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Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI): The Disability Determination and Appeals Process

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Summary

The Social Security Administration (SSA) has issued final regulations that outline new processes to be used in the determination and appeals of applications to the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. These final regulations prescribe a more streamlined process that seeks to improve the quality of initial determination decisions and bring about administrative finality after the decision of the Administrative Law Judge (ALJ). These new regulations also add a procedure for (1) an expedited decision on cases likely to be awarded benefits, (2) a review by a federal official, and (3) the elimination of the existing Appeals Council and its replacement with a Decision Review Board (DRB), which will not hear cases on appeal, but will examine a sample of cases deemed likely to have errors.

The changes derived from concerns raised by numerous outside observers as to the timeliness, accuracy, and consistency of decisions made under the current determination and appeals systems. These systems, which include an initial determination and redetermination by a state agency and the opportunity for appeals to an ALJ and the SSA Appeals Council, were criticized for taking too long to come to the correct decision. Because of this, some observers felt that many otherwise qualified applicants for the disability programs were either being denied benefits or being forced to wait too long to receive their benefits.

During the public comment period on these regulations, disability advocacy groups and others expressed concerns that these regulations would result in additional burdens on applicants and a greater number of otherwise qualified applicants being denied benefits. In response to the comments, the SSA relaxed some of the procedural requirements in the regulations but maintained the core elements of the determination and appeals processes including the elimination of the Appeals Council.

These final regulations go into effect on August 1, 2006, in the SSA's Boston region. After a period of at least one year, the SSA hopes to roll out these new procedures nationally. At that time these regulations, which took almost three years to create and were the subject of nearly 900 public comments, will change the way the SSA handles some 4.6 million new disability program applications it receives each year and the nearly 500,000 appeals cases heard each year by ALJs.

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Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI): The Disability Determination and Appeals Process

Introduction

On March 31, 2006, the Social Security Administration (SSA) issued final rules governing the processes used to determine eligibility for disability benefit programs and to adjudicate disputes that arise from these determinations.[1] These final rules were the result of nearly three years of discussion by the SSA that included several public forums, congressional hearings, and a published Notice of Proposed Rulemaking (NPRM) that generated approximately 900 public comments.[2]

The final rules and the new determination and appeals processes represent some of the most significant administrative changes in the history of the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs and are expected to impact all facets of what has been called "the largest system of administrative adjudication in the Western world."[3] When fully implemented, these rules and procedures will affect the way the SSA and its affiliated state Disability Determination Services (DDS) handle some 4.6 million new applications for disability benefits filed each year as well as the way the nearly 1,000 SSA Administrative Law Judges (ALJs) decide nearly 500,000 disability appeals cases annually.[4]

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[1] Administrative Review Process for Adjudicating Initial Disability Claims, 71 *Federal Register* 16424, Mar. 31, 2006.

[2] Administrative Review Process for Adjudicating Initial Disability Claims, 70 *Federal Register* 43590, July 27, 2005. The 885 public comments submitted in response to this Notice of Proposed Rulemaking can be found on SSA's website at [https://s044a90.ssa.gov/apps10/erm/rules.nsf/5da82b031a6677dc85256b41006b7f8d/3112961b7090db578525704b00508cac!OpenDocument&Highlight=0,Adjudicating]. For more information on this Notice of Proposed Rulemaking, see CRS Report RL33179, *Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI): Proposed Changes to the Disability Determination and Appeals Processes*, by Scott Szymendera.

[3] Lance Liebman, *Disability Appeals in Social Security Programs* (Washington: Federal Judicial Center, 1985), p. 1.

[4] Social Security Administration, *Annual Statistical Supplement to the Social Security Bulletin, 2005* (Washington: GPO, 2005), pp. 2.F5, 2.F6, 2.F8, 2.F9, 2.F11.

The new regulations prescribe a more streamlined process that seeks to improve the quality of initial determination decisions and bring about administrative finality after the decision of the ALJ. The existing Appeals Council is replaced with a Decision Review Board (DRB) and applicants will no longer have the right to seek an administrative appeal of the decision of an ALJ.[5] Rather, dissatisfied applicants will have to either seek relief in the federal court system or file a new application for disability benefits.[6]

The SSDI program provides monthly cash benefits and medical coverage to persons under 65 who meet the statutory definition of disability found in Section 223(d) of the Social Security Act.[7] To qualify for SSDI benefits, a person must have a disabling condition that is expected to result in death or last at least 12 months and which renders him or her unable to perform his or her past work or any other work that exists in the national economy. SSDI is an insured program that is funded by payroll taxes and only persons with a history of work in covered employment are eligible. Monthly benefit amounts are based on the past earnings of the beneficiary. Benefits are also available in some cases to the spouses and children of beneficiaries.[8] At the end of February 2006, there were more than 8.3 million SSDI beneficiaries receiving an average benefit of $795.90 per month.[9]

SSI is a means tested program that provides monthly cash benefits to persons under the age of 65 who meet the statutory definition of disability and the means test and persons over the age of 65 who meet the means test.[10] To qualify under the means test, a person must have limited income and limited assets. An increase in assets or income can reduce the monthly benefit amount or render a person ineligible

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[5] The existing Appeals Council is an administrative body within the SSA that hears cases on appeal from claimants dissatisfied with the decision of the ALJ. It has the power to reverse the decision of th ALJ and award benefits, uphold the decision of the ALJ and deny benefits, or remand a case back to the ALJ for further action.

[6] An applicant can reapply for benefits immediately. However, submitting a new application can delay the start of benefits and eligibility for Medicare benefits. By law, 42 U.S.C. §§ 405(b)(3) and 1383(c)(1), the SSA is required to notify claimants of the possible negative effects reapplying for benefits as opposed to pursuing an appeal of a negative decision. In addition, the doctrine of *res judicata* prevents the SSA from reconsidering a new application for benefits if the agency has already issued a decision on the same facts and issues from the same applicant. The SSA's policy on *res judicata* is outlined in Section GN 03101.160 of its Program Operations Manual System (POMS), the agency's internal guidance given to its employees. The POMS can be found on SSA's website at [https://s044a90.ssa.gov/apps10/poms.nsf/aboutpoms].

[7] 42 U.S.C. § 423(d). For an overview of the SSDI program see CRS Report RL32279, *Primer on Disability Benefits: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)*, by Scott Szymendera.

[8] For more information see CRS Report RS22294, *Social Security Survivors Benefits*, by Kathleen Romig and Scott Szymendera.

[9] Social Security Administration, *OASDI Monthly Statistics, February 2006* (Washington: GPO, 2006), Table 5.

[10] The statutory definition of disability for the SSI program is the same as that used for the SSDI program. For an overview of the SSI program see CRS Report RL32279.

for future benefits. Participation in the SSI program usually ensures a person's eligibility for Medicaid benefits and 44 states and the District of Columbia add a state supplementary payment to the basic SSI benefit.[11] At the end of February 2006, there were more than 7.1 million SSI beneficiaries receiving an average benefit of $449.10 per month.[12]

Currently, the SSA maintains multi-stage determination and appeals processes for applications to the SSDI and SSI programs.[13] These processes begin with an initial determination of disability by a state agency, followed by multiple opportunities for administrative appeals before an ALJ and the Appeals Council. Unsuccessful applicants are also entitled to appeal their decisions to the federal courts.

In the several years preceding the issuance of the final rules, researchers and others, including the Government Accountability Office (GAO) and the nonpartisan Social Security Advisory Board, raised concerns as to the accuracy, timeliness, and consistency of disability determination and appellate decisions. These concerns were echoed by the Commissioner of Social Security in her testimony before Congress and were among the forces behind the effort to change the determination and appeals systems used by disability program applicants.[14]

Timeliness

The GAO and the Social Security Advisory Board have raised concerns about the length of time involved in the entire disability determination and appeals process.[15] In addition, the GAO and others have commented that the overall length of this process was a contributing factor to the historically low return to work rate of

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[11] Arkansas, Georgia, Kansas, Mississippi, Tennessee, West Virginia and the Commonwealth of the Northern Mariana Islands do not pay a state supplement to SSI beneficiaries.

[12] Social Security Administration, *SSI Monthly Statistics, February 2006* (Washington: GPO, 2006), Table 1.

[13] For more information on the existing determination and appeals processes, see CRS Report RL33179, *Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI): Proposed Changes to the Disability Determination and Appeals Processes*, by Scott Szymendera.

[14] U.S. Congress, House Committee on Ways and Means, Testimony Social Security Commissioner, Jo Anne B. Barnhart, *Social Security Administration's Management of the Office of Hearings and Appeals*, hearings, 108th Cong., 1st sess. (2003).

[15] General Accounting Office, *SSA Disability Redesign: Focus Needed on Incentives Most Crucial to Reducing Costs and Time, GAO /HEHS-97-20* (Washington: GPO, 1997); General Accounting Office, *Social Security Disability: Disappointing Results from SSA's Efforts to Improve the Disability Claims Process Warrant Immediate Attention* (Washington: GPO, 2002); Social Security Advisory Board, *How SSA's Disability Programs Can be Improved* (Washington: GPO, 1998).

disability program participants.[16] Data from FY2004 showed that SSDI and SSI applicants waited an average of 95 days for an initial determination and could wait up to an average of 1,048 days, over 2½ years, before getting a final administrative decision from the SSA Appeals Council.[17]

The new rules address the issue of timeliness in several ways. The SSA will identify cases that are likely to receive benefits and these cases will be acted on by the Quick Disability Determination (QDD) unit in each state within 20 days. In addition, the new rules create firm deadlines for seeking appellate relief and submitting evidence that are expected to cut down on many of the delays in the process. By closing the record after the decision of the ALJ and eliminating the Appeals Council, it is hoped that these new rules will bring administrative finality to the process sooner and shorten the overall time from initial application to final, binding, decision.

Accuracy

Observers also raised concerns about the accuracy of initial disability determination decisions. Although retrospective data on the accuracy of individual decisions was mixed, the high rate of reversals at the appellate level seemed to indicate that persons who were eligible to receive benefits were not receiving them during the initial determination stage, forcing them to wait longer and often incur additional costs before getting program benefits.[18]

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[16] Monroe Berkowitz, "Improving the Return to Work of Social Security Disability Beneficiaries," in Jerry L. Mashaw, et al., *Disability Work and Cash Benefits* (Kalamazoo, MI: W. E. Upjohn Institute for Employment Research, 1996); Richard V. Burkhauser and David Wittenburg, "How Current Disability Transfer Policies Discourage Work: Analysis from the 1990 SIPP," *Journal of Vocational Rehabilitation,* vol. 7 (1996), pp. 9-27; General Accounting Office, *SSA Disability: Program Redesign Necessary to Encourage Return to Work, GAO/HEHS 96-62* (Washington: GPO, 1996); General Accounting Office, *Social Security: Disability Programs Lag in Promoting Return to Work, GAO/HEHS-97-46* (Washington: GPO, 1997); Joann Sim, "Improving Return-to-Work Strategies in the United States Disability Programs, With Analysis of Program Practices in Germany and Sweden," *Social Security Bulletin*, vol. 59, no. 3 (1999), pp. 41-50.

[17] Social Security Administration, *Fiscal Year 2004 Performance and Accountability Report* (Washington: GPO 2005), p. 17.

[18] Social Security Administration, *FY2004 Performance and Accountability Report* (Washington: GPO, 2005), pp. 91-92; *SSI Annual Statistical Report, 2003* (Washington: GPO, 2004), pp. 117-122; The Lewin Group, Inc., Paul Ettinger McCarthy Associates, L.L.C., and Cornell University, *Evaluation of SSA's Disability Quality Assurance (QA) Processes and Development of QA Options That Will Support the Long-Term Management of the Disability Program: Final Report* (Falls Church, VA: The Lewin Group, Inc., 2001); Hugo Benitez-Silva, Moshe Buchinsky, and John Rust, *How Large Are the Classification Errors in the Social Security Awards Process? NBER Working Paper 10219* (Cambridge, MA: National Bureau of Economic Research, 2004); Social Security Administration, *Annual Statistical Report on the Social Security Disability Insurance Program, 2003* (Washington: GPO, 2004), pp. 134-136.

To address the problem of inaccurate initial determinations, the new rules incorporate in-line and end-of-line quality assessments into the determination and appeals processes. The initial determinations of DDS officers will be subject to review by a federal Reviewing Official (RO) and all decisions will be subject to screening and review by the Decision Review Board (DRB) which, unlike the current Appeals Council, will review cases likely to contain errors. In addition, at each stage of the determination and appellate process, decision makers will be able to draw upon the expertise of a federal Medical and Vocational Expert System (MVES), which will be composed of medical and vocational experts who meet national standards set by the SSA in consultation with the Institute of Medicine. Currently, there is no national network of medical and vocational experts and no national standards for the experts used in the process.

Inconsistency Across States

The Social Security Advisory Board found significant differences by state in initial disability allowance rates.[19] The board also found inconsistency across states in the rate that decisions made by DDS offices were reversed on appeal by ALJs. The new rules seek to bring more consistency into the determination process by requiring that each state's DDS either utilize medical and vocational experts from the MVES or use their own experts who meet the same national standards set by the SSA in consultation with the Institute of Medicine.

The Disability Determination and Appeals Processes

Implementation

On March 31, 2006, the SSA issued final rules establishing new processes that will be used by the agency and its state DDS affiliates to determine the disability status of SSDI and SSI applicants and to adjudicate appellate disputes that arise from these determinations. As specified in the *Federal Register* announcement of the new regulations, the new processes will be phased in by the SSA. The new determination and appeals process will first go into effect on August 1, 2006, in the SSA's Boston Region, with an expansion into other regions of the country after a period of at least one year.[20]

Once fully implemented, all new disability program applicants will have their initial claims and any appeals processed according to the new regulations. **Figure 1**, at the end of this report, provides a graphical overview of the new determination and appellate systems created by these regulations, whereas the following sections

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[19] Social Security Advisory Board, *Disability Decision Making, Data and Materials* (Washington: GPO, 2001), pp. 51, 70.

[20] The Boston Region consists of the states of Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, and Vermont.

detail each step in the new process with an emphasis on new procedural rules and deadlines that applicants and appellants will face.

Initial Determination

An applicant to the SSDI or SSI program will begin by submitting an application to the SSA. The evaluation of disability will take place, as it does now, in the appropriate state DDS office. The DDS is a state agency with state employees who evaluate SSDI and SSI applications according to federal guidelines and the statutory definitions of disability used by the SSDI and SSI programs. However, once the application has been transmitted to the DDS, two significant new processes will take effect. Applications will be subject to review and consultation by a national group of medical and vocational experts, and applications will be screened to determine if they qualify for a expedited decision-making process.

Medical Vocational Expert System (MVES). The regulations establish a national MVES that will consult with state DDS examiners and other decision makers in the determination and appeals processes.[21] The MVES will be a national pool of medical, psychological, and vocational specialists who will be selected according to standards set by the SSA in consultation with the Institute of Medicine.[22] As of the announcement of the regulations, the Institute of Medicine has not yet issued its final report on the qualifications of the MVES to the SSA and the SSA had not yet determined the exact nature of the qualifications that will be required of the MVES.

State DDS agencies will be permitted to continue to use their own specialists as consultants, provided that the specialists meet the same qualifications as the members of the MVES. States will have one year after the qualifications are published to ensure that their specialists are in compliance. After this one-year period, the SSA will not reimburse a state DDS agency for any consultations performed by specialists that do not meet the qualifications set by the agency.

Quick Disability Determination (QDD). All initial disability claims will be screened by the SSA and those deemed likely to meet the statutory definition of disability and likely to have readily available supporting evidence will be transferred to a QDD unit established within each states DDS. This unit will have 20 days to evaluate each case and either award benefits or transfer the case back to the state DDS for normal processing. All positive determinations made by this unit will have to be made in consultation with a medical or psychological expert from the MVES or one who meets a set of standards established by the SSA. As of the announcement

[21] In the NPRM, the MVES is referred to as the Federal Expert Unit.

[22] The Institute of Medicine is a part of the National Academies, which includes the National Academy of Science, the National Academy of Engineering and the National Research Council. The Institute of Medicine is not a government agency, but rather is a non-partisan organization that provides scientific expertise and advice to policymakers and the public. Information on the Institute of Medicine's work with the SSA on the establishment of the MVES can be found on the Institute of Medicine's website at [http://www.iom.edu/CMS/3795/24393.aspx].

of the regulations, the SSA had not yet created the screening tool that will be used to determine which cases are sent to the QDD for expedited processing.

Federal Reviewing Official (RO)

An applicant dissatisfied with the decision of the state DDS will be able to request a review by the federal Reviewing Official (RO). The RO will be a federal employee who will be centrally managed by the SSA. Although the *Federal Register* announcement of the new regulations indicates that the RO will be an attorney, the SSA has not yet issued specific qualifications for the position or identified where in the federal service or pay scale this position would be located.

Requesting a Review from the RO. An applicant will have 60 days from the date he or she receives notice of initial determination to request a review by the RO. This request will have to be filed at an SSA office, or, in the case of a person with prior railroad service, at an office of the Railroad Retirement Board.[23] Applicants who feel that they may miss this 60 day deadline, or applicants for whom the 60 day deadline has already passed may request, in writing, an extension. This request for an extension will have to show good cause for why the deadline is likely to be missed or was missed. To establish good cause for the purposes of requesting an extension of the deadline to seek a review by the RO, the applicant must show one of the following:

- The actions of the SSA misled the applicant; or
- The applicant has a physical, mental, educational, or linguistic limitation that prevented him or her from meeting the deadline; or
- The applicant was prevented from meeting the deadline by some other unusual, unexpected, or unavoidable circumstance beyond his or her control.[24]

The regulations include the following examples of circumstances that may establish good cause for missing the deadline to request a review by the RO:

- The applicant was seriously ill and his or her illness prevented him or her from contacting the SSA either in person or through another person;
- There was a death or serious illness in the immediate family of the applicant;
- Important records were destroyed or damaged by fire or other accidental cause;
- The applicant tried "very hard" to find the necessary information to support his or her claim but was unable to in a timely manner.[25]

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[23] Applicants to the SSDI program will also be able to file a request for a review by the RO at the Veterans Administration Regional Office in the Phillippines.

[24] 20 C.F.R. § 405.20.

[25] 20 C.F.R. § 405.20.

RO Procedures. The RO will review the decision of the DDS but will not hold a new hearing. The RO will be able to collect new evidence on the application and the applicant will have the right to submit new evidence on his or her behalf. The RO will have subpoena power and the applicant will be able to ask the RO to subpoena evidence on the applicant's behalf. If the RO disagrees with the decision of the DDS, or if new evidence is submitted by the applicant or collected by the RO, the RO will have to consult with the MVES before making a decision. Notice of the final decision of the RO will be sent to the applicant and will explain in plain language the reasons for the decision and why the RO agrees or disagrees with the previous decision of the DDS.

Administrative Law Judge (ALJ) Hearing

If an applicant is dissatisfied with the decision of the RO, he or she will be able to have his or her case heard in a *de novo* hearing before an SSA Administrative Law Judge (ALJ) in which new evidence may be submitted. An ALJ is an SSA employee who conducts hearings on matters before the agency. Other than through the ALJ, the SSA will not be represented at this hearing and the hearing is designed to be non-adversarial in nature. The hearing may be conducted in person or via video conference and the ALJ will have the right to conduct a pre-hearing and post-hearing conference to assist with the decision. In certain cases, the ALJ may make a decision that is wholly favorable to the applicant without conducting a hearing.[26]

Requesting an ALJ Hearing. An applicant will have 60 days from the receipt of notice of the decision of the RO to request a hearing before an ALJ. This request must be made in writing and must be filed at an SSA office, or in the case of some former railroad employees, at an office of the Railroad Retirement Board.[27] Applicants who miss this 60 day deadline may request, in writing, an extension. This request for an extension will have to show good cause for why the deadline is likely to be missed or was missed. To establish good cause for the purposes of requesting an extension of the deadline to seek a hearing before an ALJ, the applicant must show one of the following (which are identical to the good cause requirements listed earlier for missing the deadline for seeking a review from the RO):

- The actions of the SSA misled the applicant; or
- The applicant has a physical, mental, educational, or linguistic limitation that prevented him or her from meeting the deadline; or

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[26] The ALJ will also be able to make a decision without conducting a hearing if the applicant states in writing that he or she does not wish to appear before the ALJ or if the applicant lives outside of the United States and does not inform the SSA of their intention to appear before the ALJ.

[27] Applicants to the SSDI program will also be able to file a request for an ALJ hearing at the Veterans Administration Regional Office in the Phillippines.

- The applicant was prevented from meeting the deadline by some other unusual, unexpected, or unavoidable circumstance beyond his or her control.[28]

The regulations include the following examples of circumstances that may establish good cause for missing the deadline to request a hearing before an ALJ (these are identical to the examples listed earlier in the case of an RO review):

- The applicant was seriously ill and his or her illness prevented him or her from contacting the SSA either in person or through another person;
- There was a death or serious illness in the immediate family of the applicant;
- Important records were destroyed or damaged by fire or other accidental cause;
- The applicant tried "very hard" to find the necessary information to support his or her claim but was unable to in a timely manner.[29]

Time and Place of the ALJ Hearing. The ALJ will send the applicant a notice indicating the time and place where the hearing will be conducted and the issues that will be decided at the hearing. This notice will be sent to the applicant at least 75 days prior to the scheduled date of the ALJ hearing. The ALJ will have the right to change the time and place of the hearing, but must give the applicant "reasonable notice" of such change.[30] Hearings are held in the 50 states, the District of Columbia, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the United States Virgin Islands. The ALJ may also schedule the hearing to be held via video teleconference. The applicant will have the right to object to the use of video teleconference and in such cases an in-person hearing will be scheduled.

If an applicant objects to the time or place of the scheduled ALJ hearing, the applicant will have up to 30 days after receiving the hearing notice to file his or her objection in writing to the ALJ. There is no good cause or other exemption to this 30 day deadline for objecting to the time and place of the scheduled ALJ hearing. The ALJ will rule on the applicant's objection after considering the impact that rescheduling the hearing would have on the efficient administration of the hearing process.

If an applicant objects to the issues that will be decided at the hearing, he or she must notify the ALJ in writing no later than five business days before the date of the hearing. There is no good cause or other exemption to this five day deadline for submitting an objection to the issues to be decided at the ALJ hearing. This notice must include the reasons for the applicant's objection. The ALJ will rule on this objection either before the hearing or at the hearing.

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[28] 20 C.F.R. § 405.20.

[29] 20 C.F.R. § 405.20.

[30] 20 C.F.R. § 405.315.

Submitting Evidence to the ALJ. Any written evidence that the applicant wishes to be considered by the ALJ will have to be submitted no later than five business days before the hearing. The ALJ will have the right to decline to consider any evidence submitted by an applicant after this deadline.

If an applicant misses the five day deadline to submit written evidence to the ALJ and wishes to have written evidence accepted *before the hearing takes place*, he or she must show that one of the following circumstances has occurred (these are the same good cause circumstances listed earlier):

- The actions of the SSA misled the applicant; or
- The applicant has a physical, mental, educational, or linguistic limitation that prevented him or her from meeting the deadline; or
- The applicant was prevented from meeting the deadline by some other unusual, unexpected, or unavoidable circumstance beyond his or her control.[31]

If an applicant misses the five day deadline to submit written evidence to the ALJ and wishes to have written evidence accepted *after the hearing has taken place but before the ALJ has issued a decision*, he or she must show that there is a "reasonable possibility that the evidence, alone or when considered with the other evidence of record, would affect the outcome" of the claim *and* that one of the above circumstances has occurred.[32]

If the applicant can demonstrate that his or her circumstance falls into one of these categories, the ALJ will be required to accept the late evidence. Although the regulations do not specify examples of circumstances that would meet these requirements, the Commissioner of Social Security has indicated that cases in which an applicant tried to obtain evidence from a physician but was unable to through no fault of his or her own may be considered as meeting these requirements for the acceptance of late evidence.[33]

The Decision of the ALJ. The ALJ will make a decision based on the evidence presented in advance of the hearing and any testimony or statements given at the hearing. The ALJ may also consult with the MVES and has the power to issue subpoenas to collect additional evidence. The ALJ will send to the applicant a written decision notice that explains in clear language the decision made and the reasons for the decision. Although the ALJ is not required to consider the previous decision of the RO as evidence, the ALJ must indicate in the decision notice why he or she agrees or disagrees with the decision of the RO. After the ALJ has made his or her decision, the record in the case is considered closed to new evidence and the decision of the ALJ is considered the final administrative decision of the SSA.

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[31] 20 C.F.R. § 405.331.

[32] 20 C.F.R. § 405.331.

[33] The Commissioner of Social Security made these comments in a briefing to Congressional staff on March 28, 2006. These comments are consistent with other "good cause" exemptions found in the regulations that include, as examples, cases in which an applicant tried unsuccessfully to obtain information in support of his or her claim.

Requesting Consideration of Additional Evidence. Although the record of a case is considered closed after the ALJ issues a decision, the ALJ will consider new evidence submitted after the decision if such evidence is submitted to the ALJ within 30 days of the decision. The ALJ will be required to consider this evidence if the applicant can show that there is a "reasonable possibility that the evidence, alone or when considered with the other evidence of record, would affect the outcome" of the ALJ's decision and that one of the good cause circumstances identified above has occurred.[34]

The Decision Review Board (DRB)

The Decision Review Board (DRB) will be a group of ALJs and administrative appeals judges appointed by the Commissioner of Social Security to review certain decisions made by ALJs in disability cases. The DRB is not a appellate body and applicants dissatisfied with the decision of the ALJ in their cases *may not* ask for a review by the DRB. Except in cases of dismissals, the SSA will determine which cases are to be reviewed by the DRB.[35]

During the first year of implementation in the Boston region, the DRB will review every decision made by ALJs. During this year, the SSA will examine these cases and use them to create a model that will predict which ALJ decisions are most likely to have been made in error and this data will be used to create a screening tool that will be used to select which cases will be reviewed by the DRB. The DRB will review both favorable and unfavorable decisions by ALJs.

Applicants will be notified when they receive the ALJ's decision if their case has been selected for review by the DRB. If a case is selected, the applicant will have the right to submit a brief written statement on his or her own behalf within 10 days of receiving the notice of review by the DRB. There is no good cause or other exemption to this 10 day deadline for submitting a statement to the DRB. This statement must conform to strict standards set by the regulations and is the only type of evidence that an applicant will have the right to submit.[36]

The DRB will not conduct a formal hearing or ask for additional statements or evidence from an applicant. Rather, it will primarily review the record of the case established at the ALJ hearing. The DRB will have 90 days from the date of the notice to the applicant to make a decision in a case. If the DRB has not made a decision on a case within 90 days, then the decision of the ALJ becomes the final

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[34] 20 C.F.R. § 405.373.

[35] An ALJ can dismiss a case if the applicant fails to meet their responsibilities as part of the hearing process, for example, if an applicant fails to appear at a scheduled hearing. The decision of the ALJ to dismiss a case is subject to appellate review by the DRB at the request of the applicant.

[36] 20 C.F.R. § 405.427 reads, in part: "The written statement may be no longer than 2,000 words, and, if typed, the typeface must be 12 point font or larger. The written statement should briefly explain why you agree or disagree with the administrative law judge's decision and should cite applicable law and specific facts in the record."

binding decision of the SSA. The DRB may rule directly on a case or remand a case back to the ALJ for further proceedings.

Reopening and Revising a Decision

Except in limited circumstances, the decision of the ALJ or DRB is the final administrative decision of the SSA and this decision cannot be reopened or revised except on order of the federal courts.[37] An applicant can, however, request that a decision be reopened or revised within six months of the decision and this decision will be reopened if the SSA finds that there is good cause for a reopening or revision. The SSA will determine that good cause exists if a clerical error in the computation of benefits was made or if the evidence that was considered "clearly shows on its face that an error was made."[38] The discovery or existence of new and material evidence *will not* be considered good cause and *will not* be grounds for a decision to be reopened or revised.[39]

Judicial Review

The decision of the ALJ or the DRB is the final administrative decision of the SSA. However, applicants can request a judicial review of the SSA's decision by filing an action in the United States District Court within 60 days of the date of the final decision of the SSA. Applicants who feel that they may miss this 60 day deadline, or applicants for whom the 60 day deadline has already passed, may request, in writing to the DRB, an extension. This request for an extension will have to show good cause for why the deadline is likely to be missed or was missed. To establish good cause for the purposes of requesting an extension of the deadline to seek judicial review, the applicant must show one of the same good cause circumstances listed earlier, namely:

- The actions of the SSA misled the applicant; or
- The applicant has a physical, mental, educational, or linguistic limitation that prevented him or her from meeting the deadline; or
- The applicant was prevented from meeting the deadline by some other unusual, unexpected, or unavoidable circumstance beyond his or her control.[40]

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[37] The regulations do allow for the SSA or the applicant to request that a case be reopened for several other reasons such as fraud or a mistake made when determining insured status. A complete explanation of these circumstances can be found in the regulations at 20 C.F.R. §§ 404.987-404.996.

[38] 20 C.F.R. § 404.989.

[39] 20 C.F.R. § 405.515 amends 20 C.F.R. § 404.989 to remove new and material evidence from the definition of good cause for a case to be reopened or revised.

[40] 20 C.F.R. § 405.20.

How the New Regulations Respond to Public Comments on the NPRM

The SSA received 885 public comments on its NPRM that outlined the proposed changes to the disability determination and appeals processes. In addition, several large disability-related groups and the Social Security Advisory Board made public their comments on the NPRM and the Subcommittees on Human Resources and Social Security of the House Committee on Ways and Means held a joint hearing on the proposed rules. At this hearing, the Commissioner of Social Security, representatives from the Consortium for Citizens with Disabilities, the National Organization of Social Security Claimants' Representatives, the National Council of Disability Determination Directors and a member of the federal bench all testified.[41]

While it would be difficult for the Congressional Research Service (CRS) to summarize each of the nearly 900 public comments, a review of these comments, as well as a review of the testimony and public statements given, does indicate some consensus among commenters on the new disability determination and appeals processes proposed in the NPRM. Generally, commenters expressed the following concerns with the proposed regulations:

- The procedural rules and deadlines included in the proposed regulations would cause hardship for SSI and SSDI applicants.
- The requirement that applicants submit evidence that may undermine their claim may violate standards of ethical conduct for lawyers.
- Closing the record after the ALJ hearing would prevent applicants from submitting important new evidence that could strengthen their claims.
- Eliminating the Appeals Council would take away an important appellate step in the process and would result in an increased reliance on the federal courts to settle disability cases.

This section of the report will examine each of these concerns in more detail and will analyze how the final regulations address, or fail to address, these concerns.

Procedural Rules and Deadlines

Commenters expressed concern over the new procedural rules and firm deadlines that were included in the proposed regulations. They felt that these rules and deadlines would create additional hurdles that disability program applicants would have to overcome to get their cases heard. In addition, there was concern that the disabling conditions many applicants have would make compliance with

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[41] U.S. Congress, House Committee on Ways and Means, Subcommittees on Human Resources and Social Security, *Joint Hearing on Commissioner of Social Security's Proposed Improvements to the Disability Determination Process*, hearings, 109th Cong., 1st sess. (2005).

deadlines and other procedural regulations difficult and could result in otherwise qualified applicants being denied benefits because of procedural violations.

One proposed rule that commenters were especially concerned about was the requirement that applicants submit all written evidence at least 20 days before the ALJ hearing. Commenters expressed concern that this would not be possible in many cases as applicants often wait until just before a hearing to secure representation. In addition, because much of the evidence to be submitted must be obtained from doctors and hospitals, there was a concern that applicants would be penalized if a doctor or hospital was late in getting them copies of their medical records.

Some commenters, including the National Organization of Social Security Claimants' Representatives, which represents attorneys who represent applicants in proceedings before the SSA, also felt that the requirement that evidence be submitted in advance violated the clauses in Sections 202(j)(2) and 1631(c)(1)(A) of the Social Security Act that require the ALJ to decide cases on the basis of evidence "adduced at the hearing."[42] These commenters also felt that this limitation on evidence violated case law which established the duty of the ALJ to develop a record at the hearing.[43]

The final regulations address some of the concerns raised by the commenters over the burdens that could be imposed by procedural rules and deadlines. The general good cause exemption that allows many deadlines to be waived is clarified in the final rules and, according to the Commissioner of Social Security, now includes a provision for cases in which applicants, despite their best efforts, are unable to secure the evidence they need in a timely manner. In addition, the 20 day deadline for submitting evidence before an ALJ hearing was changed and applicants will now have up to five business days before the ALJ hearing to submit written evidence. The time between the hearing notice and the scheduled date of the hearing also was expanded from 45 to 75 days to allow applicants more time to secure the evidence they need to support their cases.

The final regulations do not address the legal concerns raised by commenters that the requirement that evidence be submitted in advance violates the adducement rule found in the Social Security Act as well as established in case law. In its preamble to the final regulations, the SSA did not address either of these issues.

Submission of Contrary Evidence

Commenters expressed concern with the requirement in the proposed regulation that applicants submit all evidence, including evidence that may be contrary to their claim when applying for benefits or seeking a hearing before an ALJ. Commenters felt that this placed an unfair burden on claimants and that requiring attorneys to submit evidence that could be used against their clients would violate the ethical

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[42] 42 U.S.C. §§ 402(j)(2) and 1383(c)(1)(A).

[43] The National Organization of Social Security Claimants' Representatives cite *Pratts v. Chater,* 94 F.3d 34 (2nd Cir. 1996); *Delorme v. Sullivan,* 924 F.2d 841 (9th Cir. 1991); and *Baker v. Bowen,* 886 F. 2d 289 (10th Cir. 1989) as examples of case law in this area.

standards of the profession. The National Organization of Social Security Claimants' Representatives in its comments stated that its members could find themselves subject to sanctioning by state bar associations if they complied with this regulation.

The final regulations do not contain this rule and instead contain only a requirement that any evidence submitted by an applicant not be redacted.

Closing the Record After the ALJ Hearing

Commenters on the proposed rules expressed concern over the closing of the record of a case after the ALJ hearing. Commenters felt that this rule would prevent applicants, many of whom have physical conditions that may change during the lengthy application and appeal process, from presenting evidence that could demonstrate their eligibility for benefits. There was a concern that if new evidence of a disability were found after the ALJ hearing, the applicant would have no administrative relief available and would have to either file for judicial review in federal court or reapply for benefits and start the entire process over again at the beginning. Commenters felt that this change would result in an increased number of otherwise qualified applicants being denied benefits because they were not able to get the evidence they needed presented before the ALJ and thus were faced with a closed record and no avenue for administrative appeal.

The final regulations partially address these concerns. The rules regarding the submission of new evidence after the ALJ hearing were relaxed and applicants will have up to 30 days after the decision to submit such evidence. In addition, the standard for the acceptance of such evidence was relaxed to include evidence that has a "reasonable probability" affecting the outcome of a case. Also, under the final rules, an ALJ is required to consider new evidence that meets the specified standards.

Although the standards for submitting new evidence to the ALJ after the decision are relaxed in the final rules, the rules governing the reopening or revision of decisions are not. The existing rules for reopening and revising decisions after the ALJ hearing are maintained with the exception that a reopening or revision for good cause must occur within six months of the ALJ's decision. In addition, the rule that the discovery or existence of new and material evidence does not constitute good cause for the purposes of reopening or revising a decision remains in place.

Eliminating the Appeals Council

Commenters expressed concern that eliminating the Appeals Council and removing the right of most claimants to seek an administrative appeal of the decision of the ALJ would deprive applicants of an important safeguard in the process and result in a greater number of cases being filed in the federal courts. Commenters also felt that the elimination of the Appeals Council would result in an increased number of otherwise qualified applicants being denied benefits.

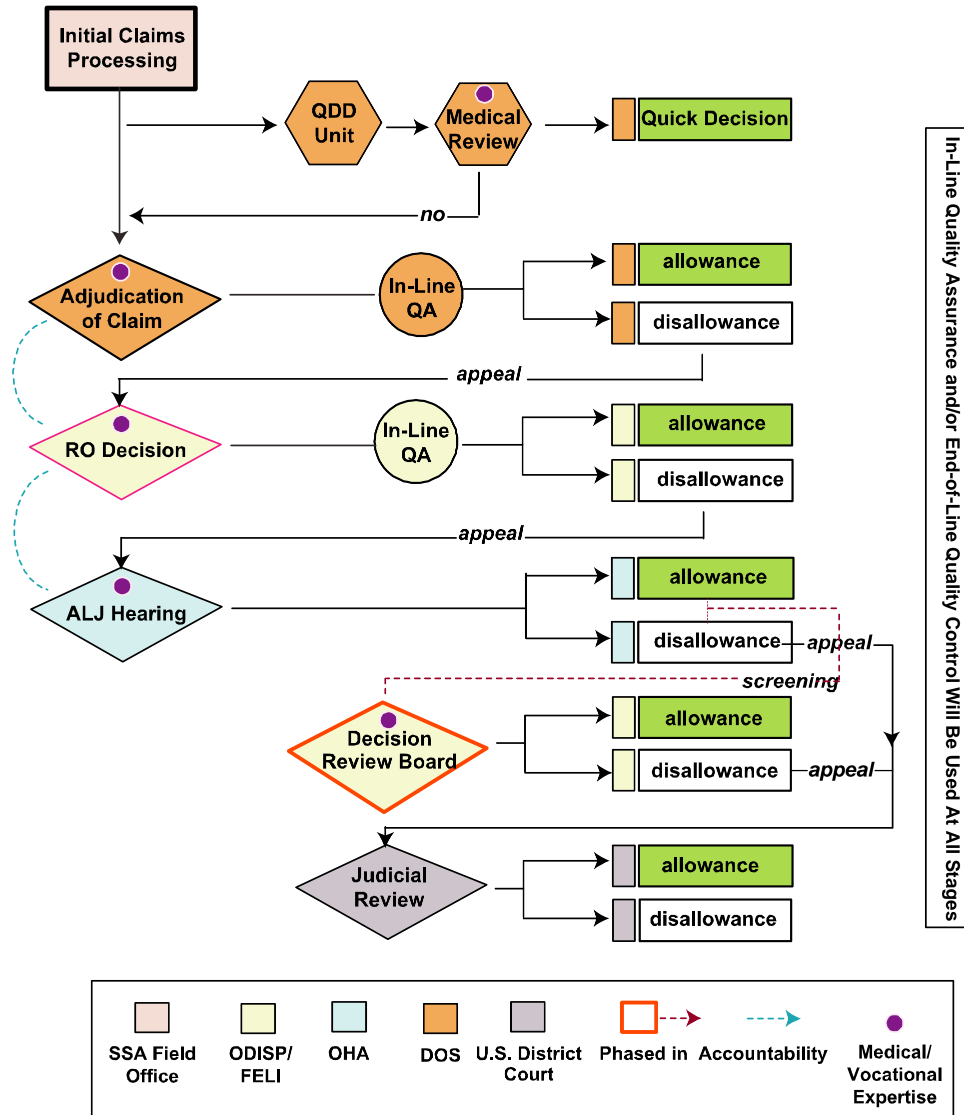
Commenters cited the importance of having an administrative appellate body that applicants could use to correct both mistakes made by the ALJs in the interpretation of evidence and facts in their cases as well as errors made in the

administration of the hearings that may have affected their rights to due process and fair administrative hearings. Although the DRB may pick up some of these factual errors through its screening tool, it was felt that by denying applicants the right to file for appeals, there would be no remedy for due process violations or abuses by ALJs. In addition, the Appeals Council represents the final opportunity for applicants to submit evidence on their behalf and make their case for disability benefits in a non-adversarial procedural environment.

Commenters also felt that the elimination of the Appeals Council would result in a greater number of applicants filing for judicial review in the federal courts. This concerned commenters who pointed out that an increase in the federal court caseload would result in greater delays for applicants seeking benefits and these delays would run counter to the stated goal of a quicker and more streamlined determination and appellate process. In addition, commenters pointed out the increased costs associated with filing a case in the federal courts and the different rules that govern such cases. Some applicants currently may be able to seek relief from the Appeals Council without representation or using non-attorney representation, however, such a scenario would be almost impossible in the federal courts where applicants will face a myriad of procedural rules and an adversarial process.

Despite the large number of comments opposing the elimination of the Appeals Council and the statements of major disability groups against this provision, the final regulations eliminate the Appeals Council for those cases originating in the Boston region during the first year and in all other regions as the new regulations are implemented nationwide. The new rules do preserve the right of applicants whose cases were dismissed to seek appellate relief from the DRB and the final regulations include the provision that, during the first year, all ALJ decisions in the Boston region will be reviewed by the DRB.

Figure 1. The Disability Determination and Appeals Processes



Source: The Social Security Administration, available at [http://www.ssa.gov/disability-new-approach/NewApproachFlowchart.pdf].

Note: A detailed diagram of the existing determination and appeals processes is available on the website of the Social Security Administration at [http://www.ssa.gov/disability/disability_process_files/od_process.pdf].