

# MEDICAL PROOF, SOCIAL POLICY, AND SOCIAL SECURITY'S MEDICALLY CENTERED DEFINITION OF DISABILITY

*Frank S. Bloch*†

INTRODUCTION .....	190
I. DISABILITY AS AN ELIGIBILITY CRITERION: THE PROBLEM OF DEFINITION .....	193
A. Defining Disability as an Eligibility Criterion .....	195
B. Refining the Definition: Significant Changes Reflected in the Current Disability Standard .....	201
1. <i>Clarifying the Role of Vocational Factors: Kerner v. Flemming and the 1967 Amendments</i> .....	202
2. <i>Clarifying the Medical-Basis Requirement for Pain and Other Subjective Symptoms: Pain Cases and the 1984 Amendments</i> .....	204
3. <i>The Special Case of Defining Disability for Children: Original Supplemental Security Income Definition, Sullivan v. Zebley, and the 1996 Amendments</i> .....	207
II. APPLYING THE DEFINITION: SETTING STANDARDS AND WEIGHING PROOF .....	209
A. Setting Standards for Objectivity and Consistency ...	210
1. <i>Sequential Evaluation Process</i> .....	211
2. <i>Listings and Guidelines: Listing of Impairments and Medical-Vocational “Grids”; Quick Disability Determinations and Presumptive Disability</i> .....	213
B. Classifying and Weighing Medical Proof .....	220
1. <i>“Medically Acceptable Clinical and Laboratory Diagnostic Techniques”</i> .....	220
2. <i>Acceptable Medical Sources</i> .....	221
3. <i>Medical Opinions: Treating and Consulting Physicians</i> .....	222
4. <i>SSA’s New Federal Medical and Vocational Expert System and Institute of Medicine Study on Use of Medical Expertise</i> .....	224
III. FOCUSING ON MEDICAL PROOF: THE PROBLEM OF MASKING SOCIAL POLICY.....	225

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† Professor of Law, Vanderbilt University Law School. Special thanks to my research assistant, David M. Chooljian (candidate for J.D. & M.D. degrees at Vanderbilt University in 2007).

A. Matching Definition and Policy .....	225
B. Accuracy, Consistency, and Fairness: The Role of Medical Expertise .....	228
C. The Problem of "False Positives" and "False Negatives" .....	231
CONCLUSION .....	233

## INTRODUCTION

Disability is one of the well-known categories of "deserving poor"<sup>1</sup> that have defined eligibility for public benefit programs in the United States since the colonial period.<sup>2</sup> Yet the first major federal public benefits law, the Social Security Act of 1935 (the Act),<sup>3</sup> did not include disability as a basis of entitlement. This was in part because the framers of the Act could not decide whether the government should provide disability benefits in the form of public assistance, social insurance, or both.<sup>4</sup> An important lingering concern was that lawmakers would not be able to define disability adequately enough to keep a federal disability benefit program under control.<sup>5</sup> The debate over public assistance versus social insurance ended effectively in a tie in the 1950s when Congress added disability as a basis of eligibility for

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<sup>1</sup> The label "deserving poor" often distinguishes a narrow category of beneficiaries excused from the moral responsibility to work. See Joel F. Handler, "Ending Welfare as We Know It"—*Wrong for Welfare, Wrong for Poverty*, 2 GEO. J. ON POVERTY L. & POL'Y 3, 4 (1994) ("Only the aged, young children, and the unambiguously disabled are excused from work. They are the 'deserving' poor."). Some have applied the same label with respect to disability rights legislation. See, e.g., JOEL F. HANDLER & ELLEN JANE HOLLINGSWORTH, *THE "DESERVING POOR": A STUDY OF WELFARE ADMINISTRATION* 17 (1971) (describing the distinction arising in the nineteenth century between morally blameless poor and morally degenerate pauperism); Peter B. Edelman, Symposium, *Toward a Comprehensive Antipoverty Strategy: Getting Beyond the Silver Bullet*, 81 GEO. L.J. 1697, 1705 (1993) ("The surprisingly easy enactment of the Americans with Disabilities Act in 1990 proved the disabled had 'arrived' as a category of the deserving poor." (footnote omitted)).

<sup>2</sup> See William P. Quigley, *Reluctant Charity: Poor Laws in the Original Thirteen States*, 31 U. RICH. L. REV. 111, 115 (1997) (noting that providing assistance only to those people who were unable to work was among the themes of colonial-era poor laws that the states had adopted). The notion that people with disabilities should be cared for came to the colonies from the English Poor Laws, which themselves reflected existing sentiments. Professor Quigley identifies the Statute of Labourers of 1349–50, which prohibited begging by persons able to work, as an English law intended to distinguish between poor people able to work and those unable to work well before the enactment of the first Poor Laws. See William P. Quigley, *Five Hundred Years of English Poor Laws, 1349–1834: Regulating the Working and Nonworking Poor*, 30 AKRON L. REV. 73, 87–88 (1996).

<sup>3</sup> Social Security Act, ch. 531, 49 Stat. 620 (1935) (codified as amended in scattered sections of 42 U.S.C.).

<sup>4</sup> The core distinction between public assistance and social insurance is that eligibility for the latter is contingent on having contributed to the program through taxes paid on wages, while public assistance is a noncontributory program with eligibility contingent on financial need. This point is developed *infra* at text accompanying notes 33–44.

<sup>5</sup> See DEBORAH A. STONE, *THE DISABLED STATE* 69, 71 (1984). This point is developed *infra* at text accompanying notes 52–62.

both programs—first for joint federal-state public assistance programs<sup>6</sup> and then a few years later for the federal social insurance program.<sup>7</sup> Congress dealt with its concern about an open-ended eligibility criterion by enacting a medically centered definition of disability for social insurance,<sup>8</sup> which it later adopted for federal public assistance benefits as well. This definition limits benefits to persons who can show not only that they are unable to work—a term that the Act partially defines as the ability to engage in “substantial gainful activity”<sup>9</sup>—but also that their inability to work is due to a “medically determinable physical or mental impairment.”<sup>10</sup>

The same basic definition remains in place today with statutes,<sup>11</sup> regulations,<sup>12</sup> and court decisions<sup>13</sup> introducing certain modifications over the years.<sup>14</sup> That definition has also carried with it a heavy administrative price.<sup>15</sup> Although disability benefits make up a relatively small number of the total number of Social Security claims—out of approximately 53.5 million current beneficiaries, approximately 11.2 million are receiving benefits based on disability<sup>16</sup>—determining whether disability benefit claimants are disabled consumes the bulk of the administrative resources of the Social Security Administration

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<sup>6</sup> See *infra* notes 45–48 and accompanying text for a detailed discussion of the Aid to the Permanently and Totally Disabled program.

<sup>7</sup> See *infra* notes 49–55 and accompanying text for a detailed discussion of the Old Age, Survivors, and Disability Insurance program.

<sup>8</sup> See Social Security Amendments of 1956, Pub. L. No. 880, ch. 836, sec. 103, § 223(c)(2), 70 Stat. 807, 815 (codified as amended at 42 U.S.C. § 423(d)(1)(A) (2000)).

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> For a detailed discussion of the evolving definition of disability, see *infra* Part I.B. For a detailed discussion of specific statutory shifts in the definition, see, e.g., *infra* notes 76–88, 102–07, 118–19 and accompanying text.

<sup>12</sup> For a detailed discussion of specific regulatory development, see, e.g., *infra* notes 100, 108, 116, 120 and accompanying text.

<sup>13</sup> For a detailed discussion of specific case law development, see, e.g., *infra* notes 89–92, 95–99, 102–03, 113–15 and accompanying text.

<sup>14</sup> For a detailed discussion of the current definition, see *infra* text accompanying notes 76–79.

<sup>15</sup> As stated in the preamble introducing new rules on SSA’s administrative review process for disability claims, “[t]he adjudication of disability claims now constitutes the major part of [SSA’s] workload . . .” Administrative Review Process for Adjudicating Initial Disability Claims, 71 Fed. Reg. 16,424, 16,424 (Mar. 31, 2006).

<sup>16</sup> See OFFICE OF POLICY, SOC. SEC. ADMIN., MONTHLY STATISTICAL SNAPSHOT (last visited Aug. 2006), [http://www.ssa.gov/policy/docs/quickfacts/stat\\_snapshot/index.html](http://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/index.html). The percentage is considerably higher in the Supplemental Security Income (SSI) program compared to the Old Age, Survivors, and Disability Insurance (OASDI) program. See OFFICE OF POLICY, SOC. SEC. ADMIN., ANNUAL STATISTICAL SUPPLEMENT TO THE SOCIAL SECURITY BULLETIN, 2005, at 5.1, 7.1 (2006), <http://www.ssa.gov/policy/docs/statcomps/supplement/2005/supplement05.pdf> (reporting 5,700,754 out of 6,987,845 for SSI and 6,192,210 out of 47,707,380 for OASDI in December 2004) [hereinafter 2005 STATISTICAL SUPPLEMENT].

(SSA).<sup>17</sup> More specifically, SSA received approximately 4.5 million new claims for disability benefits in Fiscal Year 2004,<sup>18</sup> and during Fiscal Year 2005, SSA's Office of Hearings and Appeals received almost 650,000 administrative hearing requests, of which almost 600,000 involved disability benefits.<sup>19</sup> This administrative load has an impact on SSA beyond the cost of disability determinations;<sup>20</sup> the heavy disability benefit workload affects virtually the entire Social Security claims-and-appeals process.<sup>21</sup>

This Article examines the practical difficulties of implementing the Act's definition of disability and the policy implications arising from those difficulties, with special emphasis on various SSA initiatives set on improving the use of medical expertise in the disability determination process. Although a number of these initiatives have been helpful in addressing the important medical components of the disability determination process, including the 2006 revisions to SSA's administrative review process<sup>22</sup> and a related study that SSA commissioned from the Institute of Medicine (IOM), the agency's focus on the medical aspects of disability determination may overstate the role of medical assessment and expertise in determining eligibility for disability benefits. The Act's medically centered definition of disability requires significant proof of medical impairment primarily as a means of controlling a statutory scheme with broad social, economic, and political goals. This Article contends that the disability determination process must not elevate medical assessments beyond their intended role; rather, proper implementation of the statutory disability standard requires a careful, policy-centered approach to medical and vocational proof.

The remainder of this Article will proceed as follows: Part I explains how the Act came to include disability benefits and the importance of the Act's medically centered definition of disability. It also discusses certain key amendments to the Act that have refined this definition and how those amendments affect a proper understanding of Social Security disability benefit programs. Part II looks at the problem of applying the statutory definition of disability in a manner consistent with available proof while remaining true to the Act's social

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<sup>17</sup> See *supra* note 15.

<sup>18</sup> See 2005 STATISTICAL SUPPLEMENT, *supra* note 16, at 2.65.

<sup>19</sup> See *id.* at 2.67.

<sup>20</sup> SSA spent approximately \$2.2 billion administrating the Disability Insurance program in Fiscal Year 2004, representing 2.8% of total benefits paid—compared to approximately \$2.4 billion on the Old-Age and Survivors Insurance program, representing just 0.6% of total benefits paid. See *id.* at 1.

<sup>21</sup> See Administrative Review Process for Adjudicating Initial Disability Claims, 71 Fed. Reg. 16,424, 16,424 (Mar. 31, 2006) (“[N]early every one of [SSA’s] components has a role in administering the disability programs.”).

<sup>22</sup> See *id.*

policy goals. It analyzes the effectiveness of key regulations and procedures intended to implement the disability standard objectively and consistently, with special emphasis placed on the practical tasks of compiling and assessing medical proof. Part III addresses the policy implications of focusing on medical proof of disability by examining how efforts to implement the Act's medically centered definition of disability can, and cannot, achieve accurate, consistent, and fair disability decisions. It argues that while medical evidence plays an important role in the Social Security disability determination process, reaching disability decisions consistent with the Act's broader social, economic, and political goals requires a more limited role for medical expertise in deciding eligibility. The Article concludes with some suggestions as to how this understanding of the Act's medically centered definition of disability can help guide SSA as it works to improve the disability determination process.

## I

### DISABILITY AS AN ELIGIBILITY CRITERION: THE PROBLEM OF DEFINITION

Congress decided not to include disability as a basis for eligibility when it created the Social Security program in part because the Act emphasized contributory social insurance over need-based public assistance.<sup>23</sup> Authorizing disability-based social insurance benefits would have forced Congress to make potentially divisive choices affecting labor and social policy that no one seemed prepared to undertake.<sup>24</sup> Although the Committee on Economic Security,<sup>25</sup> whose recommendations formed the basis of the Roosevelt Administration's Social Security bill, recognized that disability insurance should be part of a program for economic security, it decided to postpone a decision on social insurance disability benefits.<sup>26</sup> The decision to limit cover-

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<sup>23</sup> The dominant view among the framers of the Social Security program was that public assistance would "wither away" once social insurance took hold on the theory that the combination of employment and protection from loss of employment would protect virtually everyone. See THEODORE R. MARMOR, JERRY L. MASHAW & PHILIP L. HARVEY, *AMERICA'S MISUNDERSTOOD WELFARE STATE: PERSISTENT MYTHS, ENDURING REALITIES* 40 (1990); Jacobus tenBroek & Richard B. Wilson, *Public Assistance and Social Insurance—A Normative Evaluation*, 1 *UCLA L. REV.* 237, 238 (1954); Jonathan Zasloff, *Children, Families, and Bureaucrats: A Prehistory of Welfare Reform*, 14 *J.L. & POL.* 225, 266 (1998).

<sup>24</sup> For a thoughtful analysis of these issues, see Matthew Diller, *Entitlement and Exclusion: The Role of Disability in the Social Welfare System*, 44 *UCLA L. REV.* 361, 393–95 (1996).

<sup>25</sup> President Franklin D. Roosevelt appointed the Committee on Economic Security in 1934 to design a social security program for the United States. See Frances Perkins, *Foreword to EDWIN E. WITTE, THE DEVELOPMENT OF THE SOCIAL SECURITY ACT*, at v, v–vi (1962).

<sup>26</sup> See WITTE, *supra* note 25, at 189, 210 (noting that the Committee had not given much consideration to disability insurance because the government already provided assistance and recognizing that further research should be conducted in the future). This failure to include disability in the original set of Social Security programs can also be seen

age of the original Act's three joint federal-state public assistance programs to the elderly,<sup>27</sup> the blind,<sup>28</sup> and dependent children<sup>29</sup> went essentially unnoticed.

Eventually, Congress added disability benefit programs to the Act. In the 1950s, it established disability as a basis for eligibility for both federal-state public assistance and federal social insurance benefits.<sup>30</sup> Congress also included disability as a basis of eligibility for federal public assistance benefits for both adults and children when it established the Supplemental Security Income (SSI) program in the early 1970s.<sup>31</sup> Thus, Congress had occasion to define disability four times in the context of adding disability benefit coverage to the Act. Congress had to address a number of important issues when considering whether to enact disability benefit programs, including the question of cost.<sup>32</sup> The key issue, however, was who should be covered, or, more precisely, how to decide who is disabled and therefore entitled to benefits. The following sections describe the original definition that Congress used and the revisions it has made to the definition over time.

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as consistent with a broader strategic view; after all, the original Act's limited coverage was part of the political plan. As President Roosevelt explained in his message transmitting the new legislation to Congress:

It is overwhelmingly important to avoid any danger of permanently discrediting the sound and necessary policy of Federal legislation for economic security by attempting to apply it on too ambitious a scale before actual experience has provided guidance for the permanently safe direction of such efforts. The place of such a fundamental in our future civilization is too precious to be jeopardized now by extravagant action.

4 FRANKLIN D. ROOSEVELT, *A Greater Future Economic Security of the American People—A Message to the Congress on Social Security* (January 17, 1935), in *THE PUBLIC PAPERS AND ADDRESSES OF FRANKLIN D. ROOSEVELT* 43, 44 (Samuel I. Rosenman ed., 1938).

Nonetheless, Congress began to extend coverage almost before the ink was dry. Already in 1939, Congress extended Social Security insurance benefits to the spouses and minor children of recipients of old-age insurance benefits, along with the survivors of insured workers. *See* Social Security Act Amendments of 1939, Pub. L. No. 76-379, 53 Stat. 1360, 1364-65 (codified as amended in scattered sections of 42 U.S.C.).

<sup>27</sup> 42 U.S.C. §§ 201-210 (2000).

<sup>28</sup> *Id.* §§ 1001-1006.

<sup>29</sup> *Id.* §§ 401-541.

<sup>30</sup> *See infra* notes 61-81 and accompanying text.

<sup>31</sup> Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329; H.R. REP. NO. 92-231 (1972), as reprinted in 1972 U.S.C.C.A.N. 4989.

<sup>32</sup> Cost was seen as particularly relevant with respect to the social insurance program. Thus, President Eisenhower explained that a separate trust fund had been established for the DI program "in an effort to minimize the effects of the special problems in this field on the other parts of the program—retirement and survivors' protection." DWIGHT D. EISENHOWER, Statement by the President Upon Signing the Social Security Amendments of 1956, in 1956 PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES 638, 639 (1958).

### A. Defining Disability as an Eligibility Criterion

Congress took up the question of adding disability as an eligibility criterion for Social Security benefits in a proposal that President Harry S. Truman put forward in the late 1940s to reinforce state public assistance programs and soften the influence of categorical eligibility.<sup>33</sup> This debate had two related components, both of which highlighted important issues of social policy: first, whether public assistance programs, social insurance programs, or both should be extended to include disability benefits;<sup>34</sup> second, if so, how these programs should define “disability.”<sup>35</sup>

The public assistance-social insurance debate centered on differing views of disability status.<sup>36</sup> Because Congress had anchored the social insurance program to a contributory base and a sense of earned right or entitlement that went with it,<sup>37</sup> it was only reasonable to assume that lawmakers and administrators would characterize disability insurance similarly. Those who believed the purpose of the social insurance program was to protect workers against disability, which they understood as among the “hazards and vicissitudes of life,”<sup>38</sup> viewed this categorization as a plus.<sup>39</sup> In contrast, those who worried that disability-based social insurance benefits could become a respectable passport out of work viewed it as a threat.<sup>40</sup>

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<sup>33</sup> See H.R. 2892, 81st Cong. (1949). The idea to add disability benefits had come up earlier but without much effect. Thus, the Social Security Advisory Council noted as early as 1938 that providing disability insurance benefits to persons who are “permanently and totally disabled” and their dependents would be “socially desirable,” but it did not put forward a firm proposal due to disagreement over how to implement such a program. See ADVISORY COUNCIL ON SOC. SEC., FINAL REPORT OF THE ADVISORY COUNCIL ON SOCIAL SECURITY 32 (1938).

<sup>34</sup> See Diller, *supra* note 24, at 370–84.

<sup>35</sup> See *id.* at 384–92.

<sup>36</sup> See *id.* at 393–94; tenBroek & Wilson, *supra* note 23, at 239–40.

<sup>37</sup> Although the framers were fully aware that the program did not provide a contractual right to benefits, they nonetheless endeavored from the beginning to create the impression that the program would provide benefits in return for having paid for them. See Jacobus tenBroek & Floyd W. Matson, *The Disabled and the Law of Welfare*, 54 CAL. L. REV. 809, 819–20 (1966). See generally Matthew H. Hawes, *So No Damn Politician Can Ever Scrap It: The Constitutional Protection of Social Security Benefits*, 65 U. PITT. L. REV. 865 (2004) (drawing its title from a comment attributed to President Franklin D. Roosevelt concerning the decision to make social security benefits contributory: “With those taxes in there, no damn politician can ever scrap my social security program.”).

<sup>38</sup> 3 FRANKLIN D. ROOSEVELT, Message to the Congress Reviewing the Broad Objectives and Accomplishments of the Administration (June 8, 1934), in THE PUBLIC PAPERS AND ADDRESSES OF FRANKLIN D. ROOSEVELT, *supra* note 26, at 287, 291 (calling for creation of a national social program to provide economic security and protect against “the hazards and vicissitudes of life”).

<sup>39</sup> See, e.g., tenBroek & Wilson, *supra* note 23, at 239–42 (referring to disabilities as an inevitable hazard to the economy that must be addressed).

<sup>40</sup> See Diller, *supra* note 24, at 393 (noting that opponents of disability insurance believed that the availability of benefits as an entitlement “would constitute a significant disincentive to work”); tenBroek & Wilson, *supra* note 23, at 242–43.

Congress packaged the disability-based public assistance benefits, on the other hand, in a fundamentally different manner.<sup>41</sup> Not only did Congress define these benefits as need-based and noncontributory,<sup>42</sup> it also administered the public assistance programs through federal grants to states, subject to certain conditions, that left much of the responsibility for funding and significant control over eligibility and payment of benefits to the states.<sup>43</sup> As a result, disability-based public assistance benefits would be nothing more than federally supported state welfare benefits. For those who saw disability as a suspect category and feared that disability insurance benefits would be a threat to the national work ethic, limiting Social Security disability benefits to public assistance programs was far less dangerous.<sup>44</sup> Despite the vigorous debate, Congress did not succeed in implementing any type of disability benefit at that time.

When Congress did finally establish disability coverage in the 1950s, it did so in a piecemeal fashion. In 1950, Congress added a new federal-state public assistance program, Aid to the Permanently and Totally Disabled (APTD), to the public assistance title of the Act.<sup>45</sup> Despite the lead-up to the enactment of APTD, there was virtually no substantive discussion of disability as an eligibility criterion.<sup>46</sup> The APTD provisions provided simply that benefits would be available to “needy individuals eighteen years of age or older who are permanently and totally disabled”<sup>47</sup> and left it up to the states to implement the general eligibility standard. Perhaps most importantly, the provi-

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<sup>41</sup> See S. REP. NO. 81-1669 (1950) (Conf. Rep.), as reprinted in 1950 U.S.C.C.A.N. 3482; Diller, *supra* note 24, at 410–15.

<sup>42</sup> See Diller, *supra* note 24, at 413 (noting that under a public assistance system, “administrators making eligibility determinations would be unconstrained by claims that applicants had a right to benefits based on their past contributions”).

<sup>43</sup> This structure, which was consistent with the tradition of state and local responsibility for public welfare at the time Congress first passed the Act, became known as “cooperative federalism” and defined the relationship between federal and state control over welfare policy until Congress replaced the last of the original Act’s federal-state public assistance programs, Aid to Families with Dependent Children (AFDC), with the current block-grant Temporary Assistance to Needy Families (TANF) program in 1996. See generally Frank S. Bloch, *Cooperative Federalism and the Role of Litigation in the Development of Federal AFDC Eligibility Policy*, 1979 Wis. L. REV. 1 (discussing the contours of “cooperative federalism” in the development of Social Security).

<sup>44</sup> See Diller, *supra* note 24, at 393, 412–16; tenBroek & Wilson, *supra* note 23, at 240. The OASDI program is presently codified at 42 U.S.C. §§ 401–434 (2000).

<sup>45</sup> See Social Security Act Amendments of 1950, ch. 809, sec. 351, §§ 1401–1405, 64 Stat. 477, 555–58.

<sup>46</sup> See *id.* at 557–58 (excluding inmates at nonmedical public institutions and patients being treated for mental diseases or tuberculosis but providing no positive definition of “disabled”).

<sup>47</sup> 42 U.S.C. § 1351 (1952).



sions granted subsistence level benefits, which were still subject to the type of state supervision customary for welfare beneficiaries.<sup>48</sup>

In 1956, Congress added disability insurance (DI) benefits to the social insurance title of the Act, thereby completing the transformation of the Act's old age social insurance program to its present form: the Old Age, Survivors, and Disability Insurance (OASDI) program.<sup>49</sup> Unlike with APTD, the enactment of DI engendered lively discussion regarding the definition of disability.<sup>50</sup> The debate began in earnest even before Congress authorized the OASDI program.<sup>51</sup> In 1954, Congress enacted a "disability freeze" designed to allow wage earners who became disabled and thus ceased contributing social security taxes to remain eligible for retirement benefits when they reached retirement age.<sup>52</sup> Congress defined disability for this purpose as the "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 . . ." <sup>53</sup> Although introducing a disability freeze fell far short of actually providing a cash benefit, many lawmakers at the time were still concerned about the potentially open-ended nature of disability as the key eligibility criterion for the freeze program.<sup>54</sup> SSA responded by developing a set of medical guidelines with the assistance of a panel of medical experts, thereby highlighting the "medically determinable physical or mental impairment" language of the disability standard.<sup>55</sup>

The disability freeze thus allowed supporters of disability insurance benefits to point to the medical guidelines as proof that medical science could rein in a statutory disability standard.<sup>56</sup> This concept

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<sup>48</sup> See *id.* ("The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Administrator [Secretary of Health and Human Services], State plans for aid to the permanently and totally disabled.").

<sup>49</sup> Social Security Amendments of 1956, ch. 836, sec. 103, § 223, 70 Stat. 807, 815–24. Survivor benefits were added in 1939. See *supra* note 26.

<sup>50</sup> See Diller, *supra* note 24, at 398 (discussing the "battle over disability insurance," including differing views of the definition of "disabled" status).

<sup>51</sup> See *id.* at 401.

<sup>52</sup> Social Security Amendments of 1954, ch. 1206, sec. 106, §§ 213–216, 68 Stat. 1052, 1079–81. In effect, quarters during which one was disabled—which otherwise would be credited with zero earnings—were removed from the insurance and benefit calculation formulas; the same basic rules apply today. See 42 U.S.C. § 416(i) (2000).

<sup>53</sup> Social Security Amendments of 1954, ch. 1206, sec. 106, § 216, 68 Stat. 1052, 1080.

<sup>54</sup> See Diller, *supra* note 24, at 414 (noting that Congress expected an "onslaught of marginal claims" to follow the enactment of the APTD).

<sup>55</sup> *Id.* at 416.

<sup>56</sup> See *id.* at 416–17 (noting that proponents of a new disability benefits program were able to argue that experience with the disability freeze demonstrated "the feasibility of devising an evaluation system based on medical factors"). Not everyone was convinced, however. The Senate Committee on Finance, noting that "it would be desirable to have

was not new; early on, the Social Security Advisory Council had proposed limiting qualifying impairments to those that could be determined by "objective" medical examinations or tests.<sup>57</sup> The medical guidelines thus proved to be critical in persuading those who perceived disability insurance as a dangerous shift in labor policy.<sup>58</sup> Of course, the disability criterion still carried some element of the "deserving poor" status in the sense of marking persons unable to work as morally blameless.<sup>59</sup> However, in this context, it functioned more as a proxy for "earned" disability retirement.<sup>60</sup> Supporters could point to the definition of disability with its emphasis on clinical determinations of physical or mental impairments as a safeguard against potentially uncontrollable fraud and abuse.<sup>61</sup> In effect, the disability freeze paved the way for disability-based social insurance benefits by provid-

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more experience with the disability freeze" and that it was "impressed by the testimony of the many medical experts who have testified that many problems would be encountered in evaluating physical and mental impairments for purposes of determining eligibility for disability benefits," concluded:

Difficulties in determining eligibility, and other factors, lead to uncertainty as to the future costs of a cash disability program . . . . The old-age and survivors insurance system is on a sound financial basis; your committee strongly believes that it must be kept so and should not be altered by adding a benefit feature that could involve substantially higher costs than can be estimated.

S. REP. NO. 84-2133 (1956), *as reprinted in* 1956 U.S.C.C.A.N. 3877, 3880. Even the final conference report contained strong cautionary language:

In providing in the conference agreement that determinations of disability for cash disability benefits be made by State agencies under the same arrangements as are now utilized in making determinations for the disability freeze, it is understood and expected that the Secretary of Health, Education, and Welfare will fully utilize his authority to review and revise determinations of State agencies in order to assure uniform administration of the disability benefits and to protect the Federal Disability Insurance Trust Fund from unwarranted costs.

H.R. REP. NO. 84-2936 (1956) (Conf. Rep.), *as reprinted in* 1956 U.S.C.C.A.N. 3954, 3957.

<sup>57</sup> Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 629 (1999) (noting that throughout the development of the DI program, the Advisory Council favored restricting eligibility to claims based on objectively determined medical impairments).

<sup>58</sup> See Diller, *supra* note 24, at 407-08 (discussing how a stricter definition of "disabled" status was necessary to overcome opposition to DI).

<sup>59</sup> See *supra* note 1.

<sup>60</sup> See Lance Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833, 843 (1976) ("The medical disability requirement obviously expresses some special solicitude for the sick. But this concern may only reflect the feeling that those who are 'sick' have suffered an involuntary decline in working capacity. From this perspective, the medical disability requirement becomes an attempt to draw a line between voluntary and involuntary unemployment.").

<sup>61</sup> See Crossley, *supra* note 57, at 629-30. The political importance of the medical component is developed in STONE, *supra* note 5, at 68-86.

ing a disability standard that Congress incorporated—with only slight changes in wording—into the DI program two years later.<sup>62</sup>

The next time Congress addressed disability as an eligibility criterion was in the early 1970s, when it transformed the Act's federal-state public assistance programs for the elderly, blind, and disabled into a fully federalized program administered by SSA.<sup>63</sup> SSI was the result of legislative compromise over President Richard Nixon's proposed "Family Assistance Plan" that would have federalized all of the public assistance titles of the Act, including Aid to Families with Dependent Children (AFDC).<sup>64</sup> In the end, AFDC remained a federal-state program—later replaced by Temporary Assistance to Needy Families (TANF)<sup>65</sup>—while SSI provided federal public assistance benefits to the elderly, blind, and disabled.<sup>66</sup> The new SSI program included not only disabled adults, whom the APTD program previously covered, but also disabled children.<sup>67</sup> As a result, Congress had to define disability for both adult and child public assistance beneficiaries.

With respect to adults, Congress simply incorporated the social insurance disability standard into the new federal SSI public assistance program.<sup>68</sup> Although doing so raised serious policy questions about

<sup>62</sup> See Social Security Amendments of 1956, ch. 836, sec. 103, § 223(c)(2), 70 Stat. 807, 815 (codified as amended at 42 U.S.C. § 423(d)(1)(A) (2000)) ("The term 'disability' means 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."). Congress also limited the exposure by restricting eligibility to persons at least fifty years old, but it then removed that limitation in 1960. See Social Security Amendments of 1960, Pub. L. No. 86-778, § 401, 74 Stat. 924, 967 (codified in scattered sections of 42 U.S.C.).

<sup>63</sup> H.R. REP. NO. 92-231 (1972), as reprinted in 1972 U.S.C.C.A.N. 4989, 4991.

<sup>64</sup> See David A. Super, *The Quiet "Welfare" Revolution: Resurrecting the Food Stamp Program in the Wake of the 1996 Welfare Law*, 79 N.Y.U. L. REV. 1271, 1278 (2004).

<sup>65</sup> See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

<sup>66</sup> See Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329; H.R. REP. NO. 92-231 (1972), as reprinted in 1972 U.S.C.C.A.N. 4989. Congress refused to federalize a controversial program for families with dependent children but did agree to create a new fully federal public assistance program for the elderly, blind, and disabled. For a thorough description of this effort, see generally DANIEL P. MOYNIHAN, *THE POLITICS OF A GUARANTEED INCOME* (1973) (discussing the political conditions surrounding the proposed and nearly passed Family Assistance Plan). See also VINCENT J. BURKE & VEE BURKE, *NIXON'S GOOD DEED* 151-87 (1974) (describing the congressional process surrounding the Family Assistance Plan and its eventual replacement with SSI); CHRISTOPHER LEMAN, *THE COLLAPSE OF WELFARE REFORM* (1980) (analyzing the attempts at welfare reform in the 1970s and the political environment characterizing the debate at the time).

<sup>67</sup> Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329; H.R. REP. NO. 92-231 (1972), as reprinted in 1972 U.S.C.C.A.N. 4989, 4998.

<sup>68</sup> Congress phrased the disability standard for Supplemental Security Income somewhat differently, requiring claimants to be "unable to engage in any substantial gainful activity." 42 U.S.C. § 1382c(a)(3)(A) (2000). The substance of the two standards, however, is the same. See *Bowen v. Yuckert*, 482 U.S. 137, 140 (1987) ("Both titles of the Act define 'disability' as the 'inability to engage in any substantial gainful activity . . .'").

the distinction between social insurance and public assistance, questions which Congress had debated with great intensity two decades before,<sup>69</sup> neither SSA nor Congress noted the distinction at the time and both have applied virtually all post-SSI initiatives relating to DI disability determinations to the adult SSI program as well. Thus, many of the social policy issues that were debated in the 1940s with respect to disability-based public assistance and social insurance benefits were washed over when Congress adopted a uniform standard for both programs.<sup>70</sup>

The story was somewhat different with respect to the definition of disability for children, because the original SSI disability standard for children amounted to a “double spin-off” from the DI disability standard for adults.<sup>71</sup> As noted above, Congress adopted the DI disability definition in its entirety for the adult SSI disability benefits program, without significant debate. With even less thought given to the matter, Congress defined disability for child SSI benefits by simply cross-referencing the DI-based adult disability standard: “in the case of a child under the age of 18, [the child is disabled] if he suffers from any medically determinable physical or mental impairment of comparable severity [to that of a disabled adult].”<sup>72</sup> Apart from importing the “medically determinable physical or mental impairment” language from the DI disability standard,<sup>73</sup> Congress did not prescribe any particular role for medical evaluation in determining disability for children.<sup>74</sup> SSA implemented the new child disability standard differently, however, by requiring claimants to meet or equal specified medical criteria set out in its Listing of Impairments.<sup>75</sup>

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<sup>69</sup> See *supra* notes 37–57 and accompanying text.

<sup>70</sup> Adopting the same disability standard for both programs raises a new set of policy issues. See, e.g., Diller, *supra* note 24, at 443–55 (discussing the different consequences for persons who are found eligible for SSI under the DI-based SSI standard and those who are denied SSI but might have been eligible under a separated public assistance-oriented definition of disability).

<sup>71</sup> See Social Security Amendments of 1972, § 1614, 86 Stat. 1329, 1471 (codified as amended at 42 U.S.C. § 1382c(a)(3)(C)(i) (2000)).

<sup>72</sup> *Id.* Neither the legislation nor its legislative history explains how administrators should apply the “comparable severity” standard in a way that would take into account differences between adults and children with disabilities. See generally Frank S. Bloch, *Three Steps and You’re Out: The Misuse of the Sequential Evaluation Process in Child SSI Disability Determinations*, 37 U. MICH. J.L. REFORM 39, 49–51 (2003) (explaining that Congress recognized that children are often among the most needy, but failed to specify how to implement benefits for children).

<sup>73</sup> § 1614, 86 Stat. at 1471.

<sup>74</sup> See *id.*

<sup>75</sup> See Additional Medical Criteria for Determinations of Disability for Children Under Age 18, 42 Fed. Reg. 14,705 (Mar. 16, 1977) (using “comparable severity” standard to apply the adult standard to children). The Listing is used primarily as a screening device in adult cases to grant benefits on medical evidence alone, without considering vocational qualifications. See *infra* text accompanying notes 154–60. Operationally, SSA applied only the first

## B. Refining the Definition: Significant Changes Reflected in the Current Disability Standard

The current DI and adult SSI disability standard consists of three basic components. First and foremost is a severity requirement, defined as the inability “to engage in any substantial gainful activity.”<sup>76</sup> More specifically, an individual is not disabled simply because he or she can no longer perform current or previous work; one must be unable to perform any work that exists in the national economy given one’s age, level of education, and work experience.<sup>77</sup> The second component of the standard is the medical causation requirement discussed above: A claimant’s inability to engage in substantial gainful activity must result from a “medically determinable physical or mental impairment.”<sup>78</sup> Finally, the Act includes a duration requirement, which limits eligibility for benefits to cases where the claimant’s disability has lasted, or can be expected to last, at least twelve months or can be expected to result in death.<sup>79</sup> Each of these requirements must be met to satisfy the disability standard. For example, a short-term disability, no matter how severe, is not sufficient to establish eligibility for benefits.

Thus, the basic statutory definition of disability has changed little since Congress first formulated it in 1954 in connection with the disability freeze program. To be sure, Congress has revised the statutory definition a number of times in the last forty years.<sup>80</sup> Sometimes the changes were little more than restatements of existing policy, such as replacing what was effectively a requirement of permanent disability—long-continued and of indefinite duration—with the current duration

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three of a five-step “sequential evaluation process” that it uses for adult claims. *See infra* text accompanying notes 135–49.

<sup>76</sup> 42 U.S.C. §§ 423(d)(1)(A), 1382c(a)(3)(A) (2000). Because the SSI standard is phrased almost identically, the substance of the two standards is the same. *See supra* note 68.

<sup>77</sup> *See* 42 U.S.C. §§ 423(d)(2)(A), 1382c(a)(3)(B) (2000) (defining “work which exists in the national economy” as “work which exists in significant numbers either in the region where [the claimant] lives or in several regions of the country”). The Act also sets out a more generous severity standard for DI claimants over the age of fifty-five whose disability is based on blindness by looking to the claimant’s past ability to perform work for a “substantial period” and “with some regularity.” *Id.* § 423(d)(1)(B) (defining “disability” in such cases as an “inability . . . to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time”).

<sup>78</sup> *Id.* §§ 423(d)(1)(A), 1382c(a)(3)(A).

<sup>79</sup> *Id.* § 423(d)(1)(A) (defining “disability” as an “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months”).

<sup>80</sup> *See infra* notes 81–83 and accompanying text.

requirement,<sup>81</sup> or specifying that SSA consider the combined effects of a claimant's impairments.<sup>82</sup> Other changes, such as eliminating alcoholism and drug addiction as bases for eligibility,<sup>83</sup> represented significant policy shifts but did not affect the core disability standard. Two amendments—regarding the role of vocational factors<sup>84</sup> and determinations based on pain<sup>85</sup>—warrant special comment, because they refined the general disability standard in ways that helped clarify the purpose of the medical causation and severity requirements and the role of medical assessment in determining disability. Recent changes in the SSI disability standard for children are discussed briefly as well to show how SSA applies these requirements in a different disability benefit context.

1. *Clarifying the Role of Vocational Factors: Kerner v. Flemming and the 1967 Amendments*

The causation requirement, which has not changed since the inception of the DI program, most clearly reflects the medical influence on the definition of disability. However, the true extent of that influence, both in theory and in practice, cannot be understood apart from the relationship between the causation and severity requirements.<sup>86</sup> Applying the Act's general disability standard, including its medical causation requirement, requires a two-part, individualized as-

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<sup>81</sup> Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 303, 79 Stat. 286, 366-68 (codified as amended at 42 U.S.C. § 423 (2000)). This was not seen as a significant change in the standard. See S. REP. NO. 89-404, at 99 (1965), as reprinted in 1965 U.S.C.C.A.N. 1943, 2039 ("[I]n the great majority of cases in which total disability continues for at least a year the disability is essentially permanent.").

<sup>82</sup> See Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, § 4(a)(1), 98 Stat. 1794, 1800 (codified as amended at 42 U.S.C. § 423(d)(2)(B) (2000)). Before the Act was amended, the Fifth Circuit had held that "the fact-finder must consider whether work exists for a person with the combination of impairments exhibited by the claimant." *Delloio v. Heckler*, 705 F.2d 123, 128 (5th Cir. 1983); see *Burnam v. Schweiker*, 682 F.2d 456, 458 (3d Cir. 1982).

<sup>83</sup> See Contract with America Advancement Act of 1996, Pub. L. No. 104-121 § 105, 110 Stat. 847, 852-55 (codified in scattered sections of 42 U.S.C.). Although SSA once recognized alcoholism and drug addiction as qualifying impairments, at various times the agency required persons receiving benefits on these bases to participate in treatment programs and to have a representative payee to handle their funds. See *Dru Stevenson, Should Addicts Get Welfare? Addiction & SSI/SSDI*, 68 BROOK. L. REV. 185, 189 (2002). Of course, they had to show also that their alcoholism or drug addiction prevented them from engaging in substantial gainful activity. See *id.* ("[A]n alcoholic or addict had to provide convincing evidence that a combination of severe symptoms, whether related to the addiction or not, genuinely prevented the applicant from engaging in any gainful work activity.").

<sup>84</sup> Social Security Amendments of 1967, Pub. L. No. 90-248, § 158(d)(2)(A), 81 Stat. 821, 868 (codified as amended at 42 U.S.C. § 423(d)(2)(A) (2000)).

<sup>85</sup> Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, § 3, 98 Stat. 1794, 1799 (codified as amended at 42 U.S.C. § 423(d)(5)(A) (2000)).

<sup>86</sup> The duration requirement, while important in the sense that it precludes eligibility based on a short-term or temporary disability, is not a major factor in most disability determinations.

assessment: what are the work-related limitations that a claimant's medical impairments cause, and do those limitations preclude the claimant from engaging in substantial gainful activity?<sup>87</sup> The latter part of this assessment raises questions about the role of vocational factors.

SSA had always accepted that relevant vocational qualifications should be considered in deciding severity; that is, whether a claimant, given his or her medical impairments, is capable of performing substantial gainful activity.<sup>88</sup> Nonetheless, an important ambiguity remained when applying the second part of the disability assessment that linked impairment and severity. Did the "unable to perform substantial gainful activity" requirement limit disability benefits to persons whose medical impairments preclude them from performing the requirements of any work for which they are qualified, regardless of availability, or could claimants qualify for benefits if their medical impairments kept them from being able to find work in the then-existing job market?

A number of courts, led by the Second Circuit in the important 1960 decision *Kerner v. Flemming*,<sup>89</sup> adopted the latter view and awarded benefits not only on the basis of what the claimant's impairments would allow the claimant to do, but also on the basis of "what employment opportunities are there for a [person] who can do only what [the claimant] can do."<sup>90</sup> In effect, these courts saw the second part of the assessment as qualifying the importance of a particular claimant's medical impairments in determining eligibility for benefits. By asking whether, given certain limitations resulting from medically determinable physical or mental impairments, there is any substantial gainful activity that the claimant would be *hired* to do, labor market conditions became as important to determining eligibility for benefits as the claimant's medical condition, if not more so.

Responding to the *Kerner* line of cases, Congress amended the Act in 1967 to address specifically the role of vocational qualifications and labor market conditions in determining disability.<sup>91</sup> The amendment

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<sup>87</sup> See *supra* notes 77–78 and accompanying text.

<sup>88</sup> See *id.*

<sup>89</sup> 283 F.2d 916 (2d Cir. 1960).

<sup>90</sup> *Id.* at 921 ("Mere theoretical ability to engage in substantial gainful activity is not enough if no reasonable opportunity for this is available."). For examples of other cases around that time that required SSA to consider job availability, see, e.g., *Sayers v. Gardner*, 380 F.2d 940, 949–52 (6th Cir. 1967) (requiring SSA to consider job availability due to employer hiring practices); *Mefford v. Gardner*, 383 F.2d 748, 764 (6th Cir. 1967) (requiring SSA to consider the labor market in the claimant's home area); *Kirby v. Gardner*, 369 F.2d 302, 305–06 (10th Cir. 1966) (requiring SSA to consider job availability due to employer hiring practices).

<sup>91</sup> The link between *Kerner* and the 1967 amendments is discussed in Liebman, *supra* note 60, at 853–55, and Diller, *supra* note 24, at 421–25.

added what amounts to an explanation of the original severity requirement:

[A]n individual . . . shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.<sup>92</sup>

The new language served two purposes. First, it reaffirmed the relevance of vocational qualifications when evaluating a claim for disability benefits by incorporating a claimant's age, level of education, and work experience into the severity requirement.<sup>93</sup> Second, it effectively removed any consideration of labor market conditions from the decision of whether to grant an individual disability benefits.<sup>94</sup> According to this language, SSA should deny benefits not only to claimants who can perform work that they have performed in the past, implying but not requiring that any such job would still be available to them,<sup>95</sup> but also to claimants who are capable of doing any other type of work—so long as it exists in the national economy.<sup>96</sup> The language specifically excluded from consideration whether the work exists where the claimant lives, whether those jobs are available, and whether the claimant would be hired.

## 2. *Clarifying the Medical-Basis Requirement for Pain and Other Subjective Symptoms: Pain Cases and the 1984 Amendments*

Although it had been well settled since the 1960s that DI benefits could be awarded based on disabling pain,<sup>97</sup> the requirements for establishing pain-based disability remained unclear through the early 1980s.<sup>98</sup> At one level, the issue was whether pain itself could be a

<sup>92</sup> Social Security Amendments of 1967, Pub. L. No. 90-248, § 158(d)(2)(A), 81 Stat. 821, 868 (codified as amended at 42 U.S.C. § 423(d)(2)(A) (2000)). The same language is included in the subsequently enacted SSI disability standard. *See* 42 U.S.C. § 1382c(a)(3)(B) (2000).

<sup>93</sup> *See* Social Security Amendments § 158(d)(2)(A), 81 Stat. at 868.

<sup>94</sup> *See id.*

<sup>95</sup> For recent confirmation that the past work requirement addresses capacity to work and not the opportunity to reclaim a past job, see *Barnhart v. Thomas*, 540 U.S. 20, 24 (2003) (denying benefits on the basis of ability to perform "previous work," even though the claimant's previous work as an elevator operator had become obsolete).

<sup>96</sup> *See id.*

<sup>97</sup> *See, e.g.,* *Page v. Celebrezze*, 311 F.2d 757, 762 (5th Cir. 1963); *Butler v. Flemming*, 288 F.2d 591, 595 (5th Cir. 1961).

<sup>98</sup> Before the regulation and Ruling, discussed *infra* at text accompanying notes 101–102, were published and well before the courts' and Congress's views came together in 1984, Professor Lance Liebman described the issue as follows:



qualifying impairment.<sup>99</sup> Consistent with existing policy, SSA issued regulations in 1980 that included pain, or any other subjective symptom, as a basis for eligibility so long as a medically determinable impairment caused the pain or other symptom.<sup>100</sup> These regulations made sense because the medical causation requirement effectively calls for medical proof of the underlying impairment.<sup>101</sup> However, SSA did not address the more difficult question relating to the second part of the disability assessment: what sort of proof was required to prove that the pain resulting from the medically determined impairment was sufficiently severe to preclude the claimant from engaging in substantial gainful activity? Although a controversial 1982 Social Security Ruling elaborated on this point, the Ruling still failed to distinguish clearly the different proof requirements for causation and severity. As a result, at least for some claims, the Ruling was interpreted as requiring medical proof of severity as well.<sup>102</sup> Litigation ensued, with one of the leading court of appeals decisions on the issue explaining the proper approach as follows: “While the claimant has the burden of proving that the disability results from a medically determinable physical or mental impairment, direct medical evidence of the cause and effect relationship between the impairment and the degree of claimant’s subjective complaints need not be produced.”<sup>103</sup>

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The claimant alleges that a certain injury is so painful that he cannot perform any work. [SSA] concludes that, because similar injuries have not completely disabled other workers, inability to work is caused by a failure of will, and hence he labels the disability as nonmedical. When courts review those cases, their opinions express a social judgment as to whether *that* level of pain is a sufficient reason to quit work altogether.

Liebman, *supra* note 60, at 852–53.

<sup>99</sup> See *id.* at 852–53.

<sup>100</sup> See 20 C.F.R. §§ 404.1529, 416.929 (2006) (stating that the effect of any symptom must be evaluated based on “medically determinable impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged . . .”).

<sup>101</sup> 42 U.S.C. §§ 423(d)(1)(A), 1382c(a)(3)(A) (2000).

<sup>102</sup> See Titles II and XVI: Evaluation of Symptoms, S.S.R. 82-58, at 771 (Cum. Ed. 1982), *superseded by* Titles II and XVI: Evaluation of Symptoms, S.S.R. 88-13, at 652 (Cum. Ed. 1988). Although the Ruling stated ambiguously that it “emphasize[d] the need for a sound medical basis to support the overall evaluation of impairment severity and underscore[d] the importance of detailed findings from reporting medical sources when the consideration of symptoms may be a significant part of functional capacity assessment,” *id.*, it also contained language in an example that SSA later conceded “some adjudicators may have misinterpreted . . . to allow allegations of pain to be disregarded solely because the allegations are not fully corroborated by objective medical findings typically associated with pain.” Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984) (quoting the settlement agreement entered into by the parties, including SSA); see also Polaski v. Heckler, 585 F. Supp. 1004, 1009–10 (D. Minn. 1984) (critiquing the need for medical proof as erroneous and indicating that SSR 82-58 showed that “subjective complaints of pain [would] not be seriously considered unless established by objective medical evidence”).

<sup>103</sup> This language was contained in a settlement agreement reached by the parties, which the court indicated was “a correct restatement” of Eighth Circuit case law. *Polaski*,

At about the same time, Congress resolved any doubt by enacting what amounts to a special statutory standard for evaluating disability based on pain.<sup>104</sup> Now, the Act directly states that the claimant must provide specific medical proof of a medical impairment that “could reasonably be expected to produce” the degree of pain or other subjective symptom that the claimant alleges keeps him or her from being able to work.<sup>105</sup> SSA implemented the new statutory standard by prescribing a two-step process for evaluating pain-based disability claims.<sup>106</sup> First, the claimant must prove the existence of an underlying medical impairment that “could reasonably be expected to produce” the degree of pain or other symptom that the claimant alleges keeps him or her from being able to work.<sup>107</sup> This, of course, is fully consistent with the medical causation component of the statutory definition of disability. Then, if the claimant can make such a showing, SSA will consider all other evidence in the record to determine if the claimant “is under a disability”—in other words, is unable to engage in substantial gainful activity.<sup>108</sup>

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739 F.2d at 1322; *see also* *Polaski v. Heckler*, 751 F.2d 943, 944–45 (8th Cir. 1984) (reviewing the history of the litigation).

<sup>104</sup> *See* Social Security Disability Benefits Reform Act of 1984, Pub. L. 98-460, §3, 98 Stat. 1794, 1799 (codified at 42 U.S.C. § 423(d)(5)(A) (2000)).

<sup>105</sup> *Id.* The full text of the statute is as follows:

An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability . . . . [T]here must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished . . . (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability.

*Id.* Congress saw this language as essentially codifying existing regulations on pain. *See* H.R. REP. NO. 98-1039, at 28–29 (1984). Courts also generally saw the new provision as consistent with the case law that had developed up to the time of the 1984 amendments. *See, e.g., Green v. Schweiker*, 749 F.2d 1066, 1070 (3d Cir. 1984).

<sup>106</sup> *See* 20 C.F.R. §§ 404.1529, 416.929 (1992).

<sup>107</sup> *See id.* §§ 404.1529(b), 416.929(b).

<sup>108</sup> *See id.* §§ 404.1529(b)–(c)(1), 416.929(b)–(c)(1). With respect to proof of severity, the regulations include the following:

Since symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms . . . . We will consider all of the evidence presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your treating, examining or consulting physician or psychologist, and observations by our employees and other persons.

*Id.* §§ 404.1529(c)(3), 416.929(c)(3).

3. *The Special Case of Defining Disability for Children: Original Supplemental Security Income Definition, Sullivan v. Zebley, and the 1996 Amendments*

As noted above, SSA implemented the child SSI disability standard—a medically determinable impairment of “comparable severity” to that required for adult claims<sup>109</sup>—by requiring that child claimants meet or equal the criteria set out in its Listing of Impairments.<sup>110</sup> SSA applies the Listing at the third step of a five-step “sequential evaluation process” used to determine disability for adult claims.<sup>111</sup> Stopping the sequential evaluation process at Step 3 meant that child disability determinations were made based on medical proof alone and a level of severity established exclusively through medical criteria.<sup>112</sup> Beginning in the early 1980s, a number of cases challenged this approach by arguing that limiting the disability decision to whether a child claimant met the Listing requirements did not allow for a full evaluation under the statutory standard. Although the first lower court decisions upheld the practice,<sup>113</sup> the Supreme Court held in the 1990 case *Sullivan v. Zebley*<sup>114</sup> that the Listing-only rule was inconsistent with the statutory “comparable severity” standard.<sup>115</sup> SSA promptly implemented the *Zebley* ruling by adding an “individualized functional assessment” to the disability evaluation process for child claimants who did not meet or equal the requirement of the Listing.<sup>116</sup> However, a few years later, in response to increased SSI rolls

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<sup>109</sup> See Additional Medical Criteria for Determinations of Disability for Children Under Age 18, 42 Fed. Reg. 14,705 (Mar. 16, 1977).

<sup>110</sup> The Listing sets out a number of physical and mental impairments, classified by body systems, together with specific findings that, when proved, establish that the impairment is severe enough to qualify the claimant for benefits. See 20 C.F.R. pt. 404, subpt. P, app. 1 (2006). SSA originally created the Listing for adult claims; however, it includes a supplemental part that addresses impairments that only affect children, or affect children differently than adults. See *id.* at pt. 404, subpt. P, app. 1(B). The Listing is discussed in more detail *infra* at text accompanying notes 154–61.

<sup>111</sup> The sequential evaluation process is discussed *infra* at text accompanying notes 135–49.

<sup>112</sup> The Listing has a far more limited role for adult claims; if an adult does not meet or equal the requirements of the Listing, the sequential evaluation process continues through two additional steps that incorporate the claimant’s “residual functional capacity” (RFC) for work and the effect of various vocational factors, such as the claimant’s age, level of education, and work experience. See *infra* text accompanying notes 142–48.

<sup>113</sup> These courts found that SSA’s reliance on the Listing was a reasonable approach to achieving the goal of the program, citing, *inter alia*, a lack of legislative history on point and the fact that “comparable severity” was not defined in the statute. See, *e.g.*, *Hinckley v. Sec’y of Health & Human Servs.*, 742 F.2d 19, 22–23 (1st Cir. 1984); *Powell v. Schweiker*, 688 F.2d 1357, 1360–63 (11th Cir. 1982).

<sup>114</sup> 493 U.S. 521 (1990).

<sup>115</sup> *Id.* at 533–36.

<sup>116</sup> See Determining Disability for a Child Under Age 18, 56 Fed. Reg. 5,534, 5,535 (Feb. 1, 1991). The revised rules for child SSI claims were codified at 20 C.F.R. § 416.924(b) (1992).

attributed to *Zebley* and the new regulations, Congress replaced the original “comparable severity” standard with the current standard for children.<sup>117</sup>

As amended, the current child SSI disability standard provides that “[a]n individual under the age of 18 shall be considered disabled . . . if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations . . . .”<sup>118</sup> Congress thus modified the severity requirement without changing the causality requirement. Although it is clear that a child’s qualifying functional limitations must result from a medically determinable physical or mental impairment, congressional guidance with respect to the more critical severity requirement was far from clear. Without saying so directly, Congress signaled to SSA that child disability determinations should return to a focus on the Listing.<sup>119</sup> Current regulations do just that, and once again, SSA has based child SSI benefits on a level of severity defined primarily by medical criteria.<sup>120</sup>

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<sup>117</sup> See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 211(a)–(b), 110 Stat. 2105, 2188–89. The *Zebley* decision was seen immediately by commentators as a significant victory for child claimant advocates. See Richard P. Weishaupt & Robert E. Rains, *Sullivan v. Zebley: New Disability Standards for Indigent Children to Obtain Government Benefits*, 35 ST. LOUIS U. L.J. 539, 539–40 (1991). The extensive legislative and administrative activity that took place between the Supreme Court decision in *Zebley* and the 1996 amendments is described in Bloch, *supra* note 72, at 71–87.

<sup>118</sup> 42 U.S.C. § 1382c(a)(3)(C)(i) (2000). Child SSI claimants must also meet the traditional duration requirement—their impairments must have lasted or be expected to last at least twelve months—and they cannot be engaging in substantial gainful activity. See *id.*; *id.* § 1382c(a)(3)(C)(ii) (“Notwithstanding clause (i), no individual under the age of 18 who engages in substantial gainful activity . . . may be considered to be disabled.”).

<sup>119</sup> As explained in the conference report, “the Listing of Impairments and other current disability determination regulations as modified by [various provisions in the 1996 amendments] properly reflect the severity of disability contemplated by the new statutory definition.” H.R. REP. NO. 104-725, at 328 (1996). The report also provided directions for evaluating domains of functioning in the Listing. See *id.* (“In those areas of the Listing that involve domains of functioning, the conferees expect no less than two marked limitations as the standard for qualification.”). Moreover, Congress directed SSA to modify certain sections of the Listing that referenced a child’s “maladaptive behavior” and to stop using individualized functional assessments. See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 211(b), 110 Stat. 2105, 2189 (modifying the provision for individual functional assessment in 20 C.F.R. §§ 416.924(d), 416.924(e) (1996)).

<sup>120</sup> See 20 C.F.R. § 416.924(d) (2006). In keeping with the new statutory language, the regulation allows—in addition to meeting or medically equaling the requirements of the Listing—the possibility of showing “functional equivalence” to a listed impairment. *Id.* For a critique of these regulations, see Bloch, *supra* note 72, at 87–93.

## II

APPLYING THE DEFINITION: SETTING STANDARDS AND  
WEIGHING PROOF

Any person seeking either DI or SSI disability benefits must prove entitlement according to all of the relevant provisions of substantive law, including whether he or she is disabled according to the applicable disability standard.<sup>121</sup> SSA uses essentially the same four-level administrative process for disability claims and appeals that has been in place since the early years of the program.<sup>122</sup> The first two levels—initial decisions and reconsideration of a denial, if requested—are handled by local SSA offices together with state agencies—Disability Determination Services (DDS)—that have the responsibility for making the actual disability determinations.<sup>123</sup> The state agencies make the disability determinations based on a paper record without a face-to-face hearing;<sup>124</sup> however, the disability examiner, working together with a medical consultant, can request an additional consultative medical examination.<sup>125</sup> The next level of appeal is a *de novo* administrative hearing before an administrative law judge (ALJ).<sup>126</sup> Finally,

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<sup>121</sup> The Act specifically states that a claimant “shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the [Social Security Administration] may require.” 42 U.S.C. § 423(d)(5)(A) (2000); *see also* 20 C.F.R. §§ 404.1512(a), 416.912(a) (2006) (placing the burden on the claimant to prove to SSA that he or she is blind or disabled).

<sup>122</sup> SSA recently unveiled its new “Disability Service Improvement” effort, which will reform the process in a number of important respects, discussed *infra*, but the preexisting four-step process is still in place for most claims. *See Administrative Review Process for Adjudicating Initial Disability Claims*, 71 Fed. Reg. 16,424, 16,424 (Mar. 31, 2006). The revised process is discussed in Frank S. Bloch, Jeffrey S. Lubbers & Paul R. Verkuil, *The Social Security Administration’s New Disability Adjudication Rules: A Significant and Promising Reform*, 92 CORNELL L. REV. 235 (2007).

<sup>123</sup> The fact that state agencies are involved at all in making disability determinations for SSA is itself linked to the medical causation requirement of the statutory disability standard. The medical profession, including the American Medical Association, staunchly opposed the creation of a federal cadre of medical officers at SSA, which they saw, at least in part, as an opening to “socialized medicine.” SSA struck a compromise by using physicians in the disability determination process employed through already existing state rehabilitation agencies. *See* STONE, *supra* note 5, at 77–78; Jill Quadagno, *Physician Sovereignty and the Purchasers’ Revolt*, 29 J. HEALTH POL. POL’Y & L. 815, 818 (2004); Anthony Taibi, Note, *Politics and Due Process: The Rhetoric of Social Security Disability Law*, 1990 DUKE L.J. 913, 921.

<sup>124</sup> The process is slightly different when SSA terminates eligibility due to a finding of nondisability based on medical factors; in such cases, reconsideration also includes a “disability hearing” held by a “disability hearing officer.” 20 C.F.R. §§ 404.916(a), 416.1416(a) (2006).

<sup>125</sup> *See id.* §§ 404.1517, 416.917. Local SSA offices can deny claims at the first step of the sequential evaluation process without involving DDS, since that step looks only at current employment. *See id.* §§ 404.1520, 416.920.

<sup>126</sup> Claimants can add new evidence to the record, in addition to any testimony offered at the hearing. *See id.* §§ 404.935, 404.950, 416.1435, 416.1450. The ALJ may also order additional evidence, including a consultative medical examination. *See id.* § 404.1522.

claimants dissatisfied with the ALJ's decision can seek review at SSA's Appeals Council.<sup>127</sup> A decision by the Appeals Council is SSA's final decision on the claim, subject only to judicial review in the federal courts.<sup>128</sup>

SSA is charged with considering all of the evidence available in the claimant's record and, at least in those cases where SSA will deny the claim, SSA must affirmatively develop a complete medical history.<sup>129</sup> In an effort to manage the disability determination process efficiently and consistently, SSA has promulgated various rules and regulations for applying the disability standard and for classifying and weighing medical proof, which are discussed in the following sections.

#### A. Setting Standards for Objectivity and Consistency

SSA has developed a number of different standards and guidelines for implementing the statutory disability standard. First and foremost is the "sequential evaluation process," which serves as a roadmap for determining disability for all DI and adult SSI claims.<sup>130</sup> In 2006, SSA introduced a limited bypass of the sequential evaluation process, known as quick disability determinations (QDDs), which SSA can use for claims in which it can expect to reach a decision in twenty days or less.<sup>131</sup> Two other standards, the Listing of Impairments<sup>132</sup> and the "grids" in the Medical-Vocational Guidelines,<sup>133</sup> are themselves critical parts of the sequential evaluation process and may serve important roles during QDDs as well. Another standard, standing somewhat apart from the rest, is Presumptive Disability, which applies only to a limited group of SSI claims.<sup>134</sup>

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<sup>127</sup> The Appeals Council can also review the decision of an administrative law judge on its own motion. *See id.* §§ 404.969, 416.1469(b). Claimants may submit new evidence to the Appeals Council but only in relation to their condition prior to the date of the administrative hearing decision. *See id.* §§ 404.976(b)(1), 416.1476(b)(1).

<sup>128</sup> *See id.* § 404.981.

<sup>129</sup> *See* 42 U.S.C. § 423(d)(5)(B) (2000) ("In making any [disability] determination . . . , [SSA] shall consider all evidence available in such individual's case record, and shall develop a complete medical history of at least the preceding twelve months for any case in which a determination is made that the individual is not under a disability.").

<sup>130</sup> *See* 20 C.F.R. §§ 404.1520, 416.920 (2006).

<sup>131</sup> *See* Administrative Review Process for Adjudicating Initial Disability Claims, 71 Fed. Reg. 16,424, 16,427 (Mar. 31, 2006).

<sup>132</sup> *See* Addition of Medical Criteria for Evaluating Down Syndrome in Adults, 65 Fed. Reg. 31,802 (May 18, 2000) (codified at 20 C.F.R. pt. 404, subpt. P, app. 1 (2006)).

<sup>133</sup> *See* 20 C.F.R. pt. 404, subpt. P, app. 2 (2006).

<sup>134</sup> *See id.* § 416.933.

### 1. *Sequential Evaluation Process*

SSA uses a five-step “sequential evaluation process” to determine disability for all current DI and adult SSI claims.<sup>135</sup> A somewhat different, truncated version of the sequential evaluation process is used for child SSI claims.<sup>136</sup> The five-step process is structured to focus on different aspects of the disability standard that raise particular factual and legal issues relevant to finding whether a claimant is disabled.<sup>137</sup> The process operates like a flow chart. At each step, either it resolves the claim—depending on which step, by finding that the claimant is disabled or is not disabled—or it continues to the next step. For evaluations that reach the fifth and final step, the process concludes with a finding that the claimant is, or is not, disabled.<sup>138</sup> The sequential evaluation process is used throughout the administrative process and is accepted by the courts as the framework for analysis of a disability claim.<sup>139</sup> When followed fairly and accurately, the sequential evaluation process is an effective way to implement the statutory standard.

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<sup>135</sup> See *id.* §§ 404.1520, 416.920. Earlier regulations had used the term “sequential evaluation process” to describe the five-step procedure, and it remains widely used. See, e.g., *Bowen v. Yuckert*, 482 U.S. 137, 153 (1987); *Plummer v. Apfel*, 186 F.3d 422, 428 (3d Cir. 1999); *Beech v. Apfel*, 100 F. Supp. 2d 1323, 1327 (S.D. Ala. 2000).

<sup>136</sup> That process and the Supreme Court case and subsequent legislation that led up to it are discussed *supra* at text accompanying notes 110–20. A similar truncated process is used for pre-1991 claims by spouses under the OASDI program. See 20 C.F.R. § 404.1577 (2006). This system is a carryover from when spouses had to meet a stricter disability standard, stated as the inability to engage in “any gainful activity” and without consideration of vocational factors.

The process that SSA uses for determining that a beneficiary is no longer disabled is essentially an extended version of the sequential evaluation process used for initial determinations. See *id.* §§ 404.1594(f), 416.994(b)(5). The process includes up to eight steps, three of which address questions unique to the medical improvement standard. The five other steps are tied directly or indirectly to the regular five-step process. *Id.* The eight-step process is based on a “medical improvement” standard, which Congress passed as part of a major set of Social Security amendments in 1984. *Id.* These amendments were passed in response to a series of lawsuits challenging SSA’s Continuing Disability Review (CDR) process. See, e.g., *Dotson v. Schweiker*, 719 F.2d 80, 81–83 (4th Cir. 1983); *Kuzmin v. Schweiker*, 714 F.2d 1233, 1237 (3d Cir. 1983); *Simpson v. Schweiker*, 691 F.2d 966, 969 (11th Cir. 1982); *Cassiday v. Schweiker*, 663 F.2d 745, 747 (7th Cir. 1981). The standard requires a showing of medical improvement in a claimant’s impairment or combination of impairments related to his or her ability to work before benefits can be terminated unless one of a number of exceptions applies. See Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, § 2(a), 98 Stat. 1794, 1794 (codified at 42 U.S.C. § 423(f) (2000)). See generally Eileen P. Sweeney, *The New “Medical Improvement” Standard in Social Security and SSI Disability Cases*, 14 SOC. SEC. REP. SERV. 965, 968–84 (1986) (analyzing in depth the medical improvement standard and its exceptions).

<sup>137</sup> See 20 C.F.R. §§ 404.1520, 416.920 (2006); see, e.g., *Yuckert*, 482 U.S. at 157; *Plummer*, 186 F.3d at 428; *Beech*, 100 F. Supp. 2d at 1327.

<sup>138</sup> See 20 C.F.R. §§ 404.1520, 416.920 (2006); see, e.g., *Yuckert*, 482 U.S. at 157.

<sup>139</sup> As one court stated, “[i]t is important for the [administrative law judge] to follow the orderly framework set out in the [sequential evaluation process] to ensure uniformity and regularity in outcome as well as fairness to the claimant.” *Mitchell v. Schweiker*, 551 F. Supp. 1084, 1087–88 (W.D. Mo. 1982); see also *Yuckert*, 482 U.S. at 153 (citing *Heckler v.*

The first two steps are the most efficient. Step 1 looks at whether the claimant is currently performing substantial gainful activity.<sup>140</sup> This step does not involve any medical proof because it limits the evaluation to the nature and extent of the claimant's current employment, if any. If the claimant is engaging in substantial gainful activity, then he or she is not disabled—that is, not *unable* to engage in substantial gainful activity—and SSA will deny the claim. If not, the process moves to the second step. Step 2 looks at whether the claimant has a nonsevere medically determinable physical or mental impairment,<sup>141</sup> defined as an impairment that does not “significantly limit [the claimant's] physical or mental ability to do basic work activities.”<sup>142</sup> In contrast to Step 1, the proof at Step 2 is entirely medical. If the claimant does not have an impairment or combination of impairments that qualify as severe, then any limitation on the claimant's ability to work is *not* due to a medically determinable physical or mental impairment, and SSA will deny the claim. If the claimant does have a severe impairment, the process continues to the third step.

Step 3 is also relatively efficient: It is a screening device for granting benefits to persons with impairments severe enough to meet or equal the criteria set forth in a list of disabling impairments known as the Listing of Impairments (“Listing”).<sup>143</sup> As with evaluations in Step

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Campbell, 461 U.S. 458, 461 (1983)) (stating that the use of the sequential evaluation process “contribute[s] to the uniformity and efficiency of disability determinations”).

<sup>140</sup> See 20 C.F.R. §§ 404.1520(a)(4)(i), 416.920(a)(4)(i) (2006). In this context, “currently” means at any time relevant to the application for benefits.

<sup>141</sup> See *id.* §§ 404.1520(4)(ii), 416.920(4)(ii). A severe impairment can also be made up of a combination of impairments. *Id.*

<sup>142</sup> *Id.* §§ 404.1521(a), 416.921(a); see Titles II and XVI: Medical Impairments That Are Not Severe, S.S.R. 85-28 (Cum. Ed. 1985) (defining nonsevere as “a slight abnormality” that “has no more than a minimal effect on a claimant's ability to do basic work activities . . .”). The Ruling adds that “[g]reat care should be exercised in applying the not severe impairment concept.” S.S.R. 85-28. Because an evaluation at Step 2 does not consider vocational factors, a finding of nonseverity may cut off the full sequential evaluation process prematurely in cases where the claimant might be found disabled on the basis of vocational factors in combination with medical evidence. Following extensive litigation involving claims of improper denials at this step, the Supreme Court upheld the regulation. See *Yuckert*, 482 U.S. at 137. In an important concurring opinion, however, Justice Sandra Day O'Connor found, citing S.S.R. 85-28, that SSA did not intend to implement more than a de minimis severity requirement, and she urged that it be applied only to “claimants with slight abnormalities that do not significantly limit any ‘basic work activity . . . .’” *Id.* at 158 (O'Connor, J., concurring). Later cases have relied on both *Yuckert* and S.S.R. 85-28 to enforce a de minimis severity requirement at Step 2. See, e.g., *Corrao v. Shalala*, 20 F.3d 943, 949 (9th Cir. 1994); *Hudson v. Bowen*, 870 F.2d 1392, 1396 (8th Cir. 1989).

<sup>143</sup> 20 C.F.R. §§ 404.1520(a)(4)(iii), 416.920(a)(4)(iii) (2006). The Listing includes a certain number of impairments together with findings required to show that the impairment qualifies as sufficiently severe. The severity criteria in the Listing are set at a high level—inability to perform “any gainful activity,” as compared to the usual “any substantial gainful activity”—to insure that a disability finding is warranted without looking to the



2, evaluations in Step 3 are limited to medical proof.<sup>144</sup> However, the medical evaluation, because it is framed in terms of the various criteria set out in the Listing, can be far more complex.<sup>145</sup> If the impairment meets or equals the requirements of the Listing, SSA grants the claim. If not, the process continues to the fourth step.

The last two steps take on the more difficult cases—those that cannot be resolved through the first three steps—and address the more complex medical-vocational aspects of the disability standard. As a preliminary matter, Steps 4 and 5 both include an assessment of the claimant’s “residual functional capacity” (RFC), which is a measure of how a claimant’s physical and mental limitations affect his or her ability to work.<sup>146</sup> Step 4 is still relatively focused; it examines whether the claimant, given his or her RFC, is able to perform work that he or she had done in the past.<sup>147</sup> If so, the claimant can still perform jobs that, by definition, are within his or her vocational competence and SSA will deny the claim. If not, the process continues to Step 5, the final step.<sup>148</sup> Only at Step 5 does the process fully address the medical-vocational disability standard. It determines whether there is a significant amount of work available in the national economy that the claimant can do, taking into account his or her RFC, age, education, and work experience.<sup>149</sup> If so, the claimant is not disabled; if not, then he or she is disabled.

2. *Listings and Guidelines: Listing of Impairments and Medical-Vocational “Grids”; Quick Disability Determinations and Presumptive Disability*

SSA uses a number of listings and guidelines to help determine eligibility for disability benefits. It incorporates the two most important ones, the Listing of Impairments and the “grids” in the Medical-

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claimant’s age, level of education, or work experience. The Listing is discussed further *infra* at text accompanying notes 154–60.

<sup>144</sup> See 20 C.F.R. § 404.1528 (2006).

<sup>145</sup> See *id.* §§ 404.1527, 404.1528.

<sup>146</sup> See *id.* §§ 404.1545(a)(1), 416.945(a)(1) (“Your residual functional capacity is the most you can still do [in a work setting] despite your [physical and mental] limitations.”).

<sup>147</sup> *Id.* §§ 404.1520(a)(4)(iv), 416.920(a)(4)(iv).

<sup>148</sup> *Id.*

<sup>149</sup> *Id.* §§ 404.1520(a)(4)(v), 416.920(a)(4)(v). Although generally claimants have the burden of proof on the issue of disability, it shifts to SSA at Step 5. SSA must prove that there are other jobs in the national economy that the claimant can perform. This court-created shift of burden is justified on practical and fairness grounds. Even if a claimant had access to the necessary vocational information, it would be practically impossible to prove the inability to perform all jobs available in the national economy. See *Bowen v. Yuckert*, 482 U.S. 137, 153 (1987); see also *Erickson v. Shalala*, 9 F.3d 813, 816–17 (9th Cir. 1993); *Williams v. Shalala*, 997 F.2d 1494, 1497 (D.C. Cir. 1993); *Allen v. Sullivan*, 977 F.2d 385, 387 (7th Cir. 1992).

Vocational Guidelines, into the sequential evaluation process.<sup>150</sup> Two others provide for special treatment of certain types of claims.<sup>151</sup> QDD is a recent innovation that amounts to an expedited version of the sequential evaluation process for claims that SSA will likely grant quickly.<sup>152</sup> Presumptive Disability is a feature unique to SSI claims, whereby a preliminary finding of disability can be made for claimants with certain specified impairments to authorize early payment of benefits.<sup>153</sup> Each of these is described briefly below, with particular reference to the role of medical findings and medical expertise in defining disability.

The Listing<sup>154</sup> identifies a number of physical and mental impairments that SSA considers to be “severe enough to prevent an individual from doing any gainful activity.”<sup>155</sup> The Listing is divided into fourteen sections, each of which covers a different major body system except for a new section added in 2000 covering impairments that affect multiple body systems.<sup>156</sup> Each section includes two parts: a general introduction and a “Category of Impairments” that sets forth individual impairments and the specific criteria for establishing that a claimant with that impairment is disabled.<sup>157</sup> The introduction defines certain key terms the section uses and may also specify medical findings necessary to meet the requirements of a particular listed impairment.<sup>158</sup> This structure links the introductions to current medical knowledge and practices.<sup>159</sup> As part of a recent trend to make the Listing reflect current medical knowledge and to make it more func-

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<sup>150</sup> 20 C.F.R. §§ 404.1562, 416.962 (2006).

<sup>151</sup> See *id.*

<sup>152</sup> Administrative Review Process for Adjudicating Initial Disability Claims, 71 Fed. Reg. 16,424, 16,427 (Mar. 31, 2006).

<sup>153</sup> Presumptive disability payments are authorized by 42 U.S.C. § 1383(a)(4)(B) (2000). For more information on presumptive disability payments, see *infra* note 266 and accompanying text.

<sup>154</sup> See 20 C.F.R. pt. 404, subpt. P, app. 1 (2006).

<sup>155</sup> *Id.* §§ 404.1525(a), 416.925(a). The Listing consists of two parts: Part A for impairments that affect adults and children in the same manner and Part B for impairments that affect only children. See *id.* §§ 404.1525(b), 416.925(b).

<sup>156</sup> Addition of Medical Criteria for Evaluating Down Syndrome in Adults, 65 Fed. Reg. 31,802 (May 18, 2000) (codified at 20 C.F.R. pt. 404, subpt. P, app. 1 (2006)).

<sup>157</sup> See 20 C.F.R. §§ 404.1525(c), 416.925(c) (2006). The claimant has the burden of proof in providing the medical findings necessary to show that he or she is disabled. See *id.* §§ 404.1512(a), 416.912(a). General findings concerning criteria for a particular listing are not sufficient; the medical evidence must address the specific requirements upon which the listing relied. See, e.g., *King v. Heckler*, 742 F.2d 968, 973 (6th Cir. 1984) (holding that treating physician’s recommendations laced sufficient evidence to meet Listing 1.05(C)).

<sup>158</sup> See 20 C.F.R. §§ 404.1525(c)(2), 416.925(c)(2) (2006).

<sup>159</sup> For example, the introduction to the section on the respiratory system notes that a diagnosis of cystic fibrosis must be confirmed by elevated sweat sodium or chloride concentrations, which is one of the “gold standard” tests in the diagnosis of that disease. See *id.* pt. 404, subpt. P, app. 1 § 3.00(D).

tionally based and accessible to claimants, many of the fourteen introductions provide guidelines on how a claimant's condition can meet a definition in the section's categories of impairments. For example, a number of introductions emphasize the importance of using Listing criteria to organize claims and evaluations for particular body systems that are allegedly causing a disability. These introductions also direct the evaluation of whether extrasystemic effects are causing disability to the applicable Listing criteria of other body systems.<sup>160</sup> This approach is especially important when a claimant suffers from an illness that affects multiple body systems. In such situations, the Listing forces claimants to focus on the systems that are affected in such a way as to prevent gainful activity.<sup>161</sup>

Until recently, SSA rarely revised the Listing and hardly ever did so in a comprehensive manner.<sup>162</sup> Over the past few years, however, SSA has reviewed the Listing and its component parts comprehensively and has revised the listings for many body systems.<sup>163</sup> These include, among others, the Genitourinary System, the Cardiovascular System, Hematological Disorders, Skin Disorders, Malignant Neoplastic Disorders, and Special Senses and Speech.<sup>164</sup> In 2005, SSA also revised the section covering impairments that affect multiple body systems,<sup>165</sup> and there are indications that SSA is considering adding at least one other new section.<sup>166</sup> As part of this overall process, SSA has

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<sup>160</sup> See, e.g., *id.* pt. 404, subpt. P, app. 1 § 1.00(L) (noting that abnormal curvatures of the spine can affect body systems other than the musculoskeletal system and referring claimants to the corresponding section of the list of impairments).

<sup>161</sup> See *id.*

<sup>162</sup> There have been a few exceptions when particular listings prove to be controversial or are the subject of litigation. A prominent example is the mental impairment listings, which were criticized strongly in *Mental Health Ass'n of Minn. v. Schweiker*, 554 F. Supp. 157, 161–63, 166–67 (D. Minn. 1982) (holding that SSA unfairly withheld benefits from mentally impaired individuals age eighteen to forty-nine and declaring SSA's standard for mental impairments in younger individuals under Appendix Listing § 12 void). As a result, Congress ordered the Secretary of Health and Human Services to revise these listings at the time of the 1984 amendments to the Act. See Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, §5(a), 98 Stat. 1794, 1801 (“The revised criteria and listings . . . shall be designed to realistically evaluate the ability of a mentally impaired individual to engage in substantial gainful activity in a competitive workplace environment.”).

<sup>163</sup> See 20 C.F.R. pt. 404, subpt. P, app. 1 (2006).

<sup>164</sup> Based on an Advanced Notice of Proposed Rulemaking (ANPRM), the rules used to evaluate respiratory system disorders will be changing as well. See Revised Medical Criteria for Evaluating Respiratory System Disorders, 70 Fed. Reg. 19,358–61 (Apr. 13, 2005).

<sup>165</sup> See Revised Medical Criteria for Evaluating Impairments That Affect Multiple Body Systems, 70 Fed. Reg. 51,252–59 (Aug. 30, 2005) (codified at 20 C.F.R. pt. 404, subpt. P, app. 1 § 10 (2006)).

<sup>166</sup> See New Medical Criteria for Evaluating Language and Speech Disorders, 70 Fed. Reg. 19,351–53 (Apr. 13, 2005) (providing an ANPRM on the potential creation of a new section on Language and Speech Disorders). The new section would presumably encompass medical conditions that currently appear in separate sections, such as strokes and pervasive developmental disorders.

attempted to bring together both medical professionals and interested client groups, as well as their advocates, by publishing advanced notices of proposed rulemaking (ANPRM). SSA has also held occasional meetings to discuss possible changes in Listing criteria.<sup>167</sup> In addition, SSA recently commissioned a study from IOM to evaluate the quality and effectiveness of the Listing. A report on that study is expected to be published in late 2006.<sup>168</sup>

As discussed above, the Listing is used at Step 3 of the sequential evaluation process<sup>169</sup> after SSA determines that the claimant is not engaging in substantial gainful activity and that he or she has a “severe” impairment that limits significantly his or her ability to perform basic work activity.<sup>170</sup> The criteria for impairments that appear in the Listing are set intentionally at a level of severity significantly stricter than the severity requirement of the statutory disability standard.<sup>171</sup> The concept behind the stricter severity standard for listed impairments is “per se” disability.<sup>172</sup> Under this stricter standard, claimants must show that their individual listed impairments render them unable to engage in “any gainful activity,”<sup>173</sup> as opposed to “any substantial gainful activity.”<sup>174</sup> There is no qualifying role for vocational factors, such as the claimant’s age, level of education, or work experience.<sup>175</sup> The

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<sup>167</sup> See, e.g., Revised Medical Criteria for Evaluating Growth Impairments, 70 Fed. Reg. 53,323–24 (Sept. 8, 2005) (announcing plans to update and revise child SSI listings on growth impairments and inviting public comments via Internet posting on SSA’s website or by telefax or regular mail); Revised Medical Criteria for Evaluating Endocrine Disorders, 70 Fed. Reg. 46,792 (Aug. 11, 2005) (inviting public comments on SSA plans to update and revise the rules for evaluating endocrine disorders of adults and children). As the ANPRM on child growth disorders states: “The purpose of this notice is to give you an opportunity to send us comments and suggestions for updating and revising those rules as we begin the rulemaking process.” Revised Medical Criteria for Evaluating Growth Impairments, 70 Fed. Reg. 53,323, 52,324 (Sept. 8, 2005).

<sup>168</sup> The IOM published an interim report of the same study in late 2005, which is discussed *infra* at text accompanying notes 195–97, 227–31, and 272. See COMM. ON IMPROVING THE DISABILITY DECISION PROCESS: SSA’S LISTING OF IMPAIRMENTS AND AGENCY ACCESS TO MED. EXPERTISE, INST. OF MED. OF THE NAT’L ACADS., IMPROVING THE SOCIAL SECURITY DISABILITY DECISION PROCESS: INTERIM REPORT (2006) [hereinafter IOM INTERIM REPORT].

<sup>169</sup> See *supra* notes 135–49 and accompanying text.

<sup>170</sup> See *supra* note 149 and accompanying text.

<sup>171</sup> See *Sullivan v. Zebley*, 493 U.S. 521, 532 (1990) (“The Secretary explicitly has set the medical criteria defining the listed impairments at a higher level of severity than the statutory standard.”).

<sup>172</sup> See *Burns v. Barnhart*, 312 F.3d 113, 119 (3d Cir. 2002) (“Step three allows the claimant to demonstrate that his disability meets or equals an impairment listed in [the Listing of Impairments] . . . . If the impairment meets or equals a listed impairment, the claimant is considered disabled *per se* and the evaluation process ends.”).

<sup>173</sup> 20 C.F.R. §§ 404.1525(a), 416.925(a) (2006).

<sup>174</sup> 42 U.S.C. § 1382c(a)(3)(A) (2006).

<sup>175</sup> 20 C.F.R. §§ 404.1525(a), 416.925(a) (2006) (“The Listing of Impairments . . . describes for each of the major body systems impairments that we consider to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her

Listing's stringent severity standard for findings of per se disability justifies awarding benefits at Step 3, just as the use of that same standard requires SSA to continue through the remaining two steps of the sequential evaluation process for claimants whose medical condition does not meet or equal the strict Listing criteria.<sup>176</sup>

SSA promulgated a set of Medical-Vocational Guidelines to assist claimants in meeting SSA's burden of proof in cases that reach Step 5 of the sequential evaluation process after SSA determines that the claimant cannot return to his or her former work.<sup>177</sup> There are two parts to any Step 5 disability assessment, during which SSA has the burden of showing that the claimant retains the capacity to perform other substantial gainful activity before it denies a claim.<sup>178</sup> First, as noted earlier, SSA measures the claimant's remaining capacity to perform work activity by using a RFC assessment.<sup>179</sup> After making such an assessment, SSA then decides whether a significant number of jobs exists in the national economy that the claimant could perform, given his or her RFC, age, level of education, and work experience, that would permit the claimant to pursue substantial gainful activity.<sup>180</sup> The key to the Guidelines is the so-called "grids,"<sup>181</sup> which consist of three tables that specify—again, given a claimant's RFC, age, level of education, and work experience—whether a sufficient number of jobs exists in the national economy that he or she can perform.<sup>182</sup>

SSA issued the Guidelines to "consolidate and elaborate upon long standing medical-vocational evaluation policies" and to "make clearer to claimants and their representatives how disability is determined where vocational factors must be considered."<sup>183</sup> At the time SSA promulgated the Guidelines, it indicated that the Guidelines

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age, education, or work experience."); *see also* *Zebley*, 493 U.S. at 532 ("The listings define impairments that would prevent an adult, regardless of his age, education, or work experience, from performing *any* gainful activity, not just 'substantial gainful activity.'").

<sup>176</sup> *See supra* notes 146–49 and accompanying text.

<sup>177</sup> *See* 20 C.F.R. pt. 404, subpt. P, app. 2 (2006). *See generally* John J. Capowski, *Accuracy and Consistency in Categorical Decision-Making: A Study of Social Security's Medical-Vocational Guidelines—Two Birds With One Stone or Pigeon-Holing Claimants?*, 42 MD. L. REV. 329 (1983) (examining the extent to which the Guidelines have helped achieve the twin goals of accuracy and consistency in awarding SSI benefits).

<sup>178</sup> *See* *Burns v. Barnhart*, 312 F.3d 113, 119 (3d Cir. 2002).

<sup>179</sup> *See supra* note 146 and accompanying text.

<sup>180</sup> *See* 20 C.F.R. § 404.1560(c) (2006)

<sup>181</sup> Capowski, *supra* note 177, at 340 ("Appendix 2 of the Medical-Vocational Guidelines is made up of three tables—often referred to as the 'grid'—one each for sedentary, light, and medium work.").

<sup>182</sup> *See* 20 C.F.R. pt. 404, subpt. P, app. 2 §§ 201.00, 202.00, 203.00 (2006). The grids are based on various government publications, such as the Dictionary of Occupational Titles and the Occupation Outlook Handbook, which is published by the U.S. Department of Labor. *See id.* § 200.00(b).

<sup>183</sup> Rules for Adjudicating Disability Claims in Which Vocational Factors Must Be Considered, 43 Fed. Reg. 55,349 (Nov. 28, 1978).

were fully consistent with congressional intent that medical factors remain predominantly important in disability determinations under the Act.<sup>184</sup> The Supreme Court upheld the use of the grids to determine disability in 1983,<sup>185</sup> noting that “[t]he Social Security Act directs [SSA] to ‘adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same’ in disability cases.”<sup>186</sup> The Court was careful, however, to note also that the Guidelines make it clear that if no rule accurately describes an individual’s capabilities, the grids cannot be applied to reach a decision on disability.<sup>187</sup>

QDDs are part of a set of substantial changes to the disability determination process that SSA published in 2006, which in addition to the Listing and the Guidelines, will assist SSA in making accurate and consistent disability determinations.<sup>188</sup> The idea is to identify selected types of claims, based on personal characteristics of the claimant, where a favorable disability decision could be made within twenty days.<sup>189</sup> To execute this process, SSA will use a “predictive” model that will focus on claims that have a “high potential that the claimant is disabled” and where the evidence necessary to establish disability “can be easily and quickly obtained.”<sup>190</sup>

Just how this model will operate is unclear. It appears that SSA will evaluate QDDs using the same sequential evaluation process as other claims.<sup>191</sup> Therefore, it could be that SSA will base most of the claims it identifies for QDDs on vocational factors, such as where the claimant is relatively old, has a limited amount of education, or has only unskilled work experience. In the alternative, the model could amount to a “super-Listing” that identifies preselected, easily proved impairments that can be granted quickly by using the relevant medical criteria in the Listing. Such an approach would not replace the Listing; rather, it would distinguish between those cases where SSA can

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<sup>184</sup> See *id.* at 55,350. SSA also indicated that it believed that the new regulations would “not have any significant effect on the current allowance-denial rates.” *Id.* at 55,355.

<sup>185</sup> See *Heckler v. Campbell*, 461 U.S. 458 (1983). The Court in *Campbell* did leave open the question of the legality of the age classifications in the grids. See *id.* at 464 n.8; *Broz v. Schweiker*, 677 F.2d 1351, 1359–61 (11th Cir. 1982), *vacated*, 461 U.S. 952 (1983).

<sup>186</sup> *Campbell*, 461 U.S. at 466 (quoting 42 U.S.C. § 405(a) (2000)).

<sup>187</sup> See *id.* at 462 n.5 (citing 20 C.F.R. pt. 404, subpt. P, app. 2 §§ 200.00(a), (d)).

<sup>188</sup> See *supra* note 122.

<sup>189</sup> See *Administrative Review Process for Adjudicating Initial Disability Claims*, 71 Fed. Reg. 16,424, 16,429–30 (Mar. 31, 2006).

<sup>190</sup> *Id.*

<sup>191</sup> *Id.* at 16,430 (“We have clarified that [disability determination services] will adjudicate QDDs, using the same definition and procedural rules as are applied to all other initial determinations.”).

make a Listing-based decision to award benefits quickly and those where a possible grant based on the Listing would take more time.

A fourth tool for SSA is early “presumptive disability” payments, which the Act authorizes for up to six months for SSI disability benefit applicants where it is very likely that SSA will find the claimant to be disabled.<sup>192</sup> SSA may award these benefits, which are not available to DI applicants, without particular evidence of severity if the claimant has one of a group of listed impairments or conditions,<sup>193</sup> or if “medical evidence or other information . . . is sufficient . . . to find that there is a high degree of probability that [the claimant is] disabled or blind.”<sup>194</sup> Here again, the medical causality requirement is met; the flexibility in presumptive disability cases is in the severity requirement. Unlike disability decisions based on the Listing, which require both a diagnosis of a listed impairment and medical findings tied to severity, decisions on presumptive disability can be made based on proof of a qualifying impairment alone.

SSA recently commissioned IOM, as part of a larger project, to review the medical criteria for presumptive disability.<sup>195</sup> Recognizing that presumptive disability is a special designation reflecting particular social policy goals, the IOM distinguished between the nature and quality of medical criteria and the question of the appropriate level of severity, the latter of which it declined to address.<sup>196</sup> Thus, IOM focused on the accuracy of selection criteria in relation to the general disability standard and recommended that SSA adopt more explicit criteria aimed at including the highest number of potential presumptive grantees, namely those with impairments highly likely to meet the statutory definition of disability, with an established, acceptable reversal rate once the full disability determination process is complete.<sup>197</sup>

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<sup>192</sup> See 42 U.S.C. § 1383(a)(4)(B) (2000).

<sup>193</sup> See 20 C.F.R. § 416.934 (2006) (providing for a finding of presumptive disability in certain cases of leg amputation, allegations of total deafness or blindness, bed confinement, longstanding immobility, stroke, cerebral palsy, muscular dystrophy, muscle atrophy, Down syndrome, severe mental deficiency, and ALS).

<sup>194</sup> *Id.* § 416.933; see also SOC. SEC. ADMIN., POMS SECTION DI 23535.005, <https://s044a90.ssa.gov/apps10/poms.nsf/lx/0423535005!opendocument> (last visited Nov. 15, 2006) (detailing an expanded list of impairment categories for presumptive-disability and presumptive-blindness cases).

<sup>195</sup> IOM issued an interim report on the criteria for presumptive disability and the use of medical expertise in 2005. See IOM INTERIM REPORT, *supra* note 168, at 55–62. IOM will not complete the rest of the project, primarily involving questions related to the Listing of Impairments, before the end of 2006.

<sup>196</sup> See *id.* at 58 (“Presumptive disability is primarily a social policy . . . . Therefore, the committee is unable to recommend specific categories to include or delete because the selection criteria are not solely medical.”).

<sup>197</sup> See *id.* at 57–60 (noting that the policy includes some conditions with relatively high reversal rates and excludes some with consistently high acceptance, thus necessitating a revision in the standards to improve accuracy).

## B. Classifying and Weighing Medical Proof

SSA regulations include a number of requirements and guidelines for evaluating and weighing medical proof in disability claims.<sup>198</sup> Some rules arise directly from the statutory medical causation requirement that a claimant's inability to engage in substantial gainful activity results from a medically determinable physical or mental impairment.<sup>199</sup> SSA has developed other regulations, both independently and in response to court rulings, to manage conflicting medical proof from a wide variety of medical sources.<sup>200</sup> SSA has also established various mechanisms for including medical experts in the process, most recently by creating a new national unit of medical and vocational experts.<sup>201</sup> Each of these practices influences the role that the medical component of the disability standard plays in disability determinations, as discussed in more detail below.

### 1. "Medically Acceptable Clinical and Laboratory Diagnostic Techniques"

The Act specifies that a qualifying "physical or mental impairment" must "result[ ] from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."<sup>202</sup> SSA regulations implementing this requirement provide that qualifying impairments must be proved with "medical evidence consisting of signs, symptoms, and laboratory findings."<sup>203</sup> The same regulations also specify that a claimant's own statement of his or her symptoms is not itself sufficient proof of these impairments.<sup>204</sup>

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<sup>198</sup> See 20 C.F.R. §§ 416.908, 416.913–416.919 (2006).

<sup>199</sup> See *id.* § 416.908 (stating that where a claimant is not doing substantial gainful activity, SSA first evaluates his or her physical or mental impairment(s) to determine whether the claimant is disabled or blind, and the "impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques").

<sup>200</sup> See *infra* note 217.

<sup>201</sup> See 20 C.F.R. § 405.10 (2006) (establishing the Medical and Vocational Expert System, comprised of the Medical and Vocational Expert Unit and a national network of qualified medical, psychological, and vocational experts to assist officials and judges in deciding claims, to assist state agencies in determining disability, and to maintain a national registry of vocational experts).

<sup>202</sup> 42 U.S.C. § 423(d)(3) (2000).

<sup>203</sup> 20 C.F.R. §§ 404.1508, 416.908 (2006).

<sup>204</sup> *Id.*; see also *id.* §§ 404.1528(a), 416.928(a) (explaining that a claimant's statements alone are not enough to establish that there is a physical or mental impairment); *id.* §§ 404.1528(b), 416.928(b) (defining signs as "anatomical, physiological, or psychological abnormalities which can be observed, apart from [the claimant's] statements (symptoms)"). Any medical reports that are unsupported by medically acceptable findings may be discounted. See, e.g., *Edwards v. Sullivan*, 985 F.2d 334, 337 (7th Cir. 1993).



These strict requirements for medical proof underscore the importance of the gatekeeping role of medicine and medical science in the disability determination process.<sup>205</sup> Nonetheless, some courts have interpreted this requirement relatively broadly in cases where medical proof of the underlying impairment is necessarily more complicated, such as those based on difficult-to-prove diseases and syndromes.<sup>206</sup> Likewise, SSA recognizes Chronic Fatigue Syndrome (CFS) as a medically determinable impairment, despite the absence of any widely accepted laboratory findings that document the condition.<sup>207</sup> However, it is not surprising that despite this flexibility regarding medical causality, it remains very difficult for a claimant to establish entitlement to benefits by proving the requisite level of severity on the basis of these types of impairments.<sup>208</sup>

## 2. *Acceptable Medical Sources*

SSA regulations recognize the critical importance of establishing a medically determinable physical or mental impairment by distinguishing between “acceptable” and “other” sources of medical proof.<sup>209</sup> Only acceptable sources, mostly licensed physicians and licensed or certified psychologists, are qualified to provide evidence of a medically determinable impairment.<sup>210</sup> Then, once evidence from an acceptable medical source proves the existence of an impairment,

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<sup>205</sup> See *supra* notes 56–62 and accompanying text.

<sup>206</sup> See, e.g., *Green v. Schweiker*, 749 F.2d 1066 (3d Cir. 1984); *Rodriguez v. Schweiker*, 523 F. Supp. 1240 (E.D. Pa. 1981).

<sup>207</sup> See Titles II and XVI: Evaluating Cases Involving Chronic Fatigue Syndrome, 64 Fed. Reg. 23,380 (Apr. 30, 1999) (listing potentially relevant physical and mental findings usable to document Chronic Fatigue Syndrome). Fibromyalgia is another impairment that cannot be diagnosed through objective testing. See, e.g., *Green-Younger v. Barnhart*, 335 F.3d 99, 108 (2d Cir. 2003) (noting that “a growing number of courts” recognize that there are no objective tests that conclusively confirm a diagnosis of fibromyalgia); *Glenn v. Apfel*, 102 F. Supp. 2d 1252, 1259 (D. Kan. 2000) (“[T]he symptoms of fibromyalgia are subjective, pain all over, fatigue, disturbed sleep, and stiffness, and there are no objective clinic tests to determine its severity.”). See generally Aimée E. Bierman, Note, *The Medico-Legal Enigma of Fibromyalgia: Social Security Disability Determinations and Subjective Complaints of Pain*, 44 WAYNE L. REV. 259 (1998) (providing a thorough analysis of the difficulty of harmonizing fibromyalgia with the standards for proving disabilities). For an extensive discussion of the evidence required to establish a diagnosis of fibromyalgia, see *Alexander v. Barnhart*, 287 F. Supp. 2d 944 (E.D. Wis. 2003). SSA also acknowledges that obesity is a medically determinable impairment that may, on its own, warrant a finding of disability. See Titles II and XVI: Evaluation of Obesity, S.S.R. 00-3p (Cum. Ed. 2000).

<sup>208</sup> See, e.g., *Buxton v. Halter*, 246 F.3d 762, 775 (6th Cir. 2001) (“[T]his case is not like most other CFS cases, in that [the claimant] here is not arguing that the ALJ failed to consider her exertional limitations, such as her fatigue . . . . Those cases [where the claimant prevailed] are further distinguishable, however, . . . because here, we do not have anything as concrete and unequivocal as the claimants in those cases had regarding the nature of their disabilities and thus, their limitations.”).

<sup>209</sup> 20 C.F.R. § 404.1520 (2006).

<sup>210</sup> See *id.* §§ 404.1513(a), 416.913(a). Licensed or certified school psychologists, licensed optometrists and podiatrists, and qualified speech-language pathologists are also

SSA looks to other sources to provide evidence of severity, including nurse-practitioners, physicians' assistants, educational and social welfare agency personnel, family, clergy, and neighbors.<sup>211</sup>

This classification of acceptability of medical sources effectively maintains the sanctity of the medical-causation component of the disability standard. Not only must claimants provide medical proof of their impairments,<sup>212</sup> that proof must come from a formally recognized, "acceptable" source.<sup>213</sup> At the same time, this distinction acknowledges that the second part of the standard—severity<sup>214</sup>—is not as clearly tied to medical proof.

### 3. *Medical Opinions: Treating and Consulting Physicians*

As previously mentioned, SSA is statutorily obligated to consider all of the evidence available in a claimant's file before reaching a decision on disability.<sup>215</sup> In furtherance of this mandate, agency regulations provide specific guidelines for evaluating medical opinions.<sup>216</sup> One set of rules, covering consistency and sufficiency, addresses the question of when the record is ready for the claim to be evaluated.<sup>217</sup> Another set of rules explains that SSA should weigh conflicting medical opinions by primarily considering whether the source of the opinion—typically a physician—examined or treated the claimant, the extent to which medical evidence supports the opinion, and whether the opinion conforms to the rest of the record.<sup>218</sup> In appropriate cases, SSA weighs the medical opinions of specialists more heavily than it does those of general practitioners.<sup>219</sup>

Although these various rules generally apply to all disability determinations, they assume special importance when a conflict emerges between an opinion of the claimant's own doctor, referred to as a "treating physician," and an opinion of an SSA-selected physician

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considered acceptable medical sources for establishing certain specified impairments. *See id.*

<sup>211</sup> *See id.* §§ 404.1513(d), 416.913(d); *see also* *Shontos v. Barnhart*, 328 F.3d 418, 426 (8th Cir. 2003) (finding that the ALJ had erroneously disregarded "other" medical sources in determining the severity of claimant's impairment).

<sup>212</sup> § 404.1520.

<sup>213</sup> 42 U.S.C. § 423(d)(5)(A) (2000); 20 C.F.R. § 404.1512 (2006).

<sup>214</sup> 42 U.S.C. § 423(d) (2000).

<sup>215</sup> *See id.* § 423(d)(5)(A).

<sup>216</sup> *Id.*

<sup>217</sup> Essentially, the rules allow the administrator to make a decision if the medical evidence is consistent and sufficient, inconsistent but sufficient after weighing the inconsistencies, or unavoidably inconsistent and/or incomplete; further development is required where the evidence, consistent or not, is insufficient. *See* 20 C.F.R. §§ 404.1527(c), 416.927(c) (2006).

<sup>218</sup> *Id.* §§ 404.1527(d), 416.927(d).

<sup>219</sup> *See id.* §§ 404.1527(d)(5), 416.927(d)(5); *see also* *Hensley v. Barnhart*, 352 F.3d 353, 356 (8th Cir. 2003) (discounting the opinions of two treating physicians).

hired to perform a consultative examination and to evaluate the extent of the claimant's disability.<sup>220</sup> The DDS medical consultant, who reviews the medical record but does not observe the claimant, may have yet a different opinion. The guidance that these rules provide on how to weigh different sources of medical opinion can be critical for an individual disability claim. Indeed, SSA promulgated the current rules following years of litigation during which courts regularly found that SSA, through DDS staff and the decisions of ALJs, did not give appropriate weight to opinions of treating physicians, as compared to those of consulting physicians and medical consultants.<sup>221</sup>

The regulations set out rules of preference and, in certain circumstances, conclusive authority regarding the weight SSA should accord the opinions of treating physicians.<sup>222</sup> Specifically, a treating physician's opinion concerning the nature and severity of a claimant's medical condition is given "controlling" weight if the opinion "is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] case record."<sup>223</sup> If it does not give the opinion controlling weight, SSA evaluates the opinions of treating physicians according to the weighing factors mentioned above, which emphasize both examination of the claimant and a treatment relationship between the physician and the claimant.<sup>224</sup> The net result of the rules, therefore, is that SSA usually accords the greatest weight, even if not controlling weight, to the opinions of treating physicians, followed next by opin-

<sup>220</sup> 42 U.S.C. § 423(d)(5)(B) (2000).

<sup>221</sup> One of the leading cases in this area is *Stieberger v. Bowen*, 801 F.2d 29 (2d Cir. 1986). See also *Coffman v. Bowen*, 829 F.2d 514 (4th Cir. 1987) (reversing the ALJ's denial of benefits for, *inter alia*, prematurely dismissing treating physician's conclusions); *Sprague v. Bowen*, 812 F.2d 1226 (9th Cir. 1987) (holding that SSA may disregard treating physician's testimony only if SSA could set forth specific, legitimate reasons based on substantial evidence for doing so). For a discussion of the history of SSA disability determinations and the treating physician rule, see Rachel Schneider, Note, *A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. CHI. L. SCH. ROUND-TABLE 391 (1996).

<sup>222</sup> 20 C.F.R. § 718.104(d) (2006).

<sup>223</sup> *Id.* §§ 404.1527(d)(2), 416.927(d)(2). In addition, the following directive was inserted into the Act at the high point of the treating-physician litigation:

In making any [disability] determination the Commissioner of Social Security shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.

42 U.S.C. § 423(d)(5)(B) (2000). Although stated in terms of obtaining evidence, as opposed to weighing opinions, the directive nonetheless strongly reflects that treating physicians are the preferred sources of medical proof.

<sup>224</sup> 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2) (2006).

ions of consulting physicians, and then finally those of medical consultants.<sup>225</sup>

4. *SSA's New Federal Medical and Vocational Expert System and Institute of Medicine Study on Use of Medical Expertise*

The final rules that SSA recently published, which outline comprehensive revisions of the disability determination process, include the creation of a new federal Medical and Vocational Expert System (MVES) that will oversee a national network of medical, psychological, and vocational experts.<sup>226</sup> State DDS examiners and newly established federal "reviewing officials," who will take charge of disability claim files between the DDS decision and an ALJ hearing, can access these experts.<sup>227</sup> In a significant break from past practices, the MVES will consist of medical personnel with federally prescribed qualifications and training.<sup>228</sup> While developing the details of the new rules, SSA commissioned IOM to make recommendations on how its use of medical expertise could be improved.<sup>229</sup> SSA has indicated that it may make further decisions in the future that take into account IOM recommendations regarding the qualifications and the categories of medical experts on which it will rely.<sup>230</sup> IOM submitted an interim report of this project in late 2005 that proposed board certification for

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<sup>225</sup> See *id.* §§ 404.1527(d)(1), 416.927(d)(1) ("Generally, we give more weight to the opinion of a source who has examined [the claimant] than to the opinion of a source who has not examined [the claimant]."). Opinions of treating physicians are generally entitled to greater weight than the opinions of consulting physicians; treating physicians have had more personal contact with the claimant over a longer period and their opinions have independent professional credibility because they were formed during the course of providing treatment. See, e.g., *Lewis v. Callahan*, 125 F.3d 1436, 1440 (11th Cir. 1997) (stating that treating sources are most able to provide a detailed, longitudinal picture of claimant's medical condition that cannot be obtained from objective medical findings alone or from reports of consultative examinations or brief hospitalizations (citing 20 C.F.R. § 404.1527(d)(2) (1997))); *Lester v. Chater*, 81 F.3d 821, 833 (9th Cir. 1995) ("The treating physician's continuing relationship with [a] claimant makes him especially qualified to evaluate reports from examining doctors, to integrate the medical information they provide, and to form an overall conclusion as to [a claimant's] functional capacities and limitations . . . ."); cf. *Ward v. Chater*, 924 F. Supp. 53, 56 (W.D. Va. 1996) (holding that substantial evidence supported the ALJ's rejection of a treating physician's assessment of claimant's ability to work given that the physician's treatment notes did not confirm his otherwise unexplained conclusion that claimant could lift ten pounds only occasionally).

<sup>226</sup> See *Administrative Review Process for Adjudicating Initial Disability Claims*, 71 Fed. Reg. 16,424, 16,427 (Mar. 31, 2006).

<sup>227</sup> See *id.* at 16,431–32. The rules also create the new position of federal reviewing officials. See *id.* at 16,427. The role of the new reviewing official is discussed in Bloch, Lubbers & Verkuil, *supra* note 122.

<sup>228</sup> See 71 Fed. Reg. at 16,431–32.

<sup>229</sup> See *id.* at 16,431; IOM INTERIM REPORT, *supra* note 168, at 2.

<sup>230</sup> See 71 Fed. Reg. at 16,431–32.

most medical experts used by SSA and set out various options for training.<sup>231</sup>

### III

#### FOCUSING ON MEDICAL PROOF: THE PROBLEM OF MASKING SOCIAL POLICY

The Act's medical causation requirement plays a critical role in the disability determination process by forcing a focus on medical proof of disability.<sup>232</sup> The Act's medically centered definition of disability gives its disability programs a measure of scientific objectivity. SSA therefore rigorously enforces the requirement of medical proof of an underlying impairment to qualify for DI or SSI disability benefits, both in its regulations and in practice.<sup>233</sup> Nonetheless, SSA has been unable to direct its medical proof requirements toward improving disability decision making, despite other significant controls on the type of proof required to establish qualifying disability. Long delays in reaching decisions and high rates of appeals have kept SSA under pressure over the years to refine its use of medicine and medical expertise in the disability determination process.<sup>234</sup> As SSA moves forward with recent procedural reforms, including those reforms in areas to be addressed by the IOM report, SSA seems to be looking for ways to increase the role of medical guidelines and medical proof. However, as we have seen, medical guidelines and medical proof have their limits. The problem appears to be that acknowledging those limits seems tantamount to facing an insurmountable void: If we cannot rely on medical science and medical expertise to determine disability, how else can we improve the process?

#### A. Matching Definition and Policy

In some respects, the current Social Security disability standard—the inability to engage in substantial gainful activity as the result of a medically determinable physical or mental impairment—remains as elusive today as it was when the disability freeze legislation first intro-

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<sup>231</sup> See IOM INTERIM REPORT, *supra* note 168, at 37-5126-53. The final report will not be completed before the end of 2006.

<sup>232</sup> See 42 U.S.C. § 423(d)(5)(a) (2000).

<sup>233</sup> See 20 C.F.R. §§ 404.1508, 416.908 (2006).

<sup>234</sup> The U.S. General Accounting Office has been a leader in this regard. See generally U.S. GEN. ACCOUNTING OFFICE, SOCIAL SECURITY DISABILITY: DISAPPOINTING RESULTS FROM SSA'S EFFORTS TO IMPROVE THE DISABILITY CLAIMS PROCESS WARRANT IMMEDIATE ATTENTION (2002), available at <http://www.gao.gov/new.items/d02322.pdf> (reviewing the limited success of various initiatives to improve the disability claims process); U.S. GEN. ACCOUNTING OFFICE, SOCIAL SECURITY ADMINISTRATION: MORE EFFORT NEEDED TO ASSESS CONSISTENCY OF DISABILITY DECISIONS (2004), available at <http://www.gao.gov/new.items/d04656.pdf> (examining the implementation of methods to improve the quality and consistency of disability adjudication).

duced it in 1954.<sup>235</sup> Its two key components, medical causation<sup>236</sup> and severity,<sup>237</sup> create a tension in the disability determination process that can confuse the relationship between the medical dimensions and the social policy goals of the Act's DI and SSI disability programs. Congress has amended the Act numerous times to clarify the definition of disability for purposes of DI and SSI disability benefit eligibility;<sup>238</sup> in doing so, it has also refined the social policy objectives of those programs. Correspondingly, SSA has revised its regulations that implement the statutory standard and its own definition of disability, including the various guidelines, listings, and standards that SSA uses to grant or deny individual claims for DI and SSI disability benefits.<sup>239</sup>

The challenge for SSA is to develop rules and practices for disability determinations that link these two components of the statutory disability standard and to reach disability determinations consistent with the broad social policies of the Act. SSA regulations implementing two of the amendments discussed above, the 1967 amendments clarifying the role of vocational factors<sup>240</sup> and the 1984 amendments on pain-based disability,<sup>241</sup> illustrate the importance of this effort.<sup>242</sup>

The 1967 amendments addressed conflicting interpretations of the meaning of the severity requirement between some courts of appeals and SSA. This conflict stemmed from ambiguity left by Congress as to a major policy issue regarding the disability standard ambiguous in the original DI legislation. The central issue was whether SSA should determine being "unable to engage in substantial gainful activity" in relation to the claimant's medical condition alone—a reasonable construction of the medical causation requirement—or whether the focus of disability determination would expand

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<sup>235</sup> Social Security Amendments of 1954, ch. 1206, sec. 106, §§ 213–216, 68 Stat. 1052, 1079–81 (1954) (codified as amended at 42 U.S.C. §§ 413–416 (2000)).

<sup>236</sup> See 42 U.S.C. §§ 423(d)(1)(A), 1382c(a)(3)(A) (2000); see also *supra* note 78 and accompanying text.

<sup>237</sup> See 42 U.S.C. §§ 423(d)(1)(A), 1382c(a)(3)(A) (2000); see also *supra* note 76 and accompanying text.

<sup>238</sup> See *supra* notes 92–93, 105–06, 118 and accompanying text.

<sup>239</sup> See, e.g., Supplemental Security Income; Determining Disability for a Child Under Age 18; Interim Final Rules with Request for Comments, 62 Fed. Reg. 6,408, 6,421 (Feb. 11, 1997) (implementing the 1996 amendments); Disability Insurance and Supplemental Security Income; Determining Disability and Blindness; Multiple Impairments, 50 Fed. Reg. 8,726, 8,728 (Mar. 5, 1985) (implementing the 1984 amendments).

<sup>240</sup> See Social Security Amendments of 1967, Pub. L. No. 90-248, sec. 158, § 223(d)(2)(A), 81 Stat. 821, 868 (codified as amended at 42 U.S.C. §§ 423(d)(2)(A), 1382c(a)(3)(B) (2000)).

<sup>241</sup> See Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, sec. 3, § 223(d)(5), 98 Stat. 1794, 1799 (codified as amended at 42 U.S.C. § 423(d)(5)(A) (2000)).

<sup>242</sup> See 20 C.F.R. §§ 404.1529, 404.1560 (2006) (implementing the pain-based disability determinations); *id.* §§ 404.1520(a)(4)(v), 416.920(a)(4)(v) (implementing the medical-vocational standard).

beyond medical capacity to include the claimant's actual ability to obtain gainful employment.<sup>243</sup> Congress effectively merged the two approaches by rewriting the severity requirement; as a result, a claimant must be unable to perform not only his or her prior work, but also any other substantially gainful work that exists in the national economy.<sup>244</sup> Congress did this, however, without undercutting the basic medical causality requirement and the predominant importance of medical assessments. Although SSA must take into account a claimant's age, level of education, and relevant work experience, some form of medically determinable impairment must be the cause of any inability to perform basic work activity.<sup>245</sup>

By contrast, the pain provisions of the 1984 amendments focused directly on the need for medical proof of disability. The issue was not whether pain could be severe enough to preclude substantial gainful activity, but rather how SSA should apply the medical causation requirement to claims based on pain.<sup>246</sup> The current statutory standard for claims based on pain and the regulations implementing that standard—first identify a physical or mental impairment that could reasonably be expected to produce the degree of pain alleged and then establish the existence of that degree of pain and show how it precludes one from engaging in substantial gainful activity—reflects the proper balance between medical and vocational proof called for in Social Security disability determinations. We must know that a person receiving disability benefits based on pain has a legitimate claim for public support, which in this case means a medically determinable impairment causing his or her pain; however, we cannot be certain that the pain is severe enough to preclude gainful activity.<sup>247</sup> Moreover, the two-part evaluation for pain-based disability claims mandated by

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<sup>243</sup> See S. REP. NO. 90-744, at 46-49 (1967); see also *supra* notes 92-96 and accompanying text.

<sup>244</sup> See sec. 158, § 223(d)(2)(A), 81 Stat. at 868. For a more thorough discussion, see *supra* text accompanying notes 92-96.

<sup>245</sup> As explained in both the Senate and House Reports accompanying the 1967 amendments:

The bill would provide that . . . an individual would be disabled only if it is shown that he has a severe medically determinable physical or mental impairment or impairments; that if, despite his impairment or impairments, an individual still can do his previous work, he is not under a disability; and that if, considering the severity of his impairment together with his age, education, and experience, he has the ability to engage in some other type of substantial gainful work that exists in the national economy even though he can no longer do his previous work, he also is not under a disability . . .

S. REP. NO. 90-744, at 48-49 (1967); see also H.R. REP. NO. 544, at 30 (1967).

<sup>246</sup> See *supra* text accompanying notes 104-08.

<sup>247</sup> Cf. Liebman, *supra* note 60, at 844 ("The central difficulty with the medical disability requirement has been that persons with indistinguishable physical ailments report differing degrees of physical limitation or pain, and differ as well in the extent to which they modify their behavior.")

SSA regulations distinguishes not merely causation from severity but also medical proof—required for causation—from all other proof—allowed for severity.<sup>248</sup> Thus, a typical case will involve serious medical proof of the underlying impairment, including the extent to which it might reasonably be expected to cause pain, supplemented by a wide range of nonmedical proof regarding the manner in which the impairment limits the claimant's ability to work.

The third amendment discussed above, the 1996 revision of the disability definition for child SSI claims,<sup>249</sup> illustrates the danger of following a formula without examining its applicability. Here again, Congress retained the causality requirement while modifying the severity requirement.<sup>250</sup> The problem is that medical causality, originally incorporated into the SSI child disability benefits program without any particular rationale, does not fit particularly well with the new “functional limitations” concept behind the program's new severity requirement.<sup>251</sup> Instead of creating a unique approach for child disability claims, Congress and SSA have reverted to relying on the medically focused criteria in the Listing. This is tempered, at least, by the option of showing “functional equivalence” supported by a wider range of evidence, including nonmedical proof. This elevates the medical aspect of the disability standard beyond its proper gate-keeping role and has resulted in a stilted set of regulations that try to tie eligibility to the Listing. As a result, it is more difficult than it should be for SSA to evaluate the substantial nonmedical aspects of functional loss that should drive a disability benefit program for children.<sup>252</sup>

#### B. Accuracy, Consistency, and Fairness: The Role of Medical Expertise

The medical causation requirement is a permanent and reasonable fixture in Social Security disability law that creates the unquestionable need for medical expertise in the disability determination process. If disability could be defined based on medical criteria alone, the role of medical expertise would be simple to state: develop an accurate, consistent, and fair set of criteria that match the social policy

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<sup>248</sup> 20 C.F.R. §§ 404.1529(b)–(c), 416.929(b)–(c) (2006); *see also supra* text accompanying note 108.

<sup>249</sup> *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, sec. 211(a), § 1614(a)(3), 110 Stat. 2105, 2188 (codified at 42 U.S.C. 1382c(a)(3) (2000)).

<sup>250</sup> *See supra* text accompanying notes 118–19.

<sup>251</sup> *See* sec. 211(a), § 1614(a)(3), 110 Stat. at 2188.

<sup>252</sup> This point is developed in Bloch, *supra* note 72, at 82–93.



goals of the program.<sup>253</sup> Because it is not and cannot be so defined, the quest for accuracy, consistency, and fairness in DI and SSI disability decisions must include properly managing the use of medical expertise in the disability determination process.

The full medical-vocational definition of disability set forth in the Act and SSA regulations is far too complex to be implemented without a proper framework. As explained above, the sequential evaluation process provides such a framework throughout SSA's administrative process, which carries over to judicial decisions as well.<sup>254</sup> Although not itself a substantive rule, the sequential evaluation process serves to frame the critical issues involved in determining disability for particular claims. The medical causation requirement is addressed at Step 2; as a result, any claim that proceeds past this step has established a medically determinable physical or mental impairment with competent medical proof.<sup>255</sup> The last three steps address the severity requirement, but the importance of medical proof and the extent of medical expertise needed can be quite different, depending on the step at which a particular claim is resolved.<sup>256</sup> The sequential evaluation process, in turn, relies at two critical steps on two other SSA guides for disability assessment: the Listing of Impairments at Step 3 and the "grids" included in the Medical-Vocational Guidelines at Step 5.<sup>257</sup>

The Listing can claim legitimacy largely from its reliance on medical expertise. Most importantly, SSA uses medical experts to create the individual listings in the Listing and their accompanying medical criteria.<sup>258</sup> These individual listings and the findings required to "meet" a listing effectively merge the medical causation and severity requirement aspects of the statutory disability standard by controlling the decision that a claimant is disabled within the meaning of the Act, but only for claims that are granted at Step 3 of the sequential evaluation process.<sup>259</sup>

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<sup>253</sup> Whether this could be achieved is another matter altogether. The Listing of Impairments presents a limited context for examining this question, which may be addressed in a forthcoming IOM report that SSA commissioned. See *supra* note 168 and accompanying text.

<sup>254</sup> See *supra* Part II.A.1.

<sup>255</sup> See *supra* notes 141–43 and accompanying text.

<sup>256</sup> Thus, a disability finding may turn on a claimant's ability to perform particular tasks at a recent job, the transferability of skills used in one job to another, the number of pounds the claimant can lift, or the results of a specified laboratory test.

<sup>257</sup> See *supra* text accompanying notes 154–60 and 177–82.

<sup>258</sup> Medical experts, of course, also help determine whether the impairments of an individual claimant meet or equal the requirement of a particular listing. When performing this role, however, their expertise does not implicate directly the definition of disability.

<sup>259</sup> Moreover, SSA must evaluate a claim that reaches Step 3 of the sequential evaluation process under the Listing and must find the claimant eligible for benefits if the rele-

The fact that SSA awards benefits at Step 3—and only at Step 3—based on a fully medical definition of disability is a critical point relative to the significance of the medical definition of disability, as well as the proper use of medical expertise in determining disability for purposes of DI and SSI disability benefits. Remember that the severity requirement for individual listings not only is stricter than “any substantial gainful activity,” but also excludes a claimant’s vocational qualifications from consideration.<sup>260</sup> As a result, persons classified as disabled according to the Listing are *more than* disabled according to the *statutory* standard. In other words, medical criteria alone can define who is disabled at Step 3 because the Listing does not purport to define who is entitled to disability benefits as contemplated in the Act.<sup>261</sup> However, when the inquiry must go further to determine whether a claimant is disabled according to the statutory definition, medical criteria alone cannot suffice.

Similarly, the grids included in the Guidelines effectively define disability—and nondisability—for certain claims at Step 5 of the sequential evaluation process.<sup>262</sup> The criteria used in the grids appear to be more vocational than medical because most of the variables in the grids used to determine disability address vocational qualifications.<sup>263</sup> However, for a significant number of claims, the vocational criteria are not in dispute.<sup>264</sup> In those cases, the disability finding turns on the claimant’s RFC, which, in turn, requires medical proof.<sup>265</sup> The medical role here is far more limited than with the List-

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vant Listing criteria are met. See 20 C.F.R. §§ 404.1520(a)(4)(iii), 416.920(a)(4)(iii) (2006). This remains true even though SSA could determine that the claimant was not disabled if the evaluation could continue through the last two steps of the sequential evaluation process. See *id.* For example, SSA must find a claimant with an impairment that meets the requirements of a listing disabled, even if the evidence shows that the claimant would be able to perform past relevant work and therefore be ineligible for benefits at Step 4. See *Ambers v. Heckler*, 736 F.2d 1467, 1470 (11th Cir. 1984) (“Consideration of the fact that [the claimant] could return to her past work is not a relevant inquiry once she met the Listing . . . .”); see also *Berryman v. Massanari*, 170 F. Supp. 2d 1180, 1185 (N.D. Ala. 2001); *Williams v. Apfel*, 73 F. Supp. 2d 1325, 1341 (M.D. Fla. 1999).

<sup>260</sup> See *supra* text accompanying notes 172–75.

<sup>261</sup> This point is developed further in the context of “false positives” and “false negatives” *infra* at text accompanying notes 268–73.

<sup>262</sup> See *supra* text accompanying note 182.

<sup>263</sup> See *supra* notes 177–82 and accompanying text.

<sup>264</sup> The most common disputes concerning vocational variables involve the level and transferability of skills. See, e.g., *Burnett v. Comm’r of Soc. Sec. Admin.*, 220 F.3d 112, 126 (3d Cir. 2000) (“Although [the claimant’s] age and education level are undisputed, from the record we cannot be confident that [she] possess [sic] no skills or is not semi-skilled with transferable skills.”). See generally 20 C.F.R. §§ 404.1568(d), 416.968(d) (2006) (describing how it is determined what skills can be transferred to another job and the degree of transferability).

<sup>265</sup> See *supra* note 146 and accompanying text. Medical proof of limitations caused by medically determinable impairments is considered in making RFC assessments. See 20 C.F.R. §§ 404.1545(a), 416.945(a) (2006). Moreover, the claimant’s RFC capacity is based

ing criteria, however, because any decision based on a claimant's RFC level is conditioned by the vocational variables in each of the RFC-defined grids.<sup>266</sup>

### C. The Problem of "False Positives" and "False Negatives"

The question of whether someone is disabled and therefore unable to work involves many highly personal and subjective aspects. Therefore, in attempting to reach the "correct" determination, the question arises as to whether it is even possible to ascertain the answer. Looking specifically at determining disability for purposes of Social Security benefits, we have seen that the statutory definition raises two different questions. The first question is the easy one, at least in terms of getting it right: Does the claimant have a medically determinable physical or mental impairment?<sup>267</sup> In answering this question, medicine and medical expertise play an important and unambiguous role. The second question is one that we are not going to get right all the time, especially not in close cases, even if a right decision could be distinguished from a wrong one: Does the claimant's impairment preclude him or her from engaging in substantial gainful activity?<sup>268</sup> Although medicine and medical expertise still have a role to play, it is only a modest one given all of the factors that one must consider, including the claimant's age, level of education, and work experience.<sup>269</sup> Indeed, the whole enterprise of deciding whether someone is disabled must be looked at modestly. As Professor Jerry L. Mashaw has pointed out, acknowledging that we will not know for sure if close cases are decided rightly or wrongly may be the best we can do.<sup>270</sup>

The problem of uncertainty in disability determinations also arises with respect to the various listings and guidelines discussed above. For example, what is a correct decision on presumptive disability? Certainly, it is not whether the claimant is, in fact, eligible for SSI disability benefits, let alone whether the claimant is "disabled." Presumptive disability is tied to a broader set of social policy considera-

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on the consideration of the claimant's "symptoms (such as pain), signs, and laboratory findings together with other evidence . . . obtain[ed]." *Id.* at pt. 404, subpt. P, app. 2 § 200.00(c).

<sup>266</sup> For example, for a claimant with certain vocational characteristics, the critical proof can be whether, as the result of a medically determined physical or mental impairment, he or she is able to lift a maximum of ten pounds at one time, or lift or carry light objects occasionally. *See id.* §§ 404.1567(a), 416.967(a) (defining RFC sedentary work classification).

<sup>267</sup> *See supra* text accompanying notes 8 and 55.

<sup>268</sup> *See supra* notes 68–77 and accompanying text.

<sup>269</sup> *See supra* note 175 and accompanying text.

<sup>270</sup> *See* Jerry L. Mashaw, *How Much of What Quality? A Comment on Conscientious Procedural Design*, 65 CORNELL L. REV. 823, 828 (1980); *see also* JERRY L. MASHAW, BUREAUCRATIC JUSTICE 23–34 (1983).

tions than simple eligibility for disability benefits, as reflected by the fact that presumptive-disability findings and the early payments that go with them are offered only in the public assistance program. As a result, medical expertise can play only a limited role in setting the criteria for determining who is presumptively disabled. This is why IOM declined to recommend eligibility criteria in this context.<sup>271</sup> Moreover, IOM noted in the course of its recommendations that presumptive eligibility for SSI benefits could be justified for a variety of different medically related reasons where the selection criteria would not call for particular medical expertise.<sup>272</sup>

As noted earlier, SSA has commissioned the IOM to conduct a study and offer recommendations on its use of the Listing of Impairments.<sup>273</sup> In that context, the same question arises: What is a correct decision based on the Listing? Notably, unlike presumptive disability, a finding of disability based on the Listing results in an award of full benefits,<sup>274</sup> and therefore the claimant must qualify as disabled according to the statutory standard. Indeed, to establish eligibility for benefits through the Listing, the claimant must meet the higher severity standard of “prevent[ing] an individual from doing any gainful activity.”<sup>275</sup> Even under this standard, however, a finding that a claimant is disabled does not mean that the claimant, in fact, cannot work. Thus, the fact that someone eligible for DI or SSI can still work does not mean that the decision to grant benefits was not “right.”<sup>276</sup>

The medical-proof-only criteria in the Listing are not intended to implement the statutory definition of disability as such. They are an administrative tool, which is why disability decisions under the Listing are limited correctly to a screening-in role at Step 3 of the sequential evaluation process. The medically based severity requirement of the

<sup>271</sup> See IOM INTERIM REPORT, *supra* note 168, at 58.

<sup>272</sup> See *supra* notes 195–97; see also IOM INTERIM REPORT, *supra* note 168, at 60–61 (noting that other options include when the claimant’s condition is worsening, when the claimant does not have funds for—or access to—treatment that could keep the condition from worsening, or when the claimant’s condition is so serious that granting benefits presumptively is warranted even though there is a significant chance that full eligibility is likely not to be established).

<sup>273</sup> See Administrative Review Process for Adjudicating Initial Disability Claims, 71 Fed. Reg. 16,424, 16,431 (Mar. 31, 2006); IOM INTERIM REPORT, *supra* note 168.

<sup>274</sup> See *supra* note 143 and accompanying text.

<sup>275</sup> See *supra* note 155 and accompanying text.

<sup>276</sup> As Professor Liebman has observed:

The obvious rightness of the Secretary’s per se rules for total disability—automatic qualification for a person who has lost both arms, for example—also suggests that our definition of disability incorporates common expectations and shared values about what infirmities a person *ought* not to have to bear and keep working. As to persons so disabled, we say, in essence, “No one expects you to work any longer. If this happens to you, you can stop work and receive Social Security benefits.”

Liebman, *supra* note 60, at 853.

Listing is used to separate out those cases where the claimant's medical impairments warrant stopping the disability determination process short of addressing the statutory standard.<sup>277</sup> If the medical facts are not strong enough, the claim is not denied. The evaluation proceeds by relaxing the hold of medical proof and facing the statutory disability standard directly, which incorporates nonmedical criteria and contemplates nonmedical proof.<sup>278</sup>

The Act's medical-vocational disability standard is defined by a complex set of rules, regulations, and practices intended to structure the disability determination process in a way that will facilitate deciding who is eligible for DI and SSI benefits. Much of this effort has been directed at setting standards for classifying and weighing medical proof because these standards are needed to assure compliance with the medical causation requirement of the disability standard. In addition, these standards can also help direct the use of medical proof in determining eligibility according to the full statutory definition of disability. However, SSA should be careful because it seems at times to be tempted to give medicine a larger role than warranted in implementing a medically centered—but not medically based—definition of disability. Instead, SSA should recognize both the value and limits of medical input at particular stages in the process, such as granting benefits at Step 3 of the sequential evaluation process, and design a supporting role for medical criteria and its cadre of medical experts with respect to the rest of the disability determination process.

#### CONCLUSION

The disability benefit programs are relative newcomers to the Social Security Act. These programs overcame substantial resistance to their inclusion as both social insurance and public assistance at the time Congress passed the Act in 1935 and for twenty years thereafter. Among the key concerns was fear that such programs would quickly grow out of control due, in substantial part, to doubt as to the ability of lawmakers and administrators to define and determine disability. To address these concerns, Congress wrote a medical causality requirement into the original statutory disability standard, which remains in place today for both DI and SSI disability benefits. Over the years, although both Congress and SSA have rethought who can qualify for benefits and how they can prove eligibility, the requirement that a claimant's inability to work must "result from a medically determinable physical or mental impairment" remains unchanged.

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<sup>277</sup> See *supra* note 68 and accompanying text.

<sup>278</sup> See *supra* Part II.A.2.

Properly understood, medical causation is a threshold requirement; a *sine qua non* that exists alongside a more complex severity requirement that seeks to distinguish among medically determinable impairments to arrive at those that entitle a claimant to benefits. SSA—sometimes on its own and sometimes prompted or pushed by Congress and the courts—has produced a series of rules, guidelines, and practices that for the most part recognize this important but limited role of medicine and medical expertise in defining and determining disability. For example, its rules on pain-based disability, “acceptable” medical sources for diagnosis of underlying impairments, and weighing the opinions of “treating physicians” all allow the agency to control proof of medical causality without restricting the flow of nonmedical evidence of severity.

SSA is on the threshold of a new era in disability determination. In 2006, SSA unveiled and began to implement its new “Disability Service Improvement” process. As part of this process, SSA plans to establish firm federal control over the qualifications and use of medical experts by creating a new Medical and Vocational Expert System (MVES). SSA is also seeking the guidance of the IOM in reviewing and revising its Listing of Impairments.

SSA is to be commended for seeking to assure the use of good medicine and competent medical expertise as a key to improving its disability determination process. However, the use of good medicine and medical expertise are only the means to an end. Projects such as the MVES and the use of exclusively medical guidelines such as the Listing must not serve to inflate the medical component of Social Security disability determinations. As we have seen, the Act has a medically centered, not medically based, definition of disability. The proper role of medicine and medical expertise in the administration of the Act’s disability benefit programs must be to reach policy-centered, not necessarily medically centered, disability decisions.