

ADMINISTRATIVE CONFERENCE OF
THE UNITED STATES

Report for
RECOMMENDATION 87-7

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

by

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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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I. INTRODUCTION

The Appeals Council is the final administrative step for review of claims for benefits under the purview of the Social Security Administration (SSA).¹ The Appeals Council has always

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This study was undertaken during the summer and fall of 1987 under the auspices of the Administrative Conference of the United States, which provided valuable support and assistance. The Administrative Conference also evaluated our report and prepared its own recommendations, adopted December 18, 1987, to be codified at 1 C.F.R. §305.87-7, and reproduced as an attachment to this report.

The authors are indebted to a number of people for their extraordinary support and assistance in this project. In addition to the sources listed in Chart 7, 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.

been a central unit in the adjudicatory bureaucracy, overseeing

- 1 As we note, the Appeals Council has largely eluded public scrutiny, and there are few written reports or assessments that focus upon it. Those of most value to the current authors include the following works:
- J. Mashaw, C. Goetz, F. Goodman, W. Schwartz, P. Verkuil, & M. Carrow, Social Security Hearings and Appeals (1978) (A study for the National Center for Administrative Justice) [hereinafter "National Center Study"].
- J. Mashaw, Bureaucratic Justice: Managing Social Security Disability Claims (1983) [hereinafter "Mashaw"].
- D. Cofer, Judges, Bureaucrats, and the Question of Independence: A Study of the Social Security Administrative Hearing Process (1985) [hereinafter "Cofer"].
- D. Stone, The Disabled State (1984) [hereinafter "Stone"].
- L. Liebman, Disability Appeals in Social Security Programs (1985) [hereinafter "Liebman"].
- Secretary of Health and Human Services, Report on the Implementation of Section 304(g) of Public Law 96-265 (1982) (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 Rep"].
- Legal Counsel for the Elderly, Disability Practice Manual for Social Security and SSI Programs (1985) [hereinafter "LCE"]; Legal Counsel for the Elderly, Disability Practice Manual for Social Security and SSI Programs, 1986-1987 Supplement (1987) [hereinafter "LCE (1987)"].
- National Organization of Social Security Claimants' Representatives, Social Security Practice Guide (1986) [hereinafter "NOSSCR"].
- Symposium on Federal Disability Benefit Programs, cosponsored by the Administrative Conference of the United States, the American Bar Association, the ABA Administrative Law Section, the ABA Commission on Legal Problems of the Elderly, Case Western Reserve Law School, and the Cleveland Foundation, Oct. 11-12, 1985, unofficial transcript, p. 261-99 [hereinafter "Cleveland transcript"].

(Footnote continued)

the work of an immense and diverse network of federal and state adjudicators, handling a wide variety of cases.²

1(continued)

Chassman & Rolston, "Social Security Disability Hearings: A Case Study in Quality Assurance and Due Process," 65 Cornell L. Rev. 801 (1980) [hereinafter "Chassman & Rolston"].

K. Davis, Discretionary Justice: A Preliminary Inquiry (1969) [hereinafter "Davis"].

F. Bloch, Federal Disability Law and Practice (1984) [hereinafter "Bloch"].

Billman, "Representation of Disability Claimants at the Appeals Council," 7 Social Security Forum No. 12, 4 (Dec. 1985).

Current Problems in the Social Security Hearings and Appeals Process, Hearing before the Subcommittee on Social Security of the Committee on Ways and Means, House of Representatives, 99th Cong., 2d Sess. (March 18, 1986) [hereinafter "1986 Hearing"].

Social Security Disability Reviews: The Role of the Administrative Law Judge, Hearing before the Subcommittee on Oversight of Government Management of the Committee on Governmental Affairs, United States Senate, 98th Cong. 1st Sess. (June 8, 1983) [hereinafter "1983 Hearing"].

Social Security Hearings and Appeals: Pending Problems and Proposed Solutions, Hearings before the Subcommittee on Social Security of the Committee on Ways and Means, House of Representatives, 97th Cong., 1st Sess. (Oct. 27, 1981) [hereinafter "1981 Hearing"].

Senate Finance Committee, S. Rep. No. 96-408 (Nov. 9, 1979) (accompanies H.R. 3236, "Social Security Disability Amendments of 1980", Pub. L. No. 96-265) p. 11-35, reprinted in U.S. Code Cong. & Admin. News, Vol. 3, p. 1277, 1290-1312 (1980) [hereinafter "Senate Finance Committee"].

Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, WMCP 100-4, Committee on Ways and Means, U.S. House of Representatives, Mar. 6, 1987 [hereinafter "1987 Background Material"].

2 There are several existing studies of intermediate administrative appellate bodies:
(Footnote continued)

Recently, the operation and sheer existence of the Appeals Council have become highly controversial. The Appeals Council has been called a "black hole," a "rubber stamp" and a "widget factory assembly line." Such diverse interests as SSA claimants' representatives,³ members of Congress,⁴ neutral scholars,⁵ federal judges,⁶ and even Reagan administration officials⁷ have criticized

2 (continued)

Cass, Background Report for Recommendation 83-3: Agency Review of Administrative Law Judges' Decisions, Reports and Recommendation of Administrative Conference of the United States 115 (1983) [hereinafter "1983 ACUS Rep."].

Cass, "Allocation of Authority Within Bureaucracies: Empirical Evidence and Normative Analysis," 66 B.U.L. Rev. 1 (1986) [hereinafter "Cass"].

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) [hereinafter "Freedman Rep."].

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) [hereinafter "Ellis Rep."].

C. Koch, Administrative Law and Practice §§ 6.71-6.79 (1985) [hereinafter "Koch"].

- 3 Statement of Eileen Sweeney, Staff Attorney, National Senior Citizens Law Center, 1986 Hearing, *supra* note 1, at 28 ("[S]erious consideration should be given to eliminating the Appeals Council or severely limiting its functions.")
- 4 Legislation has regularly been introduced that would abolish the Appeals Council. See, e.g., "Social Security Procedural Improvements Act of 1987," H.R. 2117, 100th Cong., 1st Sess., introduced by Rep. Archer, April 22, 1987.
- 5 Cofer, *supra* note 1, at 190 ("The arguments are persuasive that the \$18 million a year expense of the AC could be put to better use.") and at 196.
- 6 Salling v. Bowen, 641 F. Supp. 1046, 1058-59 (W.D. Va. 1986).

the Appeals Council, questioned its mandate, and called for its abolition.

One is tempted to conclude that any institution which attracts such varied criticism from so many distinct sources must be doing something right. But is it?

The Administrative Conference of the United States, at the behest of SSA, has asked us to study this question. Below we have set out an extensive discussion of the operation of the Appeals Council, its relationship to the rest of the adjudicatory bureaucracy and the courts, and our recommendations for improvements.

We have been materially aided, throughout this study, by an extremely high level of cooperation from the Appeals Council itself, from other components of SSA, and from outside commentators. We have found these sources⁸ to be frank, constructive and generous with their time. Any errors or omissions, of course, remain our responsibility.

What we have observed is that the Appeals Council is composed of talented and dedicated individuals, pursuing in anonymity a set of diverse tasks which we consider to be simultaneously both exceedingly important and virtually impossible. The magnitude of the current caseload, and the Appeals Council's efforts to dispatch it with diligence and compassion, defy effective management. Although the purposes of the Appeals Council are profound, and the capabilities of its current members are impressive, we find that the institution, as it currently functions, is unsatisfactory; it is not effectively achieving its goals, nor is there any real prospect for its ability to perform materially better in the future.

Accordingly, we recommend comprehensive modifications in the

7 Donald Lambo, "Ritualism in Social Security," The Commercial Appeal, April 16, 1981.

8 Although our numerous sources spoke quite freely with us, and generally without restrictive attribution rules, we have generally elected here 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.

The list of people we interviewed in connection with this study is appended as chart 7. Needless to say, inclusion on that list does not signify agreement with our findings or support for our conclusions.

objectives, composition and operation of the Appeals Council. We conclude, at the most fundamental level, that the mission of the Appeals Council ought to be altered -- from its current focus on "processing the cases" for accuracy and consistency, to a more long-range focus on using the review mechanism as a tool for developing system-wide improvements in the operation of the SSA adjudicatory bureaucracy as a whole. Accompanying modifications ought thereafter to be made in the size of the Appeals Council, the qualifications of its members and their relationship to the other segments of the claims network.

We have organized this report into three basic sections: Background, Goals, and Findings and Recommendations.

The Background section itself contains three subsections. The first provides an overview of federal disability law, surveying the two types of claimants' cases that together constitute over 95% of the Appeals Council's docket. The second subsection outlines the SSA claims adjudication process, explicating the sequence of bureaucratic steps through which a claimant passes before, and after, presentation to the Appeals Council. The third and most important of these introductory subsections is a description of the authority, organization and operation of the Appeals Council and its related offices, elaborating the precise standards and procedures through which cases are processed.

The Goals section next identifies a sequence of six institutional objectives that have been advanced for the Appeals Council. Different people have identified different goals, or possible goals, for the organization, and we have attempted here to parse out the overlapping and partially-conflicting imperatives facing the SSA bureaucracy in general and the Appeals Council in particular. We then evaluate the success of the institution in meeting -- or at least pursuing -- these goals, and we conclude that the overwhelming crush of cases (currently running at close to 50,000 cases per year for the 20 members of the Appeals Council to resolve) simply precludes meaningful accomplishments on any aspect of goal structure.

Finally, in the Findings and Recommendations section, we offer some suggestions on how to defeat this "tyranny of the caseload." As noted, our primary concern is to redirect the Appeals Council from exclusive concern for the unending run of individual cases, into the mode of using its unique perspective -- it is the most important national reviewer for the disparate administrative and judicial systems -- as a perch from which to develop, promote and implement policy proposals that could streamline the claims process, making it more accurate, more uniform, more efficient and more acceptable to the public.

This is a tall order for any component of any adjudicatory

bureaucracy, let alone for a small and often-ignored arm of a behemoth like SSA. But we think it can be accomplished and that with these changes, the Appeals Council can once again play a leadership role in, and make a meaningful contribution to, the Social Security Administration and the millions of claimants it serves.

One final introductory note: we have repeatedly been struck by the general lack of information available to the public regarding the internal organization and operation of the Appeals Council. Despite the importance of the Appeals Council, and despite its centrality to the SSA network as a whole, precious little has been written about the Appeals Council; most outside commentators, even those who focus on the hearings and appeals process, have chosen to devote their attention elsewhere. We discern important costs in this relative "invisibility," and we hope that this study itself, and the vetting of it through the Administrative Conference, can begin the process of restoring the prominence and the effectiveness of the Appeals Council. Respect for the members of the Appeals Council, for the claimants, and for the disability system as a whole, requires no less.

II. BACKGROUND

A. Federal Disability Programs

This report encompasses the disability provisions of two basic federal public benefits programs: Retirement, Survivors, Disability and Health Insurance (RSDHI),⁹ and Supplemental Security Income (SSI).¹⁰ Together, the disability components of these two programs account for \$29 billion of annual disbursements to 7 million recipients,¹¹ making them the western world's largest program of income support for people unable to engage in substantial gainful activity.¹²

9 Certain portions of the 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, et. seq. (§§423 et. seq. for the disability portions). Implementing regulations are at 20 C.F.R. Part 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.

10 The SSI program (also known as Title XVI of the Social Security Act) is codified at 42 U.S.C. §§1381-83c (1982). Implementing regulations are at 20 C.F.R. Part 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 Report to the Congress, 29, 31 (1987); information supplied to the authors by SSA. In 1987, 404,800 new allowances of disabled workers are expected in disability cases. SSA Report, supra at 29.

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 1980's, but was significantly below the 1975 peak, when 592,000 new awards (Footnote continued)

1. Social Context

There is, to be sure, a wide variety of other specialized disability programs -- federal and state, public and private -- existing side-by-side in the United States today.¹³ These include state Workers' Compensation programs,¹⁴ Veterans Administration benefits,¹⁵ private insurance companies,¹⁶ and separate federal

12 (continued)

were made to disabled workers alone. 50 Social Security Bulletin No. 5, p. 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 (1985). See also Stone, supra note 1, passim (US was relatively late to enter industrialized states' process of defining disability and granting benefits.)

- 13 For comparisons among various categories of disability programs, See Bloch, supra note 1, passim (discussing RSDHI, SSI, Veterans' benefits, federal civil service benefits, and black lung benefits); Swansburg, "The Relationship Between Pain and Disability Benefits: A Literature Survey," Background paper prepared for Commission on the Evaluation of Pain, October 1985 (comparing RSDHI, SSI, Veterans' benefits, workers' compensation, and private insurance programs); "Social Security Programs in the United States, 1987," 50 Social Security Bulletin, No. 4, p. 5-66 (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 87-130 (E. Berkowitz ed. 1979).
- 14 Workers' Compensation programs are defined and administered by state governments, and there is substantial variation among them. In general, they provide wage-loss compensation for partial or total disabilities arising during the course of employment. The disability may be permanent or temporary, but historically, rehabilitation, rather than an expectation of long-term receipt of benefits, was stressed as the rationale for the program. Swansburg, supra note 13, at 20-29; Price, "Workers' Compensation: Coverage, Benefits and Costs, 1983," 49 Social Security Bulletin No. 2, p. 5-11 (Feb. 1986).
- 15 The Veteran's Administration (VA) manages two disability compensation programs: for service-connected partial or total disability, and for non-service-connected total
- (Footnote continued)

programs dedicated to "black lung" victims,¹⁷ retired railroad workers,¹⁸ etc.¹⁹ RSDHI and SSI, however, are unique in terms both of social importance and of the volume of administrative burdens for SSA in general and for the Appeals Council in particular.

Federal disability law is as complex as it is consequential, and part of that complexity is due to the piecemeal pattern in which the legislation for these two programs was enacted.²⁰

15 (continued)

- disability. In addition to cash benefits, the VA provides medical treatment, rehabilitation services and other programs. Swansburg, supra note 13, at 14-19; Bloch, supra note 1, at 319-424.
- 16 Private insurance carriers offer an array of individual or group disability insurance policies. These vary widely in their terms, cost and coverage. Swansburg, supra note 13, at 30-37; C. Soule, Disability Income Insurance: The Unique Risk, passim (1984).
- 17 Title IV of the Federal Coal Mine Health and Safety Act of 1969 (The Black Lung Benefits Act), 30 U.S.C. §§901-45, 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 SSA, but has been transferred to the Department of Labor, effective with applications filed in 1973. Bloch, supra note 1, at 500-89.
- 18 The Railroad Retirement Act, 45 U.S.C. §§201-31u, established a federal pension program for retired and disabled railroad employees. It is administered by the Railroad Retirement Board. Bloch, supra note 1, at 19-25; 20 C.F.R. Part 404, Subpart O (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. Bloch, supra note 1, at 427-96.
- 20 Liebman, "The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates," 89 Harvard L. Rev. No. 5, p. 833, 834 (1976) identifies three costs of the disjointed political process that has generated disability law: difficulty for the public in comprehending the system and its fair application; de facto delegation of authority from
(Footnote continued)

Although the Social Security Act was passed in 1935,²¹ and monthly benefit checks were regularly provided to retired workers and their survivors, it was 1956 before Congress made comparable support available for workers disabled prior to retirement age.²² By 1958 certain benefits were also extended to the dependants of a disabled worker,²³ and in 1960, the previous age restriction (which had permitted paying benefits only to disabled workers over age 50) was lifted.²⁴ In 1974, the current SSI program was inaugurated, superseding prior state-run,²⁵ but partially federally funded) welfare and disability programs. Other significant

20(continued)

Congress to diverse judicial and administrative bodies who make eligibility law independently and sporadically; and rigidity in the system, with resistance to comprehensive evaluation and change.

- 21 42 U.S.C. §301 et. seq., 49 Stat. 620. Efforts to expand the act to encompass disability benefits were initiated promptly, and the gradual enlargement of the program began. For histories of the evolution of the RSDHI disability program, see Berkowitz & Fox, "The Struggle for Compromise: Social Security Disability Insurance, 1935-1986," background paper prepared for National Academy of Sciences Institute of Medicine Committee for a Study of Pain, Disability and Chronic Illness Behavior, *passim* (1986); Berkowitz, "The American Disability System in Historical Perspective," in Disability Policies and Government Programs 16-74 (E. Berkowitz ed. 1979); W. Achenbaum, Social Security: Visions and Revisions, *passim* (1986); Bloch, *supra* note 1, at 4-17; Senate Finance Committee, *supra* note 1, *passim*; Advisory Council on Social Security, "Permanent and Total Disability," Report to Senate Committee on Finance, Doc. No. 163, 80th Cong., 2d Sess., (May 27, 1948); M. Derthick, Policymaking for Social Security 23-27, 295-315 (1979).
- 22 Social Security Amendments of 1956, Pub. L. No. 84-880, §103, 70 Stat. 807, 815-24 (1956). The 1954 amendments had provided a "freeze" for a disabled worker's earnings record, ensuring that his or her 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, Pub. L. No. 83-761, 68 Stat. 1080 (1954).
- 23 Social Security Amendments of 1958, Pub. L. No. 85-840, 72 Stat. 1021 (1958); Bloch, *supra* note 1, at 8-9.
- 24 Social Security Amendments of 1960, Pub. L. No. 86-778, §§401(a), 402(a), 403(b), 74 Stat. 918, 967, 969 (1960).

legislative modifications, in the disability programs occurred in 1977,²⁶ 1980,²⁷ and 1984;²⁸ more modest adjustments have been made almost annually, and SSA issues new implementing regulations or internal instructions with great frequency.²⁹

Under the current structure, each of the two major disability programs (under RSDHI and SSI) has two eligibility requirements: one financial, one medical. A claimant must satisfy both applicable tests in order to be eligible for benefits under either

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- 25 42 U.S.C. §§1381-83c, Pub. L. No. 92-603, 86 Stat. 1465, (1972).
- 26 Social Security Amendments of 1977, Pub. L. No. 95-216, §§101, 201, 331, 91 Stat. 1509, 1510, 1514, 1541 (1977). The 1977 amendments raised payroll taxes and reduced benefit levels, in order to protect the financial integrity of the RSDHI disability trust fund.
- 27 Social Security Disability Amendments of 1980, Pub. L. No. 96-265, §304, 94 Stat. 441, 453 (1980). The 1980 amendments provided for more frequent and searching review of approved claims, improved work incentives, and limitations on benefit levels.
- 28 Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, 98 Stat. 1794 (1984). 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, "The Social Security Disability Benefits Reform Act of 1984," 18 Clearinghouse Rev. 819 (Nov. 1984).
- In 1986, 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, and continuation of Medicaid for people whose earnings cause their income to exceed the financial eligibility criteria for SSI, provided that they have not medically recovered from the disabling conditions.
- 29 "Frequent" issuance of regulations, of course, does not always equate with "timely" issuance. In a number of instances, SSA has been very slow to promulgate regulations regarding emerging areas of law, including, for example, several provisions required by the 1984 Amendments which have not yet been issued.

program. As elaborated below, however, the medical criteria for the programs are identical: a claimant who is medically eligible for either program will perforce be medically eligible for both. Also, although the financial eligibility tests of the two programs are very different, it is possible for a claimant to satisfy both programs' definitions. A disabled person may, therefore, be eligible for RSDHI, SSI or both.

2. Financial Eligibility -- RSDHI

The RSDHI program is essentially an insurance plan. A person obtains coverage under it by working in employment that is "covered" by SSA, and paying premiums, which are automatically deducted (as "FICA" tax)³⁰ from the worker's payroll check and matched by the employer.³¹ If, for any particular calendar quarter of a year, a worker has earned a sufficient amount in wages,³² and has accordingly had a proportionate amount of Social

30 FICA stands for Federal Insurance Contributions Act. Monies received in these premiums are pooled into four independent trust funds (one for disability, another for the retirement and survivors account, another for hospital insurance, and a fourth, somewhat different, account for supplementary medical insurance) from which benefits are paid.

31 20 C.F.R. Part 404, Subpart K (1986). Social Security now covers 125 million workers in the United States, 95% of the entire labor force. SSA, *supra* note 11, at Introduction. Self-employed workers are also embraced by RSDHI, although the procedures for remitting the taxes are different. 20 C.F.R. §§404.1065-96 (1986). 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.

32 The amount of earnings necessary to qualify for a quarter of coverage is adjusted annually by an automatic statutory index. In 1987, \$460 was required (i.e., earning at least \$460 in covered employment during one calendar quarter of the year would ensure that the worker had paid enough tax to qualify for one quarter of coverage.) In 1986, the required minimum amount was \$440. U.S. Department 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 he or she earns, even if all the work and all the income occurred in only one quarter. Thus, a worker who earns at least \$1840 (4 x \$460) at any time during 1987 will be credited with four quarters of coverage for the year.

Security tax withheld, the worker is deemed to have earned a "quarter of coverage" for purposes of calculating RSDHI eligibility.³³

Financial eligibility for RSDHI disability benefits requires that the worker a) have earned a sufficient number of these quarters of coverage and b) that the quarters of coverage be relatively "recent" with respect to the onset of the disabling impairment.³⁴ For most claimants, these standards require a) 40 quarters (i.e., 10 years) of work in covered employment at any time during the worker's life and b) 20 of the quarters of coverage must be within the 40 quarter period immediately prior to disability.³⁵

RSDHI disability coverage thus "lapses" if a worker voluntarily leaves covered employment a significant time before the onset of a disabling impairment. If the impairment is determined to have become disabling prior to this insured status lapsing, the claimant will be eligible to receive permanent monthly disability checks.³⁶ If the onset is after coverage

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- 33 Regulations for calculating quarters of coverage are at 20 C.F.R. §§404.140-46 (1986).
- 34 The first condition (obtaining what SSA calls "fully insured status") is a threshold for eligibility for any of the RSDHI programs. 20 C.F.R. §§404.110-15 (1986). The second condition (for "disability insured status") is the special test for the disability portion of RSDHI. 20 C.F.R. §§404.130-33 (1986).
- 35 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 he or she became disabled, with a minimum of six quarters of coverage. 20 C.F.R. §§404.110(b)(2), 404.130(c) (1986).
- 36 RSDHI disability benefits are not really "permanent," for several reasons. For example, subject to certain exceptions, if a claimant's impairment medically improves and he or she is then able to return to work, disability benefits will be terminated. Pub. L. No. 98-460, §2(a) (amending 42 U.S.C. §423(f)); 20 C.F.R. §§404.1588-98 (1986). Various rehabilitation incentives -- including notably 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
(Footnote continued)

expires, there is no RSDHI disability coverage at all.³⁷

3. Financial Eligibility -- SSI

In contrast to RSDHI, SSI is a means-based welfare program, not an insurance program, so no "quarters of coverage" calculation is necessary,³⁸ and there is no requirement that the claimant ever have worked. Instead, the focus of the SSI financial eligibility inquiry is on the claimant's level of need, and scrutiny is made of both "income" and "resources."

For SSI purposes, income is defined broadly (e.g., to include earned as well as unearned income, and to include "in kind" support such as subsidized room or board), but a series of exclusions is also allowed (e.g., to deduct a flat amount for work-related expenses and a percentage of other receipts.)³⁹ The

36(continued)

the process of recovery. 20 C.F.R. §§404.1592, 1592a, 2101-2127; 416.992, 2201-2227 (1986). See also Department of Health and Human Services Commission on the Evaluation of Pain, Report of the Commission on the Evaluation of Pain 19-21 (1986); Rocklin and Mattson, "The Employment Opportunities for Disabled Americans Act: Legislative History and Summary of Provisions," 50 Social Security Bulletin No. 3, p. 25-35 (Mar. 1987) (describing the "Section 1619" provisions through which PL 99-643 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," a determination that he or she was entitled to benefits for a period of time but is no longer disabled. Benefits would then be payable for those months in which the claimant was under a disability. 20 C.F.R. §§404.320-22, 416.992a (1986).

37 The worker might still, under these circumstances, be eligible for retirement or survivors coverage, but not for disability insurance.

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

maximum federal SSI income eligibility levels for 1987 are \$340 per month for an individual or \$510 per month for a couple.⁴⁰

The SSI resource test is a ceiling on the value of assets that a person may own and still qualify for benefits. Again, certain items are excluded (a car, a residence),⁴¹ but the maximum allowance, after exclusions,⁴² is low: \$1800 for an individual or \$2700 for a couple in 1987.

4. Medical Eligibility -- RSDHI and SSI

Although the two programs incorporate these quite different tests for financial eligibility, they employ the same standard of medical eligibility,⁴³ and they implement the identical statutory definition 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 12 months."⁴⁴

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- 39 20 C.F.R. Part 416, Subpart K (1986). Up to \$20 per month of earned or unearned income is disregarded, as well as \$65 plus one-half the remainder of monthly earned income.
- 40 U.S. Department of Health and Human Services, press release, Oct. 23, 1986. The 1986 levels were \$336 per month for an individual and \$504 per month for a couple. Id.
- 41 20 C.F.R. Part 416, Subpart L (1986).
- 42 LCE (1987), supra note 1, at 1. The 1986 resource limits were \$1700 and \$2550. Id. The Spending Reduction Act of 1984, Pub. L. No. 98-369, §2611, provided for five annual gradual increases in the resource levels, going from \$1500 to \$2000 for an individual and from \$2250 to \$3000 for a couple. The statute does not provide for further increases after 1989.
- 43 The regulations governing RSDHI medical assessment, 20 C.F.R. Part 404, Subpart P (1986) are substantially identical to the corresponding sections for SSI, 20 C.F.R. Part 416, Subpart I (1986).
- 44 42 U.S.C. §§423(d)(1)(A), 1382c(a)(3)(A) (1982).

The Act also specifies that an individual

(Footnote continued)

The mechanism for assessing a claimant against this standard is SSA's "sequential evaluation process,"⁴⁵ a multi-step inquiry into several key variables.⁴⁶ (See Chart 1)

Step 1: Substantial Gainful Activity

The first stage of the algorithm asks whether the claimant is engaged in "substantial gainful activity." For this purpose, "substantial" activity is that which involves significant physical or mental duties,⁴⁷ and "gainful" activity embraces all work of the sort ordinarily done for pay or profit.⁴⁸ Current regulations

44 (continued)

"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." 42 U.S.C. §§423(d)(2)(A), 1382c(a)(3)(B) (1982).

45 The sequential evaluation process has, by regulations, governed disability adjudications since 1979. It is incorporated into SSA publications and into decisional documents sent to claimants.

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 no work experience. Social Security Ruling 82-63 (Oct. 1982).

46 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, then the evaluation proceeds no further.

47 20 C.F.R. §§404.1572(a), 416.972(a) (1986).

establish a presumption that earning income in excess of \$300 per month ordinarily indicates that the individual is performing substantial gainful activity, and is therefore ineligible for benefits.⁴⁹ However, even if the claimant is paid less than this amount, and even if he or she participates in the work force on only a part-time basis with reduced responsibilities, the performance of such work-like activities (unless they are of trifling importance or require unusual supervision or support) may be indicative of a latent ability to perform substantial gainful activity.⁵⁰

Step 2: Severity

The next step on the sequential analysis is the question of whether the claimant's impairment is "severe" -- i.e., does it significantly limit the physical or mental ability to engage in basic work activities,⁵¹ and does it satisfy the statutory

48 20 C.F.R. §§404.1572(b), 416.972(b) (1986).

49 20 C.F.R. §§404.1574(b)(2)(vi), 416.974(b)(2)(vi) (1986). Earnings of less than \$190 per month after 1979 will ordinarily demonstrate that the activity is not substantial and gainful. 20 C.F.R. §§404.1574(b)(3)(vi), 416.974(b)(3)(vi) (1986). Monthly earnings between those two figures are examined on a case-by-case basis. 20 C.F.R. §§404.1574(b)(6), 416.974(b)(6) (1986).

Different monetary cutoff levels are applicable to blind persons, who are not presumed to be engaged in SGA until the earnings rise to a significantly higher level. 20 C.F.R. §404.1584(d) (1986).

Different rules are also applicable to self-employed persons. 20 C.F.R. §§404.1575, 416.975 (1986).

50 20 C.F.R. §§404.1571, 416.971 (1986). Activities such as taking care of oneself, pursuing sedentary hobbies, etc., do not ordinarily constitute substantial gainful activity.

Under the "Section 1619 program" of Pub. L. No. 99-643 (1986), 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 CDR cases.

51 20 C.F.R. §§404.1521, 416.921 (1986). "Basic work activities" include walking, standing, seeing, hearing, understanding, using judgment, responding appropriately to co-workers, etc. Id. The severity regulation provides

(Footnote continued)

12-month duration requirement.⁵²

This particular step in the sequential evaluation has been in turmoil: several circuit courts had invalidated the "severity" test, finding either that it was facially inconsistent with the Social Security Act or that SSA had regularly misapplied it by transforming what was intended to be a *de minimus* preliminary screening process for eliminating only a few obviously non-meritorious claims into a much more powerful barrier justifying peremptory denials of large numbers of substantial cases.⁵³

The Supreme Court recently upheld the logic of the severity step, determining that it was consistent with the enabling statute for SSA to pose some sort of threshold screening test. The Court did not, however, reach the question of whether the severity step, as applied in practice by SSA, was a valid exercise.⁵⁴ In the

51(continued)

"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." 20 C.F.R. §§404.1520(c), 416.920(c) (1986).

- 52 20 C.F.R. §§404.1509, 416.909 (1986). 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 Social Security Ruling 82-52 (1982).
- 53 All 11 regional federal courts of appeal had either enjoined the Secretary's use of the severity regulations or imposed a narrowing construction upon it before the Supreme Court spoke. (O'Connor, concurring in Bowen v. Yuckert, U.S. (1987), 55 LW 4740.) See Pratt v. Heckler, 629 F. Supp. 1496 (D.D.C. 1985); McDonald v. Heckler, 624 F. Supp. 375 (D.Mass. 1985), 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); Baeder v. Heckler, 768 F.2d 547 (3rd Cir. 1985).
- 54 Bowen v. Yuckert, U.S. ___ (1987) (55 LW 4735) The majority declared that the statutory language and accompanying legislative history had demonstrated Congressional approval of the severity step as a threshold screen. Although the statute directed consideration of (Footnote continued)

interim, SSA has issued a new Social Security Ruling on severity, again defining it as a bar to only the weakest cases.⁵⁵

Step 3: Listings

The next step on the sequential evaluation asks whether the claimant's impairment matches or is equivalent to one or more of the medical conditions deemed to be presumptively disabling and defined in the regulations' "Listing of Impairments."⁵⁶ If the claimant's abnormalities, singly or in concert, "meet or equal"⁵⁷

54 (continued)

vocational as well as medical factors in making the disability determination, it did not require that vocational factors be incorporated into each step of the sequential evaluation, and the assessment of severity could be based on medical criteria alone.

The majority did not reach the issue of the severity step's validity as applied in practice by SSA (55 LW 4739 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: prior to the current severity regulation, only 8% of disability claims had been denied as non-severe; later, 40% were eliminated at that stage; after circuit courts began invalidating the regulation, the nationwide rate of "non-severe" denials fell to 25%. 55 LW 4740. Three dissenters, led by Justice Blackmun, agreed with Justice O'Connor that the validity of the severity step as applied remains problematic. 55 LW 4741.

55 Social Security Ruling 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 [step two of the sequential analysis] 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)."

56 20 C.F.R. §§404.1525, 416.925; Appendix 1 following 20 C.F.R. Part 404, Subpart P (1986).

a listed criterion, benefits will be awarded, without further inquiry into the particular effects of the impairment upon this claimant's life.

The listings contain more than 100 minutely-defined medical conditions, organized by 13 body systems (e.g., musculoskeletal, cardiovascular, neurological). Each one specifies, with a high degree of precision, what the impairment is and what tests are required to diagnose its presence and severity. Approximately

- 57 20 C.F.R. §§404.1526, 416.926 (1986). 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 8-9% of all disability awards have been based on "equaling" a listing; in 1976 this standard was responsible for over 45% of the awards. 1987 Background Material, supra note 1, at 36.
- 58 A separate, comparable 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. 20 C.F.R. §§404.1525(b)(2), 416.925(b)(2) (1986).
- 59 For example, the first listed impairment, rheumatoid arthritis, is defined as follows:

1.02 Active rheumatoid arthritis and other inflammatory arthritis.

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 3 months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last for at least 12 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

(Footnote continued)

three-quarters of all disability awards are based on these listings.⁶⁰

Step 4: Past Relevant Work

If the claimant's condition does not meet or equal a listing,⁶¹ the sequential evaluation then directs attention to the question of whether the claimant would still be able, despite all

9(continued)
disability evaluation).

20 C.F.R. Part 404, Subpart P, Appendix 1, Part A, Sec. 1.02 (1986).

- 0 The irregularity in bases for disability awards is suggested by the following chart:

<u>Basis for disability 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%	44%	14%	9%
Vocational factors	10%	16%	18%	27%	24%	24%

Stone, *supra* note 1, at 226; "Social Security Disability Insurance Program," Staff Data and Materials for Committee on Finance, US Senate, 97th Cong., 2d Sess., August 1982, p. 111; 1987 Background Material, *supra* note 1, at 36.

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. 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." 20 C.F.R. §§404.1577-78 (1986). Similarly, children under age 18 claiming SSI disability benefits are eligible only based on the listings.

There have been allegations that SSA and DDSs have systematically circumvented the legal standards of the sequential evaluation process by effectively terminating the analysis after step 3. 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. *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*, ___ U.S. ___, 106 S.Ct. 2022 (1986).

impairments, to return to his or her previous employment.⁶² If a resumption of former job duties is possible, the claim will be denied.⁶³

Step 5: Grids

If the claimant could not meet the demands of a previous occupation, the next inquiry is whether there exists other substantial gainful activity in the national economy that the claimant could perform, notwithstanding all impairments. The primary mechanism for making this assessment is the "Medical-Vocational Guidelines" (or "grids"),⁶⁴ a series of charts

62 20 C.F.R. §§404.1520(e), 416.920(e) (1986).

63 In investigating the possibility of a claimant returning to past relevant work, SSA looks at that work which 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. 20 C.F.R. §§404.1565(a), 416.965(a) (1986); Social Security Ruling 82-62; 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 previous work experience gained in the distant past is no longer considered vocationally relevant.

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

64 20 C.F.R. Part 404, Subpart P, Appendix 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, in effect, 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, for each individual claimant, the specific job categories that he or she could satisfy. Use of the grids for this purpose was endorsed by the Supreme Court in Heckler v. Campbell, 461 U.S. 458 (1983). See 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 U. Md. (Footnote continued)

contained in the regulations which are designed to consider simultaneously the four key variables affecting ability to work: a) "residual functional capacity" (defined as being a measure of how much basic work activity -- standing, sitting, lifting, carrying, etc. -- the claimant can still do, despite all impairments);⁶⁵ b) age;⁶⁶ c) education;⁶⁷ and d) previous work experience and transferability of acquired skills.⁶⁸

Each of these variables is reduced to a few categories (e.g., residual functional capacity is clustered as "sedentary," "light,"⁶⁹ or "medium," depending upon the level of exertional capability) and the the grids combine all the variables into 82 "rules," each one of which is deemed "disabled" or "not disabled."⁷⁰ If a

64 (continued)

L. R. No. 2 p. 329-383 (1983) passim (description of grids and analysis of their effectiveness in promoting sound decisions).

65 20 C.F.R. §§404.1545, 416.945 (1986).

66 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. 20 C.F.R. §§404.1563, 416.963 (1986).

67 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. 20 C.F.R. §§404.1564, 416.964 (1986).

68 The categories for previous work experience are: unskilled, semi-skilled, and skilled. Skills may be categorized as transferable or non-transferable. 20 C.F.R. §§404.1568, 416.968 (1986).

69 Residual functional capacity may also be classified as capable of heavy or very heavy work, 20 C.F.R. §§404.1567, 416.967 (1986), but these categories are not used on the grids.

70 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. If that same person were of advanced age, however, with all the other variables unchanged, a finding of "disabled" would be made under Rule 202.02. 20 C.F.R. Part 404, Subpart P, Appendix 2, Table 2 (Footnote continued)

claimant's medical-vocational demographics place him or her squarely on a grid rule, then the outcome of the case is determined thereby.

Step 6: Off The Grids⁷²

Some claimants do not fit precisely onto the grids, either because no combination of rules precisely describes their situation, or because the impairment alleged is "non-exertional" in nature. The grid rules are dispositive with respect to strength limitations only; if the claim is entirely or partially based on mental impairments, sensory limitations (extreme allergies, sensitivity to temperature, etc.), pain, drowsiness or the like, then the grids are merely advisory. The disability decision then becomes a more generic inquiry into whether there exists a substantial number of job categories (not necessarily job openings or jobs for which the claimant might actually be hired) that the claimant could perform. This final step in the sequential evaluation process is thus a recapitulation of the

70(continued)
(1986).

71 20 C.F.R. §§404.1569, 416.969 (1986).

72 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 64, at 359 (describing the provisions regarding non-exertional impairments as an "escape clause" from the grids.)

73 The claim of an individual who was unable to perform the "full range" of work would not be decided directly by the grids. 20 C.F.R. Part 404, Subpart P, Appendix 2, Section 200.00(h) (1986); Social Security Ruling 83-12 (1983).

74 20 C.F.R. Part 404, Subpart P, Appendix 2, Section 200.00 (1986).

75 The test of ability to work is whether there exists a significant number of jobs in the national economy (not necessarily in the claimant's region) that the claimant would be able to perform. 20 C.F.R. §§404.1566, 416.966 (1986).

disability inquiry in toto: considering all of this person's medical and vocational limitations, could he or she perform job functions in the competitive economy?

5. Standards of Proof

The burden of proof of eligibility for disability benefits rests generally with the claimant.⁷⁶ Social Security regulations recognize three categories of medical evidence: signs, symptoms and laboratory findings.⁷⁷ Signs are anatomical, physiological or psychological abnormalities that can be observed by trained professionals using medically acceptable clinical diagnostic techniques. Symptoms are an individual's own descriptions of physical or mental impairments. Laboratory findings are the results of medically established tests such as x-rays, blood tests, etc.

Although all these categories of proof must be considered by SSA in making a disability determination,⁷⁸ the Social Security Act exhibits a profound preference for "objective," reproducible tests and findings.⁷⁹ The regulations specify that symptoms alone

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- 76 20 C.F.R. §§404.1512, 416.912 (1986). Courts have shifted the burden of coming forward with the evidence, from the claimant to SSA, at step 5 (the "grids") of the sequential evaluation process, in recognition of the fact that the government is more knowledgeable than any individual claimant about the job categories and demands existing in the national economy. 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); Bowen v. Yuckert, U.S. ___ (55 LW 4735, 4737, n. 5) (1987). This shifting burden is not mentioned in the regulations, but is "consistent with SSA policy and practice." Associate Commissioner Frank Smith, memorandum on Circuit Court Case Study, June 17, 1986, p. 7. The original decision creating the shift was Kerner v. Flemming, 283 F.2d 916 (2d Cir. 1960).
- 77 20 C.F.R. §§404.1528, 416.928 (1986). Regulations also specify the acceptable sources and preferred contents of medical evidence. 20 C.F.R. §§404.1513, 416.913 (1986).
- 78 20 C.F.R. §§404.1512, 416.912 (1986).
- 79 42 U.S.C. §423(d)(5) (1982) and Pub. L. No. 98-460, §§ 3(a)(1) and (2) (statutory standard for evaluation of complaints of disabling pain; since lapsed under terms of its "sunset" provision but sustained in a Social Security Ruling). Note, "Proving Disabling Pain in Social Security (Footnote continued)

are insufficient to prove the existence of an impairment;⁸⁰ there must be professional corroboration. Similarly, conclusory statements from a medical examiner, such as a claimant's doctor writing simply that the claimant "is unable to work," are not binding upon SSA⁸¹ and -- if not buttressed by additional evidence explaining the conclusion -- are unlikely to be very weighty.⁸²

Observers acknowledge that, as a general matter, the definition of disability embodied in the Social Security Act and its regulations is extremely strict,⁸³ and, unlike many other

79(continued)

Disability Proceedings: The Social Security Administration and the Third Circuit Court of Appeals," 22 Dugesne L. Rev. 491, 505-506 (1984); Goldhammer & Bloom, "Recent Changes in the Assessment of Pain in Disability Claims before the Social Security Administration," 35 Administrative L. Rev. 451 (1983), *passim*; Stone, *supra* note 1, at 79 (insistence upon objective criteria evidencing disability served to enhance the "strictness" of the eligibility criteria and the restraints upon program growth). However, 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 Polaski v. Heckler, 739 F.2d 1320 (8th Cir. 1984) and 751 F.2d 943 (8th Cir. 1984); Avery v. Secretary of HHS, 797 F.2d 19 (1st Cir. 1986); Foster v. Heckler 780 F.2d 1125 (4th Cir. 1986).

80 20 C.F.R. §§404.1528(a), 1529, 416.928(a), 929 (1986).

81 20 C.F.R. §§404.1527, 416.927 (1986).

82 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. Social Security Ruling 82-48c; Stieberger v. Heckler, 615 F. Supp. 1315, 1343-1350 (D.C. N.Y. 1985), vacated 801 F.2d 29 (2d Cir. 1986); Schisler v. Heckler, 787 F.2d 76 (2d Cir. 1986).

83 National Academy of Sciences, Institute of Medicine, Committee on Pain, Disability and Chronic Illness Behavior, (Footnote continued)

disability programs, is designed to address only the most catastrophic medical losses, associated with near-total and near-permanent inability to work. Individuals who readily meet the medical criteria of other types of disability programs (workers' compensation, Veterans Administration, etc.) are therefore frequently denied by SSA.⁸⁴ A claimant must be, in short, extremely sick⁸⁵ or injured to qualify for disability benefits under RSDHI or SSI.

83 (continued)

Pain and Disability: Clinical Behavioral, and Public Policy Perspectives 22-23, 33 (1987); Heaney, "Why the High Rate of Reversals in Social Security Disability Cases?" 7 Hamline L. Rev. No. 1, p. 1, 4 (Jan. 1984).

84 See 20 C.F.R. §§404.1504, 416.904 (1986). Part of the disparity is due to the fact that some of the other programs (VA benefits, workers' compensation) are authorized to pay benefits for partial and temporary disability, whereas SSA targets exclusively those suffering from complete, long-term impairments. Swansburg, *supra* note 13, *passim*; Bloch, *supra* note 1, at 44-47. Part of the difference, however, is also due to the strictness of the Social Security Act's definition of disability, and SSA's tradition of construing medical eligibility standards quite restrictively.

85 Occasional shocking instances have been reported in the press, where SSA denied benefits (or terminated the ongoing receipt of benefits) of claimants whose disabilities were manifest and overpowering -- sometimes so egregiously that death (by suicide or due to the medical impairment) has followed shortly after the SSA decision. See 1986 Hearing, *supra* note 1, at 7-11; D. Lauter, "Disability-Benefit Cases Flood Courts," 6 National L. J., No. 6, p. 1, 30 (Oct. 17, 1983).

Courts, too, have occasionally found SSA to be outrageous in denying benefits to deserving claimants, and in pursuing an excessively hard-line stance in litigation. Hawkins v. Heckler, 608 F. Supp. 1201 (D.Kan., 1985); Ornelas v. Heckler, 598 F. Supp. 1089 (D.Colo. 1984); Jones v. Heckler, 583 F. Supp. 1250 (N.D. Ill. 1984); Merli v. Heckler, (D.N.J., Civ. Act. No. 83-189, filed June 7, 1984); McLean v. Heckler, (E.D. Pa., Civ. Act. No. 83-3429, filed May 14, 1984.)

On the other hand, it should also be noted, as we discuss further below, that the courts see only a skewed sampling of SSA's work in disability cases, and are never presented with the opportunity to review the thousands of cases in which

(Footnote continued)

6. Benefit Levels

The amount of a claimant's monthly RSDHI benefits payment is calculated by a complex weighing of his or her prior annual average earnings in covered employment, as indexed by inflation in the national average wage level.⁸⁶ At the start of 1987, the average RSDHI benefit paid to a disabled worker was \$488 per month;⁸⁷ the maximum⁸⁸ possible for a disabled worker and dependents was \$1007 per month.

A disabled person's SSI check is calculated to bring his or her countable income up to the support level⁸⁹ (\$340 in 1987).⁹⁰ The average monthly payment to a disabled SSI recipient was \$284 in 1986.

85(continued)

the adjudicatory bureaucracy has operated with accuracy, efficiency and sensitivity.

86 20 C.F.R. Part 404, Subpart C (1986).

87 U.S. Department of Health and Human Services, press release Oct. 23, 1986. The average monthly payment to a disabled worker in 1986 was \$482.

SSA has calculated that the present value of all RSDHI benefits to a newly entitled worker in December 1985 totalled \$66,800, including approximately \$39,000 in direct payments, \$4800 in payments to dependents, and \$20,700 in Medicare benefits. Wilkin, "Present Value of OASDI and Medicare Benefits for Newly Entitled Disabled Workers," Social Security Administration Actuarial Note No. 128 (Sept. 1986).

88 Statistics supplied by Social Security Administration.

89 20 C.F.R. Part 416, Subpart D (1986).

90 Forty-eight states and the District of Columbia voluntarily provide to at least some SSI recipients a small supplementation (e.g., \$15 per month in the District of Columbia) above this minimum federal level. SSA, 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). A few states provide sufficient supplementation to bring the recipient up to the officially-defined "poverty level."

In addition to monthly disbursements to disabled workers, eligibility for RSDHI or SSI can confer two additional types of benefits. One is benefits for family members: a disabled worker's spouse, children, divorced spouse or survivors may be eligible for certain types of RSDHI assistance, regardless of whether they themselves are disabled.⁹² A second type of benefit is eligibility for health care: an individual who has been entitled to RSDHI disability benefits for⁹³ 34 months is also therefore eligible for Medicare benefits,⁹⁴ and an individual who is entitled to SSI disability benefits is also thereby entitled to Medicaid coverage in most states.⁹⁴

RSDHI and SSI differ in two respects in the sequencing of initial monthly disability payments. In RSDHI, there is a statutory waiting period of five calendar months after the onset of disability before the first monthly check;⁹⁵ SSI payments can start immediately.⁹⁶ On the other hand, an RSDHI application may have retroactive applicability, enabling the claimant to receive benefits for up to 12 months prior to the filing of the application (if the onset date of the disabling impairment is proven sufficiently far back in time),⁹⁷ whereas SSI eligibility

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- 91 50 Social Security Bulletin No. 5, p. 19 (May, 1987). The average monthly SSI payment to a disabled couple was \$370 in 1986. *Id.*
- 92 20 C.F.R. Part 404, Subpart D (1986). The average monthly RSDHI payment to a spouse of a disabled worker was \$131 in December, 1986; the average payment to an eligible child was \$141. 1987 Background Material, *supra* note 1, at 31. SSI benefits are payable to an eligible individual and spouse only, not to dependents, but in rare cases an eligible person's stipend may be increased if there is an "essential person" (e.g., one who helps care for the disabled person) in the household. 20 C.F.R. §§416.220-23 (1986).
- 93 42 U.S.C. §426(b) (1982).
- 94 42 U.S.C. §1396(a)(10)(A)(i) (1982).
- 95 42 U.S.C. §423(c)(2) (1982); 20 C.F.R. §404.315(d) (1986).
- 96 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 even before a final determination of eligibility is made. 20 C.F.R. §§416.931-34 (1986).

does not provide for any compensation predating the application filing date, regardless of the date of onset.

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 his or her 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,⁹⁹ so unless the individual's prior earnings (and, hence, his or her monthly RSDHI disability payment) were low, the SSI disability payment would be low or zero.

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- 97 20 C.F.R. §416.315(d) (1986). 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 5 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.
- 98 20 C.F.R. §§416.340-50, 501 (1986).
- 99 20 C.F.R. §§416.1121(a), 1123(d) (1986).

B. Disability Claims Process

RSDHI and SSI applications are both handled through the same claims network,¹⁰⁰ a bifurcated array involving both federal officials and state agencies operating under supervision by SSA.¹⁰¹ (See Charts 2 and 3)

1. Initial Application

A claimant begins the process by filing an application at one of SSA's 1300 district or branch offices.¹⁰² In fiscal year 1986

- 100 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 Legal Counsel for the Elderly, supra note 1, at 51-73.
- 101 42 U.S.C. §§421(a), 1383b(a) (1982); 20 C.F.R. §§404.1503, 416.903 (1986). Prior to 1980, the relationship between SSA and the state agencies was one of contract. In the 1980 amendments, Pub. L. No. 96-265, Congress changed it to a regulatory one.

The federal part of the claims bureaucracy is organized as follows: SSA (headed by a Commissioner) is one of five principal operating units of the Department of Health and Human Services. 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 Deputy Commissioner for Operations and the Associate Commissioner for Central Operations. The corps of Administrative Law Judges, 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.

- 102 20 C.F.R. Part 404 Subpart G (1986). The application form solicits information regarding the claimant's work history, medical problems, dependents, etc. It may be completed in person or through a representative. Id.

An SSA claims representative at the district office has
(Footnote continued)

1.2 million RSDHI disability claims and 1.2 million SSI disability claims were filed.¹⁰³

The district office begins the formulation of a two-part "initial determination," by investigating the claimant's financial eligibility for RSDHI, SSI or both.¹⁰⁴ If the claimant is found ineligible, a notice of denial is mailed.

If the claimant satisfies the applicable financial eligibility tests, the file is forwarded to another office for making the second part of the initial determination, regarding 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 regulation of SSA.¹⁰⁵ The DDS develops the medical file by soliciting existing records and other documents from the claimant's physicians, hospitals, clinics,

102 (continued)

usually been available to interview the applicant and assist in the completion of the form. As a result of recent staffing cuts, SSA offices are now increasing their reliance upon claimants or their representatives filling in the forms themselves, without official assistance. These "self-help" procedures will be utilized with greater frequency, unless the claimant asserts an inability to do so. Memorandum from Office of Chicago Regional Commissioner to All District, Branch, Teleservice Center, and Satellite Office Managers, January 28, 1987.

103 SSA, *supra* note 11, at 29, 31. In FY 1987, an estimated 1.3 million RSDHI disability claims are anticipated. *Id.* at 29.

104 20 C.F.R. §§404.902-05, 416.1402-05 (1986). For RSDHI claims, the district office obtains a copy of the wage earner's earnings record (showing all SSA-covered income and quarters of coverage) from 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.

105 20 C.F.R. Part 404 Subpart Q; Part 416, Subpart J (1986). The 1980 Amendments made it possible for SSA to replace the DDS in a particular state, and perform the medical evaluation itself, where the DDS is not conforming to SSA standards. The actual practice has not yet been modified in any states. 42 U.S.C. §421, Pub. L. No. 96-265, Sec. 304(a)-(f), 94 Stat. 453-56 (1980).

106 The DDS may pay reproduction costs for obtaining these
(Footnote continued)

etc.¹⁰⁶ If necessary, 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.¹⁰⁷

The DDS decision regarding medical eligibility, pursuant to the sequential evaluation process outlined above, is made by a two-person team, comprising one medical consultant and one disability examiner.¹⁰⁸ These officials conduct a paper review only -- they do not meet with the claimant.¹⁰⁹

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records. 20 C.F.R. §§404.1514, 416.914 (1986). If the DDS is not as vigorous as it should be in collecting medical records, the shortage of such documentation usually redounds to the claimant's disadvantage, because it is the claimant who must bear the burden of proof. See 20 C.F.R. §§404.705, 1516, 416.916 (1986); Weinstein, supra note 82, 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 Commissioner Hardy, Feb. 3, 1987.

- 107 20 C.F.R. §§404.1517-18, 416.917-18 (1986). The quality and sufficiency of typical DDS consultative examinations have become controversial issues. Bloch, supra note 1, at 234, 273-76; Committee on Government Operations, U.S. House of Representatives, "Consultative Examinations Investigation," 99th Cong., 2d Sess., Report 99-981, passim (Oct. 9, 1986); Stone, supra note 1, 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 (1986).

- 108 The 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. Bloch, supra note 1, at 235; Department of Health and Human Services Commission on the Evaluation of Pain, supra note 36, at 23; Weinstein, supra note 82, at 908.
- 109 The 1984 Disability Amendments directed SSA to conduct a "demonstration project," experimenting with a face-to-face (Footnote continued)

An "initial determination" of this sort is also made when a previously-allowed claim is 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. 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.

109(continued)

interview between the claimant and the DDS disability examiner at the initial determination level in both new application and CDR cases. This interview would substitute for the reconsideration level. H.R. Rep. No. 618, 98th Cong., 2d Sess., 17 (1984); 8 Social Security Forum 1, p. 3 (Jan. 1986). Ten states have been selected for participation in this experiment. 51 Fed. Reg. 15465 (Ap. 24, 1986). A report to Congress about the experiment is due in September 1988.

110 CDR procedures vary somewhat from the initial sequential evaluation process, as 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. There are three categories of cases, classified 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. 20 C.F.R. §§404.1590, 1594, 416.990, 994 (1986). See also General Accounting Office, "Social Security: Adjusting Continuing Disability Review Priorities," Oct. 1986 (report critiquing the selection of types of cases for early CDRs); Sweeney, "The New 'Medical Improvement' Standard in Social Security and SSI Disability Cases," passim, March, 1986.

SSA has not yet fully implemented the new provisions for conducting CDRs, and few new termination cases have yet worked their way up the appellate ladder. ALJs nationwide received only 117 requests for hearings in CDR cases in May 1987, and the Appeals Council received only 8 CDR cases that month. OHA Key Workload Indicators, May 1987, p. 6.

111 42 U.S.C. §§423(f), 1382c(a)(5) (1982), Pub. L. No. 98-460, Sec. 2(a). Legal Counsel for the Elderly (1987), supra note 1, at 12-34.

The 1980 legislation provided for a review of current beneficiaries, and this process was greatly accelerated by
(Footnote continued)

A sample of DDS decisions is then subjected to "Quality Assurance Review" by regional and national tiers of SSA appraisers, who have the power to reverse state agency determinations, or to send them back for the DDS to correct. 112

111(continued)

the Reagan Administration. Approximately 1 million cases were then reviewed, and almost half of them were terminated, producing huge financial savings for 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. Staff report of Social Security Subcommittee, U.S. House of Representatives Committee on Ways and Means, "Disability Legislation 1983: Background and Issues," (June 28, 1983); 1987 Background Materials, *supra* note 1, at 43; Cofer, *supra* note 1, at 116; Weaver, "Social Security Disability Policy in the 1980's and Beyond," in Disability and the Labor Market: Economic Problems, Policies and Programs 29-63 (M. Berkowitz and M. Hill eds. 1986); Staff Data and Materials prepared for Committee on Finance, US Senate, "Social Security Disability Insurance Program," 97th Cong., 2d Sess., 47-64 (Aug. 1982); Report from Secretary of HHS Margaret Heckler to the Congress regarding Pub. L. No. 96-265, Jan. 4, 1985, p. 67-72.

112 42 U.S.C. §421(c); 20 C.F.R. §§404.1503(d), 416.903(d) (1986). City of New York v. Heckler, 578 F. Supp. 1109, 1113-14 (E.D.N.Y. 1984), *aff'd sub nom Bowen v. City of New York*, 476 U.S. 467 (1986).

There are two distinct sampling programs pursuant to which SSA reviews the work of the DDSs. Under one, 65% of all DDS awards are reviewed, prior to effectuation, by regional and national tiers of SSA officials. In 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 -- in FY 1986, this totaled 83,000 cases, divided equally among favorable and unfavorable actions -- for review by SSA regional offices. The SSA Central Office then reviewed 10,000 of the regional offices' cases, to promote consistency across the nation. Through these reviews, 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. SSA, *supra* note 11, at 13.

(Footnote continued)

Thereafter, the claimant is notified, and if the decision is not "fully favorable," the claimant has 60 days within which to appeal.¹¹³ Approximately 1-1/2 million initial determinations in disability cases are made each year, of which 40% are favorable.¹¹⁴ The process consumes, from application to

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On the other hand, there have been instances of DDS offices distorting their accuracy records by deliberately removing erroneous cases from the supposedly random sample of files to be sent to SSA quality assurance reviewers, and substituting hand-picked correctly-decided cases, in order to inflate the office's performance rankings. Report of Thomas W. Hayes, Auditor General, State of California, February 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 SSA prior to effectuation. Later, to save administrative costs, 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 SSA before payment. Senate Finance Committee, *supra* note 1, at 1283-84; Cofer, *supra* note 1, at 114; 1987 Background Materials, *supra* note 1, at 37.

- 113 20 C.F.R. §§404.909, 416.1409 (1986). 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 SSA assumes (until evidence to the contrary is presented) that the claimant receives the notice 5 days after it is dated, 20 C.F.R. §§404.901, 416.1401 (1986). SSA allows extension of the time period for good cause, 20 C.F.R. §§404.909(b), 911, 416.1409(b), 1411 (1986).
- 114 1987 Background Materials, *supra* note 1 at 41. In FY 1986, there were 1,558,346 initial determinations on new applications, of which 39% were allowances, and there were 47,737 initial determination on CDRs, of which 94% were continuances. The allowance rate in CDR cases was unusually high, due to SSA's policy of starting the CDR process by looking at those cases in which medical improvement was not expected. During the first nine months of FY 1987, as SSA began looking at more cases in which improvement had been considered "possible" or "expected," the rate of terminations jumped significantly. 13 NSCLC Washington Weekly, No. 37, p. 1 (Sept. 25, 1987).

notification, approximately 80 days.¹¹⁵

2. Reconsideration

If the claimant is dissatisfied with the initial determination, he or she may request "reconsideration."¹¹⁶ Under reconsideration, the same procedures are followed as in making an initial determination, but different people within the respective offices make the assessments.¹¹⁷ That is, if the initial denial

- 115 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. SSA, supra note 11, at 14.

One analyst estimated that the average cost to SSA (in 1978) of processing an initial application was \$205. Schwarz, "Commentary: Adjudication Process Under U.S. Social Security Disability Law: Observations and Recommendations," 32 Admin. L. R. 555, 562 (1980) (assessment based on interview with New Mexico DDS employee and letter from SSA Associate Commissioner). By this reckoning, reconsideration activity also cost \$205, an average ALJ hearing cost \$464, and Appeals Council activities were priced at \$219 per disposition. Id. at 562, 564. See also "Component Workload Unit Cost," provided by SSA (estimating DDS decisions as costing \$276-353 each, ALJ hearings at \$837-913, and Appeals Council reviews at \$451-526.)

- 116 20 C.F.R. §§404.907-22, 416.1407-22 (1986). There has been no reconsideration 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. 20 C.F.R. §§404.907, 416.1407 (1984). 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 117.
- 117 SSA has promulgated new regulations, implementing a requirement of the 1984 Amendments, to authorize 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. (Footnote continued)

was based 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.¹¹⁸

Again, the claimant is notified by mail of the decision, and again accorded 60 days to appeal further.¹¹⁹ Approximately 380,000 reconsideration decisions were issued in 1986, of which 17% were favorable.¹²⁰ The reconsideration process typically takes two months or more.¹²¹

3. ALJ Hearing

The next tier in the application process is a *de novo* in-person hearing before a federal administrative law judge.¹²²

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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 process. 20 C.F.R. §§404.914-18, 416.1414-18 (1986); Legal Counsel for the Elderly (1987), *supra* note 1, at 7-11; Memorandum from Eileen Sweeney, National Senior Citizens Law Center, to Legal Services Advocates and Members of the Private Bar Representing Social Security and SSI Beneficiaries in Cessation Cases, February 5, 1986.

A person who receives a medical termination notice has the option to elect to receive continuing benefits pending appeal to the reconsideration and ALJ stages. (This provision was enacted for SSI cases by the 1984 Amendments; it has become a subject of annual congressional debate for the RSDHI disability program.)

- 118 There have been some pilot projects providing for face-to-face meetings between claimant and decisionmaker at the DDS reconsideration level in new applications. Cofer, *supra* note 1, at 184.
- 119 20 C.F.R. §§404.933, 416.1433 (1986).
- 120 1987 Background Materials, *supra* note 1, at 41.
- 121 The time frame for reconsideration is comparable to that for an initial determination, and subject to the same types of delay.

This is ordinarily the claimant's first opportunity to meet face-to-face with the person who makes a decision on the application, and it is the first occasion for taking testimony under oath from other witnesses. It is also typically the first stage at which the claimant obtains legal or other representation.¹²³

SSA now employs nearly 700 ALJs at 132 hearing offices around the country.¹²⁴ They are paid at the GS-15 level and protected by

- 122 42 U.S.C. §§405(b)(1), 1383(c)(1) (1982); 20 C.F.R. §§404.929-65, 416.1429-1465 (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 throughout the federal government. Cofer, supra note 1, at 65-66.

- 123 Approximately 65% of claimants have legal representation at the ALJ hearing and 18% have non-attorney representation. 9 Social Security Forum No. 3, p. 7 (Mar. 1987). SSA must approve all fees for attorney representation. The fee could reach any amount, but SSA will withhold from its payments to the claimant no more than 25% of past due benefits for direct transmittal to the attorney. 42 U.S.C. §406; 20 C.F.R. Part 404, Subpart R; Part 416, Subpart O (1986). The average attorney fee was \$1,548 in FY 1986 and \$1409 in FY 1985. OHA Operational Report, Sept. 30, 1986, p. 24. There is a controversy regarding the direct payment of attorney fees in SSI cases. See Galbreath v. Bowen, 799 F.2d 370 (8th Cir. 1986), cert. granted — U.S. — (1987).

SSA rules regarding the size and speed of awards of attorneys fees have become controversial, as many claimants' representatives assert that recent OHA initiatives threaten to make disability law so unremunerative that private practitioners will be driven out of the field. SSA and the HHS Inspector General, on the other hand, have asserted that attorney's fees have become too high, on a per-hour basis. See 9 Social Security Forum, No. 8, p. 1 (Aug. 1987).

ALJs are often charged with a special responsibility to help an unrepresented claimant make out a case. See Heckler v. Campbell, 461 U.S. 458, 471 (1983) (Brennan, J., concurring).

- 124 Normal attrition continuously reduces the number of ALJs; the corps is irregularly supplemented with a new class of ALJs. The last class, in 1986, added 36 new ALJs, but current projections suggest that the corps will shrink to
(Footnote continued)

Administrative Procedure Act safeguards.¹²⁵

124 (continued)
below 650 in 1987.

125 5 U.S.C. §§554(d), 3105, 5362, 7521 (1982).

The national Chief ALJ of SSA occupies a GS-16 position. ALJs attached to most other federal agencies are generally at the GS-16 grade, with national or regional chiefs at GS-17. SSA's regional chief ALJs have been approved for GS-16 slots, but the upgrading is not now being accomplished. Most other efforts by SSA ALJs to have their status upgraded have not received support from SSA or the Office of Management, Budget, and Personnel. See National Center Study, supra note 1, at 41-42.

The Civil Service Reform Act of 1978, Pub. L. 95-454, 92 Stat. 111, incorporated many original provisions of the APA and provides the bureaucratic independence essential for an ALJ's decisional autonomy. ALJs are screened, employed and paid by the Office of Personnel Management, not by SSA. Agency ratings of ALJ performance for compensation entitlement purposes is prohibited, and ALJs may be removed only for good cause. The ALJs are not responsible to, or subject to the supervision of, anyone in the agency performing investigative functions. Ass'n of Administrative Law Judges v. Heckler, 594 F. Supp. 1132 (D.D.C. 1984); 5 U.S.C. §§5372, 4301(2)(D); Lubbers, "A Unified Corps of ALJs: A Proposal to Test the Idea on the Federal Level," 65 Judicature No. 5, p. 266-276 (Nov. 1981).

The Merit Systems Protection Board (which superseded the Civil Service Commission in 1979) implements the standards providing that ALJs may be disciplined or removed from office only for good cause. 5 U.S.C. §7521(a) MSPB procedures are lengthy and exhaustive; they afford substantial protection for ALJs, and SSA has not been notably successful in disciplining aberrant ALJs, even for issues such as unusually low case production. Cofer, supra note 1, at 146-49; Rosenblum, "Contexts and Contents of 'For Good Cause' as Criterion for Removal of Administrative Law Judges: Legal and Policy Factors," 6 Western New Eng. L. R. No. 3, p. 593, passim (1984). However, even the threat of disciplinary proceedings may have a substantial impact on ALJ behavior, creating a climate in which autonomy is circumscribed.

The Social Security Act antedated the APA by seven years and served as a model for the Attorney General's Committee which
(Footnote continued)

The ALJ may order additional consultative examinations before or after the hearing,¹²⁶ may call a vocational or medical expert to testify,¹²⁷ and will question the claimant and any other witnesses.¹²⁸ The claimant (or a representative) may submit

125 (continued)

drafted the APA. Although the full applicability of the APA to ALJ hearings is not explicit in legislation, as a practical matter APA standards have been incorporated into most SSA practice. Cofer, supra note 1, at 66-70. With respect to RSDHI, at least, the Supreme Court has declared that the APA and the Social Security Act are equivalent in requiring the same procedures. Richardson v. Perales, 402 U.S. 389, 409 (1971); National Center Study, supra note 1, at 35-38.

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

127 A vocational expert appears in approximately 20% of the ALJ hearings, most often when there is an issue concerning non-exertional impairments or the level and transferability of the claimant's skills. 9 Social Security Forum No. 3, p. 7 (1987). Usage of VE testimony has increased over the past several years, but is still substantially below the level experienced in the late 1970's, prior to implementation of the "grid" rules; id at 8; OHA Operational Report, Sept. 30, 1986, p. 30.

If a vocational expert will testify, the ALJ will notify the claimant in advance, and provide an opportunity for cross-examination. 20 C.F.R. §§404.1566(e), 416.966 (1986); Bloch, supra note 1, at 279-81.

128 There is no SSA advocate opposing the claimant in the hearing. An experiment, in selected locales, with "government representatives" who would develop an advocacy position, cross-examine claimants' witnesses, etc., has been terminated. The government representative would appear only in cases where the claimant also had a representative at the hearing, but would prepare the file in any case. 20 C.F.R. §§404.965, 416.1465 (1986); 52 Fed. Reg. 88 (May 7, 1987) (ending the experiment).

SSA had argued that the Government Representation Experiment
(Footnote continued)

additional medical records, submit a brief, deliver opening and closing remarks, and question all witnesses. Hearings are non-adversarial, and the level of formality varies.¹²⁹ A hearing is tape recorded and on the average lasts approximately 30-60 minutes.¹³⁰

128 (continued)

might be able to make ALJ hearings quicker, more accurate and more productive, as well as saving money, by charging the government representative with the task (otherwise performed by the ALJ) of developing and presenting a complete record. OHA Operational Report, Sept. 30, 1984, p. 4-5.

The experiment was run for three years before it was halted in response to a 1986 injunction issued by a Virginia federal district court. *Salling v. Bowen*, 641 F. Supp. 1046 (W.D. Va. 1986) (experiment enjoined as being improperly implemented, failing to promote accuracy, uniformity or productivity, and violating due process). SSA then decided not to resume the experiment, for "managerial, administrative and budgetary considerations," 52 Fed. Reg. 88 (May 7, 1987) but has not released any data about the comparative effects of government representation. Congress had also expressed displeasure at the experiment, and in 1986, the House passed a bill that would have aborted the program. Claimants' representatives also considered the Government Representation Experiment a disaster, arguing that it made the administrative proceedings excessively formal, adversarial, and intimidating.

129 See National Center Study, *supra* note 1, at 64-99 for a critical description of the ALJ hearing process.

130 Hearings in which the claimant is unrepresented are typically much shorter (e.g., 20-30 minutes); hearings with counsel, and especially with multiple witnesses, may run two hours or more.

SSA has recently purchased state-of-the-art four-track tape recording equipment for all hearing offices, to reduce the number of instances when hearing tapes were inaudible. OHA Operational Report, Sept. 30, 1986, p. 4.

The claimant is often the only witness in the case, but frequently a spouse or friend will appear, and sometimes a medical or other expert as well. Legal Counsel for the Elderly, *supra* note 1, at 75-77. In Fiscal Year 1986, the percentages of involvement in hearings were: claimant involved 97% of the time; family or friend, 34%; vocational (Footnote continued)

The volume of disability cases decided by ALJs -- and the accompanying workload and backlog per ALJ -- have fluctuated wildly in recent years.¹³¹ SSA's Office of Hearings and Appeals has undertaken a number of controversial measures in recent years to enhance the productivity of ALJs, including "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 claimants' representatives, as official attacks upon the ALJs' decisional independence.¹³²

130 (continued)

expert, 21%; medical advisor, 10%; translator, 4%; and claimant's physician, 1%. ⁹ Social Security Forum No. 3, p. 7 (Mar. 1987).

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

Fiscal Year	Receipts	Dispositions	Pending (End of)	Average ALJs on duty	Average Dispositions per ALJ	Processing Time(days)
82	320,680	296,548	152,896	754	34	174
83	363,533	342,998	173,431	797	37	184
84	271,809	337,459	107,781	763	37	185
85	245,090	245,829	107,042	730	29	167
86	230,655	220,313	117,384	703	27	172
Oct 86	22,575	17,561	122,938	686	26	176
Nov 86	19,904	15,492	126,810	685	23	178
Dec 86	21,388	17,557	130,641	684	26	181
Jan 87	18,400	17,072	134,570	675	26	194
Feb 87	22,695	17,075	140,190	672	26	195
Mar 87	26,550	20,891	145,849	668	32	199
Apr 87	21,158	20,676	148,429	663	32	201
May 87	19,244	19,027	149,432	661	29	202
Jun 87	26,252	23,643	151,255	660	37	206
Jul 87	20,527	22,846	150,877	652	36	207

Office of Hearings and Appeals, Key Workload Indicators, July, 1987, p. 1.

132 Cofer, supra note 1, passim; See also sources cited supra note 168.

Approximately three months after the hearing, the claimant will be notified by mail of the ALJ's decision, and accorded a further 60-day appeal opportunity.¹³³ 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.¹³⁴ The ALJ stage,

133 20 C.F.R. §§404.968, 416.1468 (1986).

134 In FY 1986, 46,638 cases (21.1% of the total presented to ALJs) were dismissed without a hearing decision, including 20,198 mental impairment cases returned to DDSs for further work-up. The FY 1985-86 figures are unusual and reflect the fact that, when 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 (that is, 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 Report, Sept. 30, 1986, p. 24-26.

The following charts demonstrate current and expected future ALJ work loads:

<u>Number of hearing dispositions:</u>	<u>1986</u>	<u>1987 (estimated)</u>
RSDHI disability cases	91,039	118,776
SSI	48,774	63,405
Concurrent cases	65,698	85,496
Other types of cases	14,802	19,323
Total	220,313	287,000

	1985	1986	1987 (est.)
No. of ALJs (as of Sept. 30)	705	696	685
Average monthly hearing dispositions per ALJ	29	27	35
Average hearings pending per ALJ	152	169	158

SSA, supra note 11, at 32-33.

(Footnote continued)

from the time of request for a hearing through the date of a decision, typically takes six or seven months.¹³⁵

4. Appeals Council

The last level of administrative consideration is provided by the SSA Appeals Council, whose result is a final decision of the Secretary of HHS, thus exhausting administrative remedies. The Appeals Council is described in detail in the succeeding subsection.

5. Judicial Review

A claimant dissatisfied with the final agency

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The historical record of ALJ activity is uneven. ALJs took actions favorable to the claimant in 8.4% of the cases in FY 1958; 15.2% in FY 1960; 28.9% in FY 1965; and 41.6% in FY 1970. (Of these cases, 71.4% were disability claims in FY 1960; 82% involved disability in 1970.) Department of Health, Education, and Welfare, Briefing Pamphlet for the Bureau of Hearings and Appeals, June 30, 1971, p. 15.

- 135 OHA Key Workload Indicators, July 1987. The average processing time from the date of the request for hearing to the date of the hearing has recently ranged from 108 days in FY 1985 to 140 days in July 1987. The average time from the hearing to the ALJ's decision has recently ranged from 65 days in FY 1982 to 85 days in the second quarter of 1987. *Id.* At the start of FY 1986, the Associate Commissioner established the goal of 155 days average processing time for hearings. Actual performance was 172 days average. OHA Operational Report, Sept. 30, 1986, p. 4.

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, 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. There has also been litigation regarding SSA delays in paying a claim after the ALJ has ruled favorably on the case. Holman v. Heckler, No. 78-0494, (M.D. Pa. May 1, 1987).

- 136 Exhaustion of administrative remedies is required before a
(Footnote continued)

determination¹³⁶ may appeal, within 60 days, to the U.S. District Court,¹³⁷ and from there to a Circuit Court of Appeal and to the Supreme Court.¹³⁸

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claimant may pursue a claim in federal court. 42 U.S.C. §405(g), (h); Weinberger v. Salfi, 422 U.S. 749 (1975). However where the Secretary or the court deems it appropriate, the exhaustion requirement may be waived. Bowen v. City of New York, ___ U.S. ___, 106 S. Ct. 2022 (1986).

An expedited appeals process is available, to omit the ALJ and/or Appeals Council stages and proceed directly from reconsideration to federal court, when the claimant and 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. §§404.923-28, 416.1423-28 (1986); Office of Hearings and Appeals Handbook, at 5-38-18D.

- 137 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. Pursuant to 28 U.S.C. §636, the magistrate may hear the case (often proceeding more quickly than the court would) and make a recommended decision for the judge. 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).

- 138 20 C.F.R. §§404.981, 416.1481 (1986). Federal court jurisdiction is founded upon 42 U.S.C. §405(g).

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 over disability cases; it heard none in FY 1985. Institute of Medicine, supra note 83, at 48-49.

See National Center Study, supra note 1, at 125-50 for a (Footnote continued)

The statutory standard of review upholds the Secretary's findings of fact, if they are supported by substantial evidence.¹³⁹ The court will also review the case for errors of law, although this is a somewhat less common basis for appeal.¹⁴⁰ The reviewing court may affirm, modify, reverse or remand the Secretary's decision.¹⁴¹ Reversals (awarding benefits to the claimant) occur when the Secretary's decision is not supported by substantial evidence and the claimant moreover satisfies the burden of proof of disability.¹⁴²

Remands to the Secretary can occur in a variety of

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critical assessment of the operation of judicial review.

139 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. House Conference Report No. 96-944 on Social Security Disability Amendments of 1980, Pub. L. No. 96-265, 94 Stat. 441 (1980), reprinted in US Code Cong. & Admin. News, Vol. 3, p. 1409 (1980).

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, p. 3 (Sept. 6, 1960).

140 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, 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).

141 A federal district court also holds equitable power to issue injunctions in SSA disability cases. Califano v. Yamasaki, 442 U.S. 682 (1979).

142 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).

circumstances. A court may order a remand for a new hearing or new decision if an improper legal standard or procedure was adopted, if the administrative record was incomplete, or if SSA failed to accord proper weight to the evidence.¹⁴³

A remand will also be ordered, on the Secretary's motion, for further administrative action to review or correct SSA's administrative decision to deny benefits. The Secretary's motion must be made before an answer is filed, and is to be based on good cause.¹⁴⁴

The number of new federal district court cases filed against SSA in disability matters each year fluctuates widely: roughly 9,000 cases were filed in 1981; 13,000 in 1982; 27,000 in 1983; 26,000 in 1984; 19,000 in 1985; 9,000 in 1986; and 4,000 in the first five months of 1987. Throughout this period, there have been 40-50,000 SSA disability cases pending in the federal courts at any given time.¹⁴⁵

The "reversal rate" (the percentage of cases in which the federal court awards benefits) has gyrated similarly: 20% in 1982, 30% in 1983, 57% in 1984, 46% in 1985, and 38% in 1986.¹⁴⁶

143 Aubeuf v. Schweiker, 649 F.2d 107 (2d Cir. 1981); Camp v. Schweiker, 643 F.2d 1325 (8th Cir. 1981); Diabo v. Secretary of HEW, 627 F.2d 278 (D.C. Cir. 1980); Allen v. Weinberger, 552 F.2d 781 (7th Cir. 1977).

144 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 SSA's incentive for developing the case properly on its first opportunity. Bloch, supra note 1, at 308; Senate Finance Committee, supra note 1, at 58

145 Calendar year data provided by the Chief Counsel for SSA Don Gonya, June 24, 1987. Of the total of SSA cases, 96% involved claims for disability benefits. In Fiscal Year 1986, 10,716 new cases were filed in federal courts appealing SSA denials. Of these, 10,070 (96%) concerned disability: 5930 on the disability portion of RSDHI, 1255 on SSI and 2885 concurrent.

The recent dip in court cases is largely attributable to the 1984-86 moratorium on Continuing Disability Reviews, which had generated large numbers of federal filings.

146 Gonya, supra note 145. These figures do not include court remands. The annual number of court remands is large and (Footnote continued)

Even beyond the quantity of individual cases reviewed, the federal judiciary has had a major impact on the disability programs, shaping the procedures and standards adhered to by SSA, and generally nudging the system in the direction of expanded eligibility.¹⁴⁷

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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. Data provided by SSA.

In FY 1986, 8,604 final court decisions were reached in SSA disability cases. There were 4212 affirmations, 3308 reversals and 1084 dismissals. In addition, there were 9143 court remands in FY 1986. At the end of FY 1986, 47,334 disability cases were pending in federal courts. SSA, supra note 11, at 33.

Going further back in time, statistics reveal that US district courts took action favorable to the claimant in 41.1% of the time in FY 1958, 33.7% in FY 1960, 31.3% in FY 1965, and 26% in FY 1970. US Department of Health, Education, and Welfare, Briefing Pamphlet for the Bureau of Hearings and Appeals, June 30, 1971, p. 24.

Disability cases quickly became the most important component of the SSA federal court litigation load, after the RSDHI disability program was inaugurated in 1954, and especially after monthly disability benefits became payable in 1957. In 1955, 58 civil suits were brought challenging Title II denials; none involved disability. In 1956, 10 of 79 civil actions (13%) concerned disability; comparable figures for other early years were: 1957, 40 of 90 (44%); 1958, 120 of 203 (59%); 1959, 426 of 542 (79%). Report to the Secretary from SSA Commissioner Mitchell, Sept. 6, 1960, p. 1.

147 Weinstein, supra note 82, passim; 1981 Hearing, supra note 1, at 11; Stone, supra note 1, at 152-61; Liebman (1976), supra note 20, at 845 (court's freedom to ignore operation of disability program as a whole, and aggregate financial consequences of expanding eligibility standards, incline judges toward allowances). Contra Mashaw, supra note 1, at 186 (judicial review has had only minor impact on the bulk of administrative decisions); L. Liebman and R. Stewart, "Bureaucratic Vision," 96 Harvard L. Rev. 1952, 1959 (1983) ("Thus, the ALJs and the judges reverse particular denials, but do not make the law of the system.")

6. Observations

The preceding description of the standards and procedures for handling RSDHI and SSI disability claims prompts a series of observations, which may provide helpful generalizations for considering the work of the Appeals Council.

a. The SSA disability mechanism is responsible for receiving, documenting and adjudicating a staggering number of claims each year. At every tier of the appeals process, the volume of traffic is a key driving force behind SSA procedures: the DDS apparatus must cope with almost two million initial application and reconsideration actions each year; the SSA ALJs collectively churn out more case decisions annually than the whole of the federal Article III judiciary;¹⁴⁸ the federal courts have become the final resting place for 10,000 claims each year.¹⁴⁹

148 Weinstein, supra note 82, at 900.

Of the 1003 ALJs that were employed by the federal government as of July 21, 1987, 673 (67%) were in SSA. Letter to authors from Appeals Council Member William Taylor, July 31, 1987.

SSA has long been the federal government's leading institution for ALJs. In 1980, SSA had 698 ALJs, and the next highest agency totals were: National Labor Relations Board 115, Department of Labor 66, Interstate Commerce Commission 55, Occupational Safety and Health Review Commission 48. SSA housed approximately 60% of the government's 1146 ALJs. Cofer, supra note 1, at 14. Although SSA employed only 6.6% of the federal ALJs in June 1947 and only 7.2% in June 1954, its share grew to 33.2% in July 1962 and 54.4% in February 1974. Lubbers, "A Unified Corps of ALJs: A Proposal to Test the Idea at the Federal Level," 65 *Judicature* No. 5, p. 266, 268 (Nov. 1981).

149 In 1986, Social Security cases represented 21% of the federal courts' civil docket where the United States was a party. This was 5% of the federal courts' total civil docket. (Comparable figures for 1984 were 37% and 12%, respectively.) Gonya, supra note 145.

This volume of cases has prompted numerous proposals to establish a dedicated "Social Security Court" (or a "Disability Court") which would have 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.
(Footnote continued)

The level of effort for these cases is unprecedented: no other administrative agency processes anywhere near the same number of cases that engorges SSA annually.¹⁵⁰ Moreover, while the surge in the disability caseload appears to have crested, there is no indication of retreat in the powerful economic, social and medical factors which originally created it.¹⁵¹ To the contrary, the enormous volume of disability adjudications is probably destined to be a permanent feature of the SSA landscape.

Concomitant with the volume of cases is the proliferation of 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.¹⁵² The task of establishing any degree of consistency and national uniformity among such diverse and far-flung individuals is daunting.

b. The nature of the typical disability case and process is similarly distinct from most other administrative fare. Disability cases are extremely fact-based: although there is a dense thicket of statutory and regulatory law, SSA adjudicators generally feel that their sole task is to apply known law to new facts, not to make policy, to extrapolate to unforeseen areas, or to enlarge the various pigeon-holes into which cases are slotted.

149 (continued)

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. 2, p. 229-251 (Summer 1982); Arner, "The Social Security Court Proposal: An Answer to a Critique," 10 J. of Legis. 2, p. 324-50 (Summer 1983); Rains, "A Specialized Court for Social Security? A Critique of Recent Proposals," 15 Florida St. L. Rev. No. 1, p. 1 (Spring 1987); "An Address by Justice Antonin Scalia, United States Supreme Court," 34 Federal Bar News & Journal No. 6, p. 252 (July-Aug 1987); 1981 Hearing, *supra* note 1, at 13-14; R. Pear, "New Court Sought for Benefit Cases," N.Y. Times, Mar. 9, 1986, p. 1.

150 1983 ACUS Report, *supra* note 2, *passim*.

151 Weinstein, *supra* note 82, at 904.

152 HHS Commission on the Evaluation of Pain, *supra* note 36, at 49.

To the extent that one can describe bipolar models of agency decisionmaking,¹⁵³ SSA is structured to present the paradigm of the "judicial" style of neutral adjudication based upon objective determination of descriptive facts, rather than the "political" style of focussing upon the identity of interested parties and the intensity of their respective concerns. This is not to imply that SSA is above politics,¹⁵⁴ but the nature of the typical disability case -- requiring a fine parsing of intimate facts of one person's daily existence -- necessarily tilts the system and its implementers in the direction of fine-grained attention to the factual record, rather than to the reform of social policy.

c. In addition to being grounded largely in the facts, rather than the law, the SSA disability caseload is noteworthy for several 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 be able to apply medical (including psychiatric) evidence to a vocational setting. In short, the fact that the cases are relatively confined in scope has not made them easy to comprehend.¹⁵⁵

Second, the cases, albeit small from a social viewpoint,¹⁵⁶

153 1983 ACUS Report, supra note 2 at 117.

154 There have been frequent proposals to take 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 SSA from the caprice of economic and political factors properly affecting the rest of the government. See D. Koitz, "Social Security: Legislation to Create an Independent Agency," Congressional Research Service, Library of Congress, Issue Brief No. IB86120 (Aug. 18, 1986). See also National Center Study, supra note 1, at 58, 71 (SSA receives over 100,000 inquiries from congressional offices and distorts its usual notification procedures in order to be responsive.)

155 Stone, supra note 1, 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").

are terribly important to the individual recipient, often providing the barest cushion against absolute economic deprivation. Moreover, SSA benefits (at least for the RSDHI program) are seen as an "earned entitlement," not as social welfare; they are insurance benefits for which the worker has paid over a lengthy period of time.¹⁵⁷ The claimant therefore presents as a party to a contract, not as a supplicant for the dole,¹⁵⁸ and the cases are typically contested vigorously.¹⁵⁹ There is, for many claimants, little to lose in filing or appealing a case, and a powerful incentive to do so.

A third characteristic of SSA disability cases is their

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- 156 On the average, an RSDHI claimant receives \$488 per month, and an SSI recipient 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. HHS Commission on the Evaluation of Pain, supra note 36, at 165. In addition, the value of associated services (Medicare, rehabilitation) may be substantial.
- 157 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 be beyond the manipulating control of a victim of medical disaster. Liebman (1976), supra note 20, at 857.
- 158 In addition, there is standard language used by many reviewing courts, to the effect that the Social Security Act is a remedial statute and must be construed liberally. See, e.g., Damon v. Sec'y of HEW, 557 F.2d 31,33 (2d Cir. 1977); Mandrell v. Weinberger, 511 F.2d 1102, 1103 (10th Cir. 1975).
- 159 One unfortunate, but probably not uncommon, 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 him or her from engaging in such focussed, 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.

inherent subjectivity. It may be impossible ever to "know" another person's impairments and judge them objectively; certainly many of the most compelling and damaging disabling conditions -- pain, for example¹⁶⁰ -- elude outside measurement.¹⁶¹ Social Security disability law explicitly eschews judgments made on the "average person" basis; instead, each claimant is entitled to individualized case-by-case analysis.¹⁶² SSA decisionmakers, therefore, of necessity make -- or should make -- credibility judgments in every case.

The fact that typically only the ALJ stage proceeds as a face-to-face confrontation between claimant and adjudicator makes this credibility judgment much more difficult but no less important. In many instances, moreover, a disability case turns fundamentally upon the decisionmaker's subjective sense of the expertise, reliability and credibility of a treating physician, consultative examiner or other expert whose opinion is offered only through documents, not by oral examination under oath.¹⁶³ Despite the fact that the disability programs have traditionally been presented to the public, and "sold" to the Congress, as incorporating exclusively an "objective," "medical" assessment,¹⁶⁴

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- 160 See HHS Commission on the Evaluation of Pain, supra note 36, passim; Institute of Medicine, supra note 83, passim.
- 161 Liebman and Stewart, supra note 147, at 1957 ("It is doubtful that there can be any "correct" disposition of individual cases presenting such [disability] questions."); Weaver, supra note 111, at 49 (comparing the difficulty of determining the occurrence of the insured contingency in the disability program and the retirement and survivors programs).
- 162 Stone, supra note 1, at 159; Capowski, supra note 64, at 349 (grids have been criticized for departing from individualization and adopting "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.
- 163 Some judgments required of SSA decisionmakers are (or are usually) straightforward: in the typical case, assessments of a claimant's age and education, for example, are unproblematic, 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, at base, the rendering of subjective opinions.

in reality the definition of disability necessarily embraces a variety of vocational, economic, social and political considerations, making close cases frequent and ineffably complex.¹⁶⁵

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

There is, moreover, a profound variation in the award rates of the various tiers of review, with the probability of success fluctuating as one climbs the appellate ladder.¹⁶⁶ The system

164 See Cofer, supra note 1, passim.

165 Liebman (1976), supra note 20, at 850 (inability to work may truly be attributable to a combination of medical handicaps and adverse labor market conditions).

166 There has been variability within each tier of review, as well as across tiers. At the initial determination level in 1986, for example, 52.6% of the claimants 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 71.1% 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 Social Security Forum No. 5, p. 7-8 (May 1987). Similar variability is reported in S. Kochlar, "Appeals under the SSI Program: January 1974-August 1976," 42 Social Security Bulletin No. 4, p. 24 (Apr. 1979) (reconsideration award rates ranged from 46.9% in Alaska to 17.6% in New Hampshire; ALJ award rates ranged from 64.8% in Kansas to 24.5% in Connecticut); Senate Finance Committee, supra note 1, at 52-3; National Center Study, supra note 1, at 21-4.

Some of the variability in award rates may be due to the fact that the record remains open throughout the early stages of administrative appeal, and the ALJ is typically dealing with a much more comprehensive set of medical
(Footnote continued)

thus tends to reward the persistent, fostering the notion that a claimant (or claimant's representative) 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 forgoing recital of background data -- but perhaps underlying much of it -- is the political fact that SSA (and the disability programs no less than others) has become a hotly, often bitterly, contested battleground. On the national level there are regular alarms about the programs and their respective trust funds being "in crisis."¹⁸⁷ On the bureaucratic level, there has been intense acrimony within the program units, especially within the Office of Hearings and Appeals, as ALJs and others resist what they have seen as policymakers' attempts to compromise their decisional independence under the guise of promoting efficiency and productivity.¹⁸⁸ SSA was once commonly

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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. Bellmon Rep., supra note 1, passim; National Center Study, supra note 1, at 3.

- 167 Report of the National Commission on Social Security Reform, January 20, 1983; Stone, supra note 1, at 186-92; W. Achenbaum, Social Security: Visions and Revisions, (1986).
- 168 The tensions inside OHA, particularly between the ALJs and the series of Associate Commissioners, have been examined in a number of studies and several lawsuits. 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. Cofer, supra note 1, passim; 1981 Hearings, supra note 1, passim; Rosenblum, supra note 125, passim; Chassman & Rolston, supra note 1, passim; City of New York v. Heckler, 578 F. Supp. 1109 (E.D.N.Y. 1984), aff'd 742 F.2d 729 (2d Cir. 1984), aff'd sub nom Bowen v. City of New York, 476 U.S. 467, 106 S.Ct. 2022 (1986); Ass'n of Administrative Law Judges v. Heckler, (Footnote continued)

cited as "an agency at war with itself";¹⁶⁹ if the skirmishes have now abated or been driven underground, a substantial reservoir of mutual suspicion and hostility lingers nonetheless.¹⁷⁰

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594 F. Supp. 1132 (D.D.C. 1984); Nash v. Califano, 613 F.2d 10 (2d Cir. 1980); Settlement agreement in Bono v. SSA, recorded in US District Court for the Western District of Missouri, No. 77-0819-CV-W-4, June 7, 1979; letter from Gregory J. Ahert, Director, Human Resources Division, US General Accounting Office, to Senator Max Baucus, June 2, 1981, regarding "Social Security Administration Policies for Managing Its Administrative Law Judges."

169 1981 Hearings, supra note 1, at 20.

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

C. The Appeals Council

1. Legal Authority

There is no explicit statutory requirement for an Appeals Council; indeed, the only even implicit statutory mandate for further post-ALJ administrative review of a disability claim is:

"The Secretary is further authorized, on his own motion, to hold such hearings and to conduct such investigations and other proceedings as he may deem necessary¹⁷¹ or proper for administration of this chapter.

The Appeals Council was created by rulemaking procedures and is now governed by a handful of regulations contained¹⁷² in 20 C.F.R. §§404.967-83 (for RSDHI) and §§416.1467-83 (for SSI).¹⁷³ These generally define the circumstances under which the Appeals Council will review a case,¹⁷⁴ the procedures to be followed before the Appeals Council,¹⁷⁴ and the claimant's recourse¹⁷⁵ after a final adverse decision of the Secretary.

171 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 law any of the powers conferred upon him by this section...." 42 U.S.C. §405(1).

There is a statutory requirement for SSA review of a number of ALJ awards under the Bellmon Amendment, Sec. 304(g) of Pub. L. No. 96-265, but even this 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, establishing the standards for agency review of a hearing decision, and stating that in its review the agency retains "all the powers which it would have had in making the initial decision." 5 U.S.C. §557(b) (Supplement III, 1985).

172 Additional Appeals Council procedures are described at 20 C.F.R. §422.205 (1986).

173 20 C.F.R. §§404.970, 416.1470 (1986).

174 20 C.F.R. §§404.976, 416.1476 (1986).

The Appeals Council is also governed by norms inferior to the statute and regulations. These include "Social Security Rulings," which are interpretive statements, based upon statutes or recent decisions by courts, SSA policymakers, ALJs, the Appeals Council, and others.¹⁷⁶ SSA generates and disseminates SSRs (but does not publish them in the Federal Register) and collects them quarterly and annually.¹⁷⁷ The status of these Rulings is somewhat ambiguous. SSA says 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"¹⁷⁸ and that a Ruling "is binding on all components of the Social Security Administration."¹⁷⁹ Many ALJs, on the other hand, do not consider rulings binding upon them, since SSRs are not promulgated via APA notice-and-comment rulemaking procedures.¹⁸⁰

- 175 20 C.F.R. §§404.981, 416.1481 (1986).
- 176 Social Security Rulings on Federal Old-Age, Survivors, Disability, Supplemental Security Income, and Black Lung Benefits, Cumulative Edition, 1986, p. iii. 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.
- 177 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 is being discontinued because SSA has decided to publish the Rulings as frequently as necessary, instead of quarterly.
- 178 Social Security Rulings, supra note 163, at iii.
- 179 Id.; 20 C.F.R. §422.408 (1986).
- 180 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 which are "substantive", rather than merely "interpretative", are not law. The Appeals Council and 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 (Footnote continued)

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 the process of 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 ALJ or Appeals Council stages of the claims process, but its contents do help shape the case file that may be presented for appellate review; the DDSs certainly feel bound by POMS' strictures. The POMS statements are intended to be interpretive only; there has nevertheless been controversy over instances where POMS might be read as imposing new, unpublished substantive standards restricting eligibility for benefits.¹⁸¹

The SSA Office of Hearings and Appeals (OHA) also maintains

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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).

A 1982 proposal that would have rescinded the Richardson memorandum (47 Fed. Reg. 26860 June 22, 1982) was officially withdrawn after public opposition arose. The 1984 amendments then underscored the requirement that SSA must utilize notice and comment procedures for all major disability policies.

181 Schweiker v. Hansen, 450 U.S. 785 (1981) (SSA claims manual has no legal, binding force); Salling v. Bowen, 641 F. Supp. 1046, 1052-3 (W.D. Va. 1986); Bloch, *supra* note 1, at 225; Cofer, *supra* note 1, at 125. The 1984 Disability Act requires SSA to publish all major disability policies under the APA's notice-and-comment procedures. Beyond that, the Congressional Conference Committee which considered the 1984 Amendments noted "while 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 (Sept. 19, 1984).

The POMS now runs to over 40,000 pages, and efforts are underway to streamline and reduce it. SSA Commissioner Dorcas Hardy, Memorandum on POMS, January 6, 1987, p. 1.

an "OHA Handbook," providing similar types of procedural guidance to ALJs and the Appeals Council. As with the POMS, the avowed purpose of the Handbook is to implement, not to alter, basic disability law, but, again, the dividing line between those two functions is not always bright.¹⁸²

SSA does not consider its previous decisions in disability cases -- whether reached by a DDS, ALJ or Appeals Council -- to be of precedential value. OHA does circulate noteworthy decisions in the OHA Law Reporter, published quarterly, but this "is not to be considered an authority which can be cited, but rather an informative aid which may lead to individual research."¹⁸³ Selected administrative cases are displayed with identifying details redacted.

Finally, it should be noted that SSA's posture vis-a-vis decisions of federal courts remains controversial (and largely outside the scope of this study). Under prior policies, SSA would accept as binding the decisions of the U.S. Supreme Court, but also asserted the authority to "non-acquiesce" in an adverse decision of a circuit court of appeal. In a non-acquiescence situation 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. In June and December of

182 Office of Hearings and Appeals Handbook, provided to authors July, 1987. The OHA Handbook comprises a multi-volume series of loose-leaf binders, Part 5 of which is applicable to the Appeals Council. The contents of the handbook have been irregularly updated via issuance of replacement or additional insert pages. At least Part 5 of the Handbook, however, has largely fallen into desuetude, with very few updates issued during the past five years (despite substantial alteration in the operation of the Appeals Council) and it is no longer relied upon for day-to-day guidance, as 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," Dec. 1986, p. 36.

183 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.

1985, SSA changed its policy to one of "acquiescence." Now, if a circuit court decision is at variance with an agency policy, SSA issues an "Acquiescence Ruling," advising agency adjudicators and claimants within that circuit about how SSA will implement the court's decision there. SSA reserves, of course, the right to appeal the issue, or to relitigate it in the same or other circuit courts.¹⁸⁴

2. History

The Appeals Council was established in January, 1940, by the Social Security Board, which at that time administered the provisions of the Social Security Act.¹⁸⁵ The original charter

- 184 "Interim Circular No. 185" for inclusion in OHA Handbook, June 3, 1985; Social Security Rulings, *supra* note 176, at iii; Proposed regulation, 52 Fed. Reg. 15, p. 2557 (Jan. 23, 1987).

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 National Law J., No. 6, p. 1 (Oct. 17, 1983); Stieberger v. Heckler, 615 F. Supp. 1315 (S.D.N.Y. 1985) vacated on other grounds, 801 F.2d 29 (2d Cir. 1986); Heaney, *supra* note 83, at 9.

Between January, 1986 and April, 1987, SSA issued 26 acquiescence rulings, 21 of which have addressed retirement and survivors issues; none of the disability-related acquiescence rulings have concerned critical matters. Statement by Rep. Bill Archer, 133 Cong. Rec. E1507, April 23, 1987.

- 185 The initial legal authority for the Appeals Council came in a set of "Basic Provisions Adopted by the Social Security Board for Hearings and Review of Old-Age and Survivors Insurance Claims," Jan. 1940. This document elaborated 14 provisions regarding the procedures and structures for adjudicating claims, long before the enactment of the disability programs. Provisions 9-11 dealt with the Appeals Council, establishing it as the supervisory structure for referee (ALJ) proceedings.

The outstanding early history of the hearings and appeals structure is C. Horsky and A. Mahin, "The Operation of the Social Security Administration Hearing and Decisional Machinery," (1960) (mimeo on file with authors) p. 293 et. (Footnote continued)

established a three-person Appeals Council, appointed February 13, 1940, with responsibility for directing and supervising referees (later, ALJs) and for reviewing their hearing decisions.¹⁸⁵ Cases began trickling into the Appeals Council in July, 1940.

When the Social Security Board was abolished in 1946, its functions were transferred to the Administrator of the Federal Security Agency, who in turn delegated most of those powers to the Commissioner of Social Security. The Appeals Council, however, remained intact, 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.¹⁸⁷

In 1953 the Federal Security Agency was folded into the new Department of Health, Education and Welfare,¹⁸⁸ and the Appeals Council was bureaucratically located within the Office of the Commissioner of SSA.¹⁸⁹ Delegation of authority over hearings and

185 (continued)
seq.

- 186 Id. The original three members of the Appeals Council were Joseph McElvain (Director), John J. Deviny and Ernest R. Burton.
- 187 Horsky, supra note 185, at 294-95; Reorganization Plan No. 2 of 1946, transmitted to Congress May 16, 1946, pursuant to Reorganization Act of 1945, approved December 20, 1945; Agency Order No. 57, issued July 16, 1946.
- 188 Horsky, supra note 185, at 296.
- 189 20 Fed. Reg. 1997, Sec. 8.10 (Mar. 30, 1955); superseded by 22 Fed. Reg. 1050 §8.10 (Feb. 20, 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 underneath the mandate of 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 subordinate to one. Only later did the "other" duties of the Associate Commissioner overwhelm those associated with the Appeals Council. Department of HEW, "Briefing Pamphlet for the Bureau of Hearings and Appeals," June 30, 1971, p. 9; letter to Rep. Eugene J. Keogh from Alvin M. David, Director, Division of Program Evaluation and Planning, July 3, 1964 (responding to Congressional inquiry regarding the rationale for placing the Appeals Council under the
(Footnote continued)

appeals, however, continued to flow from the Secretary directly to the Appeals Council.¹⁹⁰

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" Appeals Council.¹⁹¹ The bureaucratic relationship between the Secretary, the Commissioner, and the Appeals Council is a factor frequently cited by members,¹⁹² underscoring the Appeals Council's status and autonomy.

The Appeals Council has grown irregularly in size, from its

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Commissioner instead of within the Office of the Secretary.)

190 20 Fed. Reg. 1997, Sec. 8.20(b) (Mar. 30, 1955). Among the express delegations from the Secretary to the Appeals Council are: 33 Fed. Reg. 5837 (Apr. 16, 1968) (authority to review Title II and Title XVIII hearings); 34 Fed. Reg. 6985-86 (Apr. 26, 1969) (same); 35 Fed. Reg. 7033-34 (May 2, 1970) (Black lung cases); 38 Fed. Reg. 15648 (June 14, 1973) (SSI cases); 39 Fed. Reg. 27746 (July 31, 1974) (same); 40 Fed. Reg. 21062 (May 15, 1975) (Medicare); 40 Fed. Reg. 25080 (June 12, 1975) (same); 40 Fed. Reg. 27506 (June 30, 1975) (same); 43 Fed. Reg. 26615 (June 21, 1978) (same).

191 Horsky, supra note 185, at 300; OHA Handbook, supra note 182, at 5-10.

More properly, since the Associate Commissioner serves in a dual capacity as a) director of the Office of Hearings and Appeals and b) Chair of the Appeals Council, he or she 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 OHA, have been somewhat aloof from the other components of SSA. As recently as 1985-86, OHA was accorded a special bureaucratic 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.

192 This factor was mentioned often in our interviews with Appeals Council members. See also Cleveland transcript, supra note 1, at 266.

original complement of three members in 1940, to six in 1956, eight in 1959, seven in 1960,¹⁹³ and nine in 1975. In 1976, the Council was increased to 14¹⁹⁴ members; by 1983 it had grown to its current strength of 20.

To date, the Appeals Council has received relatively little public critical scrutiny, as most observers have focused attention on other, more visible aspects of the bureaucracy, such as the DDS or ALJ. The Appeals Council remains, therefore, to a large extent, a subject of confusion and uncertainty among outside observers,¹⁹⁵ even including many who are intimately familiar with other aspects of the SSA process.

3. Composition

- 193 Horsky, supra note 185, at 311-12.
- 194 Letter from Appeals Council member William Taylor, June 25, 1987, on file with authors.
- 195 The conspicuous exceptions to this generalization are two works by Professor Jerry Mashaw, supra note 1, which provide searching reviews of the operation of the Appeals Council. NOSSCR, supra note 1, at 15-50 to 15-59, is also useful. Most other analysts, including Bloch, supra note 1, at 246-47, 287-91, and Legal Counsel for the Elderly, supra note 1, at 55-56, simply summarize the applicable regulations concerning the Appeals Council.

Other inquiries into the operation of SSA generally, and the Office of Hearings and Appeals in particular, have not highlighted the Appeals Council. See Subcommittee on Social Security of the Committee on Ways and Means, U.S. House of Representatives, "Recent Studies Relevant to the Disability Hearings and Appeals Crisis," 94th Cong., 1st Sess., (Dec. 20, 1975), passim; Center for Administrative Justice, "Final Report of Study on the Social Security Administration Hearing System," (Oct. 1977), passim; Bellmon Rep., supra note 1, passim; 1983 Hearing, supra note 1, passim; President's Private Sector Survey on Cost Control (Grace Commission), "Report on the Department of Health and Human Services, Social Security Administration," (1983), passim; Cleveland transcript, supra note 1, passim; 1986 Hearing, supra note 1, passim; General Accounting Office, "Administrative Law Process: Better Management Is Needed" (FPCD-78-25, May 15, 1978), passim; General Accounting Office, "Management Improvements in the Administrative Law Process: Much Remains to be Done" (FPCD-79-44, May 23, 1979), passim; and studies identified in Cofer, supra note 1, at 76-80.

The Appeals Council is today composed of 20 members,¹⁹⁶ plus the Associate Commissioner for Hearings and Appeals (who serves as Chair of the Appeals Council)¹⁹⁷ and the Deputy Associate Commissioner (who is an ex officio member).¹⁹⁸ One member is designated the Deputy Chair and manages the day-to-day operations of the Appeals Council.¹⁹⁹

The selection process for new members begins with the posting of a "merit promotion vacancy announcement."²⁰⁰ The job description requires that an applicant have seven years of progressively more responsible experience as a member of the bar involved in the preparation, presentation, or hearing of formal cases before courts or governmental regulatory agencies.²⁰¹

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- 196 Throughout early 1987 there were two prolonged vacancies on the Appeals Council; both were filled during summer, 1987.
- The Appeals Council has been bolstered, from time to time, by the addition of one or more ALJs who join the Appeals Council for a 30-day temporary duty assignment and take cases as a regular member. This program was terminated in March, 1987 for budgetary reasons.
- 197 The Associate Commissioner ordinarily is occupied with other duties and does not regularly participate in the work of the Appeals Council.
- 198 The Deputy Associate Commissioner used to be a Co-Deputy Chair of the Appeals Council, but no longer has the title. Deputy Associate Commissioners vary in the degree of "hands-on" involvement in the work of the Appeals Council.
- 199 There have been only two operational Deputy Chairs of the Appeals Council, Irwin A. Friedenberg 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.
- 200 The vacancy announcement may be advertised only inside SSA, within the entire Department of Health and Human Services, or more broadly. The wider the search field, the longer search process required. In early 1987, in the interest of filling two vacancies expeditiously, the Appeals Council advertised only within HHS.
- 201 Prior to 1976, the standards for appointment as a member of the Appeals Council did not require that the appointee be an
(Footnote continued)

A "Best Qualified" list of applicants who meet 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 OHA. Although this recommendation must ultimately be approved by the Deputy Commissioner for Programs, as well as by the Commissioner, in practice it is the Deputy Chair (with a varying degree of involvement by the Associate Commissioner) who makes the selection.

There has been strikingly little partisan "political" input in the selection process: there are no instances of pressures to appoint political cronies or to exclude applicants based on 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.²⁰² Similarly, we discovered no instances where a member has been²⁰³ forced, or even asked, to resign from the Appeals Council.

The current members of the Appeals Council include six women, three blacks, and one Hispanic.

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attorney. At present, all members of the Appeals Council are attorneys.

The original philosophy of 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, were without legal training. Attorney General's Committee on Administrative Procedure, Monograph No. 16, "Social Security Board", Apr. 1940, p. 38.

- 202 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.
- 203 Even the physical location of the Appeals Council seems to emphasize its independence. The Appeals Council sits in Arlington, Virginia, substantially removed from both SSA headquarters in Baltimore and HHS headquarters in Washington, D.C. (Other components of OHA, including the Associate Commissioner and the national Chief ALJ are also in Arlington.)

There is a preference for hiring new members of the Appeals Council from within or near OHA: 5 of the current members were ALJs immediately prior to appointment to the Appeals Council, 7 were in the HHS Office of the General Counsel, 4 were branch Chiefs within the Office of Appeals Operations, and 4 held other positions, mostly within SSA.²⁰⁴

The turnover among members is low: 7 current members have been on the Appeals Council more than 10 years, 6 have served 5-10 years, and 7 have served less than 5 years.²⁰⁵

The training that a new member receives varies, depending upon the person's previous experience and knowledge. Sometimes a new Appeals Council member will attend the same training course that new ALJs attend.²⁰⁶

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

Appeals Council members are not protected by the Administrative Procedures Act, as ALJs are.²⁰⁷ They participate in the "merit pay" system and receive performance evaluations from the Deputy Chair.²⁰⁸ In principle, this arrangement allows the

204 Data from letter dated June 25, 1987, by Appeals Council member William Taylor, on file with authors. 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.

205 Id. In 1986, two Appeals Council members transferred to ALJ positions. OHA Operational Report, Sept. 30, 1986, p. 10.

206 A new member might also receive additional "on the job training," such as having the Deputy Chair or a particular designee serve as the "B" member on the new member's early cases. See infra, text accompanying note 279.

207 As noted, ALJs enjoy virtually lifetime tenure and are immune from any substantial system of performance evaluation. See Rosenblum, supra note 125, passim.

208 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
(Footnote continued)

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 reported that no Associate Commissioner has ever tried to intervene in the work of the Appeals Council, pressuring members to deny (or pay) more claims in general or any specific claim in particular.²⁰⁹

Several other observers have concurred in the assessment that members of the Appeals Council do enjoy a high degree of "de facto" protection, even without formal jurisprudential guaranties, and there are no known instances of abusive political pressure. Some have expressed concern, however, that SSA policymakers are able nevertheless to create an "adjudicative climate" which subtly and indirectly inclines the Appeals Council toward more or fewer awards,²¹⁰ noting that the Appeals Council always reflects, to

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numerical assessment of each member's compliance with the case handling goals noted below, See *infra* note 268. Quality is harder to assess; the Deputy Chair samples the decisional documents of each member (he does not review the entire file) and judges them for conformity to the applicable law, clarity of explanation, and apparent basis upon substantial evidence. He asserts that he does not take into account the frequency with which a member grants or denies review, and he tries not even to calculate how often each member pays 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 might be 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.

209 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.

210 It is difficult to test empirically the existence and strength of any SSA-imposed adjudicative climate, because the statutory role -- and therefore the caseload and the product -- of the Appeals Council has been so different
(Footnote continued)

some extent, the interests and style of the OHA Associate Commissioner. And some have expressed the view that the Appeals Council is still perceived, at least 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 of which has responsibility for all cases arising in three designated judicial circuits. (See Chart 4) Within each geographic group, the four, five, or six members divide the cases randomly and equally. (For example, member William Taylor will ordinarily be 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.)²¹¹ This

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during the Reagan years from what it was during 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 recent survey of SSA ALJs, 70.1 percent (339 of 484 respondents) indicated agreement with the statement "Tacit agency pressure is placed upon SSA ALJs to hand down fewer 'reversals' during times of national governmental economic retrenchment." Cofer, supra note 1, at 211, 223.

The award rates of ALJs have not been noticeably different under different SSA leadership, but some might argue that ALJs are more insulated (both through legal protection and through geographic dispersion) against policy pressure than are members of the Appeals Council.

Members of the Appeals Council have denied 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.

211 One purpose of the geographic groupings is to provide a 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.

(Footnote continued)

means, in general, that each member receives two or three dozen new cases on a typical work day.²¹²

4. Staff

Each member of the Appeals Council has an administrative assistant, who performs clerical functions. There is, in addition, an Office Manager and staff for 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 located in the same complex (but not necessarily the same building) as the Appeals Council itself.²¹³

OAO is broken into five case-handling divisions²¹⁴ and then

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When the geographic groupings are shifted, however, as they were in June, 1987, in an effort to equalize the number of cases assigned to each member, the sense of continuity is disrupted.

- 212 The workload of the Appeals Council fluctuates dramatically. Statistics for individual members' workloads have only recently been maintained by computer, so there is some uncertainty in the figures. Members variously reported that caseloads ran approximately 300 cases per member during February, 1987, rising to almost 600 cases per member by May, 1987.
- 213 There is a proposal 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 about two years.
- 214 Divisions I, II and III handle RSDHI and SSI disability appeals where the primary issue concerns 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. The Division of Civil Actions has responsibility for all cases in which the claimant has filed a complaint in federal court after an adverse decision by the Appeals Council. (OAO is now experimenting with a system of "modules," in which the branch which handled the case initially will maintain responsibility over it even
(Footnote continued)

into 32 branches, each of which has responsibility for cases coming from a defined geographic location.²¹⁵ OAO houses some 320 analysts, who perform the primary review function, making recommendations which the Appeals Council members accept in the vast majority of instances.

OAO analysts are usually non-lawyers, compensated at GS-11 - 13 levels. They typically have backgrounds of prior employment within SSA: as claims representatives in a district office, as DDS employees, or as examiners from the Office of Disability Operations.²¹⁶ An OAO analyst typically reviews approximately 25

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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 Report, Sept. 30, 1986, p. 18.) There is also a Division of Support Services, with four branches, which provide varying types of assistance to the case handling division of OAO.

215 For example, Branch 18 (within Division III) has responsibility 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.

At the present time, the OAO branches do not parallel the Appeals Council members' four geographic groupings. This means that a particular analyst might send files to several different members, and that 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.

216 Analysts are selected by a merit selection process which is intensely competitive: since an analyst's job would be a promotion for many SSA employees, when OAO posts an announcement for 30-40 new positions, it can expect in the neighborhood of 1200 applications.

OAO analysts typically have 5 years of prior experience within SSA. Approximately 40% are women; approximately 20% are minority.

(Footnote continued)

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.²¹⁷ Analysts typically

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The current corps of analysts is composed of approximately 200 at GS-13, 100 at GS-12 and only a few at GS-11. Turnover is traditionally low, but has increased somewhat since promotion from GS-12 to GS-13 has become tighter.

A new analyst receives four weeks of classroom training regarding the medical problems of the human body systems, 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.

Analysts typically remain with the branch for a long time. Some are eventually promoted to "branch chief" within the OAO hierarchy; others who acquire law degrees may be selected as ALJs or members of the Appeals Council.

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

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 review is assessed as requiring 3 hours of analyst work; processing a denial requires 3.25 hours; and reversing an ALJ decision requires 5 hours. Among the more time-consuming functions, processing a supplementary review case is ranked at 8 hours and working through an initial action on a court remand is graded at 6 hours. These standard time values are scheduled for in-depth review and revalidation shortly. See Office of Management Analysis, Planning and Innovation, "Office of Appeals Operations Management Survey Report," Dec. 1986, p. 23. (hereinafter "OMAPI Report.")

The purpose of grading analysts according to STVs (rather than just 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

(Footnote continued)

have no personal contact with the ALJ, the claimant, ²¹⁸ or a representative, performing entirely a paper review.

In addition to OAO's analysts, Appeals Council members also have access to a small Medical Support Staff (three full-time physicians and a few dozen part-time consulting specialists)

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types of case actions (which are usually adverse to the claimant).

OAO production goals establish 4 levels of performance for the analysts, and promotion possibilities are largely governed by these measures of output. The number of review-level cases handled per month by analysts has declined (FY 1983, 36 cases per month; FY 1984 34.6; FY 1985 27.3; FY 1986 18.8), due to the moratorium on CDRs, the remanding of mental impairment cases back to the DDSSs, and a substantial increase in analyst time devoted to more time-consuming court cases. OMAPI Report, supra, at 19.

The numerical scoring concentrates on quantity; there is no objective measurement of the quality of the analyst's work, and no numerical scoring of accuracy. See Office of Hearings and Appeals, "Performance Standards for Hearings and Appeals Analyst," Oct. 1, 1983. Quality of an analyst's work is, 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. OHA Operational Report, Sept. 30, 1986, p. 8.

218 One source of tactical advice for claimants' representatives urges them to attempt, at least by telephone or in writing, to develop a relationship with the analyst working on the case, to foster a more personal sense of involvement in the claimant's plight. National Organization of Social Security Claimants Representatives, supra note 1, at 15-50. There is no evidence that this type of "personal involvement" has any impact on the outcome of the case, but direct contact with an analyst may have the effect of hastening the work on the case, ensuring that the file does not become lost in the stack, or ensuring that all documents sent to the Appeals Council have, in fact, been received.

employed by the Appeals Council to inspect files referred to them when some aspect of the medical record is unclear.²¹⁹ There is also a one-person Vocational Staff, responsible for hiring vocational experts and coordinating their activities in the field.

5. Appeals Council Caseload -- "Review Level" Cases

The Appeals Council deals with claims in three different settings: at the "review level" (that is, immediately after the ALJ tier); in a "new court filing" (that is, after a denied claimant has initiated a civil action in federal district court, and SSA's answer is due); and for "court decisions" (that is, after a district judge has issued a final decision in the case, or has ordered it ordered returned to SSA for a new hearing or other administrative processing.)²²⁰

219 OHA Handbook, supra note 182, at 5-37-10.

The medical support staff is used primarily where new evidence is presented to the Appeals Council or where the ALJ appeared not to have understood the medical record. If the opinion of the medical staff is going to be relied upon by the Appeals Council as a basis 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. Ass'n of Administrative Law Judges v. Heckler, 594 F. Supp. 1132 (D.D.C. 1984). This notice and comment procedure, however, has not been adhered to in all cases.

In addition, the Appeals Council works with OHA's "Congressional Inquiries Unit" and "Critical Case Unit" regarding high priority or emergency cases.

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

	<u>Receipts</u>	<u>Dispositions</u>
Review level cases		
FY 1986	51,100	52,000
87	73,500	70,500
88	81,500	79,500
New court cases		
FY 1986	11,850	11,860
87	15,850	15,850
88	17,350	17,350

Court remand cases

(Footnote continued)

Although there are certain similarities in the Appeals Council's work on the different categories, the distinctions merit separate consideration. This subsection therefore describes procedures applicable to the Appeals Council's work on review level cases; subsequent subsections deal with the other two types.

a. Types of Cases. There are two primary categories of review level cases: "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 (generally ALJ awards) in the absence of any claimant appeal.)

Request for Review. A claimant who is denied, in whole or in part,²²¹ at the ALJ stage may request review by the Appeals Council. This request may be initiated via an SSA form or another written statement.²²² A brief or a letter of contentions, stating

220(continued)		
FY 1986	18,400	7,250
87	10,700	20,350
88	10,200	13,750

(Review level figures exclude Bellmon cases) OMAPI Report, supra note 217, at 24. The numbers alone do not provide a true representation of the relative burden on the Appeals Council, however, because review level cases are typically dispatched much more quickly than the other two categories, where cases are handled relatively more deliberatively.

- 221 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 (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.
- 222 When a claimant files a request for Appeals Council review of an ALJ's decision, he or she is entitled to a copy of all pertinent documents in the case file, a copy of the tape recording of the ALJ hearing, and a period of time within which to comment. If the claimant is unrepresented, or if the representative who assisted the claimant at the ALJ stage is also involved at the Appeals Council stage, the duration of the comment period is typically shorter than it would be if the claimant retains a new representative at the Appeals Council stage.

(Footnote continued)

specific objections to the ALJ's decision and citing arguments for reversal, may be filed simultaneously or later.²²³ It should be noted that current regulations do not afford the claimant a "right" to Appeals Council review; the claimant merely makes a request, which the Appeals Council may dispose of in several ways, as noted below.²²⁴

"Own-Motion" Review. The Appeals Council also considers on its "own motion" a number of cases in which the ALJ award was favorable to the claimant.²²⁵ Own-motion review has a checkered

222 (continued)

Some claimants' representatives have complained that the Appeals Council has become somewhat more grudging in providing copies of all exhibits and in allowing an adequate time for inspection and comment. The Appeals Council response is that there has been no change in policy regarding these matters: the claimant is to be afforded full access to the file, and standardized letters and time frames are to be used. An OAO analyst is empowered to give one extension of time; a further extension requires a member's approval. Most members are said to be relatively liberal in enlarging the time periods, if there is a showing that the claimant or representative is actually pursuing additional important evidence, rather than simply being slow in writing a brief.

223 20 C.F.R. §§404.968, 75, 416.1468, 75 (1986).

Some claimants' representatives have observed that the standard of practice before the Appeals Council is relatively low: claimants' representatives often see the Appeals Council as unpromising, and file a pro forma request for review simply in order to preserve the right to proceed to federal court. The cases are typically litigated much more vigorously before the ALJs and federal judges, where the probability of success is appreciably greater.

224 The vocabulary of Appeals Council activities can be confusing. When a claimant "requests review," the Appeals Council does investigate the file to determine whether the case should be taken for possible changes. This screening, as described below, 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 for the purpose of considering alterations in it.

history: in the period prior to 1975, the Appeals Council staff routinely reviewed all ALJ allowances and most other decisions;²²⁶ from 1975 to 1980, as case loads rose, the Appeals Council stopped taking own-motion cases, and heard only request-for-review cases;²²⁷ since 1980, the Bellmon Amendment²²⁸ has again required

- 225 The overwhelming percentage of own-motion cases has been review of ALJ allowances, but the Appeals Council has also considered, pursuant to its own motion authority, a small number of unappealed ALJ denial cases. In June 1984, the sampling was 2% of the denials; this level was increased to 5% in 1986, and then reduced to 2% (due to workload considerations) in early 1987. In July 1987, the program of own-motion review of ALJ denials was suspended altogether.
- In FY 1986, the Appeals Council saw 483 unappealed ALJ denials and evaluated the ALJ's decision as correct 97.3% of the time. OHA Operational Report, Sept. 30, 1986, p. 8; OHA Operational Report, Sept. 30, 1983, p. 5.
- 226 Own-motion review was held to a strict standard of overturning an ALJ's award only in instances of "gross error." The Appeals Council reversed 1% of the ALJ disability awards in 1963, and only 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" in deviation from the criteria 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 to SSA Commissioner Robert M. Ball from Joseph E. McElvany, Director, Bureau of Hearings and Appeals, November 17, 1964.
- 227 As requests for ALJ hearings -- and the accompanying backlogs and delays -- mushroomed in 1975-1980, analysts from OAO, who ordinarily assisted the Appeals Council in its reviews, 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 it 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 Hearing, supra note 1, at 10.
- 228 Social Security Disability Amendments of 1980, Pub. L. No. 96-265, Sec. 304(g). In 1980, Congress was concerned about what it perceived as too-generous application of disability standards, particularly by ALJs. At the instigation of Senator Bellmon, therefore, Congress tightened the rules,
(Footnote continued)

the Appeals Council to take a substantial number of own-motion review cases.

The Appeals Council now receives, for own-motion consideration, a randomly-selected sample of approximately 10-15%²²⁸ of ALJ awards in RSDHI disability cases -- a volume of approximately 300-400 cases per month. The selection of the sample, based solely on claimants' Social Security numbers, is performed by the mailroom clerks²³⁰ in the Office of Disability Operations (ODO) in Baltimore, and files are forwarded to the

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enhanced quality control, and instructed the Appeals Council to create a more balanced oversight structure for ALJs by taking cognizance of ALJ awards, as well as of denials.

The statute did not require the Appeals Council to review any particular number of ALJ awards, 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 acting on his or her own, without forwarding the file to any member, if the case contains no errors. Request-for-review cases, on the other hand, must be seen by at least one member, even if the analyst finds no reason to disturb the ALJ's conclusions.

229 The Bellmon amendment did not specify a selection routine for own-motion review. 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 generally been somewhat lower: 12.1% (5,736 ALJ allowances) in FY 1986; 14.4% (14,564 cases) in FY 1984. OHA Operational Report, Sept. 30, 1986, p. 8 and OHA Operational Report, Sept. 30, 1984, p. 4. In February, 1987, the figure was further reduced by the Associate Commissioner to 10%, due to Appeals Council workload considerations. SSA has also limited this own-motion review to RSDHI disability cases, since the statute did not require sampling the SSI or concurrent files and there would be practical difficulties in doing so. See infra, note 230.

The random selection for own motion review is done according to the terminal two digits of the claimant's Social Security number. (Since February, 1987, numbers ending in 00-10 have been selected. The selection numbers are changed approximately semi-annually.)

230 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)
(Footnote continued)

Appeals Council before the ALJ's award is effectuated.²³¹ The Appeals Council has 60 days from the date of the ALJ's decision to decide whether to take own-motion review.²³² It is noteworthy that own-motion cases, once a substantial portion of the Appeals Council's docket, have trickled off to very low levels: the Appeals Council took review of only 59 such cases in May 1987, and reversed only 23 of those.²³³

One special kind of Bellmon review that proved particularly controversial during its pendency was "targeted" review, in which individual ALJs were selected, based upon their unusually high award rates or unusually low productivity, for Appeals Council scrutiny.²³⁴ This targeting was seen by many as an assault upon

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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.)

SSI disability cases are effectuated through one of the SSA's district offices around the country. Concurrent RSDHI/SSI cases are bifurcated, with ODO managing the Title II component and another unit managing the Title XVI component. Since the case file is segregated in this way, it would be physically difficult to deliver a sampling of concurrent case files to the Appeals Council for own-motion review. Own-motion review, therefore, is now confined to RSDHI disability files.

- 231 The ALJ's "Notice of Favorable Decision" advises a claimant that the Appeals Council may take own-motion review of the case. A claimant is not notified when his or her case has been selected for inclusion in the sample of cases forwarded to the Appeals Council by ODO. The claimant is notified, as described below, if the Appeals Council elects to grant review of the case.
- 232 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 ODO for effectuation. This detour may delay a case for 3-5 weeks. When the case is returned to ODO, its effectuation is expedited so that payment to the claimant is delayed as little as possible.
- 233 OHA Key Workload Indicators, p. 10 (May, 1987). For the first eight months of FY 1987 cumulatively, the Appeals Council took 619 own-motion cases, reversing 258, remanding 255, affirming 80, and taking other action in 26. Id.
- 234 The 1980 amendments did not specify the strategies for
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the judicial independence of the ALJs, and an attempt to pressure

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selecting cases for own-motion review; SSA developed the two techniques (targeting a number of individual ALJs or offices, and random sampling of other awards), and implemented them through Program Policy Statements, which were not published as notice-and-comment rulemaking.

The targeting program proceeded despite internal SSA studies that failed to demonstrate a conclusive statistical correlation between ALJs who had high allowance rates and ALJs who made frequent errors. Cofer, supra note 1, at 118-20.

The initial Bellmon review implementation plans called for review of all allowances by any ALJ who granted benefits 70% of the time or more. Entire hearing offices with allowance rates of 74% or more would also be fully reviewed.

Later ALJs were targeted according to the frequency 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 his or her cases resulted in a grant of review by the Appeals Council. See 1983 Hearing, Testimony of Associate Commissioner Louis Hays, supra note 1, at 14-42.

The operation of the Bellmon review program was contested in Ass'n of Administrative Law Judges v. Heckler, 594 F. Supp. 1132 (D.D.C. 1984), in which District Court 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.

On June 21, 1984, the Associate Commissioner for 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 frequency with which the Appeals Council acted to correct an 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 9th Circuit determined that the standards for
(Footnote continued)

them into denying more claims.²³⁵ After 1984 the targeting aspect of own-motion review was eliminated.²³⁶

A third category of own-motion review is similar to targeted review, but serves a less controversial quality control or training function. Under it, most or all decisions by a new ALJ, during his or her first six months of hearing cases, are presented to the Appeals Council for monitoring consistency with SSA rules and procedures.²³⁷

Another kind of own-motion review involves "protests": assertions by ODO or another processing center that a particular ALJ award decision could not lawfully be implemented because of some technical error (e.g., lack of RSDHI coverage, failure to incorporate the five-month waiting period). In addition to these relatively rare minor oversights, ODO and other SSA components have increased the number of "substantive" protest cases -- where the ALJ's award is challenged as factually or legally incorrect -- and the "protest" caseload now runs approximately 100-150 per month.²³⁸

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conducting targeted review were substantive rules (not merely interpretive statements, as SSA had argued) and were therefore invalid for failure to comply with APA procedures. Reinstatement of benefits was therefore ordered for claimants who lost when a targeted ALJ's award was reversed by the Appeals Council. W.C. v. Bowen, 807 F.2d 1502 (9th Cir. 1987).

- 235 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 would then conduct the review itself. Comments by Burton Berkley, Deputy Chair of Appeals Council, Cleveland transcript, supra note 1, at 269.
- 236 For many people, the targeting program was synonymous with the phrase "Bellmon review," but SSA considers both targeted and randomly-selected own-motion review to be "Bellmon review." Appeals Council forms today continue to label as "Bellmon" cases all files randomly selected for non-targeted own-motion review.
- 237 This category of own-motion review long pre-dates the Bellmon Amendment. The Chief ALJ may prolong or shorten the 6-month period.
- 238 ODO and other SSA components detect errors of three basic
(Footnote continued)

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types. In one, newly-received evidence that was not available to the prior decisionmaker (ALJ or Appeals Council) may suggest that the prior decision should be reviewed. (For example, a new W-2 form may indicate that the claimant has recently performed substantial gainful activity that the ALJ was unaware of.)

The second type of correction occurs when the ODO or processing center's claims authorizer (an expert in the non-medical aspects of disability cases, graded as GS-10) begins the process of calculating the exact sum of benefits due under an ALJ award. At this point, 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 GS-11 supervisor (a technical assistant) a 1-2 page protest memorandum will be prepared, and forwarded with the file to the Appeals Council.

The third type of error is uncovered when the claims authorizer suspects there may be 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 (GS-11) or a disability specialist (GS-12) who may identify unexplained 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 40 such protest memoranda per month, about half based on financial issues and half on medical criteria. Other effectuating components also identify similar types of errors, and it appears that an increasing number of these are "substantive" (focusing on the medical aspects of the disability) rather than purely "technical." Standard procedures call for all these matters to be directed to the Appeals Council for correction. Occasionally, however, when the error appears to be simply typographical, the claims authorizer may telephone the ALJ to suggest re-issuance of a corrected decision.

If the protest concerns only the onset date and the size of the claimant's initial lump-sum payment, the effectuating components 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,

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A final category of cases that used to come occasionally before the own-motion review function of Appeals Council arose from the Government Representation Project (GRP). In this program, in effect from 1983 to 1986, several local hearing offices experimented with having a governmental attorney develop a case as an adversary to the claimant, argue at the hearing, and cross-examine the claimant's witnesses.²³⁹ The government representatives could not formally "appeal" a case past the ALJ stage, but did have authority to "suggest" when a particular award decision ought to come to the attention of the Appeals Council.²⁴⁰

b. Types of Actions. When a case comes to the Appeals Council for review-level work, whether on a claimant's request for review or on the Appeals Council's own motion, there are then 241 three options: dismiss the case, deny review or grant review.

The Appeals Council will dismiss a case if the request for review is not timely filed and no extension has been granted, or if the claimant requests dismissal.²⁴² The Appeals Council will

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in an "old" case (i.e., when ODO's workload prevents it from delivering a protest to the Appeals Council within 45 days of the ALJ's decision), partial effectuation will begin.

Almost all of ODO's protests are accepted by the Appeals Council, and result in taking own-motion review (or in a reopening) to undo the error.

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.

239 20 C.F.R. §§404.965, 416.1465 (1986). See sources, supra note 128.

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

241 20 C.F.R. §§404.967, 416.1467 (1986). Technically, the term "grant review" is overly broad here: The Appeals Council does "grant" a claimant's request for review, but it "takes" review of Bellmon cases on its own motion. For convenience, the former verb is generally used in this section to refer to both types of actions.

deny review if it determines that the ALJ's decision and order are correct and should not be altered. It will grant review when there is a defect or potential defect in the ALJ's work.

In FY 1986, the Appeals Council disposed of 44,621 cases, of which it dismissed 5,273 (11.8%); denied review in 28,906 (64.8%); and granted review in 10,442 (23.4%).²⁴³

When review is granted, the Appeals Council may notify the claimant about the issues to be considered.²⁴⁴

242 20 C.F.R. §§404.971, 416.1471 (1986). A claimant may request dismissal of the appeal if he or she has second thoughts about the strategic desirability of appealing the adverse portions of a partially-favorable ALJ decision, at the risk of having the Appeals Council 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-motion review of the case within the 60-day period. Powell v. Heckler, 783 F.2d 396 (3d Cir. 1986), amended opinion, 789 F.2d 176 (1986); contra Delong v. Heckler, 771 F.2d 266 (7th Cir. 1985).

243 See Chart 5 and OHA Operational Report, Sept. 30, 1986, p. 27. In FY 1985, the Appeals Council disposed of 71,166 cases, dismissing 7662 (10.8%), denying review in 53,624 (75.4%) and granting review in 9880 (13.9%). *Id.* The grant review rate and the dismissal rate for these years are unusually high, because Pub. L. No. 98-460 required returning thousands of mental impairment cases to the DDSs at that time for further evaluation under new standards. Many other remands were required in CDR cases, for evaluation under a medical improvement standard.

244 20 C.F.R. §§404.973, 416.1473 (1986). 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 his or her 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
(Footnote continued)

The Appeals Council then has four further options: reverse, remand, modify or affirm.

A reversal is a flat change in the ALJ's decision: either changing a denial to an award (in a request-for-review case) or changing an award to a denial (pursuant to own-motion review). It is typically used when the ALJ has done an adequate job in developing the factual record (so no further evidence-taking is necessary) but has stated or applied the law incorrectly, in a fashion the Appeals Council can remedy itself.

A remand sends the case back to the ALJ,²⁴⁵ for an entirely

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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.

245 There are three main options regarding a standard practice for remanding cases from the Appeals Council to an ALJ. One would be for remands generally to go back to the same ALJ who heard the case initially (on the principle of judicial economy, since an ALJ already familiar with the case may require less time to correct it, and also on the principle that the ALJ who made the error should have the responsibility for -- and can directly learn by -- cleaning up the mistake.) A second option would adopt the general practice of deliberately sending a remand to a different ALJ (on the principle that the original ALJ may have a fixed idea about the case and be less able to re-examine it afresh.) Finally, remand cases could be assigned simply by rotation among the ALJs in the local office, as initial case assignments are, without regard to whether a particular ALJ had previously been involved.

SSA's practice has varied among these options. Before 1979, Appeals Council remands generally were returned to the originating ALJ. After the settlement in Bono v. SSA (case in US district court for the Western District of Missouri, alleging unfair OHA pressures on ALJs, settled June 7, 1979), remand assignments were generally doled out by rotation among ALJs in the particular local office. In the majority of instances, this meant that the remanded hearing was conducted by a different ALJ. Statement by then SSA Chief ALJ Paul Rosenthal, 8 Social Security Forum No. 5, p. 4 (May 1987).

(Footnote continued)

new hearing, for the collection of additional evidence, for the re-writing of an opinion,²⁴⁶ or the like.²⁴⁷

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Most recently, SSA has returned to the general practice of assigning a remand case to the same ALJ who issued the original decision, unless a) there has been an allegation of unfairness at the first hearing, b) the Appeals Council has special reason to specify that a new ALJ should be used or c) administrative factors in the local office make it much more convenient or efficient to designate a new ALJ. Memorandum from Acting Chief ALJ James R. Rucker, Jr., to Executive Staff, June 23, 1987.

246 Recently the Appeals Council has 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. The Appeals Council then re-writes the decision itself or remands to the originating ALJ with instructions, not necessarily to change the result, but to write a better opinion. A better ALJ opinion -- longer, more detailed, more expository of the facts and the law -- it is reasoned, will be both more informative to the claimant and more defensible in court. Memorandum from Frank V. Smith, III, Associate Commissioner of Office of Hearings and Appeals 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 Report, Sept. 30, 1986, p. 6.

In some instances, the Appeals Council has effectively re-written the ALJ decision itself, 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, 8 Social Security Forum No. 2, p. 1 (Feb. 1986); Social Security Ruling 82-13 (1982); Edwin Semans, Jr., "Note to Executive Secretariat," Dec. 30, 1986 (Appeals Council frequently remands cases to ALJs to correct errors, even when ultimate decision to deny benefits is not disturbed; Appeals Council also frequently re-writes decision itself.) In general, the current practice is for the Appeals Council to write the new decision itself, unless additional facts are needed or a critical finding is required from the ALJ.

247 An ALJ may protest a remand decision, complaining to the Appeals Council (or to the Associate Commissioner for OHA)
(Footnote continued)

The Appeals Council may also modify an ALJ order, altering part of the decision or opinion, without a remand.

An affirmance of the ALJ decision leaves it intact. Affirmance is a reflection that the concerns which caused the Appeals Council to decide to grant review in the first place have now been satisfied, and no correction is necessary.

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 overall caseload of the Appeals Council (44,621 cases in FY 1986) instead of only to those 10,442 cases in which the Appeals Council granted review, the reversals were 5.5%²⁴⁸ of the total cases, remands were 15.2% and affirmances were 2.5%.

c. Standard of Review. Until 1976, the Appeals Council

247(continued)

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.

248 OHA Operational Report, Sept. 30, 1986, p. 27. These figures do not separately identify cases in which the Appeals Council modified the ALJ's decision -- those are included as either affirmances or reversals, depending upon the Appeals Council's ultimate resolution of the case.

The FY 1986 figures are unusual in the high number of remands, due to statutory intervention requiring remands of large numbers of mental impairment cases. The remand rate (as a fraction of overall Appeals Council cases) was 8.3% in FY 1985, 7.3% in FY 1984, 5.6% in FY 1983, 7.7% in FY 1982, and 7.9% in FY 1980. The reversal rate was 4.3% in FY 1985, 5.3% in FY 1984, 5.1% in FY 1983, 4.4% in FY 1982, and 4.9% in FY 1980. Id.

Going back further, statistics reflect action by the Appeals Council favorable to the claimant in 3.6% of its decisions in 1960; 9.6% in FY 1965, and 12.4% in FY 1970. (At least three-quarters of these cases were disability appeals.) Department of Health, Education, and Welfare, Briefing Pamphlet for the Bureau of Hearings and Appeals, p. 21 (June 30, 1971).

conducted essentially a *de novo* review of the ALJ's work.²⁴⁹ Internal modifications then led to transforming the Appeals Council into somewhat more of a true appellate body, and regulations today specify five grounds upon which the Appeals Council will grant review of a case:

- (1) There appears to be an abuse of discretion by the administrative law judge;
- (2) There is an error of law;
- (3) The action, findings or conclusions of the administrative law judge²⁵⁰ are not supported by substantial evidence;

249 The departure from *de novo* review in RSDHI disability cases was made pursuant to regulation published at 41 Fed. Reg. 51588 (Nov. 23, 1976). The SSI disability program had never been the subject of *de novo* review at the Appeals Council level. 39 Fed. Reg. 37977 (Oct. 25, 1974).

The 1976 change was instigated by the attempt to reduce the workload of the Appeals Council, in order to free up personnel (OAO analysts and others) who could be detailed to various local hearing offices to assist ALJs in dealing with their backlog of cases.)

250 The substantial evidence test is also employed upon review in federal court, but there has been a controversy over whether the district judge is to investigate the existence of substantial evidence to support the decision of: (a) the Appeals Council or (b) the ALJ. Where the Appeals Council reverses the ALJ on a close-to-the-borderline case, there may be substantial evidence to sustain either a denial or an award. See *Parris v. Heckler*, 733 F.2d 324 (4th Cir. 1984) (inquiry is whether decision of Appeals Council, not decision of ALJ, is supported by substantial evidence); *Parker v. Heckler*, 763 F.2d 1363 (11th Cir. 1985), *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 (1986) (same); *Mullen v. Bowen*, 800 F.2d 535 (6th Cir. 1986) (same); *Fierro v. Bowen*, 798 F.2d 1351 (10th Cir. 1986) (same); *Bauzo v. Bowen*, 803 F.2d 917 (7th Cir. 1986) (same). The ALJ's findings of fact, of course, 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 vast 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

(Footnote continued)

(4) There is a broad policy or procedural issue that may affect the general public interest;²⁵¹ or
 submitted.²⁵² (5) There is new and material evidence

The Appeals Council does not maintain statistics on the relative frequency of use of these five bases for review, but the general impression is that assertions of "lack of substantial evidence to support the ALJ's decision," and "presentation of new and material evidence" are the most frequently utilized.²⁵³

There has been controversy about the degree to which the Appeals Council is constrained by this list in the regulations: are these five the only bases upon which the Appeals Council may grant review, or is the list simply illustrative, with the Appeals Council also free to review cases for other, unstated reasons? To date, circuits have generally granted the Appeals Council the broader power to take cases for diverse reasons, not confining it to the published list.²⁵⁴

d. New Evidence. Appeals Council receipt of additional evidence, whether provided before or after the decision to grant review of the case, has been problematic.²⁵⁵

250 (continued)
 scrutiny.

251 20 C.F.R. §§404.970(a), 416.1470(a) (1986). The categories are elaborated in OHA Handbook, supra note 182, at 5-40.

252 20 C.F.R. §§404.970(b), 416.1470(b) (1986). To qualify as "material" under current Appeals Council procedures, the evidence must relate to the period of time covered by the ALJ's decision.

253 Claimants also frequently allege an 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 182, at 5-40-21.

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

255 20 C.F.R. §§404.976, 416.1476 (1986).

Receipt of new evidence was anticipated to be a "puzzling problem" as early as 1940, and regarding even the hearing stage (not only the appeals stage) of the claims process.
 (Footnote continued)

New evidence may be generated in a variety of circumstances: a) a claimant who appeared *pro se* before the ALJ finally secures representation at the Appeals Council stage, and the new representative discovers or develops additional evidence that was missed at the ALJ stage; b) in the interval between the ALJ hearing and the Appeals Council review, the claimant, especially one with an ongoing or deteriorating condition, secures a more recent medical review or treatment, which also has a bearing upon assessment of the impairment for the time period considered by the ALJ; or c) the providers of medical services are simply tardy in response.²⁵⁶ ALJ or DDS requests for copies of needed medical records.

As a formal matter, the administrative evidentiary²⁵⁷ record in a disability case is closed after the ALJ's decision.²⁵⁷ This rule was replaced by statute in 1980 for RSDHI cases,²⁵⁸ and by regulation in 1986 for SSI and concurrent claims.²⁵⁹ This means

255 (continued)

Attorney General's Committee on Administrative Procedures, Monograph No. 16, "Social Security Board", Apr. 1940, p. 41.

- 256 There is also a suspicion that some unethical attorneys may deliberately withhold important evidence during the DDS and ALJ phases, and present it for the first time to the Appeals Council or in federal court. If this evidence makes the difference between denying and awarding benefits, then its late submission means that the favorable decision will be delayed. This delay has the effect of substantially increasing the claimant's eventual lump-sum of retroactive benefits, and the attorney's fees are typically calculated as 25% of this past-due amount. There are no data about the existence or frequency of this practice, and it would appear foolish (as well as unethical) for an attorney to risk losing any fee by withholding evidence from the ALJ (where the probability of an award is greatest) in the hope of increasing the fee by winning a later victory before a subsequent adjudicator. Nevertheless, many SSA officials believe the practice exists.
- 257 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.
- 258 42 U.S.C. §402(j)(2) (1982), Pub. L. No. 96-265, §306.
- 259 52 Fed. Reg. 4001 (Feb. 9, 1987), codified at 20 C.F.R. §§404.970, 976, 416.1470, 1476 (1987) (effective with (Footnote continued))

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 period of time which the ALJ considered. If the new evidence pertains solely to a condition that has arisen or worsened since the ALJ hearing, the Appeals Council will not evaluate it, but will return it to the claimant with a suggestion that the documents may be relevant to a new application for benefits, should the pending one be denied.

259 (continued)
applications filed after May, 1986).

- 260 As a practical matter, it is often very difficult to determine whether proffered 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 pendency of the current application. The Appeals Council considers itself to be 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 look more sympathetically on the new evidence and will order a remand for its receipt. See Weinstein, *supra* note 82, at 917 ("When 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 182, 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.
- 261 A new application for benefits may be filed even before the old one is finally adjudicated. To the extent that the two relate to the same time period, however, denial of the first claim will be conclusory unless it is reopened, and SSA is generally reluctant to reopen old claims.

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 thereby arguing in the alternative: my onset date of disability was in 1984 and, if SSA does not accept that, my 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, there may arise a confusing contradiction within SSA about the onset date of disability.

SSA procedures are supposed to identify promptly these
(Footnote continued)

e. Reopening ALJ Decisions. Related to the issue of receipt of new evidence is the controversy over the "reopening" of cases. Regulations provide a series of circumstances for reopening and revising prior disability decisions and determinations: a) within 12 months, for any reason; b) within four years, for good cause (e.g., new evidence, discovery of a clerical error) or c) at any time,²⁶² for a variety of reasons including fraud, gross error, etc.

The Appeals Council has frequently exercised the reopening power in "protest" situations -- where the case was not selected for own-motion review and the 60-day own-motion period has expired, but the processing center, in effectuating the ALJ's award, discovers some technical defect inhibiting payment. The case is then returned²⁶³ to the Appeals Council for reopening to correct the error.

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situations in which two contemporaneous applications are being evaluated at different tiers of review, but they are not always successful.

It should also be noted that filing a second application, after the first has been denied, is no panacea. An SSI claimant who pursues this course would lose a substantial retroactive award, for the period of months covered by the first application but prior to the second. An RSDHI disability claimant could be even more disadvantaged; if his or her insurance coverage lapses during the interval, the second (and all subsequent) applications will be denied on the basis of financial ineligibility, regardless of any deterioration in medical condition.

262 20 C.F.R. §§404.987-96, 416.1487-94 (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. 20 C.F.R. §416.1488(b) (1986).

263 This reopening could be beneficial or detrimental to the claimant. If the ALJ's award decision 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 182, at 5-42.)

One example is where an ALJ, in awarding substantial retroactive RSDHI disability benefits, omits the technical
(Footnote continued)

More controversially, the Appeals Council has also come to rely upon the reopening provisions to consider a case that would have been selected for conventional own-motion review, but the bureaucracy has moved so slowly that the 60-day own-motion period has already elapsed. In this 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.²⁶⁴

In response to claimants' complaints about this expansive application of the reopening power, one circuit court has held that the first category of grounds for reopening (reopening for any reason, within 12 months of the prior determination) may be exercised only by a claimant, not by the Appeals Council.²⁶⁵ Another circuit court has authorized governmental use of this grounds for reopening, but only by the particular decisionmaker who had originally issued the decision to be reopened (so only the ALJ, not the Appeals Council, could reopen an ALJ's award.)²⁶⁶

f. Timing. The amount of time required for Appeals Council case handling at the review level varies enormously, depending upon the type of action taken and the size of the Appeals Council's contemporary workload. Numerous complaints about very old cases languishing for months have led to proposals to restrict the time available for the Appeals Council to 60 or 90 days.²⁶⁷

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step of reopening and redetermining the claimant's prior adverse, but unappealed, decision on a previous application. Until it is reopened, the prior decision may stand as a res judicata bar to payment of benefits for the period of time it covers. 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.

- 264 Wilson, "Procedural Challenges to Social Security Appeals Council Practices," 20 Clearinghouse Rev. 8, 937-42 (Dec. 1986); Buckel, "Reopening a 'Final' Social Security Decision: Must There Be New Evidence?" Cornell Law School Social Security Seminar, (Dec. 19, 1986).
- 265 McCuin v. Bowen, 817 F.2d 161 (1st Cir. 1987); Contra Munsinger v. Schweiker, 709 F.2d 1212 (8th Cir. 1983); see also Chrupcala v. Heckler, No. 86-1469 (3d Cir. Sept. 28, 1987).
- 266 Butterworth v. Bowen, 796 F.2d 1379 (11th Cir. 1986).
- 267 1986 Hearing, supra note 1, at 77 (testimony of Associate (Footnote continued))

The Appeals Council has adopted a series of internal goals for processing time, and it regularly monitors analysts' and members' conformity to these standards.²⁶⁸ In 1985, average

267 (continued)

Commissioner Frank Smith.)

Most of the horror stories about very old cases are attributable to "lost" files: situations where the request for review is never properly associated with a claims folder, where the file is mistakenly mailed away, or where the file is simply forgotten in a storage area. Some delays are also due to the complexity of a particular case or to a legitimate need to obtain additional evidence. Lost files should become somewhat less common as the Appeals Council gains experience with its new computer case management system, but even this system (which OAO does not share) may prove inadequate to the task of monitoring so many cases.

At least some of the ire over Appeals Council delays may be traced to the fact that a typical disability claimant has already endured a very lengthy SSA process prior to requesting Appeals Council review (or having the Appeals Council take the case on its own motion). The glacial pace of SSA case handling in general frequently results in over a year's lag between the initial application and its presentation to the Appeals Council. Further tardiness at this stage merely compounds one of the aspects of the SSA claims system that claimants find most aggravating.

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

a) 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 was attributable to OAO and 6 days to the Appeals Council.

b) 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.

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

(Footnote continued)

processing time in request-for-review cases was 116 days;²⁶⁹ it had decreased to 96 days by May, 1987.²⁷⁰

g. Progression of a Typical Case. Although the "review level" cases vary substantially in their content and procedures, a more-or-less standardized routine has developed for processing a "typical" case. This part therefore describes the Appeals Council's mechanism for handling the usual files.

268 (continued)

d) In an own-motion case, the Appeals Council is supposed to decide, before the 60-day Bellmon period expires, whether to grant review. 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 90 days to decide how to dispose of the case.

e) In court cases, an answer (together with transcript) is to be filed within 60 days of service of the complaint. Several years ago, this deadline was met less than 20% of the time; now it is satisfied 95% of the time.

f) 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.

g) The goal for Appeals Council action on an ALJ's recommended decision in a court remand case (See *infra*, text at note 308) is 45 days. The current performance is 84-90 days, of which 10 1/2 days are consumed by the Appeals Council and the rest by OAO or the claimant.

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

269 1986 Hearing, *supra* note 1, at 77. Among the factors cited in explanation for these long delays were heavy demands upon Appeals Council and OAO in response to class action litigation; delays while awaiting pending new regulations on mental impairments and medical improvement; and diversions of staff to service court cases more rapidly.

270 OHA Key Workload Indicators, May 1987, p. 13. 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.*

When a case is delivered to the Appeals Council -- either on the claimant's request for review or through random or protest selection for possible own-motion review -- the file is routed to the geographically appropriate division and branch of the Office of Appeals Operations. There it is randomly assigned to an analyst, who is instructed to complete work on it within 10 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 listens to, and takes written notes about, all or part of the tape in perhaps 15-20% of the cases. (The analyst is required to listen to the tape if (a) he or she recommends taking own-motion review, (b) there is an allegation of an unfair hearing, 271 (c) there has been testimony by a medical or vocational expert.)

The analyst then prepares a report summarizing the file, highlighting key issues, and recommending a course of action for the Appeals Council. The primary vehicle for this reporting in request-for-review cases is a three-page "face sheet," a form on which the analyst checks appropriate boxes and fills in blanks to reflect the salient characteristics of the claim and the ALJ's handling of it.²⁷² The analyst may also choose to write a one- or

271 In a request-for-review case, the analyst must listen to the testimony of the medical advisor or vocational expert in order 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, SSA has discovered -- once 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 (e.g., the quality of the tape degraded in improper storage after the analyst heard it; the segment containing the expert's testimony was audible, but the rest was not; this was not a type of case in which the analyst was required by existing standards to listen to the tape prior to writing a proposed decision) but sometimes it means simply that the analyst has not listened to the tape as required, and the member has not detected the omission.

272 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
(Footnote continued)

two-page narrative statement describing the case, further and justifying a recommendation in greater detail.²⁷³ The analyst then drafts a proposed decision and appropriate notification letters to the claimant. Typically, an analyst might spend a total of three or four hours working on a case file, although there is wide variation among analysts and among cases.²⁷⁴

Essentially the same procedure is utilized for own-motion cases, except that where the analyst determines that own-motion

272 (continued)

legal basis the analyst identifies to support the recommendation.

The face sheet does not call for a narrative reciting the facts 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 requesting, as a routine matter, a copy of the analyst's work under the Freedom of Information Act and the Privacy Act. The current SSA policy is that the analyst's notes -- as well as the notes that may be exchanged between members of the Appeals Council in reviewing a file -- are to be released to the claimant upon request. (For several months during 1986, this policy was under review, and requests were handled on a case-by-case basis, with some unevenness in outcome.)

273 Analysts do not have much time for writing the narratives, and analysts are evaluated by OAO more on the volume, rather than on the quality, of the work they do. Members of the Appeals Council, on the other hand, frequently appreciate the fuller insights contained in the written statement, rather simply the multiple-choice form. An analyst may thus experience some conflict in attempting to serve two masters: the analyst is simultaneously an assistant to a member of the Appeals Council and a staff member of the OAO branch.

274 Some analysts regularly complete twice or three times as many cases per month as others. Cases in which the analyst intends to recommend a grant of review usually take appreciably longer (they much more often, for example, require the analyst to write a substantial narrative) than cases where review should be denied. One analyst estimated that in a typical request for review case, processing a standard denial might take an analyst 30-45 minutes. On the other hand, making a recommendation for granting review (or for denying review where new evidence had been submitted after the ALJ's decision and the Appeals Council would have to respond to it) might take two or three hours.

review should not be taken, the face sheet is shorter (one page) and more conclusory.²⁷⁵ If the analyst concludes that own-motion review is inappropriate, the case is finished: these files are not reviewed by any Appeals Council member, but are promptly forwarded for effectuation of the ALJ's award.

From OAO, the file is delivered to a member of the Appeals Council.²⁷⁶ If the analyst has recommended denying review, then only one member will be assigned to the case.²⁷⁷ If that member concurs in a denial, that is the end of the case: the file is returned to staff to 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 federal court complaint, which will require further monitoring. If there is no civil action, the file is ultimately deposited for long-term storage at a federal records center.

If the analyst has recommended granting review, and the member agrees, (or if the analyst has recommended denying review²⁷⁸ but the member disagrees) the case will be seen by two members.

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- 275 The own-motion face sheet or "effectuation sheet" omits all the demographic data of the longer form, and essentially asks the analyst only to 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.
- 276 The Appeals Council has recently procured a modest data processing capability, based on Wang computers. This system is designed to track case files, assess timeliness and monitor bottlenecks. OHA Operational Report, Sept. 30, 1986, p. 14-15. In our observation, the system was a substantial step forward, but far from adequate to meet the needs. See infra, section IV.E.3.f.
- 277 20 C.F.R. §422.205(c) (1986). See Chart 6A.
- 278 20 C.F.R. §422.205(b) (1986). The principle is that it is the members, not the analysts, who decide whether to review a case, so regardless of the analyst's recommendation, it is up to the first member to determine whether the case ought to be seen by a second member. (The exception to this principle is in own-motion cases: There, if the analyst recommends taking review, the case will be 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. It used to be done in a fashion that permitted the "A" member to "shop around" for a "B" member,
(Footnote continued)

The first (designated the "A" member) reviews the file and sends it along with a note about the proposed outcome.²⁷⁹ The secondary (or "B") member conducts a similar evaluation. If the "A" and "B" members agree, their decision is final. Notices are mailed to the claimant and the decision is implemented.

If the "A" and "B" members do not initially agree on an outcome, they meet to discuss the case.²⁸⁰ If the disagreement persists, the Deputy Chair of the Appeals Council (or a designee) serves as a "C" member, reads the file, and resolves the

278 (continued)

and try to select one who might be inclined to take a position similar to that favored by the "A" member. The old system also afforded discretion to office staff in allocating case loads.

Now the selection is done numerically by the claimant's Social Security number. The "A" member is designated from within the appropriate geographic grouping, based on an even division of numbers among the 4-6 members of the group. The "B" 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 his or her caseload (both "A" and "B" cases) for that day among the available alternates.

279 OHA Handbook, supra note 182, at 5-38. Some "B" members consider themselves responsible for undertaking a "de novo" review of the case, with a level of scrutiny equal to that of the "A" member. Others approach a "B" case with a presumption of going along with the "A" member's preferences if possible.

280 Most differences between "A" and "B" members are quickly resolved in this fashion, with informal conversations identifying and resolving differences in perspectives.

281 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), 20 C.F.R. §422.205(e) (1986). In fact, however, this procedure has been implemented on only one occasion in the past several years, regarding a non-disability question of SSI.

matter.²⁸¹ (This tie-breaking procedure is followed perhaps 20-40 times per month.)

Regulations permit oral argument before the Appeals Council,²⁸² but this practice was never very common, and has atrophied virtually out of existence due to transportation costs and time concerns.²⁸³ In the past several years the Appeals Council has heard oral argument in only a half dozen Social Security cases, none of which involved disability.²⁸⁴ Appeals Council action is thus entirely a paper review.²⁸⁵

The decision of the Appeals Council is then effectuated, a process which may require returning the file to the OAO analyst for re-writing the decisional documents and notifications.²⁸⁶

282 20 C.F.R. §§404.976(c), 416.1476(c) (1986).

283 For an oral argument, SSA would either pay for Appeals Council members to travel to the claimant's locale, or pay the claimant's expenses for coming to Arlington, Virginia. 20 C.F.R. §§404.999a-999d, 416.1495-99 (1986). Oral argument requires a panel of at least three members. 20 C.F.R. §422.205(b) (1986).

284 To warrant oral argument, there must be a significant issue of law or policy within the competence of the Appeals Council. This has happened occasionally with medicare-providers cases (which have recently been scheduled to be reassigned for hearing by ALJs within the Health Care Financing Administration of HHS) and rarely with SSA programs (e.g., definition of income for SSI financial eligibility, effect of state law on marriage or legitimacy for RSDHI), but not with disability claims.

285 It is striking how frequently claimants and their representatives report that they have never had any human 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 experienced great difficulty even in locating the responsible officials to check on the status and future timetable of a case, and they unanimously reported to us an image of the Appeals Council as a hidden, isolated institution, unresponsive to outside inquiry.

286 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.
(Footnote continued)

If the members have decided to remand the case, the file is mailed, with appropriate instructions, to the local hearing office. If the decision is 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 immediately a fully favorable decision (e.g., the members intend to hold the case at the Appeals Council pending further development, or to issue a "partially favorable" decision that grants some, but not all of the benefits sought by the claimant), then the claimant is notified of the proposed action and afforded 20 days to comment. 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.

An Appeals Council decision, whenever it is reached, is written to conform in substance, if not always in detail, to the standards governing ALJ opinions. That is, the Appeals Council is supposed to explain what evidence it relied upon, what legal authority is central, and -- if the Appeals Council overturns a finding by the ALJ -- which considerations have led to the outcome.²⁸⁷ During the past two years, the Appeals Council has

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OAO analysts reported to us that members accepted their recommendations as often as 98% of the time, while members said they rejected analysts' conclusions 10-20% 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 20-35%.

made an effort 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 standardized "boilerplate" language, but Appeals Council decisions on the merits are supposed to be more individualized.²⁸⁸

The Appeals Council member, like all other decisionmakers within the SSA claims system, must arrange his or her work habits to cope with the pressures of the caseload. Recent caseloads have ranged up to 500 cases per member per month, meaning that each member receives two or three dozen cases per day, and must try to dispose of them as rapidly as possible.²⁸⁹ A case might stay on a member's desk a few days to a few weeks.²⁹⁰

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

288 See OHA Handbook, *supra* note 182, 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 83, at 11.

289 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 much higher -- 750-800 cases per month -- if one includes cases taken as a "B" member or as an "Alternate A" member (i.e., cases reassigned in the absence of the person who would ordinarily be the "A" member.)

290 This volume of cases is a striking contrast to that accomplished elsewhere. Within SSA, for example, an ALJ might average 30 cases per month. Other agencies are radically different in this regard; many other ALJs carry caseloads of less than one-tenth the size of an SSA ALJ. 1983 ACUS Report, *supra* note 2, *passim*.

(Footnote continued)

A member therefore typically spends only 10-15 minutes reviewing an average case, although there is wide variation. A decision to agree with an analyst's recommendation to deny review is often very quick; decisions to grant review may take much longer. In reviewing a file, the member virtually never listens to the tape recording of the hearing.²⁹¹ Instead, he or she will

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In our observation, members of the Appeals Council were literally snowed under with files: virtually every member's office is jammed with case files, stacked on every available flat surface, and there are huge laundry hampers full of cases awaiting in the corridors. Whenever we would enter a member's office for an interview, a familiar minuet transpired, with the member lifting a stack of files off the couch, to clear a place for us to sit, then looking helplessly around the office for a clear spot to deposit them.

Other observers have noted the overwhelming physical reality of the piles 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 Branch. In DCA, 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."

Report by Process Review and Engineering Branch; Division 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," p. 4 (Apr. 1984).

- 291 Hearings before Social Security ALJs are not routinely transcribed, unless the case goes to court, so the only way to access the record of events before the ALJ is to listen to the tape recording. OHA Handbook, supra note 182, 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 particular occasions where there had been an allegation that the ALJ's tone and manner had created an unfair hearing
(Footnote continued)

review the analyst's report (including any notes the analyst may have taken if the analyst listened to the tape), read the ALJ's decision, and look deeply enough into the rest of the file to satisfy himself or herself that the analyst's recommendation is correct.²⁹²

6. Appeals Council Caseload -- New Court Filings

After a claim has traversed the entire administrative structure, a disappointed claimant may file a civil complaint in a federal district court. The decision of the Appeals Council constitutes a final action by the Secretary of HHS, exhausting administrative remedies and providing the basis upon which a request for judicial intervention may be grounded.

The number of new civil actions varies enormously from year to year, with recent statistics foreshadowing a figure of perhaps 10,000 new cases annually. The HHS Office of the General Council exercises the lead responsibility in preparing an answer or other initial responsive pleading, but the Appeals Council and other components of OHA have major responsibilities, too.

a. Preparing the Answer. When a civil action is initiated, the OAO Division of Civil Actions (DCA) obtains the claims file from the branch which initially handled it.²⁹³ A DCA analyst

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environment.

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

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

292 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, and the analyst will have forgotten details by then.

293 The Division of Civil Actions of OAO is separated into seven geographic branches. Each DCA branch is responsible for all cases in its area that proceed into federal court (except for a few experimental modules in other OAO divisions that are maintaining cognizance over their cases even if they
(Footnote continued)

determines whether the court complaint was timely,²⁹⁴ arranges for transcription of the tape recording of the ALJ hearing,²⁹⁵ and

293 (continued)

proceed from initial review into court.) Recently there have been proposals to move DCA out of OAO, and make it a litigation unit within the Office of the Associate Commissioner.

SSA has experienced a substantial problem of lost or misplaced case folders, 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 there is a failure in the system for storing cases within OHA and tracking their movement from one office to the next. See Process Review Report, supra note 290, passim.

294

If the court complaint is not timely (i.e., it was filed more than 60 days after receipt of the Appeals Council's denial, and no enlargement of time had been requested), the DCA analyst may seek a court dismissal of it. This is accomplished by preparing an affidavit of the Branch Chief, stating that the file reflects untimely filing, and mailing it to the SSA chief counsel for submission to the court. This type of case action is not reviewed by any member of the Appeals Council.

The Appeals Council has the authority to extend the 60-day period for filing a federal district 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 60 days without a member's approval. OHA Handbook, supra note 182, at 5-68-10. If more than one extension is required, or if the original request for extension was not filed within the 60 day period, the analyst passes the case to a member for a decision about extension.

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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 OAO transcribes tapes when there is insufficient time 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
(Footnote continued)

helps assemble a completed file.

If new evidence was submitted after the Appeals Council's first consideration of the case, but before the federal court complaint, the DCA analyst evaluates it, and makes a recommendation as to whether the additional material warrants altering the Appeals Council's original action on the claim.

b. Supplemental Review. If new evidence does not persuade the Appeals Council to change its decision, the case proceeds in court.²⁹⁶ However, the attorney handling the litigation for the government (an HHS regional attorney²⁹⁷ or local U.S. Attorney)

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quality of the tape recordings of ALJ hearings. If the tape is inaudible, no transcript can be prepared, the case can not 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 the attempt to rectify this problem.

A recent study by the Office of Audit of the HHS Inspector General discovered that there had been major problems 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. HHS Office of Inspector General, Office of Audit, "Review of Office of Hearings and Appeals Automated Mass Storage and Retrieval System," (1984).

296 A transcript and answer must be filed within 60 days of the complaint. Only a few years ago, 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. OHA Operational Report, Sept. 30, 1986, p. 18. At the same time, OHA file and tape storage systems were improved. Now, the answer is timely filed approximately 95% of the time.

297 A Regional Chief Counsel is HHS's chief litigator in one 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 percentage. Some regional attorneys are designated as special assistant US Attorneys, and all interact closely with Department of Justice litigation staff.

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may then ask the Appeals Council to conduct a "supplemental review." If the litigator concludes that the case -- even if correctly denied, under existing SSA standards -- may prove indefensible in court,²⁹⁸ he or she may recommend that the agency

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The Office of General Counsel (OGC) of the Department of Health and Human Services -- and especially the segment of OGC that serves as chief counsel to 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.

The pattern of interaction among these four groups of government attorneys (the HHS regional counsel, the SSA chief counsel in Baltimore, the local U.S. attorney, and the Department of Justice in Washington) varies considerably from locale to locale. In some areas, the HHS regional office takes the lead; elsewhere it is the U.S. attorney's office that handles the bulk of the disability litigation.

298 The Social Security Administration used to win the overwhelming majority of its federal court cases (in both 1978 and 1979; SSA was affirmed 87% of the time and reversed only 13% of the time in court.) 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 145, 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 SSA." Liebman and Stewart, supra note 147, at 1960.

SSA officials strongly believe that the agency's credibility in court has been severely damaged in recent years, particularly by the tide of CDR (termination of benefits) litigation. As one official put it, "We just can't win a case in the Second Circuit."

See also remarks by OHA Associate Commissioner Eileen Bradley in SSA videotape "Bradley Speaks" (1987) (saying "We can't be that bad" [as court loss statistics would suggest] and asking why SSA cases are overturned so often).

SSA officials and members of the Appeals Council also assert that many federal district court reversals or remands stem
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take the case back, on a Secretary's motion for remand, for further administrative processing (to pay the claim, to bolster the evidentiary record or to enhance the written rationale for denial.)

Because of the shorter court time deadlines in a supplemental review situation, an expedited procedure is followed: the attorney sends a memorandum to the Appeals Council, outlining the defects in the case, the difficulty in defending it, and the reasons why a remand may be appropriate. The memorandum and case file are routed back to the DCA analyst who studies them and makes an oral presentation to a panel of two Appeals Council members. These two members (usually including one who reviewed the case when it first came to the Appeals Council)³⁰⁰ then decide whether

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from a judge's simple sympathy for the disadvantaged claimant and an expansive -- or abusive -- interpretation of the "substantial evidence" test. They conclude that some judges afford very little deference to SSA findings of fact, and are regularly willing to re-weigh the evidence, effectively second-guessing an ALJ's credibility judgements. Therefore, they conclude, it may be futile to pursue a particular case in court, even if the Appeals Council believes its denial of benefits was proper.

Other observers, however, believe that the courts most often perform an honest and straightforward review of SSA decisions, affirming the majority, and reversing or remanding only when the administrative process has truly made an egregious error.

299 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.

300 In some cases (where the original analyst had recommended denial of review, and a member had agreed), only one member of the Appeals Council has had prior exposure to the case. In others, both a former "A" and "B" member might be available. Assignment of members to supplemental review panels, however, is performed by the same computer selection routine that governs review level work, and no effort is made to increase (or decrease) the probability that the same member or members will again work on the case. The mechanism stresses equitable distribution of the caseload
(Footnote continued)

to seek a remand from the court or to insist on defending it.³⁰¹ A panel review of this sort occurs quite frequently -- perhaps 30-40 times per week. A typical panel meeting might last 15-30 minutes. In 83% of the 1507 cases brought for supplemental review during the past two years, the Appeals Council panel has agreed upon a remand.³⁰²

300(continued)

among members, rather than an attempt at "continuity" (since a substantial period of time may already have elapsed between the review level and the supplemental review of the case).

301 In one sense, a panel's decision, upon supplemental review, 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 around. Often the member primarily responsible for the first decision is also involved in the supplemental review, which provides a closer look at a problem case.

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 significant, the supplemental review in effect adds a new possible 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 is 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 National Center Study, supra note 1, 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.

302 Figures are through August 31, 1986. The supplemental
(Footnote continued)

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

Similar procedures are followed for the analyst's oral presentation. A super panel is quite rare, occurring 69 times in the two years since the procedure was inaugurated.³⁰² On only 10

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review program was initiated in FY 1985. OHA Operational Report, p. 8 (Sept. 30, 1986).

303 SSA regional attorneys vary widely in their use of protests to Appeals Council panels and super panels, some being more sanguine about defending a flawed case in court.

The regional attorneys also vary widely in the vigor with which they assert the SSA position in a marginal disability case. Sometimes a regional attorney will not even file a brief, an omission which irritates members of the Appeals Council who feel that their position has been undercut.

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 SSA is at fault for failing to appreciate the difficulty -- and the growing professional responsibility considerations -- in pursuing an unjustified case. Weinstein, supra note 82, at 926.

304 Prior to the institution of the super panel procedures, a regional attorney who was 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.)

There is some sentiment for returning to that system, based on the judgement that super panels consume a substantial amount of members' and analysts' time, especially since the Deputy Chair (who sits on all super panels and also appoints one of the other members) is likely to have the last word on remand anyway.

of these occasions has the Appeals Council resisted the regional attorney's urging for a remand.³⁰⁵

7. Appeals Council Caseload -- Court Decisions

Once the decision has been made to defend a case in court, the Appeals Council may participate in its evolution in yet other ways.

At the outset, however, what is most noteworthy is the relative degree of uninvolvedness by the Appeals Council at this stage -- there is no system for regular monitoring of a disability case as it progresses through the judicial system. That is, whether the court ultimately affirms or reverses the SSA position, the Appeals Council is not directly notified, and members may learn of the court outcome only haphazardly, if at all. Even if a case is remanded from the court to the Appeals Council, there is little direct feedback to the particular member or members who worked the case initially.³⁰⁶

305 Under the 1980 amendments, the Secretary must show "good cause" to support a remand order. A claimant's attorney might resist a Secretary's motion for remand, concluding that an outright court reversal of SSA is appropriate on the present record and that the additional administrative processing would be used by SSA only to bolster (not to pay) 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) (Secretary's motion for remand denied, where good cause was not shown and it appeared government was seeking remand merely to delay the case.)

306 In part, this failure to follow the court disposition of a particular case is simply a function of the numbers: since an Appeals Council member deals with so many cases, he or she retains little special interest or curiosity about those that might be resolved, months or years later, in court. In part, too, it is due to a sentiment among members that often little could be learned from studious attention to 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.

In a similar fashion, ALJs are not routinely advised about the subsequent fate of cases they decide. If the Appeals Council or federal judge reverses an ALJ's decision without remanding it, there is no feedback mechanism that serves the function of education of the ALJ.

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a. Court Remands. The Appeals Council as an organization may play a major role in a case remanded by a federal court with instructions to conduct a new hearing, compile new evidence, etc. If the court's directive is sufficiently clear, requiring no elaboration by the Appeals Council, a "fast track" procedure is utilized, routing the file directly to the appropriate local hearing office for an ALJ to carry out the court's orders. If the Appeals Council determines that some interpretation or additional guidance is required, the Appeals Council supplies that exposition before transmitting the case to an ALJ.³⁰⁷

306 (continued)

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

307 There is some controversy over the reliance upon "fast track" remands. It is undoubtedly quicker for an OAO analyst to forward a court order down to the ALJ directly, without occupying the time and attention of an Appeals Council member. But many people feel that analysts are not always able to discern which cases require additional commentary or instruction from the Appeals Council before release to the ALJ. Some members prefer to see all remand orders, even if they turn out to be relatively straightforward, not requiring any elaboration beyond the "short form" that an analyst would use on his or her own.

Where the Appeals Council does elaborate on the court's order, it most 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 might also, at this point, seek an appeal, a reargument, or a clarification of the court's remand order, but these are quite rare.

The historical record reveals wide variation on whether court remands are likely to be processed by the Appeals Council only, or be referred to ALJs, too. For example, in FY 1965, 13.2% of the court remands were retained by the Appeals Council and never further remanded to the 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%. Department of Health, Education, and
(Footnote continued)

In a court remand situation, regulations do not permit an ALJ to issue a final decision as would be done in the usual circumstance. Instead, the ALJ prepares a "recommended decision," which is forwarded to the Appeals Council. A copy is also provided to the claimant, who is afforded an opportunity to respond before the Appeals Council considers it. The Appeals Council may then adopt or modify the recommended decision (or, rarely, re-remand it for further work by the ALJ), and the final decision is sent out over the signature of two members. 308

The standard of review followed by the Appeals Council in court-remanded cases is not the "substantial evidence" test used in analyzing ordinary ALJ decisions; instead, since the Appeals Council exercises more responsibility in this type of situation, it relies on something more akin to a "preponderance of the evidence" test in determining what to do with the case. 309 For similar reasons, 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.

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Welfare, Briefing Pamphlet for the Bureau of Hearings and Appeals, June 30, 1971, p. 24.

308 20 C.F.R. §§404.977, 416.1477 (1986).

SSA is interested in expediting this process, and has issued a proposed rule, 52 Fed. Reg. 38466 (Oct. 16, 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, then, the case would be subject to request-for-review or own-motion review as are other ALJ decisions.

309 An ALJ decision in an ordinary case becomes "final" if nothing is done to review it. In a court remand situation, 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. In rare cases, even a third remand may be required, although internal procedures require the approval of the Director of OAO before an analyst could recommend a third remand, and the approval of the Deputy Chair before a member could order one.

b. Court Appeals. The Appeals Council is also occasionally involved in SSA actions subsequent to a court decision, and may be consulted about the desirability of appealing an adverse decision, seeking clarification of its terms, etc. These litigation policy decisions, of course, involve many other components of SSA, as well as litigators from the Departments of HHS and Justice.

8. Other Appeals Council Functions

In addition to reviewing disability cases, the Appeals Council performs a variety of other functions. These include hearing a small but non-trivial number of non-disability cases (e.g., survivor's claims, where the relationship is contested; Medicare services providers' claims, etc.)³¹⁰

In addition, although the vast bulk of Appeals Council decisions are fact-based, not interpretive or policymaking, the Appeals Council also participates in the formulation of SSA policy in several ways.³¹¹ One is through the process of highlighting decisions that might usefully be converted into Social Security Rulings, and referring those matters to the Office of Regulations, which prepares SSRs.³¹² Another policymaking step is in deciding the rare case that truly does break new ground in construing Social Security law in new circumstances.³¹³

310 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 Administrative L. J. No. 1, p. 1 (1987).

311 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 Horsky, supra note 185, at 300b.

312 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 focus for ALJs and members to identify recurrent problems in implementing SSA policies and practices, some of which may be corrected via 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.

A third policy-related role is the occasional tasking of the Appeals Council to study the impact of proposed new disability standards. For example, when the regulations for the new mental impairments listings were being evaluated for additional cost assessments by the Office of Management and Budget, the Appeals Council was asked to undertake a substantial examination of the likelihood that large numbers of cases would be decided differently under the new standards.³¹⁴ Individual Appeals Council members have also participated in SSA task forces mandated to review and recommend changes in major SSA policies such as "severity" or medical improvements, and they have also served OHA committees studying internal reorganization possibilities.³¹⁵

In addition, informal "policy" is made whenever members meet with each other, consult about shared problems, and derive a mutually-acceptable solution that might be applied in future cases, even if it does not "govern" the subsequent decisions in a strict sense. The full Appeals Council holds monthly meetings, at which precedential matters of this sort might be addressed, and

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- 313 One example of a set of cases in which 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, 416.1470 (1986), arose in SSI disability cases a few years ago. 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.
- 314 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, 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 1.

- 315 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 run of cases, by identifying recurrent issues or problems.

the regional groups of members confer much more frequently.³¹⁶

The Appeals Council used to play a somewhat larger role in making policy. Regular en banc Appeals Council meetings used to discuss substantive policy matters much more frequently, and the Appeals Council would vote, and record its agreement in short "minutes," which were then disseminated as guidance within OHA. These minutes were not binding on other components of SSA, but they served to advertise within the adjudicatory process how the Appeals Council was going to handle a particular question and, therefore, suggested what DDSs and ALJs should do in order to have their decisions affirmed.³¹⁷

Finally, members of the Appeals Council are also occasionally called upon to perform various administrative, training, and public relations services.³¹⁸

9. Costs of Appeals Council

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

The best fiscal information available for FY 1987 costs associated with the existence and operation of the Appeals Council is:³¹⁹

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- 316 Members may place substantive items of this sort on the agenda for an Appeals Council meeting, but this has occurred relatively infrequently. Informal consultation -- among members of a geographic grouping, between the "A" and "B" members on a case, or among others -- occurs on a daily basis.
- 317 The OHA Law Reporter, the Office of Hearings and Appeals' quarterly summary of selected actions by ALJs, the Appeals Council, and other bodies relevant to SSA, still contains an entry for Appeals Council minutes in its table of contents, but it is an entry that has had nothing to report for several successive quarters.
- 318 For example, members have served as instructors in the training courses for new ALJs, in legal education, and in bar association seminars.
- 319 Data provided in letter to authors from Appeals Council member William Taylor, July 15, 1987 (based on actual figures through May 1987, and estimates for entire year).

OA0 Salaries and Benefits	\$26,570,742
Other OA0 costs	<u>1,946,384</u>
OA0 Subtotal	<u>28,517,126</u>
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 OA0 and Appeals Council	\$31,670,358

III. Current and Potential Goals of the Appeals Council

Any evaluation of the success of an institution such as the Appeals Council, and any determination of its proper role within the bureaucracy, must begin with an articulation of organizational goals -- a statement of what it is that the Appeals Council is, or ought to be, trying to accomplish.

Goal identification for a subunit of a complex department is not easy -- many conflicting pressures vie for attention. Nonetheless, we have identified a spectrum of six related (indeed, partially conflicting) functions that the Appeals Council does, might or ought to pursue in some measure: (A) policy development; (B) improvement of factual accuracy in handling cases; (C) assurance of program integrity; (D) addition of consistency in decisionmaking; (E) improvement of system-wide efficiency; and (F) fostering of greater public acceptability of the program. The following sections analyze the Appeals Council's record in pursuing these objectives, laying the basis for our subsequent evaluations and recommendations.

A. Policy Development

A major -- indeed the primary -- function of most administrative review bodies is to participate in, or even lead, the process of developing, articulating and implementing agency policy.³²⁰ Whether this appellate authority resides in the head of the agency or in some lesser body, the traditional scheme of administrative law generally locates responsibility for generating policy at the top of the appellate pyramid.³²¹

This policy function may be executed in many ways: by precedential case adjudication, by generating prospective rules, or by a mixture of methods.³²² What is important to the

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- 320 5 U.S.C. §557(b) (Supp. III, 1985) ("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 ACUS Recommendation 68-6, Delegation of Final Decisional Authority Subject to Discretionary Review by the Agency, 305.68-6 (1968).
- 321 "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." 1983 ACUS Rep., supra note 2, at 122.
- 322 In the traditional model, the hearing level is dedicated to the resolution of factual questions: taking evidence and
(Footnote continued)

traditional structure of the typical government agency, however, is a self-conscious appellate authority, which deliberately attempts to look past the run of case-by-case determinations and extrapolate into more generally-applicable policy.³²³

In the Social Security Administration, however, this traditional model has been largely abandoned. Members of the Appeals Council unanimously report that their function is now almost exclusively case-handling, not policymaking. They define their role as reviewers of the work of the ALJs, processing an incessant run of individual cases with little or no time, inclination or opportunity to participate in broader policymaking. 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 emphasis upon the broader perspective.³²⁴

SSA leadership officials, too, agree that the current operation of the Appeals Council has come to resemble a factory assembly line: members' current daily fare is to process the cases individually, without much participation in the policy function.

As noted, this picture is not entirely uniform: members have occasionally identified areas appropriate for future rulemaking, and individual members have from time to time been detailed to participate in agency-wide policy-review bodies. But the Appeals Council as such has largely forfeited its former role (even then, a limited one) in the creation of SSA policy.

322 (continued)

applying existing legal categories to each succeeding set of circumstances. Of course, this, too, is to some extent a "policy" role -- 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.

323 See 1 Koch, supra note 2, §§6.73 & 9.3.

324 Mashaw, supra note 1, at 105 ("[T]he AC is not the principal policy arm of the secretary or the commissioner with respect to the [RSDHI] program."); Statement of Burton Berkley, Deputy Chair of the Appeals Council, Cleveland Transcript, supra note 1, at 271 ("We [the Appeals Council] are not a policymaking body. We adjudicate cases that come along but we adjudicate them in accordance with published policy.")

Why has this transformation occurred? Why doesn't the Appeals Council -- the only entity within SSA that regularly assays a large run of cases as they leave the administrative process and again as they flow back from courts -- use its special perspective to make a greater contribution to agency policy? Three reasons seem apparent.

First and foremost is the crush of the cases. The Appeals Council has, over the past several years, 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 30 cases each day, with the certain knowledge that a failure to dispatch them means that 60 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, as it has been for close to a decade, it is not surprising that all its institutional resources will be bent to that purpose, and all other possible functions will atrophy.

In addition to the tyranny of its caseload, the Appeals Council's policy function has been degraded further by a second factor: the evolution by SSA of a substantial³²⁵ alternative mechanism for creating policy via rulemaking.

SSA has developed a complex, multi-faceted capability for making policy pronouncements. Formal regulations, promulgated through the Federal Register notice-and-comment procedures of the APA; less weighty interpretive standards of Social Security Rulings; and numerous less formal internal policy statements, circulars and manuals all testify to SSA's³²⁶ ability to make policy without substantial Appeals Council input. These various

325 Rulemaking and adjudication are partially complementary, but partially competing, methods of enunciating agency policy. The Attorney General's Manual on the Administrative Procedure Act (1947), intended to give advice to the 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 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 valuation of respondent's past conduct. . . ." Id. at 14-15.

mechanisms are not perfect -- many, in fact, are ponderously slow, incomplete or inconsistent -- but they evidence the fact that SSA has not waited for the Appeals Council. 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, geography, which has contributed to the decline of the Appeals Council's policy role. Located in Arlington, Virginia, deliberately separated from the Baltimore headquarters of SSA and from the Washington, DC, headquarters of HHS, the Appeals Council has been largely

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- 326 The balance among regulations, SSRs, and the less visible policy devices is a difficult one to strike. On the one hand, considerations of speed, ease, and flexibility will incline an agency toward the less ponderous devices -- and SSA has a particularly tough time producing formal regulations with any dispatch. 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 -- and SSA has a special responsibility for avoiding the creation of "secret law."

We note that Congress has pressed SSA to publish more, to rely less upon internal policy pronouncements that are not generally available to the public, Pub. L. No. 98-460, §10; and we also observe that the agency seems to be retreating somewhat from reliance upon SSRs. It is, however, beyond the scope of this work to attempt to delineate a proper dividing line between the various policy tools.

- 327 "In reviewing adjudications or in adjudicating matters himself, the agency head necessarily is sensitive to the political considerations that informed the policy decisionmaking. 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 Rep., supra note 2, at 122. See also Freedman Rep., 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).

insulated from partisan interference in individual cases. This physical removal, however, has also made it more difficult for commentary to flow in the other direction.³²⁸ 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.

In short, the Appeals Council has been almost entirely cut out of the action in SSA policymaking. This was largely not a deliberate ploy of power politics -- indeed, our conversations with SSA officials revealed that they want and need a greater policy input from the Appeals Council, and that they have been disappointed at not hearing more from that source. Rather, the image emerges of a conduit between the Appeals Council and the Baltimore headquarters -- a channel for important input into agency policy -- that has become clogged due to the magnitude of the Appeals Council's case responsibilities, and that has subsequently fallen into disuse. Appeals Council members were generally surprised to learn from us that the SSA officials would welcome their input on policy, and the policymakers, conversely, were surprised that the Appeals Council was not attempting to assert a bigger role. Until the Appeals Council caseload can be thinned out appreciably, however, there is little hope for reactivation of a policy link between Arlington and Baltimore.

Independence vs. accountability. An important ramification of the recent evolution of the Appeals Council into exclusively a case-handling role is the question of members' 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.

The rationale for this structure is the concept that the Appeals Council acts as the "head of the agency," performing a review function in the Secretary's stead, to carry out -- not to be isolated from -- policy decisions. Indeed, in many other agencies this model (policy review by non-APA-protected officials

328 In addition to its physical removal, OHA has been bureaucratically aloof from the rest of 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 OHA, distance is maintained. The Appeals Council is not located within the same building as the Associate Commissioner or the Chief ALJ.

after neutral fact-finding by independent ALJs) seems to make sense.³²⁹

In the context of SSA, however, this legal fiction now seems to obfuscate more than it assists. In fact, the Appeals Council is not the alter ego of the Secretary: the Appeals Council never meets with the Secretary, the Commissioner or even the Deputy Commissioner, and those officials have little awareness of the Appeals Council's daily work. The Appeals Council does not carry out the will of political appointees: members have indignantly stressed that they would resent any attempt to influence their decisions in particular cases or en masse. The Appeals Council does not see its role as dismissing an ALJ's fact-finding in order to advance a partisan choice: the members instead feel they are bound by precisely the same legal standards and policies that ALJs are supposed to be following.

Moreover, Appeals Council members today enjoy de facto protection. They are no more and no less "accountable" than ALJs; no more or less prone to ignore lawful direction; no more or less subject, in any operational sense, to agency discipline.³³⁰ The selection process and the qualifications for membership, similarly, are much more like those of ALJs than they are like 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 to review cases, then the relationship between ALJ and

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

330 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.

Appeals Council seems to parallel that between federal district courts and circuit courts, and equivalent job protection and status for both tiers seem compelling. Why insist on the maintenance of de facto independence but resist making it de jure?

If, on the other hand, the function of the Appeals Council is more policy-oriented, more akin to those of the SSA leadership, then why should members not discard their current (misleading) partial trappings of independence and become frankly political?

To a large extent, this question, too, boils down to the issue of caseload: if the Appeals Council is so burdened by individual files that it does little else besides review ALJ decisions, then it seems futile to pretend that the Appeals Council is performing a "Secretarial" function requiring direct accountability. Whether that model of administrative structure is sensible in other agencies, where the smaller number (and greater importance) of the cases makes Secretarial intervention possible, it is simply not an accurate portrait of today's SSA.

B. Factual Accuracy in Case Handling

If the Appeals Council has today largely ceded to others within the SSA bureaucracy any major role in agency policy formulation, the next leading goal, or potential goal, of an appellate review body would concern factual accuracy -- the attempt to ensure correct administrative action on individual claims. This is, in fact, what members of the Appeals Council say they now do: review individual cases seriatim, to catch errors made by ALJs.

1. Identifying and Measuring Accuracy

At the outset, it must be stressed that "accuracy" in a disability case is execrably difficult to define, let alone measure, pursue or achieve. No one we spoke with was able to begin the articulation of a workable definition of accuracy, and previous³¹ studies of and by SSA have similarly foundered upon this point. The inability to derive an objective definition of accuracy has often resulted in conflating this goal with other (only slightly less subjective) program goals such as "uniformity" or "consistency," which we elaborate below.

Why is it so difficult to define and measure accuracy? The

331 National Center Study, supra note 1, at xx ("Investigation of the accuracy of the BHA hearing process...leads very quickly to the realization that there is no accepted external standard for evaluating accuracy."); Cass, supra note 2, at 15; Cofer, supra note 1, at 86.

crux of the problem lies in the complexity, subtlety and subjectivity of the underlying variable itself: disability.³³² The human organism is marvelously complex; the impairments which can affect it are diverse and protean. Disability, moreover, is not exclusively a medical concept -- at core, in fact, it is a vocational measurement which inherently 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 of the cases: one ALJ has estimated that there are some 3000 variables at play in making disability adjudications, and they may interact in a nearly infinite variety of combinations. To objectify the correct melding of all these factors would be an unmanageable burden.

Even if it were possible, excessive reliance upon rigid rules would be undesirable for institutions of broad remedial purposes such as the disability programs.³³³ Even those relatively pronounced categorizing rules already in the system are not slavishly applied: the Listings of Impairments may be "equaled," rather than precisely "met," acknowledging the variability of individual circumstances; even the "age" category of the grids (which would appear at first blush to be the least susceptible to manipulation)³³⁴ is not to be applied "mechanically in a borderline situation."

This does not necessarily mean that accuracy is an empty term: the statutory definition of disability must be honored, and SSA regulations attempt, as far as possible, to translate it into operational terms. It does mean, however, that accuracy is to a

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- 332 As noted, the Appeals Council handles a variety of other types of cases, but disability appeals constitute 95% of the burden. Significantly, the other types of cases (where age, survivorship, etc. are in issue) pose far fewer concerns over the concept of accuracy.
- 333 Davis, *supra* note 1, at 19 ("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.")
- 334 20 C.F.R. §§404.1563, 416.963 (1986). In fact, however, 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.

large extent in the eye of the beholder, and that the adjudicatory system is based, as it must be, on the idea that only subjective human judgment can integrate all the variables so as to give the closest approximation of decisional accuracy.

2. Some False Measures of Accuracy

The absence of a simple operational definition of disability and an accompanying irrefutable standard of accuracy has led to experimentation with other substitute standards of accuracy, each of which we find seriously deficient.

a. The Last Word. The most commonly used de facto 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 the determinations of ALJs; the various tiers of "quality assurance" review within SSA give report cards to the units they monitor; and federal court reversals are often taken as a measure of erroneous determinations by the administrative bureaucracy. While we believe these cross-unit variations are significant, we do not consider them to be per se statements about accuracy, for a variety of reasons.

First, the underlying case at issue evolves constantly throughout the review ladder. Under existing SSA procedures, it is relatively easy to add new evidence to the file as the case progresses from DDS to ALJ to Appeals Council and even to federal court. The subsequent authorities may not, therefore, truly be second-guessing the earlier adjudicators; it may be quite a different case that is marshalled at each step.

Second, the review process at the several stages is asymmetric. DDS work, for example, is typically an assessment of papers only; ALJs see the claimants face to face, and can judge credibility directly; the Appeals Council has access to the tape recording of the hearing, but precious little time to do anything other than a paper review. That these tiers will come to different decisions in many cases is not surprising; to call one of them "more accurate" merely because it is chronologically last is problematic.

In addition, the various layers of review differ in the substantive standards they apply. The ALJ hearing is explicitly de novo, 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; in fact, those being reviewed contend that it is often a substitution of judgment or personal preferences. That is, the Appeals Council members feel that federal court reversals are sometimes based upon sheer sympathy for the claimant, not upon a dispassionate analysis of substantial evidence to support the

earlier decision. Ironically, ALJs often feel the same way about the Appeals Council -- that its reversals often derive from different opinions on the merits, not from a true "substantial evidence" assessment.

Finally, the reviewers' perspective about accuracy is bound to be affected by the run of cases reviewed. Federal courts, for example, see a highly skewed selection: only denials (or terminations) are brought to court, and then only when the claimant and a representative can assemble a colorable case. Each federal judge, moreover, sees only a small number of cases per year, not the vast outpouring of SSA work.

Federal judges never come into contact with any of the hundreds of thousands of cases paid by the SSA bureaucracy each year. Nor do they see the general competence, sensitivity and generosity with which those cases are usually handled. Rather, they see only those cases, from the two million or so presented each year, in which some valid argument can be made that the system has failed. The court's perspective thus naturally inclines toward that of the champion of the downtrodden faced by a callous bureaucracy. They do 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% are made on reconsideration; 12% at the ALJ stage and .2% by the Appeals Council. Courts, for all their time and attention, account for only .4% of all awards.³³⁵

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 SSA as part of the Bellmon amendment.³³⁶ For this study, 3600 randomly selected ALJ decisions (both awards and denials) were presented for review by three groups: other ALJs, Appeals Council members, and quality control monitors for SSA's Office of Assessment. After studying the files, the Appeals Council group reported that it agreed with only 63% of the original ALJ awards. However, the Appeals Council also disagreed with 21% of the ALJ denials. Even wider disparities were reported among the ALJ and Office of Assessment groups, suggesting a conclusion that "accuracy" in decisionmaking, even when review is confined within relatively standardized limits, remains highly subjective.

335 But see Heaney, supra note 83, at 15 ("The Court of Appeals for the Eighth Circuit is fully aware of the large volume of cases that are reviewed by the Secretary, and can appreciate the administrative problems that may arise as a result of processing so many cases. Nevertheless....")

336 Bellmon Rep., supra note 1, passim.

b. **The 50% Solution.** If there is no clearly "superior" level of decisionmaker, no ultimate arbiter of accuracy, what should one expect from SSA appeals? Some outside observers, as well as some participants within SSA, seem to be drawn to a focus upon crude statistics, as if the reversal rates of the various tiers of administrative and court review could, by themselves, demonstrate the accuracy, and the value, of a particular adjudication.

Thus, some opine that the 17% allowance rate at reconsideration, and the 5% allowance rate at the Appeals Council are, *per se* "too low"; while others argue that the approximately 50% award rates at the ALJ and federal court stages are, on their face, "too high."

We reject this focus upon the raw data as a valid index of the propriety of adjudication. We do not purport to know what the "correct" award rate ought to be at any particular tier or for the disability system as a whole, and we distrust axiomatic assertions translating award statistics into statements about accuracy, institutional vigor, or the like.

The most careful empirical studies of the statistical outcomes of litigation seem to support our skepticism. Priest and others who have studied general civil litigation have concluded that controversies going to court tend to result, over a large run of cases, in a roughly even split in results between plaintiffs and defendants. The reasons for this 50% phenomenon are multiple, but they center upon the litigants (and their attorneys) symmetrically assessing the costs and benefits of litigation, as revealed through evolving precedent.³³⁷

If the Priest observations were applicable to SSA, then it would be easier to establish statistical benchmarks for appellate reviewers. That is, if litigants chose to appeal only the close, marginal cases to a subsequent level, then a 50% reversal rate at each stage would not be surprising and would not, by itself, be indicative of gross error. As the easy cases are weeded out of the system (by paying those obviously disabled and by convincing obvious ineligible of the futility of further pursuit of the claim) the system would continuously pass up for appellate scrutiny only those cases that are sufficiently close to the dividing line that reasonable adjudication could go either way.³³⁸

337 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).

In fact, however, our observation of the tiers of review in this context suggests the inapplicability of the Priest formula to SSA disability adjudications. There is simply no reason to be confident that, as the SSA operation is currently structured, it is the particularly close cases that work their way up the appellate hierarchy.

The "open record" aspect of disability cases, already discussed above, is one cause of this -- a case may progressively improve with age, as new data are provided to the adjudicators. Second, the factor of litigation costs, vital to Priest's study of courts, is distorted in this administrative setting. Filing an initial application for disability benefits requires some effort by the claimant, as well as perhaps some badgering of doctors and hospitals to produce copies of needed medical records. Requesting reconsideration, on the other hand, is virtually free in most cases -- just signing an SSA form. The ALJ stage is probably the most costly for the claimant, involving both time and psychic energy to prepare for a hearing, and usually the services of an attorney.³³⁹ The next step, presentation to the Appeals Council, may require a small amount of time from the representative, and nothing from the claimant. Finally, filing in federal court is more difficult for the claimant, and can require a substantial court fee, but the principal hurdle against a civil action is simply the difficulty in finding an attorney who will take the case *pro bono* or for a contingency fee -- the amount of money or effort the client must devote to discovery, preparation or trial is far less than in most litigation.

Finally, SSA cases are distinct from most court fare studied by Priest in that the agency has so little ability to compromise or settle. Indeed, SSA has virtually no authority for negotiation, and must basically choose to defend its denial of benefits (even if the case against payment of the claim is

338 Mashaw, *supra* note 1, at 206, ("The Nagi study [S. Nagi, Disability and Rehabilitation (1970)] also casts light on the problem of "close" cases. . . . [T]hey discovered that the cases they had consigned to the middle categories turned up with equal frequency in awards and denials. This finding tends to confirm the conventional wisdom in the Social Security system that there is an irreducible category of marginal claims that will never be consistently decided.")

339 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.

imperfect) or abandon its position altogether (even if the claimant ought not to be paid under existing standards.) The stark limitation upon compromise is another factor militating against the operation of the 50% solution.

In short, we are aware of no a priori reason to expect that a 50% award rate -- or any other arbitrarily-chosen figure -- would be "correct" for SSA disability adjudications. The formulae that might suggest such an outcome elsewhere are simply 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 True Costs of Inaccurate Decisions

Even if inaccuracy is difficult to define and measure, we know that it exists. Indeed, we know that its occurrence is inevitable in a system as large as SSA: even if each tier of review were able to avoid substantial error in 90% of its cases, there would still be hundreds or thousands of appeals, many of which would present very bad errors indeed. The gross numbers alone suggest the importance of trying to identify the categories of decisional errors and to locate those who bear the costs.

In a binary categorization system, where claimants are pigeon-holed as "disabled" or "not disabled," there are two possible kinds of errors. Type I errors, false negatives, occur when an eligible individual is improperly denied benefits. Type II errors, false positives, arise when a truly ineligible claimant is wrongly adjudicated as disabled, and benefits are paid. Both types of errors are to be avoided (although, as noted below, the costs of the two types, and the costs of avoiding each, may be asymmetric) but, in disability adjudications as in most similar situations, measures that tend to minimize one type of error will often have the unfortunate side effect of increasing the incidence of the opposite type of error.

Also relevant to the assessment of accuracy is the question of processing costs. As elaborated below, the administrative costs of SSA are substantial, and the overhead costs associated with the disability program are far more expensive than those allocated to 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 60 times the cost of adjudicating eligibility,³⁴⁰ suggesting that increases in accuracy are likely to be justifiable on cost effectiveness grounds.

340 Mashaw, supra note 1, at 81-82.

a. Costs of False Denials. There are both individual and social costs from failure to provide disability benefits to those who are so incapacitated (as defined by the statute and SSA regulations) that they are lawfully entitled to federal support.

The first such cost is the failure to support those who no longer retain the capacity to support themselves through remunerative activity. Although some of these claimants may have other resources, or other social welfare programs to fall back on, for many disabled people the federal benefits provide the primary means for avoiding abject poverty and the deprivation, discomfort and disease that accompany it.

A second cost of false denials is the psychic dissatisfaction among the truly needy and deserving. These people will know that the system has failed them in a time of greatest need. Moreover, a number of these claimants are seeking RSDHI benefits that they "bought" through compulsory SSA insurance. In essence they are being cheated out of benefits they paid for over a long run of years.

Thirdly, false denials undercut the disability program as an expression of the generosity and good will of the American people. If the system as a whole is inaccurate and unreliable, then the beneficent social purposes of the legislation will be denied, cheapening our self-image as a caring community.

Finally, false denials also hurt the productive members of society, by generating insecurity about their own possible fate, should disability strike them, too. Skepticism about the accuracy of such an important social institution as SSA will inevitably create widespread dissatisfaction.

b. Costs of False Awards. The most obvious cost of an incorrect determination of eligibility is the removal from the work force of a potentially productive worker, and the consequent reduction of tax revenues and GNP. The magnitude of the productivity loss is hard to calculate: particularly for an "almost disabled" worker, and especially in any periods of less than full employment nationwide, the claimant's foregone contribution to the economy may be small.³⁴¹

341 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, however, and a few studies, 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
(Footnote continued)

Removal of a productive person from the work force also tends to impose hidden, insidious costs upon the recipient of the unwarranted disability benefits. It serves to entrench the person in a disability lifestyle, underscoring a self-image of powerlessness that can degenerate into a life of despondence, immobility and pity that is far less rewarding than maintenance of even marginal employment would be.

False positives also create public dissatisfaction. This tends to bring all of SSA -- indeed, all forms of public social support -- into disrepute, undercutting public sympathy for programs of assistance to the truly needy.

Finally, false positives also impose direct costs upon the intended beneficiaries of the system. In a very real sense, 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 in which it is -- and is likely to remain -- difficult to increase the total funding for disability programs, a false award imposes an "opportunity cost" of foregone options to pursue other social goals.

In addition, it should be noted that the costs of errors -- both Type I and Type II -- are long-term rather than transitory. That is, once an error is made by the system, it is difficult to remedy. For example, false awards, putting an undeserving claimant on the benefit rolls, may generally be corrected only via a termination action. The experience of the early 1980s, with massive terminations, demonstrated how traumatic that process can be. The revised rules regarding "continuing disability reviews" have accordingly been greatly tempered in response to that experience, and some observers conclude that the new definition of "medical improvement" will make it difficult to remove people from the rolls. Thus, an award of benefits, correct or incorrect, tends to be an action with lifetime consequences.

On the other hand, an erroneous denial is difficult to reverse, too. Even though an improperly denied claimant could simply file a new application, those who "try, try again" may not

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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); Linden, "Delays in Processing Benefits to Disability Claimants," 21 Clearinghouse Rev. No. 4, p. 357, 365 (Aug.-Sept. 1987).

be taken quite as seriously. Moreover, unless an adjudicator ruling favorably on the subsequent application takes the unusual action of reopening and revising the earlier denial, there will remain a time period for which benefits are never paid, and in the interim, financial eligibility for RSDHI may expire. To that extent, at least, a false denial carries permanent costs.

4. An Approximation of Accuracy

The difficulty of defining and measuring accuracy with any degree of reliability inclines us toward offering a "second-best" solution, that of skewing the likely errors in a relatively tolerable way.

By "second-best," we do not mean an approximation or compromise with the ideal or perfection. Instead, having concluded that the optimum or "first-best" outcome (perfect accuracy) is unattainable, and that efforts to pursue it directly will result in far worse system performance, we suggest a more modest alternative. Our "second-best" is therefore a restricted optimum, under the constraint that the true optimum is unattainable, as³⁴² seems to be true in making disability determinations.

We suggest, therefore, two principles: (a) that the SSA adjudicatory system ought to be less concerned with making accurate ultimate decisions in close cases, and more concerned with making accurate decisions early in the process in easy cases; and (b) that the SSA adjudicatory system ought to be more concerned with correcting (or anticipating) false denials than false awards.

a. Focus on Big Errors, Not Small. The first principle, less focus on the marginal cases, springs from the conclusion that it is in these cases that "accuracy" is most elusive and that the costs of error are smallest. In a case close to the dividing line between "disabled" and "not disabled," the most subjectivity is likely to be present and the greatest variability among adjudicators is likely to be shown.

Evidence suggests that the higher levels of the claims review process do not so much "correct errors" of the lower levels but simply "substitute judgment" where they disagree with prior

342 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 since been borrowed frequently for application in the analysis of a variety of public policy problems. Dictionary of Economics 368 (1972).

resolution of doubtful cases. Successive review, therefore, does not necessarily produce more accuracy; it may produce a series of disagreements, from different quarters, as to whether the case is marginally on this side or marginally on that side of an important, but largely unverifiable, dividing line.

Moreover, these close cases are not only the most difficult, they are the least important. A false award of benefits to someone who is almost impaired enough to be eligible is an inexpensive error: the costs of the mistake (foregone productivity, social unhappiness at being cheated, etc.) are likely to be minimized when the claimant's greatest possible contribution to the work force would be low in any event. Similarly, a false denial in a close case (the person is only barely eligible, and almost capable of performing substantial gainful activity) is less expensive than a false denial in an extreme case (where the wrongful withholding of benefits leads to economic deprivation of the individual and to greater distress on the part of society.)

Even though errors in close cases are less socially expensive, they are no less time-consuming for SSA and the claimant. All error cases progress through the same step-by-step administrative hierarchy of the appellate ladder, with blatant errors receiving no expedited treatment. A great deal could be accomplished, all observers agree, if accurate decisions, particularly accurate awards, could be made earlier in the process. This would reduce the claimant's delay in receiving payment and also scale back the volume of traffic presented for subsequent review.

We conclude, therefore, that an element in a second-best solution to the problem of accuracy should be greater emphasis upon the early adjudication, especially where awards can be granted, even at the expense of finely-honed review at later stages. Although this later review may effectively change the outcomes in many cases, it has less of a true claim to "accuracy" -- close cases do not benefit much by such multiple observation.

Thus, reform of the disability adjudication system ought to attempt to deal with the problem of inaccuracy by pre-empting errors at the earliest source, trying to ensure that DDSs make more accurate decisions, so fewer errors -- or at least fewer egregious errors -- are passed along to ALJs, the Appeals Council, and the federal courts.

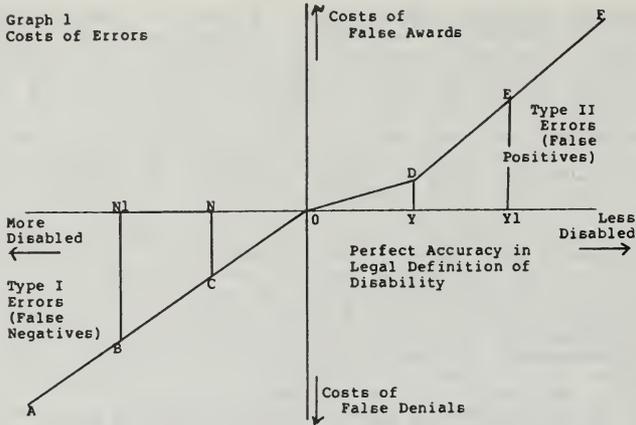
Enhancing the work of DDSs, and improving the record of early accuracy, will require devoting additional resources to the initial stages of the case evaluation ladder. As elaborated below, we recommend that the Appeals Council be a leader in this effort, taking as its central mission the emendation of the system's ability to make more timely, more accurate, decisions.

b. Focus on Denials, Not Awards. A similar analysis leads us to suggest that erroneous denials in close cases are more problematic than erroneous awards. We note above that errors of both types (false awards as well as false denials) are costly, and that the pricetag of either type of deviation is difficult to quantify. Nevertheless, our observation of the operation of the disability programs, and our sense of the various social and individual costs, convince us that the burdens of mistakes are not symmetric, and that the system ought therefore to "tilt" toward closer inspection of marginal denials rather than marginal awards.

Given the strictness of the statutory standard of disability, individuals who are even close to the eligibility criteria may have little to contribute to the economy and (absent effective rehabilitation) little prospect of future enhancement. Their withdrawal from the labor force is least likely to occasion protest from colleagues who might feel "taken advantage of" by an undeserving freeloader. Moreover, the primary financial cost of erroneous denial falls upon an individual who is least able to bear the burden, while the primary financial cost of an erroneous award is felt by an insurance program which is created precisely to pool risks and spread them over all participants in the plan.

Graph 1 therefore illustrates our second-best solution to decisional accuracy and the preferred allocation of error costs. In it, the 0 point along the axis represents perfect decisional accuracy; to the left are false denials and to the right are false awards. The total social cost of errors is given by the area between the curve (A-F) and the axis.³⁴³

343 Our chart is an adaptation of that presented in Mashaw, supra note 1, at 83. Mashaw, however, wrote that "My reading of the history of the disability program, analysis of its procedural and evidentiary rules, and observations of its operations reveal no strong reasons to believe that either type of error should be viewed as systematically more costly than the other." Id at 85. In his chart, therefore, the cost curve (A-F) is a straight line, without a kink to the right of the 0 point. See also Mashaw, "How Much of What Quality? A Comment on Conscientious Procedural Design," 65 Cornell L. Rev. 823 (1980); Chassman & Rolston, supra note 1, passim (primary emphasis for OHA quality assurance error correction efforts should be on allowance cases.)



Critical to our analysis is the relatively lower slope of the cost line to the immediate right of 0. That is, even though N (no benefits) and Y (yes benefits) are equidistant from the statutory standard, the cost of false denials in the O-Y-D triangle is lower than the cost of false awards in area O-N-C. Conversely, the benefit from correcting or avoiding a number of false awards is less than the benefit from eliminating the corresponding range of false denials, and the system ought to target the costly mistakes.

On our chart, the slopes of the next segments of the social cost curve (DEF and CBA) are equal, suggesting that the marginal benefit of correcting severe errors should be roughly equivalent. That is, major deviations in either direction (wrongly awarding benefits to someone clearly ineligible or wrongly withholding benefits from someone obviously entitled) are more costly, and we have no reason to believe that either type is particularly more common or more expensive than the other.

Thus, in our second-best analysis, the "accuracy" function of the Appeals Council would not be primarily to screen individual cases for yet another detailed parsing of a close factual record. If that type of operation promotes accuracy at all, it does so only slowly and at high cost; more importantly it most often provides "second guessing" rather than error corrections.

The true accuracy function of a sophisticated review apparatus ought to be to try to help devise a system that avoids or corrects errors -- especially wrongful denials of benefits to eligible claimants -- and does so at the earliest practical point in the system.

C. Policy Integrity

Having eschewed any major role in policy formulation, and confronting the definitional problems inherent in any focus on "accuracy," the Appeals Council today attempts to serve a major role in promoting system-wide uniformity, ensuring that the disability law is implemented as it should be by all decisionmakers nationwide. We have identified two related but severable aspects of uniformity, worthy of separate discussion: this subsection addresses the goal of "policy integrity"; the next elaborates on "consistency."

Policy integrity means simply that the applicable law is adhered to, that the lawfully-authorized controllers of the system are able to carry out their management and policymaking functions effectively, free from disruption by untrammelled mavericks.³⁴⁴

Policy integrity is important to any public institution in a democracy -- the rule of law requires fidelity to recognized authority -- and it is nowhere more important than in the Social Security Administration, which manages a public largess of such profound social significance.

Because the statutory framework for the disability program is so sketchy, the need for administrative promulgation of implementing regulations has been immense. Although these regulations are, of course, confined in scope by the legislation, there is an unusually broad range of discretionary power, and a vista of policy alternatives which the elected officials and their designees may pursue. It is through these devices that the political element, the Secretary of HHS, finds legitimate expression and control.

One important function of responsible leadership, therefore, is to ensure the maintenance of the internal law of the system --

344 See D. Dworkin, Law's Empire 243 (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.")

to oversee and enforce compliance with legally-ordained policies and procedures.

The Appeals Council is admirably well-suited and well-situated to serve a major role in promoting policy integrity. The Appeals Council is the only unit of SSA which regularly receives and adjudicates a broad run of ordinary and extraordinary cases -- it is free to draw on all demographic cohorts of claimants. It sees cases that have been processed by the entire administrative bureaucracy as well as cases that are remanded from courts. It brings together, in a few hands, the disparate outpouring of numerous lower (and higher) decisionmaking units, and can assess them for fidelity to articulated law and policy.

The Appeals Council earns relatively high marks for its policy integrity role. The current members of the Appeals Council are exceptionally well-versed in the applicable law and SSA policy, and show no hesitancy in implementing them. The Appeals Council has succeeded in identifying aberrant behaviors in many cases, and has remanded those cases to ALJs or DDSs with correcting instructions. The Appeals Council as a whole seems comfortable with its role as "police officer" for the system -- spotting deviations from established law and correcting or remanding for more faithful compliance.

In four areas, however, the policy integrity role has become problematic. Three of these are generally beyond the scope of this study, but the fourth goes to the heart of the structure and role of the Appeals Council as an institution.

1. Promulgation of Law

The first such troublesome area concerns the variety of devices for propounding Social Security law and policy. As previously mentioned, SSA has relied upon APA notice-and-comment rulemaking, informal "Social Security Rulings," and an array of evanescent internal policy statements, circulars and manuals.

The status and function of the regulations is clear: they are black-letter law, binding upon all levels of adjudication, including federal courts, unless found to be arbitrary or improperly promulgated. They attain a powerful legitimacy through the democratic process, both the appointment of politically accountable officials and the solicitation and consideration of public participation in rulemaking. Regulations must be responsive to public views and the agency must demonstrate its careful consideration of all meaningful comment even while it retains the discretion to exercise policy.

Rulings, on the other hand (and, a fortiori, the internal policy guidelines that are even less publicized or disseminated), are not as prominent or as susceptible to public participation.

They are also not binding upon reviewing courts. The controversy persists, however, as to their efficacy within the SSA system: the SSRs proclaim themselves to be binding on all levels of adjudication, and customary principles of administrative law support this status for an agency's interpretative statements, yet many ALJs have systematically maintained that they are bound only by formal regulations, not unilateral SSRs.

It is beyond the scope of this study 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. All we can say is that 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,³⁴⁵ and it is beyond our mandate to address it directly, but we must observe the occasional consternation it has generated inside 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 starkly limited.

3. Discipline

In a system as large as the SSA claims adjudication hierarchy, one must anticipate a spectrum of capabilities, interests and efforts. Just as there are some tremendously capable ALJs, there are some who regularly mangle the cases and flout SSA procedures. Similarly, state DDSs exhibit a wide range of competence and fidelity to central direction.

At this time, many observers conclude that SSA's ability to exercise control over deviant sub-units is starkly limited. The

345 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.

major sanctions -- e.g., action against an ALJ through the Merit Systems Protection Board, federalizing the functions of a DDS -- are so cumbersome and expensive that they hardly serve as effective deterrents.

Other observers, however, conclude that independence, especially for ALJs, is a virtue of the system, or that it is at least a price worth paying to preserve integrity and the appearance of propriety. Too much SSA authority to discipline lower level decisionmakers, they argue, might permit abuse.

For present purposes, our only conclusion in this area is again a note of caution: the independence accorded to ALJs and, to a lesser extent, DDSs, carries both costs and benefits. The obvious advantage is in enhanced opportunity for creativity and autonomy; the obvious cost is in reduced opportunities for the Appeals Council (or anyone else in SSA) to achieve program integrity.

4. Balancing Flexibility and Order

The virtues of policy integrity should not obscure the complementary virtues of flexibility and innovation.³⁴⁶ A sound mass justice process must allow for some individualizing discretion.³⁴⁷ This bureaucratic elbow room allows the implementing decisionmakers, the "street-level bureaucrats,"³⁴⁸ the space to make particularized adjustments in the rules. It adds adaptability and sensitivity to the legal exactitude of the administrative process.³⁴⁹

Consciously and inevitably, SSA has provided such space, or discretion, in its rule structure. No system of rules could be so tightly drawn to foreclose this discretion, and a disability determination system in particular forecloses a mechanistic approach.

346 Mashaw, *supra* note 1, at 121-22; Davis, *supra* note 1, at 17 ("Even when rules can be written, discretion is often better.")

347 Koch *supra* note 2, at 9.22[2].

348 This phrase was coined by M. Lipsky in Street-Level Bureaucracy: The Dilemma of the Individual in Public Service (1980).

349 Mashaw, *supra* note 1, at 108 ("The error costs from overgeneralization may here outweigh the gains from error avoidance. The adjudicator's feel for this type of case may often be better than any rule.")

The key questions are who in the adjudicatory bureaucracy should be primarily responsible for exercising this discretion, and what role should the Appeals Council play in fostering innovation and experimentation?

We are mindful of the importance of nationwide consistency in the federal disability programs, but we conclude that both the DDSs and the ALJs should be licensed to do more creative thinking, more experimentation with different systems for organizing and processing the cases, and more interstitial policy articulation. Particularly at the ALJ stage, where highly competent and experienced adjudicators review a large number of cases, there ought to be adequate scope for individualizing judgments not fully covered by existing rules. The discretion for handling the disability caseload in potentially improved ways is valuable and rare, and should be exercised more frequently.

As we develop further in the next section, the function of the Appeals Council with respect to this discretion should be twofold. First, the Appeals Council should ensure that the fundamental guaranties of due process are adhered to -- claimants should not be arbitrarily disadvantaged in the name of casual experimentation. The individualizing discretion of the ALJ should remain within the boundaries permitted by existing law, and the Appeals Council must be responsible for monitoring continued compliance.³⁵⁰

Second, the Appeals Council should be responsible for evaluating the success of these discretionary actions and, where appropriate, for publicizing their results and disseminating the successful techniques. The Appeals Council's perspective permits it to undertake comparisons across the range of DDSs and ALJs, and it should help infuse successful innovations into new localities.

We conclude, therefore, that the Appeals Council should not merely correct errors, attempting to eliminate individual mistakes in the cases; it should also play a more positive, outgoing role in fostering system-wide improvements and in identifying and exploring potential areas of innovation and discretion.

D. Consistency

Related to the goal of promoting policy integrity is the Appeals Council's role in attaining decisional consistency: ensuring that like cases are treated alike. Again, this is already widely taken as an important function of the Appeals

350 Koch, "Judicial Review of Administrative Discretion", 54 Geo. Wash. L. Rev. 469, 471-78 (1986).

Council as currently constituted and, again, we have found both notable success and shortcomings in the present level of performance.

Consistency, of course, relates to the fundamental fairness of the mass justice system. It implies a respect for the individual claimant, and a guaranty that the benefit system is above political or other partisan manipulation. It is also a reflection that SSA, as a national program, ought to mean the same thing to claimants wherever they are situated -- disability is a nationwide problem and the remedial effort ought to be of nationwide applicability.

Finally, the goal of consistency has special relevance in a program in which true accuracy remains elusive. That is, if we are unable to measure, or even to define, the "correctness" of an adjudication, we may nonetheless be able to appraise its "similarity" to other comparable cases. That the same mistake, as it were, should be repeatedly made in like cases is not perfection, but it is fair -- and it may be the most that is attainable in a second-best world.

1. Types of Consistency

It is worth noting at the outset that two different dimensions of consistency may be discerned. "Vertical consistency" is achieved when a case is evaluated in the same fashion, and pursuant to the same legal standards, at each succeeding tier of the appellate review ladder. It requires harmony among DDS, ALJ, Appeals Council and federal court regarding the standards for case handling, the definitions of eligibility and interpretations of policy.

"Horizontal consistency" refers to similarity of decisionmaking at different geographic locales. In a national program such as SSA, claimants in Michigan, Georgia and New Mexico ought to receive identical treatment from their local DDS, identical hearing procedures before their ALJ and, if their cases are substantially the same, identical outcomes on their applications.

In short, the same law ought to be applied vertically inside the several tiers of the bureaucracy and horizontally within each stratum.

In fact, however, the data reveal wide variations along both dimensions. Vertical inconsistency is the harder to evaluate -- as noted, there may be many reasons (including important ongoing evolution in the case itself) why reconsideration, ALJ hearing, Appeals Council review and federal court action result in such widely divergent award rates. For example, as long as the ALJ remains the only adjudicator to confront the claimant face-to-

face, the system should expect many reversals at that tier.³⁵¹

Other explanations of vertical inconsistency, however, are less benign. The DDSs, for example, have operated under noticeably different law than the ALJs -- not just procedural differences, but substantive directives such as instruction to adhere only to the Listings (or only to certain of the Listings) at the expense of the grids. The 1982 Bellmon Report, too, strongly suggested that "where you stand depends on where you sit" -- that a case would be resolved differently by adjudicators at different levels, even when they were presented with identical case files.

Horizontal inconsistency is even more manifest and alarming.³⁵² The award rates among DDSs continue to vary widely from state to state, as they have done virtually since the inception of the disability program. The ALJs, too, are disparate -- many observers note with concern that certain ALJs award benefits in only one-quarter of the cases presented to them, while others consistently find eligibility in three-quarters of the claimants.

This inconsistency is in part created from the top of the hierarchy, as different federal courts evolve different rules in cases brought to their respective jurisdictions. More of the variability, however, flows from the bottom up, as different locales generate starkly different success ratios for their claimants. The illusion of national uniformity in SSA adjudication has never been consonant with reality, and there is little indication of any ongoing improvement.

2. Role of the Appeals Council

The Appeals Council should be uniquely capable of participating in the endeavor to attain consistency. Although there are some 1300 SSA district offices, almost 700 ALJs and 900 federal district judges, there is but one Appeals Council. It is the one place in the claims bureaucracy where cases from all regions, cases which have traversed all adjudicatory tiers, are brought and adjudicated together.

The Appeals Council is already well aware of its unique

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- 351 Cofer, supra note 1, at 170; 1986 Hearing, supra note 1, at 28, Statement of Eileen P. Sweeney, Staff Attorney, National Senior Citizens Law Center.
- 352 National Center study, supra note 1, at xxi ("The inconsistency of the disability decision process is patent."); Capowski, supra note 64, at 343.

perch, and the members take seriously the responsibility for maintaining the nationwide scope of the program. If the statistics do not bespeak much success to date in creating national consistency, one can only speculate how much worse the portrait would be if there had been no single entity at the top of the pyramid attempting to reconcile divergent views.

This is not to say that the Appeals Council itself is a paragon of uniformity. Indeed, with a current membership of 20, the Council may already be too large to be able to speak with one voice. The current case handling routines further underscore a dispersion -- a case is ordinarily assigned to only one or two members; only rarely do as many as three members confer upon a case; and virtually never will more than three members address a matter together.

Moreover, as far as we could ascertain, Council-wide discussion of shared problems remains quite rare. Plenary meetings are held approximately monthly, but very little of this time is devoted to working out common approaches or strategies. The members' regional groupings could be a source of some nascent uniformity, but they are not much used for this purpose. Members told us of daily consultation with each other to discuss novel or tricky issues, but we were not persuaded that this collegiality was able to produce very much by way of a shared outlook. And we observe, although the statistics are difficult to marshal, that members do differ in their products, with some, for example, granting review of cases at least twice as often as others do. 353

In short, the Appeals Council, potentially the best locus in the network for attaining consistency, still operates much like an atomized³⁵⁴ collection of individuals, not like a true national entity.

353 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 qualities 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 185, at 38.

354 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 (Footnote continued)

3. Impediments to Consistency

Assessment of the Appeals Council's opportunities for promoting uniform decisionmaking begins with a recognition of two rather distinct types of consistency: procedural and substantive. The first, fidelity to optimal procedures, is relatively easier for the Appeals Council to pursue. It is less problematic 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 needed medical records; the taking of testimony, where appropriate, from medical or vocational advisors; the proper elaboration of allegations of mental impairment; and the step-by-step working through of the sequential evaluation process are all fundamental steps that the Appeals Council can monitor in a straightforward fashion for national consistency. There is little reason why these steps should vary according to the claimant's geography, and there is little danger that important guaranties about decisional independence would be jeopardized by insistence upon standardized procedures.

However, substantive consistency -- the attempt to ensure that like cases are ultimately resolved alike -- is far more problematic. Any attempt to harmonize the decisional output of ALJs inevitably raises fundamental concerns about compromising the APA protections so necessary to their integrity. There is little that any tier of SSA could or should do to enforce directly a substantive uniformity upon ALJs -- the danger of manipulation or apparent manipulation is too great.

Recent history, as well as sound theory of administrative law, suggest that any reforms perceived as challenges to ALJ autonomy will be fiercely resisted. SSA should never return to being "at war with itself," and OHA in particular can not sustain the kinds of tension and resentment that to some extent still characterize relations among ALJs, Appeals Council and policy officials.

4. Techniques for Improving Consistency

354(continued)

not support that type of compartmentalization, preferring instead greater integration of the Appeals Council as a national entity. The fact that regionalization could be so seriously considered is itself an indicator of the lack of cohesion among the Council, the absence of a sense that members might act as a self-conscious, integrated group striving together to help pursue national consistency in the programs.

We conclude, therefore, that perfect consistency can never be attained. ALJs will continue to vary and will continue to assert their independence. The Appeals Council should not challenge this reality, but should recognize, even endorse it, as part of the price inevitably to be paid for the benefit of an independent quasi-judicial corps. The range of reversal rates is greater than it should be, but any direct assault on the problem is bound to be futile and destructive.

Instead, there are several other steps -- less overt, less contentious, but perhaps ultimately more successful -- that the Appeals Council may be able to adopt in pursuit of greater consistency.

One such measure begins, as do many of our other recommendations, with the Appeals Council re-asserting control over its own docket. Only when the Appeals Council is able to exercise some greater selectivity in the cases it sees will it be able to play a more important role in pursuing consistency. As elaborated in the final section of our report, we propose that SSA develop mechanisms for bringing far fewer cases before the Appeals Council, while ensuring that the categories of cases to be reviewed are, in some sense, those most likely to contain errors, those which would benefit most from systematic scrutiny, or those for which inconsistency has been the greatest problem.

Once the caseload is reduced, the Appeals Council could take other steps in pursuit of program consistency. The Appeals Council could write better decisions -- opinions which are not simply conclusory boilerplate, but which analyze the evidence and the arguments with care, and explain in some detail why the Appeals Council is taking the action it does. The Appeals Council's decisions today do not contain this elaboration and are therefore not especially compelling in their logic or citation, nor very likely to inspire consistency among the lower levels.

In this context, it is disturbing that the Appeals Council does not do more to publicize and disseminate its decisions. It is ignoring an opportunity to pursue consistency through the promulgation of more of its most significant decisions, together with an appropriate index. Consistency is difficult to attain solely on a case-by-case basis; ALJs and DDSs require in addition some more systematic guidance, and the Appeals Council could promote consistency by advertising within all tiers of the system, the proper (and improper) ways of handling particular types of claims. Today, the absence of any effective feedback mechanism is striking -- ALJs and DDSs do not regularly track the progress of their cases, and do not have the opportunity of learning through appellate identification of errors. Unless some happenstance brings a remanded case back to the same ALJ or DDS who acted on it initially, there is no effective mechanism for the Appeals Council to have a broader impact on national consistency, instead of

merely correcting the particular case at bar.

Aside from feedback via case handling, other potential devices that could serve a role in enhancing consistency are currently underutilized. There is, for example, precious little interaction now 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 regularly assigned for one-month temporary duty stints as Appeals Council members) has been terminated. There has, moreover, been little recent activity in training or in continuing legal (or medical) education that might bring ALJs and members together.

Similarly, most Appeals Council members have virtually no contact with DDS or district office personnel on any regular basis. Very little has been done to explore ways in which direct meetings among personnel from the various tiers of review could be arranged to enhance better understanding of the program and, hence, consistency in its application.

E. Efficient Government

In a program that costs millions of dollars to administer, cost effectiveness cannot be ignored. The Appeals Council has a role to play in assuring efficiency in its own process and that of the entire system.

1. Cost Effectiveness in General

Once again, the size of SSA's disability operation is staggering: over two million initial applications are processed each year; over one million appellate reviews are conducted; the number of beneficiaries in current pay status has reached seven million; and the volume of discrete facts found, laws construed, and regulations implemented is incalculable.

Many of the cases, moreover, involve highly complex matters of medicine and science; whether by choice or by the pressure of events, SSA has been near the cutting edge of modern developments in psychiatric impairments, pain, and AIDS, to name a few.

All of this is accomplished on a budget of about \$650 million for administration of the disability portion of RSDHI. SSA calculates that the costs of administering the disability provisions of the law is 3.4% of annual income -- a figure that may seem modest, but is 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.³⁵⁵

Mashaw estimated some years ago that the average cost of a

disability determination was about \$500 and the lump sum value of an award was about \$30,000, generating a figure for processing costs that is only one sixtieth of the total cost.³⁵⁵ We suspect that this ratio has, if anything, become even more favorable over the ensuing years, as benefit levels rise faster than overhead costs.³⁵⁷

This apparent efficiency, however, does not imply that SSA can be indifferent to costs -- indeed, the substantial downsizing of the agency's manpower pool (projected to shrink from 74,600 permanent staff in 1983 to 66,700 in 1987) demonstrates that productivity remains highly prized.

Moreover, a 60:1 ratio does not, by itself, translate into a finding 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 -- it is, rather, 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 particular cost. The Appeals Council, as it currently operates, changes the result in only about 5% of the cases delivered to it, and remands for further action perhaps another 10%. This is far from a trivial contribution -- on an annual Appeals Council docket of 50,000 cases, it means that 7500 cases receive some 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 people.

Moreover, the timeliness cost of the Appeals Council is

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- 355 SSA 1987 Annual Report, supra note 11, at 30. These figures exclude the costs of administering the SSI disability program for which general revenues, rather than the SSA trust funds, are tapped.
- 356 Mashaw, supra note 1, at 81-82.
- 357 HHS has calculated that the present value of the average costs associated with a newly entitled disabled worker were \$66,800 in December, 1985, including approximately \$39,000 in direct payments of benefits, \$4800 in benefits to dependents, and \$20,700 in Medicare benefits. Wilkin, supra note 87, at 4.

substantial: even if the system improves to the point where all request-for-review cases are disposed of within 90 days, the claimant is still forced to wait that three months, with very little expectation of any favorable action. Appeals Council reopenings, moreover, can substantially delay administrative finality, prolonging the wait for access to court.

2. Sources of Inefficiency

Although it is precariously difficult to assign rigorous costs and benefits inside a complex organizational structure such as SSA, or a subunit such as the Appeals Council, we were able to identify a number of areas of waste or inefficiency, which prevent the Appeals Council from achieving optimal levels of productivity.

The first such stumbling block is the Appeals Council's current "system" for processing words and data, for tracking files, and for compiling statistics. The computer hardware, software and support services are at best primitive; the technological revolution seems essentially to have missed the Office of Hearings and Appeals.³⁵⁸

Members cannot, for example, directly make any changes or corrections in letters or decisions that go out over their signatures -- even typographical errors require returning the entire file to OAO for time-consuming reprocessing. The Appeals Council, moreover, 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 a relic.

The kindest conclusion one could draw from exposure to the Appeals Council's stunted computational capacity is that the situation must have been far worse only a few months 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 we suspect that meaningful relief will not arrive soon, without outside pressures.

Another major source of inefficiency is the Appeals Council members' lack of personal staff support. When cases arrive at the Appeals Council from OAO, there is no one to pre-screen them for the member, to sort the pedestrian from the significant. The

358 Despite representations that the Appeals Council's word processing equipment would be at the technological "state of the art," Testimony of Louis B. Hays, Associate Commissioner for Hearings and Appeals, 1983 Hearing, *supra* note 1, at 24, OHA has, in fact, supplied the Appeals Council with only an inadequate volume of obsolescent hardware.

members are thus forced to spend too much time on purely ministerial duties, distracting them from the ability to serve a more reflective, sophisticated function. Members thus wind up doubling as their own clerks, hardly an efficient use of their talents.

In a related matter, we observed considerable cost in the organization and location of OAO analysts. They are spread through a number of buildings, making communications and simple file transfers cumbersome. The OAO branches, moreover, do not parallel the members' geographic groupings, yielding a situation in which an analyst might send cases to a large number of different members (so the analyst never really learns any member's particular style and preferences) and each member may conversely receive work from 30 analysts (preventing members from learning in detail the strengths and weaknesses of the individuals whose work they review and rely upon.)³⁵⁹

3. Protecting Judicial Resources

A consistent justification for the existence of the Appeals Council is its ability to screen cases before they reach the courts, paying more deserving claims administratively and protecting the district judges from what might otherwise become a "flood" of litigation.³⁶⁰

The protection of judicial resources is indeed an important value: claimants, SSA and the federal judiciary are all better off if claims can be resolved prior to filing a civil action. And the strain upon federal courts is already substantial: some 20-25% of the federal civil cases filed against the United States are SSA disability contests (although because these cases tend to be resolved expeditiously, they may account for only 2% of the federal courts' actual work.)³⁶¹

The sheer size of the SSA caseload again suggests that even minor perturbations in SSA's rate of resolution of claims could cause major disruptions for a federal judiciary not equipped to handle that volume of traffic. Of the annual 2 million new

359 We understand that 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.

360 E.g., Statement of Burton Berkley, Deputy Chair, Appeals Council, Cleveland Transcript, supra note 1, at 274.

361 Flanders, "What Do the Federal Courts Do? A Research Note", 5 Rev. of Litigation 199, 206 (1986).

disability cases, perhaps 10,000 (.5%) will wind up, years later, in court. If SSA were able, for some reason, to dispatch only 99%, instead of 99.5%, of the cases administratively, the burden of federal actions would thus double.

The final tier of SSA, the Appeals Council, now receives approximately 50,000 cases per year. Of these, perhaps 10,000 will subsequently result in federal court actions. How much credit can the Appeals Council actually take for this winnowing? 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 this function. It does, to be sure, pay a number of claims, and remand another fraction to ALJs who may yet rule in favor of the claimant. But the Appeals Council itself does precious little to "satisfy" denied claimants or persuade them not to press further. The Appeals Council decisions are so standardized and non-responsive that they "convince" no one; the review proceedings before the Appeals Council are so opaque that no one could be placated by this as a day in court.

The real deterrent to court action -- the real force protecting the federal courts against a flood of claimants -- is not the Appeals Council, but the cost, cumbersomeness and delay of federal litigation. Typically, the claimant must find a representative willing to invest time and money pro bono or for a contingency fee; must endure long uncertainty (during which time no benefits are paid); and must realize that even if the court is sympathetic, a remand for a new hearing, rather than an outright award of benefits, is the most likely outcome. We conclude that all these factors would operate just as powerfully even if there were no Appeals Council posing as a guard at 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 from which none can take solace. Sometimes the Appeals Council, with all its delays and impassivity, does succeed in exhausting claimants -- not in persuading them that the claims are without merit, but in engendering a cynical sense of defeat, that the vast bureaucracy just isn't worth fighting any more. This process does, in fact, help keep cases out of court, but it does so only at an intolerable price of justice denied.

F. Acceptability

Acceptability among, and support from, a variety of constituencies is an important value for an organization like SSA. A level of public confidence is necessary to the performance of its primary missions; Congressional support is essential for continued institutional survival; and the reputation for fairness

and competence among other politically relevant groups is important to the agency's operations.

As the pinnacle of the SSA adjudicatory bureaucracy, the Appeals Council can play a major role in fostering greater acceptability of the program, and it can play this role in a variety of ways with different audiences. Unfortunately, we conclude that the Appeals Council to date has either ignored this responsibility altogether, or actually aggravated existing poor public appraisals of SSA.

1. Satisfaction Among Claimants and Their Representatives

The most direct -- and the most difficult -- target for building greater acceptability is the group of disability claimants and their representatives who are personally served by SSA and the Appeals Council. These are the bureaucracy's "customers," and their satisfaction is an important element of a mass justice system.³⁶²

Obviously, those who lose -- who are denied the benefits they claim -- are going to experience a certain level of dissatisfaction no matter how much care and sensitivity the system exhibits. Because not every claimant is entitled to benefits, and because the agency's responsibility is to make choices -- often difficult, close choices -- among claimants who ordinarily do have some significant handicaps, there will inevitably be a cadre of disappointed litigants.

Moreover, it is predictable that a program as large as SSA, even if operated in the best faith with the most modern management tools, will make some mistakes, including some quite egregious ones. Even if the error rate is statistically low, the absolute number of mistaken denials -- and the incidents of callous or ignorant bureaucratic treatment -- will be significant.

Even discounting these inherent problems, however, the degree of claimant satisfaction with SSA and the Appeals Council is low. People are able to distinguish between being denied and being badly treated by the system, and people are often able to maintain respect for an organization, even after it rejects their requests,

362 See generally, J. Mashaw, Due Process in the Administrative State (1985). An emerging school of thought, which he labels as proponents 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.

if they feel it is fundamentally fair. In the case of the Appeals Council, however, claimants and their representatives frequently express two critical areas of dissatisfaction.

The first source of unhappiness concerns delay.³⁶³ The Appeals Council simply takes too long to affect too few cases. In request-for-review situations, the Appeals Council is perceived as simply a way-station, a tedious process that must be traversed, even though the prospect for relief is small, in order for the claimant to progress to federal court where the chances for victory are greater.

In own-motion review situations, claimants again see the Appeals Council as a cause of delay, postponing the effectuation of an ALJ award, or³⁶⁴ -- even worse -- as a threat to benefits won at the ALJ level.

In court cases, too, the Appeals Council is seen as largely a source of unwarranted delay, or worse. By pulling weak cases back from court on a Secretary's motion for remand, the Appeals Council is often interpreted as functioning to strengthen the case for

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- 363 Of course, the Appeals Council is hardly responsible for all the delays that mark the Social Security system; it is merely the latest administrative source of delay. See 1986 Hearing, *supra* note 1, at 25-26, Statement of Arthur S. Flemming, CoChair, Save Our Security Coalition, ("In evaluating the impact of the delays at the Appeals Council level, it is important to recognize that this appeal is the last step within the agency in an appeal procedure which may have already lasted well over a year, possibly even 2 years in some cases."); Linden, *supra* note 341, at 357 (summarizing results of court-ordered study conducted by SSA regarding processing times for current and retroactive payments.)
- 364 It is worth noting that in our interviews with claimants' representatives, when we asked about their impressions of the current work of the Appeals Council, the nearly unanimous response suggested an impression that own-motion review, which might result in reversal of an ALJ award, was a major (if not the major) portion of the workload. In fact, statistically, OHA now receives only a small number of own-motion cases (perhaps 300-400 per month) and the Appeals Council grants review in an almost de minimus number (perhaps 60-80 per month). The fact that even well-informed claimants' representatives are so out-of-date in their understanding of the current operation of the Appeals Council is itself an indication of a poor job in promoting acceptability.)

denial, rather than paying the claim -- covering up, rather than redressing, ALJ errors.

Finally, even when the Appeals Council does take cognizance of a case, it is twice as likely to remand as to reverse, meaning that subsequent proceedings before an ALJ -- entailing more delay and perhaps another full hearing -- are the likely outcome.

Recent statistics do suggest a somewhat better timeliness performance on the part of the Appeals Council. At the least, the delays do not seem to be getting worse, and the incidence of lost files is decreasing. Management reforms, however, can go only a small part of the way toward reconciling the inherent delays in a system for coping with the Appeals Council's current volume of cases.

The second major complaint that claimants and their representatives assert about the Appeals Council concerns the remoteness and the impersonality of the process.

Claimants never see an Appeals Council member or OAO analyst. Even high-volume representatives, who deal with the institution repeatedly, report little or no human contact at any stage of the case handling. The unanimous impression is that the Appeals Council is distant, aloof, and impassive. Representatives confess that they don't know much about, or even care much about, the Appeals Council -- it is so arcane that they rarely take it seriously.

This sense of the Appeals Council as a "black box," the internal composition and operation of which are kept mysterious, generates an apprehension of arbitrariness -- no one knows why the Appeals Council acts as it does, and each representative can relate anecdotes about egregious ALJ errors that were blithely overlooked by the Appeals Council as well as weak, almost casual requests for review that were 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 Appeals Council feeling that their dignity as claimants has been acknowledged and respected by the process.

Partly this sense of remoteness is due to the fact that representation before the Appeals Council is entirely on paper, with no possibility of an oral appearance. Partly it is due to the curt nature of the Appeals Council's mailed notifications and decisional documents. Partly it is due to the restraint the Appeals Council has imposed upon itself regarding travel or public appearances -- with a few notable exceptions by the Deputy Chair, members of the Appeals Council do not attend conferences, offer

workshops, or deliver speeches to groups of claimants representatives.

2. Public Confidence and Support

This "invisibility" of the Appeals Council is even more extreme among the public at large.³⁶⁵ Few people outside those intimately involved in the disability process have ever heard of the Appeals Council, and we think it only barely an exaggeration to assert that no one, other than people currently or formerly associated with OHA, has even a rudimentary understanding of how the Appeals Council operates.

At a time when public confidence in, and support for, SSA in general seems to be in jeopardy, it is striking how little has been done to utilize the resources of the Appeals Council to redress the problem.

3. Acceptability Among ALJs

Another vital constituency for the Appeals Council is the corps of ALJs, whose decisions it reviews.

The appellate function inherently creates certain tensions -- some degree of antagonism is inevitable between junior and senior tiers on an appellate ladder. Disagreements about particular cases or about implementing practices, however, are unremarkable and for the most part can be handled civilly and collegially.

What we observe, in addition, is a much more profound level of disrespect by ALJs of the Appeals Council as an institution. Even ALJs who have had personal experience with the Appeals Council, and who express respect for the capabilities and sincerity of at least some of the members, have little faith in the organization as a whole.

ALJs complain, first of all, about the fact that Appeals Council members are "merit systems" employees, not APA protected. The ALJs conclude that members are susceptible to political pressures, or that they might feel themselves so subject, and ALJs assert that it is improper for bonus-eligible employees to review quasi-judicial decisions on such fact-intensive cases. ALJs have repeatedly battled the OHA leadership over issues such as productivity and performance ratings, and have argued that their own statutory decisional independence is an essential guaranty of

365 Koitz, "Social Security: Legislation to Create an Independent Agency," Issue Brief by Congressional Research Service, 7 (1986); Mashaw, *supra* note 1, at 144 ("It is perhaps the fate of SSA to be misunderstood.")

the fairness of the system; they have no truck with less-secure employees in a judicial appellate role.

Secondly, ALJs resent the fact that their decisions are subject to review by members whose qualifications and capabilities are no greater than their own. At the present, the job qualifications for members and ALJs are substantially identical, and OHA has attracted a number of ALJs to join the Appeals Council. But the tradition has not always been so grand: there have been non-lawyers on the Appeals Council in the not-too-distant past (many ALJs appear to think that there still are some) and most members have never had the occasion to attend, let alone to conduct, a real hearing.³⁶⁶ Since the two jobs are graded and paid at the same level, there is little incentive for the best ALJs to aspire to climb the appellate ladder (unless geographic attractions apply) and we observed more than one current member of the Appeals Council who frankly expressed a preference for an appointment as an ALJ, if one could be arranged for the Washington, DC, or Baltimore areas.

In short, ALJs do not now see the Appeals Council as a legitimate appellate body. They suspect it of political manipulability, and they believe it has been captured by its caseload and forced into over-reliance upon the work of non-lawyer OAO analysts. ALJs have precious little opportunity to interact with Appeals Council members, and little occasion, therefore, to dispel any myths about them. Within OHA, therefore, as among the claimants and general public, there is a genuine problem of Appeals Council acceptability.

4. Confidence Among the Courts

The SSA disability process has been in a period, from which it is perhaps emerging, of considerable judicial distrust. Affirmation rates in court fell to an all-time low, and restraining orders, contempt citations and hostile dicta proliferated.

The Appeals Council, in the midst of all this, was surprisingly unscathed. Indeed, it is noteworthy how frequently the federal courts simply looked past the actions of the Appeals

366 The original plan for establishing the Appeals Council envisioned a great degree of fungibility between the members and the 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 185, at 39.

Council (formally, the final and reviewable Secretarial action) to dissect the work of the ALJ. Even in the eyes of the reviewing tribunal, the Appeals Council was often deemed irrelevant, as doing little, if anything, to protect or defend the process and the results of the hearing level.

Recently the Appeals Council has attempted to become somewhat more responsive to court activity. It has revised the prior "harmless error" policy, and is now granting review over more ALJ denials, even where the ultimate decision was correct, to re-write the decision so the process and rationale may be more acceptable in court. Similarly, it has streamlined the process for seeking Secretarial remand on selected cases, to provide further administrative work-up on cases difficult to sustain in court.

In fact, there is some danger that the Appeals Council may now be becoming too preoccupied with court actions, at the expense of its other roles in enhancing administrative behavior. That is, institutional resources directed at evaluating and defending particular cases when they go to court are resources that cannot be utilized for improving performance at the lower levels of the bureaucracy in order to minimize errors early in the process.

5. Acceptability with the Congress

SSA is a perennial on Capitol Hill, with the agency's programs -- and the Congress' pursestrings -- rising and falling with the vicissitudes of politics. The clearest prediction we are able to make at this time is that, in an era of deficits and belt-tightening, there is little prospect for success of proposals to spend more money on any domestic program, including disability. The extent to which this is an indicator of "acceptability," however, is more difficult to assess.

OHA has certainly received more than its fair share of scrutiny, being the subject of a variety of reports and hearings in recent years. Most of this attention, however, has been lavished on the ALJ stage, and on the controversies over productivity and reversal rates.

The Appeals Council, on the other hand, has attracted far less notice -- it is no more prominent in the attention of Congressional representatives and staff than among other sectors. Even the most recent sweeping legislative proposals, which would abolish the Appeals Council altogether, do so mostly as an afterthought, or as a side effect of the creation of a new federal Social Security Court.³⁶⁷

367 See e.g., 1986 Hearing, supra note 1, at 3 (Statement of Rep. Archer).

At a deeper level, even the Congressional staff who know the most about the Appeals Council seem to have little to say in support or opposition. They see it as positioned to perform some potentially valuable institutional functions, but not as being notably successful in carrying out any particular mandate.

Thus, the Appeals Council seems to have little impact with the Congress -- neither generating hostility nor ingratiating itself with supporters -- and can claim little success in fostering greater acceptability for the program as a whole.

IV. Findings and Recommendations

A. Introduction

The Appeals Council is -- or ought to be -- an important institution. It alone has the authority to issue final administrative adjudications, acting in the name of the Secretary of HHS in matters of considerable moment to individual claimants. It alone reviews and adjudicates the thousands of disability cases, as they pour in from ALJs and DDSs around the country, surveying the grand run of decisions that constitute the agency's combined institutional experience. It alone sees the full panoply of court cases, participating in the disability litigation and all its antecedents in a way no other bureaucratic unit can do. Finally, the Appeals Council is important because it has a call upon the talents and knowledge of a corps of members and OAO analysts possessing unique experiences gained from long operation in a special bureaucratic perspective. No one should take the Appeals Council -- its powers and its objectives -- lightly.

Having investigated the purposes, structure and operation of the Appeals Council, and having assessed its institutional performance and its potential for the future, we conclude that four possible avenues are available. The current options, as we see them, are:

1. Preserve the status quo, retaining the Appeals Council essentially as it stands;
2. Abolish the Appeals Council entirely, redistributing its missions and resources elsewhere;
3. Modify the Appeals Council, optimizing its performance as a case-handling entity;
4. Reform the Appeals Council, emphasizing its role as a mechanism for identifying, promulgating and disseminating ideas for improvement in the adjudicatory bureaucracy as a whole.

As we elaborate below, each of these options deserves to be taken seriously, and each holds certain attractions. At length, however, for reasons spelled out in this section of our report, we strongly prefer Model 4, and we recommend its immediate adoption.

B. Model 1: Preserving the Status Quo

Maintenance of the present system, with no major alterations, is always a logical possibility. One should not rush to dispose of a government institution that has weathered the bureaucratic storms for almost half a century.

In fact, the Appeals Council has managed to do a job, and to do it with some success. It has, to date, somehow been able to keep chugging along, it has not crashed precipitously into bureaucratic rubble, and it has helped, in some measure, to promote several important SSA objectives over the years.

Although the Appeals Council has drawn heavy criticism from diverse quarters, it has also managed nonetheless to churn out 50,000 cases per year and has generally maintained a low profile, suggesting that even its most severe critics have chosen to target most of their ire elsewhere, as other components of the SSA bureaucracy have earned (or fallen into) even greater public and Congressional scrutiny. Adherants of the "If it ain't broke, don't fix it" school might therefore argue that the organization, for all its flaws, does somehow do something useful, and that radical change promises no guaranty of greater success.

In fact, however, the system is broken; it does need fixing, and urgent attention is required. The record of the Appeals Council, despite the best efforts of some very capable people, is wholly unsatisfactory. Fundamental change in several areas is now required.

Our review of the foundations of the organization convinces us that the Appeals Council as an institution fails to achieve the goals identified for it, and fails any more to contribute much to their pursuit by other bureaucratic units. This is not a transitory or superficial phenomenon -- it is the inherent result of deep, permanent flaws in the structure of the Appeals Council, and in the selection of its central mission.

The goals of the Appeals Council are of surpassing importance; unfortunately they are simultaneously of surpassing complexity and difficulty. Some of the goals (such as enhanced policy development) have simply been abandoned by the current Appeals Council due to the crush of the case load; others (such as attaining fine-grained decisional accuracy in the closest cases) are simply too ambitious, beyond the ken of any even theoretical disability adjudicator or reviewer. Achievement of other goals has been subverted by failures in the organization or operation of the Appeals Council, particularly by the overwhelming flow of cases.

We find, moreover, that the Appeals Council, as currently operating, imposes unacceptable costs upon the disability program of the Social Security Administration: costs of money, diverted resources, delay, and public image that are substantial and, we believe, avoidable.

We hasten to add that our criticism of the Appeals Council, and our conviction that Model 1 is no longer viable, should not be confused with any hostility toward its current personnel. Indeed,

we have a great deal of respect and admiration for the members of the Appeals Council, many of whom embody the grandest traditions of the federal civil service. The incumbents include individuals of great talent and character, striving mightily to promote the professionalism, fairness, and sympathy that we would all like to see in SSA. Our distaste for the current functioning of the Appeals Council is therefore in no way an indictment of its members' skills or commitment; unfortunately, the members' sincerity in approaching their task is exceeded only by the impossibility of the task itself.

In short, we reject Model 1. The existing structure of the Appeals Council has nothing behind it more compelling than simple bureaucratic inertia, and we conclude that the time has come for profound change.

C. Model 2: Abolishing the Appeals Council

The diametric opposite of Model 1's preservation of the status quo would be Model 2's proposal for outright elimination of the Appeals Council, with its remaining functions and staff being transferred elsewhere.

1. Arguments for Model 2

This course of action has been recommended repeatedly, with increasing vigor, by a diverse group of voices. Many claimants' representatives, for example, have called for abolition, as have a number of scholars. Congressional legislation is regularly introduced that would accomplish this objective, and federal court judges have endorsed the idea. Early in the Reagan Administration, the leadership of SSA, too, seemed to favor this course.

There are, in fact, good reasons to support abolition. As noted above, Appeals Council review is now largely superfluous: it changes the results in only 5% of the cases,³⁶⁸ a statistic which by itself may constitute a prima facie case for abolition. The Appeals Council, as discussed, does not contribute appreciably to the institutional goals of SSA, and there is little intuitive reason why a fourth tier -- a fourth bite at this particular apple -- is worthwhile.

The Appeals Council, moreover, is expensive: it consumes millions of dollars, a number of talented people who could be used productively elsewhere, and time -- time which delays the finality of the adjudicative process and thereby squanders one of SSA's most precious resources, the support and confidence of the

368 See supra note 248 and accompanying text.

claimants.

These major indictments of the current Appeals Council, and the difficulty of adequately restructuring it, suggest that a clean break may be the wise course -- abandon the Appeals Council as a failed enterprise, rather than try to resuscitate it. The Appeals Council, in short, might be considered an idea whose time has passed, and in an era where streamlining government is important, it may not be a sound use of resources to try to teach this old dog new tricks.

2. Implementation of Model 2

Abolition of the Appeals Council would not be difficult to accomplish. Its personnel could be redistributed elsewhere within the agency -- temporary displacements would no doubt occur, but at a time when SSA is reducing its workforce so substantially, 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 conveniently be hived off elsewhere. For example, ODO and other SSA service centers could send their "protest" cases⁶⁹ back to the originating ALJ, instead of to a central reviewer. True "technical errors" could then be efficiently corrected at the source, via a reopening. Also, the quality assurance role of the Appeals Council could be served by a dedicated quality assurance staff (perhaps a rump of the existing Appeals Council and OAO) which, in conjunction with SSA's national Chief ALJ, could provide on-the-job training for new ALJs. The Bellman review function could be statutorily removed, or performed by other, less important, units.

One salient aspect of Model 2, and a frequently-cited argument against it, is the fact that under an abolition scheme, ALJ decisions would become the final agency actions, immediately reviewable in court, without interposition of a further "Secretarial" review. While this would certainly be a departure from the most commonplace structure of administrative law (in which usually -- but not always -- there is another post-hearing administrative stage prior to recourse to the courts), we do not find this arrangement implausible.

First, there is nothing in the APA inconsistent with the Model 2 scheme. The fact that the statute implicitly permits an Appeals Council does not mean that one is required, and ALJs are legally competent to have the last word for the agency. (As a practical matter, ALJs now deliver the last real word for the

369 See supra text accompanying note 238.

agency in most cases, because the Appeals Council caseload prevents it from effectively intervening.)

Second, there is no reason to fear that ALJs, once freed from the spectre of Appeals Council review, would suddenly become more aberrational (or more independent or more generous.) In fact, the ALJs are likely to continue to behave responsibly, for all the reasons that they now do -- the Appeals Council contributes little to "ALJ discipline," and abolition would not remove any of the system's important "checks".

Most importantly, we conclude that abolition of the Appeals Council would not, as some have asserted, immediately "flood" the federal courts with massive increases in the number of disability filings. We share the concern for protection of federal court dockets, and are sensitive to the need to avoid bumping still more of the cases from administrative to judicial resolution. But we conclude that compared to the various other barriers to entry into the federal courts -- including cost, delay, simple exhaustion and the need for an attorney -- the factor of Appeals Council review is negligible, and its removal would not make an appreciable difference to the system.

3. Conclusions about Model 2

We have a great deal of sympathy for this course of action. We have found the existing Appeals Council seriously wanting, and it is not obvious that remedial actions are possible or likely. Nevertheless, our skepticism about the institution does not obscure our respect for its potential; and our appreciation for the vital needs that the Appeals Council might address makes us want to give systemic reform one more chance. Therefore, we do not at this time recommend abolition.

However, should our preferred recommendations, or something like them, not be accepted and implemented, then we would fall back to the abolition option. In short, the Appeals Council can not continue as it is; if the recommended improvements are not promptly forthcoming, or if they prove inefficacious, then the Appeals Council ought to be abolished.

D. Model 3: Optimizing for Case Handling

The next major alternative for the Appeals Council is to restructure the present organization in order to perfect its ability to handle the cases, and to improve the prospects for making a meaningful contribution to the pursuit of traditional goals such as accuracy and consistency. Under this alternative, the Appeals Council would continue in largely familiar patterns, with basically consistent objectives, but would be improved in order to do the job better.

1. Arguments for Model 3

The principle upon which Model 3 is based is that the most important function of appellate administrative review, and the job which the present Appeals Council has the most experience and expertise at doing well, is the scrutiny of individual cases. Members know how to read an ALJ opinion, they know how to peruse a claims file, and they can spot poor hearing procedure and bad decisional products. ALJs, for all their strengths, make errors, and the Appeals Council can correct them, before the wrongly denied applicant is put to the time and expense of litigation, and before the wrongly allowed applicant is incorporated into the disability rolls. Even if perfect accuracy is elusive, there is much that the Appeals Council could still do to interdict the most blatant errors.

Aside from pursuing accuracy, the Appeals Council could also do more to develop consistency within the program. Treating like cases alike is fundamental to due process, and the absence of central control would threaten even greater dispersion among the lower decisionmaking units. Although the Appeals Council to date has not been notably successful in generating this national uniformity, perhaps relatively modest reforms would enhance its performance. By handling individual cases more purposefully, and by developing additional feedback mechanisms that directly address the problems of vertical and horizontal inconsistency, the Appeals Council may be able to pursue these goals more effectively.

2. Arguments against Model 3

Our criticisms of a focus on decisional "accuracy" as a goal have already been elaborated: we consider it an undefinable and largely unmeasurable target. The disability cases are simply too subjective, and too variable; appellate review too often becomes merely a vehicle for the subsequent authority to substitute its judgment for that of the prior decisionmaker -- in close cases (which is where the most interesting problems are) this may change the results, but it is hard to call it an honest improvement toward "accuracy." Moreover, even if this level of accuracy were not so elusive, we would still not consider it especially worth the price: exquisite accuracy in the close cases is not very valuable socially -- at least not so valuable that we would be troubled by stopping at only three, rather than four, levels of administrative adjudication.³⁷¹

Consistency, too, is a valuable commodity, but we question

370 See supra text following note 331.

371 See supra text accompanying note 331.

whether it can be achieved by simply reviewing and correcting individual cases. Even if the Appeals Council could be strengthened in its capability for enforcing consistency, we conclude that there is a limit to the amount of uniformity that could be achieved just via working the cases.

Moreover, the Appeals Council as a case-handling institution imposes certain other costs upon the system as a whole -- costs of delay, reduced public acceptability, etc. -- that would not be ameliorated merely by refining its present routines. Even if the Appeals Council were streamlined, and dispatched its docket with greater finesse, that would still not be enough to justify its lofty position in the bureaucracy.

3. Implementation of Model 3

If the Appeals Council were to be modified to enhance its case-processing role, a number of important changes would be required. Essentially, these would "judicialize" the Appeals Council, making it more of a true court-like body, designed to deal expeditiously and carefully with its docket.

While we do not, at this time, recommend adoption of Model 3, we think that it deserves to be elaborated and taken seriously, and that the contrast between it and Model 4 will help explain the basis for our preferred outcome.

Model 3 would incorporate the following six features:

a. Legal and Bureaucratic Protection for the Members. Under Model 3, the Appeals Council really would be serving as appellate reviewer of the work of ALJs, and we would consider it inappropriate for members to lack the same protections that ALJs enjoy.³⁷² If the relationship between ALJ and Appeals Council is to approximate the relationship between a district and circuit court, then both tiers would need the same full 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 the Appeals Council members, like the ALJs, perform a quasi-judicial function, not a quasi-political one; guaranties of independence are important for propriety and for the appearance of propriety.

Concomitant 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 would also assume that the Associate Commissioner's slot would remain, but

372 See supra note 125.

that position would no longer carry an ex officio seat on the Appeals Council.)

Also under this plan, the Appeals Council, along with the corps of Administrative Law Judges, would be bureaucratically relocated outside the normal line of the SSA hierarchy. Oversight, even benign administrative oversight, by political officials such as a Commissioner, Deputy Commissioner and Associate Commissioner would be inappropriate for a truly judicial body. Instead, the adjudicators would have to be physically and bureaucratically insulated from SSA, which would stand as an interested party in the ongoing case decisions. The Office of Hearings and Appeals as a whole, therefore, would be moved to the Office of the Secretary of HHS or, better still, to an independent adjudicatory agency.

b. Less "Second-Guessing" of ALJs. The current articulated standard of review of the Appeals Council is a check for "substantial evidence" to support the conclusions of the ALJ.³⁷³ However, no one believes that this 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, finding the evidence unpersuasive, etc. This type of examination not only consumes too much of the Appeals Council's time, it undercuts the respect for the ALJ and elevates second-hand over first-hand assessments of demeanor, credibility, etc.

A corrective device could be simply a call for greater self-restraint on the part of members, reserving their attention for the truly unsupportable ALJ actions. A more concrete step, however, would be to revise the standard of review, to one which enabled the Appeals Council to undo an ALJ action only when it was found to be "arbitrary." Because we think that under Model 3 the Appeals Council would reserve its attention for the most egregious ALJ errors, reining in the worst deviations from established practices, we conclude that an arbitrariness standard would be the appropriate method for handling the cases expeditiously.

c. Time Limits. To be effective as a Model 3 tribunal, the Appeals Council would have to do its work in less time. The single most frustrating aspect of appellate review for claimants and their representatives is the long duration of the uncertainty that they must endure while waiting for the Appeals Council to act or, more often, to decline to act.³⁷⁴ Whatever else it does, the Appeals Council, under Model 3, would simply have to improve this

373 See supra text accompanying notes 250-52.

374 See supra text accompanying note 267.

record. Fixed timetables might be applied, and claimants might be privileged to proceed directly to court if these were not honored. The reopening powers would not be exercised simply to enlarge the Appeals Council's time.

d. Broaden the Caseload. Under Model 3, the Appeals Council would not be confined solely to receipt of claimants' requests for review of ALJ denials. It would, in addition, return to the practice of taking a substantial volume of "own motion" cases, both ALJ awards and unappealed ALJ denials.³⁷⁵

The appropriate volume of cases for a Model 3 Appeals Council is a trickier question. In principle, an administrative appellate body ought to review all ALJ decisions. If the purpose of the Appeals Council is to promote accuracy and uniformity, then the most logical way of achieving those ends is through perusal of all the cases, not just a random or other sample.

On the other hand, as a practical matter, even an enhanced Appeals Council (and even one that was increased in size, which our vision of Model 3 does not contemplate) could not effectively consider a four-fold enlargement in its current case load. Some selection process, therefore, would have to be continued.

e. Close the Record After the Hearing. Again, as an appellate body, the Model 3 Appeals Council would not receive new evidence. It would review a closed record and leave it to the trial level (the ALJ) to consider any petition for reopening for the receipt of new material evidence.³⁷⁶

f. Better Support. The Appeals Council now labors under an inadequate supply of space, support personnel, and computational capacity. These would have to be upgraded under Model 3, perhaps in a fashion similar to our recommendations for improvements in these services, as contained in part E.3.f., below.

4. Conclusions about Model 3

We believe that Model 3 would be feasible. It would represent a substantial upgrading of the current Appeals Council, and would be designed to optimize its ability to handle prodigious volumes of cases expeditiously. Model 3 focuses exclusively on the goals of accuracy and consistency, and shaves off any explicit attention to the other possible goals of the organization; if the Appeals Council were transformed into this type of highly specialized entity, we believe that its performance on those

375 See supra text accompanying note 233.

376 See supra text accompanying note 255.

critical parameters could be appreciably upgraded, at modest cost.

On the other hand, we do not consider this option wise, and we do not recommend its adoption. Our reticence stems from the twin observations 1) that merely reviewing cases once again for accuracy and consistency is not such an overwhelming value in a system as large and subjective as SSA -- this task could be done, but it would not be worthwhile, and it would risk hypertrophy of what should be one of the system's lesser capabilities -- and 2) that the bureaucracy has other needs and other more important shortcomings that the Appeals Council is uniquely suited to address. If SSA uses the Appeals Council only as a stopgap, to process and correct the caseload, that could probably be accomplished well enough, but it would be a serious waste of a potentially valuable asset that can and should play a bigger role in the disability system.

For that reason, Model 3 is disfavored. Many of its specific implementing steps have inherent value, and several are recapitulated or modified in the discussion of the model we do prefer, but the overall organizing concept of Model 3 -- to entrench and refine the Appeals Council's current fixation with the individual cases -- we think inappropriate.

E. Model 4: Optimizing for System Reform

The final option, the one that has attracted our support, would reformulate the Appeals Council as a rather different sort of entity. It would still handle individual cases, and still serve a role in the identification and correction of errors, but that would no longer be the driving force behind its existence. Instead, the Appeals Council would function principally in a "systems reform" capacity, attempting to discover, elaborate, and implement changes in the entire disability adjudication system that could lead to better, earlier decisionmaking.

The individual cases, in this scheme, would remain important in their own right, but would also assume even greater significance as the raw data upon which analyses for system reform could be constructed. In other words, in Model 4, the cases (although far fewer of them) are still the primary input into the operation of the Appeals Council, but the primary output of the organization becomes "clarifications of policies" or "ideas for change," rather than simply a mass of corrected individual adjudications.

1. Arguments for Model 4

The rationale for the systems reform concept starts with the assessment that the Social Security Administration needs more assistance in the performance of the functions of policy development and program integrity, and that the Appeals Council is

well matched to fulfill this need. We do not see SSA's disability programs as being in shambles -- in fact, they appear to be functioning with surprising regularity, managing, somehow, to deal with overwhelming stresses each year. But the institution does need more help, more guidance in avoiding pitfalls and more insight in operating with greater efficiency and with a modicum of public support.

The Appeals Council, we conclude, is admirably well-suited to provide at least some of this needed assistance. It comprises an expert, experienced corps of senior officials, competent and imaginative, and blessed (or cursed) with access to a steady stream of diverse cases. It is the opportunity to collect these cases that occasions our hope for a "systems reform" role for the Appeals Council -- this is the only locus in the bureaucracy where all this rich raw data may be efficiently processed for thoughtful adjudication, and the important lessons extracted for the benefit of the entire system.³⁷⁷

Moreover, we believe that in the long run, there is no trade-off between the error-correction function and the systems-reform function. That is, the whole point of reforming the system is to enable it to operate with greater precision and speed -- if the plan works, the entire SSA adjudicative bureaucracy will operate more efficiently, making more accurate decisions and making them sooner. There would thus be fewer errors thrown up to the level of the Appeals Council, and fewer wrongful administrative denials to pursue in court. To return to the aquatic analogy, this function of the Appeals Council endeavors not merely to stem the flood of cases that threatens to overwhelm the federal courts; it aims at turning off the spigot of cases at, or near, the source, so that the raging torrent no longer develops.

2. Arguments against Model 4

One concern is that, even if systems reform does lead to better long-run performance by the adjudicatory bureaucracy as a whole, in the short run there will be fewer cases handled, and fewer errors caught, by the Appeals Council. Thus, at least some of the eligible claimants, those who are now denied by ALJs but paid by the Appeals Council, will be disadvantaged. They would have to go to court to enforce their claims, or abandon them altogether. It is hard to predict exactly how many people there might be in this category, but the number might not be negligible, and this would be a significant start-up cost of the transition to the new system.

377 See supra text accompanying note 344.

Another plausible concern is the apprehension that even if the institution of the Appeals Council is well-suited to systems reform work, some of the current members of the organization might not be so personally well-adapted to the new role. They were, after all, not selected with this type of function prominent in the job description, and their training and experience has largely emphasized other values. We take this objection seriously, but do not find it controlling. In fact, our observation of a number of current members convinces us that as a whole, they are well suited to this new type of work, and can be retrained to perform at a high level. The experience of recent years 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.

3. Implementation of Model 4

This plan differs in important ways from the "case-handling" paradigm sketched above as Model 3, but in many respects, the needed reforms in the current operation of the Appeals Council are congruent, and some of the recommendations made in this section will parallel, or expand, the comments made in part D above. Other recommendations, however, reflect the unique demands of an organization dedicated to systems reform, as opposed to individual case processing. We have identified six basic categories of changes that this model would require in the operation of the current Appeals Council.

a. Control the Case Load. This is the critical starting point for many of our subsequent recommendations. The Appeals Council simply must regain control over its docket -- as long as it labors under the weight of 50,000 or more case files per year, we despair of giving the members anything else useful to do. The recent volume of traffic has consumed all the resources of the organization, and has bent the members entirely to the task of churning out the cases, usurping any opportunity for reflection or innovation.

We do not know precisely how many cases is the "right" number for the Appeals Council to accept under the recommended plan, but we estimate that something on the order of 5,000 to 10,000 cases per year at the review level (i.e., 10-20% of the current caseload) would be appropriate. It is vitally important that the Appeals Council stay in the business of handling a substantial number of cases -- without that unique source of input information, the Appeals Council would become just another policy body divorced from the reality of the adjudication process. At

378 See supra text accompanying note 289.

the same time, however, the members must be able to surmount the piles of files, reflect upon the lessons that they contain, and carefully strategize about how to derive and implement needed changes.

In addition to regulating the volume of its cases, the Appeals Council must also be able exercise more control over the types of cases it sees, and we propose that the cases to be considered by the Appeals Council should be selected by the Appeals Council itself -- not by the disappointed claimants or by mailroom clerks' random choice. The Appeals Council should develop a strategy, assessing which categories of cases are most appropriate for scrutiny at any particular time -- and the categories could change with some frequency. We envision at least three general types of cases that the Appeals Council could usefully, and selectively, attack by careful sampling of a focussed group of cases.

i. New issues. The Appeals Council might well select for review a fixed number of cases that implement any new and potentially difficult regulations or procedures. (It could, for example, concentrate on recent mental impairment cases, on AIDS-related cases,³⁷⁹ or on cases that raise some particularly tricky issue of the new medical improvement standards.) Thus, the Appeals Council could provide quick feedback about the fashion in which the field offices and ALJs were beginning to process new matters, promptly identifying areas in which further clarification or training was necessary.

ii. Known problem areas. The Appeals Council might also focus attention, at a particular time, on any of several longstanding SSA disability issues, in which existing regulations were known to be problematic. Allegations of disabling pain unaccompanied by corresponding physical findings, for example, or assertions of disability via substance abuse, are perennial problems, and they might benefit from a sharp inquiry into the cases as they are actually handled in the field. The intersection between SSA cases and the decisions of a particular federal court in an acquiescence situation might be another example. The Appeals Council could undertake to study any of these issues by surveying a run of the ALJ and DDS outputs, in a way no other entity could easily do.

The Appeals Council might also be able to develop, over time, a profile of certain types of "error-prone" cases -- situations in which an ALJ or DDS is more likely to mistakes. Over time, it might become known that accuracy was particularly contentious in cases, for example, that raise transferability-of-skills disputes,

379 See Social Security Ruling 86-20 (1986).

or in cases where the claimant's treating physician and the SSA consulting physician disagreed regarding the diagnosis. Many authorities already concur that mistakes are not distributed randomly throughout the SSA caseload, but only the Appeals Council could conveniently perform the detailed analysis to try to figure out precisely where the worst occasions for repeated error truly lay.

The possibility of targeting particular ALJs, instead of particular types of cases, is more problematic.³⁸⁰ At this time we would not recommend a system of Appeals Council focus on "error-prone" ALJs, because the trauma of targeted Bellmon review was so destructive for the system and so damaging to the fabric of the relationship between the Appeals Council and its clients. But we would note that the dispersion of award rates among ALJs is greater than the system can be comfortable with, and it is possible that review guided at least in part by the track record of individuals or individual offices could play a role.

In this vein, the Appeals Council should be able to accept cases "certified" by ALJs who were uncertain about the application of a particular policy or standard. The Appeals Council, in fact, could invite this type of certification on selected matters, to determine precisely which types of cases were proving problematic for the lower tiers of the adjudication process.

iii. Random selection. Although we are generally uncomfortable with chance as an element in the selection process -- the concept smacks of justice by lottery rather than by individualized assessment -- we would permit the Appeals Council to elect, if it deemed fit, to review a certain number of cases at random. This would be a component of the Appeals Council's mandate for "fishing expeditions" to discover possible areas of cases for further future inquiry. That is, careful review of a run of random cases might suggest, for the first time, that there is another problem of the sort identified above, that would warrant intensive scrutiny.³⁸¹ We do not anticipate that this random selection would be a very important part of the Appeals Council's docket in the near future (there are plenty of problems of the first and second categories to keep it occupied for some time) but if this backlog were whittled down, random selection

380 See *supra* text accompanying note 234.

381 Observers in other administrative contexts have supported the value of these "fishing expeditions": "A succession of mine-run cases may hold hints of the emergence of new problems the significance of which the agency's staff may not be as likely to recognize." Freedman Rep., *supra* note 2, at 153.

might become an engine for identifying additional categories for review.

In all of this, the Appeals Council should have the ability to adjust its own jurisdiction, to change the makeup of the cases from time to time, and to remain flexible enough to uncover new areas in which its ability to study a run of cases with care could enable it to make a special contribution to the policymaking process.

It is worth noting here that the Appeals Council should be concerned with both allowances and denials -- until evidence suggests that attention should be focussed in either direction on a particular line of cases, the Appeals Council should look carefully at both sides of the product. Similarly, the Appeals Council should be at least as concerned with the product of the "best" ALJs and the "best" hearing offices, as with those at the other end of the spectrum -- part of the mandate is to discover what works well within the system, what attributes allow the best individuals and offices to be the best, and how their successes and strengths can be replicated throughout the system.

b. Enhance the Appeals Council's Role in Providing Input to the Policy Process. Fundamental to our concept of the Appeals Council is the notion that its basic mandate should be to offer assistance to the policymaking and policy-implementing process. The underlying purpose of its still-voluminous review of the individual cases is to provide a data base upon which the members can intelligently provide advice and assistance to the officials who make important policy decisions. We see this role being implemented in three ways.

i. Recommendations. First, when the issue at stake concerns large, important areas of policy, the Appeals Council can serve in an advisory capacity. The Appeals Council should conduct independent studies of its case load, and offer its conclusions and recommendations directly to the responsible policy officials. Also, the Appeals Council should delegate members to serve on various agency-wide ad hoc study groups, designed to discuss and propose new policies and practices. Again, the Appeals Council's perspective, based on systematic review of the cases, should provide an important source of knowledge for these committees.

The Appeals Council already has some experience in serving in these capacities; members have occasionally served on SSA study groups, and have suggested new SSRs.³⁸² What we propose is that this activity be greatly expanded and made into a centerpiece of the members' activities -- to transcend the individual cases and

382 See supra text accompanying note 311.

study and recommend new regulations, SSRs, and other policy changes that could lead to better disability adjudications.³⁸³

ii. Policymaking. Second, the Appeals Council should play a bigger role regarding the range of somewhat smaller policy choices -- those that do matter in processing the cases, but do not rise to the dignity of a regulation or SSR. Here, the Appeals Council should directly exercise leadership, providing guidance to the ALJs and the DDSs in the form of well-reasoned and carefully-articulated case decisions and policy pronouncements, which would have precedential impact on future deliberations. At least two vehicles are already available for this purpose: case decisions and Appeals Council "minutes".

The usual run of disability cases is so fact-specific that occasions for issuing forward-looking decisions are not frequent, but the Appeals Council should seek them, and seize the opportunity to promote uniformity by advertising throughout the system any common, successful approaches to the cases. Similarly, the Appeals Council can accomplish much the same goal, outside the context of any particular case, by returning to its former practice of issuing minutes that reflect its agreed posture regarding the details of some specific case or category of case matters.³⁸⁴ These, too, can upgrade the entire claims adjudication process, by developing, based upon mature consideration of the cases, improved mechanics that can be relied upon nationwide.³⁸⁵

In this context, the Appeals Council should also be responsible for advertising its work -- both its precedential cases and its minutes -- throughout the disability system. It should ensure that ALJs, DDSs, district offices, and claimants' representatives know in advance the best types of procedures and substantive standards that ought to be followed in the cases. The Appeals Council can thus promote uniformity and policy integrity by filling in the gaps inevitably left by the more weighty and ponderous tools such as rulemaking.

383 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." Freedman Rep., supra note 2, at 138.

384 See supra text accompanying note 317.

385 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 64, at 376.

This does not require that all Appeals Council decisions be published -- even a reduced caseload of 5,000 or 10,000 is a chore to disseminate -- but it does mean that the Appeals Council should look for opportunities to make its decisions worthy of publication, and ought to distribute far more of them far more widely. The current OHA Law Reporter is but a shadow of the degree of publication (and of effective indexing) that we have in mind.³⁸⁶

iii. Experimentation. The third avenue for participation in the policy process is for the Appeals Council to use its unique vantage-point to identify, encourage and exploit opportunities for conscious experimentation. The various DDSs, district offices and ALJs have a wealth of diverse experience on handling claims, but these resources are largely untapped. The Appeals Council should study the lower tiers, discover which ones have developed innovative improvements, help them refine their experiments, and, as appropriate, export the best ideas to other units. Although the substantive definitions and standards for eligibility should remain consistent throughout the country, there is less need for the implementing procedures to remain rigidly in lock-step, and local experiments, as supervised and studied by the Appeals Council, could hold the prospect for greater efficiency in the future.³⁸⁷

386 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." Freedman Rep., supra note 2, at 149.

387 The preservation of this type of individualizing discretion is essential for a complex administrative structure such as SSA. The lower tiers must be accorded the opportunity to work the cases with intelligence and sensitivity, not just 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 64, at 354, 372 (discretion for ALJs is essential and inevitable for SSA); Ellis Rep., supra note 2, at 166-67 ("[T]he consensus...is that the responsibility vested in the hearing examiners under the discretionary review procedures, has improved the quality of the examiners' work (Footnote continued)

c. Revise the Case Correction Role. Although the major role of the Appeals Council should be to use the cases as sources for ideas about system reform, it will still have the occasion to review a large run of individual cases. A number of subsidiary matters arises in this context.

i. Consider the cases in more detail. Fundamental to our concept of a reformed Appeals Council is the picture of an appellate body that really considers the cases carefully, analyzes them with deliberation and reflection, and is able to take the time to accord each one a thoughtful, provocative inspection. We have in mind, in short, a body that goes more slowly, pondering the cases more exhaustively.

We also have in mind a body that operates in a more integrated, collegial fashion, with members analyzing cases collectively and consulting about them frequently. We want the members to discuss and debate with each other often, trying to compare ideas and seek common solutions. Greater reliance should be placed upon decisions by panels, perhaps composed of three members, in order to ensure greater consistency and enable all members to learn together. Meetings en banc should become more frequent as the crush of cases is reduced.

We also recommend making greater use of the claimants and their representatives. Oral arguments should be held with some frequency, to identify the important, precedential aspects of the cases, and to raise ideas for management initiatives. Claimants should be notified about the issues that the Appeals Council is inspecting, and encouraged to respond with detailed argumentation. Organizations of claimants' representatives should be apprised whenever the Appeals Council changes the mixture of cases, and the types of problems, it is going to address, and they should be invited to submit amicus briefs. There is a great deal of expertise and knowledge available in the claimants' bar, and the Appeals Council should try to draw upon it with regularity.

The Appeals Council decisionmaking process, too, should slow down, and the files must be perused carefully -- no more whipping them in and out of a member's office with an average of 15 minutes' consideration or less.³⁸⁹ In order to extract the

387(continued)

product,...and has enabled the [Board] to dispose of many cases without review.")

388 See supra text accompanying note 282.

389 See supra text accompanying note 291.

possible lessons of the cases, the members and analysts will have to process them much more diligently -- including, where necessary to the purpose for study of the particular type of case, playing the tape recording of the hearing.

Finally, the decisions issued by the Appeals Council will have to be substantially upgraded: if the opinions are to have precedential impact, and if they are to carry due weight among the federal courts and the street level bureaucrats, then they will have to earn respect through the detailed presentation of law, evidence, and logic. We look forward to the Appeals Council drafting opinions that -- even if not rivaling the federal judiciary in length or diversity -- are at least clear, responsive, forward-looking and individualized enough to be free of mindless boilerplate or rote summarizing of the documentation.

ii. Role in correcting the cases. When the reformed Appeals Council moves more slowly and carefully through the cases it reviews, it is not immediately obvious what its role should be in correcting the errors that it may find. Three possibilities, in fact, appear.

First, the Appeals Council might have no role whatsoever in correcting errors -- even when it discovered mistakes, it could leave the ALJ's work undisturbed, because the function of the Appeals Council under our proposal is to look to the system as a whole, not to any one tiny output of it. A second model would permit the Appeals Council to remand an erroneous case back to the ALJ -- not with binding instructions to reverse it, but with a commentary explaining what problems have been identified, and suggesting that the ALJ might wish to exercise his or her discretion to look at the matter again. Finally, the Appeals Council might retain its current capacity for correcting, or remanding with instructions, any cases it deems flawed, even while it would devote the bulk of its attention to generalizations that it may draw from the particular incident.

Each of these variants has its attraction. The first two would enable the Appeals Council to concentrate its attention exclusively upon its central mandate, without the distraction of having to worry about effectuating individual cases. The second would even have the additional virtue of ensuring that error cases are not totally overlooked -- the ALJ might elect to remedy any mistake that the Appeals Council identified.

At length, however, we consider the third variant the most desirable. Under it, the Appeals Council could continue to focus primarily upon its reform capacity, without sacrificing entirely its current case-handling role. It would directly ensure that errors were not allowed to slip through, and it could use the occasion of decisions and remand orders to instruct the bureaucracy personally, teaching via the mechanism of prompt,

focussed 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 there can be a serious question about the Appeals Council role in case correction -- even if we ultimately do not propose to alter its existing powers -- is itself instructive. It demonstrates, first of all, that the primary function of a reformed Appeals Council is to transcend the individual cases, to generalize from them, and to identify the larger lessons they present. Second, it also demonstrates that the reason to act upon ALJ errors is not (as it too often seems to have been) simply to forestall a losing court battle -- instead of correcting "harmless error" for the purpose of making cases stand up better in court, the Appeals Council should inquire into all types of "error", to determine why they are made, how they can be prevented, and how deserving claimants can be identified and paid most quickly and easily.

iii. Standard for review of cases. When it inspects cases and moves to correct them, the Appeals Council should become less "interventionist", less prone to overturn ALJ findings and substitute its own judgment. Two rather different standards of review are required.

First, regarding ALJ determinations of fact, the Appeals Council should be bound by a standard of "arbitrariness," rather than the current "substantial evidence" test. As noted above, the "substantial evidence" criterion is breached too often; even when honored, it encourages the Appeals Council to try to fine-tune the cases for a degree of subtle accuracy that we do not consider significant. We want the Appeals Council to try to correct big errors -- substantial deviations from established standards -- and to use its experience for large policy purposes, not to second-guess an ALJ on a close call.

Second, regarding ALJ interpretations of law, the Appeals Council need show less deference. An ALJ who misunderstands the governing principles of a case, or who misstates the law, ought to be corrected. The dividing line between "factual" and "legal" issues may be a subtle and elusive one in an area so laced with detail, but it is a distinction that reviewing courts traditionally must make, and it should be an Appeals Council responsibility, too.

iv. Close the record after the ALJ stage. As noted above, we think the case record ought to be closed before the file is transmitted to the Appeals Council.³⁹⁰ The system ought to encourage claimants to make every effort to collect and submit all probative evidence to the ALJ; if new and material evidence arises subsequently, the claimant may seek a remand back to the hearing

level and submit a motion to reopen the file for its receipt. In the absence of good cause for reopening, the additional evidence could be associated with a new application. We do not think that the Appeals Council should be in the business of receiving new evidence -- its review should be more nearly appellate, on a closed record.

We appreciate that it is often difficult for claimants to assemble all the potential evidence quickly, and that where an ongoing condition continues to deteriorate, it is somewhat artificial to select any particular cutoff date for closing the file. However, orderly litigation, and a respect for the finality of administrative judgments, suggest the importance of segregating the trial-level and the appellate-level functions more strictly.

v. Improve timeliness standards. The problem of Appeals Council delays would be greatly mitigated under Model 4: most cases would not have to lie before the Appeals Council at all in order to exhaust administrative remedies, and those that did should be able to receive more swift consideration as an adjunct to the reduced caseload. Nevertheless, it might be advantageous to specify timeliness standards at the outset, and we think that the Appeals Council should be held to quite high levels of promptness.³⁹¹ Under Model 4, the Appeals Council ought to be able to decide, within 30 days of the ALJ's decision, whether the case meets one of its current profiles. It could then have an additional 60 days to work the case (more, if delays were attributable to the need to await some commentary or other input from the claimant.)

Cases remanded by the Appeals Council to the ALJ would be processed on the hearing office's regular calendar, although they might receive some special expedited handling.

390 See supra text accompanying note 255.

391 OHA leadership recognizes the imperative of improving the agency's performance on timeliness. See Bradley, supra note 298 ("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 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.)

The Appeals Council should not, moreover, be empowered to reopen a case merely because it has missed the ordinary deadline for review -- only factors such as fraud, clerical error, or obvious mistake should disturb the finality of the decision.

vi. Final agency action. We note that under this system, as in Model 2, the vast majority of ALJ decisions would become final agency determinations, with prompt payment for awards and immediate reviewability in federal court for denials. This arrangement is certainly unusual for modern administrative practice, where most departments provide for some degree of head-of-agency review between the hearing level and the judiciary.³⁹²

But neither the APA nor sound principles of SSA management require a fourth administrative tier. There is nothing magical about having the agency input come after, rather than only before, the hearing. And we find nothing compelling about a "Secretarial" review that, in fact, is already so divorced from the political leaders that it has long been quasi-judicial anyway.³⁹³

Little is lost, by claimants or by SSA, if the final administrative word comes most of the time directly from the ALJ, instead of coming after a cursory review by an over-burdened Appeals Council.

Similarly, for reasons discussed above, we do not believe that this model will result in a surge of federal court actions. In the short run, the other inhibiting factors will continue to operate, retarding frivolous recourse to the courts, as they always have -- it is these factors, not the current Appeals Council, that has winnowed civil actions. Moreover, in the long run, the reformed Appeals Council should actually be able to

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- 392 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) Also, under the Contract Disputes Act, Pub. L. No. 95-563, the Board of Contract Appeals makes final agency decisions in government contracts cases. 31 U.S.C. §1304 (a).
- 393 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 all those in SSA, are concerned instead with "micro" decisions, such as public benefits, in which "political" factors are irrelevant. See Lubbers, supra note 125, at 268.

reduce substantially the burden on the judiciary, as the administrative process becomes more accurate, more efficient, and more reliable.

d. Improve the Status of the Appeals Council and the Caliber of its Membership. Certain changes should be made in the personnel practices of the Appeals Council, in order to enhance its ability to carry out the systems reform mission more effectively.

i. Upgrade the position. Members of the Appeals Council are now graded at the GS-15 level, the same as SSA ALJs. While we are sympathetic to the proposition that the ALJs themselves are under-graded compared to their brethren at other agencies, it is abundantly clear that the members of the Appeals Council must be ranked one step higher still. 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 by itself carry a dollop of prestige that would help underscore the new role and new importance of the Appeals Council. It could symbolize the growth of the institution and SSA's commitment to it.³⁹⁴

Secondly, and more importantly, the promotion is essential to help attract the most qualified people to the position. Membership on the Appeals Council is not now a financial step up for an ALJ, and there is little else to induce the best and brightest of the hearing corps to aspire to membership on the Appeals Council. Money, of course, 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 should see appointment to it as the pinnacle of a career; for now, the most immediate way to elevate the institution is to dedicate a few supergrade or Senior Executive Service slots to it.³⁹⁵

ii. Upgrade the prerequisites. As the job of Appeals Council member becomes more attractive, and as progressively

394 Other observers have also noted the importance of ensuring that an administrative review panel have superior status. Freedman Rep., supra note 2, at 143.

395 Upgrading the status of Appeals Council members to GS-16 would not cost the agency much money, because a) most of the current members are already paid near the federal salary cap anyway and b) we propose reducing substantially the number of members. The symbol, however, would carry considerable importance.

higher-caliber people are drawn to apply for advancement to it, the selection process can become increasingly picky.³⁹⁶ It is particularly desirable that the senior ranks of the ALJ corps be seen as a fertile source of new members. The ALJs' hearing experience, their familiarity with the disability system, and their perspective on the cases are unrivaled. The Appeals Council would gain in stature by attracting the cream of the ALJ crop as members, and this would automatically give it greater credibility among the courts, the SSA leadership, and the public, as well as among the remainder of the ALJs.

We would not, however, make ALJ experience an absolute prerequisite for membership on the Appeals Council. We have met with too many other people, including current members, whom we believe capable of playing important roles in the Appeals Council, and who received their background training in other parts of the system. The Appeals Council, after all, should seek members based upon their individual talents and character traits, independent of the fora in which those attributes were honed. Personal knowledge of the hearing system is certainly valuable for an Appeals Council member, but it is not the only type of experience that has proven valuable. In short, we wind up recommending a strong, but not an absolute, preference for drawing new members from the ranks of the ALJs.

iii. Member independence. We recommend that Appeals Council members should have the high level of independence now guaranteed for ALJs by the Administrative Procedure Act. We concede that under Model 4, where the primary function of the Appeals Council would be the promotion of policy development and policy integrity, there would necessarily be a strong affiliation between members and the senior policy officials of the SSA. This might seem to require less need for full independence than does Model 3, in which the members truly function exclusively as appellate judges, and where their entire role depends upon the reality and the image of autonomy.

Nevertheless, we find more to gain than to lose from APA protection for members of the Appeals Council, even under Model 4. Independence will promote status. Independence will give the members the freedom to suggest novel, even risky, new policies for efficient and equitable case handling, without excessive worry about the prevailing political climate. And since members will still, under Model 4, be reviewing and issuing binding decisions

396 "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." Freedman Rep., supra note 2, at 143.

about eligibility in a great many individual cases each year, they will still be functioning in a quasi-judicial capacity, and should be acknowledged as such.

We are not impressed by the spectre of independence causing members to deviate wildly from SSA policies. We do not foresee any substantial danger that APA-protected members would abuse their status by irresponsible actions for which they could nevertheless remain above discipline. In fact, the track record of fidelity to SSA is good, and the selection criteria and the proposed bureaucratic role of the members should only serve to reinforce this tendency.

iv. Number of members. The current Appeals Council has grown to its present size largely in response to the mushrooming caseload -- as many as 20 members are needed simply to handle the contemporary number of files. In a modified posture, optimized to help manage and improve policies, the Appeals Council could be smaller, and a more compact group would carry the advantages of greater integration and consistency.

There is no magic number for the size of the organization, but a smaller group, such as eleven members, seems appropriate: large enough to be able to draw within its ambit a significant volume of cases, yet small enough to sit comfortably around a single table and reflect together upon their observations, to collegially develop a shared outlook and policy.

We envision an Appeals Council that operates with a high value upon internal consultation and collaboration, that meets en banc with great frequency, and that sticks with a problem long enough for the group as a whole to develop a shared consensus on a policy or recommendation. To accomplish this degree of harmony, the Appeals Council will need to be a more manageable size.

v. Titles of the organization. Under Model 4, the Appeals Council would no longer take "appeals" -- it would decide upon its caseload on its own, not at the instigation of a disappointed litigant. A new title, such as "Review Council," therefore seems more appropriate. "Members" could retain their current titles, although we do recommend that the "Deputy Chair" be recast as a "Chair," both to reflect the current reality about who actually leads the Appeals Council on a day-to-day basis, and to underscore the organization's independence from the Associate Commissioner, who would no longer hold an ex officio seat.

vi. Bureaucratic location. Under Model 4, the Appeals Council will need direct access both to the agency's top policymakers, and to the ALJs and lower-level claims processors. It serves, in a sense, as the liason between them -- independent enough to adjudicate cases, but connected enough to affect policy.

This combination requires a new bureaucratic stature: placement of the Appeals Council under a Deputy and Associate Commissioner is logically inconsistent with the role we have in mind. 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 here -- the Appeals Council must be closer to the action.

Accordingly, we recommend bureaucratic relocation of the Appeals Council³⁹⁷ to make it a component within the Office of the Commissioner. Its unique mandate should enable the Appeals Council to assume this special placement, and its combination of roles would most consistently fit at the top of the SSA hierarchy, outside the purview of any line office.

e. Enhance the Appeals Council Role in Court Cases. The bulk of these recommendations deals with the "review level" operations of the Appeals Council, and that is where the greatest needs and opportunities for improvement are to be found. However, the Appeals Council also plays a major role in shaping SSA's response to cases in litigation, and this, too, is an important source of experience for the systems reform role of Model 4.

i. Supplemental review. We recommend that the Appeals Council continue its current court interface work essentially as it has been. "Supplemental review" has an odd aura about it -- it is peculiar that SSA should get a fifth chance to consider the case, and to improve the documentation justifying a denial, rather than simply defend the case as it stands (or else pay the claim.)³⁹⁸ This practice has also introduced a new standard for awards ("presentation of a compelling or sympathetic -- but not legally "disabling" -- case that a court will like"), unavailable to claimants earlier in the process. Supplemental review may also be used improperly as a crutch -- suggesting that careful early claims work is less necessary, because erroneous denials can be

397 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, *supra* note 125, *passim*. 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.

398 See supra text accompanying note 296.

corrected later, if the claimant has the tenacity (and the resources) to proceed to court.

We like the idea of attempting to negotiate or settle cases without litigation, by using alternative dispute resolution techniques that have proven efficacious elsewhere, but SSA really has little to negotiate with or compromise over. The disability program ought not to be in the practice of paying benefits to a claimant simply because he or she would be an evocative litigant in a court, if lawful eligibility criteria are not met.

On balance, we have no clearly better alternative strategy to propose, and we note that participation in the supplementary review function carries the virtue of providing the Appeals Council with a valuable window on the world of federal litigation, complementing its perspective on the administrative processing of claims.

ii. Court remands. For similar reasons, we basically endorse the current³⁹⁹ operation of the Appeals Council in court remand situations. Although some internal adjustments should be made (e.g., less reliance upon "fast track" remands, and more careful articulation of guidance to the ALJ), we think that the Appeals Council can serve as a useful intermediary in cases coming down from the courts, even if it did not see that particular case on the way up.

iii. Appeals. The Appeals Council ought to be⁴⁰⁰ more involved in advanced court litigation strategy, as well. This is a complicated and frustrating area of practice -- lawyers from HHS and Justice frequently disagree over whether appeals are tactically wise, legally justified, or of sufficiently high priority. These differences will continue, no doubt, but the Appeals Council should have a voice in discussing them. The Appeals Council can contribute a special bureaucratic perspective in appellate planning -- not the only⁴⁰¹ such perspective, but a valid one that should not be ignored.

399 See supra text accompanying note 307.

400 See supra text following note 309.

401 SSA officials acknowledge that litigation strategy decisions are complex, and that the current process for making them is sometimes tumultuous. See Bradley, supra note 298, ("I'm interested in litigation management. I think SSA, and OHA, is 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 (Footnote continued)

More generally, the Appeals Council should improve its ability to monitor disability cases as they proceed through court. Members should track the cases they work on, studying courts' reactions and attempting to extract lessons of future applicability.

It is worth inserting here the hope that the federal courts will let SSA improve under Model 4. SSA's recent performance and track record in the federal courts have been abysmal, and the agency's reputation has fallen so low that little deference can be expected. Perhaps this disrepute has recently bottomed out, and perhaps the worst incidents (the initial wave of CDRs, targeted Bellmon review) that triggered the animosity are largely behind us. But there is a danger that the federal courts will be reluctant to retreat again to the customary standard of "substantial evidence" review. The courts see only a skewed sampling -- only denials where there is a good argument that the claimant has been wronged -- and it is natural that federal judges would continue to see themselves as the champions of the disenfranchised, without recognizing that the SSA pays administratively 99.6% of the awards without judicial intervention.

As SSA's performance improves -- assisted, we hope, by a reconfigured Appeals Council -- its success rate in court should begin to improve, too. We hope that the lag between the two changes will not be too great -- that courts will acknowledge, and give credence to, systematic improvements in the disability adjudication process. But we are not sanguine that ponderous bureaucracies, such as the Social Security Administration and the federal judiciary, will react with either grace or speed. Our recommendations, therefore, are not a short term panacea, but a formula for longer term accomodation, and subsequent monitoring will be required.

f. Enhance Support Systems. To support the improvements called for in Model 4, the Appeals Council will require a variety of types of assistance.

i. Reorganize OAO. We imagine a somewhat smaller operation in OAO, as fewer analysts will be needed to handle the smaller caseload. (Partially offsetting this reduction in volume

401(continued)

to that whole judicial process. That is also the Commissioner's priority, at least in terms of the 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.")

of cases, however, will be the need to work the remaining cases with greater intensity.) Certainly OAO should be reorganized to team a defined group of analysts and support personnel with each small panel of members. These units should become more coherent and mutually supportive than is permitted by the overlapping responsibilities of today's structure.

The possibility also exists of merging OAO and the Appeals Council into a single bureaucratic unit, although this is a closer question under Model 4. Since members' functions would be tied primarily to systematic reform, instead of to work on the cases, there might emerge a greater functional distinction between roles of members and the roles of analysts than there has previously been. This might suggest less need to integrate the two groups. On the other hand, it does seem preferable to organize these work units tightly, and OAO in the future could focus its attention on recruiting analysts who were not only good at reading the claims files, but who were also adept at assisting the members in performing their other functions, too. On balance, therefore, we also recommend merging OAO into the Appeals Council.

ii. Law clerks. Members of the Appeals Council should also have personal law clerks, a modest expense for the bureaucracy, and a significant asset in organizing the work. The savings in efficiency, in enhanced productivity for the members' performance of their primary obligations, should be substantial.

iii. Computer support. The data processing and word processing capabilities of the Appeals Council are in need of major improvement. The current hardware is minimal and already obsolescent. The software is far beneath the standard of the industry, and the Appeals Council is not yet able to attempt many of the manipulations it ought to be able to perform with ease. The staff support is virtually non-existent; indeed, even the current level of performance would not be available, but for the ingenuity of a single self-educating staff member.

The first order of business must be modern word processing capability. The needs of the Appeals Council are not so sophisticated, and its demands are not so heavy that the highest technology system is required; but a solid and adequately-proliferated network would be a major asset. We do not have the expertise to recommend a specific system, but it seems clear that each member should have a word processing capacity -- the savings in delays for minor corrections alone would be substantial, and would be even greater if the analysts, too, were brought into the modern world.

Data processing, too, is a crying need. The Appeals Council now is barely able to track its files, and the system is not considered sufficiently reliable to dispense with old manually-maintained index cards as a backup system. 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 useful policy generalizations out of the flow of individual adjudications. At present, the data processing capability of the Appeals Council is in its infancy, and abrupt upgrading is required.

All Appeals Council and ALJ decisions are now produced via a word processor, but the memory of each decision is ordinarily erased as soon as it is issued, in order to save storage capacity. We recommend that this deletion practice be halted immediately, and that the full text of all OHA adjudications be retained indefinitely, for a variety of purposes. The Appeals Council may 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 assist them in researching precedential cases; and other uses may appear with current or future data search techniques.

More generally, we recommend that the Appeals Council, or OHA on behalf of the ALJs as well, seek the advice of qualified systems engineers who specialize in the storage and retrieval of this type of material. Consulting experts of this sort are frequently relied upon by private industry and law firms, and SSA, too, could benefit from their ability to evaluate the institution's needs and match it with the available technology.

iv. Office space. Finally in the category of "support," we recommend changes in the members' office arrangements. OHA is now scattered over five buildings in Arlington, Virginia, and we think it ought to be consolidated in one location, preferably within the SSA headquarters complex in Baltimore. The principle of using physical remoteness to underscore the judicial independence of the members is, we think, a valid one, but it bends before the greater value of having the Appeals Council sit nearer the policymakers it is intended to assist. Under Model 4, the Appeals Council, and the whole of OHA, should become more of a player in the policy process, and that requires a headquarters location.

g. Enhance the Appeals Council's Visibility. Mashaw wrote of the Social Security claims procedure in general that, "The internal workings of the process that might inspire confidence...are invisible."⁴⁰² Nowhere is this more true than for the Appeals Council. Precious little is known about the nature and operation of the organization, and its members and their activities are largely shrouded from view.

402 Mashaw, supra note 1, at 143.

In part, this invisibility may spring from a degree of defensiveness about the institution -- reluctance to advertise the true facts about the low reversal rates and the high volume of cases per member per day. But the invisibility has incited a substantial cost in terms of public acceptability, and we recommend that it be reversed.

In particular, we recommend that the Appeals Council publicize itself, and conduct outreach activities designed to enhance the public's and, in particular, the claimants' bar's, knowledge about its work. Claimants and their representatives have a lot to say about the operation of the disability adjudication system, and the Appeals Council can be one point of contact. We do not expect this greater interaction to result in easy conformity of views or harmony of interests, but we do think that the worst aspects of an image of arbitrariness and futility can be cast aside. And, of course, it should become easier for claimants or their representatives to contact the Appeals Council, to learn the status and scheduling of a particular case.⁴⁰³

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- 403 The current SSA mechanism, which a claimant is supposed to follow 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 217, at 26.

We think that Appeals Council members should make more public appearances, participate in bar activities more, and write about their work, in the interests of enhancing public acceptability of their activities. They should meet with federal judges, too, to discuss disability matters in general and case-handling in particular.

Inside the SSA, the members of the Appeals Council should endeavor to build bridges to the ALJs and to other parts of the organization. We liked the "visiting ALJ" program and think it should be reinstated -- at least one, and maybe more, seats on the Appeals Council should be reserved for ALJs who accept a temporary assignment with the Appeals Council, 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 ought to be traffic in the opposite direction, too. That is, Appeals Council members ought to take occasional temporary duty assignments as ALJs, conducting hearings in the field, to learn from that perspective, too. Even those members who have "graduated" from the ALJ corps could benefit from an occasional refresher.

Similar interfaces, and perhaps similar exchange programs, ought to be instituted with the other components of SSA -- the district offices, the state disability determination services, etc. Since Model 4 gives the Appeals Council responsibility for participating in the process of enhancing the operations of the entire disability adjudication network, it ought to have more regular and meaningful contact with the lowest tiers, too. In this way, the Appeals Council may be able to get some sort of handle on the operations of the behemoth that the disability program has become, and help derive top-to-bottom improvements in it.

Most importantly, the Appeals Council will require greater visibility within the higher echelons of SSA. For too long, the Appeals Council has been too isolated; it must now re-emerge as a key player, with direct action channels to the leadership. The "policy development" role can succeed only if the policymakers want it to -- they must be willing to accept the Appeals Council members as participants, and must consciously alter existing routines in order to admit a new set of perspectives.

V. Conclusion.

Having considered the available models for future Appeals Council operations, we conclude: 1) that the status quo is too deeply flawed to be sustained -- the present structure is not doing the job to anyone's satisfaction; 2) that the Appeals Council should not be abolished -- at least not yet, before one more effort at serious reform; 3) that a "case correction" role could be carved out to let the Appeals Council perform this function more successfully -- but this role would still prove unsatisfactory, pursuing a chimera of accuracy and wasting the Appeals Council's real comparative advantage; and 4) that the role of systems reformer -- suggesting new policies, developing new practices, and implementing new experiments -- is the most valuable mandate for the Appeals Council, enabling it to put its case-handling experience to the best use, and empowering it to aid SSA in the most needed fashion.

The systems reform mode of the Appeals Council, and the several specific implementation steps we have outlined, are not easy or inexpensive. Nor is there any guaranty of success. Effectuation will require the conscious action of the SSA leadership, including the personal attention of the Commissioner.

But we are confident that the proposal is feasible, and we are convinced that it would be highly advantageous. The Appeals Council stands now as both over- and under-utilized. It is buried in case files, but its acquired expertise is never marshalled or implemented. Our study of the Appeals Council has made us appreciate its potential, and despair of its wastage. The Social Security Administration, and its claimants, can and should do better.

Chart 1

SSA's Sequential Evaluation Process for Assessing Disability

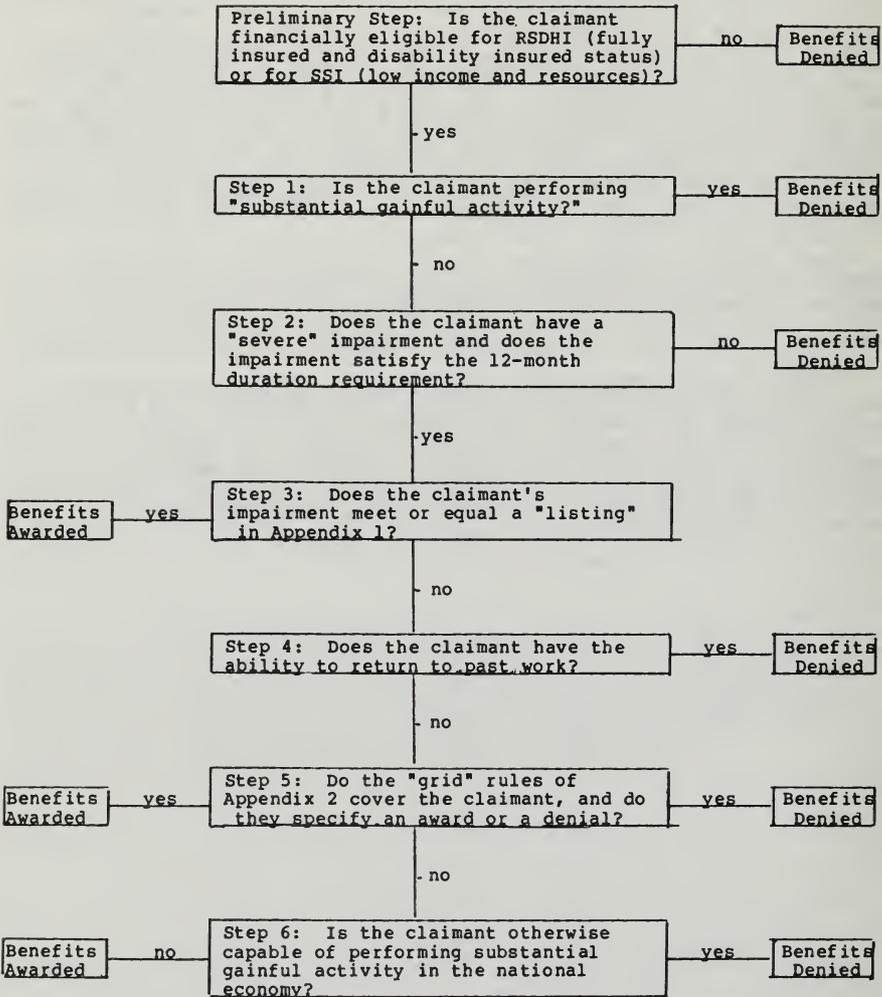
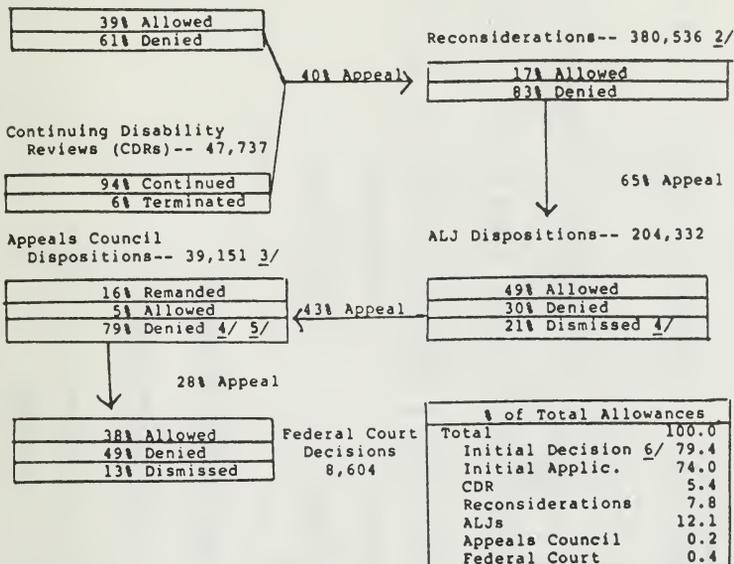


Chart 2

TABLE 4.—DISABILITY DETERMINATIONS AND APPEALS, FISCAL YEAR 1986

Title II, Title XVI and Concurrent Title II and XVI Decisions
For Disability Claims by Workers, Widows, Widowers and
Disabled Adult Children 1/

Initial Determinations -- 1,558,346



1/ The data relate to workloads processed at the various levels in FY 86, but include some cases where the initial level decision was made in a prior period. The data include determinations on initial applications as well as continuing disability reviews (both periodic reviews and medical diary cases).

2/ Title II only. Title XVI and concurrent Title II/XVI cessation cases go directly to an ALJ hearing.

3/ Includes ALJ decisions cases not appealed further by the claimant but reviewed by the Appeals Council on its "own-motion" authority.

4/ Includes periodic review cases in which benefits were reinstated under Secretary Heckler's suspension of the continuing disability review process in April 1984.

5/ Includes dismissals, denials of request for review, and affirmations of denial.

6/ Initial determinations plus CDRs.

SOURCE: "Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means," WMCP: 100-4, Committee on Ways and Means, U.S. House of Representatives, March 6, 1987.

Chart 3
Partial SSA Organization Chart

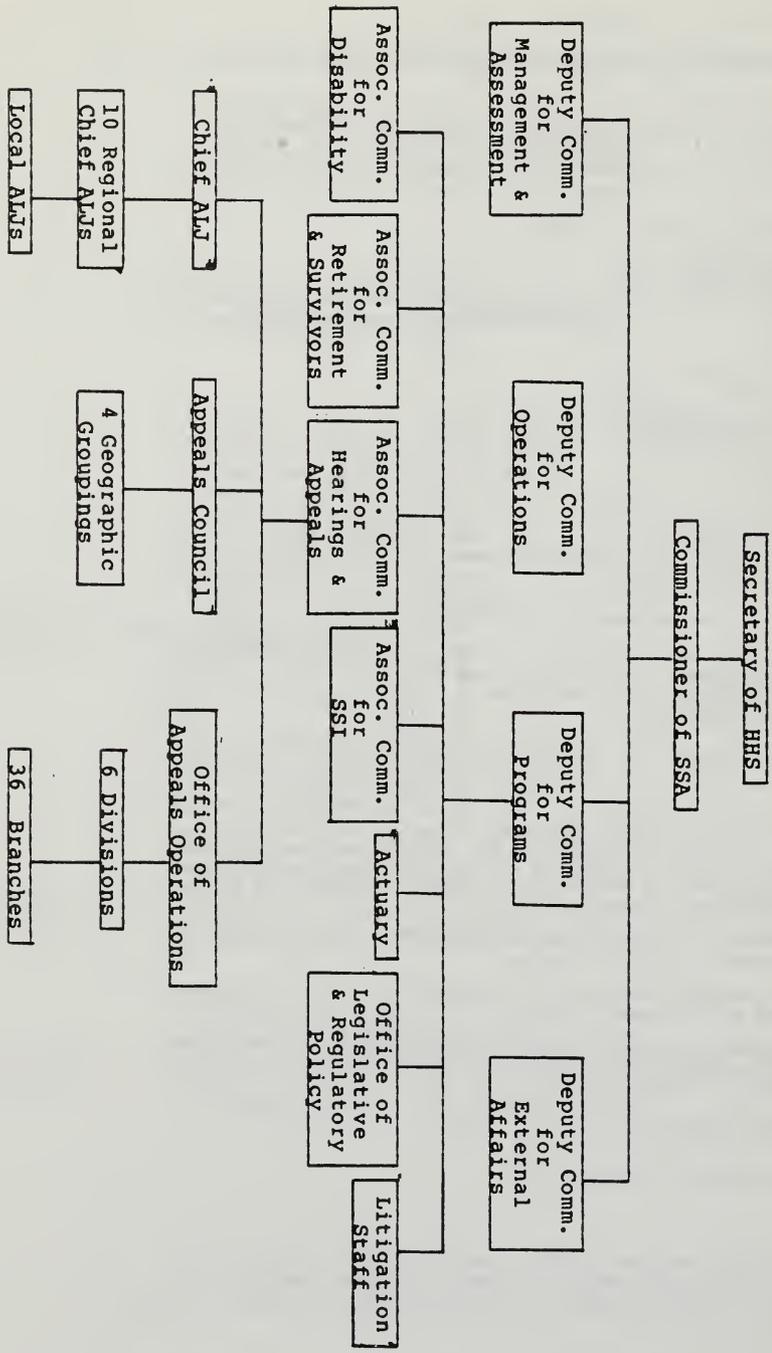


Chart 4

Geographic Groupings of Appeals Council Members

		SSN Terminal Digit Case Nos.
Group I	John W. Chambers	000-249
1, 2, 11 Circuits	William Raffel	250-499
	William C. Taylor	500-749
	John Wojciechowski	750-999
Group II	Larry K. Banks	000-199
3, 4, 7 Circuits	Verrell D. Dethloff, Jr.	200-399
	Adelaide E. Edelson	400-599
	Constance T. O'Bryant	600-799
	Lawrence Weiner	800-999
Group III	Marilyn W. Carney	000-165
5, 8, 9, DC Circuits	Felix V. DeJesus	166-331
	Samuel H. Depew	332-498
	Harriet A. Simon	499-665
	Margaret W. Tryon	666-832
	Roland L. Vaughn, Jr.	833-999
Group IV	David G. Danziger	000-249
6, 10 Circuits	Jeanette E. Perry	250-499
	Manny H. Smith	500-749
	Andrew E. Wakshul	750-999

Chart 5

Source: SSA OHA Key Workload Indicators, July, 1987

INTERNATIONAL SUMMARY - INDIANAS

FISCAL YEAR	ADJUSTED PRESENTS	DISPOSITIONS	PENDING (END OF)	AVG. NO. ALJs ON DUTY 1/	AVG. STAFF RATIO 2/	AVG. DISP. PER ALJ 3/	AVERAGE PROCESSING TIME		AVG. NO. OF CASES PENDING PER ALJ 3/	AVG. AGE OF PENDING CASES 5/	DAYS MONTH OF PEND. 6/
							HEAR. TO HEAR. TO DISP. 4/	HEAR. TO DISP. 4/			
PT 73	72,202	68,356	36,780	420	2.2	14	174	174	117	N.A.	184
PT 74	121,504	80,783	77,233	478	2.7	13	164	164	122	N.A.	224
PT 75	154,962	121,026	111,169	591	2.9	16	153	153	173	N.A.	269
PT 76	157,688	89,769	84,916	647	3.6	21	288	288	153	N.A.	293
T.O. 7/	45,418	50,271	51,351 9/	637	3.6	21	233	233	137	N.A.	187
PT 77	193,657	186,822	74,747	629	3.8	27	177	177	136	N.A.	193
PT 78	196,428	215,445	190,212	653	3.9	27	151	151	143	N.A.	138
PT 79	226,240	210,775	224,399	656	3.9	30	159	159	169	N.A.	152
PT 80	252,023	224,589	179,764	699	4.4	32	164	164	188	N.A.	163
PT 81	281,737	262,608	155,896	754	4.7	34	121	121	203	N.A.	164
PT 82	320,530	342,998	173,431	797	4.6	37	121	121	228	N.A.	167
PT 83	371,809	337,459	107,781	763	4.7	37	121	121	144	N.A.	157
PT 84	415,990	245,829	107,042	730	4.5	29	108	108	154	N.A.	154
PT 85 3/	245,990	220,313	117,384	703	4.6	27	115	115	173	N.A.	161
PT 86	230,655										
PT 87											
October	22,575	22,575	17,561	686	4.5	26	115	115	176	N.A.	165
November	19,904	42,479	15,492	685	4.6	23	116	116	167	N.A.	172
December	21,388	63,867	17,557	50,610	4.6	26	116	116	193	N.A.	179
1st Qrt.	68,273	68,273	52,415	684	4.6	26	116	116	179	N.A.	177
January	18,400	86,673	17,072	69,487	4.6	26	120	120	202	N.A.	184
February	22,695	109,368	17,075	67,520	4.5	26	124	124	213	N.A.	195
March	26,550	135,918	20,891	107,453	4.6	22	130	130	226	N.A.	192
April	72,019	140,292	57,314	109,729	4.6	26	124	124	213	N.A.	195
2nd Qrt.	21,158	161,450	20,676	130,405	4.6	26	124	124	213	N.A.	195
May	19,244	160,694	15,027	146,429	4.7	29	136	136	228	N.A.	201
June	26,252	206,986	23,147	151,256	4.7	29	136	136	228	N.A.	201
3rd Qrt.	70,776	111,676	65,549	175,278	4.7	34	136	136	237	N.A.	195
July	20,327	231,617	24,846	198,124	4.8	36	140	140	207	N.A.	192

1/ PT 73 - 86 includes RCALJs. Beginning PT 87 excludes RCALJs. Beginning PT 83 includes only hearing office full-time permanent staff PT 73 - PT 76; PT 79 - PT 82 includes RCALJs and temporary positions; beginning PT 83 includes only hearing office full-time permanent staff excluding interpreters.

2/ PT 73 - 82 includes RCALJs. PT 83 - PT 86 ALJ average dispositions are calculated using one-fourth of a work month for each RCALJ, adjustments for ALJs on leave, and the learning curve for new ALJs. Beginning PT 87 the RCALJs are excluded from the calculations.

3/ Median Times for PT 73 - PT 74; beginning PT 75 mean times - SSI cases not included until PT 76 transition quarter.

4/ SSI cases not included until PT 76 transition quarter. Fiscal year figures are based on cases pending at the end of the year. Monthly figures are based on cases pending at the end of the month.

5/ Fiscal year figures are based on cases pending at the end of the year. Monthly figures are based on cases pending at the end of the month.

6/ T.O. - transition quarter which covers period June 20, 1976 - October 2, 1976.

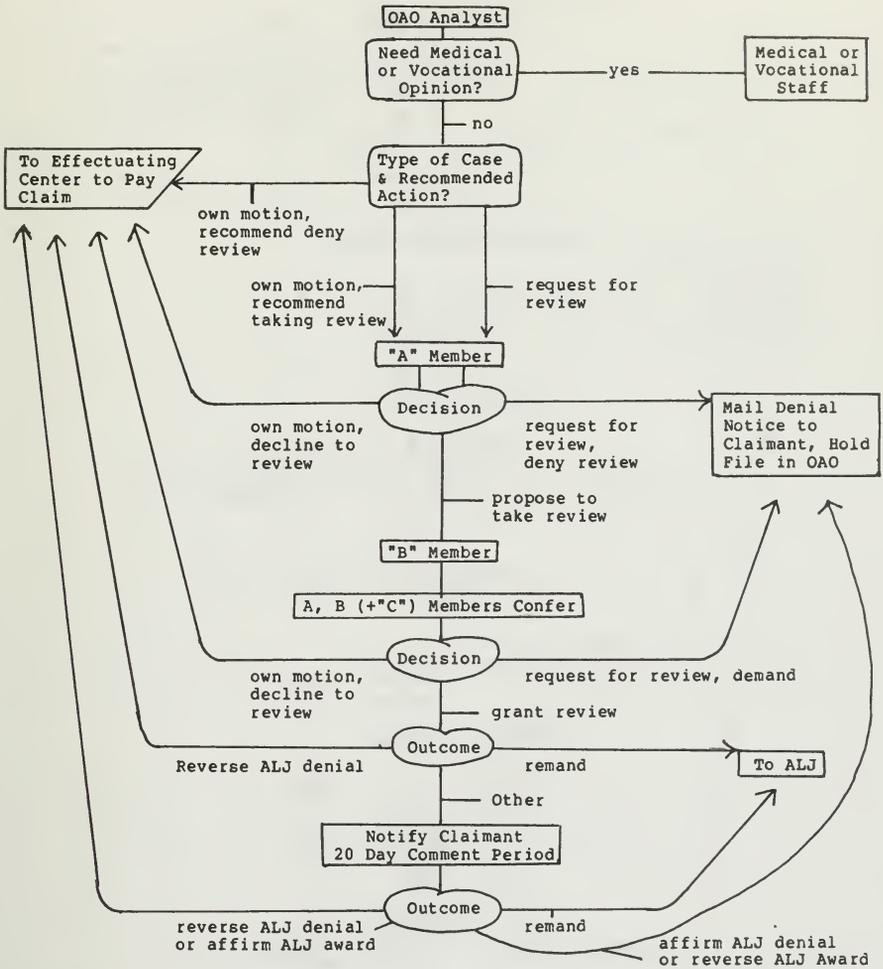
7/ Adjusted up 2,013 cases from PT 77 due to conversion from a manual to an automated reporting system.

8/ Some statistics were affected by the Secretary Memorandum on the Processing of continuing disability reviews, various class action court orders and implementation of the 1980 Disability Benefits Reform Act.

NOTE: This data includes pending and processing times for sanction cases which began in 1983.

Source: Average number of ALJs on duty and average support staff ratio from Staffing Report, Office of Statistical Management.

Chart 6A - OHA Workflow -- Review Level



File may be returned to OAO at any stage for further workup or rewriting decisional documents.

Chart 6B - OHA Workflow -- New Court Cases

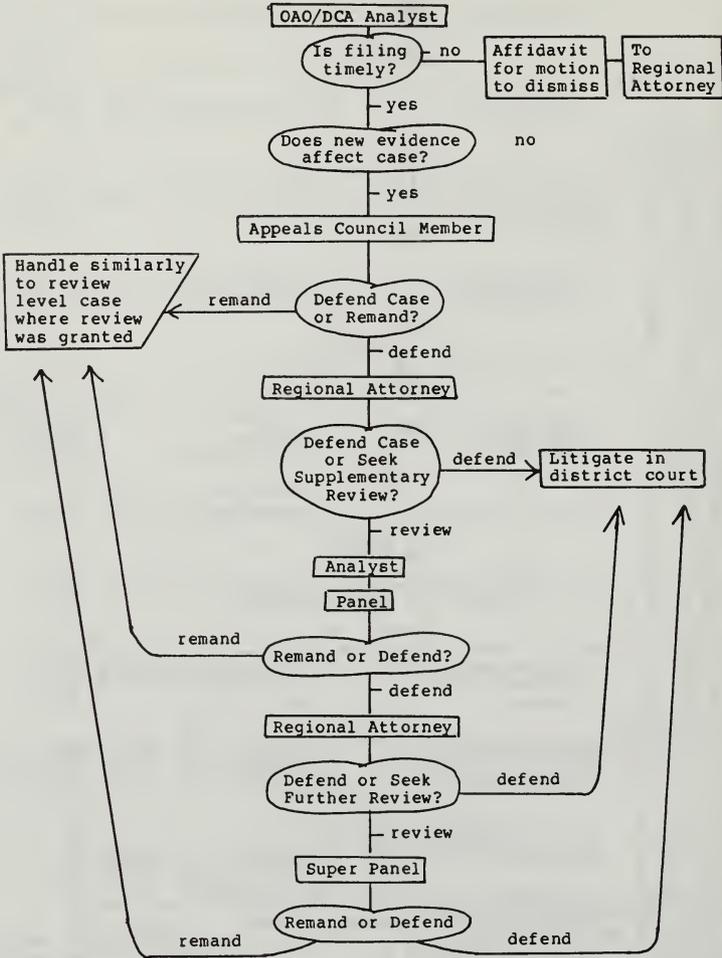


Chart 6C - OHA Workflow -- Court Remands

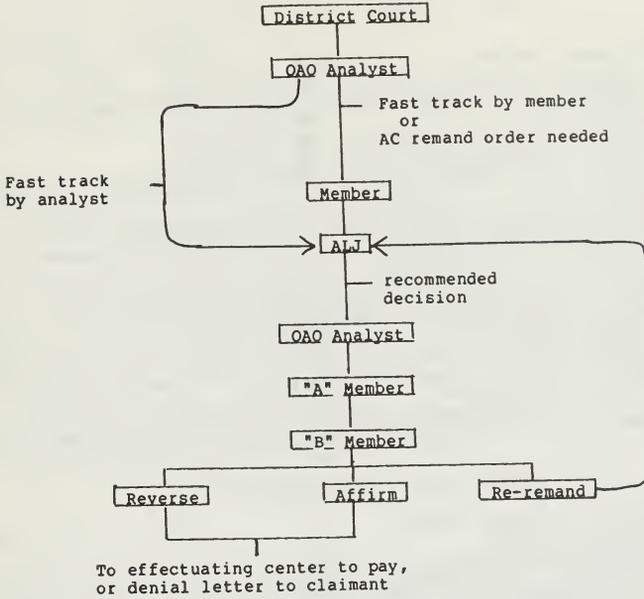


Chart 7

List of Sources Interviewed

1. SSA Officials and Former Officials

Eileen Bradley, Associate Commissioner for Hearings and Appeals
Hal Bryson, Office of Disability Operations
Louis Enoff, Deputy Commissioner for Programs
Donald Gonya, Associate General Counsel of HHS and SSA Chief Counsel; former Acting Associate Commissioner for Hearings and Appeals
Louis Hays, Associate Administrator for Operations, HCFA; former Associate Commissioner for Hearings and Appeals
Sid Leibovitz, SSA Historian
Joe Mieczkowski, District Manager, Washington, D.C.
Patricia M. Owens, Vice President, Paul Revere Insurance Group; former Associate Commissioner for Disability
Harvey Schein, Office of Disability Operations
Dan Skoler, Director, Education and Training Division, Federal Judicial Center; former Deputy Associate Commissioner for Hearings and Appeals
Frank Smith, Chief Counsel, Family Support Administration; former Associate Commissioner for Hearings and Appeals

2. Appeals Council Members and Former Members

Burton Berkley, Deputy Chair
John Chambers, Member
Adelaide Edelson, Member
Herman Elegant, former Member
Irwin Friedenber, former Deputy Chair
Constance O'Bryant, Member
Harriet Simon, Member
William Taylor, Member
Margaret Tryon, Member
Roland Vaughn, Member
Andrew Wakshul, Member

3. OAO Officials

Ora Brown, Branch Chief
Gary Gilliam, Analyst
Carolyn Goodwin, Analyst
William LaVere, Deputy Director
Edwin Semans, Director
Sue Wiley, Analyst

4. Administrative Law Judges

*Harry Farbman, Miami, FL
*Mark Haase, Columbus, OH
*Paul Harkey, Dallas, TX
William Lissner, Richmond, VA
*Paul Rosenthal, Santa Ana, CA; former National Chief ALJ
Jim Rucker, National Chief ALJ, Washington, DC
Sanford Serber, Washington, DC

5. Claimants' Representatives and Spokespersons

Bruce Billman, private practice, Woodbridge, VA
Nancy Coleman, ABA Commission on the Elderly, Washington, DC
Joan Fairbanks, ABA Commission on the Elderly, Washington, DC
*Lyle Lieberman, private practice, Miami, FL
*Steven Owen, private practice, Washington, DC
*Rudolph Patterson, private practice, Macon, GA
Michael Schuster, Legal Counsel for the Elderly, Washington, DC
*Marvin Schwartz, Social Security Disability Foundation, New York;
former ALJ
Nancy Shor, National Organization of Social Security Claimants
Representatives, New York
Eileen Sweeney, National Senior Citizens Law Center, Washington, DC
*Carl Weisbrod, private practice, Dallas, TX
*Sally Hart Wilson, National Senior Citizens Law Center,
Los Angeles, CA

6. Congressional Sources

Fred Arner, Social Security Disability Foundation, former
Social Security Subcommittee Staff
Pat Dilley, Staff Director, Social Security Subcommittee, Ways
and Means Committee
Joe Humphrys, Senate Finance Committee Staff
Margaret Malone, Senate Finance Committee Staff
Carolyn Weaver, American Enterprise Institute, former Senate
Finance Committee Staff
Karen Worth, Senate Finance Committee Staff

7. Court Personnel

*Robert Carr, U.S. Magistrate, Charleston, SC
*Dale Cook, Chief Judge, U.S. District Court for the Northern
District of Oklahoma; former Director of Bureau of
Hearings and Appeals

8. Academia

*Frank Bloch, Professor of Law, Vanderbilt University
*Jerry Mashaw, Professor of Law, Yale University

*Interviewed via telephone