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Screening Out Worthy Social Security Disability Claimants and Its Effect on Homelessness

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Screening Out Worthy Social Security Disability Claimants and Its Effect on Homelessness

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I. INTRODUCTION

The homeless person is so familiar to American society that on Halloween, children dress up as homeless men and women. This apparent familiarity with the problem has not, however, fostered universal sympathy for the homeless, nor does society generally acknowledge that homeless persons deserve more governmental assistance.¹ Despite such disagreement, there is at least one sub-group of the homeless that most people would agree deserve assistance. This sub-group is the disabled homeless: people unable to work because of a disabling mental or physical impairment. The millions of dollars distributed as federal disability payments² are tangible evidence of a broadly based desire to help the disabled.

Despite such efforts and expenditures, large numbers of disabled homeless people³ remain who do not receive Social Security Disability

1. For a view of the perception of the unworthy homeless, see M. KATZ, *THE UNDESERVING POOR* 9, 10 (1989) ("Contemporary politicians, moralists, and editorial writers still frequently refer to the deserving and the undeserving poor. . . . [T]hese terms serve to isolate one group of poor people from the rest, and to stigmatize them."); Whitman, *Shattering Myths About the Homeless*, U.S. NEWS & WORLD REP., Mar. 20, 1989, at 27-28 ("The danger . . . is that the public . . . may dismiss [the homeless] as the undeserving poor."); and Wright, *The Worthy and Unworthy Homeless*, 25 Soc'y 64, 64 (July-Aug. 1988) ("Americans have always found it necessary to distinguish between the 'deserving' and 'undeserving' poor.").

2. See *infra* text accompanying notes 48 & 54.

3. See *infra* notes 7 & 8 (citing figures on the proportion of the homeless who are disabled by mental and physical impairments).

Insurance ("SSDI")⁴ or Supplemental Security Income ("SSI")⁵ benefits,⁶ the two major federal aid programs targeting the disabled. Approximately one-third of the homeless suffer from a major mental impairment.⁷ Potentially disabling physical impairments, such as

4. Social Security Amendments of 1956, Pub. L. No. 84-880, § 101(a), 70 Stat. 807 (codified as amended at 42 U.S.C. §§ 401-433 (1988)). The criteria used to determine whether an applicant meets the disability requirements for SSDI benefits are located at 20 C.F.R. § 404.1520-.1523 (1989).

5. Social Security Amendments of 1972, Pub. L. No. 92-603, § 1601, 86 Stat. 1465 (codified as amended at 42 U.S.C. §§ 1381-1383 (1988)). The criteria used to determine whether an applicant is eligible for SSI benefits are located at 20 C.F.R. § 416.920-.924 (1989)).

6. Although approximately one-third of the homeless are mentally disabled and others are physically disabled, *see infra* notes 7 & 8, few receive SSDI or SSI benefits (or any other kind for that matter). A study conducted in Chicago found that only 18% of homeless persons received disability benefits. J. WRIGHT & E. WEBER, *HOMELESSNESS AND HEALTH* 8 (1987). The figure was only 8.2% in a Los Angeles study. R. FARR, P. KOEGEI & A. BURNAM, *A STUDY OF HOMELESSNESS AND MENTAL ILLNESS IN THE SKID ROW AREA OF LOS ANGELES* 210 (1986). A review of eight studies of homeless people found that 18% to 44% of homeless persons received Social Security (retirement) benefits, welfare, or SSI. R. Tessler & D. Dennis, *A Synthesis of NIMH-Funded Research Concerning Persons Who Are Homeless and Mentally Ill* 20-23 (Feb. 9, 1989) (unpublished study on file at the *University of Miami Law Review* office). Most of those NIMH-funded studies indicated that at least twice as many people were eligible for some kind of maintenance program. *Id.* at 23. A study in Los Angeles showed that only 25.4% of homeless persons surveyed received public assistance of any kind. Robertson & Cousineau, *Health Status and Access to Health Services Among the Urban Homeless*, 76 AM. J. PUB. HEALTH 561, 562 (1986). Studies of homeless people who have been independently identified as mentally ill found less than one quarter received any type of public benefits: in Boston, 21%; in Los Angeles, 15%; and in Milwaukee, only 13%. R. Tessler & D. Dennis, *supra*, at 33; *see also Oversight of Social Security Continuing Reviews: Effect and Impact on Administrative Law Judges and Individual Beneficiaries: Hearing Before the Subcomm. on Civil Service, Post Office, and General Services of the Committee on Governmental Affairs United States Senate*, 98th Cong., 1st Sess. 17-21 (1984) (testimony of Dr. Nancy Morrison) [hereinafter *Hearing*] (discussing the tendency of disability evaluators to underestimate the severity of mental impairments); *infra* note 135 (text of Dr. Morrison's testimony); *cf.* *City of New York v. Heckler*, 578 F. Supp. 1109, 1119 (E.D.N.Y.) (noting that 40% of New York City shelter residents had been denied or terminated from SSI or SSDI benefits; at least one-third of those housed had a history of psychiatric hospitalization), *aff'd*, 742 F.2d 729 (2d Cir. 1984); *infra* note 15.

7. Mental illness, especially schizophrenia, is the most common causal disorder among homeless persons. In addition, the homeless suffer from Acquired Immune Deficiency Syndrome (AIDS), accidental injury, and degenerative diseases as well. INSTITUTE OF MEDICINE COMM. FOR HEALTH CARE OF HOMELESS PEOPLE, *HOMELESSNESS, HEALTH AND HUMAN NEEDS* 39-40 (1988) [hereinafter *INSTITUTE OF MEDICINE*]. There is a rough consensus that approximately one-third of the homeless population suffers from a major mental illness. R. FARR, P. KOEGEI & A. BURNAM, *supra* note 6, at 140 (26%); HUMAN SERVICES TRIANGLE, INC., *LISTENING TO THE HOMELESS: A STUDY OF HOMELESS MENTALLY ILL PERSONS IN MILWAUKEE* i (1985) (40%); PHOENIX SOUTH COMMUNITY MENTAL HEALTH CENTER, *THE HOMELESS OF PHOENIX: WHO ARE THEY AND WHAT SHOULD BE DONE?* 18 (1983) (20%); J. WRIGHT & E. WEBER, *supra* note 6, at 37 (20% to 40%); Bassuk, Rubin & Lauriat, *Is Homelessness a Mental Health Problem?*, 141 AM. J. PSYCHIATRY 1546, 1547-48 (1984) (noting 40% diagnosed with major mental illness and previously hospitalized for psychiatric care); Fischer, Shapiro, Breakey, Anthony & Kramer,

tuberculosis, diabetes, hypertension, and trauma-related injuries, occur at lower, but still significant frequencies.⁸ The severity of both

Mental Health and Social Characteristics of the Homeless: A Survey of Mission Users, 76 AM. J. PUBLIC HEALTH 519, 521 (1986) (37%). See generally INSTITUTE OF MEDICINE, *supra*, at 50-59 (reviewing studies of mental illness and substance addiction among the homeless); Bachrach, *The Homeless Mentally Ill and Mental Health Services: An Analytical Review of the Literature*, in THE HOMELESS MENTALLY ILL 11, 16-19 (H. Lamb ed. 1984) (review 12 studies herein demonstrating that approximately one-third of homeless persons surveyed suffered from mental illness).

Schizophrenia and affective disorders (bipolar and major depressive disorders) are considered major mental illnesses and in the absence of adequate treatment and support may cause homelessness. INSTITUTE OF MEDICINE, *supra*, at 51. On the other hand, although homeless living may worsen these conditions, it is unlikely to cause them. Fischer & Breakey, *Homelessness and Mental Health: An Overview*, 14 INT'L J. MENTAL HEALTH 6 (1986).

Personality disorder, although not normally considered a major mental illness, can contribute to homelessness by interfering with the patient's ability to cope with her environment and relate to others. Personality disorders may also evoke negative reactions in others. INSTITUTE OF MEDICINE, *supra*, at 51. Other mental disorders, such as phobic disorders and milder depressive reactions, are more commonly the result of the stress of homelessness. *Id.* at 51.

8. Physical impairments also disable large numbers of homeless people. One study indicated that 41% of the homeless had some form of chronic physical disorder. J. WRIGHT & E. WEBER, *supra* note 6, at 137. See generally INSTITUTE OF MEDICINE, *supra*, note 7, at 39-50 (discussing the physical health problems most frequently observed among the homeless).

Tuberculosis, characteristically associated with exposure, poor diet, and alcoholism, is a significant health problem among the homeless. *Id.* at 48. One study indicated that between 1.6% and 6.8% of the homeless have clinically active tuberculosis and the asymptomatic infection rate may be as high as 35% to 50%. Slutkin, *Management of Tuberculosis in Urban Homeless Indigents*, 101 PUB. HEALTH REP. 481, 481 (1986).

Other studies conclude that tuberculosis afflicts the homeless at a rate much greater than that of the general population. See Brickner, Scanlon, Conan, Elvy, McAdam, Schere & Vicic, *Homeless Persons and Health Care*, 104 ANNALS INTERNAL MED. 405, 406 (1986); Centers for Disease Control, *Drug Resistant Tuberculosis Among the Homeless-Boston*, 34 MORBIDITY & MORTALITY WEEKLY REP. 429, 429 (1985); Glicksman, Brickner & Edwards *Tuberculosis Screening and Treatment of New York City Homeless People*, 45 ANNALS N.Y. ACAD. SCI. 419, 419 (1984); Nardell, McInnis, Thomas & Weidhaas, *Exogenous Reinfection with Tuberculosis in a Shelter for the Homeless*, 315 NEW ENG. J. MED. 1570, 1571 (1986).

Approximately five percent of the general population suffers from diabetes mellitus. Drapkin, *Medical Problems of the Homeless*, in HOMELESS IN AMERICA 98 (C. Caton ed. 1990). The rate among the homeless is probably higher "since occurrence of [the] disorder is enhanced by physical and psychological stress, both of which are endemic among the homeless." *Id.* But see J. WRIGHT & E. WEBER, *supra* note 6, at 81 (showing diabetes rates among the homeless lower than the national average); Marwick, *The Sizeable Homeless Population: A Growing Challenge for Medicine*, 253 J. AM. MED. ASSOC. 3217, 3218 (1985) (same).

At least 10% of the homeless suffer from hypertension. See J. WRIGHT & E. WEBER, *supra* note 6, at 81; Bargmann, *Washington, D.C.: The Zacchaeus Clinic—A Model of Health Care for Homeless People*, in HEALTH CARE OF HOMELESS PEOPLE 323, 326 (1985); Kellogg, Conanan, Vicic & Brickner, *Hypertension: A Screening and Treatment Program for the Homeless*, in HEALTH CARE OF HOMELESS PEOPLE 109, 113 (1985). Hypertension increases the risk of cardiovascular disease, strokes, and kidney failure. Drapkin, *supra*, at 97.

"[T]rauma and trauma-related problems accounted for approximately one-quarter of all admissions of homeless patients to San Francisco General Hospital." Kelly, *Trauma: With the Example of San Francisco's Shelter Programs*, in HEALTH CARE OF HOMELESS PEOPLE 77, 84

mental and physical conditions is exacerbated because the homeless generally receive inadequate medical care and they often have difficulty following a treatment regimen.⁹ Loss of disability benefits (or the failure to qualify for them) has contributed, along with other fac-

(1985). Twenty-five percent of over 200 homeless persons surveyed in Los Angeles reported suffering trauma during the preceding two months. Marwick, *supra*, at 3218; see also Alstrom, Lindelius & Salum, *Mortality Among Homeless Men*, 70 BRIT. J. ADDICTION 245, 247-49 (1975) (discussing the high mortality rate among homeless men from accidents); Brickner, Greenbaum, Kaufman, O'Donnel, O'Brian, Scalice, Scandizzo & Sullivan, *A Clinic for Male Derelicts: A Welfare Hotel Project*, 77 ANNALS INTERNAL MED. 565, 567 (1972) (reporting trauma due to accidents and assaults); Olin, "Skid-Row" Syndrome: A Medical Profile of the Chronic Drunkenness Offender, 95 CANADIAN MED. A.J. 205, 212-13 (1966) (same).

Sexual assault is so common that a shelter worker commented: "It's not a question of whether a homeless woman will be raped, but simply a question of when." INSTITUTE OF MEDICINE, *supra* note 7, at 41 n.*. In San Francisco in 1983, 9% of all treated adult sexual assault victims were homeless even though the homeless were estimated to make up only .4% of the population. Kelly, *supra*, at 87.

"Other health problems that may result from or that are commonly associated with homelessness include malnutrition, parasitic infections, dental and periodontal disease, degenerative joint diseases, venereal diseases, hepatic cirrhosis secondary to alcoholism, and infectious hepatitis related to intravenous (IV) drug use." INSTITUTE OF MEDICINE, *supra* note 7, at 41.

9. When the mentally ill become homeless and have no fixed address, the community mental health system is least effective in providing treatment, maintenance, and rehabilitation services. INSTITUTE OF MEDICINE, *supra* note 7, at 30. Other factors which make it difficult for the homeless persons to receive adequate health care include an undersupply of services, provider hostility or resistance, cultural differences, and especially, in rural areas, transportation. *Id.* at 82. The homeless become disaffiliated because they perceive chronic rejection. Mack, *Chicago DOs Champion Homeless Cause*, 31 THE DO 34, 37 (1990).

In one study, 81% of homeless persons had no health insurance coverage of any kind; 7% were covered by Medicaid; 4% by Medicare; 5% by private insurance; and 2% by veterans' benefits. Robertson & Cousineau, *supra* note 6, at 561. A study of over 10,000 homeless persons seen more than once and for whom benefits status was known indicated higher figures: 21% of the homeless participated in Medicaid; another 11% received Medicare or veterans benefits. J. WRIGHT & E. WEBER, *supra* note 6, at 143. Medicaid recipients have better access to health care than low-income people without Medicaid or other health insurance. Rogers, Blandon & Maloney, *Who Needs Medicaid?*, 307(1) NEW ENG. J. MED. 13, 15 (1982). "All treatment is complicated by alcohol and drug abuse, poor clothing, poor shelter, and malnutrition." Drapkin, *supra* note 8, at 78.

[F]ollow-up treatment . . . is discouragingly difficult since these people often are not prone to follow instructions related to taking medication, diet, or follow-up appointments. . . . Some therapies require taking oral medication regularly (as with seizure disorders, hypertension, and tuberculosis), adhering to specific diets (as with hypertension and diabetes mellitus), and taking medication regularly by injection (as with insulin-dependent diabetes mellitus).

Id.

tors, to the rise of homelessness.¹⁰ Although disability benefits¹¹ alone are generally too modest to enable homeless beneficiaries to overcome homelessness, the funds are nevertheless a critical resource for people who are unable to work.¹² Receipt of SSI benefits is particularly

10. Homelessness is sometimes caused by a termination of Social Security disability benefits. Bassuk, *The Homelessness Problem*, 251 SCI. AM. 40, 41 (1984) ("[I]t seems not unreasonable to infer that loss of disability benefits reduced some people to not being able to pay for their housing."); Robinson, *Government Benefits: Social Security Disability*, 1987 ANN. SURV. AM. L. 195, 198 & n.22 (1988) ("Lack of [Social Security disability] funds often forced mentally ill claimants into hospitals or, worse, into homelessness."); Miami Herald, Dec. 9, 1989, at 31A, col. 1, 31A, col. 1 (Senator David Pryor of Arkansas stated that [w]hen an SSI recipient is cut off, it can lead to homelessness.").

The project coordinator for an SSI outreach program in [New York's] shelter program for the homeless estimated that 40% of those housed in the shelters had been denied or terminated from SSI or SSDI benefits. At least one third of those housed in the system had a history of psychiatric hospitalization.

City of New York v. Heckler, 578 F. Supp. 1109, 1119 (E.D.N.Y.), *aff'd*, 742 F.2d 729 (2d Cir. 1984).

One recipient whose benefits were cut off despite her suffering from Hodgkin's disease and a degenerative spinal disk condition said after her successful appeal: "I don't know what I would do if they stopped my money again. I'm scared, absolutely. I'm always afraid I would end up in the streets." Miami Herald, Dec. 3, 1989, at 1A, col. 1, 14A, col. 1; *see also* Belcher & Singer, *Homelessness: A Cost of Capitalism*, 18 SOC. POL'Y 44, 47 (1988) (Homelessness results from, in addition to cuts in government benefits, "inadequate SSI payments."); Jones, *Street People and Psychiatry: An Introduction*, 34 HOSP. & COMMUNITY PSYCHIATRY 807, 808 (1983) (Cutbacks in federal support programs like SSI are among the significant causes of homelessness.). The termination of benefits pushes some mental patients into acute paranoia or even suicide. City of New York v. Heckler, 578 F. Supp. at 1115. A legislative assistant to Senator Carl Levin of Michigan claimed at least eight people committed suicide because their benefits were cut off. She added that Senator Levin's bill, which would reform the disability review, was motivated by the case of a constituent who committed suicide after losing her disability benefits. Miami Herald, Dec. 3, 1989, at 1A, col. 1, 14A, col. 1. An Ohio study of over 1,000 homeless persons, however, stated that only 2.3% reported a termination of government benefits as the major reason for becoming homeless. OHIO DEP'T OF MENTAL HEALTH: OFFICE OF PROGRAM EVALUATION & RESEARCH, *HOMELESSNESS IN OHIO: A STUDY OF PEOPLE IN NEED 20* (1985) [hereinafter OHIO DEP'T OF MENTAL HEALTH]; *see* Dakin, *Homelessness: The Role of the Legal Profession in Finding Solutions Through Litigation*, 21 FAM. L.Q. 93, 110 (1987) (The loss of benefits impacts the homeless and nearly homeless.). *But cf.* Belcher, *Adult Foster Care: An Alternative to Homelessness for Some Chronically Mentally Ill Persons*, 1 ADULT FOSTER CARE J. 212, 220 (1987) (One year after their release from mental hospitals, patients with SSI or General Relief income fared no better than those without income in terms of maintaining housing.).

11. "Disability benefits" in this Comment refers to SSDI and SSI benefits.

12. Life on the streets is substantially better for those who persist and successfully negotiate the relief systems Though rarely can enough [money] be accumulated to secure a permanent or decent place to live, the necessities of food, second hand clothing, storage space in lockers, and other comforts can be purchased so long as a frugal budget is adhered to.

Baxter & Hopper, *The New Mendicancy: Homeless in New York City*, 52 AM. J. ORTHOPSYCHIATRY 393, 404 (1982).

The majority of SSI beneficiaries have no other significant source of regular income. Of nearly three million disabled SSI beneficiaries (including 550,000 persons aged 65 or older), just over 37% received Social Security (retirement) benefits averaging \$281 per month, 5.7%

important to the needy because most states link SSI eligibility to Medicaid.¹³ This failure to reach the homeless continues despite the stated policy of the Social Security Administration ("SSA") to make a "special effort" to provide aid to the homeless.¹⁴

One reason so many disabled homeless people do not receive benefits is that worthy claimants fail to qualify due to narrowly drawn SSDI and SSI eligibility requirements.¹⁵ In the late 1970's, the federal government began pressuring the Department of Health and Human Services, and through it, the Social Security Administration ("SSA"), which it controls, to tighten eligibility requirements in order to slow the rapid growth of SSDI and SSI expenditures.¹⁶ As a result, in

had earnings averaging \$162 per month, and 9.9% had unearned income other than Social Security averaging \$92 per month. U.S. DEP'T HEALTH & HUMAN SERV. SOCIAL SEC. ADMIN., SOCIAL SECURITY BULLETIN: ANNUAL STATISTICAL SUPPLEMENT 322 (1989) [hereinafter SOCIAL SECURITY BULLETIN] A Chicago study found the median monthly income of homeless persons to be "just under \$100." J. WRIGHT & E. WEBER, *supra* note 6, at 8.

New York City's Shelter Outreach Project considers SSI benefits so important to rehabilitating clients that it "makes a concerted effort to assist shelter residents to apply for SSI." Crystal, *Health Care and the Homeless: Access to Benefits*, in HEALTH CARE OF HOMELESS PEOPLE 279, 282-83 (1985).

13. Notice, 55 Fed. Reg. 3,645 (1990).

14. CENTER ON SOCIAL WELFARE POLICY & LAW, MEMORANDUM TO WELFARE SPECIALISTS (July 17, 1984) (citing SSA Program Circular 05-84-OOSI and a May 24, 1984, letter to the United States Catholic Conference for Health and Human Services Secretary Heckler).

15. Although some of the disabled homeless do not receive benefits because they fail to apply, there is also evidence that many of those who applied were denied. Forty percent of New York City shelter residents had been denied or terminated from SSI or SSDI benefits. *City of New York v. Heckler*, 578 F. Supp. 1109, 1119 (E.D.N.Y.), *aff'd*, 742 F.2d 729 (2d Cir. 1984). A psychiatrist testified before a Senate subcommittee about non-homeless patients with obvious mental disabilities who were denied benefits. See *infra* note 135. There were also well-publicized cases of persons with physical disabilities being denied benefits. Robinson, *supra* note 10, at 198 & n. 23. One Administrative Law Judge ("ALJ") argued that the sharp rise in the early 1980's both in the number of appeals and the proportion of those that were successful were due in part to overly restrictive eligibility requirements. Heaney, *Why the High Rate of Reversals in Social Security Disability Cases?*, 7 HAMLINE L. REV. 1, 1 & 10 (1984). Many worthy claimants are denied at the second step of the five-step evaluation process. See *infra* text accompanying notes 25-27.

16. Robinson, *supra* note 10, at 195-97. The tightening of eligibility requirements was only part of a campaign to reduce the disability rolls. Heaney, *supra* note 15, at 2; Robinson, *supra* note 10, at 195, 197. The SSA not only became more restrictive with initial eligibility determinations but it accelerated the review of beneficiaries to eliminate individuals who were no longer disabled. H.R. REP. NO. 618, 98th Cong., 2d Sess. 1, 10, *reprinted in* 1984 U.S. CODE CONG. & ADMIN. NEWS 3038, 3047. In response to sharply rising costs, Congress provided for periodic reviews of disability determinations in the Social Security Disability Amendments of 1980, Pub. L. No. 96-265, § 311, 94 Stat. 460 (codified as amended at 42 U.S.C. § 421(i)(1) (1988)).

A study of terminated SSDI beneficiaries by the General Accounting Office indicated that of the nearly 316,000 persons cut from Social Security's disability rolls between 1981 and 1984, 63% eventually won appeals to restore their benefits. U.S. GEN. ACCOUNTING OFFICE,

1978, the Department of Health and Human Services promulgated a more restrictive, five-step evaluation process to evaluate SSDI and SSI claims.¹⁷

The first step asks whether the applicant is currently employed. If so, the applicant is presumptively not disabled, and the claim is denied.¹⁸ The second step (the "severity regulation"), which is the focus of this Comment, is used as a screening device to eliminate frivolous claims and requires the claimant to demonstrate a "severe impairment."¹⁹ If the claimant is able to do so, she proceeds to step three at which point the disability analyst determines whether the claimant's medical condition is one contained in, or is equivalent to one contained in, the Social Security Administration's "Listing of

SOCIAL SECURITY DISABILITY: DENIED APPLICANTS' HEALTH AND FINANCIAL STATUS COMPARED WITH BENEFICIARIES' 45-46 (1989) [hereinafter DENIED APPLICANTS]. The proportion of beneficiaries who were erroneously denied benefits was probably higher because some applicants did not have the resources to pursue appeals. An internal Social Security report on terminated SSI recipients reflected massive errors in that program's terminations as well. Its sample study of 1,293 of the 185,000 SSI beneficiaries terminated in 1987 and 1988 for failure to respond to informational requests indicated that over 54% should not have been terminated. SOCIAL SEC. ADMIN., STUDY OF SUPPLEMENTAL SECURITY INCOME NONPAY STATUS (N20) CASES: EXECUTIVE SUMMARY 1 (1989) (results summarized in DEP'T OF HEALTH & HUMAN SERVICES: SOCIAL SEC. ADMIN., CHICAGO REGIONAL OFFICE, REGIONAL MEMORANDUM NO. 140-89, at 1 (1989)). Many beneficiaries were unable, because of their disabilities, to understand or act upon notices warning that benefits would be suspended if they failed to requalify. *Id.* at 4-5.

In addition to tightening eligibility requirements both on initial application and on review, the Social Security Administration went as far as to violate its own eligibility requirements in an effort to deny claimants. *City of New York v. Heckler*, 578 F. Supp. 1109, 1125 (E.D.N.Y.) (federal district court ordering 50,000 disability cases reopened in New York due to the "Secretary's illegal policy"), *aff'd*, 742 F.2d 729 (2d Cir. 1984); *Mental Health Assoc. of Minn. v. Schweicker*, 554 F. Supp. 157, 168 (D. Minn. 1982) (issuing preliminary injunction for the Chicago region after declaring the same policy), *aff'd*, 720 F.2d 965 (8th Cir. 1983). One SSA medical consultant reported feeling "uncomfortable" because he and his colleagues believed many younger mentally ill claimants who were denied benefits were unable to work. *City of New York v. Heckler*, 578 F. Supp. at 1116; *see also supra* note 135. For a discussion of how this failure to provide benefits to the disabled impacts homelessness, *see supra* note 10.

17. 20 C.F.R. §§ 404.1520 (SSDI), 416.920 (SSI) (1989).

18. "If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition . . ." *Id.* §§ 404.1520(b) (SSDI), 416.920(b) (SSI).

19. "If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled." *Id.*; *see infra* notes 73-75 and accompanying text. Prior to the enactment of the five-step sequential evaluation process, claimants only needed to demonstrate that their condition was "not slight." 20 C.F.R. § 404.1502(a) (1968); *see also* Brief of the *Amici Curiae* States in Support of Respondent at 3, *Bowen v. Yuckert*, 482 U.S. 137 (1987) (No. 85-1409) [hereinafter Brief for *Amici Curiae* States]; Smith, *Developments in Social Security Law*, 21 IND. L. REV. 367, 369 (1988).

Impairments.”²⁰ If so, the claimant is presumptively disabled, thereby ending the evaluation.²¹ If, however, the claimant meets steps one and two, but cannot satisfy step three, the claimant proceeds to step four in which the disability analyst determines whether the claimant is capable of doing any work of the type the claimant performed in the past.²² If so, the claimant is not disabled.²³ If not, the claimant proceeds to step five in which the disability analyst determines whether a significant number of jobs exist in the national economy of the type which the claimant can perform.²⁴ If there is work available, disability benefits are denied.

After the SSA implemented the sequential evaluation process, not only was there a rise in the number of applicants who were denied benefits, but the proportion of those denied at the step two screening increased from eight to forty percent.²⁵ Although no major study has identified at precisely which step or steps arguably worthy claimants²⁶ are denied, the significant rise in the number of denials occurring at step two²⁷ is cause for concern.

This Comment argues that step two should be modified in several ways to ensure more accurate eligibility determinations in the evalua-

20. “If you have an impairment(s) which meets the duration requirement and is listed in Appendix 1 or is equal to a listed impairment(s), we will find you disabled” 20 C.F.R. §§ 404.1520(d) (SSDI), 416.920(d) (SSI) (1989).

21. *Id.*

22. If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment(s), we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled.

Id. §§ 404.1520(e) (SSDI), 416.920(e) (SSI).

23. *Id.*

24. (1) If you cannot do any work you have done in the past because you have a severe impairment(s), we will consider your residual functional capacity and your age, education, and past work experience to see if you can do other work. If you cannot, we will find you disabled.

(2) If you have only a marginal education, and long work experience (i.e., 35 years or more) where you only did arduous unskilled physical labor, and you can no longer do this kind of work, we use a different rule (see § 404.1562).

Id. §§ 404.1520(f) (SSDI), 416.920(f) (SSI).

25. *Bowen v. Yuckert*, 482 U.S. 137, 157 (1987) (O'Connor, J., concurring).

26. *See supra* notes 6-8.

27. In *Yuckert*, Justice O'Connor cited cases from 11 federal courts of appeals that had either invalidated step two, or had construed it narrowly. *See infra* note 87. In addition to this “chorus of judicial criticism,” she noted empirical evidence that step two has been employed to deny benefits to claimants meeting the statutory definition of disability. *Yuckert*, 482 U.S. at 156-57 (O'Connor, J., concurring). She observed that “[a]llowance rates in Social Security disability cases have increased substantially when federal courts have demanded that the step two regulation not be used to disqualify those *who are statutorily eligible*.” *Id.* at 157 (emphasis added).

tion process. Section II provides a brief historical overview of Social Security retirement and disability programs. Section III sets out in greater detail the five-step eligibility determination procedure.²⁸ Section IV examines step two's failure to assess accurately the severity of claimants' mental and physical impairments. Section IV also critically examines *Bowen v. Yuckert*,²⁹ a United States Supreme Court opinion upholding step two against a facial challenge that step two was in direct conflict with its enabling legislation. Following the discussion of *Yuckert*, this Comment argues that the disability analyst should be required to consider a claimant's age, education, and work experience ("vocational factors") when making the disability determination, as is required by the enabling legislation, and as argued in *Yuckert*. Section V proposes modifications to step two which would make disability analysts more likely to identify disabled applicants. Section VI concludes that not only would the proposed modifications promote the goals of the disability programs, but that any increased administrative costs would be offset both by the resulting increase in the accuracy of disability determinations and by the resulting societal benefits.

II. A BRIEF HISTORY OF SOCIAL SECURITY BENEFITS

To appreciate the purpose of current disability benefits programs and to assess whether those programs are equal to the task, it is helpful to briefly review their institutional history and conceptual basis. Congress created federal benefits for the disabled through amendments to the Social Security Act of 1935 ("the Act").³⁰ The Act established a national payroll tax on employers and employees which is paid into a trust fund to provide a retirement pension.³¹ The conceptual model for this program was essentially that of retirement insurance.³² Workers who qualified by contributing through the pay-

28. In 1978, the Secretary of Health and Human Services ("Secretary") who administers SSDI and SSI through the SSA, promulgated the criteria used to determine whether an applicant is eligible for benefits under these programs. The criteria for SSDI are described at 20 C.F.R. §§ 404.1520-.1523. The identical SSI requirements may be found at *id.* §§ 416.920-.924.

29. 482 U.S. 137 (1987).

30. Social Security Act, ch. 531, 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. §§ 301-306 (1988)). For a discussion of the amendments adding disability benefits, see *infra* text accompanying notes 34-54.

31. Social Security Act, ch. 531, § 801, 49 Stat. 636 (1935) (payroll tax on employees); *id.* § 901, 49 Stat. 637 (tax on employers).

32. Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833, 837 (1976).

roll tax were entitled to receive a retirement benefit.³³

The Act did not, however, provide for disability benefits. The first step in that direction, a direction which ultimately led to SSDI, was the disability "freeze" program enacted by the Social Security Amendments of 1954.³⁴ The freeze program attempted to eliminate the automatic reduction in the worker's Social Security pension benefits that would result by reason of disability prior to attaining age sixty-five.³⁵ Prior to the freeze program, workers who became disabled before retirement age often lost their retirement benefits under the pension program because the formula used to determine the amount of the monthly benefit to be paid upon retirement was based on the average amount of the worker's monthly contribution.³⁶ Thus, if a worker failed to make a monthly contribution, the average amount fell, and the accrued benefit diminished accordingly.³⁷ If the worker failed to contribute over an extended period of time (i.e., the period of disability), then the accrued benefit could be completely eliminated before reaching age sixty-five.³⁸ The freeze program protected the worker from loss of accrued benefits by calculating the claimant's entitlement without regard to the months intervening between the onset of the disability and attaining retirement age.³⁹ Although the freeze program preserved the amount of the retirement benefit a worker was entitled to receive at age sixty-five, it made no provision for disability benefits in the interim.⁴⁰

In 1956, Congress created SSDI,⁴¹ the first of two federal programs⁴² to pay benefits to millions of disabled workers.⁴³ SSDI entitled any qualified, disabled taxpayer between the ages of fifty and sixty-five to receive benefits immediately, instead of waiting until retirement age.⁴⁴ In 1960, Congress eliminated the age fifty require-

33. Social Security Act, ch. 531, § 202(a), 49 Stat. 623 (1935).

34. Social Security Amendments of 1954, Pub. L. No. 83-761, § 106, 68 Stat. 1079-81 (amended 1960).

35. S. REP. NO. 1987, 83rd Cong., 2d Sess. 21, *reprinted in* 1954 U.S. CODE CONG. & ADMIN. NEWS 3710, 3729.

36. *Id.*

37. *Id.*

38. *Id.*

39. Social Security Amendments of 1954, Pub. L. No. 83-761, § 106, 68 Stat. 1079 (amended 1960).

40. *Id.*

41. Social Security Amendments of 1956, Pub. L. No. 84-880, § 101(a), 70 Stat. 807 (codified as amended at 42 U.S.C. §§ 401-433 (1988)).

42. For a discussion of SSI, the other major disability program, see *infra* notes 49-54 and accompanying text.

43. See *infra* text accompanying notes 48 & 54.

44. Social Security Amendments of 1956, Pub. L. No. 84-880, § 102(a), 70 Stat. 815 (1960).

ment,⁴⁵ so that currently a taxpayer who can demonstrate a medical disability and who has worked the required minimum length of time is entitled to disability payments.⁴⁶ SSDI expanded rapidly, both in terms of the numbers of beneficiaries and in total government expenditures.⁴⁷ SSDI is now a major federal aid program, providing approximately 2.8 million beneficiaries with an average 1989 benefit of \$530 per month.⁴⁸

Another significant expansion of disability benefits occurred in 1974, when Congress established the SSI program.⁴⁹ Although the disability evaluation is identical under both programs,⁵⁰ SSI differs markedly from SSDI in its non-medical eligibility requirements and benefits paid. SSI does not require beneficiaries to make payroll tax contributions to the Social Security system in order to qualify, instead claimants must demonstrate that they have limited income and financial resources.⁵¹ Therefore, the claimant's independent income and resources reduce the size of the claimant's SSI disbursement.⁵² A claimant with no income or resources would be entitled to receive the maximum federal benefit, which, in 1989, was \$386 per month for individuals, and \$579 per month for married couples.⁵³ As of March

45. Social Security Amendments of 1960, Pub. L. No. 86-778, § 401(a), 74 Stat. 967 (codified at 42 U.S.C. § 423(a) (1988)).

46. Claimants must have worked 20 of the previous 40 quarters. 42 U.S.C. § 423(c)(1)(B)(i) (1988). Claimants whose disability occurs before age 31 must have worked during half the quarters since their 21st birthday and at a minimum, must have worked six quarters. *Id.*

47. Robinson, *supra* note 10, at 196-97.

48. SOCIAL SECURITY BULLETIN, *supra* note 12, at 2.

49. See Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (codified as amended at 42 U.S.C. §§ 1381-1383 (1988)). The program began on January 1, 1974. *Id.* § 301, 86 Stat. 1465 (codified at 42 U.S.C. § 1381(a) (1988)). SSI effected a merger of former state administered and federally subsidized programs including old age assistance, aid to the blind, and aid to the totally and partially disabled. *Id.* §§ 1601-1602, 86 Stat. 1465 (codified at 42 U.S.C. §§ 1381-1382 (1988)); SOCIAL SECURITY BULLETIN, *supra* note 12, at 62.

50. See 20 C.F.R. §§ 404.1520 (SSDI), 416.920 (SSI) (1989) (containing identical regulations to determine disability).

51. 42 U.S.C. § 1382(a)(1) (1988). The maximum monthly benefit of \$386 for an individual is reduced by the amount of the claimant's earned or unearned income. SOCIAL SECURITY BULLETIN, *supra* note 12, at 62. To be eligible for SSI, an applicant must have "limited resources," which is defined as property and other assets valued at less than \$2,000 for a single adult or child, and under \$3,000 for a married couple. Certain resources are excluded from the calculation, including a home (up to a certain value), an automobile necessary for transportation to work, and life insurance. *Id.*

52. See 20 C.F.R. §§ 416.1100-.1266 (detailing the rules governing income and resource calculation).

53. SOCIAL SECURITY BULLETIN, *supra* note 12, at 65. A state supplement to the federal SSI payment exists which varies from an average of \$209 per month in California to no payment in 22 states. *Id.* at 325.

31, 1990, there were approximately 4.6 million SSI beneficiaries.⁵⁴

III. THE ELIGIBILITY DETERMINATION

Before considering any proposal to reduce the number of disabled homeless people who do not receive SSDI or SSI, one must become familiar with the disability determination process which involves identical regulations under SSDI and SSI.⁵⁵ Application for benefits under both programs begins at the local Social Security District Office.⁵⁶ The District Office makes all non-medical eligibility determinations, such as work activity and insured status for SSDI claims, and income and resource status for SSI claims.⁵⁷ If the claimant meets all non-medical eligibility requirements, the application and supporting evidence are forwarded to the state disability determination service.⁵⁸ Although disability determination services are state agencies, they are fully funded by, and are under the direction of, the SSA.⁵⁹

At the state disability determination agency, the case is reviewed by a lay disability analyst.⁶⁰ Evidence is provided primarily by the claimant and the claimant's treating physician, although indigent claimants are also examined by consulting physicians whose fees are paid by the SSA.⁶¹ In order for the physician's medical findings to qualify as evidence of disability, the findings must be in the form of symptoms, signs, and laboratory findings.⁶² Even the treating physi-

54. This figure includes 1.4 million elderly recipients and 3.2 million disabled recipients. Notice, 55 Fed. Reg. 3,646 (1990).

55. See 20 C.F.R. §§ 404.1520-.1523 (SSDI), 416.920-.924 (SSI).

56. STAFF OF SENATE COMM. ON FINANCE, 97TH CONG., 2D SESS., STAFF DATA AND MATERIALS RELATED TO THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM 90 (Comm. Print 1982) [hereinafter MATERIALS RELATED TO THE SSDI PROGRAM].

57. *Id.* The regulations governing insured status for SSDI are contained in 20 C.F.R. §§ 404.101-.146. The SSI regulations regarding income, resources, and living arrangements are found in *id.* §§ 416.1100-.1266. For a more readable description of the non-medical factors for SSI eligibility, see Note, *An Evaluation of Non-Medical Entitlement Factors Under the Supplemental Security Income Program*, 28 WAYNE L. REV. 269, 271-85 (1981).

58. MATERIALS RELATED TO THE SSDI PROGRAM, *supra* note 56, at 90.

59. *Id.* The state agency, or Disability Determination Unit, maintains a contract with the SSA to review applications for disability under federal guidelines. Eskin, *The Effect of Mental Disorders in Applications for Social Security Disability Benefits*, 29 N.H.B.J. 79, 91 (1988).

60. MATERIALS RELATED TO THE SSDI PROGRAM, *supra* note 56, at 90.

61. 20 C.F.R. §§ 404.1517(a) (SSDI), 416.917(a) (SSI).

62. *Id.* §§ 404.1527-.1528 (SSDI), 416.927-.928 (SSI). Reports of pain will be considered to the extent that they are supported by other findings. *Id.* §§ 404.1529 (SSDI), 416.929 (SSI). Claimants are also ineligible if they are found not to be following prescribed treatment. *Id.* §§ 404.1530 (SSDI), 416.930 (SSI). There are decisions at the level of the federal courts of appeals, however, holding that the inability to afford the treatment is a valid reason for not following treatment. See, e.g., *Lovejoy v. Heckler*, 790 F.2d 1114, 1117 (4th Cir. 1986); Taylor

cian's opinion will not be considered without medical findings.⁶³ For mental impairments,⁶⁴ the disability analyst must rate the severity of the reported symptoms and the degree of impairment in tasks that are indicative of day-to-day functioning and the capacity for work.⁶⁵ After developing the medical record, the disability analyst consults with a state agency medical or psychological consultant to determine whether the claimant is disabled.⁶⁶

Congress has defined "disability" for both SSDI and SSI purposes as the inability to engage in any "substantial gainful activity"⁶⁷ by reason of any "medically determinable physical or mental impairment."⁶⁸ In determining whether a claimant meets this definition, the disability analyst performs a five-step sequential evaluation known as the Initial Determination,⁶⁹ as set forth in 1978 by the Department of

v. Bowen, 782 F.2d 1294, 1294 (5th Cir. 1986); Gordon v. Schweicker, 725 F.2d 231, 237 (4th Cir. 1984); Tome v. Schweicker, 724 F.2d 711, 714 (8th Cir. 1984).

63. 20 C.F.R. §§ 404.1527 (SSDI), 416.927 (SSI).

64. The regulations for mental disabilities follow the approach of the AM. PSYCHIATRIC ASS'N DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS (3d ed. 1980) [hereinafter DSM-III]. The Listing of Impairments includes eight clusters of disorders: organic mental illnesses; schizophrenic, paranoid and other psychotic disorders; affective disorders; mental retardation and autism; anxiety related disorders; somatoform disorders; personality disorders; and substance addiction disorders. 20 C.F.R. pt. 404, subpt. P, app. 1, §§ 12.02-.09.

65. 20 C.F.R. §§ 404.1520a(b)(3) (SSDI), 416.920a(b)(3) (SSI). For the eight disorders articulated in the DSM-III, with the exception of mental retardation and substance addiction, the claimants must show impaired functioning through restrictions in daily living activities; maintaining social functioning; concentration, persistence or pace; and/or repeated episodes of deterioration in work or work-like settings. *Id.* pt. 404, subpt. P, app. 1, §§ 12.02-.04, 12.06-.08. Rating the degree of impairment in areas in which mentally disabled people have difficulty functioning is especially subjective. Eskin, *supra* note 59, at 83; *see also* City of New York v. Heckler, 578 F. Supp. 1109, 1113 (E.D.N.Y.), *aff'd*, 742 F.2d 729 (2d Cir. 1984).

66. 20 C.F.R. §§ 404.1615(c) (SSDI), 416.1015(c) (SSI).

67. "Substantial gainful activity" is defined as earnings of \$300 per month. *Id.* §§ 404.1572, 404.1574(b)(2)(vi), 416.972, 416.974(b)(2)(vi).

68. 42 U.S.C. § 423(d)(1)(A) (1988). Section 423(d)(1)(A) defines an impairment as one that "can be expected to result in death or . . . has lasted or can be expected to last for a continuous period of not less than 12 months." *Id.* Section 423(d)(2)(A) adds that:

For the purposes of paragraph (1)(A)-

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

Id. § 423(d)(2)(A).

69. In 1984, 39.8% of claimants were awarded benefits at the Initial Determination. Of those denied, 44.9% appealed. Eskin, *supra* note 59, at 96 n.84 (citing SOCIAL SEC. ADMIN., KEY WORKLOAD INDICATORS 15 (July 1985); and OFFICE OF HEARINGS & APPEALS, OPERATIONAL REPORT 21 (1984)).

Health and Human Services.⁷⁰ The severity regulation is the second of the five steps.⁷¹

Step one. The disability analyst determines whether the claimant is presently working. If employed, the claimant is per se not disabled and the claim is denied without further evaluation.⁷² If the claimant is not working, the evaluation proceeds to step two.

Step two. At the severity regulation stage, the claimant must demonstrate a "severe impairment," which is one that "significantly limits the claimant's physical or mental capacity to perform basic work-related functions."⁷³ "Basic work activities" include the ability to lift, walk, and carry out simple instructions.⁷⁴ If the claimant cannot demonstrate a severe impairment, the claim is denied without further consideration.⁷⁵ If the claimant is able to show a severe impairment, the evaluation continues to step three.

Step three. The claimant's impairment is compared to the Listing of Impairments,⁷⁶ prepared by the SSA, which indicates those medical conditions considered to be per se disabling.⁷⁷ Any claimant with an impairment of sufficient duration⁷⁸ contained in the listing or equivalent to a listed impairment, is presumed to be disabled without further inquiry.⁷⁹ Claimants with impairments not meeting any condition in the listing proceed to step four.

Step four. The claimant's "residual functioning capacity" is compared to the mental and physical demands of work that the claimant has performed in the past. A claimant who retains the

70. 20 C.F.R. §§ 404.1520 (SSDI), 416.920 (SSI).

71. *Id.* §§ 404.1520(c) (SSDI), 416.920(c) (SSI).

72. *Id.* §§ 404.1520(d) (SSDI), 416.920(d) (SSI).

73. *Id.* §§ 404.1520 (SSDI), 416.920 (SSI); see *infra* text accompanying note 95.

74. 20 C.F.R. §§ 404.1521(b) (SSDI), 416.921(b) (SSI). "Basic work activities" are "the abilities and aptitudes necessary to do most jobs." *Id.* Examples include:

- (1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;
- (2) Capacities for seeing, hearing, and speaking;
- (3) Understanding, carrying out, and remembering simple instructions;
- (4) Use of judgment;
- (5) Responding appropriately to supervision, co-workers and usual work situations; and
- (6) Dealing with changes in a routine work setting.

Id.

75. *Id.* §§ 404.1520(c) (SSDI), 416.920(c) (SSI).

76. *Id.* §§ 404.1520(d) (SSDI), 416.920(d) (SSI).

77. The Listing of Impairments, *id.* pt. 404, subpt. P, app. 1, "describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made." *Id.* §§ 404.1525(a) (SSDI), 416.925(a) (SSI).

78. *Id.* §§ 404.1509 (SSDI), 416.909 (SSI); see *supra* note 68.

79. 20 C.F.R. §§ 404.1520(d) (SSDI), 416.920(d) (SSI).

capacity to engage in work previously performed is not disabled.⁸⁰ If the claimant cannot perform past work, the disability analyst evaluates the claim under the fifth, and final, step.

Step five. The disability analyst determines whether any work exists in the national economy that the claimant can perform considering her age, education, and work experience.⁸¹ If so, the claimant is not disabled.

IV. STEP TWO'S ROLE IN THE SOCIAL SECURITY ADMINISTRATION'S FAILURE TO PROVIDE BENEFITS TO THE DISABLED

Step two, promulgated in 1978, requires the applicant to demonstrate a more severe impairment than was previously required in order to avoid denial and to qualify for a thorough medical review.⁸² Prior to 1978, claimants were required to demonstrate that the impairment was not "slight."⁸³ The severity regulation now requires a showing that the impairment is severe.⁸⁴ Therefore, claims based on

80. *Id.* §§ 404.1520(e) (SSDI), 416.920(e) (SSI).

81. *Id.* §§ 404.1520(f) (SSDI), 416.920(f) (SSI). Further, claimants may be found to have either exertional or non-exertional impairments. For those with exertional impairments, disability analysts may, at steps four and five, refer to standard "Medical Vocational Guidelines," *id.* pt. 404, subpt. P, app. 2, §§ 200.00-204.00 (the "Grid"), in place of expert testimony. Under the Grid, claimants are indexed using four categories: jobs, age, education, and work experience.

Jobs are classified according to physical exertion requirements: sedentary, light, medium, heavy, and very heavy. *Id.* §§ 404.1567 (SSDI), 416.967 (SSI). Age is categorized as "younger person" (less than 50 years old), "person approaching advanced age" (ages 50 to 54), "person of advanced age" (age 55 or over), and "close to retirement age" (ages 60 to 64). *Id.* §§ 404.1563 (SSDI), 416.963 (SSI). Education is broken down into "illiterate," "marginal" (completed sixth grade or less), "limited" (completed seventh to eleventh grades), "high school education and above," and "inability to communicate in English." *Id.* §§ 404.1564 (SSDI), 416.964 (SSI). Work experience is categorized as "unskilled," "semi-skilled," and "skilled." *Id.* §§ 404.1568 (SSDI), 416.968 (SSI). Disability analysts also determine whether skills learned in one occupation are transferable to another. *Id.* §§ 404.1568(d) (SSDI), 416.968(d) (SSI).

Non-exertional impairments are defined as "certain mental, sensory, or skin impairments" or "impairments [which] result solely in postural and manipulative limitations or environmental restrictions." *Id.* pt. 404, subpt. P, app. 2, § 200.00(e). See generally *Odle v. Heckler*, 707 F.2d 439, 440 (9th Cir. 1983) (noting that exertional impairments included osteomyelitis in ribs, osteoarthritis in knee, and peptic ulcer; non-exertional impairments included deafness, dizziness, and drug dependence); *McCoy v. Schweicker*, 683 F.2d 1138, 1148 (8th Cir. 1982) (noting that non-exertional impairments include chronic impairment of the respiratory system producing sensitivity to dust, excessive heat, toxic fumes, psychiatric impairment, and chronic alcoholism).

82. See *supra* note 19.

83. "[M]edical considerations alone may justify a finding that the individual is not under a disability where the only impairment is a slight neurosis, slight impairment of sight or hearing, or similar abnormality or combination of abnormalities . . ." 20 C.F.R. § 404.1502(a) (1968).

84. 20 C.F.R. §§ 404.1520(c) (SSDI), 416.920(c) (SSI).

impairments that are more than slight but not severe (i.e., moderate), which would have satisfied the pre-1978 standard, fail to meet the threshold required by the severity regulation. The impact of the heightened threshold has been reflected by the sharp rise in the proportion of denials occurring at step two, which jumped from 8.4% in 1975, to 40.3% in 1982.⁸⁵ The effect of the severity regulation is so devastating that prior to the United States Supreme Court's 1987 decision in *Bowen v. Yuckert*,⁸⁶ which upheld the validity of the step two, all of the federal courts of appeals, except the District of Columbia Circuit, had either enjoined the use of the severity regulation or had narrowly construed it.⁸⁷ After the use of the severity regulation was enjoined in Illinois for example, the approval rate rose significantly.⁸⁸

85. HOUSE COMMITTEE ON WAYS AND MEANS, 98TH CONG., 1ST SESS., BACKGROUND MATERIALS AND DATA ON MAJOR PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS 79 (Comm. Print) (1983). The advent of the security regulation, however, was not the only reason for the increase in denials. The proportion of denials under the "slight impairment" standard rose to almost one-third under pressure from the SSA. Smith, *supra* note 19, at 369-70.

86. 482 U.S. 137 (1987).

87. *Id.* at 156 nn.1-2. (O'Connor, J., concurring). O'Connor cited cases in which federal courts of appeals enjoined the severity regulation's use because applicants were denied benefits without consideration of their age, education, or work experience, contrary to the statute:

Dixon v. Heckler, 785 F. 2d 1102 (CA2 1986) (preliminary injunction), cert. pending, No. 86-2; *Wilson v. Secretary of Health and Human Services*, 796 F. 2d 36 (CA3 1986); *Baeder v. Heckler*, 768 F. 2d 547 (CA3 1985), *Johnson v. Heckler*, 769 F. 2d 1202 (CA7 1985), cert. pending *sub nom. Bowen v. Johnson*, No. 85-1442; *Brown v. Heckler*, 786 F. 2d 870 (CA8 1986); *Yuckert v. Heckler*, 774 F. 2d 1365 (CA9 1985); *Hansen v. Heckler*, 783 F. 2d 170 (CA10 1986).

Id. at 156 n.1.

O'Connor also cited cases which narrowly construed the regulation:

McDonald v. Secretary of Health and Human Services, 795 F. 2d 1118 (CA1 1986) (relying upon Social Security Ruling 85-28); *Evans v. Heckler*, 734 F. 2d 1012 (CA4 1984); *Stone v. Heckler*, 752 F. 2d 1099 (CA5 1985); *Estran v. Heckler*, 745 F. 2d 340 (CA5 1984); *Farris v. Secretary of Health and Human Services*, 773 F. 2d 85 (CA6 1985); *Salmi v. Secretary of Health and Human Services*, 774 F. 2d 685 (CA6 1985); *McCruter v. Bowen*, 791 F. 2d 1544 (CA11 1986); *Brady v. Heckler*, 724 F. 2d 914 (CA11 1984).

Yuckert, 482 U.S. at 156 n.2 (O'Connor, J., concurring).

88. *Yuckert*, 482 U.S. at 157 (O'Connor, J., concurring). The approval rate went from 34.3% to 52% at the initial level, and from 14.8% to 34.1% on Reconsideration, the first level of appeal. *Id.*

After the initial application, the claimant is entitled to receive a written decision from the District Office which explains the reasons for the decision and mentions the right to appeal. 20 C.F.R. §§ 404.906(h) (SSDI), 416.1406(h) (SSI). Appeals of the disability analyst's determination may be based on denials at step two, or any other step in the process. *Id.* §§ 404.907 (SSDI), 416.1407 (SSI). The appeals process has four levels. First, a claimant may file for a Reconsideration within 60 days of the Initial Determination. *Id.* §§ 404.900, .907 & .909 (SSDI), 416.1400, .1407 & .1409 (SSI). The Reconsideration is the first level of appeal and it is essentially a peer review performed by a different disability analyst. *Id.* §§ 404.915

This Comment makes two major objections to step two. First, step two is inconsistent with its enabling legislation and is therefore facially invalid. The enabling legislation requires the SSA to consider an applicant's age, education, and work experience in making a disability determination, yet the step two regulation provides that the disability analyst will not consider these factors.⁸⁹ The United States Supreme Court in *Bowen v. Yuckert*,⁹⁰ however, found step two facially valid. Nevertheless the Court's interpretation of the statute, and thus, its reasons for upholding step two are fundamentally flawed.⁹¹ The failure to consider the claimant's age, education, and work experience is critical because consideration of these vocational factors is extremely important in making an accurate disability determination. A heart condition, for example, may disable a fifty-eight-year-old laborer with no other work experience and a sixth-grade education, whereas the same condition may not disable a thirty-year-old,

(SSDI), 416.1415 (SSI). The claimant may provide additional data or explanations upon Reconsideration. *Id.* §§ 404.916(e) (SSDI), 416.1416(e) (SSI). In 1984, 19.6% of those appealing were awarded benefits on Reconsideration. Of those denied, 72.9% appealed to the next level. Eskin, *supra* note 59, at 96 n.84 (citing SOCIAL SEC. ADMIN., KEY WORKLOAD INDICATORS 4, 15 (July 1985)).

The second appeal level is a hearing before an Administrative Law Judge ("ALJ") of the SSA's Bureau of Hearings and Appeals. 20 C.F.R. §§ 404.929 (SSDI), 416.1429 (SSI). This is the first decision maker to meet the claimant face-to-face. The claimant has the right to make oral and written statements and to present witnesses. *Id.* §§ 404.950 (SSDI), 416.1450 (SSI). In 1984, 51.6% of those appealing were awarded benefits by the ALJ. Of those denied, 69.9% appealed. Eskin, *supra* note 59, at 96 n.84 (citing SOCIAL SEC. ADMIN., KEY WORKLOAD INDICATORS 4, 9 (July 1985); and OFFICE OF HEARINGS & APPEALS OPERATIONAL REPORT 23, 27-28 (1984)).

From the ALJ's final decision or dismissal of the request for review, the claimant may seek a third level of review by appealing to the Appeals Council of the Bureau of Hearings and Appeals located in Arlington, Virginia. 20 C.F.R. §§ 404.967 (SSDI), 416.1467 (SSI). The Appeals Council will review a case only if there appears to be: abuse of discretion by an ALJ; an error of law; findings not supported by substantial evidence; or the existence of an important policy or procedural issue. *Id.* §§ 404.970(a) (SSDI), 416.1470(a) (SSI). The Appeals Council reversed 5.3% of the cases it heard in 1984. Eskin, *supra* note 59, at 96 n.84 (citing SOCIAL SEC. ADMIN., KEY WORKLOAD INDICATORS 9 (July 1985); and OFFICE OF HEARINGS & APPEALS, OPERATIONAL REPORT 23, 27-28 (1984)).

The applicant's fourth and final avenue of appeal is to challenge the disability determination in United States district court. 20 C.F.R. §§ 404.981 (SSDI), 416.1481 (SSI). United States district courts awarded benefits in 15.4% of the appeals heard in 1984. Eskin, *supra* note 59, at 96 n.84 (citing OFFICE OF HEARINGS & APPEALS OPERATIONAL REPORT 23, 27-28 (1984)). The district court's scope of review is limited by 42 U.S.C. § 405(g) (1983) ("The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive . . ."). "Substantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938) (citations omitted).

89. See *infra* text accompanying note 95.

90. 482 U.S. 137 (1987).

91. See *infra* text accompanying notes 105-17.

college-educated insurance salesman. The second objection is that even if one accepts that step two is facially valid, there is strong evidence that unacceptably high numbers of worthy applicants are being denied benefits because disability analysts tend to underestimate the severity of certain impairments that frequently afflict the homeless.⁹²

A. *The Challenge to Step Two's Facial Validity*

Janet Yuckert challenged step two in federal district court⁹³ on the ground that it fails to consider the applicant's age, education, and work experience in making a disability determination, contrary to the Congressional definition of disability for the purposes of SSDI. The pertinent provisions of 42 U.S.C. § 423(d) provide:

- (1) The term "disability" means— (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment
- (2) For the purposes of paragraph (1)(A)— (A) an individual . . . shall be determined to be under a disability . . . only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, *considering his age, education, and work experience*, engage in any other kind of substantial gainful work which exists in the national economy⁹⁴

The statute specifically requires that these "vocational factors" be considered when a disability analyst evaluates the applicant's ability to work. In contrast, step two of the regulations promulgated by the Secretary of Health and Human Services (the "Secretary") provides:

If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. *We will not consider your age, education, and work experience.*⁹⁵

Yuckert argued that the regulation was facially invalid because it was inconsistent with the statutory provision.⁹⁶ Six courts of appeals found the severity regulation facially inconsistent with Congress' defi-

92. See *infra* text accompanying note 135 (discussing underestimation of the severity of mental impairments); *infra* pp. 641-43 (discussing underestimation of the severity of physical impairments).

93. *Yuckert*, 482 U.S. at 143.

94. 42 U.S.C. § 423(d) (1988) (emphasis added).

95. 20 C.F.R. §§ 404.1520(c) (SSDI), 416.920(c) (SSI) (1989) (emphasis added). For a listing of basic work activities, see *supra* note 74.

96. *Yuckert v. Heckler*, 774 F.2d 1365, 1366 (9th Cir. 1985), *rev'd*, 482 U.S. 137 (1987).

nition of disability and enjoined its use.⁹⁷ Five other courts of appeals found it consistent with the statutory definition, but nevertheless, limited its application.⁹⁸ These limitations narrowed the Secretary's authority to find a claimant ineligible for benefits based on a judgment that the claimant's impairments were not severe.⁹⁹ The Supreme Court resolved the conflict in *Bowen v. Yuckert*¹⁰⁰ by finding the severity regulation facially valid.¹⁰¹

In a six-to-three decision,¹⁰² the Court held that "both the language of the [Social Security] Act and its legislative history support the Secretary's decision to require disability claimants to make a *threshold showing* that their 'medically determinable' impairments are severe enough to satisfy the regulatory standards."¹⁰³ Writing for the majority, Justice Powell concluded that there was no need to consider the vocational factors at step two because it "identif[ies] at an early stage those claimants whose medical impairments are so slight that it is unlikely they would be found to be disabled even if their age, education, and experience were taken into account."¹⁰⁴ The essence of the majority's argument is that there is no conflict between the regulation and the statute because step two requires only a *de minimis* showing of impairment, enough to warrant full evaluation under steps three, four, and five.

A problem with the majority's reasoning is that step two's language does not support the Court's premise that the regulation requires only a *de minimis* showing of impairment. Instead of a *de minimis* standard, the regulation requires a showing of a "severe impairment" which "significantly limits [the] ability to do basic work

97. See *supra* note 87.

98. See *supra* note 87.

99. See cases cited *supra* note 87.

100. 482 U.S. 137 (1987).

101. *Id.* at 146. The Court declined to address the issue of whether the regulation was valid as applied. *Id.* at 154 n.12.

102. Justice Powell wrote the majority opinion and was joined by Chief Justice Rehnquist, and Justices White, Stevens, O'Connor, and Scalia. *Id.* at 138. Justice O'Connor wrote a concurring opinion joined by Justice Stevens. *Id.* at 155. Justice Blackmun wrote a dissenting opinion joined by Justices Brennan and Marshall. *Id.* at 159.

103. *Id.* at 145 (emphasis added).

104. *Id.* at 153. The majority noted that the need for an efficient evaluation process is critical considering that applicants file over two million claims for disability benefits yearly. *Id.*

The Court also cited Social Security Ruling 85-28, which stated that the Secretary only intended to screen out claimants with slight abnormalities. "[A] finding of 'not disabled' is made at [step 2] when medical evidence establishes only a slight abnormality . . . which would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered." *Yuckert*, 482 U.S. at 154 n.12 (quoting SSR 85-28 (cum. ed. 1985)).

activities."¹⁰⁵

There is a second, more subtle problem with the Court's premise that step two requires only a *de minimis* showing of impairment. Without knowing the claimant's age, education, or work experience, a disability analyst who determines that a claimant's medical condition is not disabling can only be certain of that determination if she proceeds under the assumption that the claimant suffers from the most debilitating combination of vocational characteristics imaginable. Thus, when the analyst denies a claim at step two, she would be confident that regardless of the claimant's particular vocational factors, the determination would not be affected because it was based on a worst case scenario. Yet the regulation establishes no assumption regarding the severity of the vocational factors. In fact, the regulation expressly provides that the SSA "will not consider [the claimant's] age, education, or work experience"¹⁰⁶ at step two. Thus, the Court's claim that disability analysts apply the regulation at a *de minimis* level fails when examined critically.

Justice Blackmun, writing for the dissent, charged that the majority defeated the intent of 42 U.S.C. § 423(d) by separating paragraph (2)(A), which requires consideration of the vocational factors, from paragraph (1)(A),¹⁰⁷ which contains the definition of disability, before comparing them to the severity regulation.¹⁰⁸ By characterizing paragraph (2)(A) as an independent statutory requirement for a disability finding,¹⁰⁹ the majority interpreted the statute to mean that as long as the disability analyst can find the claimant able to engage in any substantial gainful activity under paragraph (1)(A), without regard to the claimant's age, education, or work experience, the claimant is not disabled. The plain language of paragraph (2)(A), however, indicates that it is more accurately described as an annotation to paragraph (1)(A) than as a separate requirement. The first sentence of paragraph (2)(A) reads: "For the purposes of paragraph (1)(A)—" and then requires the analyst to consider the claimant's vocational factors in making the disability determination under paragraph (1)(A).¹¹⁰ The majority concludes that step two is consistent

105. 20 C.F.R. §§ 404.1520(c) (SSDI), 416.920(c) (SSI) (1989).

106. *Id.* §§ 404.1520(d) (SSDI), 416.920(d) (SSI).

107. See *supra* text accompanying note 94 for the pertinent provisions of paragraphs (2)(A) and (1)(A).

108. *Yuckert*, 482 U.S. at 159-60 (Blackmun, J., dissenting); see Smith, *supra* note 19, at 379 ("The weakness in the Court's comparison of the statute and regulation is that its version of the statute is deficient. The Court ignored the key phrase: 'For the purposes of (1)(A).'").

109. *Yuckert*, 482 U.S. at 147-48.

110. 42 U.S.C. § 423(d) (1988). For the text of paragraphs (1)(A) and (2)(A), see *supra* text accompanying note 94.

with 42 U.S.C. § 423(d) of the statute even though its interpretation involves literally ignoring the introductory language of paragraph (2)(A).¹¹¹

The majority offered a second argument to avoid comparing paragraph (2)(A) to the language of the severity regulation, stating that paragraph (2)(A) "limits the Secretary's authority to grant disability benefits, not deny them."¹¹² The dissent effectively refuted this argument by recalling that "the disability-insurance benefits program . . . creates a statutory entitlement for those persons eligible," and that disabled persons "*shall* be entitled to a disability insurance benefit."¹¹³ The dissent also challenged the majority's conclusion that language in accompanying Congressional Reports explicitly endorsed the severity regulation by expressing a reluctance to interfere with the sequential evaluation process.¹¹⁴ The dissent cited a House Report which criticized the severity regulation but deferred to an already planned re-evaluation by the Secretary.¹¹⁵ The House expressed concern over criticism that the SSA was terminating benefits "solely and erroneously on the judgment that the person's medical impairment is 'slight,' according to very strict criteria."¹¹⁶ The Report continued: "*However*, the committee notes that the Secretary has already planned to re-evaluate the current criteria for non-severe impairments [i.e., step two], and urges that all due consideration be given to revising those criteria to reflect the real impact of impairments upon the ability to work."¹¹⁷

Justice O'Connor filed a concurring opinion in which she expressed concern over Yuckert's contention that the Secretary employed step two to "systematically . . . deny benefits to claimants who *do* meet the statutory definition of disability."¹¹⁸ She noted that the eleven regional courts of appeals had either enjoined the use of the severity regulation or had narrowly construed it.¹¹⁹ Justice O'Connor suggested that the lower courts' frustration with the Secretary's appli-

111. One commentator called the maneuver "a type of judicial sleight of hand." Smith, *supra* note 19, at 378.

112. *Yuckert*, 482 U.S. at 148.

113. *Id.* at 160 n.1 (Blackmun, J., dissenting).

114. *Id.* at 175-76 (citing H.R. REP. NO. 618, 98th Cong., 2d Sess. 1, 7-8, *reprinted in* 1984 U.S. CODE CONG. & ADMIN. NEWS 3038, 3044-45).

115. *Id.*

116. *Id.* at 175 (quoting H.R. REP. NO. 618, 98th Cong., 2d Sess. 1, 7, *reprinted in* 1984 U.S. CODE CONG. & ADMIN. NEWS 3038, 3045).

117. *Id.* (quoting H.R. REP. NO. 618, 98th Cong., 2d Sess. 1, 7-8, *reprinted in* 1984 U.S. CODE CONG. & ADMIN. NEWS 3038, 3044-45).

118. *Id.* at 156 (O'Connor, J., concurring).

119. *Id.* at 156 nn.1-2.

cation of the severity regulation accounts, in part, for the courts of appeals' decisions to enjoin the regulation's use.¹²⁰ She noted the sharp rise in the number of denials occurring at step two after the promulgation of the severity regulation.¹²¹ Justice O'Connor concluded that "[o]nly those claimants with slight abnormalities that do not significantly limit any 'basic work activity' can be denied benefits without undertaking [the] vocational analysis,"¹²² that is, without considering the claimant's age, education, and work experience.

The consequence of the *Yuckert* holding is that individuals who are relatively older, with a lower education level and/or limited work experience,¹²³ are just as likely to be denied at step two as are younger, better-educated, and more experienced individuals with the same impairment. By refusing to take into account the claimant's age, education, and work experience, disability analysts divorce the individual from her medical condition. After *Yuckert*, the disability analyst applying step two cannot consider the disparate impact of the aforementioned heart condition on the older, less-educated laborer and the younger, college-educated salesman.¹²⁴ By denying applications at step two without careful consideration of the claimant's vocational characteristics, disability analysts tend to underestimate the disabling effect of medical impairments on elderly, uneducated persons with limited work experience. This places the elderly, uneducated, disabled individual at a greater risk of becoming homeless, or if already homeless, less able to escape homelessness.¹²⁵

120. *Id.* at 156 & nn.1-2.

121. *Id.* at 157 (citing *Baeder v. Heckler*, 768 F.2d 547, 552 (3d Cir. 1985)). For the actual figures, see *supra* text accompanying note 85.

122. *Yuckert*, 482 U.S. at 158 (O'Connor, J., concurring).

123. See *supra* note 81 for the SSA's definitions of relatively advanced age, low education level, and limited work experience.

124. See *Yuckert*, 482 U.S. at 164-65 & n.4 (Blackmun, J., dissenting).

125. See *supra* notes 10 & 12 and accompanying text. The failure to consider vocational factors prejudices the claims of the homeless and non-homeless alike. Any disabled person denied benefits is placed at greater risk of becoming homeless. See *supra* note 10. This Comment does not argue that the failure to consider age and educational level impacts the homeless more than the non-homeless because the homeless are not significantly older or less educated than the general population. Most homeless men would fall into the SSA's category of "younger person[s]," 20 C.F.R. §§ 404.1563 (SSDI), 416.963 (SSI) (1989), because the average age of individual homeless men is between 34 and 37 years-old. CENTER FOR METRO. STUDIES, UNIV. OF MISSOURI-ST. LOUIS, REP. NO. 1986-2, A CONTEMPORARY ASSESSMENT OF URBAN HOMELESSNESS: IMPLICATIONS FOR SOCIAL CHANGE 41 (1986).

As to education, approximately 45% of the homeless have a high school diploma, compared with 55% of the general population. INSTITUTE OF MEDICINE, *supra* note 7, at 6-7. In 1985, 55% of Chicago's homeless were high school graduates. P. ROSSI, G. FISHER & G. WILLS, THE CONDITION OF THE HOMELESS IN CHICAGO 65 (1986). In Ohio, the figure was 45.6% in 1985. OHIO DEP'T OF MENTAL HEALTH, *supra* note 10, at 34.

B. *The Failure to Assess Medical Disability Accurately*

The failure to consider vocational factors in disability determinations is not the only shortcoming of step two. Many worthy claimants are denied benefits because they suffer from certain impairments, the severity of which disability analysts often fail to appreciate.¹²⁶ Chief among these impairments is mental disability.

1. MENTAL DISABILITY

Research in a variety of settings indicates that approximately one-third of all homeless persons suffer from a mental disorder.¹²⁷ This high incidence of mental illness among the homeless is, in part, due to the movement known as deinstitutionalization.¹²⁸ Deinstitutionalization resulted in the release of over 250,000 former mental patients from mental hospitals from the 1960's to the early 1980's.¹²⁹ Although many of the former patients were placed in single room occupancy hotels or cheap apartments, they were among the most susceptible to becoming homeless.¹³⁰ Deinstitutionalization is often

126. See *infra* note 135; *infra* pp. 641-43.

127. See, e.g., J. WRIGHT & E. WEBER, *supra* note 6, at 50-59; Bachrach, *supra* note 7 at 16-20. See generally sources cited *supra* note 7.

128. Three factors were behind the policy of attempting to shift treatment of the mentally impaired from the institution to the community: (1) the development and application of psychotropic medications; (2) "concern with the civil liberties of individuals confined in state psychiatric institutions;" and (3) "greater awareness of the dehumanizing aspects of institutional environments." INSTITUTE OF MEDICINE, *supra* note 7, at 28.

In the community, the patient was to receive services including housing, rehabilitation, treatment, and entitlement procurement. DEP'T OF HEALTH & HUMAN SERVICES, TOWARD A NATIONAL PLAN FOR THE CHRONICALLY MENTALLY ILL 2-24 (1980). "In reality, few communities have established adequate networks of services for the deinstitutionalized mentally ill." INSTITUTE OF MEDICINE, *supra* note 7, at 29. "Deinstitutionalization and noninstitutionalization have become increasingly difficult to implement successfully because they depend heavily on the availability of housing and supportive community services." *Id.*

"There appears to be virtually no relationship between community mental health centers and community services for the mentally ill." E. TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL 26 (1988). "Housing and living conditions for mentally ill individuals in the community are grossly inadequate." *Id.* at 22. See generally *id.* at 22-29.

129. Appelbaum, *Crazy in the Streets: The Policy of Deinstitutionalization*, CURRENT, Oct. 1987, at 7; Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899, 902 (1984). The population of public mental hospitals reached a high of 559,000 in 1955, and fell to 130,000 by 1980. INSTITUTE OF MEDICINE, *supra* note 7, at 28.

Inpatient care has largely been limited to short-term care, which results in a revolving door policy. "A 1982 survey of psychiatric inpatients in New York found that 24% of them had ten or more previous psychiatric admissions." Karras & Otis, *A Comparison of Inpatients in an Urban State Hospital in 1975 and 1982*, 38 HOSP. & COMMUNITY PSYCHIATRY 963, 963-67 (1987).

130. INSTITUTE OF MEDICINE, *supra* note 7, at 30-31. "Seriously mentally ill individuals

cited as one of the principal causes of homelessness.¹³¹

Despite the fact that a large proportion of homeless persons suffer from a mental disability, very few receive disability benefits.¹³² Part of the difficulty is that the severity of mental impairments is difficult to assess.¹³³ Thus, mentally disabled applicants are often erroneously denied benefits.¹³⁴ Disability analysts frequently underestimate the severity of mental impairments,¹³⁵ or worse, they may intentionally minimize the severity in order to lighten their work-load by terminating the evaluation process at an early juncture.¹³⁶

Compounding the difficulty are a number of SSA practices that reflect a lack of sensitivity toward the mentally disabled.¹³⁷ During

are regularly released from hospitals with little or no provision for aftercare or follow-up treatment." E. TORREY, *supra* note 128, at 14. One doctor estimates that there are twice as many mentally ill people living on the streets than there are residing in mental hospitals. *Id.* at 8-9. "The mentally ill are particularly vulnerable to bureaucratic errors. Some do not even understand the communications they receive from SSA. Others are afraid of the system." *City of New York v. Heckler*, 578 F. Supp. 1109, 1115 (E.D.N.Y.), *aff'd*, 742 F.2d 729 (2d Cir. 1984).

131. See, e.g., Applebaum, *supra* note 129, at 4, 7-8; Bassuk, *The Homeless Problem*, 251 SCI. AM. 40 (1984); Belcher, *Adult Foster Care: An Alternative to Homelessness for Some Chronically Mentally Ill Persons*, 1 ADULT FOSTER CARE J. 212, 213-14 (1987); Lamb, *supra* note 129, at 899.

132. See *supra* note 6.

133. "Discriminating and experienced judgment is needed to assess whether psychological conflicts are highly significant . . ." THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 1404 (R. Berkow 14th ed. 1982) [hereinafter THE MERCK MANUAL]. Somatic symptoms reflecting psychic stress are difficult to assess with the result that "emotional disturbance is often overlooked or even denied by the patient and sometimes by the doctor." *Id.* at 1489-90. "[T]he patient may deny actual depression of mood or attribute it to his alleged physical disorder." *Id.*

134. See *supra* note 6; see also *infra* notes 135-36.

135. A psychiatrist testified before a Senate subcommittee that the mentally ill are frequently denied benefits because examiners grossly underestimate the severity of their illness. *Hearing, supra* note 6, at 18-21.

In the last few years, all new applicants from my programs have been turned down when they applied for [SSI] [E]ach one of these applicants was diagnosed as schizophrenic, has been ill for more than a year, is on medications, have been hospitalized at some point, and were all incapacitated to the extent that they were involved in full-time day treatment programs. With this information available, Social Security denied their claims.

Id. at 18. Dr. Morrison explained that due to the strong stigma associated with mental illness, patients "cover up" and "deny their symptoms, and in this way, their illness is overlooked." *Id.* Dr. Morrison noted that some denials are reversed on appeal but "these procedures require that the person go before a judge to present himself as a mentally ill person and to present himself as one who is unable to function in society. This is a very terrifying and demeaning experience for these individuals." *Id.* at 21.

136. "[D]enials under the 'slight impairment' rubric . . . was subject to abuse by staff wishing to avoid vocational development of cases and the ensuing detailed vocational history and forms required." Smith, *supra* note 19, at 369-70.

137. For example, the "SSA largely ignored the longitudinal history of mentally ill claimants, including disabilities existing during remission or when symptoms were controlled

the recent SSA campaign to reduce the number of beneficiaries,¹³⁸ the mentally disabled were targeted on both the initial determination and the continuing disability reviews. A federal district court in New York found that the SSA engaged in a "fixed, clandestine policy against those with mental illness."¹³⁹ In Chicago, the SSA office mandated that mentally impaired applicants under the age of fifty would not be determined disabled unless they had one of the step three impairments.¹⁴⁰ This practice truncated the evaluation at step three, precluding the possibility of an award at step four or five. The SSA sometimes enforced the new policy in relative secrecy via internal memoranda and quality assurance studies.¹⁴¹ The result of this, and other practices, was that although the mentally disabled made up only approximately eleven percent of those receiving benefits, they made up twenty-eight percent of those who lost benefits during the purge of the disability rolls.¹⁴²

2. PHYSICAL DISABILITY

Physical disability is also common among the homeless.¹⁴³ Physical disabilities which are peculiar to the homeless may be unusual in their severity, and/or origin, and thus may cause disability analysts to underestimate their importance. For example, homeless persons show a high degree of psychological distress,¹⁴⁴ attributable to

by medication or ameliorated by social supports." Rubenstein, Gattozzi & Goldman, *Protecting the Entitlements of the Mentally Disabled: The SSDI/SSI Legal Battles of the 1980s*, 11 INT'L J.L. & PSYCHIATRY 269, 273 (1988). See generally Eskin, *supra* note 59 (reviewing changes that were implemented to address some of these concerns).

138. See *supra* note 16.

139. *City of New York v. Heckler*, 578 F. Supp. 1109, 1115 (E.D.N.Y.), *aff'd*, 742 F.2d 729 (2d Cir. 1984).

140. *Mental Health Ass'n v. Schweicker*, 554 F. Supp. 157, 160-61 (D. Minn. 1982) (noting that candidates for disability benefits were evaluated on the basis of a list which ranked their levels of severity), *aff'd in part and modified in part*, 720 F.2d 965 (8th Cir. 1983).

141. *Heckler*, 578 F. Supp. at 1115-16. See *supra* text accompanying note 76 for a discussion of the step three impairment listing.

142. Yohalem, *Social Security Disability Insurance and SSI: The Chronically Mentally Ill Face Arbitrary Cutoff*, 16 CLEARINGHOUSE REV. 998, 998-1001 (1983).

143. See *supra* notes 7-8 (discussing mental and physical impairments among the homeless).

144. Gelberg & Linn, *Psychological Distress Among Homeless Adults*, 177 J. NERVOUS & MENTAL DISEASE 291, 293 (1989); see CENTER FOR METRO. STUDIES, UNIV. OF MISSOURI-ST. LOUIS, REP. NO. 1986-2, *supra* note 125, at 63-64. Conditions characterized by uncertainty, unpredictability, and lack of control produce a rise in adrenal output. Frankenhaeuser, *Psychobiological Aspects of Life Stress*, in COPING AND HEALTH 203 (S. Levine & H. Ursin eds. 1980). The lack of money is the strongest stress factor. Dill & Feld, *The Challenge of Coping: Women and Depression*, in LIVES IN STRESS: WOMEN AND DEPRESSION 179, 180-81 (D. Belle ed. 1982). "[S]tudies indicate that stress is an important risk factor for a wide range of adverse health outcomes such as cardiovascular diseases, diabetes, gastrointestinal disturbances including ulcers and colitis, increased susceptibility to

problems such as a lack of food and shelter, concern for safety, and alienation from meaningful relationships.¹⁴⁵ Psychological distress may contribute to chronic physical conditions, such as diabetes and hypertension, which are commonly observed among the homeless.¹⁴⁶ Stress may also frustrate efforts to treat psychological disorders¹⁴⁷ or cut short a period of remission.¹⁴⁸

The devastating effects of street life may cause homeless people to be disabled from conditions that are considered routine by the general population.¹⁴⁹ Homeless persons typically lack adequate access to medical care, and they have difficulty following any treatment regimen that includes bed rest, a controlled diet, and proper hygiene.¹⁵⁰ Not only do the homeless find it difficult to recover from some diseases, but they are particularly likely to contract infectious diseases.¹⁵¹

malignancies, infectious diseases and even death. All disease, particularly chronic illness, has its emotional concomitant." Paltiel, *Is Being Poor a Health Hazard?*, in TOO LITTLE, TOO LATE: DEALING WITH THE HEALTH NEEDS OF WOMEN IN POVERTY 189, 196 (C. Perales & L. Young eds. 1988).

The idea of a stress-induced disability is not without precedent. In the area of workers' compensation, one may be found disabled on the basis of job-related stress. In *Albanese's Case*, 378 Mass. 14, 389 N.E.2d 83 (1979), a shipping foreman was awarded workers' compensation when he experienced distress and chest pains and was unable to return to work following a series of heated encounters with workers involving a decision by management to eliminate overtime pay. *Id.* The Massachusetts Judicial Supreme Court held that "if an employee is incapacitated by a mental or emotional disorder causally related to a series of specific stressful work-related incidents, the employee is entitled to compensation." *Id.* at 14-15, 389 N.E.2d at 86. Although courts traditionally have allowed compensation when the mental disability resulted from acute stress brought on by a discrete act, the trend is in favor of allowing compensation for mental disability caused by chronic, day-to-day stress. See Sersland, *Mental Disability Caused by Mental Stress: Workers' Compensation Cases*, 33 DRAKE L. REV. 751, 767-72 (1983-1984); Note, *When Stress Becomes Distress: Mental Disabilities Under Workers' Compensation in Massachusetts*, 15 NEW ENG. L. REV. 287, 295-97 (1980). Whether the psychological distress associated with sleeping on the street on a winter night while risking rape or assault and not knowing where one's next meal will come from is roughly equivalent to either arguing with coworkers or directing air traffic seems to be a question worth considering.

145. OHIO DEP'T OF MENTAL HEALTH, *supra* note 10, at 20.

146. See *supra* notes 8 & 144.

147. "Until basic needs have been met . . . rehabilitative efforts are premature and of limited value. . . . Even a keen attentiveness to 'therapeutic' needs is undermined in the absence of basic provisions for food, shelter, clothing, and safety." Baxter & Hopper, *supra* note 12, at 406.

148. "The symptoms of those with mental disabilities are easily exacerbated on the streets, often taking on a character and severity that is frightening to the homeless themselves." *Id.* at 401.

149. See J. WRIGHT & E. WEBER, *supra* note 6, at 103 ("[H]omelessness itself is an existential condition with strongly deleterious consequences for physical well-being.")

150. See *supra* note 9.

151. "Living in groups, crowding, environmental stresses, and poor nutrition may predispose homeless people to infections of the upper respiratory tract and lungs." INSTITUTE OF MEDICINE, *supra* note 7, at 47-48.

Because these exacerbating conditions do not occur with such frequency in the general population, disability analysts may underestimate their disabling effect. Even homeless claimants themselves may fail to realize that their living conditions put them at a higher risk of disability. Disability analysts may also determine that a homeless claimant is not disabled based on the mistaken assumption that the claimant is receiving medical attention and can follow the prescribed treatment. Thus, even diligent disability analysts may be unable to evaluate properly the applicant's condition because it is impossible to estimate the effects which may result from the unique conditions under which homeless people must live.

V. PROPOSED MODIFICATIONS TO STEP TWO

The foregoing examination of the application of step two indicates that it has failed to screen out groundless claims without incurring an unacceptable level of erroneous denials. The problem lies both in step two itself and in its application by disability analysts. The regulation itself is deficient because it fails to acknowledge the complexity of disability by expressly prohibiting consideration of the vocational factors. Disability analysts' application of the regulation also results in erroneous denials because they tend to underestimate the severity of certain conditions prevalent among the homeless. Both of these problems are responsible for an unacceptably high error rate, which contributes to homelessness. In order to reduce the error rate while preserving the essential function of step two, the following modifications to the disability regulations are proposed.¹⁵²

A. *The Regulation Itself*

Congress should direct the Department of Health and Human Services to promulgate an amended step two which would require disability analysts to consider the claimant's age, education, and work experience when determining whether a claimant is sufficiently dis-

152. The recommended changes in the severity regulation are not considered to cure all of the problems in the eligibility determination process. The severity regulation is only one difficult part of the eligibility determination for homeless (and housed) people. Other steps in the sequential evaluation process merit attention. Step one, for example, which disqualifies the claimant if currently working, may have the unfortunate effect of requiring a claimant to continue to work even if continuing to work at that position will aggravate the claimant's condition.

Also problematic is the behavior of some homeless persons who avoid medical and social services. There may also be some reluctance on the part of social workers and others to expend limited resources on applications for SSI and SSDI benefits because of a belief that denial is all but certain. Changes in the sequential evaluation process and its application would be an important first step in changing these attitudes.

abled to qualify for SSDI or SSI benefits.¹⁵³ These vocational factors are directly relevant to both the impact of the impairment and the claimant's ability to work. The same medical impairment that significantly limits an older, poorly educated person with limited work experience from working may be of comparatively little consequence to a younger, better educated, and more experienced person. Further, the impact of the vocational factors on the claimant's ability to engage in substantial gainful employment would be relatively easy to assess. The failure to consider these factors not only contradicts the statutory definition of disability, but it denies the inherent complexity of the determination. Congress can, and should, rectify the Supreme Court's error in *Bowen v. Yuckert*.¹⁵⁴

B. *Application of Step Two*

Apart from the shortcomings of the severity regulation in its present form, problems exist with the application of the regulation.¹⁵⁵ The following modification to the regulation is intended to reduce the number of mentally disabled claimants who are unfairly denied disability benefits at step two:

In cases where an individual claims to have a mental disability, and that individual is able to demonstrate at least one hospitalization for psychiatric treatment, or a previous diagnosis of a progressive, degenerative mental disorder such as schizophrenia from a qualified physician, then the state disability determination agency shall bear the burden of proof to show that the individual's mental impairment is not "a severe impairment" under the step two severity regulation.

The adoption of this modification would shift the burden of proof from the claimant to the state agency if the claimant can demonstrate a history of treatment for mental illness. The modification would require disability analysts to make an in-depth analysis of any such claimant's mental disability before terminating the application at step

153. When Congress wrote the three vocational factors into the definition of disability, its intent was not to broaden the courts' ability to consider non-medical factors, but rather to restrict it. "Congress felt the need to clarify the definition of disability because, in its view, the rising cost of the disability-insurance program was due in part to court decisions that had interpreted the definition too broadly." *Bowen v. Yuckert*, 482 U.S. 137, 171 (1987) (Blackmun, J., dissenting) (citation omitted). The new definition specifically ruled out certain other possible factors. For example, the statute provides that the definition of disability shall be applied to the claimant "regardless of whether . . . work [the claimant could perform] exists in the general area in which he lives, or whether a specific job vacancy exists, or whether he would be hired if he applied for work." S. REP. NO. 744, 90th Cong., 1st Sess. 263-64 (1967); H.R. REP. NO. 544, 90th Cong., 1st Sess. 163 (1967).

154. 482 U.S. 137 (1987).

155. See *supra* note 135 and accompanying text; *supra* pp. 641-43.

two. The reversal of the burden of proof would only apply to step two. Further, in order for claimants to receive benefits, they would still need to satisfy the requirements of step three, four, or five.

The proposed modification is appropriate given the nature of many mental disorders.¹⁵⁶ Only thirty percent of schizophrenic patients recover completely, and relapses and acute episodes requiring therapeutic intervention are common.¹⁵⁷ Shifting the burden of proof to the agency would also help to alleviate the paradox that mentally disabled claimants often encounter in the application process. The application process requires considerable organization, concentration, and perseverance by the claimant. Consequently, only highly functional (but less disabled) claimants are able to assemble the evidence necessary to meet the burden of proof.¹⁵⁸ Although a claimant may be assisted by a social worker, the helping individual will likely be assisting many clients and thus have only limited time and energy to invest in the application process.¹⁵⁹ Allowing the claimant to provide a hospital record or a diagnosis is a more feasible alternative.

The second group likely to suffer erroneous denials at step two is comprised of persons whose disability was caused or aggravated by living in a state of homelessness. In order to ensure that disability analysts accurately assess the disabling effect of medical conditions aggravated by homelessness, the following modification to the regulation is proposed:

156. Although past history of psychiatric hospitalization is an imperfect predictor, studies in this area indicate a high proportion of the homeless have needed treatment for mental illness in the past. See OHIO DEP'T OF MENTAL HEALTH, *supra* note 10, at 136 (29.9%); PHOENIX SOUTH COMMUNITY MENTAL HEALTH CENTER, *supra* note 7, at 18 (17%); A. STEVENS, L. BROWN, P. COLSON & K. SINGER, WHEN YOU DON'T HAVE ANYTHING: A STREET SURVEY OF HOMELESS PEOPLE IN CHICAGO 31 (1983) (23%); Gelberg, Linn & Leake, *Mental Health, Alcohol and Drug Use, and Criminal History Among Homeless Adults*, 145 AM. J. PSYCHIATRY 191, 192-96 (Feb. 1988) (44% in Los Angeles); see also MICHIGAN DEP'T OF MENTAL HEALTH, MENTAL HEALTH AND HOMELESSNESS IN DETROIT: A RESEARCH STUDY 21 (1985) (26%); HUMAN RESOURCES ADMINISTRATION OF THE CITY OF NEW YORK, CHRONIC AND SITUATIONAL DEPENDENCY: LONG-TERM RESIDENTS IN A SHELTER FOR MEN 20 (1982) (33.2% of men).

157. THE MERCK MANUAL, *supra* note 133, at 1404-05.

158. During its campaign to reduce the number of beneficiaries, see *supra* note 16, many mentally disabled beneficiaries were terminated when they failed to return a detailed recertification form. N.Y. Times, Feb. 8, 1982, at B2, col. 4, B2, col. 4.

159. Though they may be entitled to income assistance of some kind (SSI, Welfare, VA) the procedures for obtaining it are beyond the reach of the majority of the homeless. . . . Gathering the necessary documents can be time consuming, the process arduous and confusing, and the outcome often negative Experienced caseworkers who accompany homeless persons through the bureaucratic mazes and help them manage the money when it arrives, are in short supply.

Baxter & Hopper, *supra* note 12, at 403-04.

When an individual claims to be homeless, the disability analyst must enter findings as to whether the claimant is disabled by any of the following types of conditions: hepatitis, tuberculosis, diabetes, hypertension, chronic pulmonary obstruction, burns, frostbite, psychological distress, malnutrition, or any other illness that may be exacerbated by reason of homelessness.¹⁶⁰ The disability analyst must also enter findings concerning whether any medical condition present is disabling considering the individual's prospects for receipt of medical attention and the individual's ability to follow the prescribed course of treatment.

Disability analysts should consider these types of medical conditions in the disability determination whether or not the claimant lists them as disabling factors. This is appropriate because even the claimant may fail to realize the disabling nature of these unusual medical conditions. Disability analysts routinely refer claimants to consulting physicians if they fail to provide the necessary medical information.¹⁶¹ The state agency should require consulting physicians to enter findings for each of these types of medical conditions so that disability analysts have the information necessary to make such a determination. Although some applicants might fraudulently claim to be homeless, hoping to increase the chance of receiving benefits, the proposed modification only requires that the disability analysts make additional findings; it does not guarantee the receipt of benefits. Further, physicians would not be required to accept the applicant's word regarding their homeless status; they need only assess the degree of disability. Although these findings do not guarantee that all medically disabled homeless persons would qualify for SSDI or SSI benefits, they should reduce the number of erroneous denials by providing disability analysts with all factors affecting the homeless person's degree of disability.

VI. CONCLUSION

In its present form, step two places an unwarranted burden on disability claimants. Although a screening mechanism is necessary, having step two perform that function at the cost of an unacceptable

160. The listing of medical disabilities in this Comment is not intended to be exhaustive. Significant disabling conditions existing among the homeless, but which are not examined here, include alcohol and drug addiction, which qualify as impairments under the SSDI and SSI programs. 20 C.F.R. §§ 404.1535-.1539 (SSDI), 416.935-.939 (SSI) (Alcoholism and drug addiction must be medically determined and the claimant must undergo appropriate drug treatment.). For estimates of the rate of alcohol and drug addiction among the homeless, see INSTITUTE OF MEDICINE, *supra* note 7, at 60-66; Arce, Tadlock, Vergare & Shapiro, *supra* note 7, at 815; and Bassuk, *supra* note 10, at 43.

161. See *supra* note 61.

error rate is incongruous with the "outreach" programs that seek out potential SSDI and SSI beneficiaries and with the SSA's stated policy of making a "special effort" to aid the homeless.¹⁶² Notwithstanding any unstated desire on the SSA's part to reduce beneficiary rolls, the purpose of both SSDI and SSI is to provide financial support to those who are unable to work due to a medical disability.¹⁶³ The proposed modifications would reduce the number of disabled persons (homeless or otherwise) erroneously denied benefits at step two.

There are at least two potential arguments against the adoption of these proposals. The first is that the modifications would only replace one type of error with another: false positives (granting benefits to persons who are not disabled) instead of false negatives (denying benefits to persons who are disabled). The proposed modifications would, however, reduce the number of false negatives without significantly increasing the rate of false positives because of the operation of the five-step, sequential evaluation process. Any applicant who survives step two still must demonstrate disability at step three, four, or five to qualify for benefits.¹⁶⁴ In contrast, false negatives at step two are denied without further review.¹⁶⁵

The second objection to the proposals is that they would result in increased costs for several reasons. First, the number of SSDI or SSI beneficiaries would probably rise because analysts will be unable to meet the shifted burden of proof, thus resulting in fewer erroneously denied claims. Second, the volume of applications would presumably increase if claimants and people assisting them, such as social workers, believe that the likelihood of success justifies the expenditure of time, money, and effort necessary to apply for SSDI and SSI.¹⁶⁶ Third, requiring specific findings for homeless applicants, shifting the burden of proof for mental disabilities, and requiring consideration of vocational factors, would make the evaluation process more time-consuming and expensive. Society should be concerned about these additional costs which, of course, would be partially offset by fewer appeals of erroneous denials,¹⁶⁷ because they diminish the funds avail-

162. See CENTER ON SOCIAL WELFARE POLICY & LAW, *supra* note 14; see also Liebman, *supra* note 32, at 858 (discussing outreach programs).

163. Social Security Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 924; Social Security Amendments of 1972, Pub. L. No. 86-778, § 1601, 86 Stat. 1465 (codified at 42 U.S.C. § 1381 (1988)).

164. See *supra* text accompanying notes 76-81.

165. See *supra* text accompanying note 75.

166. See *supra* note 159 (noting that experienced caseworkers are in short supply).

167. As a result of the SSA's draconian efforts to reduce the disability rolls, the number of appeals, and percentage of those that were successful, increased sharply. The rate of reversals at the ALJ level increased nearly 30% from 1975 to 1981. Heaney, *supra* note 15, at 10. The

able for SSDI and SSI beneficiaries generally.

Any cost/benefit analysis of the proposals, however, must include an examination of the benefits to society that would offset the increased costs to the SSA. Every disabled person who receives SSDI or SSI as a result of the step two modifications has a greater likelihood of escaping homelessness or of avoiding it altogether. The resulting individual and societal benefits of reducing personal misery, and homelessness in general, are unquantifiable but substantial. Homelessness exacts profound costs. It causes a waste of human resources, increases the incidence of crime,¹⁶⁸ accelerates the spread of diseases such as AIDS,¹⁶⁹ and decreases business revenues in districts where the homeless discourage shoppers. Further, although not every disabled person may be permanently medically disabled, those who become homeless may remain disabled indefinitely, due to the delete-

reversal rate in the United States Court of Appeals for the Eighth Circuit reached 60% in 1983; the normal rate is 16% to 19%. *Id.* "Something is fundamentally wrong with the system when the reversal rate is so high." *Id.* One of the several reasons suggested by Judge Heaney for the high reversal rate was that the Secretary was administering the law in a more restrictive manner. *Id.* at 1.

The number of Social Security application appeals reaching federal district court (the fifth and final step) nearly quadrupled from fiscal year 1980 to 1984. In 1980, there were 7,814 cases, and by 1984, the number had risen to 27,903. THE CENTER FOR SOCIAL GERONTOLOGY, INC., SOCIAL SECURITY DISABILITY LAW IN THE 4TH, 5TH, AND 11TH CIRCUIT: A COMPENDIUM FOR TRAINING AND PRACTICE, at SC-41 (1986). By June 30, 1984, the federal courts had a backlog of 51,657 Social Security cases. *Id.*

168. There is evidence that mental patients, especially schizophrenics, are arrested for violent crime more frequently than the general population. Zitrin, Hardesty, Burdock & Drossman, *Crime and Violence Among Mental Patients*, 133 AM. J. PSYCHIATRY 142, 142-49 (1976) (noting that patients discharged from Bellevue Hospital are twice as likely to commit murder, five times more likely to commit aggravated assault, seven times more likely to commit rape, and eight times more likely to commit robbery). However, psychotics are more dangerous only if they are not being treated. E. TORREY, *supra* note 128, at 22. "Almost all psychotics who go on to commit serious violence have been psychiatric patients, but few have been in receipt of any treatment in the six months leading up to their offense." Taylor, *The Risk of Violence in Psychotics*, 4 INTEGRATIVE PSYCHIATRY 12, 12-24 (1986). When schizophrenics are not treated, studies show they "may become violent because of under-control of their core schizophrenic symptoms." Yesavage, *Inpatient Violence and the Schizophrenic Patient: An Inverse Correlation Between Danger-Related Events and Neuroleptic Levels*, 17 BIOLOGICAL PSYCHIATRY 1131, 1135 (1982); see also Weaver, *Increasing the Dose of Antipsychotic Medication to Control Violence*, 140 AM. J. PSYCHIATRY 1274 (1983) (letter to the editor). Finally, reports show that three-quarters of the people with psychoses who committed crimes were homeless at the time. Weller, *Aspects of Violence*, 2 LANCET 615, 617 (Sept. 12, 1987). Society suffers an increase in violence as a result of its failure to treat the homeless psychotic.

169. As many as 10% of New York City shelter residents may have AIDS or be infected with the HIV virus, a percentage that will likely increase as long as residents continue to have homosexual relationships and share needles while injecting intravenous drugs. N.Y. Times, Apr. 4, 1988, at B1, col. 5, B1, col. 6. Homeless people tend to live in places with high unemployment, welfare dependency, and prostitution rates, where intravenous drug abuse is most common. Fineberg, *The Social Dimensions of AIDS*, 259 SCI. AM. 128, 131 (1988).

rious conditions of living on the street.¹⁷⁰ These losses are even more disturbing when one considers the great number of homeless children.¹⁷¹

Benefits programs, such as SSDI and SSI, strive to serve two sometimes competing conceptual masters: the humanitarian ethic and the work ethic.¹⁷² It is humane to provide for the truly needy; yet, anyone capable of performing work is expected to be self-reliant. Step two, in its present form, serves the work ethic by denying benefits to the able-bodied, although it does so at the cost of violating the humanitarian ethic by denying benefits to many legitimately disabled persons as well. The proposed step two modifications would serve the humanitarian ethic by reducing the number of worthy claimants denied at step two, although they would require more care and effort. If we, as a society, are not willing to adopt modest measures necessary to ensure that those unfortunate enough to become disabled are not dealt a second blow by being put out on the street, then perhaps we,

170. See Baxter & Hopper, *supra* note 12, at 401-05 (discussing the progressive isolation and disempowerment of homeless persons).

171. "Families with children" is the fastest growing subgroup of the homeless. INSTITUTE OF MEDICINE, *supra* note 7, at 11. Surveys conducted in 27 cities indicate that as many as 20% of the homeless are children. UNITED STATES CONFERENCE OF MAYORS, A STATUS REPORT ON HUNGER AND HOMELESSNESS IN AMERICA'S CITIES: 1988, at 26 (1988). Homeless children do not escape the problems facing the adult homeless. In fact, given the impact on their development, homeless children may suffer an even greater harm. See, e.g., Bassuk & Rosenberg, *Why Does Family Homelessness Occur? A Case Control Study*, 78 AM. J. PUB. HEALTH 783 (1988); Bassuk & Rubin, *Homeless Children: A Neglected Population*, 57 AM. J. ORTHOPSYCHIATRY 279 (1987); Bassuk, Rubin & Lauriat, *supra* note 7.

Homeless children suffer nearly twice as much from chronic physical disorders as the general child ambulatory population. SOCIAL & DEMOGRAPHIC RESEARCH INST., UNIV. OF MASSACHUSETTS-AMHERST, THE NATIONAL HEALTH CARE FOR THE HOMELESS PROGRAM: THE FIRST YEAR 61-64 (1987). Finally, homeless children exhibit higher levels of developmental lags and depression. Bassuk & Rosenberg, *supra*, at 786; Bassuk & Rubin, *supra*, at 281, 284.

Children have, until recently, faced an added obstacle to receiving SSI benefits. In *Sullivan v. Zebley*, 110 S. Ct. 885 (1990), the United States Supreme Court held that children, like adults would qualify for benefits at step three by having one of the conditions listed on the Listing of Impairments, or by having a disability of comparable severity. *Id.* at 897. Prior to this holding, children had to demonstrate that they suffered from a condition *contained* in the Listing of Impairments, unlike adults who may also qualify by having a condition *equivalent* to one contained in the listing. *Id.* at 894.

172. Cf. Liebman, *supra* note 32, at 848.

Two ideas compete for priority in the Social Security Program. One is need. . . . The second concept is insurance. The government's representations have generated expectations and reliances by working persons, and the program must redeem its promises so that its ongoing commitments will be credible. . . . [There is a] complex interplay of these two concepts in a program plainly attempting to respond to both of them.

Id.

and not the homeless, are guilty of violating the work, as well as the humanitarian, ethic.

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