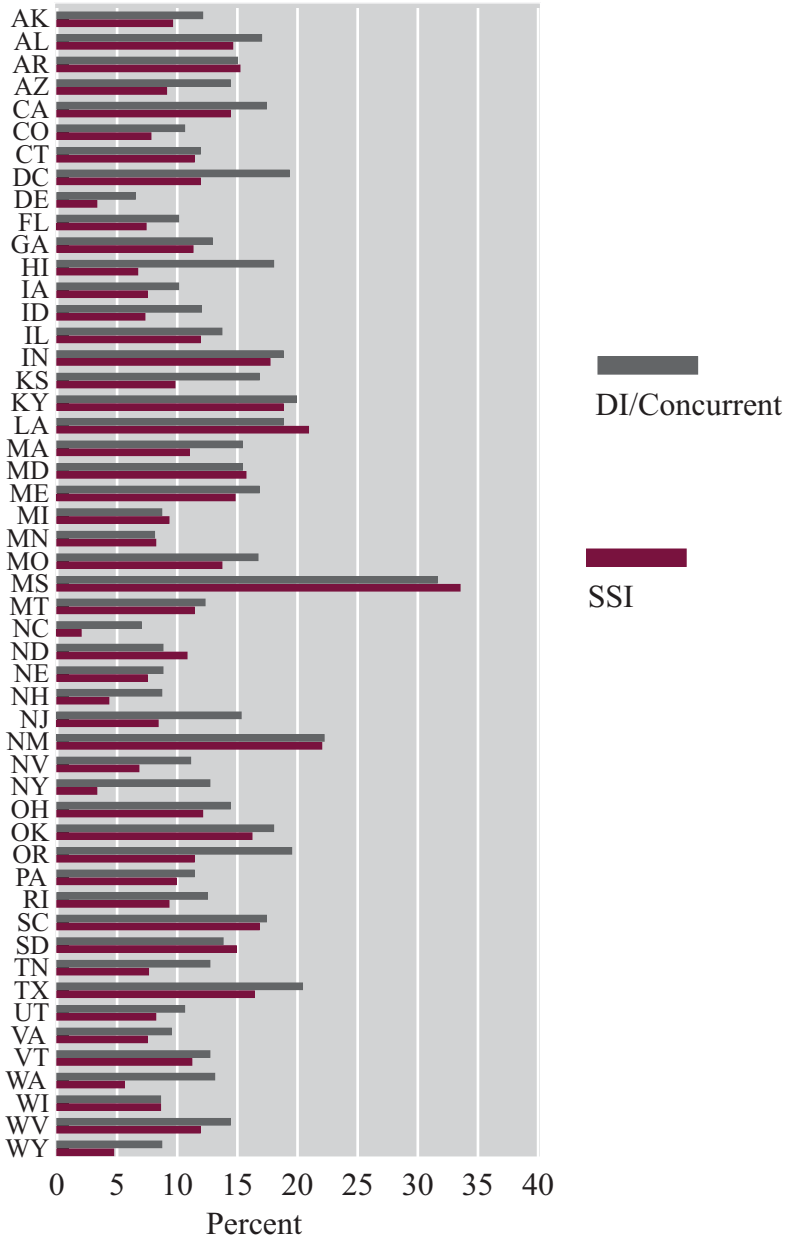
Chart 47

Percentage of State Agency Initial Denials Based on Non-Severe Impairment Fiscal Year 2004



One of the early steps in the sequential evaluation of disability is the determination of whether an impairment is severe. State agencies vary widely in the degree to which they deny claims because the impairment is not severe. For DI and concurrent (DI-SSI) applications, denials for this reason in 2004 ranged from 7 percent of all denials in Delaware to 32 percent in Mississippi. For SSI adult applications, denials for this reason ranged from 2 percent in North Carolina to 34 percent in Mississippi.

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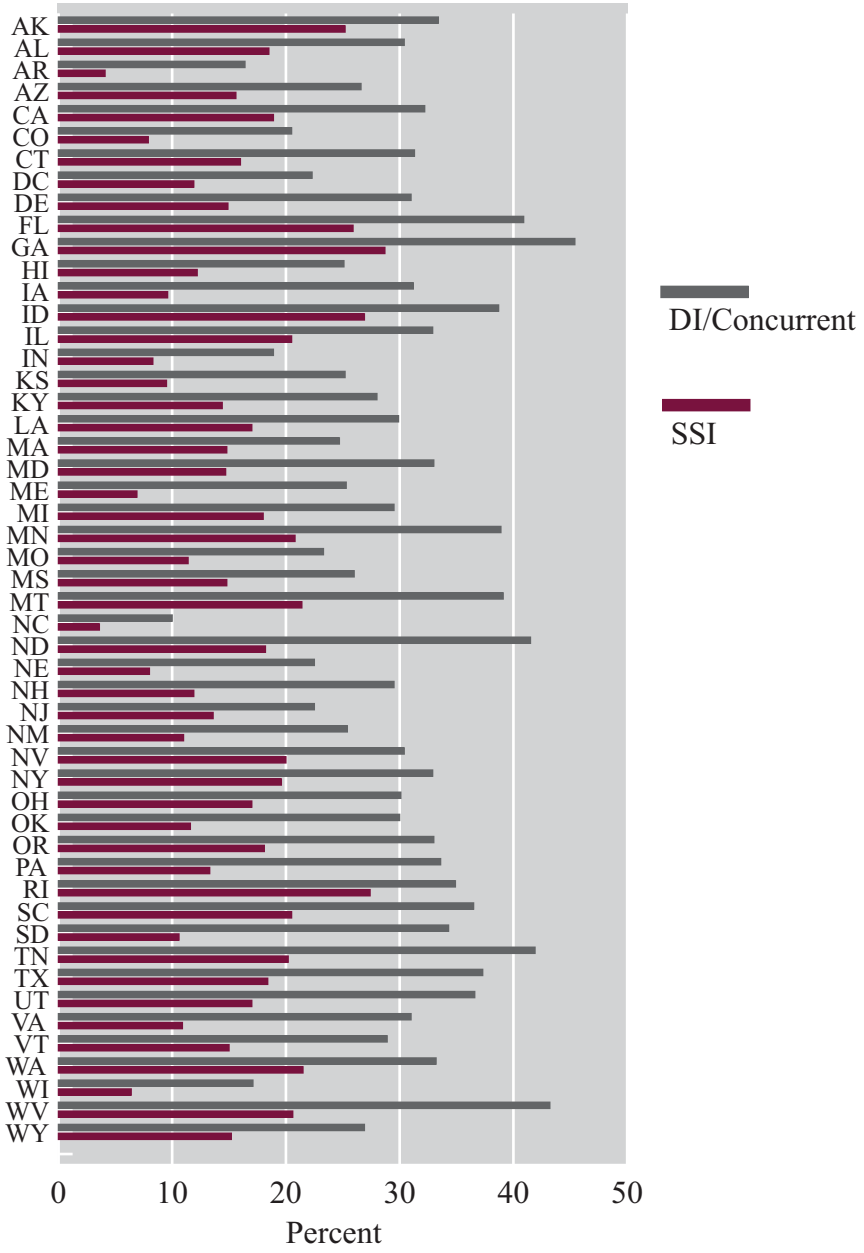
Chart 48

Percentage of State Agency Initial Denials Based on Ability to Perform Usual Work Fiscal Year 2004



At a later step in the sequential evaluation of disability, the examiner determines if the claimant can perform his or her usual work. State agencies vary widely in the degree to which they deny claims for this reason. For DI and concurrent applications, denials for this reason in 2004 ranged from 10 percent of all denials in North Carolina to 45 percent in Georgia. For SSI adult applications, denials for this reason ranged from 4 percent in North Carolina to 29 percent in Georgia.

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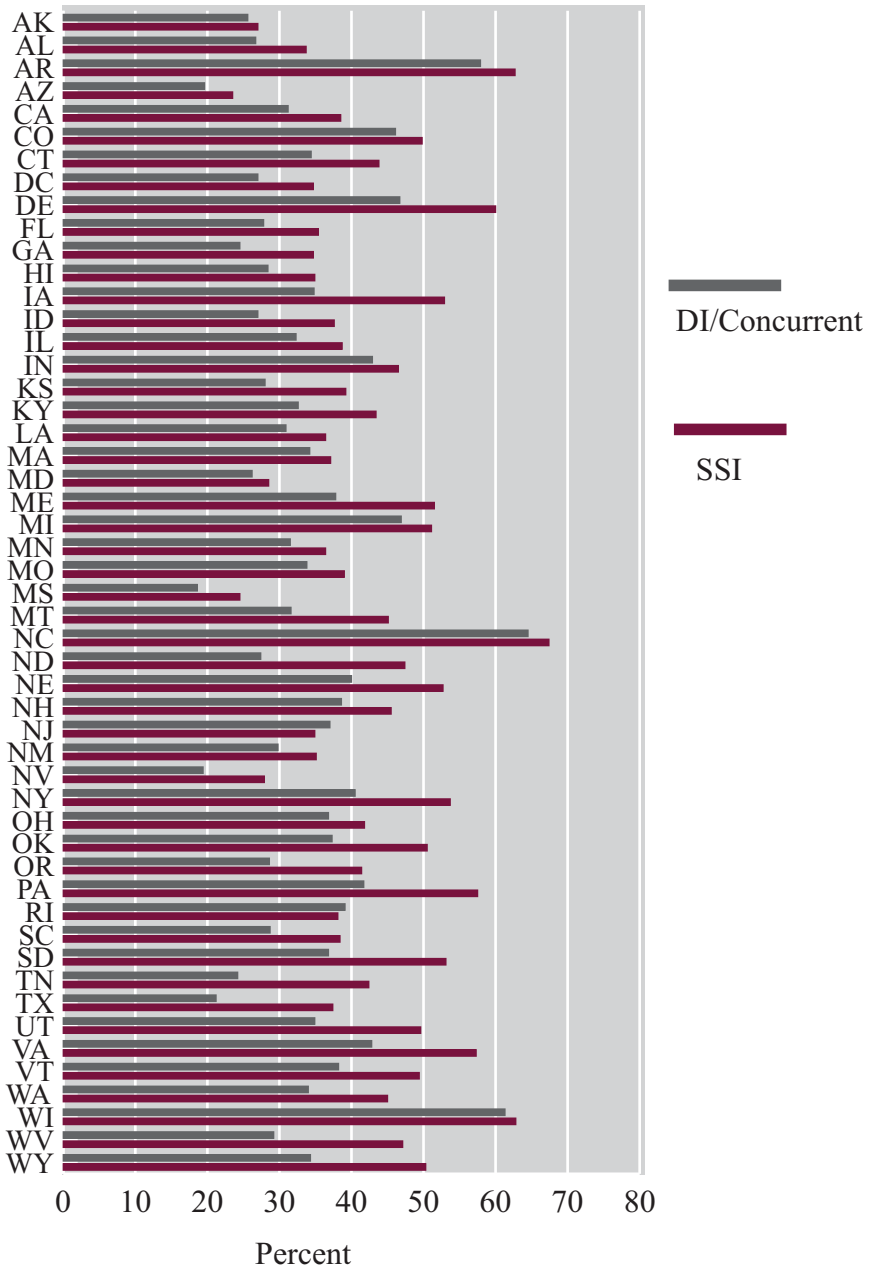
Chart 49

Percentage of State Agency Initial Denials Based on Ability to Perform Other Work Fiscal Year 2004



At the final step in the sequential evaluation, the examiner determines if the claimant can do work other than his or her usual past work. State agencies vary widely in the degree to which they deny claims for this reason. For DI and concurrent applications, denials for this reason in fiscal year 2004 ranged from 19 percent of all denials in Mississippi to 65 percent in North Carolina. For SSI adult applications, denials for this reason ranged from 24 percent in Arizona to 67 percent in North Carolina.

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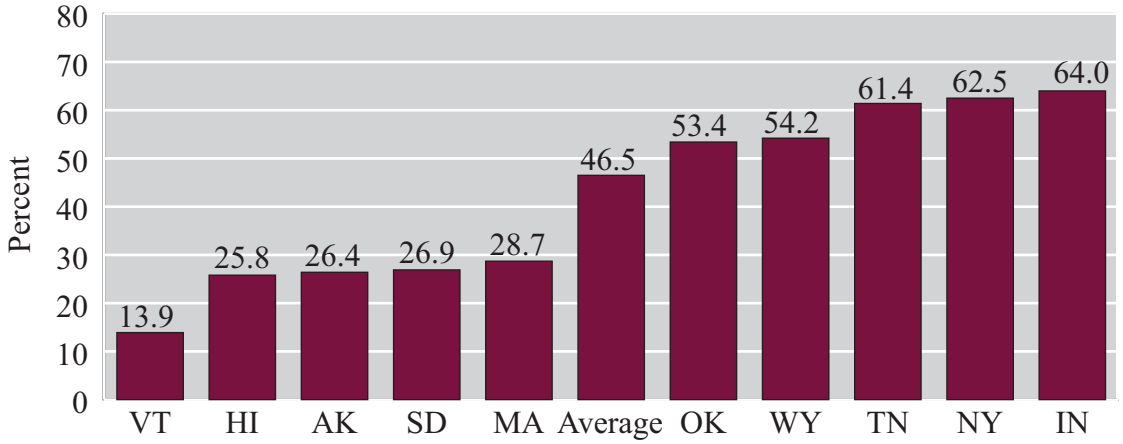
Chart 50

Percentage of Initial-Level Claims with Consultative Examinations Fiscal Year 2004



To supplement medical evidence of record or when such evidence is not available, DDSs procure consultative examinations. In fiscal year 2003, the use of consultative examinations for initial disability decisions ranged from 14 percent in Vermont to 64 percent in Indiana. The national average was 47 percent.

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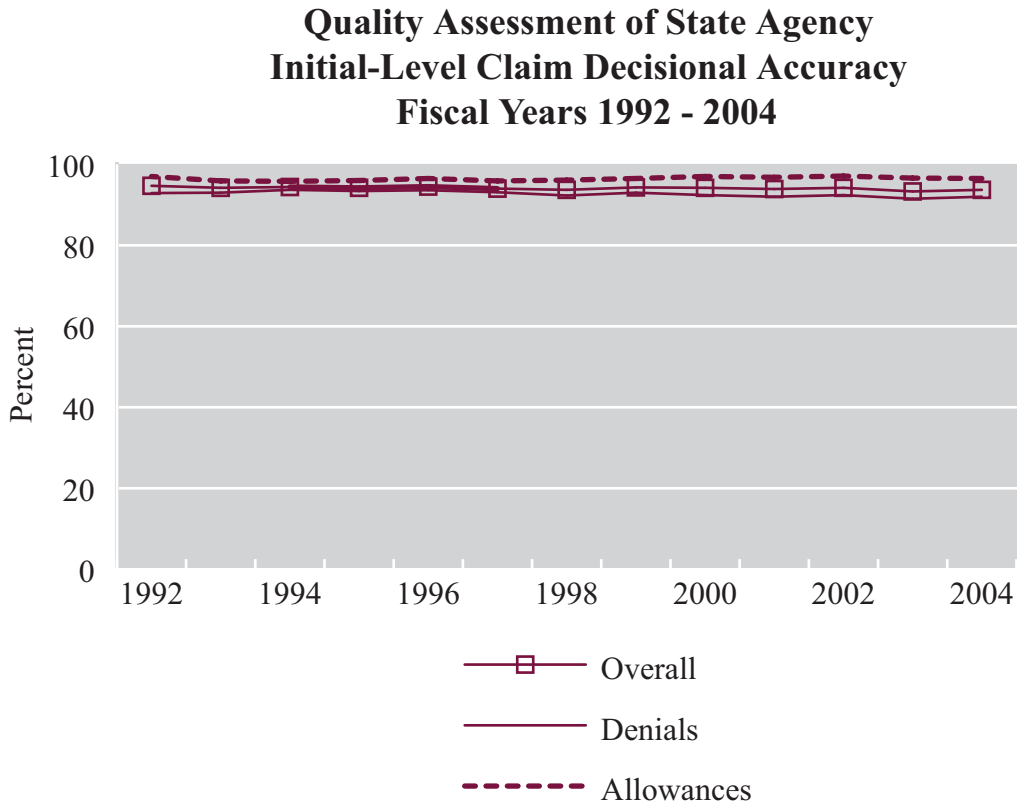
Chart 51



Despite all the variations in DDS decision making, SSA's Office of Quality Assurance has found a remarkably high level of DDS initial claims accuracy.

SSA reviews random samples of each State's allowances and denials. The samples are designed to produce accuracy rate estimates in which one can be confident that 95 percent of all samples of a similar size will produce an accuracy rate estimate that is within 5 percentage points of the accuracy rate that would be obtained if all allowances and denials were reviewed.

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VIII. State Administrative Arrangements

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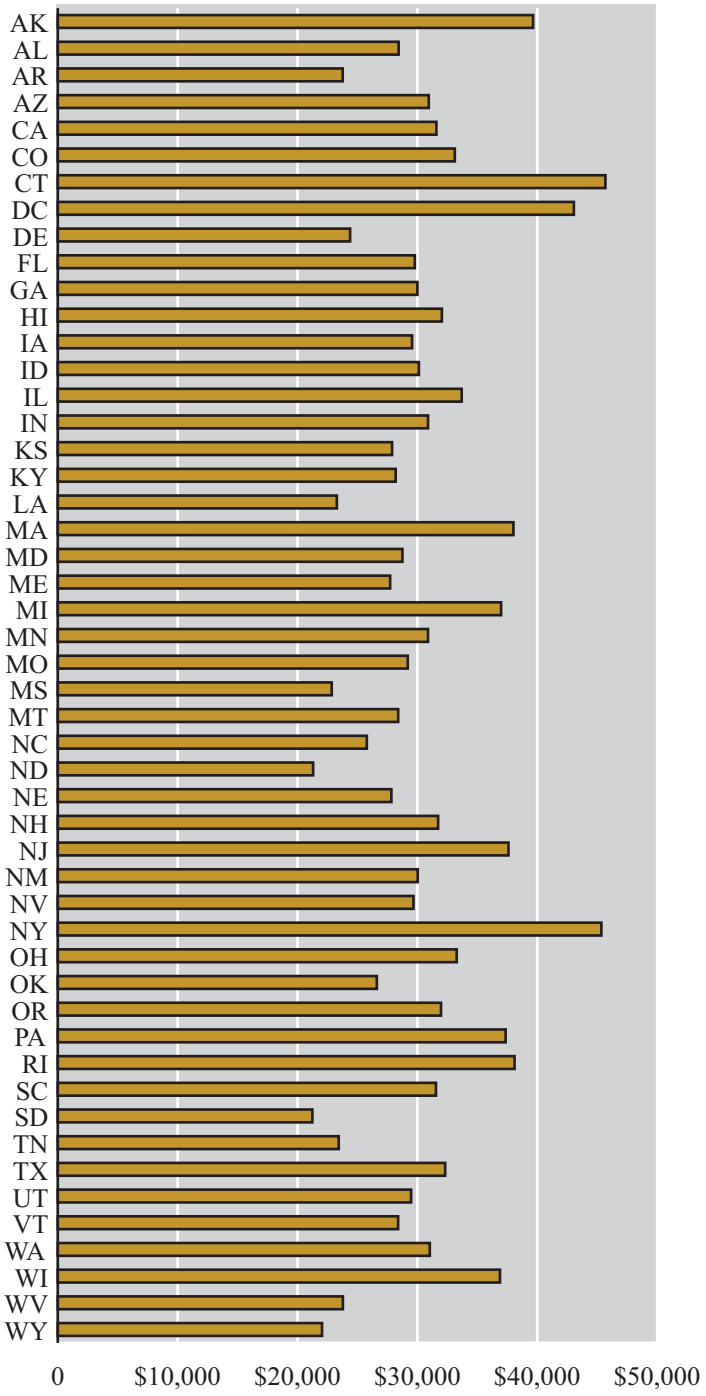
Chart 52

Minimum Salary Levels for Initial-Level State Agency Disability Examiners Fiscal Year 2004



Minimum salary for full-time non-trainee initial disability examiners varies widely, from $21,238 in South Dakota to $45,684 in Connecticut. (Comparable data were not available for Virginia.)

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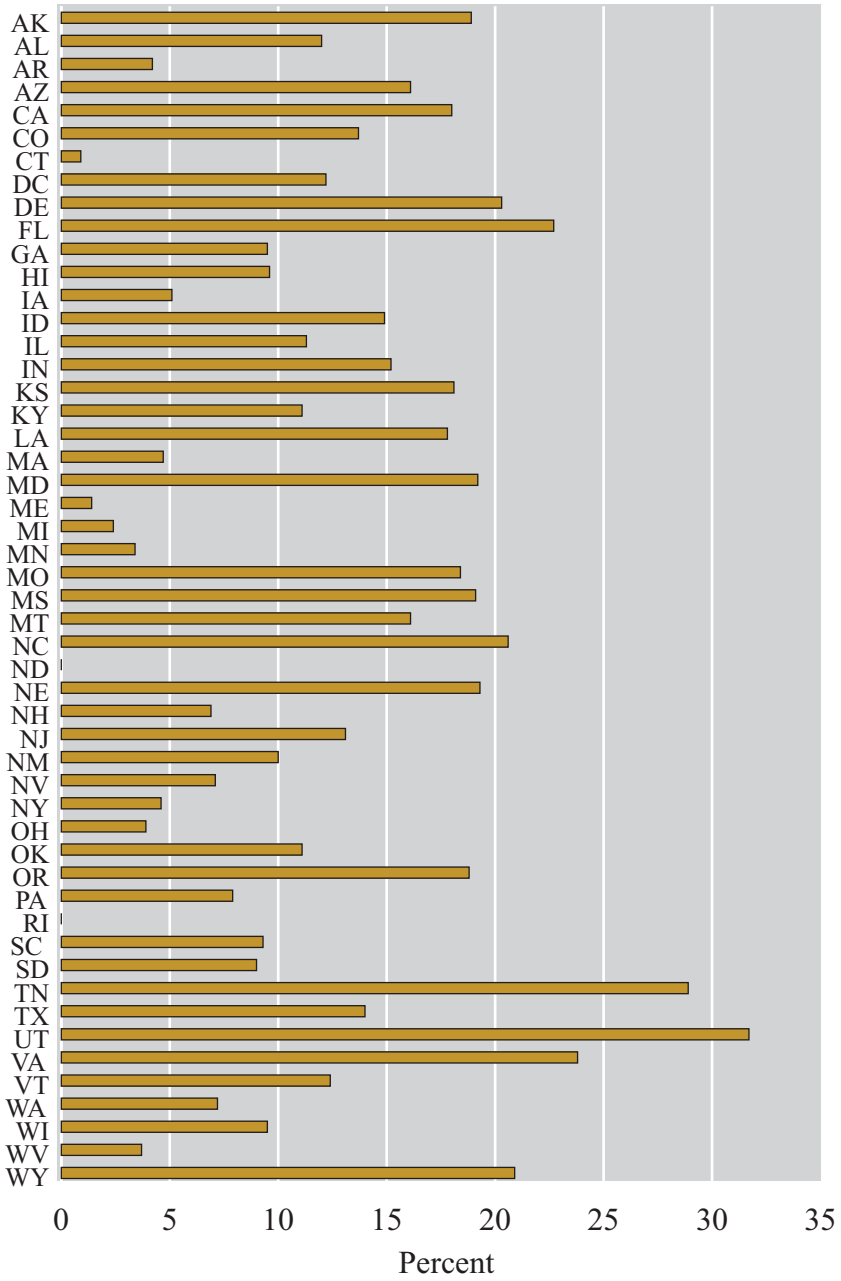
Chart 53

State Agency Examiner Attrition Rates
Fiscal Year 2004



The overall average DDS examiner attrition rate in 2004 was 12.9 percent. The range in 2004 was from zero percent in Rhode Island and North Dakota to 32 percent in Utah. The rate can vary widely from year to year especially in small States, where a few losses amount to a large percentage. Some States have historically high rates due to low salaries. It is believed by many in the DDSs that it takes at least 2 years before an examiner has sufficient experience to work without close supervision.

For purposes of comparison, Office of Personnel Management data for 2004 show an overall separation rate (including transfers) of 17 percent for the Federal executive branch and 6 percent for the Social Security Administration.

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IX. Hearings and Appeals

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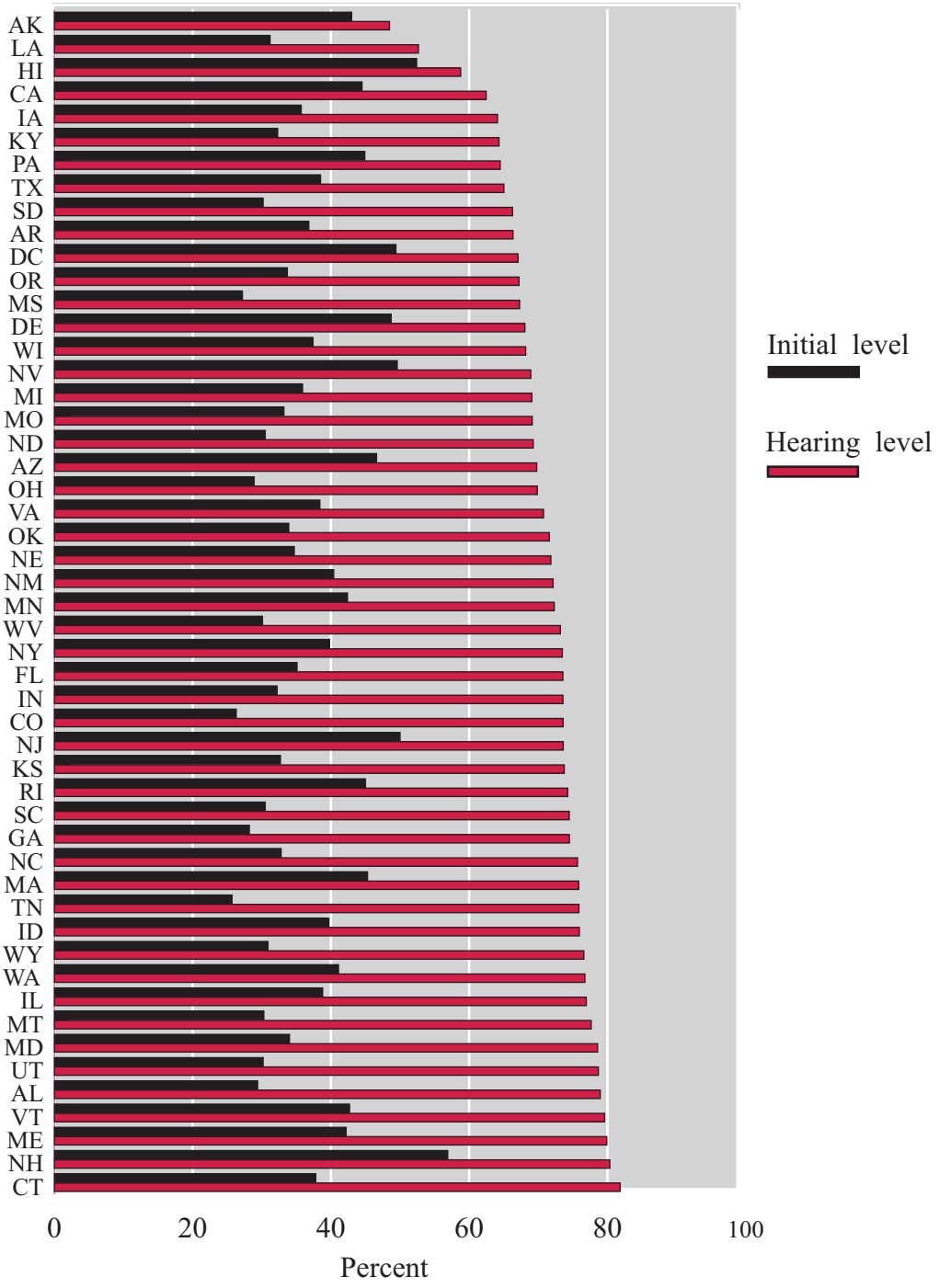
Chart 54

Allowance Rates at Initial (Fiscal Year 2003) and Hearing (Fiscal Year 2004) Levels by State



There is a wide range from State to State in the hearing-level allowance rates on disability claims. In 2004 allowance rates ranged from 48 percent in Alaska to 82 percent in Connecticut. Percentages shown are percentages of decisions and do not include dismissals. Further analysis shows there is no overall correlation between the initial-level and the hearing-level allowance rates.

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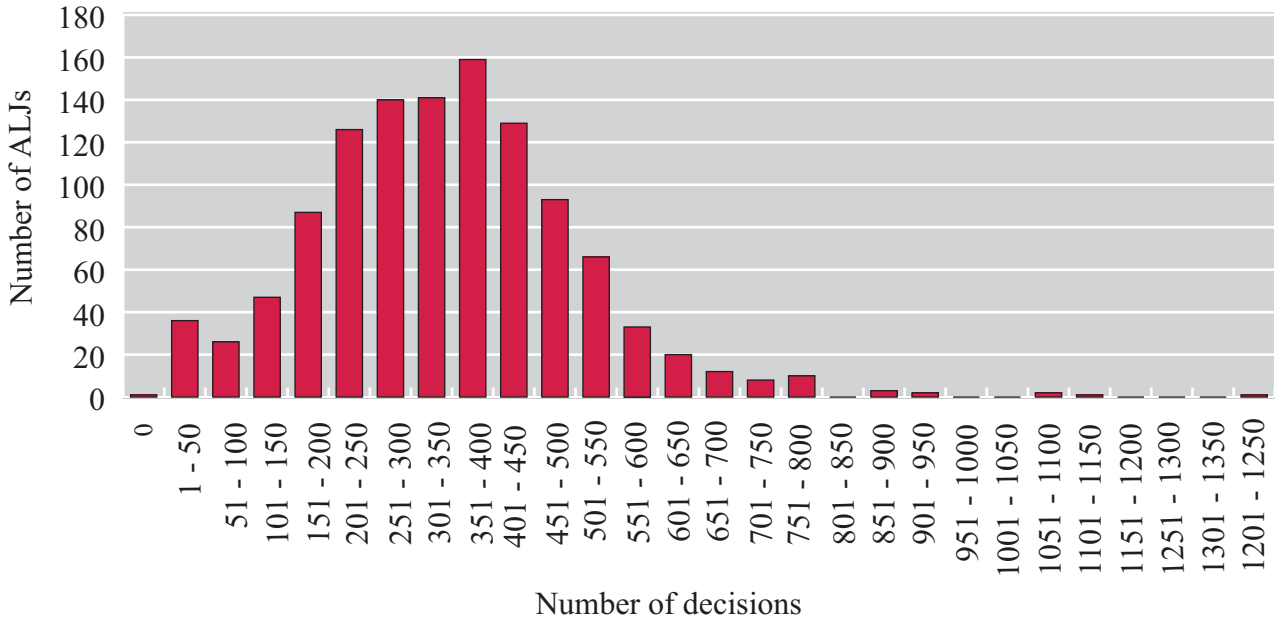
Chart 55

Frequency Distribution of the Number of ALJ Decisions in Fiscal Year 2002, SSA Cases



This chart shows how many of the 1,144 administrative law judges (ALJs) working in 2002, issued a number of decisions falling within certain ranges. (The figures displayed are for decisions in SSA cases in FY 2002.) For example, 159 ALJs issued between 351 and 400 decisions, and 129 issued between 401 and 450.

The middle 50 percent of ALJs issued between 235 and 436 decisions on SSA cases in FY 2002. The bottom 10 percent issued 153 or fewer. The top 10 percent issued 531 or more.

There are several possible reasons for low numbers of decisions by judges. Some judges spent much of their time on Medicare cases, and the SSA cases shown on this chart reflect only a small percentage of their work. Some judges produced few cases due to the time they spent on management or union duties or on details or other assignments. Some new ALJs began processing cases at the end of calendar year 2001 and did not become fully productive until later in calendar year 2002. Other judges left the agency during the year and may have produced a small number of cases.

There are also possible reasons for high numbers of decisions. For example, some ALJs have been involved in initiatives to identify cases that can be allowed without a hearing.

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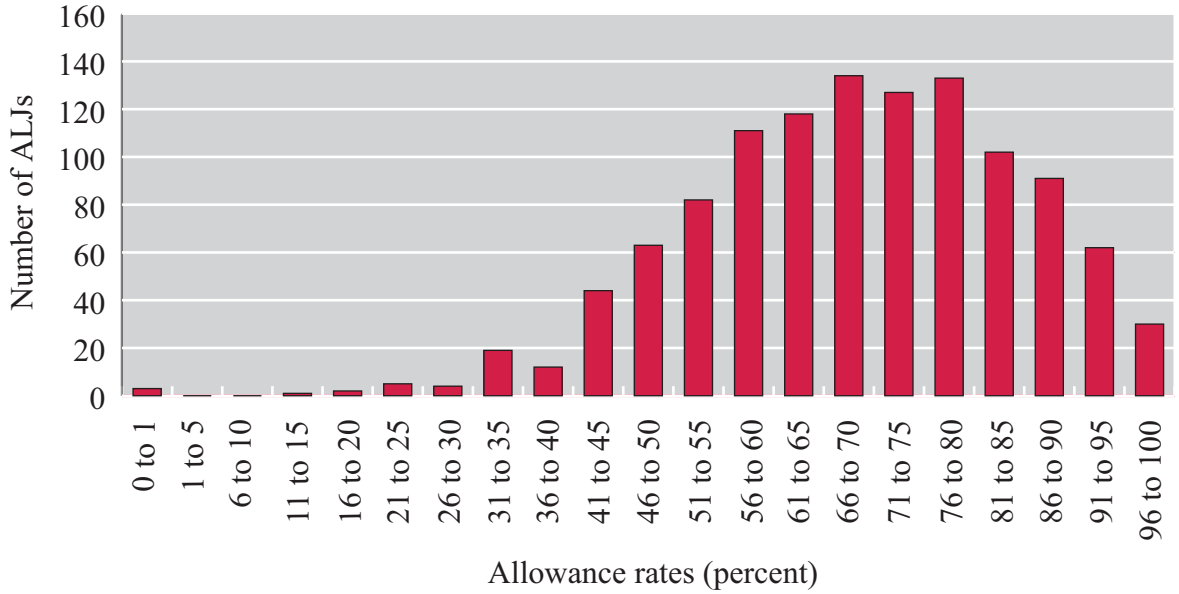
Chart 56

Frequency of Distribution of ALJ Allowance Rates in Fiscal Year 2002 SSA Cases



This chart shows how many of the 1,144 ALJs working in 2002 have decision allowance rates within a particular range. (The rates displayed are for decisions in SSA cases in FY 2002.) For example, 118 ALJs had allowance rates between 61 and 65 percent, and 134 had allowance rates between 66 and 70 percent.

The allowance rates for decisions (that is, excluding dismissals) of the middle 50 percent of ALJs ranged between 57 percent and 80 percent in FY 2002. The bottom 10 percent had allowance rates of 47 percent or less. The top 10 percent had allowance rates of 89 percent or more.

ALJs who made few decisions, as shown on the previous chart, might easily have either very high or very low allowance rates with little effect on the overall allowance rate. ALJs involved in initiatives to identify cases that can be allowed without a hearing may have high allowance rates.

There is no overall correlation between allowance rates and the number of decisions shown in Chart 55.

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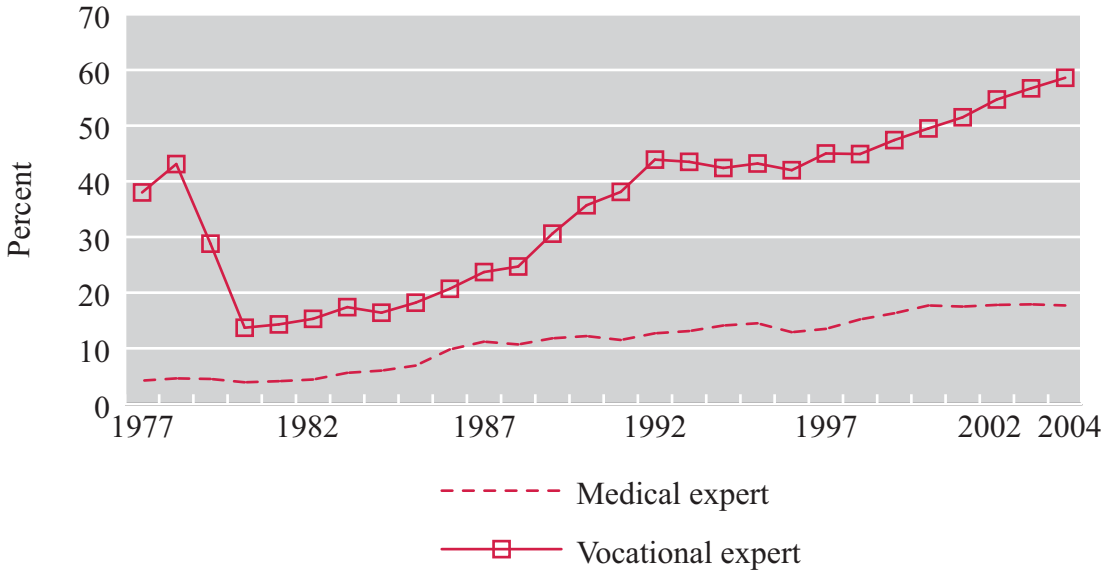
Chart 57

Medical and Vocational Expert Participation in ALJ Hearings Fiscal Years 1977 - 2004



The use of vocational experts has increased greatly since 1980. (The adoption of the vocational regulations in 1979 was supposed to reduce their use. Later court decisions and regulatory changes contributed to increased use.) Vocational experts are now used in more than half of all ALJ hearings. Over the same period, the use of medical experts has grown from about 4 percent of hearings to more than 17 percent.

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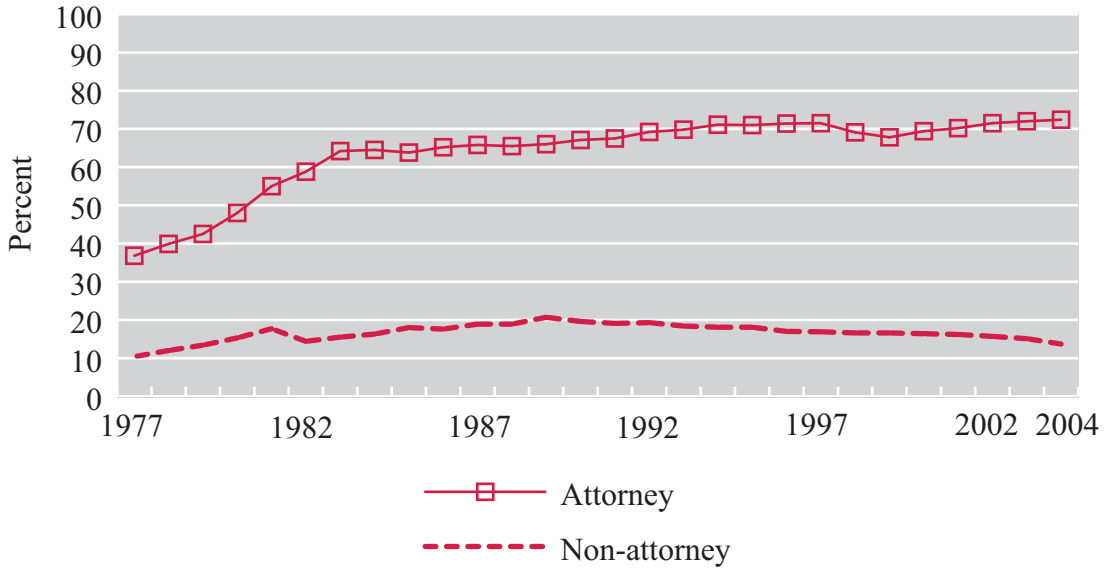
Chart 58

Cases With Representation at ALJ Hearings
Fiscal Years 1977 - 2004



The percentage of DI and SSI claimants represented by attorneys at ALJ hearings has nearly doubled since 1977. The figures for attorney and non-attorney representatives are not additive, since some claimants may have both types of representatives. Representation varies greatly with the type of claim. In FY 2004, 84 percent of DI-only claimants had an attorney, 80 percent of DI-SSI concurrent claimants had an attorney, and 60 percent of SSI-only claimants had an attorney. Non-attorney representatives were present in 10 percent of DI-only claims, 13 percent of concurrent claims, and 13 percent of SSI-only claims.

Until recently, attorney fees could be withheld and paid directly from past-due benefits only in Social Security, but not in SSI, claims; and fees could be withheld only for attorneys, not for non-attorney representatives. The Social Security Protection Act of 2004 extended, for a period of 5 years, withholding of attorney fees to SSI cases. The Act also authorized, for a period of 5 years, a national demonstration project to allow non-attorney representatives the option of fee withholding under both DI and SSI claims for a period of 5 years. The demonstration project began February 28, 2005, and fee withholding for SSI benefits became effective for cases effectuated on or after the same date.

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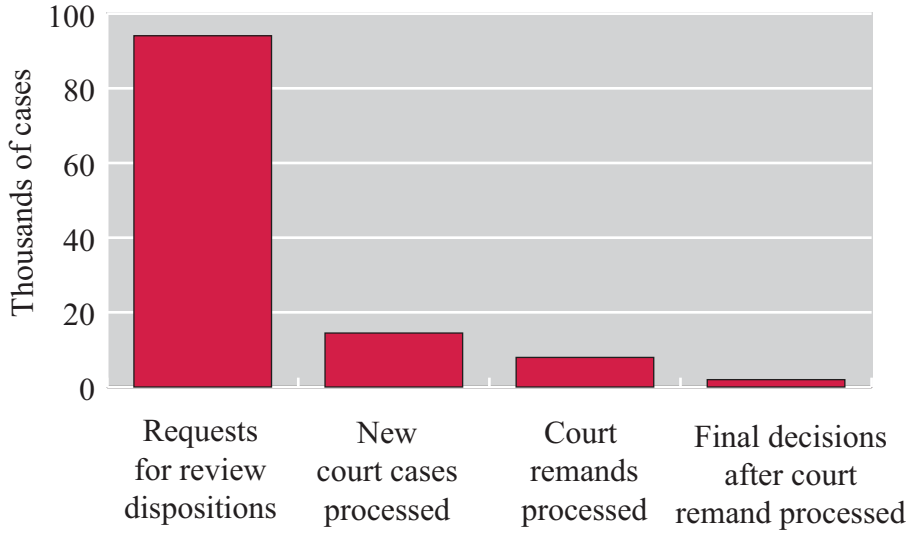
Chart 59

Appeals Council Workloads
Fiscal Year 2005



In addition to dealing with requests for review or appeals from hearing-level decisions, the Appeals Council:

- reviews new court cases to determine whether they should be defended on the record or whether the Commissioner should seek a voluntary remand and prepares the certified administrative record for new court cases of appealed SSA decisions
- processes remands from the courts
- reviews final court decisions and makes recommendations as to whether appeal should be sought

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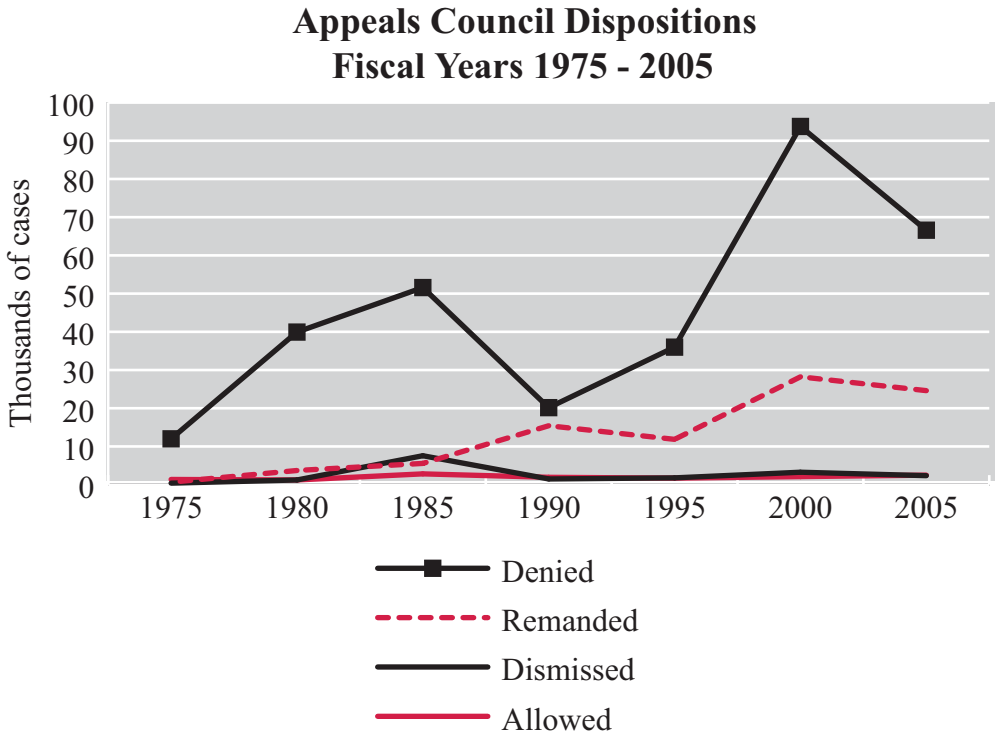
Chart 60



Over the years, most of the cases handled by the Appeals Council have been either denied or remanded back to the ALJ level. The number of cases being remanded back to the ALJs has grown considerably, accounting for 26 percent of the Appeals Council dispositions in 2005.

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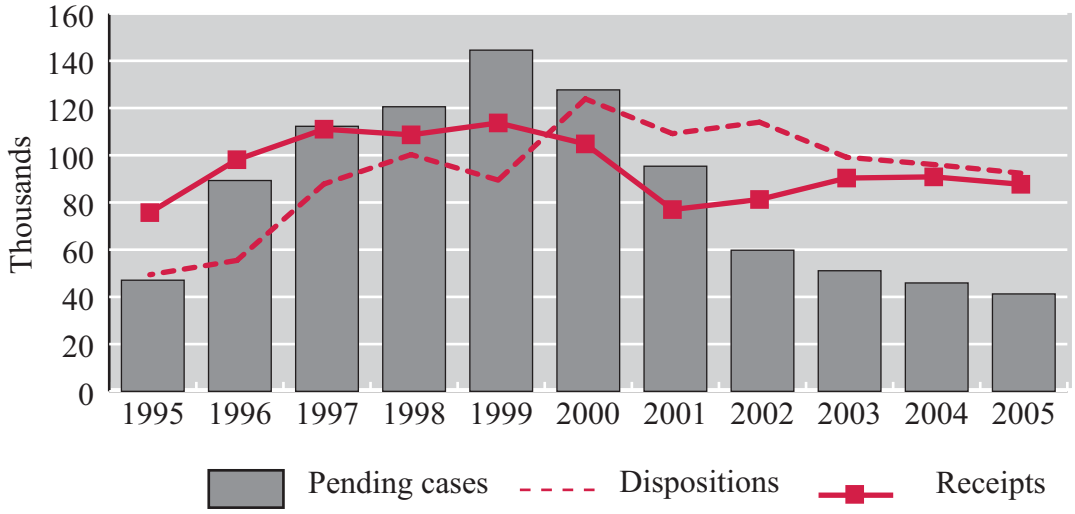
Chart 61

Appeals Council Requests for Review
Fiscal Years 1995 - 2005



With dispositions exceeding receipts, the number of requests for review pending at the Appeals Council has dropped since 1999 to less than a third of what it was in that year. Processing time has fallen to half of what it was at its peak in 2000.

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X. Processing Times

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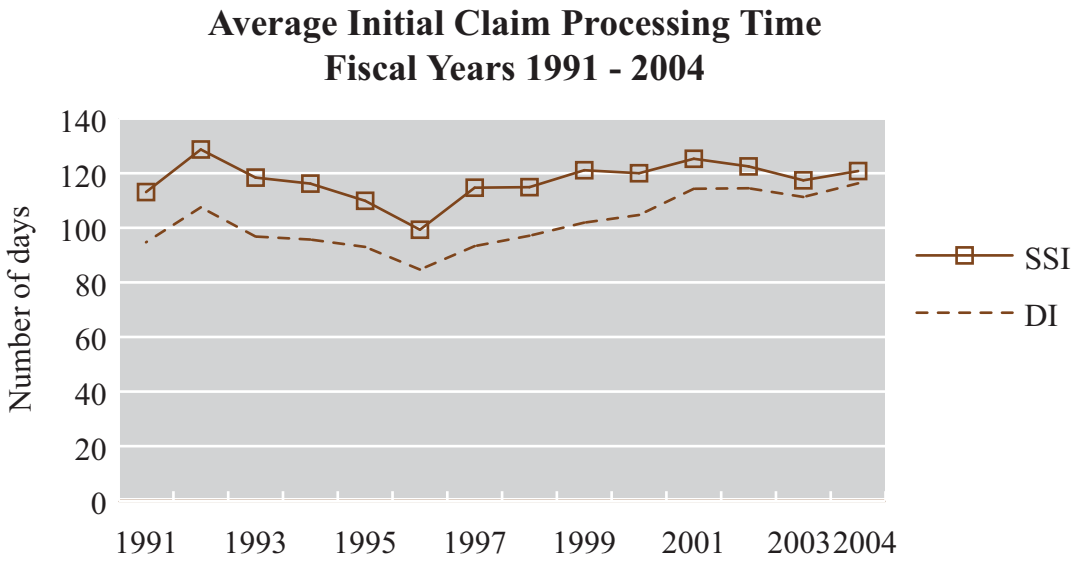
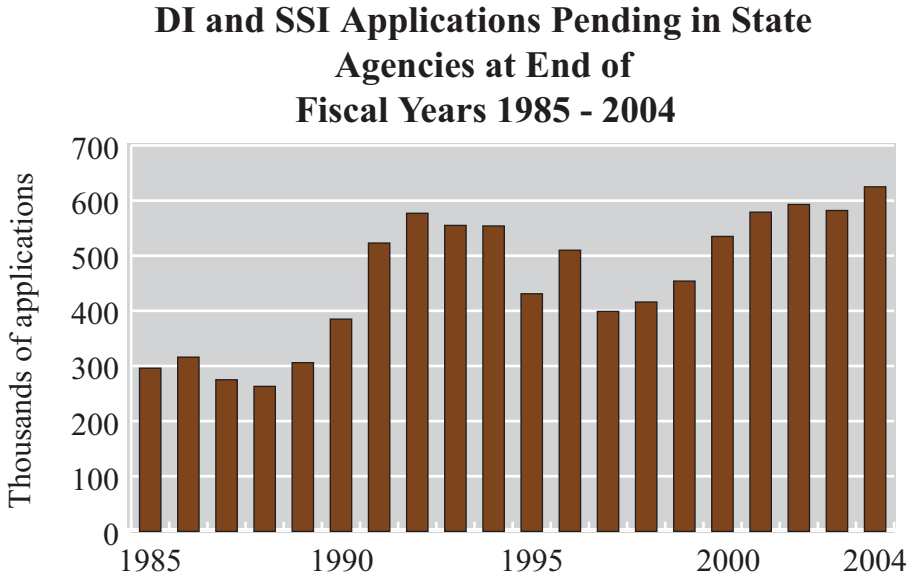
Chart 62



Processing time shown is the time from the date of the application to the date the award or denial notice is generated. It includes field office and processing center as well as State agency time.

Chart 63



The State agency workload soared between 1989 and 1992, largely due to a recession (which tends to increase the relative economic value of disability benefits), the Supreme Court's *Zebley* decision that liberalized the definition of eligibility for children, and changes in SSA's regulations for determining whether an individual has a mental impairment. The result was an increase in processing times and in the number of applications pending in the State agencies at the end of the year. Although the pending workload declined in the mid-1990s, it is now higher than it was in the early 1990s, and roughly double what it was in the latter half of the 1980s.

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Chart 64

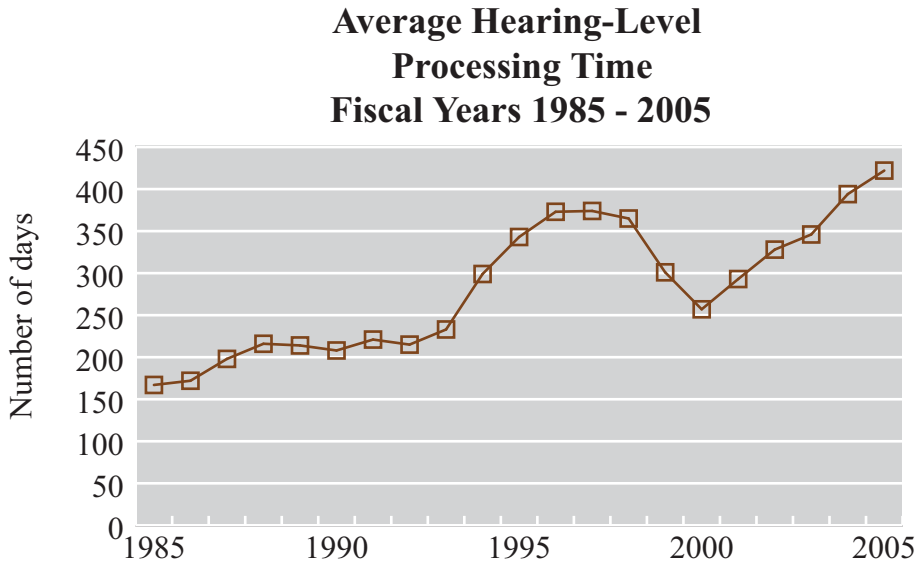
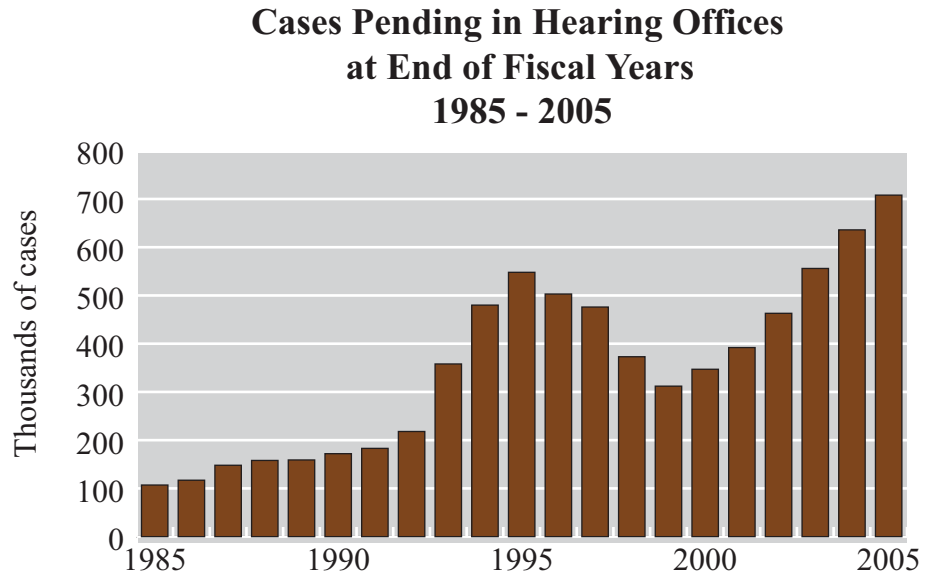


Chart 65



Average hearing office processing times for Social Security and SSI cases (nearly all of which are disability cases) soared in the mid-1990s, as the wave of initial claims filed in the early 1990s made their way through the system. After falling to 274 days in 2000, processing times have risen to 422 days in 2005. The size of the pending workload in hearing offices has also risen, and both processing times and pending levels are substantially higher than they were in the mid-1990s. Since 1985, processing times have more than doubled and the pending caseload has grown 6 times over.

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* required the transfer of Medicare hearings from SSA to the Department of Health and Human Services not later than October 1, 2005. In 2004 SSA received 57,564 requests for Medicare hearings and disposed of 64,082. At the end of 2004, SSA had 28,675 Medicare cases pending.

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XI. Federal Courts

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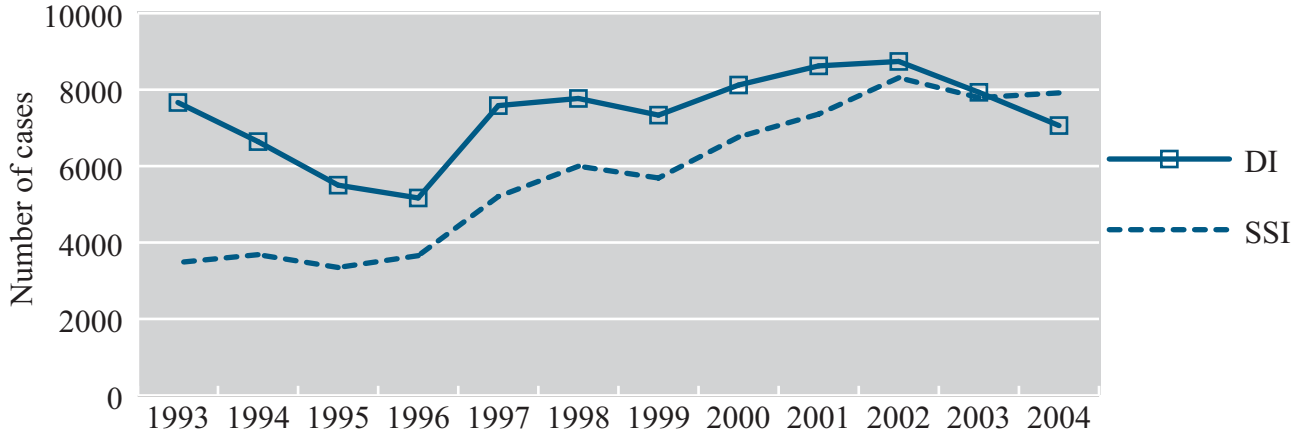
Chart 66

New Disability Cases Brought to District Courts Fiscal Years 1993-2004



Trends at the district court level reflect activity at the administrative level. As the 2003 Judicial Business of the United States Courts commented, "Following a seven-year period in which the Social Security Administration used additional resources to process administratively a large backlog of Social Security claims (thereby causing case filings related to these claims to increase each year since 1999), Social Security filings declined . . . in 2003." In 2004, DI and SSI cases accounted for 5.3 percent of all new cases brought to the district courts.

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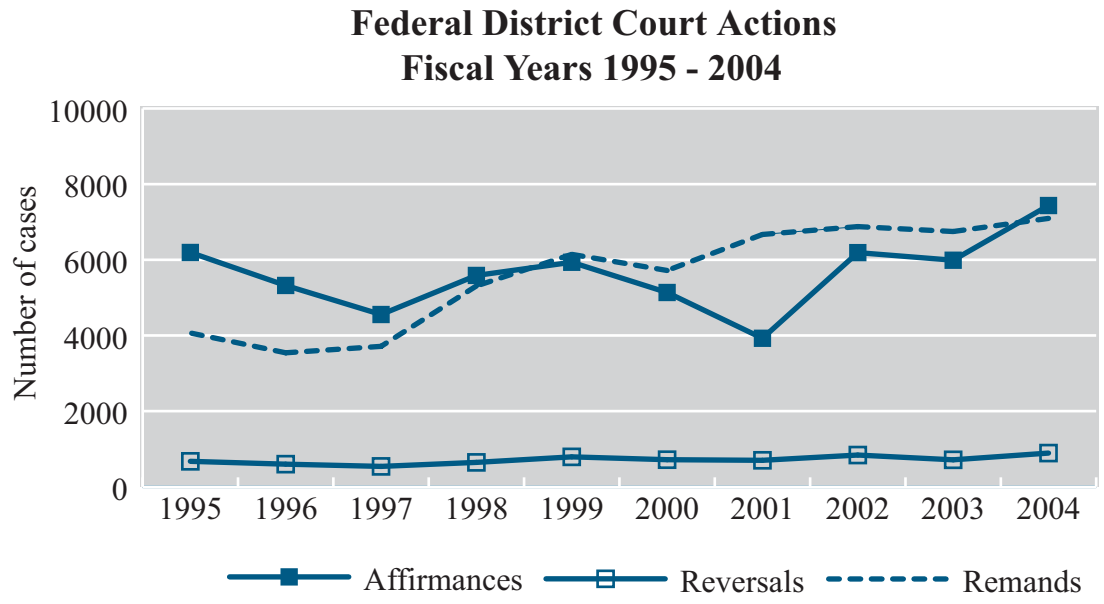
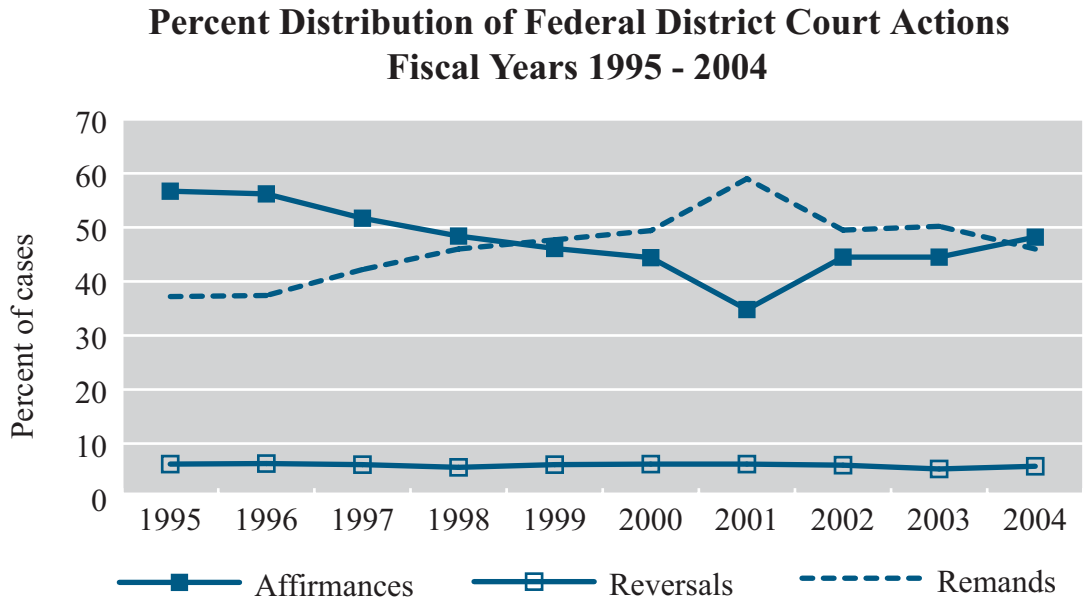
Chart 67





Since 1995, Federal courts have reversed relatively few agency decisions. The reversal rate was about 6 percent over the entire period. However, between 1996 and 2001 the rate of cases remanded back to the agency for further action rose from 37 percent to 59 percent. In 2004 the remand rate stood at 46 percent. In 2004, 67 percent of court remands were subsequently allowed by the agency.

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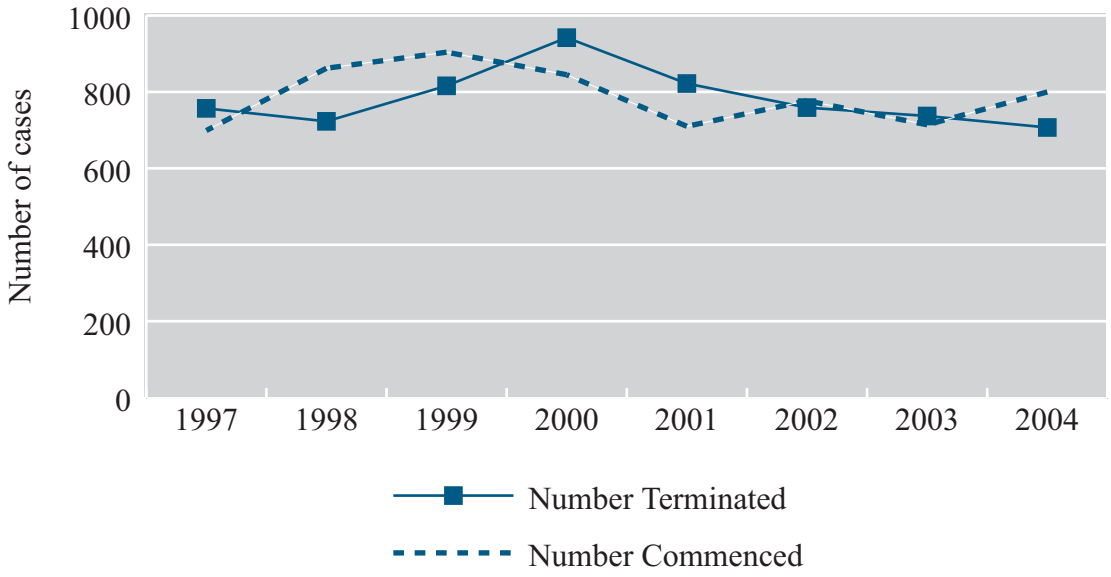
Chart 68

Social Security Cases Commenced and Terminated in U.S. Courts of Appeals Fiscal Years 1997-2004



The number of Social Security cases appealed to U.S. courts of appeals has varied somewhat over the years shown but has not exceeded 2 percent of the cases taken to those courts.

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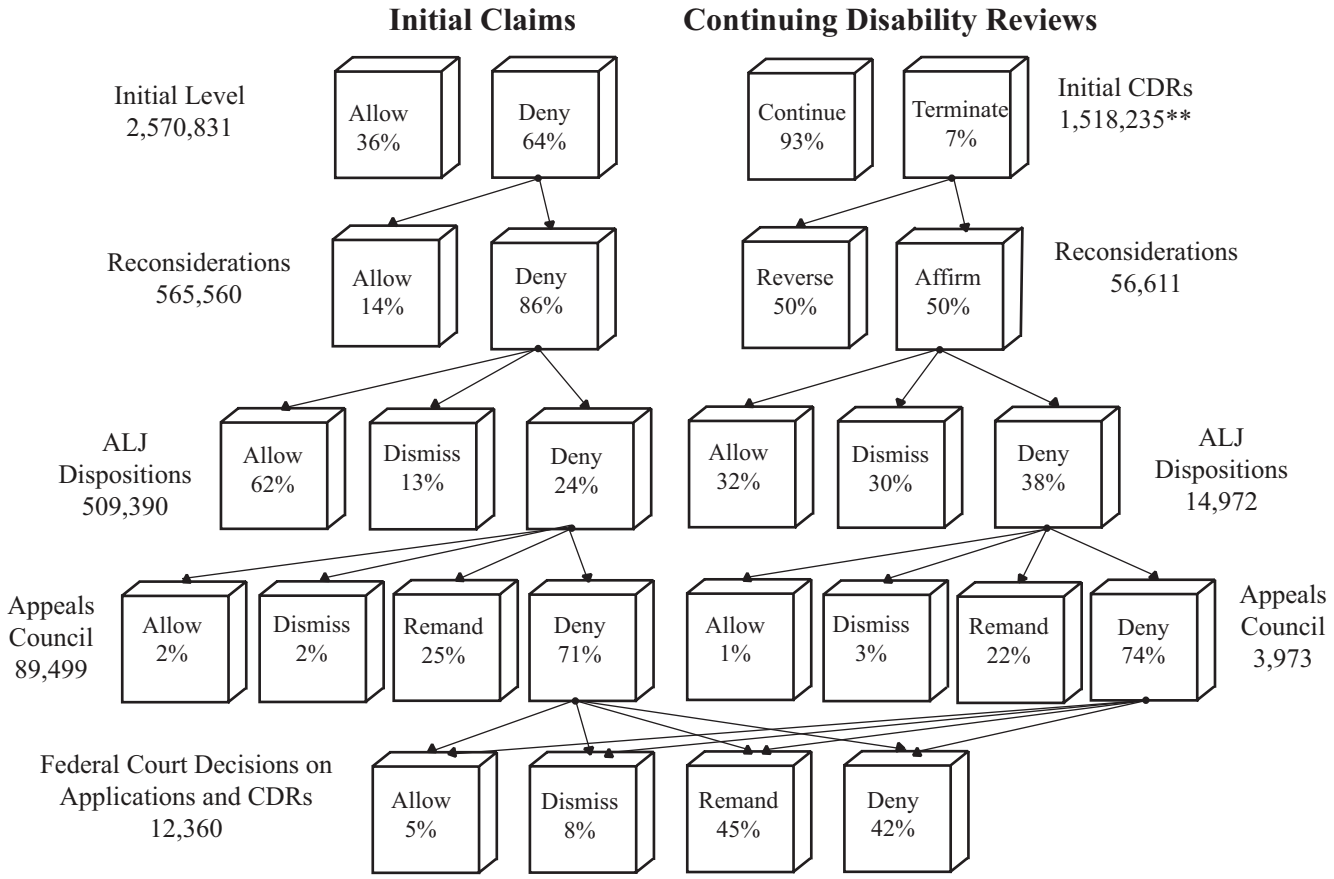
Chart 69

DI and SSI Disability Determinations and Appeals Fiscal Year 2005*



Percent of distribution of all claim allowances at each adjudicative level.

Initial Decisions	69.8
Reconsiderations	5.9
Hearing Level	24.1
Appeals Council	0.2
	100.0

* Includes all Title II and Title XVI disability determinations. The data relate to workloads processed (but not necessarily received) in fiscal year 2005. That is, the cases processed at each adjudicative level may include cases received at one or more of the lower adjudicative levels prior to FY 2005.

** Includes non-State CDR mailer continuations. Also includes 16,696 CDRs where there was "no decision." The continuance and termination rates are computed without the "no decision" cases.

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XII. DATA SOURCES AND NOTES

Chart 1. DI: www.ssa.gov/OACT/STATS/table6c7.html
SSI*: Annual Report of the Supplemental Security Income Program*, table IV.B1.

Chart 2. *District Office Workload Report* (DOWR) State summaries for FY 2003; insured population estimates as of December 31, 2002 by SSA, Office of Research, Evaluation, and Statistics. (Note: DOWR category includes applications for disabled workers, children, widows and widowers, end-stage renal disease, and Medicare-qualified government employees.)

Chart 3. www.ssa.gov/OACT/STATS/table4c2DI.

Chart 4. *SSI Annual Statistical Report*, 2003, table 45;
http://ferret.bls.census.gov/macro/032004/pov/new46_100125_05.htm.
http://www.census.gov/popest/states/asrh/SC-est2004-01.html

Chart 5. *SSI Annual Statistical Report*, 2003, table 45;
http://ferret.bls.census.gov/macro/032004/pov/new46_100125_03.htm.
http://www.census.gov/popest/states/asrh/SC-est2004-01.html

Chart 6. *SSI Annual Statistical Report*, 2003, table 41;
http://www.census.gov/hhes/poverty/histpov/hstpov3.html

Chart 7. SSA, Office of Disability Programs, *State Agency Operations Report*, and Office of Hearings and Appeals, Hearing Office Tracking System and OHA Case Control System.
Note: A revised process was introduced October 1, 1999 in 10 States, under which initial denials could be appealed directly to the hearing level without a reconsideration. Hearing level data include all forms of cases reaching the hearing level, including those involving Social Security retirement and SSI aged issues,but not Medicare. The vast majority involve disability issues.

Chart 8. SSA, Office of Disability Programs, *State Agency Operations Report*.

Chart 9. SSA, Office of Disability Programs, *State Agency Operations Report.*
Note: A revised process was introduced October 1, 1999, in ten States, under which initial denials could be appealed directly to the hearing level without a reconsideration.

Chart 10. SSA, Office of Hearings and Appeals, *Key Workload Indicator Reports*.

Chart 11. DI: http://www.ssa.gov/OACT/STATS/table6c7.html
SSI*: Annual Report of the Supplemental Security Income Program,* 2005, table IV.B2.

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Chart 12. SSA, *Actuarial Study 114*, table 4, updated to 2003 by Office of the Chief Actuary, July 2004.

Chart 13. SSA, Office of Disability Programs, *State Agency Operations Report*; Office of Hearings and Appeals, Case Control System.
Note: A revised process was introduced October 1, 1999, in ten States under which initial denials could be appealed directly to the hearing level without a reconsideration.

Chart 14. *Annual Statistical Report on the Social Security Disability Insurance Program*, 2003, tables 52-55; *SSI Annual Statistical Report,* 2003, tables 53-56.

Chart 15. SSA, Office of Disability Program, CDR Control File and *State Agency Operations Report*.

Chart 16. SSA, *Annual Report of Continuing Disability Reviews, Fiscal Year 2004*, Appendix A, table A5.
Note: The data shown for SSI children are for CDRs other than reviews of low-birth-weight children and redeterminations at age 18. The *Personal Responsibility and Work Opportunity Reconciliation Act of 1996* required SSA to perform a CDR not later than 12 months after birth for recipients whose low birth weight is a contributing factor material to the determination of their disability. The same act required SSA to redetermine the eligibility of SSI beneficiaries using adult initial criteria during the one-year period beginning with the beneficiary's 18th birthday. (The *Balanced Budget Act of 1997* later gave the agency more leeway in scheduling those reviews and redeterminations.)

Chart 17. SSA, *Report to Congress on Continuing Disability Reviews*, *Fiscal Year*, 2004, Appendix B.

Chart 18. SSA, *Actuarial Study 114*, table 5, updated by Office of Chief Actuary, December, 2004.

Chart 19. SSA, *Actuarial Study 114*, table 5, updated by Office of Chief Actuary, December, 2004.

Chart 20. *Annual Report of the Supplemental Security Income Program*, 2005, table IV.B6; 2000 *Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*, table II.F19; 2005 *Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*, table IV.B2 (intermediate projections beginning 2005).

Chart 21. *Annual Statistical Supplement,* 1980, table 44, 1982 table 31, 1999 table 4.C2; http://www.ssa.gov/OACT/STATS/table4c2DI; http://www.ssa.gov/OACT/STATS/DIbenies.html.

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Chart 22. *Annual Report of the Supplemental Security Income Program*, 2005, table IV.B6; http://eire.census.gov/popest/data/states/ST-EST2003-01.php

Chart 23. *Annual Statistical Supplement*, 2004, table 5.J14; http://www.census.gov/popest/states/asrh/SC-est2004-01.html.

Chart 24. *SSI Annual Statistical Report*, 2003, table 9; http://www.census.gov/popest/states/asrh/SC-est2004-01.html; http://ferret.bls.census.gov/macro/032004/pov/new46_100125_05.htm

Chart 25. *SSI Annual Statistical Report*, 2003, table 9; http://www.census.gov/popest/states/asrh/SC-est2004-01.html; http://ferret.bls.census.gov/macro/032004/pov/new46_100125_03.htm

Chart 26. SSA, Office of the Chief Actuary*, Actuarial Study 118*, table 25.

Chart 27. SSA, Office of Disability Program, 831 file.

Chart 28. SSA, *Annual Statistical Supplement* 2003, table 6.C3

Chart 29. SSA, *Annual Statistical Report on the Social Security Disability Program*, 2003 Table 21; SSA, *SSI Annual Statiscal Report*, 2003, table 25

Chart 30. SSA, *Annual Statistical Supplement*, table 5.D5; *SSI Annual Statistical Report*, table 25.

Chart 31. SSA, *Annual Statistical Supplement*, table 5.A1, table 70 (1985), table 67 (1984).

Chart 32. SSA, *Annual Report of the Supplemental Security Income Program*, table IV.B6.

Chart 33. SSA, Office of Research, Evaluation, and Statistics, 831 file.

Chart 34. SSA, Office of Chief Actuary, from 10 percent sample file.

Chart 35. SSA, *Annual Statistical Supplement*, table 5.D3.

Chart 36. SSA, *Annual Statistical Supplement*, table 7.E3.

Chart 37. SSA, *Annual Statistical Supplement* 2003, table 7.E3

Chart 38. SSA, *Annual Statistical Report on the Social Security Disability Program*, 2003, table 3; 2004 benefit figure from http://www.ssa.gov/pressoffice/basicfact.htm; converted to constant dollars using CPI-W from http://www.ssa.gov/OACT/STATS/cpiw.html.

Chart 39. SSA, *Annual Report of the Supplemental Security Income Program*, 2005, table IV.A2; converted to constant dollars using CPI-W from http://www.ssa.gov/OACT/STATS/cpiw.html.

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Chart 40. SSA, *Annual Report on the Social Security Disability Program*, 2003, table 62; *SSI Annual Statistical Report*, 2003, table 35.

Chart 41. SSA, *Annual Statistical Report on the Social Security Disability Programs*, 2003, tables 63 and 65; *SSI Annual Statistical Report*, 2003, table 35. SSI data are for non-institutionalized recipients.

Chart 42. SSA, Office of Disability Programs, *State Agency Operations Report*.

Chart 43. SSA, Office of Disability Programs, *State Agency Operations Report*.

Chart 44. SSA, Office of Disability Programs, 831 file. Initial DDS determinations for DI only. Does not include SSI. Percentages do not reflect effects of reconsideration, ALJ, or higher appellate decisions.

Chart 45. SSA, Office of Disability Programs, 831 file.

Chart 46. SSA, Office of Disability Programs, 831 file. Data include only initial DDS determinations for DI-only and concurrent claims. "Other" category includes denials for failure to attend a scheduled consultative examination, failure to cooperate in submitting evidence of disability, and failure to follow prescribed treatment.

Chart 47. SSA, Office of Disability Programs, 831 file. Data are for adult claims only.

Chart 48. SSA, Office of Disability Programs, 831 file. Data are for adult claims only.

Chart.49. SSA, Office of Disability Programs, 831 file. Data are for adult claims only.

Chart 50. SSA, Office of Disability Programs, *State Agency Operations Report*.

Chart 51. SSA, Office of Quality Assurance; *1995 Accountability Report*, p. III-31; ODPQ web: Federal Quality Assurance Review, Initial Disability Determinations, Regional Accuracy Rates by Decision/Documentation Return Categories, fiscal year reports; http://eis.ba.ssa.gov/odpq/reports/net_ovr.htm.

Chart 52. SSA, Office of Disability Determinations

Chart 53. SSA, Office of Disability Determinations

Chart 54. OHA Case Control System.

Chart 55. SSA, Office of Hearings and Appeals

Chart 56. SSA, Office of Hearings and Appeals

Chart 57. SSA, OHA case control system

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Chart 58. SSA, OHA case control system

Chart 59. Office of Hearings and Appeals *Annual Report*, FY 2005, pp. 9-10.

Chart 60. Office of Hearings and Appeals, *Key Workload Indicators*, FY 2005, pp. 23.

Chart 61. Office of Hearings and Appeals, *Key Workload Indicators*, FY 2005 pp.19-23.

Chart 62. SSA, Disability and Supplemental Security Income claims systems.

Chart 63. SSA, Disability and Supplemental Security Income claims systems.

Chart 64. Office of Hearings and Appeals, *Key Workload Indicator Reports*.

Chart 65. Office of Hearings and Appeals, *Key Workload Indicator Reports*.

Chart 66. SSA, Office of General Counsel docket system.

Chart 67. *Judicial Business of the United States Courts,* table C-2A.

Chart 68. *Judicial Business of the United States Courts,* table B-1A.

Chart 69. SSA, Office of Disability and Income Security Programs.

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PART TWO

Selected Aspects of Disability Decision Making

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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. The intent of the materials in Part Two of this report 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 program. We believe that the information presented here will be useful to readers of this report, and other Board reports on the disability program. (For a complete listing of SSAB publications, please refer to our website at www.ssab.gov.)

The materials provide a description of how disability determinations are made, reviewing in some detail the complex process of how adjudicators apply Social Security's definition of disability, using the agency's rules for sequential evaluation of an individual's impairment. We also include a description of the multiple steps that claimants must follow in applying for DI and SSI benefits. These steps are further complicated for those individuals who appeal their cases through the administrative and judicial appeals process.

There is also an overview of the major initiatives that the Social Security Administration has undertaken to improve the disability decision making process since our last edition of this report in 2001. Development and implementation of an electronic disability case processing system, (eDib), was accelerated in early 2002 and will facilitate several agency initiatives. In addition, the reader will find a description of SSA's Disability Service Improvement (DSI) changes designed to capitalize on the efficiencies gained from SSA's recent implementation of its electronic case processing system.

Other background information includes:

- a summary of major disability legislation;
- a chronology of significant judicial and legislative actions, and agency rules that have affected the way disability determinations are made;
- a description of the various SSA components that have substantive responsibilities in the disability process;
- a bibliography of materials related to disability; and
- a glossary that explains the terms used in this and other Board reports on disability issues.

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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. The definition is the same for adults in both the Disability Insurance (DI) program and the Supplemental Security Income (SSI) program. Children under age 18 may be found disabled under the SSI program. To be eligible, children 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.

There is no universal statutory definition of disability. There are hundreds of Federal, State, and private disability 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.

When enacted, the Social Security disability program was structured essentially as an early retirement program. Benefits were limited to those individuals aged 50 and over, computed in a manner analogous to retirement benefits, and based on a finding that the inability to work would be of a "long-lasting or indefinite duration." The underlying premise was that if a person has a disability, he or she is unemployable. This model has resulted in a definition of disability in which the primary eligibility requirement is the inability to work due to a medically determinable physical or mental impairment. While subsequent amendments removed the age limitation and established the 12-month duration requirement, the basic definition equating disability and inability to work continues.

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 5-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 5, the last step, non-medical evidence of eligibility, medical evidence, and vocational evidence are required. Each step of the sequential process requires progressively more 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 one. With the exception of SSI statutorily blind individuals, any severe or disabling impairment

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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 5 sequential evaluation steps are followed in order as shown below.

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

If the individual is working and earning an average of $860 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 and is periodically updated.

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 (or combination of impairments) does not significantly limit an 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, 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."

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

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The Listing of Impairments is a medical reference base for the determination of those physical or mental impairments which are considered severe enough to prevent an individual from working. Most of the listed impairments are permanent impairments or expected to result in death. For the other listings, the required evidence must show that the 12-month duration requirement will be, or has been met. 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: growth impairments; musculoskeletal; special senses and speech; respiratory; cardiovascular; digestive; genito-urinary; hematological; endocrine; impairments that affect multiple body systems; neurological; mental; malignant neoplastic diseases; 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 from consideration the variations of individual reaction to illness and injury. In some disorders the findings that establish the diagnosis are considered to be sufficient to establish 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 determine whether the listing is met. On the other hand, determining whether an impairment or combination of impairments is equal in severity and duration 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 the severity of the unlisted impairment are comparable in severity and in duration 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 and duration to a listed impairment.

In deciding the medical equivalence, regulations require that adjudicators consider the opinion of program physicians or psychologists. A Social Security Ruling (SSR 86-8) was issued in 1986 and was designed to clarify the application of the equals concept. Apart from a slight increase in the number of allowances made on the basis of equaling the listing in the early 1990s, the number of “equals” decisions has remained at less than 10 percent of all allowance decisions.

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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 remaining 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 all relevant evidence. The purpose of the RFC assessment is to determine the extent to which the individual's impairment(s) reduces the ability to engage in specific work-related physical and/or mental functions. This residual capacity assessment is meant to reflect the most a person can do, despite any limitations. Disability examiners may participate and have input into the RFC assessment at the initial and reconsideration level; however, regulations provide that program physicians or psychologists are responsible for the actual completion of the RFC.[7]

When establishing the 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, it could, when considered in combination with other, severe impairments, reduce the range of work an individual could do at all or prevent an individual from performing past work. Adjudicator conclusions about an individual's functional ability 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 be reasonably accepted as consistent with the medical evidence. Medical source opinions must be considered and discussed in the RFC assessment, and 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 relevant work that he or she has done in the past 15 years. At this step, the vocational

[7]In the 10 prototype DDSs, "single decision maker" disability examiners are permitted to adjudicate most cases without a mandatory concurrence by a doctor. SSI child cases and cases involving a mental impairment may not be adjudicated without a doctor's concurrence.

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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 past relevant work, the adjudicator moves on to the fifth and final step of the process.

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

At step 5, the burden is on the Social Security Administration to determine whether or not, given the individual's remaining functional abilities, there are sufficient jobs in the national economy that the person can perform. Using the RFC assessment, the adjudicator consults the Medical-Vocational Guidelines – commonly known as the vocational grids. These grids were developed to provide a framework for determining whether or not the claimant's remaining functional abilities, in combination with age, education, and work experience significantly limit the number of jobs that she/he may be capable of performing. SSA published the grids 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 will direct a finding of disabled or not disabled only when all of the applicable criteria of a specific rule are met. 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.[8]

The medical-vocational guidelines, which are based solely on strength requirements, function as reference points – or guiding principles – for cases involving severe non-exertional impairments. 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 vocational rules will not direct the conclusion of the claim. Instead, the adjudicator will use the principles of the guidelines to evaluate the relevant facts of the case. This is often a difficult area for adjudicators and results in much more subjective decision making.

When SSA developed the grids, the agency calculated 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.

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[8]On November 4, 2005, SSA published a Notice of Proposed Rulemaking that would revise the definitions of the age categories used as one criterion in determining disability. SSA proposes to raise the starting age of each age category by 2 years. In this example, the advanced age group would begin at age 57, not at age 55.

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In claims reaching this stage of the sequential process, vocational issues are the most complicated. Adjudicators primarily rely on the *Dictionary of Occupational Titles* (DOT) as well as other companion publications.[9] However, in some DDSs, disability examiners have access to a Vocational Specialist (VS) and may request assistance from the VS in a particularly difficult case. At the hearing level, the administrative law judge may request the testimony of a Vocational Expert (VE) in cases involving complicated vocational issues. If there is a conflict in the occupational information supplied by the DOT and the Vocational Specialist or Expert, the adjudicator must resolve that conflict and provide a basis for relying on the VE or VS statements rather than on the DOT information.

The percentage of DI claims awarded by State agencies on the basis of vocational factors has nearly tripled, increasing from 18 percent of all awards in 1983 to 51 percent in 2004. At the hearing level, over 80 percent of awards are based on vocational factors. Denials based on the claimant's ability to perform usual work have risen from nearly 19 percent in 1981 to 31 percent by 2004. Denials based on the ability to perform other work have increased from 11 percent in 1981 to 34.5 percent in 2004.

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[9]The *Dictionary of Occupational Titles* was last updated in 1991 and is no longer maintained by the Department of Labor. SSA, however, continues to use it as one of its sources of data about job requirements in the national economy. Although this information is fundamental to the sequential evaluation process and SSA's medical-vocational regulatory guidelines, the agency has not vigorously pursued alternatives.

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II. STEPS IN THE SOCIAL SECURITY DISABILITY APPLICATION AND APPEALS PROCESSES[10]

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 entitlement. For DI cases, these requirements include such factors as whether or not the claimant is insured for disability benefits. In SSI cases, individuals must provide proof of citizenship status and documentation of their income and resources.

The field office is also responsible for obtaining information from the claimant about her or his impairment and how it limits the ability to do work. Information about the claimant's medical sources, tests, and medications is collected, as well as information about the individual's past work, education and training. The completeness of the information on this "Disability Report" can influence whether the claimant's application is ultimately approved or denied and affects the speed with which the decision is made.

To collect more thorough information at the disability interview, SSA has developed a "disability claim starter kit." This kit is sent out in advance of the interview and provides the claimant with preparatory materials for the interview. The claimant or the representative can complete the forms and worksheets contained in the kit and mail them to the field office, or use the Internet to transmit the information to SSA. Telephone interviews and Disability Reports filed over the Internet now comprise a growing number of the applications filed. As a result, fewer applicants are actually being seen in the field offices.

DDS Role

After securing the Disability Report, the SSA field office sends it to a Disability Determination Service (DDS), a State-run agency that makes disability determinations for SSA. There, a disability examiner, using SSA's regulations, policies, and procedures, develops the relevant medical evidence and then, working with a physician and/or a psychologist, evaluates the medical and non-medical aspects of the case and determines whether the claimant is disabled under the Social Security law. While these State agencies are not under SSA's direct administrative control, SSA does provide program standards, leadership, and oversight.

The claimant is required to establish that he or she is disabled by providing medical and other evidence of a disabling condition. However, the DDS is responsible for making every reasonable effort to help the claimant get medical reports from the claimant's physicians, as well as

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[10]This section describes the disability application and appeals process in effect as of December 2005. In March 2006, the Commissioner of Social Security issued regulations that will significantly alter many of these processes. Section III of this report summarizes the changes.

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hospitals, clinics, or institutions where the person has been treated. The DDS pays a fee 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 attend a special examination called a "consultative examination," paid for by the DDS. (SSA pays the DDS for the cost of these examinations, as well as for the cost of obtaining medical reports.) This examination is particularly important in the case of applicants who may not have a current medical provider or in cases where the necessary information is not readily available. SSA requires that every reasonable effort be made to obtain the evidence from the claimant's treating sources before a consultative examination is scheduled.

In making a decision on a claim, the DDS conducts the process in an informal, non-adversarial manner. Claimants are not seen in person by the State agency adjudicators, but telephone contacts are not unusual. The claimant may present information he or she feels is helpful to the case. The information that the claimant provides and all the evidence that SSA and the State agency obtain from medical and other sources will be considered. The individual may submit the information, or it may be provided by the claimant's representative.

Once a decision is rendered, the claimant receives a written notice. The reasons for the allowance or the denial determination are stated in the notice. The claimant is also informed of the right to appeal the determination. When a claim is approved, the award letter shows the amount of the benefit and when payments start.

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) review by Federal courts. 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 of this particular claim, unless good cause can be shown for failure to make a timely request.

Reconsideration

Generally, reconsideration is the first level of appeal in the administrative review process and consists of a case review by the DDS. It 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 to supplement the information that was submitted at the time of the original determination.

If the reconsideration team concurs with the initial denial of benefits, the individual may then request a hearing before an administrative law judge.

Administrative Law Judge Hearing

Administrative law judges (ALJs) are based in the 140 hearing offices located throughout the Nation. At the hearing, claimants and their representatives may appear in person (or by

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videoconference), submit new evidence, examine the evidence used in making the determination under appeal, 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 has been submitted for consideration.

The decision making process is different between the DDSs and ALJs. That is, 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 that was not previously available to the DDS and was not considered in that determination. 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 are reversed at the hearing level.

Appeals Council Review

The final administrative appeals step is to 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 a 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 2004, 14,977 cases, or approximately 21 percent of Appeals Council decisions, were appealed to the courts.

Social Security cases comprised about 5.3 percent of the district court caseload in 2004, and it took an average of about 11 months for the courts to render decisions on Social Security appeals. The SSA appeals to district court have declined somewhat in the past few years. However, as the baby boomers enter their "disability prone" years, this workload is likely to increase.

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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. The Social Security Administration may, similarly, appeal district or circuit court decisions that are favorable to the claimant.

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III. AGENCY INITIATIVES SINCE 2001

At a hearing before the Social Security Subcommittee of the House Committee on Ways and Means in May 2002, the Commissioner of Social Security announced modifications to agency initiatives that deal with delays and backlogs in the adjudication of Social Security claims. She acknowledged concerns that the Hearings Process Improvement plan had created additional bottlenecks in the process, and also announced that several changes would be made at the hearings level including: instituting early ALJ screening to identify claims that could be decided on the record; developing a short-form for fully favorable decisions; allowing bench decisions immediately following a hearing; creating a law clerk position; ending the hearing office technician rotation requirement; expanding videoconferencing of hearings; using speech recognition technology; and digitally recording hearings. The Commissioner also announced that the 10 State prototype initiative would be modified to eliminate the claimant conference requirement, and that other elements, such as the single decision maker, would be made available nationwide. In addition, the Commissioner indicated that the agency would accelerate the development of an electronic claims folder.

In September of 2003 at another hearing before the Social Security Subcommittee, the Commissioner announced the broad outline of a "new approach" to disability adjudication. She stated that, after a period of consultation with various interested parties, she would issue a Notice of Proposed Rulemaking detailing the plans for the new approach. The notice was published in the July 27, 2005 *Federal Register* with a 90 day comment period.[11] Final regulations were published on March 31, 2006. SSA plans to to implement the new regulations gradually, region-by-region, starting with the Boston region and only after each State has fully implemented the new electronic disability process (eDib).

Electronic Disability Processing (eDib)

The new electronic disability processing system will affect all levels of the disability claims process and result in a program which, in nearly all cases, will have no paper folders. The initial application and supporting documents will be entered into the eDib system at the field office and transmitted electronically to the State Disability Determination Service. Currently, all SSA field offices are using this electronic system for initial claims and reconsiderations. There is also increased emphasis on Internet and telephone claims.

At the DDS level, the claim is received electronically and medical evidence is incorporated into an electronic folder by scanning paper evidence (locally or through the use of a remote contractor), or by receipt of electronic evidence directly from the medical providers (by fax, through a secure website, or by transmission of evidence in a native electronic format). As of the end of March 2006, 33 DDSs had fully implemented eDib to the extent that for nearly all cases electronic folders had completely replaced paper ones. The electronic folder is expected to be fully implemented in 2006. A new electronic case processing system that is integrated into SSA's eDib system has also been developed for the appeals process.

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[11] The Social Security Advisory Board submitted comments on these regulations. The Board's comments can be seen on its website: www.ssab.gov.

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The implementation of a thoroughly electronic disability claim system, including an electronic claims folder, is expected to result in many improvements to the process including:

- reduced delays in transmitting claims folders among and within offices;
- quicker receipt of medical evidence;
- substantial savings in postage and storage costs;
- elimination of time-consuming rearrangement of folder contents to meet the needs of different stages of the process;
- elimination of the problem of lost folders that can both cause delays in processing and prevent proper evaluation of prior claims;
- elimination (because of the use of digital recording) of the problem of lost or inaudible hearing tapes that can require re-hearing of cases;
- facilitation of simultaneous rather than sequential case evaluation where multiple reviews are required (for example, where a case involves both orthopedic and mental issues); and
- facilitation of case consultation or other review by individuals located remotely from the office with jurisdiction over the case.

Disability Service Improvement

The "new approach" to adjudication described in the July 27, 2005 *Federal Register* notice, and renamed Disability Service Improvement (DSI) in the March 31, 2006 final regulations has the expressed objectives of:

- reducing average disability determination processing time;
- increasing decisional consistency and accuracy;
- ensuring that the right decision is made as early in the process as possible;
- ensuring that adjudicators at every step of the process are held responsible for quality of adjudication; and
- ensuring that claimants provide all material evidence on a timely basis.

The major elements of the new approach are:

- a "quick decision" process designed to identify and approve within 20 days claims for which an allowance is obviously appropriate;
- creation of a Medical and Vocational Expert System (MVES) that would be a network of medical and vocational experts (including both Federal and State employees and consultants) to provide consultation and evaluation for claims at all levels, and the establishment of Federal standards for the qualification and payment rates for medical and vocational experts;
- replacing the reconsideration step of the appeals process (which is handled by State Disability Determination Services) with a new reviewing official step that would be handled by a Federal employee (an attorney) often in consultation with the MVES;
- replacing the Appeals Council with a Decision Review Board that would select and review a sample of hearing cases and eliminating the right of claimants who are dissatisfied with the results of a hearing to request further administrative review (except where the hearing request was dismissed without a decision and in certain other limited cases);
- the introduction of several new or modified procedural rules (including rules relating to

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the specificity and clarity of decision notices), the responsibility of adjudicators to explain how their decision relates to determinations at earlier stages, the completeness and timeliness of evidence, the bases for seeking good cause determinations (for example, for missing filing or evidence submission deadlines), and the closing of the record;

- the adoption of a new system of in-line and end-of-line quality review and increased Federal involvement in training of those involved in the adjudicatory process at all levels; and
- the establishment of a Disability Program Policy Council with representation from all components involved in the program including all levels of adjudication to make policy and procedural recommendations.

Quick Decisions – Under the DSI regulations, States will establish a quick disability determination process for those who are obviously disabled. Appropriate claims will be identified and referred directly to special units in the State agencies for expedited action. Claims will be directed to these units by the Social Security Administration on the basis of a predictive-model software screening tool that identifies claims that have a high probability of being allowed and that have readily available evidence. States would be required within 20 days either to allow these claims or reassign them to the regular adjudication system. States are required to complete State-level processing of at least 98 percent of all Quick Decision Cases within 20 days. The MVES will have to verify that there is sufficient medical evidence to support the decision.

MVES and Standards – Under the existing adjudication system, claims are jointly adjudicated by lay disability examiners employed by the State and by medical or psychological consultants who are State employees or contractors. In certain "single decision maker" States certain categories of cases are now adjudicated by disability examiners alone. Where there is insufficient medical evidence to reach a decision, States also contract with outside medical sources to conduct consultative examinations of the claimant. Some States also employ vocational specialists. At the hearing level, a consultative examination can also be requested (generally arranged and paid for by the State agency), and the administrative law judge can also utilize a medical or vocational expert (arranged and paid for by the hearing office).

The new DSI regulations will establish a Medical and Vocational Expert System that oversees a national network of medical and vocational experts. Qualification standards are to be issued by the Commissioner. State medical and vocational consultants who meet those standards may be a part of the MVES and must, in any case, meet the standards by one year after the standards are published in order for States to continue receiving reimbursement for their compensation. The MVES will be used by all levels of administrative adjudication to meet their needs for medical and vocational expertise and payment for their services will be at rates set by the Commissioner. The prototype experiment under which several States are making decisions as single decision makers (without a medical consultant signoff) will end.

Federal Reviewing Official – State Disability Determination Services will no longer provide reconsideration for claimants dissatisfied with the initial decision. Instead, claimants denied at the initial level by the State agency will have the opportunity to appeal to a Federal reviewing official. The reviewing official will make a new decision on the claim on the basis of the evidence in the file and issue a written explanation of the reasons for agreeing or disagreeing with the State agency decision. As in the existing State-level reconsideration process, there will be no face-to-face meeting with the claimant. Claimants will be permitted to submit additional

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evidence, and the reviewing official will also be able to obtain this evidence, using subpoena power if necessary. The reviewing official will affirm the original decision of the State agency, or reverse that decision. Reviewing officials will not remand cases back to the State agency but may ask the State agency to provide additional evidence or to clarify its decision. If there is new and material evidence, the reviewing official will be required to consult with a medical, vocational, or psychological expert in the MVES. Such consultation will also be required if the reviewing official's decision is to reverse the State agency denial. The introduction to the regulations indicates an intent on the part of SSA to use attorneys for the reviewing official position and to send a copy of each reviewing official decision to the State agency for quality management purposes.

Administrative Law Judge Hearing – Claimants wishing to appeal an unfavorable reviewing official decision can ask for a hearing before an administrative law judge who would make a new decision on the claim. The regulations do not modify the basic structure of the administrative law judge hearing but do propose a number of significant procedural changes. The administrative law judge will set a time and place for the hearing, and the claimant will be notified at least 75 days in advance of the hearing date. The claimant will have to submit any additional evidence to be considered at the hearing no later than 5 days prior to the hearing. Evidence can be submitted after this deadline only if certain good cause requirements are shown. The proposed regulations specifically authorize administrative law judges to require prehearing statements from the claimant, to subpoena testimony and documents, and to conduct pre- and post-hearing conferences (generally by telephone). Failure to appear at these conferences could result in a dismissal. The administrative law judge would be required to include in the decision a discussion of why it accepted or differed from the decision of the reviewing official. The introduction to the regulations indicates that this discussion would be used to provide feedback to the reviewing official.

Decision Review Board – Under current regulations, claimants who are dissatisfied with the results of a hearing may request a review of the hearing decision by the Appeals Council. The Council may accept or decline the request for review. The Council may also, on its own motion, decide to review hearing decisions including decisions that were unfavorable to the claimant and decisions that were favorable. Under the new regulations, claimants would no longer have the right to request an administrative review of the hearing decision. Instead, the Appeals Council would be replaced by a Decision Review Board (DRB) that would select the cases (both allowances and denials) to review. The DRB could also review, for the purpose of clarifying policy, cases that deal with problematic issues. The DRB would be composed of administrative law judges and administrative appeals judges.

Between 60 thousand and 70 thousand hearing cases each year are dismissed without a hearing decision for a variety of reasons such as failure of the claimant to appear or cooperate, late filing, or absence of an issue appropriate for a hearing. Dismissals are not subject to appeal to the court, but claimants currently have the right to ask the Appeals Council to review the dismissal. If the administrative law judge dismisses the request for a hearing, the claimant would have 30 days from the notice of dismissal to ask the administrative law judge to vacate the dismissal. If the administrative law judge upholds the dismissal, the claimant could ask for a review by the Decision Review Board.

The *Social Security Act* provides that claimants may seek relief in Federal District Court if they are dissatisfied with the final decision of the Commissioner after exhausting the

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administrative appeals available. Under the prior regulations, the decision becomes eligible for appeal to the court when the Appeals Council has made an adverse decision on the case or has rejected the claimant's request for Appeals Council review. Under the new regulations, the administrative law judge's decision will be the final decision of the Commissioner unless the Decision Review Board selects the claim for review. If the Decision Review Board selects the claim for review, it must reach a decision within 90 days of notifying the claimant that it has taken jurisdiction. If it does not reach a decision within 90 days, the administrative law judge's decision becomes final and subject to appeal to the court.

Closing of the Record – Under current regulations, new evidence can be introduced at any point in the administrative adjudication process with the exception that, at the Appeals Council level of review, the evidence must relate to the claimant's eligibility for periods prior to the date of the hearing decision, and must be new and material. At the court level, the statute permits the court to admit new and material evidence but only if there is good cause for its not having been previously provided.

The new regulations would generally require evidence to be submitted by 5 days prior to the date of the hearing Exceptions would be made only if the claimant is unable (for specified "good cause" reasons) to submit the evidence by the deadline No new evidence can be submitted once the Decision Review Board decides to review an ALJ decision. Claimants may submit a statement indicating why they disagree with the hearing decision. If the Decision Review Board finds that the ALJ decision is not supported by substantial evidence, it will remand the case to the ALJ for further development. Courts would continue to be allowed to accept new and material evidence on a good cause basis since that is authorized by statute.

Reopening – Once a decision on a Social Security claim has become final it is not subject to revision, but, under certain specified conditions, a "final" claim can be reopened. Under current regulations, a final decision can be reopened for any reason within 12 months of the initial decision and within 4 years for certain good cause reasons, including new and material evidence. The decision can be reopened at any time for more limited reasons such as when evidence indicates that fraud was involved, or if the issue relates to the crediting of wages. The new regulations retain existing re-opening rules except that the final ALJ hearing decision can be re-opened for good cause only within six months of the hearing decision, and new and material evidence will not constitute good cause for re-opening the hearing decision.

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IV. MAJOR SOCIAL SECURITY ACT DISABILITY LEGISLATION

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 designed for "aid to the permanently and totally disabled." Aid in this case meant "money payments to, or medical care on behalf of, or any type of remedial care recognized under State law in behalf of" 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) and 1952 (P.L. 590, 82nd 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 defined as the "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. (A similar freeze provision was enacted into law in the 1952 Social Security amendments but expired before it went into effect. That legislation defined disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment "which can be expected to be permanent," or blindness.)

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 found 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."

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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.

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 that are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."

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

The Federally-aided State programs of aid to the aged, blind and disabled were replaced by 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. States were permitted to provide supplementary payments, administered either by the states or by SSA.

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 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 to partially or completely take over from a State DDS the function of making disability determinations if the DDS failed to follow Federal regulations and guidelines or if the State no longer wished 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 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 expeditious re-entitlement to benefits for individuals whose attempts to return to work prove unsuccessful. The amendments also included temporary authority for return-to-work demonstration projects. This authority was extended several times.

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

These amendments required that beneficiaries found to be no longer eligible be given the opportunity for an evidentiary hearing at the reconsideration level. In addition, the amendments provided for the continuation of benefit payments during appeal of a termination decision through the ALJ level. These provisions were adopted on a temporary basis and were extended several times and ultimately made permanent.

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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 on the use of subjective evidence of pain as well as on the state of the art of preventing, reducing or coping with pain. The Secretary was also required to establish uniform standards for determining disability that would 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 a continuation of the provisions relating to face-to-face reconsiderations in continuing disability reviews and payments during appeal. The amendments added a new requirement for a pre-review notice to beneficiaries informing them that their continuing eligibility was being reexamined.

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 unfavorable determinations should be reviewed to ensure a high degree of accuracy. This legislation also made permanent the provisions for continued payment during appeal of adverse continuing disability reviews.

Benefits for Drug Addicts and Alcoholics were restricted in 1994 (P.L. 103-296) and subsequently eliminated in 1996 (P.L. 104-121)

Following widespread 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.[12] Congress consequently placed restrictions on benefit eligibility for addicts and alcoholics in 1994. These restrictions included: requiring the 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.

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[12] U.S. General Accounting Office. *Social Security: Major Changes Needed for Disability Benefits for Addicts*. HEHS 94-128. May 1994.

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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), a stricter definition of eligibility for childhood disability benefits was enacted. This new standard provided that the child have "a medically determinable physical or mental impairment which results in marked and severe functional limitations." Individual functional assessments were eliminated, as was the 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* (TWWIIA) created a program under which Social Security and SSI disability beneficiaries could receive a ticket with which to obtain vocational rehabilitation and other employment support services from providers of their choice.

It also 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. The Ticket Act expanded state authority originally granted under the 1997 *Balanced Budget Act* to provide Medicaid coverage to working people with disabilities who, because of income and assets, would not otherwise qualify for Medicaid coverage. This program is commonly referred to as "Medicaid Buy-in" because working individuals pay a premium for Medicaid coverage. TWWIIA also provided for several demonstration projects including one to examine the effect of a benefit reduction of $1 for each $2 of earnings for DI beneficiaries.

Social Security Protection Act of 2004, (P.L. 108-203)

The *Social Security Protection Act of 2004* included a wide variety of provisions, some of which were related to the work incentives and assistive services stemming from the T*icket to Work and Work Incentives Improvement Act of 1999*. These included a technical amendment to the Ticket Act, expanded waiver authority in connection with demonstration projects and mandated that SSA issue a receipt to disabled beneficiaries each time they report their work and earnings. The Act also allows Benefits Planning, Assistance and Outreach (BPAO) services and Protection and Advocacy (P&A) services to be provided to beneficiaries in SSI 1619(b) States, those individuals receiving a (SSI) State supplement payment, and those that are in an extended period of Medicare eligibility.

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V. CHRONOLOGY OF SIGNIFICANT JUDICIAL, LEGISLATIVE, AND AGENCY ACTIONS THAT HAVE AFFECTED THE DISABILITY ADJUDICATION PROCESS

Following is a chronology of major court cases, legislation and agency regulations and rulings that have affected the way disability determinations are made. Over the years, there have been a variety of external factors that have affected 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. The *Equal Access to Justice Act of 1980* (EAJA), 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 has had an impact on court case activity. In a large portion of district court cases that are lost by the agency, a fee petition under EAJA is filed and settled.

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 was limited in the same way as the applicant. The change in the burden of proof gradually crept into all levels of disability adjudication over the next 5 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, 4 other circuit courts of appeals had issued similar holdings.

1965 Appeals courts in 2 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 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 appealed 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." In the 1967 amendments, 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.

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

1975 In *Cardinale v. Mathews*, the District Court for 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 of a showing of good cause when remanding cases at the request of the agency and a requirement, in the case of court remands for additional evidence, 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 regulations. 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 to be contrary to Fourth Circuit law and enjoined the agency from refusing to follow the law of the circuit.

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By the end of 1984, 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. This 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. These rulings were binding only on the administrative law judges.

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 when denying benefits based on a non-severe impairment at step 2 of the sequential evaluation process.

The Commission on Pain (established in 1984) 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 that research was completed.

1988 SSA issued a new ruling on pain that 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.

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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.

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

Several circuit courts overruled the provision of law that required that widow(er)s had to meet or equal the medical listings. In the *1990 Reconciliation Act*, Congress settled the matter by providing that widow(er)s would have the same eligibility requirements as workers, and thus would be evaluated under the full 5 steps of sequential evaluation in order to determine eligibility 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 utilized 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 the credibility of an individual's statements; 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 77,717 cases would be re-adjudicated by the agency under the 1991 regulations.

1996 SSA issued a set of 9 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.

1997 Following the enactment of the *Personal Responsibility and Work Opportunity*

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Reconciliation Act of 1996 (PRWORA), SSA issued interim final rules to implement the childhood disability provisions. In accordance with the statutory amendments, the interim final rules modified the 1990 *Zebley* decision and deleted references to the former standard of "comparable severity." Other revisions to the rules, including the elimination of the individualized functional assessment and the deletion of references to "maladaptive behavior," were made as well. The interim final rules defined the statutory standard of "marked and severe functional limitations" in terms of "listing-level severity," i.e., an impairment that meets, medically equals, or functionally equals the severity of an impairment in the Listing of Impairments.

2001 SSA published final rules to implement the childhood disability provisions of the PRWORA. The final regulations continued to define the statutory standard of "marked and severe functional limitations" as being marked limitations in two areas of functioning or an extreme limitation in one area, but they renamed and reorganized the broad areas of functioning (called "domains"). The final rules also added a new domain, "health and physical well-being."

2002 In *Barnhart v. Walton*, the Supreme Court held that SSA's interpretation of the statutory definition of disability, which requires that a claimant's impairment related inability to work must last, or be expected to last, 12 months, was based upon a lawful construction of the statute and entitled to deference. The Court also upheld SSA's regulation precluding a finding of disability when a claimant returns to work within the 12 month period after onset of an impairment and prior to the agency making the initial decision on the application.

2003 In *Barnhart v. Thomas*, the Supreme Court held that SSA's determination that a claimant was not disabled because she could return to her previous work, without investigating whether or not the previous work existed in significant numbers within the national economy, was a reasonable interpretation of the *Social Security Act* and was entitled to deference.

In the class action case of *Encarnacion v. Barnhart*, the Second Circuit Court of Appeals held that the Commissioner's regulations requiring consideration of the combined impact of a child's impairments are consistent with the Act. The Court stated that SSA's policy of considering the impact of combined impairments within domains, but not across domains, when determining marked and severe functional limitations in children, was not a "plainly erroneous procedure."

2004 SSA published a final rule designed to conform existing Medicare eligibility regulations to a change made by the *Ticket to Work and Work Incentives Improvement Act of 1999*. The change allows for working disabled individuals, who engage in substantial gainful activity (SGA) after completing a trial work period, to receive continued Medicare entitlement for 78 months, an increase of 54 months beyond the previous limit of 24 months.

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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 components and their responsibilities in the disability process.

Office of the Commissioner

- The Commissioner is directly responsible for all programs administered by SSA, including the disability programs. She provides executive leadership to SSA. Among other things, her office is responsible for development of disability policy, administrative and program direction, and program interpretation and evaluation. The Commissioner is responsible for ensuring to the public, the Congress, and the President that the disability programs are working as the law requires.
- The Executive Director for Disability Service Improvement reports directly to the Commissioner and serves as an advisor to the Commissioner on new initiatives for the disability program and helps draft legislation for these new initiatives.

Office of Operations

The Office of Operations oversees the operation of SSA's field and regional offices, as well as several other components that provide support to the field structure. The organizations listed here are the public face of SSA.

- ***Field office*** employees take disability claims, provide information to claimants and potential claimants, and meet with the public to provide information about the disability programs.
- ***Regional offices*** have oversight responsibilities for the DDSs in their regions. They are the primary liaison between SSA and the DDSs. Some of their duties include: managing DDS workload and budget issues, providing support to DDS automation activities, and monitoring DDS performance. In addition, they also answer field office and DDS questions.
- ***The Office of Central Operations*** (OCO) processes certain disability claims and maintains disability beneficiary rolls after entitlement. OCO is responsible for the adjudication of disability claims filed by persons in foreign countries.
- ***The Office of Disability Determinations*** (ODD) is SSA's lead component for State DDS workload and budget. By working closely with the regional offices, ODD provides guidance and oversight of the national disability workload and budget. Its responsibilities include:
  - Developing and submitting budget proposals to SSA's Office of Budget for disability programs, initiatives, and mandates. This includes developing budgets for DDS operations and automation activities, based on DDS submissions.

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- Planning, coordinating, and managing systems-related activities for DDS automation initiatives, including the development of user specifications.
- Analyzing, planning, distributing, and monitoring all DDS funding on a State-by-State basis including establishing and monitoring workload and productivity targets for each DDS.
- Operating a fully functioning Federal Disability Determination Services that processes DDS workloads on a temporary or transitional basis and also evaluates the impact of policy and procedural changes in DDS operations.

Office of Disability and Income Security Programs

The staff components of the Office of Disability and Income Security Programs carry much of the responsibility for program policy of the disability programs. Those offices and their responsibilities include:

- ***Office of Income Security Programs***
  - The Office of Income Security Programs develops, coordinates and promulgates Retirement and Survivors Insurance and Supplemental Security Income policies, as well as non-medical administrative policies that affect the adjudication of disability claims. It plays an important role in the disability program in that many individuals who file for retirement benefits also file for disability, and most individuals who apply for SSI are disabled.
  - The office develops agreements with States and other agencies that govern State supplementation programs and Medicaid eligibility. Additionally, OISP plays an important role as SSA's lead for coordinating Medicare issues with the Centers for Medicare and Medicaid Services.

- ***Office of Disability Programs***
  - This office plans, develops, evaluates, and issues the policies and procedures for the disability program. This includes providing guidance to the medical personnel working in central and regional offices as well as in the DDSs.
  - It coordinates and provides policies, procedures, and process requirements in support of the electronic disability process (eDib).
  - The office conducts data analyses and develops studies to identify areas where policy clarification is needed.
  - It develops training programs for disability adjudicators.

- ***Office of Employment Support Programs***
  - The Office of Employment Support Programs develops and administers policies that are designed to promote the employment of beneficiaries with disabilities. In addition, OESP is responsible for the implementation of legislation related to employment support programs.
  - The office provides operational advice, technical support and direction to central office, regional office, and field components in the implementation of employment support programs.
  - It provides assistance in educating the public about disability program work incentives, rehabilitation, and other forms of employment support.

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- ***Office of Program Development and Research***

  The Office of Program Development and Research provides broad program analysis and development in support of the disability programs. The office carries out its mission by:
  - Directing studies of program policy issues related to the development and evaluation of disability program initiatives and legislative and policy proposals.
  - Identifying trends in the disability programs and compiling and analyzing data on aspects of the programs.
  - Designing, implementing, and evaluating disability demonstration projects that target special populations and program issues.

- ***Office of International Programs***
  - Staff in this office develop and implement policies and coordinate activities relating to the operation of Social Security programs (including the disability programs) outside of the United States.
  - OIP negotiates and administers international Social Security agreements which include the disability program.
  - The office provides training programs and technical consultation on Social Security programs, including the disability program, to Social Security officials and other experts outside of the United States.

Office of Disability Adjudication and Review

The Office of Disability Adjudication and Review provides the mechanisms by which individuals and organizations dissatisfied with determinations affecting their rights to and amounts of benefits may administratively appeal these determinations.

- The ***Office of the Chief Administrative Law Judge*** manages and administers the nationwide network of hearing offices and supporting regional offices. The Chief Administrative Law Judge maintains channels of communication between the Deputy Commissioner and the Regional Chief Administrative Law Judges and the ALJ corps.
- The ***Office of Appellate Operations*** consists of the Appeals Council and its support staff.
- The ***Office of Policy, Planning and Evaluation*** plans, analyzes, and develops policy for the disability adjudication and review process.

Office of Quality Performance

The Office of Quality Performance directs the development of the agency quality management program, including in-line and end-of-line quality performance management. It works with other components to direct the agency-wide quality performance management program. It also provides oversight for SSA's computer matching operations.

- The ***Office of Quality Control*** reviews, evaluates, and assesses the integrity and quality of the administration of SSA programs. It assesses the review of claims by the State DDSs, the Federal reviewing officials, the hearing offices, and the disability review boards. It recommends corrective changes in programs, policies, procedures, or legislation aimed at quality and productivity improvement or program simplification.

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- The ***Office of Continuous Improvement*** promotes the sharing of information across organizational boundaries that allows managers to make informed decisions. It identifies and addresses emerging quality issues and works with operating components to implement and facilitate quality improvements at all levels.
- The ***Office of Quality Data Management*** serves as a clearinghouse for quality data management activities.

Office of Budget, Finance, and Management

- The ***Office of Budget*** prepares budgets and full-time equivalent allocations for all components within SSA, as well as for the DDSs.
- With input from other SSA components, the ***Office of Acquisition and Grants*** prepares and manages contracts and grants for research projects, and other initiatives that that relate to disability.
- The ***Office of Facilities Management*** manages office space and file storage facilities on behalf of the agency. This includes field offices, hering offices, and the program service centers where retirement, survivors and disability claims are processed.

Office of the Chief Actuary

- 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 drafting policy statements.

Office of the Chief Information Officer

- The Office of the Chief Information Officer develops the Information Resource Management Plan and defines the Information Technology vision and strategy for the Social Security Administration, which includes systems that operate the disability programs.
- The office shapes the application of technology in support of SSA's Strategic Plan. This is done with an eye on the future information technology needs of the Social Security programs, including the disability programs. The office provides oversight of major information technology acquisitions to ensure they are consistent with SSA architecture and with the budget, and is responsible for the development of SSA information technology security policies.

Office of the Chief Strategic Officer

- This office coordinates with all SSA components to develop and manage SSA's Strategic Plan, which includes initiatives for the disability programs.
- It also directs the development of SSA's Annual Performance Plan and Annual Performance Report, and tracks SSA performance in relation to established performance measures, including disability program goals.

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Office of Communications

- The Office of Communications produces pamphlets, booklets, fact sheets, videos, and information kits about disability benefits.
- The office is the primary liaison with the press, other government and non-government agencies, and disability advocates on issues relating to SSA's activities.
- It responds to Congressional and White House correspondence and public inquiries on a variety of program issues, including requests from individuals regarding their claims for disability benefits.

Office of the General Counsel

- 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.
- The office advises the Commissioner on legal matters, including ones involving the disability program, and is responsible for providing all legal advice to the Commissioner, Deputy Commissioner, and all subordinate organizational components (except the Office of the Inspector General) of SSA regarding the operation and administration of SSA.

Office of Human Resources

- The Office of Human Resources is responsible for personnel services for the components that handle disability issues.
- It plans and produces training on disability and non-disability issues.

Office of Legislation and Congressional Affairs

- This office serves as the focal point for all legislative activity in SSA, including those related to the disability programs. It analyzes legislative and regulatory initiatives and develops specific positions and amendments.
- With input from other SSA components, the office develops legislative proposals regarding the disability programs. It is responsible for briefing Congressional staffs on SSA's proposals and responding to questions raised about the disability programs.
- The office answers questions from other SSA components regarding disability legislation. It provides advisory service to SSA officials on legislation of interest to SSA pending in Congress.
- It responds to other government organizations (e.g., the White House) about disability issues.

Office of Policy

- 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 and evaluates data for planning and other information purposes.

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Office of Systems

- The Office of Systems coordinates the planning and implementation of SSA's computer infrastructure, software development, and electronic service delivery.
- It is responsible for the development of eDib (an agency-wide disability case processing system) and for the design and implementation of the electronic claims file.
- SSA's telecommunications network services all components, including the DDSs, by providing electronic transmission of mission critical instructions, broadcasts, and administrative messages.

Office of the Inspector General

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

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As ongoing sources of information and data on the Social Security disability programs, we recommend the following websites:

- Social Security Advisory Board: www.ssab.gov
- Disability Research Institute: www.dri.uiuc.edu/
- SSA Office of Policy: www.ssa.gov/policy/
- SSA Office of the Chief Actuary: www.ssa.gov/OACT

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Glossary

Administrative law judge (ALJ): SSA Administrative law judges 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 time limits and in the following order: 1) 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 for an independent reexamination of her/his case. 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 agree to or reject the request for review and may also initiate a review on its own motion. Individuals who disagree with a final administrative decision may pursue their appeals through the Federal District Court, the Circuit Court of Appeals, and the Supreme Court. See the description of Disability Service Improvement in the section titled "Agency Initiatives Since 2001" for a discussion of changes that will be made in the administrative review process.

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 that makes the final decision in the administrative review process. See administrative review process.

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

Average: Values shown as averages in this chart book are arithmetic means.

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.

Consultative examination (CE): A physical or mental examination purchased by SSA from a treating source or another medical source. The examination is usually purchased when the claimant's medical sources cannot or will not provide SSA with sufficient medical evidence about the individual's impairment.

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Continuing disability review: A periodic reevaluation of a disabled beneficiary's impairments to determine if the person is still disabled within the meaning of the law. See medical improvement review standard.

Conversion: The simultaneous cessation of payment of a specific type of benefit and a switch over to 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.

Decision Review Board (DRB): As part of Disability Service Improvement, the Decision Review Board will be phased in as a replacement for the Appeals Council in the administrative review process. The DRB will select and review a sample of hearing cases. With some exceptions, claimants who are dissatisfied with the results of a hearing will not be able to request administrative review by the DRB.

Decisional accuracy: SSA measures the accuracy of DDS initial decisions through a quality assurance review process. This process randomly samples DDS decisions to capture 70 initial allowances and 70 initial denials per quarter for each DDS. The accuracy rate is based on the percentage of cases sampled that have neither a decisional deficiency (where the case file contains sufficient documentation to support an opposite decision) nor a documentation deficiency (where the medical documentation in file is not sufficient to support any disability determination).

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

DI worker: An individual entitled to Disability Insurance benefits based on her/his own earnings record.

Disability: For purposes of Title II (OASDI) benefits and of 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 which makes the initial and reconsideration determination of whether or not a claimant is disabled or a beneficiary continues to be disabled within the meaning of the law.

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Disability examiner: An employee of a State DDS who collects and analyzes medical evidence and, in conjunction with a medical professional, makes the determination on a claimant's disability.

Disability Service Improvement (DSI): The new approach to disability adjudication put into effect by regulation on March 31, 2006. Disability Service Improvement will be implemented in SSA's Boston region in August 2006 and is expected to be implemented in all of SSA's regions over a period of about 5 years.

Duration: To be eligible for benefits, a claimant must have a disabling impairment that has lasted or is expected to last for a continuous period of at least 12 months or to result in death. See sequential evaluation process.

eDib: SSA's electronic disability case processing system that allows the agency to process claims in a fully electronic environment. Paper copies of any evidence or documents are converted to and stored in an electronic format.

Equals the listing: A step in the sequential evaluation process. An impairment may be found to be "medically equivalent" to an impairment(s) found in the Listing of Impairments if the relevant medical signs, symptoms, and laboratory findings are equal in severity to those of a listed impairment. See sequential evaluation and Listing of Impairments.

Examiner: See Disability examiner.

Federal Reviewing Official: As part of Disability Service Improvement, attorneys will function as Federal Reviewing Officials and will review the initial determination upon the request of the claimant. This review replaces the reconsideration step of the administrative review process.

Hearing: The level following reconsideration in the administrative review process. The hearing is a *de novo* procedure at which the claimant and/or the 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 140 offices around the country where hearings are held.

Incidence: 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 in a given year per 1,000 persons insured for disability benefits.

Listing of Impairments: The Listing of Impairments contains specific medical findings that either establish a diagnosis or confirm the existence of an impairment. The Listing of Impairments is divided into 2 parts—Part A describes, for each major body system, impairments that are considered severe enough to prevent an adult from doing any gainful activity. Part B contains additional criteria that apply only to the evaluation of impairments of persons under the age of 18. 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. See sequential evaluation.

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Medical and Vocational Expert System: Part of Disability Service Improvement, a network of medical and vocational experts to provide consultation and evaluation for claims at all levels.

Medical expert (ME): A physician or mental health professional who provides impartial expert opinion at the hearing level of the SSA disability claims process.

Medical improvement review standard: The evaluation criteria used to determine whether or not a beneficiary continues to be disabled. Medical improvement will be found when there is a decrease in the medical severity of a beneficiary's impairment and that decrease is related to the ability to work. See continuing disability review.

Meets the listing: A step in the sequential evaluation process. When the specific medical findings in a particular listing are documented by the required medical signs, symptoms, and laboratory findings, then the individual will be found to meet the relevant listing. See sequential evaluation process and Listing of Impairments.

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 total number of persons receiving benefits per 1,000 of a specified population. For DI benefits, the prevalence rate is the total number of beneficiaries per 1,000 persons insured for disability benefits.

Quick Disability Determinations: A process, part of Disability Service Improvement, designed to identify and approve within 20 days claims for which an allowance is obviously appropriate.

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 additional evidence and information that the claimant or the representative may submit in connection with the reconsideration. This determination is made by a different adjudicative team from the one who made the original determination. See administrative review process.

Sequential evaluation process: The 5-step process used in determining whether an individual meets the definition of disability in the law. 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 ends, with a finding that he or she is not disabled. 2) Medical severity—If it is determined that the claimant's medical impairments do not significantly limit the ability to perform basic work activities, the process ends, with a finding that he or she is not disabled. 3) Listing of Impairments—If a claimant has an impairment that meets the criteria listed in the regulations, or has an impairment or combination of impairments that is medically equivalent, the process ends, with a finding that he or she is 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, the process ends, with a finding that 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, otherwise he or she is found not disabled. See also duration.

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Supplemental Security Income (SSI): Supplemental Security Income, Title XVI of the *Social Security Act*, is a Federal program that provides benefits to low-income aged, blind, and disabled individuals whose income and asset do not exceed specified limits.

State agency: A common term for Disability Determination Services.

Substantial gainful activity: A level of work or earnings that makes an individual ineligible for disability benefits.

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 the normal retirement age, or recovery from their disabling condition.

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

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

Vocational expert (VE): A professional expert on the availability and occupational requirements of jobs in the labor market who provides impartial expert opinion at the hearing level of the SSA disability claims process.

Zebley: The Supreme Court's *Sullivan v. Zebley* decision ruled that SSA's policy regarding disability determinations for children in the Supplemental Security Income (SSI) program 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. In 1997, Congress enacted legislation establishing a new definition of disability for SSI children that eliminated the individualized functional assessment and replaced it with a statutory standard of "marked and severe functional limitations."

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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 the 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 1 from the same political party) by the Speaker of the House (in consultation with the Chairman and the 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 statute provides that the initial members of the Board serve terms that expire over the course of the first 6-year period. The Board currently has 2 vacancies. 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.

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.

Hal Daub, Chairman

Hal Daub is currently a partner in the law firm of Blackwell Sanders Peper Martin in Omaha, Nebraska and Washington, D.C. Previously, he was President and Chief Executive Officer of the American Health Care Association and the National Center for Assisted Living. He served as Mayor of Omaha, Nebraska from 1995 to 2001, and was an attorney, principal, and international trade specialist with the accounting firm of Deloitte & Touche from 1989 to 1994. Mr. Daub was elected to the U.S. Congress in 1980, and reelected in 1982, 1984, and 1986. While there he served on the House Ways and Means Committee, the Public Works and Transportation Committee, and the Small Business Committee. In 1992, Mr. Daub was appointed by President George H.W. Bush to the National Advisory Council on the Public Service. From 1997 to 1999, he served on the Board of Directors of the National League of Cities, and from 1999 to 2001, he served on the League's Advisory Council. He was also elected to serve on the Advisory Board of the U.S. Conference of Mayors, serving a term from 1999 to 2001. From 1971 to 1980, Mr. Daub was vice president and general counsel of Standard Chemical Manufacturing Company, an Omaha-based livestock feed and supply firm. A former U.S. Army Infantry Captain, he is a Distinguished Eagle Scout, 33rd Degree Mason, is active in the Salvation Army, Optimists International and many other charitable and philanthropic organizations. He is the current chairman-elect of the Community Health Charities of America. Mr. Daub is a graduate of Washington University in St. Louis, Missouri, and received his law degree from the University of Nebraska. Term of office: January 2002 to September 2006.

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Dorcas R. Hardy

Dorcas R. Hardy is President of DRHardy & Associates, a government relations and public policy firm serving a diverse portfolio of clients. After her appointment as Assistant Secretary of Human Development Services, Ms. Hardy served as Commissioner of Social Security from 1986 to 1989 and was appointed by President Bush to chair the Policy Committee for the 2005 White House Conference on Aging. Ms. Hardy has launched and hosted her own primetime, weekly television program, "Financing Your Future," on Financial News Network and UPI Broadcasting and "The Senior American," an NET political program for older Americans. She speaks and writes widely about domestic and international retirement financing issues and entitlement program reforms and is the author of *Social Insecurity: The Crisis in America's Social Security System and How to Plan Now for Your Own Financial Survival*, Random House, 1992. Ms. Hardy consults with seniors' organizations, public policy groups and businesses to promote redesign and modernization of the Social Security, Medicare and disability insurance systems. Additionally, she has chaired a Task Force to rebuild vocational rehabilitation services for disabled veterans for the Department of Veterans Affairs. She received her B.A. from Connecticut College, her M.B.A. from Pepperdine University and completed the Executive Program in Health Policy and Financial Management at Harvard University. She is a Certified Senior Advisor and serves on the Board of Directors of The Options Clearing Corporation, Wright Investors Service Managed Funds, and First Coast Service Options. First term of office: April 2002 to September 2004. Current term of office: October 2004 to September 2010.

Barbara B. Kennelly

Barbara B. Kennelly became President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare in April 2002 after a distinguished 23-year career in elected public office. Mrs. Kennelly served 17 years in the United States House of Representatives representing the First District of Connecticut. During her Congressional career, Mrs. Kennelly was the first woman elected to serve as the Vice Chair of the House Democratic Caucus. Mrs. Kennelly was also the first woman to serve on the House Committee on Intelligence and to chair one of its subcommittees. She was the first woman to serve as Chief Majority Whip, and the third woman in history to serve on the 200-year-old Ways and Means Committee. During the 105th Congress, she was the ranking member of the Subcommittee on Social Security. Prior to her election to Congress, Mrs. Kennelly was Secretary of the State of Connecticut. After serving in Congress, Mrs. Kennelly was appointed to the position of Counselor to the Commissioner at the Social Security Administration (SSA). As Counselor, Mrs. Kennelly worked closely with the Commissioner of Social Security, Kenneth S. Apfel, and members of Congress to inform and educate the American people on the choices they face to ensure the future solvency of Social Security. Mrs. Kennelly served on the Policy Committee for the 2005 White House Conference on Aging. Mrs. Kennelly received a B.A. in Economics from Trinity College, Washington, D.C. She earned a certificate from the Harvard Business School on completion of the Harvard-Radcliffe Program in Business Administration and a Master's Degree in Government from Trinity College, Hartford. Term of office: January 2006 to September 2011.

David Podoff

David Podoff was a senior advisor to the late Senator Daniel Patrick Moynihan on Social Security and other issues while serving as Minority Staff Director and Chief Economist for the Senate Committee on Finance. While on the Committee staff 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, the Finance Committee he was a Senior Economist with the Joint Economic Committee and

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directed various research units in the Social Security Administration's Office of Research and Statistics. He has taught economics at the Baruch College of the City University of New York, 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 J. Schieber is Vice President/U.S. Director of Benefits Consulting 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. First term of office: January 1998 to September 2003. Current term of office: October 2003 to September 2009.

Members of the Staff

Joe Humphreys, Staff Director
Katherine Thornton, Deputy Staff Director

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Beverly Rollins
George Schuette
Jean Von Ancken
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