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The Fourth Bite at the Apple: A Study of the Operation and Utility of the Social Security Administration's Appeals Council

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THE FOURTH BITE AT THE APPLE: A STUDY OF THE OPERATION AND UTILITY OF THE SOCIAL SECURITY ADMINISTRATION'S APPEALS COUNCIL

CHARLES H. KOCH, JR. AND DAVID A. KOPLOW

The Social Security Administration's Appeals Council performs the fourth and final administrative evaluation of appealed disability claims. Very little information about the Appeals Council has been available to claimants and their representatives, even though claimants must request Appeals Council review before filing an appeal in federal court. In response to criticism and controversy surrounding this obscure branch of the Social Security Administration, the Administrative Conference of the United States (ACUS) asked Professors Koch and Koplow to study the Appeals Council's effectiveness in disability claims and adjudication. In this Article, the authors examine Appeals Council operations and the Council's relationship to the administrative and judicial disability claims procedure and make recommendations for streamlining and improving the claims process. These recommendations, originally presented in a report to the ACUS, were evaluated and substantially adopted by ACUS and are presently being considered by the Social Security Administration.

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THE FOURTH BITE AT THE APPLE: A STUDY OF THE OPERATION AND UTILITY OF THE SOCIAL SECURITY ADMINISTRATION'S APPEALS COUNCIL

CHARLES H. KOCH, JR.* AND DAVID A. KOPLOW**

THE APPEALS Council provides the final administrative review of benefit claims under the purview of the Social Security Administration (SSA).¹ As a central unit in the adjudicatory bureaucracy, the Council reviews the work of an immense and diverse network of federal and state adjudicators and handles a wide variety of cases.²

Recently, however, the operation and the very existence of the Appeals Council have become highly controversial. Indeed, SSA claimants' representatives have argued that "serious consideration should be given to eliminating the Appeals Council or severely limiting its

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1. This Article derives from a study undertaken during the summer and fall of 1987 under the auspices of the Administrative Conference of the United States (ACUS), which provided valuable support and assistance. The ACUS evaluated the study and prepared its own recommendations, which were adopted December 18, 1987 and codified at 1 C.F.R. § 305.87-7 (1987). See also REPORTS AND RECOMMENDATIONS OF ADMINISTRATIVE CONFERENCE OF THE UNITED STATES 625 (1987).

The authors are indebted to a number of people for their extraordinary support and assistance in this project. Special appreciation is due to Jeff Lubbers of the Administrative Conference of the United States, Gil Fisher of the Social Security Administration, Bill Taylor and Burt Berkley of the Appeals Council and Eileen Sweeney of the National Senior Citizens Law Center, who were exceptionally generous with their time and attention throughout the project. In addition, our thanks go to Mariam Naini, our research assistant, and Karen Bouton, our typist.

2. Existing studies of intermediate administrative appellate bodies include the following: C. KOCH, ADMINISTRATIVE LAW AND PRACTICE §§6.71 to .79 (1985); Cass, *Allocation of Authority Within Bureaucracies: Empirical Evidence and Normative Analysis*, 66 B.U.L. REV. 1 (1986) [hereinafter *Allocation of Authority*]; R. CASS, BACKGROUND REPORT FOR RECOMMENDATION 83-3: AGENCY REVIEW OF ADMINISTRATIVE LAW JUDGES' DECISIONS, REPORTS AND RECOMMENDATIONS OF ADMINISTRATIVE CONFERENCE OF THE UNITED STATES 115 (1983) [hereinafter 1983 ACUS REPORT]; E. ELLIS, REPORT IN SUPPORT OF DISCRETIONARY REVIEW OF DECISIONS OF PRESIDING OFFICERS: SUBPARAGRAPH 1(B) OF RECOMMENDATION No. 6, 1 REPORTS AND RECOMMENDATIONS OF THE ADMINISTRATIVE CONFERENCE OF THE UNITED STATES 155 (1971); J. FREEDMAN, REPORT OF THE COMMITTEE ON AGENCY ORGANIZATION AND PROCEDURE IN SUPPORT OF INTERMEDIATE APPELLATE BOARDS: SUBPARAGRAPH 1(A) OF RECOMMENDATION No. 6, 1 REPORTS AND RECOMMENDATIONS OF THE ADMINISTRATIVE CONFERENCE OF THE UNITED STATES 125 (1971).

functions,'³ while members of Congress,⁴ neutral scholars,⁵ federal judges,⁶ and Reagan administration officials⁷ have criticized the Appeals Council, questioned its mandate, and called for its abolition. As a result, the Administrative Conference of the United States, at the behest of the SSA, requested us to study the Appeals Council. In this Article, we discuss the operation of the Appeals Council and its relationship to the rest of the adjudicatory bureaucracy and the courts. We also make recommendations for improvements.⁸

We have been struck repeatedly by the lack of information available to the public about the internal organization and operation of the Appeals Council. Despite the importance of the Appeals Council and its central position in the SSA network, little has been written about the Appeals Council. Most outside commentators, even those who focus on the hearings and appeals process, have devoted their attention elsewhere. We discern important costs in this "invisibility" and hope that dissemination of our findings through the Administrative Conference and the *Florida State University Law Review* can aid in the process of restoring the prominence and effectiveness of the Appeals Council.

This Article is organized into three basic sections: "Background," "Goals," and "Findings and Recommendations." The "Background" section provides an overview of federal disability law, outlines the SSA's claims adjudication process, and describes the organization and operation of the Appeals Council and the precise standards and procedures for case handling. The "Goals" section identifies six institutional objectives for the Appeals Council and describes the overlapping and partially conflicting imperatives facing the SSA bureaucracy and the Appeals Council. It then evaluates the success of the institution in attaining these goals, and concludes that the

3. *Current Problems in the Social Security Hearings and Appeals Process: Hearing Before the Subcomm. on Social Security of the Comm. on Ways and Means, House of Representatives*, 99th Cong., 2d Sess. (Mar. 18, 1986) (statement of Eileen Sweeney, Staff Attorney, National Senior Citizens Law Center) [hereinafter *1986 Hearing*].

4. See H.R. 2117, 100th Cong., 1st Sess. (1987) (introduced by Rep. Archer).

5. See D. COFER, JUDGES, BUREAUCRATS, AND THE QUESTION OF INDEPENDENCE: A STUDY OF THE SOCIAL SECURITY ADMINISTRATION HEARING PROCESS 12, 13 (1985). "The arguments are persuasive that the \$18 million a year expense of the [Appeals Council] could be put to better use." *Id.* at 190.

6. See *Salling v. Bowen*, 641 F. Supp. 1046, 1058-59 (W.D. Va. 1986).

7. Lambro, *Ritualism in Social Security*, *The Commercial Appeal* (Apr. 16, 1981).

8. We received an extremely high level of cooperation from the Appeals Council, other components of the SSA, and outside commentators. We found these sources to be frank, constructive, and generous with their time.

Although our numerous sources spoke freely and generally without restrictive attribution rules, we have elected not to quote them directly or cite them by name. In an already heavily footnoted Article, citation of individual interviews would excessively burden the text.

overwhelming crush of cases (currently close to 50,000 cases per year for the twenty members of the Appeals Council) precludes the complete accomplishment of any of these goals. The "Findings and Recommendations" section offers suggestions on how to defeat this "tyranny of the caseload." Our primary concern is to redirect the Appeals Council from focusing exclusively on individual cases toward using its unique perspective to develop, promote, and implement streamlined proposals that make the claims process more accurate, uniform, efficient, and acceptable to the public.

I. BACKGROUND

This section contains an overview of federal disability law, the SSA disability claims adjudication process, and the organization and operation of the Appeals Council.

The federal disability overview section focuses on the financial and medical criteria that a claimant must satisfy in order to be eligible for the programs, the standards of proof required for a finding of eligibility, and the available benefits.

The section on claims adjudication reviews each stage in the process, from initial application to judicial review. This section also contains observations about the claims process and the nature of SSA disability cases.

Finally, the Appeals Council section provides a detailed review of the Appeals Council, including the legal authority for its existence, its history, its composition and its staff. This section also contains a detailed review of the adjudication process at the Appeals Council level, a review of other Appeals Council functions and a review of the costs of the Appeals Council.

A. *Federal Disability Programs*

This Article encompasses the disability provisions of two basic federal public benefits programs: Retirement, Survivors, Disability, and Health Insurance (RSDHI);⁹ and Supplemental Security Income

9. Certain portions of the Retirement, Survivors, Disability and Health Insurance (RSDHI) program are also known as Old Age, Survivors, and Disability Insurance (OASDI). These were enacted as Title II of the Social Security Act and are codified at 42 U.S.C. §§ 401 to 433 (Supp. 1986) (see §§ 423 to 425 for the disability portions). Implementing regulations are located at 20 C.F.R. § 404 (1986). The Health Insurance provisions of RSDHI are contained in Title XVIII of the Social Security Act and are now largely administered by the Health Care Financing Administration of the Department of Health and Human Services. The health insurance provisions are codified at 42 U.S.C. § 1395 (1982).

(SSI).¹⁰ As of 1987, the disability components of these two programs together accounted for approximately \$29 billion of annual disbursements to seven million recipients,¹¹ making them the Western world's largest income support program for people unable to engage in substantial gainful activity.¹²

A variety of other specialized disability programs exists in the United States.¹³ These include state workers' compensation programs,¹⁴ Veterans' Administration programs,¹⁵ and private insurance

10. The SSI program (also known as Title XVI of the Social Security Act) is codified at 42 U.S.C. §§ 1381 to 1383c (1982). Implementing regulations are located at 20 C.F.R. § 416 (1986).

11. Statistics on program size:

Year	RSDHI DISABILITY				SSI DISABILITY	
	Number of Recipients		Total Payments		Number of Recipients	Total Payments
	workers	others	workers	others		
1987(est.)	2.8m	1.3m	\$17.5B	\$2.4B	2.9m	\$9.2B
1986	2.7m	1.3m	\$17.1B	\$2.4B	2.8m	\$8.5B
1985	2.7m	1.2m	\$16.3B	\$2.4B		
1984	2.6m	1.2m	\$15.4B	\$2.3B		
1983	2.6m	1.2m	\$15.2B	\$2.4B		

SOCIAL SECURITY ADMINISTRATION, 1987 ANNUAL REPORT TO THE CONGRESS 29, 31 (1987) [hereinafter 1987 SSA REPORT TO THE CONGRESS].

12. In 1986, 417,000 workers and 341,000 of their dependents were added to the disability rolls. This was the largest number of new awards of any year in the 1980s, but was significantly below the 1975 peak, when 592,000 new awards were made to disabled workers alone. Sherman, *Fast Facts and Figures about Social Security, 1987*, 50 SOC. SECURITY BULL. 5, 10 (May 1987). For a comparison of social insurance programs (covering disability as well as other support devices) in other nations, see SOCIAL SECURITY ADMINISTRATION, *SOCIAL SECURITY PROGRAMS THROUGHOUT THE WORLD-1983* (1984); D. STONE, *THE DISABLED STATE passim* (1984).

13. For comparisons among various categories of disability programs, see F. BLOCH, *FEDERAL DISABILITY LAW AND PRACTICE passim* (1984) (discussing RSDHI, SSI, veterans' benefits, federal civil service benefits, and black lung benefits); D. Swansburg, *The Relationship Between Pain and Disability Benefits: A Literature Survey* (Oct. 1985) (background paper prepared for the Commission on the Evaluation of Pain); *Social Security Programs in the United States, 1987*, 50 SOC. SECURITY BULL. 5 (Apr. 1987) (describing RSDHI, SSI, unemployment, workers' compensation, and numerous other programs); Johnson, *Disability, Income Support, and Social Insurance*, in *DISABILITY POLICIES AND GOVERNMENT PROGRAMS* 87 (E. Berkowitz ed. 1979).

14. Workers' compensation programs, created and administered by state governments, vary substantially. In general, they provide compensation for partial or total disabilities arising during the course of employment. Price, *Workers' Compensation: Coverage, Benefits and Costs, 1983*, 49 SOC. SECURITY BULL. 5 (Feb. 1986). The disability may be permanent or temporary, but rehabilitation, rather than an expectation of long-term receipt of benefits, has been stressed as the rationale for the program. D. Swansburg, *supra* note 13, at 20-29.

15. The Veterans' Administration (VA) manages a disability compensation program for service-connected partial or total disability, as well as a program for non-service-connected total disability. In addition to cash benefits, the VA provides medical treatment, rehabilitation services and other programs. D. Swansburg, *supra* note 13, at 14-19; F. BLOCH, *supra* note 13, at 320, 328-31.

plans.¹⁶ Additionally, various federal programs have been established to aid, for example, "black lung" victims,¹⁷ retired railroad workers,¹⁸ and federal employees.¹⁹ RSDHI and SSI, however, are uniquely important, not only because of their huge volume of disbursements and recipients, but also because of the heavy administrative burden this volume places on the SSA. The Appeals Council, as stated earlier, is particularly burdened by this volume.

Federal disability law is as complex as it is important.²⁰ Part of this complexity results from the piecemeal fashion in which legislation for these two programs was enacted.²¹ Although the Social Security Act was passed in 1935,²² it was not until 1956 that Congress made support available to workers disabled prior to retirement age.²³ By 1958, benefits were extended to the dependents of disabled workers.²⁴ In 1960, the previous age restriction, limiting benefits to disabled workers over

16. Private insurance carriers offer an array of individual or group disability insurance policies. These vary widely in their terms, cost, and coverage. C. SOULE, *DISABILITY INCOME INSURANCE: THE UNIQUE RISK* *passim* (1984); D. Swansburg, *supra* note 13, at 30-37.

17. Title IV of the Federal Coal Mine Health and Safety Act of 1969 (The Black Lung Benefits Act), 30 U.S.C. §§ 901 to 945 (1982), provides federal benefits to coal miners who become totally disabled by pneumoconiosis, or "black lung" disease, as a result of inhaling coal dust in mines. The program was originally administered by the SSA, but has been transferred to the Department of Labor, effective with applications filed in 1973. F. BLOCH, *supra* note 13, at 499-589.

18. The Railroad Retirement Act of 1974, 45 U.S.C. § 231 (1982), established a federal pension program for retired and disabled railroad employees. The Railroad Retirement Board administers the program. F. BLOCH, *supra* note 13, at 19-25; 20 C.F.R. §§ 404.1401 to .1413 (1986).

19. Prior to January 1, 1984, federal employees were exempt from most of the RSDHI program but were eligible for disability benefits under the Civil Service retirement program. Newer employees are now included in SSA programs. F. BLOCH, *supra* note 13, at 427-96.

20. Berkowitz, *The American Disability System in Historical Perspective*, in *DISABILITY POLICIES AND GOVERNMENTAL PROGRAMS* 21 (E. Berkowitz ed. 1979).

21. Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833 (1976). Liebman identifies three costs of the disjointed political process that has generated disability law: it is difficult for the public to comprehend the system and its fair application; de facto delegation of authority from Congress to diverse judicial and administrative bodies leads to inconsistent results; and complex compartmentalized programs lead to rigidity in the system, with resistance to comprehensive evaluation and change. *Id.* at 834.

22. See Social Security Act, ch. 531, 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. §§ 301 to 1397f (1982)).

23. See Social Security Amendments of 1956, ch. 836, 70 Stat. 807, 815-24. The 1954 amendments had provided a freeze for a disabled worker's earnings record, ensuring that the worker's ordinary retirement pension would no longer be reduced due to having paid little or no FICA tax during a period of disability. Social Security Amendments of 1954, ch. 1206, 68 Stat. 1052, 1080. "FICA" stands for Federal Insurance Contributions Act. I.R.C. ch. 21 (1986).

24. See Social Security Amendments of 1958, Pub. L. No. 85-840, 72 Stat. 101; F. BLOCH, *supra* note 13, at 8-9.

age fifty, was repealed.²⁵ In 1974, the current SSI program was established, superseding prior state-run welfare and disability programs partially funded by the federal government.²⁶ Other significant legislative modifications in the disability programs occurred in 1977,²⁷ 1980,²⁸ 1984,²⁹ and 1986.³⁰ Minor adjustments have been made almost annually, and the SSA issues new regulations or internal instructions with great frequency.³¹

1. *Financial Eligibility*

Currently RSDHI and SSI have two eligibility requirements: one financial and one medical.³² A claimant must satisfy both to be eligible for benefits under either program.³³ As elaborated below, however, the medical criteria for the programs are identical.³⁴ Additionally, although the financial eligibility tests of the two programs are very different, a claimant may satisfy both programs' definitions. Therefore, a disabled person may be eligible for RSDHI, SSI, or both.³⁵

a. *Financial Eligibility—RSDHI*

The RSDHI program is essentially an insurance plan. A person obtains coverage by working in employment "covered" by the SSA.

25. See Social Security Amendments of 1960, Pub. L. No. 86-778, §§ 401(a), 402(a), 403(b), 74 Stat. 924, 967, 969.

26. See 42 U.S.C. §§ 1381 to 1383c (1982).

27. Social Security Amendments of 1977, Pub. L. No. 95-216, §§ 101, 201, 331, 91 Stat. 1509, 1510, 1514, 1541. The 1977 amendments raised payroll taxes and reduced benefit levels to protect the financial integrity of the RSDHI disability trust fund. W. ACHENBAUM, *Social Security: Visions and Revisions* 67-68 (1986).

28. Social Security Disability Amendments of 1980, Pub. L. No. 96-265, § 304, 94 Stat. 441, 453. The 1980 amendments provided for a more frequent and searching review of approved claims, improved work incentives, and limitations on benefit levels. See *id.*

29. Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, 98 Stat. 1794. The 1984 Act modified many disability provisions, including those regarding assessment of medical improvements in continuing disability review cases, assessment of pain, consideration of multiple impairments, and evaluation of mental impairments. Sweeney, *New Disability Legislation Enacted*, 18 CLEARINGHOUSE REV. 819 (1984).

30. The Employment Opportunities for Disabled Americans Act, Pub. L. No. 99-643, 100 Stat. 3574 (1986), made permanent what had been experimental SSI provisions for continuing benefits (and Medicaid eligibility) for people who engage in substantial gainful activity. It also continued Medicaid for people whose earnings caused their income to exceed the financial eligibility criteria for SSI, provided they had not medically recovered from the disabling conditions.

31. See, e.g., [Regulations volume] Social Sec. Report Serv. (W) (1983) (containing nearly 1500 pages of regulations). "Frequent" issuance of regulations, of course, does not necessarily equate with "timely" issuance. In a number of instances, the SSA has been very slow to promulgate regulations regarding emerging areas of law.

32. LEGAL COUNSEL FOR THE ELDERLY, *DISABILITY PRACTICE MANUAL FOR SOCIAL SECURITY AND SSI PROGRAMS* 1 (1983) [*hereinafter* PRACTICE MANUAL].

33. *Id.*

34. *Id.*

35. See *id.*

Premiums, in the form of FICA taxes,³⁶ are automatically deducted from the worker's payroll check and are matched by the employer.³⁷ If a worker earns a sufficient amount in wages³⁸ in a given quarter of a calendar year, the worker is deemed to have paid enough premiums to earn a "quarter of coverage" for purposes of calculating RSDHI eligibility.³⁹

Financial eligibility for RSDHI disability benefits requires that the worker earn a sufficient number of quarters of coverage and that the quarters of coverage be relatively "recent" with respect to the onset of the disabling impairment.⁴⁰ For most claimants, these standards require forty quarters (ten years) of work in covered employment at any time during the worker's life, twenty of which must be earned within the forty-quarter period immediately prior to disability.⁴¹

Thus, RSDHI disability coverage lapses if a worker voluntarily leaves covered employment for a significant time before the onset of a disabling impairment. If the impairment is determined to have become disabling prior to a lapse in coverage, the claimant will be eligible to

36. I.R.C. ch. 21 (1986). Self-employed workers are also embraced by RSDHI, although the procedures for remitting the taxes are different. 20 C.F.R. §§ 404.1065 to .1096 (1986). Monies received from these premiums are pooled into four independent trust funds (one for disability, a second for the retirement and survivors account, a third for hospital insurance, and a fourth, somewhat different account for supplementary medical insurance) from which benefits are paid.

37. As of 1987, Social Security covered 125 million workers in the United States, which accounted for 95% of the entire labor force. 1987 SSA REPORT TO THE CONGRESS, *supra* note 11, at Introduction.

38. RSDHI coverage is earned by working, not by paying the FICA tax, so even if the tax is erroneously not withheld, the worker may still accumulate quarters of coverage. See 20 C.F.R. §§ 404.1001 to .1096 (1986). The amount of earnings necessary to qualify for a quarter of coverage is adjusted annually by an automatic statutory index. *Id.* § 404.143(a)(2). In 1987, earning at least \$460 in covered employment during one calendar quarter of the year would qualify a worker for one quarter of coverage. 52 Fed. Reg. 8247 (Mar. 17, 1987) (to be codified at 20 C.F.R. Appendix to Subpart B). In 1986, the required minimum was \$440. U.S. Dep't of Health and Human Services, Press Release (Oct. 23, 1986).

A worker earns one quarter of coverage (up to a maximum of four quarters per year) for each multiple of the basic amount earned, even if all the work and all the income occurred in only one quarter. 20 C.F.R. § 404.143(a) (1986). Thus, a worker who earned at least \$1840 (4 x \$460) at any time during 1987 would be credited with four quarters of coverage for the year.

39. Regulations for calculating quarters of coverage are located at 20 C.F.R. §§ 404.140 to .146 (1986).

40. Earning a sufficient number of quarters of coverage results in obtaining what the SSA calls "fully insured status," a threshold of eligibility for any RSDHI program. *Id.* §§ 404.110 to .115. Earning sufficient recent quarters of coverage results in "disability insured status"; this is the special test for the disability portion of RSDHI. *Id.* §§ 404.130 to .133.

41. Special rules apply to younger workers who may not have had a full opportunity to accumulate an adequate number of quarters of coverage prior to becoming disabled. These special rules generally require the claimant to have earned quarters of coverage equivalent to one-half the number of quarters between age 21 and the time of disability, with a minimum of six quarters of coverage. *Id.* §§ 404.110(b)(2), 404.130(c).

receive permanent monthly disability checks.⁴² If the disability occurs after coverage expires, no RSDHI disability benefits will be granted.⁴³

b. Financial Eligibility—SSI

In contrast to RSDHI, SSI is a means-based welfare program, not an insurance program. Therefore, no “quarters of coverage” calculation is necessary, and the claimant need not ever have worked.⁴⁴ Instead, the focus of the SSI financial eligibility inquiry is on the claimant’s level of need, considering both income and resources.⁴⁵

For SSI purposes, income is defined broadly to include earned as well as unearned income and “in kind” support such as subsidized room or board.⁴⁶ Certain exclusions, however, are allowed.⁴⁷ For example, a flat amount for work-related expenses and a percentage of other receipts can be deducted.⁴⁸ The SSI “resource test” is a ceiling on the value of assets that a person may own without losing eligibility. Again, certain items are excluded (for example, a car or a residence),⁴⁹ but the maximum allowance, after exclusions, is low: \$1800 for an individual or \$2700 for a couple as of 1987.⁵⁰

42. RSDHI disability benefits are not really permanent. For example, subject to certain exceptions, if a claimant’s impairment diminishes, allowing resumption of work, disability benefits will be terminated. Pub. L. No. 98-460, § 2(a), 42 U.S.C. § 1305 (1982) (amending 42 U.S.C. § 223(f)); 20 C.F.R. §§ 404.1588 to .1598 (1986). Various rehabilitation incentives—including a provision for a “trial work period” allowing a disability benefits recipient the opportunity to attempt re-entry into the work force without losing benefits—support the process of recovery. 20 C.F.R. §§ 404.1592, .2101 to .2127; 416.992, .2201 to .2227 (1986); *see also* DEP’T OF HEALTH AND HUMAN SERV. COMM’N ON THE EVALUATION OF PAIN, REPORT OF THE COMM’N ON THE EVALUATION OF PAIN 19-21 (1986) [hereinafter REPORT OF THE COMM’N ON THE EVALUATION OF PAIN]; Rocklin & Mattson, *The Employment Opportunities for Disabled Americans Act: Legislative History and Summary of Provisions*, 50 SOC. SECURITY BULL. 25 (Mar. 1987) (describing the section 1619 provisions through which Pub. L. No. 99-643 (1986), extended programs designed to support employment attempts of SSI disability recipients, by providing special SSI payments and Medicaid coverage).

Moreover, at age 65, a Title II disability recipient is automatically transferred from the “disability” portion of RSDHI to the “retirement” account. 20 C.F.R. § 404.316(b)(2) (1986).

A claimant may also be awarded a “closed period of disability,” which is a determination that the claimant is entitled to benefits for a period of time but is no longer disabled. Benefits are then payable for those months in which the claimant was under a disability. *Id.* §§ 404.320 to .322, 416.992a.

43. However, under these circumstances, the worker may be eligible for retirement or survivors coverage.

44. SSI is financed out of general federal tax revenues, not out of the RSDHI trust funds.

45. PRACTICE MANUAL, *supra* note 32, at 5.

46. 20 C.F.R. § 416.1102 (1986).

47. *Id.* § 416.1103.

48. *Id.* §§ 416.1100 to .1112.

49. §§ 416.1201 to .1266.

50. 50 Fed. Reg. 38,982 (1985) (codified at 20 C.F.R. § 416.1205 (1986)).

2. Medical Eligibility—RSDHI and SSI

Although the programs use different tests for financial eligibility, they employ the same standard of medical eligibility⁵¹ and virtually identical statutory definitions of “disability”: “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 which has lasted or can be expected to last for a continuous period of not less than [twelve] months.”⁵²

The mechanism for assessing a claim against this standard is the SSA’s “sequential evaluation process,”⁵³ a multi-step inquiry into several key variables.⁵⁴

Step 1: Substantial Gainful Activity

The first inquiry is whether the claimant is engaged in “substantial gainful activity.” “Substantial” activity is that which involves significant physical or mental duties,⁵⁵ and “gainful” activity embraces all work ordinarily done for pay or profit.⁵⁶ Earnings in excess of a certain amount are presumed to indicate substantial gainful activity, and

51. The regulations governing RSDHI medical assessment, 20 C.F.R. §§ 404.1501 to .1599 (1986), are substantially identical to the corresponding sections for SSI. *See id.* §§ 416.901 to .998.

52. 42 U.S.C. § 423(d)(1)(A) (1982) (“inability to engage in”); *cf. id.* § 1382c(a)(3)(A) (“unable to engage in”).

The Act also specifies that an individual:

shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

Id. §§ 423(d)(2)(A), 1382c (a)(3)(B).

53. By regulation, the sequential evaluation process has governed disability adjudications since 1979. *See* 44 Fed. Reg. 18,170-71 (1979) (codified at 20 C.F.R. §§ 404(P), 416(I)). It is incorporated into SSA publications and into decisional documents sent to claimants.

54. 20 C.F.R. §§ 404.1520, 416.920 (1986). If at any stage of the sequential evaluation, it is determined that the claimant is or is not disabled, the evaluation proceeds no further. PRACTICE MANUAL, *supra* note 32, at 7. Two special disability categories do not fit neatly into the sequential evaluation process but may be important to a particular claimant. One grants benefits to a claimant who has only a marginal education and work experience of 35 years or more doing arduous physical labor, and who is no longer able to perform that type of work due to a severe impairment. 20 C.F.R. §§ 404.1562, 416.962 (1986). The other special category grants benefits to a claimant who is of advanced age, has a limited education, and has no work experience. S.S.R. 82-63 (1982). For an illustration of the SSA’s “sequential evaluation process, see Chart 1, *infra* page 320.

55. 20 C.F.R. §§ 404.1572(a), 416.972(a) (1986).

56. *Id.* §§ 404.1572(b), 416.972(b).

preclude eligibility.⁵⁷ However, even if the claimant is paid less than this amount and is working only on a part-time basis with reduced responsibilities, the performance of such work may indicate a latent ability to perform substantial gainful activity, unless the work has trifling importance or requires unusual supervision or support.⁵⁸

Step 2: Severity

The next inquiry is whether the claimant's impairment is "severe"—i.e., whether it significantly limits the claimant's physical or mental ability to engage in basic work activities,⁵⁹ and satisfies the statutory twelve-month duration requirement.⁶⁰ This particular step in the sequential evaluation has caused much turmoil. Several circuit courts had invalidated the "severity" test, finding either that it was facially inconsistent with the Social Security Act or that the SSA had regularly misapplied it by transforming a *de minimis* preliminary screening process into a much more powerful barrier justifying peremptory denials of large numbers of substantial cases.⁶¹

The Supreme Court recently upheld the logic of the "severity" step, finding it consistent with the enabling statute, allowing the SSA to pose some sort of threshold screening test.⁶² However, the Court did

57. *Id.* §§ 404.1574(b)(2)(vi), 416.974(b)(2)(vi). Different monetary cutoff levels are applicable to blind persons, who are not presumed to be engaged in substantial gainful activity until their earnings rise to a significantly higher level. *Id.* § 404.1584(d). Different rules are also applicable to self-employed persons. *Id.* §§ 404.1575, 416.975.

58. *See id.* §§ 404.1571, 416.971. Activities such as taking care of oneself, pursuing sedentary hobbies, etc., do not ordinarily constitute substantial gainful activity. *See id.* §§ 404.1572(c), 416.972(c).

Under the section 1619 program of Pub. L. No. 99-643 (1986), 42 U.S.C. § 1305 (1982), the question of substantial gainful activity will remain relevant at the initial application level of an SSI claim, but will not be used in SSI continuing disability review cases.

59. "Basic work activities" include walking, standing, seeing, hearing, understanding, using judgment, responding appropriately to co-workers, etc. 20 C.F.R. §§ 404.1521, 416.921 (1986). The severity regulation provides:

If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience.

Id. §§ 404.1520(c), 416.920(c).

60. *Id.* §§ 404.1509, 416.909. The duration requirement is not really a part of any single step of the sequential analysis. The claim must be assessed for duration at all stages, but discussion of it fits most logically into this segment of the analysis. *See S.S.R.* 82-52 (1982).

61. "[A]ll 11 Regional Federal Courts of Appeals have either enjoined the Secretary's use of the step 2 [severity] regulation or imposed a narrowing construction upon it." *Bowen v. Yuckert*, 482 U.S. 137, 156 (1987) (O'Connor, J., concurring); *see, e.g., Baeder v. Heckler*, 768 F.2d 547 (3rd Cir. 1985); *McDonald v. Heckler*, 624 F. Supp. 375 (D.Mass. 1986); *McDonald v. Heckler*, 629 F. Supp. 1138 (1986), *aff'd in part, vacated in part, and remanded sub. nom. McDonald v. Secretary of HHS*, 795 F.2d 1118 (1st Cir. 1986); *Pratt v. Heckler*, 629 F. Supp. 1496 (D.D.C. 1985).

62. *Bowen*, 482 U.S. at 154.

not reach the question of whether the severity step, as applied in practice by the SSA, was a valid exercise.⁶³ In the interim, the SSA has issued a Social Security Ruling on severity, again defining it as a bar to only the weakest cases.⁶⁴

Step 3: Listings

The next step in the sequential evaluation is to determine whether the claimant's impairment meets or equals one or more of the presumptively disabling medical conditions defined in the regulations' "Listing of Impairments."⁶⁵ If the claimant's abnormalities, singly or together, meet or equal⁶⁶ a listed criterion, benefits will be awarded without further inquiry into the impairment's effects upon the claimant's life.⁶⁷

The listings contain more than 100 precisely defined medical conditions, organized by thirteen body systems (e.g., musculoskeletal, cardiovascular, neurological).⁶⁸ Each listing specifies the impairment and the tests required to diagnose its presence and severity.⁶⁹ Approxi-

63. *Id.* at 154 n.12. The concurrence (Justice O'Connor, joined by Justice Stevens) noted that statistics tended to support the allegation that the severity step had been molded into a substantial barrier. *Id.* at 157. Prior to the current severity regulation, only 8% of disability claims had been denied as nonsevere; later, 40% were eliminated at that stage. *Id.* After circuit courts began invalidating the regulation, the nationwide rate of "nonsevere" denials fell to 25%. *Id.* Three dissenters, led by Justice Blackmun, agreed with Justice O'Connor that the validity of the severity step as applied remains problematic. *Id.* at 179.

64. S.S.R. 85-28 (1985) states in part:

An impairment or combination of impairments is found "not severe" and a finding of "not disabled" is made at this step when medical evidence establishes only a slight abnormality or a combination of slight abnormalities which would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered (i.e., the person's impairment(s) has no more than a minimal effect on his or her physical or mental ability(ies) to perform basic work activities).

Id. at 22.

65. 20 C.F.R. §§ 404.1525, 416.925 (1986); *id.* § 404 subpart P, app. 1.

66. *Id.* §§ 404.1526, 416.926. The "equals" option applies to impairments (or combinations of impairments) which are not listed, but which are "medically equivalent" to a listing and impinge upon the ability to perform basic work activities in a manner equivalent to a listed impairment. In recent years only 8% to 9% of disability awards have been based on "equaling" a listing. In 1976 this standard was responsible for over 45% of the awards. HOUSE COMM. ON WAYS AND MEANS, 100TH CONG., 1ST SESS. BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS 36 (Comm. Print 1987) [hereinafter 1987 BACKGROUND MATERIAL].

67. 20 C.F.R. § 404.1520(d) (1986).

68. See *id.* § 404 subpart P, app. 1. A separate set of listings exists for the evaluation of impairments of persons under the age of 18, where the progression or effects of the disease may be different from those for adults. *Id.* §§ 404.1525(b)(2), 416.925(b)(2).

69. See *id.* § 404 subpart P, app. 1. For example, the first listed impairment, rheumatoid arthritis, is defined as follows:

1.02 *Active rheumatoid arthritis and other inflammatory arthritis.*

mately three-quarters of disability awards are based on these listings.⁷⁰

Step 4: Past Relevant Work

If the claimant's condition does not meet or equal a listing,⁷¹ the next question in the sequential evaluation is whether the previous employment performed by the claimant could be resumed despite the claimant's impairments.⁷² If resuming the former job is possible, the claim will be denied.⁷³

With both A and B.

- A. History of persistent joint pain, swelling, and tenderness involving multiple major joints (see 1.00D) and with signs of joint inflammation (swelling and tenderness) on current physical examination despite prescribed therapy for at least three months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last for at least twelve months; and
- B. Corroboration of diagnosis at some point in time by either.
 - 1. Positive serologic test for rheumatoid factor; or
 - 2. Antinuclear antibodies; or
 - 3. Elevated sedimentation rate; or
 - 4. Characteristic histologic changes in biopsy of synovial membrane or subcutaneous nodule (obtained independent of Social Security disability evaluation).

Id. part 404 subpart P, app. 1, part A, § 1.02.

70. The irregularity in basis for disability awards is suggested by the following chart:

	Basis for disability					
<u>Allowance:</u>	<u>1960</u>	<u>1965</u>	<u>1970</u>	<u>1975</u>	<u>1980</u>	<u>1986</u>
Meets listing	70%	52%	39%	29%	62%	67%
Equals listing	20%	32%	43%	45%	14%	9%
Vocational factors	10%	16%	18%	26%	24%	24%

D. STONE, *supra* note 12, at 226; SOCIAL SECURITY DISABILITY INSURANCE PROGRAM: *Hearing Before the Comm. on Finance, U.S. Sen.*, 97th Cong., 2d Sess. 111 (Aug. 18, 1982). 1987 BACKGROUND MATERIAL, *supra* note 66, at 36.

71. Widows, widowers and surviving divorced spouses claiming RSDHI disability benefits based upon the work record of a deceased spouse are eligible for disability benefits only based on the listings. 20 C.F.R. §§ 404.1577, .1578 (1986). These claimants do not traverse the same sequential evaluation process as others, and are not evaluated within the context of the vocational factors of the "grids." See *id.* Similarly, children under age 18 claiming SSI disability benefits are eligible only based on the listings. *Id.* § 416.924.

Allegations have been made that the SSA and Disability Determination Services (DDS's) have systematically circumvented the legal standards of the sequential evaluation process by effectively terminating the analysis after step three. See *City of New York v. Heckler*, 578 F. Supp. 1109 (E.D.N.Y. 1984), *aff'd sub nom.* *Bowen v. City of New York*, 476 U.S. 467 (1986). Claimants—especially those alleging mental impairments—who did not win benefits at the listings stage were sometimes categorically denied, without individualized examination of vocational factors. *Id.*

72. 20 C.F.R. §§ 404.1520(e), 416.920(e) (1986).

73. *Id.* In investigating the possibility of a claimant returning to past relevant work, the SSA looks at work that (a) constituted substantial gainful activity, (b) lasted long enough for the claimant to learn the job, and (c) was performed within the past 15 years. *Id.* §§ 404.1565(a), 416.965(a); S.S.R. 82-61 (1982); see also *Lauer v. Bowen*, 818 F.2d 636 (7th Cir. 1987). It is assumed that gradual changes may occur in the standards and requirements of most jobs, so

Step 5: Grids

If a claimant cannot resume the former job, the next inquiry is whether the claimant can perform other substantial gainful activity despite all impairments.⁷⁴ The primary mechanism for this assessment is the "Medical-Vocational Guidelines" or "grids,"⁷⁵ a series of charts designed to consider four key variables affecting ability to work. These variables are: (a) "residual functional capacity," a measure of how much basic work activity (standing, walking, lifting, carrying, etc.) the claimant can still do;⁷⁶ (b) age;⁷⁷ (c) education;⁷⁸ and (d) previous work experience and transferability of acquired skills.⁷⁹

Each variable is reduced to a few categories. For example, residual functional capacity is clustered as "sedentary," "light," or "medium," depending upon the level of exertional capability.⁸⁰ The grids combine all the variables into eighty-two "rules," each deemed "disabled" or "not disabled."⁸¹ If a claimant's medical-vocational coordi-

previous work experience gained in the distant past is no longer considered vocationally relevant. 20 C.F.R. §§ 404.1565(a), 416.965(a) (1986).

"Past relevant work" is not confined to the demands of the job as it was actually performed by the claimant. Rather, the SSA directs its inquiry into the functional demands and job duties of the occupations as they are generally required by all employers throughout the national economy. S.S.R. 82-61 (1982).

74. PRACTICE MANUAL, *supra* note 32, at 22.

75. 20 C.F.R. part 404, subpart P, app. 2 (1986). Unlike the listings, which assess the claimant based on "medical" criteria alone, the grids also incorporate the principal "vocational" factors. In so doing, the grids take "administrative notice" of the existence of jobs in the national economy that could be performed by a person of defined vocational characteristics. This notice procedure replaces the pre-1978 reliance upon the testimony of vocational experts, and obviates the necessity of identifying the specific job categories that each individual claimant could satisfy. *See id.* Use of the grids for this purpose was endorsed by the Supreme Court. *Heckler v. Campbell*, 461 U.S. 458 (1983). *See generally* Capowski, *Accuracy and Consistency in Categorical Decision-Making: A Study of Social Security's Medical-Vocations Guidelines—Two Birds With One Stone or Pigeon-Holing Claimants?*, 42 MD. L. REV. 329 (1983) (analyzing effectiveness of grids in promoting sound decisions).

76. 20 C.F.R. §§ 404.1545, 416.945 (1986).

77. *Id.* §§ 404.1563, 416.963. The age categories are: approaching retirement age (60-64), advanced age (55-60), closely approaching advanced age (50-54), and younger (18-49). The categories are not to be applied mechanically in a borderline situation. *See id.*

78. *Id.* §§ 404.1564, 416.964. The education categories are: unable to communicate in English, illiterate, marginal (completed sixth grade or less), limited (completed 7th-11th grade), high school and above. *See id.*

79. *Id.* §§ 404.1568, 416.968. The categories for previous work experience are: unskilled, semi-skilled, and skilled. Skills may be categorized as transferable or nontransferable. *See id.*

80. *Id.* §§ 404.1567, 416.967. Residual functional capacity may also be classified as capable of heavy or very heavy work, but these categories are not used on the grids. *See id.*

81. *Id.* part 404, subpart P, app. 2, tables 1-3. For example, a person (a) with the residual functional capacity for light work, (b) closely approaching advanced age, (c) of limited or less education, and (d) who is skilled or semi-skilled with skills not transferable, would be found "not disabled" under Rule 202.11 of subpart P. If the person is of advanced age, however, with all the other variables unchanged, a finding of "disabled" would be made under Rule 202.02 of subpart P. *Id.*

nates fall squarely on a grid rule, then that outcome determines the case.⁸²

*Step 6: Off The Grids*⁸³

Some claimants do not fall squarely onto the grids, either because no combination of rules precisely describes their situation, or because the alleged impairment is “non-exertional.”⁸⁴ In such cases, the grids are merely advisory.⁸⁵ The claim procedure then turns on the presence or absence of a substantial number of job categories that the claimant could perform.⁸⁶ This final step in the sequential evaluation process thus recapitulates the disability inquiry *in toto*: Considering all of a person’s medical and vocational limitations, could the person perform job functions in a competitive economy?

3. *Standards of Proof*

The burden of proving eligibility for disability benefits generally rests with the claimant.⁸⁷ Social Security regulations recognize three categories of medical evidence: signs, symptoms and laboratory findings.⁸⁸ “Signs” are anatomical, physiological, or psychological abnormalities observable by trained professionals using medically acceptable clinical diagnostic techniques.⁸⁹ “Symptoms” are the clai-

82. *Id.* §§ 404.1569, 416.969.

83. The regulations do not identify this as a separate step in the sequential evaluation process, considering it to be simply a variation of step 5 and the focus on the medical-vocational grids. However, because the substantive standards and the procedures of evaluation are significantly different when the case is not evaluated within the strength limitations context of the grids, it seems more compelling to denominate a sixth step in the analysis. *Compare* Capowski, *supra* note 75, at 359 (describing the provisions regarding nonexertional impairments as an “escape clause” from the grids).

84. 20 C.F.R. part 404, subpart P, app. 2, § 200.00(h) (1986); S.S.R. 83-12 (1983). The claim of an individual who was unable to perform the “full range” of work would not be decided directly by the grids. S.S.R. 83-12 (1983).

85. 20 C.F.R. part 404, subpart P, app. 2, § 200.00 (1986).

86. *Id.* §§ 404.1561, 416.961. The test of ability to work is whether a significant number of jobs exist in the national economy (not necessarily in the claimant’s region) that the claimant would be able to perform. *Id.* §§ 404.1566, 416.966.

87. *Id.* §§ 404.1512, 416.912. Courts have shifted the burden of coming forward with the evidence from the claimant to the SSA at step 5 of the sequential evaluation process because the government is more knowledgeable than individual claimants about the job categories and demands in the national economy. *E.g.*, *Bowen v. Yuckert*, 482 U.S. 137, 146 n.5 (1987); *Torres v. Schweiker*, 682 F.2d 109 (3rd Cir. 1982), *cert. denied*, 459 U.S. 1174 (1983); *Tennant v. Schweiker*, 682 F.2d 707 (8th Cir. 1982). This burden shifting is not mentioned in the regulations, but is “consistent with SSA policy and practice.” Assoc. Comm’r Frank Smith, Memorandum on Circuit Court Case Study 7 (June 17, 1986). The original decision creating the shift was *Kerner v. Flemming*, 283 F.2d 916 (2d Cir. 1960).

88. 20 C.F.R. §§ 404.1528, 416.928 (1986). Regulations also specify the acceptable sources and preferred contents of medical evidence. *Id.* §§ 404.1513, 416.913.

89. *Id.* §§ 404.1528, 416.928.

mant's own descriptions of physical or mental impairments.⁹⁰ "Laboratory findings" are the results of x-rays, blood tests, and other medically recognized tests.⁹¹

The SSA must consider all of these categories in making a disability determination.⁹² The most compelling evidentiary category, however, is that of "objective" reproducible tests and findings.⁹³ The regulations specify that without professional corroboration, symptoms alone are insufficient to prove the existence of an impairment.⁹⁴ Similarly, conclusory statements from a medical examiner, such as a claimant's doctor's writing that the claimant "is unable to work," will not carry much weight unless buttressed by additional evidence explaining the conclusion.⁹⁵

The definition of disability embodied in the Social Security Act and its regulations is extremely strict.⁹⁶ Unlike many other disability programs, the Social Security Administration Act is designed to redress only the most catastrophic medical losses—those associated with near-total and near-permanent inability to work. Individuals who readily meet the medical criteria of other types of disability programs are fre-

90. *Id.*

91. *Id.*

92. *Id.* §§ 404.1512, 416.912.

93. See 42 U.S.C. § 423(d)(5) (1982) and Pub. L. No. 98-460, § 3(a)(1)-(2); see also Note, *Proving Disabling Pain in Social Security Disability Proceedings: The Social Security Administration and the Third Circuit Court of Appeals*, 22 DUQ. L. REV. 491, 505-06 (1984); Goldhammer & Bloom, *Recent Changes in the Assessment of Pain in Disability Claims before the Social Security Administration*, 35 ADMIN. L. REV. 451 *passim* (1983); D. STONE, *supra* note 12, at 79 (concluding that insistence upon objective criteria evidencing disability served to enhance the strictness of the eligibility criteria and the restraints upon program growth). However, the SSA's preference for objective evidence does not authorize it to overlook testimony from a claimant or others regarding subjective conditions such as pain. See *Avery v. Secretary of HHS*, 797 F.2d 19 (1st Cir. 1986); *Foster v. Heckler*, 780 F.2d 1125 (4th Cir. 1986); *Polaski v. Heckler*, 739 F.2d 1320 (8th Cir. 1984) and 751 F.2d 943 (8th Cir. 1984).

94. 20 C.F.R. §§ 404.1528(a), .1529; 416.928(a), .929 (1986).

95. *Id.* §§ 404.1527, 416.927; Weinstein, *Equality and the Law: Social Security Disability Cases in the Federal Courts*, 35 SYRACUSE L. REV. 897, 931 (1984). The opinion of a treating physician, who has observed the claimant repeatedly over time, is ordinarily entitled to greater weight than the opinion of a consultative physician, who may have seen the claimant only once. *Aubeuf v. Schweiker*, 649 F.2d 107, 112 (2d Cir. 1981); *Davis v. Califano*, 599 F.2d 1324 (5th Cir. 1979); *Hephner v. Matthews*, 574 F.2d 359 (6th Cir. 1978). Nevertheless, it is the logic and the supporting evidence of the physician, rather than a conclusory opinion, that is compelling. S.S.R. 82-48c (Cum. Ed. 1986); see also *Schisler v. Heckler*, 787 F.2d 76 (2d Cir. 1986); *Stieberger v. Heckler*, 615 F. Supp. 1315, 1343-50 (S.D. N.Y. 1985), *vacated* 801 F.2d 29 (2d Cir. 1986).

96. NAT'L ACADEMY OF SCIENCES, INSTITUTE OF MEDICINE, COMM. ON PAIN, DISABILITY, AND CHRONIC ILLNESS BEHAVIOR, *PAIN AND DISABILITY: CLINICAL, BEHAVIORAL, AND PUBLIC POLICY PERSPECTIVES* 22-23, 33 (1987) [hereinafter INSTITUTE OF MEDICINE]. Heaney, *Why the High Rate of Reversals in Social Security Disability Cases?*, 7 HAMLINE L. REV. 1, 4 (1984).

quently denied by the SSA⁹⁷ and must be extremely sick or injured to qualify for disability benefits under RSDHI or SSI.

4. *Benefit Levels*

RSDHI monthly disability benefits are calculated using a complex formula. The claimant's prior annual average earnings in covered employment are adjusted for inflation by comparison to the national average wage level for the corresponding years.⁹⁸ In 1988, the average RSDHI benefit paid to a disabled worker was \$491 per month; the average for a disabled worker with dependents was \$905 per month.⁹⁹ In general, consistent with the insurance plan nature of RSDHI, the higher the claimant's prior covered earnings, the higher the payments the claimant receives. An SSI monthly disability check is designed to bring the claimant's income up to the established federal support level.¹⁰⁰

5. *Other Benefits*

A disabled worker's spouse, children, divorced spouse, or survivors may also be eligible for certain types of RSDHI assistance, regardless of whether they are disabled.¹⁰¹ SSI benefits are payable to an eligible individual and spouse only, but in rare cases an eligible person's stipend may be increased if an "essential person" (e.g., one who helps care for the disabled person) is part of the household.¹⁰² Additionally, an individual who has been entitled to RSDHI disability benefits for twenty-four months is also eligible for Medicare benefits,¹⁰³ and an individual who is entitled to SSI disability benefits is also thereby entitled to Medicaid coverage in most states.¹⁰⁴

97. D. Swansburg, *supra* note 13, *passim*; see 20 C.F.R. §§ 404.1504, 416.904 (1988). Part of the disparity occurs because some of the other programs such as VA and workers' compensation are authorized to pay benefits for partial and temporary disability, whereas the SSA targets exclusively those suffering from complete, long-term impairments.

98. 20 C.F.R. § 404, Subpart C (1986).

99. SOCIAL SECURITY ADMINISTRATION, 1988 ANNUAL REPORT TO THE CONGRESS 18 (1988).

100. The support level benefit amount is reduced by the amount of the claimant's countable income as determined under 20 C.F.R. part 416, subpart K (1986); *id.* part 416, subpart D.

Forty-eight states and the District of Columbia voluntarily provide to at least some SSI recipients a small supplementation above this minimum federal level. 1987 SSA REPORT TO THE CONGRESS, *supra* note 11, at 2. These supplementations may be "voluntary" or part of a mandatory "pass through" required for state receipt of Medicaid funds. *Oklahoma v. Schweiker*, 655 F.2d 401 (D.C. Cir. 1981).

101. 20 C.F.R. § 404, subpart D (1986).

102. *Id.* §§ 416.220 to .223.

103. 42 U.S.C. § 426(b)(2)(A)(i) (1982).

104. 42 U.S.C. § 1396 appropriates funds to be distributed to medical assistance plans for individuals and families meeting certain requirements, including those qualifying for SSI disability benefits. *Id.* § 1396(a)(10)(A)(i).

6. *Timing of Benefit Payments*

RSDHI benefits differ from SSI benefits in two respects. First, a statutory waiting period of five calendar months after the onset of disability applies before the first RSDHI check is issued;¹⁰⁵ SSI payments can start immediately.¹⁰⁶ Second, RSDHI benefits may apply retroactively, enabling the claimant to receive benefits for the twelve months preceding the filing of the application if a prior date of onset of the disabling impairment is proven;¹⁰⁷ SSI eligibility, on the other hand, does not provide any compensation predating the application filing date.¹⁰⁸

B. *Disability Claims Process*

Both RSDHI and SSI applications are handled through the same claims network.¹⁰⁹ The process involves both federal officials and state agencies operating under the supervision of the SSA.¹¹⁰

105. *Id.* § 423(c)(2); 20 C.F.R. § 404.315(d) (1986).

106. 20 C.F.R. § 416.501 (1986). An SSI claimant who is "presumptively eligible" (i.e., who presents strong evidence of the likelihood of meeting the financial and medical eligibility criteria) can be awarded up to three months of disability benefits before a final determination of eligibility is made. *Id.* §§ 416.931 to .934.

107. *Id.* § 404.621(a)(1). The number of months of retroactive RSDHI disability benefits is maximized if the onset of disability is 17 months prior to the date of application. The first five of these months will then be allocated to the waiting period and 12 months of back benefits will be payable. An onset date further back in time will not increase beyond 12 the number of months of retroactive award.

108. *Id.* §§ 416.340 to .350, .501. A claimant may be eligible for both RSDHI and SSI concurrently. This could occur, for example, if the individual worked for a sufficiently long time in Social Security-covered employment to establish RSDHI entitlement, but if the individual's wages were relatively low, so that current resources and income are beneath the SSI ceilings. A monthly RSDHI benefit check does count as income for SSI purposes, so unless the individual's prior earnings (and, hence, monthly RSDHI disability payment) were low, the SSI disability payment would be low or zero.

109. The SSA provides separate application forms for RSDHI and SSI, and a claimant who applies for both will receive parallel responses, again on separate forms. The procedures for investigating and administering the medical aspects of the two programs are identical, however, and concurrent applications are handled largely in tandem. For samples of the applicable forms and SSA notices, see PRACTICE MANUAL, *supra* note 32, at 51-73.

110. 42 U.S.C. §§ 421(a), 1383(a) (1982); 20 C.F.R. §§ 404.1503, 416.903 (1988). Prior to 1980, the relationship between the SSA and the state agencies was contractual. In the 1980 amendments, Act of June 9, 1980, Pub. L. no. 96-265, 94 Stat. 441, Congress changed the relationship to a regulatory one.

The federal part of the claims bureaucracy is organized as follows. The SSA (headed by a Commissioner) is one of five principal operating units of the Department of Health and Human Services. The SSA has four deputy commissioners (for Management and Assessment, Policy and External Affairs, Operations, and Programs). Each of these oversees one or more associate commissioners. The network of local SSA district offices is organizationally placed directly under the Deputy Commissioner for Operations. The Office of Disability Operations is located under the

1. Initial Application

A claimant begins the process by filing an application at one of the SSA's district or branch offices.¹¹¹ The district office begins a two-part initial determination by first investigating the claimant's financial eligibility for RSDHI, SSI or both.¹¹² If the claimant is found financially ineligible, a notice of denial is mailed.

If the claimant satisfies the applicable financial eligibility tests, the file is forwarded to another office for the second half of the initial determination, which pertains to medical eligibility. This office is part of a state government agency (usually within the state's vocational rehabilitation service) operating as a federally funded Disability Determination Service (DDS) under the SSA's regulation.¹¹³ The DDS develops the medical file by soliciting records and other documents from the claimant's physicians, hospitals, clinics, etc.¹¹⁴ The DDS may also obtain additional medical assessments by ordering a "consultative examination," in which a physician under contract with the DDS performs specified tests or measurements.¹¹⁵ A two-person team composed of a medical consultant and a disability examiner makes the DDS decision regarding medical eligibility.¹¹⁶ The process consumes,

Deputy Commissioner for Operations and the Associate Commissioner for Central Operations. The corps of Administrative Law Judges (ALJ's), the Appeals Council, and the Office of Appeals Operations are all located under the Deputy Commissioner for Programs and the Associate Commissioner for Hearings and Appeals. See Chart 2, *infra* page 321.

111. 20 C.F.R. §§ 404.611, 416.325 (1986).

112. *Id.* §§ 404.902 to .905, 416.1402 to .1405 (1988). For RSDHI claims, the local district office obtains a copy of the wage earner's earnings record (showing all SSA-covered income and quarters of coverage) from the SSA's Office of Operational Policy and Procedures. For SSI cases, the Office of Central Operations and the local district office investigate the claimant's income and resources.

113. *Id.* part 404, subpart Q; part 416, subpart J. The 1980 amendments made it possible for the SSA to replace the DDS in a particular state, and perform the medical evaluation itself, where the DDS fails to conform to SSA standards. 42 U.S.C. § 421(b) (1982).

114. The DDS may pay reproduction costs for obtaining these records. 20 C.F.R. §§ 404.1514, 416.914 (1988). If the DDS is not as vigorous as it should be in collecting medical records, the shortage of such documentation usually disadvantages the claimant, who bears the burden of proof of disability. See *id.* §§ 404.705, 1516, 416.916; Weinstein, *supra* note 95, at 931.

Apprehensions about the adequacy of DDS workups of the medical file have been exacerbated recently as SSA budget cuts have reverberated in reduced DDS staffing and services. See letter from Reps. Rostenkowski, Pickle & Jacobs to SSA Comm'r Hardy (Feb. 3, 1987).

115. 20 C.F.R. §§ 404.1517 to .1518, 416.917 to .918 (1986). The quality and sufficiency of typical DDS consultative examinations have become controversial issues. See COMM. ON GOV'T OPERATIONS, CONSULTATIVE EXAMINATIONS INVESTIGATION, H.R. REP. No. 981, 99th Cong., 2d Sess. *passim* (1986); F. BLOCH, *supra* note 13, at 234, 273-76; D. STONE, *supra* note 12, at 121-24. A claimant's failure to cooperate with a consultative examiner is grounds for denial of the claim. 20 C.F.R. §§ 404.1518, 416.918 (1988).

116. These officials conduct a paper review only; they do not meet with the claimant. The

from application to notification, approximately eighty days.¹¹⁷ Approximately 1.5 million initial determinations in disability cases are made each year; forty percent are granted.¹¹⁸ If the decision is not "fully favorable," the claimant has sixty days to appeal.¹¹⁹

An initial determination is also made when benefits are periodically reviewed. These "Continuing Disability Reviews" (CDRs) are undertaken to assess possible improvement in the claimant's condition and to remove from the disability rolls people who are no longer eligible for benefits.¹²⁰ The CDRs, and the standards and procedures for conducting them, have been controversial in recent years and were suspended from 1984-86, pending the enactment and implementation of new statutory standards.¹²¹

disability examiner or specialist ordinarily does the bulk of the work on the application. The medical consultant is a physician employed part-time or full-time by the DDS to evaluate medical conditions beyond the expertise of the disability examiner and assess the claimant's residual functional capacity. These two officials may also be assisted by a vocational expert. F. BLOCH, *supra* note 13, at 235; *see also* REPORT OF THE COMM'N ON THE EVALUATION OF PAIN, *supra* note 42, at 23.

117. Average DDS processing time for initial RSDHI applications rose from 63 days in September 1985 to 89 days in February 1986, then fell to 80 days in September 1986. Similarly, average SSI disability case processing time rose from 55 days in September 1985 to 85 days in February 1986 and declined to 79 days in September 1986. Part of the overall rise is attributed to the learning process required in implementing the new regulations concerning mental impairments and medical improvements. 1987 SSA REPORT TO THE CONGRESS, *supra* note 11, at 14.

118. 1987 BACKGROUND MATERIAL, *supra* note 66, at 41.

119. 20 C.F.R. §§ 404.909, 416.1409 (1988). In this instance, as with all succeeding time limits described below, the 60-day period runs from the date of the claimant's receipt of the decision, and the SSA assumes (until evidence to the contrary is presented) that the claimant receives the notice five days after it is dated. *Id.* §§ 404.901, 416.1401. The SSA allows extension of the time period for good cause. *Id.* §§ 404.909(b), .911; 416.1409(b), .1411.

120. CDR procedures vary somewhat from the initial sequential evaluation process. They focus on the extent to which the claimant's condition has improved or been mitigated by new medical techniques, and whether any improvement affects the claimant's ability to work. Cases fall into three categories according to the initial likelihood of subsequent medical improvement, and the frequency of review varies from once every six months to once every seven years. *Id.* §§ 404.1590, .1594; 416.990, .994; *see also* General Accounting Office, *Social Security: Adjusting Continuing Disability Review Priorities* (Oct. 1986) (critiquing the selection of types of cases for early CDRs); Sweeney, *The New 'Medical Improvement' Standard in Social Security and SSI Disability Cases passim*, (Mar. 1986).

121. LEGAL COUNSEL FOR THE ELDERLY, *DISABILITY PRACTICE MANUAL FOR SOCIAL SECURITY AND SSI PROGRAMS* 12-34, (Supp. 1987) [hereinafter *DISABILITY PRACTICE MANUAL*, SUPP. 1987].

The 1980 legislation provided for a review of current beneficiaries, and this process was greatly accelerated by the Reagan administration. Approximately one million cases were then reviewed, and almost half of them were terminated, producing huge financial savings for the SSA. However, over half of those terminations were later reversed on appeal, and the standards, the seemingly brusque CDR procedures, the often improper CDR practices, and the prolonged delays occasioned by the skyrocketing caseloads alienated many people. *See, e.g.*, STAFF REPORT OF SOCIAL SECURITY SUBCOMM., HOUSE COMM. ON WAYS AND MEANS, *DISABILITY LEGISLATION 1983: BACKGROUND AND ISSUES* (Comm. Print 1983); 1987 BACKGROUND MATERIALS, *supra* note 66, at 43; D. COFER, *supra* note 5, at 116; Weaver, *Social Security Disability Policy in the 1980's*

Prior to claimant notification, a sample of DDS decisions is subjected to "Quality Assurance Review" by regional and national SSA appraisers who have authority to reverse state agency determinations or to remand them for correction.¹²²

2. Reconsideration

A dissatisfied claimant may request "reconsideration."¹²³ Under reconsideration, the same procedures are followed as in making an initial determination, but different people within the respective offices make the assessments.¹²⁴ For example, if the initial denial was based

and Beyond, in *DISABILITY AND THE LABOR MARKET* 29 (1986); *SOCIAL SECURITY DISABILITY INSURANCE PROGRAM: Hearing Before the Comm. on Finance, U.S. Sen.*, 97th Cong., 2d Sess. 47-64 (Aug. 18, 1982); Report from Secretary of HHS Margaret Heckler to the Congress Regarding Pub. L. No. 96-265, 94 Stat. 441, at 67-72 (Jan. 4, 1985).

122. 42 U.S.C. § 421(c) (1982); 20 C.F.R. §§ 404.1503(d), 416.903(d) (1988).

The SSA reviews the work of the DDS according to two distinct sampling programs. Under one, 65% of all DDS awards are reviewed, prior to effectuation, by regional and national tiers of SSA officials. In fiscal year (FY) 1986, this amounted to 250,000 decisions, of which only 0.25% were returned to the DDS for correction or collection of additional evidence. The other review program selects 5% of all DDS decisions—a total of 83,000 cases in FY 1986, divided equally among favorable and unfavorable actions—for review by SSA regional offices. The SSA Central Office then reviews 10,000 of the regional offices' cases to promote consistency across the nation. Through these reviews, the SSA has concluded that DDS disability decisions were highly accurate, being correct 96.6% of the time for initial determinations and 95.5% of the time for reconsideration actions. 1987 SSA REPORT TO THE CONGRESS, *supra* note 11, at 13.

On the other hand, in some instances DDS offices have distorted their accuracy records by removing erroneous cases from the supposedly random sample of files to be sent to the SSA quality assurance reviewers and substituting correctly-decided cases. Report of Thomas W. Hayes, Auditor General, State of California (Feb. 17, 1987).

Historically, the degree of SSA review of DDS decisions has varied substantially. Before 1972, up to 70% of state disability allowances were routinely reviewed by the SSA prior to effectuation. Later, to save administrative costs, the SSA sampled only 5% of the awards, and only for post-effectuation analysis. Under the 1980 amendments, Congress required an increasing percentage (15% in FY 1981, 35% in FY 1982 and 65% thereafter) of DDS allowances to be reviewed by the SSA before payment. SENATE COMM. ON FINANCE, S. REP. NO. 408, 6th Cong., 2d Sess. 1283-84 (1979), *reprinted in* 3 U.S. CODE CONG. & ADMIN. NEWS, 1277, 1290-1312 (1980) [hereinafter S. REP. NO. 408]; D. COFER, *supra* note 5, at 114; 1987 BACKGROUND MATERIAL, *supra* note 66, at 37.

123. 20 C.F.R. §§ 404.907 to .922, 416.1407 to .1422 (1986). No reconsideration has taken place in SSI or concurrent SSI/RSDHI continuing disability cases. An SSI recipient whose benefits were to be cut off would proceed immediately from an adverse initial determination to an ALJ hearing. *Id.* §§ 404.907, 416.1407 (1988). This procedure, however, has been altered with the institution of "disability hearings" at the reconsideration stage in all RSDHI and SSI CDR cases. *See infra* note 124.

124. *Id.* §§ 404.915, 416.1415 (1986). The SSA has promulgated new regulations, implementing a requirement of the 1984 amendments authorizing face-to-face "disability hearings" before a DDS disability examiner at the reconsideration stage in cases where benefits are being terminated due to a claimant's medical improvement. These disability hearings will address only the question of the claimant's medical condition; other issues (SSI income level, performance of substantial gainful activity, etc.) will continue to be handled in the ordinary reconsideration

on financial eligibility grounds, a new person within the SSA district office will review the files; if the original determination was based on a finding of medical ineligibility, a new two-person team at the DDS will examine that aspect of the case. The claimant may submit additional evidence at this time, but ordinarily does not appear in person before the SSA or DDS decisionmakers.¹²⁵

Again, the claimant is notified by mail of the decision, and again accorded sixty days to appeal.¹²⁶ Approximately 380,000 reconsideration decisions were issued in 1986, of which seventeen percent were favorable.¹²⁷ The reconsideration process typically takes a minimum of two months.¹²⁸

3. *Administrative Law Judge Hearing*

Should the claimant choose to appeal, the next step is a *de novo* hearing before a federal administrative law judge (ALJ).¹²⁹ This hearing ordinarily affords the claimant the first opportunity to meet face-to-face with the person who makes a decision on the claim. It is also the first occasion to take sworn testimony from other witnesses and typically the first stage at which the claimant obtains legal or other representation.¹³⁰

The ALJ may order additional consultative examinations before or after the hearing,¹³¹ call vocational or medical experts to testify,¹³² and

process. *Id.* §§ 404.914 to .918, 416.1414 to .1418 (1988); *DISABILITY PRACTICE MANUAL*, SUPP. 1987, *supra* note 121, at 7-11; Memorandum from Eileen Sweeney, Nat'l Senior Citizens Law Center, to Legal Services Advocates and Members of the Private Bar Representing Social Security and SSI Beneficiaries in Cessation Cases (Feb. 5, 1986).

125. 20 C.F.R. §§ 404.933, 416.1433 (1986). Pilot projects have provided for face-to-face meetings between the claimant and decisionmaker at the DDS reconsideration level in new applications. D. COFER, *supra* note 5, at 184.

126. 20 C.F.R. §§ 404.933, 416.1433 (1986).

127. 1987 BACKGROUND MATERIAL, *supra* note 66, at 41.

128. The time required for reconsideration is comparable to that for an initial determination and is subject to the same types of delay.

129. 42 U.S.C. §§ 405(b)(1), 1383(c)(1) (1986); 20 C.F.R. §§ 404.929 to .965, 416.1429 (1986). These decisionmakers were originally designated as "hearing examiners" until Congress changed the designation in 1972 in an effort to upgrade the stature and autonomy of the position. D. COFER, *supra* note 5, at 65-66.

130. At the ALJ hearing approximately 65% of the claimants have legal representation and 18% have non-attorney representation. 9 Soc. SECURITY F. 7 (Mar. 1987). ALJs are often charged with a special responsibility to help an unrepresented claimant. *See Heckler v. Campbell*, 461 U.S. 458, 471 (1983) (Brennan, J., concurring).

131. *See* 20 C.F.R. §§ 404.929 to .965, 416.1429 to .1465 (1986). The classic description of a non-adversarial SSA administrative hearing is that the ALJ must "wear three hats," executing simultaneous responsibility for (1) ensuring that the claimant—especially when appearing pro

question the claimant and any other witnesses.¹³³ The claimant (or a representative) may submit additional medical records and a brief, deliver opening and closing remarks, and question all witnesses. Hearings are non-adversarial, and the level of formality varies.¹³⁴ A hearing is tape recorded and lasts an average of thirty to sixty minutes.¹³⁵

The volume of disability cases decided by ALJs has fluctuated widely in recent years.¹³⁶ The SSA's Office of Hearings and Appeals has undertaken a number of controversial measures to enhance the productivity of ALJs. These measures include "reconfiguring" the local hearing offices by "pooling" the staff attorneys and hearing assistants who had previously been assigned to specific ALJs, setting national "targets" for case processing speeds, arranging peer counseling for low-producing ALJs, and attempting direct job discipline. Most of these measures have been bitterly resented by ALJs and

se—puts forward the strongest case possible, (2) developing the record fully and critically, and (3) deciding the case.

132. *Id.* A vocational expert (VE) appears in approximately 20% of the ALJ hearings, most often when the issues concern non-exertional impairments or the level and transferability of the claimant's skills. 9 Soc. SECURITY F. 7 (Mar. 1987). Usage of VE testimony has increased over the past several years, but is still substantially below the level experienced in the late 1970s, prior to implementation of the "grid" rules. *Id.* at 8; *see also* OHA OPERATIONAL REP. 30 (Sept. 30, 1986).

133. 20 C.F.R. §§ 404.944, 416.1444 (1986). No SSA advocate opposes the claimant in the hearing. An experiment in selected locations, with "government representatives" who would develop an advocacy position, cross-examine claimants' witnesses, etc., has been terminated. 52 Fed. Reg. 88 (1987) (ending the experiment); 20 C.F.R. §§ 404.965, 416.1465 (1986).

134. *See* J. MASHAW, C. GOETZ, F. GOODMAN, W. SHWARTZ, P. VERKUIL & M. CARROW, SOCIAL SECURITY HEARINGS AND APPEALS (1987) (a study for the National Center for Administrative Justice) [hereinafter NAT'L CENTER STUDY]. For a critical description of the ALJ hearing process, *see id.* at 64-99.

135. Hearings in which the claimant is unrepresented are typically much shorter (e.g., 20 to 30 minutes); hearings with counsel, and especially with multiple witnesses, may run beyond two hours. OHA OPERATIONAL REP. 4 (Sept. 30, 1986).

The claimant is often the only witness in the case. However, a spouse, a friend, or an expert frequently appears as well. In FY 1986, the percentages of involvement in hearings were: claimant involved 97% of the time; family or friend, 34%; vocational expert, 21%; medical advisor, 10%; translator, 4%; and claimant's physician, 1%. 9 Soc. SECURITY F. 7 (Mar. 1987).

136. Moratoria on CDR cases are responsible for a large part of the recent fluctuation. Data regarding ALJ hearing workload are as follows:

Fiscal Year (Oct.)	Number of Cases Received	Cases Disposed	Cases Pending (end of)	Average ALJs on duty	Average Disposed per ALJ	Process Time (days)
1982	320,680	296,548	152,896	754	34	174
1983	363,533	342,998	173,431	797	37	184
1984	271,809	337,459	107,781	763	37	185
1985	245,090	245,829	107,042	730	29	167
1986	230,655	220,313	117,384	703	27	172

OHA KEY WORKLOAD INDICATORS (July 1987).

claimants' representatives as official attacks upon ALJs' decisional independence,¹³⁷ an independence guaranteed by the Administrative Procedures Act.¹³⁸

Approximately three months after the hearing, the claimant will be notified by mail of the ALJ's decision and accorded a further sixty-day appeal opportunity.¹³⁹ The ALJ stage, from the time of request for a hearing through the date of a decision, typically takes six to seven months.¹⁴⁰

4. Appeals Council

A claim denied at the ALJ stage may be appealed to the SSA Appeals Council. The Appeals Council is described in detail in the succeeding subsection.

5. Judicial Review

A claimant dissatisfied with the final agency determination¹⁴¹ may appeal within sixty days to a federal district court.¹⁴² The statutory

137. D. COFER, *supra* note 5, *passim*.

138. See Administrative Procedure Act, 5 U.S.C. §§ 554, 3105, 7521, 5362, 3344, 1305 (1982).

139. 20 C.F.R. §§ 404.968, 416.1468 (1986). Of the 220,313 cases taken to the ALJ stage in FY 1986, 173,675 went to a hearing. Of these, 106,385 (61%) resulted in an award of benefits. In FY 1986, 46,638 cases (21.1% of the total presented to ALJs) were dismissed without a hearing, including 20,198 mental impairment cases that were returned to DDSs for further proceedings. The FY 1985-86 figures are unusual and reflect that, when the SSA issued the new mental impairment listings in August, 1985, thousands of cases had to be returned for review under the new standards. Dismissal rates in prior years were significantly lower: 12.4% in FY 1985, 15.1% in FY 1984, 9.7% in FY 1980. In a typical year, most of these dismissals arise when a claimant abandons the matter or when time deadlines are not met. An ALJ may also award benefits, without conducting a hearing, if the documentary record is sufficient.

Based on the entire ALJ caseload (including dismissals), ALJs awarded benefits in 48.3% of the cases in FY 1986, 50.9% in FY 1985, 51.6% in FY 1984, and 55.8% in FY 1980. Excluding dismissals, the allowance rates were 61% in FY 1986, 58% in FY 1985, 61% in FY 1984, and 62% in FY 1980. OHA OPERATIONAL REP. 24-26 (Sept. 30, 1986).

140. OHA KEY WORKLOAD INDICATORS (July 1987). At the start of FY 1986, the Associate Commissioner established the goal of 155 days average processing time for hearings. Actual performance averaged 172 days. OHA OPERATIONAL REP. 4 (Sept. 30, 1986).

The expanding ALJ caseload over several years generated huge backlogs and extraordinary delays pending an ALJ hearing. Some courts intervened to establish or require fixed time limitations on SSA actions. *E.g.*, *Blankenship v. Secretary of HEW*, 587 F.2d 329 (6th Cir. 1978). The Supreme Court, however, in *Heckler v. Day*, 467 U.S. 104 (1984), ruled that district courts did not have the legal authority to create such timeliness standards on a broad class-wide basis, and could continue to do so only within the context of individual cases. *Id.* at 119.

141. Exhaustion of administrative remedies is required before a claimant may pursue a claim in federal court. 42 U.S.C. § 405(g), (h) (1982); *Weinberger v. Salfi*, 422 U.S. 749 (1975). However, where the Secretary or the court deems it appropriate, the exhaustion requirement may be

standard of review followed in judicial appeals upholds the Secretary's findings of fact if they are supported by "substantial evidence."¹⁴³ The court will also review the case for errors of law, although this is a less common basis for appeal.¹⁴⁴ The reviewing court may affirm, modify, reverse, or remand the Secretary's decision.¹⁴⁵ Reversals occur when the Secretary's decision is not supported by substantial evidence and the claimant satisfies the burden of proof of disability.¹⁴⁶

waived. *Bowen v. City of New York*, 476 U.S. 467 (1986).

An expedited appeals process is available to bypass the ALJ or Appeals Council stages and proceed directly from reconsideration to federal court when the claimant and the SSA stipulate that the only issue remaining in the case is the alleged unconstitutionality of a provision of Social Security law. 20 C.F.R. §§ 404.923 to .928, 416.1423 to .1428 (1986); OFFICE OF HEARINGS AND APPEALS HANDBOOK 5-38-18D (1984) [hereinafter OHA HANDBOOK].

142. 20 C.F.R. §§ 404.981, 416.1481 (1986). Federal court jurisdiction is founded upon 42 U.S.C. § 405(g) (1982). It is noteworthy that appeal of SSA decisions, unlike those of most other administrative agencies, lies with the federal district court, rather than directly with the court of appeals. The volume of the cases, and their orientation to facts rather than law, probably compel this level of review.

Many federal courts now routinely channel disability cases for consideration by a U.S. magistrate, rather than the district judge. The magistrate may hear the case (often proceeding more quickly than the court could) and make a recommended decision for the judge. 28 U.S.C. § 636 (1982). The district judge will review the magistrate's recommendations (and the parties' comments thereon) and retain power to affirm, reverse or modify them. *Matthews v. Weber*, 423 U.S. 261 (1976). By consent of the parties, a magistrate may be authorized to conduct all proceedings and enter a final judgment, with no review by the district judge. 28 U.S.C. § 636(c) (1982).

In FY 1985, 394 cases were appealed to circuit courts. (This was 7.5% of the cases denied or dismissed by district courts.) That year, the circuit courts ruled in favor of claimants in 21% of the cases. The Supreme Court rarely takes cognizance of disability cases, hearing none in FY 1985. INSTITUTE OF MEDICINE, *supra* note 96, at 48-49.

For a critical assessment of the operation of judicial review, see NAT'L CENTER STUDY, *supra* note 134, at 125-50.

143. 42 U.S.C. § 405(g) (1982). Substantial evidence is defined as "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971) (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)).

Critics have argued that district courts often ignore the substantial evidence test and engage in making de novo factual determinations. H.R. SOCIAL SECURITY DISABILITY AMENDMENTS OF 1980, H.R. CONF. REP. NO. 944, 96th Cong., 2d Sess., reprinted in 1980 U.S. CODE CONG. & ADMIN. NEWS 1409.

As early as 1960, SSA Commissioner Mitchell argued: "Nevertheless, in some cases, courts have not followed the 'substantial evidence' rule and have made their own assessment and appraisal of the facts." Report to the Secretary from SSA Commissioner Mitchell 3 (Sept. 6, 1960).

144. A federal court does not show the same deference to the administrative conclusions of law as it does to findings of fact. *Ridgely v. Secretary of HEW*, 345 F. Supp. 983, 988 (D. Md. 1972), *aff'd*, 475 F.2d 1222 (4th Cir. 1973); *Ferran v. Flemming*, 293 F.2d 568 (5th Cir. 1961).

145. 42 U.S.C. § 405(g) (1982). A federal district court also holds equitable power to issue injunctions in SSA disability cases. *Califano v. Yamasaki*, 442 U.S. 682 (1979).

146. *Simpson v. Schweiker*, 691 F.2d 966 (11th Cir. 1982); *Patti v. Schweiker*, 669 F.2d 582 (9th Cir. 1982); *Wander v. Schweiker*, 523 F. Supp. 1086 (D. Md. 1981).

Remands to the Secretary occur in a variety of circumstances. A court may order a remand for a new hearing or new decision if an improper legal standard or procedure was adopted,¹⁴⁷ if the administrative record was incomplete,¹⁴⁸ or if the SSA failed to accord proper weight to the evidence.¹⁴⁹ Additionally, a remand may also be ordered on the Secretary's motion, to allow SSA to review or correct an ALJ decision denying benefits.¹⁵⁰ The Secretary's motion must be made before an answer is filed and must be based on good cause.¹⁵¹

The number of new federal district court cases filed against the SSA in disability matters each year fluctuates widely: roughly 9000 cases were filed in 1981; 13,000 in 1982; 27,000 in 1983; 26,000 in 1984; 19,000 in 1985; 9000 in 1986; and 4000 in the first five months of 1987.¹⁵² The reversal rate has fluctuated similarly: 20% in 1982, 30% in 1983, 57% in 1984, 46% in 1985, and 38% in 1986.¹⁵³ Throughout this period, 40,000 to 50,000 SSA disability cases have been pending in the federal courts at any given time.

Even beyond the quantity of cases reviewed, the federal judiciary has had a major impact on the disability programs, shaping the procedures and standards adhered to by the SSA, and generally nudging the system in the direction of expanded eligibility.¹⁵⁴

147. See, e.g., *Aubeuf v. Schweiker*, 649 F.2d 107 (2d Cir. 1981).

148. *Diabo v. Secretary of HEW*, 627 F.2d 278 (D.C. Cir. 1980).

149. *Camp v. Schweiker*, 643 F.2d 1325 (8th Cir. 1981).

150. 42 U.S.C. § 405(g) (1982). Prior to the 1980 amendments, the Secretary had an absolute right to have the case remanded for further administrative consideration. This unqualified authority arguably reduced the SSA's incentive for developing the case properly on its first opportunity. F. BLOCH, *supra* note 13, at 308; S. REP. NO. 408, *supra* note 122, at 58.

151. 42 U.S.C. § 405(g) (1982).

152. Calendar year data provided by Don Gonya, Chief Counsel for the SSA (June 24, 1987). Of the total of SSA cases, 99% involved claims for disability benefits. In FY 1986, 10,716 new cases were filed in federal courts appealing SSA denials. Of these, 10,700 (96%) concerned disability: 5930 on the disability portion of RSDHI, 1255 on SSI and 2885 concurrent. OHA KEY WORKLOAD INDICATORS (July 1987).

153. Gonya, *supra* note 152. These figures do not include court remands. The annual number of court remands is large and irregular (17,711 in FY 1985; 11,993 in FY 1984). Many of these were mandated by the 1984 legislative changes in medical improvement standards and by the resolution of major class actions.

In FY 1986, 8604 final court decisions were reached in SSA disability cases, resulting in 4212 affirmations, 3308 reversals, and 1084 dismissals. In addition, court remands totaled 9143 in FY 1986. At the end of FY 1986, 47,334 disability cases were pending in federal courts. 1987 SSA REPORT TO THE CONGRESS, *supra* note 11, at 33.

154. Weinstein, *supra* note 95, *passim*; see also *Social Security Hearings and Appeals: Pending Problems and Proposed Solutions, Hearings Before the Subcomm. on Social Security of the House Comm. on Ways and Means*, 97th Cong., 1st Sess. (1981) [hereinafter *1981 Hearings*]; D. STONE, *supra* note 12, at 152-61; Liebman, *supra* note 21, at 845 (asserting that court's freedom to ignore the operation of disability program as a whole and the aggregate financial consequences of expanding eligibility standards, inclines judges toward allowances). *Contra* J. MAS-

6. Observations

From the preceding description of the standards and procedures for handling RSDHI and SSI disability claims, the following observations may be made.

(a) The SSA disability mechanism is responsible for receiving, documenting, and adjudicating a staggering number of claims each year. At every step of the appeals process, the volume of cases drives SSA procedures. The DDS apparatus must cope with almost two million initial application and reconsideration actions each year, and the SSA ALJs collectively render more decisions annually than the entire federal article III judiciary.¹⁵⁵ The federal courts have become the final resting place for 10,000 claims each year.¹⁵⁶ No other administrative agency processes anywhere near the same number of cases as the SSA.¹⁵⁷ Moreover, while the surge in the disability caseload may have crested, the powerful economic, social, and medical factors that created it remain operative.¹⁵⁸

Concomitant with the volume of cases is the proliferation of the SSA decisionmaking units, including 19,000 staff members in more than 1300 district offices, 4300 disability examiners in 111 DDS branches, and 700 ALJs in 132 hearing offices.¹⁵⁹ Establishing any de-

HAW, *BUREAUCRATIC JUSTICE: MANAGING SOCIAL SECURITY DISABILITY CLAIMS* 186 (1983) (asserting that judicial review has had only minor impact on the bulk of administrative decisions); Liebman & Stewart, *Bureaucratic Vision*, 96 HARV. L. REV. 1952, 1959 (1983) ("the ALJs and the judges reverse particular denials, but do not make the law of the system").

155. Weinstein, *supra* note 95, at 900. Of the 1003 ALJs that were employed by the federal government as of July 21, 1987, 673 (67%) were in SSA. Letter from William Taylor, Appeals Council Member (July 31, 1987) (on file with authors).

156. In 1986, Social Security cases represented 21% of the federal courts' civil docket where the United States was a party. This load was 5% of the federal courts' total civil docket. (Comparable figures for 1984 were 37% and 12% respectively.) Gonya, *supra* note 152.

This volume of cases has prompted numerous proposals to establish a dedicated "Social Security Court" (or a "Disability Court") with jurisdiction over all disability appeals from a final order of the Secretary of HHS. Advocates of this institution claim that it would free the district courts from a substantial burden and promote national uniformity in the implementation of disability law. Opponents assert that the true burden on the federal judiciary is overstated, because disability cases tend to be resolved relatively quickly and easily, and that recourse to a "generalist" district court is an important safeguard for claimants, whose interests would be less searchingly protected by "specialists" on a disability bench. Ogilvy, *The Social Security Court Proposal: A Critique*, 9 J. OF LEGIS. 229, 238-40 (1982); Rains, *A Specialized Court for Social Security? A Critique of Recent Proposals*, 15 FLA. ST. U.L. REV. 1 (1987); *An Address by Justice Antonin Scalia, United States Supreme Court*, 34 FED. BAR NEWS & J. 252 (July-Aug. 1987); 1981 *Hearings*, *supra* note 154, at 13-14; Pear, *New Court Sought for Benefit Cases*, N.Y. Times, Mar. 9, 1986, at 1, col 5. *But see* Arner, *The Social Security Court Proposal: An Answer to a Critique*, 10 J. OF LEGIS. 324 (1983).

157. 1983 ACUS REPORT, *supra* note 2, *passim*.

158. Weinstein, *supra* note 95, at 904.

159. REPORT OF THE COMM'N ON THE EVALUATION OF PAIN, *supra* note 42, at 49.

gree of consistency and national uniformity among such diverse and widespread individuals is a daunting task.

(b) Typical disability cases are different from most other administrative matters because disability cases are extremely fact-based. Despite a dense thicket of statutory, regulatory, and case law, SSA adjudicators generally feel that their sole task is to apply known law to new facts, not to make policy, extrapolate decisions in unforeseen areas, or enlarge the various slots into which cases are pigeonholed.

To the extent that one can describe bipolar models of agency decisionmaking,¹⁶⁰ the SSA is structured to follow the "judicial" style of neutral adjudication based upon an objective determination of descriptive facts, rather than the "political" style of focusing upon the identity of interested parties and the intensity of their respective concerns. This is not to imply that the SSA is above politics,¹⁶¹ but the nature of the typical disability case necessarily tilts the system in the direction of fine-grained attention to the intimate facts on the record, rather than to the reform of social policy.

(c) In addition to being grounded largely in fact, rather than law, the SSA disability caseload exhibits other unusual characteristics. First, it tends to be quite complex, requiring the adjudicator to be familiar with a wide range of medical and vocational sources and concepts, as well as a substantial body of statutes, regulations, SSA rulings, and SSA implementing policies. The decisionmaker must ordinarily master a substantial file of medical records replete with references to obscure impairments and arcane scientific jargon, and must be able to apply medical, including psychiatric, evidence to a vocational setting. In short, the fact that each case is of relatively limited scope does not mean that the overall body of jurisprudence is easy to comprehend.¹⁶²

Second, although each individual case may be insignificant from a societal viewpoint,¹⁶³ each is terribly important to the particular claim-

160. 1983 ACUS REPORT, *supra* note 2, at 117.

161. Frequent proposals have been made to take the SSA out of the Department of Health and Human Services and make it an independent agency, as well as to remove it still further from the unified federal budget. Advocates contend that these restructurings would insulate the SSA from the caprice of economic and political factors properly affecting the rest of the government. See Koitz, *Social Security: Legislation to Create an Independent Agency*, Congressional Research Service, Library of Congress, Issue Brief No. IB86120 (Aug. 18, 1986); see also J. MASHAW, *supra* note 154, at 58, 71.

162. D. STONE, *supra* note 12, at 166 (quoting former Commissioner Ball as stating that the medical criteria of the listings are "so necessary to the program but give us the most trouble" and paraphrasing former Commissioner Cardwell that the vocational criteria are "impossible to specify but we do it anyway").

163. In 1987, for example, the average RSDHI claimant received \$488 per month. An SSI

ant, because the disability benefits often provide the barest cushion against destitution. Moreover, SSA benefits (at least for the RSDHI program) are not seen as social welfare, but as an "earned entitlement" that the worker has paid for over a lengthy period of time.¹⁶⁴ The claimant appears as a party to a contract, not as a supplicant for the dole,¹⁶⁵ and the cases are typically contested vigorously.¹⁶⁶ Many claimants have little to lose by filing or appealing a case, and have a powerful incentive to do so.

A third characteristic of SSA disability cases is their inherent subjectivity. It may be impossible to judge another person's impairments objectively; certainly many of the most compelling and damaging disabling conditions—pain,¹⁶⁷ for example—elude outside measurement.¹⁶⁸ Social Security disability law explicitly eschews judgments made on the "average person" basis; instead, each claimant is entitled to individualized case-by-case analysis.¹⁶⁹ SSA decisionmakers, therefore, must judge credibility in every case.

Because face-to-face confrontation between claimant and adjudicator takes place only at the ALJ stage, this credibility judgment be-

recipient received substantially less. On the other hand, these figures can add up quickly on an actuarial computation, so that the total present value cost of awarding permanent monthly benefits to a worker disabled at age 50 may exceed \$100,000. REPORT OF THE COMM'N ON THE EVALUATION OF PAIN, *supra* note 42, at 165. In addition, the value of associated services (Medicare, rehabilitation) may be substantial.

164. Liebman suggests a continuum of social welfare programs, from those generally considered most legitimate (such as RSDHI) to those carrying more stigma (such as SSI). Disability programs are typically seen as being further toward the "honorable" end of the spectrum—as having been "earned" or at least having eligibility beyond the manipulating control of a victim of medical disaster. Liebman, *supra* note 21, at 857.

165. In addition, many reviewing courts use standard language to the effect that the Social Security Act is a remedial statute and must be construed liberally. See, e.g., *Damon v. Secretary of HEW*, 557 F.2d 31, 33 (2d Cir. 1977); *Mandrell v. Weinberger*, 511 F.2d 1102, 1103 (10th Cir. 1975).

166. One unfortunate but probably common exception to the generalization about vigorous pursuit of a claim occurs when one symptom of the claimant's impairment, such as a disabling mental condition, operates by itself to prevent the claimant from engaging in such focused, goal-oriented behavior, or even from retaining (and cooperating effectively with) a representative to pursue the matter. Similarly, an uneducated or illiterate individual may be intimidated by the SSA bureaucracy and by the rigor and complexity of its rules, and cowed into dropping a meritorious case.

167. See REPORT OF THE COMM'N ON THE EVALUATION OF PAIN, *supra* note 42, *passim*; INSTITUTE OF MEDICINE, *supra* note 96, *passim*.

168. Liebman & Stewart, *supra* note 154, at 1957 ("[I]t is doubtful that there can be any 'correct' disposition of individual cases presenting such [disability] questions"); Weaver, *supra* note 121, at 49 (comparing the difficulty of determining the occurrence of the insured contingency in the disability program and the retirement and survivors programs).

169. D. STONE, *supra* note 12, at 159; Capowski, *supra* note 75, at 349 (criticizing grids for departing from individualization and adopting "the average man" concept). The listings, too, are at least in part directed to the impact of a condition upon an "average" person, independent of the actual effects upon a particular claimant.

comes even more difficult to make. In many instances, a disability case turns upon the decisionmaker's subjective sense of the expertise, reliability, and credibility of a treating physician, consulting examiner, or other expert whose opinion appears only in unsworn documents.¹⁷⁰ Ironically, the disability programs have traditionally been presented to the public, and "sold" to Congress, as incorporating exclusively "objective" "medical" assessments.¹⁷¹ In reality, the definition of disability necessarily embraces a variety of vocational, economic, social, and political considerations, making close cases frequent and ineffably complex.¹⁷²

(d) The SSA claims adjudication structure is also procedure-laden. A claim may traverse four administrative and three judicial decision-making levels (not counting possible remands) before running its course over two or more years. Claimants are given numerous "bites at the apple," including three explicitly *de novo* stages.

Moreover, a profound variation exists in the award rates of the various tiers of review, with the probability of success fluctuating as one climbs the appellate ladder.¹⁷³ The process tends to reward persever-

170. Some judgments required of SSA decisionmakers are usually straightforward: in the typical case, assessments of a claimant's age and education, for example, are elementary, and many of the listings are defined with a level of detail that leaves relatively little scope for individual flexibility. Other listings, however (e.g., those defining mental impairments or substance abuse), and the assessment of an individual's "residual functional capacity," often require subjective opinions.

171. See D. COFER, *supra* note 5, *passim*.

172. Liebman, *supra* note 21, at 850 (inability to work may truly be attributable to a combination of medical handicaps and adverse labor market conditions).

173. Variability exists within each tier of review and across tiers. At the initial determination level in 1986, for example, 52.6% of the claims in Massachusetts, and 52.2% in Connecticut, were allowed, while comparable award rates for Louisiana and West Virginia were only 28.3% and 28.6% respectively. Allowances at the reconsideration level ranged from a high of 31.5% in Massachusetts to a low of 6.9% in Mississippi. ALJ award rates ranged from 71.7% in Hawaii and 71.6% in Montana to 45.5% in Michigan, Iowa, and Alaska. Finally, federal court allowances varied from 50.9% (for Region VII—Iowa, Kansas, Missouri and Nebraska) to 24.8% (Region VI—Arkansas, Louisiana, New Mexico, Oklahoma and Texas). DISABILITY ADVISORY COUNCIL BRIEFING BOOK, *reprinted in* 9 SOC. SECURITY F. 7, 7-8 (May 1987).

Some of the variability in award rates may be due to the record remaining open throughout the early stages of administrative appeal, so the ALJ is typically dealing with a much more comprehensive set of medical records and other documents than is available to the DDS. Similarly, the Appeals Council may be provided with materials that were not before the ALJ.

However, a great deal of the variability is also due to the different attitudes, procedures or "mind sets" of the various decisionmakers. In one SSA study, three different sets of reviewers, from DDS, ALJ and SSA Office of Assessment groupings, came to very different results even when confronted with the same cases. SECRETARY OF HEALTH AND HUMAN SERVICES, REPORT ON THE IMPLEMENTATION OF SECTION 304(G) OF PUBLIC LAW NO. 96-265, *passim* (known widely as the BELLMON REPORT in recognition of the senator whose amendment to the Social Security Disability Amendments of 1980 resulted in the study) [hereinafter BELLMON REPORT]; NAT'L CENTER STUDY, *supra* note 134, at 3.

ance, fostering the notion that a claimant who has the endurance to battle the system may eventually fare better than a more disabled but less tenacious counterpart.

(e) Less obvious from the foregoing background is the fact that the SSA programs (and the disability programs no less than others) have become a hotly, often bitterly contested battleground. On the national level, alarms are regularly sounded about the programs and their respective trust funds being "in crisis."¹⁷⁴ Within the program units, especially the Office of Hearings and Appeals (OHA), ALJs and others have resisted what they see as policymakers' attempts to compromise their decisional independence under the guise of promoting efficiency and productivity.¹⁷⁵ The SSA was once commonly cited as "an agency at war with itself."¹⁷⁶ The skirmishes have now abated or been driven underground, but a substantial reservoir of mutual suspicion and hostility still lingers.¹⁷⁷

C. *The Appeals Council*

Review by the Appeals Council is the "fourth bite at the apple" for SSA claimants. The Council's order is a final decision of the Secretary of Health and Human Services (Secretary) that exhausts all administrative remedies.

1. *Legal Authority*

No explicit statutory requirement supports the Appeals Council; the only even implicit statutory mandate for further post-ALJ administrative review of a disability claim provides that "[t]he Secretary is further authorized, on his own motion, to hold such hearings and to

174. REPORT OF THE NAT'L COMM'N ON SOCIAL SECURITY REFORM (Jan. 20, 1983); D. STONE, *supra* note 12, at 186-92; W. ACHENBAUM, *SOCIAL SECURITY: VISIONS AND REVISIONS* (1986).

175. A number of studies and several lawsuits have examined the tensions inside OHA, particularly between the ALJs and the series of associate commissioners. In many instances, the gist of the controversy is how far OHA leadership may proceed in administratively organizing and streamlining the handling of cases without impermissibly compromising the quality and independence of the ALJs. This is an exceptionally difficult line to draw, and controversy has reigned since at least 1975. D. COFER, *supra* note 5, *passim*; 1981 *Hearings*, *supra* note 154, *passim*; Rosenblum, *Contexts, and Contents of "For Good Cause" as Criterion for Removal of Administrative Law Judges: Legal and Policy Factors*, 6 W. NEW ENG. L. REV. *passim* (1984); Chassman & Rolston, *Social Security Disability Hearings: A Case Study in Quality Assurance and Due Process*, 65 CORNELL L. REV. 801 (1980).

176. 1981 *Hearings*, *supra* note 154.

177. The various components of the OHA (policymakers, ALJs, members of the Appeals Council, the union of OAO analysts, etc.) appear to be on somewhat more harmonious terms than they were, for example, during the height of the CDR caseload explosion. In our interviews, however, we still found a substantial amount of latent distrust.

conduct such investigations and other proceedings as he may deem necessary or proper for the administration of this subchapter."¹⁷⁸

The Appeals Council was created by rulemaking procedures and is now governed by a handful of regulations.¹⁷⁹ These regulations generally define the circumstances under which the Appeals Council will review a case,¹⁸⁰ the procedures to be followed before the Appeals Council,¹⁸¹ and the claimant's recourse to federal court after a final adverse decision of the Secretary.¹⁸² The Appeals Council is also governed by norms inferior to the statute and regulations. These include "Social Security Rulings" (SSRs), which are interpretive statements based upon statutes or recent decisions by the courts, SSA policymakers, ALJs, the Appeals Council, and others.¹⁸³ The SSA generates and disseminates SSRs and collects them quarterly and annually but does not publish them in the Federal Register.¹⁸⁴ The status of these rulings is therefore ambiguous. The SSA claims that rulings "do not have the force and effect of the law or regulations but are to be relied upon as precedents in determining other cases"¹⁸⁵ and that a ruling "is binding on all components of the Social Security Administration."¹⁸⁶ Many ALJs, on the other hand, do not consider rulings binding upon them

178. 42 U.S.C. §§ 405(b)(1), 1383(c)(1) (1982). The statute also warrants the Appeals Council performing the final agency review function for the Secretary: "The Secretary is authorized to delegate to any member, officer or employee of the Department of Health and Human Services designated by him any of the powers conferred upon him by this section" *Id.* § 405(l).

SSA review of a number of ALJ awards is required under the Bellmon Amendment, § 304(g) of Pub. L. No. 96-265, 94 Stat. 411, but even this review would not necessarily have to be performed by the Appeals Council; the function could be delegated elsewhere.

Another statutory provision guiding the work of the Appeals Council is section 557(b) of the Administrative Procedure Act. This section establishes the standards for agency review of a hearing decision, and states that in its review the agency retains "all the powers which it would have in making the initial decision." 5 U.S.C. § 557(b) (Supp. III, 1985).

179. Regulations governing RSDHI are located at 20 C.F.R. § 404.967 (1986). For regulations governing SSI, see *id.* at § 416.1467. For additional Appeals Council procedures see *id.* at § 422.205.

180. *Id.* §§ 404.970, 416.1470 (1986).

181. *Id.* §§ 404.976, 416.1476 (1988).

182. *Id.* §§ 404.981, 416.1481.

183. SOCIAL SECURITY RULINGS ON FEDERAL OLD-AGE, SURVIVORS, DISABILITY, SUPPLEMENTAL SECURITY INCOME, AND BLACK LUNG BENEFITS at iii (Cum. Ed. 1986) [hereinafter SOCIAL SECURITY RULINGS]. A Ruling may also be based on opinions of the Office of the General Counsel, Commissioners' decisions, and "other interpretations of the law and regulations." *Id.*

184. The SSA has used "Policy Interpretation Rulings" (formerly called "Program Policy Statements") as a vehicle to inform SSA adjudicators quickly about clarifications or interpretations in an operational policy. These rulings or statements were eventually published in the quarterly rulings. However, the use of Policy Interpretation Rulings has been discontinued because SSA has decided to publish the Rulings as frequently as necessary, instead of quarterly.

185. SOCIAL SECURITY RULINGS, *supra* note 183, at iii.

186. *Id.*; see also 20 C.F.R. § 422.408 (1988).

because SSRs are not promulgated under the Administrative Procedure Act's (APA) notice-and-comment rulemaking procedures.¹⁸⁷

The SSA also maintains the Program Operations Manual System (POMS), which collects standard policies and operating procedures for internal SSA use. The POMS, which is not "published" under APA standards but is generally available for public review at SSA offices, is designed to provide interstitial guidance to district offices and DDSs where the statute and regulations are incomplete. It supplies step-by-step guidance for developing a claims file, helping to ensure national uniformity in the implementation of SSA practices. By its own terms, POMS is not directly applicable to the ALJs or the Appeals Council, but its contents help shape the case file that may be presented for appellate review. Although the POMS statements are intended to be interpretive only,¹⁸⁸ controversy has arisen in instances where POMS might be read as imposing new, unpublished substantive standards restricting eligibility for benefits.¹⁸⁹

The SSA Office of Hearings and Appeals (OHA) also maintains an *OHA Handbook*¹⁹⁰ that, like the POMS for the DDSs, offers procedural guidance to ALJs and the Appeals Council. As with the POMS, the avowed purpose of the handbook is to implement, not to alter,

187. 5 U.S.C. § 553 (1982). ALJs frequently consider themselves bound by statute, case law and published regulations only, and conclude that SSRs, at least those that are "substantive", rather than merely "interpretative," are not law. The Appeals Council and the SSA are equally adamant that SSRs are binding on all components of the agency.

There is a complex history regarding the applicability to SSA of APA standards regarding rulemaking. HHS and SSA, like other federal agencies, have always been within the ambit of the APA, but the exception in section 553 of the act, covering "public property, loans, grants, benefits, or contracts," tended to exempt much of HHS (especially SSA) rulemaking from the requirements of notice and comment. In 1971, Secretary of HEW Elliott Richardson had the department voluntarily eschew that exception. 36 Fed. Reg. 2532 (Feb. 5, 1971).

188. F. BLOCH, *supra* note 13, at 225.

189. *E.g.*, *Schweiker v. Hansen*, 450 U.S. 785 (1981) (the SSA claims manual has no legal, binding force); *Salling v. Bowen*, 641 F. Supp. 1046, 1052-53 (W.D. Va. 1986); F. BLOCH, *supra* note 13, at 225; D. COFER, *supra* note 5, at 125. The 1984 Disability Act requires the SSA to publish all major disability policies under the APA's notice-and-comment procedures. Beyond that, the Congressional Conference Committee that considered the 1984 amendments noted "[w]hile it is not required in the legislation, the conferees urge the Secretary to publish under the APA public notice-and-comment rulemaking procedures all OASDI and SSI regulations which relate to benefits." 130 CONG. REC. H9831 (daily ed. Sept. 19, 1984).

190. OHA HANDBOOK, *supra* note 141, at introductory note. The OHA HANDBOOK comprises a multi-volume series of loose-leaf binders, Part five of which is applicable to the Appeals Council. Its contents have been irregularly updated by issuing replacement or additional insert pages. Part five has fallen into disuse; very few updates have been issued during the past five years despite substantial alteration in the operation of the Appeals Council. Various staff memoranda and circulars have filled the void. Reportedly, a revision of the OHA HANDBOOK is underway. OFFICE OF MANAGEMENT ANALYSIS, PLANNING AND INNOVATION, OFFICE OF APPEALS OPERATIONS MANAGEMENT SURVEY REPORT 36 (Dec. 1986).

basic disability law; again, however, the dividing line between those two functions is not always bright.

The SSA does not accord precedential value to its previous decisions in disability cases, whether reached by a DDS, an ALJ, or the Appeals Council. The OHA does circulate noteworthy decisions in the *OHA Law Reporter*, published quarterly; this reporter, however, "is not to be considered an authority which can be cited, but rather an informative aid which may lead to individual research."¹⁹¹ Selected administrative cases are displayed with identifying details removed.

Finally, it should be noted that the SSA's posture vis-a-vis decisions of federal courts remains controversial and largely outside the scope of this Article. Under prior policies, the SSA would accept as binding the decisions of the United States Supreme Court, but also asserted the authority to "non-acquiesce" in an adverse decision of a circuit court of appeals. In a non-acquiescence situation, the SSA would implement the adverse order in the case at bar, but would decline to give it prospective applicability in other cases even within the same circuit.¹⁹² In June and December of 1985, the SSA changed its policy to one of "acquiescence." Now, if a circuit court decision is at variance with an agency policy, the SSA issues an "Acquiescence Ruling," advising agency adjudicators and claimants within that circuit about how the SSA will implement the court's decision. Of course the SSA reserves the right to appeal the issue, or to relitigate it in the same or other circuit courts.¹⁹³

2. History

The Appeals Council was established in January 1940 by the Social Security Board, which at that time administered the provisions of the

191. 11 OHA Law Reporter 1, unnumbered preface page (Jan. 1987). The *OHA Law Reporter* publishes selected Appeals Council decisions and remands, ALJ decisions, federal court cases, Appeals Council minutes, Social Security Rulings, Federal Register Notices, and other materials. It carries a disclaimer that "material herein does not necessarily represent the official policy of the Office of Hearings and Appeals, the Social Security Administration or the Department of Health and Human Services." *Id.*

192. The SSA's non-acquiescence practice had been criticized as a flagrant violation of judicial authority, and defended as a necessary concomitant of a national program which (as with the Internal Revenue Service or the National Labor Relations Board) used non-acquiescence to promote uniformity. Lauter, *Disability-Benefit Cases Flood Courts*, 6 NAT'L LAW J. at 1 (Oct. 17, 1983); Stieberger v. Heckler, 615 F. Supp. 1315, 1351-74. (S.D.N.Y. 1985); (non-acquiescence policy violates separation of powers and due process), *vacated on other grounds*, 801 F.2d 29 (2d Cir. 1986); Heaney, *supra* note 96, at 9.

193. *Interim Circular No. 185* (June 3, 1985) (for inclusion in OHA HANDBOOK); SOCIAL SECURITY RULINGS, *supra* note 183, at iii.

Social Security Act.¹⁹⁴ The original charter established a three-person Appeals Council with responsibility for directing and supervising referees (later, ALJs) and for reviewing their decisions.¹⁹⁵

When the Social Security Board was abolished in 1946, its functions were transferred to the administrator of the Federal Security Agency (FSA), who in turn delegated most of those powers to the Commissioner of Social Security. The administrator of the FSA, however, retained authority over the Appeals Council, and thus began the tradition under which the Appeals Council receives its mandate directly from the Secretary (or head of the Department) rather than from the Commissioner.¹⁹⁶

In 1953, the FSA was folded into the new Department of Health, Education and Welfare,¹⁹⁷ and the Appeals Council became a part of the Office of the Commissioner of the SSA.¹⁹⁸ Authority over hearings and appeals, however, continued to flow from the Secretary directly to the Appeals Council.¹⁹⁹

Even today, the Associate Commissioner for Hearings and Appeals exercises only "administrative direction" over the Appeals Council, and members are to exercise independent judgment with "complete decisional authority for all programs within the jurisdiction" of the

194. BASIC PROVISIONS ADOPTED BY THE SOCIAL SECURITY BOARD FOR HEARINGS AND REVIEW OF OLD-AGE AND SURVIVORS INSURANCE CLAIMS (Jan. 1940) [hereinafter BASIC PROVISIONS]. This document elaborated 14 provisions regarding the procedures and structures for adjudicating claims, long before the enactment of the disability programs. Provisions 9 through 11 dealt with the Appeals Council, establishing it as the supervisory structure for referee (ALJ) proceedings.

195. *Id.* at 38.

196. For an outstanding early history of the hearings and appeals structure, see C. Horsky & A. Mahin, *The Operation of the Social Security Administration Hearing and Decisional Machinery* 293-312 (1960) (mimeograph on file with authors).

197. *Id.* at 296.

198. 20 Fed. Reg. 1997, § 8.10 (1955), *superseded by* 22 Fed. Reg. 1050, § 8.10 (1957). In effect, the Appeals Council was merely reorganized as the Office of Hearings and Appeals in August, 1959. That is, instead of putting a previously independent Appeals Council under an Associate Commissioner who already had other responsibilities, the real reform was to merge additional duties into the Appeals Council. The head of the Appeals Council became an office director, not a subordinate to one. Only later did the "other" duties of the Associate Commissioner overwhelm those associated with the Appeals Council. DEP'T OF HEW, BRIEFING PAMPHLET FOR THE BUREAU OF HEARINGS AND APPEALS 9 (June 30, 1971); Letter from Alvin M. David, Director, Division of Program Evaluation and Planning, to Eugene J. Keogh (July 3, 1964) (responding to Congressional inquiry regarding the rationale for placing the Appeals Council under the Commissioner instead of within the Office of the Secretary).

199. 20 Fed. Reg. 1997, § 8.20(b) (1955). Among the express delegations from the Secretary to the Appeals Council are: 33 Fed. Reg. 5837 (1968) (authority to review Title II and Title XVIII hearings); 34 Fed. Reg. 6985-86 (1969) (same); 35 Fed. Reg. 7033-34 (1970) (black lung cases); 38 Fed. Reg. 15,648 (1973) (SSI cases); 39 Fed. Reg. 27,746 (1974) (same); 40 Fed. Reg. 21,062 (1975) (Medicare); 40 Fed. Reg. 25,080 (1975) (same); 40 Fed. Reg. 27,506 (1975) (same); 43 Fed. Reg. 26,615 (1978) (same).

Appeals Council.²⁰⁰ This bureaucratic relationship between the Secretary, the Commissioner, and the Appeals Council is a factor frequently cited by members in underscoring the Appeals Council's status and autonomy.²⁰¹

The Appeals Council has grown irregularly in size, from its original complement of three members in 1940, to six in 1956, eight in 1959, seven in 1960, and nine in 1975.²⁰² In 1976, the Council was increased to fourteen members; by 1983 it had grown to twenty members.²⁰³

To date, the Appeals Council has received relatively little critical public scrutiny, as most observers have focused attention on more visible aspects of the bureaucracy, such as the DDS or ALJ. The Appeals Council remains, therefore, a subject of confusion and uncertainty among outside observers,²⁰⁴ including many who are intimately familiar with other aspects of the SSA process.

3. *Composition*

In addition to its twenty members, the Appeals Council has an Associate Commissioner for Hearings and Appeals, who serves as Chair of the Appeals Council,²⁰⁵ and a Deputy Associate Commissioner, who is an ex officio member.²⁰⁶ One other member is designated the Deputy Chair and manages the day-to-day operations of the Appeals Council.²⁰⁷

200. C. Horsky & A. Mahin, *supra* note 196, at 300; OHA HANDBOOK, *supra* note 141, at 5-10. Because the Associate Commissioner serves in a dual capacity as director of the Office of Hearings and Appeals and chair of the Appeals Council, the Associate Commissioner provides only administrative direction in the former capacity, while retaining the right to exercise greater substantive leadership in the latter role.

The Appeals Council, and all of the OHA, have been somewhat aloof from the other components of the SSA. As recently as 1985-86, the OHA was accorded a special status, reporting directly to the Commissioner, until it was again placed within the jurisdiction of the Deputy Commissioner for Programs. Even today, however, there is strikingly little contact between the Appeals Council members and other related offices.

201. This factor was mentioned often in our interviews with Appeals Council members.

202. C. Horsky & A. Mahin, *supra* note 196, at 311-12.

203. Letter from William Taylor, Appeals Council member, *supra* note 155.

204. This generalization has two conspicuous exceptions. See NAT'L CENTER STUDY, *supra* note 134; J. MASHAW, *supra* note 154 (providing searching reviews of the operation of the Appeals Council). Nat'l Organization of Social Security Claimants' Representatives, SOCIAL SECURITY PRACTICE GUIDE § 15.04 (MB) (1986), is also helpful. Most other analysts simply summarize the applicable regulations concerning the Appeals Council. See, e.g., F. BLOCH, *supra* note 13, at 246-47, 287-91; PRACTICE MANUAL, *supra* note 32, at 50-54.

205. The Associate Commissioner ordinarily is occupied with other duties and does not regularly participate in the work of the Appeals Council.

206. The degree of "hands-on" involvement in the work of the Appeals Council varies among deputy associate commissioners.

207. Only two persons have held the operational deputy chairs of the Appeals Council, Irwin

The selection process for new members begins with the posting of a "merit promotion vacancy announcement."²⁰⁸ The job description requires that an applicant have seven years of increasingly responsible experience as a member of the bar, involving the preparation, presentation, or hearing of formal cases before courts or governmental regulatory agencies.²⁰⁹

A "Best Qualified" list of applicants who possess the minimum credentials is then reviewed by the Deputy Chair, who interviews some applicants, checks references, and makes a recommendation to the Associate Commissioner of the OHA. Although this recommendation must ultimately be approved by both the Commissioner and the Deputy Commissioner for Programs, in practice it is the Deputy Chair, with a varying degree of involvement by the Associate Commissioner, who makes the selection.

The selection process has been characterized by strikingly little partisan politics; we know of no instances where pressure was applied to appoint political cronies or to exclude applicants because of political persuasions. Numerous sources confirm that the selection process is traditionally based on merit among career civil servants, rather than on loyalty to a particular person or ideology.²¹⁰ Similarly, we discovered no instances where a member has been forced, or even asked, to resign from the Appeals Council.²¹¹ As of 1987, members of the Appeals Council included six women, three blacks, and one Hispanic.

A. Friedenbergl from 1976 to 1980 and Burton Berkley from 1980 to the present. Prior to 1976, when the caseload and the Appeals Council itself were smaller, the Associate Commissioner (then called a Bureau Director) or the Deputy Associate Commissioner provided the day-to-day leadership of the Appeals Council.

208. The vacancy announcement may be advertised only inside the SSA, within the entire Department of Health and Human Services, or even more broadly. The wider the search field, the longer the search. In early 1987, in the interest of filling two vacancies expeditiously, the Appeals Council advertised only within HHS.

209. Prior to 1976, the standards for appointment as a member of the Appeals Council did not require that the appointee be an attorney. At the time of our original report all members of the Appeals Council were attorneys.

The original philosophy of the SSA procedures was that attorneys were not necessary in order to assure fairness, and that their presence might make the enterprise more formal and adversarial than it should be. It was deliberate, therefore, that seven of the original referees (ALJs) and one of the first three members of the Appeals Council had no legal training. *Atty General's Comm. on Admin. Proced., Monograph No. 16*, at 37-38; SOCIAL SECURITY BOARD (Apr. 1940).

210. One former SSA policymaker advised us that political influence in the selection of Appeals Council members was unlikely for practical reasons: a GS-15 employee is simply so far down the government ladder that grand political machinations are not brought into the appointment process.

211. Even the location of the Appeals Council reflects its independence. The Appeals Council sits in Arlington, Virginia, substantially removed from both the SSA headquarters in Baltimore and the HHS headquarters in Washington, D.C. (Other components of the OHA, including the Associate Commissioner and the national Chief ALJ, are also in Arlington.)

In hiring new members of the Appeals Council, candidates from within or near OHA are preferred. At the time our original report was prepared, five of the members had been ALJs immediately prior to appointment to the Appeals Council, seven had been in the HHS Office of the General Counsel, four had been branch chiefs within the Office of Appeals Operations, and four had held other positions, mostly within the SSA.²¹²

The turnover among members is low. As of 1987, seven current members had been on the Appeals Council more than ten years, six had served from five to ten years, and seven had served less than five years.²¹³

The training of a new member varies, depending on previous experience and knowledge. Sometimes a new Appeals Council member will attend the same training course that new ALJs attend.²¹⁴

Members of the Appeals Council are compensated at the GS-15 level, the same grade as ALJs.²¹⁵ Although the Deputy Chair's position has been approved for inclusion in the federal Senior Executive Service, the SSA has not yet dedicated a slot for this purpose.

Unlike ALJs, Appeals Council members are not protected by the APA.²¹⁶ Members participate in the "merit pay" system and receive performance evaluations from the Deputy Chair.²¹⁷ In principle, this arrangement allows the OHA policymakers a substantial degree of authority over Appeals Council members, but that authority has not been exercised, at least not directly. Members have consistently re-

212. Letter from William Taylor, *supra* note 155. Obviously, in a period of high caseloads, the Appeals Council benefits by bringing on board new members who will not require extensive background training before they can assume a full complement of cases.

213. *Id.*

214. A new member might also receive additional "on the job training," such as having the Deputy Chair or a particular designee serve as the second member on the new member's early cases.

215. See NAT'L CENTER STUDY, *supra* note 134, at 41-42.

216. As noted, ALJs enjoy virtually lifetime tenure and are exempt from any substantial system of performance evaluation and compensation. See Rosenblum, *supra* note 175, *passim*.

217. Appeals Council members are evaluated on the timeliness and quality of their work. Timeliness has recently been quantified, as the new computer tracking system allows a numerical assessment of each member's compliance with the case handling goals noted below. See *infra* note 258. Quality is harder to assess; the Deputy Chair samples the decisional documents of each member and judges them for conformity to the applicable law, clarity of explanation, and apparent basis upon substantial evidence. The Deputy Chair asserts that he does not take into account the frequency with which a member grants or denies review, and he does not calculate how often each member allows or denies a claim. Members are then rated on a five point scale: unsatisfactory, minimally satisfactory, fully satisfactory, exemplary, and outstanding. In a typical year perhaps two-thirds of the members are rated "exemplary" and the rest "fully satisfactory." Performance evaluations affect members' eligibility for merit pay increases, as well as end-of-year bonuses, and can have a substantial financial impact.

ported that no associate commissioner has ever tried to intervene in the work of the Appeals Council by pressuring members to deny or allow more claims in general or any claim in particular.²¹⁸

Several other observers agree that, even without formal guarantees, members of the Appeals Council enjoy a high degree of *de facto* protection, and no instances of abusive political pressure have come to light. Some have expressed concern, however, that SSA policymakers nevertheless are able to create an adjudicative climate that subtly and indirectly inclines the Appeals Council toward more or fewer awards,²¹⁹ noting that the Appeals Council always reflects, to some extent, the interests and style of the OHA Associate Commissioner. Some have expressed the view that the Appeals Council is still perceived in some quarters as an even more partisan "arm of the Secretary."

The members of the Appeals Council are organized into four geographic groups, each with responsibility for all cases arising in three designated judicial circuits.²²⁰ Within each geographic group, the members divide the cases randomly and equally. For example, member William Taylor is ordinarily assigned one quarter of all the cases from the first, second, and eleventh circuits; he receives all of those cases in which the last three digits of the claimant's Social Security number are 500 through 749.²²¹ This means, in general, that each

218. In principle, a member of the Appeals Council could be subject to discipline, including poor performance evaluation or reduced pay, for failure to adhere to the Secretary's policies. ALJs, on the other hand, are subject to discipline only through the more cumbersome process of the Merit Systems Protection Board, which, as a practical matter, provides a high degree of insulation. See 5 U.S.C. § 7521(a) (1982).

219. It is difficult to test empirically the existence and strength of any SSA-imposed adjudicative climate, because the statutory role—and consequently the caseload and the results of the Appeals Council—have been so different during the Reagan administration from the Carter administration. The entire disability system, moreover, has undergone so many changes that it is impossible to identify any stable baseline from which to make comparative judgments.

In a survey of the SSA's ALJs, however, 70.1% (339 of 484 respondents) agreed with the statement that "[t]he agency pressure is placed upon the SSA's ALJs to hand down fewer 'reversals' during times of national governmental economic retrenchment." D. COFER, *supra* note 5, at 211, 223. On the other hand, members of the Appeals Council deny feeling any direct or indirect pressure on cases, but one member told us that obviously members can "see which way the wind blows."

The Appeals Council does not ordinarily keep statistics that note the various members' respective award rates, and there seems to be no general awareness of which members are relatively "tough" or "generous." Members do seem to know, however, which other ones are more likely to take a generally skeptical or a sympathetic approach to selected types of cases.

220. See Chart 2, *infra* page 321.

221. One purpose of the geographic groupings is to provide stability and consistency, enabling each member to learn the personalities, strengths, and idiosyncracies of a particular set of ALJs, district courts, OAO analysts, and others. When the geographic groupings are shifted to equalize the number of cases assigned to each member, as they were in June 1987, the sense of continuity is disrupted.

member receives two or three dozen new cases on a typical work day.²²²

4. Staff

Each member of the Appeals Council has an administrative assistant who performs clerical functions. In addition, an office manager and other staff serve the Appeals Council as a whole. The main support, however, comes from the Office of Appeals Operations (OAO), a companion unit within the Office of Hearings and Appeals. OAO is housed in Arlington, Virginia, with most staff members working in the same complex, though not necessarily in the same building as the Appeals Council itself.²²³

OAO is divided into five case-handling divisions²²⁴ and then into thirty-two branches, each responsible for cases coming from a defined geographic location.²²⁵ OAO houses some 320 analysts. These analysts perform the primary review function and make recommendations that the Appeals Council members accept in the vast majority of instances.

OAO analysts are usually non-lawyers, compensated at GS 11-13 levels. Most have backgrounds of prior employment within the SSA as

222. The workload of the Appeals Council fluctuates dramatically. Statistics for individual members' workloads have only recently been maintained by computer, so the figures are uncertain. Members reported that caseloads ran approximately 300 cases per member during February 1987, rising to almost 600 cases per member by May 1987.

223. A proposal has been presented to consolidate into one building all the OHA units, which are currently dispersed among five buildings. If the plan is approved and funded by the Office of Management and Budget, the reshuffling will occur in approximately two years.

224. Divisions I, II, and III handle RSDHI and SSI disability appeals where the primary issue is the claimant's medical eligibility. Division III also handles health insurance issues. Division IV handles the RSDHI and SSI appeals where the issue is other than medical, such as relationship or dependency for RSDHI claims, or income or resources for SSI claims. Division V, the Division of Civil Actions, is responsible for all cases in which the claimant has filed a complaint in federal court after an adverse decision by the Appeals Council. The OAO is now experimenting with a system of "modules," in which the branch which handled the case initially will maintain responsibility over it even after the case leaves the Appeals Council and is filed in federal court, instead of automatically transferring all those cases to the Division of Civil Actions. OHA OPERATIONAL REP. 18 (Sept. 30, 1986). A Division of Support Services, with four branches, provides varying types of assistance to the case handling division of the OAO.

225. For example, Branch 18 (within Division III) is responsible for all appeals from the state of Alabama. A branch may handle one or a few states (or, in states which produce a large number of claims, a portion of a state).

A branch is the basic work group for the analysts. Consultations or transfers with analysts in other branches are somewhat unusual. However, if one branch is excessively burdened with work, some of its overflow may be shifted to other branches.

Currently, the OAO branches do not parallel the Appeals Council members' four geographic groupings. Thus, a particular analyst might send files to several different members, and a particular member might receive files from 30 or more different analysts. OHA is now in the process of revising this structure, in order to provide greater familiarity and continuity.

claims representatives in a district office, as DDS employees, or as examiners from the Office of Disability Operations.²²⁶ Normally, analysts perform only a paper review and have no personal contact with the ALJ, the claimant, or a representative. An OAO analyst typically reviews approximately twenty-five cases per month, although some handle twice that many, and the competitive selection process for promotion to GS-13 tends to emphasize the volume of cases produced.²²⁷

To assess analysts' productivity, each type of case is assigned a Standard Time Value (STV), taking into account its complexity and the variety of tasks it will require. For example, a dismissal of a request-for-review²²⁸ is assessed as requiring three hours of analyst work; processing a denial requires 3.25 hours; and reversing an ALJ decision requires five hours. Among the more time-consuming functions, processing a supplementary review case is ranked at eight hours and working through an initial action on a court remand is graded at six hours. These standard time values were scheduled for in-depth review and revalidation at the time of our original study.²²⁹

The purpose of grading analysts according to STVs (rather than simply counting the number of cases on a one-for-one basis) is to prevent the emergence of perverse incentives that might incline analysts to improve their productivity ratings by tilting in the direction of preferring quicker types of case actions, which are usually adverse to the claimant.

OAO production goals establish four levels of performance for the analysts, and promotion possibilities are largely governed by these measures of output. The numerical scoring concentrates on quantity; no objective measurement of the quality of the analyst's work and no numerical scoring of accuracy exist.²³⁰ Quality of an analyst's work is,

226. Analysts are selected by an intensely competitive merit selection process. Because an analyst's job would be a promotion for many SSA employees, when OAO posts an announcement for 30 to 40 new positions, it can expect approximately 1200 applications.

Most OAO analysts have five years of prior experience within the SSA. Approximately 40% are women and 20% minority.

A new analyst receives four weeks of classroom training regarding the medical problems of the human body, the SSA appeals process, and the documentation of a disability case file. Training Program: Hearings and Appeals Analysts (Feb. 14 - Mar. 9, 1983). Each new analyst is also assigned a senior analyst mentor or reviewer who provides on-the-job training and feedback. The senior analyst provides feedback on all of the new analyst's cases for three months, and reviews all work on court cases for a further six months.

227. Analysts' promotions from GS-11 to GS-12 are non-competitive and relatively routine. Promotion to GS-13 and the status of "senior analyst," however, is quite competitive.

228. See *infra* text accompanying notes 234-47 (discussing request-for-review).

229. See OFFICE OF MANAGEMENT ANALYSIS, PLANNING AND INNOVATION, OFFICE OF APPEALS OPERATIONS MANAGEMENT SURVEY REPORT 23 (1986) [hereinafter OMAPI REPORT].

230. See OFFICE OF HEARINGS AND APPEALS, PERFORMANCE STANDARDS FOR HEARINGS AND APPEALS ANALYST (1983).

however, assessed more subjectively and is a factor in evaluation for promotion.

The Office of Appraisal does perform some quality assurance review of the work of analysts, and OAO branch chiefs and Appeals Council members are in a position to review at least some of the products of the analysts they oversee. In FY 1986, the Office of Appraisal sampled 2140 analyst recommendations and found they contained the correct substantive decision 96% of the time.²³¹

In addition to OAO's analysts, Appeals Council members have access to a small Medical Support Staff composed of three full-time physicians and a few dozen part-time consulting specialists. This staff is employed by the Appeals Council to inspect files when some aspect of the medical record is unclear.²³² Additionally, a one-person Vocational Staff is responsible for hiring vocational experts and coordinating their activities in the field.

5. Appeals Council Caseload—Types of Cases

The Appeals Council deals with claims in three different settings: at the "review level," immediately after the ALJ tier; in a "new court filing," after a denied claimant has initiated a civil action in federal district court; and for "court decisions," after a district judge has issued a final decision or has returned the case to the SSA with orders for a new hearing or other administrative processing.²³³

231. OHA OPERATIONAL REP. 8 (Sept. 30, 1986).

232. OHA HANDBOOK, *supra* note 141, at 5-37-10. The Medical Support Staff is used primarily where new evidence is presented to the Appeals Council or where the ALJ did not understand the medical record. If the opinion of the medical staff is relied upon by the Appeals Council for its decision, a copy of the medical staff opinion should be provided to the claimant for comment, and it is to be entered into the administrative record. *Association of Admin. Law Judges v. Heckler*, 594 F. Supp. 1132, 1139 (D.D.C. 1984).

233. The volume of activity in each of these three categories is indicated by the following OHA estimates of workload for the Office of Appeals Operations:

	<u>Receipts</u>	<u>Dispositions</u>
Review level cases		
FY 1986	51,100	52,000
1987	73,500	70,500
1988	81,500	79,500
New court cases		
FY 1986	11,850	11,860
1987	15,850	15,850
1988	17,350	17,350
Court remand cases		
FY 1986	18,400	7,250
1987	10,700	20,350
1988	10,200	13,750

(Review level figures exclude Bellmon cases) OMAPI REPORT, *supra* note 229, at 24.

a. Review Level Cases

Review level cases fall into two primary categories: “requests-for-review” in which a claimant denied by the ALJ seeks reversal by the Appeals Council and “own-motion review” in which the Appeals Council reviews cases in the absence of any claimant appeal.

1. *Request-for-Review*. A claimant who is denied in whole or in part²³⁴ at the ALJ stage may request review by the Appeals Council.²³⁵ This request may be initiated by an SSA form or another written statement.²³⁶ A brief or a letter of contentions stating specific objections and citing arguments for reversal may be filed simultaneously or later.²³⁷ Current regulations do not afford the claimant a “right” to Appeals Council review;²³⁸ the claimant merely makes a request, which the Appeals Council may dispose of in several ways.²³⁹

The Appeals Council has three options upon receiving a case: dismiss it, deny review, or grant review.²⁴⁰ The Appeals Council will dismiss a case if the request is filed late and no extension has been granted, or if the claimant later requests dismissal.²⁴¹ The Council

234. A partially favorable decision may be issued, for example, when the ALJ determines that the claimant is disabled, but that the disability commenced at a later date than the claimant asserts; or, for a “closed period” case, that the disability terminated at an earlier date than the claimant asserts. Another type of partially favorable decision is one in which an ALJ finds the claimant disabled and financially eligible for one program (e.g., SSI) but not financially eligible for the other.

235. 20 C.F.R. §§ 404.967, 416.1467 (1986).

236. A claimant filing a request for Appeals Council review of an ALJ’s decision is entitled to a copy of all pertinent documents in the case file, a transcript of the tape recording of the ALJ hearing, and a period of time to comment. *Id.* §§ 404.974, 416.1470.

237. *Id.* §§ 404.968, .975; 416.1468, .1475.

238. *Id.* §§ 404.970, 416.1470.

239. The vocabulary of Appeals Council activities can be confusing. When a claimant “requests review,” the Appeals Council investigates the file to determine whether the case should be considered for possible changes. This screening involves examining the complete file, reading all the exhibits, and sometimes playing a portion of the tape recording of the hearing. This process, however, is not termed “review”—that label is reserved for the action of the Appeals Council after it has decided to accept the case.

240. 20 C.F.R. §§ 404.967, 416.1467 (1986). Technically, the term “grant review” is overly broad here. The Appeals Council “grants” a claimant’s request-for-review, but it “takes” review of Bellmon cases on its own motion. *See infra* text accompanying notes 281-86. For convenience, “grants” is generally used in this section to refer to both types of actions. For an illustration of the review-level process, see Chart 3, *infra* page 322.

241. 20 C.F.R. §§ 404.971, 416.1471 (1986). A claimant may request dismissal of the appeal upon second thoughts about the strategic desirability of appealing adverse portions of a partially favorable ALJ decision, when the Appeals Council might reverse the favorable portions.

One court has ruled that where a claimant requests review of a partially favorable ALJ decision, the Appeals Council may not disturb the favorable portions unless it has taken own-

will deny review if it determines that the ALJ's decision and order are correct. It will grant review if a defect appears in the ALJ's work.²⁴²

If review is granted, the Appeals Council has four options: reverse, remand, modify, or affirm.²⁴³ A reversal is used to alter the ALJ's decision when the ALJ has done an adequate job in developing the factual record but has misstated or misapplied the law, and the Appeals Council needs no further fact finding in order to make a legally correct decision. A remand sends the case back to the ALJ²⁴⁴ for an entirely new hearing, for the collection of additional evidence, or for the rewriting of an opinion.²⁴⁵ (An ALJ, however, may protest the remand.)²⁴⁶ The Appeals Council may modify an ALJ order by

motion review of the case within the 60-day period. *Powell v. Heckler*, 783 F.2d 396 (3d Cir.), *amended opinion*, 789 F.2d 176 (3rd Cir. 1986). *Contra Delong v. Heckler*, 771 F.2d 266 (7th Cir. 1985).

242. 20 C.F.R. §§ 404.970, 416.1470 (1986). In FY 1986, the Appeals Council disposed of 44,621 cases; of these, it dismissed 5273 (11.8%), denied review in 28,906 (64.8%), and granted review in 10,442 (23.4%). See OHA OPERATIONAL REP. 27 (Sept. 30, 1986).

243. 20 C.F.R. §§ 404.979, 416.1479 (1986).

244. The Council has three main options for remanding cases to an ALJ: (1) remand to the ALJ who heard the case initially, on the principle of judicial economy, because an ALJ familiar with the case may require less time to correct it, and on the principle that the ALJ who made the error should have the responsibility for, and can directly learn by, correcting the mistake; (2) remand to a different ALJ, on the principle that the original ALJ may have a fixed impression about the case and be less objective; or (3) rotate remands among the ALJs in the local office without regard to whether a particular ALJ had previously been involved.

Most recently, the SSA has returned to the general practice of assigning a remanded case to the ALJ who issued the original decision, unless (a) unfairness has been alleged at the first hearing; (b) the Appeals Council has some special reason to specify that a new ALJ should be used; or (c) administrative factors in the local office make it more convenient or efficient to designate a new ALJ.

245. 20 C.F.R. §§ 404.979, 416.1477 (1986). Recently, the Appeals Council departed from its prior "harmless error" policy by granting review over more ALJ decisions in which the correct outcome was reached, but the hearing process or the written opinion was flawed. 8 Soc. SECURITY F. 1 (Feb. 1986). In such cases the Council rewrites the decision itself or remands to the originating ALJ with instructions, not necessarily to change the result, but to write a better opinion. It is reasoned that a longer, more detailed ALJ opinion will be more informative to the claimant and more defensible in court. Memorandum from Frank V. Smith, III, Assoc. Comm'r of OHA, on "Circuit Court Case Study—Action" (June 17, 1986) (advising ALJs and Appeals Council members on the results of a study of 800 circuit court decisions, reflecting judicial policies and preferences); OHA OPERATIONAL REP. 6 (Sept. 30, 1986).

In some instances, the Appeals Council has effectively rewritten ALJ decisions, bolstering the expressed rationale for a denial and putting the strongest face on a case that may go to court. Memorandum from Edwin Semans, Jr., Director of OAO (Jan. 30, 1986); S.S.R. 82-13 (Cum. Ed. 1982); Note from Edwin Semans, Jr., to Executive Secretariat (Dec. 30, 1986) (describing how the Appeals Council frequently remands cases to ALJs to correct errors, even when the ultimate decision to deny benefits is not disturbed and how the Appeals Council also frequently rewrites the decision)

246. An ALJ may protest a remand decision by complaining to the Appeals Council (or to

altering part of the decision or opinion without a remand. An affirmation leaves the ALJ's decision intact, reflecting a conclusion that the issues prompting the Appeals Council to grant review have now been resolved and no correction is necessary.²⁴⁷

2. "*Own-Motion*" Review. The Appeals Council also considers a number of cases on its "own motion."²⁴⁸ Own-motion review has a checkered history. Before 1975, the Appeals Council staff reviewed all ALJ awards and most denials.²⁴⁹ From 1975 to 1980, as caseloads rose, the Appeals Council stopped taking own-motion cases and heard only request-for-review cases.²⁵⁰ Since 1980, the Bellmon Amendment²⁵¹ has again required the Appeals Council to take a substantial number of own-motion review cases.

the Associate Commissioner for OHA) that the remand is unnecessary, its terms are unclear, etc. If this protest is initially made informally or orally (e.g., in a telephone call), the Appeals Council practice is to suggest that the ALJ file a motion for clarification of the remand order, with a copy to the claimant. The issue may then be dealt with on the record, rather than *ex parte*. ALJs rarely proceed with this formal process.

247. In FY 1986, the Appeals Council granted review in 10,442 cases. It reversed the ALJ in 2434 (23.3%), remanded 6782 (65%), and affirmed 1226 (11.7%). When compared to the total number of cases appealed (44,621 in FY 1986), rather than to the number of cases actually reviewed, only 5.5% were reversed, 15.2% were remanded, and 2.5% were affirmed. OHA OPERATIONAL REP. 27 (Sept. 30, 1986).

248. 20 C.F.R. §§ 404.969, 416.1469 (1986).

249. Own-motion review was held to a strict standard and could overturn an ALJ's award only in instances of "gross error." The Appeals Council reversed only 1% of the ALJ disability awards in 1963, and 1.3% in 1964. Own-motion reversals in non-disability cases were considerably more common, largely because the eligibility criteria there were more objective and a "gross error" deviation would be more evident; the disability standards were sufficiently subjective that an award would be upheld, even if the Appeals Council deemed it somewhat erroneous. Memorandum from Joseph E. McElvany, Director, Bureau of Hearings and Appeals, to Robert M. Ball, SSA Commissioner (Nov. 17, 1964).

250. As requests for ALJ hearings mushroomed in 1975-1980, analysts from the OAO who ordinarily assisted the Appeals Council were dispatched to hearing offices around the country to assist ALJs in conducting hearings and writing opinions. This stopgap measure ameliorated the pressures on ALJs, but deprived the Appeals Council of the ability to consider own-motion cases. When own-motion review was not reinstated administratively by 1979, the Congress required it in 1980. *See 1981 Hearings, supra* note 154, at 10.

251. Social Security Disability Amendments of 1980, Pub. L. No. 96-265, § 304(g), 94 Stat. 441 (codified at 42 U.S.C. § 421(c) (1982)) [*hereinafter* Disability Amendments of 1980]. In 1980, Congress was concerned about what it perceived as a too-generous application of disability standards, particularly by ALJs. At the instigation of Senator Bellmon, Congress enhanced quality control and instructed the Appeals Council to create a more balanced oversight structure for ALJs by reviewing both ALJ awards and denials.

The statute did not require the Appeals Council to review a particular number of ALJ awards but merely to consider taking them for a review. Thus, a case randomly selected for own-motion review may be disposed of by an OAO analyst rather than forwarded to a Council member if the case contained no errors. Request-for-review cases, on the other hand, must be seen by at least one member, even if the analyst finds no error. R. FRANCIS, SOCIAL SECURITY DISABILITY CLAIMS: PRACTICE AND PROCEDURE § 9:03 (1983).

The Appeals Council now receives for own-motion consideration a randomly selected sample of 10% to 15%²⁵² of ALJ awards—approximately 300 to 400 cases per month. Mailroom clerks in the Office of Disability Operations²⁵³ (ODO) select the cases according to Social Security numbers and forward the files to the Appeals Council before the ALJ's award is effectuated.²⁵⁴ The Appeals Council has sixty days from the date of the ALJ's decision to decide whether to take own-motion review.²⁵⁵ Once a substantial portion of the Appeals Council's docket, own-motion cases have trickled off to very low levels. In May 1987, for example, the Appeals Council took review of only fifty-nine such cases and reversed only twenty-three of those.²⁵⁶

A special kind of Bellmon Review that proved particularly controversial was "targeted" review, in which ALJs were selected for Appeals Council scrutiny based upon their unusually high award rates or unusually low productivity. Many ALJs interpreted such targeting as an assault on their judicial independence and as an attempt to

252. The Bellmon Amendment did not specify a selection routine for own-motion review. The SSA selected the figure of 15% for random sampling, and intended to take the review level up to 25% later. The actual percentage of cases taken, however, has been lower: 12.1% (5736 ALJ allowances) in FY 1986; 14.4% (14,564 cases) in FY 1984. OHA OPERATIONAL REP. 8 (Sept. 30, 1986); OHA OPERATIONAL REP. 4 (Sept. 30, 1984). In February 1987, the figure was further reduced by the Associate Commissioner to 10% due to Appeals Council workload considerations.

253. The ODO is a large bureaucratic unit, located near the Baltimore SSA headquarters, which serves as a processing center for "effectuating" (i.e., calculating the amount of the award and issuing the checks) in RSDHI disability cases in which the claimant is age 58 or younger. (This accounts for 80% of all RSDHI disability claims.)

254. The ALJ's "Notice of Favorable Decision" advises a claimant that the Appeals Council may possibly take own-motion review of the case. A claimant is not notified when the case has been included in the sample of cases forwarded to the Appeals Council by the ODO. The claimant is notified only if the Appeals Council elects to grant review of the case.

In a request-for-review case, the claimant is not notified that the Appeals Council has decided to grant review; the first reply the claimant receives is the notification of the Appeals Council's decision to reverse, remand, modify or affirm.

In an own-motion situation, the claimant is similarly not notified about the Appeals Council decision whether to review the case: if review is denied, the file is forwarded for effectuation, and the claimant may never realize that the case had been considered for review. If the Appeals Council takes review, and decides to remand the case to the ALJ, the claimant's first notification will be a copy of the remand order. If the Appeals Council takes review with the intention of modifying or reversing a favorable ALJ decision, it mails to the claimant a notice of its proposed disposition, and affords the claimant 20 days to comment. Thereafter, the claimant receives a copy of the Appeals Council's final decision.

255. 20 C.F.R. §§ 404.969, 416.1469 (1986). If the Appeals Council does not take own-motion review of the case, it is returned to the ODO for effectuation. This detour may delay a case for three to five weeks. When the case is returned to the ODO, its effectuation is expedited so that payment to the claimant is delayed as little as possible.

256. OHA KEY WORKLOAD INDICATORS 10 (May 1987).

pressure them into denying more claims.²⁵⁷ After 1984, "targeting" was eliminated.²⁵⁸

A third category of own-motion review is similar to targeted review, but serves a less controversial function. Under it, the Appeals Council reviews most or all of the decisions by a new ALJ for consistency with SSA rules and procedures.²⁵⁹ This category of own-motion review long pre-dates the Bellmon Amendment. The Chief ALJ may prolong or shorten the usual six-month period of review.

A fourth type of own-motion review involves "protests," which are assertions by the ODO or another processing center that an ALJ

257. The Appeals Council was not involved in the selection of ALJs to target. The Deputy Chair deliberately recused himself from those deliberations, to avoid a situation in which the Appeals Council would help single out ALJs for review and then conduct the review itself. Symposium on Federal Disability Programs, Cosponsored by ACUS, the ABA Commission on the Legal Problems of the Elderly, ABA Administrative Law Section, Case Western Reserve Law School and the Cleveland Foundation 269 (Oct. 11-12, 1985) (unofficial transcript) [hereinafter *Cleveland Transcript*] (comments by Burton Berkley, Deputy Chair of Appeals Council).

258. The initial Bellmon Review implementation plans called for review of all allowances by any ALJ who granted benefits 70% of the time or more. See Disability Amendments of 1980, *supra* note 251. Entire hearing offices with allowance rates of 74% or more would also be fully reviewed. Later, ALJs were targeted according to the frequencies with which the Appeals Council granted own-motion review of their cases; a targeted ALJ could be reviewed 100%, 75%, 50%, or 25% of the time. An ALJ could be removed from the target list when only 5% of the ALJ's cases resulted in a grant of review by the Appeals Council. See *Social Security Disability Reviews: The Role of the Administrative Law Judge, Hearing Before the Subcomm. on Oversight of Government Management of the Senate Comm. on Government Affairs*, 98th Cong. 1st Sess. 14-42 (1983) [hereinafter *1983 Hearing*] (testimony of Associate Commissioner Louis Hays).

The operation of the Bellmon Review program was contested in *Association of Admin. Law Judges v. Heckler*, 594 F. Supp. 1132 (D.D.C.1984), in which Judge Joyce Hens Green held that the program "was of dubious legality" and tended to produce improper pressure to issue fewer allowance decisions, but that the plaintiff organization was not entitled to relief in light of defendant's later modification of the program and an absence of specific harm suffered. *Id.* at 1141-43.

On June 21, 1984, the Associate Commissioner for the OHA discontinued the targeted ALJ portion (by then, referred to as the "selected ALJ" portion) of Bellmon Review, stating that the program had achieved its objective of narrowing the difference in own-motion rates (the frequencies with which the Appeals Council acted to correct the ALJ decision) between the targeted judges and the national random sample. Memorandum from Frank V. Smith III, to all Administrative Law Judges (June 21, 1984).

In 1987, the Ninth Circuit Court of Appeals determined that the standards for conducting targeted review were substantive rules (not mere interpretive statements, as the SSA had argued) and were therefore invalid because they failed to comply with APA rulemaking procedures. Reinstatement of benefits was therefore ordered for claimants who lost when a targeted ALJ's award was reversed by the Appeals Council. See *W.C. v. Bowen*, 807 F.2d 1502 (9th Cir. 1987).

259. For many people, the targeting program was synonymous with the phrase "Bellmon Review," but the SSA considers both targeted and randomly-selected own-motion review to be "Bellmon Review."

decision could not be implemented because of a technical error (e.g., lack of RSDHI coverage or failure to incorporate the five-month waiting period). The ODO and other SSA components have also made an increasing number of "substantive" protests in cases where the ALJ's award is challenged as factually or legally incorrect.²⁶⁰ In the past, these protests were rare, but they have increased to approximately 100 to 150 cases per month.

A final category of own-motion review cases arose from the Government Representation Project in effect from 1983 to 1986.²⁶¹ Several local hearing offices experimented with having a government attorney develop a case as an adversary to the claimant, argue at the hearing, and cross-examine the claimant's witnesses.²⁶² The government representatives could not formally "appeal" a case but did

260. The ODO and other SSA components detect errors of three basic types. In one, newly-received evidence that was not available to the prior decisionmaker (ALJ or Appeals Council) may suggest that the decision should be reviewed. (For example, a new W-2 form may indicate that the claimant has recently performed substantial gainful activity of which the ALJ was unaware.)

The second type of error may be detected when the ODO or processing center's claims authorizer (an expert in the non-medical aspects of disability cases) begins calculating the benefits due under an ALJ award. The claims authorizer picks key dates (onset of disability, application, expiration of insured status, etc.) from the ALJ's decision, and may detect inconsistencies, omissions, or simple typographical errors. If this error is confirmed by a supervisor, a one- or two-page protest memorandum will be forwarded with the file to the Appeals Council.

The third type of error is uncovered when the claims authorizer suspects a defect in the ALJ's medical assessment. (A "reject criteria list" identifies types of cases where errors are more likely.) The file is forwarded to a disability examiner or a disability specialist who may identify anomalies in the ALJ's consideration of the medical record. If so, a protest memorandum is prepared, bringing the issue to the attention of the Appeals Council.

ODO prepares approximately forty such memoranda per month, about half based on financial issues and half on medical criteria. Other effectuating components also identify similar errors, and it appears that an increasing number of these focus on the medical, rather than "technical," aspects of the disability. Standard procedures call for all these matters to be directed to the Appeals Council for correction. Occasionally, when the error appears to be simply typographical, the claims authorizer may telephone the ALJ to suggest issuing a corrected decision.

If the protest concerns only the onset date and the size of the claimant's initial lump-sum payment, the effectuating office will begin payment of the current monthly benefits portion of the ALJ's award and notify the claimant that the retroactive amount is being reviewed. Similarly, in an "old" case (i.e., when the ODO's workload prevents it from delivering a protest to the Appeals Council within forty-five days of the ALJ's decision), partial effectuation will begin. Almost all of the ODO's protests are reviewed by the Appeals Council. The ODO also plays a similar role in reviewing and protesting Appeals Council awards. Errors at this stage are less frequent, generating perhaps 20 protests per year.

261. See 47 Fed. Reg. 36,123 (1982); 52 Fed. Reg. 4004 (1987).

262. 47 Fed. Reg. 36,117 (1982); see also 20 C.F.R. §§ 404.965, 416.1465 (1986); *supra* text accompanying note 132.

have authority to "suggest" that an award decision should come to the attention of the Appeals Council.²⁶³

3. *Standard of Review.* Until 1976, the Appeals Council conducted essentially a de novo review of the ALJ's work,²⁶⁴ but internal modifications²⁶⁵ made the Appeals Council more of an appellate body. Current regulations specify five grounds upon which the Appeals Council may grant review of a case:²⁶⁶ (1) abuse of discretion by the ALJ, (2) error of law, (3) lack of substantial evidence,²⁶⁷ (4) existence of a broad policy or procedural issue that may affect the general public interest,²⁶⁸ or (5) presentation of new and material evidence.²⁶⁹ Although the Appeals Council does not maintain statistics on these five bases for review, assertions of "lack of substantial evidence to support the ALJ's decision," and "presentation of new and material evidence" are probably the most frequently cited.²⁷⁰

263. The government representative would transmit the file to the OAO with a detailed memorandum explaining why the Appeals Council should consider the case. Although the Appeals Council was not required to accept the government representative's suggestion, it did frequently take own-motion review in that situation.

264. The departure from de novo review in RSDHI disability cases was made pursuant to a regulation published at 41 Fed. Reg. 51,588 (1976). The SSI disability program had never been the subject of de novo review at the Appeals Council level. 39 Fed. Reg. 37,977 (1974).

265. The 1976 change was instigated by an attempt to reduce the workload of the Appeals Council in order to free the OAO analysts and others who could be dispatched to various local hearing offices to assist ALJs with their backlog of cases.

266. 20 C.F.R. §§ 404.970, 416.1470 (1986).

267. The "substantial evidence" test is also employed in federal court review. *E.g.*, Richardson v. Perales, 402 U.S. 389 (1971). Controversy exists, however, on whether the district judge is to look for substantial evidence to support the decision of the Appeals Council or of the ALJ. Where the Appeals Council reverses the ALJ on a borderline case, substantial evidence may sustain either a denial or an award. *See* Parris v. Heckler, 733 F.2d 324 (4th Cir. 1984) (whether decision of Appeals Council, not decision of ALJ, is supported by substantial evidence); *see also* Bauzo v. Bowen, 803 F.2d 917 (7th Cir. 1986); Mullen v. Bowen, 800 F.2d 535 (6th Cir. 1986); Fierro v. Bowen, 798 F.2d 1351 (10th Cir. 1986); Parker v. Heckler, 763 F.2d 1363 (11th Cir.), *reh'g granted and opinion vacated*, 774 F.2d 428 (11th Cir. 1985), *en banc decision issued sub nom.* Parker v. Bowen, 788 F.2d 1512 (11th Cir. 1986). The ALJ's findings of fact remain highly relevant to the court's scrutiny of the "substantial evidence" supporting the decision of the Appeals Council.

In practice, however, reviewing courts typically devote the bulk of their attention to a review of the ALJ's decision and the evidence adduced in connection with the hearing. The work of the Appeals Council, which constitutes the final action of the Secretary, usually receives far less scrutiny.

268. 20 C.F.R. §§ 404.970(a), 416.1470(a) (1986).

269. *Id.* §§ 404.970(b), 416.1470(b). To qualify as "material" under current Appeals Council procedures, the evidence must relate to the time period covered by the ALJ's decision. *Id.*

270. Claimants also frequently allege unfairness at the hearing, citing the ALJ's behavior or apparent attitude. Unfairness may be evidenced on the hearing record, or it may require additional investigation. OHA HANDBOOK, *supra* note 141, at 5-40-21.

The extent to which the Appeals Council is constrained by the grounds for review set forth in the regulations is controversial. It is unclear whether those five are the only grounds under which the Appeals Council may grant review or whether the list is simply illustrative, allowing review for unstated reasons. To date, circuit courts have granted the Appeals Council the broader power to take cases for diverse reasons, rather than confining it to the published list.²⁷¹

4. *New Evidence.* The administrative evidentiary record in a disability case is closed after the ALJ's decision.²⁷² This rule was enacted by statute in 1980 for RSDHI cases²⁷³ and by regulation in 1986 for SSI and concurrent claims.²⁷⁴ This means that the Appeals Council will consider evidence that was not presented to the ALJ only if the evidence is new and material and relates to the time period that the ALJ considered.

Notwithstanding this rule, receipt of additional evidence by the Appeals Council, before or after the decision to grant review of the case, has been problematic.²⁷⁵ Generally, new evidence may be considered in three instances. First, if a claimant who appeared pro se before the ALJ secures representation at the Appeals Council stage, new evidence discovered by the representative may be considered.²⁷⁶ Second, a recent medical review or treatment secured by the claimant in the interval between the ALJ hearing and the Appeals Council review may be considered if it has a bearing upon the assessment of the impairment.²⁷⁷ Finally, copies of needed medical records may be considered if they were unavailable at the ALJ hearing due to a physician's or hospital's failure to respond to a request for the records.²⁷⁸ If the new evidence pertains solely to a condition that has arisen or

271. See, e.g., *Bauzo v. Bowen*, 803 F.2d 917 (7th Cir. 1986); *Parker v. Bowen*, 788 F.2d 1512 (11th Cir. 1986); *Razey v. Heckler*, 785 F.2d 1426 (9th Cir. 1986).

272. 20 C.F.R. §§ 404.970(b), 416.1470(b), 52 Fed. Reg. 4004 (1987). The ALJ may close the record at the conclusion of the hearing or may keep it open for a specified period of time to receive a claimant's brief, late documents, or the results of a post-hearing consultative examination. R. FRANCIS, *supra* note 251, at § 8:39.

273. 42 U.S.C. § 402(j)(2) (1982).

274. 20 C.F.R. §§ 404.970, .976, 416.1470, .1476 (1987).

275. *Id.* §§ 404.976, 416.1476 (1986).

276. *Id.* §§ 404.968, 416.1468(a).

277. *Id.* §§ 404.976, 416.1476.

278. There is a widespread, although undocumented, suspicion that some unethical claimants' representatives may deliberately withhold important evidence from the DDS and ALJ phases and present it for the first time to the Appeals Council or in federal court. If this evidence results in a finding of disability, its late submission effectively means delay of the favorable decision. This delay substantially increases the claimant's eventual lump-sum of retroactive benefits, and the attorney's fees are typically calculated as 25% of this past-due amount.

worsened since the ALJ hearing,²⁷⁹ the Appeals Council will generally not evaluate it, but will return the evidence to the claimant with a comment that the documents may be relevant to a new application for benefits, should the pending one be denied.²⁸⁰

5. *Reopening ALJ Decisions.* Related to the evidence issue is the controversy over "reopening" cases. Regulations provide that disability decisions may be reopened and revised: (1) within twelve months, for any reason; (2) within four years, for good cause (e.g., new evidence, discovery of a clerical error); or (3) at any time, for a variety of reasons, including fraud and gross error.²⁸¹

The Appeals Council has frequently exercised its reopening power in "protest" situations where the case was not randomly selected for standard own-motion review and the sixty-day own-motion period has expired, but the processing center discovered some technical defect inhibiting effectuation of the ALJ's award. The case is then returned to the Appeals Council for reopening to correct the error.²⁸²

279. It is often very difficult to determine whether new evidence relates only to the period after the ALJ's decision or whether it also supports inferences about the claimant's condition during the period covered by the current application. The Appeals Council considers itself relatively expansive in its willingness to receive new evidence, having concluded that if it refuses to accept the new evidence and the claimant then files a civil action, the federal court is likely to view the evidence more sympathetically and will order a remand for its receipt. See Weinstein, *supra* note 95, at 917 ("[w]hen the new evidence is highly persuasive, the good cause standard [for a remand from the district court to the Appeals Council] is apt to prove highly malleable."); OHA HANDBOOK, *supra* note 141, at 5-38-18B. Many claimants' representatives, however, report that the Appeals Council has not been especially liberal in considering new evidence and that recourse to the courts is frequently required.

280. 20 C.F.R. §§ 404.976(b), 416.1476(b) (1986). A new application for benefits may be filed even before the old one is finally adjudicated. F. BLOCH, *supra* note 13, at 241. To the extent that the two relate to the same time period, however, denial of the first claim will be conclusive unless it is reopened. *Id.*

A second application that relates to a different time period may be pursued at any time. For example, an SSI claimant may file an application in 1984 and appeal its denial while simultaneously filing a new application in 1986. In effect, the claimant is arguing in the alternative that the onset date of disability was in 1984 and, if the SSA does not accept that argument, that the condition further deteriorated so that by 1986 it became disabling. However, if the new claim is allowed by a DDS or ALJ while the old claim is pending in court, a confusing contradiction may arise within the SSA about the onset date of disability.

Filing a second application after the first has been denied is not a panacea for the claimant. An SSI claimant who pursues this course would lose a substantial retroactive award for the period covered by the first application but prior to the second. A RSDHI disability claimant could be even more disadvantaged because if the claimant's insurance coverage lapses during the interval, the second (and any subsequent) application will be denied on the basis of financial ineligibility, regardless of any deterioration in medical condition.

281. 20 C.F.R. §§ 404.987 to .996, 416.1487 to .1494 (1986). Reopening an SSI case "for good cause" is limited to the first two years after the decision, instead of four years as in RSDHI disability cases. *Id.* § 416.1488(b).

282. This reopening could be beneficial or detrimental to the claimant. If the ALJ's deci-

The Appeals Council has also relied upon the reopening provisions to consider a case that would have been selected for own-motion review but was not, because the bureaucracy moved so slowly that the sixty-day limit for own-motion review had expired.²⁸³ In this more controversial context, the reopening provisions greatly enlarge the Appeals Council's opportunity to reverse an ALJ's award and delay the finality of the administrative process.²⁸⁴ In response to claimants' complaints about this expansive application of reopening power, the First Circuit Court has held that the first category of grounds for reopening (reopening for any reason within twelve months of the prior determination) may be exercised only by a claimant, not by the Appeals Council.²⁸⁵ The Eleventh Circuit has authorized governmental use of these grounds for reopening, but only by the original decisionmaker, so only the ALJ could reopen an award.²⁸⁶

6. *Processing Time.* The time required for Appeals Council case handling varies enormously, depending upon the action taken and the size of the Appeals Council's current workload. Although the Appeals Council has adopted internal goals for processing time,²⁸⁷

sion overlooked a technical requirement (e.g., onset date before the expiration of insured status), correction of it could increase or decrease the size of the award. Sometimes mere typographical errors may be corrected via a telephone call from the OAO analyst to the ALJ, who issues a corrected decision. OHA HANDBOOK, *supra* note 141, at 5-42. An ALJ who awards substantial retroactive RSDHI disability benefits may omit the technical step of reopening and redetermining the claimant's prior adverse, but unappealed, decision on a previous application. Until it is reopened, a prior decision may stand as a *res judicata* bar to payment of benefits for the time period it covers. R. FRANCIS, *supra* note 251, at §§ 6.20, 8.13. The SSA program service center might discover this problem in effectuating the ALJ's award, and forward the file to the Appeals Council for resolution.

283. Wilson, *Procedural Challenges to Social Security Appeals Council Practices*, 20 CLEARINGHOUSE REV. 937 (Dec. 1986).

284. *Id.*

285. *McCuin v. Bowen*, 817 F.2d 161 (1st Cir. 1987). *Contra Munsinger v. Schweiker*, 709 F.2d 1212 (8th Cir. 1983).

286. *Butterworth v. Bowen*, 796 F.2d 1379 (11th Cir. 1986).

287. The internal Appeals Council and OHA processing time goals and performances are as follows:

On request-for-review cases, the goal is to dispose of all cases within 90 days, measured from the filing of a request for review until the Appeals Council issues its decision. As of May 1987, the average was actually 96 days, of which 90 days were attributable to OAO and 6 days to the Appeals Council. If a request-for-review case comes into the Appeals Council from OAO within 85 days, the members are supposed to dispose of it before the 90th day; they are rated for merit pay purposes on their ability to do so.

In an own-motion case, the Appeals Council is supposed to decide whether to grant review before the 60-day Bellmon period expires. This deadline is almost always met; if not, the "reopening" provisions have been exercised. Effective July 2, 1987, the Appeals Council has determined that the reopening regulations will not be used to take jurisdiction over an old Bellmon case. After the decision to grant review, the Appeals Council may take an additional

and although it regularly monitors conformity to these standards, numerous complaints about cases languishing for months have led to proposals for review deadlines of sixty or ninety days.²⁸⁸

7. Progression of a Typical Case. When a case is delivered to the Appeals Council, either on the claimant's request for review or through own-motion review, the file is routed to the appropriate branch of the Office of Appeals Operations (OAO). There, it is randomly assigned to an analyst who must complete work on it within ten days.

The analyst reviews the entire file, including the ALJ's decision. A tape recording of the hearing is included with the file and the analyst must listen to the tape if: (a) the analyst recommends taking own-motion review, (b) an allegation of an unfair hearing has been raised, or (c) a medical or vocational expert has given testimony.²⁸⁹ The analyst therefore listens to the tape in perhaps fifteen to twenty percent of the cases. The analyst then prepares a report summarizing the file, highlighting key issues, and recommending a course of action for the Appeals Council.

In request-for-review cases, the analyst completes a three-page "face sheet" form, checking appropriate boxes and filling in blanks

90 days to decide how to dispose of the case.

In court cases, an answer (together with transcript) is to be filed within 60 days of service of the complaint. This is now successfully accomplished 95% of the time.

When a case is remanded from a court, OHA's goal is a processing time of 42 days before the case is remanded back to the ALJ. The current performance average is approximately 30 days.

The goal for Appeals Council action on an ALJ's recommended decision in a court remand case is 45 days. Actual performance in this area has been 84-90 days. *See infra* text accompanying notes 331-33.

"Aged" cases (over 150 days) are flagged for special handling, and members are supposed to dispose of them first, within 7 days of receipt.

Every case, regardless of other considerations, is to be resolved within 60 days of arrival at the Appeals Council.

288. *1986 Hearing*, *supra* note 3, at 77 (testimony of Associate Commissioner Frank Smith). In 1985, average processing time in request-for-review cases was 116 days, *id.*, but as of May 1987 it had decreased to 96 days. OHA KEY WORKLOAD INDICATORS 13 (May 1987). In own-motion cases, the average processing times are 138 days in OAO and 4 days in the Appeals Council, for a total of 142 days. *Id.*

289. In a request-for-review case, the analyst must listen to the testimony of the medical advisor or vocational expert to determine whether the ALJ's decision to deny benefits was based on substantial evidence. The analyst ordinarily does not replay the claimant's testimony (the Appeals Council is unlikely to reverse an ALJ's decision not to credit the claimant's testimony) but does need to double-check the sufficiency of the record supporting denial.

In some instances, however, the SSA has discovered, after the case has gone to court, that the hearing tape is inaudible and no transcript can be prepared. There may be benign explanations for this, but sometimes it means simply that the analyst has not listened to the tape as required, and the member has not detected the omission.

to reflect the salient characteristics of the claim and its handling by the ALJ.²⁹⁰ The analyst may also choose to write a one- or two-page statement describing the case further and justifying a recommendation in greater detail.²⁹¹ The analyst then drafts a proposed decision and appropriate notification letters to the claimant. An analyst might spend a total of three or four hours on a case file, although the amount of time varies widely among analysts and cases.²⁹²

In own-motion cases, analysts follow essentially the same procedure, except that where the analyst determines that own-motion review should not be taken, the face sheet is only one page.²⁹³ If the analyst concludes that own-motion review is inappropriate, the case is not reviewed by the Appeals Council; instead, it is forwarded for effectuation of the ALJ's award.

When an analyst completes the report on a case, the file is delivered from the OAO to a member of the Appeals Council. If the analyst has recommended denying the requested review, then only one member will be assigned to the case.²⁹⁴ If that member concurs in a denial, the file is returned to staff who mail the denial notice to the claimant. The file is then held in the originating OAO branch for 120 days in case the claimant files a civil action in federal court. If the

290. The face sheet asks, *inter alia*, which ALJ handled the case, whether the claimant is represented by counsel, what the basis was for any unfavorable aspect of the decision, whether the ALJ correctly assessed the claimant's residual functional capacity and other vocational issues, and what legal basis the analyst identifies to support the recommendation.

The face sheet does not call for a narrative of the case or the arguments of counsel; these are available in the ALJ's decision document or in a brief.

Some claimants' representatives have begun routinely requesting a copy of the analyst's work under the Freedom of Information Act and the Privacy Act, 5 U.S.C. § 552 (1982). SSA policy is that the analyst's notes and the notes exchanged between members of the Appeals Council in reviewing a file are to be released to the claimant upon request.

291. Analysts, who do not have much time for writing the narratives, are evaluated by the OAO more on the volume, rather than on the quality, of their work. Members of the Appeals Council, however, frequently appreciate the greater insights contained in the written statement, rather than the multiple-choice form. Thus, an analyst may be serving two masters, serving simultaneously as an assistant to a member of the Appeals Council and as a staff member of the OAO branch.

292. Some analysts regularly complete two to three times as many cases per month as others do. Cases in which the analyst intends to recommend a grant of review usually require a narrative and take longer than cases where review should be denied. One analyst estimated that processing a standard denial might take from 30 to 45 minutes, whereas a recommendation in favor of granting review might take from two to three hours. Denying review where new evidence had been submitted after the ALJ's decision might also require more time.

293. The own-motion face sheet or "effectuation sheet" omits all of the demographic data of the longer form, and requires that the analyst only check the correctness of the ALJ's conclusions. If the analyst decides that own-motion review should be taken, a more detailed form is used.

294. 20 C.F.R. § 422.205(c) (1986); see Chart 3, *infra* page 322; see also R. FRANCIS, *supra* note 251, at § 9.03.

claimant does not initiate a civil action, the file is deposited for long-term storage at a federal records center.

If the analyst recommends review and the member agrees—or if the analyst recommends denying review but the member disagrees—the case is seen by two members.²⁹⁵ The first reviews the file and sends it to the second member with a note about the proposed outcome. The second member conducts a similar evaluation.²⁹⁶ If the members agree, their decision is final. If the members do not agree, they meet to discuss the case.²⁹⁷ If the disagreement persists, the Deputy Chair of the Appeals Council (or a designee) reads the file and resolves the matter.²⁹⁸ This tie-breaking procedure is followed perhaps twenty to forty times per month.

If the members decide to remand the case, the file is mailed with appropriate instructions to the local hearing office.²⁹⁹ If the Council decides to reverse an ALJ's denial and pay the claim, the file is mailed to the appropriate processing center for effectuation. If the members decide to grant review, but do not elect to issue a fully favorable decision immediately (e.g., to hold the case pending further development, or grant only a portion of the benefits) the claimant is

295. 20 C.F.R. § 422.205(b) (1986). In principle, the members, not the analysts, decide whether to grant the claimant's request for review. Thus, it is up to the first member to determine whether the case should be seen by a second member, regardless of the analyst's recommendation. The exception to this principle is own-motion cases where, if the analyst recommends taking review, the case is seen by two members, even if the first member disagrees with the analyst's recommendation.

The method for assigning the two members to a case has become very complex. Formerly, the first member could "shop around" for another member who might be inclined to take a similar position. The old system also afforded discretion to office staff in allocating case-loads.

Now the selection is done randomly, according to the claimant's Social Security number. The first member is designated from within the appropriate geographic grouping, based on an even division of numbers among the four to six members of the group. The second member is selected by allocating cases among all the members (i.e., not just those in the same geographic group) according to the sixth, seventh and eighth digits of the claimant's Social Security number.

These patterns, however, are not rigidly applied. Whenever a member is absent from the office, the computer distributes the caseload for that day among the available alternates.

296. OHA HANDBOOK, *supra* note 141, at 5-38. Some members, when assigned to a case as a second member, consider themselves responsible for undertaking a de novo review of the case, with a level of scrutiny equal to that of the first member. Others approach such a case with a presumption toward agreeing with the first member's preferences if possible.

297. Most differences between team members are quickly resolved in this fashion, with informal conversations identifying and resolving differences.

298. 20 C.F.R. § 422.205(b) (1986). Regulations permit the Appeals Council to consider a case en banc (i.e., with five or more members participating). *Id.* § 422.205(e). However, this procedure has been implemented on only one occasion in the past several years, regarding a non-disability question of SSI.

299. *Id.* §§ 404.977(e), 416.1477(e).

notified and afforded twenty days to comment.³⁰⁰ The file is returned to the OAO branch to await receipt of the additional information or argumentation. When completed, the file ultimately returns to the same analyst, and to the same two members who saw it the first time around, for a final decision.

Regulations permit oral argument before the Appeals Council,³⁰¹ but this practice has atrophied because of transportation costs and time concerns.³⁰² In the past several years the Appeals Council has heard oral argument in only a half-dozen Social Security cases, none involving disability.³⁰³ Appeals Council action is thus entirely a paper review.³⁰⁴

An Appeals Council decision is supposed to be written to conform in substance to the standards governing ALJ opinions.³⁰⁵ The Appeals Council is required to explain the evidence relied upon, the central legal authority, and, if the Appeals Council overturns a finding by an ALJ,³⁰⁶ the considerations that led to the outcome.³⁰⁷ Dur-

300. *Id.* §§ 404.977(d), 416.1477(d).

301. *Id.* §§ 404.976(c), 416.1476(c).

302. For an oral argument, the SSA would either pay for Appeals Council members to travel to the claimant's place of residence or pay the claimant's expenses for coming to Arlington, Virginia. *Id.* §§ 404.999(a) to .999(d), 416.1495 to .1499. Oral argument requires a panel of at least three members. *Id.* § 422.205(b).

303. To warrant oral argument, there must be a significant issue of law or policy within the competence of the Appeals Council. *Id.* §§ 404.976(c), 416.1476(c).

304. It is striking how frequently claimants and their representatives report that they have never had any contact with Appeals Council members or OAO analysts while cases are pending before the Appeals Council. Many express considerable frustration at the inability to engage the decisionmakers, or even to contact them by telephone. They say they have even experienced great difficulty in locating the responsible officials to check the status and future timetable of a case; they unanimously report to us an image of the Appeals Council as a hidden, isolated institution that is unresponsive to outside inquiry. *See also* R. FRANCIS, *supra* note 251, at § 9.13.

305. 20 C.F.R. §§ 404.953, 416.1453 (1986).

306. Appeals Council members agree with the analysts' recommendations regarding the ultimate outcome of the case in a very high percentage of claims. Interestingly, however, the exact percentage of such agreements is unclear.

OAO analysts reported to us that members accepted their recommendations as often as 98% of the time, while members said they rejected analysts' conclusions 10 to 20% of the time. We are not certain why there was such a wide difference in perceptions: perhaps we interviewed unrepresentative individuals from each group (unusually able analysts, unusually idiosyncratic members); perhaps each group's professional self image encourages it to promote its own perspective (e.g., analysts stress agreement, to demonstrate that they are serving the members well, while members stress disagreement, to underscore the Appeals Council's independence, as an organization not "captured" by its staff).

A similar disparity arose when we asked how often "write-backs" occur (i.e., instances where a member returns the file to the analyst for correcting a decisional document or letter, even though the ultimate outcome of the case was not being changed). Analysts said this occurred in perhaps 10% of the cases; members estimated 20 to 35%.

307. *E.g.*, *Parker v. Bowen*, 788 F.2d 1512 (11th Cir. 1986); *Beavers v. Secretary*, 577 F.2d 383 (6th Cir. 1978); *Combs v. Weinberger*, 501 F.2d 1361 (4th Cir. 1974); *Bohr v. Schweiker*, 565 F. Supp. 610 (E.D. Pa. 1983).

ing the past two years, the Appeals Council has attempted to improve the caliber of its opinions, making them more responsive to the evidence and to the claimant's contentions. Notices about denials of review are still composed largely of "boilerplate" language, but Appeals Council decisions on the merits are expected to be more individualized.³⁰⁸

An Appeals Council member, like all other decisionmakers within the SSA claims system, must cope with the pressures of the caseload. Recent caseloads have reached 500 cases per member per month; this means that each member receives two or three dozen cases per day.³⁰⁹ A member, therefore, typically spends only ten to fifteen minutes reviewing an average case. Agreement with an analyst's recommendation to deny review is often very quick, while decisions to grant review may take much longer. Council members virtually never listen to the tape recording of the hearing;³¹⁰ instead, they usually review the analyst's report, read the ALJ's decision, and examine the rest of the file to decide whether the analyst's recommendation is correct.³¹¹ A case might stay on a member's desk from a few days to a few weeks.³¹²

308. See OHA HANDBOOK, *supra* note 141, at 5-38-18 B-4. Claimants and their representatives, however, report that Appeals Council decisions occasionally still appear to be boilerplate, and that even when a degree of individualization has been undertaken, the opinions are still conclusory, incomplete, and not fully comprehensible.

ALJ opinions, too, have been criticized as relying too heavily upon standardized boilerplate and rote recital of medical history, without sufficient analysis or elaboration of rationale. Heaney, *supra* note 96, at 11.

309. It is difficult to compute a meaningful statistic for how many cases an Appeals Council member might work on in a month, because it is debatable what should count as a separate case when the same file is worked on more than one occasion, and by more than one member. One member explained that, although the Appeals Council statistics might report an average of only 500 cases per month, the true figure would be 750 to 800 cases per month if one included cases worked by two members.

310. Hearings before Social Security ALJs are not routinely transcribed, unless the case goes to court; therefore, the only way to access the record of events before the ALJ is to listen to the tape recording. OHA HANDBOOK, *supra* note 141, at 5-43. Members may do so, but only in rare instances do they take the time. Typical was one member's report that she had listened to a hearing tape only three times in six years, on cases where the claimant alleged that the ALJ's tone and manner had created an unfair hearing environment.

Moreover, ALJs are now using new four-track recorders, but the Appeals Council members still have only older two-track machines; thus, members are not able to play hearings without sending them back for conversion.

In a close case, a member might send the file back to the OAO with instructions to the analyst to listen to the tape again and prepare a better abstract.

311. A member might telephone the analyst to have a more detailed conversation about a particular case. These consultations are rare, however, because a substantial amount of time might elapse between the analyst's and the member's respective reviews of the file; the analyst will have forgotten details by then.

312. The high volume of cases is in striking contrast to the number handled elsewhere. For

b. New Court Filings

The Appeals Council decision constitutes a final action by the Secretary of HHS.³¹³ At this point, the claimant has exhausted available administrative remedies and may file a civil complaint in federal district court.³¹⁴

When a claimant initiates a civil action,³¹⁵ the HHS Office of General Counsel exercises the lead responsibility for managing the government's role in the litigation, but the Appeals Council may have a major involvement, too. First, the OAO Division of Civil Actions (DCA) obtains the claims file from the OAO branch that initially handled the case.³¹⁶ A DCA analyst determines whether the court complaint was timely,³¹⁷ arranges for transcription of the tape re-

example, while an SSA ALJ might average 30 cases per month, ALJs in other agencies carry caseloads of less than one-tenth that size. 1983 ACUS REPORT, *supra* note 2, *passim*.

In our observation, members of the Appeals Council are snowed under with files. Every member's office is jammed with case files stacked on every available flat surface, and huge laundry hampers full of case files are waiting in the corridors. Whenever we entered a member's office for an interview, a familiar routine transpired: the member would lift a stack of files off the couch to clear a place for us to sit and then look helplessly around the office for an empty spot to deposit them.

Other observers have noted the huge stacks of files within OHA:

Space constraints were evident in each component in the various buildings. Folders were lying in neat piles on the floor in aisles in the different sections of the D&F [Docket and Files] Branch. In DCA [Division of Civil Actions], hampers filled with folders sat in the corridors while other folders rested on the floor in large piles blocking an aisle awaiting placement on shelves in a holding area. Elsewhere, large numbers of full folder boxes were lying on the floor wherever space was available while waiting to be shipped to the Glebe Building.

Process Review and Engineering Branch, Div. of Management Studies and Analysis, Office of Management Planning and Analysis; Office of Management, Budget and Personnel, Review of Folder Movement in the Office of Hearings and Appeals 4 (Apr. 1984) [hereinafter Review of Folder Movement].

313. PRACTICE MANUAL, *supra* note 32, at 55. For an illustration of the case-flow process, see Chart 4, *infra* page 323.

314. *Id.*

315. 42 U.S.C. § 405(g) (1987).

316. The Division of Civil Actions (DCA) of the OAO is separated into seven geographic branches. Each DCA branch is responsible for all cases in its area that proceed to federal court (except for a few experimental modules in other OAO divisions). Recently proposals have been made to move the DCA out of the OAO and make it a litigation unit within the Office of the Associate Commissioner.

The SSA has experienced a substantial problem with lost or misplaced case files, delaying its response to new court filings in a number of instances. Sometimes the file is truly lost and must be reconstructed from other sources. More often, however, a failure occurs in the system for storing cases within the OHA and tracking their movement from one office to the next. Review of Folder Movement, *supra* note 312, *passim*.

317. If the court complaint is not timely (i.e., it was filed more than sixty days after receipt of the Appeals Council's denial, and no additional time had been requested), the DCA analyst may seek a court dismissal by preparing an affidavit of the Branch Chief, stating that

coding of the ALJ hearing,³¹⁸ and helps assemble a completed file.

If new evidence was submitted after the Appeals Council's first consideration of the case but before the filing of the court complaint, the DCA analyst makes a recommendation as to whether the Council's original decision should be reversed in light of the new evidence.³¹⁹ If new evidence does not effect a reversal, the case proceeds in court.³²⁰

The attorney for the government (an HHS regional attorney³²¹ or local U.S. attorney) may then ask the Appeals Council to conduct a "supplemental review." This may occur when the litigator concludes

the file reflects untimely filing. This type of case action is not reviewed by any member of the Appeals Council.

The Appeals Council has the authority to extend the sixty day period for filing a court complaint, if the claimant so requests in writing and demonstrates good cause for the additional time. 20 C.F.R. §§ 404.982, 416.1482 (1986). The current practice is liberal with respect to requests for extensions. An analyst may grant up to an additional sixty days without a member's approval. OHA HANDBOOK, *supra* note 141, at 5-68-10.

318. 20 C.F.R. §§ 404.974, 416.1474 (1986). Transcription service is usually provided by private consultants, who have not always been reliable. The Contracts Staff of the OAO transcribes tapes when time is insufficient for sending it to an outside contractor, or where the contractor has already returned a transcript with an indication that much of it is inaudible. SSA has also experienced frequent, severe problems with the quality of the tape recordings of ALJ hearings. If the tape is inaudible, no transcript can be prepared, the case cannot be defended in court, and a new hearing is ordinarily required. SSA recently purchased a fleet of new high-quality four-track tape recorders for all ALJs in an attempt to rectify this problem.

A recent study by the Office of Audit of the HHS Inspector General revealed that major problems arose with the audibility, storage, and retrieval system for tape recordings of ALJ hearings, and that the recent automated upgrading of that system had been disastrously ineffective. Dept. of Health and Human Services, Social Security Admin., Office of Inspector General, Office of Audit, REVIEW OF OFFICE OF HEARINGS AND APPEALS AUTOMATED MASS STORAGE AND RETRIEVAL SYSTEM (1984).

319. See R. FRANCIS, *supra* note 251, at § 10.06.

320. A transcript and answer must be filed within sixty days of the complaint. Only a few years ago, the SSA was missing this deadline as often as 90% of the time, and contempt citations from district courts were common. In response, the HHS Office of General Counsel moved some attorneys and reprographics staff from Baltimore to Arlington, Virginia, to work more closely with OHA. At the same time, OHA file and tape storage systems were improved. Now approximately 95% of the answers and transcripts are filed on time. OHA OPERATIONAL REP. 18 (Sept. 30, 1986).

321. A "Regional Chief Counsel" is HHS's chief litigator in each of the several regional offices around the country and is primarily responsible for handling all of that region's departmental litigation, of which SSA disability cases constitute the overwhelming majority. Some regional attorneys are designated as Special Assistant U.S. Attorneys, and all interact closely with the Department of Justice litigation staff.

The Office of General Counsel (OGC) of the Department of Health and Human Services, especially that segment of OGC that serves as chief counsel to the SSA, also handles some of the disability litigation. The Baltimore headquarters staff is most likely to become involved in major test cases, class actions or appellate level work, where the Department of Justice's Office of the Solicitor General may also participate.

that the case is indefensible in court,³²² even if it was correctly denied under SSA standards. The litigator may thus recommend that the agency take back the case on a Secretary's motion for remand to pay the claim, bolster the evidentiary record, or enhance the written rationale for denial.

In a supplemental review case, the Appeals Council follows an expedited procedure in order to respond in a timely fashion to the demands of the court's calendar. The litigating attorney sends a memorandum to the Appeals Council outlining defects in the case, the difficulties in defending it, and the reasons for a possible remand. The memorandum and case file are returned to the DCA analyst, who prepares an oral presentation for a panel of two Appeals Council members,³²³ usually including one who participated in the initial review. These two members choose either to seek a remand from the court or to insist on defending the case.³²⁴ This type of panel review occurs quite frequently, perhaps thirty to forty times

322. The SSA used to win the overwhelming majority of its federal court cases. In both 1978 and 1979, the SSA was affirmed 87% of the time and reversed only 13% of the time. The SSA's winning percentage began to fall in 1980, dropping to as low as 43% in 1984, before recovering to 54% in 1985 and 62% in 1986. (Figures do not include remands.) Gonya, *supra* note 152, at 2. As recently as 1983, some observers noted that federal court decisions generally upheld SSA's management practices and "also reflect a high degree of judicial confidence in the competence of the SSA." Liebman, *supra* note 21, at 1960. For additional information, see the SSA videotape *Bradley Speaks* (1987) (remarks by OHA Associate Commissioner Eileen Bradley saying "we can't be that bad" [as court loss statistics would suggest] and asking why SSA cases are overturned so often).

323. The analyst may also need to undertake some legal research, and will typically prepare a short "panel memorandum," highlighting key facts and attaching salient exhibits.

From the time of receipt of a telecopied version of the regional attorney's memorandum, OAO and the Appeals Council have five days in which to respond.

324. In one sense, a panel's decision to take a case back for further administrative action is an admission that the Appeals Council erred in denying review (or in denying benefits) the first time. In another sense, however, a voluntary remand might not be a confession of error; new evidence might have been provided that alters the nature of the case.

Even more significantly, the supplemental review in effect adds a possible new criterion for an award of disability benefits: the indefensibility of the case in court. This is the first time in the administrative ladder that this factor has been explicitly addressed, and it introduces a set of considerations independent from the medical and vocational factors of the listings or grids.

This factor of practical litigation policy is otherwise strikingly absent in the SSA claims adjudicative hierarchy. Most other government agencies have, and regularly utilize, the authority to settle or compromise cases, or to elect not to prosecute a matter for tactical reasons. SSA exercises a comparable power only very late in the process—after administrative remedies have been exhausted and a federal court case has been filed. See NAT'L CENTER STUDY, *supra* note 134, at 131-32. The SSA flexibility, moreover, is not really a power to settle or compromise a claim—only rarely is there a discrete issue (such as onset or termination date of disability) over which bargaining is possible. More typically, SSA is able to exercise only the discretion to abandon its position and pay the claim entirely.

per week, with a typical panel meeting lasting from fifteen to thirty minutes.³²⁵

If the panel decides that the case should be pursued in court but the litigating attorney still believes that a remand is more appropriate, the attorney may request an additional review before a "super-panel." This panel is composed of one member from the original panel, the Deputy Chair of the Appeals Council, and a third member designated by the Deputy Chair.³²⁶

Similar procedures are followed for the analyst's oral presentation. A super-panel is quite rare, occurring only sixty-nine times in the two years following the procedure's inauguration.³²⁷ An Appeals Council super-panel has resisted the regional attorney's urging for a remand on only ten occasions.³²⁸

c. Court Decisions

The Appeals Council does not regularly monitor a disability case after it goes to court. In fact, the Appeals Council is not directly notified of the courts' decisions, and members learn of the outcome in most cases only haphazardly, if at all. Even if a case is remanded

325. In 83% of the 1507 cases brought for supplemental review during 1985 and the first half of 1986, the Appeals Council panel agreed upon a remand. OHA OPERATIONAL REP. 8 (Sept. 30, 1986).

326. SSA regional attorneys vary widely in their use of protests to Appeals Council panels and super-panels and in the vigor with which they assert the SSA position in court. Sometimes a regional attorney will not even file a brief, irritating members of the Appeals Council who feel that their position has been undercut. Weinstein, *supra* note 95, at 926.

Similar tensions occasionally arise with respect to appeals of cases lost in the district court. Regional attorneys or Department of Justice litigators have not always been as keen as Appeals Council members on fighting to sustain SSA positions. The attorneys, on the other hand, may feel that the SSA is at fault for failing to appreciate the difficulty and the growing professional responsibility considerations of pursuing an unjustified case. *Id.*

327. Prior to the institution of the super-panel procedures, a regional attorney disappointed by a panel's decision to pursue the claim could protest directly to the Deputy Chair of the Appeals Council and ultimately to the Associate Commissioner for OHA or to the SSA Chief Counsel.

Some favor a return to that system, based on the judgment that super-panels consume a substantial amount of members' and analysts' time, especially since the Deputy Chair (who sits on all super-panels and appoints one of the other members) is likely to have the last word on remand anyway.

328. Under the 1980 amendments, the Secretary must show "good cause" to support a remand order. Disability Amendments of 1980, *supra* note 251. A claimant's attorney might resist a remand, concluding that the SSA would use the additional processing time only to bolster its weak case. Nevertheless, the Secretary's motion for remand is almost invariably granted. *But see* Larkin v. Heckler, 584 F. Supp. 512 (N.D. Cal. 1984) (denying Secretary's motion for remand where good cause was not shown and it appeared the government was seeking a remand merely to delay the case).

from the court to the Appeals Council, the individual members who worked the case initially receive little personal feedback.³²⁹

The Appeals Council may play a major role in a case remanded by a federal court with instructions to conduct a new hearing or to compile new evidence. If the court's directive is sufficiently clear, the Council uses a "fast track" procedure, and the file goes directly to the appropriate local hearing office so that an ALJ may carry out the court's orders. In other instances, the Appeals Council will supplement the court's remand order with interpretation or additional guidance before sending the case to an ALJ.³³⁰

In a case remanded from a court, the ALJ does not issue a final decision as would be done in the usual adjudication.³³¹ Instead, the ALJ prepares a "recommended decision," which is forwarded to the Appeals Council. A copy of the recommendation is also provided to the claimant, who has an opportunity to respond before the Appeals Council considers it. The Appeals Council may then adopt or modify the recommendation.³³² Rarely, the Council may reremand a case for

329. Because Appeals Council members deal with so many cases, they retain little special interest or curiosity about those that might be resolved months or years later in court. Members also believe that often little can be learned from reviewing court actions: if the district court judge is simply re-weighing the administrative findings of fact, there is nothing of an important precedential nature in the feedback. For an illustration of procedures following remand, see Chart 5, *infra* page 324.

In 1987 the SSA recently created a Litigation Strategy Task Force to review SSA litigation policies and procedures and make recommendations regarding improvements. The Associate Commissioner for the OHA chairs the Task Force, and three Appeals Council members serve on it. Memorandum from Eileen Bradley (Sept. 14, 1987).

330. The reliance upon "fast track" remands has resulted in some controversy. It is undoubtedly quicker to forward a court order to the ALJ directly, without occupying the intervening time and attention of an Appeals Council member, and OAO analysts have sometimes been given the authority to make the decision whether to use this fast track. Some people, however, feel that analysts are not always able to discern the cases that require additional Appeals Council commentary or instruction before release to the ALJ. Some members therefore prefer that the Council see all remand orders, even those that will clearly not require any elaboration beyond the "short form" that an analyst would use.

Where the Appeals Council does elaborate on the court's remand order it typically does so to resolve an apparent conflict between the order and a Social Security Ruling or to instruct the ALJ to update the medical evidence in the record. The Appeals Council may also seek an appeal, a reargument, or a clarification of the court's remand order, but it does so only rarely.

The historical record reveals wide variation on whether court remands are processed by the Appeals Council itself, or are referred to ALJs. For example, in FY 1965, 13.2% of the court remands were retained by the Appeals Council and were never further remanded to an ALJ; comparable figures for other years are: FY 1966, 26.6%; FY 1967, 47.4%; FY 1968, 23.3%; FY 1969, 16.9%; FY 1970, 36.5%; and FY 1971, 43.5%. DEP'T OF HEW, BRIEFING PAMPHLET FOR THE BUREAU OF HEARINGS AND APPEALS 24 (June 30, 1971).

331. 20 C.F.R. §§ 404.983, 416.1483 (1986).

332. *Id.* §§ 404.977, 416.1477. The SSA is interested in expediting this process, and has

further work by the ALJ. The final decision is sent out over the signature of two Council members.³³³

In evaluating these recommended decisions, the Appeals Council does not follow the "substantial evidence" test used in evaluating ordinary ALJ decisions; instead, the Appeals Council relies on something akin to a "preponderance of the evidence" test, and is more willing to revise an ALJ's work. OAO analysts and Appeals Council members typically devote much more time and attention to review of an ALJ's recommended decision in a remand case than they would to an ALJ's final decision in a standard "review level" case.

The Appeals Council is also occasionally involved in SSA actions following a court decision, and may be consulted about the feasibility of appealing an adverse decision or of seeking clarification of its terms. These litigation decisions involve many other components of the SSA, as well as litigators from the Departments of Justice and HHS.

6. *Other Appeals Council Functions*

In addition to reviewing disability cases, the Appeals Council performs a variety of other functions. For example, it hears a small number of nondisability cases (e.g., survivor's claims where the relationship is contested, and Medicare services providers' claims).³³⁴

Although the vast bulk of Appeals Council decisions are fact-based, rather than interpretive or policymaking, the Council helps formulate SSA policy in several ways.³³⁵ The Council highlights deci-

issued a proposed rule, 52 Fed. Reg. 38,466 (1987), under which an ALJ could issue a conventional decision, not merely a recommended decision, in remand cases. Instead of automatically coming before the Appeals Council, the case would be subject to request-for-review or own-motion review, as are other ALJ decisions.

333. An ALJ decision in an ordinary case becomes "final" if nothing is done to review it. In a court remand, however, the recommended decision does not become final unless the Appeals Council adopts it. The Appeals Council and DCA devote far more time and attention to remanded cases than to others.

If the Appeals Council is not satisfied with the work of the ALJ, it may order a second remand. F. Bloch, *supra* note 13, at 291. In rare cases, even a third remand may be required, although internal procedures require the approval of the Director of OAO before an analyst recommends a third remand, and the approval of the Deputy Chair before a member orders one.

334. Disability cases account for approximately 95% of the Appeals Council's docket. Medicare cases are in the process of being transferred to a new cadre of ALJs and a new appellate body within the Health Care Financing Administration of HHS. See Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L. J. 1 (1987).

335. The position description for a member of the Appeals Council as far back as 1960 included the role of "participating in the formulation of substantive and procedural policies," and "participating in the planning and preparation of all necessary rules and regulations relating to fair hearings." See C. Horsky & A. Mahin, *supra* note 196, at 300b.

sions that might usefully be converted into Social Security Rulings (SSRs), for example, and refers those matters to the Office of Regulations, which prepares SSRs.³³⁶ Deciding the rare case that breaks new ground in construing Social Security law in new circumstances is another policymaking step.³³⁷

A third policy-related role is the occasional assigned study, through task forces, of the impact of newly proposed disability standards. When the Office of Management and Budget evaluated regulations for the new mental impairments listings, for example, it asked the Appeals Council to examine the possibility that large numbers of cases would be decided differently under the new standards.³³⁸ Individual Council members have also participated in SSA task forces asked to review and recommend changes in major SSA policies such as those involving severity or medical improvements. Council members have similarly served on OHA committees studying internal reorganization possibilities.³³⁹

"Policy" is also made whenever members consult about shared problems and reach mutually acceptable solutions that might be applied in future cases, even if these results do not strictly govern subsequent decisions.³⁴⁰

336. New SSRs can come from many sources. One official we interviewed suggested that one of the most valuable current functions of the Appeals Council is its occasional role as a forum for ALJs and members to identify recurrent problems in implementing SSA policies and practices, some of which may be corrected by SSRs. The Appeals Council may also have the opportunity to comment on the evolution of other expressions of SSA policy and law, such as draft regulations or internal circulars.

337. For example, in an SSI disability case a few years ago the Appeals Council granted review because of a "broad policy or procedural issue that may affect the public generally," 20 C.F.R. §§ 404.970(a)(4), 416.1470(a)(4) (1986). In that instance, the Appeals Council decided as a matter of first impression that Bureau of Indian Affairs' payments to a Navajo tribal entity, which then passed the funds to a group of approximately 150 individuals, should count against the ultimate recipients' SSI income and resource ceilings.

338. To conduct this study, Appeals Council members examined hundreds of "dead" cases (i.e., ones in which mental impairment claims had been raised and ultimately resolved) and prepared alternative evaluations, pursuant to the existing and the proposed standards. When the study revealed that the new mental impairment listings were unlikely to result in a large increase in the number of awards made, the Office of Management and Budget (OMB) approved the new regulations. Similarly, members of the Appeals Council devoted a substantial amount of time to participation in the studies culminating in the BELLMON REPORT, *supra* note 173.

339. These ad hoc review bodies were chartered in response to public criticisms of particular SSA policies. The Appeals Council members were asked to participate, based on their perspectives as reviewers of a large number of cases, by identifying recurrent issues or problems.

340. The full Appeals Council holds monthly meetings, and members may place substantive items of this type on the agenda, but they have rarely done so recently. Informal consultation among members of a geographic grouping, between the members assigned to a particular case or among others, occurs on a daily basis.

The Appeals Council previously played a larger role in making SSA policy. Council members in earlier years frequently discussed substantive policy matters at regular en banc meetings. The Council would then vote and record its policy agreements in short minutes that were disseminated as guidance within OHA. These minutes were not binding on other components of the SSA, but they served as notice within the adjudicatory process on how the Appeals Council would handle a particular question, thereby hinting what DDSs and ALJs might do in order to have their decisions affirmed.³⁴¹

7. *Costs of the Appeals Council*

The more subjective costs and benefits of the Appeals Council are reviewed below. Even the calculation of the organization's objective financial costs is not straightforward because SSA accounting is not ordinarily performed in a fashion that permits separate cost assessments of discrete bureaucratic units.

At the time of our original report the best information available for FY 1987 costs associated with the operation of the Appeals Council was:³⁴²

OAQ Salaries and Benefits	\$26,570,742	
Other OAQ Costs	<u>1,946,384</u>	
OAQ Subtotal		\$28,517,126
Appeals Council		
Salaries and Benefits	2,805,251	
Other Appeals Council Costs	<u>\$ 347,981</u>	
Appeals Council Subtotal		<u>3,153,232</u>
Total for OAQ and Appeals Council		<u>\$31,670,358</u>

II. CURRENT AND POTENTIAL GOALS OF THE APPEALS COUNCIL

A determination of the Appeals Council's proper role within the bureaucracy must begin with an articulation of its organizational goals. Goal identification for a subunit of a complex department is not easy where many conflicting issues compete for attention. Nonetheless, we have identified six related functions that the Appeals Council performs or should perform: (1) policy development, (2) im-

341. The *OHA Law Reporter* is the Office of Hearings and Appeals' quarterly summary of selected actions by ALJs, the Appeals Council, and other bodies relevant to the SSA. It still contains an entry for a section on Appeals Council minutes in its table of contents, but this section has had nothing to report for several successive quarters.

342. Letter from William Taylor, *supra* note 155 (based on actual figures through May 1987 and estimates for the entire year).

provement of factual accuracy, (3) assurance of program integrity, (4) consistency in decisionmaking, (5) improvement of system-wide efficiency, and (6) fostering of greater public acceptance.

A. Policy Development

The primary function of most administrative review bodies is participation in the development and implementation of agency policy.³⁴³ Whether this appellate authority resides in the head of the agency or in some lesser body, the traditional scheme of administrative law generally places responsibility for generating policy at the top of the appellate pyramid.³⁴⁴

Policy functions may be executed by precedential case adjudication, by generating prospective rules, or by a mixture of methods.³⁴⁵ Whatever the method, however, it is important that the appellate authority look past case-by-case determinations to extrapolate generally applicable policy.³⁴⁶

The Appeals Council has largely abandoned this traditional model. All members of the Appeals Council report that they now function almost exclusively as case handlers, not as policymakers. They define their role as reviewers of ALJ decisions, processing an incessant run of cases and having little time to participate in broader

343. 5 U.S.C. § 557(b) (1982) ("on appeal from or review of the initial decision, the agency has all the powers which it would have in making the initial decision except as it may limit the issues on notice or by rule . . ."); see also ACUS RECOMMENDATION 68-6, DELEGATION OF FINAL DECISIONAL AUTHORITY SUBJECT TO DISCRETIONARY REVIEW BY THE AGENCY 305.68-6 (1968).

344. An agency head may, if he deems it proper, reverse the ALJ on any ground so long as there is a reasonable basis for the ultimate decision, a requirement that would obtain in all events. In reviewing adjudications or in adjudicating matters himself, the agency head necessarily is sensitive to the political considerations that informed the policy decisions. Indeed, it is his capacity, unique within the agency, to evaluate those considerations that prompted the APA's crafters to retain agency review of adjudications; wholly independent adjudications, lacking the agency head's sensitivity to factors not easily captured in rule form, might produce policies at odds with those the agency, acting within its delegated power, seeks to advance. 1983 ACUS REPORT, *supra* note 2, at 122; see also J. FREEDMAN, *supra* note 2, at 126-27, 134-37. But see Strauss, *Rules Adjudication and Other Sources of Law in an Executive Department: Reflections on the Interior Department's Administration of the Mining Law*, 74 COLUM. L. REV. 1231, 1264 (1974).

345. A hearing officer often makes policy interstitially by helping agency standards evolve in individual cases. Nonetheless, the underlying distinction remains: in most agencies, the hearing level is for finding facts, while the appellate level is for generating and overseeing policy.

346. See C. KOCH, *supra* note 2, at §§ 6.73, 9.3.

policymaking.³⁴⁷ SSA leadership officials agree that the Appeals Council operation resembles a factory assembly line.³⁴⁸ The job description of the Appeals Council as an entity has been defined, for practical purposes, as "getting the cases worked," paying attention to the particular file in front of the Council at a particular time, without much participation in the policy process.

Why has this transformation occurred? The Appeals Council, after all, is the only entity within the SSA that regularly reviews cases as they leave the administrative levels and again as they are remanded by the courts. Why does the Council not use its special perspective to contribute more to agency policy? Three reasons are apparent.

First and foremost is the crush of the cases. Over the past several years the Appeals Council has been swallowed whole by its docket. When 40,000, 60,000 or 80,000 case files per year stack up in the Appeals Council mailroom, the entire bureaucracy must be marshalled to process them. When a member of the Appeals Council is confronted by thirty cases each day, aware that a failure to dispatch any of them means that sixty files will require action tomorrow, there is precious little time for reflection, for the pausing from chaos, to generate mature policy recommendations. When the Appeals Council is so driven to process its files, it is not surprising that all its institutional resources will be bent to that purpose, and all other possible functions will atrophy.

Second, the Appeals Council's policy function has been degraded further by the evolution of alternative mechanisms for creating policy through rulemaking.³⁴⁹ The SSA has developed a complex system

347. J. MASHAW, *supra* note 154, at 105. "[T]he [Appeals Council] is not the principal policy arm of the [S]ecretary or the [C]ommissioner with respect to the [RSDHI] program." *Id.* Burton Berkley, Deputy Chair of the Appeals Council, stated: "We [the Appeals Council] are not a policymaking body. We adjudicate (sic) cases that come along but we adjudicate (sic) them in accordance with published policy." Cleveland Transcript, *supra* note 257, at 271.

348. As an exception, however, members have occasionally identified areas appropriate for future rulemaking, and individual members have been assigned to participate in agency-wide policy-review bodies.

349. Rulemaking and adjudicating are partially complementary, partially competing, methods of enunciating agency policy. *The Attorney General's Manual on the Administrative Procedure Act* (1947), intended to advise agencies on compliance with the APA, observed:

[T]he entire Act is based on a dichotomy between rule making and adjudication Rule making is . . . essentially legislative in nature, not only because it operates in the future but also because it is primarily concerned with policy considerations. The object of the rule making proceeding is the implementation or prescription of law or policy for the future, rather than the evaluation of a respondent's past conduct.

Id. at 14.

of making policy pronouncements. Formal regulations promulgated through APA rulemaking procedures, less weighty interpretive standards of Social Security Rulings (SSRs), and numerous internal policy statements, circulars, and manuals demonstrate the SSA's ability to make policy without substantial Appeals Council input.³⁵⁰ Many of these various mechanisms are ponderously slow, incomplete, or inconsistent, but they show that the SSA has not waited for the Appeals Council to act. The process of policy-generation has had to continue, and SSA has developed systems for propounding policy in a variety of forms, even without the usual sort of assistance provided by appellate administrative review bodies.

This process suggests a third factor contributing to the decline of the Appeals Council's policy role: geography. Located in Arlington, Virginia, and separated from the Baltimore headquarters of the SSA and from the Washington, D.C., headquarters of HHS, the Appeals Council has been insulated from partisan interference. This distance, however, has made communication with the SSA and HHS headquarters more difficult.³⁵¹ It is simply less convenient to rely upon the Appeals Council for policy input when its members are not physically present in the arena where policy is being made.

The Appeals Council, therefore, has been almost entirely excluded from SSA policymaking, though not through a deliberate ploy of power politics. On the contrary, SSA officials revealed in conversations with the authors that they want and need greater policy input from the Appeals Council and that they have been disappointed at not hearing more from that source. At the same time, Appeals

350. It is difficult to achieve a balance among regulations, SSRs, and the less visible policy devices. On the one hand, considerations of speed, ease, and flexibility will incline an agency toward the less ponderous devices—and the SSA has a particularly tough time producing formal regulations efficiently. On the other hand, the public's right to know about, and to influence, the content of the standards governing claims adjudication will create pressures to adopt the more formal mechanisms. Additionally, the SSA as a public service entity designed to implement broad remedial statutes, has a special responsibility to avoid the creation of "secret law."

We note that Congress has pressed the SSA to publish more and to rely less upon internal policy pronouncements that are not generally available to the public. *See Social Security Disability Reform Act of 1984*, Pub. L. No. 98-460, § 10, 98 Stat. 1805 (1984). We also observe that the agency seems to be retreating somewhat from reliance upon SSRs. It is beyond the scope of this Article, however, to attempt to delineate a proper dividing line between various policy tools.

351. In addition to its physical removal, the OHA has been bureaucratically aloof from the rest of the SSA, prizing a direct bureaucratic link to the Commissioner or to the Secretary, outside the usual action channels. This, too, supports the aura of independence in adjudication, but it simultaneously deprives the Appeals Council of a voice in policymaking.

Even within the OHA, distance is maintained. The Appeals Council is not located within the same building as the Associate Commissioner or the Chief ALJ.

Council members were generally surprised to learn from us that SSA officials would welcome their input on policy. The image emerges of a communications conduit between the Appeals Council and the Baltimore headquarters that has become clogged by the Appeals Council's case responsibilities and has consequently fallen into disuse. Until the Appeals Council caseload can be thinned out appreciably, there is little hope for reactivation of a policy link between Arlington and Baltimore.

An important ramification of the Appeals Council's case-handling role is the question of member accountability. Traditionally, Appeals Council members have been ordinary SSA civil service employees, evaluated for performance and eligible for merit pay, unlike ALJs, whose independence is secured by APA protections.

This structure is based on the legal fiction that the Appeals Council acts as the "head of the agency" in the Secretary's stead, to carry out policy decisions. Indeed, in many agencies this model of policy review by non-APA-protected officials after neutral fact-finding by independent ALJs seems to make sense.³⁵² In the context of the SSA, however, this legal fiction is a hindrance. The Appeals Council is not the "alter ego" of the Secretary; it never meets with the Secretary, the Commissioner, or even the Deputy Commissioner. Those officials have little awareness of or input to the Appeals Council's daily work. The Appeals Council does not carry out the will of political appointees and members have stressed that they would resent any attempt to influence their decisions. The members feel instead that they are bound by precisely the same legal standards and policies that ALJs follow.

Moreover, Appeals Council members today enjoy *de facto* protection. They are as "accountable" as ALJs, no more or less prone to ignore policymakers' direction, and equally subject to agency discipline.³⁵³ Furthermore, the selection process and the qualifications for

352. "Thus, officials insulated from outside contacts and internal controls might be more concerned with the accuracy of ALJs' factual determinations, while policy-sensitive officials are more concerned with the effect of ALJs' decisions on particular parties or policies." *Allocation of Authority*, *supra* note 2, at 28.

353. We do not undertake here to assess the extent and effectiveness of the APA protections accorded to Social Security Administration ALJs. Some have concluded that the Merit Systems Protection Board apparatus is so rigid that effective discipline of aberrant ALJs, even for important transgressions, is a practical impossibility. Others have contended that SSA actions have, in fact, produced changes in ALJ behaviors, through indirect pressures and the creation of a particular "adjudicative climate." In any event, it is clear that the legal protections—as distinguished from the *de facto* protections—enjoyed by the ALJs are stronger than those accorded to the members of the Appeals Council.

membership in the Council more closely resemble those of ALJs than those of SSA policymakers.

This combination of de facto protection but de jure vulnerability seems anomalous. If members of the Appeals Council perform essentially ALJ-like functions, and if their mission is strictly case review, then the relationship between ALJs and the Appeals Council should parallel that between federal district courts and circuit courts. Equivalent job protection and status for both tiers seem logical. Why insist on the maintenance of de facto independence but resist making it de jure? On the other hand, if the function of the Appeals Council is more policy oriented, why should not members discard their partial and misleading trappings of independence and become frankly political?

This question, too, boils down to the issue of caseload. If the Appeals Council is so burdened that it does little other than review ALJ decisions, it seems futile to pretend that the Appeals Council is performing a "Secretarial" function requiring direct accountability. That administrative model may be sensible in other agencies where the smaller number and greater importance of the cases make intervention by the agency Secretary possible. It is simply not, however, an accurate portrait of today's Social Security Administration.

B. Factual Accuracy in Case Handling

Inasmuch as the Appeals Council has relinquished a major role in formulating agency policy, the next leading or potential goal of an appellate review body might concern correct administrative action on individual claims. This is, in fact, what members of the Appeals Council identify as their current concern: reviewing individual cases to catch errors made by ALJs.

1. Identifying and Measuring Accuracy

Accuracy in a disability case is extremely difficult to define, let alone measure or achieve. No one we spoke with was able to articulate a workable definition of "accuracy." Previous studies of and by the SSA have similarly foundered upon this point.³⁵⁴ Lack of an objective definition has often resulted in conflating this goal with other, only slightly less subjective program goals such as "uniformity" or "consistency," which we elaborate below.

354. See NAT'L CENTER STUDY, *supra* note 134, at xx ("Investigation of the accuracy of the [Bureau of Hearings and Appeals] hearing process . . . leads very quickly to the realization that there is no accepted external standard for evaluating accuracy."); *Allocation of Authority*, *supra* note 2, at 15; D. COFER, *supra* note 5, at 86.

Why is it so difficult to define and measure accuracy? Part of the problem lies in the complexity and subjectivity of the underlying variable itself: disability.³⁵⁵ The human organism is marvelously complex; the impairments that can affect it are diverse and protean. Disability, moreover, is not exclusively a medical concept; rather, it is a vocational measurement that draws upon variations in economic conditions, social mores, and the political climate.

Rigid rules are neither possible nor desirable in adjudicating disability cases. They are impossible because of the vast array of circumstances to be found in the claims. One ALJ estimated that some 3000 variables affect disability adjudications and that these variables may interact in a nearly infinite variety of combinations. Objectifying the correct melding of all these factors would be impossible.

Even if objectification were possible, excessive reliance upon rigid rules would be undesirable for institutions of broad remedial purposes such as the disability program.³⁵⁶ Even the relatively discrete categorizing rules already in the system are not slavishly applied. The Listings of Impairments, for example, may be "equaled," rather than precisely "met";³⁵⁷ even the "age" category of the grids (which is the least susceptible to manipulation) is not to be applied "mechanically in a borderline situation."³⁵⁸

Accuracy, however, is not an empty term; the statutory definition of disability must be honored, and SSA regulations attempt to translate it into operational terms.³⁵⁹ The adjudicatory system is based on the idea that only subjective judgment can integrate all the variables to give the closest approximation of decisional accuracy. Accuracy, therefore, is "in the eye of the beholder."

2. *Some Erroneous Measures of Accuracy*

Lack of a simple definition of "disability" and "accuracy" has led to experimentation with substitute standards of accuracy, all of which we find deficient.

355. As noted, the Appeals Council handles other types of cases, but disability appeals constitute 95% of its caseload. Significantly, the other types of cases (where age, survivorship, etc., are in issue) pose far fewer concerns over the concept of accuracy. See Kinney, *supra* note 334, at xx.

356. K. DAVIS, *DISCRETIONARY JUSTICE* (1969). "Rules will not suffice. Rules must be supplemented with discretion . . . For many circumstances the mechanical application of a rule means injustice; what is needed is individualized justice, that is, justice which to the appropriate extent is tailored to the needs of the individual case." *Id.* at 19.

357. 20 C.F.R. § 416.911 (1986).

358. *Id.* §§ 404.1563, 416.963. In fact, the flexibility contained in many of these provisions is rarely exercised. SSA adjudicators, for example, infrequently take advantage of their ability to apply the "age" categories other than mechanically.

359. See *id.* § 404.1520.

a. The Last Word

The most commonly used standard of accuracy seems to be that whoever speaks last, and effectively affirms or reverses earlier decisionmakers, is deemed to be the most accurate authority. Thus, the Appeals Council is said to check the accuracy of ALJ determinations, the various quality assurance reviewers within the SSA evaluate the units they monitor, and federal courts correct administrative errors. While we believe these cross-unit variations are significant, we do not consider them to be particularly indicative of accuracy, for several reasons.

First, a disability case constantly evolves throughout the review ladder. Subject to the rules of evidence,³⁶⁰ new material may be added to the file as the case progresses from DDS to ALJ to the Appeals Council and even to federal court. Therefore, subsequent authorities may not actually be second-guessing the earlier adjudicators; the case may be different at each step.

Second, the review process is asymmetric. DDSs typically assess paperwork only; ALJs see the claimants face to face and can assess their credibility directly. Although the Appeals Council has access to the tape recording of the hearing, it has little time to do more than a paper review. That different administrative levels make different decisions under these circumstances is not surprising, but it does not make sense to conclude one is "more accurate" merely because it comes chronologically later.

Additionally, substantive standards vary with the different review levels. The ALJ hearing is explicitly *de novo*,³⁶¹ and in fact, ALJs seem to demonstrate no deference whatsoever to DDS conclusions. The Appeals Council and the reviewing courts are supposed to be bound by a "substantial evidence" test,³⁶² yet many contend that the next level often simply substitutes its own judgment or personal preference. That is, Appeals Council members believe that federal court reversals are sometimes based more upon sympathy for the claimant than on a dispassionate analysis of the evidence supporting the earlier decision. Ironically, ALJs often feel the same way about the Appeals Council—that its reversals often result from different opinions on the merits rather than from a true "substantial evidence" assessment.³⁶³

360. See *supra* text accompanying notes 272-80.

361. 20 C.F.R. §§ 404.946, 416.1446 (1986).

362. E.g., *Richardson v. Perales*, 402 U.S. 389, 402 (1971).

363. See *infra* text accompanying notes 452-54.

Finally, the reviewers' perspective about accuracy is bound to be affected by their familiarity with the cases reviewed. Federal courts, for example, see a highly skewed selection: only denials or terminations, and then only when the claimant and a representative can assemble a colorable case. Moreover, each federal judge sees only a few cases per year, not the vast outpouring of SSA work. The courts' perspective thus naturally inclines toward that of a champion of the downtrodden faced with a callous bureaucracy. Federal judges may not appreciate that court action is itself aberrational: of the annual total of awards made in all disability cases, approximately 79% come at the initial level, 8% on reconsideration, 12% at the ALJ stage, and 0.2% by the Appeals Council. Courts account for only 0.4% of all awards.³⁶⁴

The difficulty of relying upon "who speaks last" as a definition of accuracy is underscored by a 1982 study mandated by Congress and conducted by the SSA as part of the Bellmon Amendment.³⁶⁵ For this study, 3600 randomly selected ALJ decisions were presented for review by three groups: other ALJs, Appeals Council members, and quality control monitors for the SSA's Office of Assessment. After studying the files, the Appeals Council group reported agreement with only 63% of the original ALJ awards. The Appeals Council also disagreed, however, with 21% of the ALJ denials.³⁶⁶ Even wider disparities were reported among the ALJ and Office of Assessment groups,³⁶⁷ suggesting a conclusion that "accuracy" in decisionmaking, even when review is confined within relatively standardized limits, remains highly subjective.

b. *The Fifty Percent Solution*

If the notion of an ultimate, "superior" arbiter of accuracy is invalid, how can one judge the propriety of SSA appeals adjudication? Focusing upon crude statistics, as if the reversal rates by themselves demonstrate the accuracy of a particular adjudication, is not a valid answer. Thus, we reject the notion that the 17% allowance rate at reconsideration³⁶⁸ and the 5% allowance rate at the Appeals Council³⁶⁹ are *per se* too low, and the approximately 50% award rate at the ALJ³⁷⁰ and federal court stages³⁷¹ too high.

364. 1987 BACKGROUND MATERIALS, *supra* note 66, at 69.

365. BELLMON REPORT, *supra* note 173, *passim*.

366. *Id.* at ii.

367. *Id.* at i.

368. 1987 BACKGROUND MATERIAL, *supra* note 66, at 41.

369. OHA OPERATIONAL REP. 24 (Sep. 30, 1986).

370. *Id.* at 27.

371. Gonya, *supra* note 152.

Our skepticism about the validity of any crude statistical test for accuracy is supported by comparisons with other contexts. Studies of general civil litigation have concluded that controversies going to court tend over a long run of cases to result in a roughly even split between plaintiffs and defendants.³⁷² Multiple reasons explain this 50% phenomenon, but they center upon the litigants and their attorneys symmetrically assessing the costs and benefits of litigation, as suggested by evolving precedent. If these observations were applicable to the SSA, then it would be possible to establish plausible statistical benchmarks for appellate reviewers. That is, if litigants appealed only the close disability cases to a higher level, then a 50% reversal rate at each appeals stage would not be surprising nor indicative of gross error. As the easy cases were weeded out of the system, (by paying those obviously disabled and by convincing obvious ineligibles of the futility of further pursuit of the claim) the system would continuously pass for appellate review only those cases that were sufficiently close to the dividing line that reasonable adjudication could go either way.³⁷³ Our observation of the SSA review tiers, however, suggests that it is wrong to assume that only the close cases work their way up the appellate hierarchy.

The "open record" aspect of disability cases, noted above, is one of the reasons why this assumption is fallacious. A case may progressively improve with age, as subsequent adjudicators receive new data. Second, the factor of litigation costs, which is vital to Priest's study of the courts, is distorted in this administrative setting, where the costs vary substantially from stage to stage. Filing an initial application for disability benefits requires some effort by the claimant, and perhaps some badgering of doctors and hospitals to produce copies of medical records. Reconsideration, on the other hand, is virtually free in most cases; it only requires signing an SSA form. The ALJ stage is probably the most costly, involving time, patience, and usually the services of an attorney.³⁷⁴ The next step, presentation to the Appeals Council, may require a small amount of the representative's time, though usually nothing from the claimant. Finally, filing in federal court is much more difficult and requires a substantial

372. Priest & Klein, *The Selection of Disputes for Litigation*, 13 J. OF LEGAL STUD. 1 (1984); Priest, *Reexamining the Selection Hypothesis: Learning from Wittman's Mistakes*, 14 J. OF LEGAL STUD. 215 (1985). *But see* Wittman, *Is the Selection of Cases for Trial Biased?*, 14 J. OF LEGAL STUD. 185 (1985).

373. J. MASHAW, *supra* note 154.

374. Attorneys and other representatives who accept fees for services in disability hearings usually do so on a contingency basis, and the claimant does not make any out-of-pocket expenditures that might serve as disincentives to proceed with the case.

court fee. An even more important hurdle against a civil action, however, is finding an attorney who will take the case pro bono or for a contingency fee. The costs and effort involved in discovery, preparations, and trial, on the other hand, are far less than in most litigation.

Finally, SSA cases are different from most court cases studied by Priest in that the SSA has virtually no authority to compromise or settle. Indeed, SSA has little scope for negotiation and must basically choose to defend its denial of benefits (even if the case against paying benefits is uncertain) or abandon its position altogether (even if SSA might be sustained in court).

In short, there is no reason to expect that a 50% award rate—or any other fixed rate—would be “correct” for SSA disability adjudications. The formulae that might suggest such an outcome elsewhere are not applicable here. The substantial variation in disability award rates among the various tiers of review is certainly provocative and important, but the statistics themselves cannot be interpreted as conclusive measures of accuracy.

3. *The Actual Costs of Inaccurate Decisions*

Even if inaccuracy is difficult to define and measure, we know that it exists. Indeed, inaccurate decisions are inevitable in a system as large as the SSA. Even if each level of review could avoid substantial error in ninety percent of its cases, hundreds or thousands of appeals would still take place. The gross numbers alone suggest the importance of identifying errors and deciding who should bear the costs.

In a system where claimants are categorized as either “disabled” or “not disabled,” two kinds of errors are possible: an eligible claimant may be improperly denied benefits, or an ineligible claimant may be wrongly granted benefits. Both types of errors are to be avoided, but measures designed to minimize one type of error may inadvertently increase the incidence of the other.

Relevant to the assessment of accuracy is the question of processing costs. The administrative costs of the SSA are substantial, and the overhead costs of the disability program are more expensive than those of the other components of RSDHI. Even at this level, however, processing costs remain relatively low. Mashaw points out that the cost of benefits is roughly sixty times the cost of adjudicating eligibility,³⁷⁵ suggesting that increases in accuracy are likely to be justifiable on cost effectiveness grounds.

375. J. MASHAW, *supra* note 154, at 81-82.

One side of the coin concerns the errors of "false denials," wrongly rejecting truly disabled claimants. Failure to provide disability benefits to those entitled to them results in both individual and social costs. The first such cost is the failure to support those who are incapable of supporting themselves through remunerative activity. Although some of these claimants may have other resources or be eligible for other social welfare programs, for many disabled people federal benefits provide the primary bulwark against abject poverty.

A second cost of erroneous denials is dissatisfaction among the needy and deserving, who will feel that the SSA system has failed them in a time of great need. Moreover, many claimants are seeking RSDHI benefits that they "bought" through compulsory SSA insurance. In essence, those wrongly denied are being deprived of benefits they paid for over the years.

Third, erroneous denials undercut the disability program as an expression of the generosity and goodwill of the American people. If the system is inaccurate and unreliable, the beneficent purposes of this social legislation are frustrated, eroding our self-image as a caring community. Finally, erroneous denials also hurt the productive members of society by generating insecurity about their fate, should disability strike them. Skepticism about an important social institution such as the SSA will inevitably create widespread dissatisfaction.

On the other side of the coin are the costs of erroneous awards. The most obvious cost of an incorrect determination of eligibility is the removal of a potentially productive worker from the work force, with consequent losses in tax revenues and GNP. The magnitude of the loss is hard to calculate, particularly for an "almost disabled" worker. Especially in periods of substantial unemployment, the claimant's lost contribution to the economy may be small.³⁷⁶

Removal of a productive person from the work force, however, also imposes a hidden, insidious cost upon the recipient of unwar-

376. The SSA does not regularly monitor or compile statistics about claimants who are denied or terminated from disability benefits, so it is not possible to estimate how many of them may later successfully return to the competitive economy. Anecdotal evidence and a few studies, however, suggest that those who consider themselves to be sufficiently disabled that they apply for disability benefits are generally unlikely to return to productive work, even if their applications for benefits are denied. If they do attempt to work, their wages tend to be low and intermittent. See Bound, *The Health and Earnings of Rejected Disability Insurance Applicants*, Dep't. of Economics, Harvard Univ. (Dec. 1985), reprinted in Nat'l Bureau of Economic Research, Working Paper No. 2816 (Jan. 1989); Linden, *Delays in Processing Benefits to Disability Claimants*, 21 CLEARINGHOUSE REV. 357, 365 (1987).

ranted disability benefits: it may serve to entrench the person in a disability lifestyle, underscoring a self-image of powerlessness that can degenerate into a life of despondence, immobility and self pity that is far less rewarding than maintenance of even marginal employment would be.

Erroneously granted benefits also create public dissatisfaction. They tend to bring all of the SSA—indeed, all of the government's social programs—into disrepute, undercutting public sympathy for assistance programs for the truly needy. Finally, erroneously granted benefits impose direct costs upon the intended beneficiaries of the system because claimants compete with each other for public funds. The greater the aggregate of mistaken awards, the smaller the pool available for distribution among the truly disabled. Given a political climate inhospitable to proposals to increase the funding of disability programs, a mistaken award imposes an opportunity cost of lost options to pursue other social goals.

It is important to note that error costs, regarding both false positives and false negatives, are long-term rather than transitory, because the SSA system has difficulty in efficiently correcting its mistakes. For example, erroneous awards may generally be corrected only by a termination action. Massive terminations in the early 1980s demonstrated how traumatic that process can be. The revised rules regarding "continuing disability reviews" (CDRs) have been greatly tempered in response to that experience, and it is possible that the new definition of "medical improvement" will make removal from the rolls more difficult. Thus, an award of benefits, correct or incorrect, tends to be an action with long-term consequences.

An erroneous denial too is difficult to reverse. Even though an improperly denied claimant could file a new application, reapplications may be viewed with less objectivity. Moreover, unless an adjudicator who rules favorably on the later application takes the unusual action of reopening and revising the earlier denial, benefits will not be paid for the intervening time period.³⁷⁷ In addition, the claimant's financial eligibility for RSDHI may expire before the new application is filed. To that extent, an erroneous denial carries permanent costs.

4. An Approximation of Accuracy

The difficulty of defining and measuring accuracy inclines us toward offering a "second-best" solution: skew the likely errors into a

377. 20 C.F.R. § 404.987 to .989, 416.1487 to .1493 (1986).

relatively tolerable pattern.³⁷⁸ By “second-best” we do not mean a compromise with perfection. Having concluded that perfect accuracy is unattainable and that efforts to pursue it directly will result in poorer system performance, we suggest a more modest two-pronged alternative: (a) that the SSA adjudicatory system be less concerned with accuracy in close cases on appeal and more concerned with accuracy in easy cases early in the process; and (b) that the SSA adjudicatory system be more concerned with correcting or anticipating erroneous denials rather than erroneous awards.

We derive the first principle—less focus on the marginal cases—from our conclusion that “accuracy” is most elusive and the costs of error are lowest in close cases. Furthermore, greater subjectivity and variability among adjudicators are likely to be found in borderline cases. Higher levels of the claims review process in these circumstances may not so much correct errors made by the lower levels as simply substitute judgments based on disagreement with the previous decision. Successive review, therefore, does not necessarily improve accuracy; rather, it may produce only a series of disagreements as to whether the case is marginally on this or that side of a not-so-bright line.

Given the strictness of the statutory disability standard, individuals even close to meeting the eligibility criteria may have little to contribute to the economy. Moreover, the primary cost of erroneous denials falls upon an individual least financially able to bear the burden. The primary cost of an erroneous award, on the other hand, falls upon an insurance program created precisely to pool risks and spread them over all participants in the plan.

Close cases are not only the most difficult ones, they are the least important. An erroneous award of benefits to a claimant who is impaired enough to be almost eligible is an inexpensive error. The costs of the mistake are likely to be low when the claimant’s greatest possible contribution to the work force would be minimal in any event. Similarly, an erroneous denial in a close case, where the claimant is only barely eligible, and is almost capable of performing substantial gainful activity, is less expensive than in a case of extreme disability, where the wrongful withholding of benefits leads to economic deprivation of the claimant.

378. The concept of the “second best” was apparently first developed by R.G. Lipsey and K. Lancaster in their studies of macroeconomics and the efforts to attain perfect competition in the marketplace. It has been borrowed frequently for application in the analysis of a variety of public policy problems. See *DICTIONARY OF ECONOMICS* 368 (1984).

Although errors in close cases are less socially expensive, they are not less time-consuming for the SSA and the claimant. All cases progress through the same steps on the appellate ladder; cases with blatant errors receive no accelerated treatment. Accurate decisions, particularly accurate awards made earlier in the process, would expedite the payment to the claimant and reduce the volume of cases presented for subsequent review.

We conclude that a "second-best" solution to the inaccuracy problem would place greater emphasis upon early adjudication, especially where awards can be granted quickly, even at the expense of more fine-grained review at later stages. Although later review may change the outcome in many cases, close cases generally do not benefit from multiple review. We believe, therefore, that the Appeals Council should not screen cases for yet another analysis. That procedure promotes accuracy only slowly and at high cost; more importantly, it often provides second guessing rather than error corrections. Instead, the Appeals Council should devise a system that avoids or corrects errors, especially wrongful denials, at the earliest possible point in the system. Improving the accuracy of DDSs will require additional resources at the initial stages of case evaluation. We recommend that the Appeals Council establish a primary goal of improved accuracy and efficiency in the early stages of casework so that fewer errors are passed along to ALJs, the Appeals Council, and the federal courts.

C. Policy Integrity

The Appeals Council currently attempts to play a major role in promoting system-wide uniformity. We have identified two related aspects of uniformity: "policy integrity," discussed here, and "consistency," considered below. "Policy integrity," means that the applicable law is followed by all players in the bureaucracy, and that those in authority in SSA are able to carry out their management and policymaking functions effectively.³⁷⁹

Policy integrity is especially important for SSA, because the sketchy statutory framework for the disability program has resulted in an immense need for administrative regulations. Although these regulations have a limited scope, elected officials and their designees

379. See D. DWORKIN, *LAW'S EMPIRE* (1986). "Law as integrity asks judges to assume, so far as this is possible, that the law is structured by a coherent set of principles about justice and fairness and procedural due process, and it asks them to enforce these in the fresh cases that come before them, so that each person's situation is fair and just according to the same standards." *Id.* at 243.

enjoy an unusually broad range of discretionary power and policy alternatives through which the political element finds legitimate expression and control.

One important function of responsible leadership, therefore, is maintenance of the system's internal law. The Appeals Council is well-situated to play a major role in promoting policy integrity. The Appeals Council is the only unit of the SSA that regularly adjudicates a wide variety of cases, including those processed by the administrative bureaucracy and those remanded from the courts. The geographic and bureaucratic diversity of the Appeals Council's cases should enable it to assess policy adherence nationally.

The Appeals Council has been fairly successful in promoting policy integrity. The current members of the Appeals Council are well-versed in the applicable laws and SSA policies and they are active in implementing them. The Appeals Council also has succeeded in identifying aberrant case handling and in remanding appropriate cases to ALJs or DDSs with correcting instructions. The Appeals Council seems comfortable spotting deviations from established law and correcting or remanding for greater compliance.

In four areas, however, the policy integrity role has experienced problems: (1) promulgation of SSA laws; (2) non-acquiescence in court rulings; (3) discipline; and (4) balancing flexibility and policy. Three of these areas are beyond the scope of this Article, but the fourth is fundamental to the structure and operation of the Appeals Council.

1. Promulgation of SSA Laws. The first area concerns the variety of procedures for setting forth Social Security law and policy. The SSA has relied upon APA notice and comment rulemaking, informal Social Security Rulings (SSRs), internal policy statements, circulars, and manuals.

Regulations, unless deemed arbitrary or improperly promulgated, are binding upon all levels of adjudication—including the federal courts.³⁸⁰ SSRs, on the other hand, and, *a fortiori*, the internal guidelines of lesser status and lower visibility, are not open to public participation and are not binding upon reviewing courts. Their efficacy within the SSA system remains controversial because SSRs proclaim themselves to be binding on all levels of adjudication,³⁸¹ but many ALJs have systematically maintained that they are bound only by formal regulations, not unilateral SSRs.

380. See 1 H. KOCH, ADMINISTRATIVE LAW AND PRACTICE § 3.13 (1985).

381. S.S.R., *Preface* (Cum. Ed. 1982).

It is beyond the scope of this Article to attempt to reconcile this difference, or even to recommend practices to circumvent it. The balance among factors such as legal dignity, speed, flexibility, publicity, etc., is a difficult one. However, as long as this conflict endures, with ALJs insisting that they may overlook policy documents that SSA insists with equal vigor are binding, then the Appeals Council's role in ensuring policy integrity inside the Social Security system will be incomplete and frequently frustrated.

2. *Non-acquiescence.* A similar factor, cited by many observers and participants, has been the problematic nature of SSA's approach to decisions of the federal circuits. Again, the recent changes in SSA's acquiescence practices may have largely mooted this controversy,³⁸² and it is beyond our mandate to address it directly, but we must observe the occasional consternation it has generated inside the SSA and the difficulties it has posed for the Appeals Council's attempts to achieve policy integrity.

Put simply, when the law is in disarray, when the policies of different legal authorities are not well-integrated, then obviously the Appeals Council's power to impose order upon the internal mechanisms of the bureaucracy will be severely limited.

3. *Discipline.* A third problem in implementing policy integrity concerns discipline. The SSA's disciplinary authority is starkly limited. The major sanctions—action against an ALJ through the Merit Systems Protection Board or federalizing the functions of a DDS—are so cumbersome and expensive that they are not effective deterrents.

However, too much SSA authority to discipline lower-level decisionmakers might permit abuse. The independence accorded to ALJs and, to a lesser extent, DDSs, carries both costs and benefits. One benefit is opportunity for creativity and autonomy; one cost is reduced opportunities for program integrity. Independence, especially for ALJs, should be considered a virtue of the system and a price worth paying to preserve integrity and a sense of propriety.

4. *Balancing Flexibility and Policy.* The virtues of policy integrity should not obscure complementary virtues of flexibility and innovation.³⁸³ A sound mass-justice process must allow some discretion.³⁸⁴

382. SSA and Department of Justice decisions about which cases to appeal, and which to accept, however, remain problematic, sustaining many of the same questions and concerns as did the prior policy of non-acquiescence.

383. J. MASHAW, *supra* note 154, at 121-22; K. DAVIS, *supra* note 356, at 17.

384. C. KOCH, *supra* note 2, at § 9.22[2].

The "street-level bureaucrats"³⁸⁵ or implementing decisionmakers need space to make adjustments in the rules and add sensitivity to the administrative process.³⁸⁶ The SSA has provided such space for discretion in its rule structure. The key problem lies in defining who should be responsible for exercising this discretion, and what role the Appeals Council should play in fostering innovation and experimentation.

Both the DDSs and the ALJs should be allowed more creativity and scope for experimentation in organizing and processing the cases. At the ALJ stage, highly competent and experienced adjudicators review a large number of cases. They should be granted adequate flexibility in making individualized judgments on cases not fully covered by existing rules. Discretion for handling the disability caseload in potentially improved ways should be exercised more frequently.

The function of the Appeals Council here should be twofold. First, the Appeals Council should ensure the fundamental guarantees of due process—claimants should not be disadvantaged in the name of casual experimentation. The individualized discretion of the ALJ should remain within legal boundaries, and the Appeals Council should require continued compliance with principles of basic fairness.³⁸⁷ Second, the Appeals Council should also evaluate these discretionary actions and publicize successful results and techniques. The Appeals Council's broad perspective permits it to make useful comparisons across the national range of ALJs and DDSs, infusing successful innovations into new localities. Rather than merely correct individual errors, the Appeals Council should play a positive role in fostering system-wide improvements and in exploring potential areas of innovation.

D. Consistency

Another goal related to policy integrity is decisional consistency. This function of the Appeals Council is already important, and we have found both notable successes and shortcomings in the present level of performance.

385. M. LIPSKY, *STREET-LEVEL BUREAUCRACY: THE DILEMMA OF THE INDIVIDUAL IN PUBLIC SERVICE* (1980).

386. J. MASHAW, *supra* note 154. "The error costs from over generalization may here outweigh the gains from error avoidance. The adjudicator's feel for this type of case may often be better than any rule." *Id.* at 108.

387. Koch, *Judicial Review of Administrative Discretion*, 54 GEO. WASH. L. REV. 469, 471-78 (1986).

Consistency in case adjudication indicates respect for the individual claimant and ensures that the benefit system is above political or other partisan manipulation. As a national program, the SSA should provide the same system of benefits to claimants wherever they reside.

The goal of consistency has special relevance where accuracy remains elusive. Even if we are unable to measure or even define the "correctness" of an adjudication, we may be able to appraise its "similarity" to comparable cases. If a mistake is repeated in like cases, perfect accuracy is not achieved, but a sort of fairness results; and fairness may be the most that is attainable in a second-best world.

We discern two dimensions of consistency. "Vertical consistency" is achieved when decisionmakers evaluate a case according to the same procedures and legal standards at each tier of the appellate review ladder. It requires harmony among all the adjudicatory levels regarding standards for case handling, definitions of eligibility, and interpretations of policy. "Horizontal consistency" refers to the similarity of decisions in different venues. Claimants in Michigan, Georgia and New Mexico, for example, should receive similar treatment from their local DDSs, similar hearing procedures before their ALJs, and, if their cases are substantially the same, similar outcomes on their applications. The data, however, reveal wide variations in both horizontal and vertical consistency.

Vertical consistency is hard to evaluate. ALJ hearings, Appeals Council reviews and federal court actions may produce widely divergent award rates for many reasons. As long as the ALJ remains the only adjudicator to confront the claimant face to face, for example, the system should expect many reversals at that tier.³⁸⁸

Other causes of vertical inconsistency are less acceptable. The DDSs have operated under different law from the ALJs—not just procedural differences, but substantive differences, such as instructions to adhere to all or only some of the listings at the expense of the grids. The 1982 Bellmon Report, too, strongly suggested that cases are resolved differently by adjudicators at different levels, even when they are presented with identical case files.

Horizontal inconsistency is even more manifest and alarming.³⁸⁹ The award rates among DDSs have varied widely from state to state

388. D. COFER, *supra* note 5, at 12-13; 1986 Hearing, *supra* note 3, at 28 (statement of Eileen P. Sweeney, Staff Attorney, National Senior Citizens Law Center).

389. See NAT'L CENTER STUDY, *supra* note 134 at xxi; see also Capowski, *supra* note 75, at 343.

virtually since the inception of the disability program. The ALJs, too, vary in their award rates; some ALJs award benefits in only one-quarter of their cases, while others consistently find eligibility in three-quarters of the claims.³⁹⁰

This inconsistency is created partly because different federal courts evolve different rules in their respective jurisdictions. More inconsistency, however, flows from the lower adjudicative levels, as different locales generate starkly different success ratios for their claimants. Thus, national uniformity in SSA adjudication has always been illusory and there is little evidence of ongoing improvement.

1. Role of the Appeals Council

The Appeals Council should be uniquely helpful in achieving an acceptable level of consistency. The disability system includes approximately 1300 SSA district offices, 700 ALJs, and 900 federal district judges, but only one Appeals Council—it is the one location where cases from all regions and administrative tiers are adjudicated.

The Council is aware of its unique position, and its members take seriously their responsibility for maintaining nationwide consistency. If the statistics do not reflect much success, one can only speculate how much more inconsistency would exist without a single entity at the top of the pyramid attempting to reconcile divergent views.

The Appeals Council itself, however, is no paragon of uniformity. Indeed, with its current twenty members, the Council may be too large to speak with one voice. The current case handling routines further contribute to inconsistency. A case is ordinarily assigned to only one or two members; rarely do three members confer upon a case, and virtually never will more than three members address a matter together.

Moreover, Council-wide discussion of shared problems remains quite rare. Plenary meetings are held approximately monthly, but little of this time is devoted to solving common case-handling problems. Although the members' regional groupings could provide some uniformity, the groupings are not used much for this purpose. Members told us of daily consultation with each other on novel or tricky issues, but we were not persuaded that this collegiality was able to produce much of a shared outlook.³⁹¹ We observed (although the sta-

390. See D. COFER, *supra* note 5, at 85.

391. As far back as 1940, the Social Security Board recognized the importance of collegiality among the members of the Appeals Council:

To set up such a Council may seem a somewhat expensive means of conducting the hearing and review system. The review of cases and their just decision requires qual-

tistics are difficult to marshal) that members differ in their products; some, for example, grant review of cases at least twice as often as others do. As a result, the Appeals Council, potentially the best element in the network for attaining consistency, operates more as a collection of individuals than as an organized unit of a national bureaucracy.³⁹²

In assessing the Appeals Council's opportunities for promoting uniform decisionmaking, we recognized two categories of consistency: procedural and substantive. Procedural consistency is the easier one to pursue. It is not difficult for a central reviewing body to insist that ALJs and DDSs adhere to an established sequence of steps in developing and evaluating claims. The accumulation of records, the taking of testimony, the proper elaboration of mental impairment allegations, and the sequential evaluation process are all fundamental steps that the Appeals Council can monitor. These steps should not vary geographically, and the danger is small that standardized procedures would jeopardize decisional independence.

On the other hand, substantive consistency—like cases being resolved alike—is far more difficult to achieve. Any attempt to harmonize decisions of ALJs inevitably raises concerns about compromising the APA protections necessary to their integrity. Little can or should be done by the various tiers of the SSA to enforce a substantive uniformity upon ALJs; the danger of manipulation is too great.

Recent history suggests that ALJs will fiercely resist any reforms perceived as challenges to their autonomy.³⁹³ The SSA should never return to being "at war with itself," and OHA in particular cannot endure the tension and resentment that, to some extent, still characterize relations among ALJs, Appeals Council members, and policy officials.

2. *Improving Consistency*

Perfect consistency is unattainable. ALJs will continue to vary and will continue to assert their independence. The Appeals Council

ities of a high order, however, and their review is likely to be better than the initial decision which is adequate in the great bulk of cases only if several minds collaborate in the process.

BASIC PROVISIONS, *supra* note 194, at 38.

392. A decade or so ago, there were proposals (partially implemented at that time, but just as quickly abandoned) to "regionalize" the Appeals Council by breaking its members into district groups that would physically sit in various regional headquarters and handle cases on-site. We would not support that type of compartmentalization, preferring instead greater integration of the Appeals Council as a national entity. That regionalization could be so seriously considered is itself an indicator of the lack of cohesion among the Council.

393. D. COFER, *supra*, note 5, at 170-76.

should not challenge this reality, but should endorse it as part of the price to be paid for the benefits of an independent quasi-judicial corps. Although disparity in reversal rates is greater than it should be, a direct assault on the problem is bound to be futile and destructive. Instead, the Appeals Council might adopt less overt and less contentious but perhaps ultimately more successful approaches in its pursuit of consistency.

One such measure begins, as do many of our other recommendations, with the Appeals Council re-asserting control over its docket. Only when the Appeals Council is able to exercise some selectivity in the cases it reviews will it be able to play a more important role in pursuing consistency. As we elaborate in the final section of this Article, we propose that the SSA bring far fewer cases before the Appeals Council. The categories of cases to be reviewed should be those most likely to contain errors, those which would benefit from systematic scrutiny, or those in which inconsistency has been the greatest problem.

Once the caseload is reduced, the Appeals Council should write opinions that are not simply conclusory boilerplate, but that carefully analyze the evidence and the arguments and explain the outcome in detail. Current decisions do not contain this elaboration and are not, therefore, especially compelling in logic or citation. As a result, they do not inspire consistency at the lower levels.

In this context, it is disturbing that the Appeals Council does little to disseminate and publicize its decisions. The Council is ignoring the opportunity to promote consistency through promulgation of its most significant decisions, together with an appropriate index. The absence of a direct feedback mechanism is striking. ALJs and DDSs do not regularly track the progress of their cases and are not informed of appellate corrections, unless pure happenstance brings a remanded case back to the ALJ or DDS staffer who handled it initially. Thus, the Council lacks effective mechanisms that would have the greatest impact on national consistency. Consistency is difficult to attain solely on a case-by-case basis; ALJs and DDSs require more systematic guidance. The Appeals Council should take advantage of one opportunity to promote consistency within all tiers of the system by publishing the proper and improper ways of handling particular types of claims.

Other procedures that could enhance consistency are currently underutilized. For example, little interaction takes place between ALJs and Appeals Council members. The Appeals Council has virtually no budget for travel to local hearing offices and the "visiting ALJ" program (under which ALJs were assigned for one-month temporary

duty as Appeals Council members) has been terminated. Furthermore, training or continuing legal or medical education activities that might bring ALJs and Council members together seldom take place.

Similarly, most Appeals Council members have virtually no regular contact with DDS or district office personnel. Few attempts have been made to explore the ways in which direct meetings among personnel from various tiers of review could be arranged to enhance understanding of the program and consistency in its application.

E. Efficient Government

Cost effectiveness cannot be ignored in a program that costs millions of dollars to administer. The Appeals Council should be involved in improving the efficiency of its own process and that of the entire disability system.

The size of the SSA's disability operation is staggering: over two million applications are processed each year,³⁹⁴ over one million appellate reviews are conducted.³⁹⁵ Many cases involve highly complex medical and scientific matters. Whether by choice or by the pressure of events, the SSA has been near the cutting edge of modern developments in psychiatric impairment, pain, and AIDS cases.

In 1987, a budget of approximately \$650 million for administration of the disability portion of RSDHI was allocated to these SSA disability operations.³⁹⁶ The SSA calculates that the costs of administering the disability provisions of the law is 3.4% of their annual income.³⁹⁷ This figure may seem modest, but it was also four times the corresponding figure for the administration of the retirement and survivors portions of RSDHI, where the intricacies of disability determination are not at play.³⁹⁸

A 1983 study estimated that the average cost of a disability determination was approximately \$500 and the lump sum value of an award was about \$30,000, generating a processing cost only one sixtieth of the total cost.³⁹⁹ We suspect that this ratio has become even more favorable over the years, as benefit levels rise faster than overhead costs.

394. 1987 SSA REPORT TO THE CONGRESS, *supra* note 11, at 29, 31.

395. *Id.*

396. *Id.* at 30.

397. *Id.*

398. *Id.* at 29, 31. These figures exclude the costs of administering the SSI disability program for which general revenues, rather than the SSA trust funds, are tapped.

399. J. MASHAW, *supra* note 154, at 81-82.

This apparent efficiency, however, does not imply that the SSA can be indifferent to costs—indeed, the substantial reduction of the agency's manpower pool (shrinking from 74,600 permanent staff in 1983 to 66,700 in 1987)⁴⁰⁰ demonstrates that productivity remains highly prized. Moreover, the 60:1 ratio does not mean that any greater spending on administrative processing would necessarily be cost efficient. That is, the value of an "accurate" disability decision (if one could be defined) is not the full \$30,000; rather, it is the difference in aggregate social utility between having those funds in the hands of taxpayers or in the hands of a proper disability recipient. A correct decision is valuable, but it is not worth anywhere near the full sum of the payments.

Focusing on the Appeals Council, the question is whether this fourth tier of administrative decisionmaking is worth its cost. Currently, the Appeals Council changes the result in only about 5% of the cases it reviews.⁴⁰¹ Remands for further action account for perhaps another 10%.⁴⁰² This contribution is far from trivial; on an annual Appeals Council docket of 50,000 cases, it means that 7500 cases receive substantial alteration. But the Appeals Council and its affiliated support unit, the Office of Appeals Operations, also consume substantial SSA resources: almost \$32 million per year, and several hundred relatively high-graded employees.

The timeliness cost of the Appeals Council, moreover, is substantial: even if the system improves to the point that all request-for-review cases are disposed of within ninety days, the claimant is still forced to wait three months with little expectation of favorable action. Additionally, Appeals Council reopenings can substantially delay administrative finality and prolong the wait for access to court.

1. Sources of Inefficiency

Although it is difficult to assign rigorous costs and benefits inside a complex organization such as the SSA or a subunit such as the Appeals Council, we identified several factors that prevent the Appeals Council from achieving optimal productivity.

The first factor is the Appeals Council's current system for processing words and data, tracking files, and compiling statistics. The computer hardware, software, and support services are at best primi-

400. 1987 SSA REPORT TO THE CONGRESS, *supra* note 11, at 34.

401. OHA OPERATIONAL REP. 27 (Sept. 30, 1986).

402. *Id.*

tive.⁴⁰³ For example, members cannot directly make changes or corrections in their own letters or decisions; even typographical errors require returning the entire file to the OAO for reprocessing. Furthermore, the Appeals Council has only a rudimentary statistical base; the categories for recording various types of case actions are anomalous and poorly understood. Even the telephone system is antiquated.

The kindest conclusion one could draw from the Appeals Council's stunted computational capacity is that the situation must have been far worse not long ago when even the current equipment was unavailable. The promise of better systems, including computer integration with SSA headquarters, always looms on the horizon, but that relief will not arrive soon without outside pressures.

Another source of inefficiency is the Appeals Council members' lack of personal staff support. When cases arrive at the Appeals Council from the OAO, no one pre-screens them to sort the pedestrian from the significant. The members are thus forced to spend too much time on purely ministerial duties, hardly an efficient use of their talents.

We also observed considerable inefficiency in the organization and location of OAO analysts. They are spread through several buildings, making communications and simple file transfers difficult. The OAO branches do not parallel the members' geographic groupings; an analyst might send cases to many different members and each member may conversely receive work from thirty analysts. The analysts and Council members, therefore, never become familiar with each other's strengths, weaknesses, styles and preferences.⁴⁰⁴

2. *Protecting Judicial Resources*

One asserted justification for the existence of the Appeals Council is its ability to screen cases before they reach the courts, paying the more deserving claims administratively and thereby protecting the district judges from a potential flood of litigation.⁴⁰⁵ This protection of judicial resources is important: claimants, the SSA and the federal judiciary all benefit if claims can be resolved prior to filing a civil

403. Despite representations that the Appeals Council's word processing equipment would be "state of the art," 1983 *Hearing, supra* note 258, at 246 (testimony of Louis B. Hays, Assoc. Comm'r for Hearings and Appeals), the OHA has, in fact, supplied the Appeals Council with only inadequate, obsolete hardware.

404. We understand that the SSA is currently undertaking measures to redress this problem by combining OAO and the Appeals Council under one administrator and by matching one OAO branch with one Appeals Council member.

405. See, e.g., Cleveland Transcript, *supra* note 257, at 274.

action. The strain upon federal courts is already substantial: 15 to 20% of the federal civil cases filed against the United States are SSA disability contests.⁴⁰⁶ (Because these cases tend to be resolved expeditiously, however, they may account for only 2% of the federal courts' actual work.⁴⁰⁷)

The sheer size of the SSA caseload suggests that even minor perturbations in the SSA's rate of resolution of disability claims could cause major disruptions for a federal judiciary not equipped to handle that volume of traffic. Of the annual two million new disability cases, perhaps 10,000 (.5%) will wind up, years later, in court. Thus, if the SSA were able to dispatch only 99%, instead of 99.5%, of the cases administratively, the burden of federal actions would double.

The Appeals Council now receives approximately 50,000 cases per year. Of these, perhaps 10,000 will result in federal court actions. How much protection of the federal docket is provided by the action of the Appeals Council, and how much is more properly attributable to other factors?

We conclude that the Appeals Council itself now contributes relatively little to the protection of the federal docket. It does, of course, pay some claims and remand others to ALJs who may rule in favor of the claimant. But the Appeals Council itself does little to appease denied claimants or persuade them not to litigate. Council decisions are so standardized and nonresponsive that they "convince" no one; the review proceedings are so opaque that few claimants accept this process as a satisfying day in court.

The real deterrent to court action is not the Appeals Council; the cost, red tape, and delay involved in federal litigation are the more likely deterrents. Typically, the claimant must find a representative willing to invest time and money either pro bono or for a contingency fee and then must endure a long period of uncertainty while receiving no benefits. Even if the court is sympathetic, a remand for a new hearing is the most likely outcome, rather than an outright award of benefits. These factors would operate just as powerfully without the Appeals Council guarding the courthouse door.

There is one mechanism through which the Appeals Council does directly reduce the volume of cases going to court, but it is a factor that is even more unsettling. Sometimes the Appeals Council does succeed in exhausting claimants with its delay and impassivity. Far from persuading the claimants that their claims are without merit,

406. Flanders, *What Do the Federal Courts Do? A Research Note*, 5 REV. OF LITIGATION 199, 206 (1986).

407. *Id.*

the Council engenders a sense of defeat, a belief that the benefits are not worth the battle against a vast bureaucracy. This process does keep cases out of court, but only at the price of justice denied.

F. Acceptability

Acceptability of the adjudicatory process among various constituencies is vital for the SSA. Public confidence is necessary to the performance of its primary missions, Congressional support is essential for its survival, and a reputation for fairness and competence among other groups is important to its operations.

As the apex of the SSA adjudicatory bureaucracy, the Appeals Council can foster greater acceptability of the program in a variety of ways. However, the Appeals Council has either ignored this responsibility altogether or actually aggravated existing poor public appraisals of the SSA.

1. Acceptability with Claimants and the Public

The most direct and difficult target for building greater acceptability of the Appeals Council is the group of disability claimants and their representatives. These are the bureaucracy's clients; their satisfaction is an important element of a mass justice system.⁴⁰⁸

Obviously, those who are denied benefits are going to feel somewhat dissatisfied no matter how much sensitivity and care are demonstrated by the system. A program as large as the SSA, moreover, will inevitably make mistakes, including some egregious ones, even when it operates in good faith with modern management tools. Even if the error rate were statistically quite low, the raw number of erroneous denials and the incidence of callous bureaucratic treatment would be significant.

Even discounting these problems, though, claimant satisfaction with the SSA and the Appeals Council is low. Claimants can distinguish between being denied and being badly treated, and can respect an organization even after it rejects their claims, if they feel its handling of their cases is fundamentally fair. In the disability appeals process, however, claimants and their representatives frequently express two critical areas of dissatisfaction.

408. See generally J. MASHAW, *DUE PROCESS IN THE ADMINISTRATIVE STATE* (1985). An emerging school of thought, which Mashaw labels as proponent of a "dignitary theory," has as its "unifying thread. . . the belief that the ways in which legal processes define participants and regulate participation, not just the rationality of the substantive results, must be considered when judging the legitimacy of public decision making." *Id.* at 161-62.

The first source of unhappiness concerns delay.⁴⁰⁹ The Appeals Council takes too long to affect too few cases. In request-for-review situations, the Appeals Council is perceived as a mere way-station that must be visited before proceeding to federal court, where the chances for victory are greater. In own-motion review cases, claimants see the Appeals Council not only as a delaying factor, but worse, as a threat to the benefits they won at the ALJ level.⁴¹⁰ In court cases, the Appeals Council is also perceived as a source of unwarranted delay. The Secretary's motion to remand weak cases that would otherwise proceed in court is often interpreted by the claimant as covering up, rather than redressing, ALJ errors. Finally, when it does take cognizance of a case, the Appeals Council is twice as likely to remand as to reverse,⁴¹¹ resulting in subsequent proceedings before an ALJ, entailing further delay and perhaps another full hearing.

Claimants' second major complaint about the Appeals Council concerns the remoteness and the impersonality of the process. Claimants never see an Appeals Council member or OAO analyst, and even high-volume representatives report little or no personal contact. The prevailing impression is that the Appeals Council is aloof and impassive. Representatives confess that they know and care little about the Appeals Council. The organization is so arcane that they rarely take it seriously.

This perception of the Appeals Council as a "black box," with a mysterious internal composition and operation, generates a sense of arbitrariness—no one knows why the decisions come out as they do. Representatives relate incidents of egregious ALJ errors that the Council blithely overlooked, as well as weak, almost casual requests for review that the Council granted.

No claimant ever feels that he or she has had "a day in court" before the Appeals Council. Few could feel satisfied that the case was fairly heard and carefully scrutinized. Few—regardless of the outcome of the cases—come away from the encounter with the Ap-

409. Of course, the Appeals Council is hardly responsible for all of the delays that mark the Social Security system; it is merely the latest administrative source of delay. *See 1986 Hearing, supra* note 3, at 25-26 (statement of Arthur S. Flemming, Co-Chair, Save Our Security Coalition); Linden, *supra* note 376, at 357 (summarizing results of court-ordered study conducted by the SSA regarding processing times for current and retroactive payments).

410. Our interviews revealed that claimants' representatives believe own-motion review to be a major portion of the Appeals Council workload. In fact, the OHA now receives only a small number of own-motion cases (perhaps 300 to 400 per month) and the Appeals Council grants review in only 60 to 80 per month. Thus, even well-informed claimants' representatives lack an understanding of the most important aspects of the Appeals Council operation.

411. *See* OHA OPERATIONAL REP. 27 (Sept. 30, 1986).

peals Council feeling that their dignity as claimants has been acknowledged and respected by the process.

This sense of remoteness results partly from Council review that is entirely on paper, with no possibility of a hearing.⁴¹² The curttness of the Council's mailed notifications and decisional documents, as well as its self-imposed restraint regarding travel or public appearances, augments this remoteness. With a few exceptions by the Deputy Chair, Appeals Council members do not attend conferences, offer workshops, or deliver speeches to groups of claimants' representatives.

The "invisibility" of the Appeals Council is even more apparent among the public at large.⁴¹³ Few people outside the disability process have ever heard of the Appeals Council, and only those currently or formerly associated with the OHA have even a rudimentary understanding of its operations. At a time when public confidence in the Social Security Administration seems to be in jeopardy, it is striking how little has been done to utilize the resources of the Appeals Council to help redress the problem.

2. *Acceptability with ALJs*

The appellate function inherently creates certain tensions between tiers on an appellate ladder, but in most contexts, the customary disagreements about cases or practices may be handled civilly and collegially.

We have observed, however, that the expectation of mutual respect has not prevailed within SSA. ALJs feel a profound disrespect for the Appeals Council as an institution. Even ALJs who have had personal experience with the Appeals Council, and who appreciate the capabilities and sincerity of at least some of its members, have little faith in the organization as a whole. ALJs complain that Appeals Council members are merit system employees, not APA protected, and are therefore susceptible to political pressures. ALJs assert that it is improper for bonus-eligible employees to review quasi-judicial decisions on such fact-based cases. ALJs have repeatedly battled the OHA leadership over productivity and performance ratings, and have argued that their own statutory independence is an essential guarantee of fairness; they have little use for less-secure employees in an appellate role.⁴¹⁴

412. See 20 C.F.R. §§ 404.976(c), 416.147(c) (1986).

413. See Koitz, *Social Security: Legislation to Create an Independent Agency* 7 (1986) (prepared for Congressional Research Service); J. MASHAW, *supra* note 154, at 144.

414. See *supra* note 175 and accompanying text.

ALJs also resent having their decisions subjected to review by members whose qualifications and capabilities are no greater than their own. The present job qualifications for Council members and ALJs are substantially the same. Indeed, a number of ALJs have joined the Appeals Council. Non-lawyers, however, have served on the Appeals Council in the not too distant past, and many ALJs believe that some non-lawyers still are serving. Moreover, most Council members have never attended, let alone conducted, a real disability hearing.⁴¹⁵ Because the two jobs are graded and paid at the same level, the best ALJs have little incentive to climb the appellate ladder. More than one current member of the Appeals Council, in fact, expressed a preference for moving in the other direction, taking an appointment as an ALJ, if one could be arranged for the Washington, D.C., or Baltimore area.

In short, ALJs generally do not see the Appeals Council as a legitimate appellate body. They suspect that it is subject to political manipulations and believe that it has been forced into over-reliance upon the work of non-lawyer OAO analysts. ALJs have little opportunity to interact with Appeals Council members and, therefore, little occasion to dispel any myths. Within OHA, then, as among the claimants and general public, acceptability of the Appeals Council is a genuine problem.

3. *Acceptability with the Courts and Congress*

The SSA disability process has experienced considerable judicial distrust. Frequently, the federal courts have looked past the actions of the Appeals Council to dissect the work of the ALJ. Even in the eyes of the reviewing tribunal, the Appeals Council is often deemed irrelevant to the process and the results of the hearing level.⁴¹⁶

The Appeals Council has attempted to become more responsive to court activity. It has revised the prior "harmless error" policy and now grants review over more ALJ denials, re-writing even correct decisions to make the procedure and rationale more acceptable to the courts.⁴¹⁷ It has also streamlined Secretarial remand procedure on selected cases, providing further administrative work-up on difficult

415. The original plan for establishing the Appeals Council envisioned a great degree of fungibility between its members and hearing examiners: "Members of the Appeals Council will be authorized to serve as referees and should exercise such authority from time to time as a means of keeping them in touch with the problems connected with conducting hearings and developing the records." BASIC PROVISIONS, *supra* note 194, at 39.

416. See *supra* note 329 and accompanying text.

417. 8 Soc. SECURITY F. 1 (Feb. 1986).

cases. In fact, the Appeals Council may be becoming too preoccupied with court actions at the expense of its other roles, because resources directed at court actions cannot be utilized for minimizing administrative errors early in the process.

The SSA's programs—and the Congress' purse strings—are subject to the vicissitudes of politics. In an era of budget deficits and belt-tightening, proposals to increase domestic spending, including disability, have poor prospects for success. Whether this phenomenon relates to Congressional acceptability, however, is difficult to assess.

The OHA has certainly received more than its share of scrutiny in recent years. Most of this attention, however, has been lavished on the ALJ stage and the controversies over productivity and reversal rates. The Appeals Council has attracted far less notice—it is no more prominent in the attention of Congressional representatives and staff than among other sectors, and is little noticed by them. Even legislative proposals that would abolish the Appeals Council altogether do so indirectly, almost as an afterthought, such as through the creation of a new federal Social Security Court.⁴¹⁸ Congressional staff familiar with the Appeals Council have little to say in support or opposition. They perceive the Appeals Council as potentially valuable institutionally but not notably successful in carrying out a particular mandate. Thus, the Appeals Council has little impact with the Congress and little success in fostering program acceptability.

III. FINDINGS AND RECOMMENDATIONS

The Appeals Council is—or should be—an important institution. It alone issues final administrative adjudications on the thousands of disability cases pouring in from ALJs and DDSs around the country. It alone sees the full panoply of court cases, and it alone can call upon the talents of members and OAO analysts with such a special bureaucratic perspective.

Having investigated the purposes, structure and operation of the Appeals Council and having assessed its institutional performance and potential, we conclude that four options are available to improve the functioning of the Appeals Council: (1) Retain the Appeals Council essentially as it stands; (2) Abolish the Appeals Council entirely, redistributing its responsibilities and resources elsewhere; (3) Modify the Appeals Council to optimize its performance as a case-

418. See, e.g., 1986 Hearing, *supra* note 3, at 3 (statement of Representative Archer).

handling entity; or (4) Reform the Appeals Council, emphasizing its role in promulgating improvements in the adjudicatory bureaucracy. Each of these options deserves serious consideration and has certain merits. For reasons spelled out in this section, however, we strongly prefer Model (4) and recommend its immediate adoption.

A. Model (1): Retain the Appeals Council Essentially As It Stands

Maintenance of the present system without major alterations is a legitimate possibility. One should not rush to dispose of a government institution that has weathered bureaucratic storms for almost half a century. In fact, the Appeals Council has managed to do its job with some success, has helped to promote several important SSA objectives, and has managed to churn out 50,000 cases per year. Adherents of the "if it ain't broke, don't fix it" school might argue that the organization, for all its flaws, does something useful and that radical change promises no greater success.

Our review convinces us, however, that something in the system is broken. The Appeals Council fails to achieve its goals because of deep, permanent flaws in its structure and in the selection of its goals. Despite the best efforts of some very capable people, the record of the Appeals Council is wholly unsatisfactory. Several areas require fundamental changes.

The Appeals Council's present goals are important but also complex and difficult. Some of those goals, such as enhanced policy development, have been abandoned because of the crush of the caseload. Others, such as attaining decisional accuracy in the closest cases, are too ambitious. Achievement of other goals has been subverted by failures in the organization or operation of the Appeals Council. Moreover, current operations of the Appeals Council impose unacceptable costs upon the disability program. These costs (money, diverted resources, delay, and public image) are substantial and, we believe, avoidable.

Therefore, we reject Model (1). The existing structure of the Appeals Council is supported by nothing more than bureaucratic inertia. The time has come for profound change.

B. Model (2): Abolish the Appeals Council

The converse of Model (1) is Model (2), a proposal for outright elimination of the Appeals Council. This action has been recommended repeatedly by many claimants' representatives and several

scholars.⁴¹⁹ Congressional legislation that would accomplish this objective is regularly introduced.⁴²⁰

Valid reasons exist to support abolition. Appeals Council review is now largely superfluous. It changes the results in only 5% of the cases,⁴²¹ a statistic that may constitute a *prima facie* case for abolition. The Appeals Council does not contribute appreciably to the institutional goals of the SSA, and few factors suggest that a fourth tier—a fourth bite at this particular apple—is worthwhile.

The Appeals Council, moreover, is expensive. It consumes millions of dollars, employs talented people who could be used productively elsewhere, and wastes time, delaying the finality of the adjudicative process and eroding the support and confidence of the claimants.

These problems and the difficulty of adequately restructuring the Appeals Council suggest that a clean break may be wise. The Appeals Council might be considered outdated in an era when streamlining government is important. Teaching this old dog new tricks may not be a sound use of resources.

Abolition of the Appeals Council would not be difficult. Its personnel could be redistributed within the agency. Temporary displacements would no doubt occur, but the talents of members and OAO analysts could be put to good use in other niches. Similarly, the vestigial functions of the current Appeals Council could be handled elsewhere. OAO and other SSA service centers, for example, could send their “protest” cases⁴²² back to the originating ALJ. Technical errors could be efficiently corrected at the source through a reopening. The quality-assurance role of the Appeals Council could be served by a quality assurance staff that could provide on-the-job training for new ALJs in conjunction with the SSA’s national Chief ALJ. The Bellmon Review⁴²³ function could be statutorily removed or performed by other units.

One factor operating against Model (2) is that following abolition of the Appeals Council, ALJ decisions would become final agency actions and immediately reviewable in court. While this arrangement would be a departure from the common structure of administrative law (another post-hearing administrative stage usually exists prior to a court appeal), we find the arrangement plausible.

419. See D. COFER, *supra* note 5.

420. See, e.g., *supra* note 4.

421. OHA OPERATIONAL REP. 27 (Sept. 30, 1986).

422. See *supra* text accompanying note 238.

423. For a general discussion of Bellmon Review, see *supra* note 258.

The Model (2) scheme is consistent with the APA, which implicitly permits an Appeals Council but does not require it.⁴²⁴ ALJs are legally competent to have the last word for the agency. As a practical matter, ALJs now deliver the last real word in most cases because the Appeals Council caseload prevents it from effectively intervening.

Once freed from the specter of Appeals Council review, ALJs would not necessarily become more aberrational, independent, or generous. The ALJs would likely perform as they have in the past. Since the Appeals Council contributes little to ALJ discipline, abolition would not remove any of the system's important checks.

Most importantly, abolition of the Appeals Council would not immediately flood the federal courts with massive increases in disability filings. Compared to the various other barriers to entry into the federal courts, including cost, delay, exhaustion, and the need for an attorney, the factor of Appeals Council review is negligible. Its removal would not make an appreciable difference to the system.

We have a great deal of sympathy for this course of action. The present operation of the Appeals Council is seriously wanting, and remedial actions are not likely to occur. Nevertheless, our skepticism about the institution's effectiveness does not obscure our respect for its potential. Therefore, we do not recommend abolition at this time.

On the other hand, should our preferred recommendations or similar measures not be accepted and implemented, we would endorse the abolition option. The Appeals Council cannot continue as it is. If the recommended improvements are not promptly forthcoming, or if they prove inefficacious, the Appeals Council should be abolished.

C. Model (3): Improve the Appeals Council's Case-Handling Role

The next alternative is a restructuring of the Appeals Council to improve the accuracy, consistency, and efficiency of the case-handling process. Under this alternative, the Appeals Council would continue to pursue its leading current objectives, but would be reorganized to perform more efficiently.

Model (3) is based upon the principle that the most important function of appellate administrative review is the scrutiny of individual cases. The Appeals Council can correct ALJ errors before a wrongly-denied applicant is forced to litigate or before a wrongly-allowed applicant is put on the disability rolls. Even if perfect accu-

424. See 42 U.S.C. §§ 405(b)(1), 1383(c)(1) (1982).

racy is elusive, the Appeals Council could still do much to interdict blatant errors.⁴²⁵

The Appeals Council could also improve consistency within the program. Treating like cases alike is fundamental to due process, and the absence of central control may result in even greater inconsistency among the lower decisionmaking levels. Although the Appeals Council has not been notably successful in generating national uniformity, modest reforms would enhance its performance. By handling individual cases more purposefully and by developing additional feedback procedures that address vertical and horizontal inconsistency, the Appeals Council may be able to pursue these goals more effectively.

However, Model (3) has several disadvantages. First, as discussed above, decisional "accuracy" is undefinable and unmeasurable. Disability cases are too subjective and variable; appellate reviews too often substitute one authority's judgment for that of another. Even if accuracy were not so elusive, exquisite accuracy in close cases is not so valuable that we would oppose stopping at three, rather than four, levels of administrative adjudication.⁴²⁶

Consistency, too, is important. However, we question whether consistency can be achieved by reviewing and correcting individual cases. Even if the Appeals Council could improve its capacity for enforcing consistency, the amount of uniformity that could be achieved solely by working the cases is limited.

Finally, the Appeals Council imposes other costs upon the system, such as delay and reduced public acceptability, that would not be mitigated merely by refining its present routines. Even if the Appeals Council were streamlined, its greater efficiency would not justify its lofty position in the bureaucracy.

Enhancing the Council's case-processing role would require important changes. Essentially, the Council would become a more court-like body designed to handle its docket expeditiously and carefully. While we do not recommend adoption of Model (3), it deserves serious attention and the contrast between it and Model (4) will help explain our preference for Model (4).

Model (3) would incorporate the following six features:

(1) *Legal and Bureaucratic Protection for the Members.* Under Model (3), the Appeals Council would be serving as a true appellate reviewer of the work of ALJs, and it would be inappropriate for

425. See *supra* text following note 331.

426. *Id.*

Council members to lack the protections that ALJs enjoy.⁴²⁷ If the relationship between the ALJ level and Appeals Council should approximate the relationship between a district and circuit court, then both tiers would need the same measure of APA independence. The fiction of the Appeals Council performing a "political" act, in the name of the Secretary, is utterly inapplicable to the high-volume, fact-intensive world of Social Security disability. The reality is that Appeals Council members, like ALJs, perform a quasi-judicial function, not a quasi-political one; formal guaranties of independence are important for propriety and for the appearance of propriety.

With this enhanced status under Model (3) would come a change of title from "member" to "administrative appeals judge," and from "Deputy Chair" to "Chief Judge." We assume that the Associate Commissioner's position would remain but it would no longer carry an ex officio seat on the Appeals Council.

The Appeals Council, along with the corps of ALJs, would be relocated outside the SSA hierarchy. Supervision by political officials such as a commissioner, deputy commissioner, and associate commissioner would be inappropriate for a judicial body. Instead, the adjudicators would be physically and administratively insulated from the SSA. The Office of Hearings and Appeals, therefore, would be moved to the Office of the Secretary of HHS or, better still, to an independent adjudicatory agency.

(2) *Less "Second-Guessing" of ALJs.* The Appeal Council's standard of review consists of a check for "substantial evidence" to support the conclusions of the ALJ.⁴²⁸ However, it is difficult to believe that this standard is always honored. Instead, the Appeals Council (like the federal courts that review it) often substitutes its own judgment for that of the prior adjudicator (finding a witness not credible or the evidence unpersuasive, for example). This examination consumes too much time, undercuts respect for the ALJ, and favors second-hand assessments of demeanor and credibility.

One solution could be greater restraint on the part of Appeals Council members. A more concrete step would be a revision of the standard of review. For example, the Appeals Council's power to reverse could be limited to ALJ decisions that are found to be "arbitrary." Under Model (3), the Appeals Council would reserve its attention for the most egregious ALJ errors, and we conclude that such an "arbitrariness" standard would be appropriate for handling the cases expeditiously.

427. See *supra* text accompanying note 138.

428. See *supra* text accompanying note 267.

(3) *Time Limits.* The most frustrating aspect of appellate review for claimants and their representatives is the long period of uncertainty they face while waiting for the Appeals Council to act or, more often, to decline to act.⁴²⁹ Under Model (3), the Appeals Council would have to improve its efficiency. It could follow fixed timetables and allow claimants to proceed directly to court if these timetables were not honored. Reopening powers could not be exercised as a way of extending the Appeals Council's time for review.

(4) *Broaden the Caseload.* The Appeals Council would not be confined to claimants' requests for review. It would again take a substantial volume of "own motion" cases: both ALJ awards and unappealed ALJ denials.⁴³⁰

The appropriate volume of cases for a Model (3) Appeals Council is a trickier question. Ideally, an administrative appellate body should review all ALJ decisions to promote accuracy and uniformity. On the other hand, even an enhanced Appeals Council could not effectively consider a four-fold increase in the current caseload. Some selection process would have to be continued.

(5) *Close the Record After the Hearing.* As an appellate body, the Model (3) Appeals Council would not receive new evidence. It would review a closed record. Only the trial (ALJ) level could consider petitions for reopening for new evidence.⁴³¹

(6) *Improved Support System.* The Appeals Council does not have adequate space, personnel, or computers. These work elements would have to be upgraded.

Although Model (3) is feasible, it would require a substantial enhancement of the current Appeals Council to improve its ability to handle prodigious volumes of cases expeditiously. Model (3) focuses exclusively on the goals of accuracy and consistency. If the Appeals Council were transformed into this highly specialized entity, its performance could be appreciably upgraded at a modest cost.

On the other hand, we do not consider this option wise and do not recommend its adoption for two reasons. First, reviewing cases once again for accuracy and consistency is not of overwhelming value in a system as large and subjective as the SSA. It would not be worthwhile and it would risk hypertrophy of what should be one of the system's lesser capabilities. Second, the disability bureaucracy has other needs that the Appeals Council is uniquely suited to address.

429. See *supra* text accompanying note 288.

430. See *supra* text accompanying notes 248-63.

431. See *supra* text accompanying notes 280-85.

Model (3) would seriously waste a potentially valuable asset to the disability system.

D. Model (4): Optimize for System Reform

We support the final option, which would redesign the Appeals Council as a different entity. The Appeals Council would still handle individual cases and correct errors, but it would function principally in a "systems reform" capacity, discovering, elaborating and implementing changes in the entire disability adjudication system that could lead to earlier, more accurate, decisionmaking.

In this scheme, cases would provide raw data for system reform analyses. In Model (4), the cases (although far fewer of them) would still be the primary input into the operation of the Appeals Council; its primary output, however, would be clarifications of policies or ideas for change, rather than a mass of corrected adjudications.

We begin with the premise that the Social Security Administration needs more assistance in policy development and program integrity. The Appeals Council is admirably suited for providing some of this assistance. It retains an experienced corps of senior officials with access to a steady stream of diverse cases. The Appeals Council is the only place in the bureaucracy where such rich data may be efficiently processed and important lessons extracted for the benefit of the entire system.⁴³²

Moreover, in the long run, no trade-off occurs between the error-correction function and the systems-reform function. If this plan works, the entire SSA adjudicative bureaucracy will operate more efficiently, making more accurate decisions and making them earlier. Fewer errors would reach the Appeals Council stage, and fewer wrongful administrative denials would have to be pursued in court.

There are some disadvantages to Model (4). Under it, the Appeals Council would handle fewer cases and catch fewer errors. Therefore, those whose claims are now denied by ALJs but granted by the Appeals Council would be disadvantaged. They would have to abandon their claims altogether or appeal them in court. The number of claimants in this category might be considerable and produce a significant cost of transition to the new system.

It is also possible that some of the current members of the organization might not adapt well to their new roles. They were not selected for this function and their training and experience have largely emphasized other values. Our observation of current members, how-

432. See *supra* text accompanying note 350.

ever, convinces us that they are well-suited to the suggested work and can be retrained. In recent years, the SSA has not emphasized systems reform opportunities for Appeals Council members, but we are confident that the current membership could make a substantial contribution and that successors selected with this role in mind could do even better.

Model (4) differs in important ways from the "case-handling" of Model (3). In many respects, however, the reforms are similar. Some of the recommendations made in this section parallel or expand the comments made above. Other recommendations reflect the unique demands of an organization dedicated to systems reform. We have identified seven basic changes that this model would require:

1. Control the Caseload

This is the critical starting point for many of our recommendations. The Appeals Council must regain control over its docket. As long as it labors under the weight of 50,000 or more cases per year, its members will not have time for anything else.⁴³³ The cases have consumed all the resources of the organization, usurping any opportunity for policy reflection or innovation.

We do not know precisely the "right" number of cases for the Appeals Council to accept under the recommended plan, but we estimate that 5,000 to 10,000 cases per year at the review level (i.e., 10 to 20% of the current caseload) would be appropriate. The Appeals Council should always handle a substantial number of cases so that it does not become just another policy body divorced from the reality of the adjudication process.

In addition to regulating the volume of its cases, the Appeals Council must also control the types of cases it reviews. These cases should be selected by the Appeals Council itself, not by disappointed claimants or mailroom clerks. The Appeals Council should develop a strategy for identifying cases appropriate for scrutiny, and the categories could change frequently. We envision at least three general types of cases that the Appeals Council could consider through careful sampling.

(a) *New Issues*. The Appeals Council might select for review a fixed number of cases implementing new and potentially difficult regulations or procedures. It could, for example, concentrate on recent mental impairment cases, on AIDS-related cases,⁴³⁴ or on cases that

433. See *supra* text accompanying note 309.

434. See S.S.R. 86-20 (Cum. Ed. 1986).

raise some particularly novel issue of the new medical improvement standards. Thus, the Appeals Council could provide feedback about the ways in which the field offices and ALJs are processing new matters and promptly identify areas needing further clarification or training.

(b) *Problem Areas.* The Appeals Council might also focus on longstanding SSA disability issues with difficult regulations. Allegations of disabling pain unaccompanied by corresponding physical findings, for example, or assertions of disability through substance abuse, are recurring problems. The intersection between SSA cases and the decisions of a particular federal court in an acquiescence situation might be another example.

The Appeals Council might also develop a profile of cases in which an ALJ or DDS is more likely to err. It might be observed, for example, that accuracy is particularly troublesome in cases that raise transferability-of-skills disputes, or in cases where the claimant's physician and the SSA consulting physician disagree on the diagnosis. Mistakes are not distributed randomly throughout the SSA caseload, and the Appeals Council could conveniently determine the sources of repeated errors.

Targeting particular ALJs, instead of particular types of cases, is more difficult.⁴³⁵ We would not recommend Appeals Council focus on "error-prone" ALJs. The trauma of targeted Bellmon Review was very destructive for the system and very damaging to the relationship between the Appeals Council and its clients. We note, however, that the dispersion of award rates among ALJs is greater than the system can comfortably tolerate. It is possible that review, guided at least in part by the track record of specific ALJs or offices, could be beneficial.

In this vein, the Appeals Council should also accept cases "certified" by ALJs uncertain about the application of a particular policy or standard. The Appeals Council moreover could invite certification on selected matters, to determine which types of cases are problematic.

(c) *Random Review.* Although we are uncomfortable using chance in the selection process since the concept smacks of justice by lottery, we would permit the Appeals Council to review a number of cases at random. Careful review of random cases might suggest which problems warrant intensive scrutiny.⁴³⁶ Random selection

435. See *supra* text accompanying note 259.

436. Observers in other administrative contexts have supported the value of these "fishing expeditions." J. FREEDMAN, *supra* note 2, at 153.

probably will not be an important part of the Appeals Council's docket in the near future but it might ultimately become a vehicle for identifying additional categories for review.

The Appeals Council should adjust its own jurisdiction and change the makeup of the categories from time to time, thereby remaining flexible enough to uncover new areas where it could contribute to the policymaking process.

The Appeals Council should review both allowances and denials and should analyze the work of both the "best" and the "worst" ALJs and hearing offices. Part of the Council's proposed role is to discover what procedures work well, what attributes allow the best ALJs and offices to excel, and how their successes can be replicated throughout the system.

2. Expand the Appeal Council's Role in Formulating Policy

The Appeals Council should offer assistance in the policymaking and policy-implementing process. The underlying purpose of its case review would be to provide a database through which the members could advise and assist the SSA officials making policy decisions. This purpose could be realized in three ways.

First, when the issue concerns important areas of policy, the Appeals Council can serve in an advisory capacity. The Council should conduct independent studies of its caseload and offer its conclusions and recommendations directly to policy officials. The Council members should also serve on various agency-wide ad hoc study groups designed to propose new policy. The Appeals Council's perspective should provide an important source of information for these committees.

The Appeals Council already has experience in these capacities; members have occasionally served on SSA study groups and have suggested new SSRs.⁴³⁷ We propose that this activity be greatly expanded and made the centerpiece of the members' activities, to transcend the individual cases and recommend regulations, SSRs, and other policy changes that could lead to improved disability adjudication.⁴³⁸

Second, the Appeals Council should play a larger role regarding a range of smaller policy questions—those that do matter in processing

437. See *supra* text accompanying notes 334-40.

438. Administrative appellate boards are frequently charged with this type of role in policymaking: "The [intermediate review] Board is expected to contribute through its work to the formulation, rather than the mere application, of agency policy." J. FREEDMAN, *supra* note 2, at 138.

the cases, but do not rise to the level of a regulation or SSR. Here, the Appeals Council should directly exercise leadership through carefully articulated case decisions and policy pronouncements that would have precedential impact on future deliberations. Two vehicles are already available for this purpose: case decisions and Appeals Council "minutes." Most disability cases are so fact-specific that occasions for issuing forward-looking decisions are rare. The Appeals Council should seek out these occasions, however, and seize the opportunity to promote uniformity by publicizing successful approaches. Similarly, the Appeals Council can pursue the same goal, outside the context of any particular case, by returning to its former practice of issuing minutes that reflect its posture on case matters.⁴³⁹ This practice, too, would upgrade the entire claims adjudication process by providing improved mechanics that can be relied upon nationally.⁴⁴⁰

The Appeals Council should also publicize its cases and minutes throughout the disability system. It should ensure that ALJs, DDSs, district offices, and claimants' representatives are familiar with consistent procedures and standards. The Appeals Council would thereby promote uniformity and integrity, in contrast to the somewhat arbitrary current system. While this practice would not require publication of all Appeals Council decisions, the Appeals Council should publish more noteworthy cases as a foundation for consistent and equitable decisions. The current *OHA Law Reporter* offers only a small fraction of the publication and indexing we consider necessary for a comprehensive and useful compilation of decisions.⁴⁴¹

A third avenue for participation in the policy process is experimentation. The various DDSs, district offices and ALJs have a wealth of experience in handling claims, but these resources are largely untapped. The Appeals Council should study the lower tiers, discover innovative improvements, refine those improvements, and export them to other units. Although the substantive definitions and standards for eligibility should remain consistent throughout the coun-

439. See *supra* text accompanying note 341.

440. Policies derived from careful scrutiny of actual cases, rather than solely from abstract theorizing about the agency's needs, are particularly likely to be useful and valid. See Capowski, *supra* note 75, at 376.

441. Other observers have also noted that an appellate body can play a useful role in the agency, promoting consistency in decisionmaking, by advising the lower tiers about which adjudicative processes will be ratified on appeal, and which are likely to be rejected. "[H]earing examiners have learned that the Review Board's success in the predictable application of standards has increased their opportunities to make decisions that will not be appealed or that will stand upon appeal." J. FREEDMAN, *supra* note 2, at 149.

try, the implementing procedures need not remain rigid. Local experiments, supervised, encouraged and studied by the Appeals Council, might create greater efficiency in the future.⁴⁴²

3. *Revise the Case-Correction Role*

Although the main objective of the Appeals Council should be system reform, it would still review many individual cases. Various subsidiary matters arise in this context.

Our concept of a reformed Appeals Council is that of an appellate body with sufficient time to give each case a thoughtful, careful inspection. We also envision an organization that operates more collegially, with members collectively analyzing cases. The members should discuss cases, compare ideas, and seek common solutions. Greater reliance should be placed upon panel decisions. These panels could be composed of perhaps three members, and meetings en banc would become more frequent as the crush of cases is reduced.

We also recommend making greater use of the claimants and their representatives. The Council should hold oral arguments more frequently to identify precedential aspects of the cases and to raise ideas for management initiatives. It should also notify claimants about issues under consideration and encourage them to respond with detailed arguments. Whenever the Appeals Council changes the mixture of cases and the types of problems to be addressed, it should inform claimants' representatives and invite them to submit amicus briefs. Considerable expertise and knowledge is available in the claimants' bar; the Council should draw upon it regularly.

The Appeals Council should slow the decisionmaking process to allow for more thoughtful consideration. The process of deciding cases within an average of fifteen minutes must be discontinued. Council members and analysts should evaluate cases more thoroughly, debating their implications and listening to tapes of the hearings if necessary.

Finally, the Appeals Council will have to substantiate its written opinions if they are to have precedential impact and carry due weight among the ALJs and street level bureaucrats. The Appeals Council

442. The preservation of this type of individualized discretion is essential for a complex administrative structure such as the SSA. The lower tiers must be accorded the opportunity to work the cases with intelligence and sensitivity, not just with blind adherence to policies that are inevitably styled with the standard situations foremost in mind. This is not to deny the importance of rules, nor to justify extreme departures from them, but we do maintain that the role of human judgment must be sustained. See Capowski, *supra* note 75, at 354, 372 (discretion for ALJs is essential and inevitable for the SSA); Ellis, *supra* note 2, at 166-67.

should draft opinions that are clear, responsive, forward-looking and individualized—in other words, free of mindless boilerplate or rote summaries of the documentation.

(a) *Role in Correcting the Cases.* When the reformed Appeals Council moves more slowly and carefully through its cases, three possibilities for error correction are feasible. First, the Appeals Council might play no role in correcting errors. Even when it discovered mistakes, it could leave the ALJ's work undisturbed, since the focus of the Appeals Council would be on the system as a whole, not on any one output of it. A second model would permit the Appeals Council to remand the errors to the ALJ with a commentary explaining what problems have been identified and suggesting that the ALJ might reopen and revise the case. Finally, the Appeals Council might retain its current capacity for correcting or remanding any case it deems flawed, while still devoting most of its attention to policymaking.

Each of these variants has advantages. The first two would enable the Appeals Council to concentrate upon formulating policy without the distraction of effectuating individual cases. The second would also ensure that errors are not totally overlooked.

We consider the third variant the most desirable. Under it, the Appeals Council could focus primarily upon reform without sacrificing entirely its current case-handling role. The Council could detect errors, prevent them from slipping through the system, and use the occasion of error as an opportunity to instruct the bureaucracy personally through prompt, focused feedback. By correcting, or remanding, the errors that it sees, the Appeals Council would be forced to stay in intimate contact with the cases—its legitimate source of expertise for a policy role—and assist claimants, ALJs, and others directly.

The mere fact that a serious question may be raised about the Appeals Council role in case correction is itself instructive. It demonstrates that the primary role of the Council should be to transcend the adjudication of individual cases, in order to generalize from them and identify the larger issues they present. The question also suggests that the reason for the Council to act upon ALJ errors is not simply to forestall a losing court battle. Instead, the Appeals Council should inquire into all types of errors to determine how they can be more efficiently prevented, and how deserving claimants can be identified and paid more quickly and easily.

(b) *Standard of Review.* When it inspects and corrects cases, the Appeals Council should become less "interventionist." Two different standards of review are required. First, regarding ALJ determi-

nations of fact, the Appeals Council should be bound by a standard of "arbitrariness," rather than the current "substantial evidence" test. As noted earlier,⁴⁴³ the "substantial evidence" criterion is breached too often. This criterion also encourages the Appeals Council to attempt to achieve an excessively subtle degree of accuracy. Rather, the Appeals Council should correct substantial deviations from established standards and use its experience for larger policy purposes. It should not second-guess an ALJ in close cases.

Secondly, regarding ALJ interpretations of law, the Appeals Council should show less deference. An ALJ who misunderstands the governing principles of a case or misstates the law should be corrected. The distinction between "factual" and "legal" issues may be subtle; nevertheless, it is one that reviewing courts traditionally must make, and should be an Appeals Council responsibility too.

(c) *Close the Record After the ALJ Stage.* The case record should be closed before the file is transmitted to the Appeals Council.⁴⁴⁴ The system should encourage claimants to submit all probative evidence to the ALJ. It is often difficult for claimants to assemble all the potential evidence quickly, and where an ongoing condition continues to deteriorate, selecting a cutoff date for closing the file seems arbitrary. Orderly litigation and respect for administrative judgments, however, suggest the importance of segregating trial- and appellate-level functions more strictly. If new evidence arises, the claimant may seek a remand and submit a motion to reopen the case. Absent good cause for reopening, the additional evidence should be submitted with a new application. The Appeals Council should not receive new evidence; its review should be appellate, on a closed record.

(d) *Timeliness Standards.* The problem of Appeals Council delay would be greatly mitigated under Model (4); most cases would not require Appeals Council review to exhaust administrative remedies. Those few that did would receive quicker consideration as an adjunct of a reduced caseload. Nevertheless, timeliness standards might be advantageous at the outset and the Appeals Council should be required to adjudicate cases within a specified, short, time frame.⁴⁴⁵

443. See *supra* text accompanying notes 264-71.

444. See *supra* text accompanying notes 272-80.

445. The OHA leadership recognizes the imperative of improving the agency's performance on timeliness. Eileen Bradley states:

There are two themes in terms of overall OHA concerns that I will strike repeatedly, sound consistently, and they are: service to our claimants. We need to assure that the claimants in this country get their day in court as expeditiously as possible. Justice delayed, in my view, is no justice at all. Irrespective of the validity of the claimant's claim, that claimant believes he or she is entitled, and we have a right

Under Model (4), the Appeals Council should be able to decide within thirty days of the ALJ's decision whether the case meets one of its current profiles. It could then have an additional sixty days to work the case, or more if commentary or other input from the claimant were necessary. Furthermore, the Appeals Council should not reopen a case merely because it has missed the ordinary deadline. Only factors such as fraud, clerical error, or obvious mistake should disturb the finality of the ALJ decision.

(e) *Final Agency Action*. Under this system, as in Model (2), the vast majority of ALJ decisions would become final agency determinations, allowing prompt payment of awards and immediate reviewability of denials in federal court. This arrangement is certainly unusual for modern administrative practice in that most departments provide for some degree of administrative review between the hearing level and the judiciary.⁴⁴⁶ Neither the APA nor sound principles of SSA management, however, require a fourth administrative tier. We find nothing compelling about a "Secretarial" review that has long been quasi-judicial anyway.⁴⁴⁷ Therefore, little is lost by claimants or the SSA if the final administrative word comes from the ALJ, rather than after a cursory review by an over-burdened Appeals Council.

We do not believe that this model will result in a surge of federal court actions. As noted above, other inhibiting factors, such as cost and delay, will continue to retard frivolous recourse to the court. These factors, rather than the current Appeals Council, have winnowed civil actions. Moreover, the reformed Appeals Council should actually be able to reduce substantially the burden on the judiciary, as the administrative process becomes more accurate, efficient, and reliable.

and an obligation to respect that belief. I find it unconscionable that a claimant must wait 365 days to know where he or she stands with respect to a benefit package. We have got to do better. [The second "theme" is protecting the trust fund.]

SSA videotape *Bradley Speaks*, *supra* note 322.

446. In child labor civil penalty cases, the Secretary of Labor has delegated to ALJs the authority to make final agency decisions. 29 C.F.R. § 580.32 (1986). In addition, the Board of Contract Appeals makes final agency decisions in government contracts cases. 31 U.S.C. § 1304 (a)(3)(C) (1982).

447. The theory of administrative reviewers performing a "Secretarial" function may have some validity in situations where ALJs handle cases involving important aspects of economic regulation of key industries or corporations. Today, however, the vast majority of ALJs, including those in the SSA, are concerned instead with "micro" decisions, such as public benefits in which political factors are irrelevant. See Lubbers, *A Uniform Corps of ALJs: A Proposal to Test the Idea on the Federal Level*, 65 JUDICATURE 268 (1981).

4. *Improve the Status of Appeals Council Membership*

Changes made in the personnel policy of the Appeals Council should allow it to carry out the systems reform mission more effectively.

(a) *Upgrade the Position.* Members of the Appeals Council, like Social Security Administration ALJs, are now graded at the GS-15 level. Members of the Appeals Council should be ranked one step higher. Providing a GS-16 rating for the Appeals Council has two immediate advantages. First, in a world where pay and status are inevitably linked, the promotion would carry a prestige that would underscore the new role and importance of the Appeals Council.⁴⁴⁸ It would symbolize the growth of the institution and SSA's commitment to it.

Second, and more importantly, the promotion is essential to attract the most qualified people. Membership on the Appeals Council is not now a financial step up for an ALJ; little else is available to induce the best and brightest of the hearing corps to aspire to membership on the Appeals Council. Money is only one factor in an individual's career decisions, but it is undeniably an important one and it is the most visible short-term fix that can be made. Over time, the reputation of the Appeals Council should grow, and ALJs would seek appointment to it as the pinnacle of a career. For now, the most immediate means of elevating the institution is to dedicate a few supergrade or Senior Executive Service slots to it.⁴⁴⁹

(b) *Upgrade Job Prerequisites.* As the job of Appeals Council member becomes more attractive, the selection process can become more selective.⁴⁵⁰ The senior ranks of the ALJ corps should be seen as a fertile source of new members, and recruitment from this group should be encouraged. The ALJs' hearing experience and perspective on the cases are unrivaled. The Appeals Council would gain in stature by attracting the cream of the ALJ crop as members, giving it greater credibility among the courts, the public, and the SSA leadership.

448. Other observers have noted the importance of ensuring that an administrative review panel have superior status. J. FREEDMAN, *supra* note 2, at 143.

449. Upgrading the status of Appeals Council members to GS-16 would not cost the agency much money, because most of the current members are already paid near the federal salary cap and because we propose reducing the number of Council members. The symbol, however, would carry considerable importance.

450. "There can be no compromise with [the principle of first-rate appointments] if the Review Board is to win respect or acceptance from hearing examiners, the agency staff, and the practicing bar." J. FREEDMAN, *supra* note 2, at 143.

We would not, however, make ALJ experience an absolute prerequisite for membership on the Appeals Council. Many other people, including current members, are capable of playing important roles in the Appeals Council even though they may have received their background training in other parts of the system. The Appeals Council should establish membership requirements based upon individual talents and character traits, not solely experience. In short, we recommend a strong, but not absolute, preference for drawing new members from the ranks of the ALJs.

(c) Member Independence. Appeals Council members should have the same high level of independence guaranteed to ALJs by the APA. It is true that the primary function of the Appeals Council under Model (4) would be promotion of policy and program integrity, and we recognize that as a result of their association, Council members and SSA senior officials might form a strong bond. The APA independence necessary in Model (3), where the members function exclusively as appellate judges, might therefore not seem so necessary here.

Nevertheless, we believe that under Model (4) the gains from APA protection would outweigh the losses. Independence will enhance status and allow the members freedom to suggest novel policies for efficient and equitable case handling without political risk. Furthermore, members would continue to review cases and issue binding decisions; this is a quasi-judicial function that should be acknowledged with APA independence.

We do not believe that members would abuse their APA-protected status by irresponsible deviation from SSA procedure. Historically, the Appeals Council has been faithful to SSA policy; the selection criteria and the proposed role of the members should serve only to reinforce this tendency.

(d) Council Size. The current Appeals Council has grown to its present size of twenty members because of the mushrooming caseload. A smaller Appeals Council would improve cohesion and provide greater integration and consistency. A group of approximately eleven members seems appropriate. It would be large enough to handle a significant volume of cases, yet small enough to sit comfortably around a table, discuss members' observations, and develop a shared outlook and policy.

We envision an Appeals Council that emphasizes internal consultation and collaboration, meets frequently en banc, and thoroughly analyzes problems in order to develop a consensus on policies or recommendations. To reach this degree of harmony, the Appeals Council must be smaller.

(e) *Title and Location of the Organization.* Under Model (4), the Appeals Council would no longer take "appeals." It would establish its own docket, accepting cases that present important policy considerations. A new title, such as "Review Council," therefore seems more appropriate. "Members" could retain their current titles, although we recommend that the Deputy Chair be renamed "Chair" to clarify who actually presides over Council matters. This new name would also emphasize the organization's independence from the Associate Commissioner, who would no longer hold an ex officio seat.

Under Model (4), the Council will need direct access to the agency's top policymakers, the ALJs, and lower-level claims processors. The Council would act as liason among them, with enough independence to adjudicate cases and with enough cohesiveness to affect policy. This relationship requires bureaucratic relocation. Placement of the Appeals Council under a Deputy and Associate Commissioner is logically inconsistent with the role here outlined. Conversely, removal of the Appeals Council (as contemplated in Model (3)) to the Office of the Secretary or to an independent agency also seems wrong; the Appeals Council must be closer to the action.

Accordingly, we recommend that the Appeals Council be relocated within the Office of the Commissioner.⁴⁵¹ The Council's unique mandate should enable it to assume this special placement. Its diverse roles, moreover, would most consistently fit at the top of the SSA hierarchy, outside the purview of any line office.

5. *Enhance the Appeals Council's Role in Court Cases*

The greatest opportunities for improvement of the Appeals Council may be found at the review level; however, the Appeals Council also plays a major role in shaping the SSA's response to cases in litigation, and this role represents an important source of experience for the systems reform mission of Model (4).

We recommend that the Appeals Council continue its current court interface work essentially as it has been doing. Supplemental review has an odd aura about it; it is peculiar that the SSA should have a fifth chance to consider a case and to improve the documen-

451. There have been proposals to remove ALJs still further from agency politics and the appearance of sensitivity to agency pressures by creating an independent, integrated corps of ALJs available to serve all federal agencies. See Lubbers, *A Unified Corps of ALJs: A Proposal to Test the Idea at the Federal Level*, 65 JUDICATURE 266, 266-276 (1981). The same could be imagined for all federal appellate review boards. This strategy has considerable logical appeal under Model (3), where Appeals Council members function exclusively as judges, but it is less applicable under Model (4), where the members are to focus on policy matters and a close connection to the agency is essential.

tation justifying a denial, rather than defend it as it stands or pay the claim. This practice has also introduced for the first time in the claims evaluation process a new awards standard authorizing payment of a "sympathetic" case, even if it does not quite fit the legal standard of disability. Supplemental review may also be used improperly as a crutch, suggesting that careful early claims work is less necessary because erroneous denials can be corrected later, if the claimant has the tenacity and resources to proceed to court.

Rather than litigation, we favor alternative dispute resolution techniques to negotiate or settle cases. The SSA, however, really has little room for negotiation or compromise. The disability program should not pay benefits to claimants merely because they are evocative litigants in court; if lawful eligibility criteria are not met, eligibility should be denied.

On balance, we have no clearly better alternative strategy to propose. We note that supplementary review provides the Appeals Council with a valuable window to the world of federal litigation, complementing its perspective on the administrative processing of claims.

For similar reasons, we endorse the current operation of the Appeals Council in court remand situations.⁴⁵² Although some internal adjustments should be made (for example, less reliance upon "fast track" remand and better guidance to the ALJ), we think the Appeals Council can serve usefully as an intermediary in cases remanded from the courts, whether or not the Council saw the case prior to litigation in court.

The Appeals Council also should be more involved in advanced court litigation strategy.⁴⁵³ This area of practice is complicated and frustrating; lawyers from HHS and the Department of Justice frequently disagree over whether appeals are tactically wise, legally justified, or sufficiently important. These differences will undoubtedly continue, but the Appeals Council should have a voice in discussing them. The Appeals Council's special bureaucratic perspective should not be ignored in appellate planning.⁴⁵⁴

452. See *supra* text accompanying notes 331-33.

453. *Id.*

454. SSA officials acknowledge that litigation strategy decisions are complex, and that the current process for making them is sometimes tumultuous.

I'm interested in litigation management. I think SSA, and OHA, is [sic] getting beaten over the head unnecessarily, that we are losing cases we should be winning and that we are appealing cases we shouldn't even appeal or touch and we need to have an SSA strategy with OHA making a significant contribution to that whole judicial process. That is also the Commissioner's priority, at least in terms of the

The Appeals Council should also begin to monitor disability cases as they proceed through court. Members should track their cases, studying court actions for future guidance. We hope that the federal courts will support the SSA improvements under Model (4). The SSA's recent performance in the federal courts has been abysmal, and the agency's reputation has fallen so low that little deference from the courts can be expected. Perhaps this disrepute has bottomed out, and perhaps the worst incidents—the initial wave of Continuing Disability Reviews (CDRs) and the targeted Bellmon Reviews—that triggered the animosity no longer exist. Nevertheless, federal courts may be reluctant to retreat promptly to the “substantial evidence” standard of review. The courts see a skewed sampling—only denials where a good argument can be made that the claimant has been wronged—and federal judges might naturally see themselves as the champions of the disenfranchised, failing to recognize that the SSA pays 99.6% of the awards without judicial intervention.

As the reorganized Appeals Council improves the administrative review process, the SSA's success rate in court should begin to improve, too. We hope that the lag between the two changes will not be great and that courts will acknowledge the systematic improvements in the disability adjudication process.

6. *Improve Support Systems*

The Appeals Council will require assistance to support the improvements called for in Model (4).

We envision a somewhat smaller operation in the OAO, since fewer analysts will be needed to handle the smaller caseload. This reduction, however, will be largely offset by greater attention to the remaining cases. The OAO should be reorganized into teams of analysts and support personnel, each affiliated with a small panel of Appeals Council members. These units should become more coherent and more mutually supportive than the present organization of the OAO.

Merging the OAO and the Appeals Council into a single unit is another possibility, although this is a closer question in Model (4). Because members would work primarily for system reform, a greater functional distinction might emerge between members and analysts.

SSA part of it. I would like to see us improve our relationships with the court so that they have a better understanding about what SSA law is about.

SSA videotape *Bradley Speaks*, *supra* note 322.

Although this distinction might suggest less need to integrate the two groups, it would still be preferable to organize these work units tightly. In the future, OAO could focus on recruiting analysts skilled at both reading the claims files and assisting the members with their other functions. Accordingly, we recommend merging the OAO into the Appeals Council.

Members of the Appeals Council should also have personal law clerks. These positions would be only a modest expense for the bureaucracy but a significant asset in organizing the work. Hiring law clerks should increase Council efficiency and productivity, allowing the members to concentrate on their primary obligations.

The data processing and word processing capabilities of the Appeals Council need major improvement. The current hardware is deficient and obsolete. The software is far below standards in the field, and the Appeals Council is unable to perform many necessary functions. Staff support is virtually nonexistent; indeed, even the current level of performance would not be available but for the ingenuity of a single, self-taught staff member.⁴⁵⁵

We also recommend changes in the members' office arrangements. The OHA is now scattered over five buildings in Arlington, Virginia. It should be consolidated in one location, preferably within the SSA headquarters complex in Baltimore. We think the principle of using physical remoteness to underscore the judicial independence of the members is valid, but it bends before the greater value of having the

455. The needs of the Appeals Council do not demand the highest technology, but a solid computer network would be a major asset. Clearly each member should have word processing capacity. The time savings for minor corrections alone would be substantial and would be even greater if SSA analysts were brought into the modern world.

The data processing system must also be updated. The Appeals Council is now barely able to track the files. Indeed, the system is so unreliable that index cards are used as a backup. Yet, the statistical base of Appeals Council operations is important and it would become far more so under Model (4), as the Appeals Council attempts to extract policy generalizations out of individual adjudications. The data processing capability of the Appeals Council is wholly inadequate and immediate upgrading is necessary.

All Appeals Council and ALJ decisions are now produced by a word processor, but the record of each decision is ordinarily erased as soon as it is issued in order to save storage capacity. We recommend that this practice be halted immediately and that the full text of all OHA adjudications be retained indefinitely. The Appeals Council could use these closed cases as part of its research on error prone or otherwise problematic cases. Claimants' representatives might use them, with identifying details removed, to research precedents. Other uses may appear with current or future data search techniques.

The Appeals Council, or the OHA on behalf of the ALJs as well, should seek the advice of qualified systems engineers who specialize in the storage and retrieval of such material. Consulting experts in this field are frequently relied upon by private industry and law firms; the SSA, too, could benefit from their ability to evaluate the institution's needs and match them with the available technology.

Appeals Council sit nearer the policymakers it assists. Under Model (4), the Appeals Council and the whole of the OHA should play a greater part in the policy process, requiring a headquarters location.

7. *Increase the Appeals Council's Visibility*

Mashaw wrote of the Social Security claims procedure in general that "[t]he internal workings of the process that might inspire confidence . . . are invisible."⁴⁵⁶ Nowhere is this more true than for the Appeals Council. Most people know little about the nature and operation of the organization, and its members and activities are largely shrouded from view. This invisibility may result in part from a degree of defensiveness or reluctance to publicize the facts about low reversal rates and the high volume of cases per member per day. Obscurity, however, has been costly in terms of public acceptability. We recommend a change in this respect.

We recommend in particular that the Appeals Council publicize itself and conduct outreach activities designed to enhance the public's and the claimants bar's knowledge about its work. Claimants and their representatives have much to say about the operation of the disability adjudication system; the Appeals Council can be one point of contact. We do not expect greater interaction to result in conformity of views or harmony of interests, but we do think that the worst aspects of the Council's image of arbitrariness and futility can be ameliorated. Furthermore, it should become easier for claimants or their representatives to contact the Appeals Council to learn the status and scheduling of their cases.⁴⁵⁷

456. J. MASHAW, *supra* note 154, at 143.

457. The current SSA mechanism that a claimant follows in order to inquire about the status of his or her case pending before the Appeals Council is one of Rube Goldberg complexity:

For example, if a claimant were to inquire regarding the status of an appeal, he would normally direct his questions through the local district office (DO). The DO employee would initially obtain an HA04 query from the OHA Case Control System (CCS) and call OHA's Congressional and Public Inquiries Staff (CPIS).

The CPIS employee would record the message and obtain another HA04 query to identify which OAO branch was acting on the claimant's request for review. The CPIS employee would contact the appropriate branch control section.

The OAO contact would then record the request and institute a manual search of the branch to determine which analyst had been assigned the case. The OAO "contact" would then obtain the last known status of the case and inform CPIS.

The CPIS employee would record the response and reply to the DO employee for further communication to the claimant. This practice has not only been time consuming, but it also demands involvement of many more personnel than are necessary.

OMAPI REPORT, *supra* note 229, at 26.

We also believe that Appeals Council members should make more public appearances, participate more in bar activities, and write about their work to enhance public acceptability. They should meet with federal judges to discuss disability matters in general and case-handling in particular.

Inside the SSA, the members of the Appeals Council should build bridges to the ALJs and to other parts of the organization. To this end, the "visiting ALJ" program should be reinstated. At least one seat on the Appeals Council should be reserved for ALJs as a temporary assignment to test whether they would like to apply for membership, to infuse new perspectives into the Appeals Council, and to enhance the corps' appreciation for the work of their reviewers.

Conversely, we think that there should be traffic in the opposite direction. Appeals Council members should take occasional assignments as ALJs, conducting hearings in the field. Even those members who have "graduated" from the ALJ corps could benefit from an occasional refresher.

Similar interaction and exchange programs should be instituted with the other components of the SSA, such as the district offices and the state disability determination services. Because Model (4) calls for the Appeals Council to participate in enhancing the operations of the entire disability adjudication operation, the Council should have regular contact with the lowest tiers. Thus, the Appeals Council might be able to come to grips with the operations of the bureaucratic behemoth and help formulate system-wide improvements.

Most importantly, the Appeals Council will require greater visibility within the higher echelons of the SSA. The Appeals Council has been isolated for too long; it must now re-establish itself as a force with direct channels to the leadership. The "policy development" role can succeed only if the policymakers support it; they must accept the Appeals Council members as participants and must consciously alter existing routines in order to admit a new set of perspectives.

IV. CONCLUSION

We have observed that the Appeals Council is composed of talented and dedicated individuals, pursuing in anonymity a set of diverse tasks that we consider exceedingly important but virtually impossible to accomplish. The size of the current caseload defies effective management, despite the Appeals Council's efforts to dispatch it with diligence and compassion. Although the purposes and capabilities of the Appeals Council are impressive, we find the insti-

tution's functioning unsatisfactory. The Appeals Council is not effectively achieving its goals, and will not likely perform much better in the future. Accordingly, we recommend comprehensive modifications in the objectives, composition, and operation of the Appeals Council.

Having considered four models for future Appeals Council operations, we conclude that: (1) the status quo of the Appeals Council is too deeply flawed to be sustained and the present structure is not performing to anyone's satisfaction; (2) the Appeals Council should not be abolished, at least not before one more effort at serious reform; (3) a "case correction" role could be expanded and improved, but pursuing a chimera of accuracy would prove unsatisfactory and waste the Appeals Council's real potential; and (4) the role of system reform—suggesting new policies, developing new practices, and implementing new experiments—is the most valuable role for the Appeals Council, enabling it to put its case-handling experience to the best use and empowering it to aid the SSA in the most valuable way.

The systems reform role for the Appeals Council and the specific implementation steps we have outlined are not easy or inexpensive, nor is success guaranteed. Effectuation will require deliberate measures by the SSA leadership, including the personal attention of the Commissioner. We are confident, however, that the proposal is feasible and that it would be highly advantageous. The Appeals Council, as it now stands, is both over- and under-utilized. It is buried in case files and unable to marshal its unique expertise or perspective. We appreciate the potential of the Appeals Council and despair of its wastage; the Social Security Administration can and should do better.

Chart 1
SSA's Sequential Evaluation Process for Assessing Disability

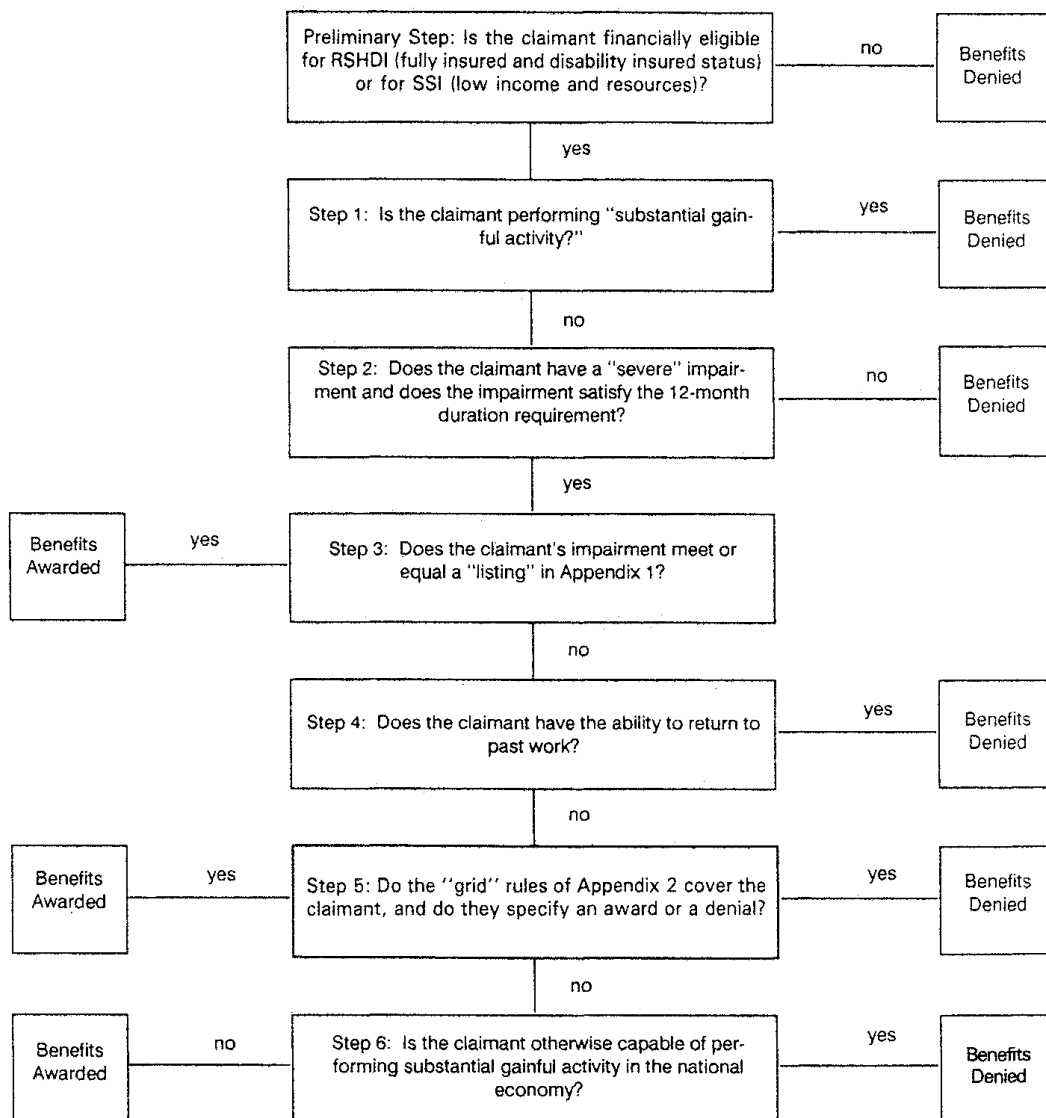


Chart 2
Partial SSA Organization Chart

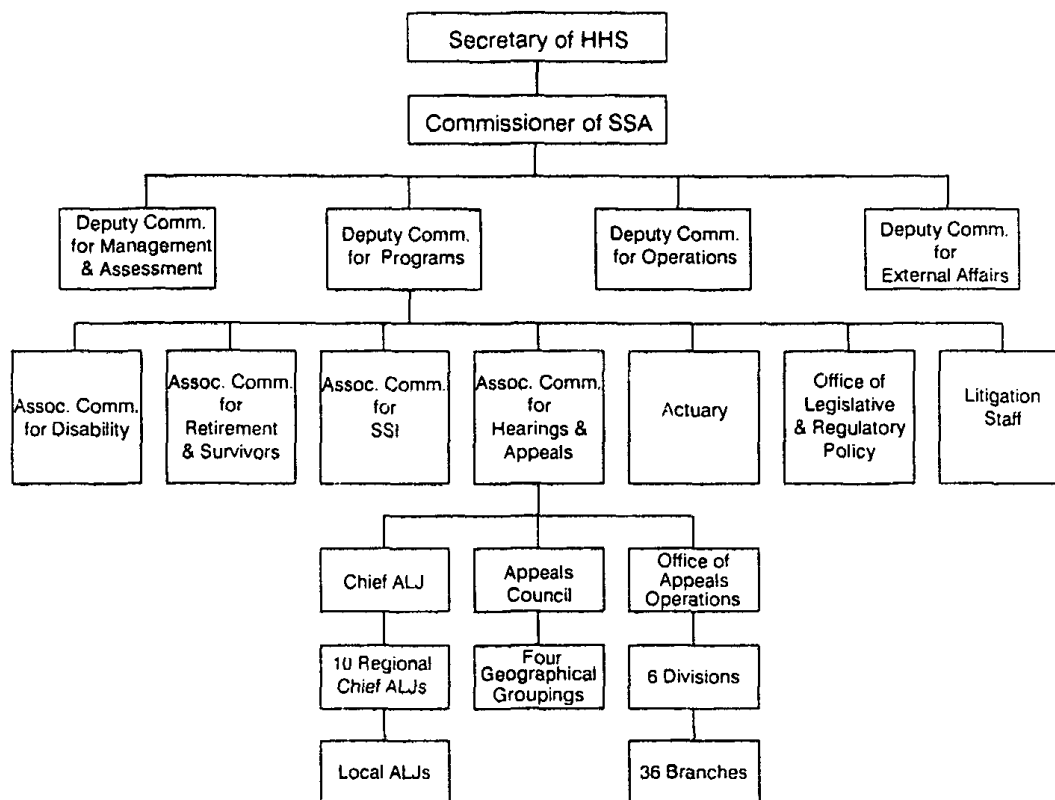
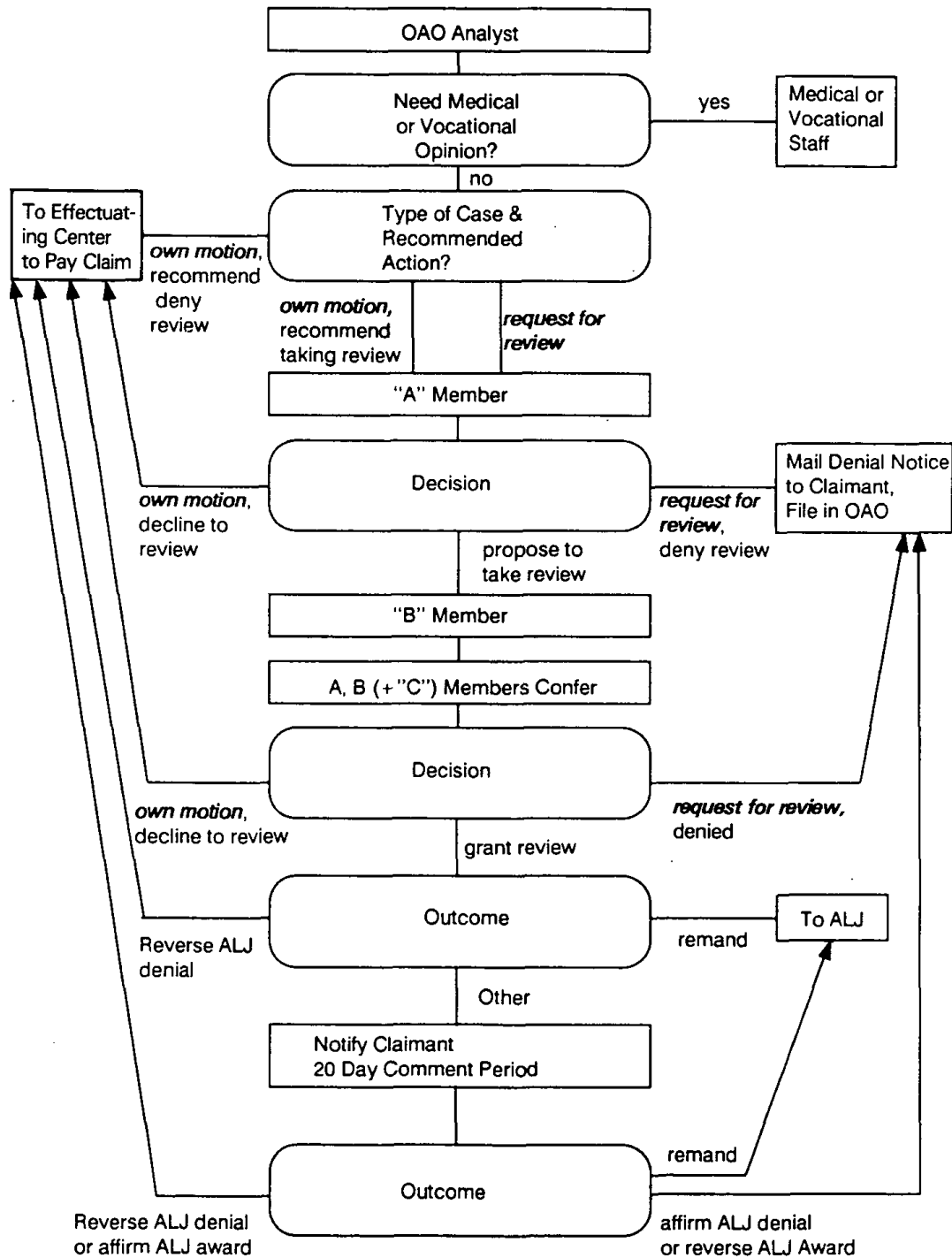


Chart 3
OHA Workflow — Review Level



File may be returned to OAO at any stage for further workup or rewriting decisional documents.

Chart 4
OHA Workflow — New Court Cases

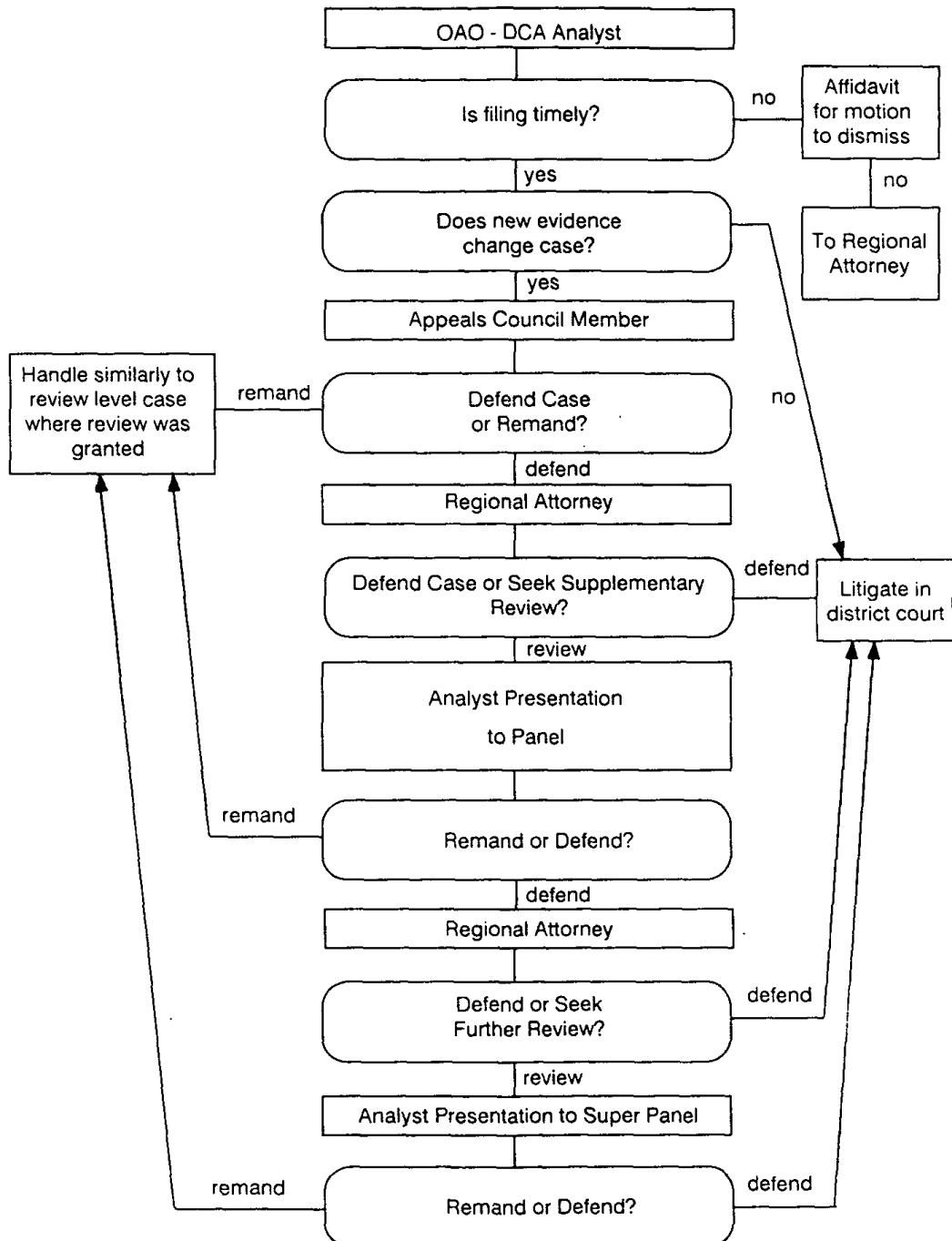


Chart 5
OHA Workflow – Court Remands

