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Disability Appeals in Social Security Programs

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DISABILITY APPEALS IN SOCIAL SECURITY PROGRAMS

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1985

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Cite as L. Liebman, Disability Appeals in Social Security Programs (Federal Judicial Center 1985).

FJC-ETS-85-5

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I. INTRODUCTION

The United States makes income-support payments to persons who are permanently and totally disabled under two programs: Old Age, Survivors, and Disability, popularly known as Social Security Disability or SSD, and Supplemental Security Income, known as SSI. These are vast federal undertakings. In June 1984, there were about 3.8 million recipients of SSD benefits, including disabled dependents of covered workers, who received benefits at an annual rate of about $18 billion. SSI disability benefits were paid to more than 2.4 million persons at an annual rate of $6.1 billion in federal payments and about $1.1 billion in state supplements.

But the disability system is more than a large check-writing machine. Deciding whether an individual is disabled frequently requires a difficult and complex decision. For that reason, the existence of the two disability programs has required the U.S. Social Security Administration to create the largest system of administrative adjudication in the Western world. Since 1974, claims for disability benefits under the two programs have averaged about 1,250,000 per year. In addition, the government must review the continuing eligibility of perhaps six million persons (a 1980 statutory amendment requires a review every three years for most cases). Moreover, because more than 20,000 disability cases have been taken to the federal district courts each year in recent years,[1] the programs impose heavy burdens on the federal court system and raise urgent questions about the role of the judiciary in the administrative state.

The disability determination system has recently become controversial. Responding to constituent complaints about Reagan administration efforts to trim the rolls, Congress has granted disability applicants and recipients greater procedural rights.[2] The Association of Administrative Law Judges has sued the secretary of Health and Human Services, claiming that the Social Security Administration improperly attempted to restrict the administrative

1. Administrative Office of the United States Courts, 1984 Annual Report of the Director, at 138–39.

2. Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, 42 U.S.C. § 423 (Supp. 1985).

law judges' role in evaluating individual cases. And in May 1983, the Supreme Court upheld the Social Security Administration's "grid" regulations—a matrix for categorizing applicants according to age, education, physical condition, and work experience as a step in the process of deciding eligibility.

The disability determination process poses two difficult intellectual issues. The first is where to place the borderline of eligibility. Many people do not do well in the labor market. They drink or use drugs or are not very healthy, or they lack skills or cannot obtain the kind of work they used to do. Which of them suffer from a "medically determinable physical or mental impairment,"[3] and so are entitled to benefits, and which of them do not, and thus must live on what they can earn plus Aid to Families with Dependent Children (AFDC) or general relief or food stamp benefits that are less generous than disability payments? Every case is different, many are close to the line, and it is hard to make fair decisions.

The second issue is how to resolve the tension between Social Security as a benefit program and Social Security as an insurance program. Social Security has been described to the public as an insurance program. Individuals who have achieved eligibility within the Social Security system believe they are entitled to disability benefits if medical problems make them unable to continue working. Many steps toward administrative rationality and efficiency—inevitable and appropriate in so large a program—seem to conflict with the individual's claim to a fair response to his individual situation.

The difficulties of drawing the eligibility line and ensuring individual attention to individual situations are the two reasons why judicial review has played such an important role in these programs. The courts deal with individual cases and give individual responses. The public and Congress seem to want the judiciary to ensure that the administrative agency, inevitably bureaucratic and budget-conscious, treats claimants properly and decides cases correctly. But the resulting burden on the courts is heavy.

Disability coverage was first incorporated into the Social Security Act in 1954 with the so-called disability freeze, which preserved disabled workers' eligibility for retirement benefits.[4] In

3. 42 U.S.C. § 416 (1983).

4. The "disability freeze" provided that covered workers who became disabled were made eligible for benefits once they reached age sixty-five as if they had continued working. Thus, the work record of disabled persons was preserved. The freeze is still part of the law and figures in cases concerning protection against later reduction of retirement benefits due to the period out of work. *See* 42 U.S.C. § 416(i) (1983).

1956, cash benefits were authorized for workers fifty or older who became permanently and totally disabled. The age requirement was eliminated in 1960.

Supplemental Security Income, enacted by Congress in 1972, is a federal income-support program for needy individuals who are aged, blind, or disabled. The definition of disability in the SSI statute copied that used for Social Security Disability. For SSI eligibility, however, one need not have achieved covered-worker status within the Social Security program. SSI is financed out of general revenues and administered with a means test. However, like Social Security Disability, and unlike AFDC, there are no work requirements for beneficiaries, and payments rise automatically with the cost of living.

II. THE DISABILITY SYSTEM

Agency Procedures

A claimant for disability benefits under SSD or SSI files an application in a district or branch office of the Social Security Administration, which then obtains relevant financial information. Generally, disability (including blindness) determinations are made by state agencies, although states have the option of allowing the federal government to make the determinations. At least at the initial stage, therefore, there generally is the unusual scenario of a state agency deciding who qualifies for federal benefits under a federal program, following federal regulations.[5] The state agency is responsible for gathering medical data, although the Social Security Administration will provide information that it can obtain more readily. Decisions are often made on a written record; a sample of these decisions is reviewed by the Social Security Administration.[6]

If the state agency denies a claim, the claimant has sixty days in which to request a reconsideration. The claim will be reviewed by a different individual in the state disability determination unit, and the new determination will be based on the evidence originally submitted, together with further evidence the claimant may provide. During the 1970s, about 250,000 claimants applied for reconsideration each year. Very few cases are reversed at the reconsideration stage, but a claimant must file for reconsideration in order to be able to request a hearing.

After a denial at the reconsideration level, a claimant may request a hearing conducted by an administrative law judge of the Social Security Administration's Bureau of Hearings and Appeals. The administrative law judge has the duty to investigate all issues and develop the record in order to make a fair determination as to disability. The claimant is allowed to produce new evidence at the hearing, orally or in writing, and to be represented. Although all

5. In fact, it is more complicated, because a pre-1973 recipient of state disability benefits is "grandfathered" and thus receives federal SSI benefits if he meets the standards his state imposed prior to the creation of the SSI program. For guidance in such cases, consult Wheeler v. Heckler, 719 F.2d 595 (2d Cir. 1983).

6. *See* 42 U.S.C. § 421(c) (1983).

testimony is made under oath, strict rules of evidence are not followed (e.g., hearsay is allowed). At the close of the hearing, the administrative law judge may issue a written decision affirming, reversing, or modifying the administrative determination.

There are about 150,000 annual requests for a hearing before an administrative law judge. About 25,000 of these go to the final administrative step in the reviewing process: the Appeals Council. The Appeals Council is made up of fifteen full-time employees of the Social Security Administration. If a claimant requests review by the Appeals Council, two members must agree in order for review to be granted. Review will be granted if (1) there appears to have been an abuse of discretion by the administrative law judge, (2) there has been an error of law, (3) the hearing decision is not supported by substantial evidence, or (4) the case presents a broad policy or procedural issue. Additionally, if new material evidence is submitted, the Appeals Council may review the entire record. The Appeals Council can affirm, modify, or reverse a decision made at the hearing level or remand if additional evidence is needed. The Appeals Council also scans, with staff assistance, a group of administrative law judge decisions and can consider a case on its own motion if the judge's decision is not in accord with the appropriate laws and regulations. Decisions both favorable and unfavorable to the claimant are subject to this review.

If the Appeals Council issues an unfavorable ruling (including denial of review), the claimant has sixty days in which to file a civil action in federal district court. Jurisdiction is based on 42 U.S.C. § 405(a) (1983) and applies only to final decisions by the Appeals Council. (Denials based on res judicata or failure to comply with time requirements are not reviewable.[7]) The court's scope of review is similar to that of the Appeals Council. It is limited to (1) whether the decision was supported by substantial evidence, and (2) whether the proper legal standards were applied. Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[8] The court can affirm, modify, or reverse an administrative decision, with or without a remand.[9]

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7. R. Francis, Social Security Disability Claims: Practice and Procedure § 10.04 (1983).

8. Richardson v. Perales, 402 U.S. 389, 401 (1971).

9. In cases that have reached at least the reconsideration level, where the sole remaining issue is a challenge to the constitutionality of the applicable law, the individual may be permitted to file an action in U.S. district court without pursuing further administrative appeals steps. *See* U.S. Department of Health and Human Services, Operational Analysis of the Office of Hearings and Appeals (Sept. 30, 1979).

Eligibility for Disability Benefits

In order to be entitled to disability benefits, a claimant must show that his inability to work is medical in nature and that he is totally disabled. Additionally, SSD (but not SSI) claimants must be "covered" employees within the meaning of the act. There also are special SSD eligibility requirements for disabled dependents of covered workers. These requirements are briefly outlined here. Most of them are treated in more detail in chapter 3.

Medical Impairment

The requirement that the impairment be a medical one underscores the point that disability benefits are meant only for "sick" persons and are not intended to be a surrogate unemployment insurance or welfare program. However, giving more generous benefits to those who are medically eligible than to those who are merely unemployed or poor requires the drawing of distinctions that are sometimes fuzzy. The problem is just how clear this medical eligibility standard can be. Afflictions such as alcoholism, drug addiction, and some behavioral disorders fall into a gray area.[10] An individual's first drinks are freely chosen, but once an alcoholic, he cannot control himself. The medically disabled test does not yield a clear answer.

The language of the Social Security Act defines a "physical or mental impairment" as one "that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."[11] The statutory language shows Congress's desire to supply an objective definition of medical impairment. The problem is that in some cases denying benefits to a claimant because medical tests show no sufficient abnormality runs counter to the expectations of an insured claimant that his case will be decided according to the impact of the illness or injury on him as an individual. People respond differently to similar ailments. For example, the same physical ailment may permit one person to continue working but may cause disabling pain to another.[12] This is one likely expla-

10. *See* Badichek v. Secretary of HEW, 374 F. Supp. 940 (E.D.N.Y. 1974), where the court attempted to determine whether the claimant's alcoholism was "an escape of choice from a life of daily labor" or "helpless self-entrapment in an unconquerable addiction."

11. 42 U.S.C. § 423(d)(3) (1983).

12. The leading discussion of "pain" in the SSD program is in Ber v. Celebrezze, 332 F.2d 293 (2d Cir. 1964).

nation for the relatively high reversal rate—about 50 percent—during hearings before administrative law judges, who are more likely to look at individual circumstances in the face-to-face hearings than are those who handle the initial claims and reconsiderations.

Total Disability: Use of the Grid

The second requirement is that the claimant be unable to work. Unless the impairment is one that is deemed an automatic disability, the claimant must show that he "cannot . . . engage in any . . . kind of substantial gainful work which exists in the national economy . . . ."[13] Automatic disabilities are those either listed in appendix 1 of the regulations that govern the SSD and SSI programs (20 C.F.R. § 404, subpt. P, app. 1 (1984)) or "medically equal" to them.

The disability program covers only those workers who are totally disabled, not those who are forced to change jobs with a resultant loss in earnings. One problem that results is that the claimant might be medically able to take another type of job, but cannot find one for various reasons. The 1960 case *Kerner v. Flemming*[14] held that the secretary of Health and Human Services had the burden of showing that obtaining work near the claimant's home was a realistic possibility. Most courts of appeals agreed. In response to these decisions, Congress amended the statute in 1967, saying that the claimant had to be unable to do not only his previous work but also "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."[15] Thus, economic conditions, personal factors, and the attitudes of employers are irrelevant in determining whether a claimant is eligible for disability benefits.[16]

Regulations were promulgated in 1978 in an attempt to provide a more standardized test of whether an individual is capable of gainful employment. Once it is determined that the claimant is unable to continue work at his previous job, the state-agency decision maker ascertains his "residual functional capacity" in order to determine whether the claimant can perform sedentary, light, or medium work. Reference is then made to a table for the proper cat-

13. 42 U.S.C. § 423(b)(2)(A) (Supp. 1985).
14. 283 F.2d 916 (2d Cir. 1960).
15. 42 U.S.C. § 423(d)(2)(A) (1983).
16. *See* 20 C.F.R. § 404.1566 (1984).

egory. Each table gives a finding (Disabled or Not Disabled) for combinations of age, education, and work experience.

These grid regulations are quite strict, especially for workers younger than fifty.[17] But the grid is not applicable in all cases. If the claimant falls between two of the residual functional capacity categories—that is, can perform some jobs in one of the categories, but not all—or is suffering from impairments other than those that restrict physical exertion, the administrative law judge decides according to the general statutory language that governed all disability cases until promulgation of the grid regulations.[18]

In *Heckler v. Campbell,*[19] the U.S. Supreme Court upheld the grid as a valid exercise of the secretary's power to promulgate rules. The Court saw a conflict between the desire for objective, standard, and consistent guidelines and the right of each claimant to an individualized hearing. It noted that a disability case presents two issues: assessing the individual claimant's skills and abilities and then determining whether jobs exist for claimants with those skills and abilities. Since the latter question is not unique to individual claimants, no case-by-case consideration is required. The Court noted that the regulations replaced the subjective and individualized, and therefore haphazard and inconsistent, testimony of vocational experts as to what job might be available for this claimant. Instead, the grid supplies a uniform conclusion about the availability of jobs for all persons whose medical condition is categorized in the same way. In *Campbell,* the Court ruled that Mrs. Campbell had the right to challenge the finding as to her classification, but a general regulation such as the grid could only be overturned if "arbitrary and capricious."

The Supreme Court's decision in *Campbell* is not the final word on the conflict between administrative efficiency and individual equity in disability programs. But it shows that the Court sees the need for broad administrative categories, even at the cost of refusing some opportunities for individualized claims to be considered. The court of appeals decision reversed in *Campbell* did not expressly invalidate the grid regulations, but only insisted that the secretary specify alternative jobs for the claimant, giving her the opportunity to show that she could not perform them. The Supreme Court saw that this would defeat the purpose of the guidelines. Nevertheless, the guidelines do not resolve every case. As mentioned above, only so-called "exertional" impairments are covered by the grid regulations. (Mrs. Campbell was subsequently

17. R. Francis, *supra* note 7, at § 13.02.
18. *See, e.g.,* Broz v. Schweiker, 677 F.2d 1351 (11th Cir. 1982).
19. 103 S. Ct. 1952 (1983).

awarded benefits because of a psychological impairment.) And, at least with respect to age, the secretary "will not apply those age categories mechanically in a borderline situation."[20]

"Covered" Employment (SSD Benefits Only)

The above discussion of eligibility applies to claimants under both SSD and SSI. To qualify for SSD benefits, claimants must also have worked in employment covered by the Social Security tax for the requisite number of quarters. An individual must be "fully insured" as defined in 42 U.S.C. § 414 (1983) (one quarter of coverage for each year between age twenty-two and death, disability, or age sixty-two, whichever comes first) and either have twenty quarters of coverage in the last forty before the onset of disability or, if as of the last quarter the individual is not yet thirty-one, have had covered quarters in one-half of the elapsed quarters since he turned twenty-one (with a minimum of six covered quarters). Blind persons need only be fully insured. Benefits are computed by the same formulas used for retirement and survivors' benefits.

The purpose of the requirement of covered employment is linked to the insurance aspects of the Social Security system. There is a perceived connection between an individual's contributions and the benefits received. Thus, someone who has paid Social Security taxes is deemed to have a greater claim on public assistance than someone who has not. Social Security benefits are viewed as an entitlement, not a handout. The SSI program, in which benefits are paid according to a means test, is thus somewhat more of a redistributional welfare program.

SSD Benefits for Disabled Dependents

Disabled adult children of deceased, retired, or disabled covered workers, whose disability begins before they turn twenty-two, are eligible for benefits based on their parents' coverage. It is odd that SSD benefits are provided to disabled adults whose parents were covered by the Social Security system and not to identically sick or injured adults unlucky enough not to have had such parents (disabled immigrants, for example). Eligibility according to parentage can only be explained as an additional benefit offered to the parent

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20. 20 C.F.R. § 404.1563 (1984), *noted in Campbell,* 103 S. Ct. at 1955 n.5. *But see* Cummins v. Schweiker, 670 F.2d 81 (7th Cir. 1982), where the court denied benefits to a forty-nine-year-old claimant who would have qualified had he been fifty. Judge Posner wrote: "Because the judgment of disability is dichotomous there will always be some line short of which the applicant is deemed disabled and beyond which he is not . . . . [I]t was to some extent arbitrary but that is in the nature of line-drawing." *Id.* at 83.

by the Social Security system. The definition of disability for a dependent is the same as that for disabled workers. In addition, when widows and widowers of covered workers are older than fifty and disabled, they may also receive benefits. The test for disability here is more strict; the disability must be in, or equivalent to, those listed in appendix 1 of the disability regulations. Age, education, and previous work experience are not taken into account.

In addition to the requirements already discussed, there are some technical requirements concerning who may file a claim, when it must be filed, and what an application must contain.[21]

Judicial Review

Once a claimant has exhausted his administrative remedies, he can obtain federal district court review by commencing an action within sixty days from the final decision by the agency. (The secretary can grant additional time.[22]) The district court can affirm, modify, reverse, or remand. Many judges refer disability cases to magistrates either for fact-finding and recommendations or for actual termination with the consent of the parties (28 U.S.C. § 636(b)(c) (1983)). In 1984, magistrates submitted findings and recommendations in more than ten thousand Social Security appeals (the bulk of which were disability claims) and terminated 768 Social Security cases with the consent of the parties.[23] In those cases in which there is no consent to termination, either the claimant or the United States, if dissatisfied, may object to all or part of the magistrate's findings.[24] If there is an objection, the court will review de novo the portions of the magistrate's conclusions in question.[25] The judge will then affirm, reverse, or modify the magistrate's findings. If the parties consent to the magistrate's entering final judgment, any appeal must be brought to the court of appeals or, if the parties agree at the time of consent, to the district judge.[26]

More than half of the disability cases that reach federal courts result in affirmance of the secretary's decision to deny or terminate eligibility for benefits. In about 10 percent of the cases, the secretary's denial is reversed. About 30 percent are remanded, and

21. *See* 20 C.F.R. § 404, subpt. 6 (1984).
22. 42 U.S.C. § 405(g) (1983).
23. Administrative Office of the United States Courts, 1984 Annual Report of the Director, at 205, 207.
24. *See* 28 U.S.C. § 636(b) (1983).
25. R. Francis, *supra* note 7, at § 10.11.
26. 28 U.S.C. § 636(c)(4), (5) (1983).

about two-thirds of those eventually result in decisions favorable to claimants.[27]

The judicial review process serves two distinct functions. On the one hand, it provides a review of individual appeals to determine if the secretary's findings are supported by substantial evidence or if a significant procedural error occurred in the administrative process. Review of individual appeals (including those brought as class actions), however, also provides an occasion for the courts to review systemic patterns of activity within the system. This section discusses the standards for review that govern judicial review of these cases generally, as well as the judicial role in reviewing systemic challenges. The chapter that follows then considers the substantive or procedural questions that are at issue when these cases reach the district courts.

Review of Individual Appeals

Quantitatively, the main role of the judiciary in administration of the disability programs is in reviewing claims from individuals whose eligibility has been denied at the final review stage within the agency.[28] At least in terms of statutory authorization, the judi-

27. J. Mashaw, C. Goetz, F. Goodman, W. Schwartz, P. Verkuil & M. Carrow, Social Security Hearings and Appeals 125 (1978).

28. In a recent and provocative book, *Bureaucratic Justice*, Prof. Jerry Mashaw of the Yale Law School, who had earlier written approvingly of the judicial role in Social Security Disability review, questions the efficiency and fairness of judicial review of individual adjudications in this program. Professor Mashaw writes that judicial review can and should have only a minor impact on the functioning of the Social Security Administration. Since most cases that reach the courts (or the administrative law judges) are decided as individual matters, they do not result in procedural or policy changes within the agency. Professor Mashaw argues that this is proper, since case-by-case review is by its nature incapable of addressing the "aggregative and probabilistic concerns" of the system as a whole. Thus, even if judicial review has some symbolic value, the fact that persons who appeal are (1) on average wealthier than most claimants and more likely to be white, and (2) more likely to be awarded benefits, results in severe problems of equity when coupled with the lack of administrative responsiveness to court decisions.

Professor Mashaw suggests that administrative law judge hearings and judicial review be abolished, and that the internal "law" of the bureaucracy be followed. As an alternative to judicial review, he proposes that applicants be given an opportunity for personal appearances before eligibility is denied, or that cases be reviewed by a panel of medical or vocational experts. It is not certain, however, that such alternative systems would be less costly or fairer than the present one. There would remain the question of whether such a procedure would be constitutional. For discussion of this issue, see Liebman & Stewart, *Bureaucratic Vision*, 96 Harv. L. Rev. 1952 (1983), and Maranville, *Book Review*, 69 Minn. L. Rev. 325 (1984).

Another question that arises is whether the court should remand or simply reverse (or modify) in cases where the administrative law judge has made a decision either based on improper legal standards or not supported by substantial evidence. Generally, unless more evidence is needed, or the administrative decision is unclear, courts will reverse. Young v. Harris, 507 F. Supp. 907 (D.S.C. 1981), expressed the

cial role in reviewing individual denials of benefits is quite limited: Are the findings supported by substantial evidence, and was there serious procedural error?

Findings supported by substantial evidence. The law is clear that the courts are not to examine the case de novo, but are only to determine if the secretary's findings are supported by substantial evidence.

The modern standard for substantial evidence is "more than a scintilla, but less than a preponderance." Courts often cite *Richardson v. Perales,* which held that " 'supported by substantial evidence' was more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept to support a conclusion."[29] This standard has been interpreted to mean that a slight preponderance either way should always lead to an affirmance.[30]

The "reasonable mind" standard, together with the requirement that, in reviewing agency decisions, the court look at the record as a whole, and not just the evidence supporting the secretary,[31] is flexible enough to allow the courts to closely monitor administrative law judges. For example, if there were strong medical evidence supporting a disability claim, a "reasonable" administrative law judge would not simply discount it. Rather, the judge would, if skeptical, seek additional opinions. Thus, while the courts probably do not engage in a true de novo review, since "close cases" should result in an affirmance of the secretary's findings, they are free to examine the case in detail and reverse erroneous decisions. They are also free to remand and order that additional evidence be taken.

The administrative law judge must assume an affirmative role in the development of the claimant's case, especially when the claimant is not represented by counsel. Therefore, the mere lack of evidence supporting the claimant should not, in itself, result in denial of eligibility. In *Garcia v. Califano,*[32] the court held that even

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standard for reversal as no substantial evidence and no purpose to reopening the record. A "clearly erroneous" decision will warrant reversal. Hill v. Califano, 454 F. Supp. 74 (E.D. Tenn. 1977).

An interesting comparison can be made with the program of non-service-connected benefits for disabled veterans, in which there are no administrative law judge hearings or judicial review. 38 U.S.C. § 501 (1979). The constitutionality of the statutory provisions precluding judicial review of individual claims in that program has never been firmly decided (*see* Johnson v. Robinson, 415 U.S. 361 (1974)), and there has been support in Congress to allow judicial review. There is substantial assistance to veterans in pursuing their claims, largely by nonprofit veterans organizations. 38 U.S.C. § 3402 (1982).

29. 402 U.S. at 401 (1971) (citing Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938)).

30. Toborowski v. Finch, 363 F. Supp. 717 (E.D. Pa. 1973).

31. *See, e.g.,* Day v. Weinberger, 522 F.2d 1154 (9th Cir. 1975).

32. 463 F. Supp. 1098 (N.D. Ill. 1979).

though the record did not support the claimant, the lack of substantial evidence supporting the secretary required reversal. (If *Garcia* is followed, it seems that the burden of production, at least, is not on the claimant, but instead is on the secretary.) The duty of the administrative law judge to help the claimant in this manner has recently received strong endorsement from two Supreme Court justices.[33]

In 1980 the Social Security Act was amended to tighten the standard for remanding cases to the agency for further consideration. Previously, the court could order a remand, upon a showing of good cause, for the purpose of taking additional evidence. Additionally, the secretary could, without qualification, obtain a remand by making a motion before filing his answer. The 1980 amendment added a "good cause" requirement to secretary-initiated remands. Also, the standards for judicial remand for more evidence were clarified, requiring that the evidence be material and that good cause be shown for failing to incorporate this evidence into the record previously. "Material" evidence is evidence that is relevant and probative and that might have changed the outcome of the administrative proceeding.[34]

Procedural error. Generally, if "harmless error" occurred in the administrative process, the claimant is not entitled to a remand.[35] This is especially important in cases in which the claimant asks for judicial review because he was not represented by counsel. Courts have agreed that the mere absence of counsel is not sufficient cause for a remand. Instead, there must have been prejudice or unfairness to the claimant.[36] However, the fact that counsel was waived is not dispositive.[37] If counsel is not present, the administrative law judge must assume a more active role in bringing forth evidence favorable to the claimant. Failure to do so will be grounds for remand.[38]

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33. See the opinions of Justices William Brennan and Thurgood Marshall in Heckler v. Campbell, 103 S. Ct. 1952 (1983).

34. *See* Chaney v. Schweiker, 659 F.2d 676 (5th Cir. 1981). Some recent examples of "good cause" remands include record evidence insufficient to deny or uphold claims, Brenem v. Harris, 621 F.2d 688 (5th Cir. 1980); and relevant evidence not explicitly weighted by the hearing examiner, Dobrowolsky v. Califano, 606 F.2d 403 (3d Cir. 1979).

35. *See* Bailey v. Secretary of HEW, 472 F. Supp. 399 (E.D. Pa. 1979).

36. *See* Sims v. Harris, 631 F.2d 26 (4th Cir. 1980).

37. Livingston v. Califano, 614 F.2d 342 (3d Cir. 1980).

38. *Dobrowolsky,* 606 F.2d at 403.

Review of Systemic Challenges

One way in which the courts influence the functioning of the disability system is by review of systemic procedural issues, whether challenged in the form of a class action or in an individual claimant's appeal from the denial of eligibility. The courts take their jurisdiction from 28 U.S.C. § 1361.[39]

An important example of this sort of litigation is the many challenges to delays in processing disability applications. Although there is no explicit time limit in the statute, courts have relied on the "reasonable notice and opportunity for a hearing" language in 42 U.S.C. § 405(6) (1983), as well as the Administrative Procedure Act, 5 U.S.C. § 555(b) (1977) ("within a reasonable time, each agency shall proceed to conclude a matter presented to it") and 5 U.S.C. § 706(1) (1977) (a reviewing court shall "compel agency action unlawfully withheld or unreasonably delayed").[40] In some of these proceedings, injunctive remedies were ordered and sustained on appeal.[41]

In *Heckler v. Day,*[42] the Supreme Court vacated such an injunction. The U.S. District Court for the District of Vermont had issued an injunction ordering the secretary of Health and Human Services "to conclude the reconsideration process and issue reconsideration determinations within 90 days of requests for reconsideration made by claimants." The injunction also required administrative law judges to provide hearings within 90 days after the request is made by claimants; and it ordered payment of interim benefits to claimants who did not receive a determination within 180 days of a request for reconsideration or a hearing within 90 days of a request. The court of appeals affirmed.[43]

The Supreme Court majority (5–4) accepted the secretary's argument that Congress had "balanced the need for timely disability determinations against the need to ensure quality decisions in the face of heavy and escalating workloads and limited agency re-

39. "The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." Ellis v. Blum, 643 F.2d 68, 78 (2d Cir. 1981); *and see* cases cited therein.

40. *See* Caswell v. Califano, 435 F. Supp. 127, 134 (D. Me. 1977), *aff'd,* 583 F.2d 9 (1st Cir. 1978).

41. *See, e.g.,* White v. Mathews, 559 F.2d 852 (2d Cir. 1977), *cert. denied,* 435 U.S. 908 (1978), in which the court of appeals noted the "glacial pace at which the Social Security Administration has adjudicated claims to disability payments," and the potential for unfairness to qualified claimants, given that more than half of all denials that are appealed to the hearing level are reversed, and that there were at that time no pretermination hearings under the disability program.

42. 104 S. Ct. 2249 (1984).

43. Day v. Schweiker, 685 F.2d 19 (2d Cir. 1982).

sources."[44] It found in the legislative history evidence that Congress had expressly rejected proposals for mandatory deadlines.

Courts are regularly faced with constitutional and statutory procedural challenges to aspects of the operation of disability programs. Many cases have held that courts have broad power to impose necessary relief.[45] Taken as a whole, however, the judicial response to procedural attacks on the system has been to grant the secretary broad discretion and has demonstrated judicial awareness of the administrative difficulties posed by such large and complicated programs.[46]

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44. Heckler v. Day, 104 S. Ct. at 2254.

45. *E.g.*, Califano v. Goldfarb, 430 U.S. 199 (1977); Califano v. Yamasaki, 442 U.S. 682 (1979); Nash v. Califano, 613 F.2d 10 (2d Cir. 1980).

46. J. Mashaw, Bureaucratic Justice 186 (1983).

III. SUBSTANTIVE ISSUES

Duration

The original statutory definition of disability was "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 to be of long-continued and indefinite duration." In 1965, this was amended: "to be of long-continued and indefinite duration" was replaced by "which has lasted or can be expected to last for a continued period of not less than 12 months." This eased the burden of proof on the claimant, in effect establishing a presumption that year-long disabilities are considered "essentially permanent."[47]

The permanence requirement represents an attempt to identify a category of especially needy workers who should receive the limited amount of available funds. Workers who suffer short-term impairments are more likely to have alternative sources of income (e.g., workers' compensation, state temporary disability benefits in several states, or savings). Perhaps most important is the fact that SSD began, and to some extent still functions, as an early retirement system. Thus, someone who suffers a short-term impairment and will likely be able to resume employment is not eligible for benefits.

Medical Impairment

A claimant must show that his medical impairment is not only permanent but also severe. The reasons for this requirement are many. Perhaps most important is the desire to award benefits only to those who *cannot* work; "medically disabled" thus serves as a shorthand for involuntary unemployment. Benefits are intended to replace income that the worker expected to receive, but could not. Workers who leave for other reasons (e.g., laziness, dislike of current job) are not entitled to receive benefits. In addition to the fear

47. R. Dixon, Social Security Disability and Mass Justice: A Problem in Welfare Adjudication 52 (1973).

of malingerers (and the need to apportion limited funds), there is the prevailing attitude that those who leave work because of accident or illness are somehow more deserving than those who leave for other reasons.

The administrative problem that results from this eligibility requirement is a function of the fact that individuals do not respond to the same impairment in the same manner. The question, Is the claimant unable to work because of his disability? cannot be answered without looking at many factors that are difficult to evaluate (e.g., the claimant's ability to withstand pain and his mental and emotional condition). Since the administrative law judges' role is to grant each claimant an individualized hearing, the ideal of a test for disability that is objectively and generalizably solely medical can never be realized.

The determination that a claimant is disabled encompasses both medical and vocational issues and requires a five-step process. As the first step, it must be determined whether the claimant is currently engaged in substantial gainful activity. If so, the claim is disallowed. If not, as the second step, the agency must make a finding as to the existence of a severe mental or physical impairment; if none exists, the claim will be denied. Third, the impairment is compared with those in appendix 1 of the SSD and SSI regulations (regularly referred to as "the Listings").[48] If it meets or equals an impairment in the Listings, the claimant will automatically be considered disabled. If not, he will have to show both that he cannot perform his former work (step 4) and that he is prevented from doing any other work (step 5). This last step may involve the grid regulations. Few cases involving the Listings are appealed; those that are often turn on whether the claimant's impairment "equals" the Listings or on newly available evidence.[49]

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48. Following are some examples of impairments found in the Listings: muscular dystrophy when accompanied by "serious and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station" (11.13); sickle cell disease, (a) with documental painful crises occurring at least three times in the five months prior to adjudication, or (b) requiring extended hospitalization at least three times in the twelve months prior to adjudication, or (c) causing an impairment in a body system covered in the Listings (7.05); mental retardation, manifested by (a) severe mental and social incapacity (e.g., dependence on others for bathing or dressing, inability to understand spoken language, or inability to avoid danger), or (b) an IQ of 59 or less, or (c) an IQ of 60 to 69 and a physical or other mental impairment imposing "additional and significant work-related limitation of function" (12.05).

There are two parts of appendix 1, one pertaining to adults and one to children. Each part contains thirteen sections pertaining to major body areas. Each section contains an introductory discussion of the tests used and definitions of various terms, and the criteria for various impairments to establish disability. The claimant's impairment must either meet or equal the Listings.

49. R. Francis, *supra* note 7, at § 11.24.

In actual adjudications, the facts do not fall so clearly into these five categories. The ability of a claimant to engage in work is often a factor in determining whether or not he is medically impaired. Undoubtedly, the fact that a particular claimant appeared to be unable to perform work has led courts to find severe impairments in cases involving alcoholism, drug addiction, subjective pain, and mental and emotional disorders.

"Involuntary" Impairment: Alcoholism and Drug Addiction

Disability benefits are intended for persons who cannot work through no fault or choice of their own. The issue of alcoholism is especially instructive, as it seems to fall in the boundary region between voluntary and involuntary impairments. Not surprisingly, much litigation has arisen in this area.

Courts have generally emphasized the involuntary nature of alcoholism by making loss of control of drinking an explicit requirement. *Griffis v. Weinberger*[50] held that there need be no "underlying" physical or mental disorder; thus chronic alcoholism, by itself, can be a disability. This would suggest that it is irrelevant whether the alcoholic's first drinks were voluntary.

Some courts have used this "loss of control" standard to limit eligibility by closely scrutinizing the claimant's behavior. *Martin v. Schweiker*[51] denied benefits partially on the finding that the claimant did not show functional limitations. However, the court also noted that "alcoholism is in many instances a curable disease"[52] and that the claimant had sober periods, refused to participate in Alcoholics Anonymous, and was not motivated to continue therapy. *Rutherford v. Schweiker*[53] also denied benefits, but on the basis of almost opposite facts. Here, the court noted that the claimant had undergone treatment, with some success. That, and the fact that there was no "significant secondary damage," led the administrative law judge to make and the court to uphold a finding of no disability. The dissent argued that this was an improper standard.

Several cases have held that damage resulting from prior alcohol abuse can be the basis of a disability claim. In *Singletary v. Secretary of Health, Education and Welfare,*[54] the court of appeals held

50. 509 F.2d 837 (9th Cir. 1975).
51. 550 F. Supp. 199 (N.D. Cal. 1982).
52. *Id.* at 202.
53. 685 F.2d 60 (2d Cir. 1982).
54. 623 F.2d 217 (2d Cir. 1980).

that regardless of whether the claimant suffered from the *disease* of alcoholism ("we need not discuss whether alcoholism is a moral issue or a disease, a point on which there is much disagreement"[55]), his liver disease resulting from alcohol consumption was a disability. It may have been relevant that Mr. Singletary also suffered from dizziness and leg and foot ailments unrelated to his alcohol intake. The suggestion that voluntary alcohol consumption can lead to disability opens up many questions: Was Mr. Singletary's liver disease voluntary in that he assumed the risk when drinking? It is hard to imagine a cigarette smoker with lung cancer being denied benefits. But what of injuries sustained because of reckless driving, Russian roulette, or suicide attempts? Under the 1980 amendments, any impairment that arises during the commission of a felony or in connection with jail confinement is irrelevant to the determination of disability.[56]

Swaim v. Califano[57] involved psychological effects of alcohol consumption. The claimant, an alcoholic who was hospitalized at various times, also had a history of violent behavior. During his hearing, however, he testified that his drinking was largely under control. In questioning the vocational expert, the administrative law judge explicitly assumed that Mr. Swaim was "friendly and cooperative," and the vocational expert responded that Mr. Swaim could perform certain sedentary jobs. The court of appeals remanded, holding (1) Mr. Swaim's testimony was insufficient evidence that his drinking problem was under control, and (2) the administrative law judge erred in assuming the claimant suffered from no psychological problems. It is not clear from the case whether the claimant's antisocial tendencies were due to his alcohol problem, but it is doubtful that they alone would constitute a disability in the absence of psychiatric diagnosis of some disorder, and none is mentioned in the opinion. Mr. Swaim seems to have been eligible because his antisocial conduct was caused in part by alcoholism. Thus, the case may hold that nonphysiological impairments that are caused by alcohol abuse can be the basis for eligibility.

There has been less litigation concerning drug abuse and addiction. The claimant in *Griffis* also was a drug abuser, and it seems the court's holding encompasses both issues. Perhaps the 1980 amendments regarding impairments resulting from felonies will restrict the *Griffis* opinion to cases involving drugs that are legally available.

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55. *Id.* at 220.
56. 42 U.S.C. § 423(d)(6) (1983).
57. 599 F.2d 1309 (4th Cir. 1979).

Mental Impairment

Another area to which "medical determinability" is a difficult standard to apply is that of mental and emotional impairments. It seems clear that mental impairments can give rise to disability, even in the absence of any physical impairment. Psychosomatic disorders that lead to intense pain are also covered. A recent case in point is *Strayhorn v. Califano,*[58] in which the court concluded that because of the claimant's great pain, but lack of evidence of neurological damage, the administrative law judge should have considered the possibility that the claimant's pain was psychosomatic and ordered a psychiatric examination. However, not all behavioral disorders have been considered valid disabilities. *Ryan v. Secretary of Health, Education and Welfare*[59] held that chronic anxiety aggravated by "frustration and bitterness" was not a disability. And *Dean v. Gardner*[60] held that psychoneurotic disorders were disabling only if demonstrable through clinical and laboratory diagnostic techniques. However, more recent cases seem to follow the same line as those involving alcoholism: While mere existence of psychoneurosis or anxiety will not establish a disability,[61] if there is a resultant functional impairment, courts are likely to be sympathetic.

A recent case, *Tennant v. Schweiker,*[62] awarded disability benefits primarily on the basis of "inadequate personality." This disorder was described as manifesting "inadaptability, ineptness, poor judgment, social instability, and a lack of physical and emotional stamina." It is not clear if other courts will follow suit and take such a broad view of mental disorders. There is a "slippery-slope" danger in this ruling; "inadequate personality" is certainly a vague concept. Can a line be drawn that separates Mr. Tennant from persons whose personalities, mental capacities, and ability to satisfy the demands of the workplace leave them at the end of the job queue and not employed? The court was probably influenced heavily by the testimony of four psychiatrists that Mr. Tennant had some sort of personality disorder. Perhaps more important was the claimant's employment record. In twelve years he had held forty-six jobs, none for more than six months.

The administrative law judge relied on the grid regulations in reaching his conclusion that Mr. Tennant was not disabled. Because the court obviously believed that Mr. Tennant could not

58. 470 F. Supp. 1293 (E.D. Ark. 1979).
59. 393 F.2d 340 (9th Cir. 1968).
60. 393 F.2d 327 (9th Cir. 1968).
61. *See* Alvarado v. Weinberger, 511 F.2d 1046 (1st Cir. 1975).
62. 682 F.2d 707 (8th Cir. 1982).

work, much as he tried, it may have jumped at the chance to find a "nonexertional" impairment that would justify an award of benefits. *Tennant* may indicate that, in the wake of *Campbell,* there will be more litigation in the area of nonexertional impairments, including psychiatric disorders, since these are not covered by the grid regulations. *Smith v. Secretary of Health and Human Services,*[63] however, held that the presence of nonexertional impairments will not bar use of the grid unless they are severe enough to restrict a full range of gainful employment. Since the claimant's nonexertional impairment still allowed him to perform some sedentary work, the claim was denied. However, the decision in *Smith* is incorrect. It expressly contradicts the doctrine that claimants who can perform only some work at a given level are not to have that table of the grid applied to them.[64] In *Kirk,* the Court held that Mr. Kirk's nonexertional impairments did not restrict his ability to do *any* work at the designated level.

During 1981 and 1982, continuing eligibility reviews mandated by a 1980 statute[65] found several hundred thousand recipients of disability benefits ineligible. Many of those found ineligible were persons whose original eligibility had been based on mental or emotional illness. Some of these cases were widely publicized as examples of government heartlessness. The Social Security Disability Benefits Reform Act of 1984 (Pub. L. No. 98-460), enacted in fall 1984 in the midst of the presidential campaign, ordered the secretary of Health and Human Services to adopt new regulations governing eligibility for disability benefits. Proposed regulations were issued on February 4, 1985. The proposed regulations say that disability determinations should be based "not only on clinical findings by a physician but also on a realistic assessment of an individual's ability to work in a competitive situation."[66] The Department said that changing to the new rules would cost the government $900 million per year.[67]

Pain

The issue of subjective pain raises some of the same problems as that of mental and emotional illness. For example, if hypochondria is an allowable disability, it might appear inconsistent not to

63. 544 F. Supp. 63 (S.D. Ohio 1982) (quoting Kirk v. Secretary of HHS, 667 F.2d 524 (6th Cir. 1981)).

64. *See Broz,* 677 F.2d 1351 (11th Cir. 1982), vacated and remanded for reconsideration in light of Heckler v. Campbell, 103 S. Ct. 2421 (1983).

65. 42 U.S.C. § 421(i) (1983).

66. 20 C.F.R. pt. 404 (1985).

67. N.Y. Times, Dec. 9, 1984, at 1, col. 6.

regard subjective pain as relevant. Accepting the relevance of pain reflects the courts' concern that SSD determinations be individualized, that is, focused on the effects of medical problems upon an individual claimant.

This perspective is drawn, to a large extent, from the insurance aspect of the program. Because benefits are not a handout, but rather are earned through work and contributions, eligibility must be weighed from the perspective of the individual applicant. A worker who has paid the Social Security tax expects to be covered if disabled. Hence the fact that the worker's subjective symptoms might not be verifiable by diagnostic techniques does not alter the consequences of the impairment for the individual.

Congress wrestled with the issue of subjective pain in enacting the Social Security Disability Benefits Reform Act of 1984, rejected the various proposed statutory changes on the subject, and finally called for a study of the issue to be completed in 1985.

Refusal of Medical Treatment

Can the claimant's medical problem be corrected through treatment? Because the act is meant to insure only those who cannot work, benefits will be denied if an available and safe medical treatment would allow the claimant to engage in substantial gainful activity.[68] However, this is not to say that a claimant must undergo any and all offered surgical procedures or risk losing benefits.[69]

A leading case, *Nichols v. Califano,*[70] employed a reasonableness test. Among the factors the court said should be considered in determining whether the claimant's refusal was justifiable were the physician's outlook as to the likely success of the procedure, the relationship between the physician and the patient (a trusted family physician's recommendation is entitled to more weight), the painfulness or dangerousness of the procedure, the severity of the impairment, and the patient's age, background, and medical history. A recent case, *Schena v. Secretary of Health and Human Services,*[71] suggested that claimants could justifiably refuse "recommended" as opposed to "prescribed" treatment.

Another interesting case is *Hoover v. Celebrezze,*[72] which held that an inability to afford surgery will not result in denial of bene-

68. *See, e.g.,* Henry v. Gardner, 381 F.2d 191 (6th Cir. 1967).
69. McCarty v. Richardson, 459 F.2d 3 (8th Cir. 1972).
70. 556 F.2d 931 (9th Cir. 1977).
71. 635 F.2d 15 (1st Cir. 1980).
72. 235 F. Supp. 147 (W.D.N.C. 1964).

fits. This case provides a contrast to the gainful employment tests discussed below, which do not allow economic or social factors to be considered in determining the claimant's capacity for work.

Lewis v. Califano[73] held that a claimant's refusal to undergo surgery because of her religious beliefs was justifiable and could not be the basis for a denial of benefits. *Stone v. Harris*[74] overturned a district court decision that a five-foot-tall woman who weighed 333 pounds was not entitled to benefits because her condition was remediable. The court of appeals found that the secretary had ignored Ms. Stone's psychological condition in making her determination and so could not assume that the condition (obesity) was willful ("a baseless prejudice"). Thus it appears that obesity stands in a category similar to that of alcoholism and can at least sometimes be the basis for a disability claim.

Medical Evidence

The subjective evidence point thus suggests the conflict between the bureaucratic and adjudicative perspectives on the disability program. Courts, while attempting both to allow the secretary broad discretion and to adhere to the substantial evidence test, have nevertheless insisted that the extent of the individual's pain and the individual's response to that pain be included among the factors used in evaluating claims. The administrative law judge is thus under an affirmative duty to investigate the claimant's subjective reports of pain. And pain, by itself, can be the basis for a disability claim despite the statute's language: "demonstrable by medically acceptable clinical and laboratory diagnostic techniques."[75] In *Whitt v. Gardner*,[76] the court of appeals held that this language did not require the exclusion of all but objective evidence. Other courts of appeals followed. It is clear that pain alone can constitute a disability, provided that it is severe enough to preclude work.[77]

Courts have been more cautious, however, in cases in which objective evidence conflicts with testimony of disabling pain. This might be regarded as an evidentiary problem: Presumably, "objective" medical reports are more credible than the testimony of the

73. 616 F.2d 73 (3d Cir. 1980).
74. 657 F.2d 210 (8th Cir. 1981).
75. 42 U.S.C. § 423(d)(3) (1983).
76. 389 F.2d 906 (6th Cir. 1968).
77. *But cf.* Green v. Schweiker, 694 F.2d 108, 112 (8th Cir. 1982) ("Ordinarily subjective evidence of pain must be corroborated by medically acceptable clinical and laboratory diagnostic techniques"), *cert. denied*, 103 S. Ct. 1790 (1983).

claimant. The burden remains on the plaintiff to show that the pain is disabling.[78] The claimant's testimony is not conclusive.[79]

The degree of discretion the administrative law judge has in cases of conflicting testimony is not clear. One can compare *Eppard v. Richardson*[80]—subjective evidence of pain cannot overcome medical evidence to the contrary—with *Brittingham v. Weinberger,*[81]—if the administrative law judge considers the claimant credible, he can make a finding of disability despite contrary medical opinion. The proper test seems to be the latter one. Because subjective evidence is supposed to be one of the factors considered, to limit its use to cases in which there is either no contrary evidence or supporting objective evidence is not logical. Because the only remaining question concerning such subjective reports is the degree to which they can be believed, it seems that the administrative law judge should be able to make a finding of disability if the claimant is credible.

Courts have consistently held that administrative law judges do not have wide discretion in discounting objective evidence that is favorable to the claimant. Administrative law judges cannot simply ignore uncontested medical evidence in favor of the claimant. In *Day v. Weinberger,*[82] the claimant testified that she suffered from disabling pain. Five physicians who treated her agreed that she was suffering from muscular strain, and two expressed uncontradicted opinions that she was disabled. Nevertheless, the administrative law judge, relying on (1) lack of diagnosis through objective techniques of the cause of the claimant's pain, (2) lack of symptoms noted in a medical textbook, and (3) personal observations, held that the claimant was not entitled to disability benefits. The court of appeals held that these did not constitute the "clear and convincing" reasons that are required if uncontested expert opinion is to be rejected. Specifically, the court noted that the administrative law judge, who is not a medical expert, should not be able to make an independent examination for the purposes of overruling expert opinion.

A related issue is how to weigh the testimony of different types of doctors. The claimant will often seek to introduce evidence from his treating physician or from other examining physicians. Sometimes the administrative law judge will appoint a physician to examine the claimant. Medical advisers who do not actually do an ex-

78. *See* Ferguson v. Schweiker, 641 F.2d 243 (5th Cir. 1981).
79. Bolton v. Secretary of HHS, 504 F. Supp. 288 (E.D.N.Y. 1980).
80. 411 F. Supp. 1 (W.D. Va. 1976).
81. 408 F. Supp. 606 (E.D. Pa. 1976).
82. 522 F.2d 1154 (9th Cir. 1975).

amination are also employed. The weight that should be given to contrary medical opinions is especially important in hearings where there is conflicting testimony. Many considerations come into play. On the one hand, the Social Security Administration is properly suspicious of the credibility of a claimant's personal physician, who may also be a friend; the agency thus relies more on its own medical examiners. However, it is certainly possible that agency-appointed doctors may have a pro-agency (i.e., leaning toward denial) bias. Additionally, a physician who has treated the claimant over a period of time is apt to be more familiar with his medical condition. This might be especially important in cases of multiple impairments in which no single limitation is disabling. Finally, there is the desire to grant the administrative law judge a fair degree of discretion in evaluating testimony, through use of the substantial evidence rule. Nevertheless, courts have not hesitated to overturn decisions that have evaluated medical testimony improperly.

The regulations state that the conclusion of a physician that a claimant is disabled will not establish disability unless supported by specific evidence. The agency must determine disability, as it may involve nonmedical vocational factors.[83] However, many courts have held that a treating physician's testimony will be binding unless contradicted by substantial evidence. A leading case is *Allen v. Weinberger*.[84] The claimant's surgeon, Dr. Carlos Acosta, diagnosed him as "permanently and totally disabled." However, an orthopedic surgeon who examined the plaintiff four months after his surgery expressed the belief that the plaintiff could perform light work. Two surgeons who reviewed the evidence concluded that he had not been disabled for twelve months, as required. The administrative law judge and the Appeals Council both held that Dr. Acosta's opinion was not supported by any clinical findings. The district court upheld the secretary. The court of appeals reversed in part, noting that (1) it was Dr. Acosta who performed the surgery and (2) only one of the other three physicians had examined the claimant, and he did so only once. The court concluded that the secretary's finding that Mr. Allen had not been disabled for twelve months was not supported by substantial evidence. (The court did, however, affirm the finding that the claimant was no longer disabled, relying on a medical opinion to that effect rendered after an examination subsequent to Dr. Acosta's. Although another specialist expressed a seemingly contradictory view, the

83. *See* 20 C.F.R. §§ 404, 1527 (1984).
84. 552 F.2d 781 (7th Cir. 1977).

court concluded that because the record did not indicate which, if either, doctor had a superior opportunity to observe the plaintiff, it was for the secretary, and not the courts, to resolve the conflict.)[85]

The holding in *Allen* was followed in *Eiden v. Secretary of Health, Education and Welfare,*[86] which held that a treating physician's opinion was binding when uncontradicted, even though in this case the physician's findings were not supported by "objective" clinical or laboratory findings. Another interesting case is *Cassiday v. Schweiker,*[87] which involved a termination of benefits that had initially been awarded largely because of the opinions of Ms. Cassiday's treating physicians. In the termination proceeding, however, the secretary relied solely on medical reports made subsequent to the initial finding of disability. The court ordered the benefits reinstated, holding that the agency could not "isolate parts of what is essentially a continuous medical record and then apply tie-breaker rules to each of the constituent elements."[88] Apparently, the termination here was not justified under the *Miranda* standards to be discussed later.

Another case relying on a claimant's doctors' testimony to overturn the secretary's decision was *Stubbs v. Mathews.*[89] Although the court noted that a doctor's conclusion of "total disability" might not be an application of the proper statutory standard, the administrative law judge did not take advantage of his opportunity to cross-examine the physicians.[90] Thus, the provision in the regulations reducing the weight of such conclusory testimony might be limited in its effect by reading into the broad responsibilities of the administrative law judge a specific duty to develop the basis of these statements, through cross-examination or other means.

The use of evidence given by doctors appointed by the Social Security Administration, especially medical advisers who do not actually examine the claimant, remains a much-litigated issue. Although *Perales* held that such testimony could constitute substantial evidence, courts have consistently given it less weight than that of examining physicians.

Perales has been characterized as a retreat from the standard for administrative due process established by the Supreme Court in *Goldberg v. Kelly.*[91] Justice Harry A. Blackmun, who wrote the

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85. *Id.* at 787 (citing Cyrus v. Celebrezze, 341 F.2d 192 (4th Cir. 1965)).
86. 616 F.2d 63 (2d Cir. 1980).
87. 663 F.2d 745 (7th Cir. 1981).
88. *Id.* at 748.
89. 544 F.2d 1251 (8th Cir. 1977).
90. *Id.* at 1255.
91. 397 U.S. 254 (1970); *see* Brudno, *Fairness and Bureaucracy: The Demise of Procedural Due Process for Welfare Claimants,* 25 Hastings L.J. 813 (1974).

majority opinion, distinguished the situation from that of *Goldberg v. Kelly,* which held, inter alia, that an opportunity to confront adverse witnesses was required in an AFDC termination hearing. First, *Perales* involved an initial eligibility proceeding, as opposed to a termination. Second, notice was given and the written reports of the physicians were available for inspection. Third, Mr. Perales could have subpoenaed the physicians. Finally, in the case of medical testimony, credibility and veracity are not likely to be at issue.

The role of the medical adviser, as envisioned in the *Perales* opinion, is that of an expert witness whose function is an "explanation of medical problems in terms understandable to the layman-examiner."[92] In this case, the adviser was assuming that the facts contained in the reports were true and was not vouching for their accuracy.[93]

Since *Perales,* courts have allowed advisers' opinions but have limited the reliance that can be placed on them. *Strickland v. Harris,*[94] reversed a finding of no disability based on a reviewing physician's summary of a report by the examining physicians. The court relied on the fact that the adviser's findings seemed contrary to those of the underlying reports. This might have been a somewhat easier case, since it appears that the adviser was not acting in the neutral role suggested in *Perales.*

The medical adviser must also remain in an advisory role. In *Woodard v. Schweiker,*[95] the court overturned a denial based substantially on an adviser's recommendation. In this case, the administrative law judge announced that he would be "bound" by the adviser's responses. The court held that this amounted to an abdication by the administrative law judge of his fact-finding and decision-making role.

Rodriguez v. Secretary of Health and Human Services[96] upheld a denial of benefits in somewhat similar circumstances. The court relied on the fact that there was ample evidence, including that of neutral examining physicians, to support the findings of the two medical advisers who testified that Mrs. Rodriguez was not disabled. The court also noted that the reports of the advisers should receive some weight, given their qualifications.

Courts have similarly divided over Social Security Administration-ordered consultative examinations. In *Hancock v. Secretary of*

92. 402 U.S. at 408.

93. *Cf.* Douglas, J., dissenting: "The use of circuit-riding doctors who never see or examine claimants to defeat their claims should be beneath the dignity of a great nation." *Id.* at 413.

94. 615 F.2d 1103 (5th Cir. 1980).

95. 668 F.2d 370 (8th Cir. 1981).

96. 647 F.2d 218 (1st Cir. 1981).

Health, Education and Welfare,[97] the court overturned a denial based on the report of a consulting surgeon who had examined the claimant only once. The court found that this report could not constitute substantial evidence. But on the basis of similar facts, the court in *Perez v. Secretary of Health, Education and Welfare*[98] concluded "we cannot say that the evaluation was baseless and that the Secretary was obliged to disregard it." The court emphasized the fact that the consulting physician's testimony was supported by clinical evidence.

The rules on medical testimony are another example of the flexibility with which courts employ the "reasonable mind" standard of judicial review. By enforcing various rules of evidence upon the administrative law judges, the courts are free to look at the record as a whole and correct (through reversal or remand) what they regard as unreasonable findings. However, this makes it possible for the court to engage in an almost de novo review. This can be avoided by (1) affirming the secretary in "close cases" (e.g., *Toborowski*) and (2) leaving issues such as credibility up to the administrative law judge (provided the record contains specific findings).

Substantial Gainful Activity

Except for those in appendix 1 (the Listings), no impairment is considered disabling unless the claimant can also show that he is unable to engage in *any* substantial gainful activity. Thus, if a person is able to engage in some sort of work and does not, he will not be eligible for benefits. An impairment that reduces an individual to a less desirable or less well paid job does not result in eligibility for disability benefits.

The explanation for this requirement can be found in the uneasy compromise of insurance and welfare ideas that underlies the Social Security system. On the one hand, need is an element in apportioning benefits. Since those who are not totally disabled (i.e., can work at another job) have potential alternative sources of income, it seems inequitable to award them benefits. Covered employees who *are* totally disabled would have to receive lesser benefits, and presumably they are the neediest. Also many persons do work in low-paying or unpleasant jobs for much of their lives. It seems inequitable to pay benefits to those who previously had

97. 603 F.2d 739 (8th Cir. 1979).
98. 622 F.2d 1 (1st Cir. 1980).

better jobs, and not to those who did not. There remains, however, the insurance aspect of the system, which argues for payments to persons whose capacity for work has declined, through no fault of their own, from what it was when they paid the tax and were encouraged to think of themselves as "insured."

Since disability insurance covers only medical impairments, the inability to find any work must be caused by such an impairment. And, since the 1967 amendments, the statutory standard has been very strict—the sole cause of the claimant's inability to find work must be his impairment. Economic and social conditions, such as the lack of jobs near the claimant's home or the unwillingness of employers to hire partially disabled persons, are not valid reasons. Thus, even though the claimant would not have been unemployed but for the medical impairment, if the secretary can show that there are jobs that the claimant is functionally capable of performing, no benefits will be awarded.

It is important to note that although the claimant has the burden of showing disability under the statute, once he demonstrates that a mental or physical impairment resulted in the loss of a previous job, the secretary has the burden of coming forward with evidence showing the existence of a job that the claimant would be able to perform.[99] The secretary, however, only has to show that there are specific jobs in the economy that the claimant is capable of doing, not that he would actually be hired.

The standard the secretary must meet is "reasonable availability," and this availability must apply to the individual claimant.[100] It is not enough that it is conceivable that the claimant could be employed.[101] The existence of scarce jobs is likewise not sufficient.[102] Of course the statute requires disallowance of the claim if there are jobs the claimant could do anywhere in the country.

Much recent litigation has centered on the so-called grid requirements used in measuring an applicant's ability to engage in gainful activity. For example, in *Campbell,* the case that reached the Supreme Court, the administrative law judge found that the claimant was limited to light work. This required use of table 2 of the grid.

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99. R. Francis, *supra* note 7, at § 19.02.

100. *See* Martin v. Secretary of HEW, 492 F. Supp. 459 (D. Wyo. 1980), in which the agency's finding that the claimant was qualified to do light or sedentary work was overturned since no consideration was given to the claimant's pain.

101. Williams v. Mathews, 456 F. Supp. 1125 (M.D. La. 1978).

102. *See* Ray v. Secretary of HEW, 465 F. Supp. 832 (E.D. Mich. 1978). A vocational expert testified that there were about two hundred jobs in the greater Detroit area alone that the claimant was capable of performing. The court, noting that this comprised about .00013 of the work force in the claimant's region, concluded that jobs did not exist in "significant numbers," as required under 42 U.S.C. § 423(d)(2)(A).

Her age (fifty-two: "closely approaching advanced"), education (limited, but able to communicate in English), and previous work experience (unskilled) mandated a finding of not disabled under rule 202.10. The Supreme Court's validation of the grid requirements in *Campbell* seems to mean that at least for "exertional" impairments, the secretary is no longer bound to come forward with examples of jobs that exist in the national economy.

The grid regulations contain a special provision for longtime unskilled workers.[103] Workers who have performed arduous unskilled physical labor for at least thirty-five years and suffer an impairment that prevents this type of work are automatically considered unable to do lighter work, unless they are actually working or have proper job training for other work. As to this rule, disability coverage functions to a degree as an early retirement program for persons who have been injured and cannot return to their former work, but are at an age at which pursuing a wholly different career is difficult.

If a claimant actually does engage in employment during the alleged disability period, he will have demonstrated a prima facie case of ability to engage in substantial gainful activity.[104] However, there is an exception for employment "on the basis of sympathy."[105] Additionally, infrequent activity will not bar recovery, even if the earnings obtained are high. In *Patane v. Harris,*[106] the claimant earned between $500 and $750 a month for five years as an outside director of five small, closely held corporations. The court ruled that although the compensation was not insignificant, the activity was not substantial. In *Kendrick v. Califano,*[107] the court held that it was error for the secretary to require a continuous twelve-month period of no substantial gainful activity where the claimant had worked sporadically.[108] The *Kendrick* court also held that since the claimant's disability (leukemia) *could be expected* to last for twelve months or result in death, the fact that he might not have already been disabled for a continuous twelve-month period was not determinative.

The statute also provides for a "trial work period," during which an individual can test his ability to work, without losing benefits. This applies for both SSD and SSI, and lasts for nine months of

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103. *See* 20 C.F.R. § 404.1562 (1984).
104. *See id.* § 404.1571.
105. Rodriguez v. Secretary of HEW, 355 F. Supp. 304 (D.P.R. 1973).
106. 507 F. Supp. 115 (E.D. Pa. 1981).
107. 460 F. Supp. 561 (E.D. Va. 1978).
108. *Cf.* Condon v. Finch, 305 F. Supp. 63, 65 (D.N.H. 1969) ("It is clear that Congress intended that a worker actually be out of work for a continuous period of twelve months before he became entitled to disability insurance benefits").

performing services. (The months do not have to be consecutive.) While the program is designed to encourage reentry into the labor force, one commentator warns lawyers that notwithstanding this provision, such work may be taken by the Social Security Administration as evidence that a medical recovery has taken place and that a beneficiary is no longer eligible for benefits.[109]

Covered Status

A claimant must be able to prove that his disability began at or before termination of covered status; that is, the claimant must have had earnings on which he paid taxes during twenty of the last forty quarters ending with the quarter in which the disability occurred. Benefits can be received for up to twelve months immediately preceding the month in which an application is filed, provided that the claimant meets the requirements for eligibility during those months.[110]

One question that arises is what to do in cases where a latent disability originates while the claimant is covered, but becomes disabling only after coverage has expired. In *Cassel v. Harris,*[111] the court concluded that benefits should be awarded. The court relied on the fact that the Social Security Act is " 'to be broadly considered and liberally applied' "[112] and also noted a parallel to workers' compensation claims, where the statute of limitations does not begin to run until the disability becomes evident. This doctrine was limited by an insistence that the claimant make four showings: (1) it was highly probable that the condition began during coverage; (2) the condition was potentially disabling; (3) the disabling condition lay dormant during the period of coverage; and (4) the present disability evolved "naturally, directly, and exclusively" from the condition present during coverage.

Termination

The issue of the legal standards for terminating the eligibility of disability benefit recipients has become a major subject of litigation as a result of the Reagan administration's attempts to reduce the disability rolls through use of the statutorily mandated (but accel-

109. R. Francis, *supra* note 7, at §§ 16.06, 16.09.
110. 20 C.F.R. § 404.621 (1984).
111. 493 F. Supp. 1055 (D. Colo. 1980).
112. *Id.* at 1058 (quoting Stewart v. Cohen, 309 F. Supp. 949, 956 (E.D.N.Y. 1970)).

erated) triennial review of the continued eligibility of beneficiaries. The leading case on termination of benefits is *Miranda v. Secretary of Health, Education and Welfare.*[113] There, the court held that "once having found a disability, the Secretary may not terminate the benefits without substantial evidence to justify so doing." The court said that such substantial evidence could be "current evidence showing that a claimant was improved" or could be "evidence that claimant's condition is not as serious as was at first supposed." However, "[i]t would be wrong . . . to terminate . . . on [the] basis other than [the secretary's] reappraisal of the earlier evidence."[114]

Exactly when the secretary can terminate benefits in cases other than those of medical improvement is not made clear in *Miranda,* and different courts have offered different interpretations. *Weber v. Harris*[115] suggests that benefits can be terminated in any case in which there is new evidence that suggests a claimant's condition is not as serious as it first appeared. However, *Benko v. Schweiker*[116] held that the secretary must show that (1) the initial diagnosis was difficult, (2) the condition was not as severe as determined then, and (3) these findings are demonstrated by new and material evidence (i.e., evidence not available at the first hearing). The court was anxious to avoid the possibility of the secretary's being able to relitigate a claim by providing "merely one more medical opinion."

It is also not clear which party bears the burden of proof in termination hearings. *Patti v. Schweiker*[117] held that while the burden of proof remains on the claimant to show disability, the secretary must meet a presumption of disability and come forward with evidence to rebut the presumption. This seems to be a compromise between the res judicata principles of *Miranda* and *Benko* and the rule that the burden of proof in disability hearings rests on the claimant. However, the Third Circuit rejected *Miranda* in *Torres v. Schweiker,*[118] holding it inconsistent with the principle that the burden of proof remains on the claimant.

The matter will now be dealt with under new statutory language. The Social Security Disability Benefits Reform Act of 1984 was enacted by a vote of 99 to 0 in the Senate and 402 to 0 in the House of Representatives. The new law provides that a recipient can be terminated only if the secretary finds substantial evidence

113. 514 F.2d 996 (1st Cir. 1975).
114. *Id.* at 998.
115. 640 F.2d 176 (8th Cir. 1981).
116. 551 F. Supp. 698 (D.N.H. 1982).
117. 669 F.2d 582 (9th Cir. 1982).
118. 682 F.2d 109 (3d Cir. 1982), *cert. denied,* 103 S. Ct. 823 (1983).

that his medical condition has improved, that therapy has been beneficial, that the condition is not as disabling as originally thought, or that the original decision was made in error or fraudulently obtained, *and,* whichever of the above is the case, that he is able to work.[119] It is too early to analyze the significance of the new law. Overall, it seems largely a codification of judicial interpretations in earlier termination cases. But there is no doubt that the new statute reflects a congressional judgment that at least some of the termination policies implemented by the agency in the early 1980s were too harsh.

The new law also provides that recipients who appeal termination decisions will continue to receive benefits until the administrative law judge acts on the appeal (although the recipient is required to repay if he eventually loses, with the possibility of mitigation of the repayment requirement under the Social Security Act's general waiver-for-hardship provision).[120]

Administrative Proceedings

The claimant may appeal, alleging procedural shortcomings at the administrative level. Absence of counsel (by itself) is not sufficient grounds for reversal or remand. However, if the claimant can demonstrate a resultant unfairness or prejudice, he may get such relief. Additionally, if no counsel is present, the administrative law judge is given a "special duty" in aiding development of the claimant's evidence.[121]

The administrative law judge's duty to develop the facts is relevant even when the claimant is represented by counsel.[122] However, the administrative law judge does not have to explore every possible theory. In *Gaultney v. Weinberger,*[123] a claimant who had failed to prove the existence of a disability from any physical disorder then turned to a psychiatric theory, but produced no evidence. The court held that in this case the administrative law judge had no duty to explore this theory further. The court relied in part on

119. 42 U.S.C. § 423(f) (Supp. 1985).

120. *See* Pub. L. No. 97-455 (1982), which first ordered continuation of benefits during appeal.

121. *See* Rials v. Califano, 520 F. Supp. 786 (E.D. Tex. 1981), in which the court noted that the hearing lasted only twenty minutes, with no cross-examination of the vocational expert and little emphasis on the claimant's subjective pain. The court concluded that because a reasonable counsel would have developed such evidence, a new hearing was required. *See also* Sims v. Harris, 631 F.2d 26 (4th Cir. 1980); *Broz,* 677 F.2d 1351.

122. Thorne v. Califano, 607 F.2d 218 (8th Cir. 1979).

123. 505 F.2d 943 (8th Cir. 1974).

the fact that the claimant had the burden of proof. Perhaps the court simply disbelieved the claimant here, because this holding raises a difficult question. If indeed the claimant has a psychiatric problem, he may very well conduct his claim as if he were suffering from a physical ailment (or instruct his counsel to that effect). Should he be denied benefits because of this?[124]

The administrative law judge also has a duty to make explicit findings so that the courts can determine whether the proper evidentiary rules were followed. Failure to do so may result in a remand. In coming to the decision, the administrative law judge must explain the weight given to various pieces of evidence.[125] *Cotter v. Harris*[126] held that the administrative law judge must explain his reasons for rejecting evidence, as well as those for accepting it. This can act to enforce, for instance, the evidentiary rule that favors the claimant's physician's testimony over that of a consulting physician. The same rule applies to the Appeals Council.[127]

Administrative Hearing Requirements

The contours of administrative hearings for Social Security recipients were laid down in *Mathews v. Eldridge.*[128] In that case, the U.S. Supreme Court held that *Goldberg v. Kelly,* which required a hearing before AFDC payments could be cut off by the New York City welfare department, did not require a full due process hearing before termination of SSD benefits. The Court reasoned that since benefits were not awarded on the basis of need, an interruption in income was not as serious an occurrence as it would be for an AFDC family. (A decision to cut off benefits that was subsequently overturned would result in the awarding of retroactive benefits.) Unlike the situation in *Goldberg v. Kelly,* in *Mathews v. Eldridge* the agency sent a detailed questionnaire to recipients who were losing their benefits, allowed them access to information relied on by the agency, and sent them a tentative assessment of their chances of regaining benefits (while allowing submission of additional evidence and arguments). The Court also placed some emphasis on its view that in disability cases, the primary evidence is objective (medical data), whereas in welfare cases, the claimant's

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124. *Cf.* Adams v. Weinberger, 548 F.2d 239 (8th Cir. 1977), which held that claimant's testimony that it would be "no problem" for him to quit drinking could not in itself bar a disability claim based on alcoholism.

125. *See, e.g.,* Stawls v. Califano, 596 F.2d 1209 (4th Cir. 1979).

126. 642 F.2d 700 (3d Cir. 1981).

127. *See* Combs v. Weinberger, 501 F.2d 1361 (4th Cir. 1974) (while the Appeals Council could choose not to believe the uncontradicted testimony of the claimant, it had to make a specific holding on the issue of credibility).

128. 424 U.S. 319 (1976).

credibility sometimes assumes a larger role. (This discussion raises the question of the relevance of *Mathews v. Eldridge* to cases in which the claimant is relying on subjective pain as a basis for receiving disability benefits.) After weighing the risks and losses to claimants against the government's interest in efficient management, the Court concluded that the procedure of terminating benefits prior to the hearing was constitutional.

The distinctions between *Mathews v. Eldridge* and *Goldberg v. Kelly* identified by the Supreme Court are not completely convincing, and the case may represent the Supreme Court's desire to stem the tide of due process suits that arose after *Goldberg v. Kelly.* Certainly many disability recipients could suffer grievously from an interruption in income, and the "need" distinction is a broad generalization.[129] This is especially true for SSI recipients and for persons receiving dependents' benefits. Additionally, the determination is not solely a matter of "objective" medical evidence, since in those claims not involving the Listings, the claimant's vocational factors must be considered. There is evidence that a claim is more likely to be approved if the claimant is allowed a face-to-face hearing.[130]

Whether or not *Mathews v. Eldridge* was adequately distinguished from *Goldberg v. Kelly,* the administrative process for disability determinations that *Mathews v. Eldridge* approved is now accepted as constitutionally satisfactory. The key element in that process is a hearing before an examiner that is not adversarial. Rules concerning evidence are more relaxed; specifically, hearsay is admissible. However, the claimant retains the right to cross-examine. In *Lonzolla v. Weinberger,*[131] the Appeals Council, on an "own motion" review, ordered the claimant to undergo a medical exam after he had been found disabled by an administrative law judge. The examining physician found the claimant's complaints to be "totally subjective," and the Appeals Council, after allowing the claimant to respond in writing, reversed. The court of appeals held that the Social Security Administration's use of evidence not introduced at the hearing violated the claimant's rights. The claimant had the right to subpoena and cross-examine the physician, and to introduce rebuttal evidence.

The right to cross-examine has also been extended to use of medical texts. In *Generalla v. Weinberger,*[132] the use of texts by an

129. *See* Mashaw, *The Supreme Court's Due Process Calculus for Administrative Adjudication in* Mathews v. Eldridge: *Three Factors in Search of a Theory of Value,* 44 U. Chi. L. Rev. 28 (1976).

130. *Id.* at 43 n.55.

131. 534 F.2d 712 (7th Cir. 1976).

132. 388 F. Supp. 1086 (E.D. Pa. 1974).

administrative law judge, in a hearing in which no medical experts were called, was held to violate the claimant's rights. However, as with right-to-counsel issues, there apparently must be actual prejudice in order for a court to upset an administrative decision because of inadequacies in examination of witnesses.[133]

The claimant may request that the Social Security Administration grant a rehearing. Either errors or new material evidence can provide good cause for a rehearing. In order to be material, the new evidence must be likely to have made a difference to the original decision.[134] Additionally, if the claimant had the opportunity to present the evidence at the original hearing, no rehearing will be allowed.[135]

Other recent cases have dealt with due process and equal protection issues. In *Gullo v. Califano,*[136] a claimant was forced to submit to a medical examination, on which the administrative law judge placed substantial reliance, and was not given an opportunity to challenge the findings. The court held that this constituted a denial of due process. *Jackson v. Schweiker*[137] held that the administrative procedure of treating the difference between rent actually paid and fair rental value as unearned income for SSI recipients did not violate the due process or the equal protection clause. But the case was remanded because the formula used for imputation of income did not adequately account for the value of rental savings to each individual.

Attorneys' Fees

One issue that occasionally arises is that of attorneys' fees. Approval by the Social Security Administration is required for fees that a representative—including a nonattorney—seeks to charge. In court cases, approval of the court is required. In all cases, the fee can be no higher than 25 percent of past-due benefits.[138] A written application must be made to the Social Security Administration (or to the court) within sixty days of notice of a favorable determination. (If the agreement was for a flat or an hourly fee, a petition can be filed after an unfavorable determination.) The guidelines used in determining the fee are given at 20 C.F.R. §§ 404.1725(b) and 416.1525(b) (1984). They include the services per-

133. *See* Hollis v. Mathews, 520 F.2d 338 (8th Cir. 1975).
134. Ruiz-Olan v. Secretary of HEW, 511 F.2d 1056 (1st Cir. 1975).
135. *See, e.g.,* Lumsden v. Califano, 479 F. Supp. 839 (D. Ariz. 1979); Delikosta v. Califano, 478 F. Supp. 640 (S.D.N.Y. 1979).
136. 609 F.2d 649 (2d Cir. 1979).
137. 683 F.2d 1076 (7th Cir. 1982).
138. *See* 20 C.F.R. § 404.1730 (1984).

formed, the complexity of the case, the amount of time, the skill level required, the results achieved, the level of review that the case reached, and the fee requested. The competing considerations involved are encouraging attorneys to represent disability claimants and safeguarding the claimant's "already-inadequate stipend."[139]

Generally, the court only has jurisdiction to set fees based on services before the court. Thus if the court sets a fee below 25 percent of past-due benefits, a separate petition can be filed with the secretary concerning services performed during the administrative stages. The Sixth Circuit does not follow this rule and grants the Office of Hearings and Appeals power to set all fees—court and administrative—in cases that result in a favorable determination on remand, while allowing the court to do the same if it issues the final, favorable decision.[140]

Other Issues

Two other procedural issues have recently received extensive publicity. One arose when the president of the Association of Administrative Law Judges alleged that the Social Security Administration had directed administrative law judges to ignore court decisions favorable to claimants and had put pressure on them to deny claims.[141] The association filed suit against the secretary of Health and Human Services in January 1983.[142] An earlier case, *Nash v. Califano,*[143] held that an administrative law judge had standing to challenge the Social Security Administration's Peer Review Program (which reviewed administrative law judge performance in nonappealed cases) and its Quality Assurance Program (which established 50 percent as an "acceptable" reversal rate) as violations of the Administrative Procedure Act.

The second issue is the policy of the Social Security Administration to "nonacquiesce" in court decisions with which it disagrees. When a court of appeals decides an issue against the government's position, the agency complies as to the individual's case but tells its officials, including administrative law judges, to continue applying the policies that reflect the agency's view of the correct legal interpretation. The result is that only those claimants with the finan-

139. MacDonald v. Weinberger, 512 F.2d 144 (9th Cir. 1975).
140. R. Francis, *supra* note 7, at § 5.22.
141. Pear, *Pressure to Cut Off Benefits Reported by Disability Judges,* N.Y. Times, June 9, 1983, § 2, at 9, col. 5.
142. Association of Administrative Law Judges v. Schweiker, No. 83-0124 (D.D.C. filed Jan. 19, 1983).
143. 613 F.2d 10 (2d Cir. 1980).

cial resources to reach federal district court are assured of a hearing under the standards established by the court of appeals. In enacting the Social Security Disability Reform Act of 1984, Congress rejected a proposed statutory change that would have ordered the secretary to apply a court of appeals decision to all disability cases within the circuit or else seek Supreme Court review of the decision. On June 2, 1985, Secretary of Health and Human Services Margaret Heckler announced that henceforth the department would follow adverse court of appeals decisions at the administrative law judge and Appeals Council levels within a judicial circuit, unless the department sought to litigate the issue further in the court of appeals or the Supreme Court.[144] This issue is likely to engender further controversy in the years ahead.

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