



1993

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Recommended Citation

Phyllis E. Bernard, *Social Security and Medicare adjudications at HHS: Two Approaches to administrative Justice in an Ever-Expanding Bureaucracy*, 3 *Health Matrix* 339 (1993)

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SOCIAL SECURITY AND MEDICARE ADJUDICATIONS AT HHS: TWO APPROACHES TO ADMINISTRATIVE JUSTICE IN AN EVER-EXPANDING BUREAUCRACY

Phyllis E. Bernard, J.D., M.A.†

I. INTRODUCTION

IN GREEK LEGEND, the Hydra was a nine-or-so-headed monster vanquished by Hercules in his famous Twelve Labors. The Hydra presented an awe-inspiring challenge to Hercules: as soon as Hercules cut off one of its heads, two more grew in its place. Further, the center head was immortal.

For someone like myself, an attorney whose work has often involved labors with the U.S. Department of Health and Human Services (HHS), the story of Hercules' battle with the Hydra resonates. Litigating against HHS can quickly bring to mind images of the Twelve Labors. HHS — not the Department of Defense — is the largest federal agency, even after creation of the Department of Education. At an annual budget of approximately \$600 billion, if HHS stood alone as a nation, it would be the fourth largest in the world, following the U.S., Japan, and Germany. In terms of specific programs, most of HHS' formidable resources are allocated to So-

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I wish to thank my faculty colleague Michael Gibson for his helpful comments and support. Jeff Lubbers of the Administrative Conference of the United States deserves many thanks for his valuable insights. Of course, any remaining errors are my own.

cial Security retirement and disability, plus Medicare; programs which, despite heralded cut-backs, continue to grow.

What is the immortal center head? In this droll, impressionistic analogy, the Hydra-as-HHS has not one but two center heads which appear immortal. One cries and strives for individual justice. The other fights back, concerned that the needs of the many might have to outweigh the needs of the few, or the one.

In the Greek myth, Hercules ultimately bested the Hydra by poisoning the roots and decapitating the center. Hopefully, in the American reality, the Hydra-as-HHS need only be tamed, not destroyed, and the immortal center can reach accommodation with itself. This article takes a small step in the direction of seeking accommodation.

SEEKING ACCOMMODATION NOW TO PREPARE FOR FUTURE GROWTH

Administrative agency adjudications probably present the clearest arena for examining the seemingly immortal, contrary pulls between individual and mass justice. In HHS those dynamics play out most vividly in two different models of adjudication: the SSA model, using hundreds of employees as administrative law judges (ALJs); and the Provider Reimbursement Review Board (PRRB) model under the Medicare program, using a small panel of independent political appointees as adjudicators, usually sitting en banc. The SSA model (especially for disability cases) generates a high volume of decisions where the initial amount in controversy ranges from small to moderate. It accomplishes this through a process that, in terms of construing evidence, somewhat resembles a judicial assembly-line. The PRRB model, on the other hand, produces a vastly smaller volume of cases involving high initial amounts in controversy. The judicial process there resembles hand-crafted piecemeal work.

In and of themselves conducting a comparison of these two models might well intrigue any scholar of administrative law. However, they deserve examination as more than a mere academic exercise because, just when it seemed HHS could grow no further, HHS is due to expand yet again. After the year 2000, just a few years away, America's post-war baby-boomers will begin making their first claims for coverage by the Social Security safety net. Honoring those claims over the ensuing decades will present an unprecedented fiscal and administrative challenge. Further, the increased

demands of claimants on the Social Security entitlement programs will, in turn, create increased demands on the federal court system — if the processes for administrative resolution and judicial review remain as they currently are.

One government organization recently attempted to grapple with a segment of this future challenge now. The Federal Courts Study Committee (the Committee) was established by the 100th Congress . . . to “examine problems and issues” currently confronting the nation’s courts, and to “develop a long-range plan for the future of the federal judiciary.”¹ This was an historic task, the first such undertaking since the Federal Judiciary Act of 1789. Its statutory mandate required the Committee to assess whether and

1. Pub. L. No. 100-702, § 102, 102 Stat. 4644 (1988) (codified at 28 U.S.C. § 331 (West Supp. 1992)). The Federal Courts Study Committee consisted of 15 members appointed by Chief Justice William H. Rehnquist according to Congress’ statutory instruction, *viz.*, that they be “representative of the various interests, needs and concerns which may be affected by the jurisdiction of the Federal courts.” Pub. L. No. 100-702, § 103(b) (1988). In keeping with that objective, the Committee included two members from each house of Congress, two federal district court judges, three federal courts of appeals judges, one state supreme court chief judge, two private practitioners, two federal prosecutors and one state public advocate. By December 1988, one month after the Committee’s creation, they began work.

Under the chairmanship of the Honorable Joseph P. Weis, Jr. of the U.S. Court of Appeals for the Third Circuit, the Committee solicited the views of all members of the federal judiciary by use of a survey. Clearly, information concerning workload for federal judges was critical. Therefore, the Committee sent questionnaires on this issue to all Article III judges. The response rate was extremely high — 90%. They also contacted all federal court administrators and law school deans. Next, the Committee invited suggestions from already constituted groups which fairly represented the diversity of viewpoints Congress sought: citizen groups, bar organizations, research groups, academics, and civil rights interests. In order to provide a broad forum for discussion, the Committee also held four public hearings in Atlanta, Boston, Chicago and Pasadena. A total of 78 witnesses testified in the series of hearings held in the winter of 1989-90. Finally, the Committee sought commentary and studies from organizations which observe the federal court system as some part of their on-going mission or on contract: the Administrative Office of the United States Courts, the Federal Judicial Center, the Carnegie Foundation, and the Center for Public Service Resources. Joseph F. Weis, Jr., *The Federal Courts Study Committee Begins Its Work*, 21 ST. MARY’S L.J. 15, 16-17 (1989).

The Committee cast a wide net to gather expeditiously the most significant problems and issues to bring before Congress, the Supreme Court, and the President by April 1990. In terms of administrative law, those highly ranked problems and issues seemed to revolve primarily around Social Security disability claims. This subject largely eclipsed concerns about agency and appellate review of the multitude of other federal programs. The exceptions are few: the Equal Employment Opportunity Commission, recommending “a five-year pilot program whereby the Equal Employment Opportunity Commission, with the consent of both parties, would offer binding arbitration of claims of employment discrimination,” and the National Labor Relations Board, recommending that “Congress should amend 29 U.S.C. § 160 to provide that National Labor Relations Board orders be self-enforcing and to give jurisdiction over contempts and executions to the district courts.” REPORT OF THE FEDERAL COURTS STUDY COMMITTEE [hereinafter REPORT] at 19, 60-62, 96, 100-101 (April 2, 1990). To the extent that the Report treats administrative review generally, that consideration is

how the structure of the federal court system should be changed to improve access and efficiency. Numerous committees, commissions, and task forces had previously examined segments of this conundrum. This Committee was the first to cast a broad view, attempting to identify key problems of the entire federal court system in one ambitious report.

In terms of government entitlement programs, the Committee focused its main inquiry on the Social Security disability program and its ALJs, which are so numerous as to form the largest single body of ALJs in the entire federal administrative judiciary. The Committee determined that, as a first step, the system needed to be reformed to limit severely the availability of judicial review by an Article III court. The Committee proposed that review of the Social Security administrative judiciary be had by a newly established Article I Social Security Court. Consequently, only issues of pure law could be heard by the Article III federal courts.

The Committee believed that this proposal would significantly aid in decreasing expected future congestion in federal courts. However, the Committee seemed to leave open for further research and discussion the question of whether this new model for adjudication would satisfactorily respond to increased future congestion at the agency level. Furthermore, this model would severely limit Article III court review — which many perceive as the only review which constitutionally guarantees institutional impartiality and independence of judgment. This would place much greater burdens on agency adjudicators to demonstrate somehow that individual fairness could be achieved in an almost assembly-line process.

Clearly, the Report of the Federal Courts Study Committee (Report) did not expect to reveal *and* to resolve the system's

limited to a recommendation not to establish a specialized Article III administrative court. *Id.* at 72-73, 116-24.

This article, in essence, takes up where the Committee left off. The Committee performed the formidable work of surveying the nation to determine what problems deserved highest priority for the long-range health of our federal system of justice. In so doing, the Committee developed some 100 suggestions for changes. Congress moved quickly to adopt legislation addressing the many non-controversial proposals of the Committee. Indeed, the Report was published April 2, 1990; by fall, 1990. Title III of the Judicial Improvements Act of 1990, "Implementation of Federal Courts Study Committee Recommendations," was law. For a fuller presentation of the legislation and its changes, see 136 CONG. REC. 150, Pt. II S17577-17583 (daily ed. Oct. 27, 1990) (comments of Sen. Grassley, Floor Manager and former member of the Federal Courts Study Committee, plus section-by-section analysis of Title III); 136 CONG. REC. 150 Pt. III S17904-17915 (BIDEN, MOORHEAD); 136 CONG. REC. 150 Pt. II H13315-13316 (REP. MOORHEAD) (daily ed. Oct. 27, 1990) (Rep. Moorhead, former member of the Federal Courts Study Committee).

problems in one document. In fact, the authors of the Report admonish that their efforts do not represent the end, but rather mark the beginning of a longer, more probing study of the issues raised therein. The Report counseled that "Congress, the courts, bar associations and scholars should give the problem of appellate procedure serious attention over the next five years." In particular, the Committee urged us to engage now in analyzing "the strengths and weaknesses of more far-reaching changes." Such foresighted analysis should help moderate disruption to the legal system "if and when such changes become necessary."²

Taking that charge to heart, this article adopts the recommendation by the Committee to establish a Social Security Court and marks the trajectory of that proposed "far-reaching change." This article attempts to describe where such change might lead if it were applied in time to more adjudications under the Social Security Act (SSAct).³ The article focuses specifically on how such a proposal might affect the procedures for review of disputes between large, institutional providers of services under Medicare⁴ and the government, since these payments form the largest single category of disbursements under the Medicare program, roughly \$50 billion annually.⁵ Procedures for Medicare review in the last three years have received little in-depth attention by scholars despite some interesting developments in the area.⁶

2. REPORT, *supra* note 1, at 116.

3. Federal Old-Age, Survivors, and Disability Insurance Benefits, 42 U.S.C. §§ 401 *et seq.* (1990) (original version Pub. L. No. 74-271, 49 Stat. 620 (1935)).

4. Health Insurance for the Aged and Disabled, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.* (1990) (added July 30, 1965, Pub. L. No. 89-97, 79 Stat. 291).

5. To quote from the findings of the Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration:

Medicare program benefits amounted to \$76 billion in 1986, 7.8 percent more than in 1985. Because of the nature of the program, two-thirds of benefit payments were for hospital services; almost all of the remainder were for physician services. Nationwide, Medicare is the largest single purchaser of hospital care and physician services, accounting for 29 percent of all hospital revenue and for 21 percent of physician services.

8 HEALTH CARE FIN. REV. 13 (Summer 1987).

6. An informal review of the literature shows that although writers have begun to examine the system of administrative and judicial review for institutional claims under the Medicare program, this examination generally has stopped short of the most recent changes in this system. See, e.g., Richard J. Wolf, Note, *Judicial Review of Retroactive Rulemaking: Has Georgetown Neglected the Plastic Remedies?*, 68 WASH. U. L.Q. 157 (1990); Douglas E. Cressler, Note, *Medicare Provider Reimbursement Disputes: Mapping the Contorted Borders of Administrative and Judicial Review*, 21 IND. L. REV. 705 (1988); Kathleen A. Carrigan, Comment, *Administrative Law — Jurisdictional Authority of the Provider Reimbursement Review Board*, 10 W. NEW ENG. L. REV. 183 (1988). Prof. Kinney's comprehensive overview of the Medicare appeals system also largely pre-dates the changes discussed within this arti-

THE POSSIBLE FUTURE OF ADJUDICATIONS FOR FEDERALLY SPONSORED HEALTH SERVICES

While the precise future of Medicare is unclear, one can rest assured that some form of federally sponsored health services will be an important part of our nation's future. Indeed, as of this writing, both major political parties and innumerable non-partisan organizations have proposed and lobbied hard for various plans to achieve comprehensive national health reform. For many of these proposals, Medicare, either in its current form or somehow revamped, plays a central role.

Although the overall form may not be certain, one thing is: whatever the plan for federal sponsorship of health services, there will be disputes over payment; and because these plans are supposed to offer universal coverage, the volume of disputes over health payments will increase logarithmically, compared to today's numbers.

Another factor is certain: the tenor of the long-standing, sometimes contentious debate between the provider community and HHS concerning administrative adjudication under Medicare will increase in intensity. For example, the hospitals, nursing homes and home health agencies which have been subject to HHS' process for resolving Medicare payment disputes will no longer have a margin, a cushion to rely upon in case of a protracted adjudicatory process or in case of a contrary decision. Virtually from the inception of Medicare, there has been a tacit, winking understanding that when institutional providers are unable to recover their full, bona fide costs for providing care under the Medicare program, those institutional providers will shift the costs to private payers — despite statutory provisions to the contrary. Under a comprehensive system for health services, such cost-shifting will no longer be possible.

Clearly, this would be most especially true if one of the currently leading proposals were adopted. That option would simply expand Medicare to provide universal coverage.⁷ If this does occur, we shall need to examine with great care the procedural mecha-

cle, specifically the resolution of PRRB jurisdiction to hear claims under the Prospective Payment System (PPS), where the Secretary attempted by regulation to foreclose administrative and judicial review. See Eleanor D. Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L.J. 1, 105 (1987); also J. Timothy Phillips & Don E. Wineberg, *Medicare Prospective Payment: A Quiet Revolution*, 87 W. VA. L. REV. 13 (1984); Michael Neeley-Kvarme, *Administrative and Judicial Review of Medicare Issues: A Guide Through the Maze*, 57 NOTRE DAME LAW. 1 (1981).

7. See, e.g., Karen Davis, *Expanding Medicare and Employer Plans to Achieve Universal Health Insurance*, 265 JAMA 2525 (1991). Also Donald Nutter et al., *Restructuring Health Care in the United States: A Proposal for the 1990s*, *id.* at 2516. The proposal to

nisms for resolving citizen-government disputes over health insurance payments. Will the adjudicatory model favor that of the SSA or the PRRB? Will it be a blend of the two? Will it add wholly new components? We need to develop a legal process that allows access to administrative and judicial review while not overly burdening the court system. Of course, in this best-of-all-worlds scenario, we probably need to fashion an administrative review system which manages to assure fairness with a minimum of court review. And limited court review is precisely what the Federal Courts Study Committee recommended for at least one program under the Social Security Act.

OVERVIEW OF THIS ARTICLE

We can also fully expect that if and when this increase in substantive coverage occurs, we shall see a several-fold increase in the number of persons and institutions questioning whether the procedural protections provided under the program are sufficient. If the Committee's recommendation is accepted, then the ultimate question may be whether limiting access to the Article III courts is just. Perhaps the ultimate answer will be that the propriety of limiting access to Article III court review depends upon the reliability, fairness and efficiency of the administrative review process below.

This article attempts to get a "head start" on that debate, fashioning a legal discussion before the debate is overtaken as a political issue. We begin with the Committee's recommendation as it was presented, and then extrapolate questions raised by that recommendation to the Medicare appeals system as it currently exists.

Thus, Part II outlines the Federal Courts Study Committee's recommendation that Congress create an Article I Court to replace federal district courts in the appeal of disability claims under the SSAct. Actually, the recommendation to establish a specialized court is not new, and has progenitors reaching back to the establishment of the Administrative Procedure Act itself.

Part III takes an historical look back to identify themes relevant to the current and future system for review of Medicare disputes. Certain thematic concerns shaping discussion of the Federal Courts Study Committee's recommendation have existed from the very beginning of the Social Security Act and the Administrative Procedure Act. This section traces how, decade after decade, Congress

expand Medicare coverage for all citizens has the strong support of major unions, such as the United Auto Workers, and major employers, such as Chrysler Corporation.

has expanded substantive coverage under various titles of the SSAct while procedural mechanisms for handling the increased volume of agency cases lagged far behind. Eventually, the increased pressure on the administrative system caused a shift in the tone of the discussion.

The debate over administrative and judicial review from the 1930s through the 1960s struggled with how to expand access and improve efficiency in processing appeals. In the 1970s and '80s, budget restraints loomed increasingly important — not only in terms of substantive coverage under SSAct programs, but also regarding procedure in SSAct appeals. The term “efficiency” in the administrative review process took on a connotation other than “timely, prompt.” At least from the perspective of the executive branch, an “efficient” system for adjudication became one which reasonably assured that decisions by ALJs conformed to agency methodologies for reaching budget targets. This change caused some to refocus their attention when analyzing the review system.

Of critical concern in structuring a system of administrative justice is whether those acting in a quasi-judicial capacity are insulated from improper pressures that seek to control program costs at the expense of individual justice. Thus, this section concentrates on the themes which enable us to identify the areas in the system that possibly create undue pressure on adjudicators. This discussion closes with the establishment of the Provider Reimbursement Review Board, an independent tribunal within HHS designed with the objective of insulating the decision-makers from such pressures.

Part IV turns from the lessons of the past to the challenges of the present. Concerns which plagued the system for administrative review of disputes under Title II of the SSAct, the disability program, are tested in the context of Title XVIII, the Medicare program. This section examines more closely the Secretary's non-acquiescence with regard to the most critical procedural matter which has yet faced Medicare Part A: the availability of administrative and judicial review under the Prospective Payment System (PPS). I also explore certain policies of managerial and budget control which, inadvertently, perhaps threaten the independence of the Board staff, if not the Board members.

Finally, in Part V, I make preliminary recommendations for further study. This article is only the first of a three-part, mid-range study of this subject. Further study includes questioning how creating a Social Security Court with expanded jurisdiction to cover national health insurance disputes might comport with developments

in administrative law in other Western countries. In its Report the Federal Courts Study Committee alluded to how European jurisprudence has long recognized a need for specialized courts, especially for administrative matters. Here I suggest looking more closely at that reference and question its applicability to American administrative law, our health care financing system, and American perceptions of justice.

Next in Part V, I suggest some options which the Federal Courts Study Committee did not examine in its Report. Whether we look at Medicare provider adjudications for the purpose of more efficiently clearing the current 6,000 case backlog; or, whether we look at those adjudications to create a model which can more efficiently handle a greatly increased volume of health payment disputes in the not-so-distant future — a different adjudicatory model than either that of the PRRB or the SSA may be needed. That model might create a new layer of ALJs, whose decisions are reviewed by the PRRB. Further judicial review (either to an Article I or Article III court) might be severely limited. That model might, in addition, include alternative dispute resolution to handle smaller claims (less than \$50,000) and an ombudsman system to avoid the confusion that leads to payment disputes in the first place.⁸

II. MAPPING THE CONTOURS OF THE FUTURE CHALLENGE

A. Challenges Facing the Next Generation of SSAct Appeals

The Federal Courts Study Committee attempted to direct the legal community's attention to the fact that here, in the first half of the 1990s, we face a singular opportunity to make fundamental adjustments to our system of judicial review over the next generation or more. Surely, some of the most profound questions of real and perceived justice in the modern administrative state are: Who shall have access to Article III federal court review of administrative adjudications? If there were no such review, or if the review were limited, has justice been done? On the other hand, if Article III courts are overburdened by reviewing tens of thousands of highly

8. I am grateful to say that in August, 1992 the Council of the Administrative Conference of the United States placed these inquiries on the ACUS research agenda. Also in September, 1992 the National Advisory Committee on Rural Health adopted as part of its principles of health care reform that "A reform program must include efficient, alternative systems for the resolution of payment issues and conflicts."

technical adjudications annually, does the loss of efficiency itself work an injustice?

Regarding this issue, the Committee chose to focus most closely on judicial review of one class of administrative adjudications under the SSAct — disability claims. The wisdom of this starting point readily manifests. The Social Security disability program⁹ presents a massive, easily identified — yet not readily resolved — problem in administrative justice. Access to court review confronts the need for efficiency in resolving disputes in a clash that is vivid, tangible.¹⁰

I venture to predict that before the decade has drawn to a close, we shall see a convergence of public interest in this question of access and efficiency. Whether we look to the popular press, the community of scholars, the Congress, or the executive branch, I believe that we shall see sustained, national concern over administrative justice in adjudications.

This concern will focus on much more than only disability claims. The entire range of programs under the Social Security Act will experience heightened strain as increased numbers of claimants wrestle with the government for benefits which are seen as “budget busters”: retirement benefits, survivors’ benefits, Aid to Families with Dependent Children, Medicaid, Medicare. Since the executive and legislative branches appear unwilling to confront program cuts in the open arena of the budget process, the financial exigencies of these massive benefit programs will probably be played out in the closed arena of agency adjudications. If the government continues on the course which it began in the 1980s, then, on a case-by-case basis benefits will be questioned and reduced, payment policies will be tightened, all in an effort to satisfy budget needs.¹¹ In the

9. Federal Old-Age, Survivors, and Disability Insurance Benefits, 42 U.S.C. § 423, (1990) (*amending* ch. 531, Title II § 223, as added Aug. 1, 1956).

10. The leading work on the clash between access and efficiency in the disability program is Jerry L. Mashaw, *BUREAUCRATIC JUSTICE: MANAGING SOCIAL SECURITY DISABILITY CLAIMS* (1983). *See also*, Jack B. Weinstein, *Equality and the Law and Social Security Disability Cases in the Federal Courts*, 35 SYRACUSE L. REV. 897 (1984) (giving a human face to the steps involved in this conflict).

11. For example, as the result of a hard-fought legislative, regulatory and court battle from 1982 through 1987, the Medicare program finally implemented an adjustment to hospital payments which provided a small amount of additional monies to hospitals that serve a “disproportionate share of low-income” and Medicare patients, as set forth in 42 U.S.C. § 1395ww (d)(5)(C)(i) (1992). This payment adjustment has represented for many public hospitals the critical margin which enables them to continue to serve the indigent populations for whom these hospitals are the provider of last resort. *See* Redbud Hosp. Dist. v. Heckler [1984-2 Transfer Binder] MEDICARE AND MEDICAID GUIDE (CCH) ¶ 34,085, at 9882 (N.D. Cal. July 30, 1984). The Secretary had been so reluctant to issue the regulations mandated by Congress that Congress had finally implemented the provisions by statute. *Id.* Then, approx-

meantime, the very process will, perforce, greatly increase the volume of appeals. And those claimants will likely expect to have access to a federal court for review of actions taken by the Department of Health and Human Services in order to feel that justice has been done.

How can we examine the legal nuances of stretching the Social Security Act appeals system — and judicial review of that system — to fit the demands of the next generation? At first look, the very idea of taking on the entire Act's appellate process seems indeed like wrestling a hydra-headed phantom. At second look, one program under the Act emerges as a particularly likely candidate for closer, and fruitful, examination: the Medicare program.

By sheer dollar amount, Medicare ranks second only to the retirement benefits program in importance. Moreover, its payment policies drive the entire health care industry — the second largest activity in the U.S. economy, representing 12% of the gross national product. (National health expenditures are expected to reach \$1.5 trillion by 2000, representing 15% of the GNP.)¹² Typically, hospital expenditures have outpaced growth in the GNP by about 4.5% annually.¹³ The pressures on the federal budget are considerable. If only because of demographic pressures, as the numbers of Medicare-eligible persons increase, so shall the pressures on the Medicare budget. Therefore, so shall the pressures on the appellate process increase.

Furthermore, as mentioned earlier, the Medicare program may

imately a year later, HCFA's Office of the Inspector General began to target Medicare bad debts — typically incurred by hospitals serving large proportions of indigent patients — for special audits, even after the amounts claimed had been approved by the fiscal intermediaries. See, e.g., OFFICE OF THE INSPECTOR GENERAL, OFFICE OF AUDIT, HHS, BLUE CROSS AND BLUE SHIELD OF COLORADO - REVIEW OF MEDICARE BAD DEBTS FOR THE PERIOD JULY 1, 1982 THROUGH DECEMBER 31, 1986 [includes Denver General Hospital, St. Anthony Hospital System - seeking approximately \$300,000 in additional recoveries from the hospitals] (March 1, 1988); BLUE CROSS AND BLUE SHIELD OF TEXAS, INC. - REVIEW OF MEDICARE BAD DEBTS FOR THE PERIOD SEPTEMBER 1, 1980 THROUGH DECEMBER 31, 1986 [includes Harris County Hospital District, Santa Rosa Medical Center, University of Texas Medical Branch at Galveston - seeking approximately \$4 million in additional recoveries from the hospitals] (November 22, 1988); BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC. - REVIEW OF MEDICARE BAD DEBTS FOR THE PERIOD OCTOBER 1, 1981 THROUGH SEPTEMBER 30, 1986 [includes Jackson Memorial Hospital, Southeastern Medical Center, Florida Medical Center - seeking approximately \$2.7 million in additional recoveries from the hospitals] (October 28, 1988).

12. Helen C. Lazenby & Suzanne W. Letsch, *National Health Expenditures, 1989*, 12 HEALTH CARE FIN. REV. 1 (Winter 1990); Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration, *National Health Expenditures, 1986-2000*, 8 HEALTH CARE FIN. REV. 1 (Summer 1987).

13. Division of National Cost Estimates, *supra* note 5, at 17.

earn the dubious distinction of forming the centerpiece for debate on the issue of universal health insurance. A consensus is developing that America must establish some sort of national health insurance. The precise legislative vehicle remains wholly unclear. But political will and vision may not coalesce to create an entirely new program. Therefore, some pragmatists have renewed the suggestion that we merely expand Medicare coverage to include all Americans, not only the elderly and the disabled. This option has the benefit of familiarity — and seemingly breeds less contempt as the more innovative alternatives grow less feasible.¹⁴

The Medicare program in 1986 covered approximately 31 million persons. By 2000 it is estimated that our national population will reach more than 275 million.¹⁵ Even assuming that *all* Americans would not necessarily enroll in an expanded Medicare program, the increase still would be staggering. And one must assume that the difficulties in obtaining efficient review of Medicare disputes will similarly increase many fold. Query: will this high volume of appeals be adjudicated through the faster yet less sensitive SSA-ALJ model or through the slower yet more discretionary PRRB model? Regardless, without other changes, the often-feared “flood” of appeals to the federal courts would no longer be apocryphal. Just extrapolating the numbers results in a very real increase in an already overwhelming federal caseload. Congress may then need to revisit the recommendations of the Federal Courts Study Committee. Congress may question whether an Article I court is needed in order to bank the flood of appeals to Article III federal courts. Even more so, Congress may need to question whether a new model for

14. This proposal actually is far from new, but it has progressed at a glacial pace. When President Franklin D. Roosevelt transmitted to Congress the report of the Committee on Economic Security, resulting in the Social Security Act of 1935, he affixed a formal message, recommending the following types of legislation:

1. Unemployment compensation.
2. Old-age benefits, including compulsory and voluntary annuities.
3. Federal aid to dependent children through grants to States for the support of existing mother's pension systems and for services for the protection and care of homeless, neglected, dependent, and crippled children.
4. Additional Federal aid to State and local public health agencies and the strengthening of the Federal Public Health Service. *I am not at this time recommending the adoption of so-called "health insurance," although groups representing the medical profession are cooperating with the Federal Government in the further study of the subject and definite progress is being made* (emphasis added).

H.R. DOC. 81, 74th Cong., 1st Sess. (1935), as reprinted in *STATUTORY HISTORY OF THE UNITED STATES: INCOME SECURITY* 96 (Robert B. Stevens ed., 1970).

15. Division of National Cost Estimates, *supra* note 5, at 13, 19.

administrative adjudication must be developed, one which blends the best of both, or adds new components entirely.

B. Efficiency vs. Fairness

This article, then, proceeds on the assumption that Congress will continue — on a somewhat slower track — to examine the more controversial proposals set forth within the Report. Of particular concern here is the Committee's recommendation that Congress establish a specialized court for Social Security disability claims. This Comment further assumes that, since the Committee placed a high priority on making the Social Security program more efficient, Congress may in time see a need to consider rationalizing appeals taken under the entire Social Security Act.

A point which the Committee does not underscore in its Report carries much weight here: The Social Security Act is a massive piece of legislation. It governs not only disability claims, but retirement insurance, survivors' insurance, and Medicare, plus Aid to Families with Dependent Children and Medicaid. Its provisions probably have a direct impact on more citizens of this nation than any other statute, except for the Internal Revenue Code.¹⁶ Furthermore, similar to the I.R.C., its terms are complex and highly techni-

16. I.R.C. - § 1-7605 (West 1992).

This article covers the programs under Titles II, XVI, and XVIII of the Social Security Act. The SSA-ALJ model applies not only to Social Security disputes, but also to beneficiary or supplier claims under Medicare Part B (Medical Insurance) and smaller provider claims under Medicare Part A (Hospital Insurance). The appellate procedures, comparatively, are displayed in the summary table below:

Titles II and XVI		Title XVIII	
Retirement & Disability	Medicare Beneficiary or Supplier (Part B)	Medicare Provider \$100-\$9,999 (Part A)	Medicare Provider > \$10,000 (Part A)
Initial Determination by SSA Staff	Initial determination by Carrier (private entity operating under contract as fiscal agent for HCFA)	Initial Determination by Intermediary (private entity operating under contract as fiscal agent for HCFA)	Initial Determination by Intermediary
Reconsideration by SSA Staff	Carrier Hearing	Intermediary Hearing	N/A
Hearing before SSA ALJ	Hearing before SSA ALJ	Hearing before SSA ALJ	Hearing before PRRB
Final unless acted upon by SSA Appeals Council	Final unless acted upon by SSA Appeals Council	Final unless acted upon by SSA Appeals Council	Final unless acted upon by HCFA Administrator
Appeal to Article III Federal Courts	Appeal to Article III Federal Courts	Appeal to Article III Federal Courts	Appeal to Article III Federal Courts

cal, as explained through elaborate compilations of regulations and manual provisions.

In other legal arenas, such complexity has formed the basis for creating a separate, specialized court to review in appropriate detail the arcane points involved. Practitioners in those specialty areas have largely rated these courts successful — in fact, resoundingly so.¹⁷ Any attorney can readily empathize. It must be far more convenient and efficient (perhaps, though, also intimidating?) to try cases before a judge with proven expertise in the minutiae of highly technical arguments.

Nevertheless, such efficiency can come at a cost to the larger system of jurisprudence. The judge's expertise in technical areas of fact does not insure sound outcomes with regard to law, both substantive and procedural. Furthermore, undue specialization in any court carries the potential for balkanizing the judiciary. A court's narrow focus on law in one specialty area may ineluctably lead to the development of a separate, artificial nation-within-a-nation, which is not in line with trends in law as crafted by other courts generally.

This is a delicate scale to construct. Even the component parts defy easy identification. What factors need to be considered in determining whether the process provides a proper opportunity for persons to seek redress against their own government when they believe they have suffered injury? This requires an examination of the procedures offered. Most especially this requires a strong look not only at the law, but at how well or poorly that law works when applied in practice. On the other hand, surely we cannot create a system of administrative adjudication that will permit each and every claimant an extensive live hearing with multiple levels of review. The system would grind to a virtual standstill if the procedures allowed perfect, individual fairness.

Well then, we are forced to accept that in a system of mass administrative justice a certain amount of gritty reality must creep in: we must tolerate a certain level of unfairness. However, there must

17. See, e.g., Ellen R. Jordan, *Specialized Courts: A Choice?*, 76 NW. U. L. REV. 745 (1981) (providing a helpful history and discussion of the debate concerning establishment of courts where technical expertise is required).

Due to the increased number of cases where policy must be made concerning complex scientific matters, some have even proposed establishing a federal Science Court. See, e.g., Jeffrey N. Martin, Note, *Procedures for Decisionmaking Under Conditions of Scientific Uncertainty: The Science Court Proposal*, 16 HARV. J. ON LEGIS. 443 (1979) (proposing the establishment of a federal court due to the increased number of cases where policy must be made concerning complex scientific matters).

be a check on that unfairness. Who, then, decides whether the level of imperfections has become intolerable in any given situation? The courts. Indeed, maintaining access to the Article III courts has been the safety valve which has assured a sense that justice was achievable, even in a massive system that grudgingly accepts its gritty imperfections.

The recommendation of the Federal Courts Study Committee would seem to change the balance we have heretofore known. The Committee's proposed model already exists at the Court of Veterans Appeals. Now, that model would be extended to titles under the Social Security Act. Access to Article III courts would be severely limited, compared to the current procedural structure. In their place would stand a specialized Article I court handling only disability matters.¹⁸

18. The use of non-Article III bodies, which lack the constitutionally-protected independence of judges under the federal court system, is controversial. It is also quite old. See generally Richard L. Revesz, *Specialized Courts and the Administrative Lawmaking System*, 138 U. PA. L. REV. 1111 (1990) (presenting the history and current status of specialized Article I and Article III courts); Richard H. Fallon, *Of Legislative Courts, Administrative Agencies, and Article III*, 101 HARV. L. REV. 916 (1988) (providing a full discussion of the constitutional dimensions of the controversy); George E. Dix, *The Death of the Commerce Court: A Study in Institutional Weakness*, 8 AM. J. LEGAL HIST. 238 (1964) (offering a deep look at the two characteristics which doomed that particular court (which existed from 1910-1913), and would surely doom any other specialized court).

[T]he creation of the court was essentially an attempt at administrative reform which unintentionally interjected a new element into a context of struggle among powerful groups. Bound by its functional nature to encounter the opposition of some of these groups, the Commerce Court failed because it lacked two important characteristics, either of which might have enabled it to survive the controversy:

1. The court failed to attract the active support of any of the influential interests involved.
2. It lacked the "judicial insulation" which in other cases restricts attacks upon courts to criticism within 'the context of high public respect for the judiciary.' [citation omitted]

Id. at 239.

The mechanics of personnel selection, and the environment in which thereafter they carry out their duties would be critical in determining the acceptance of the Federal Court Study Committee's recommendation. As Prof. Dix further explained with regard to the Commerce Court:

In several important aspects, the new tribunal created in the public mind an image more clearly resembling that of an administrative agency than of a legitimate judicial body. A large part of the responsibility can be traced to the personnel of the Commerce Court, who, for several reasons, tended to resemble policy-oriented administrative officials rather than impartial judicial officers.

Id. at 255.

Rightly or wrongly, that impression began with the fact that Commerce Court judges "were appointed by the Supreme Court Chief Justice from within the existing court system," which smacked of "promotion within an administrative hierarchy." Added to that, Commerce Court judges had only five-year terms of appointment, which contrasted sharply with the "life tenure of judges on other federal benches." The position of Commerce Court judges

Where did the Committee strike the balance between efficiency and fairness? True to its statutory charge, the Committee appears to have seen its task primarily as identifying methods of processing the caseload of the federal court system in a more timely manner. This is where the balance point appears set. Impliedly, the other factors in this delicate scale will come into alignment around that. And the Committee, in turn, charged scholars and others in the legal community to examine in more detail whether and how those other factors can align.

C. Reviewing the Committee's Recommendations

As described by the Federal Courts Study Committee, the current appeals process for Social Security disability claims consists of four stages.¹⁹ This process has suffered yet survived much criticism over the past 20 years, reaching an apparent climax in the 1980s.

"seemed much like the limited terms of top administrative agency personnel. Contemporaries were aware of the possible implications of the deviation from traditional methods of judicial appointment." As the Commissioner of the Interstate Commerce Commission suggested, if the Commerce Court were to be taken seriously, then judges should be appointed by the president for life terms, as are Article III judges. "I think a court appointed in the usual way would command the confidence of the country and of these conflicting interests in a way that a court constituted in any other way would not." *Id.*

In reviewing the seemingly inconsistent variety of adjudicatory models, a recent study by the Administrative Conference of the United States found:

Perhaps the most compelling comparison between two systems performing virtually identical functions involves disability determinations by the Social Security Administration and the Veterans Administration. The SSA decides large numbers of disability cases informally—that is outside the formal adjudication requirements of the APA—yet it uses ALJs to do so. The VA on the other hand decides its disability cases informally and hears decisions before three-person panels of non-ALJ deciders. Moreover the SSA decisions are subjected to close oversight by the district courts, whereas the VA decisions are reviewed by an Article I Court of Veterans Appeals with little federal court oversight.

Paul Verkuil et al., *The Federal Administrative Judiciary* (Draft) at 42 ADMINISTRATIVE CONFERENCE OF THE UNITED STATES, May 1992.

19. The Federal Courts Study Committee's count can give rise to a small bit of confusion. It counts the tiers of *appeals* as (1) a hearing before a Social Security ALJ, (2) a review by the Appeals Council of the SSA, (3) review of the administrative record in the district court, and then, (4) at the court of appeals, *de novo* review of the district court's decision. However, this count does not include the initial step of review of the claim by the state agency, which other writers on the subject include to create a five-step claims and appeals process. *E.g.*, ROBERT E. FRANCIS, *SOCIAL SECURITY DISABILITY CLAIMS: PRACTICE AND PROCEDURE*, § 1:04 (Callaghan & Co. 1991).

The SSA's own regulations count the appeals process as beginning not with the claim, nor with the ALJ hearing, but with reconsideration of the initial determination. 20 C.F.R. § 404.907 (1990):

Reconsideration is the first step in the administrative review process that we provide if you are dissatisfied with the initial determination. If you are dissatisfied with our reconsidered determination, you may request a hearing before an administrative law judge.

This negative attention centered particularly on whether the decision-makers enjoyed sufficient independence from political pressures within the executive branch so that they could perform genuinely disinterested reviews of claims against the agency. Critics often pointed to the rate of reversal upon review by Article III courts as an indication that the administrative reviewers harbored an inherent, institutional bias in favor of the government and against the private claimant.

As the process is drawn by the Federal Courts Study Committee, one might seem encouraged to accept that, like most federal programs, a claimant's appeal begins with the federal executive agency. Actually, the disability program operates in the initial phase as a federal-state joint venture. As expected, the federal Social Security Administration (SSA) receives claims for disability benefits, but then the federal district office transmits the claim to a designated state agency to process according to federal regulations and guidelines. It is the state agency, not the federal district office, which develops the medical evidence and other relevant evidence to prove or disprove a person's claim. The state determination is issued as a federal decision.²⁰ If a claimant is dissatisfied with the initial determination of disability, the Social Security regulations provide for a reconsideration of the initial determination.²¹ That reconsideration follows the same slightly circuitous procedure: federal agency to state agency to federal agency.²²

20. See 42 U.S.C. § 421(a)(1)-(2) (1988).

21. 42 U.S.C. § 421(d) (1988); 20 C.F.R. §§ 404.907-909, 911, 913-922 (1990). As set forth in § 404.916(c):

After you request reconsideration, your case file will be reviewed and prepared for the hearing. This review will be conducted in the component of our office (including a State agency) that made the initial or revised determination, by personnel who were not involved in making the initial or revised determination. Any new evidence you submit in connection with your request for reconsideration will be included in this review. If necessary, further development of the evidence, including arrangements for medical examinations, will be undertaken by this component. After the case file is prepared for the hearing, it will be forwarded by this component to the disability hearing officer for a hearing.

22. See Deborah A. Chassman & Howard Rolston, *Social Security Disability Hearings: A Case Study in Quality Assurance and Due Process*, 65 CORNELL L. REV. 801, 805 (1980) (offering some interesting insights into how the system worked in the 1970's, changes in the 1980's, and explaining one perspective on the difficulties in controlling the quality of the state and federal review function). Some of the appellate procedures have changed since this article was published; nevertheless it offers some interesting insights into how the system worked in the 1970s, leading to changes in the 1980s. Chassman and Rolston had assisted in developing and operating a quality assurance system at the SSA Office of Hearings and Appeals during the 1970s.

In the current literature, the Report for Recommendation 87-6 by the Administrative Conference of the United States (ACUS) for improving this level of disability review is, of

The Committee did not propose to modify or eliminate this initial federal-state adjudication of claims. Instead the Committee really commenced its examination of the review process with the next step, where the state agency no longer participates.

After the reconsideration, a claimant can obtain a formal SSA hearing which may be oral or written.²³ The great bulk of such hearings are solely on paper. This hearing is conducted by an administrative law judge (ALJ) who is an employee of the Social Security Administration.

The Committee did not detail the ALJ's role in the hearing, and so an additional comment is appropriate here. Historically, the ALJ in an SSA appeal did not function solely as an arbiter between the government and the citizen. The proceeding was ostensibly non-adversarial. The ALJ therefore served as more than merely judge. In the eyes of some, that dual role was as quasi-advocate for the claimant. In the eyes of others, the dual role was, instead, as quasi-prosecutor. In recent years, the trend has been to encourage increasing formalization in the procedures used at this level, in order to assure due process.²⁴

The next stage consists of a review by the Appeals Council of the SSA Office of Hearings and Appeals.²⁵ The Appeals Council was established by regulation (not statute) in 1940. The jurisdiction of the Appeals Council and the ALJs extends beyond the disability cases under Titles II and XVI (the Supplemental Security Income or SSI program) of the Social Security Act, on which the Federal Courts Study Committee focused. Rather, the Appeals Council also reviews ALJ hearing decisions concerning beneficiary claims and smaller institutional (provider) claims under the Medicare program, which is Title XVIII of the Social Security Act.²⁶

course, critical for understanding the nuances of this process in terms of administrative justice. See Allen E. Shoenberger, *State Disability Services' Procedures for Determining and Redetermining Social Security Claims for the Social Security Administration*, 1 ACUS RECOMMENDATIONS AND REPORTS 579 (1987) (discussing the weaknesses and strengths of the reconsideration process).

23. 42 U.S.C. § 421(d) (1988). The actual procedures are set out in the regulations at 20 C.F.R. § 404.929-404.961 (1992).

24. See, Frank S. Bloch, *Report and Recommendations on the Social Security Administration's Administrative Appeals Process*, ACUS REPORT AND RECOMMENDATIONS 307, 369-70 (1990) (emphasizing the independent status of the ALJ from the investigation or prosecution); and *Recommendation 90-4, Social Security Disability Program Appeals Process: Supplementary Recommendation*, *id.* at 17 (summarizing prior recommendations in this area).

25. 20 C.F.R. § 404.967 (1991).

26. 42 C.F.R. § 422.205(a) (1992). This Comment will not focus on Medicare Part B hearings, since the larger program issues (in terms, particularly of dollar amounts) are on the

Review by the Appeals Council exhausts a claimant's administrative remedies — and often the claimant's pocketbook or stamina.²⁷ If the claimant still has the wherewithal to contest the agency's determination, then she may proceed to federal district court. There the court will review the administrative record to decide whether substantial evidence supported the agency's action. This stage does not provide *de novo* review. The decision-maker at this level is an Article III judge with lifetime tenure.

The last step in the four-stage process takes the claimant to the U.S. circuit courts of appeal. Here, the judge takes *de novo* review of the decision rendered by the district court. Again, the judge enjoys lifetime tenure, protected by his status under Article III of the Constitution.

This, then, is the administrative appeals process which the Federal Courts Study Committee ranked as most in need of immediate and substantial reform when compared to other federal agencies. Verbatim, the Committee recommended the following:

Congress should create a new structure for adjudicating disability claims under the Social Security Act: hearings before administrative law judges with adequate institutional independence, whose decisions could be appealed to a new Article I Court of Disability Claims, with review in the courts of appeal limited to constitutional claims and to pure issues of law.²⁸

As envisioned by the Committee, this new three-stage process would create a non-judicial branch forum with adequate and specialized resources to conduct business currently conducted in overburdened federal courts. Since disability cases turn primarily

Part A side. The issue of Part B hearings by Social Security ALJs has received significant attention in the past several years, and I would highly recommend to the reader: Eleanor D. Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L.J. 1 (1987); ABA COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY AND ADMINISTRATIVE CONFERENCE OF THE UNITED STATES ("ACUS"), MEDICARE PROCEDURES SYMPOSIUM - REPORT AND RECOMMENDATIONS (Leesburg, VA; October, 1987); Judith G. Waxman & Alfred J. Chiplin, Jr., *Medicare Part B Appeals — And You Thought the System Was Fixed*, 23 CLEARINGHOUSE REV. 384 (Summer 1989).

27. The exhaustive report by Professors Koch and Koplow supporting ACUS Recommendation 87-7 provides a valuable and balanced picture of the Appeals Council. See Charles H. Koch, Jr. & David A. Koplow, *The Fourth Bite at the Apple: A Study of the Operation and Utility of the Social Security Administration's Appeals Council*, ACUS REPORT AND RECOMMENDATIONS 625 (1987) (providing a valuable and balanced picture of the Appeals Council); *Recommendation 87-7: A New Role for the Social Security Appeals Council*, 1 ACUS REPORT AND RECOMMENDATIONS (recommending an upgrade in the salary level, providing civil service protections, enhancing support systems, and enhancing the Council's visibility).

28. REPORT, *supra* note 1, at 55.

on complex medical facts requiring the decision-maker to possess significant technical expertise, the Committee opined that an Article I court could most efficiently handle the caseload. Because it would be staffed with administrative judges skilled in disability law, "these new Article I bodies will provide a more thorough and expert examination of the facts than federal district courts can provide, given the other demands on their time."²⁹

The majority of the Committee believed it could place great confidence in the ability of this Article I body to carry out its role not only with competence, but with institutional integrity. The integrity of the SSA ALJs as an institution has frequently been called into question. As the Committee noted, "The Social Security Administration has made controversial efforts to limit the number and amount of claims granted by the administrative law judges, leading to widespread fears that the judges' proper independence has been compromised."³⁰ In order to protect the decision-making process of this new Social Security Disability Court, the Committee would cloak these ALJs with "sufficient institutional independence to avoid the reality or appearance of" political control by the SSA.³¹ Therefore, the Committee encouraged Congress to create an independent agency within the executive branch which would employ all federal ALJs, not only SSA ALJs.³²

29. *REPORT*, *supra* note 1, at 56.

30. *REPORT*, *supra* note 1, at 55. The controversies to which the Committee alluded involved three key areas of concern:

(1) the use of medical-vocational guidelines, known as the "grid", to limit the discretion of ALJs to determine whether jobs exist that a person having the claimant's qualifications could perform — which in turn determined whether the claimant qualified for disability benefits, *Heckler v. Campbell*, 461 U.S. 458 (1983);

(2) the infamous "Trachtenberg memo" where the director of the Office of Hearings and Appeals (Robert L. Trachtenberg) ordered, among other things, a review program intended to influence ALJs into lowering reversal rates (i.e., finding more consistently in favor of the Secretary), *Nash v. Bowen*, 869 F.2d 675, 680 (2d Cir. 1989); *Association of Administrative Law Judges v. Heckler*, 594 F.Supp. 1132 (D.C.D.C. 1984). *See also* Martin H. Redish and Lawrence C. Marshall, *Adjudicatory Independence and the Values of Procedural Due Process*, 95 *YALE L.J.* 455, 499-500 (1986); and

(3) the Secretary's long-standing policy of refusing to acquiesce in decisions by federal courts which are contrary to the Secretary's chosen policies, *see* Steven P. Eichel, *Respectful Disagreement: Nonacquiescence by Federal Administrative Agencies in United States Courts of Appeals Precedents*, 18 *COLUM. J.L. & SOC. PROBS.* 463 (1985); Carolyn A. Kubitschek, *Social Security Administration Nonacquiescence: The Need for Legislative Curbs on Agency Discretion*, 50 *U. PITT. L. REV.* 399 (1989); Deborah Maranville, *Nonacquiescence: Outlaw Agencies, Imperial Courts, and the Perils of Pluralism*, 39 *VAND. L. REV.* 471 (1986); Joshua I. Schwartz, *Nonacquiescence*, *Crowell v. Benson*, and *Administrative Adjudication*, 77 *GEO. L.J.* 1815 (1989).

31. *REPORT*, *supra* note 1, at 56.

32. *Id.* This proposal, like the more specific proposal of creating a Social Security

Still working on the assumption that this configuration of expertise and independence within the executive branch would prove efficient, the majority of the Committee then proceeded to limit access to federal court review. The majority saw itself as "concentrating adjudicative resources" at the level where it could do the most good. The system then, presumably, ought to be able to rely on administrative adjudication to provide a correct and fair decision — at least with regard to the facts. This had to be so; for further review of factual issues would be precluded.

After the Social Security Court of Disability Claims rendered a decision, the claimant would no longer have access to the federal district court. The majority perceived this intermediate step as unnecessary for it was then duplicated by the courts of appeals. As reconstituted, the appeal would proceed directly to the circuit court, where the court would take jurisdiction solely over questions of law. Mixed questions of fact and law — such as whether there was sufficient evidence under a particular interpretation of the law to sustain the government's action — would not go forward. Like

Court, has a substantial history. A fuller examination of this particular issue lies beyond the scope of this Comment, but several articles (including some sparked by the 1983 bill to create an independent, government-wide ALJ corps) deserve a closer look by the reader interested in this matter: Jeffrey S. Lubbers, *A Unified Corps of ALJs: A Proposal to Test the Idea at the Federal Level*, 65 JUDICATURE 266 (Nov. 1981); Victor W. Palmer, (an ALJ in the U.S. Department of Agriculture), *The Evolving Role of Administrative Law Judges*, 19 NEW ENG. L. REV. 755 (1984); Robert H. Joost, (a Judgment Officer, U.S. Commodity Futures Trading Commission), *A Corps of Federal Administrative Law Judges: Why? What Kind? Operating How? Under Whose Control?*, *id.* at 695; L. Harold Levinson, *The Proposed Administrative Law Judge Corps: An Incomplete But Important Reform Effort*, *id.* at 733; Michael Levant, (an ALJ with the Federal Energy Regulatory Commission), *Pointing the Way to ALJ Independence*, 24 JUDGES' J. 37 (1985); Nahum Litt, (Chief ALJ, U.S. Department of Labor) and Joseph J. Simeone, (Senior Judge, Missouri Court of Appeals), *An Administrative Law Judge Corps: Its Value and Relation to the Traditional Justice System*, 11 WHITTIER L. REV. 569 (1989); and a fairly comprehensive note, *Administrative Law Judges, Performance Evaluation, and Production Standards: Judicial Independence Versus Employee Accountability*, 54 GEO. WASH. L. REV. 591 (1986).

The concern over ALJ independence remains high, for improper agency pressures exerted may often be less easily identified than in other contexts. In 1991, legislation proposing an independent ALJ corps was reintroduced. An insightful discussion of the problem appeared in the ABA JOURNAL. Quoting Judge Litt (whose article is cited above), "Agencies exercise control via different ways . . . anything as petty as parking spaces, adequate secretarial, adequate law clerks, facilities, where judges are housed, how they're housed. A whole litany of small things." Debra C. Moss, *Judges Under Fire: ALJ Independence at Issue*, 77 A.B.A. J. 56 (1991). The fundamental problem is that ALJs are employees of the very agencies whose cases they decide. As one outside observer noted, "Rather than having the independence of a district court judge, they are essentially on the payroll and subjected to the pressure of the agencies." Retaliation against outspoken, independent ALJs, allegedly, is not unknown. Retaliation allegedly can take quite coercive forms, such as limiting salary increases, or even eliminating the ALJ's job or removing him from a supervisory position.

“straight” questions of fact, their review would end with the Article I court.

A minority of the Committee, including the chairman, dissented from this proposal. Instead, they recommended a structure which would replace the current Appeals Council with a Social Security Benefits Review Board constructed on the model of the board model which reviews findings by ALJs in black lung and other disability cases, such as those decided under the Harbor and Longshore Workers’ Act.³³ The minority believed it critical for the federal district court to retain jurisdiction over the entire case. Full review would assure that the court checked whether there was substantial evidence to undergird the SSA’s decision. After the district court had completed its review, then, review by the court of appeals would be limited to questions of “pure law.”³⁴

Thus, in the Committee’s proposal we see replayed the fundamental questions essential for modeling a system of judicial review: Should the “experts” determine the technically daunting facts of the administrative case, subject only to limited court review? Should that court review focus exclusively on questions of law? And, finally, should we strike a balance point between the two by establishing an intermediate administrative court to act as “gatekeeper”? The majority of the Committee proposed to install a gatekeeper Article I court.

Granted, this proposal suggests one way out of the anticipated overload of federal court cases during the next 25 years. In that sense, it seems superficially attractive. Looking more deeply, however, the proposal raises anew many lingering doubts held about any moves to limit access to review by the one branch of government which the Constitution established as a politically neutral arbiter: the Article III courts.

On its face, the distinction between review of fact issues versus law issues has the appeal of tradition and simplicity. Yet, that appeal quickly evaporates as one recalls that — traditionally — the question of what is fact versus law versus mixed fact and law presents one of the most difficult topics in administrative law. Instead of a simple, bright line, the proposal may well have drawn a complex and wavering one.

Moreover, if the proposal shall bear any weight at all, then it must stand or fall on the real and perceived institutional integrity of

33. 33 U.S.C. § 921 *et seq.* (1986).

34. REPORT, *supra* note 1, at 58-59.

the hearing process both within the agency and in the proposed Article I court. This question goes to the heart of the proposal and its viability. It gains overwhelming importance since the Committee proposed to grant this Article I special court sole appellate jurisdiction over mixed fact-law issues, including whether there was substantial evidence to support the agency's decision. This substantial evidence test, arguably, is the most critical one in current administrative jurisprudence. If a constitutionally insulated Article III judiciary shall no longer review this issue, can we rely upon the administrative adjudicators preceding the Article I court to treat this critical issue conscientiously?

Fortunately, we are not without resources in addressing this vital question. Indeed, as stated at the outset, the Federal Courts Study Committee's Report represented a contemporary landmark because of the comprehensive scope of its undertaking. However, we, as civilized people, have been exploring this territory for some time.³⁵ Let us now turn to examine what we can learn from earlier legal discussions in this particular area.

III. LEARNING FROM THE PAST

As we seek answers to our questions, it helps to "move forward by checking in a rear-view mirror." The key concerns which shape our discussion of HHS adjudications long pre-date the 1990 Federal Courts Study Committee. In fact, they harken back to the birth of

35. Indeed, the underlying discussion traces its roots much farther than the modern American administrative state. Some of our earliest recorded guidance dates from the Egyptian origins of Western philosophy and law.

If you are a man who leads,
 Listen calmly to the speech of one who pleads;
 Don't stop him from purging his body
 Of that which he planned to tell.
 A man in distress wants to pour out his heart
 More than that his case be won.
 About him who stops a plea
 One says: "Why does he reject it?"
 Not all one pleads for can be granted,
 But a good hearing soothes the heart.

The Instruction of Ptahhotep
 (Egyptian, 6th Dynasty, 2300-2150 B.C.)

JERRY L. MASHAW, *DUE PROCESS IN THE ADMINISTRATIVE STATE VII* (1985).

During the 15th through mid-17th centuries this fundamental principle had begun to flag, resulting in the creation of infamous tribunals such as England's Star Chamber and Court of Requests (1487-1641). This particular sense of a citizen's inherent right to dispute with his government was revived in the 16th century and became enshrined in modern Western political thought through the wings of Montesquieu, and, in turn, the Federalist Papers.

both the Social Security Act (SSAct) and the Administrative Procedure Act (APA).

The SSAct and APA were developed at roughly the same time — with allowance for a brief hiatus during World War II. When we turn to contemporaneous reflections on the two legislative undertakings, some interesting gaps and parallels emerge. Those hits and misses are instructive. For, as has often been remarked, one cannot study administrative law without studying administrative agencies. Here we learn through observing what the most significant single body of administrative legislation, the APA, teaches us about problems in judicial review of the most significant single administrative agency, the Department of Health and Human Services (HHS).

In the early days, through the 1940s, their development seemed parallel and curiously unconnected. Few participants in the drafting of the APA seemed to notice the emerging administrative giant sitting at the table. Discussions about striking a balance between relying on bureaucratic (politicized?) experts and relying on the independence of Article III courts typically did not mention the Social Security Act or any of the programs which would come to be administered by HHS. Neither did debates about the proposed administrative court envision a future need for a special court solely for Social Security, much less Social Security disability.

However, by the 1960s, the young giant had grown too hefty to ignore. Concerns about administrative justice and the SSAct converged in what has become known as the “due process revolution.” This revolution began with Title XIV of the SSAct (AFDC) and came of age with interpretations concerning rights under Title II, the disability program. Its impact rapidly spread throughout virtually every federal agency.

Will the Federal Courts Study Committee’s proposal similarly reshape the nature of judicial review? We shall see both later in the theory of this article and later in the reality of the next decade.

A. The Growth of a Quiet Giant

This benign leviathan, the Social Security program, did not begin as charity nor as a giant. As Roosevelt had signed the Social Security Act of 1935 he envisioned, with the Congress, that Pub.L.74-271 created a new version of an insurance plan — not welfare. The payroll tax contributions under the Act were keyed to contributions that the recipient had made during his or her working

life. Thus, the program expected to be self-financing.³⁶ Furthermore, this program was not to remake American social philosophy; it merely presented a workmanlike solution to a discrete problem.³⁷

It is fair to say that in 1935 few people, if any, foresaw that the Social Security Act would eventually expand to be the largest single piece of programmatic legislation in the nation — measured in terms of the federal budget outlay, staff, and recipients.³⁸ Nevertheless, most did recognize that the federal government had turned an

36. For a more expanded discussion of the putative "self-financing" of Social Security, see Skocpol & Ikenberry, *The Political Formation of the American Welfare State in Historical and Comparative Perspective*, 6 COMP. SOC. RES. 87 (1983). Skocpol and Ikenberry are only two of many observers who note that the self-financing feature is illusory. Actually, the amount which a worker pays into the fund is not directly proportional to the amount which that worker receives. Therefore, the workers who contribute more subsidize the workers who contribute less.

37. It seems curious that, even with 20/20 hindsight, so many writers covering the New Deal era and the development of our current federal regulatory system note but rarely explore the importance of the 1935 Social Security Act. Robert L. Rabin in his monumental study, *Federal Regulation in Historical Perspective*, devotes less than two pages to the topic, although he acknowledges that

Social Security constituted a dramatic step in a society that still believed that public welfare was inconsistent with the ethics of individualism. And, as a mass-coverage federal welfare program, it was unprecedented.

38 STAN. L. REV. 1189, 1250 (1986).

The subject gains only passing mention in Professor Friedman's seminal work, *A HISTORY OF AMERICAN LAW*, despite the fact that the mention is capped by a halo:

The New Deal probably is the best and sharpest illustration of the way government grew in response to consumer demand . . . The New Deal program was immensely popular in its day; and what began in the 1930s has become so deeply ingrained in American life that nobody dares touch the essential New Deal, not even a Republican President as conservative as Ronald Reagan. . . The mere suggestion, by Barry Goldwater, that he might alter the Social Security system (1964) was greeted with outrage, as if he had befouled the Holy of Holies.

LAWRENCE M. FRIEDMAN, *A HISTORY OF AMERICAN LAW* 658 (2d ed. 1985).

And yet, these honorable mentions stand out because they at least exist. Some noted biographers of President Roosevelt have omitted all mention of the 1935 act. See FRANK FREIDEL, *FDR: LAUNCHING THE NEW DEAL* (1973).

38. Statistics compiled from *Current Operations Statistics, Quarterly Tables*, 54 SOC. SEC. BULL. June 1991, at 36, show payments in 1988 of a total of approximately \$374 billion in retirement, disability, and survivor benefits, unemployment benefits, temporary disability benefits, workers compensation benefits, public assistance payments and SSI payments (*id.* at 38) paid to a total of approximately 50 million persons (*id.* at 43 n.10). These figures do not include Medicare and Medicaid.

The various trust funds created under the SSAct have ended up serving as the federal "piggy bank", used to offset mounting federal deficits. The Old-Age and Survivors Insurance Trust Fund as of February 1991 showed total assets of more than \$224 billion, yet showed a cash balance of *minus* \$160 million, *id.* at 41. The Disability Insurance Trust Fund as of February 1991 showed total assets of approximately \$11.7 billion, yet a cash balance of *minus* \$55.4 million, *id.* at 42. The Hospital Insurance Trust Fund (Medicare Part A) as of February 1991 showed total assets of \$102.2 billion, and a cash balance of approximately \$1.5 billion, *id.* at 43. The Supplementary Medical Insurance Trust Fund (Medicare Part B) as of February 1991 showed total assets of \$16.6 billion, and a cash balance of approximately \$239

important corner. It had undertaken to construct a national safety net for the destitute. This safety net had large holes in it, so many still fell through. This safety net came perilously close to the ground itself; so it did not provide much of a comfort margin. But at least the federal government had made a start.

Naturally, lawyers of every description had comments and concerns to express about this new legislation. In reviewing the *Index to Legal Periodicals* for the period 1934 through 1940, more than 100 articles were published on various aspects of the new Social Security Act. Typically, these articles debated the constitutionality of the statute. Such discussion focused primarily on whether the federal government had the authority to "coerce" state governments into adopting a certain type of legislation (for example, unemployment compensation) through use of the federal taxing and spending powers.³⁹ Many others opined on the formidable task of organizing accounts for millions of American citizens, tracking individual contributions into the accounts, and determining eligibility and appropriate payments.⁴⁰ Noticeable by its near-absence is virtually any discussion about needing structured agency and judicial review in the event of dispute.

Initially, one might be tempted to suppose this apparent oversight stemmed from the fact that the due process revolution would be 30-plus years in the future: *Mathews v. Eldridge* and *Goldberg v. Kelly*. . .⁴¹ would not develop until four decades later. One might assume that back in the latter 1930s, this supposed insurance program was still seen fundamentally as a benefits program. As such,

million, *id.* at 44. The positive cash balances for the Medicare program have not always been present.

In 1977, 1978, 1980, 1981, 1982, 1984, and 1986 through 1988, the Hospital Insurance Trust Fund showed deficits ranging from approximately \$738 million in 1977 to approximately \$81 billion in 1982. During this time period it became clear that if the Medicare program continued on its then-present course, the Hospital Insurance Trust Fund would be bankrupt by the end of the 1990s. In 1982, the Hospital Insurance Trust Fund was compelled to borrow \$12 billion from the Old-Age and Survivors Insurance Trust Fund. This loan was repaid in 1985 and 1986. *Id.* at 43.

39. *E.g.*, Barbara Nachtrieb Armstrong, *The Federal Social Security Act and Its Constitutional Aspects*, CAL. L. REV. 247 (1936); Charles Denby, Jr., *The Case Against the Constitutionality of the Social Security Act*, 3 LAW & CONTEMP. PROBS. 315 (1936); Roger Sherman Hoar, *By-Products of the Social Security Decisions*, 21 MARQ. L. REV. 215 (1937); Harry Shulman, *The Case for the Constitutionality of the Social Security Act*, 3 LAW & CONTEMP. PROBS. 298 (1936).

40. *E.g.*, J. Douglas Brown, *The Development of the Old-Age Insurance Provisions of the Social Security Act*, 3 LAW & CONTEMP. PROBS. 186 (1936); David Waldron, *Social Security Amendments of 1939: An Objective Analysis*, 7 U. CHI. L. REV. 83 (1939).

41. 397 U.S. 254 (1970); 424 U.S. 319 (1976).

one might assume that disputes about such benefits might not merit the structured agency and judicial review which we, today, take as a given.

Yet, players on that contemporary legislative and regulatory stage did not view the matter so simplistically.

As alluded to earlier in this article, the principle that aggrieved citizens must be heard fully and fairly did not spring full-born from the brow of law professors writing in the 1960s. This principle is deeply embedded in our philosophical and legal traditions. Therefore, at the inauguration of the Act the Social Security Board included appeals among its many broad functions. However, the statute gave no details as to how the function should be carried out.⁴² Moreover, the Board's actions in this area received scant public attention.

Indeed, when Dean Wigmore produced a "Compilation of Practical Information That Should Be of Assistance to Lawyers Called on to Advise the Citizen Whose Personal Interests May Be Affected by the Actions of Forty or Fifty Administrative Bodies Now Functioning in the Nation's Capital — [A] List of Principal Ones That Hold Hearings, Adopt Regulations of Procedure and Render Decisions Touching Private Interests — Their Functions, etc.," he was unable to include rules and regulations of procedure and practice before the Social Security Board. This stands in stark contrast to the guidance available regarding most other agencies. Granted, the Social Security Board did issue rulings. But those were published

42. The original Section 702 of Title VII, defining the duties of the Social Security Board, merely stated:

The Board shall perform the duties imposed upon it by this Act and shall also have the duty of studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment compensation, accident compensation, and related subjects.

49 Stat. 636 (1935).

Section 703 added, with regard to expenses:

The Board is authorized to appoint and fix the compensation of such officers and employees, and to make such expenditures, as may be necessary for carrying out its functions under this Act. Appointments of attorneys and experts may be made without regard to the civil-service laws.

Id.

Under Title II, various provisions referred to the Social Security Board's role in assuring the correctness of payments, *e.g.*, Section 202(c):

If the Board finds at any time that more or less than the correct amount has theretofore been paid to any individual under this section, then, under regulations made by the Board, proper adjustments shall be made in connection with subsequent payments under this section to the same individual.

49 Stat. 623 (1935).

merely "in copious mimeograph Press Releases."⁴³

By 1939, Congress had amended Title II of the Social Security Act to make procedural protections somewhat more explicit, relying less on implication. Key among those amendments, Congress finally provided explicitly in Section 205 that the Social Security Board — or its delegatee — shall hear and decide all disputes in claims arising under the Act.⁴⁴ In what eventually became an important provision in the canons of administrative law,⁴⁵ Congress limited judicial review solely to claims which have crossed this statutory portal. Claims brought outside of Section 205 could be barred.

It is interesting to note how the role of the Social Security Board in adjudications was viewed at the time. Significantly, few writers on Social Security *per se* focused on this activity. Of course, a thorough, detailed writer describing the program would at least mention the quasi-judicial role of the Social Security Board. One writer did go so far as to describe the types of questions typically brought before the adjudicators in the Claims Operation Section of the Bureau of Old-Age Insurance.⁴⁶ Most, though, merely accepted but

43. John H. Wigmore, *Federal Administrative Agencies: How to Locate Their Rules of Practice and Their Rulings with Special Reference to Their Rules of Evidence*, 25 A.B.A. J. 25, 27 n.10 (1939).

44. Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States . . . As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive . . .

42 U.S.C. 405(g) (1988).

45. The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h) (1991) [the current codification for § 205]. See *Weinberger v. Salfi*, 422 U.S. 749 (1975) (holding that even constitutional issues must be raised through the jurisdictional avenue of Sec. 205); *Califano v. Sanders*, 430 U.S. 99 (1977) (holding that the APA does not provide a basis of federal jurisdiction which can avoid the limitations of Social Security Act Section 205). See also Dina Lassow, *Access to Federal Courts: The Impact of Weinberger v. Salfi*, 11 CLEARINGHOUSE REV. 907 (March 1978).

46. There are a number of questions involved in the adjudication of claims arising under this title. For example, there are the laws of absentees, the rights of widow and minor children, the proof of age, adoption, aliens, assignments, records applica-

had few policy recommendations concerning this aspect of the program.

One attorney for the Federal Security Agency (the predecessor of the Department of Health and Human Services) — albeit writing “as an individual only” and expressing opinions that were “in no sense binding upon” the agency — recognized the changes in a footnote to a lengthy article on the 1939 amendments. The procedural changes added by statute were characterized as “important administrative changes” — but no more than that.⁴⁷

In order to see the beginnings of concern about how the massive dimensions of the Social Security program would compel a change in the informal administration of agency justice, we must look to the inauguration of the Administrative Procedure Act.

B. The View from the Parallel Track: The Emerging APA, Administrative Adjudications, and Judicial Review

The same time period that saw the birth of the Social Security Program also saw the birth of the federal Administrative Procedure Act. The two statutes developed on roughly parallel time tracks, except for the APA's temporary “derailment” during World War II. Curiously enough, the two tracks rarely intersected in those early days. Few seemed to recognize where common interests and problems undergirded the two legislative efforts.

The APA was developed to rationalize a federal system which was widely perceived as irrational and so expansive that one could not, as an individual, force rationality upon it. The pre-APA system not only failed to provide meaningful access for citizen appeals; but, adding insult to injury, was inefficient. As the Committee on

ble to prove death and a host of other legal questions. For example, the adjudicator acts not only as a juror but as a judge. From a legal standpoint of view, they must determine the facts and adjudicate death claims upon the law in the state wherein the applicant was domiciled at the time of death. Some of the common questions are: (1) When is a person presumed to be dead? (2) Who is the survivor of a common disaster? Since there are 48 states, the adjudicators must necessarily know the law of descent and distribution in each of the states. They must know the divorce laws, laws of executors and administrators, and the jurisdiction of the court. The Board will under certain circumstances protect the rights of minor children. The appointment of guardians and committees will inevitably result. It may be well to add that the exemption law, the laws governing husband and wife, infants, inheritance taxes, marriage, and wills play a decided part in the adjudication of claims. For example, was the testator competent to make a will? Does the state in which the deceased lived recognize nuncupative wills? Was the will revoked? Does the state recognize foreign wills?

James D. Hayes, *Some Legal Aspects of the Social Security Act*, 13 NOTRE DAME LAW. 272, 282 (1938).

47. Waldron, *supra* note 40, at 99 n.66.

the Judiciary of the House of Representatives said during the course of modeling the APA,

It is practically impossible for a Member of Congress, much less an individual citizen, to find his way among these many agencies or to locate the particular officer or employee in any of the agencies with whom any particular problem should be discussed with a view to settlement. . . . [T]he condition has grown worse within the past few years in the attempts that have been made to meet serious economic and social problems.⁴⁸

Yet few who decried the injustice and inefficiency of federal agencies recognized that the Social Security Act raised the self-same difficulties, multiplied many fold. It would soon overshadow all previous burdens on the nation's patchwork system of administrative justice.

Looking back at how various public committees approached the task of overhauling the federal administrative system for the first time offers instruction to us on similar efforts with the federal courts system today. When Congress first seriously began to examine the overall process for administrative adjudications and judicial review, it found a situation of "indescribable confusion . . . due to the fact that . . . since [1861] the Congress ha[d] created administrative agencies without regard to any uniformity of the judicial review provisions and without regard to the procedure developed and proven prior to that time. . . ."⁴⁹ In order to provide some uniform

48. JUDICIARY COMMITTEE OF THE HOUSE OF REPRESENTATIVES, H. R. REP. NO. 1149, 76th Cong., 1st Sess. (1939), as quoted in *Report of the Committee on the Judiciary, House of Representatives* (Chairman, Hatton W. Sumners, Texas), H. R. REP. NO. 1980, 79th Cong., 2d Sess., at 243 (May 3, 1946).

49. FROM SENATE COMM. ON THE JUDICIARY, PROVIDING FOR THE MORE EXPEDITIOUS SETTLEMENT OF DISPUTES WITH THE UNITED STATES, AND FOR OTHER PURPOSES, S. REP. NO. 442, 76th Cong., 1st Sess., at 10 (1939), quoted in COMMITTEE ON THE JUDICIARY, H. R. REP. NO. 1980, 79th Cong., 2d Sess., at 9 (1946). More fully, the House endorsed and adopted as still relevant the Senate's early findings, including:

The results of the lack of uniform procedure for the exercise of quasi-judicial power by the administrative agencies have been at least threefold: (1) The respective administrative agencies give little heed to, and are little assisted by, the decisions of other administrative agencies or by the decisions of the courts applicable to such agencies; (2) the courts are placed at considerable disadvantage because they must verify the basic statutes of all decisions relating to other administrative agencies which are cited to them, thus slowing up the writing of opinions in particular cases; and (3) individuals and their attorneys are at a disadvantage in the presentation of their administrative appeals, with the result that there is a tendency to emphasize the importance of the judiciary in the administrative process.

We might also be tempted to endorse in our present day some of the criticism which that 1939 Senate report (again adopted by the House in 1946) levied at the causes for the "indescribable confusion" in "administrative process." Namely, in addition to the causes cited above, the Senate believed "[T]hat the law schools have placed undue emphasis on the pathological aspect of administrative procedure rather than upon the statutes and the administra-

procedure for the exercise of quasi-judicial power by agencies, and to preserve courts from "unnecessary fumbling in the administrative process"⁵⁰ due to lack of clarity about the scope of their review, Congress early on favored the gatekeeper model of a specialized court. Although the 1930s proposal would have operated on a larger scale, in many ways, this was the progenitor of the specialized Article I Social Security Court proposed by the Federal Courts Study Committee in the 1990s.

In 1933, Sen. Norris of Nebraska, followed soon by the American Bar Association, proposed to improve administrative justice through establishing what was variously called a "United States Court of Administrative Justice" or a "Federal Administrative Court." The exact features of this entity would change during the ensuing decade of debate. But its general contours largely remained as follows: Either directly or through "appropriate branches", the administrative court would "take over or review the judicial functions of the multitudinous Federal administrative tribunals."⁵¹

This, then, was the general administrative procedure proposal which lawyers, bureaucrats, scholars and politicians had "on the table" during the earliest years of the Social Security program. Naturally, this proposal spurred significant discussion about how administrative adjudication and judicial review should be handled.

1. Keeping the Doors of the Courthouse Open

In fact, in 1939 the American Bar Association's Erskine M. Ross Essay Competition solicited responses on the subject: "To What Extent Should the Decisions of Administrative Bodies be Reviewable by the Courts?" Five essays were published in a series in the *ABA JOURNAL*.⁵² One especially stands out for its enduring quality and relevance. In addition, that same essay marks the outstanding contribution of Kenneth Culp Davis when he was a young professor at the College of Law of West Virginia University.

The Davis essay (which did not win the competition, but did gain an honorable mention) was the only one of the five squarely to

tive processes. Added to all this has been the constantly growing complexity of the Federal Government and the resulting lack of training of most lawyers and businessmen therein." *Id.*

50. *Id.*

51. 58 A.B.A. Rep. 203 (1933), as quoted in *Hearings Before the Committee on the Judiciary, House of Representatives, 77th Cong., 1st Sess.*, at 63 (June 21, 25 & 26, 1945).

52. Watson Clay, *To What Extent Should the Decisions of Administrative Bodies be Reviewable by the Courts?*, 25 A.B.A. J. 940 (1939); Kenneth C. Davis, [same title], 25 A.B.A. J. 770 (1939); Clyde Duffy, [same title], 25 A.B.A. J. 838 (1939); Malcolm McDermott, [same title], 25 A.B.A. J. 453 (1939); John L. Seymour, [same title], 25 A.B.A. J. 1018 (1939).

address the growing need to assure administrative and judicial process for review of claims against the government which “shade” between right and privilege, such as “old age insurance from a fund to which an employee has contributed.”⁵³ As he opined,

Even if these matters are properly denominated privileges, they are not clearly in the nature of bounties and their grant or denial is frequently as important as the disposition of so-called vested rights. More accurate than the usual assertion that reviewability of questions of privilege should be relatively restricted is the statement that as the strength or weakness of the element of privilege in any question varies, so should reviewability vary.⁵⁴

All five essayists and virtually all other writers during the 1933-46 period recognized that whatever administrative system we devised must provide for some judicial review of agency action. For example, as Davis pointed out, adopting Judge Rosenberry’s famous quote, “In the estimation of English-speaking people generally, a right of review is no less sacred than the right to be heard in the first instance.”⁵⁵ Throughout the discussions in this decade and a half, the only real issue was how to define the scope of judicial review, not whether to have such review or not.

2. The Very Serious Numbers Game

Some writers recognized that sheer numerical growth provided the driving force pushing both for more judicial access in the name of justice and against it in the name of efficiency. The words of the President of the American Bar Association in 1937 could very well have been spoken today:

[I]t is conceded that the growth of administrative law is the outstanding legal phenomenon of the twentieth century — some authorities even say more decisions are being made by administrative tribunals than by the ordinary courts. . . .⁵⁶

How are administrative agencies able to process so many more cases than the courts, even though the factual matters may be much more complex than the average civil case?

53. Davis, *supra* note 52, at 778.

54. *Id.*

55. *Id.*

56. Arthur T. Vanderbilt, *The Bar and the Public*, 23 A.B.A. J. 871, 873 (1937). He also expressed concern about the lack of administrative law courses in ABA-approved schools, and that, when offered, they were optional. “The conclusion seems inescapable that most of our students are leaving their law schools without any adequate grasp of the outstanding legal phenomenon of the twentieth century.” Mr. Vanderbilt’s words bear a striking similarity to the address by Justice Byron White at Oklahoma City University School of Law Convocation, August 31, 1991. Transcript on file in OCU School of Law Law Review office.

According to one writer who had served in high-level presidential appointments, efficiency owed to the fact that agency proceedings were "much more informal" than the courts. Notwithstanding this informality, the agencies provided proceedings "similar to those daily occurring in the courts with the difference that the staff as well as the deciding officials were specialists in the particular class of cases and that they were not hampered by technical rules of evidence or procedure."⁵⁷ These agency hearings were conducted with the procedures that became a part of the APA: the power to summon and to permit cross-examination of witnesses, the power to subpoena documents, to hear arguments on fact and law, all on a written record. That record, in turn, was the exclusive record reviewed by a federal court on appeal.

To illustrate the power of this process, as compared with common law techniques, the writer drew an example from contemporary experience. Looking at 1936, the Court of Claims (5 judges and 6 commissioners) disposed of 473 cases tried *de novo*, while the Customs Court (9 judges) wrote 3,500 opinions disposing of 71,492 cases, using informal administrative procedures.⁵⁸

57. Col. O.R. McGuire, *Judicial Reviews of Administrative Decisions*, 26 GEO. L.J. 574, 596 (1938).

58. *Id.* at 576. Elsewhere, Col. McGuire describes in some helpful detail the even more informal process of resolving disputes between the regulator and the regulated. He offered a tangible description of informal adjudication in the "permanent structure of the Federal Government" which is the "bureaucracy, so called," that "necessarily administers the details of the laws." *See id.* at 594.

The technical procedure today in the older agencies of adjusting a controversy between the Government and the citizen arising under any statute is substantially the procedure followed in the earlier days when the public business was small. In substance, that procedure was, and is, for the aggrieved party to send a written statement to the particular department in Washington; for some subordinate employee to refer that letter to the official or employee with whom the controversy arose; for such an official or employee to make a written report admitting or controverting the statements made in the complaint; and for some departmental employee or board of employees to prepare a decision on these *ex parte* statements for some higher official or the head of the particular agency to sign after it has been reviewed by some intermediate officer or employee.

Under such a procedure, the complainant does not know what is contained in the report made by the subordinate in the field; the complainant has no opportunity to summon witnesses, place his testimony in the record, and to cross examine the Government witnesses. The deciding officer is deprived of the benefit which would accrue from such a record and he is generally deprived of the benefit of any brief or argument by the complainant or his attorney on the law and the facts. As one department of the government today has 603,000 such cases, the head of that department could not even sign the decisions much less read the records. It is quite infrequent for the head of a department even to know that such cases are pending in his department, much less attempt to personally determine any considerable number of them. All of this work is assigned to subordinates in the departmental service as it necessarily must be. That was the system in the early days and that is the system today after nearly one hundred and fifty years of operation.

This same writer, who was also Chairman of the ABA Special Committee on Administrative Law from 1935-37, seemed to see even more clearly than most that the sheer quantity of controversies between the regulators and the regulated compelled better administrative procedure within the agencies so as not to overwhelm the federal judiciary with matters requiring *de novo* (or otherwise extensive) review. He noted the Department of Labor (DOL) as an example of how an appropriate model could develop to manage a fast-growing docket of administrative cases. The Department of Labor was at that time "the youngest and one of the smallest of the executive departments of the Government." Nevertheless, during FY 1936, "it had 34,601 controversies — or approximately one and one half times as many as all of the federal civil cases concluded by all of the federal constitutional courts. . . ."⁵⁹ To cope with this volume of cases, the agency and Congress adopted a combination of interdepartmental review (resulting in a solid administrative record) and a fairly narrow scope of judicial review based solely on that record.

In a further parallel to our own times, this former chairman of the ABA committee which developed the administrative court proposal cautioned that Congress must take into account the burden posed by the substance-abuse cases of their day. He first noted that demographics and the expansion of government economic and social support would increase the volume of civil cases arising in administrative agencies. Next, he cautioned that this natural increase in caseload would jump when combined with criminal cases arising because of Prohibition. He warned that the court system of the 1930s would surely be "swamped" unless other appropriate means were developed to limit judicial access.⁶⁰ In our day, the tidal wave of criminal cases which overload the federal docket are cocaine-related litigation.⁶¹

Id. at 593.

59. *Id.* at 578.

60. To throw these cases into the courts as soon as there was disagreement with the administrative operating officer would place the courts in a far worse condition than they were in when the Prohibition Amendment to the Constitution was repealed. It is a matter of common knowledge that when such repeal took place, the district courts and even the circuit courts of appeal were hopelessly behind with their dockets by reason of such prohibition cases coming from but one bureau of the Federal Government.

Id. at 580.

61. REPORT, *supra* note 1, at 160.

3. The Point of Intersection

For our purposes, the most helpful and foresightful analysis of the proposed antecedent to the APA was a 1940 article by Professor Breck P. McAllister briefly reviewing a sample of agencies disbursing money to individuals, asking what would be the anticipated impact of the proposed legislation. For the first time we encounter someone who recognized the quiet giant at the table. For the first time an outside observer clearly noted the important intersection of problems undergirding both pieces of legislation.

Looking at the Third Annual Report of the Social Security Board in 1938, Professor McAllister found that more than 41,700,000 account numbers had been assigned. By dint of sheer numbers he saw plainly that “the dealing of this Board with individuals [would] soon dwarf the extensive operations of the agencies already considered.” Although Prof. McAllister referred here most immediately to the Veterans’ Administration and Railroad Retirement Board, his larger discussion encompassed the full range of federal administrative agencies. He cautioned that “[i]n the light of this portentous fact, it is important to know just what effects will be produced by the bill before it is handed to this agency to be put into effect in the conduct of its extensive operations.”⁶²

He became even more wary about the impact of administrative procedure on this giant because still another “growth spurt” was underway. Until January 1, 1940, the Social Security Board, under the Old-Age Insurance System, had only been making lump-sum payments. Beginning in 1940 there would also be regular monthly payments. This increase in frequency of government-citizen interaction would inevitably increase the “multitude of contested issues” — and, in turn, the need for improved “administrative machinery necessary to translate the objectives of the Act into a going concern.”⁶³

Would the Social Security Board as then constituted be able to accommodate the increased volume of contested matters? Surely not. Therefore, the writer made inquiries to the General Counsel of the Federal Security Agency. Prof. McAllister discovered that the agency was in the process of developing a proposal — “still in a tentative stage” — to create “a new Hearing and Review Division

62. Breck P. McAllister, *Administrative Adjudication and Judicial Review*, 34 ILL. L. REV. OF NW. U. 680, 685 (1940).

63. *Id.* at 685.

of the Social Security Board.”⁶⁴ This 3-member Appeals Council would be the delegated body under Section 205(g) of the Act to hear and resolve disputes when a claimant was dissatisfied with the results of his hearing before a referee.

The actual Appeals Council was established in 1940. But it, along with the referees operating under it, seemed unable to drain the swamp of administrative adjudications which had been predicted.

C. The Post-War Calm: Years of Quiet Desperation?

1. The APA as Adopted

The APA was enacted in 1946, essentially as we know it today: with judicial review for substantial evidence in support of the agency’s action and without a gatekeeper intermediary administrative court. As with so many events of the post-war period, hopes were high that this legislation would usher in a period of relative calm. The “indescribable confusion” caused by the sudden proliferation of agencies during the New Deal had at least become routine. Some New Deal agencies had faded into judicially-favored sunset (e.g., the NRA). Most agencies simply had found their activities somehow swallowed up into the war effort. As is ever the wont of wars on the homefront, World War II (as did World War I and the Civil War previously) expanded the size and reach of the federal bureaucracy under emergency conditions that fairly well assured public acceptance. Long after the military engagement ended, however, those enlarged bureaucratic structures — and the public’s tolerance of them — remained.⁶⁵

Was it, then, a war-related shift in *zeitgeist* which led to the enactment of an APA without one or more administrative courts, as had been proposed in the early days of the Social Security Act?

It might be nigh impossible to identify and objectify the changes in the socio-political atmosphere which lead to changes in legislation. Yet, when we look at the legislative history for the 1946 act, we see that during the New Deal period both houses of Congress squarely supported their own model (similar to the ABA’s) of establishing an Article III administrative court. This Article III court would consist of a chief justice and 10 associate justices, replacing the circuit courts of appeals and district courts for 15 to 20 enumerated agencies. The court would have been divided into sections,

64. *Id.* at 685, n.16.

65. See Rabin, *supra* note 37, at 1229-71.

creating specialized courts according to subject matter, under the general umbrella of the administrative court. In fact, this proposal passed the House and Senate in 1939 and 1940, only to be vetoed by President Franklin Delano Roosevelt.

President Roosevelt had already directed Attorney General Tom Clark to select a committee of "eminent" persons to study and make suggestions for improving the administrative process. That final report was completed in 1941. "During the war years 1942-43 the subject was necessarily in abeyance; but war legislation, administration, and congressional investigations brought administrative processes more and more into prominence."⁶⁶

In 1945, a revised and ultimately successful bill was introduced. That revised bill did not contain a centralized court, and applied to most agencies; exemptions were according to subject matter, not name.⁶⁷ It was debated through the following year, with numerous references to the "late President Roosevelt" and his "farseeing and rich vision."⁶⁸

That vision included a caution against the creation of a "fourth branch" of administrative agencies uncontrolled by constitutional limits. In particular, the President and his Committee on Administrative Management and the later Attorney General's Committee on Administrative Procedure expressed concern that "insidious and far reaching . . . evils" result from confusion of the administrative and judicial functions of agencies. In order to assure "public confidence" in the fairness of the process, the agency procedures must be fair from the outset. Otherwise, the conduct of the agency could well "lie under the suspicion of being rationalizations of [its] preliminary findings. . . ."⁶⁹

President Roosevelt and his committee(s) were so concerned about the need to protect the adjudicatory process from politicization that they proposed something which even the Federal Courts

66. Report of the Committee on the Judiciary, House of Representatives (Chairman, Hatton W. Sumners, Texas). H. R. REP. NO. 1980, 79th Cong., 2d Sess., at 248 (May 3, 1946).

67. Section 4 of the 1946 Act stated that with regard to rulemaking,

This section applies, accordingly to the provisions thereof, except to the extent that there is involved (1) any military naval, or foreign affairs function of the United States or (2) any matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.

Administrative Procedure Act, ch. 324 § 460 Stat. 237 (1946), *repealed* (1966), *recodified* in 5 U.S.C. §§ 551-76, §§ 701-06 (1988).

68. H. R. REP. NO. 1980, *supra* note 66, at 379. *See also id.* at 79, 241-42, 244, 299, 313, 351, 372, 381.

69. *Id.* at 242.

Study Committee today has not fully adopted: Completely separate the judicial function of an agency into a section wholly independent of the department and independent of executive control.⁷⁰ This seemed the most reliable long-term method of protecting against the pernicious encroachment of political agendas upon the judging function.

The Federal Courts Study Committee acknowledged the need to insulate decisionmakers in the adjudicatory process. Granted, prosecutorial and judging functions usually enjoy some measure of separation within modern federal agencies. Nevertheless, the policies and politics which drive the prosecutorial function now often seep into the judicial function through bureaucratic and other management pressures. As the 1990 Report notes, "recent experience suggests that the process is vulnerable to unhealthy political control." The ALJ before whom a claimant presents his disability case is an employee of the Social Security Administration. The SSA has made "controversial efforts to limit the number and amount of claims granted" by the ALJs. If the claimant seeks review by the Appeals Council of the SSA, she encounters a body that "lacks even the protection that the Administrative Procedures Act gives the administrative law judges." All in all, the situation has led to widespread fears that the judges' proper independence has been compromised.⁷¹

Notwithstanding these stinging cautions, the Federal Courts Study Committee stopped just short of squarely endorsing full independence. The Committee suggested that Congress "may wish to consider creating an independent agency in the executive branch to employ all" federal ALJs. Yet even this step towards independence wore hobbles. The Committee suggested that limits be enforced by disciplinary measures, "to prevent individual judges from abusing their independence." Retreating even farther from the idea of total separation, the Committee suggested that, alternatively, Congress may prefer to develop further safeguards within the agency itself to insulate the decisions of SSA ALJs in disability cases from the "influence of agency superiors."⁷²

Interestingly, neither the 1937-41 administrative committees nor the 1989-90 federal courts committee focused on whether it is appropriate to limit judicial review of agency decisions when the

70. *Id.*

71. REPORT, *supra* note 1, at 55.

72. *Id.* at 56.

influence of agency political agendas is deeply embedded in bureaucratic, fiscal and management controls. Oddly enough, the New Deal committees and Congress perhaps came closer to a direct response. The 1946 House Report reminded readers that even in 1938 the Senate had recognized that to achieve fairness the administrative process had to be controlled "at its source." The House had called for "legal and enforceable guides for administrative officers and agents in their daily operations," which perhaps might even render further litigation "unnecessary."⁷³ Assuredly, these do not count as "fighting words"; but the House Judiciary Committee in recommending adoption of what became our current APA asked that the recommendations of Roosevelt's committee be preserved, for they were of "permanent importance."⁷⁴

In the compromise that formed the permanent law, Congress created a special class of semi-independent hearing officers and conferred numerous procedural protections in the hearing process. Judicial review was based on the administrative record developed in the adjudication below. Such review was to be based on whether there was substantial evidence in the record to support the adjudicator's decision.⁷⁵

2. Post-War Social Security Adjudications and the APA

If the legislators who enacted the APA in 1946 expected a period of post-war calm on the agency front, did Social Security comply? Generally, yes, it did. From the remainder of the decade throughout the 1950s claims under all titles of the Social Security Act appeared to have settled into an increasingly reliable routine. The constitutional, statutory, and philosophical appropriateness of that routine would not come under searching scrutiny until another decade or more.

Meanwhile, in 1946 Congress abolished the Social Security Board, and transferred its functions within the Federal Security Agency to the Federal Security Administrator.⁷⁶ In 1953, Congress created the Department of Health, Education and Welfare

73. H. R. REP. NO. 1980, *supra* note 66, at 242.

74. *Id.*

75. Under Section 10(e) of the 1946 Administrative Procedure Act [APA], the reviewing court "shall . . . (B) hold unlawful and set aside agency action, findings, and conclusions found to be . . . (5) unsupported by substantial evidence in any case subject to requirements of sections 7 and 8 [concerning procedure for hearings and decisions] or otherwise reviewed on the record of an agency hearing provided by statute. . . ." APA, Pub. Law No. 404, § 10(e), 60 Stat. 237, 243-44 (1946).

76. Reorganization Plan No. 2 of 1946, § 4, 60 Stat. 1095-96 (1946).

(HEW).⁷⁷ The SSAct, in all its titles, had “arrived”, as indicated by the institutional symbols of power which mattered most in Washington, D.C.: a cabinet-level agency with a name that announced (1) its mission and (2) that it was a major item in the federal budget. For the first time the federal government had unequivocally lent its power to the word which New Dealers had fastidiously avoided — “welfare.” Those welfare programs, plus most of the health programs which existed in the 1950s and would develop in the 1960s (chiefly, Medicare and Medicaid) all came under the authority of the 1935 Social Security Act, as amended. Furthermore, they each were subject to the judicial review provisions of Section 205(h) and the process for administrative adjudication which the Secretary established pursuant to Section 205(g).

The 1950s saw the next real “growth spurt” for the quiet giant. In 1956, Congress expanded the SSAct beyond the original old-age benefits, and beyond rehabilitation services, to provide monthly cash benefits to disabled workers who were 50 or older, but not yet at retirement age. The threshold for coverage continued to lower until by 1960 dependents and workers younger than 50 could qualify.⁷⁸ Accordingly, in the period 1957-1960, 340,000 more persons were added to the SSA caseload.⁷⁹

As we have seen, though, the expansion of government benefits to many more millions of potentially eligible persons also expands the controversies the regulatory agency must handle. With disability claims, procedures for formal adjudications centered on the “referee” (today known as the administrative law judge or “ALJ”). The referee conducted hearings much in the informal-formal manner described in well-handled adjudications preceding the APA.⁸⁰ According to Social Security regulations, the referee was bound to “inquire fully into the matters at issue”, “receive evidence” by sworn testimony of witnesses and/or by documentation. The order and exact procedure at the hearing were — and are still — at the discretion of the referee. As with most administrative adjudication, federal rules of evidence and procedure did not apply.⁸¹

The referee in the 1950s often times was not an attorney. He

77. Reorganization Plan No. 1 of 1953, § 1, 67 Stat. 631-631 (1953).

78. Social Security Amendments of 1956, Sec. 223, 70 Stat. 815 (codified at 42 U.S.C. § 416 (1991)); Social Security Amendments of 1958, Pub. L. No. 85-840, 72 Stat. 1021 (codified at 42 U.S.C. § 401 (1991)); Social Security Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 967 (codified at 42 U.S.C. § 402 (1991)).

79. See *supra* note 38, at 52.

80. See McGuire, *supra* note 57.

81. 20 C.F.R. § 403.709 (1958).

was an employee of HEW's Social Security Administration, specializing in Social Security law. Whom did the referee represent? Usually neither the government nor the citizen had an attorney present to act as advocate. The referee, ostensibly, served as a natural arbiter. The referee's conduct in handling the case was subject to the provisions of the APA concerning selection of hearing officers or ALJs.⁸²

If a claimant was dissatisfied with the referee's decision, she could appeal the decision to the Appeals Council, which at that time was a 9-member body acting in panels of three.⁸³ From the Appeals Council's decision, appeal could be taken to federal district court specifically for review under the substantial evidence standard.

Twenty years before, when the ABA and Congress proposed to establish a centralized administrative court with specialized subject matter divisions, the legal community focused much energy on the need to assure fairness and neutrality in the adjudicatory process — even before appeal to a higher court. The agency decision-makers had to be insulated from political influences, with due separation of prosecutorial and judging functions, in order to assure a reliable outcome. At that time, even though discussions did not highlight the Social Security program itself, observers consistently argued for the general need to overcome, in John Foster Dulles' words, the "inadequacies of the 'trial examiner' system."⁸⁴

82. 5 U.S.C. § 551 (1977) et seq.; see generally CHARLES I. SCHOTTLAND and EWELL T. BARTLETT, *FEDERAL SOCIAL SECURITY; A GUIDE TO LAW AND PROCEDURE* at 118-133 (1959). Schottland was a former Commissioner of the SSA during the Eisenhower administration. As Verkiel, *et al.*, explains in their report on *The Federal Administrative Judiciary*,

Despite the characterization of benefit decisionmaking as largely institutional, Congress has, from the late 1930s, required that Social Security claimants be afforded an opportunity to be heard when disputes about coverage or amounts arose. Accordingly, when the APA was enacted in 1946, it was understood that hearings under the Social Security Act would be presided over by APA-qualified hearing examiners.

The relatively small volume of cases SSA handled prior to the enactment of the disability coverage provisions in 1956 made the matter of APA coverage one of less than critical importance. The enactment of the disability program, however, generated a large increase in adjudications, because the standard for disability has proved extremely hard to define at the edges. Since then, the SSA's volume of adjudications has risen dramatically. Under pressure of this rising caseload, Congress in 1958 and 1959 extended two one-year authorizations to the SSA to employ non-APA hearing examiners.

Verkuil, *supra*, note 18, at 27.

83. 20 C.F.R. § 403.710 (1958). The Appeals Council today has 20 members.

84. John F. Dulles, *Administrative Law: A Practical Attitude For Lawyers*, 25 A.B.A. J. 275, 282 (1939); see also Albert S. Faught, *Classification of Administrative Bodies for Purposes of Judicial Review*, 6 U. PITT. L. REV. 67, 73 (1940).

The underlying concern about the need to separate functions did not evaporate. President Eisenhower's second Hoover Commission in 1955 had renewed the recommendation for separate administrative courts. The call against politicization of quasi-judicial functions had not died. It simply spoke in much more muted tones, compared to the prior decades.

Thus, as both the Social Security Act and the Administrative Procedures Act were coming of age, paradoxically, the trial examiner method of adjudication formed the dominant mode of formal hearings for citizen-government disputes in HEW. And, unlike the early, formative years before the 1946 APA, one finds fewer legal articles focusing attention on this issue.

Perhaps that lack of articles owed to the fact that the constitutional status of Social Security benefits and other titles under the SSAct had not yet been fully and finally resolved by the Supreme Court. Formal "fair hearing" adjudications were subject to the APA, which also lent its job protection to SSA hearing officers (referees). Further, if the trial examiner method had resulted in seriously flawed decisions, the federal courts could make right the error.

But another factor perhaps played a part: volume. The sheer volume of cases potentially affected by the pernicious "evils" of the trial examiner method were few compared to the total body of controversies facing HEW's Social Security Administration.

Finally, even to the extent that the APA might have applied to HEW's proceedings at that time, the genuine bulk of the emerging giant was not represented by the formal hearing process. Most Social Security controversies were handled — as in almost all federal agencies — in the truly informal mode that federal agencies had used for many decades. As described *supra* in footnote 58, the permanent structure of the federal bureaucracy worked *ex parte*, solely on paper, usually without benefit of attorney input concerning law or fact. This was typically how hundreds of thousands of disputes were disposed of annually. Otherwise, the machinery of government would grind nearly to a halt.

Did the choice of efficiency in formal and informal adjudications work an injustice to the individual claimants? Undoubtedly, it sometimes did. Yet, the decade was curiously quiet, compared to the vibrant tumult of the early years. However, that quiet did not last much longer.

D. The Quiet Giant Finds Its Voice(s)

The 1960s and '70s witnessed the maturation of the SSAct, along the lines originally envisioned for it in the 1930s. As President Roosevelt and his Committee on Economic Security had sketched the grand design, in time the SSAct would provide for a reasonable, comprehensive safety net for the American public: unemployment compensation, old-age benefits, welfare and supportive services for children without fathers, expanded public health services, and national health insurance.⁸⁵ Eventually, they had envisioned that the SSAct would offer some basic level of support for the nation's most vulnerable citizens, an undertaking which European nations had long ago assumed.⁸⁶

The United States, however, remained a long way from establishing a truly comprehensive and sturdy safety net similar to the European models. More to the point of this article's task, though, we were clearly not yet ready to adopt a more European model for processing the large volume of claims which a national health and welfare benefits system entailed. Nor were we yet ready to limit judicial review, vesting meaningful appellate review in a high-level administrative tribunal or specialized court. Naturally, in our robust democratic tradition, an unwillingness to act did not hinder our willingness to debate.

Thus, as our erstwhile "quiet giant", the Social Security Act, matured, many conflicting voices spoke on what needed to be done to achieve bureaucratic justice within the safety net. Reduced to most basic levels, the discussions represented a bipolar dynamic. It could be presented schematically below:

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On one pole were tens of millions of individuals applying annually for benefits under the SSAct's various titles. Along with them on this pole were increasing numbers of suppliers, practitioners (i.e., physicians), and institutional providers (hospitals, nursing homes) of services rendered to beneficiaries. On the other pole were the Social Security Trust Funds,⁸⁷ which beneficiaries and providers,

85. See *supra* note 14.

86. E.g., Barbara N. Armstrong, *Old-Age Security Abroad: The Background of Titles II and VIII of the Social Security Act*, 3 LAW & CONTEMP. PROBS. 175 (1936).

87. 42 U.S.C. § 401 (1988).

etc., looked to for payment under the various titles. Who spoke for whom in this increasingly tense dynamic?

Sometimes it was the President, directly or through appointed commissions or committees, who spoke on behalf of expanding coverage to millions of citizens. Sometimes members of the House or Senate, responding to the expressed needs of their constituents, spoke through legislative reforms that expanded coverage and eased access to review. Other times, it was the citizens themselves who spoke with most lasting effect in litigation mounted by private attorneys and by entities such as the National Welfare Rights Organization, the Gray Panthers, or Legal Services Corporation.

Of course, increasing the numbers of citizens who could expect to receive some level of support from the Trust Funds often was politically less risky than decreasing the drain on the Funds. Yet, certainly someone also had to speak on behalf of that concern. This role fell to the Secretary of HEW, which in 1979 became HHS.⁸⁸ The Secretary had the statutory obligation to “insure that each of the Trust Funds and the general fund in the Treasury have borne their proper share of the costs, incurred during [the] fiscal year, for the part of the administration of” Titles II, XVI, and XVIII (disability and Medicare programs).⁸⁹ Translated into operational terms, that meant: (1) assuring the financial solvency of all the various programs under the SSAct; while at the same time (2) implementing managerial systems for promptly processing tens of millions of claims annually; and still (3) providing for the orderly, fair and consistent in-house resolution of disputes.

Caught in the middle of these conflicting voices were the agency adjudicators: the Department employees known variously (depending upon decade) as referees, hearing officers, or ALJs and the Appeals Council. As the reach of the safety net broadened, and new in-house tribunals were established, that tension followed to the new arenas, emerging later at Medicare’s Provider Reimbursement Review Board (PRRB).⁹⁰

88. See Department of Education Organization Act, Pub. Law No. 96-88, § 508, 93 Stat. 668, 692 (1979).

89. 42 U.S.C. § 401(g)(1)(A)(i) (1991).

90. This bipolar dynamic at the PRRB is discussed more fully in Part IV *infra*. However, I beg to add here a personal note. It seems so appropriate to the present discussion that if the exchange had not happened in reality, a law professor would have had to invent this story as a pedagogical anecdote.

My swearing-in (March 1986) as a Member of the PRRB was a relaxed and blessedly informal affair, to offset the seriousness of the task ahead. To lighten the afternoon, the Secretary’s Chief of Staff turned to me after the oath was completed, shook my hand and

According to the most elementary legal doctrine, the legislative branch makes the laws and the executive branch carries them out. Therefore, Congress' statutory mandates ought to govern how the Secretary's regulations, manual provisions, other agency instructions and procedures implement the legislative design. Yet, sometimes the two bodies of law — legislative and administrative — conflicted. How far could agency adjudicators reach as they attempted (sometimes creatively) to interpret administrative instructions in a way which favors the broader congressional mandate over the narrower agency practice?

This crucial question expressed the bipolar dynamic as it emerged in the legal forum. This question went to the crux of the tension between doing justice in increasing numbers of individual cases and processing efficiently increasing billions of dollars of claims against the government.

Eventually, it appeared that the answer, many believed, depended more upon the institutional independence of the adjudicators than upon full access to Article III court review of the adjudication. Thus, by the 1980s calls for the establishment of a specialized court for SSAAct claims (all titles, or some titles) had a ring of familiarity.⁹¹ The Federal Courts Study Committee's recommendation was only the latest in a series.

In this section we shall trace how the safety net was broadened — through the front door. In the next section, Part IV, shall examine the counter pressure in the bipolar dynamic, namely, indications that through subtle legal and managerial efforts the safety net may be narrowed — through the back door. Because Medicare Part A represents the bulk of program monies spent on government-financed health insurance, and because few commentators have recently analyzed the procedural concerns raised here as those concerns relate to Part A, Part IV shall focus solely on the bipolar dynamic at the PRRB.

winked, "Now, look after the Trust Fund." Immediately following, the chief lobbyist for the health care trade association which had nominated me shook my hand and jested, "Look after the hospitals."

91. See, e.g., Robert E. Rains, *A Specialized Court for Social Security? A Critique of Recent Proposals*, 15 FLA. ST. U. L. REV. 1 (1987); J. P. Ogilvy, *The Social Security Court Proposal: A Critique*, 9 J. LEGIS. 229 (1982); Frederick B. Arner, *The Social Security Court Proposal: An Answer to a Critique*, 10 J. LEGIS. 324 (1983). A separate court was established to review veterans' claims in 1988. See Note, *New Veterans Legislation Opens Door to Judicial Review . . . Slowly!*, 67 WASH. L. REV. 889 (1989).

1. Broadening the Safety Net — Through the Front Door

a. Legislation

Completing a last major agendum during his administration, President Eisenhower convened in 1960 a White House Conference on Aging. This conference focused its primary efforts on the issue of financing health care for the elderly, a topic which Congress had already taken up.

In the Social Security Amendments of 1960,⁹² the proposals which in time were enacted as the Medicare and Medicaid programs made their debut. The amendments authored by Sen. Robert S. Kerr (D-Okla) and Rep. Wilbur Mills (D-Ark) expanded existing arrangements whereby state welfare authorities reimbursed physicians and hospitals for services provided to the aged who were on public or old-age assistance. The Kerr-Mills bill additionally used this model to establish a new program whereby states could reimburse the medical expenses of elderly citizens who were “medically indigent” but not on public assistance. Initially, Congress had envisioned the federal role to be fairly limited. It would act mostly as a financial underwriter, making grants-in-aid from general federal revenues to state welfare departments on a matching basis.⁹³

If that failed to garner sufficient state support, then the position backed by others, including then-Senator John Kennedy, would have a second chance. This latter proposal would have wholly federalized health insurance for the aged and tied it to Social Security Old-Age, Survivors’ and Disability Insurance (OASDI). Further, it

92. Pub. L. No. 86-778, 74 Stat. 924-997. Although this section of the article offers a historical look at the development of the Medicare program, it does not examine the intricacies of program structure, benefits, payments and financing. Instead, we only look at those insofar as they relate to the legal issues of concern. The reader interested in gaining a deeper, and quite balanced, view of those aspects should see Marian Gornick, et al., *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, 6 HEALTH CARE FIN. REV. 13 (1985 Annual Supp.). Ms. Gornick is Director, Division of Beneficiary Studies, Office of Research, HCFA. She has been involved in Medicare and Medicaid research since 1966.

93. For one perceptive report on the conflicts and cross-currents at the conference, see Benjamin B. Kendrick, *Emerging Issues in Social Security*, 15 C.L.U. J. 124 (1961). This piece was written while Kendrick was Assistant Director of Research at the Life Insurance Association of America. Earlier, he had been Chief of Program Coordination for the Social Security Board’s Bureau of Old-Age and Survivors’ Insurance.

As perhaps is human nature, the political, legal and social commentators often discounted the gloomier views of actuaries. Kendrick’s cautions in 1961 about the “long-run hazards” of “legislative excess” that may have over-expanded Social Security beyond actuarial expectations are interesting.

would have provided a legislative basis for eventually expanding such federal health insurance to the American population generally.

Although the White House Conference and Congress supported Kerr-Mills, many states lagged in adopting implementing legislation. Thus, although President Kennedy continued to support liberalization of the SSA to include health care reimbursements for the elderly and poor, it fell to President Lyndon Johnson to bring the final Medicare⁹⁴ and Medicaid⁹⁵ provisions to enactment. Using his consummate wiles as a legislator, his recent landslide victory, and (reminiscent of the passage of the APA following President Roosevelt's death) President Kennedy's memory, Johnson managed to overcome the opposition of those who feared "socialized medicine."⁹⁶

As Prof. Kinney explains in her article on the structure of the Medicare appeals system, "[t]he political circumstances surrounding the passage of the Medicare and Medicaid programs helps explain the programs' design."⁹⁷ Originally, the House had proposed the 1960 version: reimburse inpatient hospital services for the aged. This became Part A of the Medicare program. To gain the backing of Republicans, Medicare was expanded to pay for outpatient physician services. This became Medicare Part B. The National Medical Association, followed eventually by the American Medical Association, supported expanding existing state medical assistance programs for the poor, regardless of age. This became the Medicaid

94. *Supra* note 4.

95. Social Security Amendments of 1965, Title XIX, Pub. L. No. 89-97, 79 Stat. 343 (codified at 42 U.S.C. § 1396-1396p (1992)).

96. Wilbur J. Cohen, known as "one of the principal architects of Medicare and Medicaid" recalled on the 20th anniversary of the programs the opposition which the proposals encountered:

It is difficult for many younger people today to realize how harsh many of the criticisms and arguments against these health proposals were. For instance, the Scripps-Howard newspapers on June 20, 1966, had an article with the headline 'AMA Sees Wilbur Cohen as "Enemy No. One."' At the 1966 American Medical Association House of Delegates, resolutions were introduced by physicians from Florida and Louisiana asking 'President Johnson to launch an investigation of Mr. Cohen, culminated by a swift booting out of office.'

Wilbur J. Cohen, *Reflections on the Enactment of Medicare and Medicaid*, HEALTH CARE FIN. REV. 3 (1985 Ann. Supp.).

97. Kinney, *supra* note 6. Prof. Kinney offers an excellent, detailed exposition of the Medicare program and its appeals processes as they relate to coverage issues, physician and provider payment, beneficiary eligibility, etc. I highly recommend it to the reader interested in a more in-depth examination of those issues. Since this particular article focuses on how certain broad thematic concerns about access and efficiency relate to the specific proposal by the Federal Courts Study Committee, my references to the substantive structure of Medicare will be more limited.

program.⁹⁸

The addition of Titles XVIII and XIX (Medicare and Medicaid, respectively) broadened the reach of the safety net more than any single change since 1940, when Congress provided for monthly cash payments to retirees. As the SSAct entered its second 25 years, administrative operations under these two titles grew at an unprecedented rate. What began as the Bureau of Health Insurance within HEW's SSA by 1977 had its own identity. Under President Jimmy Carter, management of the Medicare and Medicaid programs transferred to the new Health Care Financing Administration ("HCFA").⁹⁹

Why did this growth spurt overshadow all previous expansions of coverage under the SSAct? Unlike OASDI, which made cash payments directly to beneficiaries, Medicare made cash payments *on behalf of* beneficiaries to an ever-widening number of hospitals, nursing homes, mental institutions, home health agencies, rehabilitation facilities, dialysis centers (all under Part A); plus physicians, laboratories, x-ray facilities, technicians, therapists, outpatient clinics, and medical equipment suppliers (under Part B).

Although Medicaid figured importantly, due to its smaller size and its nature as a federal-state joint venture, it had substantially less impact on the federal bureaucracy.

As some commentators had forewarned concerning the rapid expansion of the Social Security program(s) in the 1930s and '40s, expanding the number of interactions between government and citizens ineluctably led to increasing numbers of controversies that require fair resolution. In 1965 it did not appear as if many legislators had heeded the lessons from the past.

Rather than establishing a clear-cut appeals process from the outset, the Congress simply carried over the limitations on judicial review which applied to all proceedings under the SSAct. Thus, Section 405(h) of the 1965 Amendments recodified and reapplied the provisions of former Section 205(h) of the SSAct, limiting judicial review to cases which had been heard according to the Secretary's procedures. This jurisdictional limit applied to beneficiary appeals regarding entitlement to benefits or amounts of benefits paid

98. Unlike their counterparts in the American Medical Association, the National Medical Association, comprised predominantly of African-American physicians, were early supporters of Medicare and Medicaid, for they viewed such coverage as part of their larger civil rights efforts. The NMA lent their support to Pres. Kennedy in his efforts during summer, 1963. See 55 J. NAT'L MED. ASS'N 464 (1963).

99. 42 Fed. Reg. 13,262 (1977).

under Part A. If the amount in controversy was greater than \$100 but less than \$1000, beneficiaries could only obtain administrative review. For amounts over \$1000, beneficiaries could seek judicial review. No express provision was made for administrative review of provider disputes under Part A. Therefore, under 405(h), neither could providers appeal to federal court.

Who heard the disputes of beneficiaries and providers? In the name of efficiency, Congress had placed the first tier of review with non-attorney, non-governmental "experts."

Ostensibly in order to benefit from the long experience of private insurance companies in handling health insurance claims, the SSA contracted with such companies to act as agents for the government in processing Medicare claims. Under this system, HEW set general guidelines about what Congress meant when it instructed the Secretary to reimburse Medicare costs that were "reasonable and necessary" — surely, two of the most elastic terms in law. Then Blue Cross and Blue Shield, for example, implemented those guidelines, acting as the "intermediary" under Part A or the "carrier" under Part B.¹⁰⁰

Adopting the trial examiner model of the Social Security referee, the same intermediary which, acting as agent for the government, had denied payment in the first place then adjudicated the beneficiary's and provider's administrative appeal of that denial. This first step in the appeal process was optimistically called the "fair hearing."¹⁰¹ Provider appeals stopped here. Beneficiaries, on the other hand, had further agency and court review available.

If the beneficiary did not succeed in convincing the intermediary

100. 42 U.S.C. § 1395 x(v)(1) (1988). As Mr. Cohen explained:

The principle of 'reasonable cost' for in-patient hospital services embodied in section 1814(b) and 1861v(1) of the Social Security Act was never seriously debated or opposed during the period 1961-65, as far as I can recollect. The provision in the latter subsection that 'the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations,' was accepted by Congress and the providers. No one criticized it during the legislative process as a 'cost-plus' principle. No one thought of it as a basis for inflationary price or cost rises. It was accepted not only because no other alternative was proposed, but because conventional wisdom at the time accepted reasonable cost as a reasonable principle.

Cohen, *supra* note 96.

We should note that Mr. Cohen surely must be accepted as the authority on these points. He had primary responsibility for "piloting the legislation through Congress and for its initial implementation." He was Chairman of President Kennedy's Task Force on Health and Social Security, and was the only person to have held the three posts of Assistant Secretary, Under Secretary and Secretary of HEW.

101. Social Security Amendments of 1965, § 102 (a) (codified as amended at 42 U.S.C. § 1395 u (e)(7) (1990)).

of its error, then the beneficiary under Part A could appeal further to a Social Security hearing officer (that decade's name for the referee, our decade's ALJ). If the hearing officer could not give satisfaction, then the beneficiary could take her controversy to the Appeals Council and thereby exhaust administrative review. If the amount in controversy exceeded \$1000, she could proceed to federal district court for review of the agency record.

For Part B disputes, Congress only offered the carrier fair hearing, whether the dispute was brought by a beneficiary or a provider.

With our 20/20 hindsight, Congress' failure to plan legislatively to accommodate the ensuing pressure on the adjudicatory system seems puzzling. Concerns about administrative justice throughout the federal system had continued in the 1960s, and the tone had a sharper edge than previously. During the period Congress was debating passage of the 1965 Amendments, concerns about administrative inefficiency and politicization of the adjudicatory process had become, to use Professor Walter Gellhorn's pithy phrase, a "hardy perennial."¹⁰² Yet, again as in prior decades, few seemed ready to make a firm, consistent connection between the needs of the overall system for administrative justice and the system as it existed under the SSAct.

That is, until the 1970s. On the legislative front, we saw still another vast expansion of the SSAct. Under President Richard M. Nixon, Title XVI was added in 1972, providing Supplemental Security Income (SSI) to any qualifying disabled person, even those under age 50 who had not been employed. Unlike OASDI, eligibility was based solely on need. Again, the addition of SSI did not bring any special statutory accommodation to meet the increased load of appeals which would surely follow. They simply were added to the regular caseload of hearings by the Social Security ALJs and reviews by the Appeals Council. Later, Congress and HEW converted several hundred non-ALJ hearing officers into ALJs to handle the rapidly expanded caseload.¹⁰³ The quantitative pressure

102. Walter Gellhorn, *Administrative Procedure Reform: Hardy Perennial*, 48 A.B.A. J. 243 (1962).

103. Social Security Amendments of 1972, Title XVI, Pub. L. No. 92-603, 86 Stat. 1465 (codified at 42 U.S.C. § 1381 (1991)). As Verkuil, *et al.* explain in their report, *The Federal Administrative Judiciary*, the use of non-ALJs to decide disability cases was originally an emergency, stop-gap measure enacted in 1958 by Congress to handle the increase in caseload that followed the 1956 increase in disability coverage. It was extended for an additional term, through 1960. The 1972 disability legislation permitted using non-ALJs to preside at SSI hearings under Title XVI. Unfortunately, under statute, only APA-qualified ALJs could hear Title II cases involved retirement, survivors, and traditional disability insurance. And,

on the administrative system produced by this last broadening of SSA coverage was enough to move Congress within three years to consider establishing a specialized Social Security Court.

Meantime, the 1972 Amendments also acted to establish the first *independent* administrative tribunal within HEW to resolve disputes, as first called for by President Roosevelt's administrative law committees.¹⁰⁴ That tribunal was the Provider Reimbursement Review Board. Finally, providers of services under Part A had an administrative forum for resolution of disputes exceeding \$10,000. Further, they had a clear jurisdictional route to federal court review. Just as importantly — perhaps most importantly? — the PRRB was constituted to be insulated from the political pressures which many believed had plagued adjudications under the Social Security ALJ and Appeals Council mechanisms.¹⁰⁵

according to the 1975 Disability Claims Process Task Force, about 40% of the cases overlapped (Titles II and XVI). By 1976, Congress had adopted legislation to authorize explicitly that non-ALJ hearing officers "could preside at all SSA adjudications" (Titles II, XVI, and XVIII) on a temporary basis. That temporary basis became permanent in Pub. L. 92-216, 91 Stat. 1559 (1977). *Supra* note 18, at 19-22.

104. *See supra* note 14 and accompanying text.

105. The implementing statute provided at 42 U.S.C. § 1395oo (1990):

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") . . .

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made . . . for the period covered by such report . . .

(2) The amount in controversy is \$10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination . . .

(c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with

The procedural changes increasing access and bringing appeals under the SSAct in line with general developments in administrative law did not spring from executive or legislative benevolence. They derived, instead, from the push of providers, beneficiaries, and their attorney representatives in the court system.

b. Litigation

The SSAct had long provided that upon termination of benefits, one could obtain a fair hearing subject to APA provisions for formal adjudications. However, it took a series of court cases in the 1970s and '80s to solidly fix the legal stature of benefits review.¹⁰⁶

During that period, federal courts made searching examinations of statutory and constitutional defects in the review processes that existed pursuant to the SSAct and regulations implementing the

respect to subpoenas shall apply to the Board to the same extent as they apply to the Secretary with respect to [Title II of the SS Act]

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmation, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmation, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. . . . Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5 notwithstanding any other provisions in section 405 of this title. . . .

(h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of Title 5 governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of Title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

106. Since this article aims to identify large thematic concerns that have shaped the broadening or narrowing of administrative and judicial review for Medicare, this section will merely highlight pertinent features of key SSAct litigation.

Act's various titles. Echoing the concerns (and solutions) of the 1939 debate over federal administrative hearing procedures,¹⁰⁷ the government scarcely contested whether benefits under the SSAct were rights or privileges. Instead, by statute and regulations the SSAct made available procedures for formal adjudication of disputes. But were those procedures sufficient in terms of extent, timing and form? In a not-so-rhythmic, rarely graceful two-step, advances in litigation to increase procedural access were followed by legislative or regulatory revisions to institutionalize the courts' decisions.

Perhaps, though, the most important and enduring by-product of this "two-step" exceeded litigation or legislation alone. The decade-and-a-half of court action to improve procedural access awakened all participants to the age-old need for a citizen "in distress" over a governmental action to have a forum where he can "pour out his heart."¹⁰⁸ The cases that we typically look to as launching the due process revolution raised awareness and expectations about being heard within the agency and, later, in court.

1) SSAct Title XIV - Welfare. *Goldberg v. Kelly*, 397 U.S. 254 launched the first salvo in that revolution. There, fourteen New York City recipients of AFDC, the federally assisted welfare program established in 1935 under Title XIV of the SSAct, sued state and local officials over hearing procedures upon termination of benefits. States had long been required to offer "fair hearings" in accordance with SSAct procedures. At issue was whether that fair hearing — constitutionally — could be delayed until after benefits had already been terminated.

At the dawn of the 1970s, having weathered the tumult of the '60s, New York did not even contest the statutory and constitutional right of AFDC recipients to have access to review. Perhaps New York City's three-fold increase in numbers of welfare recipients had overwhelmed the traditional concept of welfare as a limited discretionary charity or privilege. Perhaps the in-court and out-of-court efforts of welfare activists to reform the system had weakened reliance on the privileges versus rights distinction as a litigation strategy.¹⁰⁹ For whatever reasons, the state did not revive the classic defenses against administrative and judicial review of dis-

107. See Davis, *supra* note 52.

108. From The Instruction of Ptahhotep, *supra* note 35.

109. For a general, contemporary description of the efforts of the National Welfare Rights Organization see N.Y. TIMES, March 9, 1969, at 1.

putes concerning government benefits. Thus, the Supreme Court's validation of beneficiary rights to review resounded even more convincingly.

As the Court laid out there,

[t]he fundamental requisite of due process of law is the opportunity to be heard.' [citation omitted] The hearing must be 'at a meaningful time and in a meaningful manner.' [citation omitted]¹¹⁰

The constitutionally fatal defect in the Title XIV procedures was that "a recipient [was] not permitted to present evidence" to the official who finally determined eligibility. Nor was the recipient permitted "to confront or cross-examine adverse witnesses."

Over the next decade and more, the Supreme Court attempted to explain what it meant by "an opportunity to be heard . . . at a meaningful time and in a meaningful manner." That effort, especially in terms of the SSA and its various titles, focused primarily on issues Justice Black raised in his dissent: How do we provide access to meaningful administrative and judicial review when the volume of cases is simply staggering?

He saw the pressure of a million-plus welfare recipients in New York as arguing *against* benefits being characterized as an "entitlement." He argued in favor of holding the constitutional line, keeping such benefits mere gratuities, because operating "a welfare state" on such a vast scale was "a new experiment for our Nation."¹¹¹

In a perceptive caution about the paradoxical dynamics of programmatic legislation, Justice Black warned his brethren that the increased access to full administrative and judicial review which *Goldberg* seemed to rest on the Constitution, ultimately, would not benefit "the poor and needy." The Court may well have believed it had widened access (through the front door); however, due to the administrative burden imposed by increased numbers of claimants, the agency might need to narrow availability (through the back door).

[T]he end result of today's decision may well be that the government, once it decides to give welfare benefits, cannot reverse that decision until the recipient has had the benefits of full administrative and judicial review, including, of course, the opportunity to present his case to this Court. Since this process will usually entail a delay of several years, the inevitable result of such a con-

110. *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970).

111. *Id.* at 279.

stitutionally imposed burden will be that the government will not put a claimant on the rolls initially until it has made an exhaustive investigation to determine his eligibility. While this Court will perhaps have insured that no needy person will be taken off the rolls without a full 'due process' proceeding, it will also have insured that many will never get on the roll, or at least that they will remain destitute during the lengthy proceedings followed to determine initial eligibility.¹¹²

In this nearly prophetic passage, Justice Black outlined what became and remains the central struggle in fashioning any large-scale, nationwide system of bureaucratic justice. When (1) the benefits program covers ever-increasing millions of persons annually; and (2) increasing access to full administrative and judicial review, consistent with our ancient belief in allowing persons with a grievance against the government to be heard; offering individualized justice ultimately will (3) so increase the direct and indirect administrative costs of the benefits program that the agency must find mechanisms to limit payments in the name of efficiency and cost-control.

2) SSAct Title II - Disability. Six years later when the Supreme Court reviewed the sufficiency of hearing procedures for disability benefits under Title II of the SSAct, the administrative burden of processing millions of claims annually proved pivotal. *Mathews v. Eldridge* challenged HEW's procedures for terminating continuing disability benefits. The agency's determination that the beneficiary no longer suffered from a legally cognizable disability was based on a "paper" review of the beneficiary's case.¹¹³ Post-termination, agency procedures offered a reconsideration hearing. Was this constitutionally sufficient? Yes.

The Court laid out three now-classic factors to measure the process that was due. Typically, analysis stressed the first factor — the private interest affected — as that interest found expression in the SSAct provisions under dispute. As compared to the private interest at issue in *Goldberg*, "[e]ligibility for disability benefits . . . [was] not based upon financial need."¹¹⁴ Therefore, the Court, according to the statutory scheme, could not have assumed that Title II benefits supplied Mr. Eldridge's sole source of income. The deprivation of those benefits could not be seen as a situation of "brutal need" as it had been in *Goldberg*.¹¹⁵

112. *Id.*

113. *Mathews v. Eldridge*, 424 U.S. 219, 323-24.

114. *Id.* at 325.

115. *See id.* at 340-42.

On the other hand, we might just as productively have focused on the third factor: the government's interest in limiting the "fiscal and administrative burdens that the additional . . . procedural requirement would entail."¹¹⁶ Unlike the gloss afforded this issue six years before, the majority now emphasized "conserving scarce fiscal and administrative resources."

Surely the emphasis would have shifted. For in the span of six brief years, the SSAct disability program(s) had ballooned. As mentioned earlier, in 1972, Title XVI added a welfare disability program. By 1974, approximately 2 million persons received benefits, a more than ten-fold increase from the approximately 150,000 of 1957.

Given the sheer volume of claims requiring processing, any procedural change which increased access to administrative review would increase the already considerable burdens on the system. Echoing (but not adopting) Justice Black's dissent in *Goldberg*, the *Mathews* majority now warned that the legal analysis of procedural protections must also include something akin to a cost-benefit analysis. "Significantly, the cost of protecting those whom the preliminary administrative process has identified as likely to be found undeserving may in the end come out of the pockets of the deserving since resources available for any particular program of social welfare are not unlimited. . . ." ¹¹⁷ Indeed.

As much as anything else, *Mathews v. Eldridge* marked a dawning awareness that even for the "worthy poor" the SSAct safety net programs could not stretch infinitely. Costs attached to each increase in access, whether larger access derived from expanding benefits or from expanding procedural protections to challenge the agency's terms for granting or denying benefits. Over the next ten years, this concern grew to assume major importance in SSAct programs, and remains so today.

This concern, stated as above, presents perhaps a brutal truth. It is a truth which, understandably, policymakers and politicians usually avoid stating explicitly if possible.¹¹⁸ Instead, from the lat-

116. *Id.* at 335.

117. *Id.* at 348.

118. It is easy to understand *anyone's* reluctance to enter this fray, especially as it relates to health care payments. After one has stripped away the rhetoric, we are clearly talking about rationing the resources which make life possible. This, therefore, raises not only political and economic, but also profound ethical issues. See, e.g., James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal and Policy Analysis*, 59 TEX. L. REV. 1345 (1981); Rand E. Rosenblatt, *Rationing 'Normal' Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401 (1981); HENRY J. AARON & WILLIAM B. SCHWARTZ, *THE PAINFUL*

ter 1970s on, the language of the debate over access to administrative and judicial review and efficiency in benefits review took on a different tone, a somewhat different focus than it had in the 1930s, '40s, '50s or even '60s. Adjudicative "efficiency" began to connote more than merely a prompt, orderly review of claims for payment. Rather, an "efficient" system for adjudications under the SSAct began to imply that the adjudicatory process resulted in a consistent, predictable pattern of denials in line with the program administrator's chosen methodologies for achieving budget targets.

Few, if any programs under the SSAct illustrated the subtle shift in debate better than Medicare.

3) SSAct Title XVIII - Medicare. The enactment of the Social Security Amendments of 1965 represented a milestone in the development of the modern administrative state. Even more so than with retirement, survivors', welfare or disability benefits, the government now entered into millions of business transactions with medical institutions and individual practitioners on behalf of tens of millions of beneficiaries.

Considering the vast amounts of money at issue (even in the woefully underestimated initial figures), and considering the sheer volume of government-citizen transactions many of which inevitably would result in dispute, Congress' failure expressly to establish a formal system for administrative and judicial review of Medicare claims seems paradoxical. On the other hand, hammering out an agreement on substantive terms for the Medicare program proved so difficult that one can understand Congress might not have had much energy left for addressing "mere" procedural matters.

Yet, of course, those "mere" procedural matters quickly took on constitutional proportions.

The very structure of the mechanism for paying and reviewing Medicare claims virtually assured that institutional providers would encounter what they perceived as injustice. As alluded to earlier, the fundamental statutory principle guiding what costs would or would not be reimbursed carried within it the seeds of litigation.

In SSAct Section 1861(v)(1) the government undertook to reimburse the "reasonable and necessary" costs of providing health care services to Medicare beneficiaries. This did not mean that hospitals, for example, merely filed a patient-by-patient claim for services ren-

dered. Provider claims under Part A of Medicare quickly became the “big ticket” items drawing on the Hospital Insurance Trust Fund because their “reasonable and necessary” costs were computed thusly: A hospital aggregated its total direct and indirect (overhead) costs for rendering services to all patients throughout the cost reporting period (usually the fiscal year). The hospital then placed those costs into categories of allowable (e.g., employee expenses, interest expense, depreciation, pensions) and non-allowable costs (namely, services to non-Medicare patients or unnecessary services), according to Medicare regulations. Then the government paid a percentage of allowable costs based on the percentage of Medicare utilization (a proportion of Medicare patient days compared to total patient days). Needless to say, a statutory scheme for compensation with such broad guides offered fertile ground for dissonance over what was *under the law* “reasonable and necessary.”

The next key factor assuring a continuing sense of dissatisfaction with the fairness of the process involved how this vague statutory principle was executed. Unlike most government agencies, the Social Security Administration, through its Bureau of Health Insurance (BHI, the predecessor of the Health Care Financing Administration or HCFA), typically did not itself process provider claims for compensation. Rather, Congress, bowing to the prior experience (and political power?) of the private insurance industry, contracted with major insurance companies to act as agents for Medicare. Thus, a private insurer operating under delegation by the Secretary of HEW performed the initial review of the provider’s cost report, checking it for accuracy and making cost disallowances on behalf of BHI.

Understandably, many a provider itself might have disputed — in turn — the accuracy of the intermediary’s disallowances. Yet Title XVIII’s original procedures did not afford providers an opportunity to resolve its dispute with the government principal, HEW. The provider’s only avenue for resolving disputes which typically involved up to one-third of its operating expenses for any given year, was to deal with the private agent which had denied payment initially.

Intermediary procedures for hearing provider disputes varied. Furthermore, such hearing procedures as existed were pursuant to contract between HEW/BHI and the intermediary; not pursuant to statute or regulation. The Blue Cross Association of America, Inc., (BCA) the national membership organization to which local, non-profit Blue Cross plans belonged, offered aggrieved providers an ap-

peal to the BCA Provider Appeals Committee at BCA's Chicago headquarters. According to BCA procedures, the majority of Appeals Committee members were BCA employees, including a BCA vice-president.¹¹⁹ Until new regulations were adopted in 1974, for-profit insurers acting as intermediaries generally did not provide the hearing procedures which were part of their HEW/BHI contract. Mutual of Omaha apparently referred some provider disputes to the Social Security Administration for the type of "informal" and "advisory" consultative form of resolution which had always typified informal appeals of controversies with the federal government.¹²⁰

Beyond the composition of the hearing officers and format of the hearing, providers also might have been drawn to challenge the very propriety of some aspects of the intermediary contract. At least two factors raised questions of possible conflicts of interest. First, local Blue Cross plans were able to negotiate with state insurance departments arrangements whereby cost disallowances which the Plan achieved under the Medicare program automatically were disallowances (dollar-for-dollar) under their private Blue Cross policies,

119. As described by two leading health law attorneys, drawing on their own experience and that of other attorneys throughout the nation, an intermediary hearing before BCA was as follows:

Although the formal procedure did not permit prehearing pleadings or discovery, the BCA took informal action to acquaint the adversaries and the Appeals Committee members with the positions taken by the Plan and the provider. The BCA prepared a pamphlet containing the BCA's version of the dispute and the applicable regulations or policy, a statement of the position of the Plan, and the provider's statement of position. The Plan's statement was concise, argumentative, carefully prepared, and well reasoned. In contrast, the providers' statement normally consisted of one or more letters written during the early stages of reimbursement negotiation, without notice of their possible ultimate use, to describe the hospital administrator's unrefined and uncounseled version of the claim. As a result, the pamphlet frequently did not fairly represent the provider's position. In addition to circulating the pamphlet, BCA staff counsel sometimes briefed BCA members of the Appeals Committee on the issues several days before the hearing. Neither the provider, its attorneys, nor representatives of the national provider associations were invited to attend or were even advised of the briefings.

At the scheduled Appeals Committee hearing, first the provider and then the Plan presented testimony and documentary evidence in support of their positions, each side having the right to cross-examine witnesses. During the presentation of evidence, BCA staff counsel advised the Appeals Committee on matters such as the order of evidence and validity of objections. At the close of evidence, unless the provider requested an opportunity to submit a brief after receiving the hearing transcript, BCA staff counsel retired with the Appeals Committee while they made their decision. The BCA procedure required the Committee to render a written decision within 30 days of the hearing; that decision was final. Although the Secretary received an information copy of all committee decisions, a disappointed provider could not secure review of the Appeal Committee's decision. . . .

Leonard C. Homer & Peter Platten, *Medicare Provider Reimbursement Disputes: An Analysis of the Administrative Hearing Procedures*, 63 GEO. L.J. 107, 112-13 (1974).

120. *Id.* at 116. See also *supra* note 58 and accompanying text.

also.¹²¹ Second, much more widespread and perhaps more pernicious: More than a third of BCA's annual income was paid to it by HEW for administrative services as Medicare intermediary (for Part A) and carrier (for Part B).¹²² BCA's contractual relationship depended significantly on whether the BHI perceived it as being appropriately vigilant in containing Medicare costs. Thus, overall, the impartiality of the intermediary clearly was subject to question.

The first court squarely to address and resolve whether the procedures violated due process was the District Court for the Southern District of Florida in *Coral Gables Convalescent Home v. Richardson*.¹²³ The process of cost reporting and reimbursement for nursing homes worked much as described for hospitals. There, Aetna Life and Casualty Co. served as intermediary. Following the mechanism outlined above, it audited Coral Gables' cost reports for 1967 and '69 and disallowed 50% of current Medicare payments to the nursing home in order to recoup the alleged overpayments. True to the form described above, Aetna (a for-profit insurer) held informal conferences with the provider, but offered no administrative hearing, no appeal to HEW, no appeal to the court. Without hesitation, the Southern District of Florida applied *Goldberg v. Kelly*, and found the provider's position to be unequivocally stronger:

Plaintiff's grievance here arises not from a question involving government-administered benefits, but from one involving compensation for services rendered the government. On any balancing of interests analysis, the government's interest in protecting the treasury by prompt recapture of excess payments and by avoidance of evidentiary hearings are not overriding here.¹²⁴

Hence, the court ordered the Secretary of HEW to establish a process for review of providers' claims before a decision-maker "who must be impartial and must not have participated in the audit determination under review. . . ."¹²⁵ The adjudicator must "state his reasons for his decision and indicate the evidence on which he relied."¹²⁶ Finally, the court ordered the adoption of new regulations to effectuate the new hearing procedures "immediately."

Congress actually moved more rapidly than the executive

121. Homer & Platten, *supra* note 119, at 110, n. 26.

122. *Id.* at 132; Temple Univ. v. Associated Hosp. Servs., 361 F.Supp. 263, 266 (E.D. Pa. 1973).

123. 340 F.Supp. 646 (S.D. Fla. 1972).

124. *Id.* at 650.

125. *Id.* at 651.

126. *Id.*

branch. In the Social Security Amendments of 1972,¹²⁷ Congress retraced its steps and formalized the hearing procedures which ostensibly should have existed in some form from the outset. It created the Provider Reimbursement Review Board. Implementing regulations followed in 1974.

Unlike the private insurance company employees who had heard provider cases under delegated authority by the Secretary, and unlike Social Security Administration ALJs and the Appeals Council, the PRRB and its members were statutorily independent of BHI and the Social Security Administration. Members served full-time, three-year terms, appointed by the Secretary. In order to make the positions attractive to experienced persons able to offer expert adjudication of intricate regulatory issues (to use the language of the Federal Courts Study Committee recommendation), PRRB members were compensated on the so-called "super-grades", Senior Executive Service, scale. A member could be reappointed for one additional, consecutive term. A member could only be removed for "good cause."¹²⁸

PRRB hearings were far more formalized than the intermediary or SSA ALJ hearings. Rather than adopting the trial examiner mode, PRRB hearings were full-scale, formal, trial-type adjudications almost indistinguishable from regular court proceedings; except that federal rules of evidence and civil procedure did not apply.¹²⁹ The clearly adversarial nature of the PRRB hearing con-

127. Section 243 (a) (codified as amended at 42 U.S.C. § 1395oo).

128. 42 U.S.C. § 1395oo(h) (1992).

129. As set forth in the statute at 42 U.S.C. § 1395oo (1992):

(c) Right to counsel; rules of evidence. At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board. A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations. The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d), (e), and (f) of section 405 of this title with respect to subpoenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II of this chapter [Title II of the SSAct].

trusted sharply with the emphasis on intermediary hearings being non-adversarial, according to BHI Instructions Sec. 2626.¹³⁰

Considering that, at least currently, we might wish to encourage non-litigious resolution of disputes as much as feasible, was this a beneficial development?

Two leading health law attorneys, Leonard C. Homer and Peter Platten, responded to this concern as it related to intermediary hearings in an early and still immensely valuable article. In their analysis, they drew upon their own practice experience and surveys of attorneys throughout the nation dealing in Medicare reimbursement matters. They found that in an administrative system where there already existed inadequate separation of quasi-prosecutorial or investigative and quasi-judicial functions, increased formalization was desirable. Emphasizing the non-adversarial, consultative role of the intermediary hearing process tended "to perpetuate the potential for unfair practices such as *ex parte* communication between hearing officers and intermediary staff or the resolution of disputed issues on the basis of policies or instructions not raised at the hearing."¹³¹ Given the past history of Medicare intermediary hearing practices, Homer and Platten only questioned how to increase, not decrease, the formality of PRRB hearings.

IV. CHALLENGES OF THE PRESENT

As outlined earlier in this article, the primary dynamic operating throughout the first generation of the Social Security Act was the push to expand access to substantive benefits. From lump sum retirement and survivors' benefits, the SSAct evolved into monthly cash payments to retirees and survivors. From coordinating rehabilitation services for the disabled it grew to provide monthly cash payments to support disabled workers. The second generation expanded access to a larger number of program participants than ever before. Welfare benefits expanded beyond dependent children to include disabled persons who had not been part of the workforce. The increase which was so sizeable that it reshaped the dimensions of the SSAct and its administration was the addition of health care benefits under Medicare and Medicaid.

Throughout the first and second generations of the SSAct, we also saw an increase in procedural protections. The highly informal agency procedures for resolving disputes between citizens and the

130. [1974 Transfer Binder] CCH MEDICARE AND MEDICAID GUIDE (CCH) ¶26,733.

131. Homer & Platten, *supra* note 119, at 135.

government which dominated in the pre-APA days gradually gave way to greater formalization. Part of this formalization stemmed from the Supreme Court's recognition that due process attached to how and when the government heard and resolved disputes about SSAct payments. The push to increase access in procedural matters saw its apogee in dealing with the tens of billions of dollars involved in Medicare Part A transactions with institutions, creating the Provider Reimbursement Review Board.

The third generation of the SSAct saw the beginning of a shift to the opposite pole of the dynamic. Instead of broadening the SSAct safety net, the counter push began to narrow coverage in order to conserve the fiscal integrity of the Social Security Trust Funds. Surely one could scarcely gainsay the authority — indeed, perhaps the obligation? — of Congress to exert controls over payments from the Trust Funds. Yet, our system contains some inherent, subtle inhibitions on congressional action.

Legislative controls over payment policies are duly expressed through statutory provisions. However, because legislative changes must be effected in the public spotlight, Congress typically is much more adroit at broadening access when in the public glare, than narrowing access. Narrowing, usually, might occur through bureaucratic and managerial mechanisms within the agency; that is to say, through the proverbial “back door.”

Under Title II of the SSAct, this shift in dynamics took three major forms at the agency level. The “grid” created an evidentiary assembly line in an attempt to assure some measure of national uniformity in disability determinations.¹³² The Social Security Administrator instituted a controversial program of ALJ case review affecting upgrades and promotions for those whose decisions conformed (or failed to conform) to agency policies.¹³³ Finally, there was the agency's position where all else failed: non-acquiescence, although federal courts of appeals had ruled agency policies invalid.¹³⁴

Were such actions *per se* unreasonable or inappropriate? Not likely. Nevertheless, such practices and policies raised concerns about whether the independent judgment of the Social Security ALJ corps might have been compromised.¹³⁵ At a minimum, might such policies have had a chilling effect on the decision-maker, such

132. *Supra* note 30.

133. *Id.*

134. *Id.*

135. *Supra* note 32.

that the ALJ's proper discretion in making determinations favorable to the citizen was improperly constrained? If there was such a chilling effect, then a Social Security Court which virtually foreclosed federal court review would weaken even further the institutional assurances of justice.

Let us now turn to explore whether the process for administrative review by the PRRB has been susceptible to similar concerns about "back door" limitations on access to the Medicare program. Two key areas deserve attention: (1) PRRB jurisdiction under the Prospective Payment System (PPS) and (2) HCFA's provision of administrative support to the PRRB.

A. Non-Acquiescence on Procedure

A sharply defined struggle between access and efficiency began forming when Medicare payment methodologies shifted from retrospective payment of reasonable and necessary costs to prospective payment of the average costs for providing care to Medicare patients. By 1972, Congress had awakened to the need to exert some sort of controls on Medicare costs, and so instituted cost limits that created standards for "reasonableness" under SSAct Sec. 1861v(1)(A). When those limits proved ineffective in controlling inflation in Medicare's share of health costs, Congress enacted "target rate" limits on reasonable costs. Finally, in 1983, Congress began to transition Medicare inpatient payments to a prospective system where reasonableness played a diminished role. Instead, when the system was fully in place, providers would receive a flat payment to cover average resources consumed in providing services to the average Medicare patient.¹³⁶

Those average costs were based on national averages for treating 467 categories of medical conditions, known as diagnosis-related groups ("DRGs"). Under the new system, once fully in place, hospitals received a DRG payment per patient irrespective of the hospital's actual costs incurred; irrespective of the complexity of the patient's condition due to underlying secondary or tertiary illnesses; irrespective of actual length of stay. Hospitals did receive some initial recognition of actual costs, through Medicare's payment of hospital-specific costs based on each hospital's own costs in its base year.

DRGs were phased in, so the hospital-specific portion of the PPS payment represented an increasingly smaller portion of the

136. 42 U.S.C. § 1395ww (1992).

payment. DRGs constituted an increasingly larger portion, until by 1990 Medicare's inpatient PPS payments were fully based on DRGs. Even after full implementation of DRGs, however, the PPS payment was not truly all-inclusive. It excluded, among other things, allowable hospital costs for the base year, capital payments, and medical education costs. (Further, it did not include Part B payments, largely to physicians.)

Clearly, undeniably, PPS' objective was to contain Medicare costs and thereby protect the fiscal soundness of the Hospital Insurance Trust Fund. But did Congress also intend to foreclose administrative and judicial review of disputes under PPS?

The first PRRB case squarely to confront the issue was *Augustana Hospital & Health Care Center v. Blue Cross & Blue Shield Ass'n*.¹³⁷ Augustana Hospital, like so many other Medicare providers, had sought payment from HCFA for Medicare providers, had sought payment from HCFA for medicare's share of the cost of medical malpractice insurance, a staple overhead cost for any hospital. For a number of years HCFA had balked at paying its pro-rata share of such costs, arguing that since Medicare patients are not as litigious as other patients, Medicare should not have to pay a proportional share of malpractice insurance costs, but a lesser share. The battle raged before the PRRB and the federal courts for years, with providers consistently winning. HCFA reluctantly acquiesced in 1986, and did so retroactively.

However, the base year for determining the hospital-based portion of Augustana's payments under PPS pre-dated HCFA's official change in policy. Thus, when the intermediary calculated Augustana's allowable costs for the hospital-specific portion of the PPS payment during the phase-in period, it did not include the malpractice insurance costs which were later permitted retroactively.

Naturally, Augustana sought a revision of the hospital-specific portion to include the omitted costs. The intermediary refused, citing a regulation adopted by the Secretary, 42 C.F.R. § 405.474(b)(3)(i) (1984) that the intermediary's estimates and modifications of base year costs "are final," with only a limited set of exceptions, none of which applied explicitly to Augustana's position. The next subparagraph (ii) offered that prospective relief might be available if, and only if, "the intermediary's estimation

137. PRRB Hearing Dec. No. 88-D11, Dec. 30, 1987 (Revised Jan 11, 1988), [1988-1 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 36,779.

was unreasonable and *clearly erroneous in light of the data available at the time of estimation.*"

The PRRB majority accepted the intermediary's argument that a change in the law (HCFA's change in policy, now acquiescing to the federal court decisions) was not a change in data. Moreover, the majority accepted the intermediary's argument that the regulation § 405.474(b) cut off administrative and judicial review of most, if not virtually all, changes to the complicated construct of PPS payments; that barring such review was an essential part of installing a reliable, consistent system of flat payments designed to contain costs.

The minority (Board Member Phyllis E. Bernard, joined by Chairman Paul Morton Ganeles) reasoned:

To the extent there are limits on which PPS payment issues can be reviewed, those limits are specifically set out in 42 U.S.C. 1395ww(d)(7). This provision excludes from administrative or judicial review those adjustments to the average standardized DRG payment which are made to maintain budget neutrality. Also excluded from review are questions concerning the very establishment of DRGs, the methodology for classifying discharges within DRGs, and the appropriate weighing factors employed to reflect use of hospital resources and changes in treatment patterns, technology, etc. These highly technical and policy-driven matters are, instead, to be resolved wholly by the Secretary in consultation with the Congressional Office of Technology Assessment and the Prospective Payment Assessment Commission. . . .

Conversely, Congress made express provision for other non-technical, non-DRG aspects of PPS payments to be subject to administrative and judicial review under 42 U.S.C. Section 1395oo. In addition to the plain language of the statute, the legislative history unequivocally supports the availability of PRRB review. Both the House and Senate reports accompanying the PPS legislation expressly state that the Medicare statute 'would provide for the same procedures for administrative and judicial review of payments under the prospective payment system as is [sic] currently provided for cost-based payments.'

H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 143, *reprinted in* 1983 U.S. Code Cong. & Admin. News 362; S. Rep. No. 98-23, 98th Cong., 1st Sess. 57, *reprinted in* 1983 U.S. Code Cong. & Admin. News 197.¹³⁸

Despite what to a minority of the Board appeared to be a clear-cut congressional mandate for review, the Secretary had issued a confusing series of "interim final", then "final", then "technical corrections" regulations which had up-ended the procedures for ad-

138. *Id.* at 15,909.

ministrative review of Medicare disputes. In adopting 42 C.F.R. § 405.474(b)(3)(ii) (1984), the Secretary established a scope and standard of review for determinations before the PRRB unlike any standard previously applied to Medicare adjudications. According to the Secretary's regulation, the intermediary's estimation of the hospital's costs for determining the hospital-specific portion of the PPS rate could be reviewed "only with respect to whether the intermediary followed the provisions" of the regulation concerning, primarily, calculations and corrections to recognize certain categories of successful appeals. In this limited review, the adjudicator could only examine "whether the intermediary used the best data available at the time." As the regulation made explicit: "Specifically excluded from administrative or judicial review are any issues based on data, information, or arguments not presented to the intermediary at the time of the estimate." It is noteworthy that usually the estimate was performed *ex parte*, as a ministerial function by the intermediary, some one-and-a-half years before the provider had any notice of the estimation.

After thus limiting the scope of inquiry, the Secretary proceeded to erect a new standard for administrative and judicial review. Eschewing APA standards, the Secretary pronounced that "an intermediary's estimation will be revised . . . only if the estimation was unreasonable and clearly erroneous in light of the data available at the time the estimation was made." This regulatory standard sharply contrasted with the statutory standard for Medicare payment matters. As the *Augustana* minority pointed out:

[W]hether administrative review is meaningful or not depends upon the scope of evidence considered and the standard of review applied to that evidence. Hence, 42 U.S.C. 1395oo(d) provides that:

'A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is reviewed as a whole.'

Indeed, the scope of review for the Board is expressly made large. Congress empowered the Board to 'affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination.'¹³⁹

139. *Id.* at 15,910.

As the *Augustana* minority concluded, applying the Secretary's regulations would weaken the statute and render administrative or judicial review essentially meaningless.

Although the U.S. Court of Appeals for the D.C. Circuit had supported this type of analysis in *Georgetown University Hospital v. Bowen (Georgetown II)*,¹⁴⁰ it came as little surprise that the Administrator of HCFA, exercising his authority to review PRRB decisions, chose to affirm the *Augustana* majority. With regard to *Georgetown II*, the Administrator stated he was "cognizant of that decision, but note[d] that an appeal [was] being considered. Therefore, the Administrator respectfully decline[d] to acquiesce." While the Administrator's rationalizations about Congress allowing the Secretary to fill statutory gaps sounded strained, at best,¹⁴¹ the Administrator's more straightforward explanation based on conserving funds sounded with far more conviction:

[I]n the interest of preserving the integrity of the essentially prospective nature of the new payment system, the Administrator has interpreted the Act as permitting retroactive rate adjustments in only very limited circumstances In this regard, the Administrator recognizes that the efficacy of the prospective system, mandated by Congress to compel hospitals to be cost conscious, depends upon rates being fixed in advance with certainty. The Inspector General and the Comptroller General both recommended that the referenced estimates should be *prospectively* corrected to eliminate excess profits.¹⁴²

Notwithstanding the refreshing candor of the Administrator's closing paragraphs, the agency chose within a year to acquiesce. Yielding not to fiscal interests represented by the Inspector General and Comptroller General, but yielding instead to the recent

140. 862 F.2d 323 (D.C. Cir. 1988).

141. As explained by the Administrator and by the PRRB majority:

The statutory scheme set up by Congress is consistent with the objective of establishing final, prospective rates. Sec. 1886(d) of the Social Security Act (42 U.S.C. 1395ww) describes how the PPS rates are to be determined for the period of transition from the cost-based reimbursement system to the prospective payment system. A key element for such determination is the amount of allowable operating costs of inpatient hospital services recognized by the Medicare program for the base period. When the amount of such costs is later changed as the result of subsequent events, the statute is silent on when such change should be incorporated into the PPS rate. By failing to so specify, Congress has delegated to the Secretary the responsibility for filling this gap by regulation. The regulations implementing PPS permit appeals of base-year adjustments. However, they limit the application of the result of such an appeal to rates for PPS years beginning after the appeal, except in those limited circumstances where the Intermediary failed to use the best data available to determine the hospital-specific rate.

HCFA Administrator Decision, [1988-2 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 37,022, at 16,407.

142. *Id.* at 16,408.

Supreme Court and D.C. Circuit decisions increasing access to PRRB review, the Secretary issued HCFAR 89-1, an interpretive ruling which acknowledged *Georgetown II* controlled.¹⁴³

Attorneys accustomed to the Social Security Administration's long-standing policy of non-acquiescence, resisting for many years federal court constructions of disability law, would likely be taken somewhat off-guard by the relative speed with which the Health Care Financing Administration issued HCFAR 89-1. However, HCFA had just lost the first two Supreme Court cases testing PRRB jurisdiction.¹⁴⁴ HCFA's Office of the General Counsel had reached a consensus that the government's position in *Georgetown II* was sufficiently weak that appeal would not be advisable.¹⁴⁵ Thus, the Medicare appeals issues could be distinguished from the disability appeals, where HHS had adopted a policy of non-acquiescence because the Supreme Court had not yet ruled on the issue. Here, HHS did understand what positions the Supreme Court had or likely would have taken on the contested issues. Therefore, reasonably swift acquiescence was highly appropriate.

This sounds favorable. Yet, we are exploring here whether we can create a review mechanism that does not necessarily have to rely on timely, favorable Supreme Court oversight in order for the system to function with fairness and according to law. Especially if

143. HCFA Ruling No. 89-1, [HCFA Ruling No. 89-1 [1989-1 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 37,614, at 19,185 (Jan. 26, 1989).

144. *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 404-05 (1988), accepting the principle that providers should be permitted to reopen cost reports to claim costs which they had "self-disallowed" in accordance with program instructions, but which they believed they had a claim. This principle was first proposed in *Athens Community Hosp. v. Schweiker*, 514 F.Supp. 1336 (D.D.C. 1981), and had been rejected before the D.C. Circuit in *Athens II*, 686 F.2d 989-95 (D.D. Cir. 1982). The very next term the Supreme Court decided *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204-5 (1988), which held that Medicare's wage limits on hospital costs could not be published retroactively.

145. As the ruling explains, "[T]wo recent decisions issued respectively by the United States Supreme Court in *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988) ("*Georgetown I*") and the United States Court of Appeals for the District of Columbia Circuit in *Georgetown Univ. Hosp. v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988) ("*Georgetown II*"), control and thereby render moot for lack of an actual case or controversy various claims and appeals challenging certain Medicare reimbursement regulations that are now pending before fiscal intermediaries, the Provider Reimbursement Review Board (PRRB), HCFA and in the federal courts." HCFA Ruling No. 89-1, *supra* note 143, at 19,815.

Further, there is always the possibility that dedicated individuals may have helped moderate HCFA's non-acquiescence policies regarding PPS and other reimbursement matters (*viz.* accounting for labor-delivery room days and malpractice payments). Many observers credit the shift in HCFA's stance, among other things, to the influence of Henry R. Goldberg, an extremely experienced senior HCFA attorney who had been promoted to Deputy Chief Counsel for Litigation.

the nation eventually adopts the Federal Courts Study Committee model of a specialized Article I court for Medicare or for all Social Security appeals, then we must have in place a reliable system of administrative justice which scarcely requires the heavy reins of Article III courts in order to guide the adjudicators and the Secretary to comply with Congress' instructions. More fundamentally, we are seeking to design a system of administrative justice which fulfills the deep-rooted principles of our civilization, that a citizen should have a fair and impartial hearing of grievances against his government.

With that in mind, then, the pivotal question becomes whether the structure of the PRRB did, in fact, insulate members from any real or perceived negative reaction from the Secretary due to members' exercise of their independent judgment? Were decisions by PRRB members vulnerable to the chilling effect about which Social Security ALJs were so apprehensive, and which many outside observers believed had already crippled the impartiality of the Appeals Council?

It would seem as if the *Augustana* decision presented a singular opportunity to bring such concerns to the fore, since the policy issues and dollar amounts at stake were so large. As the Administrator explained in his decision, the Comptroller General estimated that in fiscal year 1986 alone, inaccurate PPS estimates would result in Medicare overpayments of "about \$940 million" and for the transition period of FY 1986-90, the possibly appealable money at issue amounted to "\$8 billion."¹⁴⁶

Notwithstanding the above, both dissenters, I and Mort Ganeles, when asked, have unequivocally stated that no pressure — subtle or overt — was ever exerted concerning *Augustana*. Perhaps none was needed, since the majority of the Board agreed with the Secretary's interpretation. But this "hands off" policy applied on other occasions, on other issues where the PRRB consistently and unanimously decided in favor of providers — although the Secretary declined to acquiesce — on significant substantive issues such as malpractice costs and accounting for labor/delivery room days. Perhaps the institutional independence of the tribunal led to the sense of decisional independence experienced by Board Members — just as President Roosevelt's Committee on Administrative Practices had envisioned.

146. HCFA Administrator Decision, *supra* note 141, at 16,408.

B. Bureaucratic Limitations on PRRB Independence

The independence of the PRRB has been a jealously guarded, signal feature of its role in Medicare's system of administrative justice. In the eyes of many, the Board's independent operation and support have long hinged upon the vigor with which HCFA carries out its statutory obligation to make available technical and staff support.¹⁴⁷

The issue first rose to a head in 1983 when PRRB members met with the Health Subcommittee of the House Ways and Means Committee to discuss a number of issues concerning Medicare appeals. As Board Members Bette Kraus (Chairman), Mort Ganeles and Richard Dudgeon explained in a letter summarizing their meeting at PRRB offices: "[c]learly, resources (personnel, equipment and material) is [sic] the most critical problem." The Members tried to impress upon the Subcommittee that "[f]rom its inception, the Board has operated as an orphan within HCFA, with a history of unresponsiveness and inadequate support." The Members concluded that mere admonishments to HCFA would not meet the task. Instead, Congress needed to revise the institutional structure, such that the PRRB had its own staff and budget. "The history of the Board supports our conclusion that the only way the Board will be able to fulfill its purpose is to be an agency independent of the Department of Health and Human Services as well as the Health Care Financing Administration (HCFA). . . . Clearly, the Board must be independent in fact."¹⁴⁸

From 1983 through 1987 the load of cases filed grew exponentially, while output fell off sharply beginning in 1987. During that time period the Board engaged in a vigorous struggle with HCFA to increase staff and to computerize operations in order to eliminate a case backlog that had doubled.¹⁴⁹ Computerization did not occur until late 1987, and staff not only did not increase, but decreased through attrition. In time, concern over support of PRRB operations became so acute that the Committee on Appropriations issued a report expressing "concern over the potential appearance of a conflict of interest in HCFA's unwillingness to allow the Board adequate staff."¹⁵⁰ The General Accounting Office (GAO) was

147. 42 U.S.C. § 1395oo(i) (1992).

148. Letter to S. Casbin and K. Yow (July 25, 1983) from Board Members Bette Kraus (Chairman), Mort Ganeles, Richard Dudgeon.

149. See Memorandum to Dr. Regina McPhillips (Bureau of Data Management) from Chairman, PRRB (May 15, 1986) and attached schedules of performance statistics.

150. GAO Report No. GAD/HRD-90-23 BR, *Slowness of Appeals Process for Medicare*

directed to investigate whether HCFA's relationship with the PRRB impaired the Board's effectiveness in processing cases.

The GAO finally concluded that "several events occurring around the same time may have contributed" to the decrease in case output. The years of high case output tended to correspond to years when the PRRB's position on malpractice costs and labor/delivery room days — large group appeals involving dozens of providers — resulted in numbers of "boilerplate" decisions. When HCFA finally acquiesced on these issues, the appeals settled, and PRRB case output declined somewhat.

A point not covered by the GAO, but widely recognized by providers and the Board, was that intermediaries throughout the nation had virtually stopped issuing notices of program reimbursement (NPRs) to hospitals. The NPR could be critical to a Medicare appeal.¹⁵¹ Generally, this notice constituted the threshold step for pursuing a PPS appeal, according to the Secretary's interpretation pre-HCFAR 89-1. Following publication of HCFAR 89-1 in January of 1989, intermediaries resumed issuing NPRs to hospitals and PRRB appeals under PPS doubled the PRRB's caseload within a year.¹⁵²

Case processing suffered because of lack of staff to manage cases in the early steps.¹⁵³ The GAO used HCFA's own management study as a benchmark for measuring productivity. According to HCFA's standards, the appropriate size of a technician's workload is about 220 cases. At the PRRB, though, its three legal technicians, who handled clerical functions, were each responsible for about 800 cases. Understandably, their cases "were in the initial steps of the appellate process significantly longer than the allowed time."¹⁵⁴

Most of the PRRB staff are paralegal specialists known as Board

Part A Reimbursements, [1990 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 38,492 at 22,786 (Feb. 9, 1990).

151. This was a controversial point in the early days of PPS. Consistent with the reasoning explained in my later dissent in *Augustana*, I had instituted a policy of issuing written dissents on decisions where the majority denied jurisdiction for a PPS case based on lack of an NPR.

152. The PRRB's workload statistics track cases according to the federal fiscal year, which is October 1 through September 30. For fiscal year 1864 appeals were filed; fiscal year 87,855 were filed. In fiscal year 88,1519 were filed, increasing to 2240 in fiscal year 89 and reaching a high of 3061 in fiscal year 91. The average amount in controversy in each PPRB case has risen from an average of \$250,000 in the period FY 86-89 to \$300,000. PRRB WORKLOAD STATISTICS (Jan. 17, 1992).

153. GAO Report, *supra* note 150, at 22,792.

154. *Id.* at 22,798.

Advisors. They are classified at the GS-14 level, which is a grade below the classification for most Social Security ALJs. Advisors are responsible for processing cases, reviewing case documentation (position papers from both parties), drafting the Chairman's opening statement and the list of documents submitted by both parties prior to the hearing. The Board Advisor functions as bailiff/clerk during the Board hearing. The full panel of Board Members hears each case, sitting *en banc*, although statutory authorization does exist for the Board to hear cases in split panels so that two cases could be heard simultaneously.¹⁵⁵

The Advisor plays a sensitive role at the Board decision conference following the hearing and following submittal of post-hearing briefs and supplemental evidence. At the decision conference, also held *en banc*, the Advisor presents the facts, contentions and HCFA rulings pertinent to the case. This is supposed to be done in as wholly unbiased a manner as possible, presenting with equal emphasis both the provider and the intermediary's contentions, making no personal recommendation one way or the other. The Board then discusses the case, reaches a decision and directs the Advisor to draft the decision. The draft decision is distributed among Board Members for editing and revision until the Board as a whole is satisfied that the opinion expresses the will of the tribunal.

The GAO report did not describe the Board Advisor function in the detail provided here. Perhaps that is because few people other than PRRB Members themselves fully appreciate how sensitive and potentially influential the Board Advisor's position can be in the process of administrative review. Especially as the volume of cases increases, and the pressure for output increases, PRRB Members, like any tribunal, will tend to rely more heavily on the work done by staff. Members would not abdicate their responsibility to exercise the expertise and judgement for which they were appointed. However, as workload demands increase, Members may ineluctably be called upon to rely more and more upon the Advisors' summaries and drafts in order to increase productivity.¹⁵⁶

155. In Spring, 1992 the PRRB began hearing cases in two panels (three-member and two-member) where parties agreed to waive the three-member quorum.

156. A recent revision to PRRB procedures may help to moderate the influence of the Advisor in the role of opinion-drafting. Under the "Provider Reimbursement Review Board Process" statement of procedures revised as of 1991, post-hearing briefs submitted by the provider and intermediary "should include a proposed formal decision. The Board will use the winning sides proposed decision as a basis for its final written decision." As explained further in a footnote to that statement, "The proposed decision should contain a statement of the issue(s), a summary of facts, citation of applicable law and regulations, findings and con-

Thus, it appears to me, from the triple perspective of a former litigator before the PRRB, then Member, and now neutral academic, that actually the Board Advisor position requires almost as much institutional independence from HCFA as the Board Members themselves enjoy. This does not mean that the Board Advisor position need be raised on the GS scale. (At GS-14, the position cannot be raised much higher.) This does, however, mean that the institutional lines of support and civil service/personnel control need to be maintained as clearly separate from HCFA as possible. Otherwise, the Board could quietly relapse into the early days of Medicare adjudications before intermediaries, where *ex parte* contacts flourished and few, if any, lines separated quasi-prosecutorial from quasi-judicial functions.

GAO concluded that HCFA held no animus toward the PRRB, nor "intent of impairing PRRB's effectiveness." GAO saw "HCFA's apparent unwillingness to provide the Board with staff" as related simply to "the allocation of scarce resources among competing demands."¹⁵⁷ I would raise the concern that even without evidence of bad intent by HCFA, the very existence of such control over the vital fiscal and human resources necessary to operate the PRRB can compromise its effectiveness as a forum for administrative justice.¹⁵⁸

V. PREPARING FOR THE FUTURE

In just another three years several anniversaries will roughly coincide: the 30th anniversary of the Medicare Act, the 50th anniversary of the Administrative Procedure Act, and the 60th anniversary of the Social Security Act. According to some prognosticators, those anniversaries might also coincide with our first truly serious recent congressional debate seeking to implement national health care reform. By "serious" I mean debate which is likely to result not merely in further studies, but in adopted, comprehensive legislation.

Hopefully, those debates will evidence the detailed and

clusions (contentions of the parties where appropriate should be referenced in this section not in the summary of facts), and the decision."

157. GAO Report, *supra* note 150, at 22, 798.

158. It may be very worthwhile to monitor closely the progress of the Medicare Geographical Classification Board, created by Congress on the model of the PRRB to resolve disputes concerning rural/urban classification under PPS. Originally, the PRRB was providing staff support to the MGCB. Now, HCFA has assumed direct staff support for the MGCB. Its attempt to do so with the PRRB was unsuccessful.

foresightful discussion of financing and procedure which thus far has been lacking. In particular, the mechanism for resolving a large volume of high-dollar payment disputes has typically been left as a "black box," to be filled in later, according to internal and external agency pressures. As we have seen, over time, the back-and-forth of those internal and external pressures leads to a grudging compromise on: who shall have access? on what terms? with "efficiency" defined as a speedy decision? or "efficiency" defined as a predictable, budget-neutral decision? Again, as we have seen, such an administrative process — one which is "TBA" ("to be announced") — can result in a fundamental sense that bureaucratic justice under the Social Security Act is by definition impossible. It is a contradiction in terms. And if justice cannot be had within the bureaucracy, then the call will increase for justice in the already overburdened courts.

In a curious reprise, we in the mid-1990s may have an opportunity to remake the administrative and judicial review procedures for financing of health care services with more knowledge than our predecessors had available to them. Sixty years ago the process was barely stumbling along as President Roosevelt's men and women cobbled together the Social Security Act. Few people at that time recognized the overwhelming dimensions of the program they were then instituting. Now, clearly, we recognize the leviathan at the table. We understand that whatever changes are made to Social Security Act procedures will have a far-reaching impact on tens of millions of Americans.

However, especially with the addition of the Medicare program in the 1965 amendments to the Social Security Act, we have now come to recognize that the cost of maintaining this leviathan is one of the biggest challenges facing the national budget today. We further know that if Medicare is expanded to provide universal coverage, the strain between access and efficiency will increase logarithmically.

Thus, a more sophisticated debate over health care reform in the mid-90s may place us squarely again at the intersection between the APA and the SSAct. That level of debate will raise again the issue of foreclosing full Article III judicial review, as it has been raised periodically since the 1930s; as it was raised most recently in the Report of the Federal Courts Study Committee.

Would such foreclosure be legally (and politically) viable for an expanded Medicare program or other federally sponsored health insurance? At its heart, the answer depends upon how one perceives

the essential integrity of the bureaucratic structure; not necessarily the bureaucrats themselves, but the framework within which they operate. There appear to be two major foci: (1) those who perceive Medicare administration as a fluid process, with intermediaries and providers in an on-going working relationship, well-suited for informal methods of dispute resolution; and (2) those who never lose sight of HCFA's role as the real party in interest, and thus remain wary that budget concerns might override due process. This second focus, then, sees an ever-present need for formalized review processes.

If our nation does indeed expand the Social Security Act such that Medicare offers "universal coverage", would the PRRB (or a successor tribunal modeled on the PRRB) offer the institutional independence necessary to assure fair and lawful resolution of disputes against HCFA? I believe the answer is a qualified "yes". The qualification: The administrative tribunal must be statutorily independent from HCFA (and perhaps even HHS). It must also enjoy functional independence extending beyond the adjudicators to encompass also the staff, plus operational matters concerning budget and equipment.

It seems clear, however, that even an expanded PRRB (or successor PRRB) could not efficiently handle the increased caseload which would follow universal coverage. Therefore, I believe we need to explore in greater depth further modifications to Medicare's system for administrative and judicial review, as outlined below.

A. Administrative and Judicial Review in Countries with Established National Health Insurance Programs

The Federal Courts Study Committee, in recommending that we establish a legislative court to review disability claims, alluded to the fact that such administrative courts are a common feature of European legal systems. Americans have long held a fascination with the British, and now the Canadian, experience in providing national health insurance. However, we have not examined in detail the legal procedures for review of disputes between participants in the insurance program and the government agency administering the program. Canada, Great Britain, the Republic of Ireland (whose constitution is modeled on that of the U.S.), France and Germany all have systems of national health insurance that have experienced cost pressures similar to our own.¹⁵⁹

159. See e.g., George J. Schieber, *Health Expenditures in Major Industrialized Countries*,

These countries also typically rely on administrative courts to handle specialized subject matters, a practice which is not so typical in the United States. More fundamentally, their systems of law, their political, social and philosophical traditions and expectations, do not necessarily bear as close a similarity to ours as they might seem upon a superficial appraisal. Of key importance is the basic fact that most European systems of justice derive from a code/inquisitor model instead of a common law/adversary model.¹⁶⁰ Such considerations may bear particular weight in deter-

1960-87, 11 HEALTH CARE FIN. REV. 159 (Summer 1990); Markus Schneider, *Health Care Cost Containment in the Federal Republic of Germany*, 12 HEALTH CARE FIN. REV. 87 (Spring 1991); also HENRY J. AARON & WILLIAM B. SCHWARTZ, *THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE* (1984).

160. See, e.g., ALLAN R. BREWER-CARIAS, *JUDICIAL REVIEW IN COMPARATIVE LAW* (1989); HENRY W. R. WADE, *TOWARDS ADMINISTRATIVE JUSTICE* (1963).

Also Julius H. Grey, *The Ideology of Administrative Law*, 13 MANITOBA L.J. 35 (1983) (examining Canadian administrative law, including its British and French foundations); W. A. Bogart, *Courts and Tribunals: Conflict and Co-Existence*, 8 CIV. JUST. Q. 7 (1989) (examining the relationship between courts and administrative tribunals in Canada); David P. Jones, *The Supreme Court of Canada and Administrative Law*, 14 ALBERTA L. REV. 1 (1976); P. A. Cote, *Droit civil et droit administratif au Quebec*, 17 C. DE D. 825 (1976) (examining the proper limits of civil and administrative law in Quebec province); Louis Bernier, *La Cour d'appel et le controle judiciaire de la legalite des acte de l'administration*, 8 REV. JURIDIQUE THEMIS 421 (1973) (examining the Canadian equivalent of Article III court review of and control over administrative agency actions); D. Mullan, *Judicial Restraints on Administrative Action: Effective or Illusory?*, 17 C. DE D. 913 (1976) (challenging the proposition that judicial review of agency actions is not guaranteed under the Canadian constitution).

Concerning French tribunaux: L. Neville Brown & John Bell, *Recent Reforms of French Administrative Justice*, 8 CIV. JUST. Q. 71 (1989) (describing the case overload in the French system of administrative tribunals from which appeal can only be taken to a specialized court); Christian Atias, *Culture juridique americaine et ordre savant traditionnel*, 20 REV. JURIDIQUE THEMIS 147 (1986) (examining the differences between French and American legal cultures); L. Neville Brown, *La nouvelle justice naturelle: l'administrateur 'equitable et raisonnable'*, 21 C. DE D. 67 (1980) (giving a French perspective on recent developments in British administrative law concerning fairness and reasonableness in agency action); Hans G. Crossland, *Rights of the Individual to Challenge Administrative Action Before Administrative Courts in France and Germany*, 24 INT'L & COMP. L. Q. 707 (1975); and more broadly, pointing to new trends in European administrative law, Alan Boyle, *Administrative Justice, Judicial Review and the Right to a Fair Hearing Under the European Convention on Human Rights*, PUB. L. 89 (1984).

Not surprisingly, the legal scholarship which may be most readily applicable comes from Great Britain, where a social security system and a system of national health insurance have been in place for many years. See, e.g., A. W. Bradley, *Recent Reform of Social Security Adjudication in Great Britain*, 26 C. DE D. 403 (1985); L. Neville Brown, *The British Social Security Tribunals: A New Unified System for Adjudication of Social Security Benefits*, 17 CAMBRIAN L. REV. 40 (1986) (Professor Brown is also a member of the British Council on Tribunals); James G. Logie & Paul Q. Watchman, *Social Security Appeal Tribunals: An Excursus on Evidential Issues*, 8 CIV. JUST. Q. 109 (1989); Julian Webb, *Social Security Adjudication, Judicial Review and the Technology of Poverty*, 53 MOD. L. REV. 116 (1990). *More generally*, Eric Barendt, *Grievances, Remedies and the State*, 7 OXFORD J. LEGAL STUD. 125

mining whether — for American citizens — decisions that directly or indirectly ration health care resources can be committed to the unreviewed discretion of a government agency. If the system we establish does not meet with American expectations about administrative justice, irrespective of the vaunted “efficiency” of such a procedure, that system will be perceived as lacking legitimacy.

Therefore, I recommend for and intend to pursue further research a close comparative study of: (1) the financing systems for national health insurance in the countries listed above; (2) the legal procedures for review and resolution of disputes at the agency level and beyond; and (3) how these countries have addressed the problem of access and efficiency as described in this article.

An in-depth study of these systems — not only their theory, but also their practice — constitutes a fairly long-term project. It is, however, one which I believe will be well worthwhile. We are the last major Western government not to have a national health insurance program. And yet even the provision of universal access in other countries has not insulated them from significant, oftentimes overwhelming problems of cost control. And when individual access confronts mass pressure to limit costs, justice is caught betwixt and between. It would serve us well to understand and learn carefully from the mistakes of our predecessors.

B. Developing a New Model for HHS Adjudication

In the nearer term, the next stage in my research on this general topic will explore in much greater detail the theoretical and operational components of an adjudicatory model or models for the next generation of Medicare appeals. Hopefully, the model(s) will be able to serve, if need be, to accommodate not only HHS' current Medicare appeal needs, but also the appellate needs for whatever system of federally sponsored health insurance may finally be adopted.

1. A Blended Model, Seeking Accommodation

At this early stage of analysis, it would appear that the first step

(1987); D. G. T. Williams, *The Council on Tribunals: The First Twenty-Five Years*, PUB. L. 73 (1984); D. G. T. Williams, *The Tribunal System — Its Future Control and Supervision*, 9 CIV. JUST. Q. 27 (1990) (Professor Williams was a member of the Council on Tribunals); A. I. Ogus, *Bureaucrats as Institutional Heroes*, 7 OXFORD J. LEGAL STUD. 309 (1987); Michael Sayers & Adrian Webb, *Franks Revisited: A Model of the Ideal Tribunal*, 9 CIV. JUST. Q. 36 (1990); J. W. Bridge, *Be You Never So High, The Law is Above You: Recent Developments in English Public Law with Some American Comparisons*, 8 ANGLO-AM. L. REV. 331 (1979).

in developing a model which assures both the adjudicatory discretion to render individual justice and the speed to handle large volumes of cases might blend aspects of both the PRRB and the SSA model into one. Thus, after the initial determination and reconsideration, the provider would bring an appeal to an ALJ for a full, formal adjudication or an on-paper hearing, at the parties' discretion. A party which was dissatisfied with the ALJ's determination would be able to appeal to the PRRB. A critical set of issues demand careful study here.

Specifically, if such a blending were carried out, what government entity would have direct or indirect control over the ALJ? The statutory independence of the Board Members themselves has already been assured. However, the independence of SSA's ALJ's has long been a matter of controversy. They are, obviously, employees of the agency, as are the members of the Social Security Appeals Council.

It would seem that blending the two models for adjudication would force the issue of ALJ independence to the forefront. Indeed, the perceived reliability, fairness — the inherent justice — of the entire system would stand or fall on whether the ALJ had the opportunity to exercise the type of independent discretion which any citizen has a right to expect from a person acting in a quasi-judicial capacity. It would seem then that we would have to return to incorporate a portion of the Federal Courts Study Committee's recommendation concerning the Social Security Disability Program. Namely, that if a Social Security Court is to be established, the ALJs rendering the decisions reviewed by that court must have statutory independence from the agency.

I would add that, based upon the long history of HEW/HHS and the political pressures to which costly programs can be subject, it would be important to assure such ALJs also enjoy bureaucratic independence from the agency. Otherwise, it is all too easy for the Medicare (or health insurance) ALJ corps to be "squeezed" as the PRRB staff and operations have been.

Many further questions, of course, require a closer look in developing a blended model such as this. For example, could the current SSA ALJs satisfy the need to review institutional claims by providers under the program? My personal and professional sense of the matter, having dealt with both models of HHS adjudication, is that there may be some inveterate difficulty in asking SSA ALJs to serve in both capacities. The nature of the claims, the complexities (especially the financial and evidentiary complexities), the processes, the

standards, the stakes are so different under the two programs. I seriously question whether adjudicators accustomed to handling cases under one program can effectively and fairly switch to adjudicating cases under the other program. This would seem to be a particular difficulty if the ALJs were required to handle mixed caseloads. Perhaps it is best to allow a cadre of ALJs who have been trained in that area and have developed the relevant expertise, to continue as specialists in that program.

Clearly, a number of knots remain in this puzzle. In the next stage of my research I intend to examine in detail the operational pros and cons of various models blending different aspects of the PRRB and SSA model. That analysis will include soliciting responses from various provider, intermediary and governmental entities which have had an historical interest in HHS adjudications for institutional health payments. The proposals will include more than variations on reaching an accommodation between the two current models. They will also include wholly new components: a comprehensive system for mediation of claims which would otherwise come before the PRRB; and the establishment of an ombudsman system.

2. Establishment of a System for Mediation

During the latter 1980s, informal settlement of PRRB cases before hearing became a leading method of case resolution. New PRRB hearing procedures which require parties to exchange position papers (briefs) before filing with the Board, have apparently accelerated the settlement rate.¹⁶¹

If the Medicare program is to expand exponentially, then *ad hoc* informal settlement surely is insufficient to address the caseload problem. Although the average size of a PRRB case is quite large (from 1986 through 1991, the average case size ranged from \$250,000 to \$300,000), the issues involved often can lend themselves

161. As set forth in the "Provider Reimbursement Review Board Process" notice of procedures revised 1991, after the PRRB has determined whether it has jurisdiction, the provider and intermediary:

Conduct, discovery, if necessary. Provider then prepares a draft position paper, including evidence and exhibits and submits the position paper (brief) to the intermediary (position paper is due to the intermediary 90 days prior to the due date for submittal to the Board). The intermediary then prepares its own position paper (within 60 days) and sends it to the provider. Both parties then have 30 days to send copies of those papers and evidence and exhibits to each other and to the PRRB. These are the final position papers covering the issues presented in the joint agreement statement. Supplemental position papers will not be accepted on these issues.

to mediation so long as the parties have representation which is relatively equal in skill. Designing such a system requires sensitivity to issues of due process, separation of functions, and protection against *ex parte* communications with HCFA in order to avoid the problems which had blighted the appeals process before establishment of the PRRB.

Thus, we must ask whether this even is an appropriate function for the PRRB (or its successor) to perform? If so, who would be appropriate to act as mediator? A Member? An Advisor? Another as-yet-undefined employee? Is this an appropriate function for HCFA? To what extent, if any, would HCFA's involvement be appropriate?

I recommend further study of how to design such a mediation system.¹⁶² This could be a valuable endeavor, helpful not only for future PRRB needs, but even for resolving current backlogs. One must use caution and, again, sensitivity, in evaluating the competing pressures on a mediation system. The deeply entrenched traditions of SSAct review (relying on the trial examiner mode), coupled with Medicare's checkered history on procedural protections would lead a reasonable observer to tread lightly when one suggests diminishing the PRRB's formal adversarial process. Formal adjudications surely do not dispose of cases as promptly as informal methods, but the protections of the APA have withstood the test of time.

3. Establishing an Ombudsman System

Lastly, in addition to examining ways of improving the system for resolving disputes after the transaction between government and citizen has gone awry, I recommend studying further how we can help prevent such controversies from arising in the first place. As the Administrative Conference of the United States has recently recommended in other contexts,¹⁶³ an ombudsman could perform an important role in explaining payment policies, the availability of

162. This recommendation merely endorses that of the Administrative Conference of the United States, as applied to federal agencies generally. See *Recommendation 86-3: Agencies' Use of Alternative Means of Dispute Resolution*, ACUS RECOMMENDATIONS AND REPORTS 9 (1986); background report, Phillip J. Harter, *Points on a Continuum: Dispute Resolution Procedures and the Administrative Process*, ACUS RECOMMENDATIONS AND REPORTS 165 (1986) (giving background information on Recommendation 86-3).

163. See *Recommendation 90-2, The Ombudsman in Federal Agencies*, ACUS RECOMMENDATIONS AND REPORTS 8 (1990) (suggesting the effective role that ombudsman have played in the Internal Revenue Service and that Army Material Command can be achieved in all agencies); and background report, David R. Anderson & Diane M. Stockton, *Ombudsmen in Federal Agencies: The Theory and the Practice*, *id.* at 105.

services, etc. Such guidance could be valuable to both the beneficiary and provider. If given in advance of the rendition of services, it could greatly assist in clarifying the confusing array of technical limitations on payment.

As a legal matter, though, this seemingly simple, straightforward proposal may raise a number of thorny issues. Who is the ombudsman? An employee? A volunteer? Would the ombudsman be an agent for HCFA? To what extent would HCFA be bound by representations made by the ombudsman concerning payment policies? Could payment for services be made contingent upon prior approval by the ombudsman? Of course, we can look to the experience of ombudsmen in Areawide Agencies for the Aging as a starting point,¹⁶⁴ and then extrapolate to see whether and how that model addresses the questions raised here. Again, this is a recommendation which I believe has potentially strong benefits for the next generation PRRB, and perhaps also for the current Medicare program.

164. HHS supports state long-term care ombudsmen under the Federal Older American Act of 1978 to "investigate complaints, settle disputes, monitor related legislation, regulation and policy, and provide public information and train program volunteers." Anderson & Stockton, *id.* at 200-01.