	Single	Single	Married	Married	Married
Total income (including Social Security)	$31,000	$35,000	$38,000	$50,000	$80,000
Social Security benefits	12,000	7,000	12,000	12,000	18,000
Amount of taxable benefits	0	3,250	0	6,000	15,300
Percent of benefit taxable	0	46	0	50	85
Income tax liability on all benefits taxable	0	488	0	900	2,750

DISABILITY DETERMINATION AND THE CLAIMS PROCESS

The Claims Process

The Social Security claims process is a complex multilayered structure that is inextricably linked with the disability determination process. Application for disability benefits is made at the Social Security field office where the applicant is interviewed and the sources of medical evidence are recorded. After determining whether the applicant meets the insured status requirements, the SSA field office sends the case to the State Disability Determination Service (DDS), which makes the initial determination of disability. If an applicant or beneficiary is dissatisfied with an initial denial or termination of disability benefits by the DDS, she can request a reconsideration within 60 days of receipt of the notice of denial. The reconsideration on the disability claim is carried out by DDS by personnel other than those who made the initial determination.

An applicant denied benefits at the reconsideration stage may request a hearing before an administrative law judge (ALJ) in SSA's Office of Hearings and Appeals, provided he files a request for a hearing within 60 days of receipt of the notice of denial. If the claim is denied by the ALJ, the applicant has 60 days to request review by the Appeals Council. The Appeals Council is a 24-member body located in the Office of Hearings and Appeals. The Appeals Council may also, on its own motion, review a decision within 60 days of the ALJ's decision. The 1980 disability amendments required the Appeals Council to review a percentage of ALJ hearing decisions.

The Appeals Council may affirm, modify, or reverse the decision of the ALJ, or may remand it to the ALJ for further development. The applicant is notified in writing of the final action of the Appeals Council and his right to obtain further review by commencing a civil action within 60 days in a U.S. District Court.

Under current law, as amended by the 1984 Disability Benefits Reform Act, disability insurance (DI) beneficiaries whose benefits have been terminated because of recovery or improvement in the medical condition that was the basis for the disability have the opportunity to receive a hearing at the reconsideration stage and can elect to continue to receive disability and Medicare benefits through the ALJ hearing stage of the appeals process, subject to repayment if the individual is

ultimately found not disabled.

Chart 1-2 shows the number of cases allowed and appealed at various decision levels for claim applications and continuing disability reviews (CDRs) processed by State agencies. Table 1-43 presents information for fiscal years 1980-2002 on the number of cases that were reviewed and reversed at the ALJ level. Table 1-44 presents information on the number of CDRs that were conducted in fiscal years 1977-2001 on DI cases. Due to an unprecedented increase in initial claims, the number of CDRs processed declined sharply in the early 1990s. National implementation of a new review process in 1993 has enabled the Social Security Administration to increase the number of CDRs significantly.

State agencies, which are 100 percent Federally funded, generally make disability decisions. These agencies agree to make such determinations, and in doing so to substantially comply with the regulations of the Commissioner that specify performance standards, administrative requirements, and procedures to be followed in performing the disability determination function.

The law authorizes the Commissioner to terminate State administration and assume responsibility for making disability determinations when a State DDS is substantially failing to make determinations consistent with regulations. The law also allows for termination by the State.

Claims are determined on a sequential basis. The first step is to determine whether the individual is engaging in SGA. Under current regulations, in most cases if a nonblind person is earning more than $810 a month (net of impairment-related work expenses) in 2004, he will be considered to be engaging in SGA. In the case of blind individuals, SGA is $1,350 a month in 2004. If it is determined that the individual is engaging in SGA, a decision is made that she is not disabled without considering medical factors. If an individual is found not to be engaging in SGA, the severity and duration of the impairment are explored. If the impairment is determined to be "not severe" (i.e., it does not significantly limit the individual's capacity to perform basic work activities), the individual's disability claim is denied. If the impairment is "severe," a determination is made as to whether the impairment "meets" or "equals" the medical listings published in regulations by SSA,[4] and whether it will last for 12 months. If the impairment neither "meets" nor "equals" the listing (which would result in an allowance), but meets the 12-month duration rule, the individual's residual functional capacity (what an individual still can do despite his limitations) and the physical and mental demands of past relevant work must be evaluated. If the impairment does not prevent the individual from meeting the demands of past relevant work, benefits are denied. If the impairment does, then it must be determined whether the impairment prevents other work.

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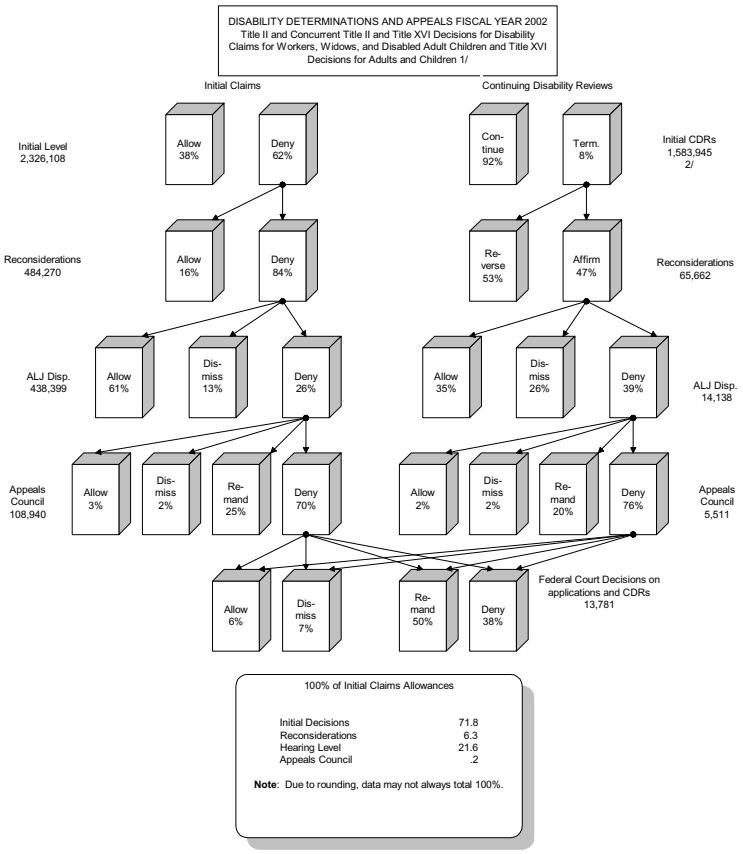
[4] The listing of impairments contains over 100 examples of medical conditions that are considered significant enough to prevent an individual from engaging in SGA. Each listing describes a degree of severity such that an individual who is not working, and has such an impairment, is considered unable to work by reason of the medical impairment. The listing describes specific medically acceptable clinical and laboratory findings and signs which establish the severity of the impairments. An impairment or combination of impairments is said to "equal the listings" if the medical findings for the impairment are at least equivalent in severity and duration to the findings of a listed impairment.

CHART 1-2—DISABILITY DETERMINATIONS AND APPEALS, FISCAL YEAR 2002



1/ Includes all Title II and Title XVI disability determinations. The data relate to workloads processed (but not necessarily received) in fiscal year 2002, i.e., the cases processed at each adjudicative level may include cases received at one or more of the lower adjudicative levels prior to FY 2002. A revised process was introduced 10/1/99 in 10 States, under which initial denials could be appealed directly to OHA without a reconsideration.

2/ Includes non-State CDR mailer continuations. Also includes 24,389 CDRs where there was "no decision." The continuance and termination rates are computed without the "no decision" cases.

Source: Office of Disability Programs, February 2003

At this stage in the adjudication process, because of a court decision and subsequent administrative and legislative ratification of this decision, the burden of proof switches to the government to show that the individual can, considering her impairment, age, education, and work experience, engage in some other kind of SGA that exists in the national economy. Such work does not have to exist in the immediate area in which he lives, and a specific job vacancy does not have to be available to him. Work in the national economy is defined in statute as work which

exists in significant numbers either in the region where such individual lives or in several regions of the country.

SSA has developed a vocational "grid" designed to reduce the subjectivity and lack of uniformity in applying the vocational factor. Through a formula, the grid regulations relate certain worker characteristics such as age, education, and past work experience to the individual's residual functional capacity to perform work-related physical and mental activities. If the applicant has a particular level of residual work capability--characterized by the terms sedentary, light, medium, heavy and very heavy--an automatic finding of "disabled" or "not disabled" is required when such capability is applied to various combinations of age, education, and work experience.

The Commissioner must review 50 percent of the disability allowances and a sufficient number of other determinations to ensure a high degree of accuracy. The Commissioner may also, on her own initiative, review any determination by a DDS.

The 1980 disability amendments required that, at least once every 3 years, the Social Security Administration reexamine every individual on the rolls who is determined to be non-permanently disabled. Where there is a finding of permanent disability, the Commissioner may reexamine the individual at such times as are determined to be appropriate. These reviews are in addition to the administrative eligibility review procedures existing before the 1980 amendments. Effective in 2001, these reviews cannot begin while an individual is "using a ticket" as defined by the Commissioner (see "Changes in the 106th Congress" below).

The 1984 Disability Benefits Reform Act required that in continuing eligibility review cases, benefits may be terminated only if the Commissioner finds that there has been medical improvement in the person's condition and that the individual is now able to engage in SGA.

Individuals are not considered to be disabled unless they furnish such medical and other evidence as the Commissioner may require. The Commissioner will generally reimburse physicians or hospitals for supplying medical evidence in support of claims for DI benefits. The Commissioner also pays for medical examinations that are needed to adjudicate the claim.

Representation and attorneys' fees.--Claimants may appoint an attorney or any other qualified person to serve as their representative in proceedings before SSA. The representative may submit evidence, make statements about facts and law, and make any request or give any notice concerning the proceedings. The representative may not sign an application on behalf of a claimant for rights or benefits, or testify on the claimant's behalf in any administrative proceeding.

The amount of any fee that an attorney or other person may charge and collect from the claimant for services performed as a representative must be authorized by SSA. SSA has two methods of authorizing fees for representation: fee petition and fee agreement.

Under the fee petition process, representatives must promptly file a fee petition with SSA after completing their services on a claim and send a copy of the fee petition to the claimant. SSA determines the amount of the fee authorized under the fee petition process based on several factors, including, but not limited to, the

extent and type of services the representative performed, the complexity of the case, and the amount of time the representative spent on the case.

Under the fee agreement process, the claimant and representative must file a written agreement with SSA before the date SSA makes a favorable determination or decision on the claim. SSA usually will approve the fee agreement if: (1) it is signed by both the claimant and representative; (2) the fee specified in the agreement does not exceed the lesser of 25 percent of the past-due benefits or $5,300 for fee agreements approved on or after February 1, 2002 (for fee agreements approved before that date, the maximum dollar limit was $4,000); (3) SSA's determination or decision in the claim is fully or partially favorable; and (4) the claim results in past-due benefits.

If the claimant is represented by an attorney and the claim is for Social Security benefits, the SSA may withhold the authorized representation fee out of past-due benefits and pay it directly to the attorney. SSA assumes no responsibility for the payment of any fees if the representative is not an attorney or the claim is for SSI benefits.

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170, signed December 17, 1999) requires the Commissioner to impose an assessment on the attorney's fee to cover SSA's costs of determining and certifying these fees. Effective January 31, 2000, the assessment is set at 6.3 percent of the attorney's fee. For years after 2000, the percentage rate will be set at a level determined by the Commissioner to achieve full recovery of the costs of calculating, withholding, and paying fees from the claimant's past-due benefits, but not in excess of 6.3 percent. The attorney is prohibited from recovering this assessment from the claimant.

Work incentives

The law provides a 45-month period for disabled beneficiaries to test their ability to work without losing their entitlement to all benefits. The period consists of: (1) a "trial work period" (TWP), which allows disabled beneficiaries to work for up to 9 months (within any 60-month period[5] with no effect on their disability or Medicare benefits; followed by (2) a 36-month "extended period of eligibility," of which during the last 33 months cash disability benefits are suspended for any month in which the individual is engaged in SGA.

Medicare coverage continues for 102 months once work activity begins (the duration of the trial work period and the extended period of eligibility, plus an additional 54 months) as long as the individual continues to remain medically disabled. When Medicare entitlement ends because of the individual's work activity, if he is still medically disabled, he may purchase Medicare protection.

If beneficiaries medically recover to the extent that they no longer meet the definition of disability, both disability and Medicare benefits are terminated after 3 months, regardless of the status of the TWP or extended period of eligibility. However, a person who contests this determination may elect to continue to receive

[5] Only one TWP is allowed in any one period of disability. By regulation, earnings of more than $580 a month in 2004 constitute "trial work."

disability benefits (subject to repayment) and Medicare while the appeal is being reviewed.

Return to work and rehabilitation

Public Law 106-170 created a Ticket to Work and Self-Sufficiency Program to help disability beneficiaries access a broader pool of vocational rehabilitation providers to enable them to achieve self-sufficiency. Under this legislation, the Commissioner of Social Security provides tickets to work to disability beneficiaries that can be used as vouchers to obtain employment services, case management, vocational rehabilitation, and support services under an individual work plan from the provider of their choice, including the State vocational rehabilitation agencies. Payments to the providers entering agreements with SSA are based on employment outcomes and long-term results or on a combination of milestones and outcomes, and come from a portion of the benefits forgone by beneficiaries when they return to work. The program is being implemented in selected sites beginning 1 year after enactment, with services available in every State within 4 years of enactment.

Until the Ticket to Work and Self-Sufficiency Program is fully implemented and for States that elect to not participate in this program, provisions remain in effect that allow for reimbursement from the DI Trust Funds to the State vocational rehabilitation agencies for rehabilitation services that result in the beneficiary's performance of SGA for a continuous period of at least 9 months. Such a 9-month period could begin while the individual is under a vocational rehabilitation program and may coincide with the TWP or the individual's waiting period for benefits. The services must be performed under a State plan for vocational rehabilitation services under title I of the Vocational Rehabilitation Act. In 1996, SSA established by regulations an Alternative Rehabilitation Provider Program which allows SSA to refer beneficiaries to private vocational rehabilitation providers and public non-State vocational rehabilitation providers if SSA does not receive notification within a specified period that the State agency has accepted a beneficiary for services or extended evaluation.

In addition, beneficiaries participating in the Ticket to Work and Self-Sufficiency Program will not be subject to unscheduled CDRs triggered by their work activities. For certain former beneficiaries whose entitlement to benefits ended solely because of their earnings from work, the Ticket to Work law provides for swift reinstatement of benefits without requiring a new application. (For more information on the Ticket to Work and Self-Sufficiency Program, refer to Section 3: Supplemental Security Income.)

Enrollment and applicant backlogs

Over the past 20 years, the DI Program experienced a period of declining enrollment followed by a rebound in growth. The number of DI beneficiaries (disabled workers and their dependents) receiving benefits first peaked at 4.9 million in May 1978. The beneficiary population then declined sharply to 3.8 million by July 1984. Thereafter, the number of beneficiaries has risen steadily, reaching 7.2 million in December 2002 (Table 1-39).

Similarly, the number of new DI benefit awards declined from 592,000 in 1975 to approximately 297,000 in 1982. As shown in Table 1-42, awards then rose almost steadily, reaching 646,000 in 1995 before declining by 1997 to 588,000. In 2002 there were 750,000 new DI benefit awards. (The large 1992 increase is partially attributable to SSA's short-term measures for dealing with increased DI applications. Increasing the volume of applications processed resulted in increases in both awards and denials.) The incidence of disability (number of awards per 1,000 insured workers) fell from an all-time high of 7.1 in 1975 to an all-time low of 2.9 in 1982. In 2002, the rate was 5.3 percent (Table 1-42).

Pending claims at DDS, hearings and appeals levels.--Until fiscal year 1991, disability claims (including initial claims, reconsiderations, hearings and appeals) remained relatively constant at about 2.5 million cases per year. In fiscal year 1991, claims began to increase significantly each year and reached 3.7 million in fiscal year 1996. In fiscal year 2001, there were over 3.4 million disability claims. During the period of fiscal years 1988-94, the number of cases pending at the State DDS also increased as the ability to hire and train DDS staff did not keep pace with the increases in claims. However, in fiscal year 1995 pending cases were significantly reduced to 590,000 due largely to increased productivity in the State DDSs and the additional budgetary resources directed to disability case processing which enabled an aggressive hiring effort in the States. In fiscal year 1996, pending cases again increased significantly. The major cause of this increase was that Congress increased SSA's workload by requiring additional drug addiction and alcoholism reviews. These reviews now have been completed, but pending cases have risen again due to workloads mandated by other welfare reform legislation (Table 1-45).

SOCIAL SECURITY'S TREATMENT IN THE FEDERAL BUDGET

SOCIAL SECURITY'S OFF-BUDGET STATUS

Under an administrative action by President Johnson, Social Security and other Federal programs that operate through trust funds were counted officially in the budget beginning in fiscal year 1969. At the time, the Old-Age, Survivors, and Disability Insurance (OASDI) Trust Funds were running a surplus while the remainder of the Federal budget was running a deficit that reflected the increasing costs of the war in Vietnam. At the time, Congress did not have its own formal budget-making process with statutory rules, restrictions on taxes and spending, and its own budget estimating office. In 1974, with passage of the Congressional Budget and Impoundment Control Act (Public Law 93-344), Congress adopted procedures for setting budget goals through passage of annual budget resolutions. Like the budgets prepared by the President, these resolutions were to reflect a "unified" budget that included trust fund programs such as Social Security.

Financial problems confronting Social Security and concern over its growing costs led to enactment of a number of benefit changes in 1977, 1980, 1981, and 1983. Measures were enacted in 1983, 1985, and 1987 making the program a more

TABLE 1-42 -- DISABLED WORKERS' APPLICATIONS, AWARDS, AWARDS AS A PERCENT OF APPLICATIONS, AND AWARDS PER 1,000 INSURED WORKERS, SELECTED CALENDAR YEARS 1965-2002

[Number of applications and total awards in thousands]

Calendar year	Number of applications	Total awards	Awards as a percent of applications	Awards per 1,000 insured workers
1965	529.3	253.5	47.9	4.7
1970	869.8	350.4	40.3	4.8
1975	1,285.3	592.0	46.1	7.1
1980	1,262.3	396.6	31.4	4.0
1985	1,066.2	377.4	35.4	3.5
1990	1,067.7	468.0	43.8	4.0
1991	1,208.7	536.4	44.4	4.5
1992	1,335.1	636.6	47.7	5.2
1993	1,425.8	635.2	44.6	5.2
1994	1,443.8	631.9	43.8	5.1
1995	1,338.1	645.6	48.3	5.1
1996	1,279.2	624.3	48.8	4.9
1997	1,180.2	587.7	49.8	4.5
1998	1,169.3	608.4	52.0	4.6
1999	1,200.1	620.6	51.7	4.6
2000	1,330.6	621.3	46.7	4.5
2001	1,498.6	690.5	46.1	5.0
2002	1,682.5	750.0	44.6	5.3

Source: Office of the Chief Actuary, Social Security Administration.

TABLE 1-43 -- ADMINISTRATIVE LAW JUDGE DI DECISION RATES, INITIAL DENIALS AND TERMINATIONS, SELECTED FISCAL YEARS 1980-2002

Fiscal year	Dismissed	Unfavorable	Favorable	Total	Percent favorable
Initial denials:					
1980	7,093	31,703	56,733	95,529	59.4
1985	14,806	61,161	92,118	168,085	54.8
1990	19,297	45,264	127,707	192,268	66.4
1991	19,880	44,594	144,945	209,419	69.2
1992	19,665	48,407	166,661	234,733	71.0
1993	20,190	47,579	171,508	239,277	71.7
1994	23,576	49,110	189,373	262,059	72.3
1995	44,234	65,415	220,558	330,207	66.8
1996	33,367	89,817	237,131	360,315	65.8
1997	53,205	89,689	199,040	341,934	58.2
1998	53,395	90,591	190,182	334,168	56.9
1999	43,228	78,553	181,938	303,719	59.9
2000	24,951	66,460	183,505	274,916	66.7
2001	20,124	58,571	168,675	247,370	68.2
2002	24,793	65,122	200,240	290,155	69.0
Terminations:					
1980	1,431	4,197	9,909	15,537	63.8
1985	4,176	2,415	3,126	9,717	32.2
1990	1,166	2,940	4,695	8,801	53.3

TABLE 1-43 -- ADMINISTRATIVE LAW JUDGE DI DECISION RATES, INITIAL DENIALS AND TERMINATIONS, SELECTED FISCAL YEARS 1980-2002- continued

Fiscal year	Dismissed	Unfavorable	Favorable	Total	Percent favorable
1991	1,007	2,140	3,935	7,082	55.6
1992	812	1,642	2,812	5,266	53.4
1993	720	1,281	2,079	4,080	51.0
1994	656	1,082	1,540	3,278	47.0
1995	821	1,173	1,807	3,801	47.5
1996	1,172	2,275	2,488	5,935	41.9
1997	1,693	3,242	3,377	8,312	40.6
1998	2,157	4,586	4,251	10,994	38.7
1999	2,076	5,318	5,376	12,770	42.1
2000	1,858	4,392	4,957	11,207	44.2
2001	1,590	3,239	3,888	8,717	44.6
2002	1,807	3,547	4,214	9,568	44.0

Source: Division of Disability Information Systems, ODSSIS, DCS, SSA.

TABLE 1-44 -- TITLE II CONTINUING DISABILITY REVIEW CESSATIONS AND CONTINUATIONS, SELECTED FISCAL YEARS 1977-2001

Fiscal year	Cessations		Continuations		Total cases		
	Number	Percent[1]	Number	Percent[2]	Cessations and continuations	Total disabled persons[3]	Percent reviewed[4]
1977	41,475	38.7	65,745	61.3	107,220	3,322,230	3.2
1980	44,273	46.8	50,227	53.2	94,550	3,454,010	2.7
1985[5]	475	14.6	2,785	85.4	3,260	3,332,870	0.1
1990[6]	15,154	10.5	129,026	89.5	144,180	3,678,509	3.9
1991[7]	5,697	12.5	39,749	87.5	45,446	3,866,645	1.2
1992	6,923	15.0	39,291	85.0	46,214	4,165,133	1.1
1993[8]	4,886	9.9	44,316	90.1	49,202	4,457,500	1.1
1994[8]	13,940	14.1	85,189	85.9	99,129	4,729,948	2.1
1995[8]	31,694	16.1	164,281	83.9	196,575	4,980,462	4.0
1996[8]	35,452	10.0	311,041	90.0	346,493	5,216,126	6.6
1997[8]	48,562	11.3	383,130	88.8	431,692	5,354,315	8.1
1998[8]	52,698	5.4	927,486	94.6	980,184	5,557,486	17.6
1999[8]	40,465	4.7	824,716	95.3	865,181	5,751,600	15.0
2000[8]	44,577	3.9	1,109,327	96.1	1,153,904	5,930,388	19.5
2001[8]	40,282	3.9	994,280	96.1	1,034,562	6,135,549	16.9

[1] Percent of cessations = number of cessations + (number of cessations + number of continuances) x 100.

[2] Percent of continuances = number of continuances + (number of cessations + number of continuances) x 100.

[3] In current pay at end of fiscal year.

[4] Percent of total disabled persons reviewed = (number of cessations + number of continuances) + total disabled persons x 100.

[5] The decline in the number of reviews in 1984 and 1985 was due to the national moratorium on reviews pending enactment and implementation of new legislation that revised criteria for continuing disability reviews (CDRs) (legislation enacted in fiscal year 1984; regulations promulgated late fiscal year 1985).

[6] The decline in CDR processing on 1990 was due to the unanticipated demands of processing approximately 40,000 class action court cases.

TABLE 1-44 -- TITLE II CONTINUING DISABILITY REVIEW CESSATIONS AND CONTINUATIONS, SELECTED FISCAL YEARS 1977-2001- continued

[7] The continued decline in CDR processing was due to the increase in the initial claims workloads.
[8] Includes non-State CDR mailer continuations.
Source: Office of Disability, Social Security Administration.

TABLE 1-45 -- DISABILITY CASES PENDING AND WAITING TIMES, FISCAL YEARS 1988-2002

[Cases pending and weeks of work on hand at State Disability Determination Services]

Fiscal Year	Total cases pending at end of year[1]	Weeks of work on hand[2]
1988	407,000	NA
1989	479,000	10.0
1990	538,000	11.7
1991	693,000	12.1
1992	725,000	10.7
1993	717,000	10.4
1994	721,000	10.3
1995	590,000	7.9
1996	702,000	9.8
1997	704,000	8.6
1998	760,000	10.4
1999	770,000	11.1
2000	901,000	12.4
2001	891,000	12.5
2002[3]	934,000	12.3

[1] Includes initial claims, reconsiderations, hearing office requests, CDRs and disability hearings.
[2] Based on dispositions.
[3] Prior to fiscal year (FY) 2002, weeks of work on hand was figured on a rolling 4-week basis; FY 2002 is figured on a 52-week basis.
Source: Office of Disability Programs, Social Security Administration, March 2003.