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DISABLED YET DENIED: BUREAUCRATIC INJUSTICE IN THE DISABILITY DETERMINATION SYSTEM

STAFF REPORT

TO THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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PREFACE

Determining if a citizen is disabled for purposes of the Social Security and Supplemental Security Income programs is among the most difficult and sensitive tasks of the Federal Government. Mistakes can have tragic consequences, exposing people who have worked their whole lives until becoming disabled to dire circumstances. While the system must respond to the needs of individuals with disabilities, it cannot afford to casually award benefits without careful scrutiny.

An investigation by the Special Committee on Aging revealed that the disability determination system, administered by the Social Security Administration, is erring on the side of bureaucratic injustice: individuals who are disabled are being denied benefits. Many of those denied, rightly or wrongly, simply accept the decision and seek the assistance of family and friends. Others, convinced that they are disabled with nowhere else to turn, appeal unfavorable decisions, only to wait months or years to win their benefits. The purpose of this study is to uncover why this unacceptable situation occurs and what can be done to remedy the problems.

Sixty-four-year-old Mrs. Rita Hartley testified at an Aging Committee hearing in July 1990, that her body wasted away without food or medical care while awaiting benefits on appeal. Fifty-seven-year-old Ms. June Herrin testified that she became homeless and slept in the back of her car on cold winter nights while appealing her denial of benefits. She won her appeal 16 months later, after three separate rejections by SSA. All this followed a heart attack and three heart-related trips to the hospital. Her words tell it best: "Because the system let me down, it forced me into the streets. I've worked and paid taxes all my life. I've been a good citizen. But the government forgot about me and it hurts." These stories are not merely anecdotes. They are symbols of a system that has lost touch with its humanity.

Becoming disabled is often a part of the aging process. The Social Security Disability Insurance program was originally conceived to provide a partial replacement for the earnings of individuals over age 50 lost due to the onset of a disability. Since the early years of the program, it has grown to encompass much broader purposes. Under the Supplemental Security Income program, benefits are now payable to disabled children, and workers under age 50 may now qualify for benefits under the Social Security Disability program. Accordingly, the fate of all generations have become interdependent through the disability programs administered by SSA.

We became deeply concerned that our investigation identified a severe budget crisis facing the Disability Determination Services (DDS's), which are administered by the States for SSA. The majority of State DDS directors stated in a survey that they had inadequate funds to perform their duties properly. Budget shortfalls

forced the DDS's to take shortcuts, delay responses, and go without needed medical evidence which might help them make fairer decisions.

Unfortunately, the impact of staffing reductions implemented during the 1980's, inadequate budgetary resources and the sheer administrative complexity of the disability determination process have left the system unable to properly fulfill its mission. When these factors are considered, and combined with the impact of a recent Supreme Court decision requiring SSA to reevaluate hundreds of thousands of children's disability claims—claims which the Court ruled SSA had unjustly denied in the first place—the threat looms of the entire disability determination process becoming overwhelmed. These factors are resulting in increased delays and errors for individuals of all ages applying for benefits.

Our primary recommendation is that SSA establish a system for interviewing applicants on a face-to-face basis to solicit information and improve the accuracy of decisions. This should be accompanied by an elimination of the reconsideration stage of the appeals process, which many experts have argued is extraneous and only serves to lengthen the process unnecessarily. Given the current budget problems, however, SSA is in no position to implement new responsibilities. While eliminating a step in the bureaucracy might go part of the way toward making funds available for face-to-face interviews, new resources will be required to restore the fairness that Congress originally intended when enacting the disability programs.

This report was prepared by the majority and Republican staffs of the Special Committee on Aging. We would like to thank Wendy Taylor, Jonathan Adelstein, David Barnhart, Diane Braunstein, and Janice Fiegener who participated in drafting the report, and the numerous outside experts who assisted in reviewing the drafts.

Much work remains before us to improve the disability determination system. The system has been the subject of intensive study and recommendations by an array of experts. This study joins their voices in calling for reform. We must not allow our citizens to suffer deprivation while waiting for the government to undo its mistakes. We must make better decisions at the early stages of the disability determination process so as to prevent people who are disabled from being denied benefits to which they are rightfully entitled.

Sincerely,

DAVID PRYOR,
Chairman.
JOHN HEINZ,
Ranking Republican Member.

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EXECUTIVE SUMMARY

Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) are the primary government disability programs that protect those individuals who can no longer support themselves through work. An investigation by the Special Committee on Aging identified longstanding problems with the system which determines if an individual should qualify for disability benefits. It also revealed that these problems have grown so large that they threaten to overwhelm the disability determination system. The system's longstanding flaws have been severely exacerbated by budget shortfalls, unanticipated workloads, and administrative shortcomings.

This report provides an overview of the SSDI and SSI programs, including their historical development, and a comprehensive description of the disability determination process. It also includes a detailed examination of the program's current status and a review of major policy studies identifying policy options. Finally, the Committee has developed a number of recommendations to further modify disability adjudications. The recommendations can be evaluated more meaningfully in the context of this extensive review.

Primary determinations are made by State agencies known as Disability Determination Services (DDS's). Within these agencies, there are two adjudicative levels, an initial determination and a subsequent reconsideration if the initial claim is denied. Once the claimant receives a second denial, an Appeal to an Administrative Law Judge (ALJ), within the Social Security Administration's (SSA) Office of Hearings and Appeals, may be requested. If the claimant continues to be denied, further appeals may be made to the Appeals Council and, if judicial review is necessary, to the Federal courts.

Together, the programs provided $31 billion in benefits in 1989 to over 6 million Americans with disabilities. Older workers, in particular, have been able to collect benefits under these programs when their physical or mental impairments have prevented them from continuing with their former work.

However, the system continues to face serious problems. A lack of uniformity among the different levels of adjudication raises questions about the decisional accuracy and fairness of the process. Currently, 7 out of 10 applicants for disability benefits are now denied at the level of the initial claim. For those who go on to appeal those initial denials, however, 6 out of 10 are later awarded benefits either by an ALJ, the Appeals Council, or after remand by Federal courts.

Similar concerns about accuracy were raised following reports from the General Acocunting Office (GAO) that 58 percent of those denied disability benefits were still not working 3 years later. The fact that denied applicants had similar health problems to those

who had been awarded benefits suggests that they may have been incorrectly denied.

According to the Social Security Administration's (SSA) own studies, while the number of people allowed benefits in error has not changed appreciably, the number of people denied in error has increased by over one-third in the last 5 years.[1] During that same time period, processing times for Social Security cases have gone up by 32 percent.[2]

To compound these problems, staff shortages and severe budget crises in the State DDS's have left the disability examiners in the tenuous position of doing little more than crisis management. A recent survey of the State disability determination directors shows that 72 percent of the States do not have adequate staff to process their caseloads in a timely manner and that the situation is growing progressively worse.[3] Many disability examiners are now forced to cut corners, eliminating all consultative examinations and discontinuing any reviews of pending Continuing Disability Reviews (CDR) cases.

SSA field office procedures also create problems by falling short of their duty to assist people who wish to apply for disability benefits. Instead of personal assistance, SSA has emphasized the use of telephone claims and self-help applications for those applying for disability benefits. While these were designed to save SSA staff time, significant evidence shows that these methods are not helping claimants.

In sum, SSA is charged with a delicate balancing act. To protect the trust funds, it must avoid awarding benefits to those who are not disabled. To protect the public, it must quickly and efficiently award benefits to those who are truly disabled. Currently, SSA is not meeting either objective. Lack of adequate staffing combined with burgeoning workloads leave SSA ill-equipped to meet its responsibilities to the public or the trusts funds. Members of Congress receive numerous complaints both from those who are unfairly denied and dragged through a long process, and those who feel that SSA is not weeding out some individuals who could return to work.

This committee report is designed to be useful for those who want to understand how the program has evolved to its present form and to become familiar with some of the major policy options now being considered. Among the most prominent proposals, which this report recommends adopting, is to replace the reconsideration phase of the appeals process with a face-to-face interview at the initial determination phase. Other needed improvements include providing adequate budgets for the DDS's to thoroughly review cases and requiring SSA field offices to provide more assistance to individuals filing claims.

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[1] U.S. General Accounting Office, Human Resources Division, "Disability Determination Service Statistics." Unpublished data prepared at the request of the Senate Special Committee on Aging from Social Security Administration statistics, Washington, D.C., 1990.

[2] U.S. Department of Health and Human Services, Social Security Administration, "National Processing Time Rates." Prepared at the request of the Senate Special Committee on Aging, Washington, D.C., 1990.

[3] Congress, Senate, Hearing of the Special Committee on Aging, *Disabled Yet Denied: Bureaucratic Injustice*, 101st Congress, 2nd sess., July 17, 1990. Testimony of Stan Kress, Director, Idaho Disability Determinations.

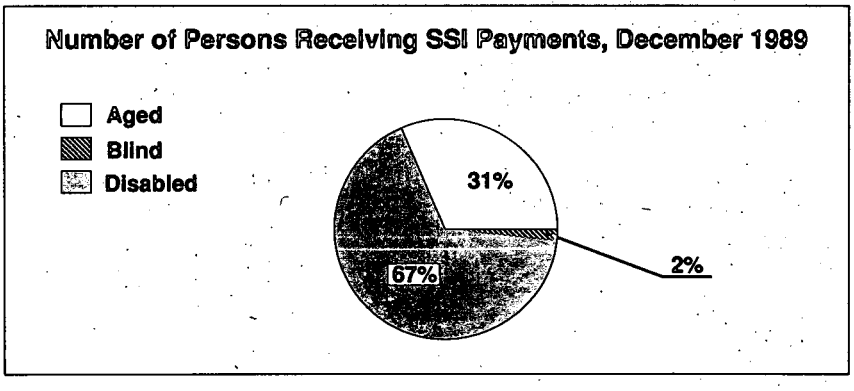
While a clear consensus on the best approach for reform is still emerging, the overriding message is clear: the status quo cannot be maintained. The disability determination system often fails to properly serve our most vulnerable citizens. Significant policy changes can prevent further unnecessary suffering by these people in their hour of need.

BACKGROUND

The Social Security Administration administers the Nation's two largest disability programs created to provide benefits to individuals with severe long-term disabilities: The Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) programs. Both programs have sustained a number of changes and grown substantially since enactment.

The SSDI program, enacted in 1956, is the Nation's primary source of cash benefits for workers and their families who cannot work because of disabling health conditions. In 1990, 4.2 million disabled workers, their spouses, and their children received SSDI benefits. That year, the SSDI program distributed $24.3 billion in benefits.

The SSI program, enacted in 1972, provides public assistance to aid low-income individuals who are aged, blind, or disabled. In 1990, 3.3 milion Americans received SSI benefits because of a disability or blindness. (See chart below.) In 1990, $11.3 billion in benefits were awarded to these SSI recipients.



EARLY HISTORY

In order to protect workers' rights to retirement benefits, Congress enacted a "disability freeze" provision in 1954 for workers who were determined to be disabled. The freeze prevented those workers disabled for an extended period of time from losing their rights to retirement benefits or risking a reduction in benefits.

Two years following the freeze, Congress enacted a cash benefit program for Disability Insurance. The eligibility requirements were intentionally stringent to limit the costs of the program and to distinguish it from unemployment insurance. The program's initial definition of disability was equally as restrictive, requiring the

worker's disability to be permanent and benefits to be limited only to those individuals at least 50 years of age.

Under an agreement with the then-Secretary of Health, Education, and Welfare (HEW), State disability determination units, housed within State vocational rehabilitation agencies, would make disability determinations based on Federal standards and regulations. At the time, the Federal-State partnership had distinct advantages because States had prior experience in administering various disability-related programs and had established a working relationship with the medical community. It also was assumed that by placing the disability determination services within the rehabilitation agencies, disabled individuals could receive a prompt and appropriate referral for rehabilitation.

Program Expansion: 1958, 1960, 1965 Amendments

The SSDI program succeeded and was slowly liberalized and expanded in later years. Amendments in 1958 and 1960 expanded the program by extending benefits to dependents and spouses of disabled workers and eliminating the age 50 requirement. As a result, disabled workers of any age who met the recency of work and insured status requirements could now be eligible for benefits. In addition, a provision in the 1960 amendments added a 9-month trial work period without termination of benefits to encourage SSDI beneficiaries to return to work. Finally, in order to clarify the original definition of disability which required that the individual's disability be "permanent," the 1965 Amendments specified that the worker's disability be expected to last at least 12 months or result in death.

Development of SSI

In 1972, Congress created the Supplemental Security Income (SSI) program to assist low-income individuals who are disabled, aged, or blind, many of whom are not covered under the SSDI program or receive low benefits under that program. The program replaced State-run welfare programs.

Adopting the same Federal-State partnership and definition of disability used under the SSDI program, the SSI program began distributing benefits in 1974. Individuals and couples applying for SSI benefits are eligible if their countable monthly income does not exceed the Federal benefit level plus $20. In 1991, this figure is $407 for an individual and $610 for a couple. In addition to the income ceilings, there are also ceilings on the amount of resources individuals may possess in order to qualify. For 1991, eligibility for SSI is restricted to qualified persons with countable resources not exceeding $2,000, or $3,000 for married couples, with certain significant exclusions.

Recent Legislation

The size and the unexpected growth in the costs of the disability program were a great source of concern during the 1970's to Members of Congress and the Administration. In 1977, Congress substantially strengthened the financial condition of the SSDI trust

fund by legislating payroll tax increases and lowering future costs by changing the indexing formula.

In 1980, Congress passed disability reform legislation that had been developing since 1974. The legislation grew out of concerns that work disincentives in the system, combined with faulty administration, might be responsible for the rapid growth in the program. The 1980 amendments were designed to enhance work incentives in the SSDI and SSI programs and tighten program administration so that benefits were paid only to those who remained eligible.

In addition, responding to a growing concern that SSDI beneficiaries were not being adequately monitored and reviewed, Congress included a provision in the 1980 amendments that required SSA to review the eligibility of beneficiaries with nonpermanent disabilities at least once every 3 years. The purpose of the legislation was to terminate the benefits of those individuals who were no longer disabled. Although the reviews were not scheduled to go into effect until 1982, SSA accelerated implementation of the process. The number of monthly case reviews increased over pre-amendment levels by 30,000 and between March 1981 and April 1984, 1.2 million cases were reviewed. As a result, 500,000 individuals' SSDI benefits were terminated.

Concern quickly rose over the quality and accuracy of the continuing disability reviews (CDR's) and many States declared a moratorium on them. Federal court decisions across the country contradicted and decried the Secretary's policies. In 1984, Congress enacted the Social Security Disability Benefits Reform Act to restore order, fairness, and uniformity to the SSDI program. Among the most significant aspects of the reform was the adoption of a medical improvement review standard. Once an individual is receiving SSDI benefits, SSA must provide substantial evidence showing that the beneficiary's medical condition had improved from the point of the initial disability determination before benefits are terminated. As a result of various provisions of the 1984 Act, SSA promulgated three sets of administrative regulations that created new standards for determining disability caused by mental impairments, established guidelines for determining "medical improvement" in CDR cases, and revised some of the medical criteria for disability determinations.

DISABILITY DETERMINATION PROCESS

Individuals faced with disabling conditions which prevent them from engaging in any substantial work activity may be eligible for benefits under the SSDI or SSI programs. The process for determining eligibility for SSDI benefits is complex and rigid. The disability standard is defined by the Social Security Act as the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment which is expected to result in death or last for a continuous period of not less than 12 months.

Individuals currently receiving benefits under either SSDI or SSI are subject to a periodic review to assure that beneficiaries are still disabled and remain eligible for benefits. Those reviews, however, are not currently being conducted with the intensity or frequency of the 1981–84 period, and in some States have been dispensed with entirely due to budget restraints. The law requires that benefits be paid only to individuals who initially met and continue to meet all the specific requirements for eligibility.

The application process within SSA consists of up to four stages, including three levels of administrative appeals for individuals denied benefits. The four stages, explained in detail below, are: (1) initial application; (2) reconsideration; (3) Administrative Law Judge; and (4) Appeals Council. A claimant who remains dissatisfied after exhausting these administrative appeals can appeal to Federal Court.

Initial Application

Individuals who wish to receive disability benefits under the SSDI program must file an application at one of SSA's 1,300 district offices. The field office is responsible for the preliminary processing of a claimant's application for SSDI benefits. A claimant may be interviewed by a SSA claims representative to gather relevant information for the file. Alternatively, a claimant may be provided a "self-help" application to fill out at home which solicits information about his or her medical condition and work history. In addition, SSA recently has placed increased emphasis on the use of teleclaims where an individual can be assisted in completing their application over the phone. To be eligible for review, the claimant must first meet the program's nonmedical eligibility requirements which include a finding of whether he or she is insured or has recently worked.

Sequential Evaluation Process for Initial Eligibility Determination

To efficiently and uniformly adjudicate disability determinations, the Social Security Administration has developed a series of five

steps known as the "sequential evaluation process," which are codified in the regulations. The process is designed to evaluate the claimant's medical conditions as well as his or her vocational limitations using all pertinent evidence and existing Federal regulations. The five-step process follows a basic flow chart model that continues until a determination of disability or nondisability is reached. (See chart below.) Unlike the later hearing stage, the claimant is not present at any time during the initial determination process.

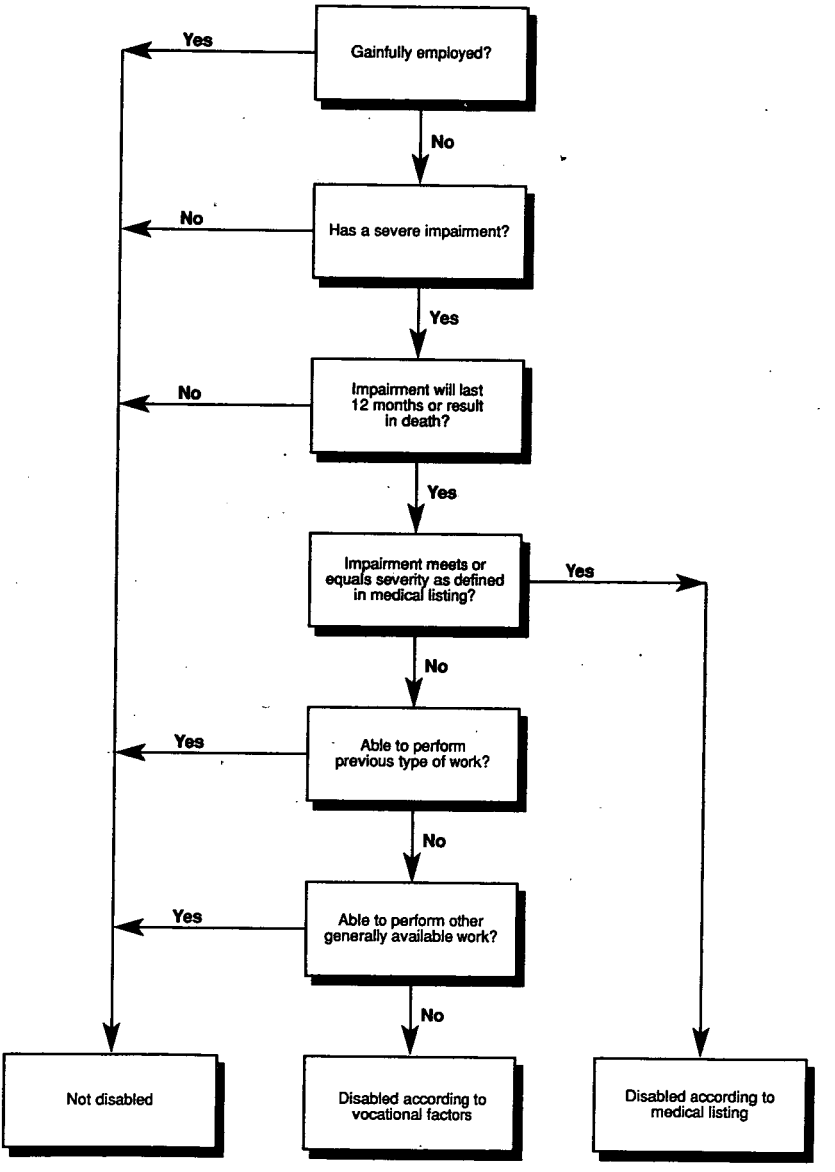
The first step of the sequential evaluation process, carried out at the SSA district offices, determines whether the claimant is currently engaging in substantial gainful activity (SGA). Work activity is generally considered substantial and gainful if the individual's earnings exceed a particular limit established in the regulations, currently defined as monthly earnings of $500. If the claimant is engaged in SGA, he or she is not considered disabled, regardless of the medical condition, and is denied benefits.

If the claimant is not engaging in substantial gainful activity, the application is forwarded to the State Disability Determination Service (DDS) to determine whether the claimant has a "severe" impairment or combination of impairments that has lasted or is expected to last for at least 12 months which will significantly limit his or her ability to perform work or is likely to result in death. At this second step, a two-person team consisting of a disability examiner and a physician should work together to collect all necessary medical evidence. The 1984 Act requires the examiner to refer to the treating physician first. If that physician provides insufficient evidence, and the other evidence of record is inadequate, the disability examiner may request a consultative exam for the applicant.

Ideally, medical personnel should perform three main functions in the disability determination process. However, many of these functions are rarely if ever performed. First, they assist in the development of medical evidence when evidence from the treating physician in insufficient. Second, they provide evidence on the claimant when required evidence is too technical or specialized to be provided by the treating physician. Third, they participate in making disability decisions at the initial and reconsideration levels.

If, once all medical evidence has been obtained, the records show that the claimant's impairment is not "severe," no further evaluation takes place and the claim is denied at this point. If the claimant does have a severe impairment, the third step of the process determines whether the individual's condition "meets" or "equals" one of SSA's medical listings. The Listing of Impairments are intended to identify and evaluate early in the process those individuals that are clearly disabled by SSA's strict medical criteria. If a claimant's impairment corresponds to a condition in the Listing, or if the impairment is similar enough to justify "medical equivalence," benefits are awarded at this stage. If the claimant's condition fails to meet or equal a medical listing, evaluation proceeds to step four.

Sequential Evaluation Process



Unlike the previous steps, the final two steps of the sequential evaluation process consider the claimant's age, education, and prior work experience along with his or her functional limitations caused by physical and mental impairments. A claimant's impairments can fail to meet or equal an impairment in SSA's medical listings but the claimant may still have vocational limitations that, when combined with his or her medical impairments, prevent the individual from working. To assess whether the claimant can perform work-related tasks at a particular level, the medical consultant determines the individual's "residual functional capacity" (RFC) for work. Specifically, the claimant's particular level of residual work capability is characterized as "Sedentary," "Light," "Medium," "Heavy," and "Very Heavy." These are defined by regulation.

The fourth step uses the claimant's RFC to evaluate whether the individual can perform any jobs that he or she had done in the past. If the impairment does not prevent the individual from performing past work, the claimant is denied benefits at this point.

If the case progresses to the final step, the burden of proof shifts to the Social Security Administration to prove that the claimant can engage in other work that exists in the national economy. By definition, work in the national economy must be available in significant numbers in the region where the individual lives or in several regions of the country. It is inconsequential whether or not such work exists in the individual's immediate area, there are any job vacancies available, or the individual would actually be hired for the position.

The most commonly used method for meeting this burden is through the use of SSA's Medical-Vocational Guidelines. The Guidelines include a set of three grids which account for the applicant's age, education, prior work experience, and residual functional capacity. Combining all of the above criteria, the grids identify whether the claimant is disabled or not disabled. However, the grids alone cannot prove nondisability, when a claimant suffers from a nonexertional disability such as a mental, sensory, or skin impairment or specific environmental restrictions. Such exceptions often require testimony or consultation from a vocational expert to identify what, if any, jobs are suitable given the applicant's complex condition. However, such determinations are rarely done at the DDS level and are more often left to the ALJ's. Thus, if the DDS decisionmaker concludes that work exists for the claimant, he or she will be denied.

Reconsideration

Once the disability determination has been made by a DDS examiner, notice of the decision is forwarded to SSA. The Administration is required to send a written notice to the claimant including a statement of the medical evidence considered and the basis for the decision. A claimant who is dissatisfied with the initial denial or termination of benefits may file a request for reconsideration within 60 days of notification. (Appeals at all levels must be filed within 60 days following notice of denial or termination. In termination cases, if the appeal is filed within 10 days, the person

can elect to have benefits continued through the reconsideration stage.) This first level of appeal is also administered at the State DDS level. Reconsideration essentially repeats the initial determination process with the exception that different examiners and consultants review the case than at the original determination. Additional evidence may be considered, but, again, the claimant does not appear. (For Continuing Disability Review cases, however, the 1984 amendments required that the claimant be provided a face-to-face evidentiary hearing.)

Administrative Hearing

Following an adverse decision at the reconsideration stage, a claimant may request a new hearing before an Administrative Law Judge (ALJ). The ALJ's are administered by SSA's Office of Hearings and Appeals (OHA). The cases are reviewed by the ALJ, often providing the claimant his or her first opportunity for a face-to-face interview with a decisionmaker. If additional information is necessary, the ALJ may seek new or existing evidence through a request, subpoena, medical consultative exam, or other reasonable means. It is the ALJ's responsibility for ensuring that each claimant's file is fully and properly developed, especially when the claimant is unrepresented. However, in view of the complexity of the process, 63 percent of claimants obtain legal counsel to represent them at hearings.

Once the file is complete, the case may be set for hearing. The claimant, on his own initiative, through an attorney, or some other representative, may submit additional evidence at the hearing. The ALJ may choose whether to use a medical advisor or seek additional medical or vocational witness testimony at the hearing. After the hearing, the ALJ weighs all of the available evidence in accordance with applicable laws, regulations, and rulings. Because new evidence may be placed before the ALJ, the record may be significantly different than the one seen at the earlier stages. The ALJ's final decision must fully summarize the evidence considered and present the claimant the reasons for the decision. Again, in termination cases, the individual has the right to elect benefit continuation through the ALJ level.

Appeals Council

The Appeals Council provides the claimant the last opportunity for administrative review. The claimant may request a review following an adverse decision by an ALJ, or the Appeals Council may initiate their own review of any case adjudicated by an ALJ. The Appeals Council may affirm the ALJ decision, reverse it, or remand the case back to the ALJ if further investigation is necessary.

Federal Court

If the claimant desires to appeal the case further, he or she may seek judicial review in the Federal District Court. The court has the authority to affirm or reverse the Appeals Council decision, or remand it for further consideration. The district court judge is sup-

posed to review the case based on the record assembled at the agency and to affirm the result if it is supported by "substantial evidence." In practice, district court's have tended to reverse or remand SSA decisions at a rate approaching 50 percent in the last decade. After the district courts decision, a dissatisfied claimant, or the Secretary, can appeal to the Circuit Courts of Appeal, and may also seek review by the Supreme Court.

Continuing Disability Reviews

Cases for both new disability applicants and continuing disability reviews (CDR's) begin in the SSA field office. The disability determination process for CDR's mirrors the process for new applicants except for the additional medical improvement standard mandated by the 1984 amendments (Public Law 98-455). In the SSI program, earnings over the SGA level of $500 is irrelevant because of work incentives that have been enacted into the program. In addition, the 1984 amendments and later revisions mandated that all SSDI and SSI CDR cases receive a face-to-face evidentiary hearing at the reconsideration stage and that they are entitled to elect benefit continuation through the ALJ level.

The incidence of review depends on the beneficiary's medical classification: Cases labeled medical improvement possible (MIP) are scheduled for review within 18 months; cases for medical improvement expected (MIE) are scheduled for review once every 3 years; and cases for medical improvement not expected (MINE) are reviewed every 5 to 7 years.

Extension of Benefits

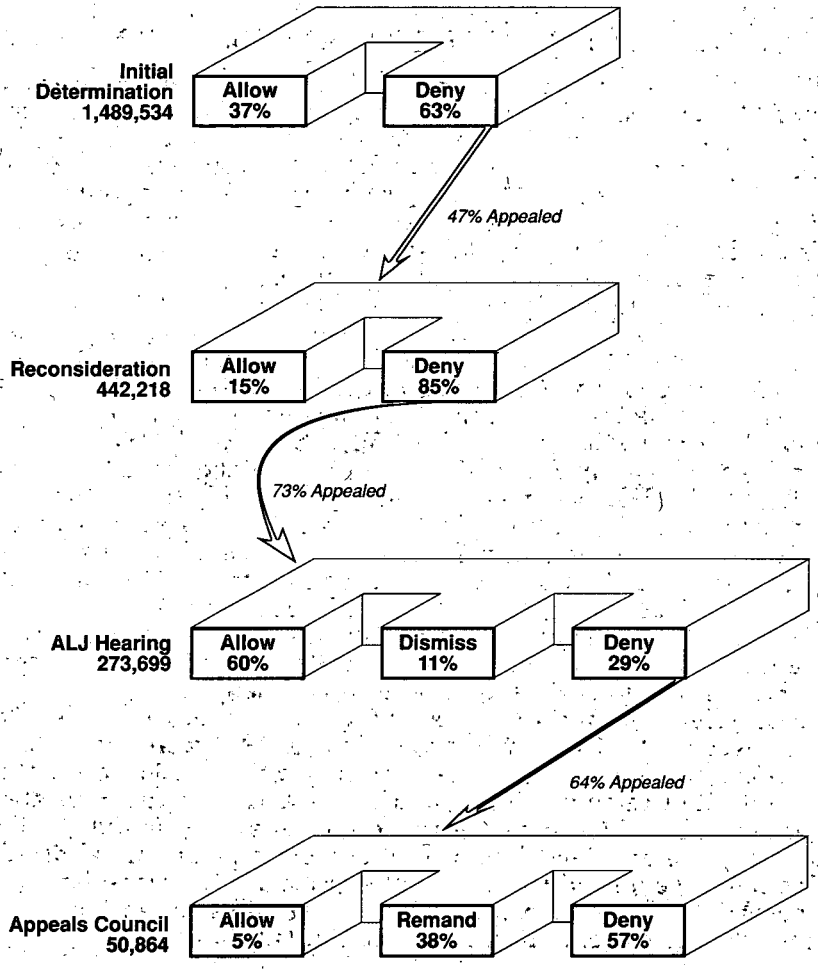
Under the 1984 Disability Benefits Reform Act, disability insurance beneficiaries whose benefits were terminated for medical reasons, such as medical improvement, may elect to continue receiving benefits through the hearing level. This authority was extended on a yearly basis until being made permanent in 1990 by Public Law 101-508 (OBRA 1990). If the final determination upholds the initial decision for termination, the individual will be subject to a recovery of benefits as an overpayment, although they are subject to waiver if the individual acted in good faith.

The importance of the initial determination stage cannot be overstated. Despite the high reversal rates at the ALJ hearing level and in the courts, over two-thirds of those individuals initially denied by the State DDS never pursue further consideration. However, a large number of these drop-outs eventually reapply for disability benefits. According to advocates for individuals who are disabled, SSA's staff has been known to discourage appeals by suggesting that denied claimants "can always reapply."

Such advice can be very damaging to the claimant for two reasons. First, individuals who receive a favorable decision after reapplying often lose most of the benefits they would have otherwise received based on the first application. In addition, such individuals run the risk of having their insured status lapse, leaving them ineligible for any benefits under SSDI. (SSA regulations require that the claimant have worked at least 5 out of the last 10 years to be eligible for SSDI benefits.) These problems will be mitigated by recently enacted legislation which provides that if a claimant files a new application instead of filing an appeal based on inaccurate or misleading information from SSA, the failure to appeal will not constitute a basis for denial of the second application.

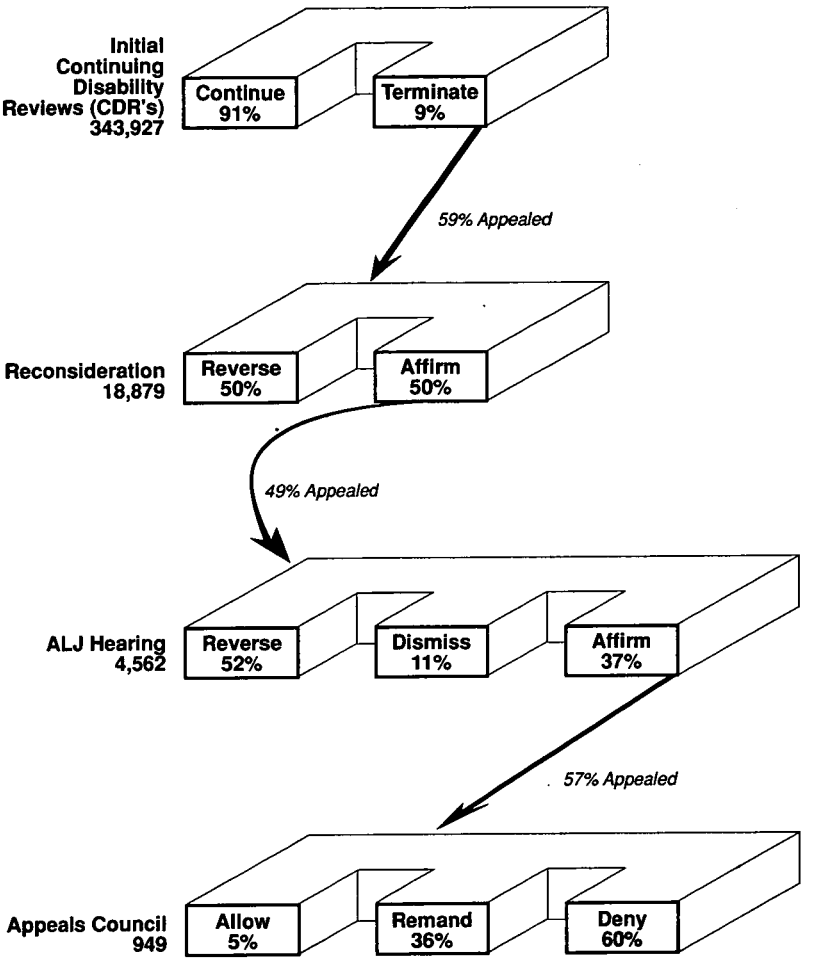
The lack of uniformity in decisions made at the different levels of adjudication is not new to the disability determination process. In 1974, as many as 30 percent of all initial denials were reversed at reconsideration and 53 percent of all claims appealed to ALJ's were reversed. Cases receiving a hearing in 1974 were more than two times as likely to be reversed as they were in 1960 when the reversal rate was only 24 percent. More recently, the reversal rates at the hearing stage have become even more pronounced. While the DDS's are denying 63 percent of all claims at the initial determination stage and 85 percent of all appeals at the reconsideration stage, the ALJ's are reversing 60 percent of all cases that have appealed the State agency decisions. (See charts below.)

Disability Determinations and Appeals, FY89



Source: U.S. Congress, House Committee on Ways and Means. Background Material and Data on Programs Within the Jurisdiction of the House Committee on Ways and Means, 1990 edition.

Continuing Disability Reviews and Appeals, FY89



Source: U.S. Congress, House Committee on Ways and Means. Background Material and Data on Programs Within the Jurisdiction of the House Committee on Ways and Means, 1990 edition.

High reversal rates raise questions over the fairness of the determination process and the ability of the system to achieve accurate results. A recent survey of all the State DDS directors, conducted by the National Council of Disability Determination Directors, asked for explanations that account for these rates. The DDS Directors attributed the most significant reason for the discrepancies to the greater latitude ALJ's exercise in interpreting SSA's regulations and Federal court decisions. Decisions at the hearing stage are not bound by SSA's Program Operations Manual (POM's) which provides stringent guidelines for determining disability, and ALJ's tend to adhere more directly to statute and SSA regulations. A second reason for the high reversal rate is that many of the cases lack proper development of evidence at both the initial and the reconsideration stages. Often, denials are made because there is insufficient evidence to prove the claimant is actually disabled. Records appearing before ALJ's are often much better developed. Third, the hearing stage permits the claimants several advantages that were not present earlier in the process, the most significant being the chance for their first face-to-face hearing with the ALJ. Prior to the hearing, claimants are rarely, if ever, seen by a decisionmaker. Claimants at this stage are far more likely to retain legal representation, improving the quality of their appeal. In addition, the claimant can bring witnesses to the hearing and the ALJ may call upon vocational and medical experts to testify. Fourth, and the reason most often offered by SSA, could be that the claimant's disability worsened from the time of the initial denial. Finally, new evidence may be collected and presented between denial by the DDS and the hearing before an ALJ, leading to a favorable decision.

The large backlog of cases and the resulting delays can drag a claimant through the process for well over a year. According to SSA, the average claim takes almost a year and a half to move from the initial application through a decision at the ALJ level. In some instances, claimants have waited over 3 years to receive benefits, and if the case goes to Federal court, it can continue even longer. According to SSA's own studies, the mean processing times have increased by more than 30 percent for SSI cases and by over 20 percent for SSDI cases.[4] As a result, claimants may suffer high costs while awaiting a decision, with some forced into absolute destitution, homelessness, and starvation.

While there are great discrepancies at the different levels of the administrative appeals process, significant variances exist among State agencies as well. In 1982, while the national DDS allowance rate was approximately 30 percent, State agency allowances ranged from a low of 24 percent to a high of 47 percent. More recently, following a 6-month period ending March 1989, the gap in State agency allowances has widened from a low of 21 percent in Louisiana to a high of around 48 percent in New Jersey, Massachusetts, and Delaware. (See chart below.)

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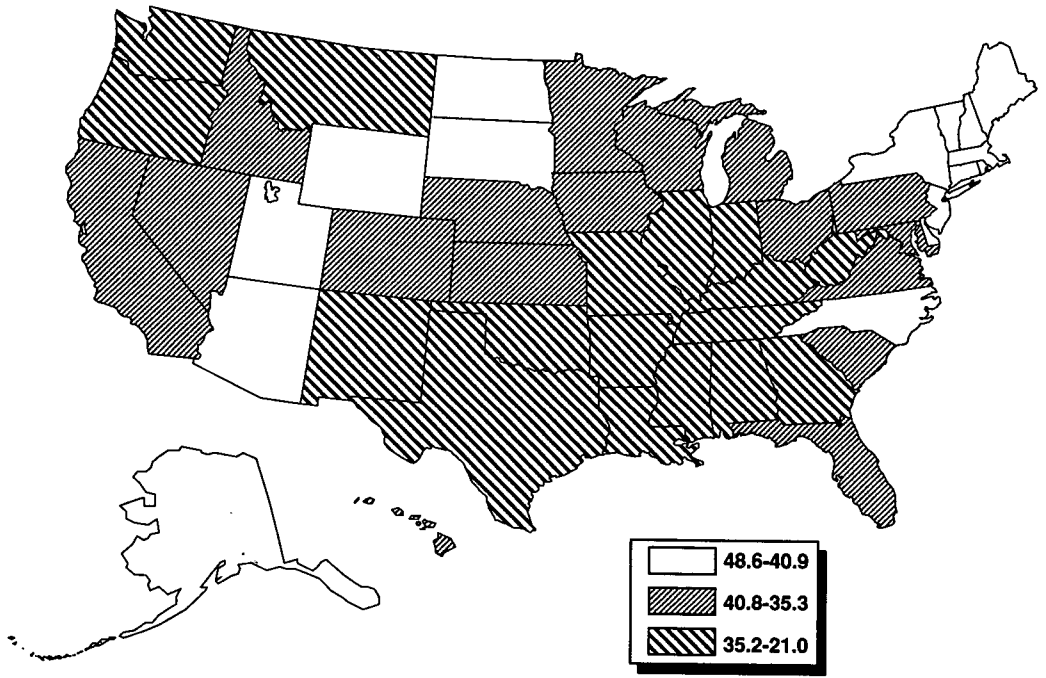
[4] U.S. Department of Health and Human Services, SSA "National Processing Time Rates."

State-by-State Allowance Rates for Initial Disability Determinations, March, 1989



The workloads of the DDS's will continue to escalate, particularly in light of the Supreme Court decision in *Zebley* v. *United States* (1990), which requires re-review of at least 250,000 children's disability cases. Current estimates for the administrative costs of implementing the Supreme Court decision range from $100 to $300 million in fiscal year 1991. Since the DDS's are already on the edge of a precipice, the additional burden of *Zebley*, without the allocation of additional dollars, is likely to push SSA's disability program well over the edge.

Accordingly, a problem of increasing concern among the States is the escalating budget crisis. Only five States reported having adequate funds for fiscal year 1990. In addition, 45 percent of the States reported there is no way they can finish this fiscal year in the black with current authority. The budget situation for the next fiscal year, 1991, appears more desperate. Almost 75 percent of the States believe that SSA's budget for DDS's in fiscal year 1991 is not adequate. One State replied that "the President's new budget will again constitute 'Bare Bones' survival funding."

SSA recently requested permission from the Office of Management and Budget (OMB) to draw upon its contingency fund to meet the pending crises, but the response from OMB has been only minimally supportive. Following a July 25th letter from Chairman David Pryor of the Senate Aging Committee and an August 1 letter from Senators John Heinz, Donald W. Riegle, Jr., and Pryor along with 19 other Senators, OMB Director Richard Darman agreed to release only $5 million. This sum is only one-tenth of the original $50 million that was requested by SSA and clearly is insufficient to address the pressing needs of the State DDS's.

In addition to the tight budget constraints, Members of Congress have expressed concern that there is not sufficient staff at the DDS's to adequately process disability claims. Over the past 6 years, staffing levels at State DDS units have fluctuated, experiencing periods of increases and reductions. For the most part, however, staffing levels have been significantly reduced. In 1989, DDS staffing levels were 11,634, with a level of 11,303 estimated in 1990. The survey of DDS Directors revealed that 72 percent of the Directors believe they do not have adequate staff to process their caseloads in a timely fashion. One State director replied: "We have sacrificed long-term stability for short-range coping."

During this period of staffing reductions, the pending caseload has increased. According to the GAO, initial cases pending at the DDS's have increased 22 percent from June 1989 to June 1990. Almost 70 percent of all State DDS Directors report that their ability to process workloads has become either worse or much worse. One State noted that its current pending workloads are 35 to 40 percent above a manageable level. It is not uncommon among the State agencies for a disability examiner to have over 200 cases at one time. SSA attributes this growth to a concentrated effort to increase productivity and achieve greater consistency among the States, as well as to an increase in automation. However, insufficient staff, low budgets, and growing caseloads are placing DDS's in a tenuous position to do little more than crisis management.

For example, in 1986, the Massachusetts DDS processed 43,000 cases with a staff of 334 people. This year, the State agency has as many as 53,000 cases with a staff of only 217 people. Coupled with a meager budget and skyrocketing backlogs, the Massachusetts program, like other States, is being forced to cut corners. The State's high rate of productivity has been declining with many cases falling between the cracks.

Budgetary constraints imposed on the DDS's by SSA have adversely impacted the quality of disability determinations. DDS decisionmakers no longer have the time or money to fully develop evidence in each claimant's file. Most States have indicated that due to current budget restrictions, they have been forced to alter their case development practices. Personal phone contact with claimants to gather pertinent information or evidence has been drastically reduced or eliminated. Many States are limited in the number of Consultative Exams (CE's) they can purchase and sometimes do not order them when they are needed. In fact, one State has indicated they will discontinue purchasing CE's on August 1 of this year. As a result, decisional fairness and accuracy are, in many cases, compromised at the expense of the claimant.

Increases in error rates, reported by SSA's quality assurance (QA) program, support the concerns raised by DDS Directors. The QA data shows a significant decline in quality since 1987. Since 1986, the QA error rate increased by about 30 percent for initial allowance decisions, and by about 60 percent for initial denial decisions.

SSA district offices are compounding the problems by failing to send complete and properly developed claims to the State agencies. Early in 1987, SSA developed the so-called "self-help" application form for individuals wishing to receive disability benefits. According to SSA memos, use of the form would reduce interviewing time by "about 20 minutes." The forms require individuals to fully detail all of the limitations caused by their impairments. SSA asserts that it will assist any individual that asks for help, but staff shortages make this virtually impossible. Although SSA requires that the form not be given to individuals who allege they have some type of mental impairment, many claimants would never acknowledge such an impairment, and the district office staff may not make such a determination.

A 1987 Atlanta SSA regional memo confirmed these problems, indicating that staff had been giving the forms to people who were incapable of filling them out, and that one needs a college education to properly complete the application. The memo reported that the form was used in almost 65 percent of all cases. Of these, one-fifth of the cases were individuals who were mentally disabled or illiterate that were sent home with the form, never receiving staff assistance to correct any errors. Over one-half of the forms were forwarded to State DDS's with incomplete and conflicting information. In such cases, State DDS's must personally contact individuals to collect information that should have been supplied at the district office. If such critically needed information is not secured, a person's claim is wrongly jeopardized.

According to Harry Behret, a Claims Representative for SSA who testified before the Committee, applicant completion of the

self-help form has been essentially "worthless." Behret said that the form was never intended to be completed by an untrained individual and "any attempt to do so is no more than an exercise in futility." [5]

Almost 80 percent of all State directors have acknowledged a deterioration in both the quality and quantity of information in the initial claims files set by the SSA field offices. Advocates for individuals with disabilities have also witnessed a negative change, noting the increase in denials by DDS's that were a direct result of improperly completed forms and a failure to secure needed information to document impairments. DDS Directors attribute this change not only to the use of self-help applications, but to an increased reliance on teleclaims and the new 800-number.

In sum, SSA is charged with a delicate balancing act. To protect the trust funds, it must avoid awarding benefits to those who are not disabled. To protect the public, it must award benefits to those who are truly disabled quickly and efficiently. Currently, SSA is not meeting either objective. Lack of adequate staffing combined with burgeoning workloads leave SSA ill-equipped to meet its responsibilities to the public or the trusts funds. Members of Congress receive numerous complaints both from those who are unfairly denied and dragged through a long process, and those who feel that SSA is not weeding out some individuals who could return to work.

To improve this record, SSA must be provided with adequate resources to process its workload thoroughly. In addition, the process should be streamlined to eliminate unnecessary delays and bureaucratic hurdles.

[5] Congress, Senate, Hearing of the Special Committee on Aging, *Disabled Yet Denied: Bureaucratic Injustice,* 101st Congress, 2nd sess., July 17, 1990. Testimony of Harry P. Behret, Claims Representative, Social Security Administration, on behalf of the American Federation of Government Employees.

REVIEW OF MAJOR POLICY STUDIES

A review of major policy studies follows which addresses six issues affecting the disability determination process at the State level, including:

—Face-to-Face Interviews;
—Value of the Reconsideration Stage;
—Development of Evidence;
—Use of Medical Personnel in State Disability Reviews;
—Allowance Rate Variations; and
—Health and Financial Status of Allowed and Denied Disability Applicants.

The following discussions are based on a review of various reports on the Social Security Administration's Disability and Supplemental Security Insurance programs. A comparison of major policy recommendations is included in the appendix. In addition to the reports cited in this section, the recommendations of Eileen Sweeney of the National Senior Citizens Law Center have been added.

FACE-TO-FACE INTERVIEWS

Allen E. Shoenberger (1988) of Loyola University School of Law, the Disability Advisory Council (1988), Fred Arner (1989), Frank Bloch (July 1989) of Vanderbilt University School of Law, the Disability Advisory Committee (1989) and the General Accounting Office (GAO) (April 1989) all discussed the use of face-to-face interviews during the initial or reconsideration stages of the disability determination process. There was general agreement among the six reports on the value and effectiveness of such interviews, especially during the early stages of the determination process.

Allen Shoenberger wrote a report for the Administrative Conference of the United States arguing that face-to-face interviews were "quite promising." Suggesting that cost and caseload might "militate against full face-to-face procedures," he recommended that interviews should be conducted in those cases where the evidence or the sense of the examiner indicate that such face-to-face interviews would significantly affect the "ultimate determination." [6] However, he advised against full implementation of interviews at either the initial or reconsideration stages until various SSA demonstration projects were completed.

At least in part, Shoenberger's support for interviews was based on his discussions with DDS hearing officers participating in SSA's

[6] Allen E. Shoenberger, *State Disability Services' Procedures for Determining and Redetermining Social Security Claims for the Social Security Administration,* 1987 Administrative Conference of the United States, Recommendations and Reports (Vol. 1), pp. 529, 610.

Personal Appearance Demonstration (PAD) projects.[7] He solicited the views of hearing officers about face-to-face interviews and what they thought the claimants felt about such interviews. Shoenberger found that every hearing officer thought claimants appreciated the opportunity for an interview and were satisfied with the interview experience. Those hearing officers with previous interviewing experience said the interviews for the PAD project made a difference in their decisions, either in reversing or strengthening a denial action.[8]

The 1988 Disability Advisory Council report recommended that the Secretary of HHS carefully assess the results of ongoing personal appearance demonstration projects with an eye toward face-to-face interviews as a possible alternative to the current disability determination process. The Council believed that personal appearances might help encourage more complete and timely development of disability cases and reduce appeals.[9]

Frank Bloch advocated substituting an optional face-to-face interview at the initial stage for the reconsideration stage of the determination process. He argued that the optional interview would improve the quality of initial decisions and, thus, reduce the number of claims appealed to the hearing level.[10]

The Disability Advisory Committee recommended face-to-face interviews in their 1989 report. The Committee noted that they were not pleased with the status quo of disability determinations. They reported that one way to ameliorate problems with the determination process was to introduce personal interviews with claimants by SSA employees at the intake phase of the application process and by DDS employees during initial and reconsideration phases.[11]

Fred Arner, in his 1989 report, stated that "it is my belief that full, timely, and consistent adjudications will only result from a face-to-face front end process over which the Social Security Administration has effective management control." [12] In designing his model disability process, Arner envisioned a federalized process located in Federal Disability Centers (FDC). Disability applications would be taken via personal appearance with the ensuing determination process including a face-to-face interview when necessary or desirable. He noted that current personal appearance demonstration projects would be "very useful in developing details of this process." Finally, denied applicants would be given an opportunity to meet with the person who denied the application in order to receive guidance on further steps of appeal, recommendations on evidence and witness development, and use of legal or representative counsel in subsequent appeals.

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[7] The Personal Appearance Demonstration (PAD) projects were conducted by DDS's in 10 States to determine whether a claimant's interview with a hearing officer would result in a more accurate evaluation of the claimant's condition as well as simplfying and quickening the determination process. In the demonstration projects, interviews replaced the reconsideration stage.

[8] See Shoenberger, supra note 1, pp. 601-02.

[9] *Report of the Disability Advisory Council* (1988), p. 93.

[10] Frank S. Bloch, *Report and Recommendations on the Social Security Administration's Administrative Appeals Process,* Administrative Conference of the United States (July 1989), p. 56.

[11] *The Report of the Disability Advisory Committee* (1989), p. 10.

[12] Frederick B. Arner, *A Model Disability Structure for the Social Security Administration,* Alfred P. Sloan Foundation (September 1989), p. 1.

The GAO reached conclusions similar to those of Bloch and Shoenberger. In their report on selective face-to-face interviews, the GAO agreed with both authors that such interviews had merit and could be effective for certain disability claims. The GAO also acknowledged that interviewing every disability claimant was not practical.[13]

The GAO based their conclusions primarily on a study they conducted and on the results of interview experiences in Missouri and Wisconsin. First, the GAO study found an "overwhelming area of disagreement" between ALJ's and DDS examiners' determinations of claimants' residual functional capacities (RFC) in certain medical categories. In a sample of hearing reversals involving back disorders, heart conditions, and lung diseases, over three-quarters were reversed because an ALJ's assessment of a claimant's RFC differed from that of the DDS examiner's. The GAO believed these differences were based, at least in part, on the impact of the ALJ's face-to-face hearings with the claimants evidence. Second, the GAO report discussed Wisconsin's and Missouri's successes with interviews "of selected categories of claimants" at the reconsideration stage. In both States, not only were reversal rates at reconsideration were well above the national average, but decision accuracy rates were higher than average also.

The GAO concluded that "the limited experience with face-to-face interviews at the reconsideration stage suggests that these interviews improve decisional quality and resolve some cases that would otherwise become appeals to ALJ's."[14] They cautioned, however, the full implementation would be "impractical" because of the large volume of cases handled by State DDS's.

Value of the Reconsideration Stage

Shoenberger (1988), Bloch (July 1989) and the Disability Advisory Committee (1989) addressed the value of the reconsideration stage of the disability determination process. Each, however, had a decidedly different point of view on the subject.

Allen Shoenberger recommended keeping the reconsideration stage. He centered his argument on the percentage of reversals occurring at reconsideration. Although the reversal rates at reconsideration declined by half since 1970, Shoenberger contended that reconsideration reversals still affected enough people to justify keeping that stage of the determination process. Reversal rates were 15 percent nationally at reconsideration during the first half of fiscal year 1989. With this percentage translating into over 66,000 reversals, it would be difficult "to conclude that nothing is achieved by a second look at a file by a DDS even if that look consists primarily of paper review."[15]

Shoenberger also believed that elimination of the reconsideration stage, without other changes to the appeals process, might double

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[13] *Social Security: Selective Face-to-Face Interviews with Disability Claimants Could Reduce Appeals,* GAO Report to the Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House sof Representatives (April 1989).

[14] Ibid., p. 23.

[15] See Shoenberger, supra note 1, p. 590.

the caseload at the hearing stage. This, he said, would have a serious impact on ALJ case loads.

Finally, with few claimants represented at reconsideration, Shoenberger said that those whose claims were allowed at the reconsideration stage would save the costs associated with paying for legal or representative counsel.

On the other hand, Frank Bloch, also writing for the Administrative Conference, recommended eliminating the reconsideration stage. Bloch wrote, "On balance, it seems that a separate, formal reconsideration process is unnecessary."[16] Block believed the "resources" used for reconsideration "could be allocated more effectively to improving the initial decision process." However, he cautioned that the elimination of the reconsideration stage without major operational changes to the initial stage would generally not improve the determination process. The Administrative Conference, after wrestling with the views of its two researchers, adopted a recommendation in 1989 urging SSA to "seek to concentrate the efforts of the disability determination team on a single initial decision process . . . . the separate reconsideration stage should be eliminated."

The Disability Advisory Committee was the least specific in its recommendations. They reached no consensus on what to do with the reconsideration stage of the determination process. They agreed, however, that the current determination process was inadequate. Though no specific recommendation was endorsed, the Committee offered several options: eliminate the reconsideration stage entirely or collapse it into the initial stage; turn the reconsideration stage over to SSA; or, if retained, provide face-to-face interviews at the reconsideration stage.

Development of Evidence

The development of evidence for the disability determination is a crucial aspect of the entire process. Mashaw, et al. (1978) of the National Center for Administrative Justice, Shoenberger (1988), Disability Advisory Council (1988), Arner (1989) and Bloch (1989) addressed the issue of evidence development. All four reports found fault, to some degree, with the development of evidence by State DDS's. Each report reached a conclusion similar to Frank Bloch's when he wrote that, "all programs encounter the problem of trying to make a disability determination on the basis of records which are all too often incomplete."[17]

Jerry Mashaw noted inadequate development of evidence by DDS's during the early stages of the determination process. Based on observations and interviews, he concluded that evidence development at the State agency level was "often incomplete."[18] Mashaw found that most evidence on a claimant's "functional limitations" and "residual capacities" was developed by hearing office staff, not the State DDS staff. The system for case development prior to the hearing stage provided "little if any evidence on these

[16] See Bloch, supra note 5, p. 56.
[17] Ibid., p. 57.
[18] Jerry L. Mashaw, et al., *Social Security Hearings and Appeals*, Lexington Books, Lexington, Massachusetts (1978), p. xxi.

crucial elements of a disability claim." [19] Beyond this lack of crucial evidence, hearing office staff reported that "with substantial frequency" case files were missing even routine claimant information such as hospital records.[20]

In his 1987 Administrative Conference report, Allen Shoenberger wrote that inadequate evidence development in the initial stage of the disability application process often led to reversals at the reconsideration stage. Shoenberger found that nearly one-half of the reversals at reconsideration were based on additional evidence considered by a DDS examiner. Rather than conducting a strictly *de novo* review at reconsideration, however, many examiners used inadequately developed evidence already in the case record to pursue additional evidence which, in many instances, led to a reversal. Shoenberger stated that, in 1986, nearly 32,000 allowances were made nationwide by reconsideration examiners who sought "additional documentation of something already partially reflected in the file." [21] He found further evidence of poor case record development during interviews with hearing officers participating in a face-to-face interview project. Many stated that objective evidence, seen during the personal interview, which affected their determinations, was "rarely available in the paper file alone."

The Disability Advisory Council, in its 1988 report, stated that inadequate evidence development at the DDS level was one factor contributing to a lack of uniformity in the application of disability eligibility standards among the States. The Council reported that a lack of uniformity partially stemmed from an appeals process which failed "to encourage the development of complete and correct evidence early in the process." [22]

Arner believed evidence and case file development were essential for the proper adjudication of a disability claim. His model for a disability process called for an initial stage of determination where "all evidence pertinent to the decision will have been obtained, and a decision with a fully developed rationale will be presented." [23] Further, Arner stated that evidentiary development at the initial stage would lead to a decision "of such quality that it will be given great deference in any subsequent administrative or judicial appeal." [24]

In a 1989 Administrative Conference report, Bloch addressed the effect that the absence of medical evidence in the case file had on State disability determinations. Based on his interviews with hearing office staff, Bloch noted that many interviewees expressed a "consistent" frustration in seeing appealed disability determinations "decided on the basis of an inadequate medical record" by State DDS's.[25] Bloch also wrote that hearing offices routinely re-

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[19] Jerry L. Mashaw, *Report to the Grants and Benefits Committee on the Social Security Hearings and Appeals Process*, 1978 Administrative Conference of the United States, Recommendations and Reports, p. 92.

[20] See Mashaw, supra note 13, p. 50.

[21] See Shoenberger, supra note 1, pp. 590–91.

[22] Report of the Disability Advisory Council (1988), supra note 4, p. 83.

[23] See Arner, supra note 7, p. 9.

[24] Ibid., p. 5.

[25] Frank Bloch, *The Use of Medical Personnel in Social Security Disability Determinations*, Administrative Conference of the United States (1989), p. 71.

ceived disability case files where even general information, such as hospital records, was not present. This information, which should have been obtained by the DDS, was "simply overlooked." Rather than being a rare instance, Bloch heard from hearing office staff that "this is less uncommon than one would hope." [26] Such hearing office views mirror the findings of Jerry Mashaw from interviews also 10 years earlier. That the view of such case file deficiency had not significantly changed over 10 years supports the observations of GAO and the DAC regarding the inadequacies of the DDS process.

Use of Medical Personnel in State Disability Determinations

The Administrative Conference of the United States, based on Frank Bloch's 1989 report, recommended that SSA "should enhance the decisionmaking role of medical personnel at the initial decision level." Professor Bloch's report stated his belief that the DDS medical staff should "play their most important role" as decisionmakers and as medical consultants in SSA's disability programs. "This type of consulting with medical personnel is an extremely important aspect of the development process, particularly at the initial decision level, as it helps focus the evaluation on the truly difficult and contested medical issues." [27] Ideally, medical staff should be involved in developing medical evidence, providing findings and opinions, and making disability determinations. In reality, their involvement in any one of these areas is generally limited and inconsistent.

Medical staff are available to DDS examiners to answer questions about the quality or completeness of medical evidence. Bloch wrote, however, that the use of medical staff to "explain and clarify evidence" is not consistent, and that their role in the process and effectiveness as consultants varies "considerably" from State to State. "Doctors are rarely called upon to explain or clarify evidence if they are not used otherwise in the disability determination process." [28]

Bloch noted that the role of DDS medical staff is "less than optimal" in evidence development. He said that procedures were generally in place for doctors to approve decisions on special examinations or tests when a case warranted such additional evidence. Although DDS examiners should at least get approval from the medical staff to request such evidence, Bloch found that "only the most unusual requests are actually discussed." [29]

Bloch recommended that DDS medical staff supervise the development of medical evidence in disability cases. He also recommended that medical staff evaluate the case record for completeness and assure that the record is clear and understandable to those making initial disability decisions, especially for the lay decisionmakers. The Administrative Conference adopted these recommendations.

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[26] Ibid., p. 77 (see footnote 519).
[27] Ibid., p. 80.
[28] Ibid., p. 79.
[29] Ibid., p. 77.

ALLOWANCE RATE VARIATIONS

The SSDI and SSI programs are plagued by significant variations in benefit allowance rates at both the initial and reconsideration stages nationally. The Disability Advisory Council (1988), Koch & Koplow (1990), Arner (1989) and Shoenberger (1988) addressed the issue of variability. However, no consensus was reached on how to correct the problem or, even, whether it was a problem at all.

The Disability Advisory Council's 1988 Report noted "significant" problems in the "structure and operation" of the disability eligibility determination process. One such problem was the wide variation between States in the allowance rates at the initial and reconsideration stages of the process. The Council argued that the "variation" and "volatility" of allowance rates over time raised serious questions about the basic operational "integrity and fairness" of SSA's disability program. They believed that the wide variation was caused by a lack of uniformity in the application of eligibility standards, stemming from an inadequately controlled Federal-State arrangement for administering the SSDI amd SSI programs, and an appeals process which fails to encourage the development of complete and correct evidence early in the process.[30] To lessen these variations in allowance rates, the Council urged SSA to strive for more accurate, appropriate, and uniform disability decisions nationwide at the initial and reconsideration levels. They believed uniformity could be at least partly improved by developing more specific rules and increasing SSA's diligence to ensure that these rules are uniformly applied.

In their comprehensive study of the Appeals Council for the Administrative Conference in 1989, Charles Koch and David Koplow also addressed, albeit briefly, the allowance rate variations. Citing 1986 data, the authors noted a wide range of allowance rates at the initial and reconsideration stages of the disability determination process. Although the authors agreed with the Council about such variability, Koch and Koplow were not as emboldened to urge a solution. They wrote that creating any consistent and uniform standards among such a diverse and varied population was "a daunting task." [31]

Arner believed that a substantial amount of the allowance rate variation was caused by the "lack of Federal management control of State agencies." However, he said there was little hard data to support this position. As a caveat to his own belief Arner noted that "it is fairly obvious that allowance rates are substantially affected by unemployment rates and other factors," including health, occupational, and demographic characteristics of the various States.[32]

Shoenberger, on the other hand, took allowance rate variability in stride when he wrote, "variations between State DDS agencies should be considered to be a normal state of affairs." [33] He be-

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[30] Report of the Disability Advisory Council (1988), supra note 4, p. 83.

[31] Charles H. Koch, Jr. and David A. Koplow, "The Fourth Bite at the Apple: A Study of the Operation and Utility of the Social Security Administration's Appeals Council," 1987 Administrative Conference of the United States (Vol. 1) pp. 625, 680; reprinted in *Florida State University Law Review*, 17:2, pp. 199, 228 (Winter 1990).

[32] See Arner, supra note 7, p. 2.

[33] See Shoenberger, supra note 1, p. 610.

lieved that those making legislative, regulatory, and administrative decisions must "anticipate and consider" that these variations occur now and, most likely, will continue in the future.

Health and Financial Status of Allowed and Denied Disability Applicants

In November 1989, the GAO reported to Congress the results of a study they conducted to determine the health and financial status of a sample of people who had applied for disability benefits, and who were either receiving benefits or remain denied through June 1987. The study found that, overall, both disability beneficiaries and denied applicants were not well-off in terms of employment, health, and financial status. The study also found that one-quarter of all denied applicants were without any form of medical insurance.

In their study, the GAO found that both the allowed and denied populations reported low income and financial status. Nearly 58 percent of those denied disability benefits were not working. Two-thirds of those denied and not working had been unemployed for at least 3 years. Over half of these nonworking denied applicants did not expect to work again. Of the denied applicants who were working, 71 percent said they were limited by their health in the kind or amount of work they could do. In reporting family income, over 60 percent of the nonworking denied applicants said they had incomes below Federal poverty levels. Forty-three percent of the allowed beneficiaries reported family incomes below the poverty level. Over one-third of the nonworking denied depended on other government programs for at least half of their family income.

To determine the health status of both allowed and denied applicants, the GAO asked study participants to assess their own health and functional situations. Seventy percent of the denied applicants said their health was poor to fair. Nearly half of those denied and not working reported only poor health. When comparing the functional capacities of nonworking denied applicants to allowed applicants, the GAO found that "the severity of functional limitations reported by the nonworking denied resembled that of the allowed population."[34] Over 70 percent of both groups reported being severely limited. And, 40 percent of the nonworking denied applicants stated that they needed the help of others for at least one personal care activity, such as assistance with eating, dressing, or getting in and out of bed. Back problems were reported as the most limiting impairment for denied disability applicants while heart or mental conditions were reported as the most limiting impairment for allowed disability claimants.

The GAO concluded that both allowed and denied disability applicants were not financially well off. Although they believed the study appeared "to raise some questions" about the accuracy of disability criteria and decisions, GAO would not draw any definite conclusions about "how well disability eligibility criteria distinguished between those who, considering functional limitations, can

[34] *Social Security Disability: Denied Applicants' Health and Financial Status Compared With Beneficiaries'.* GAO Report to the Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives (November 1989), p. 32.

and cannot work."[35] GAO stated that other variables such as motivation and attitude toward work, availability of jobs in the economy, and the disability program's "all or none" concept might impact a denied applicant's relationship to the work force.

As this literature review illustrates, the disability determination process has been the subject of intensive study and review by a variety of experts. Despite a consensus among them that the system is in need of reform, there is only a partial consensus on how to solve the problems. Given the significance of disability determinations in people's lives, caution is warranted before changes are implemented. Yet SSA has been slow to complete demonstration projects manated by Congress which are crucial in predicting the consequences of reform. Members of Congress are growing frustrated with SSA's failure to comply with its requirement to gather meaningful data.

Rather than delaying reform by awaiting further studies, the time is ripe to move based on the weight of evidence in the many analyses that have already been completed. SSA is in a position to forge new and alternative processes to make the system more responsive to the needs of claimants. The recommendations in this study are supported by a wide array of experts and organizations that have evaluated these issues.

[35] Ibid., p. 35.

RECOMMENDATIONS

1. Legislation should be enacted to collapse reconsideration into the initial determination stage. This would establish a single initial decision procedure to replace the current two-step process. Currently, both stages serve as "paper" reviews, where the applicant is never personally interviewed. Any elimination of the reconsideration stage must be accompanied by an optional personal appearance interview at the initial determination stage. (See recommendation 2.)

2. That legislation should require SSA to provide the option of personal appearance interviews at the initial determination stage for individuals who would otherwise be denied benefits.

If, at the initial review, it is determined that the claimant's case will receive an unfavorable decision, the claimant would be offered a personal interview with the decisionmaker prior to the final determination of disability.

The location of the interview must be reasonably accessible to the individual.

The interview should be optional, with no penalty to the claimant if it is not taken.

The personal interview must be given by the decisionmaker who will make the final determination on the case.

If the claimant is denied benefits following a personal interview, the appeal would be made to an ALJ, who would continue to conduct *de novo* hearings.

3. Disability examiners must assure that every method of securing evidence has been pursued before a decision is made, regardless of any timelines.

Secure new evidence where impairments are suspected but not documented.

Develop vocational evidence.

4. Ensure that notices of DDS decisions are clear and detailed. Notification should include an explanation of:

the individual's right to appeal;

the individual's right to seek legal representation; and

the State agency's reasons for a denial, including any deficiency in the evidentiary record.

5. OHA should be provided their own budget for ordering consultative exams. Currently, funds for CE's ordered by ALJ's come out of the State DDS's budgets.

6. State disability agencies must be provided adequate budgets and staff to adequately process the projected caseloads for fiscal year 1991, particularly in light of the additional cases created by the Supreme Court *Zebley* decision.

7. Consultative examiners should be paid a sufficient amount taking into consideration the local market rate.

8. Individuals should receive all needed assistance from the district office when completing the application for disability.

Given the strong evidence that the self-help forms are impairing rather than improving the determination process, SSA should reconsider its intake procedures.

Individuals who are illiterate or have mental disabilities must not be given the self-help application.

Sufficient staff should be made available at the district offices to assist any individual in completing the form.

APPENDIX

	Bloch	Shoenberger	Admin. Conf. of U.S.	Disability Advisory Council	Sweeney	Arner
Initial determination: Explanation of rights.....			Claimants should be told of adverse consequences resulting from failure to appeal.	Applicants should get full explanation of eligibility requirements and responsibilities for meeting them.	Tell people what they need to provide their cases. Assist people in completing forms; including SSA 3368. Explain requirements, ask if person can do level of work required. Tell what evidence is missing.	
Complete evidence development.	Improve development of medical and vocational evidence during a revised initial decision process by increasing communication between staff and claimant on progress of application.		At initial stages, much greater attention should be paid to obtaining medical evidence.	Assure every method of securing evidence to support claims are pursued. —standardize forms —conform to treating physician needs. Utilize innovative systems to facilitate preparation of case files and decisions.	Provide the most complete evidentiary record at initial review. Require return cases where this has not been done; create checklist.	Use FDC's for: —intensive intake; —disability interview; —development; —arranging CE's; —making ME's and VE's available; —doing VR referrals.

Use of face-to-face interviews.	Add an optional face-to-face interview with claimant.	Use of face-to-face interviews may be promising but implementation should be delayed until reports on SSA's PAD's have been completed. If face-to-face interviews are used, decentralization of state DDS units appears necessary.	Experiments and demonstration projects concerning use of face-to-face procedures at the initial determination should be continued and encouraged. If used, consider decentralization of DDS offices into decisional units.	Require person-to-person contact with applicants at both the DO's and DDS's.	Require face-to-face interviews for initial applicants and CDR's; interview must be done by person who will decide the case.	If denial likely, offer a face-to-face interview (possibly on a selective basis).
Development of medical evidence.	Enhance the decisionmaking role of permanent medical staff at initial level. Medical staff should be responsible for development of all relevant medical evidence. Certain issues should be set aside for special decision by medical staff. Medical sources should be used more effectively to provide evidence of disability (including the treating physician). Medical staff should be used to resolve conflicts on medical issues at initial decision level.		Enhance the decisionmaking role of the medical personnel. Ensure the medical member of the team has full responsibility for developing the medical evidence. Certain issues should be set aside for special decisions by medical staff. Medical staff should be used to resolve any medical conflicts that arise. Claimants should be informed of specific deficiencies in medical evidence.	Expand current efforts to increase physician understanding of disability eligibility requirements. Pay CE's a sufficient rate given the local market.	Ask treating physician for RFC assessment. Require emphasis on treating physician's report. Pay for CE when needed. Identify impairments not clearly established. Develop vocational evidence. Develop special units for focus on special cases, like AIDS and children.	

APPENDIX—Continued

	Bloch	Shoenberger	Admin. Conf. of U.S.	Disability Advisory Council	Sweeney	Arner
Staffing and budgets.....	Provide additional staff and funds to assure compilation of complete record.		Recognizes that recommendations would require greater expenditures and staffing at state agencies—costs would be offset by eliminating reconsideration and reducing appeals.		Give OHA their own budget for CE's. Increase DDS budgets.	
Notification.....	Claimants should be informed of any specific deficiency in medical evidence.		Claimants should be provided state agency reasons for denial. Claimants should be told date of expiration of insured status.	Ensure notices of DDS decisions are clear and detailed; explain right to appeal and seek representation; offer pathways for employment.	Provide clear notices. Inform applicant of right to appeal and to representation.	Urge claimant to get an attorney.
Reconsideration.....	Eliminate reconsideration. Establish a single initial decision procedure to replace the current 2-step process.	Reconsideration should be maintained.	Eliminate reconsideration, while also making other improvements at initial decision level.	Current system is not acceptable. Options include: —collapsing initial and reconsideration steps into one; —abolishing reconsideration; allow claimant to go straight to ALJ's; —place responsibility for reconsideration under SSA, not DDS's; —make reconsideration optional; —provide face-to-face hearings at reconsideration.	Eliminate reconsideration or collapse into the initial level.	Eliminate reconsideration.

Federalization.....	No change.	No change.	No comment.	Federalization may be necessary to ensure effective and consistent administration of the initial and reconsideration steps.	No change; although use the DDS at SSA/Baltimore to address tough cases or backlogs.	Federalize.

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