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SMITHERS, WHAT'S THE NAME OF THIS GASTROPOD? KING-SIZE HOMER AND THE SOCIAL SECURITY ADMINISTRATION'S SUBJECTIVE EVALUATION OF FATNESS

Christopher Pashler*

ABSTRACT

The Social Security Administration has recently come under criticism for its subjective evaluation of disability claims. Recent studies of the Agency's decisions indicate that great variances in allowance rates continue to exist within the ALJ corps. These variations in decision-making are a challenge to the Agency's credibility, given the real likelihood that disability applications filed by similarly situated adults are treated differently by the ALJ corps. Prior works have looked at inconsistency at different levels in the disability certification process, but this scholarship has not sufficiently examined why similarly situated claimants are treated differently by the Agency. This Article, however, looks at inconsistency in decision-making by focusing on a single impairment—obesity. Prior to 1999, the Agency used Medical Listing 9.09 to evaluate applications involving obese claimants, and the Medical Listing provided specific criteria for the evaluation of the impact of obesity on co-morbid conditions. This Article reviews appeals to the federal courts of adverse disability determinations concerning obese claimants following the repeal of Medical Listing 9.09 where the claimant's Body Mass Index (BMI) could be ascertained. This review illustrates that individuals with similar BMIs are not evaluated consistently by the Agency. These variations occur because the protocols subsequently adopted by the Agency to

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evaluate obesity provide little guidance as to how to evaluate the epidemiological link between fatness and health. Reform is necessary because the Agency will not be able to achieve accurate and consistent decisions in claims involving obese claimants until protocols that reflect a better understanding of how obesity impacts both health and functional limitations are developed.

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INTRODUCTION

In 1999, the Social Security Administration (SSA or Agency) repealed Medical Listing 9.09,[1] which provided objective criteria for the evaluation of obesity in applications for either Title II (SSDI) or Title XVI (SSI) benefits. The Medical Listing was replaced by SSR 02-1p (Ruling).[2] Like Medical Listing 9.09, SSR 02-1p relies on Body Mass Index (BMI) to classify and evaluate obesity.[3] Unlike Medical Listing 9.09, which classified obesity as a listing-level impairment, SSR 02-1p requires decision makers to consider obesity at four steps during the five-step sequential evaluation process.[4] The Agency suggested these changes would ensure that disability claims involving obesity would be evaluated in an appropriate manner.[5] The

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1. Revised Medical Criteria for Determination of Disability, Endocrine System and Related Criteria, 64 Fed. Reg. 46,122 (Aug. 24, 1999) (to be codified at 20 C.F.R. pt. 404) (deleting Medical Listing 9.09, *Obesity*, from the Medical Listing of Impairments). SSA uses the Listing of Impairments (Medical Listing) at Step 3 in its five-step sequential evaluation process. The five-step sequential evaluation process will be described at *infra* Part II(B). The Medical Listing identifies a number of eligibility criteria related to physical or mental impairments that the Agency has determined are severe enough to warrant granting disability without regard for the vocational considerations relevant to the statutory definition of disability. INST. OF MED. OF THE NAT'L ACADS., IMPROVING THE SOCIAL SECURITY DISABILITY DECISION PROCESS 66–67 (John D. Stobo, Michael McGeary & David K. Barnes eds., 2007) [hereinafter IOM FINAL REPORT]. At Step 3, the decision maker for the Agency evaluates whether the objective medical evidence shows that the impairment meets or medically equals the Listing. The repeal of Listing 9.09 comes at a time when the number of Americans ages 18 to 64 with reported activity limitations grew during the 1990s, and the prevalence of conditions that contribute to disability, including physical inactivity and obesity, also increased among this age group. INST. OF MED. OF THE NAT'L ACADS., THE FUTURE OF DISABILITY IN AMERICA 17–18 (Marilyn J. Field & Alan M. Jette eds., 2007) [hereinafter THE FUTURE OF DISABILITY IN AMERICA]. Additionally, childhood obesity rates have increased. *Id.* The increase in obesity, especially in adults, is problematic because studies have shown that there is a strong correlation between adult obesity and disability. *See, e.g.*, Kenneth F. Ferraro et al., *Body Mass Index and Disability in Adulthood: A 20-Year Panel Study*, AM. J. PUB. HEALTH, May 2002, at 834, 839 (study finding obesity was consistently related to disability, especially disability involving the lower extremities).

2. Initially, the Agency adopted SSR 00-3p in 2000, which was later superseded by SSR 02-1p in 2002 to reflect revisions to criteria for establishing disability. SSR 02-1p did not materially change SSR 00-3p. *See* Rutherford v. Barnhart, 399 F.3d 546, 551 n.4 (3d Cir. 2005).

3. *See* SSR 02-1p, 67 Fed. Reg. 57,859 (Sept. 12, 2002). This Ruling requires that a claimant's obesity be considered at multiple steps during the five-step sequential evaluation process. *Id.*

4. Revised Medical Criteria for Determination of Disability, Endocrine System and Related Criteria, 64 Fed. Reg. at 46,127.

5. While Homer Simpson did not apply for SSDI/SSI benefits, *The Simpsons* episode *King-Size Homer* unintentionally illustrates the difficulty SSA must have in its evaluation of SSDI/SSI applications that allege obesity as a severe impairment. *See The Simpsons: King-Size Homer* (Fox television broadcast Nov. 5, 1995). For one, reactions to obesity and beliefs about the etiology of obesity

purpose of this Article will be to discuss my review of case law concerning obese claimants that suggests the repeal of Medical Listing 9.09 has complicated how obesity is evaluated in the adjudication of disability applications and has led to inconsistent results between similarly situated claimants. The Agency's inability to reach accurate and consistent disability determinations concerning obese claimants is perhaps best illustrated by one man's predicament—Homer Simpson.[6]

Frustrated by the burdens of work at the nuclear power plant in Springfield, Homer Simpson, in an episode of *The Simpsons*, learns about his employer's disability program from a colleague who dryly refers to it as the "lottery that rewards stupidity."[7] Homer is intrigued by the possibility of working from home in an ideal home–office

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can differ among reasonable individuals. Epidemiologists differ over the impact of obesity on overall health. Some researchers suggest that obesity can impact a number of bodily systems, including an increased risk of hypertension, Type II diabetes, dyslipidemia, coronary artery disease, stroke, osteoarthritis, as well as certain cancers. *E.g.*, Huiyun Xiang, Katie Kidwell & Krista Wheeler, *Role of Disability in the Association Between Obesity and Unintentional Injuries*, 1 DISABILITY & HEALTH J. 99, 99 (2008); Cynthia L. Ogden et al., *The Epidemiology of Obesity*, 132 GASTROENTEROLOGY 2087, 2087 (2007). But there is also a question of whether an impairment, such as arthritis, can cause obesity, or whether obesity by itself can be a disabling impairment. *See generally* Sander L. Gilman, *Fat as Disability: The Case of the Jews*, 23 LITERATURE & MED. 46 (2004). With regards to the first question some researchers have suggested there is not a strong epidemiological connection between obesity and health risk and argued, for example, that obesity may be the symptom of diabetes rather than its cause. Paul Campos et al., *The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic?*, 35 INT'L J. EPIDEMIOLOGY 55, 57 (2006). To a certain extent, however, the two factions do agree that there is limited evidence to suggest there is a connection between obesity and increased risk of mortality, save for the morbidly obese who do have an increased risk of mortality. Assuming that obesity did have a minimal impact on health, in the context of determining whether the obese individual could work, the question then shifts to whether obesity, by itself, could be so limiting as to prevent an individual from completing the functional requirements of work.

6. *The Simpsons: King-Size Homer*, *supra* note 5.

7. *Id.* This comment made by the character, Lenny, seems to be at odds with the concept that the disabled belong to the class of the deserving poor. The view of the disabled worker as unworthy of aid, however, is inconsistent with what proponents of disability insurance advocated during the late 1940s through the passage of the disability insurance program in 1956. *See* Matthew Diller, *Entitlement and Exclusion: The Role of Disability in the Social Welfare System*, 44 UCLA L. REV. 361, 395–415 (1996). Proponents of the disability insurance program distinguished the disabled from the malingerer and stressed the social insurance aspect of the legislation, which would tie eligibility to contributions made during past employment. *Id.* at 377. Because disability benefits would be part of the social insurance scheme, proponents pushed for the disabled worker to receive benefits that were superior to traditional means-tested public assistance programs. *Id.* at 377–78. Despite an increasingly conservative political climate in the United States, Social Security has survived because the redistributive aspects of the program are obscured by the Act's universal coverage. *See* SAMUEL R. BAGENSTOS, LAW AND THE CONTRADICTIONS OF THE DISABILITY RIGHTS MOVEMENT 143 (2009).

environment and consults a pamphlet entitled, "Am I Disabled?," to determine if he has an impairment that would render him unable to work. His initial disappointment turns to joy when he discovers that hyperobese individuals—those weighing 300 pounds or more—could qualify for disability. After intentionally gaining sixty-one pounds, Homer becomes eligible to work at home, and his boss, C. Montgomery Burns, summons the media to the Simpson home-cum-office to document his accommodation of Homer's disability.

Perhaps the most poignant moment of the episode occurs when several young children peer into Homer's window as he sits on the couch and attempts to work by utilizing a drinking bird to operate his computer. The children gawk at Homer, only to face a strong rebuke from Homer's soulful daughter, Lisa, who insists that Homer is still a "good person" despite being fat.[8] What is striking about this scene is that these children—from a distance—quickly peer into Homer's private sphere and arrive at a value-laden judgment about his abilities and self-worth.[9] But this is not just an example of children engaging in vicious wordplay.[10] Rather, this process of evaluation and assessment is frequently used in society's consideration of what it means to be classified as disabled and what limitations are caused by

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8. Fat scholars, such as Anna Kirkland and Sandra Solovay, use the terms fatness and obesity interchangeably. In this Article, I will use the term fatness interchangeably with obesity. I use this term not in a pejorative sense but because its usage has been embraced by scholars in prior works. *See* Abigail C. Saguy & Kevin W. Riley, *Weighing Both Sides: Morality, Mortality, and Framing Contests over Obesity*, 30 J. HEALTH POL. POL'Y & L. 869, 870 (2005) (noting the word fat has been reclaimed much like the civil rights movement reclaimed the words black and queer).

9. *See* INST. OF MED., DISABILITY IN AMERICA 36 (Andrew M. Pope & Alvin R. Tarlov eds., 1991) ("In common parlance, *disability* is a value-laden, stereotyping term that categorizes people according to their impairments. People who have reduced ability to perform expected activities—that is, those who are said to have 'disabilities'—are often viewed as permanently sick."). To stereotype an individual as disabled may reflect judgment about what that individual may or may not be able to do in a particular setting. This conclusion, however, is free of moral judgment when the individual is deemed to not be responsible for her impairment. The leukemia patient is viewed with sympathy because his situation was not the result of irresponsible choices. However, the life-long smoker with lung cancer may be viewed with condemnation. The public may make the same moral judgment about the obese as the life-long smoker with lung cancer because of the association of abnormal body weight with sloth and gluttony. *See* Abigail C. Saguy & Rene Almeling, *Fat in the Fire? Science, the News Media, and the "Obesity Epidemic,"* 23 SOC. F. 53, 55 (2008).

10. *See* SUSAN WENDELL, THE REJECTED BODY 43 (1996) (noting that common stereotypes of disabled people include the disabled as dependent, morally depraved, pitiful, or super heroic for overcoming their disabilities).

disability. These judgments reflect a common understanding about who should be excused from the burdens of work because of their limitations.[11]

In consideration of an individual's medical impairments on his or her ability to perform substantial gainful activity, United States Administrative Law Judges (ALJ) for the Agency, like the children in *The Simpsons* peering in the window at Homer, examine the lives of claimants from a distance as they render a judgment about whether claimants are eligible for either Title II or Title XVI benefits. Although the SSA no longer considers obesity to be a disability by itself, the Agency still evaluates an individual's obesity at several different steps in its evaluation process.[12] I chose to look at obesity for two reasons. First, obesity can invoke strong negative reactions among reasonable individuals: sloth-like, gluttonous, and pitiful are all adjectives associated with high body weight.[13] In spite of the stigma associated with obesity, other reasonable individuals might decry the moral panic associated with obesity.[14] These opinions make the obese potentially vulnerable to inconsistent decision-making.[15] Second, I thought identifying similarly situated claimants would be possible by looking at the claimant's BMI.

To determine whether the Ruling provides adequate guidance to ensure consistent evaluation of obesity, I began to review all district and circuit court decisions following the repeal of Medical Listing

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11. Diller, *supra* note 7, at 363 (noting that the SSDI/SSI benefit program, like other public benefit programs, includes some individuals while excluding others). The system of classification is the result of "boundary drawing" that reflects "political, economic, and moral decisions." *Id.*; *see also* Lance Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833 (1976) (suggesting the restrictive eligibility requirement helps to preserve the social insurance analogy). An example of how the disability certification process excludes some categories of disability is the SSA's treatment of alcoholics and drug addicts. Until 1996, an individual could apply for benefits as the result of drug or alcohol addiction, but with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Congress eliminated this category of disability. Pub. L. No. 104-193, 110 Stat. 2105 (1996). The case of alcoholics will be discussed further in Part IV.

12. *See* SSR 02-1p, 67 Fed. Reg. 57,859 (Sept. 12, 2002). This Ruling requires that a claimant's obesity be considered at multiple steps during the five-step sequential evaluation process. *Id.*

13. Saguy & Almeling, *supra* note 9, at 57.

14. *Id.* at 58.

15. LINDA G. MILLS, A PENCHANT FOR PREJUDICE 139 (1999) (arguing that repeal of Listing 9.09 may in fact reflect the biases society has about obesity).

9.09. Out of these cases involving obese claimants, I only reviewed claims where the claimants' BMI could be ascertained. These cases were reviewed for a number of factors: age, gender, BMI, type of claim, and presence of additional impairments. I also added a category to consider whether the claimant alleged obesity as a severe impairment or whether the ALJ determined that the claimant's obesity was a severe impairment.

This review of decisions involving obese claimants following the repeal of Medical Listing 9.09 suggests the Agency is currently unable to consistently render decisions involving similarly situated obese claimants because the current Ruling is difficult to implement as it does not specify what level of analysis of the claimant's obesity is necessary.[16] My review of the case law highlights the degree of randomness that exists in the disability adjudication process, particularly for individuals whose BMI (48 or greater) would have satisfied the weight criteria for Medical Listing 9.09. Despite attempts by the Seventh[17] and Third[18] Circuits to articulate a standard for how obesity is to be addressed by the ALJ, there is some variation at the district court level in expectations of how the ALJ should evaluate obesity in the sequential evaluation process.[19]

This Article will consider whether the Agency's repeal of Listing 9.09 for use in its evaluation of obesity claims has led to variations in decisions concerning similarly situated obese individuals. At the time the Agency decided to repeal Medical Listing 9.09, commentators expressed great concern that the repeal would lead to inconsistent

16. Norman v. Astrue, 694 F. Supp. 2d 738, 748 (N.D. Ohio 2010) ("This Court concedes that SSR 02-01p does not identify a specific method of analysis.").

17. *See* Skarbek v. Barnhart, 390 F.3d 500 (7th Cir. 2004).

18. *See* Rutherford v. Barnhart, 399 F.3d 546 (3d Cir. 2004).

19. *See, e.g.*, Rockwood v. Astrue, 614 F. Supp. 2d 252, 278 (N.D.N.Y 2009) (reviewing various district court decisions that follow but declining to follow the approach utilized in Skarbek v. Barnhart, 390 F.3d 500 (7th Cir. 2004)); *see also* Sotack v. Astrue, No. 07-CV-0382, 2009 WL 3734869, at *3–4 (W.D.N.Y. Nov. 4, 2009) (observing "[d]istrict courts vary in their interpretation of the extent and explicitness of the ALJ's required explanation" of how the ALJ considered the claimant's obesity at Steps 4 and 5); *cf.* Cruz v. Barnhart, No. 04 CV-9011, 2006 WL 1228581, at *9 (S.D.N.Y May 8, 2006) (finding that remand was not needed as ALJ's acknowledgment of the claimant's obesity in the statement of facts was sufficient consideration of the impairment even though claimant did not claim obesity as a severe impairment).

evaluation of obesity claims.[20] Thus, this Article will consider whether the SSA's current guidance for the evaluation of obesity is adequate.[21] This Article will conclude that the repeal of Medical Listing 9.09 and the inadequate methodology utilized in SSR 02-1p have had a negative impact on the Agency's ability to provide consistent and fair adjudication of claims involving obesity. Reevaluation of the repeal of Medical Listing 9.09 and the Agency's protocols for the evaluation of obesity is necessary in light of the recent commentaries on the inconsistent evaluation of disability applications and the Agency's expanding caseload.[22] Additionally, our understanding of the impact of obesity on functional limitation is more advanced than it was in 1999. For instance, the Institute of Medicine (IOM) has recommended further investigation into the correlation between disability and obesity.[23] The IOM noted that obesity is a risk for other conditions, such as diabetes which, in turn, can be disabling.[24]

This Article discusses three reforms. First, the Article will suggest that the Agency should reenact a listing for obesity so that claims can be decided at an earlier stage in the evaluation process. Second, the Agency should establish more concrete guidance about at what point obesity will likely be a severe impairment. Third, the Agency should develop other criteria, in addition to BMI, that can be used to evaluate the epidemiological link between fatness and health. For example, for women, the waist-to-hip circumference provides a more accurate way to consider how a patient's obesity impacts other bodily

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20. Revised Medical Criteria for Determination of Disability, Endocrine System and Related Criteria, 64 Fed. Reg. at 46, 123 ("A number of commenters said that deleting listing 9.09 will result in longer, more costly, and less consistent determinations and decisions, and will also result in increased backlogs.").

21. SOC. SEC. ADVISORY BD., IMPROVING THE SOCIAL SECURITY ADMINISTRATION'S HEARING PROCESS 18 (2006) (suggesting that the Agency engage in a systematic review process to update the Medical Listings of Impairments and the vocational standards that are used to determine whether the individual's impairment prevents substantial gainful activity).

22. "The number of working-age adults eligible for SSDI . . . is projected to increase. . . . [T]he Congressional Budget Office projects that caseloads will increase from 6.7 million in 2000 to 10.4 million in 2015." THE FUTURE OF DISABILITY IN AMERICA, *supra* note 1, at 96 (citation omitted).

23. *Id.* at 79.

24. *Id.*

systems.[25] Thus, the Article concludes that the Agency needs to revise its current protocols to evaluate the claims of individuals who have class I or II obesity.

Part I of this Article will discuss the limitations of the current Ruling for the evaluation of obesity.[26] Part II will discuss the statutory definition of disability and the disability certification process.[27] Part III will examine Medical Listing 9.09 and the Agency's current protocols for the evaluation of obesity claims contained in SSR-02-1p.[28] Part IV will discuss my review of the reported obesity case law and how inconsistent evaluation of disability claims undermines the goals of the Act.[29] Part V of the Article will consider how obesity fits within the established conceptual framework of disability.[30] This part will explore the morality of giving disability benefits to the obese given the debate over the etiology of obesity.

I. THE LIMITS OF THE COMMON SENSE APPROACH

It is a matter of common sense that obesity can exacerbate an individual's other impairments, right? Yet, the Ruling expressly prohibits this form of intuitive judgment.[31] Unfortunately, adjudicators at both the ALJ hearing stage and the federal district court level are engaging in this form of intuitive decision-making in decisions concerning obese claimants.[32] This is problematic because

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25. RICHARD V. BURKHAUSER & JOHN CAWLEY, THE IMPORTANCE OF OBJECTIVE HEALTH MEASURES IN PREDICTING EARLY RECEIPT OF SOCIAL SECURITY BENEFITS: THE CASE OF FATNESS 6 (2006), *available at* http://www.nber.org/programs/ag/rrc/6.2.pdf (prepared for the 8th Annual Joint Conference of the Retirement Research Consortium).

26. *See* discussion *infra* Part I.

27. *See* discussion *infra* Part II.

28. *See* discussion *infra* Part III.

29. *See* discussion *infra* Part IV.

30. *See* discussion *infra* Part V.

31. SSR 02-1p, 67 Fed. Reg. 57,859, 57,862 (Sept. 12, 2002) ("However, we will not make assumptions about the severity or functional effects of obesity combined with other impairments.").

32. *See, e.g.*, Santini v. Comm'r of Soc. Sec., No. 08-5348(SRC), 2009 WL 3380319, at *5 (D.N.J. Oct. 15, 2009) (noting "there [was] no common sense reason to expect that obesity would exacerbate the impairing effects of either the seizure disorder or diabetes"), *aff'd*, 413 F. App'x 517 (3d Cir. 2011). This conclusion is, in fact, contrary to medical literature on the subject. *See infra* Part IV.

variations in approval rates fuel the perception that the Agency lacks the ability to consistently and uniformly apply the statutory definition of disability.[33] Thus, it is important to consider whether inconsistent evaluation of obesity is the result of individual bias or a regrettable outcome produced by a Ruling whose vague nature permits intuitive judgment.

While studies about inconsistency in decision-making patterns at the SSA are not new,[34] recent criticism of the Agency has focused on the decision makers.[35] One question raised by these commentators is whether variations in allowance rates between decision makers at the state level and within the ALJ corps indicate that different decision makers apply the uniform definition of disability differently.[36] Prior works have suggested that whether an individual is granted benefits

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33. SOC. SEC. ADVISORY BD., *supra* note 21, at 16; *see also* John J. Capowski, *Accuracy and Consistency in Categorical Decision-Making: A Study of Social Security's Medical-Vocational Guidelines—Two Birds with One Stone or Pigeon-Holing Claimants?*, 42 MD. L. REV. 329, 331 (1983) (noting accuracy and consistency are two of the hallmarks of a moral legal system).

34. *See, e.g.*, ROBERT G. DIXON, JR., SOCIAL SECURITY DISABILITY AND MASS JUSTICE (1973); JERRY L. MASHAW ET AL., SOCIAL SECURITY HEARINGS AND APPEALS (1978); MILLS, *supra* note 15. Additionally, the United States General Accounting Office (GAO) has also conducted several surveys of bias either at the state level or within the ALJ corps. *See generally* U.S. GEN. ACCOUNTING OFFICE, SOCIAL SECURITY: RACIAL DIFFERENCE IN DISABILITY DECISIONS WARRANTS FURTHER INVESTIGATION (1992), *available at* http://www.gao.gov/assets/160/151781.pdf.

35. Much criticism appears to be the result of a May 19, 2011 article about an ALJ in Huntington, West Virginia who had been approving a high number of disability applications. Damian Paletta, *Disability-Claim Judge Has Trouble Saying 'No,'* WALL ST. J., May 19, 2011, A1, A14, *available at* http://online.wsj.com/article/SB10001424052748704681904576319163605918524.html?KEYWORDS=damian+palett. The article reported that in 2005, ALJ Daugherty decided 955 claims and approved benefits in 90% of the cases. *Id.* From 2006 to 2008, ALJ Daugherty heard 3,645 cases and approved benefits 95% of the time. *Id.* In the first six months of fiscal year 2011, ALJ Daugherty approved payments in all of the 729 cases he heard. *Id.*

36. Norma B. Coe et al., *Why Do State Disability Application Rates Vary* Over Time? 1 (Ctr. for Ret. Research at Bos. Coll., Brief No. 12-2, 2012) (discussing reasons for variances in approval rates of disability applications within a state level determination bureau and between different state disability determination bureaus), *available at* http://crr.bc.edu/wp-content/uploads/2012/01/IB_12-2-508.pdf; *see also* SOC. SEC. ADVISORY BD., *supra* note 21, at 17. One possible explanation, of course, is that there are a considerable number of decision makers at both the state level and within the ALJ corps that are biased against numerous types of claimants. Linda Mills's 1998 study of bias also focused on ALJ compliance with SSA regulations governing the hearings process. MILLS, *supra* note 15. In her study, Mills evaluated factors that contributed to ALJ non-compliance with SSA regulations. *See generally id.* Mills's study considered qualitative evidence of stereotyping in the decision-making process. *Id.* at 68. Mills found that ALJs tended to have preconceived notions on the basis of the SSDI/SSI applicant's type of impairment, race and ethnicity, education and literacy, and gender. *Id.* at 132. In addition to Mills's studies, numerous other academics have considered bias in the disability application process.

will depend more on who reviews the application than on the underlying merits of the claim.

To this point, Professor Richard Pierce has suggested the role of the ALJ in the disability certification process should be more closely scrutinized, in part, because of the lack of Agency oversight over ALJ decision-making.[37]

Certainly decision makers are not above reproach because of the critical role ALJs serve in the enforcement of the Act by holding hearings and issuing decisions concerning applications for Title II and Title XVI benefits.[38] A hearing before an ALJ is the third level of review in the disability certification process[39] and the first time in the process that an applicant will be guaranteed a face-to-face meeting with an adjudicator who considers not only the objective medical testimony but also supporting testimony concerning the claimant's subjective allegations.[40] The ALJ serves an unusual role in the hearing process because, in part, the government is not represented in the hearing.[41] Thus, the ALJ serves many different roles during the pendency of a disability application.[42]

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37. *See* 5 U.S.C. § 4301(2)(D) (2006); 5 C.F.R. § 930.211 (2012); *see also* Richard J. Pierce, Jr., *What Should We Do About Administrative Law Judge Disability Decisionmaking?* 15–17 (George Wash. Univ. Law Sch., Pub. Law & Legal Theory Paper No. 573, Legal Studies Research Paper No. 573, 2011) (describing the difficulty in removing an ALJ, save for a showing of good cause), *available at* http://ssrn.com/abstract=1890770 or http://dx.doi.org/10.2139/ssrn.1890770. ALJs are Agency employees, but the Administrative Procedures Act provides the ALJs with a level of independence. *Id*.

38. 42 U.S.C. § 402 (2006). In fiscal year 2010, ALJs decided over 737,000 cases. SOC. SEC. ADMIN., JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES: FISCAL YEAR 2012, at 12 (2011), *available at* http://www.ssa.gov/budget/2012FullJustification.pdf.

39. The disability certification process is a complex, multi-stage process that can take years to complete. *See* 20 C.F.R. § 404.900 (2012). SSA contracts with agencies in each state, known as the Disability Determination Service (DDS), to evaluate disability applications. The DDS evaluates the application at the first two stages of the process, known as the initial stage and reconsideration stage. *Id.* § 404.900(a)(1)–(2). However, these state agencies do not have any contact with the applicant. *Id.* § 404.1527(f) (2012). After a claimant's request for reconsideration is denied by the DDS, the claimant is entitled to a hearing before an ALJ as a matter of right. *Id.* § 404.900(a)(3). If the ALJ denies the claimant's application, the individual may appeal to the Appeals Council, which can either affirm or remand the decision. *Id.* § 404.900(a)(4). If the decision is affirmed, it becomes the final decision of the Commissioner of Social Security. *Id.* § 404.900(a)(5).

40. *Id.* § 404.900(a)(3).

41. Richardson v. Perales, 402 U.S. 389, 410 (1971). *See generally* Frank S. Bloch, *Representation and Advocacy at Non-Adversary Hearings: The Need for Non-Adversary Representatives at Social Security Disability Hearings*, 59 WASH. U. L.Q. 349 (1981).

42. *See generally* Jeffrey S. Wolfe, *The Times They Are a Changin': A New Jurisprudence for Social Security*, 29 J. NAT'L ASS'N ADMIN. L. JUDICIARY 515, 559–60 (2009) (noting some ALJs have referred

Professor Pierce argued for the abolishment of the ALJ program.[43] Yet, his reasoning is somewhat incomplete because he seemingly focuses on ALJs with high grant rates while ignoring outlier ALJs at the other end of the spectrum.[44] Professor Pierce noted that during the first half of 2011, the national average of awarded benefits was close to 60%, but 100 ALJs during this period awarded benefits in over 90% of their cases; this difference serves as his evidence that the disability certification process is inaccurate.[45] According to Professor Pierce, ALJs, as a result of their independence, can be subject to the vulnerability of bias, such as the desire to be popular within the

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to this as the three-hat paradigm because the ALJ is not entirely impartial in the sense that she is responsible for representing the government's interest, has a duty to help develop the administrative record, and is supposed to be the neutral decision-maker).

43. Pierce, *supra* note 37, at 40. For a more thorough response to Professor Pierce, see JON C. DUBIN & ROBERT E. RAINS, *Scapegoating Social Security Disability Claimants (and the Judges Who Evaluate Them)* (Am. Constitution Soc. for Law & Policy, Issue Brief, 2012), *available at* http://www.acslaw.org/sites/default/files/Dubin__Rains_-_Scapegoating_Social_Security_Disability_Claimants.pdf.

44. *See* Pierce, *supra* note 37, at 28. For example, during FY 2010–2011 ALJ Gilbert Rodriguez decided 432 cases and granted benefits in 7.4% of his cases. *See Social Security Awards Depend More on Judge Than Facts*, TRAC (July 4, 2011), http://trac.syr.edu/tracreports/ssa/254/ [hereinafter TRAC]. I chose to cite ALJ Rodriguez because the number of cases he heard was lower than the average for his office (641 cases). In the reported statistics, some ALJs have very low grant rates because they handle dismissals, which can lower the percentage. However, these ALJs will be identified because their case load will likely exceed the office average.

45. Pierce, *supra* note 37, at 6. These points seem to have been embraced as evidence that the SSDI/SSI program is out of control, as Senators Hatch and Coburn expressed concern about this statistic in their communication to the Inspector General for the SSA. Orrin G. Hatch & Tom Coburn, *Hatch, Coburn Investigate Potential Abuse Within Social Security Disability Program; Ensure Stewardship of Taxpayer Dollars*, U.S. SENATE COMMITTEE ON FIN. (May 20, 2011), http://finance.senate.gov/newsroom/ranking/release/?id=8309dc74-301c-4ff7-a7e5-15a0dd64dd83. However, the assault on ALJ Daugherty is misplaced. Judge Daugherty's approval rate is not the cause of instability in the SSDI/SSI program. Rather, Judge Daugherty, who was appointed in 1990, was making decisions in the disability certification process that has been greatly liberalized over the years. *See* JENNIFER L. ERKULWATER, DISABILITY RIGHTS AND THE AMERICAN SOCIAL SAFETY NET 119–20 (2006). Professor Erkulwater describes a period of liberalization of eligibility criteria that occurred beginning in the 1980s followed by the retrenchment battles of 1981–1984, and the Reagan Administration's policy of continuing disability reviews, a process Reagan referred to as "purification." *Id.* at 107. Prior to the mid-1970s, the courts expressed great deference to the Agency. *Id.* at 124. However, by the early 1980s, the Agency increasingly found the courts hostile to its positions, and the Agency responded to adverse decisions with a policy of nonacquiescence. *Id.* The judicial ad hoc response to retrenchment led to fragmented disability standards for two reasons. *Id.* at 141. First, the courts have issued inconsistent decisions. *Id.* The fragmented policy that emerged as a result of judicial activism resulted, perhaps unintentionally, in a liberalized interpretation that is a possible explanation for the inconsistency in the disability determination process. *Id.* at 142.

region surrounding the SSA office.[46] This desire to be popular, to give benefits to more individuals than likely are qualified, is a problem but so are the ALJs at the other end of the spectrum.[47] These variations in decision-making are a challenge to the Agency's credibility because of the real likelihood that disability applications filed by similarly situated adults could be treated differently at either the DDS level or by the ALJ corp.[48]

Perhaps complete uniformity in decision-making cannot be expected. Factors such as economic changes, court decisions,[49] and regional differences in income levels and health status may explain some of these variations.[50] While inconsistency between offices may be explainable, in part, because of regional differences, grant rates within each office cannot be explained by the worthiness of these cases but perhaps attributable to individual bias. Regardless of where the inconsistency occurs, patterns of variations in allowance rates call into question whether the Agency has the ability to eliminate unfairness and inconsistency in decision-making.[51] It may be impossible to eliminate bias in decision-making, but the Agency should seek to identify sources of variations in decision-making patterns and work to reduce them.[52]

Prior articles on bias and inconsistency have not fully explored whether the source of variations in decision-making used as the actual criteria to evaluate disability is sufficient to provide strict guidance to decision makers to ensure that similarly situated

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46. Pierce, *supra* note 37, at 19.

47. *See* TRAC, *supra* note 44.

48. SOC. SEC. ADVISORY BD., *supra* note 20, at 4 ("The public also has an interest in a consistent system. Claimants and potential claimants want a system that produces the same results for people in the same circumstances. The outcome of a claim should not depend on where the decision is made or who makes it.").

49. The statutory definition of disability is a medically-centered definition, but Professor Erkulwater traces how court decisions began to shift from claims that could be verified solely by objective medical testing to create a process that gave greater weight to intangible claims by focusing on an individualized assessment of a claimant's subjective allegations. ERKULWATER, *supra* note 45, at 142–43.

50. SOC. SEC. ADVISORY BD., DISABILITY DECISION MAKING: DATA AND MATERIALS 17 (2001).

51. Alexander Strand, *Social Security Disability Programs: Assessing the Variation in Allowance Rates* 1 (Soc. Sec. Admin. Office of Research, Evaluation, & Statistics, Working Paper No. 98, 2002), *available at* http://www.ssa.gov/policy/docs/workingpapers/wp98.pdf.

52. SOC. SEC. ADVISORY BD., *supra* note 21, at 7.

individuals[53] are treated uniformly.[54] A review of how the Ruling has been interpreted suggests some decision makers are utilizing a "common sense" approach in the determination of how obesity impacts other impairments.[55] The problem with the Third Circuit's "common sense" approach, however, is this standard is sufficiently vague that opposite conclusions could be drawn by decision makers who may be disinclined to grant benefits.[56] This standard is, in part, the result of a Ruling that acknowledges that obesity can impact other bodily systems[57] but provides little guidance about what point obesity could constitute a severe impairment[58] or be reasonably expected to impact other bodily systems.[59] In addition to the lack of a clear articulation about how obesity can impact health, the Ruling also

53. There are numerous examples of where seemingly similarly situated claimants experience different results. *See infra* Part III.

54. Several scholars, however, have addressed this issue. *See, e.g.*, Jon C. Dubin, *Poverty, Pain, and Precedent: The Fifth Circuit's Social Security Jurisprudence*, 25 ST. MARY'S L.J. 81 (1993); Dara E. Purvis, *A Female Disease: The Unintentional Gendering of Fibromyalgia Social Security Claims*, 21 TEX. J. WOMEN & L. 85 (2011); *see also* SOC. SEC. ADVISORY BD., *supra* note 21, at 18 (acknowledging that the essential policy updates that correspond to changes in diagnostic criteria, changes in treatment, and rehabilitation have not taken place).

55. Diaz v. Comm'r of Soc. Sec., 577 F.3d 500, 504 (3d Cir. 2009); *see also* Centeno v. Comm'r of Soc. Sec., No. 09-6023(AET), 2010 WL 5068141, at *4 (D.N.J. Dec. 6, 2010). Specifically, the *Diaz* court noted the Agency needed to consider whether obesity would increase the severity of coexisting or related impairments to the extent that the combination of impairments would meet the requirements of a listing, especially "musculoskeletal, respiratory, and cardiovascular impairments." *Diaz*, 577 F.3d at 503. Interestingly, the court observed the claimant's morbid obesity would seem to have exacerbated her joint dysfunction "as a matter of common sense, if not medical diagnosis." *Id.* at 504.

56. *See* Santini v. Comm'r of Soc. Sec., No. 08-5348(SRC), 2009 WL 3380319, at *5 (D.N.J. Oct. 15, 2009).

57. *See* SSR 02-1p, 67 Fed. Reg. 57,859, 57,861 (Sept. 12, 2002) ("Obesity is a risk factor that increases an individual's chances of developing impairments in most body systems. It commonly leads to, and often complicates, chronic diseases of the cardiovascular, respiratory, and musculoskeletal body systems.").

58. For instance, in *Rockwood v. Astrue*, a female claimant had a BMI of 38.6, yet the ALJ did not mention the claimant's obesity at any point in his decision despite the fact the claimant's treating physician had diagnosed her with obesity. Rockwood v. Astrue, 614 F. Supp. 2d 252, 276 (N.D.N.Y 2009). On appeal, the Agency argued the claimant's weight was "in the range of her normal weight." *Id.* It would be one thing for the Agency to argue that the claimant's obesity did not impact her ability to work, but it is disingenuous to argue her weight was within a normal range because this statement is contrary to accepted classification of obesity. *See id.*

59. *Compare* Barr v. Astrue, No. CIV S-07-0284 GGH, 2008 WL 3200863, at *6 (E.D. Cal. Aug. 7, 2008) (mentioning only in passing by the ALJ that while the claimant did have a BMI of 40.6, the claimant's obesity "probably exacerbate[d] [the claimant's] sleep apnea and . . . back pain"), *with* Martinez v. Astrue, 630 F.3d 693, 698 (7th Cir. 2011) ("It is one thing to have a bad knee; it is another thing to have a bad knee supporting a body mass index in excess of 40.").

fails to specify how obesity can potentially limit functional ability.[60] The Ruling's guidance on the combined effect of obesity and arthritis provides an example of how this provision encourages decision makers to utilize the "common sense" approach.[61] Yet, reform to minimize the role of intuitive decision-making is possible given obesity does in fact differ from other disabling conditions, such as mental illness, fibromyalgia, and pain, because objective measurements of fatness make it more possible to accurately predict what the impact of obesity should be on a claimant's health and functional limitations.[62]

II. OBESITY AND THE MEDICALLY-CENTERED DEFINITION OF DISABILITY

Ensuring uniform and consistent decision-making may be hard, in part, because the SSA's individualized inquiry into medical and vocational factors can leave SSDI/SSI claimants vulnerable to bias in the administrative decision-making process since disability can be associated with stigma.[63] As the Eighth Circuit recognized,

60. SSR 02-1p, 67 Fed. Reg. 57,859, 57,862 (Sept. 12, 2002) ("The combined effects of obesity with other impairments may be greater than might be expected without obesity. For example, someone with obesity and arthritis affecting a weight-bearing joint may have more pain and limitation than might be expected from the arthritis alone.").

61. *Compare* Heino v. Astrue, 578 F.3d 873 (8th Cir. 2009), *with* Barrett v. Barnhart, 355 F.3d 1065 (7th Cir. 2004). In *Barrett*, the claimant was 5'1" tall, more than 300 pounds, and the alleged disability was a result of her arthritis and obesity. *Barrett*, 355 F.3d at 1066. In *Heino*, the claimant was 5'1" tall, with a weight range of 230 to 325 pounds, and alleged disability as a result of her osteoarthritis and obesity. *Heino*, 578 F.3d at 875. In *Barrett*, the court rejected the ALJ's conclusion that the claimant could stand for two hours a day because, in the opinion of the reviewing court, "[a] great many people who are not grossly obese and do not have arthritic knees find it distinctly uncomfortable to stand for two hours at a time. To suppose that [the claimant] could do so day after day on a factory floor borders on the fantastic . . . ." *Barrett*, 355 F.3d at 1068. In contrast, the court in *Heino* accepted the ALJ's conclusion that despite the claimant's obesity and arthritis, she retained the functional ability to stand for six hours (with breaks) in an eight-hour workday. *Heino*, 578 F.3d at 877. While this example given in the ruling was not persuasive to the court in *Heino*, positive reform of the Agency's protocols should include further elaboration of the known impact of obesity on other impairments.

62. This point on how obesity, unlike other impairments, actually provides objective criteria for the adjudicator to use should be attributed to Professor Robert E. Rains. Letter from Robert E. Rains, Professor of Law, Penn State Law, to author (May 16, 2012) (on file with author).

63. Frank S. Bloch, *Medical Proof, Social Policy, and Social Security's Medically Centered Definition of Disability*, 92 CORNELL L. REV. 189, 201 (2007) (explaining how the definition of disability, including the medical causation requirement, requires an individualized assessment of the

stereotypes about obesity could play a role in producing inconsistent outcomes: "The notion that all fat people are self-indulgent souls who eat more than anyone ought appears to be no more than the baseless prejudice of the intolerant svelte."[64] Utilizing objective measurements of obesity—BMI and hip-to-waist circumference—in the evaluation criteria, however, can minimize the risk of biased adjudication and inconsistent outcomes in the evaluation of obesity. Use of such criteria would be consistent with the medically-centered definition of disability. However, the Agency's current protocols for the evaluation of obesity fail to appropriately utilize objective measurements of obesity in a manner that would promote the consistent adjudication of claims filed by similarly situated adults.

Two potential answers emerge as to why the Ruling produces inconsistencies in decision-making. First, inconsistent decision-making might be the result of inadequate protocols that have been developed by the agency following the repeal of Medical Listing 9.09 for use by ALJs and other decision makers during the disability certification process. Medical Listing 9.09 provided specific, objective criteria for the ALJ to consider in the sequential evaluation process, including the claimant's BMI,[65] as well as the presence of additional impairments. For example, Medical Listing 9.09 stipulated that a 5'0" male who weighed 246 pounds with a history of hypertension and a diastolic blood pressure consistently in excess of 100 mm Hg would have been eligible for disability at step three in the disability evaluation process.[66] In contrast, following the repeal of

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claimant, including evaluation of the claimant's age and vocational ability); *see also* WENDELL, *supra* note 10, at 12.

64. Stone v. Harris, 657 F.2d 210, 211 (8th Cir. 1981).

65. BMI describes an individual's weight-to-height ratio and is significantly correlated with total body fat content. NAT'L HEART, LUNG & BLOOD INST., CLINICAL GUIDELINES OF THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS, at xiv (1998). Obese individuals are placed into one of three classes depending on their BMI. Class I includes individuals with a BMI between 30.0 and 34.9; Class II includes individuals between 35.0 and 39.9; and Class III includes those whose BMI is greater than 40. *Id.*

66. 20 C.F.R. pt. 404, subpart P, app. 1 (2012) (amending the Medical Listings of Impairments to remove Listing 9.09, obesity). As will be discussed further in Part II, SSA uses a five-step process to evaluate disability claims. In the example stated above, the individual would be determined to be disabled at Step 3 because the individual established that the medical evidence met or medically equaled the required showing for high blood pressure, and the inquiry would end without consideration as to

Listing 9.09, the Agency's guidance for the evaluation of disability is contained within SSR 02-1p, which outlines how obesity will be evaluated in the five-step evaluation process.[67] The Ruling states that an obese individual will meet the listing if he or she has an additional impairment by itself (or in combination) that will meet or be equivalent to the requirements of a listing.[68] In other words, in the example given, the individual would only meet or medically equal the listing if he could establish the criteria contained in the listing for high blood pressure. SSR 02-1p acknowledges that obesity may increase the severity of coexisting or related impairments but provides little guidance as to how to measure the impact of obesity on these impairments.[69] Second, the Ruling notes that there is no specific level of weight or BMI that constitutes a severe impairment.[70] As such, there is great variation among the adjudicators in how obesity is evaluated in the five-step sequential evaluation process.[71] Thus, a possible explanation for inconsistency in decision-making is attributable to the lack of clear guidance from the Agency concerning the impact of obesity on co-morbid impairments.

Understanding why inconsistencies may exist in the Agency's evaluation of obesity claims requires knowledge of how the Agency evaluates obesity following the repeal of Medical Listing 9.09. Discussion of how and at what stages the SSA considers obesity may help illustrate why the current Ruling for the evaluation of obesity is inadequate.

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whether the individual retained the functional capacity to perform work.

67. SSR 02-1p, 67 Fed. Reg. 57,859 (Sept. 12, 2002).

68. *Id.* My review of the case law suggests that cases where the claimant's obesity equals a listing are rare. *See, e.g.*, Swaney v. Barnhart, No. C05-2078, 2006 WL 4079117, (N.D. Iowa Oct. 25, 2006) (holding claimant's obesity and weight related impairments were listing level). In *Swaney*, the claimant "ha[d] a BMI of 77, and need[ed] to take frequent unscheduled bathroom breaks due to his chronic diarrhea." *Id.* at *14. More frequently, an individual's obesity is evaluated in combination with other impairments. *See, e.g.*, Dogan v. Astrue, 751 F. Supp. 2d 1029 (N.D. Ind. 2010) (holding the ALJ failed to consider the claimant's obesity in combination with his degenerative joint disease of the knees and whether this condition equaled Listing 1.02A).

69. SSR 02-1p, 67 Fed. Reg. 57,859 (Sept. 12, 2002).

70. *Id.*

71. *See infra* note 199.

A. The Concept Of Disability And The Definition Of Disability

Reform of the Agency's protocol for the evaluation of obesity should focus on objective criteria that can be utilized in the adjudicatory process. In fact, this position is embraced in the statutory definition of disability. Establishing eligibility for Title II or Title XVI benefits involves consideration of both medical and vocational factors, and the statutory definition of disability embraces multiple components.[72] The Act's eligibility requirements are exclusionary because they limit the scope of coverage by excluding claimants whose inability to work is not medical in nature and whose disability is only partial.[73] This restrictive definition of disability is intended to ensure that a work-based economy[74] will survive because only the neediest individuals will be excluded from the obligations of work.[75] However, this definition was created because of the

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72. 42 U.S.C. § 423(d)(1)–(2) (2006).

> (1) The term "disability" means—
>
> inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or
>
> . . . .
>
> (2) For the purposes of paragraph (1)(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 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. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.
>
> . . . .

Id.

73. Liebman, *supra* note 11, at 840.

74. The Act attempted to balance the tension between the marketplace's need for labor with the desire to aid the unfortunate by emphasizing the social insurance aspects of the legislation instead of the public assistance nature of the program. Bloch, *supra* note 63, at 193; Diller, *supra* note 7, at 371.

75. DEBORAH A. STONE, THE DISABLED STATE 118; NAT'L ACAD. OF SOC. INS., BALANCING SECURITY AND OPPORTUNITY: THE CHALLENGE OF DISABILITY INCOME POLICY 75 (Jerry L. Mashaw & Virginia P. Reno eds., 1996) (noting that the SSA employed a strict definition of work and that a less restrictive definition would increase the costs of the disability program). There is evidence that the disability insurance program is underinclusive. Prior studies of functional and activity limitations in the United States have shown that among individuals between ages eighteen and sixty-four, only 4.4 million are receiving benefits, but three to four times as many people with some health condition or impairment

controversy surrounding the definition of disability and the process for certifying an individual's disability.[76]

The history of the development of the disability insurance program illustrates why objective medical criteria came to play such an influential role in the disability adjudication process. Social insurance for the elderly, blind, and dependent children was not introduced until 1935, and it wasn't until the 1950s that coverage was extended to the disabled worker.[77] Early public aid programs, such as Aid to Dependent Children and Aid to the Blind, reflected a belief that simply being poor was not sufficient by itself to be deemed worthy of charity to excuse non-participation in the labor force.[78] Rather, the honor of being deemed part of the deserving poor was limited to certain categories of individuals, such as children, women, and the elderly, who were not expected to maintain employment.[79]

Despite consensus that certain types of individuals deserved aid, President Roosevelt expressed a desire to see aid to the elderly tied to contribution.[80] He believed that the program would only be considered legitimate if it was an "earned" benefit, free of the stigma associated with welfare programs.[81] With passage of the Old Age Insurance (OAI) program, the elderly emerged as the first large category of poor individuals deemed part of the deserving poor.[82] However, coverage for the disabled worker was not provided at this time because of concern about the definition of disability and about the administrative burdens and potential financial strain that extending coverage for permanent disability would impose.[83] In the

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that limited their ability to work were excluded from coverage under the Act. *See* INST. OF MED., *supra* note 9, at 52. Despite any underinclusive coverage, the Social Security disability program is consistent with other insurance schemes that all rely on built-in safeguards to discourage frivolous claims. *See* NAT'L ACAD. OF SOC. INS., *supra*, at 13.

76. STONE, *supra* note 75, at 69.

77. *Id.* at 68.

78. Diller, *supra* note 7, at 372.

79. *Id.*

80. Joel F. Handler, *"Constructing the Political Spectacle": The Interpretation of Entitlements, Legalization, and Obligations in Social Welfare History*, 56 BROOK. L. REV. 899, 916 (1990).

81. *Id.* at 916–17.

82. Peter B. Edelman, *Toward a Comprehensive Antipoverty Strategy: Getting Beyond the Silver Bullet*, 81 GEO. L.J. 1697, 1704 (1993).

83. STONE, *supra* note 75, at 71–72.

early 1940s, Social Security administrators and policymakers recognized that concern about the proposed program's administrative costs flowed from the definition of disability and acknowledged a restrictive definition was necessary to eliminate unjustified claims and to protect the program's financial integrity.[84]

In the late 1940s, Congress considered a proposal advanced by President Truman to expand the Act's coverage to include disability insurance.[85] While the legislation was defeated, testimony before the Senate Finance Committee foreshadowed the role objective medical evidence would serve in the definition of disability.[86] In 1954, Congress enacted a "disability freeze," which allowed workers who became disabled to remain eligible for benefits when they reached retirement age despite no longer paying Social Security taxes.[87] Disability was defined "for this purpose as the 'inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration.'"[88] Critics of the legislation expressed concern about the open-ended criteria for disability used in the "disability freeze" program.[89] To overcome Congressional resistance, SSA officials proposed that coverage be limited to only the most severe impairments and to exclude temporary disabilities.[90]

Additionally, SSA officials moved for a restrictive definition of disability that could be shown by objective medical testing.[91] Medical impairments qualified only if they were "demonstrable by medically acceptable clinical and laboratory diagnostic techniques."[92]

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84. *Id.* at 72.
85. Bloch, *supra* note 63, at 195.
86. STONE, *supra* note 75, at 80.
87. Bloch, *supra* note 63, at 197.
88. *Id.* (quoting Social Security Amendments of 1954, ch. 1206, sec. 106, § 216, 68 Stat. 1052, 1080 (current version at 42 U.S.C. § 421(a) (2006))). This definition of disability has remained largely untouched since 1954. The requirements for eligibility were liberalized in 1958, 1960, 1965, and 1972 by "removing the age restriction, shortening the period of required work, and allowing payments for temporary impairments" that lasted more than one year. ERKULWATER, *supra* note 45, at 36.
89. Bloch, *supra* note 63, at 197.
90. ERKULWATER, *supra* note 45, at 34.
91. *Id.*
92. *Id.*

Developing a disability standard that relied on objective medical standards and clinical judgment helped mitigate fears about the disability program.[93] Supporters suggested that "emphasis on clinical determinations" would "safeguard" against fraud and thus elevate the disabled worker to the status of deserving receipt of aid.[94]

Reform of the Ruling should be possible given the objective measurements of fatness and the clinical evidence suggesting a connection between weight and disability. Given the SSA's preference to utilize objectively verifiable medical evidence, consideration has to be given to whether the criteria used in the Ruling will yield an appropriate result.

B. The Five-Step Sequential Evaluation Process

In analyzing whether applicants for SSDI/SSI benefits fall under the statutory definition of disability, decision makers[95] for the Agency employ a five-step sequential evaluation process.[96] This framework for decision-making has been accepted by the courts and observed to be an efficient and fair way to resolve disability

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93. STONE, *supra* note 75, at 83.

94. Bloch, *supra* note 63, at 198. The debate concerning passage of the SSDI/SSI program is important because it shows the Act's framers believed medical evidence to be critical in the determination of disability and identification of accurate and true claims. This belief raises the question of how SSA should use objective medical evidence to determine whether a claimant's obesity is disabling. As will be discussed in Part III, the SSA currently uses BMI to determine whether obesity is disabling, and, therefore, it is important that BMI represent an accurate way to measure the impact of obesity on the health of an individual. If BMI is not an accurate way to consider obesity, focus should shift to establishing an alternative method to measure the impact of obesity.

95. The Commissioner of Social Security has authorized state agencies, known as the Disability Determination Service (DDS), and the Social Security Administration to make decisions concerning disability applications. 20 C.F.R. § 404.1503 (2012). The Agency relies on fifty-four DDS offices to review and make a decisions on claimants' files. SOC. SEC. ADMIN., ANNUAL PERFORMANCE PLAN FOR FISCAL YEAR 2013 (2012), *available at* http://www.ssa.gov/performance/2013/FY%202013%20APP%20and%20Revised%20Final%20Performance%20Plan%20for%20FY%202012.pdf. If the application is denied, the claimant can file a request with the SSA for reconsideration. 20 C.F.R. § 404.900 (2012). If this request is denied, the claimant can appeal an adverse decision for a de novo hearing before an ALJ. *Id.* Both the DDSs and the ALJs use the five-step sequential evaluation process. *Id* § 404.1520.

96. *Id.* §§ 404.1520, 416.920. The five steps, which will be discussed further, are composed of: Step 1 determines whether an individual is performing substantial gainful activity; Step 2 looks at whether the individual has a severe impairment; Step 3 evaluates whether the claimant's impairments meet or medically equal a Medical Listing; Step 4 considers whether the claimant can perform his past relevant work; and Step 5 looks at whether there are jobs in the national economy the claimant can perform despite his impairments.

applications.[97] This process has been described as similar to a flow chart, by which the claim could resolve itself at each step or continue to the next step.[98] Each step in the five-step sequential evaluation process attempts to achieve administrative efficiency by reaching valid, reliable, and credible decisions.[99]

Step 1 is perfunctory because the Agency only considers whether the individual is actually engaged in any substantial gainful activity (SGA).[100] Substantial gainful activity includes both full- and part-time work done for pay or profit.[101] This step excludes from coverage those individuals, whose income is above SGA levels, but whose impairment reduces their work responsibilities or pay.[102] In other words, individuals with a serious impairment, such as a terminal form of cancer, who retain the ability to work as evidenced by their current wages, will fall outside the Act's coverage. To determine gainful employment, the SSA examines whether the claimant's reported income exceeds the income guidelines published in the CFR.[103] Thus, Step 1 is able to achieve valid, reliable, and credible results because the evidence of work is easily understood to be a valid measurement of the capacity for work, and the substantial gainful activity can be measured by objective means.[104]

Assuming that an individual's income is below these levels, the decision maker will proceed to Step 2 in the process, which considers whether an individual's impairments are medically severe and have lasted or are expected to last for a period of no less than 12 months or result in death.[105] At this step, the decision maker considers two questions. First, whether the medical proof can establish that the claimant has a severe impairment. Second, whether that severe

97. Bloch, *supra* note 63, at 211.
98. *Id.*
99. NAT'L ACAD. OF SOC. INS., *supra* note 75, at 92.
100. 20 C.F.R. §§ 404.1510, 404.1520(b), 404.1571, 404.1576, 404.1592(a)–(e), 416.910, 416.971–76 (2012).
101. *Id.* § 404.1572.
102. *Id.*
103. *Id.* § 404.1574.
104. NAT'L ACAD. OF SOC. INS., *supra* note 75, at 92.
105. 20 C.F.R. §§ 404.1520(c), 404.1521, 404.1523, 416.920(c), 416.921, 416.923 (2012); *see also* Bowen v. Yuckert, 482 U.S. 137 (1987).

impairment has more than a minimal effect on the claimant's ability to perform basic work activities.[106] For example, an individual whose blurred vision makes it impossible to perform his work in computer data entry will likely satisfy the requirements of Step 2, and the analysis will proceed to the next step.

Although Step 3 has been described as efficient[107] and fair,[108] this step can perhaps be intimidating to those without medical training because the analysis is confined to whether the medical evidence alone establishes that an impairment or combination of impairments is severe enough to be presumed disabling.[109] At this step the decision maker is confined to the criteria outlined in the Medical Listings. A finding that the claimant meets or equals the requirements of a listing results in a finding of disability.

If the claimant's medical impairments do not meet or medically equal a listing, the decision maker must determine the claimant's residual functional capacity (RFC).[110] A claimant's residual functional capacity is the most an individual can do on a sustained basis despite the limitations caused by his impairments.[111] The claimant's RFC will become an essential component as the analysis shifts to primarily vocational considerations in Steps 4 and 5, which are increasingly complex because the decision-maker has to consider individual medical-vocational concerns relevant to the disability standard.[112]

At Step 4, the SSA considers whether an individual's RFC would allow performance of his past relevant work.[113] At this step, the Agency will consider work performed within 15 years prior to the application for periods long enough to learn how to perform the tasks of the position. If the individual has an RFC consistent with the

106. 20 C.F.R §§ 416.921, 404.1521 (2012).
107. Bloch, *supra* note 63, at 212; *see also* IOM FINAL REPORT, *supra* note 1, at 66.
108. IOM FINAL REPORT, *supra* note 1, at 66.
109. 20 C.F.R. §§ 404.1520(d), 404.1525–.1526, 416.920(d), 416.925–.926 (2012). The Medical Listings of Impairments is found at 20 C.F.R. pt. 404, subpart P app. 1 (2012).
110. *Id.* § 404.1520.
111. *Id.* §§ 404.1520(e), 404.1545–.1546, 416.920(e), 416.945–.946.
112. Bloch, *supra* note 63, at 230.
113. 20 C.F.R. § 404.1520.

performance of his past relevant work, he will not be considered disabled and the evaluation ends. However, if the claimant can prove that his medically determinable impairment precludes performance of past relevant work, then the evaluation will proceed to Step 5 where the burden shifts to the Commissioner of the Agency to show that there are other jobs existing in significant numbers in the national economy that the claimant retains the ability to perform.

At Step 5, the SSA considers both medical and vocational factors by considering the individual's RFC, in addition to his age, education, and work experience to see if the claimant can make an adjustment to other work.[114]

An understanding of the five-step sequential evaluation process is important to consider why the Agency's current protocols for the evaluation of obesity are inadequate. The review of case law discussed in Part III shows that obese claimants remain vulnerable at the steps in the adjudication process, particularly Step 2 where the Agency has not provided adequate guidance about when obesity should be considered a severe impairment. As will be discussed in Part III, reform is needed to better articulate how decision makers should evaluate obesity at four steps in the sequential evaluation process.[115]

C. The Medical Listings Of Impairments

The Medical Listings identify conditions that the Agency considers severe enough to warrant a finding of per se disability, and until 1999 obesity was a listed impairment.[116] The Medical Listings

114. *Id.* §§ 404.1520(g), 404.1561, 404.1566–.1569(a), 416.920(g), 416.961, 416.966–.969(a); *see also id.* pt. 404, subpart P app. 2.

115. *See* discussion *infra* Part III.

116. Revised Medical Criteria for the Determination of Disability, 43 Fed. Reg. 29,955–56 (proposed July 12, 1978) (to be codified at 20 C.F.R. pts. 404, 416) ("While it is not necessary that the individual be totally incapacitated, the type and extent of such activities would, of course, depend on the functional limitations imposed by the impairment. . . . However, basi[c] to the concept of the Listing is that the type and severity of every specified impairment would not be compatible with the effective performance of gainful work activity."); Bloch, *supra* note 63, at 214. In reality, this assumption may not be entirely correct because there are individuals whose disability would meet the criteria of the Medical Listings (e.g., quadriplegics) but continue to work. However, quadriplegics who were working would be found ineligible for benefits at Step 1 of the sequential evaluation process because their wage income would

were developed shortly after the enactment of the 1954 Disability Freeze program when an advisory committee created guides that were designed to allow adjudicators to quickly identify cases where the claimant would be given disability benefits without a more thorough analysis of his capacity to work.[117] Interest in accurate[118] decision-making intensified the focus on creating a disability certification process that relied on objective medical evidence.[119] Agency administrators had the expectation that the Listings would allow for accurate and efficient adjudication of large numbers of claimants, as well as uniformity[120] in decision-making.[121] As will be discussed further in Part III, obesity should be reinstated as a listing-level impairment, and such action would further certain programmatic objectives, such as efficiency, and help build confidence in the Agency's ability to provide more uniform and consistent evaluation of obesity as a basis for disability.[122]

The Listings are perceived as accurate because they employ a heightened standard of evaluation by assuming individuals are unable to perform any gainful activity because of the presence of

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render them ineligible for benefits.

117. IOM FINAL REPORT, *supra* note 1, at 71. The first version of the Medical Listings was fairly brief in comparison to today's version. The Listings, which bore a similarity to the Veterans Administration's 1945 Schedule for Rating Disabilities, were organized into ten categories: musculoskeletal system, special sense organs, respiratory system, cardiovascular system, digestive system, genito-urinary system, hemic and lymphatic system, skin, endocrine, and nervous system, which included neurology and psychiatry. *Id*. at 72.

118. It is not unreasonable to expect that the Medical Listings are accurate in the sense that the step seeks to identify clear cases of disability in a specific manner because the criteria yields few false positives, yet this criteria needs to be sensitive to the disabled worker by identifying a substantial number of true positives. INST. OF MED. & NAT'L RESEARCH COUNCIL, THE DYNAMICS OF DISABILITY: MEASURING AND MONITORING DISABILITY FOR SOCIAL SECURITY PROGRAMS 130 (Gooloo S. Wunderlich, Dorothy P. Rice & Nicole L. Amado eds., 2002). To some extent, the choice between a system that chooses between false positives and false negatives will reflect "value judgments" concerning the consequences of these errors. NAT'L ACAD. OF SOC. INS., *supra* note 75, at 100.

119. ERKULWATER, *supra* note 45, at 34.

120. Revised Medical Criteria for the Determination of Disability, 43 Fed. Reg. 29,956 (proposed July 12, 1978) (to be codified at 20 C.F.R. pts. 404, 416) ("The Listing of Impairments insures that . . . claimants receive equal treatment nationally . . . .").

121. IOM FINAL REPORT, *supra* note 1, at 71. Presumably the Medical Listings are both highly specific because they seldom identify false positives and also are sensitive enough to identify a high percentage of true positives. INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 118, at 130.

122. *See* discussion *infra* Part III.

impairments and the associated functional limitations.[123] Even the United States Supreme Court in *Sullivan v. Zebley*[124] noted the Medical Listings were restrictive because they assumed the impairments identified would be so severe that individuals afflicted would be unable to engage in *any* work activity:

> First, the listings obviously do not cover all illnesses and abnormalities that actually can be disabling. . . .
>
> Second, even those medical conditions that are covered in the listings are defined by criteria setting a higher level of severity than the statutory standard, so they exclude claimants who have listed impairments in a form severe enough to preclude *substantial* gainful activity, but not quite severe enough to meet the listings level—that which would preclude *any* gainful activity. Third, the listings also exclude any claimant whose impairment would not prevent any and all persons from doing any kind of work, but which actually precludes the particular claimant from working, given its actual effects on him—such as pain, consequences of medication, and other symptoms that vary greatly with the individual—and given the claimant's age, education, and work experience.[125]

Presumably, this heightened standard would mitigate any concerns about whether the Medical Listings would yield accurate results because the heightened standard (i.e., any gainful activity as opposed to substantial gainful activity) would reduce the number of false

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123. 20 C.F.R. § 404.1525 (2012) ("The Listings of Impairments . . . is in appendix 1 of this subpart. It describes for each of the major body systems impairments that we consider to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience."). Following the passage of the 1967 Amendments to the Act, which established a new disability benefit for widows and widowers age 50 and above, the Agency promulgated regulations that decided the Medical Listings utilized the level of severity contemplated in the Listings. IOM FINAL REPORT, *supra* note 1, at 74.

124. Sullivan v. Zebley, 493 U.S. 521 (1990), *superseded by statute on other grounds*, 42 U.S.C. § 1382c(a)(3)(C).

125. *Id.* at 533–34.

positives.[126] Additionally, the Medical Listings confine administrative discretion, in part, because the decision maker will not consider vocational factors, such as age, education, and prior work experience.[127]

"The Listings are organized by 14 major body systems (e.g., musculoskeletal impairments, respiratory impairments, neurological impairments)" and have been revised to include multiple body systems.[128] The Medical Listings should be credible because they theoretically reflect current medical opinion[129] and involve highly detailed diagnostic criteria that require the production of specialized medical evidence.[130] Each Medical Listing begins with an introduction that identifies the relevant concepts discussed in that Listing.[131] The introduction is followed by a "Category of Impairments" section, which outlines the specific criteria (e.g., medical signs, symptoms, and laboratory findings) that describe the required level of severity for each impairment listed in that body system.[132] A few Medical Listings are evaluated on the basis of a diagnosis alone (e.g., certain cancers), but most Listings require a diagnosis plus the presence of clinical findings or assessment of functional outcomes.[133]

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126. IOM FINAL REPORT, *supra* note 1, at 91.

127. JERRY MASHAW, BUREAUCRATIC JUSTICE: MANAGING SOCIAL SECURITY DISABILITY CLAIMS 108 (1983).

128. IOM FINAL REPORT, *supra* note 1, at 67.

129. STONE, *supra* note 75, at 100. The Medical Listings, however, have been criticized for being out-of-date because they do not accurately reflect current medical knowledge and technology. SOC. SEC. ADVISORY BD., HOW SSA'S DISABILITY PROGRAMS CAN BE IMPROVED 23 (1998), *available at* http://www.ssab.gov/Publications/Disability/report6.pdf; *see also* INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 118, at 130. Significant changes to the Medical Listings have been few and far between. Between 1955 and 1967 the Listings were revised frequently as they were only based on operating experience. IOM FINAL REPORT, *supra* note 1, at 74. The first significant revision of the Listings occurred in 1977 when the Agency published a new set of criteria that would apply to children applying for SSI. *Id.* In 1979, the SSA issued a comprehensive update to adult listings. *Id*. In 1984, Congress directed that the Listings are intended to make the decision-making process more efficient by identifying cases that can be disposed of more quickly at the initial stages of the process. *See id.* at 74–75. Despite recent revisions to the Medical Listings in the last ten years, the IOM still recommended that the Agency engage in more frequent revision to ensure the Medical Listings remain consistent and reflective of current accepted medical opinion. *Id*. at 100.

130. INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 118, at 129.

131. Bloch, *supra* note 63, at 214.

132. *Id.*

133. IOM FINAL REPORT, *supra* note 1, at 67. SSA executives have suggested that use of the Medical

The Medical Listings were also developed as a tool to increase the efficiency of the disability certification process. The speed of case processing is a major concern, especially in light of the backlog.[134] Thus, the Agency should be concerned with ensuring that the Medical Listings remain an effective mechanism to process disability applications in a timely manner. In the earliest days of the Medical Listings, the Listings accounted for more than 90% of the initial allowances; since then, that number has declined, and in 2000, the Medical Listings accounted for 60% of the allowances.[135] The number of claims that have been allowed at Step 3 by meeting or equaling the Medical Listings has declined to about 50%.[136] This is a

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Listings began to decline as a basis for allowance due to a perception that the Medical Listings moved away from medical criteria to evaluation of functional standards. *Id.* at 80. There has been some criticism that the disability certification process relies too heavily on medical evidence to establish disability because disability assessments should consider functional assessments. STONE, *supra* note 75, at 93. Advocates of a more functional approach to disability assessment triumphed with the passage of the 1984 Social Security disability reform bill, which required the Agency to revise its mental disorders listing criteria. ERKULWATER, *supra* note 45, at 157. The new rules adopted by the Agency in 1985 placed greater emphasis on individual limitations by providing additional detail about disorders and reworking the functional measures of mental disorders on activities of daily living, social functioning, or concentration, persistence, and pace. *Id.* at 177–80. Despite these significant changes, the IOM rejected the notion that the Medical Listings had never considered functional limitations because the Agency's listings had, to some degree, always considered functional limitations. IOM FINAL REPORT, *supra* note 1, at 83 (describing Listings dating back to 1967 that contained functional criteria). In fact, functional limitations are measured in medical examinations that measure cardiovascular performance under high-exertional requirements, such as treadmill stress tests or ejection fraction tests; range of motion tests to assess musculoskeletal conditions; and diagnostic tests that include medical evidence of symptomatology are used for mental disorders. STONE, *supra* note 75, at 94; *see also* 43 Fed. Reg. 29955 (proposed July 12, 1978) (to be codified at 20 C.F.R. pt. 404) ("These criteria indicate an individual's lack of ability to perform significant functions such as moving about, handling objects, hearing or speaking, or, in the case of mental impairments, reasoning and understanding."). Interestingly, Medical Listing 9.09 also contained functional criteria in addition to the criteria for height and weight. Even though medically centered evidence of disability enhances the public perception of validity, administrative efficiency, and credibility of the disability certification process, functional assessments of disability provide an equally valid test of work disability because these assessments relate to the needs of the marketplace. STONE, *supra* note 75, at 96.

134. *See generally SSA Disability Cases Continue to Climb: Rise in Backlog as of September 2011*, TRAC (Nov. 3, 2011), http://trac.syr.edu/tracreports/ssa/266/ [hereinafter TRAC]. Although it is difficult to measure, the cost of delay may impose a significant psychological burden on a claimant regardless of the severity of the claim. MASHAW, *supra* note 127, at 98.

135. IOM FINAL REPORT, *supra* note 1, at 80.

136. INST. OF MED. OF THE NAT'L ACADS., IMPROVING THE SOCIAL SECURITY DISABILITY DECISION PROCESS: INTERIM REPORT 16 (2006).

decline from the first years of the program when a high number of allowances were found to meet or medically equal a listing.[137]

If the Medical Listings are properly drafted, they will promote efficient resolution of a disability application and should provide a reliable and credible decision because they should be based on current and pervasive medical opinion.[138] Additionally, a valid result can be achieved by setting a high threshold of impairment severity.[139] To evaluate whether a Medical Listing can yield a valid result, four criteria should be considered: (1) the Medical Listing should be facially valid and reflect current disability evaluation standards; (2) the Medical Listing should be an accurate prediction of the inability to work; (3) there should be a high correlation between the Medical Listing and not engaging in substantial gainful activity; and (4) there should be an association between meeting a Medical Listing and an inability to perform the functional criteria of work.[140]

Applying these criteria to obesity establishes a close nexus between extreme obesity and a decreased ability to work.[141] The next section will discuss how the objective medical evidence can be used to establish the connection between extreme obesity and an inability to work.

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137. IOM FINAL REPORT, *supra* note 1, at 80.

138. STONE, *supra* note 75, at 93; *see also* Revised Medical Criteria for the Determination of Disability, 43 Fed. Reg. 29,955, 29,956 (proposed July 12, 1978) (to be codified at 20 C.F.R. pts. 404, 416) ("The Listing of Impairments insures that determinations utilizing these guides have a sound medical basis, that claimants receive equal treatment nationally, and that a preponderance of individuals who are unable to engage in any gainful activity can be readily identified.").

139. STONE, *supra* note 75, at 93.

140. DISABILITY RESEARCH INST., MEDICAL LISTINGS VALIDATION CRITERIA 5 (Aug. 16, 2001), *available at* http://www.dri.uiuc.edu/research/p01-02c/related_project_validation_p01-02c.doc.

141. *See, e.g.*, Roberts v. Barnhart, 283 F. Supp. 2d 1058, 1067 (S.D. Iowa 2003) (finding both that the claimant had a BMI greater than 30 and that her doctors indicated she would be unable to work because of her body odor, urination in chairs, and inability to interact appropriately with others in the workplace).

III. MEDICAL LISTING 9.09 AND THE AGENCY'S CURRENT PROTOCOLS FOR THE EVALUATION OF OBESITY

The Agency's repeal of Medical Listing 9.09 should be of particular concern for the Agency[142] because obesity is an increasingly common condition in the United States.[143] From 1980–2007, the numbers of individuals receiving disability benefits nearly doubled from 4.68 million to 8.92 million recipients. Scholars have found there may be a correlation between obesity and disability and have suggested that fatness levels can be used to predict future application for disability insurance.[144]

In addition to looking at the Agency's current protocols for the evaluation of obesity, this section will also consider the repeal of Medical Listing 9.09 and the reasons advanced by the Agency in enacting this change. The goals of the program are in many ways shaped by the choices the Agency makes in its administration of the disability adjudication process. Professor Mashaw notes there are subtler ways the Agency shapes the values of the program; for example, the choice to elicit input from a physician or vocational expert will shape the decisional output.[145] Professor Mashaw notes

142. In the disability insurance context, the SSA recognizes that obesity is a medically determinable impairment when it significantly limits an individual's mental or physical functional capacity to do basic work activities. *See* SSR 02-1p, 67 Fed. Reg. 57,859, 57,860–61 (Sept. 12, 2002).

143. *See, e.g.*, Huiyun Xiang et al., *supra* note 5, at 99 (noting the prevalence of obesity has risen from 15% in the mid-1970s to 32.9% in 2003–2004).

144. Richard V. Burkhauser, John Cawley & Maximilian D. Schmeiser, *The Ability of Various Measures of Fatness to Predict Application for Disability Insurance* 16–23 (Univ. of Mich. Ret. Research Ctr., Working Paper No. 2008-185, 2008), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1337648. Professor Burkhauser's study considered the accuracy of three measurements in predicting application for disability insurance: total body fat, percent of body fat, BMI, waist circumference, and waist-to-hip ratio. *Id.* Professor Burkhauser made several findings that suggest that the Agency's current evaluation protocols are inadequate. First, none of the measures of fatness or obesity accurately predicted disability insurance applications of African-American males. *Id.* Second, for white men, BMI consistently predicted DI application. *Id.* Third, for white women, all measurements of fatness predicted SSDI application, but waist circumference and waist-to-hip ratio more accurately predicted outcomes. *Id*. Third, for African-American women, measures of abdominal fatness were the most predictive factors of SSDI application. *Id*. In addition to Professor Burkhauser's work, numerous scholars have considered the relationship between obesity (as measured by BMI) and disability. These studies did not consider the relationship between obesity and application for disability benefits; rather, they defined disability as the loss of ability to participate in activities of daily living. *See, e.g.*, Ferraro et al., *supra* note 1.

145. MASHAW, *supra* note 127, at 60.

these choices concerning inputs may have a profound impact on the character of the disability program.[146] Thus, a goal of this section is to explore why the Agency repealed Medical Listing 9.09 and to consider whether this action sufficiently muddled the evaluation criteria to the point where inconsistent evaluation resulted. In other words, we should be able to look back at the reasons advanced for the repeal to determine whether the effect satisfies our current expectations of what the disability program represents.[147] To the extent that these emerging trends are inconsistent with our expectations, reform should focus on the development and implementation of better norms that will help achieve the promise of the disability program.[148]

A. Medical Listing 9.09

Medical Listing 9.09[149] was proposed on July 12, 1978 out of recognition that obesity could be evaluated by looking at common complicating factors.[150] The Listing acknowledged that long-term obesity is often associated with musculoskeletal, cardiovascular, peripheral vascular, and pulmonary impairments:[151]

> 10.01 Category of Impairments, Multiple Body Systems[152]
>
> . . . .
>
> . . . and one of the following:
>
> A. History of pain and limitation of motion in any weight

146. *Id.* Professor Mashaw notes the choice is between a program that provides coverage to individuals who are not able to work because of their impairments, or a broader conception of the program that provides aid to those who cannot work for a number of factors, including a medically determinable impairment. *Id.*

147. *Id.* at 61.

148. *Id.*

149. When originally proposed and subsequently adopted, Medical Listing 9.09 was classified under Medical Listing 10, Multiple Body System.

150. Revised Medical Criteria for the Determination of Disability, 43 Fed. Reg. 29,955, 29,957 (proposed July 12, 1978) (to be codified at 20 C.F.R. pts. 404, 416).

151. *Id.* at 29,966.

152. Medical Listing 9.09 contained two tables with a sliding scale based on height and weight. *Id.* For men, the table began with individuals who were 60 inches tall and weighed 246 pounds, which would be a BMI of 48. *Id.* For women, the table began with individuals who were 56 inches tall and weighed 208, which would also be a BMI of 48. *Id.*

> bearing joint or spine (on physical examination) associated with X-ray evidence of arthritis in a weight bearing joint or spine; or
>
> B. Hypertension with diastolic blood pressure persistently in excess of 100 mm. Hg measured with appropriate size cuff; or
>
> C. History of congestive heart failure manifested by past evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema; or
>
> D. Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or
>
> E. Respiratory disease with total forced vital capacity equal to or less than 2.0 L or a level hypoxemia at rest equal to or less than the values of the following table[.][153]

Thus, the criteria outlined in the Medical Listing evaluated both an individual's BMI as well as evidence of medical and functional limitations. Paragraphs A–E all required evidence that could be established by objective medical testing or other objective criteria (e.g., X-rays, blood pressure).

The long history of revisions to Medical Listing 9.09 reflects the Agency's difficulty in determining the proper standards to utilize in the evaluation of obesity claims. In addition to measuring the functional limitations caused by obesity, Listing 9.09 also examines other impairments that are evaluated in other sections of the Medical Listings. When the final Medical Listings were published, the Agency indicated it received one comment during the notice period expressing concern that the criteria for obesity would have little impact because the criteria outlined in Paragraphs A through E were sufficient to establish disability without consideration of the claimant's obesity.[154] The Agency responded by noting that the criteria specified in these paragraphs were different from the criteria utilized in other sections of the Medical Listings.[155] For instance, the

153. *Id.*

154. Revised Medical Criteria for the Determination of Disability, 44 Fed. Reg. 18,170, 18,175 (Mar. 27, 1979) (to be codified at 20 C.F.R. pts. 404, 416).

155. *Id.*

Agency noted the Medical Listing for musculoskeletal impairments required a showing of advanced joint pathology for claimants with arthritis in a weight-bearing joint, but such a showing was not required to meet the requirements of Paragraph A.[156]

Perhaps the Agency realized the criteria utilized in Listing 9.09 overlapped with other Medical Listings when, in 1982, it proposed a revision to the listing which would have eliminated the evaluation criteria in Paragraphs A–E and focused solely on claimant's weight and height.[157] According to the Agency, the revision was necessary because disabling complications related to the respiratory, cardiovascular, or musculoskeletal system could be assumed when an individual's obesity reached an extreme level.[158] The Agency still felt it was necessary for individuals whose weight did not reach these extreme levels to be evaluated for obesity due to complications to various body systems that could be caused by obesity.[159] The proposed revision to Listing 9.09 proved to be controversial, and the Agency cited two primary concerns raised by the public in the publication of the final rule. First, the Agency noted extensive comments suggesting that the stricter weight criteria would exclude individuals slightly less overweight, but still disabled.[160] Second, the Agency also noted a large number of comments concerning whether obesity by itself should be a basis for disability.[161] These two themes are very important to any future reform of the Agency's evaluation protocols for obesity because the credibility of the disability adjudication process depends on whether benefits are distributed to all eligible individuals who have been determined to be deserving of benefits consistent with the purposes of the Act. The perception of a randomized disability adjudication system is an affront to basic

156. *Id.*

157. Revised Medical Criteria for the Determination of Disability, 47 Fed. Reg. 19,620, 19,624 (proposed May 6, 1982) (to be codified at 40 C.F.R. pt. 404) (proposing changes to utilize tables that would provide disability for weights approximately 100 percent above the average weights for men and women at specific heights).

158. *Id.*

159. *Id.*

160. Revised Medical Criteria for the Determination of Disability, 50 Fed. Reg. 50,068, 50,070 (Dec. 6, 1985) (to be codified at 40 C.F.R. pt. 404).

161. *Id.*

process values that the public demands even from mass justice bureaucracies like the Agency and is symbolic of the Agency's failure to create a process that will be viewed as legitimate.[162]

Questions about how best to evaluate obesity claims persisted, and the Agency proposed the repeal of Medical Listing 9.09 on March 11, 1998 because, in the Agency's opinion, the Medical Listing did not contain appropriate indicators of listing-level severity, nor could the Listing's criteria identify individuals whose functional limitations would limit their ability to engage in gainful activity.[163] The Agency further explained that it proposed deleting Listing 9.09 because the Agency's adjudicative experience convinced it that the Medical Listing was difficult to apply, and there was concern that the listing required a finding of disability for some individuals who were clearly not disabled.[164] To determine whether Medical Listing 9.09 was effective, the SSA conducted a review of a small number of cases and found that the deletion of Medical Listing 9.09 would not have impacted those determinations.[165] In fact, the SSA concluded that in the majority of cases studied, individuals who were found disabled based on a finding that their impairments met or medically equaled Listing 9.09 would have been found disabled at Step 5 of the sequential evaluation process.[166] However, the Agency also noted

162. MASHAW, *supra* note 127, at 93.

163. Revised Medical Criteria for the Determination of Disability, Endocrine System and Related Criteria, 64 Fed. Reg. 46,122, 46,123 (Aug. 24, 1999) (to be codified at 40 C.F.R. pt. 404). The Agency's concerns are not surprising considering the Medical Listings are meant to be a screen to identify true positives, and the criteria should be so specific to identify and eliminate false positives. *See* IOM FINAL REPORT, *supra* note 1, at 90.

164. Revised Medical Criteria for the Determination of Disability, Endocrine System and Related Criteria, 64 Fed. Reg. at 46,125. While there is a cost associated with a false positive, the Agency ignored the total costs of erroneous denials. In other words, there is a demoralization cost as a result of a false negative because the false negative can undermine our confidence in the ability of the Agency to accurately administer the disability program. MASHAW, *supra* note 127, at 86. Elimination of the Medical Listing would require that the decision makers conduct an individualized inquiry that could be more subjective and lend itself to inconsistent decision-making. *See id.* Thus, a problem that emerges is not that the process itself is error-prone but that the process leads to the perception of inconsistent decision-making among similarly situated claims. *See id.*

165. Revised Medical Criteria for the Determination of Disability, Endocrine System and Related Criteria, 64 Fed. Reg. at 46, 46,125; INST. OF MED. OF THE NAT'L ACADS., *supra* note 136, at 58.

166. Revised Medical Criteria for the Determination of Disability, Endocrine System and Related Criteria, 64 Fed. Reg. at 46,125. There are numerous examples that this argument might be correct. *See, e.g.*, Celaya v. Halter, 332 F.3d 1177 (9th Cir. 2003). However, these examples support reform that

that in a significant number of cases those individuals would not have been found disabled under other Medical Listings or Step 5.[167] Although this was the type of investigation that the IOM noted was necessary to improve the accuracy of the Listings, the IOM noted the Agency's inquiry was too small to be conclusive.[168] The repeal of Medical Listing 9.09 perhaps had an unintended consequence. As a listing level impairment, the Agency effectively was communicating that obesity was per se disabling, but with the repeal of the listing, it was also communicating that obesity was no longer considered as severe as other listing level impairments.[169]

B. The Agency's Current Protocols For The Evaluation Of Disability: SSR 02-1p

Following the repeal of Medical Listing 9.09, the Agency ultimately adopted SSR 02-1p, which defines obesity as a "complex, chronic disease characterized by excessive accumulation of body

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would enable more efficient adjudication by targeting individuals who are likely to be granted benefits. In *Celaya*, the claimant was 5'7", and her weight fluctuated between 205–213 pounds. *Id.* at 1179. On appeal, Celaya argued that she met Medical Listing 9.09, but the court rejected this argument because the record did not establish that her weight was above the Medical Listing's requirement that her weight exceed 212 pounds for at least one year. *Id.* at 1181. Despite this finding, the Ninth Circuit remanded the case for further consideration of whether the claimant's obesity would have impacted her ability to perform her prior relevant work. *Id.* at 1184. While Celaya was granted benefits, she could have possibly experienced financial and/or psychological hardship during the pendency of her disability application. *Id.* Celaya first applied for benefits in August of 1996, and the ALJ's decision became final on February 25, 2000. *Id.* at 1179–80. On June 13, 2003, the Ninth Circuit remanded the case back to the Agency for further consideration. *Id.* Thus, Celaya had to wait at least seven years for a decision on her disability application. In addition to the financial and psychological costs for Celaya, the administrative costs for adjudication of Celaya's application must have been high as well. Positive reform in the evaluation should seek to eliminate these costs to both the claimant and taxpayer by identifying objective criteria that would indicate a high likelihood of limitation as the result of disability. *See also* Henriksen v. Astrue, No. 07C6142, 2008 WL 4155175, at *9 (N.D. Ill. Sept. 9, 2008) (acknowledging that the claimant's BMI would have qualified her for benefits under Medical Listing 9.09).

167. Revised Medical Criteria for the Determination of Disability, Endocrine System and Related Criteria, 64 Fed. Reg. at 46,125. While a finding that Medical Listing 9.09 had resulted in false positives is problematic and suggests the Listing was in need of revision, it is possible this finding could have been reached after a review of cases involving other Medical Listings. However, the Agency has not conducted substantive investigations into other Medical Listings. IOM FINAL REPORT, *supra* note 1, at 93. The IOM noted there is a need for the Agency to engage in a systematic and substantive review of the Medical Listings. *Id.*

168. IOM FINAL REPORT, *supra* note 1, at 93.

169. MASHAW, *supra* note 127, at 67.

fat," and concludes that "[o]besity is generally the result of a combination of factors (e.g., genetic, environmental, and behavioral)."[170] While the Ruling utilizes BMI as a method to determine the presence of obesity, the Agency notes that using BMI to determine whether an individual is obese can result in both false positives and false negatives.[171] The Ruling acknowledges that there are other measurements of body fat but notes the Agency will not purchase these additional tests on behalf of the claimant because of the Agency's belief that the medical or other evidence in the case file will be sufficient to establish whether the claimant is obese.[172]

In addition to providing guidance on how to determine if a claimant is obese, SSR 02-1p contains relatively straightforward instruction as to how to determine whether obesity constitutes a severe impairment at Step 2. The Ruling notes there is no specific level of weight or BMI that equates with a severe or not severe impairment.[173] Additionally, descriptive terms contained in the claimant's medical records for levels of obesity (e.g., "severe," "extreme," or "morbid" obesity) can be used to establish whether obesity is or is not a "severe impairment."[174] Rather than using a specific weight cut-off, the Agency uses an individualized assessment to determine whether the impairment more than minimally affects an individual's ability to perform basic work activities.[175]

At Step 3, the Ruling further states that obesity, by itself or in combination with other impairments, might be medically equivalent to a listed impairment.[176] Additionally, in cases involving the Listing

170. SSR 02-1p, 67 Fed. Reg. 57,859 (Sept. 12, 2002).

171. Like the NIH's guidelines, NAT'L HEART, LUNG & BLOOD INST., *supra* note 65, SSA utilizes three categories of obesity. Level I includes BMIs of 30.0–34.9; Level II includes BMIs of 35.0–39.9; Level III, which the Agency terms "extreme obesity," represents the greatest risk for developing obesity-related impairments and includes BMIs greater than or equal to 40.

172. SSR 02-1p, 67 Fed. Reg. 57,859, 57,860–61 (Sept. 12, 2002). The Agency's expressed view that false positives and false negatives could occur because BMI does not distinguish between fat and muscle is consistent with medical literature.

173. *Id.* at 57,861–62.

174. *Id.*

175. *Id.*

176. *Id.* at 57,862.

for adult and child mental retardation, extreme obesity will satisfy the requirement for a physical impairment imposing additional and significant limitations.[177] But equivalence is a tricky matter.[178] The Ruling does put adjudicators on notice that obesity can affect physical and mental health.[179] In addition, the Ruling added prefaces to three listings—musculoskeletal, respiratory, and cardiovascular—to provide guidance about the potential effects of obesity.[180] For instance, Medical Listing 1.00Q (musculoskeletal) provides:

> [] *Effects of obesity*. Obesity is a medically determinable impairment that is often associated with disturbance of the musculoskeletal system, and disturbance of this system can be a major cause of disability in individuals with obesity. The combined effects of obesity with musculoskeletal impairments can be greater than the effects of each of the impairments considered separately. Therefore, when determining whether an individual with obesity has a listing-level impairment or combination of impairments, and when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity, adjudicators must consider any additional and cumulative effects

177. *Id.*

178. *See* MASHAW, *supra* note 127, at 112–13. Professor Mashaw noted disability examiners gave him five possible explanations as to what equivalence means: (1) the claimant has substantial problems but does not quite meet the criteria of any of the Medical Listings; (2) the objective medical evidence is very close to the requirements of the Medical Listings, and the claimant has substantial pain similar to what would be expected for that impairment; (3) the disease is similar to a listed impairment, but there is no listing that squarely addresses the disease; (4) the diagnosis was obtained through different testing than what was contemplated in the Medical Listings; (5) the claimant has two or more conditions that either both approach a listing's criteria or have cumulative effects that equal one listing. *Id.*

179. SSR 02-1p, 67 Fed. Reg. 57,859, 57,861 (Sept. 12, 2002) ("Obesity is a risk factor that increases an individual's chances of developing impairments in most body systems. It commonly leads to, and often complicates, chronic diseases of the cardiovascular, respiratory, and musculoskeletal body systems. Obesity increases the risk of developing impairments such as type II (so-called adult onset) diabetes mellitus—even in children; gall bladder disease; hypertension; heart disease; peripheral vascular disease; dyslipidemia . . . ; stroke; osteoarthritis; and sleep apnea. It is associated with endometrial, breast, prostate, and colon cancers, and other physical impairments. Obesity may also cause or contribute to mental impairments such as depression. The effects of obesity may be subtle, such as the loss of mental clarity and slowed reactions that may result from obesity-related sleep apnea.").

180. *Id.* at 57,859.

of obesity.[181]

Interestingly, the prefaces to Medical Listings 3.00I and 4.00F are nearly identical and do not provide instruction specific to each respective bodily system.[182] Given the similarities between the instructions for how to evaluate obesity among these three Medical Listings, the Agency's commitment to ensuring its adjudicators will consider the effects of obesity is somewhat questionable.[183]

The Ruling also provides that equivalence will be appropriate if an individual has multiple impairments, including obesity, no one of which meets or equals the requirements of a listing but the combination of which is equivalent in severity to a listed impairment.[184] As an illustration, the Ruling notes that "obesity affects the cardiovascular and respiratory systems because of the increased workload the additional body mass places on these systems."[185] The Ruling suggests that obesity makes it harder for the chest and lungs to expand, which ultimately makes the heart work harder to pump blood to carry oxygen to the body.[186] This does suggest what the cumulative impact of obesity could be but seems to have been drafted as to allow a decision maker sufficient discretion to avoid false positives. However, by drafting criteria that reflect what is known about the specific, objective findings that should be present, the Agency could avoid false negatives.

Like the criteria outlined for the evaluation of obesity at Step 3, the criteria utilized for determining the functional impact of obesity at Steps 4 and 5[187] in the evaluation process are sufficiently vague enough to support both false positives and false negatives.[188] The

181. 20 C.F.R. § 404, subpart P, app. 1, § 1.00Q (2012).
182. *See id.* § 404, subpart P, app. 1, §§ 3.00I, 4.00I.
183. In a large organization such as the SSA, communication within the Agency can be difficult. *See* MASHAW, *supra* note 127, at 66. Here, the Agency is able to communicate a clear point—obesity has an impact on other bodily systems—but the message about how to consider the impact on obesity on a particular impairment is difficult to communicate. *See id*. at 66–67.
184. SSR 02-1p, 67 Fed. Reg. 57,859, 57,862 (Sept. 12, 2002).
185. *Id.*
186. *Id.*
187. Step 3 for children. *See id.*
188. For adults, this assessment will be utilized at Steps 4 and 5; for children at Step 3. *Id.*

Ruling notes that obesity can cause limitation of function and limitations in exertional and postural requirements, gross and fine motor skills, and the ability to be exposed to certain elements, such as heat or humidity.[189] Additionally, the Ruling notes the combined effects of obesity with other impairments may be greater than might be expected without obesity.[190] For example, the Ruling suggested that someone with obesity and arthritis affecting a weight-bearing joint might have more pain and limitation than might be expected from the arthritis alone.[191] The Ruling provides that an assessment of the claimant's residual functional capacity (RFC) should examine the effect obesity has upon the individual's ability to perform routine movement and necessary physical activity within the work environment. The ALJ should account for the claimant's medically determinable obesity in the RFC, even if she does not determine that the claimant's obesity is severe.[192]

While this Ruling seems relatively straightforward, a review of the case law suggests decision makers struggle with how to analyze obesity in accordance with the Ruling.[193] In the next section, I will explore how variations in application of the Ruling in the adjudication process create points of vulnerability in the five-step sequential evaluation process for obese claimants.

IV. THE AGENCY'S EVALUATION OF OBESITY FOLLOWING THE REPEAL OF MEDICAL LISTING 9.09 AND THE QUEST FOR GOOD DECISION-MAKING

In my review of 926 appeals of adverse ALJ determinations following the repeal of Medical Listing 9.09, no discernible trend in outcomes emerges, even among claimants with a higher BMI level.[194] For instance, in cases involving individuals with a BMI

189. *Id.*
190. SSR 02-1p, 67 Fed. Reg. 57,859, 57,862 (Sept. 12, 2002).
191. *Id.*
192. *Id.* at 57,863.
193. *See* discussion *infra* Part IV.A.
194. *See* data on file with author.

greater than 48, which is the level at which disability would have been granted under Medical Listing 9.09, the Agency was reversed in approximately 42% of the cases reviewed.[195] At first glance, these numbers do not appear to be problematic. After all, the disability determination process is an individualized process that takes into account a claimant's medical and vocational situation. However, given what the medical literature suggests about the etiology of obesity and the impact of obesity on health and functional limitation, the lack of some level of consistency, particularly among those individuals with a BMI greater than 48, is somewhat surprising. But one question still persists: Why should we care about patterns of inconsistency within decision-making patterns at a mass justice bureaucracy like the Agency?

The answer is simple. The disability insurance program does not share the same level of public confidence as other bureaucratic programs because of the perception that the Agency is unable to administer the program in a uniform and consistent manner.[196] Further, the high degree of variability in outcomes seems to be inconsistent with a program that is intended to operate uniformly throughout the United States and is based on a statutory definition of disability that has not been substantially revised in thirty years.[197] When cases within an office are randomly assigned, as they should be, the level of inconsistency discussed in this Article means that the most important decision in the disability certification process may be the decision made by the hearing office clerk who assigns cases to ALJs.[198]

This section will explore two points. First, this section will discuss the findings of my review of the case law that establishes variations in results between similarly situated obese individuals. Second, the various points of vulnerability for obese claimants in the sequential evaluation process will be discussed.

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195. *Id.*

196. SOC. SEC. ADVISORY BD., *supra* note 129, at 17.

197. *Id.* (noting Agency administrator stated that disability is not a national program).

198. SOC. SEC. ADMIN., SOCIAL SECURITY ADMINISTRATION'S PROGRAM OPERATIONS MANUAL (2013), *available at* https://secure.ssa.gov/apps10/poms.nsf/Home?readform.

A. Review Of Case Law

Other studies have looked at variation and inconsistency in decision-making between the states, between the ALJs, and within the federal judiciary. In light of prior work in this area, I decided to focus inconsistency in decision-making regarding one type of impairment—obesity. Looking at a single impairment helps clarify the issue of horizontal equity and is a necessary task to assess the fairness and effectiveness of certain protocols, such as SSR 02-1p.[199] I chose to look at disability applications involving obese claimants because I thought it would be possible to identify similarly situated claimants by considering the claimants' BMIs. I looked only at cases that were appealed to the federal courts. After isolating disability appeals of Title II or Title XVI applications that considered obesity following the repeal of Medical Listing 9.09, I refined my search by looking at cases where either the BMI could be ascertained because the reviewing court explicitly stated the claimant's BMI or because it could be calculated from the claimant's height and weight. This step significantly narrowed the pool of cases. This search included cases where the claimant did not allege obesity as a severe impairment.

After identifying cases in which the BMI could be determined, each case was then reviewed for the following factors: (1) the age of the claimant; (2) the gender of the claimant; (3) whether the claim was remanded or reversed; whether obesity was to be considered on remand; (4) whether the individual applied for Title II or Title XVI benefits; (5) the step at which the ALJ decided the claim; and (6) the claimant's other severe impairments.[200]

The results of this survey support a conclusion that reform of the Ruling is needed. Overall, the Agency was reversed in 42% of the cases examined, and the decisions of the ALJ were affirmed 58% of the time.[201] Approximately 66% of the cases surveyed involved female claimants, whereas 34% involved men.[202] Of the cases that

199. SOC. SEC. ADVISORY BD., *supra* note 50, at 8.
200. I will not discuss the findings for age and type of application in this Article.
201. Data on file with author.
202. *Id.*

were reversed, the ALJ was specifically directed to consider the claimant's obesity in 42% of the cases.[203] The BMI distribution was as follows: BMI 25-29 (2%); BMI 30-34 (15%); BMI 35-39 (25%); BMI 40-47 (33%); and BMI 48+ (24%).[204] Three points stand out.

First, one of the most striking patterns that emerged is that the overwhelming majority of cases reviewed involved women, especially in light of research that suggests that BMI may not be the most accurate predictor of the impact of weight on women's health. Since my preliminary review of all cases where BMI could be ascertained showed that the vast majority of these cases involved women, further study should look at the relationship of gender and obesity.[205] If women are applying for disability more frequently than men, the Agency should seek to revise its evaluation protocols to include consideration of alternative methods of ascertaining the impact of weight on health.

The second point of interest concerns the high percentage of these individuals who potentially could have met Medical Listing 9.09. Despite attempts by the Agency to address concerns about backlog, processing time, and inconsistency, it is troubling that approximately 24% of these claimants could have had their claims decided at the DDS level or at an earlier step in the sequential evaluation process.[206] Further, over 57% of the cases involved claimants with BMI of 40 or higher, which is level 3, or morbid obesity.[207] Not surprisingly, the reversal rates for individuals with a BMI greater than 40 were higher than the reversal rate for individuals with Level I or II obesity.[208] However, the reversal rate for individuals with a BMI greater than 48 was still only 44%, which is surprising because of the medical

203. *Id.*

204. *Id.*

205. Obesity may not be the only impairment that seems to disproportionately affect women. *See* Purvis, *supra* note 54, at 116 (noting the need to develop more accurate protocols for the evaluation of fibromyalgia claims given the gendered nature of the patient base).

206. Data on file with author.

207. *Id.*; *see also infra* Part V (noting that current medical research reflects that individuals whose BMI exceeds 40 will experience additional risks, including increased risk of mortality).

208. Data on file with author.

literature that suggests obesity at this level has a profound impact on health and functional ability.[209]

Cases of individuals with a BMI greater than 48 should have produced more consistent outcomes for two reasons. First, research into the impact of obesity on other impairments has enlarged our understanding of how obesity contributes to other conditions.[210] This knowledge base combined with research into how obesity interacts with other factors, such as age, should give adjudicators a reasonable picture of what to expect from individuals with an increasing BMI.[211] Second, studies reflecting exactly how obesity diminishes functional limitations suggest that more predictable decision-making patterns can be achieved.

The third major point indicates the importance of Step 2 in the sequential evaluation process. Overall, the ALJs determined that obesity was a severe impairment in 61% of the cases surveyed and was not in 33% of the cases.[212] Of cases where the ALJ determined obesity to be a severe impairment, the ALJs were affirmed 64% of the time.[213] This factor may have impacted the reversal rate as evidenced by cases where the ALJ did not determine obesity was a severe impairment. In those cases, the ALJs were affirmed in 56% and reversed in 43% of the decisions.[214] In other words, ALJs were affirmed at a higher rate if the ALJ listed obesity as a severe impairment.

This review also considered whether a claimant alleged obesity to be a severe impairment. Here, claimants listed obesity as a severe

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209. *Id.*; *see also infra* Part V.

210. Michele M. Hooper, *Tending to the Musculoskeletal Problems of Obesity*,73 CLEVELAND CLINIC J. MED. 839, 840–41 (2006) (finding that risk of osteoarthritis of the knee, rotator cuff tendinitis, and lower back pain increases with increasing BMI). *See generally* Steven M. Koenig, *Pulmonary Complications of Obesity*, 321 AM. J. MED. SCI. 249 (2001) (exploring impact of obesity on pulmonary disorders).

211. *See, e.g.*, U. Evers Larsson & E. Mattsson, *Functional Limitations Linked to High Body Mass Index, Age and Current Pain in Obese Women*, 25 INT'L J. OBESITY 893, 897 (2001) (finding that functional tests revealed high BMI value and that age could predict performance in reaching, balancing, squatting, kneeling, rising from low furniture, stepping up onto high steps, staircase-climbing and carrying grocery bags).

212. Data on file with author.

213. *Id.*

214. *Id.*

impairment on the initial application for disability benefits in 18% of the cases and did not identify obesity as a severe impairment 63% of the time.[215] This factor apparently did make a difference in whether the claimant was awarded benefits. In 21% of ALJ reversals, the claimant listed obesity as a severe impairment.[216] But, in affirmations of the ALJ decision, the claimant did not list obesity as a severe impairment in 68% of the cases.[217] These numbers suggest an obvious point: A claimant's failure to properly develop the record concerning how her obesity impacts her functional ability can have an adverse impact on the claimant's ability to be successful in the adjudication process. But an open question remains as to why so many claimants did not perceive their obesity to be disabling.

It is difficult to use this data to make predictions about future decisions because of three major problems. First and foremost, as the cases surveyed indicate, claims are not being consistently evaluated under SSR 02-1p among similarly situated individuals. This lack of consistency has undermined confidence in the Agency's ability to fairly adjudicate claims involving the obese. Second, the repeal of Medical Listing 9.09 has led to a prolonged application process for individuals who would have been determined to be disabled at Step 3 in the evaluation process. Reform should seek ways to streamline the disability certification process by relying on objective medical evidence that will be a likely indicator of inability to work and develop alternative criteria to BMI to measure the impact of obesity on co-existing impairments in marginal cases. Third, the Agency's review of obesity is under-inclusive. There may be a large number of very obese individuals whose obesity is not being evaluated because either the claimant or the ALJ does not identify the obesity as a severe impairment.

215. *Id.* I could not ascertain whether the claimant identified obesity as a severe impairment in 18% of the cases reviewed. *Id.*
216. *Id.*
217. *Id.*

B. Points Of Vulnerability For The Obese Claimant

This review of case law suggests reviewing courts vary widely in their expectations of how ALJs evaluate obesity during the five-step sequential evaluation process. In part, the differing results are a product of tension between the Act, regulations, and SSR 02-1p. This section explores two areas that ALJs struggle with: (1) at what point should obesity be a severe impairment; and (2) how obesity interacts with other impairments.

1. A Most Dangerous Step: Is Obesity a Severe Impairment?

The decisions in *Rutherford v. Barnhart*[218] and *Diaz v. Commissioner*[219] involved two morbidly obese individuals and illustrate how similarly situated individuals are treated differently when different decision makers apply the Ruling. The claimant in *Rutherford* had a BMI of 44.8 (5'2" and 245 pounds), whereas the claimant in *Diaz* had a BMI of 50.9 (4'11" and 252 pounds).[220] The denial of Rutherford's claim was upheld,[221] whereas Diaz's claim was remanded back to the ALJ. The difference in the results of these cases may be attributable to whether the claimants identified their obesity as a severe impairment[222] in either their application for disability benefits or at the hearing.[223] In *Rutherford*, the claimant did

218. Rutherford v. Barnhart, 399 F.3d 546 (3d Cir. 2005).

219. Diaz v. Comm'r of Soc. Sec., 577 F.3d 500 (3d Cir. 2009).

220. *Id.* at 502; *Rutherford*, 399 F.3d at 553.

221. *Rutherford*, 399 F.3d at 553 (noting, however, that even if the claimant's obesity had been established as a severe impairment, a remand would not have been appropriate because the claimant was unable to specify how the obesity would have affected the five-step evaluation process beyond general assertions that weight made it more difficult to perform functional requirements of work, including ability to stand, walk, and manipulate her hands and fingers). As the claimant's obesity was not a severe impairment, the ALJ gave sufficient consideration to the claimant's obesity, if only indirectly, by basing his conclusion regarding her functional limitations on the records of her physicians who were "aware of [her] obvious obesity. . . ." *Id.*

222. While it might seem appropriate for an obese individual to recognize that her weight could exacerbate other impairments, fat identity is not a self-evident status. Douglas Degher & Gerald Hughes, *The Adoption and Management of a "Fat" Identity*, *in* INTERPRETING WEIGHT: THE SOCIAL MANAGEMENT OF FATNESS AND THINNESS 11, 17 (Jeffrey Sobal & Donna Maurer eds., 1999). Researchers have found obese individuals frequently choose to engage in an avoidance strategy that simply ignores their weight. *Id.* at 19.

223. *See, e.g.*, Bowser v. Comm'r of Soc. Sec., 121 F. App'x 231, 236 (9th Cir. 2005) (finding treatment notes insufficient to establish obesity as a medically determinable impairment where BMI

not allege that her obesity was a severe impairment and instead argued that medical record references to her obesity were sufficient to put the ALJ on notice that the claimant's weight could factor into the decision.[224] The *Rutherford* court reasoned the ALJ's decision did not require him to specifically address the claimant's obesity because

could be independently calculated based on notations concerning height and weight); Skarbek v. Barnhart, 390 F.3d 500, 504 (7th Cir. 2004) (holding that ALJ did not have to consider claimant's obesity where the claimant could only "speculate[]" about the impact of his obesity on his ability to stand or walk); *cf.* Zavilla v. Astrue, No. 09–133, 2009 WL 3364853, at *17–18 (W.D. Pa. Oct. 16, 2009) (holding that the claimant did not allege disability based on obesity but that the ALJ was required to consider obesity after acknowledging obesity was relevant to the determination of the claimant's work capacity); Rockwood v. Astrue, 614 F. Supp. 2d 252, 275–77 (N.D.N.Y. 2009) (holding claimant did not allege obesity as a severe impairment, but the court specifically declined to follow *Rutherford* because ALJ did not adopt or utilize the opinions concerning the claimant's obesity contained in the medical records); Eskridge v. Astrue, 569 F. Supp. 2d 424 *passim* (D. Del. 2008); Early v. Astrue, 481 F. Supp. 2d 1233, 1239–40 (N.D. Ala. 2007) (remanding claim where claimant did not allege obesity, but claimant's treating physicians discussed claimant's obesity in treatment notes without offering any opinion concerning the resulting functional limitations); Demiranda v. Barnhart, No. Civ.A. 04-4199, 2005 WL 1592950, at *1–2 (E.D. Pa. 2005) (remanding claim where claimant did not allege obesity nor did ALJ determine it was a severe impairment, but remand was appropriate because treating physician opined that her functional limitations and other impairments were exacerbated by the claimant's morbid obesity).

224. *Rutherford*, 399 F.3d at 552. A claimant's poor development of the medical record and testimony may be partially to blame for the adverse result because of the claimant's failure to properly develop the record necessary to support a finding that the obesity was a severe impairment. *Id.*; *see also* Rickabaugh v. Astrue, No. 08–228J, 2010 WL 1142041, at *5 (W.D. Pa. Mar. 24, 2010) (noting that physician concluded severe reduction in maximal ventilatory volume on pulmonary function test attributable to obesity and that the ALJ held the record open for thirty days following the hearing, but the claimant failed to submit additional evidence); Barr v. Astrue, No. CIV S-07-0284 GGH, 2008 WL 3200863, at *4 (E.D. Cal. Aug. 7, 2008) (noting specifically that the claimant had only submitted records to the Appeals Council concerning the claimant's obesity from a nurse practitioner and physical therapist, which raised questions of whether the record had been properly developed at the ALJ hearing level). In *Rutherford*, the claimant did not list obesity as one of her impairments on her application for SSI benefits nor did the claimant testify that her back impairments were attributable to her obesity. *Rickabaugh*, 2010 WL 1142041, at *5. However, the claimant's medical records noted her weight adversely impacted the result of a pulmonary function test. *Id.* The ALJ held the record open for thirty days after the hearing to receive additional evidence regarding the results of this test, but apparently the claimant never provided further documentation that could have established the connection between her obesity and her work-related limitations. *Id.* There were other similarities between the two claimants—age (forty-five and forty-eight), region (New Jersey and Pennsylvania), and type of impairment (impairments in the right upper extremity and lower back, as well as a back disorder and degenerative joint disease). *Diaz*, 577 F.3d at 501; *Rutherford*, 399 F.3d at 549. In many ways these two cases illustrate how seemingly similarly situated individuals can be subject to different results during the disability certification process. Liebman, *supra* note 11, at 844 (noting the variety of individual reactions to illness and injury complicates the disability certification process). However, there are obvious explanations for the different results, including individual factors, such as the claimant's age, educational level, work history, and other vocational considerations. MILLS, *supra* note 15, at 69. But these cases suggest that certain types of individuals or claimants with certain impairments are vulnerable to inconsistent decision-making.

the claimant's doctors likely were aware of her "obvious" obesity, so the ALJ appropriately considered and adopted medical opinions concerning her functional limitations and impairments.[225] Following *Rutherford*, the *Diaz* court reached a different result.[226] Although Diaz did not allege obesity as a severe impairment, the different result appears attributable to the ALJ's acknowledgement at Step 2 that the claimant's obesity was a severe impairment.[227] Because the claimant's obesity was determined to be a severe impairment, the ALJ was obligated to consider her obesity at the other steps as required by SSR 02–1p.[228]

More importantly, these cases show that even abnormal body mass provides sufficient notice for the decision maker to consider obesity.[229] As *Diaz* and *Rutherford* illustrate, a claimant's failure to allege obesity can adversely impact the claimant's application.[230] If

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225. *Rutherford*, 399 F.3d at 552.

226. *Diaz*, 577 F. 3d at 505.

227. *Id.* In fact, the court distinguished *Rutherford* by noting this factual distinction. *Id.* at 504; s*ee also Rickabaugh,* 2010 WL 1142041, at *5 (distinguishing *Diaz* by noting ALJ did not expressly find Rickbaugh's obesity to be a severe impairment).

228. *Diaz*, 577 F.3d at 505.

229. *See, e.g.*, Callicoatt v. Astrue, 296 F. App'x 700, 702 (10th Cir. 2008) (finding harmless error where ALJ did not consider claimant's obesity (BMI 40.7)); Warner v. Astrue, No. 1:09-cv-01112-PWG, 2011 WL 1135810, at *3 (D. Md. Mar. 25, 2011) (noting that claimant's BMI was greater than 40, but the ALJ declined to find obesity was a severe impairment because medical records did not indicate claimant's obesity caused functional limitations); Norton v. Astrue, No. 4:09CV3100, 2010 WL 4273108, at *8 (D. Neb. Oct. 21, 2010) (noting that despite BMI of 43.3, the claimant's obesity was not determined to be a severe impairment); Adkins v. Astrue, No. 3:10CV60, 2010 WL 5825428, at *7 (E.D. Va. Sept. 28, 2010) (noting that despite claimant's BMI of 50, condition non-severe where the claimant did not allege obesity as a severe impairment nor did he testify as to any physical limitations caused by obesity); Bassett v. Astrue, No. 4:09-CV-142-A, 2010 WL 2891149, at *1 (N.D. Tex. June 25, 2010) (deciding case without mentioning claimant's obesity despite BMI of 40.6); Bogans v. Astrue, No. 8:09-CV-0682-T-27EAJ, 2010 WL 2927486, at *2 (M.D. Fla. June 22, 2010) (noting that claimant's BMI was as low as 32 when he left employment but had ballooned to 40); Radford v. Astrue, No. 5:10-CV-00022-J, 2010 WL 2651295, at *8 (W.D. Ky. May 28, 2010) (noting that claimant's BMI was 40 but ALJ did not determine that obesity was a severe impairment because the claimant did not testify as to the limiting aspects of her obesity at the hearing); Deaver v. Astrue, No. 7:07-CV-158-BH, 2008 WL 4619823, at *11 n.10 (N.D. Tex. Oct. 20, 2008) (noting the ALJ did not find that obesity was a severe impairment despite multiple references in the medical records to the claimant's morbid obesity and her BMI of 51.6); *see also* Zonak v. Comm'r of Soc. Sec*.,* 290 F. App'x 493, 496 (3rd Cir. 2008) (suggesting claimant could not rely on high BMI as "obvious" indicator of limitations); *cf.* Early v. Astrue, 481 F. Supp. 2d 1233, 1239–40 (N.D. Ala. 2007) (holding the claimant had a BMI greater than 40, and the ALJ erred when he did not consider claimant's obesity to be a severe impairment).

230. *See* Halsell v. Astrue, 357 F. App'x 717, 723 (7th Cir. 2009) (rejecting claimant's argument that ALJ erred by failing to consider her obesity based on inferences from the reports of the state-agency physician where claimant did not allege obesity as severe impairment); Briggs v. Astrue, 221 F. App'x

the claimant alleges obesity as a disabling condition or the ALJ determines that obesity is a severe impairment, reviewing courts potentially expect ALJs to provide more substantive discussion regarding how a claimant's obesity may impact other impairments or functional limitations.[231]

2. Does Obesity Exacerbate Other Health Concerns?

The lack of guidance concerning how ALJs should consider the impact of obesity on other impairments has also led to variations in decision-making patterns. SSR 02-1p at paragraph 5 provides that the Agency will consider the possibility of coexisting conditions, especially as the level of obesity increases.[232] However, no further instruction is given. The Ruling does note three areas that obesity will likely impact—cardiovascular, respiratory, and musculoskeletal.[233] In the review of case law, this observation proved to be correct as the most common severe impairments related to these areas. In total, claimants in nearly half of all the cases reviewed also

767, 771 (10th Cir. 2007) (determining obesity was not a severe impairment where the claimant did not allege it); Wind v. Barnhart, 133 F. App'x 684, 690–91 (11th Cir. 2005) (finding that because claimant did not allege obesity as a severe impairment, ALJ did not have to list obesity as a severe impairment where there was no medical evidence that the claimant's obesity impacted her ability to perform medium level work).

231. There are numerous examples. *See, e.g.*, Ellis v. Astrue, No. 09-1212, 2010 WL 1817246, at *5 (E.D. Pa. 2010); *cf.* Cruz v. Barnhart, No. 04 CIV 9011(GWG), 2006 WL 1228581, at *9 (S.D.N.Y 2006) (holding that claimant did not claim obesity as a severe impairment, but remand was not needed as ALJ's acknowledgment of the claimant's obesity in the statement of facts was sufficient consideration of the impairment). In *Ellis*, the claimant applied for SSI alleging disability on the basis of arthritis in the knees, hands, and wrists, diabetes, and high cholesterol; obesity was not identified. *Ellis*, 2010 WL 1817246, at *1. At the hearing, the claimant testified that her current weight was 268 pounds but fluctuated to as high as 298 pounds. *Id.* at *2. At Step 2 of the decision, the ALJ found that the claimant's obesity was a severe impairment. *Id.* The only other reference to the claimant's obesity came during the discussion of Step 3 where the ALJ acknowledged his legal obligation to discuss the impact of the claimant's obesity on other impairments. *Id.* at *2, *5. The court, however, found this discussion inadequate and remanded the case for further development of how the claimant's obesity impacted her bilateral knee disorder and her ability to walk and stand. *Id.* at *5. Thus, this case suggests that where the ALJ designates obesity as a severe impairment, the ALJ should take steps to elaborate how the obesity impacts his conclusions at subsequent steps in the evaluation process. However, it is possible that if the ALJ had not designated obesity as a severe impairment, a court could have reached the opposite result given the lack of discussion from the claimant regarding the impact of the obesity on her functional limitations and the lack of medical records that indicated how her obesity impacted other areas of health. *Id.*

232. SSR 02-1p, 67 Fed. Reg. 57,859, 57,861 (Sept. 12, 2002).

233. *See generally id.*

had a musculoskeletal disorder; nearly a quarter of all claimants also had a related impairment to the cardiovascular system or a respiratory disorder.[234] Yet, other disorders frequently were alleged. For instance, nearly one quarter of claimants also had a mental disorder.[235] Other common impairments related to the endocrine system, special senses and speech, pain, and impairments in the digestive system.[236] Given the frequency of certain types of impairments, it would not be unreasonable for the Agency to develop more detailed guidance to educate decision makers on how obesity impacts these other impairments.

The guidelines for evaluation at Step 3 are troublesome because it is not readily apparent how the adjudicator should consider the accumulation of related impairments.[237] They therefore reflect the Agency's difficulty in evaluating how the combination of impairments associated with obesity impact different bodily systems.[238] This is particularly so for claimants with lower BMIs. These relatively lower levels of obesity may mask the fact that the claimant's obesity has in fact greatly exacerbated other health concerns.[239]

To a certain degree, the Listings, almost by necessity, have to be broad enough to cover a wide continuum of cases. The difficulty in constructing a Ruling with sufficient specificity results from the

234. Data on file with author.
235. *Id.*
236. *See id.*
237. MASHAW, *supra* note 127, at 112.
238. *Id.*
239. *See, e.g.*, Heflick v. Astrue, No. 08-C-996, 2009 WL 1417913, at *13 (E.D. Wis. May 20, 2009) (finding claimant's BMI was only 31.5, but the ALJ failed to consider whether the claimant's obesity, in combination with her knee problem, limited her ability to walk); Parks v. Astrue, No. CIV-07-1229-D, 2008 WL 4147559, at *5 (W.D. Okla. Sept. 2, 2008) (finding the ALJ erred by failing to consider how claimant's obesity (BMI of 33) affected his chronic obstructive pulmonary disorder); Eskridge v. Astrue, 569 F. Supp. 2d 424, 439 (D. Del. 2008) (noting that the claimant had a BMI of 33.9 and that the ALJ failed to identify obesity as severe impairment); Segal v. Barnhart, 342 F. Supp. 2d 338, 342 (E.D. Pa. 2004) (noting that the claimant's BMI was 32 and that the ALJ determined her severe impairments included chronic ulcerative colitis, spastic colon, and migraines but failed to consider whether obesity impacted exertional and non-exertional functioning); Thomason v. Barnhart, 344 F. Supp. 2d 1326, 1330 (N.D. Ala. 2004) (noting the ALJ did not consider the claimant's obesity (BMI of 33.7) in addition to her other impairments, including arthritis).

Act's very goal—to provide benefits to disabled claimants.[240] While the goal may seem relatively straightforward, neither the Act nor the accompanying regulations identify a clear-cut case of disability that adjudicators could use to base their decisions.[241] Thus, where obesity falls on the ability–disability continuum cannot be established because, in fact, Congress did not draw that line for any impairment when it enacted the statutory criteria.[242] Given the potentially indeterminate nature of the SSA's rulings, potential reform should consider whether the Ruling's instructions regarding how obesity should be evaluated at Step 3 must reflect our current understanding of obesity on other bodily systems.[243]

C. Why Reform Is Necessary

In light of evidence that the Agency is unable to consistently evaluate obesity in the disability adjudication process, three reforms are necessary. First, the Agency should reinstate a Medical Listing for individuals with a BMI greater than 48. Reinstatement of the Medical Listing will help achieve more accurate and efficient adjudication of applications. The criteria developed by the Disability Research Institute to the Ruling supports a conclusion that reform of the evaluation protocols for obesity is necessary.[244] Specifically, reinstating Medical Listing 9.09 would satisfy the four criteria for whether a Medical Listing can yield a valid result. Commentators also took issue with the Agency's contention that the criteria utilized in Medical Listing 9.09 were not appropriate indicators of listing-level severity because they did not represent a degree of functional limitation that would prevent an individual from engaging in

240. MASHAW, *supra* note 127, at 56.
241. *Id.*
242. *Id.*
243. There are several examples of reviewing courts following the Listing's guidance about the interaction of obesity and other impairments, which suggest the Agency should seek to expand this guidance. *See, e.g.*, Dogan v. Astrue, 751 F. Supp. 2d 1029, 1047 (N.D. Ind. 2010) (holding the ALJ failed to evaluate musculoskeletal impairments under Medical Listing 1.02(A)); *Parks*, 2008 WL 4147559, at *4 (citing specifically the language in Medical Listing 3.00(I)); Fleming v. Barnhart, 284 F. Supp. 2d 256, 268 (D. Md. 2003) (holding the ALJ failed to evaluate musculoskeletal disorder under Medical Listing 1.11).
244. *See supra* Part II.C.

substantial gainful activity.[245] The Agency responded that the only way to be positive that individuals would be disabled under the Listings would be to require that other impairments meet or equal the severity of their respective Listings because of the widely varying effects that obesity and related impairments may have on an individual's functioning.[246] Despite initially taking the position there was no medical evidence establishing that even massive obesity had an adverse effect on a claimant's functional ability, the Agency reviewed medical literature to see if there was a correlation between obesity and loss of functional capacity and determined that these sources were consistent with their reasoning.[247] However, in the years since this decision, there have been a number of sources that directly contradict this statement.[248] As will be discussed further, here in Part IV, there is a strong correlation between morbid obesity and decreased functional ability, which would, in turn, limit ability to perform substantial gainful activity.[249]

Second, the Agency should adopt stricter guidance as to when obesity must be evaluated as a severe impairment and must be specifically addressed in the ALJ decision. If the Agency does not reform the Ruling's guidance on when obesity will likely be a severe impairment, there will continue to be inconsistencies in how obesity is addressed in the residual functional capacity assessment in claims. For example, the Seventh Circuit held that the ALJ could indirectly account for the claimant's obesity by relying on medical evidence that made no mention that Plaintiff was obese, even though the claimant's obesity must have been apparent at the hearing.[250] From this perspective, the decision in *Skarbek* is not entirely surprising because Skarbek's BMI was only 32.3, which is in the lowest category of obesity.[251] However, in *Norris v. Astrue*,[252] the court

245. *See supra* Part III.A.
246. *Id.*
247. *Id.*
248. *Id.*
249. *See* discussion *infra* Part IV.
250. Skarbek v. Barnhart, 390 F.3d 500, 504 (7th Cir. 2004).
251. *Id.*
252. Norris v. Astrue, 776 F. Supp. 2d 616 (N.D. Ill. 2011).

specifically distinguished *Skarbek* by noting Norris's BMI was 46.1 and thus more likely to have impacted her other impairments and ability to work.[253]

However, the idea that an ALJ has virtually no obligation to further develop generalized points of evidence or testimony is somewhat at odds with other regulations and SSR 02-1p. For example, in *Rockwood v. Astrue*,[254] the court acknowledged evidence concerning the claimant's obesity was "scant" but noted that despite the claimant's burden in the sequential evaluation process, the ALJ has an affirmative obligation to assist the claimant in the development of the record, even in instances where the claimant is represented by counsel.[255] Specifically, 20 C.F.R. § 404.1545(a)(3) provides that before making a determination that the claimant is not disabled, the ALJ has an obligation to assist the claimant in developing the record.[256] Additionally, SSR 02-1p at paragraph five suggests the ALJ has the power to seek additional guidance from a medical source to clarify whether the individual has obesity in situations where the clinical records only contain references to the claimant's high body weight.[257] Reform of the Agency's protocols

253. *Id.* at 639; *cf.* Rutherford v. Barnhart, 399 F.3d 546, 553 (3d Cir. 2005) (assuming the ALJ considered claimant's obesity due to her height and weight measurements being listed in medical documents).

254. Rockwood v. Astrue, 614 F. Supp. 2d 252 (N.D.N.Y. 2009).

255. *Id.* at 278–79. In fact, while Rockwood's treating physician did diagnose her as obese, it is not clear that her physicians ever determined whether the obesity exacerbated other impairments or impacted her functional ability. However, this observation could have been made by cases where the decisions of the ALJs were affirmed. *See, e.g.*, Prochaska v. Barnhart, 454 F.3d 731, 737 (7th Cir. 2006) (noting that one treating physician diagnosed claimant as obese and that other medical reports relied upon by the ALJ listed claimant's height and weight); Bowser v. Comm'r of Soc. Sec., 121 F. App'x. 231, 236 (9th Cir. 2005) (noting medical record contained one reference from the treating physician that the claimant was obese).

256. 20 C.F.R. § 404.1545(a)(3) (2012).

257. SSR 02-1p, 67 Fed. Reg. 57,859, 57,861 (Sept. 12, 2002). The Ruling, however, contains conflicting guidance because the next sentence in Paragraph 4 states, "[h]owever, in most such cases we will use our judgment to establish the presence of obesity based on the medical findings and other evidence in the case record, even if a treating or examining source has not indicated a diagnosis of obesity." *Id.* This is perhaps an example of a communications problem that can impede the furtherance of Agency goals. *See* MASHAW, *supra* note 127, at 66–67 (describing institutional challenges to the effective and efficient dissemination of information). In light of this conflicting instruction, the ALJ's decision in *Bowser v. Commissioner of Social Security* appears rational because the record only contained notes about the claimant's weight and height. *See generally Bowser*, 121 F. App'x at 231. Thus, it was only apparent that the claimant's BMI exceeded 30, and thus obese, after performing an

should seek to clarify the extent to which the ALJ must inquire as to the impact of the claimant's obesity on other impairments and functional limitations.[258]

The third reform should revise the Ruling to incorporate alternative, objective measurements of obesity. The Agency's current protocols for the evaluation of obesity place heavy emphasis on use of an applicant's BMI and result in two problems during the disability certification process. While BMI might be intrinsically valid because it would seem to actually measure the presence of fatness, the predictive value is limited because it might not be the best measurement to identify true positives.[259] The Agency's use of BMI is not unreasonable given BMI's universal acceptance and widespread use among social scientists.[260] However, there is some criticism within medical literature that BMI is a "noisy" measurement of obesity because it does not distinguish fat from muscle, bone, or other lean body mass.[261]

Thus, the first problem is whether the use of BMI to classify obesity results in false positives.[262] In fact, in Professor Burkhauser's study, he compared defining obesity using both BMI and percent of body fat.[263] Professor Burkhauser concluded that among men, BMI produced 14.20% false positives and 33.50% false negatives.[264] Among women, Professor Burkhauser concluded that BMI did not produce any false positives, but 61.25% classified as non-obese were false negatives.[265] As discussed previously, false positives are problematic because they undermine the perception that the Agency is able to consistently evaluate disability applications.[266] The high

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independent calculation. *Id.* at 236.

258. *See* SOC. SEC. ADVISORY BD., *supra* note 21, at 6 (noting 2005 study found continued inconsistent compliance with Social Security Rulings issued in 1996).

259. BURKHAUSER & CAWLEY, *supra* note 25, at 18–19.

260. Richard Burkhauser & John Cawley, *Beyond BMI: The Value of More Accurate Measures of Fatness and Obesity in Social Science Research*, 27 J. HEALTH ECON. 519, 520 (2008).

261. *Id.*

262. *Id.* at 523–24.

263. *Id.* at 524.

264. *Id.*

265. *Id.*

266. *See* discussion *supra* Part III.B.

number of women erroneously classified as non-obese is particularly disturbing because of the fact that of the district and appellate court decisions surveyed, over 70% of the claimants were women, which demonstrates that BMI is not the best measurement of the impact of fatness on health for women.[267]

The second problem, which may be more significant, is that BMI may not provide an accurate prediction of health outcomes associated with obesity.[268] For instance, both hip-to-waist circumference and waist-to-hip ratio are better predictors of cardiovascular disease than BMI.[269] Waist circumference is a better predictor of diabetes than BMI.[270] Most of the cases I reviewed involved obesity plus a co-morbid impairment. These include respiratory, musculoskeletal, and cardiovascular impairments, as well as diabetes.[271] The high presence of co-morbid conditions means that the Agency has the difficult task of assessing how obesity exacerbates these impairments. Particular attention should be given to SSR 02-1p because academics have suggested bureaucratic rationality is not possible where the rules are unnecessarily vague or unclear.[272]

Finally, the Agency denied concerns that the repeal of Medical Listing 9.09 "would have a disproportionate impact on particular groups of individuals, such as women, minorities and individuals at lower socioeconomic levels [by suggesting that the action did] . . . not discriminate against any individual or group of individuals based on their impairments."[273] Unfortunately, this statement proved to be

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267. *See supra* Part IV.A.

268. BURKHAUSER & CAWLEY, *supra* note 25, at 5.

269. Louis J. Aronne, Donald S. Nelinson & Joseph L. Lillo, *Obesity as a Disease State: A New Paradigm for Diagnosis and Treatment*, 9 CLINICAL CORNERSTONE, no. 4, 2009, at 9, 14.

270. *Id.* at 10.

271. *See supra* Part III.B.

272. MASHAW, *supra* note 127, at 107. Professor Mashaw notes, however, that there are limitations to rules because objective standards and use of presumptions utilize overbroad standards and can constrain individualized decision-making in a way that will end in bad results. *Id.* As was discussed further in Part IV.C, any reform to the Agency's evaluation protocols must seek to avoid false positives. *See* discussion *supra* Part IV.C. The more difficult reform will involve an evaluation of cases where the impact of obesity is not quite as clear and individualized inquiry of an applicant's unique characteristics are necessary. In these situations that evaluate an individual's unique characteristics, it may be difficult to develop regulations that will synthesize these factors into a clear, coherent rule that can achieve rationality. *See id.* at 107–08.

273. Revised Medical Criteria for Determination of Disability, Endocrine System and Related

incorrect, at least for women. In the cases reviewed, the majority involved women.[274] There is reason for concern because, despite the Agency's belief, cases involving obesity do seem to disproportionately involve women. While it is not clear what percentage of these cases would have resulted in a grant of benefits had Medical Listing 9.09 been in place, there is growing concern about the ability of BMI to accurately measure the associated effects of fatness, and Professor Burkhauser's research rightly questions whether other measurements of obesity would provide a better predictor of co-morbid conditions for women. If a greater number of women continue to allege disability as a result of obesity, women will likely continue to be recipients of adverse disability decisions unless the Agency clarifies its evaluation protocols.

V. FATNESS AS DISABILITY. REALLY?

After reaching the conclusion that reinstatement of Medical Listing 9.09 is necessary to achieve consistent evaluation of obesity, the question becomes: Should benefits be given to individuals for an impairment that could be partially caused by the individual's behavioral choices? The debate over obesity has intensified as scholars from a number of disciplines consider whether obesity is a pandemic or moral panic created by researchers whose conclusions cannot be supported by scientific data.[275] Putting aside the debate between fat acceptance activists and anti-obesity researchers, the more important question may be the relationship between the obese individual and his or her environment. From this perspective, obesity would fall under the social model of disability, which developed in the 1960s and 1970s, and recognized that disability was not the result of a person's defect but rather the result of the interplay between a person's mental or physical attributes and an environment that was unable to accommodate the needs of the disability.[276] In many ways,

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Criteria, 64 Fed. Reg. 46,122, 46,127 (Aug. 24, 1999) (to be codified at 20 C.F.R. pt. 404).

274. *See supra* Part IV.A.

275. Campos et al., *supra* note 5, at 55.

276. ERKULWATER, *supra* note 45, at 29.

the concept of obesity as a disability is a relatively new construct, highlighted by the well-documented rise in obesity rates in recent years.[277] Consistent with both the social and cultural models of disability, the obese could be considered disabled because their experiences are defined by prejudice and discrimination.[278] But this does not answer the question of whether we should give benefits to individuals because of an impairment that they arguably contributed to through poor choices about diet and exercise.

A. Obesity And The Conceptual Models Of Disability

As obesity rates rise and the correlation between obesity and poor health is examined, a question emerges about whether society is prepared to identify obese individuals as disabled.[279] While an individual's ability to be recognized as disabled is important for political and social recognition, this act of identification will have "major economic, social, and psychological consequences" for those classified as disabled.[280] For example, when Homer Simpson is

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277. Katharine M. Flegal et al., *Prevalence and Trends in Obesity Among US Adults, 1999–2008*, JAMA, Jan. 20, 2010, at 235, 235 (noting that from 2007–2008, the age-adjusted prevalence of obesity was 33.8%). The study found that obesity rates for adults aged 20 to 74 years increased by 7.1 percentage points for men and 8.1 percentage points for women between 1998–1994 and 1999–2000). *Id.* at 240.

278. Charlotte Cooper, *Can a Fat Woman Call Herself Disabled?*, DISABILITY & SOC'Y, Feb. 1997, at 31, 39 (arguing that she is disabled because of her experiences with a "fat-hating" culture and noting commonalities with other disabled individuals, such as pathology and restricted civil rights); *see also* WENDELL, *supra* note 10, at 46 (providing an example of large individuals being disabled by their environment—seats that are too small, doors that are too narrow, chairs that are too low and cannot be adjusted—to illustrate that disability may not result from impairment caused by bodily function).

279. Anna Kirkland, *What's at Stake in Fatness As a Disability?*, DISABILITY STUD. Q., Winter 2006 (discussing accommodation of obesity in the context of ADA litigation and the different spatial arrangements, such as seating, and other changes in the workplace that would be needed to accommodate the obese).

280. WENDELL, *supra* note 10, at 23. Professor Mashaw notes that "[t]he major cash income-support programs . . . contained in the Social Security Act, the statute establishing the Veterans' Assistance programs, and the state and federal workmen's compensation acts" provide an official, yet sometimes reluctant, stamp of approval to the partially or totally disabled worker. Jerry L. Mashaw, *The Supreme Court's Due Process Calculus for Administrative Adjudication in* Mathews v. Eldridge*: Three Factors in Search of a Theory of Value*, 44 U. CHI. L. REV. 28, 51 n.72 (1976). This classification acknowledges that disability is a politically acceptable barrier to one's ability to assume a place in the workforce. *Id.* Denial of a claim, however, can suggest the individual was unable to advance a socially acceptable reason to be excused from workforce participation. *Id.*

turned away from a movie theater because of his size, he experiences public ridicule because the theater is unable to accommodate him.[281]

Here, Homer's disability is created by stigma, stereotype, and the cultural expectations of the residents of Springfield, and his deviation from a normative understanding of acceptable body weight resulted in a socially constructed disability.[282] Thus, by classifying obese individuals as disabled, society must be prepared to accept both the non-legal and legal consequences of such a determination.[283] The need for clarity as to whether the obese can fit within our understanding of the conceptual framework of disability is especially evident given the correlation between obesity and future applications for disability benefits.[284]

Does this mean obese individuals, such as Homer, should not be entitled to any form of disability benefit? The answer given may depend on an individual's perspective of obesity as either a self-inflicted impairment or the result of factors outside the control of the individual. Professor Wendell, for instance, has argued that while a socially constructed environment that cannot accommodate larger individuals impairs obese individuals, the obese do not suffer the same level of hopelessness and pathology that are projected onto individuals with illness and severe injury.[285] It is clear, though, that our society attributes much more to obesity than just the presence of extra body fat.[286] For example, Professor Gilman argues that obesity has become associated with ill-health and a sign of pathology

281. *King-Size Homer*, *supra* note 5.

282. WENDELL, *supra* note 10, at 39 ("Societies that are physically constructed and socially organized with the unacknowledged assumption that everyone is healthy, non-disabled, young but adult, shaped according to cultural ideas, and, often, male, create a great deal of disability through sheer neglect of what most people need in order to participate fully in them.").

283. ANNA KIRKLAND, FAT RIGHTS: DILEMMAS OF DIFFERENCE AND PERSONHOOD 109 (2008). Society actually has a great impetus to become more accommodating of disability in the public sphere, as opposed to treating disability as a private matter, because failure to accommodate disabilities in the public sphere can actually increase the numbers of the disabled. WENDELL, *supra* note 10, at 40.

284. Burkhauser et al., *supra* note 144, at 21 (finding "that obese individuals (determined using BMI) are more likely to report work limitations or to report receiving DI benefits").

285. WENDELL, *supra* note 10, at 47.

286. *See* Barrett v. Barnhart, 355 F.3d 1065, 1068 (7th Cir. 2004) ("But by treating obesity as an aggravating factor, the administrative law judge may have been hinting . . . that obesity is like refusing to wear glasses or a hearing aid—essentially a self-inflicted disability that does not entitle one to benefits or boost one's entitlement by aggravating another medical condition.").

because fatness is identified as a condition that can be cured by everything from "fat camps" to medicine to surgical procedures.[287]

However, the debate about the morality of giving benefits to obese individuals is ultimately irrelevant to the question of whether an obese individual can fall under the Act's definition of disabled. The reason this debate is irrelevant comes from the statutory definition of disability itself. This definition of disability does not contemplate how the individual became disabled but only whether the individual can engage in substantial gainful activity as a result of a medically determinable impairment. Thus, the cause of the individual's medical impairment will not be considered during the disability certification process.

That being said, certain disorders—drug addiction and alcoholism—have been specifically excluded from coverage under the Act.[288] There are obvious parallels between obesity and drug and alcohol addiction disorders because of the concerns about how behavior contributes to the impairments. However, the legislative history of the revision suggests other considerations were at play. For instance, the Senate Special Committee on Aging heard testimony from the director of a homeless shelter about numerous SSI recipients at his shelter who cashed their disability checks at a nearby liquor store and about others who even died from alcohol and drugs purchased with SSI checks.[289] Senator William Cohen expressed concern that disability benefits would perpetuate and enable drug and alcohol addiction, while Senator Robert Dole questioned the wisdom of giving benefits to drug and alcohol addicts when the aid did not help addicts recover.[290] The legislative history of the 1996 revision does not suggest Congress believed addicts should be ineligible for benefits because of self-inflicted behavioral choices. Rather, the legislature seemed to express concern about public monies being

287. SANDER L. GILMAN, FAT: A CULTURAL HISTORY OF OBESITY (2008).

288. 42 U.S.C. § 1382c(a)(3)(J) (2006).

289. *Problems in the Social Security Disability Programs: The Disabling of America?: Hearing Before the S. Spec. Comm. on Aging*, 104th Cong. 19 (1995) (statement of Bob Cote, Director, Step 13 Homeless Shelter).

290. *Rising Costs of Social Security's Disability Programs: Hearing Before the Subcomm. on Soc. Sec. & Family Policy of the S. Comm. on Fin.*, 104th Cong. 2, 50 (1995).

used to purchase alcohol and drugs.[291] Additionally, there are other differences between obesity and substance abuse addiction. For instance, an alcoholic or a drug addict may pose danger to the health and safety of others, while the same threat is not caused by the obese. Thus, it is not clear the same concerns about drug and alcohol addicts would apply to obese claimants.

B. Can Obesity Fit Within A Conceptual Framework Of Disability?

A second important question raised by *The Simpsons* is whether obesity really impacts a person's functional limitations and, as a result, her capacity to engage in substantial gainful employment. Disability theorists have developed non-legal frameworks to define disability by relating it to other verifiable concepts, such as impairment and functional limitation.[292] These taxonomies outlined in different schema clarify the relationship between impairment and disability and suggest that disability is ultimately determined by the individual's interaction with his social environment.[293] For example, while Homer Simpson was able to engage in certain requirements of his position, such as using a computer, he was unable to perform other tasks, such as using a telephone, because his fingers were too fat.[294] During the episode, Homer experienced reduced capacity to engage in certain functional activities, such as performing gross and fine manipulations, but retained the capacity to perform other activities of daily living, such as driving a car.[295] Thus, it is important to understand how obesity, as an impairment, relates to disability and whether an individual's obesity will necessarily result in a finding of disability.

While it is important to understand that the definition is medically-centered, there are several concepts necessary to determine whether

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291. *Id.*
292. Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 644 (1999).
293. *Id.* at 647; *see also* Gilman, *supra* note 287, at 47 (suggesting that the functional approach adopted in the World Health Organization's International Classification of Impairments, Disabilities, and Handicaps seems beyond an ideological approach and assumes that obesity is a creation of social institutions that are unable or unwilling to respond to the disability).
294. *King-Size Homer*, *supra* note 5.
295. *Id.*

an individual will be eligible for disability benefits. Terms, such as injury, impairment, handicap, and functional limitation, help us to understand the impact of disability on an individual's ability to work. Several conceptual frameworks describe the relationship between these concepts. The two major conceptual frameworks in disability theory are the International Classification of Impairments, Disabilities, and Handicaps (ICIDH), which supplemented the World Health Organization's (WHO) International Classification of Disease, and the functional limitation approach, which is based on the works of Saad Nagi.[296] These schools of thought are similar in many respects but do use different terms to describe disability and related concepts. Both frameworks utilize four primary concepts: disease, impairment, disability, and handicap; both frameworks share a similar definition of pathology and disease and the characterizations of impairment.[297]

Professor Nagi's conceptual framework looks at disability as the expression of physical disability in the context of a social setting, whereas the Agency's definition of disability looks at the inability to perform work.[298] Specifically, Professor Nagi's framework differs from the Act's definition because it describes the concept of disability as the gap created by a physical or mental impairment and examines the individual's capabilities in the context of demands created by the social and physical environments.[299] In Professor Nagi's framework, not all impairments will lead to functional limitations, and not all functional limitations will lead to disability.[300]

This is the challenge in the Agency's evaluation of obesity claims: how to determine when obesity will likely lead to disability. As Homer demonstrated, this determination is a difficult task given that obesity will likely limit the performance of some, but not all, of the tasks associated with work.[301] Determination of an individual as

296. INST. OF MED., *supra* note 9, at 76.
297. *Id.* at 77.
298. *Id.*
299. *Id.* at 81.
300. *Id.* at 80.
301. *King-Size Homer*, *supra* note 5.

disabled is further complicated when objective measurements, such as BMI, may not provide an accurate examination of the impact of a claimant's obesity on health and functional limitation and may, in fact, not be an accurate predictor of certain classes of individuals.[302] Thus, a return to a Medical Listing for obesity may not improve the Agency's evaluation of obesity given the lack of objective medical criteria that could be utilized to identify accurate markers of disability. Rather, the Agency should seek to develop a better method of determining disability by seeking to develop criteria that would reflect the characteristics of claims that are most likely to be valid claims and use them to identify cases that could be decided without a hearing. While such an undertaking would be substantial, perhaps the Agency, by identifying protocols that reflect an understanding of how obesity impacts functional capacity, could achieve more accurate and consistent decision-making in these claims.

CONCLUSION

Interest in inconsistent evaluation of disability applications is increasing.[303] Some commentators have suggested that consistent application of the disability definition is not possible.[304] The Social Security Administration has commissioned the Administrative Conference of the United States (ACUS) to undertake a review of the federal disability appeals process, and the ACUS will issue a report with recommendations on how to overhaul the disability appeals process in 2012.[305] Congress should ignore calls for radical reform[306]

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302. *See* discussion *supra* Part IV.

303. *Social Security's Finances: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways & Means*, 112th Cong. 10 (2012) (testimony of Jeffrey Lubbers, Professor of Practice in Administrative Law, American University Washington College of Law).

304. *Social Security's Finances: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways & Means*, 112th Cong. 7 (2011) (testimony of Andrew G. Biggs, Resident Scholar, American Enterprise Institute).

305. Damian Paletta, *Disability-Benefits System Faces Review*, WALL ST. J., Dec. 15, 2011, at A8, *available at* http://online.wsj.com/article/SB10001424052970204844504577098810070396878.html#printMode.

306. *Social Security's Finances: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways & Means*, 112th Cong. 10 (2012) (testimony of Richard Pierce) (encouraging Congress to eliminate the role of the ALJ in the disability application process).

and should instead focus more on improving current Rulings to provide enhanced guidance to adjudicators to reduce the number of issues that need to be decided in the context of an individual hearing. With regards to obesity, the Agency should: (1) reenact Medical Listing 9.09 for individuals whose BMI exceeds 48; (2) specify at what point obesity will likely be a severe impairment; and (3) revise the Ruling to incorporate other methods of measuring the impact of fatness on health and functional ability.

The repeal of Medical Listing 9.09 and enactment of SSR 02-1p raise important questions about whether the action has, in fact, achieved the objectives the Agency sought to accomplish with the repeal. Failure to evaluate whether this decision has served programmatic goals will effectively hinder the Agency's ability to develop and communicate norms that will govern decisional behavior and lead to more predictable and consistent decision-making.[307]

Two major lessons emerge from the Agency's repeal of Medical Listing 9.09. First, the Medical Listings provide an efficient method to quickly identify and process the claims of individuals who are very likely disabled. Properly drafted, the Medical Listings should be able to accurately identify a high percentage of true positives, which decreases the likelihood that these true positives would not be erroneously denied because of the peculiarities of the assessment at Steps 4 and 5 of the evaluation process. Thus, the Medical Listings help promote confidence in the decision-making process because these protocols promote consistency in the disability certification process. The repeal of the Medical Listing has led to inconsistent and unpredictable decision-making patterns involving very obese individuals. In an era when the Agency is under increased scrutiny about its ability to process claims in a timely manner, the Agency should seek to utilize protocols that will identify obese individuals who will be unlikely to perform the functional requirements of work because of their weight.

The second area of concern is the Agency's use of BMI to evaluate obesity. The medical model of disability has shaped how the

307. MASHAW, *supra* note 127, at 61.

disability program decides whether an individual meets the statutory definition of disability. The creation of the disability insurance program in the 1950s was premised on the medical model because of the Act's requirement of medical certification of an applicant's disability. The purpose of this Article is not to contest the Agency's use of objective testing in the decision-making process. Certainly, objective medical testing can promote consistency in decisions because it can serve to limit ALJ discretion, but inaccurate results can and do occur when the protocols do not utilize objective testing that accurately identifies true positives. Reform should seek to better utilize alternatives to BMI for measuring the impact of weight on health in the disability certification process.

This Article has shown that patterns of inconsistency exist in the Agency's evaluation of obesity following the repeal of Medical Listing 9.09 and will continue to persist unless reform of the Ruling is pursued.