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Introduction

This novel reference work was designed to take full advantage of today’s online legal research environment. It was written to be surrounded by and linked to the primary law material of its field. The author’s aim has been to create a fully integrated electronic reference work. Issue by issue it provides immediate, “point and click” access to the relevant portions of the Social Security Act, Code of Federal Regulations, Hallex, and POMS as well as all important cases and rulings. In this way it organizes a comprehensive library of Social Security material. While it can be used apart from the Internet or printed out, in whole or part, separated from its companion online library it is far less useful.

The flexibility of the medium allows all this material to be brought to bear on the quite diverse needs of different researchers, ranging from attorneys or other experts doing Social Security representation to non-experts seeking guidance on a more general level to judges confronting a steady stream of specific Social Security issues.

The reference work, like the full collection it integrates, can be entered in several different ways. It is divided into two distinct parts, designated Part 1 and Part 2. Part 1 contains an overview of Social Security law, with extensive links from its “broad brush” sections to the topically focused sections of Part 2. Part 1 is organized around different benefit types and general features of the program. Its structure reflects the initial questions an individual may have about benefits under Social Security and how they are pursued. Part 2, by contrast, is organized around issues or topics that are particularly important in appeals or litigation. Using the Table of Contents or by moving into a part directly from the front menu a researcher can find a useful starting point in Part 1 or 2. Each section carries its own small table of contents, a set of linked references to related sections in Parts 1 and 2. Consequently, once a researcher has started off in a useful direction that direction can be pursued without frequent need to return “to the top.”

Print reference works must do a great deal of summarizing and excerpting. Since they are separated, often by significant physical distance, from their underlying primary material, it is important that they provide detailed description. A reference work that can take you straight to its cited sources with a “point and click” need not quote them. The central value of this reference work to the user lies in the links between its topic structure and the Social Security Act, the agency regulations and rulings, and the thousands of Federal court decisions that comprise this fully integrated collection. The reference work text that accompanies those links was written with three principal aims: to provide context, to highlight particularly important primary materials among the many accessible to the user, and to note when there are relatively recent changes in law or regulation that should be considered when reading older decisions. Because the detailed provisions of both Act and regulations are close at hand, this work does not repeat their every qualification or condition. Its description of governing rules is at a more general level. As a consequence, on any point about which you need precise and authoritative information, you should follow the links to the pertinent sections of the Act, regulations, and other primary material.
No work of this magnitude is a single person achievement. Meeting the challenges of building a new reference work, from scratch, for electronic publication necessarily required contributions of many kinds, from many quarters. Those who have helped in major ways are far too numerous to mention so I must acknowledge my indebtedness to them by category, secure in the knowledge that the individuals know both who they are and the depth of my gratitude. The National Center for Automated Information Retrieval and Cornell University furnished the necessary time, space, and funds to launch this project in 1988. Mead Data Central furnished data and an initial experimental run on LEXIS along with a serious opportunity to explore the design issues of CD-ROM publication. Last not least, Clark Boardman Callaghan took on the challenge of building and publishing the full work on CD-ROM. In addition to these institutions (of which only Cornell remains) and their people, I am deeply indebted to successive cohorts of student assistants who wrestled with the thousands of Social Security decisions that had to be read and classified against an evolving reference work structure, making use of an ever changing set of software tools, to several law colleagues at institutions scattered across the map who not only shared and, at times, helped buoy my enthusiasm for this new form of law scholarship but furnished useful criticism, and finally to my family who have been very, very patient.

An electronic work is not static. This reference work is not done. It will be revised as Social Security law evolves and its links must be kept up-to-date. By its nature, a work in electronic media, existing in a software environment that enables electronic annotation, invites those who use it to suggest improvements – of all kinds. If you have such suggestions, please send them, in electronic format or on paper to: Prof. Peter W. Martin, Cornell Law School, Myron Taylor Hall, Ithaca, NY 14853. By e-mail, I am: <peter-martin@lawschool.cornell.edu>.
Part 1 – Overviews
Scope of Reference Work

§ 100. Scope of Reference Work – In General

This reference work and accompanying on-line resources cover issues of entitlement and benefit calculation arising out of the set of programs popularly referred to as Social Security. These programs touch the lives of well over 90 percent of all persons living or working in the United States and provide critical income to those who have retired or ceased working due to severe physical or mental disability. They also provide income to other members of a worker’s family when the worker has retired, become disabled, or died. The law directing these payments and setting their amount is complicated. Questions about proper application of this law are raised in hundreds of thousands of administrative hearings and well over ten thousand federal court proceedings each year. This collection of materials is assembled to assist those who must resolve questions of Social Security law as judges, those who represent individuals and families seeking Social Security benefits, and individuals, family members, and organizations seeking a clearer understanding of the law that directs the distribution of hundreds of billions of dollars each year. Since these benefits are centrally important to individuals at critical points in their lives, understanding under what circumstances they are available and how much the payments will be is vital information for planning and making decisions about other forms of savings or insurance.

Rev. 11/05

[Related Sections: Part 1]

§ 101. The Programs Covered – Old-Age, Survivors, and Disability Insurance (OASDI) and Supplemental Security Income (SSI)

Although the Social Security Act of 1935 established a wide range of income support programs and many additional programs have since been added to the Social Security Act, the phrase “Social Security” is used throughout this reference work to refer more narrowly to the programs found in Title II of that act. These include old-age insurance (retirement) benefits, survivors’ benefits, and disability benefits. The full collection is referred to as Old-Age, Survivors and Disability Insurance or OASDI.

This reference work and accompanying on-line resources also cover questions of entitlement and benefit amount under Title XVI, the Supplement Security Income program (SSI). As its name suggests, Supplemental Security Income can be viewed as a backstop for Social Security, providing benefits for individuals in the same population segments who have insufficient income, either because they do not qualify for Social Security.
Security (having not had enough past covered employment) or because their Social Security benefits are too low.

Rev. 9/95

[Related Sections: Part 1]

§ 102. Programs Not Covered Although Closely Affiliated With Social Security – Black Lung, Medicare, AFDC, Private Pensions

For many individuals and families, Social Security benefits overlap with or interact with other important benefits. While SSI is a special case, other close program-to-program relationships exist. These relationships are, in most cases, structured by provisions of the statutes or regulations that regulate the interaction from both sides. Although such related benefits and their interaction with Social Security can have a major impact on the Social Security claimant, this reference work and accompanying on-line resources do not provide detailed treatment of Black Lung benefits, Medicare, private pensions, or the many other forms of income support that resemble Social Security in some respects. It does, however, include summary treatment of the Social Security side of the relationship between its benefits and the more important overlapping programs.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 103. The Issues Covered – Entitlement, Amount, Procedure, Proof or Evidence, Issues of Representation, Planning in Relation to Benefits

For the programs covered, this reference work and accompanying on-line resources cover all issues bearing on entitlement, those elements an individual must establish in order to secure benefits in the first place or keep benefits once started. Depending on the benefits involved, the issues can range from the generally straightforward matter of establishing the claimant’s age, through the more frequently troublesome question of whether a specified family relationship exists, to the nearly always difficult complex of issues surrounding a disability determination. This reference work and files cover the law of Social Security and SSI benefit calculation, including the effect on monthly payments of continuing earnings and benefit claims by other family members. The reference work deals with the administrative and judicial procedures that govern appeals from unfavorable agency determinations, and also with associated rules of proof or evidence. It covers the rules concerning representation of individuals by lawyers or others, including the provisions controlling the fees charged for such representation. Finally, the work focuses on areas where the contours of Social Security law may affect

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private planning, such as decisions about retirement or continued part-time work and about divorce, marriage, and adoption.

Rev. 11/05

[Related Sections: Part 1]

§ 104. Related Tax Issues Not Addressed

Social Security benefits are financed by special taxes. Those taxes, paid by employees, employers, and self-employed individuals, are set out in a separate set of statutory provisions that can be found, today, with the other provisions of the Internal Revenue Code. In many respects these tax provisions track the benefit provisions of the Social Security Act in perfect parallel. The definitions of employment, wages, and self-employment income that operate in the benefit context are nearly identical to those that determine the incidence of the Federal Insurance Contributions Act (FICA) and Self-Employment Contributions Act (SECA) taxes. Consequently, there are times when decisions about a tax question furnish useful authority on a benefit issue. On the other hand, the tax and benefit settings are so distinct, involving different public agencies and private attorneys, that the practical overlap is slight. This reference work and accompanying on-line resources are limited to the benefit side of Social Security. References to the program’s tax provisions are limited to a few situations in which they constitute important authority on benefit questions.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

The Different Types of Social Security Benefits

Social Security – Basic Categories

§ 150. The Different Types of Social Security Benefits – In General

When first enacted, in 1935, the Social Security program was almost exclusively a retirement benefit program. It provided for monthly benefits to covered workers who had reached the age of eligibility (then 65) and also retired. The program has since acquired two additional types of benefits. It now includes benefits for covered workers who become severely disabled, long before they reach retirement age. It also includes benefits for others, related to the worker, in the event of the worker’s retirement, disability, or death.

[Related Sections: Part 1 - Part 2]
§ 151. Benefits Categorized According to the Claimant’s Relationship to the Worker

The Social Security program provides two types of benefits for the worker whose own earnings have established entitlement: 1) disability benefits, available to covered workers who become severely disabled, and 2) old-age insurance (retirement) benefits, available to workers after reaching the age of 62. These benefits received directly by the worker are sometimes called primary Social Security benefits. In addition to these two types of primary benefits, the Social Security program provides for auxiliary or derivative benefits. These are benefits that are paid to children, spouses, former spouses, and parents of a covered worker under certain circumstances.

[Related Sections: Part 1 - Part 2]

§ 152. The Different Types of Social Security Benefits – Benefits Categorized According to the Worker’s Situation

Three different events in the worker’s life can trigger Social Security benefits – retirement, disability, and death. Benefits are available to the worker and certain family members once the worker has attained 62 and meets the program’s definition of retirement. Benefits are available to the worker and certain family members if the worker becomes severely disabled. And finally, benefits are available to certain surviving family members in the event of the worker’s death.

[Related Sections: Part 1]

Old-Age Benefits

§ 160. Old-Age Benefits – In General

Monthly old-age insurance (retirement) benefits are available to workers covered by Social Security upon reaching age 62. The amount of the monthly benefit depends upon the worker’s earnings history, upon the age at which the worker commences receiving the monthly benefit, and upon the level of the worker’s continuing earned income.

[Related Sections: Part 1]

§ 161. Old-Age Benefits – Entitlement

To receive monthly old-age insurance (retirement) benefits a person must have sufficient past work covered by Social Security to have the necessary “fully insured” status. The person must be 62 or older and, prior to the Social Security Act’s “full retirement age” (which is between 65 and 67 depending on year of birth), must not have a high level of

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continuing earnings. Unless the person is already receiving Social Security benefits of some other kind old-age benefits await the worker’s decision to file an application. However, if the person has waited until after his or her “full retirement age” to file an application, benefits can be recovered for up to 12 months prior to the application, although not for months prior to that benchmark age.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 162. Old-Age Benefits – Amount

The monthly old-age insurance (retirement) benefit is pegged to a “full retirement age” defined in the Social Security Act (which is between 65 and 67 depending on year of birth). Those who start benefits at that age get their full “primary insurance amount,” an amount that is based on their personal earnings history. Those who start benefits prior to that “full retirement age” receive a smaller monthly sum; those who start benefits later, a larger one. Prior to that “full retirement age,” benefits are also affected by the worker’s continued receipt of significant earned income. Claimants seeking benefits while they continue to work may have their monthly benefit reduced or even eliminated because of the resulting earnings.

Rev. 12/01

[Related Sections: Part 1 - Part 2]

§ 163. Old-Age Benefits – Relationship to Prior or Subsequent Benefits Received by Worker

Old-age insurance (retirement) benefits are primary benefits; they rest on the claimant’s own earnings record rather than the earnings record of another. When a person entitled to old-age insurance benefits is also eligible for a family benefit, as a spouse, say, that auxiliary benefit is reduced by the amount of the primary benefit. If the auxiliary benefit is larger than the primary, the total amount received by the individual will be that larger amount but the total will be made up of the full primary benefit plus a reduced auxiliary benefit.

Because of this interplay, if a person below his or her “full retirement age” is simultaneously eligible for a reduced spouse benefit, based on the earnings record of a retired or disabled worker, and also a reduced old-age insurance benefit, the individual cannot put off applying for the primary benefits. Application for one is deemed an application for the other. (This is not the case, however, with surviving spouse benefits and old-age insurance benefits.)
Prior receipt of disability benefits, the other form of primary benefits, has no direct effect on the amount of old-age insurance benefits. The disability will, however, result in the period of disability being dropped from the “primary insurance amount” calculation. (This prevents any ultimate old-age benefits from being dragged down by the years of no or low earnings.) If the person continues to receive disability benefits up through the month before he or she reaches the “full retirement age” defined by the Social Security Act (which is between 65 and 67 depending on year of birth), those benefits convert to old-age or retirement benefits at that point without any need to file an application.

When a person is entitled to both an old-age insurance and a disability benefit, he or she can receive only one.

Rev. 11/05

[Related Sections: Part 1]

§ 164. Old-Age Benefits – Benefits for Others That Are Linked To

When an individual is entitled to old-age insurance (retirement) benefits, his or her spouse, divorced spouse, or child may be entitled to derivative benefits on the worker’s account. Since an individual is not entitled to old-age insurance benefits until he or she has filed an application, these derivative benefits, too, must await the worker’s application. There is one exception to this rule: benefits for most divorced spouses do not depend on the worker’s having filed an application.

[Related Sections: Part 1]
Disability Benefits

§ 170. Disability Benefits – In General

Several different types of Social Security benefits are available on the basis of disability. First, disability insurance benefits are available to qualifying individuals on the basis of their own past earnings record. The amount of the benefit depends on that earnings history. Second, a surviving spouse can receive widow(er)s benefits prior to the eligibility age of 60 normally applicable to such benefits if he or she meets the Act’s disability test. Such benefits can begin as early as age 50. Third, a child can receive benefits on the basis of the earnings record of a parent beyond the normal cutoff age for such benefits if the child meets the disability test. Finally, those who are not entitled to any of these other Social Security benefits or whose benefits are low may be eligible for Supplement Security Income disability benefits.

[Related Sections: Part 1 - Part 2]

§ 171. Disability Benefits – Entitlement

To be entitled to monthly disability insurance benefits an individual must meet the program’s definition of disability, and the disability must have lasted for at least five months. In addition, the individual must have insured status for disability benefits, must be below the Act’s “full retirement age” (which is between 65 and 67 depending on year of birth), and must have filed an application.

Rev. 12/01

[Related Sections: Part 1 - Part 2]

§ 172. Disability Benefits – Amount

The monthly disability insurance benefit is the individual’s full “primary insurance amount,” an amount that is based on his or her earnings history. The age at which disability benefits begin has no effect on the monthly amount except in the unusual situation in which the person becomes eligible for disability benefits after having begun old-age insurance (retirement) benefits. In such a case, the individual will be between the age of 62 and his or her “full retirement age” (which is between 65 and 67 depending on year of birth) and the disability benefit amount will be reduced to reflect the months of early payment of old-age insurance benefits. When a person is entitled to both an old-age insurance and disability benefit, he or she can receive only one.

Disability insurance benefits may also be reduced when an individual is also receiving workers compensation or equivalent benefits under a state or federal program. Such reduction occurs when the combined total of disability insurance and such other benefits

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(including benefits to other family members) exceeds 80% of the worker’s average earnings immediately prior to the onset of disability.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 173. Disability Benefits – Relationship to Prior or Subsequent Benefits Received by Worker

When a person becomes eligible for disability insurance benefits after having begun old-age insurance (retirement) benefits, which can happen only when the individual is between the age of 62 and the Social Security Act’s “full retirement age” (which is between 65 and 67 depending on year of birth), the disability benefit amount will be reduced to reflect the months of early payment of old-age insurance benefits.

Disability benefits are primary benefits; they rest on the claimant’s own earnings record rather than the earnings record of another. When a person entitled to disability benefits is also eligible for a family benefit, as a spouse, say, that auxiliary benefit is reduced by the amount of the primary benefit. If the auxiliary benefit is larger than the primary, the total amount received by the individual will be that larger amount but the total will be made up of the full primary benefit plus a reduced auxiliary benefit.

[Related Sections: Part 1 - Part 2]

§ 174. Disability Benefits – Benefits for Others That Are Linked To

When an individual is entitled to disability insurance benefits, his or her spouse, divorced spouse, or child may be entitled to derivative benefits on the worker’s account. Since an individual is not entitled to disability insurance benefits until he or she has filed an application these derivative benefits, too, must await the worker’s application.

[Related Sections: Part 1 - Part 2]
§ 180. Disability Benefits – Disability Determination – In General

The Social Security Act has both a general definition of disability and a specific definition of blindness as a disability. The general definition of disability requires the claimant to show a medically determinable physical or mental impairment. That impairment must be expected to result in death or to last for at least 12 months. This definition combines both medical and vocational components.

[Related Sections: Part 1 - Part 2]

§ 181. Disability Benefits – Disability Determination – Procedure Employed

While the overall administration of the Social Security program lies with the Social Security Administration, disability determinations are made by state agencies. Those agencies operate under agreements with the Federal Agency and are subject to Federal law. Moreover, their determinations are ultimately subject to appeal to Federal administrative law judges and the Federal courts.

The regulations prescribe a sequential evaluation process to be followed in determining whether an individual meets the Act’s disability test. A conclusion at any step that the individual is disabled or not disabled ends the evaluation; subsequent steps do not apply. In order, the steps of that process are as follows:

1) Substantial gainful activity – If the claimant is, in fact, continuing to work and that work is found to be substantial gainful activity the process calls for a finding that he or she is not disabled.

2) Severity – A conclusion that the claimant’s medical impairments do not significantly limit the ability to perform basic work activities calls for a finding that he or she is not disabled.

3) Listed Impairments – The regulations provide a catalog of impairments that are deemed severe enough to warrant a finding that the claimant is disabled. If the claimant suffers from a listed impairment or its medical equivalent, he or she is to be found disabled.

4) Relevant past work – If a claimant’s impairments do not prevent performance of relevant work he or she has done in the past, a finding of not disabled is called for.

5) If the claimant cannot perform his or her past relevant work, the issue becomes whether or not the individual has the capacity to perform other work available in the national economy. Here, in appropriate cases, the Agency makes use of the Medical-Vocational Guidelines (also known as the grid).

[Related Sections: Part 1 - Part 2]
§ 182. Disability Benefits – Disability Determination – End of Disability

A claimant who has been found entitled to disability benefits may lose those benefits if he or she later ceases to be disabled. A determination that the disability has ended can come from the individual’s return to substantial gainful activity without any other evidence that the level of impairment has changed. However, beneficiaries are entitled to a period of trial work before that judgment is reached. A determination that the individual’s medical condition has improved to the point that he or she no longer meets the disability test will also lead to the end of benefits. The Agency is required to reevaluate beneficiaries’ impairments from time to time to determine whether they remain disabled. The frequency of such reviews depends on the likelihood of improvement. The process of reevaluation is termed a “continuing disability review.”

Before beginning such a review, the Agency must notify the individual of the review and the grounds for it. Because those subject to review have previously been determined disabled, determinations that disability has ceased generally require substantial evidence of a change.

Disability beneficiaries threatened with termination have an option to continue payments through the hearing stage, subject to having those payments treated as overpayments should the hearing decision by the Administrative Law Judge affirm the termination.

[Related Sections: Part 1 - Part 2]

§ 190. How Disability Affects Non-Disability Benefits

When an individual meets the Act’s test of disability and the insured status test for disability benefits, his or her earnings record is protected by a disability “freeze.” The freeze applies for the length of the disability (or until the individual’s “full retirement age” if that comes first). One result of a freeze is that quarters during the period of disability are not counted in determining the number of quarters needed for insured status. A second consequence of a freeze is that years included within the period are not included in calculation of the individual’s “primary insurance amount.”

To secure recognition of a period of disability, the claimant must file an application while disabled or within 12 months after the disability period has ended. An extension of that deadline for an additional 24 months is available in cases where the failure to file within 12 months was due to the individual’s mental or physical incapacity.

Rev. 12/01

[Related Sections: Part 1 - Part 2]
§ 200. Benefits Based on Family Relationship – In General

Several family relationships can be a source of Social Security benefits. In most cases, these benefits rest on family relationship and age alone without further proof of actual financial dependency on the insured worker. There are, however, special situations in which the claimant must establish not only a family tie but some measure of financial dependency. In addition family benefits are only available after a triggering event in the worker’s life – disability, retirement with entitlement to old-age insurance benefits, or death.

[Related Sections: Part 1 - Part 2]

§ 201. Benefits Based on Family Relationship – Categories Based on Family Relationship

The Social Security Act provides for:

1) benefits payable to the spouse or former spouse (divorced spouse) of a disabled or retired worker;

2) benefits payable to the surviving spouse (widow or widower) or surviving former spouse (divorced spouse) of a deceased worker, including benefits payable to younger spouses or former spouses caring for children of the deceased worker (mother or father);

3) benefits payable to the children of a disabled, retired, or deceased worker; and

4) benefits payable to the parents of a deceased worker.

Family relationship benefits for spouses once contained very different rules for men and women, but this is no longer the case. Family benefits are now provided on the same terms to men and women and their families.

[Related Sections: Part 1 - Part 2]

§ 202. Benefits Based on Family Relationship – Categories Based on Worker’s Situation

Organizing family benefits according to the worker’s situation yields the following groups:

1) benefits payable to others in the family of a retired or disabled worker (spouse, divorced spouse, children), and
2) benefits commonly known as survivors’ benefits payable to family members – surviving spouse (widow or widower), surviving former spouse (divorced spouse), surviving children, and surviving parents – on behalf of a deceased worker.

[Related Sections: Part 1 - Part 2]

§ 203. Benefits Based on Family Relationship – Establishing Family Relationship

To be eligible for family benefits, a claimant must meet the Social Security Act’s definition of the relevant family relationship, e.g., spouse, divorced spouse, child, or parent. The Act defines these terms sometimes more broadly and sometimes more narrowly than ordinary usage does.

For those individuals whose claim to Social Security benefits rests on their family relationship to a covered and insured worker, how the law determines family relationship can be critical to original entitlement, amount of benefits, or the continuation of benefits.

The Act establishes its own set of criteria under which individuals who fail to meet state law tests for spouse, surviving spouse, or child can, nonetheless, qualify for benefits. These criteria can carry additional conditions or limitations. Consequently, in most cases the applicant is better off qualifying under state law, if possible.

Sometimes, the critical issue is not whether the essential family relationship existed but when it was established or ended or whether other claimants have a qualifying family tie as well. There are occasions when the Social Security benefit system places applicants in an adversarial posture, with the entitlement of one applicant reducing or blocking entitlement of another. For example, the claim of one child, born of an earlier, asserted marriage, can, because of the maximum on benefits payable on one worker’s account, threaten a reduction in benefits clearly payable to a later spouse and her children. The claim of a subsequently established household, filled with children, including some from the new partner’s prior marriage, can have an even more dramatic effect.

Family relationship alone rarely brings benefits. Additional conditions must be met including conditions having to do with the duration of the family relationship and, in some cases, financial dependency on the covered worker.

[Related Sections: Part 1 - Part 2]

§ 204. Benefits Based on Family Relationship – Amount

Each type of family benefit has a base monthly amount set at a fixed percentage of the insured worker’s “primary insurance amount” (100%, for example, in the case of a widow or widower eligible on the basis of age, 50% in the case of a qualifying child of a disabled worker). However, the resulting benefit amount is subject to a variety of
adjustments – both reductions and increases. Some of these are the result of the number of other family benefit recipients or actions taken by other benefit recipients.

[Related Sections: Part 1 - Part 2]

§ 210. Benefits Based on Family Relationship – Survivors’ Benefits

Family members are eligible for survivors’ benefits if they are related to a deceased worker who, at the time of death, had acquired the requisite insured status. Entitlement depends on proof of the worker’s death (generally, but not always, an easy fact to establish), the worker’s insured status, and proof of the necessary family relationship. With some survivors’ benefit categories entitlement depends on additional factors such as the age of the family member or whether the family member was financially dependent on or shared a household with the deceased.

[Related Sections: Part 1 - Part 2]

§ 211. Survivors’ Benefits – Categories of Family Members Who Are Eligible

Survivors’ benefits are available to a worker’s surviving spouse (widow or widower), a surviving former spouse (divorced spouse), surviving children, and surviving parents. In addition to these categories of monthly survivors’ benefits, the Social Security Act provides for a small lump sum death benefit that is payable to the worker’s surviving spouse or children.

[Related Sections: Part 1 - Part 2]

Benefits for the Surviving Spouse of a Deceased Worker

§ 220. Benefits for the Surviving Spouse of a Deceased Worker – Entitlement

Benefits are available to the widow or widower age 60 or over and surviving divorced spouse age 60 or over of a deceased worker. If the surviving spouse or surviving divorced spouse is disabled, benefits are available as early as age 50. The Social Security Act terms these age or age and disability limited spouse benefits “widow” or “widower” benefits and requires that the deceased worker have been “fully insured.”

Another category of surviving spouse benefits termed “mother” or “father” benefits is available to the widow or widower of any age and surviving divorced spouse of any age.
of a deceased worker so long as the individual has children of that worker in his or her care. The children must be entitled to child benefits and must meet certain additional age requirements. The deceased worker in this case must have been either “fully insured” or “currently insured.”

[Related Sections: Part 1 - Part 2]

§ 221. Benefits for the Surviving Spouse of a Deceased Worker – Amount

The monthly benefit for a surviving spouse is closely related to the old-age insurance (retirement) benefit the deceased worker would have received (or was receiving). If begun at the Act’s “full retirement age” (which is between 65 and 67 depending on year of birth) the benefit received by a surviving spouse equals the worker’s full “primary insurance amount.” However, if the deceased worker had already begun retired worker benefits before his or her “full retirement age” the worker’s reduced monthly amount is passed on to the surviving spouse. Similarly, if the deceased worker had postponed receiving retired worker benefits until after his or her “full retirement age,” the resulting increase in the monthly amount carries over to the surviving spouse.

Benefits for the surviving spouse can begin benefits at age 60 or as early as age 50 if the spouse is disabled. Those who start benefits prior to the Act’s “full retirement age” receive a smaller monthly sum. The reduction for those who begin benefits at age 60 brings the benefit down to 71.5% of the deceased worker’s primary insurance amount. Those who qualify at an earlier age because of disability suffer no greater reduction.

The surviving spouse benefit paid regardless of age to a spouse caring for the worker’s child eligible for surviving child benefits is equal to 75% of the deceased worker’s primary insurance amount.

Surviving spouse benefits are reduced if the individual is under the Act’s “full retirement age” and has earnings above the annual excess earnings threshold. They are also reduced in some cases if the individual is receiving a public pension based on his or her own work in uncovered government employment.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 222. Benefits for the Surviving Spouse of a Deceased Worker – Relationship to Prior or Subsequent Benefits Received by the Individual

Surviving spouse benefits are auxiliary benefits and as such they are reduced by any primary benefits received by the same individual. A person who is entitled both to an
old-age insurance (retirement) benefit and a surviving spouse benefit will receive only
the former if it is greater than the auxiliary spouse benefit. If the spouse benefit is
greater than the primary benefit, the individual will receive a full primary benefit and a
reduced spouse benefit. The reduction will be calculated to bring the total of both
benefits up to the unreduced spouse benefit amount.

Prior receipt of other auxiliary benefits will not affect the level of benefits the individual
can receive as a surviving spouse. On the other hand, an individual cannot receive two
auxiliary benefits at once (two surviving spouse benefits, for example). In such cases,
the individual will receive only one: the higher auxiliary benefit.

[Related Sections: Part 1 - Part 2]

§ 223. Benefits for the Surviving Spouse of a Deceased
Worker – How Affected by Benefits Received by Others

Like other auxiliary benefits, benefits for the surviving spouse of a deceased worker are
subject to the family maximum. That cap is calculated by a formula that yields a figure
between 150% and 188% of the worker’s “primary insurance amount.” The family
maximum operates to reduce a surviving spouse’s benefit when additional family
members are entitled to survivor benefits. It does not take many additional family
members entitled to survivors benefits before the total exceeds the family maximum,
trigerring a reduction of the individual amounts. However, benefits to a surviving
divorced spouse are, except in the case of mother or father benefits, paid outside the
family maximum and therefore have no impact on the amount of benefits for a surviving
spouse. The existence of eligible surviving children in a separate household, on the
other hand, can cause a family maximum reduction.

In cases where two individuals are both claiming benefits as the worker’s surviving
spouse their claims have more direct impact on one another. Their claims may be
directly competitive under the relevant state law. If one of the two is claiming benefits
as a spouse on the basis of the Social Security Act’s provision deeming valid certain
ceremonial marriages which state law does not recognize, the Act allows payment of
spouse benefits to both and in such cases places the benefit of the “state law” spouse
outside the family maximum.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 224. Benefits for the Surviving Spouse of a Deceased
Worker Caring for Children (Mother’s or Father’s Benefits)

The surviving spouse and surviving divorced spouse of a currently or fully insured
worker are entitled to benefits regardless of age during the period they are caring for a
child of the worker who is entitled to surviving child benefits. These are termed “mother’s” or “father’s” benefits. When the child reaches the age of 16, unless he or she is disabled, these benefits end. They end earlier if the individual ceases to have the child in his or her care.

Normally, remarriage ends entitlement to such benefits for younger surviving spouses.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 225. Benefits for the Surviving Divorced Spouse of a Deceased Worker

Benefits are available to the former spouse of a deceased worker. The requirements that apply to surviving spouse benefits generally apply to those for a surviving divorced spouse. However, benefits to a surviving divorced spouse are, except in the case of mother or father benefits, paid outside the family maximum.

To be entitled to benefits, except those paid on account of caring for children of the deceased worker, such a former spouse must have been divorced after 10 years or more of marriage.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

Benefits for Surviving Child of a Deceased Worker

§ 230. Benefits for the Surviving Child of a Deceased Worker – Entitlement

Benefits are available to the surviving dependent children of a deceased worker if those children are under 18, or under 19 and full-time students, or age 18 and older and under a disability that began before the age of 22.

Certain categories of children must prove that they were dependent on the insured worker. For most, however, dependency is assumed. Eligibility for surviving child benefits begins when the insured worker dies.

[Related Sections: Part 1 - Part 2]
§ 231. Benefits for the Surviving Child of a Deceased Worker – Amount

The monthly benefit for a surviving child is based on the deceased worker’s “primary insurance amount.” The initial benefit amount, before reductions, is 75% of that primary insurance amount. Surviving child benefits are reduced if the child has earnings above the annual excess earnings threshold (although earnings of other family members, including the child’s surviving parent, have no effect on his or her benefits).

[Related Sections: Part 1 - Part 2]

§ 232. Benefits for the Surviving Child of a Deceased Worker – Relationship to Prior or Subsequent Benefits Received by the Individual

A surviving child cannot receive multiple Social Security benefits. The Social Security Act limits the individual to one, specifying that in most cases that one is the benefit based on the highest “primary insurance amount.”

Auxiliary benefits received as a child have no effect on the individual’s later entitlement to other Social Security benefits, either primary or auxiliary.

Rev. 12/04

[Related Sections: Part 1 - Part 2]

§ 233. Benefits for the Surviving Child of a Deceased Worker – How Affected by Benefits Received by Others

Like other auxiliary benefits, benefits for the surviving child of a deceased worker are subject to the family maximum. That cap is calculated by a formula that yields a figure between 150% and 188% of the worker’s “primary insurance amount.” The family maximum operates to reduce a surviving child’s benefit when additional family members are entitled to survivor benefits. It does not take many additional family members entitled to survivors benefits, in most cases a spouse and other children, before the total exceeds the family maximum, triggering a reduction of the individual amounts. However, benefits to a surviving divorced spouse are, except in the case of mother or father benefits, paid outside the family maximum and therefore have no impact on the amount of benefits for a surviving child. The existence of eligible surviving children in a separate household, on the other hand, can cause a family maximum reduction.

Rev. 12/04

[Related Sections: Part 1 - Part 2]
Benefits for Surviving Parent of a Deceased Worker

§ 240. Benefits for the Surviving Parents of a Deceased Worker – Entitlement

Benefits are available to the dependent parents (age 62 and over) of a deceased worker. Financial dependency on the deceased worker must be established; it is not presumed as it is in the case of most surviving children and surviving spouses.

[Related Sections: Part 1 - Part 2]

§ 241. Benefits for the Surviving Parents of a Deceased Worker – Amount

The monthly benefit for a surviving parent depends on the number of parents entitled to such benefits. When there is only one that parent’s monthly benefit is equal to 82.5% of the deceased worker’s “primary insurance amount.” When more than one parent is entitled to benefits on the worker’s account, the monthly benefit for each is equal to 75% of the deceased worker’s primary insurance amount. Surviving parent benefits are reduced if the individual is under the Act’s “full retirement age” and has earnings above the annual excess earnings threshold.

Rev. 12/01

[Related Sections: Part 1 - Part 2]

§ 242. Benefits for the Surviving Parents of a Deceased Worker – Relationship to Prior or Subsequent Benefits Received by the Individual

Surviving parent benefits are auxiliary benefits and as such they are reduced by any primary benefits received by the same individual. A person who is entitled both to an old-age insurance (retirement) benefit and a surviving parent benefit will receive only the former if it is greater than the auxiliary parent benefit. If the parent benefit is greater than the primary benefit, the individual will receive a full primary benefit and a reduced parent benefit. The reduction will be calculated to bring the total of both benefits up to the unreduced parent benefit amount.
Prior receipt of other auxiliary benefits will not affect the level of benefits the individual can receive as a surviving parent. On the other hand, an individual cannot receive two auxiliary benefits at once (a surviving spouse benefit and surviving parent benefit, for example). In such cases, the individual will receive only one: the higher auxiliary benefit.

[Related Sections: Part 1 - Part 2]

§ 243. Benefits for the Surviving Parents of a Deceased Worker – How Affected by Benefits Received by Others

Like other auxiliary benefits, benefits for the surviving parent of a deceased worker are subject to the family maximum. That cap is calculated by a formula that yields a figure between 150% and 188% of the worker’s “primary insurance amount.” The family maximum operates to reduce a surviving parent’s benefit when additional family members are entitled to survivor benefits. It does not take many additional family members entitled to survivors benefits, in most cases a spouse and children, before the total exceeds the family maximum, triggering a reduction of the individual amounts. However, benefits to a surviving divorced spouse are, except in the case of mother or father benefits, paid outside the family maximum and therefore have no impact on the amount of benefits for a surviving parent. The existence of eligible surviving children in a separate household, on the other hand, can cause a family maximum reduction.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

Benefits for Spouse of an Old-Age or Disability Benefits Recipient

§ 250. Benefits for the Spouse of an Old-Age or Disability Benefits Recipient – Entitlement

Benefits are available to the spouse (age 62 or over) of a person eligible for and receiving Social Security old-age insurance (retirement) or disability benefits. Called “wife benefits” and “husband benefits” by the Social Security Act, these are termed “spouse benefits” throughout this reference work. Spouse benefits are also available to younger spouses who have children of the retired or disabled worker in their care. The children must be entitled to child benefits and must meet certain additional age requirements.

[Related Sections: Part 1 - Part 2]
§ 251. Benefits for the Spouse of an Old-Age or Disability Benefits Recipient – Amount

The monthly benefit for the spouse of a disability or old-age insurance (retirement) benefit recipient is closely related to the benefit the worker is receiving. The spouse who begins benefits at the Social Security Act’s “full retirement age” (which is between 65 and 67 depending on year of birth) receives a benefit equal to 50% of the worker’s “primary insurance amount.”

Spouses who start benefits prior to the Act’s “full retirement age” receive a smaller monthly sum unless they qualify because they are caring for eligible children. The reduction for those who begin benefits prior to the “full retirement age” brings the benefit down to between 32.5% and 37.5% of the worker’s primary insurance amount for a spouse who claims at age 62, depending on the individual’s “full retirement age.” The spouse benefit paid regardless of age to a spouse caring for the worker’s child during the time the child is eligible for child benefits is equal to the full 50% of the worker’s primary insurance amount.

Spouse benefits are reduced if the individual or the retired worker upon whose account those benefits are based has earnings above the annual excess earnings threshold. Spouse benefits are also reduced in some cases if the individual is receiving a public pension based on his or her own work in uncovered government employment.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 252. Benefits for the Spouse of an Old-Age or Disability Benefits Recipient – Relationship to Prior or Subsequent Benefits Received by the Individual

Spouse benefits are auxiliary benefits and as such they are reduced by any primary benefits received by the same individual. A person who is entitled both to an old-age insurance (retirement) benefit and a spouse benefit will receive only the former if it is greater than the auxiliary spouse benefit. If the spouse benefit is greater than the primary benefit, the individual will receive a full primary benefit and a reduced spouse benefit. The reduction will be calculated to bring the total of both benefits up to the unreduced spouse benefit amount.

Prior receipt of other auxiliary benefits will not affect the level of benefits the individual can receive as a spouse. On the other hand, an individual cannot receive two auxiliary benefits at once. In such cases, the individual will receive only one: the higher auxiliary benefit.

[Related Sections: Part 1 - Part 2]
§ 253. Benefits for the Spouse of an Old-Age or Disability Benefits Recipient – How Affected by Benefits Received by Others

Like other auxiliary benefits, benefits for the spouse of a worker receiving disability or retirement benefits are subject to the family maximum. For retired workers, that cap is calculated by a formula that yields a figure between 150% and 188% of the worker’s “primary insurance amount.” With disabled workers it is a somewhat lower figure. The family maximum operates to reduce a spouse benefit when additional family members are entitled to benefits. Since the worker’s benefit is paid in full out of the maximum, it does not take many additional family members entitled to benefits before the total exceeds the family maximum, triggering a reduction of the individual amounts. However, benefits to a divorced spouse are, except in the case of mother or father benefits, paid outside the family maximum and therefore have no impact on the amount of benefits for others. The existence of eligible children in a separate household, on the other hand, can cause a family maximum reduction.

In cases where two individuals are both claiming benefits as the worker’s spouse their claims have more direct impact on one another. Their claims may be directly competitive under the relevant state law. If one of the two is claiming benefits as a spouse on the basis of the Social Security Act’s provision deeming valid certain ceremonial marriages which state law does not recognize, the Act allows payment of spouse benefits to both and in such cases places the benefit of the “state law” spouse outside the family maximum.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 255. Benefits for the Divorced Spouse of an Old-Age or Disability Benefits Recipient

Benefits are available to the former spouse of an insured worker who is entitled to disability or old-age benefits. Such former spouse must have been divorced after 10 years or more of marriage. The requirements that apply to spouse benefits generally apply to benefits for a divorced spouse, with a few exceptions. The three most important exceptions are: 1) such benefits are available even though the worker on whose account they rest has not yet applied for old-age benefits so long as the worker would be entitled to such benefits upon application, 2) the divorced spouse’s benefits are not affected by excess earnings received by the worker, and 3) benefits to a divorced spouse are, except in the case of mother or father benefits, paid outside the family maximum. However, the
Social Security Act requires that a divorced spouse have been divorced for at least 2 years before he or she can take advantage of the first two exceptions. That requirement does not apply in cases where the divorce follows the worker’s entitlement to old-age insurance (retirement) benefits.

[Related Sections: Part 1 - Part 2]

Benefits for Child of an Old-Age or Disability Benefits Recipient

§ 260. Benefits for the Child of an Old-Age or Disability Benefits Recipient – Entitlement

Benefits are available to the dependent children of a worker who is entitled to old-age insurance (retirement) or disability benefits if those children are under 18, or under 19 and full-time students, or age 18 and older and under a disability that began before the age of 22.

Certain categories of children must prove that they were dependent on the insured worker. For others dependency is assumed. Eligibility for these child benefits begins when the insured worker becomes entitled to old-age insurance or disability benefits.

[Related Sections: Part 1 - Part 2]

§ 261. Benefits for the Child of an Old-Age or Disability Benefits Recipient – Amount

The monthly benefit for the child of an old-age or disability benefits recipient is based on the worker’s “primary insurance amount.” The initial benefit amount, before reductions, is 50% of that primary insurance amount.

Child benefits are reduced if the child or the old-age insurance recipient parent has earnings above their respective annual excess earnings thresholds (although earnings of other family members, including the child’s other parent, have no effect on his or her benefits).

[Related Sections: Part 1 - Part 2]
§ 262. Benefits for the Child of an Old-Age or Disability Benefits Recipient – Relationship to Prior or Subsequent Benefits Received by the Individual

A child cannot receive multiple Social Security benefits. The Social Security Act limits the individual to one, specifying that in most cases that one is the benefit on the highest “primary insurance amount.”

Auxiliary benefits received as a child have no effect on the individual’s later entitlement to other Social Security benefits, either primary or auxiliary.

[Related Sections: Part 1 - Part 2]

§ 263. Benefits for the Child of an Old-Age or Disability Benefits Recipient – How Affected by Benefits Received by Others

Like other auxiliary benefits, benefits for the child of an old-age or disability benefit recipient are subject to the family maximum. For retired workers, that cap is calculated by a formula that yields a figure between 150% and 188% of the worker’s “primary insurance amount.” With disabled workers it is a somewhat lower figure. The family maximum operates to reduce a child’s benefit when additional family members are entitled to benefits. Since the worker’s benefit is paid in full out of the maximum, it does not take many additional family members entitled to benefits before the total exceeds the family maximum, triggering a reduction of the individual amounts. However, benefits to a divorced spouse are, except in the case of mother or father benefits, paid outside the family maximum and therefore have no impact on the amount of benefits for others. The existence of eligible children in a separate household, on the other hand, can cause a family maximum reduction.

[Related Sections: Part 1 - Part 2]

Supplemental Security Income (SSI)

§ 280. Supplemental Security Income – Basic Elements

Alongside the “insurance” benefits of Title II, the Social Security Act of 1935 encouraged state programs for specific categories of low-income individuals with Federal grants-in-aid. During the early years of Social Security, benefits based on past earnings reached a relatively small portion of the elderly population and benefits were low for those who qualified. During that start-up period, Old Age Assistance, the grant-
in-aid program providing need-tested benefits for those 65 and over had broader reach and higher payment levels than Social Security.

In 1974 this model of need-based benefits for potential Social Security recipients was changed, as the grant-in-aid programs for the elderly, the blind, and the disabled were replaced by Supplemental Security Income (SSI). The significant changes brought by SSI included uniform national standards of eligibility and benefit amount, 100% Federal funding of the basic benefit, and administration by the Social Security Administration. On top of the Federal SSI benefit, states can add supplementary payments. Indeed, those that had higher standards under the previous grant-in-aid approach were required to do so as a condition for continued receipt of Federal Medicaid money.

Paying benefits to those 65 or over or blind or otherwise disabled whose incomes and assets fall below a national (or the case of state supplementary benefits, a state) minimum, SSI has a very close relationship with Social Security. Since “disability” is defined in terms nearly identical to those employed with Social Security Disability Insurance and since the claims procedures and judicial review provisions of the two programs are identical, a great deal of Social Security law is SSI law as well.

Coverage, Proof, and Procedure

Social Security

§ 300. Basic Elements of Coverage

Both eligibility for Social Security benefits and the monthly payments for those who are eligible depend on how much the individual working person has earned in types of work covered by the Social Security system, over a period of years.

By the time most people are eligible for Social Security benefits, whether due to their own retirement or disability or the death or disability of a family member, the basic facts on which their coverage and benefit amount calculations rest have been established for some time. That is because the benefit provisions look back across a working lifetime using the same definitions as were applied year by year during that period in the imposition of the Social Security tax. Reporting of the income for Social Security tax purposes, its characterization for tax purposes, and payment of the tax are not legal preconditions to nor determinative of treatment of a benefit claim. On the other hand, the records of covered employment and self-employment income maintained by the Social Security Administration are based, year by year, on the information drawn from Social Security tax records of the Internal Revenue Service. Those records of income in covered work are given strong, and in some cases conclusively, presumptive effect after a short period of years. As a consequence, most, although not all, of the attention to
these questions of covered employment and self-employment concern the tax provisions which parallel the benefit sections of the Social Security Act.

The types of work covered by Social Security have steadily been expanded since the program was first established in 1935. Today, most work performed in the United States, as well as most work performed abroad by U.S. nationals, is covered. Both work done in one’s own business (“self-employment”) and work done as an employee in someone else’s business (“employment”) count. On the other hand, income that comes to an individual without work, such as interest income, dividends, and similar forms of investment, does not count. The same holds true for gifts or lottery winnings. The program is based on earned income, not unearned income.

While the fact that a person had earned income in covered work during a particular period has significance, the amount of that earned income has, in most cases, greater importance. The minimum amounts necessary to accrue four quarters of coverage for a year of work are set so low that most individuals with any taxed and reported work exceed them by such a wide margin as to render academic any question about amount. However, the final benefit amount to which an individual is entitled is based on a year by year computation of the amount earned in covered employment and self-employment.

Finally, once a person begins receiving Social Security benefits, the amount is affected by continuing earnings prior to the Act’s “full retirement age” (which is between 65 and 67, depending on the person’s year of birth). Here, the basic concepts of work, employment, and self-employment are identical to those that are involved in the original entitlement and benefit amount determinations, but certain narrow categories of work exempted from and therefore not counted for coverage are recognized in the operation of this “excess earnings test.”

All Social Security benefits, whether old-age insurance (retirement) benefits, survivors benefits, or disability benefits, depend on some person (either the claimant or the relative on whom his or her benefits depend) having sufficient covered earnings to qualify for “insured status.” Different benefits require different types of insured status, but all require that the claimant or relevant other person have insured status. The requirement reflects the notion, which the program has carried from its inception, that benefits are payable only to those individuals or families who have paid into the system through Social Security taxes during a significant period of covered work. All tests of insured status are expressed in terms of quarters of coverage, requiring a certain total of qualifying quarters or a certain number during a specified period. The reference is to calendar quarters. A year of work can, depending on the amount and timing of covered wages and self-employment income, yield up to four quarters of coverage.

Rev. 11/05

[Related Sections: Part 1 - Part 2]
§ 400. Steps in Presenting or Appealing a Benefit Claim

In general, Social Security benefits are not paid unless they are applied for. Consequently, all claims begin with the filing of an application along with such other supporting evidence as is necessary to establish the claim. With disability benefits the supporting evidence and following determination can be quite complex. With old-age insurance (retirement) benefits it can be quite simple. An application filed before the individual meets all the other requirements for entitlement can be valid but only if all requirements for entitlement are met before the Agency makes its determination.

Once the Agency has made a determination on an application, a claimant who disagrees with that determination can press an appeal through several stages. Each must be pursued in a timely fashion before moving to the next. At each stage, the claimant is notified in writing of the Agency’s decision and his or her next appeal option. A failure to exercise an available Agency appeal within the time allowed can foreclose later Agency or judicial review.

Following the Agency’s initial determination, the next stage is for the claimant to request reconsideration. A claimant dissatisfied with the Agency’s decision upon reconsideration can secure a hearing before an administrative law judge. Following a decision by the administrative law judge, the dissatisfied claimant must appeal to the Social Security Administration’s Appeals Council. In a normal case, it is only after the Council has decided on the appeal or declined to consider it that the claimant can secure judicial review of the Agency’s decision. The Social Security Act provides for judicial review by a U.S. district court.

A plan for reforming this multi-stage process, as it applies to disability benefit claims, was adopted by the Agency in 2006. See 71 Fed. Reg. 16446 (Mar. 31, 2006). The new procedures were to be phased in, over time, across the U.S., starting with ME, NH, VT, MA, RI, and CT. Initial experience in those states together with appointment of a new agency head led to proposed regulations setting out a different reform scheme in October 2007. See 71 Fed. Reg. 61218 (Oct. 29, 2007).

§ 420. Representation by a Lawyer or Other Experienced Person

Claimants are entitled to have someone else represent them in dealings with the Agency. The representative can be an attorney or some other person. Indeed, it can be anyone chosen by the claimant so long as that person has not been disqualified by the Agency because of past misconduct in such cases. The claimant must sign a statement authorizing the representative to act on his or her behalf and may, at any time, revoke the appointment. Fees for representation before the Agency and for representation in any
subsequent judicial proceedings are governed by the Social Security Act and subject to Agency or court review.

[Related Sections: Part 1 - Part 2]

§ 430. The Individual’s Earnings Record

Both insured status and benefit amounts depend on the amount of earnings in covered work during past periods. In making these determinations, the Agency relies on its own records of those earnings. Errors and omissions in those records can have serious consequences for an individual, and correcting such errors years after the fact when the individual is applying for benefits can prove impossible. Not only are there the often severe practical difficulties of collecting evidence of past earnings, but the Agency’s records of earnings are given substantial and in some cases conclusive weight. The prudent course is for an individual to make periodic checks on his or her earnings record. Within 3 years, 3 months, and 15 days after the end of any tax year, errors can be corrected without difficulty.

[Related Sections: Part 1 - Part 2]

§ 440. Proof, Presumptions, and Evidence

A claimant must prove that he or she meets all the requirements for the benefits claimed. Some of the requirements are established by the Agency’s earnings record for the claimant or the individual on whose account the benefits depend. This is true of proof of insured status and the earnings on which benefit amount calculations rest. However, other key requirements must be established by proof furnished by the claimant. This is true for such matters as age, death, family relationship, financial dependency or living arrangement, and most especially disability. As to each element that must be established by the claimant for entitlement to a particular type of benefits Agency regulations specify preferred evidence, but in nearly all cases alternative forms can be used. Throughout the Agency’s determination and appeal process strict rules of evidence do not apply. This includes the hearing before an administrative law judge.

On some issues, notably those of family status, Social Security benefit entitlement can depend on state law or even the outcome of state legal proceedings. When state law is incorporated in this fashion the incorporation is likely to include presumptions or standards of proof which may either assist or hinder a claimant.

[Related Sections: Part 1 - Part 2]
§ 450. Being Mistaken About Entitlement or Particular Social Security Rules

Under most circumstances an individual’s mistake about Social Security rules or procedures furnishes no excuse for a failure to comply. The mistake may induce the Agency to grant relief from the rule in some cases. For example, a claimant who was mistaken about how the time limit for filing an appeal is calculated might persuade the Agency that “good cause” existed to grant an extension. The Agency is not, however, under any obligation to grant relief from the mistake, even if it was caused by misinformation from Agency staff. And under some circumstances, the Agency will have no authority under the Social Security Act to grant relief.

The Act specifically provides for relief from mistakes caused by the Agency in two situations. First, a failure to apply induced by erroneous advice from the Agency can be the starting point for entitlement under a later application. Second, a failure to pursue administrative appeals caused by a mistaken belief that filing a new application could achieve the same result will warrant relief if the Agency’s notice did not make clear the difference between the two.

[Related Sections: Part 1 - Part 2]

SSI

§ 455. Supplemental Security Income – Establishing Entitlement Through the Administrative Process

While eligibility for Social Security benefits rests on a history of past employment, Supplemental Security Income (SSI) benefits rest on present economic circumstance. Playing a critical role in the SSI eligibility determination and also the SSI benefit amount calculation is a determination of the individual’s current income and resources. SSI benefits are not available, however, to all who fall below its income and resource standards but only those who qualify by age (65 or over), blindness, or disability.

As with Social Security, SSI claimants must apply and must present adequate evidence of eligibility. Except in minor respects, the administrative appeals processes for the two programs are identical. Judicial review for the two programs is based on the same provision of the Social Security Act.

[Related Sections: Part 1 - Part 2]
Taking a Social Security or SSI Claim to Court

§ 460. Taking a Social Security or SSI Claim to Court – In General

The Social Security Act provides for judicial review of final Agency determinations on entitlement, benefit amount, and other matters on which the Act or regulations provide for a decision after a hearing. Judicial review is not normally available if the claimant has not pursued his or her full appeal rights within the Agency. Also, it is not available on discretionary determinations for which the Agency does not provide a full hearing (such as a decision not to reopen an old question).

Rev. 9/95

[Related Sections: Part 1 - Part 2]

§ 461. Taking a Social Security or SSI Claim to Court – What a Court Can and Will Do

When the action has been filed in timely fashion in Federal district court, the Social Security Act provides for the court to review the Agency’s determination for legal error. Factual determinations by the Agency are reviewed against a “substantial evidence” test. In other words, Agency determinations of factual questions are conclusive so long as they are supported by “substantial evidence.”

The court will not hear new evidence; its review is limited to the transcript of the Agency proceedings. The Act specifically authorizes a reviewing court to affirm, modify, or reverse the Agency’s determination with or without remanding the decision. The court can also, upon the request of either the Agency or claimant, remand to the Agency to receive new evidence, but such remands require a showing of good cause for the failure to incorporate the evidence in the prior Agency proceedings.

Rev. 9/95

[Related Sections: Part 1 - Part 2]

§ 462. Taking a Social Security or SSI Claim to Court – Class Actions and Other Special Cases

The normal Social Security or SSI case brought in Federal district court is an action seeking judicial review of an Agency determination that an individual is not entitled to benefits he or she is seeking. In such a case, only one claimant is involved, or at most a family, and the issue is benefit entitlement or amount.
If a regulation or other policy of the Agency treats a whole class of individuals in a manner that arguably violates the statute or the Social Security Act itself contains provisions that are arguably unconstitutional, litigation by individual claimants can raise the issue, but a class action may offer a more attractive alternative.

Another type of case posing special issues of judicial review and remedy occurs when the core of a complaint about Agency policy or practice concerns not the outcome in a particular determination but delays or other procedural inadequacies. The problem is that the effective point of judicial intervention in such cases may be before the Agency has reached a final decision.

[Related Sections: Part 1 - Part 2]

Fees Charged and Award for Representation
Social Security

§ 500. Fees Charged and Awarded for Social Security Representation – In General

All fees charged for representing a claimant before the Agency or before a court on appeal from the Agency are subject to limits set by the Act and enforced by the Agency or court. When the representative is a lawyer or an experienced non-lawyer approved by the Agency and the claimant secures a favorable determination yielding past due benefits, the Agency or court will direct payment of the fees out of those benefits. The Act sets a cap on such fee awards paid out of past due benefits at 25% of those benefits.

A 1990 amendment to the Social Security Act altered the procedure for approving attorneys fees paid out of past due benefits resulting from an administrative appeal. Fees agreed to by the claimant will generally be approved so long as they do not exceed 25% or a set dollar amount, initially established by the Act at $4,000. Effective February 2002, the Agency increased that figure to $5,300. The Act also provides that the attorneys fee calculation occurs prior to operation of the SSI offset.

Under a 1999 amendment, fees paid by the Agency out of past due benefits are reduced by a 6.3% assessment to cover the Agency’s costs. A further amendment in 2004 capped that assessment at $75, subject to an annual cost-of-living adjustment. The figure for 2008 is $79.

[Related Sections: Part 1 - Part 2]
§ 505. Fees Charged and Awarded for Social Security Representation – Fees Awarded That Do Not Come Out of Claimant’s Benefits

The Equal Access to Justice Act (EAJA) applies to litigation against the United States in court. Consequently, it has no bearing on representation before the Agency prior to judicial review. However, under the EAJA a federal court can award attorneys fees against the government when the Agency’s position in a Social Security case is later found by the court not to have been “substantially justified.” This standard is not met in every successful Social Security appeal, but where it is met the EAJA may provide for a fee award that does not reduce the claimant’s past due benefits. Because of the differences between both the conditions under which such a fee award will be made and the method of calculating the fee, where both fee awards are available (an award under the Social Security Act as well as an EAJA award) the amounts must be coordinated.

[Related Sections: Part 1 - Part 2]

§ 510. Fees Charged and Awarded for Social Security Representation – Fees Charged by Non-Lawyer Representatives

The Social Security Act provides for Agency review and approval of fees charged by representatives whether or not they are recovered out of past due benefits. This provision is not limited to non-lawyers, but it is especially important to them since, with limited exceptions, fees charged by non-lawyers are not paid out of past due benefits by the Agency. The regulations list the factors governing such review. The regulations make clear that while the amount of benefits recovered is one factor, it is not determinative. Indeed, the regulations state that the Agency may approve a fee even when no benefits have been recovered. Legislation enacted in 2004 authorizes a five-year experiment in paying fees to qualifying non-lawyer representatives out of past due benefits.

[Related Sections: Part 1 - Part 2]

SSI

§ 580. Supplemental Security Income – Legal Representation

SSI claimants, like those seeking Title II benefits, are entitled to have someone else represent them in dealings with the Agency. The representative can be an attorney or some other person. Indeed, it can be anyone chosen by the claimant so long as that
person has not been disqualified by the Agency because of past misconduct in such cases. The claimant must sign a statement authorizing the representative to act on his or her behalf and may, at any time, revoke the appointment. Fees for representation before the Agency and for presentation in any subsequent judicial proceedings are subject to Agency or court review.

Prior to 2004 there was no provision with SSI, comparable to that applying to Social Security, for a portion of benefits to be withheld to cover attorneys fees. A 2004 amendment extended the Title II attorneys fees withholding provisions to SSI (complete with assessment of a processing fee) for a limited period of five years. As with Title II claims attorneys fees can be recovered under the Equal Access to Justice Act following successful litigation of an SSI claim in some but not in all cases of Agency reversal.

Rev. 12/04

[Related Sections: Part 1 - Part 2]

Benefit Calculation
Social Security

§ 600. Social Security Benefit Calculation – In General

The arithmetic of Social Security benefit calculation centers around the insured worker’s “primary insurance amount.” Those entitled to benefits start out with a base monthly payment that is a percentage of that primary insurance amount. The percentage is, in some cases, adjusted depending on the age at which the person begins benefits. If a beneficiary continues to receive earnings after applying for benefits, earnings above a set annual amount will produce a reduction in benefits prior to the individual’s “full retirement age” (which is between 65 and 67 depending on year of birth). Because of the family maximum, a cap on the monthly benefits payable on the account of a particular worker, benefits received by others can reduce the amount any one individual will receive.

Generally other pensions or transfer payments have no effect on Social Security benefits, but there are a few exceptions including a public pension offset that applies to spouse benefits and an offset for workers compensation or other public disability payments that applies to disability benefits.

In addition, under the “Windfall Elimination Provision,” workers who receive public pensions based on work that was not covered by Social Security have their old-age insurance benefits calculated under a different formula, one yielding lower monthly amounts.

Rev. 11/05

[Related Sections: Part 1 - Part 2]
§ 601. Social Security Benefit Calculation – The Role of the Primary Insurance Amount

The “primary insurance amount” is the basic unit with which all benefit calculations begin. The full primary insurance amount is the monthly benefit received by an old-age insurance (retirement) beneficiary who has begun benefits at the Social Security Act’s “full retirement age” or by a disability benefit recipient. Adjustments because of the age at which old-age insurance benefits are begun move the monthly amount up or down in relation to the primary insurance amount.

Family or auxiliary benefits are set in terms of the insured worker’s primary insurance amount. For example, the base benefit for a surviving spouse is 100% of that primary insurance amount; the base benefit for a child of a disability benefit recipient, 50%.

[Related Sections: Part 1 - Part 2]

§ 602. Social Security Benefit Calculation – Calculating the Primary Insurance Amount

The “primary insurance amount” for a worker is based on the worker’s average indexed monthly earnings. That figure is calculated from the worker’s earnings in covered work over most of his or her career, indexed for inflation so as to translate earlier earnings figures into recent earnings levels. The indexing year used is that which is two years prior to the worker’s year of eligibility. (This is the year in which the worker could claim benefits or the year of the worker’s death even if benefits are not begun until later.)

Not all years enter into this average indexed monthly earnings figure. The Social Security Act contains a formula that identifies a number of low earnings years (usually at least 5) that can be dropped before calculating the average. In addition, a “disability freeze” will remove periods of disability from the calculation.

A worker’s average indexed monthly earnings are converted into the worker’s primary insurance amount by applying a series of multipliers. The primary insurance amount equals 90% of a first low band of average indexed monthly earnings plus 32% of a large middle band plus 15% of all earnings above that middle band. The boundaries between these bands are adjusted automatically to keep up with rising earnings. (For workers becoming eligible in 2008 the 90% band covers the first $711 of average indexed monthly earnings; the 32% band, from $712 through $4,288; the 15% band, over $4,288.) This formula produces a primary insurance amount that is more adequate for low income than high income workers. In addition, a special minimum primary
insurance amount is available for workers with lengthy careers of steady low income work. Finally, under the “Windfall Elimination Provision,” workers who receive public pensions based on work that was not covered by Social Security have their old-age insurance benefits calculated under a different formula, one yielding lower monthly amounts.

Rev. 11/07

§ 603. Social Security Benefit Calculation – Shares of the Primary Insurance Amount

The different types of benefits are set at the following percentages of the insured worker’s “primary insurance amount.” Primary benefits, that is old-age insurance (retirement) benefits and disability benefits, are set at the full amount, 100%. Surviving spouse benefits are also set at 100%. Surviving parents receive 82.5% if there is only one eligible parent, 75% if there is more than one. Surviving children and a younger surviving spouse eligible while caring for eligible children have benefits set at 75% of the primary insurance amount. The children and spouse of an old-age or disability benefit recipient have benefits set at 50% of the primary insurance amount.

Rev. 11/05


All benefits for which entitlement depends in part on attainment of a certain age set the monthly benefit amount in terms of the Social Security Act’s “full retirement age” (which is between 65 and 67 depending on year of birth). Benefits that are first claimed prior to the Act’s “full retirement age” are reduced to take account of the longer period over which they may be received. The benefit types subject to such an actuarial reduction include old-age insurance (retirement) benefits and spouse benefits including those for divorced spouses.

The calculation of this “actuarial reduction” is somewhat different for each of the benefit types. In all cases the amount of reduction is based on the number of months prior to the individual’s “full retirement age” for which benefits are claimed. For old-age insurance benefits the reduction is 5/9 of 1% for each month up to 36, plus 5/12 of 1% for each additional month. Since old-age or retirement benefits can be claimed as early as age 62, the maximum reduction under this formula is 20% for those whose “full retirement age” is 65, and it will be 30% for those whose “full retirement age” is 67. The comparable formula for the spouse of an old-age or disability benefit recipient is 25/36 of 1% for
each month up to 36, plus 5/12 of 1% for each additional month. Since spouse benefits of this type can be claimed as early as age 62, the maximum reduction under this formula is 25% for those whose “full retirement age” is 65, 35% for those whose “full retirement age” is 67. Finally, for a surviving spouse, who can claim benefits as early as age 60, a still different formula yields a maximum reduction of 28.5%. The same maximum reduction applies to those surviving spouses who are entitled to benefits prior to age 60 because of disability. In other words, there is no additional reduction even though benefits in such cases may begin as early as age 50. Similarly there is no reduction for periods in which a spouse is eligible for benefits because he or she is caring for a child entitled to child benefits.

At the Act’s “full retirement age,” a claimant’s “actuarial reduction” is recalculated if there were months in the period prior to that age in which benefits were not received because of excess earnings. Such months are removed from those used to calculate the reduction amount.

For old-age insurance benefits (but not spouse benefits) there is also an adjustment for individuals who postpone claiming benefits until months or years after the Act’s “full retirement age.” These “delayed retirement credits” are not available for months beyond age 70. The Act’s credit for delaying old-age benefits after its “full retirement age” is programmed to increase. For workers reaching age 65 in 1990, the credit was 3.5% per year of delay. In successive even numbered years (1992, 1994, and so on) the credit rose .5%. It levels off at 8% for those turning 65 in 2008.

Rev. 11/07

[Related Sections: Part 1 - Part 2]


Earnings received by a disability benefit recipient may demonstrate an ability to engage in substantial gainful activity and thus lead to a finding that the individual is no longer disabled.

For all other benefit types, there is no such direct connection between entitlement and continuing earned income. However, for all other benefit types there is a reduction formula reflecting the view that benefits are a substitute for earned income, a substitute that is not necessary if the individual has substantial earned income. This earnings reduction does not apply, however, to beneficiaries who have reached the Act’s “full retirement age.”

For beneficiaries under the “full retirement age,” the earnings test operates as follows. First, it disregards earnings below an “annual earnings test.” This threshold amount is adjusted each year to take account of increases in average earnings levels in covered work. For the year 2008, the threshold expressed as an annual figure is $13,560.
Earnings above the threshold, “excess earnings,” reduce benefits $1 for every $2 of excess earnings. (Prior to a 2000 amendment, excess earnings, measured by a more generous formula, also reduced benefits of beneficiaries between 65 and 70. That formula still applies to any months of earnings in the year the individual reaches “full retirement age” prior to his or her birthday.)

The excess earnings reduction applies to the individual’s own benefit. In the case of an old-age insurance (retirement) benefits recipient, it also applies to family benefits based on the individual’s account.

A comparable reduction applies to beneficiaries working in uncovered jobs outside the U.S.

§ 606. Social Security Benefit Calculation – Effect on Benefits of Benefits Being Received by Others

In general, all benefits paid on the account of an individual are subject to a family maximum. For retired and deceased workers, that cap is calculated by a formula that yields a figure between 150% and 188% of the worker’s “primary insurance amount.” With disabled workers it is a somewhat lower figure. It does not take many beneficiaries claiming on an account to reach a total that brings the maximum into play. When benefits are reduced to bring them down to the maximum, the monthly benefit for the worker, if any, is first paid in full. Then all auxiliary benefits are reduced in pro rata fashion to reach the maximum.

One category of benefits, benefits for a divorced spouse other than those in the mother’s or father’s category, is paid outside the maximum. That means both that benefits to a divorced spouse are not reduced because of the maximum and that benefits paid to a divorced spouse are not counted against the maximum in calculating benefits to other family benefit recipients. Similarly, when benefits are paid to two eligible spouses, one entitled on the basis of state law and the other on the basis of a ceremonial marriage “deemed valid” by the Act, the payments to the “state law spouse” are outside the maximum.

§ 610. Events Causing Loss or Reduction of Benefits

Several types of events can lead to a loss or reduction of benefits. With some benefits entitlement depends on the continuation of a certain condition or set of circumstances.
Should the condition end or circumstances change, benefits may be lost. Benefits for all who are under the Act’s “full retirement age” may be reduced during periods in which they receive large amounts of earnings from work. Receipt of a government pension by a spouse benefit recipient will cause a benefit reduction in cases where that pension is based on the individual’s uncovered employment with a Federal, state or government agency.

Deportation from the country may end benefits. Also aliens may lose benefits after living outside the U.S. for more than 6 consecutive months. Finally, conviction of certain crimes, flight to avoid arrest, and incarceration can also cause benefits to be lost.

Rev. 11/05

§ 611. The General But Not Complete Symmetry of Entitlement (Disability, Death, Dependence)

In many cases benefit entitlement depends on the continuation of a certain condition or set of circumstances. These facts must be established for initial entitlement and should the condition end or circumstances change, benefits may be lost. This is true, for example, of disability. Disability benefits end when an individual who once met the disability test no longer does. Benefits received by a younger spouse who is caring for a child entitled to child benefits end when the child no longer qualifies or is no longer in the beneficiary’s care.

The Social Security Act and regulations spell out each benefit category’s conditions for initial entitlement and also conditions that will cause benefits to end. The latter list typically parallels the former but with some differences. For example, the Act explicitly provides that benefits cease with the beneficiary’s death. There are also a number of conditions for initial entitlement to family benefits that are not reflected in parallel provisions ending benefits. For example, family benefits that require an individual to establish actual dependency upon an old-age insurance (retirement) benefit recipient or that the family benefit claimant was living in the same household with the worker are not lost if those conditions later cease.

Rev. 11/05

[Related Sections: Part 1 - Part 2]
§ 620. Interplay of Multiple Benefit Calculation Effects – E.G., Excess Earnings, Family Maximum

When two different benefit adjustment rules apply to the same beneficiary or family group the interplay between those rules can have a large impact on the amounts received by particular individuals.

The most important provision dealing with this type of interplay concerns the family maximum. Reductions under the family maximum occur only after other deductions, including those based on excess earnings. That means that in families with numerous family benefit recipients, these other reductions may not be felt if one views the family as a whole. In such cases, the reduction experienced by one individual will be compensated for by increases to the others as the amount of the reduction falls out of the family maximum calculation.

[Related Sections: Part 1 - Part 2]

§ 630. Special Provisions – Deportation, Incarceration

Deportation from the U.S. on a variety of grounds will cause benefits to end for the deported individual until he or she is lawfully readmitted to the U.S. Family benefits on that person’s account are not affected so long as the recipients remain in the U.S. or are U.S. citizens.

Flight to avoid arrest and imprisonment following conviction of a felony will cause benefits to be suspended. This suspension does not apply to family benefits paid on the worker’s account. They are paid as though benefits continued to the insured individual.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 640. Cost-of-Living Adjustments

The Social Security Act provides for automatic adjustments in benefits on the basis of increases in the Consumer Price Index. The adjustment is based on the index for the third quarter of the current year compared to the third quarter of the last year in which adjustment was made. When an adjustment occurs, it takes effect with the December benefits for the year, which means that it first appears in the checks for the following January. During periods in which the Social Security reserves reach low levels, the adjustment is made on the basis of wage increases (rather than price increases) if smaller. (This occurs if the trust fund ratio drops below 20%.)

For an individual the adjustment is calculated by taking his or her monthly benefit amount and multiplying it by the increase percentage.
Whenever this benefit increase provision operates, automatic adjustments of the “primary insurance amount” formula and family maximum amounts are also calculated.

[Related Sections: Part 1 - Part 2]

SSI

§ 680. Supplemental Security Income – Benefit Amount

Since SSI was created to insure a minimum income “floor” for aged, blind or disabled persons, its benefits are reduced by other sources of income, including earnings, interest, and Social Security. Not all sources of income or all income from sources affecting benefits are counted, but the basic benefit formula begins with a monthly payment amount for eligible individuals who have no other income. For 2008 this figure is $637. Couples with both spouses eligible for SSI are treated as a unit with a monthly minimum for 2008 of $956.

The existence of “countable income” reduces the benefit amount. In states paying supplemental benefits the relationship of income to benefits is the same but the monthly minimum is equal to the Federal SSI benefit plus the state supplement.

Rev. 11/07

[Related Sections: Part 1 - Part 2]

Payment of Benefits

Social Security

§ 700. Payment of Benefits – In General

The Agency prefers direct deposit in a financial institution to mailing a check. It will arrange direct deposit unless the beneficiary does not have an account that would make it possible or specifically requests payment by check. Social Security benefit checks are mailed by the Treasury Department. Payments are mailed or deposited during the month following the month to which they relate. (For example, the December benefit payment is received in January.) Exactly when during that month is determined by the birth date of the worker on whose record the payments are based.

Benefits for family members who are living in the same household can be combined in a single joint payment.

The Social Security Act protects benefits from the claims of creditors and prohibits assignment of future benefits.
Payments to minor children and adults who are not able to manage their own financial affairs will be made to a representative payee who is responsible to use them on behalf of the beneficiary.

Rev. 11/07

[Related Sections: Part 1 - Part 2]

§ 701. Payment of Benefits – Payment Arrangements on Behalf of Individuals Who Have Difficulty Managing

Social Security payments to children under the age of 15 are made through a representative payee. That means that the payment is made to the representative, normally the parent or legal guardian in this case, who is then responsible for using the payments solely for the beneficiary. With children 15 and over, representative payment is the norm but direct payment to the child will be made under a variety of circumstances that indicate the child’s economic independence.

With adults representative payment is made only upon a showing that the beneficiary is incapable of managing benefits on his or her own.

The Act includes provisions designed to protect beneficiaries against exploitation or other abuses by representative payees. They include authority for payments to a beneficiary when Agency negligence in overseeing a representative payee results in loss of benefits.

[Related Sections: Part 1 - Part 2]

§ 710. Payment of Benefits – Overpayments and Underpayments

When individuals receive more or less than the amount to which they are entitled, the Act provides for an appropriate adjustment. If an individual has been underpaid, the Agency will pay the amount due. In the event the underpaid individual has died before this adjustment occurs, the Social Security Act provides for payment to surviving family members.

When individuals receive benefits to which they were not entitled (either because they were entitled to no benefits or because they were entitled to a smaller amount), the Act provides for recovering the overpayment. The overpaid individual or the individual’s estate can be required to make a refund or the overpayment can be recovered out of future benefits. The Act does, however, authorize waiver of recovery from a person who was without fault in causing the overpayment when the recovery would “defeat the purpose of the law” or “be against equity and good conscience.”
The Agency is authorized to recover overpayments from any federal tax refunds due the individual when he or she is no longer entitled to benefits from which overpayments might be recouped.

[Related Sections: Part 1 - Part 2]

SSI

§ 780. Supplemental Security Income – Payment, Overpayment, and Underpayment

SSI payments are made at the beginning of the month for which they are due (in contrast to Social Security). In other respects, though, the program’s provisions for payment and for dealing with over or under payment are the largely the same as those governing Title II. Because of the limited economic resources of SSI recipients, the provisions for waiving recovery of overpayments are in some respects more forgiving.

Rev. 9/95

[Related Sections: Part 1 - Part 2]

Sources of Social Security and SSI Law

§ 800. Sources of Social Security and SSI Law – In General

Social Security and SSI law is based on a single Federal statute, the Social Security Act of 1935, as amended. Under the Social Security Independence and Program Improvements Act of 1994 the Social Security Administration was removed from the Department of Health and Human Services, where it had been located, and established as an independent agency. Decisions of the Agency or in the language of the Social Security Act final decisions of “the Commissioner” are subject to review in Federal district court with appeal on up to the Supreme Court.

The primary sources of law for these programs are, as a consequence, the Act, the regulations promulgated by the Agency, other less formal Agency guidance and interpretations, and decisions by Federal courts on questions of Social Security or SSI law.

Rev. 12/03

[Related Sections: Part 1 - Part 2]
§ 801. Sources of Social Security and SSI Law – The Act

Subject to Constitutional limits, the Social Security Act is the ultimate source of law for Social Security and SSI. Agency or judicial interpretations of the Act with which Congress disagrees can be “reversed” by an amendment of the Social Security Act. Since the Act was first passed in 1935, it has been the subject of repeated amendment. Most of these statutory changes have extended benefits to new categories of recipients or liberalized the benefit formula. Some, however, have removed or reduced benefits for classes of individuals. In *Flemming v. Nestor*, 363 U.S. 603 (1960), and *Richardson v. Belcher*, 404 U.S. 78 (1971), the Supreme Court upheld Congressional power to make such amendments noting that the Act itself reserves this right.

The provisions of the Act governing Old-age Survivors and Disability Insurance benefits are contained in Title II, which begins at 42 U.S.C. § 401. SSI benefits are covered in Title XVI of the Act, which begins at 42 U.S.C. § 1381.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ 802. Sources of Social Security and SSI Law – The Regulations

The Social Security Act expressly authorizes the Agency to promulgate rules and regulations in carrying out its responsibilities. This authority extends not only to procedures for carrying out the respective programs, but also to regulations on the “nature and extent of proofs and evidence.”


Rev. 11/05

[Related Sections: Part 1 - Part 2]
§ 803. Sources of Social Security and SSI Law – The Social Security Rulings

In addition to regulations, the Agency periodically issues “Social Security Rulings.” These are interpretations of specific points of Social Security or SSI law. Generally they are based on a particular set of facts. Many of these rulings are excerpts from judicial opinions or, less frequently an administrative law judge decision, prepared by the Agency and distributed to all its components. While rulings do not have the full force of regulations with the courts, they are binding on Agency personnel.

Rev. 9/95

[Related Sections: Part 1 - Part 2]

§ 804. Sources of Social Security and SSI Law – The Program Operations Manual System or POMS

Agency staff are instructed on agency policy and procedures by a voluminous collection of material called the Programs Operations Manual System (POMS). Copies of the POMS are available at all Social Security offices. It is also accessible on the Web.

Rev. 12/02

[Related Sections: Part 1 - Part 2]

§ 805. Sources of Social Security and SSI Law – Court Decisions

The Social Security Act subjects Agency decisions in individual cases to judicial review in Federal district court. Decisions by Federal district courts or upon appeal by a U.S. Court of Appeals or the Supreme Court can reverse an Agency decision interpreting the Act or regulation.

These court decisions not only have the effect of overruling the Agency in a particular case but, to the extent that they rest on a rejection of an Agency interpretation or policy or procedure, they apply to other cases.

Following an adverse decision of the Supreme Court, the Agency has no choice but to readjust the program nationwide. However, it does not always alter national rules or policies following decisions of lower Federal courts with which it disagrees. Its practice is to issue “acquiescence rulings” that yield to Court of Appeals decisions that run contrary to Agency interpretation, but only within that court’s circuit. Securing agency
adherence to district court decisions as precedent or even those of the Court of Appeals in situations not covered by such a ruling or other Agency acknowledgment may well require pursuing an appeal in another affected case to the point of judicial review.

Rev. 12/03

[Related Sections: Part 1]

§ 806. Sources of Social Security and SSI Law – Other Resources

The Hallex, an internal manual of the Social Security Administration, Office of Hearings and Appeals, now online, provides the most immediate guidance on Social Security litigation issues to ALJs, members of the Appeals Council and supporting staff. Other useful resources on Social Security and SSI law noted in this reference work include law journal articles, some of which can be retrieved in full text via online services.

Rev. 12/03

[Related Sections: Part 1]

§ 820. Constitutional Issues in the Social Security and SSI Programs

In the lifetime of the Social Security program, a wide range of constitutional issues have been raised concerning the program’s requirements, benefit patterns, and procedures, as well as changes to the Act reducing or eliminating benefits for classes of individuals. During its much shorter life, SSI has been subject to constitutional challenge, as well.

Since both Social Security and SSI are Federal programs these challenges have been framed in terms of those Constitutional provisions that constrain the Federal government, as distinguished, in particular, from the 14th Amendment’s limits on states.

In most such cases the Social Security Act and regulations have been upheld. However, there are important exceptions. OASDI’s original disparate treatment of men and women was, for example, removed through a series of constitutional challenges.

Rev. 9/95

[Related Sections: Part 1 - Part 2]
Relationship to Other Benefits

Social Security

§ 900. Relationship of Social Security to Other Benefits – In General

Social Security benefits are generally intended to replace earnings that have ended because of retirement, disability, or death. That intention leads to provisions limiting payment of benefits to individuals who, prior to the Act’s “full retirement age,” in fact continue to have substantial earnings. There are no similar limits applying to other sources of income, particularly those generated by individual savings, private pension plans, or insurance since Social Security has from the beginning been conceived of as a foundation or base benefit rather than full earnings replacement. Supplemental Security Income (SSI) is, by contrast, a program designed to provide a floor for individuals without other adequate income (including Social Security), and it therefore takes account of most other benefits and income sources.

Despite this general pattern, there are a number of provisions designed to coordinate Social Security with other benefits under special circumstances so that unintended earnings replacement levels do not result from overlapping recovery.

[Related Sections: Part 1]

§ 901. Relationship of Social Security to Other Benefits – Medicare

Although Medicare, the related Federal programs of hospital insurance and supplemental medical insurance benefits, is closely connected to Social Security, these medical insurance benefits constitute a separate set of programs, with distinct funding and eligibility rules.

Entitlement to Social Security benefits and to Medicare can coincide, but need not. Medicare is not available on the basis of age before 65, while all Social Security benefits with an age threshold allow benefits to be claimed earlier.

The closest linkage between the two programs exists for those who qualify for Social Security disability benefits. Not only recipients of benefits for disabled workers but disabled widow(er)s and disabled children become eligible for Medicare by virtue of their Social Security eligibility. This Medicare eligibility does not follow disability benefits immediately but arises only after benefits have been received for 24 months.

[Related Sections: Part 1]
§ 902. Relationship of Social Security to Other Benefits – Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is another benefit program administered by the Social Security Administration. Its benefits are not based upon past earnings but current need, measured by low income and limited assets. SSI benefits are available to individuals who are 65 and over or blind or disabled. Since Title II benefits can be quite low for individuals who had low incomes and limited employment, overlap between Title II and SSI is reasonably common. While the two programs have different age thresholds, they employ the same definition of disability.

Rev. 9/95

[Related Sections: Part 1 - Part 2]

§ 903. Relationship of Social Security to Other Benefits – State Disability Benefits

Disability benefits provided by Federal, state, or local governments for public employment not covered by Social Security may be offset from Social Security disability benefits. This offset does not extend to private insurance benefits nor does it apply to need-tested benefits or Veterans Administration disability payments. The reduction is designed to prevent cumulative disability benefits to the individual and family that might make benefits more attractive, financially, than employment.

[Related Sections: Part 1 - Part 2]

§ 904. Relationship of Social Security to Other Benefits – Workers Compensation

Worker’s compensation benefits payable under Federal or state law may be offset from Social Security disability benefits. The reduction is designed to prevent cumulative disability benefits to the individual and family that might make benefits more attractive, financially, than employment.

[Related Sections: Part 1 - Part 2]

§ 905. Relationship of Social Security to Other Benefits – Private Pensions, Savings, Insurance

Social Security benefits are a base level of economic security on which individuals are encouraged to build. Private pensions, savings and other investments, insurance
payments, and annuities are all private arrangements that will add to Social Security. Receipt of such benefits has no effect on entitlement to or the amount of Title II benefits.

Economic resources of this type do, however, count against the income and resources test of the Supplemental Security Income program. In contrast, to Title II benefits, SSI payments are focused on those who have insufficient other income.

[Related Sections: Part 1]

§ 906. Relationship of Social Security to Other Benefits – State Pensions

When an individual’s working career includes both private sector work and public sector work, the public pension based on the latter will have no across-the-board effect on Social Security benefits. That is true whether or not all or part of the public pension payments relate to work that was not covered by Social Security. However, entitlement to a public pension based on work not covered by Social Security can lead to application of a reduced Social Security benefit formula for old-age and disability benefits. In addition, in the case of Social Security spouse benefits, the Social Security Act provides for an offset under limited circumstances. The offset is designed to treat the public pension received by the spouse as more or less comparable to a Social Security primary benefit. Just as an old-age insurance (retirement) benefit would be offset from the spouse benefit, a public pension based on uncovered government work is also.

[Related Sections: Part 1 - Part 2]

§ 907. Relationship of Social Security to Other Benefits – Federal Civil Service Pensions

When an individual’s working career includes both private sector work and a period of Federal Civil Service, the Civil Service pension based on the latter will have no across-the-board effect on Social Security benefits. That is true whether or not all or part of the Federal pension payments relate to work that was not covered by Social Security. However, the method of calculating the Social Security monthly amount is adjusted to take account of the amount of noncovered work. Furthermore, in the case of Social Security spouse benefits, the Social Security Act provides for an offset under limited circumstances. The offset is designed to treat the Civil Service pension received by the spouse as more or less comparable to a Social Security primary benefit. Just as an old-age insurance (retirement) benefit would be offset from the spouse benefit, a Federal pension based on uncovered government work is also.

[Related Sections: Part 1 - Part 2]
§ 908. Relationship of Social Security to Other Benefits – Railroad Retirement Benefits

Benefits paid under Social Security and the Railroad Retirement Act have been integrated by bringing work covered by the Railroad Retirement Act under Social Security for short-term railroad workers and leaving benefits for long term railroad workers under the Railroad Retirement Act. A period of 10 years of railroad work is the dividing line.

[Related Sections: Part 1 - Part 2]

§ 909. Relationship of Social Security to Other Benefits – Other Countries’ Social Insurance Programs

The Social Security Act contains detailed provisions for combining coverage and benefits earned in the U.S. and in certain foreign countries with comparable Social Security programs. Such combined calculations are carried out pursuant to “totalization agreements” authorized by 42 U.S.C. § 433. Even where there is no such agreement the receipt of a pension from work for a foreign employer not covered by Social Security can lead to application of a reduced Social Security benefit formula for old-age and disability benefits.

Rev. 11/07

[Related Sections: Part 1 - Part 2]

SSI

§ 915. Supplemental Security Income – Relationship to Other Benefits

Most forms of other income including benefits like unemployment insurance, workers compensation, Social Security, and veterans pensions reduce SSI, essentially dollar-for-dollar. State and local need-tested benefits intended to augment SSI do not, nor do important need-tested Federal benefits like food stamps or the complementary medical benefit programs Medicaid and Medicare.

Rev. 9/95

[Related Sections: Part 1 - Part 2]
Foreign Aspects of Social Security and SSI

§ 920. Social Security or SSI and Travel or Immigration

U.S. nationals are entitled to received Social Security benefits whether or not they continue to reside in the U.S. Non-U.S. nationals, by contrast, do not receive benefits after they have been outside the U.S. for 6 consecutive months unless they fall within one of several exceptions.

With SSI, subject to a few exceptions, absence from the United States for a full calendar month renders an individual ineligible for benefits.

Rev. 9/95

[Related Sections: Part 1 - Part 2]
Part 2 – Topics

General Issues of Coverage and Proof

§ A 100. The Need to File an Application – Social Security

Filing an application is a precondition to Social Security benefit entitlement and also to recognition of a period of disability which will later be considered in benefit calculations. There are only two situations in which the Act does not require an application. One is where a person who is receiving one type of Social Security benefits becomes eligible for another. A person who applied for and was receiving disability insurance benefits need not, when he or she reaches the Act’s “full retirement age,” apply again for old-age benefits; a person receiving spouse benefits on the account of a retired worker need not apply for widow or widower’s benefits if that worker dies.

The Act provides a second exception; it operates when misleading information received from the Social Security Administration causes a person not to apply. A later application by that person can be dated from the earlier contact. Previous law was to the contrary. In Schweiker v. Hansen, 450 U.S. 785 (1981), the Supreme Court held that the Agency was not estopped from denying benefits to a claimant who failed to file an application even though her failure to do so was the result of an erroneous statement by Agency staff.

An applicant for Social Security benefits of any kind must furnish satisfactory proof of an existing Social Security number or apply for one.

Eligible claimants can in many cases elect to have benefits paid for a period of months (6 months or 12 months depending on benefit type) prior to the month of application. Generally this election is not available when payment of benefits for the prior period would, because of the claimant’s age, give rise to a reduction in the monthly benefit amount.

Rev. 12/01

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 200. Insured Status – In General

All Social Security benefits, whether old-age, disability, or family benefits, require some person (either the claimant or the relative on whom benefits depend) to have sufficient covered wages or self-employment income to qualify for “insured status.” Different benefits require different types of insured status, but all require some type.

The tests of insured status are expressed in terms of quarters of coverage, requiring a certain number of such quarters altogether or a certain number during a specified period.
of time. The three principal insured status tests are: fully insured, currently insured, and insured for disability benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 210. Insured Status – Fully Insured

Old-age or retirement benefits and all family benefits for survivors are available on the basis of “fully insured” status. (In addition, the insured status test for disability insurance benefits is, in part, derived from the “fully insured” concept.) The test for fully insured status contains a sliding scale requiring more quarters of coverage of successive cohorts of beneficiaries. The sliding scale stretches between a minimum of 6 quarters of coverage and a maximum of 40. No one, except those in a few special classes dealt with specifically by Congress, can qualify for fully insured status without having 6 quarters of coverage (the equivalent of a year and a half of covered work). And anyone with 40 quarters of coverage (the equivalent of 10 years of covered work) has such insured status. Whether someone with fewer than 40 quarters meets the test depends on date of birth and the basis of their claim.

For all individuals reaching 62 in 1991 or thereafter and claiming old-age or retirement benefits, the full 40 quarters is required.

The sliding scale applies to those born prior to 1929, requiring one quarter of coverage for each year falling after 1950 (a year in which the program’s coverage was dramatically increased) but before the year the person becomes 62. This formula, for example, requires 37 quarters for individuals who turned 62 during 1988 (having been born in 1926), 38 quarters of coverage for those born in 1927 who turned 62 during 1989.

In the case of a deceased individual on whose account survivors benefits are claimed the full 40 quarters is not required if the deceased has one quarter for each year after the age of 21 before the year of his or her death.

Rev. 12/01

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 220. Insured Status – Currently Insured

Currently insured status is based on recent work rather than a long period of covered work. A worker with 6 quarters of coverage out of the last 13 quarters prior to death, disability, or entitlement to old-age benefits is currently insured. Benefits available on the basis of currently insured, as distinguished from fully insured, status.
include survivors benefits for children, survivors benefits for a younger spouse caring for eligible children, and lump sum death benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 250. SSI – The Need to File an Application

Otherwise eligible individuals will not receive Supplemental Security Income (SSI) benefits without filing an application. For those who can qualify for benefits, delays in filing an application, thus, translate directly into benefits lost.

Some written and even some oral contacts with the Agency can, if followed up promptly by an application, establish an earlier date for the application. The regulations provide detail on such “protective filing date” situations. Upon receipt of a written statement that can qualify, the Agency is supposed to send a notice of the need to file an application. To qualify for the earlier date, the claimant must file the application within 60 days of that notice.

As with Social Security benefits, a failure to file because of misleading information received from the Social Security Administration receives special treatment. A later application by the person misled can be dated from the earlier contact.

Rev. 9/95

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 260. SSI – Categorical Eligibility – In General

The Supplemental Security Income program (SSI) provides cash benefits to individuals whose income and assets fall below set national standards, but not all individuals. SSI’s “need-tested” benefits are provided in rough but not precise parallel to Social Security benefits, being limited to three categories – the aged, blind and disabled. Those within the SSI categories must meet certain other eligibility tests and qualify by virtue of low income and limited assets. Individuals and families with insufficient income who fall outside the SSI categories must turn to other programs for assistance.

SSI, established in 1974, replaced state programs, supported in part by Federal funds. To ease the transition special eligibility rules and certain related provisions applied (and still apply) to individuals who were receiving benefits under the predecessor programs. These provisions, still part of the law, apply to relatively few recipients.

Rev. 12/01

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ A 270. SSI – Categorical Eligibility – 65 or Older

While Social Security old-age benefits can be begun at age 62 and widow or widower benefits at age 60, SSI benefits based on age require that the individual be 65 or older. Persons already eligible for SSI by virtue of blindness or disability may be subject to slightly different rules upon turning age 65.

Since establishing age can be critical to eligibility, proof of age is addressed in detail by the regulations. The regulations spell out the Agency’s preferred types of age evidence, starting out with a public birth record. The regulations also provide for reliance on a state’s report of age, in the absence of evidence to the contrary, and for less rigorous documentary evidence when the individual claims an age of 68 or more.

Rev. 9/95

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 280. SSI – Categorical Eligibility – Blind or Disabled

An individual is eligible for SSI based upon blindness if (i) with a correcting lens, his or her vision in the better eye is 20/200 or less, or (ii) he or she has tunnel vision of 20 degrees or less. Under Social Security Disability Insurance, a claimant qualifies as disabled on the basis of blindness with vision falling below this same standard. The SSI disability category is also defined in terms largely identical to those governing Social Security Disability Insurance.

It should be noted that for SSI purposes blindness is set apart on its own, rather than being swallowed up by the disability category. Two important differences between Social Security and SSI blindness claims emerge as a result of this separation. First, SSI’s blindness test has no duration requirement. Under Disability Insurance, blindness, like any other form of disability, must last for at least 12 months. Secondly, under SSI, “Substantial Gainful Activity” is not at issue for those eligible by virtue of blindness, as it is in Social Security. After demonstrating categorical eligibility based upon blindness, an individual needs only to meet the SSI income and resource limits.

Rev. 9/95

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 300. Covered Work

Earnings from nearly all work performed within the U.S. are covered by Social Security. This includes work performed for others as an employee (wages) and also work done within an individual’s own business or partnership (net earnings from self-employment). In addition some work performed outside the U.S. by U.S. nationals is covered.
Work that is covered by Social Security is subject to a special Social Security tax (the F.I.C.A. tax if the work is done as an employee, the S.E.C.A. tax if it is self-employment). And earnings from work that is covered figure into the Act’s eligibility requirements and benefit calculations.

Work done within a family has raised special issues for Social Security which have been the subject of an evolving set of rules. Some work that would otherwise qualify for coverage will not if done for certain relatives.

The coverage of domestic work, including baby-sitting by teen-agers, long an area of significant non-compliance, received Congressional attention in 1994. Amendments to the Act increased the threshold amount for coverage based on domestic labor to $1,000 per employer per year (with that figure subject to subsequent annual adjustment) and excluded part-time domestic work by those under 18, altogether. The threshold for 2006 is $1,500.

For individuals who are receiving benefits, earnings from covered work (and other work as well) can lead to a reduction in benefits under the excess earnings test. If those benefits are based on disability, the earnings can lead to a conclusion that the person is engaged in substantial gainful activity and is, therefore, not disabled.

§ A 310. What Counts as Wages or Self-Employment Income

Social Security employs a very expansive definition of wages. It provides that all remuneration for employment, no matter what it is called or how it is paid, must be and is counted as wages, up to an annual limit. Earnings from self-employment are defined as net income from work an individual does, not as an employee, but in pursuit of his or her own trade or business. Since return on investment and income from savings as distinguished from income from work do not count toward Social Security entitlement, wages and earnings from self-employment for an individual may be significantly less than the individual’s taxable income.

There are numerous specific situations in which income that would otherwise be treated as wages from employment is instead counted as self-employment income. These situations parallel comparable provisions governing the Social Security tax.

In Social Security Bd. v. Nierotko, 327 U.S. 358 (1946), the Supreme Court construed “wages” under the Act as including “back pay” granted to an illegally discharged employee.

There are numerous Social Security Rulings covering particular issues of wage or self-employment income treatment. Prior to 1988, the Act required the Social Security
Administration to accept the employing agency’s characterization and records of remuneration for Federal employees. It now specifically authorizes the Agency to determine whether particular remuneration constitutes wages from employment.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 320. Coverage of State and Local Government Employees

The work of most state and local government employees is covered by Social Security. But, with the exception of transportation workers for whom coverage is mandatory, that coverage is a consequence of individual state decisions implemented by agreement. Having chosen to bring a sector of public employment under Social Security, however, a state cannot later withdraw coverage.

Public pensions based on uncovered state or local government work give rise to an offsetting reduction of certain Social Security benefits based on family relationship. They can also lead to a reduced Social Security benefit formula for old-age and disability benefits.

Rev. 12/03

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 400. Quarters of Coverage

The key element in all Social Security insured status tests is the “quarter of coverage.” A quarter of coverage represents a calendar quarter in which the individual’s earnings covered by Social Security exceed a specific threshold. For years prior to 1978, the determination for wages actually applied to the four separate quarters of the year (the 3 month periods ending March 31, June 30, September 30, and December 31). For 1978 and after, the number of quarters of coverage credited for a year (from 0 to 4) is calculated in terms of total covered earnings for the year. That is true of self-employment income both before and after 1978. Under this approach work during a single month, if well compensated, can give rise to the maximum four quarters of coverage for the year. During 2008 wages of $1,050 generate one quarter of coverage; $4,200, a full four. Under a 2004 amendment, quarters of coverage are not awarded for work performed in the U.S. by non-citizens who have neither been lawfully issued Social Security numbers nor granted B1 or D visas.

Rev. 11/07

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ A 450. SSI – Income and Resource Limits – In General

The Supplemental Security Income program (SSI) provides a minimum income for aged, blind or disabled persons. Because of that aim, SSI is available only to individuals whose income and assets fall below defined levels. The income and assets (“resources”) of the applicant, and sometimes the income and resources of other economically-related persons, are with certain exceptions held against those levels. The exceptions give rise to the terminology – “countable” income and resources. An individual’s countable resources must fall below a statutory maximum to be eligible for SSI. And the individual’s countable income must fall below the Federal Benefit Rate (FBR) plus the applicable state supplement, if any.

Because they are tied to the benefit level the income limits are automatically adjusted to reflected changes in the consumer price index. For 2008, they are $637 for an eligible individual, $956 for an eligible individual with an eligible spouse. For 2007, the corresponding figures were $623 and $934.

The resource limits are $2,000 for an eligible individual, $3,000 for an eligible individual with an eligible spouse.

Rev. 11/07

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 460. SSI – Income and Resource Limits – Deeming

In determining an SSI claimant’s countable income and resources, the income and resources of certain other persons – such as spouses, parents, sponsors or essential persons – may be included. In these situations, the income and resources of the others will be counted because it is “deemed” to be available to the applicant, whether or not it is actually available.

Deeming of income and/or resources can occur in one, or possibly more, of the following situations. (1) An SSI eligible individual who lives in the same household as his or her ineligible spouse will have that spouse’s income and resources deemed. (2) A child under 18 living in the same household with a parent, adoptive parent or stepparent will generally have that parent’s income and resources deemed. (3) An alien will generally have the income and resources of his or her sponsor, as well as the sponsor’s spouse, deemed for a period of several years after the alien was admitted to the U.S. for permanent residence. (4) If an individual is one of those transition recipients (carried into SSI in 1974) receiving an increased amount of SSI due to the presence of an essential person in the household (no longer a large population), the income and resources of that essential person are deemed.

The first two categories of relationships in which deeming applies, spouses and parent-child, are entitled to numerous allowances and exclusions. These will in most situations lower the amount of income and resources deemed by a significant amount. For
instance, allowances are made for the living expenses of the spouse or parent whose income and resources are to be deemed, as well as any dependents living in the household.

The income and resources deemed from a sponsor or essential person are subject to far fewer numerous allowances and exclusions. While allowances are made for the living expenses of the sponsor whose income and resources are to be deemed, as well as any dependents living in the household, no such allowances are available for the essential person. In the case of an essential person, an applicant may choose to have the essential person increment left out of the SSI payment computation. While this practice does reduce the hypothetical maximum SSI payment, in some circumstances it can, because of deeming, result in a larger actual payment. However, once dropped from the calculation, the essential person cannot be reinstated.

Rev. 9/95

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 500. Earnings Record – In General

The Agency maintains a record of earnings for all individuals working in covered employment or self-employment. This earnings record is based principally on data furnished by the Internal Revenue Service. That means that it rests ultimately on tax returns filed by the individual or the individual’s employer.

This official record of earnings, including amounts and the period of time to which they relate, is the starting point for entitlement and benefit determinations. Individuals can review this record and request corrections in it. A failure to do so can lead to the record’s being conclusive or presumptive evidence on whether the individual had earnings during a particular period and, if so, how much.

The Act sets a time limit of 3 years, 3 months, and 15 days for requesting corrections after the year in question.

The Agency now sends an earnings record statement, together with a projection of benefits, annually to all individuals 25 or older for whom it has a current mailing address. In addition, statements can be requested at any time via the Agency website or by calling 1-800-772-1213.

When a worker has been employed by an employer who did not pay the Social Security tax or report the employment, the worker’s claim to a subsequent benefit may require confronting the evidentiary weight of the official earnings record.

Occasionally, usually when the issue is application of the excess earnings test, an individual may argue that the Agency must accept the official record as evidence of the level of earnings. In those instances the Agency is in the position of attacking or seeking
to change its own record, often after the expiration of the 3 years, 3 months, and 15 days time limit.

Rev. 11/07

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 510. Earnings Record – Self-Employment Income

Earnings records that reflect self-employment rest on the individual’s own tax returns. Consequently an absence of reported self-employment earnings for a period or an amount of such earnings above zero that was not the subject of a corrected tax return within the period of limitations of 3 years, 3 months, and 15 days, will in most cases be binding on the individual. Greater leeway to correct the records by establishing earnings not shown by them exists in the case of wages paid by an employer, especially when the official earnings records show no earnings from that employer (as distinguished from some amount, later asserted to be erroneous).

In KY, MI, OH, and TN an acquiescence ruling (AR 86-20) implements the Sixth Circuit’s decision in Grigg v. Finch, 418 F.2d 661 (6th Cir. 1969) that amendments of an earnings record to reflect self-employment income after the time limit may be appropriate where no income tax return was filed and certain other conditions are met.

§ A 520. Earnings Record – Military Service Credits

For years prior to 2003, the earnings record for a member of the uniformed services included more than the individual’s “basic pay,” even though that was the only portion of his or her compensation on which the Social Security tax was paid. The additional wage credit entered on top of that amount scaled according to the individual’s basic pay. No credit was provided for an individual with less than $300 in basic pay for the year. Beyond that threshold, a credit of $100 was added for each $300 of basic pay, up to a maximum credit of $1,200 for the year. Congress ended those credits for years after 2001.

Prior to 1957 the uniformed services were not covered on a contributory basis by Social Security; however, those who served during the period 1940-56 received certain noncontributory wage credits.

Rev. 12/02

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

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§ A 530. Earnings Record – Other Credits

Special wage credits are provided for the U.S. citizens of Japanese ancestry of working age who were interned during World War II. These credits are calculated to approximate the earnings they were denied by virtue of their internment.

In addition, the Act still contains provisions authorizing benefits to generations of workers who had little chance for Social Security coverage. These dated provisions have no relevance for current generations reaching retirement age.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 540. Earnings Record – Year of Earnings

In most Social Security settings it is important to know when earnings are counted, for the provisions are framed in terms of amount of earnings during some period. Although minor exceptions exist, wages from employment are generally counted when received by the worker or, if earlier, when credited to the worker and available, without restriction, for withdrawal. Earnings from self-employment are counted in the period to which they relate as they are treated under the Internal Revenue Code.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 550. SSI – Countable Income

In the Supplemental Security Income program (SSI) “countable income” can have two related effects. When countable income exceeds the income eligibility figure, it disqualifies an individual or couple from receiving benefits altogether. Smaller amounts of countable income reduce SSI benefits dollar-for-dollar. But since countable income may be less than actual income, the true net effect on the individual’s total revenue may be less severe.

The Agency computes countable income using a practice called Retrospective Monthly Accounting (RMA). This practice is based not on projections of income for the current month, but rather on amounts of income reported in the second month prior to the current month. When an individual first becomes eligible for SSI benefits, the Agency computes payments for the first and second month based upon the first month’s income. Under RMA, benefits for the third month are also calculated based upon the first month. Thus, in situations where a new SSI recipient has “non-recurring” income in the first month, that income will be counted for all of the first three months, even though not actually received in months two and three. This practice of “triple counting,” specifically disallowed under some other aid programs, has found a mixed reception in the courts.
Certain forms of revenue or economic benefit are not considered income at all by SSI. The most significant of these are other need-tested benefits intended to augment SSI. Money received from the sale of a resource or from a loan is not counted nor are income tax refunds. But income need not be cash; free shelter and other forms of “in-kind” income are counted. The basic test is whether what is received can be used as food, clothing, or shelter or to obtain them. An important item not on this defining list is medical care. The receipt of medical care or services directly or of cash restricted to or reimbursing for medical costs does not qualify as income.

Treatment of items that fall within the SSI definition of income varies depending on whether they are characterized as “earned income.” Earned income is subject to more generous exclusions in the calculation of countable income than apply to unearned income. Earned income, either wages or net earnings from self-employment, can be in the form of cash or it can be in-kind. Earned income that is received in-kind is valued at current market value. Wages and net earnings from self-employment are defined by SSI using the same standards as apply with Social Security.

Unearned income can essentially be described as any income recognized by SSI which is not classified as earned income. Unearned income can be in the form of cash or it may be in-kind. One significant exclusion applying to unearned income concerns some types of support and maintenance assistance, such as fuel, shelter or food, which are based solely on need and received from utilities, municipalities or private non-profit organizations.

Unearned income received in-kind is subject to one of several valuation rules, depending upon the nature of the income. In-kind income which is unearned and which is not in the form of food, shelter or clothing is valued at its current market value. In-kind income which is unearned and in the form of food, shelter or clothing, referred to as “in-kind support and maintenance,” is subject to one of two valuation rules. If an individual lives in the household of another for a full month and receives both food and shelter within that household, the actual value of that in-kind support and maintenance is not calculated. Rather, the SSI benefit is reduced by a fixed value equal to one third of the Federal Benefit Rate. If an individual is not receiving both food and shelter or while receiving them is not “in the household of another,” then the in-kind support is valued according to the “presumed maximum value rule.” Under this rule, support is presumed to be valued at an amount equal to one third of the Federal Benefit Rate plus $20. The presumed maximum is rebuttable. If an individual can show that the support is worth less than the full amount, a lower value will be used.

In most instances where an individual is paying less than fair market value for food or shelter, that individual is considered to be receiving in-kind support and maintenance. As noted above, the value of such support is normally calculated at one third the federal benefit rate plus $20. However, in IN, IL, and WI, regulations required by the Seventh Circuit’s decision in Jackson v. Schweiker, 683 F.2d 1076 (7th Cir. 1989), (see 20 CFR § 416.1130(b)) provide that no actual benefit will be found where the amount of rent actually paid equals or exceeds one-third of the Federal benefit rate plus $20. Under AR
§ A 580. SSI – Countable Resources

Unlike income, resources do not affect the dollar amount of the SSI payment, but bear only on the threshold issue of eligibility. Thus, if an individual has countable resources below the statutory resource limitation, that individual is eligible for SSI benefits, the actual benefit amount of course being dependent upon the individual’s countable income. If countable resources exceed the statutory limit, then the individual is generally not eligible for SSI.

Countable resources are computed in much the same way as countable income; allowed exclusions are subtracted from total resources. There are a number of specific exclusions, for instance for such items as an automobile, a home or business property. These exclusions, listed in the regulations, can dramatically reduce the amount of countable resources. It is possible for individuals or couples to become eligible for SSI by giving away a resource or selling a resource at less than fair market value.

There is also provision for SSI to be paid, under certain circumstances, to an individual possessing excess resources while those resources are being disposed of. Such payments are treated as overpayments to the extent they exceed what would have been received had the excess been disposed of when benefits began.

§ A 600. Proof of Age

Nearly all categories of benefits involve some age requirement. For example, to be entitled to old-age benefits an individual must be at least 62, widow(er)s benefits, 60, child benefits, under 18. There are a few exceptions. Lump sum death benefits and spouse benefits for spouses caring for an eligible child are two. Even with disability benefits, age can bear on the insured status test or factor into the disability determination itself.
Where proof of age is critical, the burden of proof lies on the claimant. The regulations spell out the Agency’s preferred types of age evidence starting out with a birth certificate or hospital birth record. They do, however, allow use of other “convincing evidence” and provide several examples.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 700. Proof of Death – In General

Entitlement to survivors benefits rests upon the death of an insured worker. Proving the death, not only that it occurred but when, is normally a simple matter.

Where proof of death is required, the burden of proof lies on the claimant. The regulations spell out the Agency’s preferred types of evidence starting out with a death certificate or a statement by a funeral director or attending physician. They do, however, allow use of other “convincing evidence” when the claimant can explain why one of the preferred types is not available.

The cases that pose difficulties of proof are those in which those claiming survivors benefits were not with the worker at the time of the apparent death, including especially those in which the worker has simply disappeared.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 710. Proof of Death – Presumed from Absence

Death can be established by a period of absence. The regulations provide that if another agency of the Federal Government has declared a missing person “presumed to be” dead that will be accepted for Social Security. They also provide for presuming death in cases where the person has been absent without apparent reason and has not been heard from for seven years.

The nature and location of the burden of proving that a seven year absence could not reasonably be explained by a cause other than death has been heavily litigated. Prior to a regulation revision issued in April 1995, the Agency took the position that the claimant had the burden to show that there was no apparent reason for the person’s disappearance, an interpretation rejected by all U.S. Court of Appeals circuits presented with the issue. The revised regulations provide that death can be presumed from absence alone and explain the grounds on which that presumption can be rebutted. Upon issuing the 1995 revision, the Agency rescinded a long list of acquiescence rulings reflecting the circuit court decisions that the new regulations, in effect, apply nationwide.

Rev. 6/95

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ A 720. Proof of Death – Date of Death

In most cases satisfactory proof of death will also include proof of date of death. This is not true, however, in cases where death is presumed from unexplained absence. When another Federal agency has found the individual “presumed to be” dead, the regulations provide that the date of death is taken to be the date the person was declared missing. When death is presumed from a seven year absence the regulations give the Agency wide discretion to set the most likely date of death.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 800. Conviction of a Felony or Fleeing to Avoid Prosecution and Benefits

Benefits are not paid to any individual convicted of a felony and confined in a jail, prison, or other penal institution or correctional facility. The bar is limited to the prisoner. Other family members can continue to receive benefits as though the prisoner were eligible. Benefits resume when the individual is released.

Amendments to the Act in 1994 extended benefit suspension to individuals confined for treatment who were not convicted of a criminal offense because of mental illness and also clarified the treatment of individuals living under supervision but outside an institution. The suspension was further expanded in 2004 to cover those fleeing to avoid prosecution for a felony or to avoid confinement following conviction, as well as individuals violating parole or probation.

In CT, NY, and VT an acquiescence ruling (AR 06-1) implements the Second Circuit’s decision in Fowlkes v. Adamec, 432 F.3d 90 (2nd Cir. 2005), which held that the Agency could not conclude that an individual was fleeing to avoid prosecution, custody, or confinement from the mere fact that an outstanding felony arrest warrant or similar order exists. The decision requires some evidence that the individual knows he or she is being sought. The Agency's view is that the existence of an outstanding warrant is enough.

Under limited circumstances, prisoners receiving benefits due to disability can continue to receive benefits while participating in a court-approved program of vocational rehabilitation.

Rev. 11/07

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ A 850. SSI – Institutionalization and Eligibility

Stays in a public institution for more than 30 days can affect either eligibility for Supplemental Security Income (SSI) or the amount of benefits. As a general rule, such a stay throughout any month will make an individual ineligible for SSI during that month. Some important exceptions reduce the effect of that eligibility rule. Most significantly, residents of a medical treatment facility to which Medicaid is paying more than 50 percent of the cost of care remain eligible for SSI. However, monthly payments in such a case are reduced dramatically to a “personal needs benefit” of $30. Needless to say, there are exceptions to this $30 limit. Among others is one providing that normal SSI benefits may continue if a doctor certifies, within the first three months of an individual’s stay in an institution, that the stay is not likely to exceed three months and that normal SSI benefits are necessary for maintenance of a home to which the individual will return upon release.

Rev. 9/95

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 900. Foreign Nationality or Residence

Nationality and residence affect Social Security benefits in a variety of ways.

U.S. nationals are entitled to receive benefits whether or not they continue to reside in the U.S. Income they earn outside the U.S., including income that does not count toward Social Security coverage, may reduce benefits in a manner similar to earnings in the U.S.

Non-U.S. nationals, otherwise entitled to benefits, do not receive them after they have been outside the U.S. for 6 consecutive months. There are, however, several exceptions to this bar. One such exception exists for individuals whose benefits rest on 10 years of residence and work in the U.S. and who are outside the U.S. in a country with a Social Security system meeting certain requirements of comparability. Under provisions of the 1996 Welfare Reform Legislation (P.L. 104-193) dealing with aliens, codified to 8 U.S.C. §§ 1601-1614, the only non-citizens eligible for Social Security are those “lawfully present” in the U.S. and those covered by treaty or totalization agreements. These provisions apply to those applying for benefits on or after September 1, 1996. Under a 2004 amendment, quarters of coverage are not awarded for work performed in the U.S. by non-citizens who have neither been lawfully issued Social Security numbers nor granted B1 or D visas.

Finally, there are detailed provisions for combining coverage and benefits earned in the U.S. and certain foreign countries with comparable Social Security programs.
Such combined calculations are carried out pursuant to “totalization agreements” authorized by 42 U.S.C. § 433.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ A 950. SSI – Foreign Nationality or Residence

Only U.S. citizens and aliens lawfully admitted to the United States are eligible for Supplemental Security Income (SSI). In addition to this requirement the program carries a strict residency test.

If an individual is absent from the United States (the 50 states and the District of Columbia) for a full calendar month, that individual will become ineligible for SSI benefits. There are two important exceptions to this rule. Children who are U.S. citizens eligible for SSI benefits and who subsequently accompany parents on U.S. military assignments to foreign countries, Puerto Rico or other possessions of the U.S. continue to be eligible for SSI benefits. In addition, persons leaving the U.S. for certain educational programs are exempt from the 30 day rule.

The residency test is more narrowly defined than the requirement of citizenship. While the latter includes residents of Puerto Rico, Guam, and the Virgin Islands, for example, by virtue of the residency requirement they are eligible for SSI only while living in one of the 50 states, D.C., or the Northern Mariana Islands. In Califano v. Torres, 435 U.S. 1 (1978), the Supreme Court upheld SSI’s residency test as applied to individuals who lost benefits by moving to Puerto Rico from the continental U.S. The Court rejected the argument that the constitutional right to travel required otherwise.


[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
Benefit Calculation and Payment

§ B 100. Primary Insurance Amount

All monthly Social Security benefits are calculated in relation to a primary insurance amount (PIA). Disability benefits and old-age benefits that are first claimed at the Act’s “full retirement age” (which is between 65 and 67 depending on year of birth) are equal to the primary insurance amount. Family benefits are various percentages of the PIA, ranging from 100% for a surviving spouse to 50% for a spouse or child of an old-age or disability benefit recipient.

The current method for calculating a worker’s primary insurance amount is based upon the worker’s covered earnings over an extended period. Those earnings are indexed against the movement in general wage levels. In addition, in determining the PIA a limited number of low earnings years are dropped from the calculation.

[SUPPORTING AND ELABORATING REFERENCES] [RELATED SECTIONS: PART 1 - PART 2]

§ B 150. Full Retirement Age

Throughout most of the Social Security program’s history, its benchmark retirement age was 65. Increasingly age-based benefits were made available prior to that age, but only those waiting to start benefits until 65 or later received benefits based on a full percentage of the PIA. In 1983, as part of a comprehensive program revision, Congress enacted a long-term progressive adjustment of what has come to be called the “full retirement age” (previously the “normal retirement age”). A schedule of incremental increases beginning with the cohort of individuals who reached 62 in the year 2000 move the “full retirement age” from 65 to 67. For an individual turning 62 after 2000 but before 2022 (at which time the “full retirement age” will be 67, the benchmark age lies between 65 and 67. As the age moves back according to the statutory schedule, the total reduction for beginning benefits at the earliest possible age, e.g., 62 for old-age benefits, increases. By the time 67 becomes the “full retirement age” in 2022, the total reduction for an individual beginning old-age benefits at 62 will have risen from the 2000 maximum of 20 percent to 30 percent.

Those claiming age-based benefits who wait until after the “full retirement age” have their monthly benefits increased by a “delayed retirement credit.”

In addition, the “full retirement age” marks the point beyond which high levels of continuing earnings no longer have an impact on benefits; and for those receiving disability insurance, it is the point at which disability benefits cease and old-age benefits begin.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ B 200. Cost of Living Adjustment

Each December monthly benefits are adjusted to take account of rises in the cost of living. Unless the Social Security Trust Fund reserves are below a specified level, this adjustment is based on the percentage increase in the Consumer Price Index over the prior measurement year. If reserves are low, the increase is based on the percentage increase in wage levels over the measurement year if that is lower.

Pursuant to this adjustment, benefits rose 2.3% at the beginning of 2008. They rose 3.3% from 2006 to 2007.

Rev. 11/07

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ B 300. Excess Earnings Reduction – In General

With the exception of disability-based benefits where the receipt of continuing earnings is treated as potential proof of a lack of disability, benefits can be received by people continuing to earn income so long as the income does not exceed a set level known as the excess earnings or retirement test. That level is readjusted each year as general wage levels change. Those who have reached the Act’s “full retirement age” (which is between 65 and 67 depending on year of birth) receive full benefits no matter how high their continuing earnings. For younger beneficiaries there is a threshold beyond which earnings reduce benefits. The annual amount is $13,560 for 2008. (Prior to a 2000 amendment, excess earnings, measured by a more generous threshold, reduced payments to beneficiaries between the “full retirement age” and 70. That formula still applies to months in the year of the individual’s “full retirement age” prior to his or her birthday.)

Earnings above the threshold amount do not block benefits altogether but reduce benefits by a ratio of 2:1

The earnings of an old-age benefit recipient affect the benefits of all family members who receive those benefits on the worker’s account (other than a former spouse, divorced some time ago). The Act requires that a divorced spouse have been divorced for at least 2 years before he or she becomes exempt from benefit reduction due to the worker’s excess earnings. A 1990 amendment removed that 2 year requirement in cases where the divorce follows the worker’s entitlement to old-age insurance (retirement) benefits.

The earnings of those receiving family benefits on the account of another affect only their own benefits.

Rev. 11/05

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ B 310. Excess Earnings Reduction – Reclassification of Income

Only earned income received by the beneficiary produces a reduction in benefits under the excess earnings test. Ordinarily, investment returns including dividends paid on stock have no effect on benefits. And, ordinarily, earnings received by other family members are not counted as earnings of the beneficiary.

In determining a beneficiary’s earnings, however, the Agency does not always accept the individual’s own characterization or formal legal structures or income tax treatment of the situation. When it appears that a business has been restructured to convert income that would otherwise be earnings for a beneficiary into investment income or earnings of a close family member, the Agency may apply that income against the excess earnings test.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ B 320. Excess Earnings Reduction – Self-Employment Income

Net income from self-employment is also held against the excess earnings test. Because of the need to distinguish self-employment income from passive investment income the characterization of income from a business in which the individual no longer provides substantial services raises special difficulties.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ B 330. Excess Earnings Reduction – Business Expenses

Business expenses of a self-employed person are deducted before the excess earnings test is applied since it is net income from self-employment that counts. On the other hand, wages from employment are counted without any provision for offsetting the worker’s expenses.

The treatment of expenses of life insurance agents is the subject of Social Security Ruling, SSR No. 71-22, which provides illustrative examples.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ B 350. SSI – Benefit Level – In General

While Title II Social Security benefits can be viewed as an insurance plan aimed at maintaining income levels bearing some relation to a worker’s past earnings (in the event of retirement, death or disability), SSI was created to insure a minimum income “floor”
for aged, blind or disabled persons. Thus, while Title II benefits vary based upon each recipient’s prior earnings record, Title XVI benefits vary depending upon how far under the program’s income floor individuals are located. After analyzing countable income, SSI pays what is necessary to bring an individual to the statutory income floor. Countable income is calculated using a practice called Retrospective Monthly Accounting (RMA). Under RMA it is not a projection of current income but amounts of income received in the second month prior to the current month that determine benefits.

The base level of the SSI income floor is referred to as the Federal Benefit Rate (FBR) and is constant across the country. Many states choose to supplement the FBR. In those that do the resulting income floor is equal to the FBR plus the state supplementation. The FBR is indexed to the consumer price index in the same manner as Title II benefits. For 2008, it is $637 per month, $7,644 per year for an eligible individual.

Rev. 11/07

§ B 355. SSI – Benefit Level – Eligible Couples

SSI has a separate benefit level (with associated income and resource limits) for couples. Two elderly siblings living in the same household are treated as two eligible individuals. A husband and wife are treated as a couple, an eligible individual plus an eligible spouse. As a consequence, they receive lower total benefits and are rendered ineligible by smaller amounts of income or resources. The combined benefits ($956 per month, $11,472 per year for 2008) are divided evenly between the two.

Associated with this distinct treatment of couples are a series of SSI family relationship rules. Two individuals are treated as a couple under SSI, even though not married under state law, if they qualify under the Social Security marital status rules or even if they are simply holding themselves out as husband and wife. Couples who are living apart are treated as individuals, but only in the first full month after they have separated. Prior to October 1990, the Act required separation for six months, treating spouses still as a couple during those six months even though they had ceased to function as an economic or household unit.

Rev. 11/07

§ B 360. SSI – Benefit Level – Reduction for Countable Income

As a general rule, when an individual’s countable income increases by one dollar, the SSI benefit amount decreases by one dollar. However, since some of what SSI defines
as income is excluded from countable income, the existence of other income generally
does improve the SSI recipient’s net revenue; the true effect is less than a dollar-for-
dollar offset. This is especially the case with earned income. Moreover, some sources of
revenue or equivalent benefits are not treated as income at all by SSI. Thus, some in-
kind assistance, such as fuel, shelter or food, which is based solely on need and received
from utilities, municipalities or private non-profit organizations will not reduce SSI
benefits at all. The same is true of free medical services.

With benefits or revenue defined as income by SSI, the program excludes an initial $20 a
month. The rule applies to unearned or earned income. Because of this exclusion, for
example, an individual receiving both Social Security and SSI (and having no other
income) will have combined benefits $20 a month greater an individual receiving only
SSI. Earned income is covered by a more generous exclusion equal to the first $65
earned in a month plus one-half of additional amounts. Money set aside in an approved
plan for self-support is totally excluded.

If an individual lives in the household of another for a full month and receives both food
and shelter within that household, the actual value of that in-kind support and
maintenance is not calculated. Instead of treating this as a case of countable income, the
Act calls for a benefit reduction in a fixed amount equal to one third of the Federal
Benefit Rate.

§ B 370. SSI – Benefit Level – Reduction During Stay in
Public Institution

Residents of public institutions for one full month are ineligible for SSI benefits, unless
one of several exceptions applies. The most important exception concerns stays in
public institutions where Medicaid is paying more than 50 percent of the cost of the
stay. In such instances, the SSI benefit is reduced to a $30 personal needs allowance.
However, if a doctor certifies that the individual will not be in the institution for more
than three months and the individual needs benefits to continue paying for housing
which will be used upon release, benefits can be continued for up to three months.

§ B 400. Overpayment and Underpayment

When an individual has received a larger sum of benefits than provided for by the Social
Security Act, the law calls for recovery of the overpayment. Overpayments can result
from a failure to impose an appropriate benefit reduction or suspension. They can also result from a failure to terminate benefits when that is called for and from paying benefits to someone who it turns out was not entitled to receive them from the start.

In *Sullivan v. Everhart*, 494 U.S. 83 (1990), the Supreme Court upheld the Agency’s regulations providing for the netting of overpayments against underpayments. Under these regulations the waiver of overpayment procedure applies only to the resulting balance.

In recovering overpayments from someone who is no longer a beneficiary the Agency has quite broad debt collection authority.

When an individual who has been underpaid dies before full payment of the amount due, the Act lays out a pattern of disposing of the remaining sum rather than having it go automatically to the individual’s estate.

§ B 450. SSI – Overpayment and Underpayment

The Supplemental Security Income (SSI) provisions dealing with overpayments and underpayments are similar to those governing Title II. The most significant difference concerns certain payments which the Agency does not consider to be overpayments. For instance, SSI does not view as an overpayment up to three months of benefits received by an individual based upon presumptive disability, even if the Agency later determines that the individual was not actually disabled.

Additionally, the waiver provisions for SSI overpayments differ slightly from those for Social Security overpayments. SSI repayments can be waived if the claimant is not at fault and recovery of the overpayment would interfere with the effectiveness of the SSI program due to the small amount of the repayment. This provision means that if the administrative cost of recovering an overpayment exceeds the amount of the overpayment, it can be waived. Repayments can also be waived if the overpayment is due solely to the ownership of countable resources in excess of the statutory limit by $50 or less. These grounds for waiver are unique to SSI.

§ B 500. Recoupment of Overpayment – In General

The Agency will recover overpayments out of future benefits. Where the overpaid individual did not cause the overpayment by an intentionally false statement and benefits
are necessary to cover the individual’s basic living expenses, the Agency can spread out the overpayment recovery by taking a portion of every monthly payment.

In *Sullivan v. Everhart*, 494 U.S. 83 (1990), the Supreme Court upheld the Agency’s regulations providing for the netting of overpayments against underpayments. Under these regulations the waiver of overpayment procedure applies only to the resulting balance.

Under a 1990 amendment, the Agency is authorized to recover overpayments from Federal tax refunds due the individual when he or she is no longer entitled to benefits from which overpayments might be recouped. Provisions added to the Act in 2004 expand the authority of the Agency to recover overpayments made in one program from amounts due in another. They limit such recoupment by reduction in ongoing monthly payments to 10 percent of benefits in the case of Title II (OASDI), the lesser of: (1) the amount of the benefit for that month; or (2) an amount equal to 10 percent of the countable income for that month in the case of Title XVI (SSI).

The procedural protections that must be afforded an individual prior to recoupment are the subject of Social Security Ruling *SSR No. 94-4p*. And in October 1996, they were addressed in new and revised regulations.

§ B 510. Recoupment of Overpayment – Claimant’s Fault

Recovery of overpayments can be waived by the Agency altogether when the individual was not at fault in causing them and when recovery would defeat the “purpose of the Act” or be “against equity and good conscience.”

The issue is not whether the Agency was also at fault but whether the overpaid individual was without fault considering all the surrounding circumstances. Fault can lie in making an incorrect statement, in failing to furnish information, or even in accepting a payment that the individual should have known was incorrect.

§ B 520. Recoupment of Overpayment – Against Equity or Defeat Act’s Purpose

Even a claimant who was not at fault in causing an overpayment will be subject to recovery unless that would defeat the purpose of the Act or be “against equity and good conscience.”
Recovery is considered as defeating the purpose of the Act if the individual is dependent on Social Security benefits for basic needs. Recovery is considered to be against equity and good conscience in cases where the individual has changed position in reliance on the payments or received no benefit from the overpayment.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ B 530. Recoupment of Overpayment – What Can Be Recouped

Future benefits to the overpaid individual or family benefits paid on that person’s account are subject to recovery. If the overpaid individual dies before full recovery, the individual’s estate and any resulting Social Security survivors benefits are subject to recovery.

Under a 1990 amendment, the Agency is authorized to recover overpayments from Federal tax refunds due the individual when he or she is no longer entitled to benefits from which overpayments might be recouped. Provisions added to the Act in 2004 expand the authority of the Agency to recover overpayments made in one program from amounts due in another. They limit such recoupment by reduction in ongoing monthly payments to 10 percent of benefits in the case of Title II (OASDI), the lesser of: (1) the amount of the benefit for that month; or (2) an amount equal to 10 percent of the countable income for that month in the case of Title XVI (SSI).

Rev. 12/04

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ B 610. Title II-SSI Relationship

In addition to benefits established by Title II, the Act provides Supplemental Security Income (SSI) for individuals with low incomes who are 65 or over, blind, or disabled. Since Title II benefits are counted as income under SSI, only individuals with relatively low Title II benefits can qualify for SSI. Savings or other assets above the SSI cutoff can also prevent overlapping eligibility. For those who are not blind or disabled, SSI has an age threshold of 65, while Title II benefits can be claimed at an earlier age.

Since Title II and SSI employ the same definition of disability, potential overlap is always a possibility in disability cases. However, the individual’s other income or assets can block SSI, leaving Title II benefits as the sole possibility. A disabled claimant may be limited to SSI if he or she has insufficient covered work for the relevant Title II insured status at the time of the apparent onset of disability.

Where an individual qualifies for both, the SSI payment may be a relatively small supplement. The individual’s Title II benefit is unaffected by SSI, but the SSI payment
will be reduced by the amount of Social Security except for a monthly disregarded sum of $20.

Because of the potential overlap between Title II and SSI occasions will arise where one type of benefit is paid for a period and then, subsequently, entitlement for the same period is established in the other program. The “windfall offset” provisions of the Act apply in such cases.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ B 620. SSI Windfall Offset

When either Social Security benefits or SSI are paid an individual for a period and then subsequently entitlement for the same period is established in the other program, the “windfall offset” provisions of the Act apply. The aim of the “windfall offset” is to put the individual in the same situation as if both benefits had been paid simultaneously. Had the benefits been paid simultaneously the level of Title II payments would have reduced the SSI payment. Under the “windfall offset” if the Title II benefits have been paid first, the SSI retroactive payment is calculated as if the Title II benefits had been paid, when due, through the period for which the SSI benefits are being paid. If the SSI benefits have been paid first, the retroactive Title II payment is reduced by the amount that the SSI benefits would have been less had the Title II benefits been paid when due.

Since prior to 2005 the Act’s provision for withholding attorneys fees out of past benefits recovered with the assistance of an attorney applied to Title II but not SSI, the interplay of the “windfall offset” with the attorneys fees provisions of the Act has generated litigation. Under a 1990 amendment, the Title II attorneys fee calculation occurs prior to operation of the SSI offset.

In DE, NJ, PA, and VI an acquiescence ruling (AR 92-1) implements the Third Circuit’s decision in Mazza v. Secretary, 903 F.2d 953 (3d Cir. 1990), which interpreted the offset provision as requiring that SSI payment be determined first in retroactive concurrent payment cases with the Title II benefits determined second, subject to the offset. The Agency’s view is that Act allows application of the offset to whichever benefit is paid second. Because of the linkage between SSI eligibility and Medicaid this view can have serious adverse consequences for the claimant, as the facts in Mazza illustrate.

Rev. 11/05

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ B 630. Title II-Railroad Retirement Act Relationship

Benefits paid under Social Security and the Railroad Retirement Act have been integrated. For short-term railroad workers integration is achieved by bringing work covered by the Railroad Retirement Act under Social Security. Long-term railroad
workers are integrated under the Railroad Retirement Act. A period of 10 years of railroad work is the dividing line. A short-term railroad worker will have the railroad work counted toward insured status and benefit amount. A long-term railroad worker will have railroad work counted in determining entitlement to a period of disability.

§ B 640. Windfall Elimination Provision

The Windfall Elimination Provision (“WEP”) modifies the standard formula for calculating an individual’s primary insurance amount (PIA). The provision applies where a wage earner with earnings covered by the social security system also has “noncovered” earnings, typically from federal and state civil service employment. The provision applies only to individuals who first become “eligible” for a pension based on noncovered employment after 1985.

§ B 650. SSI – Relationship to Other Benefit Programs – In General

Since Supplemental Security Income (SSI) is set up as a program of last resort, recipients must file for any other benefits for which they may be eligible. The type of benefits covered by this requirement includes annuities, pensions, retirement and disability benefits. Significant examples are veterans’ pension benefits, workers’ compensation, Social Security, and unemployment insurance. Upon being notified by the Agency of potential eligibility for such other benefits, an applicant must, within 30 days, take appropriate steps to apply and obtain them. Failure to do so or to take necessary follow-up steps leads to ineligibility for SSI.

SSI recipients are not required to apply for other federal, state, local, or private programs providing benefits based on need. Only benefits that count as income under SSI must be applied for.

The requirement does not extend to individuals whose income is deemed available to the claimant.

Rev. 5/00
§ B 660. SSI – Relationship to Medicaid Eligibility

The Medicaid program is operated by the States with financial support from the Federal government. Individual states can approach Medicaid eligibility in three distinct ways. Under the first option, which is employed by a majority of states, an individual who is eligible for SSI is automatically eligible for Medicaid. Under this option the SSI application also serves as the Medicaid application. The second option resembles the first, in that eligibility standards for Medicaid are the same as those for SSI. However, under this second option applicants are required to file a separate application with the state agency that administers the Medicaid program.

A third option, referred to as the “209(b) option” allows states to use their own criteria to determine Medicaid eligibility. A state’s 209(b) criteria cannot be more restrictive than the standards in effect for the state SSI predecessor program in January 1972. The criteria used by the states are generally applicable to both initial and continuing eligibility determinations for Medicaid. However, there are exceptions. For instance, once a disabled person becomes eligible for Medicaid, there are circumstances under which that individual may return to work and have high enough earnings that SSI cash benefits stop, yet Medicaid coverage will remain in place.

Rev. 9/95

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ B 670. SSI – State Supplementary Benefits

When the Supplemental Security Income program (SSI) was established in 1974, its benefits fell below those being paid under the predecessor grant-in-aid programs in a fair number of states. States in which that was true were required to agree to supplement SSI for their former assistance recipients up to the prior standard, as a condition to continued receipt of federal payments for Medicaid.

All states were encouraged to supplement SSI through a variety of provisions still in effect. Critically, the Act provides that state supplementary benefits are not to be viewed as income under SSI. If they were treated as income states would have no incentive to supplement. As a further encouragement the Act provides that the Social Security Administration will assume the administrative costs of any supplementary benefits by administering them for the state. To qualify for federal administration, however, state supplements must meet certain federal criteria. These allow state residency requirements and different supplementation levels for different categories of recipients (aged, blind, disabled), for different living arrangements, and for different parts of the state. But in other respects they require tight coordination of the supplements with SSI.

Rev. 9/95

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ C 100. Protection of Benefits From Assignment or Garnishment

The Act protects benefits from attachment or garnishment by others. It denies individuals the power to assign or otherwise transfer future benefits. State law procedures that are inconsistent with this protection are overridden or preempted. Congress has enacted a few exceptions to this general bar. One applies to legal obligations to make child support or alimony payments; another, to federally reinsured student loans.

In Bennett v. Arkansas, 485 U.S. 395 (1988), the Supreme Court struck down an Arkansas statute that attached benefits paid to prisoners. The decision rested on the Social Security Act and the Supremacy Clause of the U.S. Constitution.

In Philpott v. Essex County Welfare Bd., 409 U.S. 413 (1973), the Supreme Court held that the Act bars a state’s recovery of past welfare benefits from Social Security benefits. This bar exists even when the Social Security benefits relate to the period covered by the welfare payments and would have reduced those payments if they had in fact been paid during that period.

However, in Washington State Dep’t of Soc. & Health Servs. v. Estate of Keffeler, 537 U.S. 371 (2003), the Supreme Court upheld a state agency’s use of Social Security benefits paid to it as “representative payee” on behalf of child recipients. The state, in this case, reimbursed itself for foster care expenditures to those same recipients.

Generally Supplemental Security Income (SSI) benefits receive the same protections from attachment as Social Security benefits. There is one exception to this rule; SSI does allow reimbursement of state general assistance payments made while an SSI claim was pending.

Rev. 11/07

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ C 200. Appointment and Duties of a Representative Payee

When the Agency determines that an individual is not able to manage benefit payments it can make payments to a representative payee. This decision is independent of state competency determinations although a state determination of incompetency will prompt representative payment. The representative payee can be an individual or an organization. The regulations lay out preferences and standards that apply in selection of representative payees. They also spell out the responsibilities and accountability of such payees, as well as the Agency’s financial responsibility for their adequate supervision. The Act’s provisions dealing with these matters were substantially strengthened in 2004.

Rev. 12/04

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
Judicial Review

§ D 000. Jurisdiction and Judicial Review – In General

The Act itself furnishes the framework for judicial review of Agency actions. It sets out the standard of review and establishes jurisdiction in the Federal district courts to review final Agency decisions. The claimant is entitled to a court’s review of the Agency decision, not a fresh determination. However, judges who have simply ruled on the basis of the complaint, the government’s answer, and the administrative record, without giving the claimant an opportunity to present arguments in writing, have been held in error.

In establishing the framework for judicial review, the Act also circumscribes it. The Act specifically precludes judicial review under other Federal statutes, limits review to final Agency decisions based on a hearing, and requires that the action be filed in a Federal district court within 60 days after notice of the Agency decision.

In Califano v. Sanders, 430 U.S. 99 (1977), the Supreme Court held that, absent a Constitutional issue, the Act does not authorize judicial review of an Agency decision not to reopen a claim for benefits on which a prior determination had become final. The decision not to reopen can be made without a hearing, and judicial review is limited to decisions made after a hearing. Subsequent decisions have granted review on the basis of “colorable” Constitutional issues which need not necessarily relate solely to the decision not to reopen.

In Sullivan v. Finkelstein, 496 U.S. 617 (1990), the Supreme Court held that the government can appeal a district court decision remanding a case to the Agency when it has found a regulation invalid and the remand is for a determination consistent with that holding. The Court considered such remands to be appealable “final decisions.”

In Forney v. Apfel, 524 U.S. 266 (1998) the Supreme Court held that the claimant who had sought outright reversal of the Agency’s decision can appeal a district court decision to remand rather than reverse as well.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ D 100. Need to Exhaust Administrative Remedies

Normally before seeking judicial review of Agency action, the claimant must exhaust available administrative remedies up through and including Appeals Council review. Only in exceptional circumstances will bringing an action at an earlier stage be successful. Situations in which exhausting administrative remedies may be unnecessary include claims challenging the constitutionality of provisions in the Act and those focusing on the functioning of the administrative procedure itself.
The regulations now expressly provide for an expedited appeals process furnishing a direct route to district court in cases that pose only Constitutional questions.

A failure to exhaust administrative remedies within prescribed time limits generally precludes judicial review.

A narrower doctrine of “issue exhaustion” accepted by some courts prior to 2000 would preclude arguing issues at the stage of judicial review that had not previously been raised before the ALJ or the Appeals Council. In 2000 the Supreme Court, in Sims v. Apfel, 530 U.S. 103 (2000), reversed the Fifth Circuit and held that Social Security claimants who exhaust administrative remedies need not also raise all issues in a request for review by the Appeals Council in order to preserve judicial review of those issues.

§ D 200. Timely Filing by Claimant

The Act requires that the action to review a final Agency decision be filed within 60 days. The regulations provide for extension of that period by the Agency in appropriate cases, but Agency exercise of that discretion is itself not reviewable. While courts may interpret the time limit with some flexibility, particularly in terms of when it begins to run, compliance with the limit is normally strictly enforced.

In Bowen v. City of New York, 476 U.S. 467 (1986), the Supreme Court held that the 60-day limit is not jurisdictional. Consequently, under proper circumstances a Federal district court may hold that the period’s running is tolled on equitable grounds. The Supreme Court held that a case for tolling exists when claimants do not know of an internal Agency policy that violates their rights.

Subsequent decisions suggest that, although the case for tolling is strongest in cases involving government misconduct, that is not required. Tolling may, for example, be warranted when the claimant’s mental impairment led to late filing.
§ D 300. Consequences of Government Delays in Responding to Court

When the government fails to meet court imposed litigation deadlines or fails to respond to orders that implement intermediate steps in a court’s review a wide range of judicial responses is available.

The principal constraint on the court is the Agency’s responsibility, under the Act, to make benefit determinations and to administer the program.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ D 400. Issues of Appropriate Judicial Remedy – In General

In the normal case requiring judicial review of an Agency determination, the court confronts a choice between affirming Agency action or finding it in error. In the latter case the court may reverse the determination and order the Agency to calculate and pay benefits. Alternatively, it may remand for further Agency proceedings. In the wake of the Supreme Court’s detailed discussion of remedies as they affect claims for attorneys fees under the Equal Access to Justice Act, in Melkonyan v. Sullivan, 501 U.S. 89 (1991), remands are now, themselves, divided into two categories, often referred to as “sentence four” and “sentence six” remands. The terminology is based on the two different sentences in §205(g) of the Act, 42 U.S.C. § 405(g), authorizing remand. When a court finds the Agency in error and remands the case, the court has ordered a sentence four remand. On the other hand, when a court has not passed on the substance of the Agency’s decision, but has merely remanded the case for the Agency to consider new evidence, the remand is pursuant to sentence six.

The choice between outright reversal and remand can sometimes be difficult. This is especially true when the case includes issues that involve credibility and fact-finding, on the one hand, but the proceeding has already gone on for an inordinate length of time.

In Forney v. Apfel, 524 U.S. 266 (1998) the Supreme Court held that a district court decision to remand rather than reverse is appealable.

Class actions that challenge a widespread Agency policy or practice almost invariably pose difficult questions of appropriate remedy.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ D 410. Issues of Appropriate Judicial Remedy – Interim Relief

Questions of appropriate interim relief come up most frequently when the challenged Agency action is one terminating, suspending or reducing benefits for an individual or group. If the grounds or procedure are at issue, the court may be asked to order that benefits be continued until the legal issue is finally resolved. From the claimant’s standpoint such relief is necessary to preserve the status quo. To the Agency, asserting its position on the merits, such relief threatens overpayments that may be difficult or impossible to recover.

In Heckler v. Day, 467 U.S. 104 (1984), the Supreme Court held that Federal district courts do not have authority to issue injunctions imposing deadlines on the Agency’s processing of disability claims or to require interim benefits in cases of delay.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ D 420. Issues of Appropriate Judicial Remedy – Whether Court Can or Should Grant Requested Relief

The most difficult questions of the scope of relief a court may grant under the Act or some other source of authority arise when the court is asked to order the Agency to implement a new procedure, to attain certain standards of performance, or to issue administrative guidance in particular form. In individual claims, the most difficult issue has to do with the circumstances that warrant a court’s effectively taking a decision away from the Agency rather than remanding for a new determination employing proper standards and procedures.

Since the Act both precludes judicial review under other statutes and refers only to review of Agency actions, doubt once existed about authority for other forms of relief.

In Califano v. Yamaski, 442 U.S. 682 (1979), the Supreme Court held that injunctive relief could be awarded in a proceeding under the Act.

In Heckler v. Day, 467 U.S. 104 (1984), the Supreme Court held that Federal district courts do not have authority to issue injunctions imposing deadlines on the Agency’s processing of disability claims or to require interim benefits in cases of delay.

In Schweiker v. Chilicky, 487 U.S. 412 (1988), the Supreme Court held that money damages were not an available remedy in an action against Federal officials alleging due process procedural violations in disability terminations.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ D 500. Class Actions

Where a Federal district court has jurisdiction over the claims of the individual class members under the Act, the Supreme Court held, in Califano v. Yamasaki, 442 U.S. 682 (1979), that court has the discretion to certify a class to litigate those claims.

In Weinberger v. Salfi, 422 U.S. 749 (1975), the Supreme Court held that the Act did not provide jurisdiction over the claims of unnamed class members who had not received a “final decision.”

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ D 600. Role of the Magistrate

The Federal Magistrates Act extends broad authority to Federal district courts to assign magistrates duties beyond those specifically listed in its provisions.

In Mathews v. Weber, 423 U.S. 261 (1976), the Supreme Court held that this authorized a district court’s order requiring initial reference of all actions seeking review of Social Security benefit determinations to a magistrate. The Court noted that when such references are made the Federal district judge retains ultimate responsibility for the decision. Many districts employ this procedure.

Numerous Circuits have held that if a claimant fails to object to a magistrate’s report and recommendation within the time limit laid down in the report the claimant waives the right to appeal a district court decision adopting it.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ D 700. Other Statutes Than Social Security Act as Basis for Judicial Review

The Act contains general language limiting the reviewability of Agency actions. It also specifically excludes Social Security claims from the statutes establishing general Federal question jurisdiction and jurisdiction over civil claims against the U.S.

In Califano v. Sanders, 430 U.S. 99 (1977), the Supreme Court held that the Administrative Procedure Act does not provide subject matter jurisdiction for judicial review of Agency action under the Social Security Act.

In Weinberger v. Salfi, 422 U.S. 749 (1975), the Supreme Court held that the Act’s bar of Federal question jurisdiction applies even to litigation challenging the Constitutionality of particular provisions of the Act.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ D 800. Issues of New Evidence and Requested Remand

The Act authorizes a Federal district judge to remand a case to the Agency to hear new evidence. For such a remand, the Agency need not have committed any error in the original proceeding.

Where the remand is requested by the claimant so as to permit the consideration of new evidence, the Act requires that the evidence be both new and material and that there be a showing of good cause for the failure to incorporate that evidence into the record in the prior proceeding. Even where such a remand is requested by the Agency, the Act requires a showing of good cause.

This type of remand is commonly referred to as a “sentence six” remand, as distinguished from a “sentence four” remand. The distinction, which has consequences for attorneys fee claims under the Equal Access to Justice Act, keys on the two different sentences in § 205(g) of the Act, 42 U.S.C. § 405(g), authorizing remand.

Rev. 9/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
Administrative Process

§ E 000. Administrative Process – In General

For most Social Security issues the administrative process begins with a benefit application on which the Agency makes a determination. This first determination about entitlement and benefit amount is termed an “initial determination.” If the claimant is dissatisfied with the initial determination the next step is Agency “reconsideration.”

When the determination concerns the issue of an individual’s disability it will be made by a state agency under contract with the Social Security Administration.

Reconsideration and following steps are open not only to the claimant but also to others whose rights may be adversely affected by the Agency’s determination. This would include, for example, individuals whose benefits will be reduced if the claimant’s benefits are granted.

Following a reconsideration, a dissatisfied individual’s next step is a hearing before an administrative law judge (ALJ).

Following an ALJ hearing and decision, the final administrative level of appeal is before the Appeals Council.

Not all Agency actions or decisions directly involve benefit claims. Even those that do not may be pursued within this framework. A request for correction of an earnings record, for example, leads to an initial determination that can be taken through all the following stages.

Some Agency determinations or actions are left to Agency discretion and cannot be appealed in this way. That is the case, for example, with an Agency decision not to reopen a prior determination.

A plan for reforming this multi-stage process, as it applies to disability benefit claims, was adopted by the Agency in 2006. See 71 Fed. Reg. 16446 (Mar. 31, 2006). The new procedures were to be phased in, over time, across the U.S., starting with ME, NH, VT, MA, RI, and CT. Initial experience in those states together with appointment of a new agency head led to proposed regulations setting out a different reform scheme in October 2007. See 71 Fed. Reg. 61218 (Oct. 29, 2007).

Rev. 11/07

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ E 100. Effect of Misleading Agency Information or Advice

The general rule is that mistaken advice or information furnished by Agency staff will not bind the Agency.
In Schweiker v. Hansen, 450 U.S. 785 (1981), the Supreme Court held that the Agency was not estopped from denying benefits to a claimant who failed to file an application even though her failure to do so was the result of an erroneous statement. She had not applied because an Agency staff member told her she was ineligible.

The Act now deals with this particular situation by providing that a later application can be dated from an earlier point at which misinformation furnished by Agency staff deterred the individual from applying. However, the general principle still stands.

§ E 200. Need to Comply With Agency Deadlines and Requirements

At each stage in the administrative process the determination becomes final if a request for appeal to the next level is not filed in writing within a specified number of days. If, for example, the claimant’s request for a hearing is not filed within 60 days of notice of the action being appealed, the appeal can be dismissed without a hearing. The regulations provide for Agency extension of these limits upon a showing of good cause. The regulations include examples of grounds that may be considered good cause. Social Security Ruling SSR No. 91-5 specifically addresses the importance of considering a claimant’s mental incapacity as a ground for finding good cause. SSR No. 95-1 deals with good cause in cases prior to July 1, 1991 that involved notices of Agency determinations but failed to explain the difference between seeking review and filing a new application.

In disability cases, the claimant may be scheduled for a medical examination at the program’s expense. A failure to appear for such an examination without good cause can itself furnish grounds for a conclusion that the individual is not disabled.

Finally, when an individual has requested an administrative law judge (ALJ) hearing following a reconsideration, he or she will receive notice of that hearing’s time and place. That notice is supposed to be sent at least 20 days prior to the hearing. Upon a request based on good cause the ALJ can change the time and place. The individual appealing can have an ALJ decide a case on the record, without an oral hearing. However, if an appellant or a representative simply fails to appear at a scheduled hearing that can result in a dismissal of the appeal.

Rev. 6/95
§ E 300. ALJ’s Conduct of Hearing – In General

The administrative law judge (ALJ) is responsible for setting the time and place for the hearing. ALJ’s are directed to avoid hearing sites more than 75 miles from the claimant where possible, to consider proximity to the claimant in setting the site, and to bring the hearing to the claimant’s home or hospital bed if the claimant’s condition requires it. Agency staff are supposed to check with participants before scheduling a hearing. A claimant who objects to the time or place set for a hearing should do so in writing. The Agency has begun to use videoconference hearings as a means of reaching claimants in areas that are remote from a hearing office. Claimants scheduled for a videoconference hearing can, however, upon request, be rescheduled for one conducted face-to-face.

The ALJ has authority to issue subpoenas requiring the appearance of a reluctant witness or the production of documents. The decision to do so can be upon the ALJ’s own motion or at the claimant’s request. A claimant has a right to request issuance of a subpoena, but must do so at least 5 days prior to the hearing.

At the hearing, the administrative law judge (ALJ) is responsible for looking into the issues of a case. The ALJ’s role is an active one. He or she has a duty not merely to receive evidence and to preside over the hearing, but to ask questions of the appellant and other witnesses. Hearings are tightly scheduled so that normally the ALJ will limit the proceeding to 30 minutes. But the ALJ also has the authority to stop a hearing temporarily and continue it at a later date or reopen a hearing to receive new and material evidence.

The ALJ is supposed to discharge three contending duties at once. In addition to serving as an impartial decider, the ALJ is responsible for testing the claimant’s evidence, asking questions that the Agency might ask if it were represented at the hearing. The ALJ’s third responsibility is to assure full development of the claimant’s case, especially when the claimant is not represented by an attorney.

In LA, MS, and TX an acquiescence ruling (AR 91-1) has implemented the Fifth Circuit’s ruling in *Lidy v. Sullivan*, 911 F.2d 1075 (5th Cir. 1990) that an ALJ must grant a claimant’s request for a subpoena for the purpose of cross-examining an examining physician. The Agency’s position is that the decision on whether to issue a subpoena is discretionary, requiring a showing by the claimant that the testimony sought is reasonably necessary for presentation of the claimant’s case.

Rev. 12/04

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ E 310. ALJ’s Conduct of Hearing – Evidence of ALJ’s Bias

A fair hearing requires an impartial and unbiased judge. The regulations allow a claimant to seek a different administrative law judge (ALJ) in situations where he or she suspects bias. Courts will also review claims of bias based on the ALJ’s statements or
behavior at the hearing. But establishing bias sufficient to cause a court to upset the
determination is extremely difficult. Courts have declined to find bias in statements
reflecting impatience with the claimant or characterizing the claimant’s acts in
unfavorable terms such as “uncooperative” or misstating the law.

When a reviewing court finds error in an ALJ’s decision and also grounds for concluding
that the ALJ may be committed to a denial of the claim, it can urge that the case be
assigned to another upon remand.

§ E 320. ALJ’s Conduct of Hearing – Duty to Pro Se Claimant

Courts generally hold that the basic obligation of an administrative law judge (ALJ) to
develop a full and fair record rises to a higher level when the claimant is unrepresented
and is unfamiliar with the procedures. When the claimant is confused or has language
difficulties, the duty is especially strong. This duty requires the ALJ to inquire, to probe,
to explore and even to seek additional evidence in order to assure a full record on the
issues raised by the claim.

§ E 330. ALJ’s Conduct of Hearing – ALJ’s Development of
Hearing Record

The administrative law judge (ALJ) is responsible for developing a full and fair record.
This responsibility exists even when the claimant is represented by an attorney. It arises
from the non-adversarial nature of the proceedings and the remedial purposes of the Act.
The ALJ cannot take a passive role, leaving it to the claimant, who carries the ultimate
burden of proof, to develop the relevant facts. The ALJ has the obligation to develop the
record, to ensure that all necessary and relevant information is produced.

In addition to that substantive duty, the ALJ has the responsibility to assure that there is a
verbatim record of the entire hearing. Should questions arise that are not relevant to the
claimant’s case they can be discussed off-the-record, but the ALJ must summarize the
content and conclusion of any such actions for the record. Since the ALJ’s decision
must be supported by substantial evidence, as determined in a court’s review of the
record, gaps in the transcript of the hearing raise a serious problem. So long as they are
minor and there is an adequate basis in the rest of the transcript to support the ALJ’s
decision, a court may affirm, but even small gaps at critical stages of hearing testimony
can lead a court to remand for a rehearing.
The Agency has embarked on a major initiative to replace tape recorders with digital recorders as the means of capturing ALJ hearings, part of a larger plan to create digital case files.

§ E 340. ALJ’s Conduct of Hearing – ALJ’s Treatment of Claimant

The administrative law judge (ALJ) has a duty to allow the claimant to make a full presentation of his or her case. The ALJ’s obligation to develop a full record includes a duty to ask appropriate questions of the claimant and the claimant’s witnesses.

Despite these obligations the ALJ remains in charge of the hearing and therefore may limit questions and interrupt the claimant or other witnesses and may admonish them about delays or repetitious testimony.

§ E 400. Adequacy of ALJ’s Decision

While the administrative law judge (ALJ) need not discuss every document, the ALJ cannot in making findings select for comment only the evidence that supports his or her ultimate conclusion. The ALJ’s decision must address all the evidence at some reasonable level. When there is considerable evidence that runs counter to the Agency’s position it must be dealt with.

The decision of an ALJ is subject to judicial review. That review does not constitute an independent appraisal of the record but simply a determination whether the record contains substantial evidence supporting the ALJ’s findings.

While courts express understanding for the practical burdens under which ALJs operate, they view an adequate ALJ decision as essential for appropriate judicial review. Adequacy for these purposes requires the ALJ to apply the relevant legal standards to the pertinent evidence in the record and to explain the legal and factual underpinnings of a determination in sufficient detail for a reviewing court to understand them. The decision need not refer to each item of evidence, piece-by-piece. It is enough that the findings be related to a summary of the evidence that will enable a court to follow how the determination was made.

The court’s role is not to find whether substantial evidence can be found in the record to support the ALJ’s ultimate conclusion but whether the intermediate determinations the ALJ made were supported by substantial evidence. That requires the ALJ’s decision to
contain findings on the factors and stages of determination laid out in the Act and
regulations.

Social Security Ruling SSR No. 96-7p lays out specific requirements for findings about
the credibility of the claimant’s testimony on symptoms and their effects.

The Agency amended its regulations in October 2004 to allow an ALJ to enter a wholly
favorable, oral decision into the record of a hearing, and then to issue a written decision
incorporating the findings of fact and the reasons stated orally at that hearing, by
reference.

Rev. 12/04

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ E 500. Adequacy and Timing of Agency Notice

When a claimant fails to take a step or fails to take it within the allotted time, issues can
arise about the adequacy of the Agency’s notice of the need to do so. Underlying such
arguments over notice may be a Constitutional “due process” claim. Often, however, the
issue can be framed simply in terms of the requirements of the Act, regulations, or
agency policy. For example, Spanish language notices are required not only when they
are requested by a claimant but when the Agency has reason to believe that they may be
necessary, and special provisions exist governing notice to blind recipients or claimants.

Generally, the issue is raised in the context of an Agency conclusion that the claimant’s
failure to act or to act in timely fashion precludes consideration of the claim. For
example, the Agency may assert that the claimant’s failure to request reconsideration or
seek review of an adverse hearing bars a later application on grounds of administrative
res judicata. And in return the claimant may argue that the notice of the right to appeal
did not make clear the full consequences of a failure to do so.

The claimant may argue notice defensively in situations where the claimant appeals an
Administrative Law Judge decision on narrow grounds and the Appeals Council
undertakes a broader review of the matter.

The Act excludes from operation of administrative res judicata any decision on initial
determination or reconsideration that was not appealed because of inadequate notice
about the consequences of a failure to appeal. The provision requires that the Agency
furnish clear notice of the difference between appealing and reapplying. The Act also
codifies the requirement that Agency notices be expressed in clear and simple language
and specifically requires that the notice include the address and phone number of a local
office.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ E 600. Claimant’s Right to Counsel

A claimant is entitled to representation by counsel in proceedings before the Agency. This is a statutory right, not one flowing from the U.S. Constitution. The standard notice of a claimant’s right to a hearing explains the right to be represented. The right to counsel does not mean that an attorney is assured or that the Agency will provide counsel. Social Security Ruling No. 71-23 stresses that the Act does not require legal representation and that the claimant’s evidentiary hearing can be fair and impartial without counsel. The right is effectively denied in cases where the Agency fails to give notice of the hearing to the claimant’s attorney or to determine that a claimant appearing without counsel is, in fact, represented.

In cases where due to the claimant’s psychological, intellectual, or language limitations an attorney would be especially valuable, the administrative law judge (ALJ) may be required by a court to assure that a claimant proceeding unrepresented has made an intelligent waiver of this right or had reasonable opportunity to secure counsel. In such cases, there must be a showing that the lack of counsel resulted in prejudice to the claimant or an unfair proceeding. This means that cases raising this issue are also likely to involve issues about the adequacy of the record developed by the ALJ.

Rev. 3/98

[SUPPORTING AND ELABORATING REFERENCES] [RELATED SECTIONS: Part 1 - Part 2]

§ E 700. Travel and Other Expenses

The Act authorizes and the regulations provide for the Agency’s payment of certain travel expenses incurred by claimants and their witnesses in responding to Agency requests to appear for interviews or examinations or in attending a benefit hearing. Expenses incurred by the claimant, a representative, or unsubpoenaed witness in traveling to an ALJ hearing are only reimbursed if the distance exceeds 75 miles.

[SUPPORTING AND ELABORATING REFERENCES] [RELATED SECTIONS: Part 1 - Part 2]

§ E 800. Administrative Res Judicata

Administrative res judicata is a doctrine that accords finality to Agency decisions. Once a claimant has filed an application and the Agency has disposed of it, the claimant cannot secure a fresh determination of the original claim by filing a new application. The doctrine applies regardless of the level at which the claimant allowed the first decision to become final by failing to appeal an adverse decision. Under certain circumstances, the Agency may reopen a previous final decision and revise it. If it does indeed reopen the prior determination, administrative res judicata no longer applies. Courts have sometimes found a constructive or de facto reopening in an ALJ’s reexamination of the merits of a previous decision. Mere consideration of evidence from a previous

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application is generally not sufficient to warrant such a finding. An ALJ may, for example, legitimately evaluate evidence connected with a prior application in order to make a determination of its res judicata effect. However, a case may be deemed reopened if the ALJ fails to invoke res judicata and grounds a new decision, in part, on the record from the prior application.

A new application can, of course, be filed raising new issues. Thus, for example, a disability claimant can be denied benefits after filing one claim and granted benefits following a second. The doctrine of administrative res judicata simply forces the determination on the second application to focus on disability after the time of the first final decision. So long as the claimant still meets the insured status test and the claimant can establish that since the earlier final decision he or she became disabled the second application can lead to a fresh determination of entitlement.

In AK, AZ, CA, HI, ID, MT, NV, OR, WA, and GU an acquiescence ruling (AR 97-4) implements the Ninth Circuit’s ruling in Chavez v. Bowen, 844 F.2d 691 (9th Cir. 1988). Chavez held that in making a disability determination on a subsequent disability claim under the same title of the Social Security Act (the Act) as a prior claim on which there had been a final decision by an Administrative Law Judge (ALJ) or the Appeals Council that the claimant is not disabled that prior determination has continuing force. It gives rise to a presumption of continuing nondisability which the claimant must rebut and certain findings required under the applicable sequential evaluation process for determining disability, made in the final decision by the ALJ or the Appeals Council on the prior disability claim must be adopted in the later proceeding.

Administrative res judicata can also be invoked against the Agency. It has furnished the basis for court holdings that disability claimants cannot have their benefits terminated on the basis of a fresh disability determination. The Agency is bound by its earlier final decision so that termination must be supported by evidence of a subsequent change in the claimant’s medical condition.

In MD, NC, SC, VA, and WV an acquiescence ruling (AR 00-1(4)) implements the Fourth Circuit’s decision in Albright v. Commissioner of the Social Security Administration, 174 F.3d 473 (4th Cir. 1999) (interpreting Lively v. Secretary, 820 F.2d 1391 (4th Cir. 1987)). The decisions and ruling require the Agency to give weight to an earlier ALJ determination of the claimant’s residual functional capacity when it deals with a subsequent application, with that weight depending, in part, on the amount of intervening time.

In KY, MI, OH, and TN an acquiescence ruling (AR 98-4(6)) implements the Sixth Circuit’s decision in Drummond v. Commissioner of Social Security, 126 F.3d 837 (6th Cir. 1997) which held that “[a]bsent evidence of an improvement in a claimant’s condition, a subsequent ALJ is bound by the findings of a previous ALJ,” with the consequence that SSA cannot reexamine issues previously determined in the absence of new and additional evidence or changed circumstances.
In the same states a second acquiescence ruling (AR 98-3(6)) implements the closely related, prior Sixth Circuit decision in *Dennard v. Secretary of Health and Human Services*, 907 F.2d 598 (6th Cir. 1990) which held that when a final decision on a claimant’s first application for benefits included the finding that he could not perform his past relevant work, SSA was precluded by estoppel from reconsidering the issue on a subsequent application and finding that Dennard could perform this work.

Closely related to res judicata is the doctrine of collateral estoppel. The latter applies when there has been a prior determination under another title of the Social Security Act involving the same issue and claimant. An example would be a prior determination in connection with an SSI claim of the same issue being raised in an OASDI proceeding. Res judicata requires that the prior determination involve the same program. Collateral estoppel does not warrant dismissal of a hearing request, but simply permits an ALJ or other Agency decision-maker to accept the finding in the prior proceeding unless there are grounds for believing that it was erroneous.

The Act excludes from operation of administrative res judicata any decision on initial determination or reconsideration that was not appealed because of inadequate notice about the consequences of a failure to appeal. The provision requires that the Agency furnish clear notice of the difference between appealing and reapplying.

§ E 910. Claimant Request That Agency Reopen Prior Decision

Within limits laid down by the regulations, the Agency can reopen a past final decision at the request of the claimant. Its decision whether or not to reopen is discretionary. Except under the most exceptional circumstances, an Agency decision not to reopen a prior decision is not subject to judicial review.

In general the request to reopen should be directed to the level within the Agency at which a decision became final. That would be the ALJ, for example, in a case where no timely appeal had been taken to the Appeals Council, but the Appeals Council in a case where one had.

§ E 920. Agency Decision to Reopen on Its Own Initiative

The regulations authorize the Agency to reopen a case on its own initiative under a variety of circumstances. The grounds for such a reopening grow progressively narrower with the passage of time. A reopening within the first 12 months of the initial
decision can be on any ground, within 4 years (good cause), or more (certain types of errors plus a variety of new situation cases, such as another person claiming on the same account).

The relationship between a reopening initiated by the Agency and review by the Appeals Council following an administrative law judge (ALJ) decision has been the subject of considerable litigation. The issue arises when the Appeals Council does not provide notice that it will accept review of an ALJ decision within the period provided by the regulation but later asserts the right to reopen the decision.

**§ E 950. Appeals Council Review**

Appeals Council review lies between decisions rendered by an administrative law judge (ALJ) and a claimant’s right to seek judicial review. The claimant must request review within 60 days of receiving notice of the ALJ decision or dismissal. The Appeals Council only accepts a limited number of cases for review.

The Appeals Council also has authority to review an ALJ decision favorable to the claimant or to expand the scope of the review sought by a claimant. If it does so it must give notice to the claimant.

The Appeals Council will receive new evidence bearing on the issues that were before the ALJ, but its review is limited to the record supplemented by any such new evidence. The circuits are split over whether new evidence submitted to and considered by the Appeals Council, before it ultimately denies review, should be considered as part of the record when a court subsequently reviews the ALJ’s decision against the substantial evidence standard.

When the Appeals Council reverses ALJ determinations favorable to the claimant and the claimant subsequently seeks judicial review of the Agency determination, the treatment of the substantial evidence test and deference to credibility determinations can become significantly more complicated.

As part of a broader exploration of possible changes in the disability claims process, the Agency has issued proposed regulations that substitute a new reviewing body with a narrower role for the Appeals Council. See 71 Fed. Reg. 61218 (Oct. 29, 2007).
§ E 960. General Issues of Burden of Proof and Evidence

A claimant must establish entitlement to benefits under the Act. However, there are many situations where the claimant can shift the burden of coming forward with evidence on a particular issue to the Agency by establishing a proposition falling short of the ultimate question on which entitlement rests. There are also issues on which the Act provides more particular direction on the nature and sufficiency of evidence that a claimant must present.

In seeking to establish entitlement before the Agency, the claimant is not restricted to the formal rules of evidence that would apply to a court procedure.

A court will not upset an Agency determination involving a factual determination so long as it is supported by “substantial evidence.” On the other hand, the Agency, usually through the administrative law judge (ALJ) following a hearing, must make findings on the critical facts. And the ALJ’s decision must relate those findings to the evidence in the record. On issues where findings depend heavily on the claimant’s credibility, the Agency has especially broad leeway, but must still make findings.

When the ALJ makes a determination that is subsequently reversed or modified by the Appeals Council, application of the substantial evidence test becomes more complicated, doubly so if the ALJ’s decision involved a credibility component. Since the Appeals Council will have had no opportunity to observe the claimant, the ALJ’s finding on such questions may carry greater weight with a reviewing court.

On issues where the Act incorporates state law as state courts would apply it, the Act can be seen as, in effect, incorporating state law on burden of proof or presumptions. That can convert these elements of an Agency decision into legal rather than “substantial evidence” questions for a reviewing court.

In Richardson v. Perales, 402 U.S. 389 (1971), the Supreme Court ruled that evidence that would be inadmissible in a court proceeding could, nonetheless, constitute “substantial evidence” supporting a Social Security determination.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
General Legal Issues

§ F 100. Constitutional Law and Social Security – Other Issues: e.g., Equal Protection, Substantive Due Process, Taking

Numerous amendments to the Act having adverse impacts on particular categories of beneficiaries or covered workers have been attacked on the ground that they constitute a taking of property in violation of the Fifth Amendment. All such arguments have failed with the Supreme Court.

In Bowen v. Public Agencies Opposed To Social Security Entrapment, 477 U.S. 41 (1986), the Court upheld an amendment to the Act that barred termination of agreements for coverage of state employees including terminations for which notice had already been filed.

In Richardson v. Belcher, 404 U.S. 78 (1971), the Supreme Court upheld enactment of a worker’s compensation offset provision against an attack based on the 5th Amendment.

In Flemming v. Nestor, 363 U.S. 603 (1960), the Supreme Court upheld an amendment of the Act terminating benefits to aliens deported because of Communist Party membership. It held that Congress can amend the Act in ways reducing or terminating benefits without those changes constituting a deprivation of accrued property rights that would violate the 5th Amendment.

With the exception of gender distinctions and different treatment of children born outside of marriage, nearly all categories that lead to different benefit treatment have also been upheld against attack under the equal protection component of the Fifth Amendment’s Due Process Clause.

In Bowen v. Owens, 476 U.S. 340 (1986), the Supreme Court upheld the Act’s then differential treatment of remarriage by widows and surviving divorced wives.

In Califano v. Boles, 443 U.S. 282 (1979), the Court upheld the restriction of “mothers” benefits to women who had been married to the insured worker even though that denied benefits to the mothers of children born outside marriage. The Court viewed the different treatment in terms of the respective classes of mothers and not their children.

In Califano v. Jobst, 434 U.S. 47 (1977), the Court upheld the Act’s provision terminating benefits to a disabled child upon marriage to a person who is not entitled to Social Security benefits (while continuing benefits to those who marry individuals receiving benefits).

In Mathews v. De Castro, 429 U.S. 181 (1976), the Supreme Court upheld the provisions of the Act that extend spouse benefits to younger spouses of retired or disabled workers who are caring for children also eligible for benefits but deny comparable benefits to
younger divorced spouses. The differential treatment had been attacked as a violation of the equal protection component of the Due Process clause of the 5th Amendment.

In Mathews v. Lucas, 427 U.S. 495 (1976), the Supreme Court upheld the Act’s provisions dealing with proof of dependency by children born outside marriage. The decision, which provides important interpretation of those provisions, concludes that requiring proof of financial dependency of those children who cannot establish a purported marriage or written acknowledgment of parenthood or a court order does not violate the equal protection component of the Due Process clause of the 5th Amendment.

In Weinberger v. Salfi, 422 U.S. 749 (1975), the Supreme Court upheld the 9 month duration of relationship requirement the Act applies to surviving spouses. The Court found the resulting categories free from invidious discrimination and rationally based, using an objective test to prevent the use of sham marriages to get benefits.

In Jimenez v. Weinberger, 417 U.S. 628 (1974), the Supreme Court struck down the provisions of the Act which then denied benefits to children born outside marriage whose dependency on a disabled worker did not arise until after the onset of disability. It found the differential treatment of non-marital children to be in violation of the equal protection component of the Due Process Clause of the 5th Amendment.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ F 110. Constitutional Law and Social Security – Gender Distinctions

Before the Federal courts began to strike these distinctions down, the family benefit provisions of the Act contained numerous gender differences.

In Califano v. Goldfarb, 430 U.S. 199 (1977), the Supreme Court found the Act’s distinction between widows and widowers to be unconstitutional.

However, in Heckler v. Mathews, 465 U.S. 728 (1984), the Supreme Court upheld a transition provision resurrecting a gender-based difference. In effect the challenged provision shielded women more generously than men from a new pension offset for spouse benefits during a five-year grace period. The aim, which the Court found acceptable, was protection of the expectations of those who, prior to Califano v. Goldfarb and the subsequent enactment of a pension offset, would have been eligible to receive spouse benefits.

And in Califano v. Webster, 430 U.S. 313 (1977), the Court upheld the Act’s provision (since removed by Congress) allowing women to subtract a larger number of low income years from the base upon which their primary insurance amount was calculated. The Court saw this as an effort to remedy some of the effects of past discrimination.

In Weinberger v. Wiesenfeld, 420 U.S. 636 (1975), the Supreme Court held that the provisions of the Act which then extended benefits to younger widows caring for eligible
children but not younger widowers violated the equal protection component of the Due Process clause of the 5th Amendment. The Court characterized the differential benefits as discrimination against the deceased female workers whose earnings secured their families a smaller package of benefits than comparable male workers.

[SUPPORTING AND ELABORATING REFERENCES] [RELATED SECTIONS: PART 1 - PART 2]

§ F 120. Constitutional Law and Social Security – Procedural Due Process

In *Califano v. Yamasaki*, 442 U.S. 682 (1979), the Supreme Court held that procedural due process required a prerecoupment oral hearing to determine “fault” and whether recoupment was “equitable” in the case of those seeking waiver of recoupment on these grounds. In the same case, the Court held that due process does not require a hearing when a claimant requests reconsideration of an Agency decision.

In *Mathews v. Eldridge*, 424 U.S. 319 (1976), the Supreme Court held that due process does not require a full hearing prior to termination of Social Security disability benefits. Reviewing the pre-termination procedures, the Court found that they complied with due process requirements.

In *Richardson v. Perales*, 402 U.S. 389 (1971), the Supreme Court held that written reports by physicians who had examined a disability claimant constituted substantial evidence supporting a finding that the claimant was not disabled, notwithstanding the absence of cross-examination and the existence of opposing testimony by the claimant and claimant’s medical witness. The Court found the hearing procedure followed in disability cases to be consistent with the requirements of procedural due process.

While, in many legal contexts, notice meets “due process” requirements so long as it is reasonably calculated to reach and inform the person entitled to be notified, several circuits have ruled that a notice of time limits for administrative appeal sent to a disability claimant too mentally ill to understand it is constitutionally defective.

Rev. 3/98

[SUPPORTING AND ELABORATING REFERENCES] [RELATED SECTIONS: PART 1 - PART 2]

§ F 200. General Issues of Statutory Interpretation

When issues of interpretation arise over particular provisions of the Act, standard approaches to statutory interpretation apply.

Significantly, these include judicial deference to the interpretation of the Agency, which is charged with administering the Act. As the approach is often described, if the Act has spoken precisely on the issue, that ends the matter. If it has not, then the Agency’s interpretation is followed so long as it is consistent with the provisions of the Act. On
the other hand, if the Agency interpretation is contrary to the intent of Congress reflected in the Act and its legislative history, it will not prevail.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ F 300. General Issues of Interpretation or Validity of a Regulation

The Act specifically authorizes the Agency to promulgate rules and regulations not inconsistent with its provisions. In addition, detailed provisions on a variety of points are explicitly left by the Act to Agency regulations. While very few regulations have ultimately been struck down for inconsistency with the Act, some have. And many more have been interpreted by courts in ways designed to preserve their validity.

Judicial review of a regulation is limited to determining whether its provisions exceed statutory authority or are arbitrary and capricious. Moreover, courts defer to the Agency’s interpretation of its own regulations. Courts accept the Agency’s interpretation if it is reasonable in terms of the words of the regulations and the purposes of the Act, even though, as an original matter, the court might have reached a different conclusion.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ F 400. Effect of a New or Amended Statutory Provision on Current Claims

The standard approach to interpreting amendments to the Act is to view them as addressing the future and not the past. Unless the amendments are understood as simply codifying or clarifying prior law, they are not, under this view, interpreted as applying to individuals whose claims have already been determined. The more difficult questions concern individuals whose claims are in various stages of review or appeal. Particular language of the amendment may offer guidance on this point, but more general references to entitlement or determination have given difficulty. Like all questions of interpretation, the question of how an amendment affects existing claims in various stages of adjudication is one on which the Agency’s interpretation is likely to prevail if the amendment itself is unclear and the retroactivity issue is one on which its expertise is seen as having a bearing.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ F 500. Effect of a New or Amended Regulation on Current Claims

Changes in regulations that, in the Agency’s view, merely provide clarification or codification of prior law raise few retroactivity issues when they are applied favorably to claims in the appeals process. When, however, they are seen by the claimant as having an adverse effect and as changing the law, the issue of retroactive application arises. It also arises when an administrative law judge decision rendered after the effective date of the new regulation fails to refer to its provisions.

Courts have occasionally put forth the general proposition that new regulations should only be applied retroactively to the extent that they either produce no change or benefit the claimant.

Sometimes the Agency will seek remand of a case by a district court to allow application of a new regulation. In such a case, the regulation may well constitute good cause for the remand, but courts have resisted any suggestion that such remands should be automatic.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ F 600. Legal Effect of Social Security Rulings

Social Security Rulings, now issued in the Federal Register, are, according to the Agency, binding on all its components. Courts have held that a failure to follow a ruling constitutes an abuse of discretion.

The rulings are not treated by courts as regulations. Nonetheless, they are viewed as official Agency interpretations of the Act that are due appropriate deference when an issue of statutory interpretation is before a court.

In addition to ordinary rulings, the Agency now issues a distinct class it terms Social Security Acquiescence Rulings. These acknowledge and interpret judicial opinions that take a position contrary to the Agency’s and direct Agency staff within the relevant U.S. Court of Appeals circuit to adhere to the judicial authority. These rulings apply to all levels of Agency adjudication. Social Security Ruling SSR No. 96-1p provides that unless and until an Acquiescence Ruling has been issued, judicial decisions conflicting with the Agency’s interpretation of the Act or regulations shall not be followed in the adjudication of other claims. It also notes that decisions of Federal district courts will not result in such rulings.

Rev. 9/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ F 700. Legal Effect of the POMS

The Programs Operations Manual System (POMS), previously named the Claims Manual, is a many volume set of directives and interpretations issued by the Agency for internal staff use.

In Schweiker v. Hansen, 450 U.S. 785 (1981), the Supreme Court held that the manual had no legal force and did not bind the Agency.

While its provisions on a specific point of interpretation may not bind the Agency, courts do on occasion refer to the POMS as a means of determining Agency interpretation or practice.

Rev. 12/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
Family Benefits
Entitlement as Spouse

§ H 000. Entitlement as Spouse – In General

To receive spouse or surviving spouse benefits, it is necessary that the claimant be the wife, husband, widow, widower, divorced spouse, or surviving divorced spouse of an insured worker as those terms are defined in the Social Security Act. Benefits are available to spouses of deceased workers and to spouses of workers who are receiving old-age insurance (retirement) or disability benefits.

To meet the definition of wife, husband, widow, or widower, the spouse benefit claimant must meet one of two state law tests or an independent Social Security test. The independent Social Security test can result in the Agency recognizing a “deemed valid marriage” with the insured worker where state law does not.

To meet the independent federal test, individual must demonstrate that she or he:

1. in good faith went through a marriage ceremony that would have resulted in a valid marriage had there not been a legal impediment of which the survivor was unaware, and

2. was living in the same household as the worker at the critical time.

Those who qualify for spouse benefits on the basis of either state law test need not, at the point of benefits, be living with or supported by the insured worker.

Except in the case of survivors benefits received while caring for an eligible child, to meet the definition of surviving divorced spouse, the individual must have been validly married to the deceased worker for ten years and must have received a final divorce.

Prior to a series of Supreme Court decisions, handed down during the 1970s, the Act’s spouse benefit provisions were very different for men and women.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ H 100. Spouse Issues – Marital Status – State Law – In General

A person qualifies for Social Security spouse benefits on the basis of state law if that person

(a) was the spouse of the deceased worker under the applicable law of the state in which the worker had permanent residence at the critical time, or
(b) had the same status under applicable state law with respect to the taking of
intestate personal property as a widow or widower.

The first test is met if the courts of the relevant state would find that claimant and the
insured worker were validly married at the critical time. If the insured worker is still
alive, that critical time is the time of application for spouse benefits. In the case of
survivor’s benefits, it is the time of the worker’s death.

The second test, pertinent only in a limited number of states, is met if the claimant would
have the same status as a spouse under the laws applied by the courts of the state in
determining the devolution of intestate personal property.

Any question about whether members of same-sex marriages or civil unions recognized
by state law can qualify on the basis of one or the other of these tests would seem to be

Rev. 11/05

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ H 110. Spouse Issues – Marital Status – State Law –
Common Law Marriage

Some states, although far fewer than a majority, recognize the validity of marriage by
agreement – generally termed “common law marriage.” Such a marriage is valid in these
states if the parties making the marriage agreement are of sufficient age and capacity to
marry and have no prior undissolved marriages. On the other hand, no license or
particular ceremony or set of witnesses or officiating personnel are required.

Typically, a state recognizing common law marriage will require proof of an exchange of
words in the present tense that reflect the parties’ intent to marry one another. A couple
that has a future intention to marry will generally not qualify, even though they have told
others that they are married. However, the critical issues tend to be matters of proof.
Some states allow proof of an agreement through a rebuttable presumption that arises
upon proof of cohabitation and a couple’s holding themselves out to others as husband
and wife.

A combination of standard conflicts of law principles and very tolerant common law
marriage doctrine can produce a recognized legal marriage in situations involving very
little contact with the common law marriage state. For example, in Renshaw v. Heckler,
787 F.2d 50 (2d Cir. 1986), one couple’s infrequent travels from their home in New
York (a state not recognizing common law marriage) through Pennsylvania (a tolerant
common law marriage state) were held to establish a
marriage which New York courts and therefore the Social Security program had to recognize.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ H 120. Spouse Issues – Marital Status – State Law – Validity of Ceremonial Marriage

Under some circumstances state law will characterize a ceremonial marriage as “voidable” rather than “void.” A void marriage is one which has no legal effect and requires no legal action to dissolve. A voidable marriage by contrast is one that, although involving some defect, has legal effect until and unless one of the two parties obtains a court order of dissolution or annulment.

The distinction bears on the state law qualification for Social Security spouse benefits. A void marriage does not create the requisite status of husband or wife under state law which can be a basis for spouse benefits. A voidable marriage establishes the requisite status so long as it has not been dissolved. Examples of marriages that state law may characterize as voidable, not void, include marriage to a stepchild or to a person who, because of severe mental retardation, lacks the legal capacity to marry. Some situations, such as marriages which occur during a period of restriction following a divorce, may be treated differently depending on whether the second marriage takes place in the state that imposed the restriction or in a different state.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]


In cases where the insured has married more than once, the issue of spouse benefit entitlement may reduce to one of fact: Was the first marriage dissolved prior to the worker’s entering into the second one. In dealing with such fact questions, presumptions commonly play a major role. Many states employ a presumption favoring the second marriage. Their courts presume, in effect, that the first marriage ended in divorce. In some states this presumption applies only when the first spouse is no longer alive. In other states, the presumption comes into play even when the first spouse is alive and contesting the validity of the subsequent marriage.

When a state recognizes “common law” marriage upon proof of a statement of mutual intent to marry, but then presumes such an agreement upon adequate proof of a period of cohabitation and holding out to friends and relations as a married couple, the presumption carries over to Social Security spouse benefit determinations.
The reason such state law presumptions carry over to Social Security determinations is that the Social Security Act’s reference to state law is to what the courts of the relevant state “would find.”

§ H 140. Spouse Issues – Marital Status – State Law – Validity of Divorce or Annulment

When a prior marriage has ended in a divorce of doubtful legality, that doubt infects the validity of any subsequent marriage, so long as the first spouse is alive. If the second marriage is void due to a defective divorce, it is as if the divorce had not taken place and the prior marriage remains undissolved. Whether or not the second marriage is valid often involves the issue of whether one state will or must recognize a divorce granted by another state under the particular circumstances.

In all states, the existence of a prior undissolved marriage with a living spouse will cause a second marriage to be void. Moreover, the subsequent death of the first spouse does not give validity to a ceremonial marriage which it lacked at the outset. In states and situations where common law marriage may be recognized, that doctrine may give validity to the second marriage after death of the first spouse. But so long as the partner to the first marriage is alive, that marriage’s initial and continuing validity are inconsistent with the validity of a second marriage.


A few states grant rights of inheritance to so-called “putative” spouses. These “putative” spouses qualify for spouse status under the provision of the Act that defines a spouse as anyone who would have spouse status under state intestate succession law. The doctrine of “putative” spouses protects individuals who, in good faith, enter into a void marriage – typically void because of a prior undissolved marriage of the other party.

The Act now has a provision similar to the putative spouse doctrine, but that test carries conditions that do not apply to individuals who qualify under state law so it is still generally to a person’s advantage to meet the state law test.
§ H 160. Spouse Issues – Marital Status – Focus on State Intestacy Law

A second state law test is met by those who, although not generally recognized as spouses under state law, are, nonetheless, accorded the same status as spouses in intestate succession. (The Act originally combined these two tests with the consequence that one could not qualify for spouse benefits without having the full status of spouse under state law and also the right to inherit, with the consequence that a spouse who could not inherit did not qualify.) The now disjunctive intestacy test has been held to be satisfied by those entitled to inherit “quasi-community property” as “putative spouses” under state law, i.e., individuals who, in good faith, entered into a marriage that could not be valid because a divorce was not final or effective.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]


Individuals who do not qualify as a spouse under the state law tests may qualify on the basis of a Social Security test that is, essentially, independent of state law. This test can result in the Agency recognizing a “deemed valid marriage” with the insured worker where state law does not. To meet this test the claimant must demonstrate that: she or he 1) in good faith went through a marriage ceremony that would have resulted in a valid marriage had there not been a legal impediment of which the claimant was unaware, and 2) was living in the same household as the worker at the time of the latter’s death or application in the case of a person claiming as the spouse of an old-age insurance or disability benefit recipient. The impediment must either be procedural (e.g., the marriage ceremony was flawed) or the existence of an undissolved prior marriage. If the parties are too young to marry or otherwise lack “capacity” this route to spouse benefits is unavailable.

Prior to a 1990 amendment, an individual eligible for spouse benefits on the basis of this “deemed valid” marriage test ceased to be entitled to benefits if another person qualified under state law for spouse benefits on the same worker’s account. The amendment removed this eligibility provision which had received conflicting interpretations in the courts. Under the current provisions a competing state law spouse and a spouse qualifying under the “deemed valid” marriage test can both receive benefits. In cases where there are both types of spouse claimants, the state law spouse receives benefits outside the family maximum so that those benefits have no effect on the benefits received by the “deemed” spouse or any others whose benefits are subject to the maximum.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

The statute specifies both that the claimant must have participated in a marriage ceremony in “good faith” and that the claimant shall not be eligible if it is determined that he or she entered “the purported marriage ... with knowledge that it would not be a valid marriage.” In contrast with the putative spouse doctrine as applied in some states, this “good faith” test is not a continuing one. If the claimant later learns that the marriage was not valid, but otherwise continues to qualify as the spouse by way of a “deemed ... valid marriage” the test is met.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]


Those who qualify as a spouse under state law can be long separated from the insured at the time of the worker’s retirement, disability, or death or their own benefit application yet still be entitled to spouse benefits. Those seeking to qualify on the basis of a marriage “deemed valid” under the independent Social Security test must, however, be living in the insured’s household at the time critical for benefits. That time is the time of the insured’s death in the case of survivor’s benefits or the time of application if the spouse benefit claimant seeks benefits in relation to a worker’s retirement or disability. This test is not always easy to apply since the Act considers the parties to be “living in the same household” despite temporary absences due to business, employment, illness or incarceration. A particularly difficult situation involves a short absence of one of the parties accompanied by evidence of discord between the two of them immediately prior to the worker’s death.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ H 300. Competing Spouse Claims

The spouse benefit sections leave open the possibility of more than one eligible spouse. This is explicitly the case with those who are eligible as divorced spouses. But if state law allows, it is also conceivable that there may be a legal spouse and a putative spouse both eligible for benefits. Commonly, though, the presence of two or more individuals who claim marriage to an insured worker creates a situation in which state law will recognize only one as spouse or the equivalent of spouse for inheritance purposes and will also lay down the relevant rules of evidence, burden of proof, and presumption with which the incompatible claims must be resolved.
If, under state law, the first of two competing spouses is still the legal spouse even
though the insured had been separated from that claimant and living with the second
spouse, with or without children, the second may still claim under a “deemed ... valid
marriage.”

Prior to a 1990 amendment, an individual eligible for spouse benefits on the basis of the
“deemed valid” marriage test ceased to be entitled to benefits if another person qualified
under state law for spouse benefits on the same worker’s account. The amendment
removed this eligibility provision which had received conflicting interpretations in the
courts. Under the current provisions, a competing state law spouse and a spouse
qualifying under the “deemed valid” marriage test can both receive benefits. In cases
where there are both types of spouse claimants, the state law spouse receives benefits
outside the family maximum so that those benefits have no effect on the benefits
received by the “deemed” spouse and any others whose benefits are subject to the
maximum.

The pre-1991 law was non-uniform because of differing interpretations of the Act’s
treatment of “deemed valid” marriages when there was also or had been a spouse
qualifying on the basis of state law.

The Agency’s interpretation of the provision was that once a spouse qualified for spouse
benefits on the basis of state law a “deemed” spouse could no longer qualify, even if the
amount of spouse benefits received by the competing state law spouse was small and
even if those benefits terminated. Most courts that addressed the issue affirmed this
view. See, e.g., Dwyer v. Califano, 636 F.2d 908 (3d Cir. 1980).

§ H 400. Entitlement as Divorced Spouse – In General

To meet the definition of divorced spouse, the claimant must have been validly married
to the deceased worker under applicable state law and must have received a final
divorce. Except in the case of survivors benefits received while caring for an eligible
child, the divorced spouse must also show that marriage to the deceased worker lasted
for ten years before the divorce became effective.

The Act’s special treatment of divorced spouses requires, at minimum, a two point
reference to state law. To qualify as a divorced spouse or surviving divorced spouse, one
must first have been “married” to the insured “for a period of 10 years immediately
before the date the divorce became effective.” In determining whether that marriage test
is met, state law applies. The second point of reference, of course, has to do with the
existence and timing of the divorce.

A 1990 amendment of the Act extended divorced spouse benefits to those who, although
not validly married under state law, meet the Act’s “deemed valid” marriage test.
§ H 410. Entitlement as Divorced Spouse – Duration of Marriage Prior to Divorce

To meet the definition of divorced spouse, the survivor must have been validly married to the deceased worker under applicable state law and must have received a final divorce. The divorced spouse must also prove marriage to the deceased worker for ten years immediately before the divorce became effective. This duration test does not apply to a surviving divorced spouse caring for an eligible child.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ H 500. Entitlement as Younger Spouse Caring for Eligible Child

Spouse benefits and surviving spouse benefits (including benefits for a surviving divorced spouse) are available prior to the respective age thresholds of 62 and 60, to spouses caring for a child of the insured who is entitled to child benefits. Such benefits end when the child becomes 16 or ceases to be entitled to child benefits or the spouse ceases to care for the child.

The requirement that the spouse care for the child can sometimes prove difficult to apply.

In *Mathews v. De Castro*, 429 U.S. 181 (1976), the Supreme Court upheld the provisions of the Act that extend spouse benefits to younger spouses of retired or disabled workers who are caring for children also eligible for benefits but deny comparable benefits to younger divorced spouses. The differential treatment had been attacked as a violation of the equal protection component of the Due Process clause of the 5th Amendment.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ H 600. Spouse Benefit Issues Having to do With Duration or Timing of the Marriage – In General

To qualify for spouse benefits, it is not sufficient for the individual to meet the marital relationship test at the time of application. In the case of spouses of old-age or disability benefit recipients the marital relationship must have existed for at least 1 year. In the case of surviving spouses the marital relationship must have existed for at least 9 months. (This requirement is met as of the beginning of the month in which the relevant anniversary of the marriage occurs.)

Exceptions to the duration requirement exist for situations in which the claimant and the insured are the parents of a child or in which the insured died accidentally or in which
the claimant was already eligible for Social Security or Railroad Retirement Act benefits as spouse, parent or child prior to the marriage.

In *Weinberger v. Salfi*, 422 U.S. 749 (1975), the Supreme Court upheld the 9 month duration of relationship requirement the Act applies to surviving spouses. The Court found the resulting categories free from invidious discrimination and rationally based.

§ H 700. Spouse Benefit Issues Having to do With Duration or Timing of the Marriage – Special Rules in the Event of Accidental Death

Surviving spouses who were married to the deceased worker less than 9 months before his or her death are not disqualified from receiving benefits if, at the time of marriage, the insured was expected to live for 9 months and the subsequent death was accidental or in the line of military duty or the two had previously been married for at least 9 months.

§ H 800. Effect of Remarriage on Spouse Benefit Entitlement

There is a general rule that an individual receiving benefits as a surviving spouse or divorced spouse not be married. For surviving spouses and surviving divorced spouses, however, the rule contains a major exception; it disregards marriages that occur after age 60 (or between 50 and 60 if the surviving spouse is disabled).

The rule applies, without that exception, to divorced spouses and those claiming mother or father benefits.

In all cases, a subsequent marriage ended by death or divorce poses no impediment once it is over. The requirement is not that the individual not remarry, but rather that he or she be unmarried.
Entitlement as Parent of the Insured

§ I 000. Entitlement as Parent of the Insured – In General

Benefits are available to the dependent parents (age 62 and over) of a deceased worker. Financial dependence on the deceased worker must be established; it is not presumed as in the case of most surviving children and spouses.

There are no equivalent benefits for dependent parents of retired or disabled workers.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ I 100. Entitlement as Parent of the Insured – Determining Status as Parent

For parents the Act refers only to the law “applied in determining the devolution of intestate person property by the courts of the [relevant] State.” Although distinctions may arise in other legal settings, “applicants who according to such law would have the same status relative to taking intestate personal property as a ... parent shall be deemed such.”

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ I 200. Entitlement as Parent of the Insured – Parent’s Dependency Upon the Insured

To meet the parent’s dependency test an individual must have been receiving 1/2 his or her support from the insured child at the time of the child’s death. If the child’s death is preceded by a period of disability, the support test is applied at the beginning of that period.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
Entitlement as Child

§ J 000. Entitlement as Child – In General

There are several different ways an individual can qualify as child of the insured for benefit eligibility purposes:

(a) By being treated as a child by the intestate succession law applying to personal property in the relevant state (Most children born to or of an insured or adopted by an insured qualify by this route.);

(b) By being the child of an invalid marriage that involved a marriage ceremony which failed to establish a valid marriage because of a procedural flaw or the existence of a prior undissolved marriage;

(c) By being a child born to or of the insured, not qualifying under (a) or (b), if the insured has acknowledged the child in writing or there is a court order of parentage or support; or

(d) By establishing both the fact of parentage (with satisfactory evidence) and that the insured was either living with or contributing to the support of the child.

Most children who qualify under (a), (b), (c), or (d) need prove no further connection to the insured. The statute requires that to be eligible a child must be “dependent” on the insured, but then establishes a conclusive presumption of “dependency” that applies in most cases. If the child is eligible under (a) as the adopted or the “legitimate” child of the insured, the child is deemed “dependent.” If the child fails to qualify under (a) but qualifies under either (b) or (c), the child is deemed “legitimate” and thus deemed “dependent.” Test (d) incorporates a dependency requirement explicitly. If it is satisfied there is no further one.

In addition to these rules there are special provisions for stepchildren and grandchildren that allow them to qualify in some circumstances without meeting any of the above tests.

§ J 100. Child’s Status – State Law – In General

For children the Act refers to the law “applied in determining the devolution of intestate personal property by the courts of the [relevant] State.” On certain other questions of child status, the Act’s reference is less specific. For example, the Act provides benefits for stepchildren and for adopted children. These benefits are not explicitly tied to state intestate succession law although the phrase “legally adopted” contains a clear reference to state law. Consequently, if the state does not recognize “equitable adoption,” that is, adoption arising out of intention and action, but insists that there be a judicial proceeding for an adoption to have legal effect, that carries over to a potential Social Security claim as well.
In *Trimble v. Gordon*, 430 U.S. 762 (1977), the Supreme Court held unconstitutional a state intestacy law that allowed children born outside marriage to inherit from their mother (but not their father) while providing that children born within a valid marriage could inherit from both parents. Through its effect on state intestacy laws, *Trimble* has had a major effect on Social Security child benefit entitlement.

§ J 110. Child’s Status – State Law – Focus on State Intestacy Law

For children the Act refers only to the law “applied in determining the devolution of intestate personal property by the courts of the [relevant] State.” Although distinctions may arise in other legal settings, “applicants who according to such law would have the same status relative to taking intestate personal property as a child or parent shall be deemed such.” Thus, for example the question about a child of a worker who died domiciled in Texas is whether the child can inherit. If the child is an acknowledged child born outside of marriage, the question is whether such children inherit under Texas law. In *Moorehead v. Bowen*, 784 F.2d 978, the Ninth Circuit held that under Texas intestate succession law only “legitimate” children inherited personal property. It also held, though, that Texas courts would look to the law of the state where all the relevant acts bearing on status took place on the issue of legitimacy. Since that state was California which allows children to take as legitimate if the “father receives the child into his home and openly holds ... [it] out as his natural child,” the Ninth Circuit went on to hold the child eligible.

Social Security Ruling, SSR No. 06-2p, addresses the situation in which one child qualifies for benefits on a ground other than state intestacy law and a second child, who presumably does not qualify on that ground, is established to be his or her sibling by DNA testing.

In AL, FL, and GA an acquiescence ruling (AR No. 97-3(11)) implements the Eleventh Circuit’s ruling in *Daniels v. Sullivan*, 979 F.2d 1516 (11th Cir. 1992) that to apply a state intestacy requirement that paternity be established during the lifetime of the father violates equal protection if applied to create an insurmountable barrier to Social Security child benefits.

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§ J 120. Child’s Status – State Law – Effect of State Law Presumptions

Since the reference in the Act to state law is a reference to what the courts of a state would find, it incorporates not only “substantive law” but state law presumptions that bear on the resolution of factual disputes important to a child’s status. For example, if state law presumes that a child born to a married couple during the marriage is the child of both marriage partners, that presumption will operate in a dispute over entitlement to Social Security child benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]


The Act extends child benefits to several categories of children who do not meet the state law test:

(a) children born of a marriage that is invalid due to a procedural flaw in the marriage ceremony or due to a prior undissolved marriage

(b) children born to or of the insured, not qualifying under state law, if the insured has acknowledged the child in writing or is subject to a court order of parentage or support.

Finally, the Act provides for child benefits in cases where the fact of parentage is established to the satisfaction of the Agency and the insured was either living with or contributing to the support of the child at the critical time for entitlement.

Social Security Ruling, SSR No. 06-2p, addresses the situation in which one child qualifies for benefits on a ground other than state intestacy law and a second child, who presumably does not qualify on that ground, is established to be his or her sibling by DNA testing.

In Mathews v. Lucas, 427 U.S. 495 (1976), the Supreme Court upheld the Act’s provisions dealing with proof of dependency by children born outside of marriage. The decision, which provides important interpretation of those provisions, concludes that requiring proof of financial dependency of those children who cannot establish a purported marriage or written acknowledgment of parenthood or a court order does not violate the equal protection component of the Due Process clause of the 5th Amendment.

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[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

A child born outside of marriage to the insured worker who does not qualify on the basis of state law will, nonetheless, be eligible for child benefits on the worker’s account if the worker has acknowledged in writing that the child is his son or daughter. The writing need not be in any particular form, letters or other informal documents are sufficient. A Social Security Ruling, (SSR No. 72-32), specifically provides that the document does not need the worker’s signature.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]


A child of the insured worker, born outside of marriage, who does not qualify on the basis of state law will, nonetheless, be eligible for child benefits on the worker’s account if there is adequate proof of the parent-child relationship and child is living with or supported by the worker at the time of the child’s application for benefits (or if the worker is dead and the child is applying for survivors benefits, at the time of the worker’s death). The Act and regulations spell out the type of evidence that will establish that the child was living with or supported by the insured worker. When the insured worker has meager resources, issues of the amount and regularity of support necessary to meet this test can prove especially troublesome. The Agency’s position is that regular and substantial contributions are required.

In DE, NJ, PA, and VI, an acquiescence ruling (AR 86-13) implements the Third Circuit’s ruling in McNeal v. Schweiker, 711 F.2d 18 (3d Cir. 1983) that the Agency must consider the worker’s and household’s income when evaluating the amount of the worker’s contributions to support of the child.

In MD, NC, SC, VA, and WV, an acquiescence ruling (AR 86-14) implements the Fourth Circuit’s ruling in Jones v. Harris, 629 F.2d 334 (4th Cir. 1980) that the Agency must consider the worker’s and household’s income when evaluating the amount of the worker’s contributions to support of the child.

In KY, MI, OH, and TN, an acquiescence ruling (AR 86-15) implements the Sixth Circuit’s ruling in Childress v. Secretary, 679 F.2d 623 (6th Cir. 1982) and earlier decisions that the Agency must consider the worker’s and household’s income when evaluating the amount of the worker’s contributions to support of the child.

In CO, KS, NM, OK, UT, and WY, an acquiescence ruling (AR 94-1) implements the Tenth Circuit’s ruling in Wolfe v. Sullivan, 988 F.2d 1025 (10th Cir. 1993) that the
proper test for determining whether the father was “contributing to the support” of a posthumous child is whether the father’s support was commensurate with the needs of the unborn child at the time of the father’s death and that the economic circumstances of the worker must be taken into account when making such a determination.

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A child of the insured worker, born outside of marriage, who does not qualify on the basis of state law will, nonetheless, be eligible for child benefits on the worker’s account if there is adequate proof of the parent-child relationship and child is living with or supported by the worker at the time of the child’s application for benefits (or if the worker is dead and the child is applying for survivors benefits, at the time of the worker’s death). Since this child status test is independent of state law, state law standards of proof of parentage do not apply. The Act provides that children qualifying on the basis of this test must establish parentage to the satisfaction of the Agency. In Jones v. Chater, 101 F.3d 509 (7th Cir. 1996) the Seventh Circuit concluded that this set the burden of proof at the “preponderance of evidence” level.

rev. 3/97


A child born outside of marriage to the insured worker who does not qualify on the basis of state law will, nonetheless, be eligible for child benefits on the worker’s account if the worker was ordered by a court to support the child based on a finding that it was his son or daughter or if a court, without ordering support, decreed the worker to be the child’s parent.

A child born to a parent who, even though not legally married, did participate in a marriage ceremony which was invalid because of a prior undissolved marriage or for some other reason will still be eligible for child benefits on the working parent’s account despite state law disqualification.

Unlike the comparable provision applicable to spouse benefit claimants, this test does not require that either of the parents participating in the ceremony hold a good faith belief that it will establish a valid marriage.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ J 300. Special Issues With Posthumous Child

A child born after the worker’s death can pose special problems of interpretation or proof. If the child is born within a marriage or otherwise qualifies on the basis of state law the timing poses little difficulty. However in cases where eligibility depends on the child’s living with or being supported by the worker, the test may be difficult if not impossible to meet. The provisions for written acknowledgment or eligibility based on a court order can also prove troublesome in such cases.

In CT, NY, and VT an acquiescence ruling (AR 86-21) implements the Second Circuit’s ruling in Adams v. Weinberger, 521 F.2d 656 (2d Cir. 1975) that the support test is met when the worker’s contributions to an unborn child were commensurate with its needs at the time of the worker’s death.

In MD, NC, SC, VA, and WV an acquiescence ruling (AR 86-22) implements the Fourth Circuit’s ruling in Parsons v. HHS, 762 F.2d 1188 (4th Cir. 1985) that the support test is met when the worker’s contributions to an unborn child were commensurate with its needs at the time of the worker’s death.

In AK, AZ, CA, HI, ID, MT, NV, OR, WA, and GU an acquiescence ruling (AR 86-23) implements the Ninth Circuit’s ruling in Doran v. Schweiker, 681 F.2d 605 (9th Cir. 1982) that the support test is met when the worker’s contributions to an unborn child were commensurate with its needs at the time of the worker’s death.

Several recent cases have wrestled with the question whether a child conceived posthumously, by artificial insemination, can qualify for surviving child benefits. See, e.g., Woodward v. Commissioner of Social Security, 435 Mass. 536 (2002).

In AK, AZ, CA, HI, ID, MT, NV, OR, WA, and GU an acquiescence ruling (AR 05-1) implements the Ninth Circuit’s ruling in Gillett-Netting v. Barnhart, 371 F.3d 593 (9th
Cir. 2004) that so long as state law treats posthumously conceived children as legitimate children of the deceased insured they are eligible for survivors benefits.

Rev. 11/05

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ J 400. Special Issues With Legally Adopted Child

Adoption can be a basis for receiving child benefits. At least one category of adopted children, however, must meet a more stringent set of requirements than children who are born to or of the insured. These are older children (i.e. children 18 and over qualifying for benefits by virtue of disability) whose adoption did not come until after the insured had begun old-age or disability benefits. Unless they fall within certain categories (such as stepchildren or some grandchildren) they must establish actual financial dependence on the insured in the year prior to their adoption.

Legally adopted children who are claiming survivors benefits do not have to meet an actual dependency test. Children adopted by a grandparent or the spouse of a deceased are also exempt from this test under some circumstances. And children adopted by a natural parent, a stepparent or someone on whom they were dependent prior to the adoption need not meet the test.

A child adopted by the surviving spouse of a deceased worker can qualify for surviving child benefits if the adoption proceedings were begun before the worker’s death or the adoption was completed within 2 years after that death. In addition, the child must have been living in the worker’s home or have received 1/2 support from the worker in the year before the worker’s death.

Legal adoption can also undercut child benefits in the case where a child is adopted by someone other than the parent on whose account he or she might otherwise be able to claim benefits. If that adoption occurs during the insured’s lifetime, dependence on the birth parent is no longer presumed but must be established by proof of support by the insured birth parent or by proof that the child was living with the birth parent.

In CT, NY, and VT, an acquiescence ruling (AR 86-16) has implemented the Second Circuit’s ruling in Damon v. Secretary, 557 F.2d 31 (2d Cir. 1977) that payments for foster parents will be treated as income in determining whether the worker has met the support requirement associated with adoption.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ J 500. Claims Based on Equitable Adoption of Child

Some states define children whom an individual agreed to adopt, but failed to, as “equitably adopted,” treating them as children for purposes of intestate succession.
Children who have such status under state law are eligible for Social Security. They must, however, establish dependence on the insured at one of several critical times. Those times are the insured’s death or disability or eligibility for old-age benefits or their own application. In the case of a living insured they must also establish that equitable adoption occurred before the insured’s disability or eligibility for old-age insurance benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ J 600. Special Child Issues With Stepchildren

The Act provides benefits for stepchildren without explicitly tying this status to intestate succession law. Some courts have held, however, that the status derives from state law so that a liberal state definition of stepchild may furnish a basis for benefits.

A child who would not otherwise qualify as a stepchild will, nonetheless, be eligible for child benefits on the worker’s account if the worker and the child’s other parent, even though not legally married, did participate in a marriage ceremony which was invalid because of a prior undissolved marriage or for some other reason. Unlike the comparable provision applicable to spouse benefit claimants, this test does not require that either of the parents participating in this ceremony hold a good faith belief that it will establish a valid marriage.

In AK, AZ, CA, HI, ID, MT, NV, OR, WA, and GU, an acquiescence ruling (AR 86-12) implements the Ninth Circuit’s ruling in Hutcheson v. Califano, 638 F.2d 96 (9th Cir. 1981) that “stepchild” should be defined by the appropriate state law.

Stepchildren are not eligible for benefits merely by virtue of that status. They must establish dependency on the insured worker at the time of the worker’s death or, if the worker is alive, the time of their benefit application. Prior to a 1996 amendment, living with the insured worker was one way of satisfying that requirement. As of June 1996, dependency can only be established by proof that the insured was contributing one-half the child’s support.

Prior to the 1996 amendment, once benefits for a stepchild had begun they did not depend on the marriage between the child’s natural parent and the stepparent continuing. Under the Act, as amended, if the two divorce, benefits to the child on the account of the stepparent will cease the month after the divorce becomes final.

Rev. 6/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ J 700. Child Claims Involving Grandparents – In General

An individual who is actually dependent on his or her grandparent at the time of the grandparent’s death, disability, or eligibility for old-age insurance benefits can claim child benefits on the grandparent’s account so long as the grandparent’s child (the individual’s parent) is either dead or disabled at that point. Actual dependence on the grandparent is established by proof of living with the grandparent or receiving 1/2 support at the critical time.

The Agency’s position that provisions extending child benefits to grandchildren do not reach great-grandchildren or step-great-grandchildren is set out in Social Security Ruling SSR No. 73-41.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ J 710. Child Claims Involving Grandparents – Special Issues With Child Adopted by Grandparent

An individual who is legally adopted by his or her grandparent need not meet an actually dependency test if the adoption occurred prior to the grandparent’s death, disability, or eligibility for old-age insurance benefits. Where the adoption occurs subsequent to the grandparent’s disability or old-age insurance eligibility, the individual must meet the same requirements as other adopted children.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ J 720. Child Claims Involving Grandparents – Special Issues With Stepgrandchild

An individual who is dependent on his or her stepgrandparent under circumstances that allow a child to claim on the account of a grandparent (whether or not legally adopted) is entitled to child benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ J 800. Older Child Eligible While a Full-Time Student

Ordinarily child benefit eligibility ends at age 18. A child who is a full-time elementary or secondary school student remains eligible for an additional year, to age 19, so long as he or she remains in school.
Regulations provide that in some situations scheduled attendance of fewer than 20 hours a week can constitute full-time attendance.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ J 900. Effect of Child’s Marriage

To be eligible for child benefits an individual must be unmarried. Marriage, at any age, will cause child benefits to end. One important exception exists for individuals who are eligible for child benefits because of disability. Their marriage to other individuals eligible for Social Security benefits will not end child benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
General Family Benefit Issues

§ K 100. Determining Which State’s Law to Apply

On family relationship questions bearing on survivors benefits, the Act refers to the law of the state in which the insured was domiciled (the insured’s permanent residence) at the time of his death. For family benefits claimed while the insured is still alive, the reference is to the law of the state in which the insured worker is domiciled at the time of application (the family member’s application not that of the insured). If the insured’s domicile is outside the United States and is not the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa, the relevant “state law” specified by the Social Security Act is that of the District of Columbia.

The dependence of these benefits on state law results in a lack of national uniformity. A person may qualify as a spouse of the insured worker because of the fortuity that one state’s law applies rather than another’s. A child may be eligible for benefits on the account of a deceased caretaker in one state because of its recognition of the doctrine of “equitable adoption” while the same child would be ineligible in states that follow a more rigid rule.

Since the Act’s reference is to the law which the courts of the relevant state would apply, it is generally held that if, under conflicts of law principles applied by those state courts, they would, in a particular case, determine marital status or status for intestate devolution of personal property by reference to the law of another jurisdiction, that reference carries over to these Social Security determinations. Take, for example, a state that, like most, does not recognize the establishment of a marriage without a license and religious or civil ceremony, but which would, nonetheless, for many purposes including intestate devolution of personal property recognize the validity of a “common law” marriage between a man and woman who had met the criteria for validity in another state while domiciled there. Under those same circumstances, the “common law” marriage in the other state can be the basis for Social Security spouse benefits. Determining children’s status under state intestacy law can lead to the same sort of reference.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ K 200. When State Law Has Changed, What Law Applies

When state law has been amended, deciding whether the law prior to or after the amendment applies can be critical to a family benefit claim. The Act refers to state law in effect at the time of the worker’s death in the case of survivors benefits, or at the time of application in other cases. Changes in the law occurring after that point do not, under the Agency’s view of the statute, have any effect. Some courts have, however, interpreted the Act’s reference as incorporating liberalizing changes in state law that take place after the insured’s death but before the Agency’s determination of a survivor’s claim.
Many of the key changes in state law during the past decades were the consequence of constitutional challenges to the former provisions. Under these circumstances the earlier law – the apparent reference for Social Security benefits – may be invalid.

In 1967, in *Loving v. Commonwealth*, 388 U.S. 1, the Supreme Court declared that state statutes that failed to recognize otherwise valid marriages as legal solely on grounds of racial classification were unconstitutional. The Agency promptly recognized that a marriage between a Caucasian and an Indian which a South Carolina antimiscegenation law declared “utterly null and void” would, nonetheless, qualify for Social Security benefits.

A decade later, in *Trimble v. Gordon*, 430 U.S. 762 (1977), the Supreme Court held that state intestate succession laws that discriminate against children born out of marriage violate the equal protection clause. Subsequent claims by children seeking Social Security benefits challenged by incorporation the constitutionality of state intestate succession law treatment of “illegitimates.” They argued essentially that while state courts had not yet followed *Trimble* they would be obliged to, or alternatively, that the incorporation of unconstitutional discrimination into a federal benefit program would itself deny due process.

In KY, MI, OH, and TN, an acquiescence ruling (AR 96-1) implements the Sixth Circuit’s ruling in *DeSonier v. Sullivan*, 906 F.2d 228 (6th Cir. 1990) that the Agency must apply changes in state intestacy law in the same manner as state courts would even when that means applying the law of intestate succession in effect at the time of a benefit determination rather than at the time of the worker’s death.

§ K 300. The Effect of Actual State Court Proceedings

Since the Act’s reference to state law is to the law that the courts of the relevant state would apply, it invites attention to judicial decisions of that state. However, the Act does not lay down clear principles regarding the nature of the effect individual decisions should have on Social Security determinations. The reference to courts also encourages attention to rules of evidence and defenses that would affect the application of state domestic relations rules in particular cases. If state law requires a clear statement of mutual intent to create a common law marriage, but also recognizes a rebuttable presumption of such a statement upon proof of cohabitation and “holding out,” that presumption figures in the Social Security eligibility determination. If a state would hold an individual estopped or barred by laches from challenging the validity of a marriage, those defenses may apply as well in the Social Security benefit context. However, since neither Social Security benefits nor the Agency will have been involved in those analogous state law settings, such arguments have also been called into question.
Presumptions figure prominently in cases involving competing spouse claimants. If both spouses can establish a formally sufficient marriage, the issue will often reduce to whether the first marriage had been dissolved before the second was entered into. If it had not been, the first spouse is the legal spouse. Under the law of most states, however, a presumption in favor of the validity of the later of two marriages by the same person assists the second spouse claimant. Where state law creates this presumption, state decisions concerning the evidence the first “spouse” must produce to overcome the presumption also carry over to Social Security.

The reference in the Social Security Act to state law carries an added element of difficulty when there has been a legal proceeding which adjudicated some of the key Social Security issues, but without the participation of all the affected parties. When state law has already been applied by a state judge on an issue bearing on the Social Security claim a question concerning the effect of that determination on the claim can arise. This can occur in countless ways. The state court order can be a divorce decree, annulment of a marriage or a divorce, paternity action, or order of probate.

Since family relationship claims rest on what a state court would decide, if the past adjudication would be binding on a state proceeding it is normally followed. When, for example, a court has determined a child’s status in the course of a contested divorce proceeding and that determination would be followed by state courts in disposing of inheritance the determination will be followed by a Federal court dealing with a Social Security claim.

Proceedings that lack personal jurisdiction over adversely affected family members do not, of course, have any more binding effect under Social Security law than they do under state law.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ K 400. Consequences of Survivor’s Conviction of Murder

A long-standing regulation bars payment of survivors benefits to a person convicted of murdering the insured worker. The regulation frames the prohibition in terms of a conviction of a felony (or the equivalent) for intentionally causing the insured’s death. Juvenile proceedings that yield a similar finding are covered.

This ground for denying benefits is distinct from the suspension of benefits during incarceration to those convicted of any felony. It applies only to this one crime and is not tied to imprisonment but follows directly and permanently from conviction.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ K 500. Lump Sum Death Benefits

A lump sum death benefit of $255 is paid to the surviving spouse of a deceased worker. The benefit is available even if the worker was only currently insured. It is paid to a surviving spouse who was living with the insured at the time of death. If no one meets that test, it is paid to an eligible surviving spouse who was not living with the insured. If no eligible spouse applies, the benefit is divided among eligible children.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ M 100. Entitlement to More Than One Benefit

The Act has a series of provisions that deal with overlapping Title II benefits. These cover situations where an individual is entitled to benefits on the basis of his or her own earnings plus benefits based on a family connection to one or more other insured workers.

The Act’s first principle is that primary benefits, that is benefits based on an individual’s own earnings (old-age insurance or disability benefits), displace family (auxiliary) benefits dollar-for-dollar. An individual may receive both old-age benefits and spouse benefits. The total amount will be the same as if he or she received only the larger spouse benefit. However, the total will be made up of the full old-age benefit amount plus a spouse benefit reduced by the amount of the old-age benefit.

Entitlement to multiple family benefits produces more complicated calculations. The Act’s basic principle here is that auxiliary benefits do not cumulate one upon another. Instead, in nearly all cases, the individual will receive the largest of the available family benefits (reduced by the amount of any primary benefit). A special provision deals with children entitled to benefits on more than one account. The basic rule in such cases is receipt of a benefit based on the largest Primary Insurance Amount. If a child would receive a larger benefit from an insured with a smaller PIA, however, and basing his or her benefit on that account would not have an adverse affect on the benefits of others, it is used.

Rev. 11/05

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ M 200. Relationship of Family Benefit to PIA

Subject to a family maximum which caps the total amount of monthly benefits payable on the account of any one insured, benefits for any one family member are based on a percentage of the insured worker’s primary insurance amount (PIA). The percentage is different for different categories of family benefits ranging between 50% and 100%. The actual monthly payment for a family benefit recipient depends on this PIA-based amount.
adjusted on account of continuing earnings (excess earnings), the family maximum, and in some cases the age at which benefits were begun.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ M 300. Application of the Family Maximum When There Are Numerous Family Benefit Claimants

With a few exceptions a cap or family maximum limits the total amount of monthly benefits payable on the account of any one insured. The precise monthly maximum is the product of a formula applied to the individual’s primary insurance amount (PIA). Depending on the level of the PIA the family maximum ranges between 150% of the PIA to a high of 188%. (In the case of disability benefits the percentage is likely to be lower.) Like the underlying benefits the maximum is adjusted annually to reflect cost of living changes.

When the total benefits that are subject to the family maximum exceed its cap, any benefits payable to the insured are subtracted from it and the balance is distributed to the family benefit recipients who all receive pro rata reductions in their amounts.

Benefits paid divorced spouses, except when they are mother or father benefits, are not subject to this reduction nor are benefits paid to a “state law” spouse when there is a second spouse eligible on the basis of a “deemed valid” marriage.

When one family member is also entitled to benefits on his or her own account, the amount entering into the family maximum calculation is the reduced family benefit. This lightens the impact of the maximum on benefits to other family members.

Rev. 11/05

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ M 400. Application of the Public Pension Offset to Family Benefits

The Act provides for a reduction of spouse benefits and divorced spouse benefits when the individual receives a pension based on uncovered government work (for the Federal government or a state or local government). If the pension is paid in a lump sum, that lump sum is converted into a monthly amount for purposes of this calculation.
Prior to 2004 the determination of whether or not the government work on which the pension is based was covered by Social Security was made as of the last day of the individual’s work for the governmental organization. The Act was amended that year to require five years of uncovered work, with that stricter requirement being phased in.

Rev. 12/04

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
Disability Benefits

Claimant Categories

§ N 100. Disabled Worker Claiming Disability Insurance

Social Security disability insurance benefits are paid to disabled workers who meet a special insured status test and apply for benefits. Benefits are not paid until the individual has met the Act’s disability standard for 5 months. However, this 5 month waiting period does not apply to individuals who have previously received disability benefits or to those who have had a recognized period of disability within the past 5 years.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ N 200. SSI Disability Benefit Claim

Individuals who meet the Social Security disability standard, whether or not they have the insured status necessary for disability insurance benefits, are potentially eligible for Supplemental Security Income (SSI) disability benefits. To qualify they must have income and assets falling below the SSI limits.

Entitlement to Social Security disability benefits is not necessarily inconsistent with eligibility for SSI because Social Security benefits for individuals with low past earnings can be less than the SSI income limit.

Since SSI benefits do not require insured status or, indeed, any past work, they are available when a currently disabled adult cannot establish the onset of disability while he or she met the insured status test for Social Security. They are also available to young adults and children.

In Sullivan v. Zebley, 493 U.S. 521 (1990), the Supreme Court held that the regulations limiting child SSI disability benefits to those who had a listed impairment or the equivalent violated the statutory provision extending benefits to children who suffer for impairments of “comparable severity” to those which would establish disability in an adult. Regulations responding to Zebley were issued by the Agency in February 1991. A Social Security Ruling based on Zebley, SSR No. 91-7, was issued in August 1991. These provisions gave children claiming SSI who did not meet or equal a listing a further opportunity to show disability, through a process largely analogous to the residual functional capacity assessment in adults.

The Act was amended in 1996 to eliminate the language supporting this element of individualized assessment of children.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ N 300. Disabled Widow(er) Claiming Survivors Benefits

Surviving spouse benefits are normally limited to those age 60 or over and spouses caring for eligible children. However, disability can drop the age threshold for a surviving spouse from 60 to 50 years old. To qualify, though, the disability must have commenced within seven years of the insured worker’s death or last receipt of mother or father benefits.

Although the test of disability applied to surviving spouse claimants was once stricter than the standard applied to disabled workers, it was altered by a 1990 amendment to the Act so that the tests are now the same.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ N 400. Older Child Claiming Social Security Because of Disability

Entitlement to family benefits as a child of an insured worker normally ends at age 18. However, an older individual, otherwise entitled to such benefits, can qualify if the individual is disabled and that disability began before age 22. This provision makes it possible for an adult to receive child benefits. As is true of child benefits generally, such disabled adult child benefits are not available until an insured parent dies or starts drawing old-age or disability benefits.

Rev. 11/05

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ N 500. Claim for a Period of Disability Earnings Record Freeze Apart From Benefit Claim

The Act provides that a continuous period during which an individual is disabled will be dropped from benefit and insured status calculations. Such a “disability freeze” applies to calculations for all types of benefits. It can apply to survivors benefits based on the earnings of a deceased worker who never sought disability benefits before his death. To be eligible for a determination that such treatment applies the individual must meet a special insured status test, the period of disability must have lasted at least 5 months, and the individual (or a representative) must file an application while disabled or within 12 months after the disability ends.
The time within which an application must be filed is increased to 36 months in certain cases. Because of the “disability freeze” individuals can delay applying for disability insurance benefits until long after becoming disabled so long as they can establish that the onset of disability occurred while they still met the insured status test for those benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

Context of Disability Issue

§ N 600. Claim Resting on Initial Finding of Disability

The critical issue in most disputed claims for disability benefits of all types is whether the individual meets the appropriate standard of disability at the time of application or within a relatively short time before. Title II disability benefits can be paid for a period of eligibility extending prior to the filing an application, but that period cannot be more than 12 months. Consequently, while the “disability freeze” provisions allow an application to be filed long after the onset of disability, retroactive benefits will not reach back more than a year.

Rev. 11/05

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ N 700. Claim Focusing on When Person Became Disabled

Entitlement to Title II disability benefits critically depends on exactly when an individual who is currently disabled and who was disabled at the time of filing a benefit application became disabled. That is because entitlement depends on meeting an insured status test. Unless the individual becomes disabled while still holding insured status (which would give rise of a period of disability, thus preserving insured status) benefits are unavailable. Since the insured status test requires quarters of coverage in the period immediately before the onset of disability, a disabled individual who ceased working because of health problems some time before meeting the Act’s standard of disability may not qualify for benefits unless those health problems reached the Act’s standard before the absence of earnings caused insured status to be lost. Moreover, a claimant who at one point met the Act’s standard while insured but then experienced medical improvement may not qualify for benefits because of the need to show that the current period of disability began while the person had insured status.

Less often and less critically the issue of when the claimant became disabled can go to the issue of when entitlement began. Since Title II disability benefits can only be paid for 12 months prior to application such disputes involve much smaller stakes.
Establishing an “onset date” prior to the first time the claimant sought medical attention is difficult but not impossible. Social Security Ruling SSR No. 83-20 deals with this problem.

§ N 800. Issues of Terminating Disability Benefits – In General

Unlike Social Security benefits that rest on attainment of a certain age or the death of an insured worker, disability benefits rest on a condition that can be reversible. The definition of disability requires only that a disability be expected to last a year. As a result, benefits can be paid in cases where an end to disability is foreseen. But whether or not foreseen, an end to disability ends entitlement to disability benefits and leads to termination of benefits for the claimant and any dependent family members.

The difficulty of the disability determination also increases the likelihood that new evidence will cast doubt on an initial determination of eligibility. Such a reversal of position which is possible though less likely with other types of benefits can also lead to termination and perhaps even a conclusion that benefits have been overpaid.

Disability beneficiaries threatened with termination have an option to continue payments through the hearing stage, subject to having those payments treated as overpayments should the hearing decision by the administrative law judge (ALJ) affirm the termination.

§ N 810. Issues of Terminating Disability Benefits – Medical Improvement

Since receipt of disability benefits rests on an initial determination of disability, termination of benefits on the ground that the person is no longer disabled must rest on affirmative evidence that the individual’s condition has improved. While the individual carries the burden of proof in establishing initial disability, the Agency has the burden of establishing medical improvement.

The Act gives a recipient the right to have benefits continued during an administrative appeal from an Agency determination that the recipient is no longer entitled to benefits because of medical improvement.

The Act also provides that disability benefits should not be terminated while the recipient is participating in an approved vocational rehabilitation program. This
exception is conditioned on an Agency determination that the program will increase the likelihood the individual may be permanently removed from disability benefits. The Agency’s view is that this exception does not apply in cases of medical improvement.

When a cessation determination is appealed, the Agency’s view is that the ALJ should consider only medical evidence of the recipient’s condition at the time of that determination. However, in *Difford v. Secretary of Health and Human Services*, 910 F.2d 1316 (6th Cir. 1990) the Sixth Circuit held that the Act requires the ALJ to consider the recipient’s condition at the time of the hearing.

In DE, NJ, PA, and VI an acquiescence ruling (AR 86-4) implements the Third Circuit’s ruling in *Paskel v. Heckler*, 768 F.2d 540 (3d Cir. 1985) that an individual in a vocational rehabilitation program is entitled to a “likelihood determination” before termination of benefits despite medical improvement.

In AK, AZ, CA, GU, HI, ID, MT, NV, OR, and WA an acquiescence ruling (AR 86-5) implements the Ninth Circuit’s ruling in *Leschniok v. Heckler*, 713 F.2d 520 (9th Cir. 1983) than an individual in a vocational rehabilitation program is entitled to a “likelihood determination” before termination of benefits despite medical improvement.

§ N 820. Issues of Terminating Disability Benefits – Trial Work

When a person actually returns to work that pays above a level set by the Agency the earnings are ordinarily taken as establishing that the individual is not disabled but able to engage in substantial gainful activity. However, the Act provides a period in which a previously disabled person can test his or her ability to return to work without losing benefits. This is termed a “trial work period” and is the subject of detailed regulations.

Disability beneficiaries are entitled to 9 months of trial work, not necessarily consecutive. Originally only 1 such trial work period was allowed during a period of disability. The Act now provides for a rolling 5 year (60 month) period. A beneficiary exhausts the 9 month trial work period only if he or she exceeds 9 months of trial work during this rolling 60 month period. Monthly earnings above a stipulated level, an amount less than the "substantial gainful activity" threshold, cause the month to be counted. (For 2008 this trial work earnings figure is $670.)

Following a period of trial work there is a “reentitlement period” during which benefits resume in months in which the individual’s earnings fall below the level establishing substantial gainful activity.

In *Barnhart v. Walton*, 535 U.S. 212 (2002), the Supreme Court upheld the Agency’s interpretation of the trial work provisions of the Act, namely that a “trial work period” is
not available to a claimant who returns to work within 12 months of disability onset, before entitlement has been established. Several circuits had taken the contrary view.

Rev. 11/07

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ N 830. Issues of Terminating Disability Benefits – Revised View of Original Determination

Issues concerning administrative res judicata and the circumstances under which the Agency can open up a prior determination are raised whenever disability benefits are terminated under circumstances that indicate that the Agency is reopening the original determination rather than concluding that the recipient’s condition or situation has changed.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ N 840. Issues of Terminating Disability Benefits – Reasons Other Than Medical

There are a variety of situations in which disability benefits can be terminated without regard to the individual’s medical condition. For example, a disability benefit recipient who returns to work that does not fall under a trial work period can lose eligibility because of his or her substantial gainful activity. This is true even though there has been no change in medical condition. A recipient who is incarcerated will have benefits suspended on that ground without regard to medical condition.

While the Act gives a recipient the right to have benefits continued during an administrative appeal from an Agency determination that the recipient is no longer entitled to benefits because of medical improvement, the regulations limit that right to such cases.

Rev. 3/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
Establishing Disability

§ P 000. Overall Treatment of Burden of Proof and Evidence

The Act places the burden of establishing entitlement on the disability benefit claimant. It does provide, however, for consultative medical examinations that may provide needed medical evidence of an impairment.

When a claimant has established that he or she has a serious impairment that prevents return to past relevant work, courts hold that the burden shifts to the Agency to establish that there is other work that a person with such impairments and the claimant’s vocational characteristics can perform.

These burden of proof rules are structured by a sequential evaluation process that lays out five distinct stages in the determination. Stages one through four lie in the zone where the burden is on the claimant. They include: (1) the preliminary question whether, despite impairments, the claimant is, in fact, engaged in “substantial gainful activity,” (2) the determination whether the claimant has an impairment of sufficient severity to interfere with the ability to perform work activities, (3) a comparison of the claimant’s medical impairments with the listing of numerous conditions warranting a conclusion of disability, and (4) a determination whether the claimant has the ability to perform past relevant work. In stage five where the issue is whether there is other work that a person with the claimant’s characteristics can do, the burden is on the Agency, but in any case covered by the Medical-Vocation Guidelines, the guidelines themselves may meet that burden. In cases not governed by the guidelines, there must be other evidence.

These five stages operate in sequence. Evidence that would be relevant or even dispositive at a later stage will not prevent a contrary decision at an earlier one. The regulations lay out this process in great detail. Social Security Ruling SSR No. 86-8 provides explanation.

Courts employing the substantial evidence standard have developed other more specific burden of proof or evidentiary rules, such as rules according special weight to medical testimony or reports coming from the claimant’s treating physician.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 100. Duration of Disability

Short term disabilities, no matter how severe, do not entitle an individual to receive Social Security disability benefits. To qualify for benefits the individual’s impairment must be expected to last for a continuous period of at least 12 months or to result in death. This test is particularly difficult to apply to conditions that recur in periodic episodes between which the individual is able to function reasonably.
In *Barnhart v. Walton*, 535 U.S. 212 (2002), the Supreme Court upheld the Agency’s interpretation of the Act, which is that not only must the impairment meet the 12-month test, but it must prevent substantial gainful activity for that period. *Walton* rejected the position taken by several circuits that so long as an impairment was “expected to last” for 12 months, work at the “substantial gainful activity” level within that period would not preclude entitlement. It could qualify as “trial work.”

Distinct from the duration requirement is a five-month waiting period. Even in a case meeting the duration test (for example, a claimant with a disabling impairment expected to result in death) benefits are not available for the first five months following onset.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 200. Claimant Engaged in Substantial Gainful Activity – In General

No matter how severe an individual’s physical and mental impairments, disability benefits are not available if the individual continues to engage in substantial gainful activity, that is, continues to work for significant compensation. Earnings above an amount set by regulation and adjusted annually ($940 per month for 2008) can establish an ability to engage in substantial gainful activity. However, short periods of work at or above that rate can be disregarded as “unsuccessful work attempts.” Social Security Ruling SSR No. 05-02 sets out a framework for determining when that should occur.

Applying the concept of engaging in substantial gainful activity to illegal income has proven particularly difficult. A 1994 amendment removed any doubt about whether illegal earnings count.

Individuals who meet the Act’s definition of blindness have their earnings treated differently. Their monthly earnings are measured against a higher amount in determining whether or not they retain the ability to engage in substantial gainful activity ($1,570 per month for 2008). Furthermore, blind claimants who are 55 or older can still qualify as disabled despite even larger earnings if they are no longer able to engage in their regular work.

Once benefits have begun, earnings above the substantial gainful activity level can cause their loss, but termination does not occur abruptly because of the recipient’s right to a period of trial work. Issues exist concerning the applicability of the Act’s trial work provisions to earnings received prior to the commencement of benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

Only amounts paid for productive work are counted in determining whether earnings from work establish that a claimant is not disabled. If the employment is being subsidized, the amount of the subsidy is not treated as earnings. This determination is made on an individual basis; the mere fact that a person is working in a sheltered workshop run by a charitable organization does not compel a finding that that person’s pay is subsidized.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 220. Claimant Engaged in Substantial Gainful Activity – Self-Employment Issues

Income from self-employment does not establish the capacity to do substantial gainful activity without consideration of the individual’s actual work activity. Income that a person receives as a share of profits or as a return on investment has no bearing on disability. The individual’s work activity is considered in comparison with that of unimpaired individuals. The compensation is compared to the salary that would have to be paid an employee for the same work, and the level of services rendered are weighed in determining whether the self-employment constitutes substantial gainful activity.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]


Work expenses that are the result of the individual’s impairment are subtracted from any earnings before those earnings are compared to the earnings levels used to determine whether or not the individual is engaged in substantial gainful activity. To be offset, the expenses must actually be borne by the individual and not paid by some other source. Deductible impairment expenses include equipment, drugs and medical supplies, and attendant care services.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 300. Threshold Test of Severity

The regulations provide for a determination that a claimant is not disabled on the threshold ground that the individual does not have impairments that place a significant limit on the individual’s physical or mental ability to do basic work activities. This “de minimis” test has been the subject of extensive litigation.
In *Bowen v. Yuckert*, 482 U.S. 137 (1987), the Supreme Court upheld the validity of the regulation imposing this threshold test of severity. It had been attacked on the ground that it violated the Act’s requirement that the Agency consider a claimant’s age, education, and work experience. The Court found authority in the Act to place the burden on the claimant to establish the existence of a limiting impairment.

Social Security Ruling SSR No. 85-28 frames the test in terms of whether the claimant has a medical condition that interferes with the ability to perform basic work activities, listing examples of those activities. SSR No. 96-3p focuses on the medical component of this threshold test and the necessity of taking account of limitations and restrictions resulting from pain and other impairment-related symptoms.

§ P 400. Listed Impairment or Equivalent

The regulations include a Listing of Medical Impairments, organized by body system, that provide a basis for determinations that many individuals are disabled without further evidence of their inability to work or consideration of their age, education, and work experience. Anyone with impairments that equal the type and level specified in that listing or possessing impairments that are their equivalent is determined to be disabled. Several different tests or listings may apply to a particular body system or condition. Where they are set up as alternatives all that the claimant need establish is that one of them is met.

For some medical conditions, Social Security Rulings augment the listings and elaborate on how such complaints should be evaluated throughout the sequential evaluation process. See, for example, Social Security Ruling SSR No. 03-1p dealing with the treatment of polio residuals, Social Security Ruling SSR No. 02-2p dealing with Interstitial Cystitis, and Social Security Ruling SSR No. 99-2p dealing with Chronic Fatigue Syndrome. Obesity, for which there once was a listing, is now covered by Social Security Ruling No. 02-1p.

Social Security Ruling SSR No. 96-6p requires that ALJ or Appeals Council decisions of disability based on medical equivalence rest on updated medical expert opinion.

§ P 500. Claimant’s Ability to Perform Past Relevant Work

Individuals who are not found to be disabled on the basis of the listed impairments must establish that their residual functional capacity does not allow them to meet the physical
and mental demands of work they have done in the past. How recent and of what 
duration that past work activity must be to provide a relevant baseline can sometimes be 
a difficult issue. How broadly or narrowly the prior work is characterized can also prove 
critical.

Social Security Ruling SSR No. 82-62 notes that for past work to be considered the 
individual should have been engaged in it for sufficient time to learn how to perform 
work of that type. The Agency takes the view, reflected in SSR No. 82-61, that the past 
work need not be shown to exist in significant numbers in the national economy. In 
Barnhart v. Thomas, 540 U.S. 20 (2003), the Supreme Court upheld this interpretation of 
the Act.

§ P 600. Application of MedicalVocational Guidelines (Grid) – 
In General

For disability benefit claimants who do not have listed impairments or their equivalent 
but who also lack the residual functional capacity to do their past relevant work, a 
determination on disability requires consideration of age, education, and past work 
experience. The fundamental question is whether the claimant’s impairments combined 
with these other factors leave the individual unable to do work that exists in the national 
economy.

The regulations contain a set of Medical-Vocational Guidelines. These guidelines 
provide a matrix in which claimants are located according to residual functional 
capability, age, education, and past work experience.

For any given combination of those factors, the guidelines specify a determination of 
“disabled” or “not disabled.” According to the regulations these determinations rest on 
analysis of vocational information and therefore eliminate the need for vocational expert 
testimony in cases to which the guidelines apply. Cases that do not fall within the 
guidelines, either because they involve impairments not reflected in their residual 
functional capacity categories or because they fall between the categories into which the 
other factors are broken down, require an ad hoc consideration of the claimants’ ability 
to do work in the national economy.
In *Heckler v. Campbell*, 461 U.S. 458 (1983), the Supreme Court upheld the Medical-Vocational Guidelines against the challenge that they violated the Act. The Act, the Court held, does not bar the Agency from relying on rulemaking to deal with certain classes of issues. In particular, the factual issue of whether there are jobs available in the national economy that a claimant with certain impairments and a set of vocational qualifications can perform is not unique to each claimant. It can therefore be resolved fairly through guidelines.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 610. Application of Medical-Vocational Guidelines (Grid) – Non-Exertional Impairments

Since the Medical-Vocational Guidelines define residual functional capacity in terms of such physical abilities as lifting, standing, and moving about, their application to individuals with mental impairments or pain or sensitivity to environmental factors would fail to account for the full extent of impairment. If a claimant suffers from a significant non-exertional impairment, a decision based on the guidelines that he or she is not disabled is not normally justified. In such a case, the Agency must have vocational expert testimony or similar evidence that there are jobs in the national economy which a person with the full range of the claimant’s impairments, including the non-exertional ones, can perform. Social Security Ruling SSR No. 87-19c allows the use of the guidelines as a framework in cases of non-exertional impairments when there is also vocational expert testimony.

Whether or not an individual’s non-exertional impairments force a decision outside the guidelines depends on the extent to which the level of those impairments would affect the claimant’s ability to perform the range of jobs in the otherwise relevant category (sedentary work, light work, etc.). When non-exertional impairments reduce the individual’s capacity for work only marginally, the guidelines can still form the basis of a determination and testimony of a vocational expert may not be necessary.

Social Security Ruling SSR No. 85-15 draws attention to the demands of unskilled work, including the ability to understand, carry out, and remember simple instructions; to respond appropriately to supervision, co-workers, and normal work situations; to deal with changes in routine. When a mental or other non-exertional impairment causes a substantial loss in any of these dimensions, it justifies a finding of disability despite a contrary indication based simply on the claimant’s age, education, and work experience.

Social Security Ruling SSR No. 96-4p stresses that it is not the nature of the individual’s symptoms themselves that qualify as exertional or non-exertional but rather the functional limitations or restrictions that they produce.

Because evidence of significant non-exertional impairments can provide a means of avoiding a “not disabled” determination otherwise directed by the guidelines, when the
Agency has ruled against a claimant with such impairments, improper use of the guidelines is frequently argued on appeal.

In DE, NJ, PA, and the Virgin Islands, an acquiescence ruling (AR 01-1) implements the Third Circuit’s decision in *Sykes v. Apfel*, 228 F.3d 259 (3d Cir. 2000) holding that where a claimant has a severe nonexertional impairment a finding resting on the grids alone is improper.

§ P 620. Claimant’s Residual Functional Capacity

A claimant’s “residual functional capacity” is a full summary of the ability to work the claimant has left after taking account of his or her impairments. It rests on a consideration of all impairments, physical and mental, exertional and non-exertional. As disability decisions are divided into medical and vocational elements, residual functional capacity falls on the medical side. Medical evidence and even medical judgments bear on an individual’s residual functional capacity. But in addition, the claimant’s own testimony and that of others about the claimant’s remaining physical and mental abilities must be considered. Social Security Ruling SSR No. 96-8p lays out how the Agency assesses an individual’s residual functional capacity.

Once determined, the claimant’s residual functional capacity is compared to his or her past relevant work or other work in the national economy. Social Security Ruling SSR No. 96-9p deals with that stage of the disability determination and cases where the claimant is limited by residual functional capacity to less than the full range of sedentary work.

In *Sullivan v. Zebley*, 493 U.S. 521 (1990), the Supreme Court held that the regulations limiting child SSI disability benefits to those who had a listed impairment or the equivalent violated the statutory provision extending benefits to children who suffer from impairments of “comparable severity” to those which would establish disability in an adult. As a result of Zebley, the SSA issued new guidelines that required a functional assessment of children who do not meet or equal a listing. This assessment was analogous to the residual functional assessment performed on adult SSI disability applicants who do not meet or equal a listing. The child’s individualized functional assessment was focused on the impact of the medical condition(s) on daily living activities and age appropriate activities.

An amendment to the Act in 1996 removed the statutory language supporting this individualized assessment.

Rev. 9/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ P 630. Application of Medical-Vocational Guidelines (Grid) 
– Age

Age is one of the vocational factors listed in the Act’s definition of disability. It is incorporated in the Medical-Vocational Guidelines through three age categories: younger person (under 50); person approaching advanced age (50-54); and person of advanced age (55 or over). A subgroup of the latter category is: person closely approaching retirement age (60 or over). The purpose of including age is its assumed connection to a person’s ability to adapt to new work situations. The regulations do say that these age categories should not be applied mechanically in borderline situations.

Since moving from one age category to another can change the guidelines’ directed decision from “not disabled” to “disabled,” the mere delay in processing an appeal can, in theory, change its outcome.

Because of the phased increase in “full retirement age” from 65 to 67, increasing numbers of individuals older than 65 are becoming eligible for disability benefits and finding it advantageous to claim them instead of old-age insurance. (Claiming old-age insurance benefits prior to the worker’s “full retirement age” produces a reduction in the monthly amount.) Social Security Ruling SSR No. 03-3p addresses treatment of initial disability claims brought by individuals in this age range.

Rev. 12/03

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 640. Application of Medical-Vocational Guidelines (Grid) 
– Education

Education is one of the vocational factors listed in the Act’s definition of disability. It is incorporated in the Medical-Vocational Guidelines through four categories: illiteracy, marginal education (6th grade or less), limited education (7th grade through 11th grade), high school and above (at least through 12th grade). In addition, the regulations specify that an inability to communicate in English should be taken account of in considering what work a person with the claimant’s residual functional capacity can do.

While the educational categories are expressed in terms of formal education, they are also defined in terms of skills. The regulations state that a claimant’s formal education level need not be determinative. A person with a lack of formal education can be shown to have a high level of education. The reverse is also true.

In LA, MS, and TX an acquiescence ruling (AR 86-3) implements the Fifth Circuit’s ruling in Martinez v. Heckler, 735 F.2d 795 (5th Cir. 1984) that illiteracy and inability to communicate in English necessitate specific findings, with the guidelines being used only for guidance.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ P 650. Application of Medical-Vocational Guidelines (Grid) – Work Experience

Work experience is one of the vocational factors listed in the Act’s definition of disability. It is incorporated in the Medical-Vocational Guidelines through several categories. First, there is a special provision for those whose long-term work experience has been hard unskilled physical labor. The guidelines themselves employ three experience categories: skilled, semi-skilled, and unskilled. In addition, the guidelines provide for individuals with no work experience. In connection with the skilled and semi-skilled work categories, the degree of transferability of the skills involved can also be a factor.

In determining how to categorize a claimant’s work experience the focus is on work of reasonable duration within the past 15 years.

§ P 660. Application of Medical-Vocational Guidelines (Grid) – Work Level (Light, Sedentary, etc.)

The Medical-Vocational Guidelines divide the exertional requirements of work into five categories, defined in terms of such activities as lifting (frequency and types of items), carrying, standing, sitting, and walking. The five levels are: sedentary work, light work, medium work, heavy work, and very heavy work. The categories are largely cumulative so that if a person can do heavy work, the guidelines assume an ability to do medium, light, and sedentary work.

Social Security Ruling SSR No. 83-10 fills in important details of the exertional requirements of the five categories. For example, it explains that an individual able to perform the “full range” of sedentary work must be able to sit approximately six hours out of an eight-hour day and stand or walk the remaining two hours. It also explains that most unskilled sedentary jobs require good use of both hands in repetitive hand-finger activity. Comparable details are provided for the other categories. Social Security Ruling SSR No. 83-12 notes that unskilled jobs are not ordinarily structured so that the worker can sit or stand at will. If medical evidence indicates that the only way the individual can get through a full workday is by alternating between sitting and standing at will, it follows that the individual cannot perform the “full range” of sedentary work.
§ P 680. Application of Medical-Vocational Guidelines (Grid) – Transferable or Marketable Skills

Semi-skilled or skilled work experience may or may not produce skills that can be used in other types of work. Whether the skills are transferable depends on the similarity of work activities involved. Some jobs involve such a specialized setting (mining, agriculture, fishing) that their skills are not viewed as transferable.

Social Security Ruling SSR No. 82-41 adds detail to the definition of transferability found in the regulations.

A different concept of “highly marketable skills” applies to claimants close to retirement age (60-64). Claimants in that age range with severe impairments are not considered able to adjust to sedentary or light work unless they have skills that are highly marketable.

Rev. 6/95

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

Especially Difficult Types of Impairment

§ P 710. Mental Impairment, Psychological Problems

The Act’s disability standard includes both physical and mental impairments. Cases involving the latter are, as a class, more difficult to evaluate. The regulations now lay out a procedure or approach for evaluating mental impairments. In addition, the Listing of Medical Impairments includes categories of mental impairment. Social Security Ruling SSR No. 85-16 provides guidelines for determining residual functional capacity in cases where the claimant’s mental impairment(s) do not meet or equal the listing. Social Security Ruling SSR No. 85-15 treats the relationship between such impairments and the Medical-Vocation Guidelines. It also contains a discussion of the impact of workplace stress, noting that individuals with mental impairments may function successfully in a restricted environment but fail to deal effectively with the demands of getting to work regularly and receiving supervision.

Cases in which mental impairments pose special difficulty include cases in which the claimant is seeking to establish onset of disability before insured status was lost but no contemporary mental health evaluations are available, cases in which the claimant’s mental impairments interfere with presenting the disability claim to the Agency, cases in which the manifestation of mental illness is episodic, and cases in which a degree of mental impairment is but one of a complex of impairments.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ P 720. Mental Retardation, Limited I.Q.

The Act’s disability standard includes both physical and mental impairments. Mental impairments include not only psychological conditions but limited intellectual functioning or mental retardation. The extent of intellectual impairment can also provide evidence of other categories of mental impairment. The regulations now lay out a procedure or approach for evaluating mental impairments, including cases of mental retardation. In addition, the Listing of Medical Impairments includes mental retardation.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 730. Impaired Vision, Blindness

The Act provides a detailed definition of blindness. Its test is central visual acuity of 20/200 or less in the better eye with glasses or a field of vision limited to 20 degrees or less. The Listing of Medical Impairments include additional forms and measures of visual impairment.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 740. Pain or Other Subjective Complaints

Pain and such other subjective impairments as dizziness and drowsiness create great difficulty for disability claimants and the Agency. The Act requires that a disability be medically determinable. That does not mean that the particular manifestation of a medical condition be measurable by medical tests. It does, however, exclude problems that have no evident basis in a medical condition. Determining whether a person’s complaints of pain have a sufficient medical connection is one of the most frequently litigated Social Security issues. Since judgments about the claimant’s credibility go to the core of a disability claim of this type, the issue is often framed in those terms. Where there is medical evidence of a condition that is consistent with the subjective complaints and their severity, some courts require the Agency to explain its grounds for rejecting the claimant’s testimony about pain or similar impairments.

The different circuits of the U.S. Court of Appeals have all addressed the problem. Their formulations vary but they are similar in recognizing that a disability determination can rest heavily on the claimant’s own testimony about subjective complaints, but that some medical evidence is necessary.

In November 1991 the Agency issued revised and expanded regulations dealing with this subject. It followed those regulations with a new Social Security Ruling, SSR No. 95-5p, issued in October 1995. That ruling superseded two earlier ones, SSR No. 88-13 and SSR No. 90-1p, that dealt with the evaluation of subjective complaints and associated
questions of weighing the credibility of claimant testimony. In 1996 the Agency
gathered its policies on these related matters into SSR No. 96-7p which in turn
superseded SSR No. 95-5p.

Rev. 9/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 750. Alcoholism or Drug Addiction

Alcoholism and other substance addictions pose distinct disability problems. Prior to a
1996 amendment, however, they were assessed like other sources of disability.
Alcoholism and drug addiction could qualify as disabilities apart from any other physical
or mental impairment, and they could also be a major contributing element in cases
involving other impairments.

Under the Act prior to the 1996 amendment, some courts even placed an affirmative duty
on the Agency to develop further medical evidence, notwithstanding a claimant’s denial
of the condition, in cases where there was evidence of substance abuse.

Social Security Ruling SSR No. 82-60 covers evaluation of disability claims involving
drug addiction or alcoholism under pre-amendment law.

The 1996 amendment radically changed the law on this point. Under its provisions,
nor drug addiction can be an independent basis for a disability
determination. Further, neither can be a major contributing factor to such a
determination. The amendment applied to new applications immediately and to then
current beneficiaries as of January 1, 1997.

SSI recipients who suffer alcoholism or drug addiction have been subject to specific
requirements of participation in treatment programs as a condition of eligibility.
Amendments to the Act in 1994 extended these requirements to Title II disability
recipients and added a number of other provisions focused on cases where alcoholism or
drug addiction is a contributing factor to disability benefit entitlement. Under the 1996
change in eligibility there will be far fewer beneficiaries with alcoholism or drug
addiction, but those with such a condition must be referred for treatment and, if
incapable of managing benefits, receive them through a representative payee.

Rev. 6/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 760. Multiple or Combined Impairments

When a claimant has several medical problems none of which is by itself disabling, he or
she may still qualify for disability benefits. Multiple impairments, including combined
physical and mental impairments, must be considered in terms of their cumulative effect on the individual’s ability to work. A determination which simply deals with medical problems one-by-one may be defective on this ground.

This cumulative approach toward multiple impairments applies not only to the threshold question of whether the individual has impairments of sufficient severity to warrant consideration of vocational factors but also to all subsequent stages of the evaluation.

The regulations do, however, distinguish the case in which two unrelated medical problems follow one another in time. In such a case the Agency will not combine the impairments for purposes of applying the 12-month duration test.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

Issues of Medical Evidence

§ P 800. Issues of Medical Evidence – In General

Under the Act the Agency has the ultimate responsibility for determining disability. It is not bound by the judgments of other bodies administering related benefit programs nor by the testimony of a physician who characterizes the claimant as “disabled” or “unable to work.”

It is generally stated that an administrative law judge (ALJ) hearing a disability benefit appeal has the responsibility for weighing all the medical evidence and that the claimant has the burden of proof in establishing the existence and degree of his or her physical and mental impairments. It is also generally stated that an ALJ cannot substitute his or her own medical opinion for those of medical professionals or interpret raw medical data without expert assistance. Issues of proper treatment of medical evidence arise when an Agency decision is appealed to Federal district court and it is argued that the ALJ’s decision is not supported by the record. In that setting courts have established some more detailed guidelines on proper treatment and weight for certain types of medical evidence in relation to others. Most widespread among these guidelines are the positions of the various circuits of the U.S. Court of Appeals on the weight to be given testimony by treating physicians. Another has to do with determinations by other agencies. While not being bound by the determinations of other Federal agencies administering disability programs (like the Veterans Administration), SSA must give them some weight. Courts have refused to affirm ALJ decisions that failed to give explicit consideration to such findings.

In Richardson v. Perales, 402 U.S. 389 (1971), the Supreme Court held that written reports by physicians who had examined a disability claimant constituted substantial evidence supporting a finding of not disabled, notwithstanding the absence of cross-examination and opposing testimony by the claimant and claimant’s medical witness.

In LA, MS, and TX an acquiescence ruling (AR 91-1) has implemented the Fifth Circuit’s ruling in *Lidy v. Sullivan*, 911 F.2d 1075 (5th Cir. 1990) that an ALJ must grant a claimant’s request for a subpoena for the purpose of cross-examining an examining physician. The Agency’s position is that the decision on whether to issue a subpoena is discretionary, requiring a showing by the claimant that the testimony sought is reasonably necessary for presentation of the claimant’s case.

Social Security Ruling SSR No. 96-4p draws a distinction between symptoms and impairments. It notes that no symptom or set of symptoms can, alone, establish disability. There must be medical signs or laboratory findings of a “medically determinable” physical or mental impairment.

Rev. 9/98

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 810. Issues of Medical Evidence – Treating Physician

While the Agency has the ultimate responsibility for evaluating the claimant’s medical condition, courts have held that the Agency and an administrative law judge (ALJ) hearing an appeal must give special weight or attention to reports and testimony from a physician who has treated the claimant. Such testimony and reports are distinguished from those coming from physicians who have simply examined the claimant in order to evaluate his or her condition for purposes of the claim.

The different circuits of the U.S. Court of Appeals hold different views on how the Agency should weigh treating physician testimony, on when the rule applies, and on whether it extends to the physician’s ultimate conclusion about the claimant’s condition.

Regulations on treatment of medical evidence issued by the Agency in August 1991 purport to codify or replace these judicial interpretations.

Social Security Ruling SSR No. 96-2p elaborates on those regulations, focusing on when medical opinions of a treating source are entitled to controlling weight. SSR No. 96-5p draws a sharp distinction between medical opinions and opinions of a treating source on issues that bear directly on eligibility such as whether an individual has a listed impairment, what residual functional capacity is possessed by an individual, or whether a claimant’s residual functional capacity prevents the individual from performing past relevant work. SSR No. 06-3p lays out a distinction between "acceptable medical sources" and other medical sources and how evidence from these two categories should be considered. It also addresses the weight to be given disability determinations made by other agencies for other purposes.

Rev. 9/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ P 820. Issues of Medical Evidence – Non-Examining Physician

When an administrative law judge (ALJ) hears a disability benefit appeal, the record may include a report from a Medical Expert (ME), a physician who has not examined the claimant but has simply reviewed the reports, tests, and other medical evidence provided by others. The extent to which the ALJ may rely on the testimony or report of such a non-examining physician, particularly when it rejects the diagnosis or conclusion of medical personnel who have examined or even treated the claimant, can be a critical issue.

The use of a Medical Expert is left to the ALJ’s discretion. While use of a ME may occur before, during or after a hearing, ALJs are directed to avoid off-the-record exchange with such a physician. The appropriate role of such an expert is providing impartial assessment of the available medical evidence in response to specific questions from the ALJ or the claimant.

Regulations on treatment of medical evidence, issued by the Agency in August 1991, deal with this among many other issues.

Social Security Ruling SSR No. 96-6p deals with the treatment of findings and opinions of State agency medical and psychological consultants and other program medical personnel by adjudicators at later stages in the claims process, specifically the ALJ and Appeals Council.

Rev. 9/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 830. Issues of Medical Evidence – Need for a Medical Exam

The role of a medical examination or particular medical tests in establishing physical or mental impairments can be a disputed issue. The issue can arise in one of several ways. With some conditions, Agency policy or an administrative law judge (ALJ) opinion may take the view that impairment cannot be established without the results of a particular test or procedure. Other symptoms or medical evidence will not suffice. Such a position must ultimately find support in the Act’s reference to “medically acceptable clinical and laboratory diagnostic techniques.” It is usually invoked when the individual has been examined or tested, and the results do not meet a particular threshold. The claimant’s refusal to submit to a medical examination or test can also raise the issue.

The need for a medical examination or particular test may under different circumstances be raised by the claimant. Courts have held that claimants with some medical conditions (significant signs of mental illness, for example) should be given a consultative examination as part of the disability evaluation process. Regulations issued in 1991
cover the standards to be used in determining whether or not to order and pay for such a consultative examination. Courts have not left their use totally to Agency discretion.

§ P 840. Issues of Medical Evidence – Failure to Obtain Treatment or Use Medication

When prescribed medical treatment, ranging from surgery to medication, would remove an impairment, restoring the claimant’s ability to work, a failure to follow such treatment can lead to a finding that the claimant is not disabled. The regulations recognize a variety of valid reasons for failing to follow prescribed treatment. They run from religious conviction to concern about the riskiness of the procedure. In addition, courts have recognized practical limits on the requirement, observing that when claimants are financially or psychologically unable to pursue treatment, their failure to do so should not be held against them.

Social Security Ruling SSR No. 82-59, which covers this topic, notes specifically that the claimant’s inability to pay for treatment excuses the failure to obtain it. Social Security Ruling SSR No. 87-6, dealing with epilepsy, concludes that treatment can, in most cases, allow an epileptic to engage in substantial gainful activity. The ruling focuses on the need to determine whether the claimant’s seizures are the consequence of a failure to continue medical care or take prescribed medication.

§ P 850. Issues of Medical Evidence – Side Effects of Treatment or Medication

When a claimant’s medical impairments call for a course of treatment or medication with side effects, those side effects themselves must be considered along with the underlying impairments in determining the individual’s residual functional capacity. In the course of focusing on the nature and extent of impairments and developing medical evidence, this dimension is sometimes overlooked.

§ P 860. Issues of Medical Evidence – Treatment of New Medical Evidence

During the Agency’s evaluation of a disability benefit claim new evidence can be submitted at each stage of review. In particular, the hearing before an administrative law judge (ALJ) allows full development of evidence that was not presented or available at
earlier stages. The regulations provide that even the Appeals Council may consider new and material evidence so long as it relates to the period up through the ALJ hearing.

Whether the Agency considers evidence submitted after an ALJ hearing or whether a Federal district court remands the cases so that the Agency can consider new medical evidence are largely discretionary matters.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

Establishing the Availability of Work Claimant Can Perform

§ P 900. Establishing the Availability of Work Claimant Can Perform – In General

Once a claimant has established that he or she cannot perform past relevant work, the next issue is whether there is work available in the national economy that a person with the claimant’s residual functional capacity can perform.

In cases properly resolved under the Medical-Vocational Guidelines, the guidelines themselves embody the necessary evidence of work availability of which the Agency has taken administrative notice.

In cases that fall outside the guidelines evidence of work the claimant can perform must come from other sources. An agency decision that the claimant is not disabled that does not rest on such evidence will generally be overturned. Social Security Ruling SSR No. 96-9p focuses on treatment of cases in which the claimant’s residual functional capacity assessment indicates an ability to perform less than a full range of sedentary work.

The issue of how many positions it takes to meet the Act’s test of “substantial gainful work which exists in the national economy . . . in significant numbers” has eluded resolution.

Rev. 9/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ P 910. Establishing the Availability of Work Claimant Can Perform – Dictionary of Occupational Titles

The Dictionary of Occupational Titles published by the Department of Labor is frequently used by the Agency, in combination with other government information, in determining the availability of work. The regulations provide that the Agency can take administrative notice of such information in determining whether there is work available.
in the national economy that a person with the claimant’s residual functional capacity can perform.

The Dictionary of Occupational Titles can also be used when the issue concerns the claimant’s ability to perform past relevant work. In such a case, it may assist in categorizing the claimant’s past work in terms of required functional capacity.

Finally, it can be used to challenge a vocational expert’s testimony concerning the available of work the claimant can perform. It can be used in this way if the Dictionary of Occupation Titles indicates that the cited jobs require capacities the claimant lacks.

§ P 920. Establishing the Availability of Work Claimant Can Perform – Vocational Expert Testimony or Report

In cases falling outside the Medical-Vocational Guidelines, it is common to use a vocational expert to testify on the availability of work that can be performed by individuals with the claimant’s skills and residual functional capacity. Indeed, expert testimony is probably required in most such cases if the Agency is to meet the burden of coming forward with vocational evidence that courts have placed on it.

The regulations simply state that such specialists may be used at the discretion of the Agency. Social Security Ruling SSR No. 00-4p provides more detailed agency policy on the use of vocation expert evidence.

Nothing, of course, prevents claimants from producing experts of their own at a disability benefit hearing.

§ P 930. Establishing the Availability of Work Claimant Can Perform – Hypotheticals Posed to the Vocational Expert

When a vocational expert is used at a disability benefit hearing, the expert’s testimony concerns the number and range of jobs available to individuals with residual functional capacities like those of the claimant. Since that testimony comes before the administrative law judge (ALJ) has reached a conclusion on the precise extent of the claimant’s impairments and the vocational expert is not in a position to make medical judgments, the testimony is commonly framed in terms of hypothetical individuals with impairments like those the claimant may be found to have.
When the hypotheticals on which the vocational expert testifies fail to include all elements of the claimant’s medical condition, courts may hold that an ALJ’s determination resting on that testimony is not supported by substantial evidence.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
General Issues Unrelated to Establishing Disability

§ Q 100. Special Insured Status Test for Disability Benefits – In General

The Act has a special two-part insured status test for disability benefit claimants. The first part can be satisfied by covered work performed at any time; it applies to all disability insurance claimants. This part of the test is derived from the fully insured status test. Anyone who would have met the test for fully insured status had they turned 62 at the point their disability began satisfies this element of the disability benefits insured status test.

The other part of the test can only be satisfied by recent work. This second component must be met by all disability insurance claimants, except those who are disabled by virtue of blindness. This part of the insured status test has two different versions. Which one applies to a given case depends on the age at which the individual became disabled.

One version of the recent work test applies to individuals who become disabled in or after the quarter in which they become 31. It requires 20 quarters of coverage during the 40-quarter period immediately prior to disability, not counting quarters falling even partially within a recognized period of disability.

A sliding-scale version of the recent work test applies to individuals who become disabled at a younger age. It requires only that there be quarters of coverage equal to 1/2 the quarters falling after the claimant became 21 and before the claimant became disabled, subject to a minimum requirement of 6 quarters of coverage out of the last 12.

Rev. 11/05

[Related Sections: Part 1 - Part 2]

§ Q 110. Special Insured Status Test for Disability Benefits – Variant Applied to Blind Claimants

Disability benefit claimants who meet the statutory definition of blindness meet the insured status test without having to satisfy the recent work requirements. Such claimants are insured for disability benefits if they have enough quarters to qualify for fully insured status with that calculation being made as though they turned 62 at the point their disability began.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ Q 200. Interplay of DI With Benefits Under Railroad Retirement Act

Benefits paid under Social Security and the Railroad Retirement Act have been integrated by bringing work covered by the Railroad Retirement Act under Social Security for short-term railroad workers and leaving benefits for long term railroad workers under the Railroad Retirement Act.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ Q 300. Workers’ Compensation Offset

The Act provides for a reduction of disability benefits if the individual and his or her family would otherwise receive total disability and workers compensation payments above a threshold set in terms of the disabled individual’s prior earnings. If that threshold, 80% of prior earnings, is exceeded the disability benefit is reduced by the amount of the excess.

Workers compensation payments, whether lump sum or periodic, that are intended to cover medical or other expenses rather than to replace earnings are not covered by this provision.

Social Security Ruling, SSR No. 94-6, makes clear that legal expenses incurred in obtaining a workers compensation should be deducted from that award before applying the offset provision. Social Security Ruling, SSR No. 97-3, provides that when an initial workers compensation settlement is subsequently amended or supplanted by a second one the Agency is not necessarily bound by the terms of that second stipulation. Specifically, the Agency will disregard terms of the second that have the effect of altering the terms in the original settlement so as to circumvent the offset provisions of the Act.

In Richardson v. Belcher, 404 U.S. 78 (1971), the Supreme Court upheld enactment of a workers’ compensation offset provision against an attack based on the 5th Amendment.

Rev. 12/97

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ Q 400. Public Pension Offset

The Act provides for an offset against disability benefits not only for workers compensation payments but also for state disability benefits under comparable circumstances and other Federal disability benefits as well. The terms of this offset are the same as for workers compensation. Excluded from this treatment are need-based

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benefits, public pension benefits paid for work covered by Social Security, and veterans benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ Q 500. Interplay of DI with SSI Disability Benefits

Because of the potential overlap between Social Security benefits paid under Title II and Supplemental Security Income (SSI) payable to individuals with low incomes who are 65 or over, blind, or disabled, occasions will arise where one type of benefit is paid for a period and then subsequently entitlement for the same period is established in the other program. The “windfall offset” provisions of the Act apply in such cases.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ Q 600. Interplay of DI With Black Lung Benefits

Black Lung benefits that are required by Federal law to be paid by employers are covered by the offset provision that applies to workers compensation and other federal or state disability benefits.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ Q 700. Effect of Claimant’s Being Confined to an Institution

Judgments about an individual’s ability to engage in substantial gainful activity can be especially difficult when the individual is confined to an institution under circumstances that prevent employment. Although the Act suspends benefits to individuals convicted of a felony during imprisonment, this suspension is limited to the convicted person. Thus, the question of a prisoner’s disability remains important to the prisoner’s family. Furthermore, it is important to the individual’s own entitlement upon release.

The Act specifically excludes from disability determinations impairments that arise from the commission of a felony or from imprisonment for such a crime.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
Attorneys Fees

Attorneys Fees Awarded Under Equal Access to Justice Act

§ T 000. Attorneys Fees Awarded Under Equal Access to Justice Act – In General

The Equal Access to Justice Act (EAJA), which provides for award of attorneys fees in actions against the United States, covers actions under the Social Security Act. For a Social Security appeal to qualify for such an award three conditions must be met: (1) the plaintiff must be a prevailing party; (2) the government’s opposition must be without substantial justification; and (3) there must be no special circumstances warranting denial of fees.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]


An award of attorneys fees under the Equal Access to Justice Act is not authorized if the court finds that the position of the Agency was “substantially justified.” A position that is later reversed by a court may nonetheless be “substantially justified.” In Pierce v. Underwood, 487 U.S. 552 (1988), the Supreme Court held that the test is, in essence, one of reasonableness. The Court also held that an appellate court reviewing a district court’s decision on this issue should employ an abuse-of-discretion standard.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]


Only a prevailing party is entitled to a fee award under the Equal Access to Justice Act (EAJA). When a court effectively reverses an Agency decision that denied benefits the prevailing party test is met. But many court orders that decline to affirm the Agency decision do not represent a clear victory for the claimant. Decisions that the Agency determination is not supported by the record or is in error on a point of law often produce a remand to the Agency for further proceedings. Prior to the Supreme Court’s decision in Shalala v. Schaefer, 509 U.S. 292 (1993), it was unclear whether a remand pursuant to sentence four of 42 U.S.C. § 405(g), qualified until the results of that remand became clear. Shalala v. Schaefer held, in effect, that EAJA fees can be obtained for work done prior to a sentence four remand even if the claimant does not ultimately receive benefits.
When the change in outcome is, in part, a consequence of a change in the Act or regulations or some other shift in circumstance, the prevailing party test may not be met. Another situation which poses difficulty is when the litigation raises many issues and the claimant’s ultimate success rests on only a few of them.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ T 300. Attorneys Fees Awarded Under Equal Access to Justice Act – Rate or Amount of Award

A fee award under the Equal Access to Justice Act (EAJA) is the product of a statutory rate ($125 per hour, with a potential adjustment to reflect cost of living increases or other special factors) and the amount of time spent on the matter. The fee is set by the court. In the fee award proceeding the reasonableness of the number of hours claimed by the attorney is subject to review. Any requested adjustments of the statutory rate may be a subject of dispute.

Generally rejected as a special factor warranting upward adjustment is knowledge of Social Security law itself. Enhancement on the ground of special skills or expertise requires more than command of a specialized area of the law.

The EAJA permits fees at a higher market rate in cases where the government has acted in bad faith. The “bad faith” standard requires far more egregious conduct than is called for by the basic EAJA threshold of lacking “substantial justification.”

Rev. 6/96

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ T 400. Attorneys Fees Awarded Under Equal Access to Justice Act – Fees for Work Before the Agency

Only prevailing parties qualify for a fee award under the Equal Access to Justice Act (EAJA). But since a remand to the Agency is often the means by which a Social Security claimant prevails, the issue of whether it is appropriate for the ultimate fee award to include representation in that subsequent administrative proceeding has frequently arisen.

In Sullivan v. Hudson, 490 U.S. 877 (1987), the Supreme Court held that an EAJA fee award could include such representation even though the government was not itself represented by counsel in the administrative proceeding. The proceedings were, the Court held, “adversarial” nonetheless, and being “adversarial” were within the scope of an EAJA fee award. Prior to that decision some lower Federal courts had taken the contrary position.
Subsequently, in *Shalala v. Schaefer*, 509 U.S. 292 (1993), the Supreme Court largely eliminated the prospect for fees for administrative representation following a remand pursuant to sentence four of 42 U.S.C. § 405(g). Even though *Sullivan v. Hudson* had involved a sentence four remand, *Shalala v. Schaefer* held that in sentence four remands the district court should normally divest itself of jurisdiction upon ordering the remand. The filing for EAJA fees should occur at that point and cannot, as a consequence, include fees for representation upon remand. At least in theory, fees for administrative representation following remands pursuant to sentence six of 42 U.S.C. § 405(g) remain available following *Shalala v. Schaefer*.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]


The same representation of a Social Security claimant can be the subject of an attorneys fee award under the Equal Access to Justice Act (EAJA) and the Social Security Act. Double recovery is barred. Beyond that simple principle, affirmative coordination is generally sought by the courts. Because of the EAJA’s limits it does not cover every successful Social Security appeal in federal court. Because of the different rates, when both the EAJA and Social Security Act apply one may yield a larger award than the other. Since fee awards under the Social Security Act reduce benefits while EAJA awards do not, attorneys are encouraged by courts to apply for both. When fees under both acts are allowed, the smaller of the two is paid over to the claimant. In these cases the EAJA is seen as augmenting rather than supplanting the fee provisions of the Social Security Act.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ T 600. Attorneys Fees Awarded Under Equal Access to Justice Act – Was the Claim Timely Filed Following a Final Decision

The Equal Access to Justice Act (EAJA) places a rigid time limit on attorneys fees applications. They must be filed “within thirty days of final judgment in the action.” That time limit is held to be jurisdictional. The most troublesome element of the limit is how to interpret the phrase “final judgment.” A definition added to the Act in 1985 makes it clear that a judgment is final only after the time to appeal has expired.

Prior to two Supreme Court decisions the lower Federal courts had divided over how to interpret that phrase “final judgment” when judicial remand led to a subsequent
favorable Agency decision. Some of these remand issues were resolved by the Supreme Court in Melkonyan v. Sullivan, 501 U.S. 89 (1991). In Melkonyan, the Court rejected the Agency’s position that an administrative adjudication following remand could constitute the “final judgment” starting the thirty day limit. It held that the “final judgment” was that entered by a district court “affirming, modifying, or reversing” the Agency determination or, in cases of remand upon the Agency’s request to allow consideration of new evidence, when the Agency returns to court. The decision noted that sentence six of 42 U.S.C. § 405(g) the Act requires the Agency to return to court following “new evidence” remands. With such “sentence six” remands, the final judgment occurs after the court has entered a judgment upon the Agency’s return, and the time to appeal has expired. Subsequently, in Shalala v. Schaefer, 509 U.S. 292 (1993), the Supreme Court clarified the timing for an EAJA fee claim in connection with a remand pursuant to sentence four of 42 U.S.C. § 405(g). With a “sentence four” remand, the time begins to run with the expiration of the time for filing an appeal of the order.

Given this sharp difference in the timing for a fee application, distinguishing between “sentence four” and “sentence six” remands has become critical. In Jackson v. Chater, 99 F.3d 1086 (11th Cir. 1996), the Eleventh Circuit held, however, that it is possible for a remand to have a “dual basis” – that is, for it to be based, in part, on both “sentence four” and “sentence six” – and that in such a case where success on remand is not based solely upon “sentence four” reasons, the EAJA application may be filed after the judgment is entered following the remand proceedings.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ T 700. Attorneys Fees Awarded Under Equal Access to Justice Act – Class Actions

Class action representation is covered by the Equal Access to Justice Act (EAJA). Applying the EAJA’s “prevailing party” provisions and determining a reasonable fee can pose special difficulty in such cases.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

In addition to authorizing an award of attorneys fees, the Equal Access to Justice Act (EAJA) authorizes a court to award other reasonable expenses of the litigation. The EAJA lists some expense items (such as expert witnesses, studies). Courts have divided over whether that list is exhaustive or illustrative. Costs not listed by the EAJA that some courts will allow include photocopying, telephone, postage, and travel. The argument for awarding such expenses in addition to the fee is strengthened when they are of a type normally charged to a client in the region where the matter is tried.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

Attorneys Fees Under Social Security Act

§ U 000. Attorneys Fees Under Social Security Act – In General

The Act allows claimant representation by a broad range of qualified persons, not requiring that they be attorneys. It also provides that fees for such representation are subject to Agency review and approval. No fee may be charged without Agency approval. This is true whether or not funds are withheld and whether or not the decision is favorable. The fee must be approved even if it is to be paid by a third party. Social Security Ruling SSR No. 85-3 provides for an exception when the fee will be paid by a nonprofit organization or government agency with the claimant having no liability to pay any part of it.

Fees for representation before a court reviewing an Agency determination, where the representative must be an attorney, are subject to approval by the court.

Fees that the Agency or a court approves are withheld and paid from any award of past due benefits up to 25% of those benefits when the representative is an attorney. Amendments to the Act in 2004 extended the same treatment to attorneys fees for SSI representation and established a nationwide demonstration project providing fee withholding for qualifying non-attorney representatives.

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[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ U 100. Attorneys Fees Under Social Security Act – Rate or Amount of Fees – In General

Whenever a court renders a judgment favorable to a claimant under Title II or Title XVI of the Social Security Act and the claimant was represented before the court by an attorney, the court may allow as part of its judgment a reasonable attorneys fee. That fee may not exceed 25 percent of the total of the past-due benefits resulting from the judgment and is paid out of those benefits. Prior to the 2004 amendments, fees for SSI representation were not paid out of benefits.

Rev. 12/04

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ U 110. Attorneys Fees Under Social Security Act – Rate or Amount of Fees – Special Consideration of Contingent Fee

In *Gisbrecht v. Barnhart*, 535 U.S. 789 (2002), the Supreme Court resolved a prior split among the circuits over the proper approach to determining the reasonableness of attorneys fees claimed under the Act for representation in court. Under *Gisbrecht* the reasonableness determination begins with the contingent fee agreement rather than a baseline hourly rate (the “lodestar” method). Nonetheless, the decision requires that the attorney demonstrate the reasonableness of that fee. Factors warranting a reduction include poor quality representation or a fee that is excessive in relation to the time spent on the case.

Rev. 12/02

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ U 120. Attorneys Fees Under Social Security Act – Rate or Amount of Fees – Use of “Lodestar”

*Gisbrecht v. Barnhart*, 535 U.S. 789 (2002), rejected the approach of a majority of the circuits. Under the “lodestar” approach, these circuits had focused almost exclusively on the reasonable hourly rate for work of this type and the number of hours required for the representation. Those that followed this approach give little or even no explicit recognition to the contingent fee agreement the claimant had signed, under which there would be no fee without the award of benefits.

Rev. 12/02

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]
§ U 200. Attorneys Fees Under Social Security Act – Past Due Benefits From Which Fees Are Payable

In *Hopkins v. Cohen*, 390 U.S. 530 (1968), the Supreme Court construed the Act’s ceiling on attorney’s fees, set at 25% of past-due benefits, as including not only the claimant’s benefits but those of other family members as well.

Prior to the 2004 amendments attorney fees for representing Supplemental Security Income (SSI) claimants could not be withheld from past due benefits. Because of this fundamental difference between the two programs, the offset rules affected the amount of attorney fees payable in concurrent SSI and Title II cases.

Rev. 12/04

[Supporting and Elaborating References]  [Related Sections: Part 1 - Part 2]

§ U 300. Attorneys Fees Under Social Security Act – Fees for Work Before the Agency

While the Act provides for a fee award, to be paid out of benefits for representation before the Agency, it places the determination of an appropriate award in the Agency.

A 1990 amendment to the Social Security Act created a second procedure for approving attorneys fees paid out of past due benefits resulting from an administrative appeal. Fees agreed to by the claimant will generally be approved so long as they do not exceed 25% or a set dollar amount, initially established by the Act at $4,000. Effective February 2002, the Agency increased that figure to $5,300. The Act also provides that the attorneys fee calculation occurs prior to operation of the SSI offset.

In situations where relief other than past due benefits is sought or the fixed dollar cap is too low or the fee agreement fails in some other respect to meet the statutory requirements, the representative can still petition the Agency for approval of a “reasonable fee.”

Under a 1999 amendment, all fees paid by the Agency out of past due benefits are reduced by a 6.3% assessment to cover administrative costs. That assessment was capped by the 2004 amendments at $75, an amount subject to subsequent automatic annual adjustment. The figure for 2008 is $79.

Difficult issues concern allocation of responsibility between the court and Agency when a successful claim has involved both. This is true when an attorney has represented a claimant in earlier administrative stages prior to judicial review and also when the court remands a case to the Agency for further proceedings and the attorney’s representation in that subsequent administrative proceeding is the issue.

The general view is that a court has no authority under the Act to award attorney’s fees for representing a claimant in administrative proceedings. Courts do, however, consider

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the Agency’s award for administrative proceedings work before determining the reasonable fee for representation before them.

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[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]

§ U 400. Attorneys Fees Under Social Security Act – Class Actions

Since class actions often focus on prospective or injunctive relief they may present little basis for a fee award under the Act. The Act’s provision for an award of up to 25% of past due benefits resulting from successful representation may, of course, in a class action yielding such relief permit an award. Because of the awkwardness of the Act’s fee provisions in class actions, the Equal Access to Justice Act (EAJA) is especially important to attorneys involved in such litigation.

[Supporting and Elaborating References] [Related Sections: Part 1 - Part 2]