Lost Causes? Why Iowans with Mental Illness Face an Uphill Battle for Social Security Disability Benefits

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ABSTRACT: Social Security programs provide a vital safety net for Americans with physical or mental disabilities. Like all social programs, its policies and procedures should ideally be thoughtful and well-balanced, meaning that qualified individuals receive their benefits without undue hardship or delay, with minimal fraud and administrative waste. Applying for Social Security disability is often a years-long process, during which every facet of a claim is subjected to rigorous scrutiny, and after which only about a third of all disability claimants are approved for benefits. This leads one to wonder: were only a third of claimants truly deserving of benefits? Or are there administrative hurdles that keep deserving claimants from the benefits they need? Social Security disability is a nationwide program. While one set of rules apply regardless of where the claimant lives, the claimant's home state plays a strong role in the adjudication process on both a procedural and substantive level. Procedurally, it is state agencies, not federal, that perform the actual claim adjudication process. Substantively, a claimant's medical evidence comes from his or her local treatment providers, meaning that the number of approved providers located near the claimant will often determine the strength of his or her claim. On top of this, there are only a handful of rules that are tailored to the unique aspects of a claim for mental disability; the bulk of the rules are written primarily from the standpoint of physical disabilities. But how similar is a back injury to clinical depression? From what kinds of providers would claimants with these two disorders seek treatment, and what would that treatment entail? What medical evidence would those courses of treatment create? The fundamental questions here are: Can one set of rules properly—and fairly—account for these differences? And

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what are the consequences if they do not? These are difficult questions, and they strike and the heart of the program itself.

This Note addresses those fundamental questions, with a focus on the problems Iowans with mental impairments face in proving their Social Security claims. Following an introduction, Part II lays out the application process for Social Security disability benefits, which acts both as a necessary foundation for the discussion that follows and as a general primer for anyone unfamiliar with Social Security disability programs. Part II also introduces some common mental health issues and their treatments, and gives a broad overview of the current state of mental healthcare in Iowa. Part III discusses problems Iowans with mental illness have in proving a claim for disability, and how these inherent problems were exacerbated by recent rule changes that expanded the Social Security Administration's discretion in weighing medical evidence. Next, Part IV offers solutions to correct—or at the very least mitigate—these hardships, and includes both solutions that work within the current systems, as well as some that propose more sweeping rule changes. This Note ends by concluding that without changes, many Iowans—and many other similarly-situated Americans—will continue to be denied the benefits they need.

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I. INTRODUCTION

Social Security disability benefits are available to all citizens, regardless of age, for both physical and mental impairments.[1] All claims for disability must be supported by medical evidence, which includes all medical records from a claimant's course of treatment. Not all medical evidence is equal, though; the Social Security Administration ("SSA") Rules categorizes medical evidence based on the type of medical provider who treated the claimant.[2] The highest category of medical source is the *acceptable medical source*, and evidence from an acceptable medical source is required for all claims.[3] In March 2017, the SSA changed its rules both in regard to who is considered an acceptable medical source, and in how the administration weighs medical evidence.[4] In announcing these changes, the SSA stated the new rules would better reflect how Americans receive medical care.[5] For claimants with mental impairments, however, nothing could be farther from the truth.

These changes were particularly harmful for claimants with a mental impairment in the State of Iowa. For example, while the SSA did add more practitioners to the list of acceptable medical sources, all those it added were practitioners in *physical* medicine.[6] In fact, the SSA went so far as to explicitly reject adding additional mental healthcare practitioners as acceptable medical sources.[7] Adding more mental healthcare practitioners as acceptable medical sources was critical to a state like Iowa, where, as will be seen, those practitioners considered acceptable medical sources in mental healthcare are few and far between.[8] Even more damagingly, the SSA expanded its adjudicators' discretion in assigning weight to medical evidence. This was done in two ways. First, the rule changes eliminated what was formerly known as the Treating Source Rule, under which evidence from a medical source with a longer treating relationship with the claimant was given greater weight than evidence from a medical source with a shorter or no treating

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1. *See Disability Benefits*, SOC. SEC. ADMIN., https://www.ssa.gov/benefits/disability [https://perma.cc/Y9SE-EUFB].

2. *See infra* Section III.A. As will be seen, the totality of the SSA Rules are spread across numerous sources. These include the U.S. Code, the Code of Federal Regulations, Social Security Rulings and Acquiescence Rulings, as well as internal SSA sources, such as the Program Operations Manual System ("POMS"), and the Hearings, Appeals, and Litigation Law Manual ("HALLEX"). Any reference to the SSA Rules includes all these sources.

3. *See infra* Section III.A. Throughout this Note, terms introduced in *italics* are SSA terms of art with specific definitions in the SSA Rules.

4. *See infra* Section III.A. These rule changes will be referred to generally as the "2017 changes."

5. Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. 5844, 5844 (Jan. 18, 2017) (codified at 20 C.F.R. pts. 404, 416) ("These revisions . . . reflect changes in the national healthcare workforce and in the manner that individuals receive medical care . . . .").

6. *See infra* Section III.C.

7. Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. at 5846–47.

8. *See infra* Section II.D.

relationship.[9] Following the 2017 changes, adjudicators may assign medical evidence any amount of weight, regardless of the length of treating relationship. Practically, this means the SSA is free to assign more weight to evidence from an acceptable medical source who examined the claimant for one hour than it does to evidence from an acceptable medical source who saw the claimant regularly for a decade. The second way the SSA expanded discretion in assigning weight was by classifying prior SSA medical determinations as medical *evidence*.[10] Following the changes, if the SSA finds a claimant not disabled and the claimant appeals, the medical determination from all prior adjudication levels of the current claim is considered as medical evidence *against the claimant* during the appeal process. Practically, this means the SSA now has discretion to place its own prior medical determinations on an equal footing with any other more recent medical evidence in a claimant's file. The combined end effect of these changes is that for Iowans with a mental impairment, proving a claim for disability is even more difficult than before.

This Note will focus on claimants applying for disability benefits who have at least one medically determinable *mental* impairment, are over age 18, and are not blind.[11] Although both types of Social Security disability benefits will be discussed, this Note will focus primarily on applications for Supplemental Security Income ("SSI"), a program based on financial need,[12] rather than Social Security Disability Insurance ("SSDI"), a program based on past work history.[13] This focus is because mental impairments frequently manifest when a person is a child or young adult, which often inhibits that person's ability to enter the workforce.[14] Although this Note exclusively discusses the State of Iowa, this geographical footing is not meant to imply these issues are unique to Iowa alone. The larger goal of this Note is to use data from Iowa as a way to highlight the problems disability claimants for mental impairment may face in any state with a similarly-uneven distribution of mental health resources.[15]

Part II of this Note begins with a general overview of the Social Security disability adjudication process, highlighting especially the points in the process where medical evidence plays a critical role. Following this overview is a discussion of common mental illnesses and how they are treated, and then a Section detailing the distribution of mental healthcare resources in the State

9. *See infra* Section III.C.1.

10. *See infra* notes 221–37 and accompanying text.

11. The SSA Rules contain different and additional requirements for persons under age 18 or those who are blind. These are best left outside the scope of this Note.

12. *See infra* Section II.A. In this context, "needs-based" means the claimant falls below income and resource thresholds that are fixed in the SSA Rules.

13. *See infra* Section II.A.

14. *See Mental Health by the Numbers*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/mhstats [https://perma.cc/H2Y2-N9EA]; *see also infra* Section II.A (discussing the work requirements for SSDI).

15. *See infra* Section III.D.

of Iowa. Part III highlights specific problems in the disability adjudication process as it relates to claimants with mental impairments in states like Iowa with an uneven distribution of mental healthcare resources. Included in Part III is a discussion of the types of medical evidence, and, critically, how that evidence is weighed during the adjudication process both before and after the 2017 rule changes. This Part closes with a summary of the current gap between the requirements of SSA Rules and the realities of how Iowans actually receive mental healthcare. Part IV introduces five possible solutions to address these problems, and Part V offers a brief conclusion.

Social Security disability benefits are a necessary means of survival for many Americans, whose very subsistence and quality of life depend on the effectiveness and success of the program. The 2017 changes granted the SSA a degree of discretion that arguably serves no agency purpose, saves no agency resources, and risks arbitrary denial of benefits to some of the most vulnerable people in our society. Though the SSA framed these changes as more accurately reflecting how Americans receive healthcare, nothing could be farther from the truth in states like Iowa, where the changes have highlighted the state's ongoing and endemic problems with access to mental healthcare. Without changes to address the deficiencies in the application process for claimants with mental impairments, many deserving and qualified Americans will be unable to receive needed Social Security benefits, pushing their care onto other already-strained forms of public support, and depriving them of the possibility of the "Life, Liberty and the pursuit of Happiness"[16] that has been enshrined in America's values since the founding of the nation.

II. BACKGROUND

The SSA defines *disability* as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months."[17] Claimants may apply for disability benefits under one or both of the two programs (SSDI and SSI) administered by the SSA.[18] These two programs are funded through different sources, and the amount of benefits a person may

16. THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).

17. The Social Security Act of 1935, 42 U.S.C. § 416(i)(1) (2018).

18. Though the SSA Rules are spread out throughout numerous sources (*see supra* note 2), the bulk of Social Security regulations relevant to this Note are contained in title 20, chapter III of the Code of Federal Regulations. SSDI regulations are contained in part 404, and SSI regulations are contained in part 416. Many of the code provisions in these parts are identical. However, because SSDI has additional qualifications based on work history, the sub-numeration of parts 404 and 416 is not identical. For clarity, and because claims for SSI will be the primary focus of this Note, most citations to the C.F.R. in this Note will refer to part 416. Unless explicitly stated, or unless the section is discussing provisions exclusive to one program, it should be assumed that for each part 416 citation there is an identical or substantially-similar sister code provision in part 404.

receive differs under each program.[19] A claimant qualifies for SSDI benefits based on past work history and for SSI based on financial need.[20] Despite different funding sources and work history requirements, the medical evaluation process for both programs is the same.[21] Following a basic outline of these two programs, this Part will cover the SSA adjudication process. Then, this Part will discuss what is meant by "mental illness," including examples of common mental illnesses and their courses of treatment. Finally, this Part will discuss the availability of mental health resources in the State of Iowa.

A. General Requirements for Social Security Disability Programs

Whether a claimant has a work history determines under which program he or she may apply for Social Security disability benefits. Claimants with a sufficient work history may apply under both SSDI and SSI, while claimants without a work history may only apply under SSI. These programs are briefly described below.

SSDI is available to claimants whose prior work history meets certain requirements. Two factors of a claimant's work history determine eligibility: earned income and recency of work. The SSA quantifies a person's work history into units called *quarters of coverage* or *Social Security credits* (hereinafter "credits").[22] For any quarter in which a person was awarded a credit, he or she had *disability-insured status*.[23] The number of credits needed to qualify for SSDI depends on the claimant's age, with older claimants needing more credits.[24] If a claimant stops working because of their disability, they may apply for

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19. SSDI is funded through payroll deductions mandated by the Federal Insurance Contributions Act ("FICA"). *See How is Social Security Financed?*, SOC. SEC. ADMIN., https://www.ssa.gov/news/press/factsheets/HowAreSocialSecurity.htm [https://perma.cc/Z2ZZ-SU93]; 26 U.S.C. § 3101(a) (2018) (establishing the current FICA tax rate at 6.2 percent). "SSI is financed by general funds of the U.S. Treasury . . . ." *Understanding Supplemental Security Income (SSI) Overview–2020 Edition*, SOC. SEC. ADMIN., https://www.ssa.gov/ssi/text-over-ussi.htm [https://perma.cc/5EV4-FRSH].

20. *Disability Benefits: You're Approved*, SOC. SEC. ADMIN., https://www.ssa.gov/planners/disability/approval.html [https://perma.cc/G72M-MHCL]; *Supplemental Security Income (SSI) Eligibility Requirements*, SOC. SEC. ADMIN., https://www.ssa.gov/ssi/text-eligibility-ussi.htm [https://perma.cc/ZBW7-BWKC].

21. Both SSDI and SSI evaluate whether a claimant is disabled using the same five-step process. 20 C.F.R. §§ 404.1520(a)(4), 416.920(a)(4) (2020). This process will be discussed in further detail below.

22. 20 C.F.R. § 404.143; *see Quarter of Coverage*, SOC. SEC. ADMIN., https://www.ssa.gov/OACT/COLA/QC.html#qcseries [https://perma.cc/UE75-8G57] (describing how the SSA sets the value of one credit each year based on the National Average Wage Index); *see also National Average Wage Index*, SOC. SEC. ADMIN., https://www.ssa.gov/OACT/COLA/AWI.html [https://perma.cc/AK8X-N6ET] (detailing how the index is calculated and showing historical indices dating back to 1951).

23. *Insured Status Requirements*, SOC. SEC. ADMIN., https://www.ssa.gov/oact/progdata/insured.html [https://perma.cc/8H2N-SRU7].

24. SOC. SEC. ADMIN., HOW YOU EARN CREDITS 3 (2020), https://www.ssa.gov/pubs/EN-05-10072.pdf [https://perma.cc/NP9K-J67G].

benefits under SSDI for the period of time in which they were disabled and had disability-insured status.[25] A claimant's potential monthly benefit amount under SSDI is calculated based on their average lifetime earnings, as reported through FICA contributions.[26] In 2018, the average monthly SSDI benefit amount was $1,386.[27]

Unlike SSDI, the SSI program is based solely on financial need, and there is no work history requirement. To qualify for SSI, a claimant must have *limited resources*.[28] Currently, limited resources is defined as having less than $2,000 in resources if single, or less than $3,000 in resources between a married couple.[29] In 2019, the maximum monthly benefit for SSI was $771.[30] Claimants who qualify for SSDI with a monthly benefit lower than $771 may apply concurrently for SSI benefits, so long as they meet the SSI *limited resources* requirement.[31] If approved for both SSDI and SSI, the claimant will receive their SSDI monthly benefit amount plus an SSI award that brings the claimant's total monthly benefit to the $771 SSI maximum.[32]

B. *The Five-Step Sequential Evaluation Process*

The SSA evaluates all claims using the Five-Step Sequential Evaluation Process (hereinafter the "five-step process").[33] The five-step process is followed regardless of whether a claimant is filing for benefits under SSDI, SSI, or both, and regardless of whether the claimant is filing for a physical or mental impairment.[34] There are three general types of evidence considered throughout the five-step process: financial evidence, medical evidence, and

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25. This is called a "disability freeze." *See Program Operations Manual System (POMS): DI 25501.240 Disability Freeze and Established Onset*, SOC. SEC. ADMIN., https://secure.ssa.gov/poms.NSF/lnx/0425501240 [https://perma.cc/UWE3-3FKL] ("We refer to a period of disability for a worker as a 'disability freeze.'").

26. *See infra* Section III.A (explaining the evidentiary process of calculating a claimant's benefits).

27. *Fast Facts & Figures About Social Security, 2019*, SOC. SEC. ADMIN., https://www.ssa.gov/policy/docs/chartbooks/fast_facts/2019/fast_facts19.html#page10 [https://perma.cc/YV9H-E36J] (click on "Average Benefit Amounts").

28. *Understanding Supplemental Security Income SSI Eligibility Requirements–2020 Edition*, SOC. SEC. ADMIN., https://www.ssa.gov/ssi/text-eligibility-ussi.htm [https://perma.cc/8GZX-YXQG].

29. *Id.* (defining "resources" as including cash, stocks, land, life insurance policies, personal property, and vehicles); 20 C.F.R. § 416.1205(c) (2020).

30. *SSI Federal Payment Amounts*, SOC. SEC. ADMIN., https://www.ssa.gov/oact/cola/SSIamts.html [https://perma.cc/QM3W-WVEZ].

31. *See Understanding Supplemental Security Income SSI Income–2020 Edition*, SOC. SEC. ADMIN., https://www.ssa.gov/ssi/text-income-ussi.htm [https://perma.cc/DP2D-AWSC] (demonstrating that "Social Security benefits" are an example of unearned income).

32. *See Understanding Supplemental Security Income SSI Income–2019 Edition*, SOC. SEC. ADMIN., https://web.archive.org/web/20190823153416/https://www.ssa.gov/ssi/text-income-ussi.htm [https://perma.cc/7NJH-A72X].

33. *See* 20 C.F.R. §§ 404.1520, 416.920.

34. *See* 20 C.F.R. §§ 404.1520, 416.920.

employment history evidence. Each of the five steps is presented as a question, the answer to which determines whether the claimant either moves to the next step in the process, or whether the claimant is determined to be disabled or not disabled at that step.[35]

1. Step One: Is the Claimant Earning More than Substantial Gainful Activity?

Step one exclusively considers financial evidence. If a claimant is not working at the time of application, the claim moves to step two. If the claimant is working, the SSA must assess whether he or she is doing *substantial gainful activity* ("SGA").[36] The SSA defines SGA as "work activity that is both substantial and gainful."[37] "*Substantial* work activity is work activity that involves doing significant physical or mental activities."[38] Substantial work includes a broad range of work activities, and can be full- or part-time work, work done for any level of pay, and work at any level of workplace responsibility.[39] "*Gainful* work activity is work activity that [the claimant] do[es] for pay or profit."[40] "Work activity is gainful if it is the kind of work [people] usually do[] for pay or profit,"[41] and includes both legal and illegal activities.[42] In 2019, the SGA threshold per month was $1,220.[43] If the SSA determines a claimant either earned more than SGA per month on average over his or her period of disability, or alternatively, if it determines he or she earned more than SGA for *any single month* of her period of disability, the claim is denied at step one.[44] In addition, for SSI claims, the SSA evaluates whether the claimant satisfies the limited resources requirement.[45]

If the claimant is not making SGA and is below the limitation on resources threshold, the claim proceeds to step two.

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35. *See Disability Benefits: How You Qualify*, SOC. SEC. ADMIN., https://www.ssa.gov/planners/disability/qualify.html [https://perma.cc/6EWC-4DYD]; TOM JOHNS, SSA'S SEQUENTIAL EVALUATION PROCESS FOR ASSESSING DISABILITY 6 (2009), https://www.ssa.gov/oidap/Documents/Social%20Security%20Administration.%20%20SSAs%20Sequential%20Evaluation.pdf [https://perma.cc/CA3Q-HADY].

36. 20 C.F.R. § 416.971.

37. *Id.* § 416.972.

38. *Id.* § 416.972(a) (emphasis added).

39. *Id.*

40. *Id.* § 416.972(b) (emphasis added).

41. *Id.*

42. *See* SSR 94-1c, 1994 WL 6546 (Jan. 12, 1994) (establishing that earnings from illegal activities and panhandling should be counted in determining whether a claimant is making SGA).

43. *Substantial Gainful Activity*, SOC. SEC. ADMIN., https://web.archive.org/web/20190523170705/https://www.ssa.gov/oact/cola/sga.html [https://perma.cc/MV44-RDWK]. More discussion of SGA is included in the discussion of the five-step process.

44. *See* 20 C.F.R. § 416.974a(a)–(c) (detailing how a claimant's earnings will be averaged depending on whether their work history is regular or sporadic).

45. *See id.* § 416.1205 (establishing the limitation of resources threshold at $2,000 for individuals, $3,000 for couples).

2. Step Two: Does the Claimant Suffer from a Severe Impairment that is Expected to Last for 12 Months or More, or Result in Death?

In steps two and three, the SSA evaluates the claimant's medical evidence. The purpose of step two is to determine whether the claimant has at least one severe physical or mental medically determinable impairment that is expected to last more than 12 months or result in death.[46] The two parts of this step are considered in order: first severity, then duration. A severe impairment is one that "significantly limit[s] [a claimant's] physical or mental ability to do basic work activities."[47] A medically determinable impairment is one that "result[s] from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques."[48] A claimant may allege one or more impairments that are severe, or a number of non-severe impairments which, in combination, equate to a severe impairment, or any combination of severe and non-severe impairments.[49] Regardless of severity, all impairments must be shown by the claimant's medical evidence.[50]

Because of the subjective nature of mental impairments, the SSA has an additional two-pronged process for evaluating the severity of mental impairments which it calls the *special technique*.[51] First, the SSA determines, based on the claimant's "pertinent symptoms, signs, and laboratory findings,"[52] whether he or she has a medically determinable[53] mental impairment. If it finds one or more mental impairments, the SSA next determines the degree to which each impairment limits the claimant's ability to function in a work environment.[54] The SSA assesses the degree of limitation

46. *See id.* §§ 416.920(a)(4)(ii), 416.909.

47. *See id.* § 416.922. Curiously, the C.F.R. does not contain a definition of *severe* impairment; it contains only this code section that describes *non-severe* impairments. *Id.* The "basic work activities" in this section contains both physical and mental activities. Physical work activities include "walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling," as well as "seeing, hearing, and speaking." *Id.* Mental work activities include "[u]nderstanding, carrying out, and remembering simple instructions; . . . [u]se of judgment; . . . [r]esponding appropriately to supervision, co-workers and usual work situations; and . . . [d]ealing with change[] in [the workplace]." *Id.*

48. *Id.* § 416.921.

49. *See id.* § 416.923(c) (detailing that multiple impairments may be evaluated in combination and that there is no requirement that each individual impairment be severe when evaluated separately).

50. *See infra* Section III.A.

51. *See* 20 C.F.R. § 416.920a(b)(1).

52. *Id.*

53. *See id.* § 416.921. Generally, a medically determinable impairment is any impairment that "result[s] from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques." *Id.* Only objective medical evidence can be used to prove a medically determinable mental impairment. *Id.*; *see also infra* Section III.A (discussing and defining objective medical evidence).

54. 20 C.F.R. § 416.920a(b)(2).

each medically determinable mental impairment causes in four areas of mental functioning: "understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself."[55] To assess the degree of limitation, the SSA considers both objective medical evidence, as well as any other relevant evidence in the claimant's file.[56] The SSA then rates the degree of limitation in each of the four areas for each particular alleged impairment with one of five degrees of limitation: "[n]one, mild, moderate, marked, and extreme."[57] Any mental impairment with a "none" or "mild" degree of limitation is non-severe.[58] If a claimant does not have at least one severe medically determinable mental impairment, the claim is denied.[59]

Once the SSA determines at least one impairment meets the severity requirement, it then moves to the duration requirement. For any severe impairment that is not "expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months."[60] If none of the claimant's *severe* medically determinable impairments meet the duration requirement, the claim is denied at step two. If at least one of the claimant's severe medically determinable impairments meet both the severity and duration requirements, the claim proceeds to step three.

3. Step Three: Does One or More of the Claimant's Impairments Meet a Listing?

The SSA next determines whether one or more of the claimant's severe impairments meets an enumerated set of evaluation criteria, which collectively are called the *Listings*.[61] The Listings contain evaluation criteria for common physical and mental impairments.[62] Section 12 of the Listings contains criteria and evaluation instructions for Mental Disorders.[63] Each Listing has three paragraphs, numerated A, B, and C, and each Listing can be met in one of two ways. The first way is by fulfilling both the "paragraph A" disorder-specific criteria, which must be shown through objective medical evidence, and by having either an "extreme" limitation to one or "marked"

55. *Id.* § 416.920a(c)(4). These four criteria are taken from the Listings, which are also used in step three, and which are enumerated fully in 20 C.F.R. pt. 404, subpt. P, app. 1.

56. *See id.* § 416.920a(c)(1).

57. *Id.* § 416.920a(c)(4).

58. *Id.* § 416.920a(d)(1).

59. *Id.* §§ 416.920(a)(4)(ii), 416.909.

60. *Id.* § 416.909.

61. *Id.* § 416.920(a)(4)(iii). The Listings are found in 20 C.F.R. pt. 404, subpt. P, app. 1.

62. *See id.* pt. 404, subpt. P, app. 1.

63. *Id.* § 12.00. Common mental disorders within the Listings include schizophrenia, depressive and bipolar disorders, intellectual disorders, anxiety disorders, autism disorders, eating disorders, and trauma disorders. *Id.* § 12.00(A)(1).

limitation to two of the four "paragraph B" areas of mental functioning.[64] The second way is to meet all the "paragraph C" criteria, which requires evidence showing the symptoms of the mental impairment are "serious and persistent."[65]

If the SSA determines a claimant meets a Listing, he or she is found to be disabled at step three. If not, the analysis continues to step four.

4. Step Four: Can the Claimant Return to Past Relevant Work?

At step four, the SSA uses both the claimant's medical and employment history evidence. The primary purpose of step four is to determine whether, despite a claimant's limitations, he or she could return to past relevant work.[66] To do this, the SSA first determines the claimant's *residual functional capacity* ("RFC").[67] A claimant's "[RFC] is the most [the claimant] can still do despite [his or her] limitations."[68] A claimant's RFC should accurately reflect "the individual's maximum remaining ability to perform sustained work on a regular and continuing basis; i.e., 8 hours a day, for 5 days a week, or an equivalent work schedule."[69] In determining a claimant's RFC, the SSA considers "all of the relevant medical and other evidence."[70] The "other evidence" includes non-medical opinion evidence, such as statements from family, friends, or co-workers.[71] The SSA has an affirmative duty to consider all relevant evidence in a claimant's file when assessing their RFC.[72]

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64. *See, e.g.*, *id.* § 12.02(A)–(B). The four areas of mental functioning used in step three are the same as the four areas of mental functioning used in step two. *See supra* note 55 and accompanying text. An "extreme" limitation means "[the claimant is] not able to function in this area independently, appropriately, effectively, and on a sustained basis." 20 C.F.R. pt. 404, subpt. P, app. 1 § 12.00(F)(2)(e). A "marked" limitation means "[the claimant's] functioning in this area independently, appropriately, effectively, and on a sustained basis is seriously limited." *Id.* § 12.00(F)(2)(d).

65. *See, e.g.*, 20 C.F.R. pt. 404, subpt. P, app. 1 § 12.02(C). Generally, a disorder is shown to be "serious and persistent" if the claimant is receiving ongoing treatment in a highly-structured environment, and the claimant shows minimal ability to adjust to changes in their daily life. *See id.*

66. *See* 20 C.F.R. § 416.920(a)(4)(iv).

67. *See id.*

68. *Id.* § 416.945(a)(1).

69. SSR 96-9p, 1996 WL 374185 (July 2, 1996).

70. 20 C.F.R. § 416.945(a)(3).

71. *Id.*; *see also id.* § 416.929(c)(3) (detailing how non-medical evidence may be useful in determining how the subjective symptoms of a claimant's impairment(s), often described as "pain or other symptoms," affect her everyday life and her ability to complete work activities).

72. *Id.* § 416.945(a)(1). An RFC assessment involves three areas of inquiry: physical abilities, mental abilities, and other abilities affected by a claimant's impairments. *See id.* § 416.945(b)–(d). For each of these areas, the SSA evaluates function-by-function to what degree all of the claimant's impairments, including those found to be not severe at step two, affect his or her ability to do specific work tasks. *Id.* § 416.945(a)(1)–(2); *see supra* Section II.B.3. A claimant's RFC may contain limitations or restrictions on tasks he or she is able to perform due to his or her impairments. *See* JOHNS, *supra* note 35, at 12 (stating *Limitations* "[d]efine activity levels beyond which an individual is physically unable to perform on a sustained basis[,]" while *restrictions*

Once the SSA determines a claimant's RFC, it then determines whether in spite of any limitations or restrictions the claimant can return to *past relevant work*.[73] Not all of a claimant's past work is past *relevant* work. Past work must meet three criteria to be *relevant*: recency, duration, and SGA.[74] In general, past work is *relevant* if it was work the claimant performed within the past 15 years (recency), where he or she was employed for enough time to properly learn the job skills (duration), and for doing which he or she earned SGA.[75] If after this function-by-function comparison the SSA finds the claimant can return to past relevant work—regardless of the claimant's age, education level, or whether or not that job exists in any significant numbers in the national economy—he or she is found not disabled at step four.[76] If the claimant cannot return to past relevant work, then the claim continues to step five.[77]

5. Step Five: Can the Claimant Perform Other Work?

At step five, the SSA evaluates whether, notwithstanding any RFC limitations or restrictions, the claimant can perform other work within the national economy.[78] In addition to the RFC limitations and restrictions, the SSA now also considers the claimant's age, education level, and work experience.[79] Using the claimant's past relevant work from step four, the

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"[d]efine activity levels beyond which it would be medically ill-advised for an individual to perform on a sustained basis"). These limitations or restrictions are classified as *exertional* (i.e., related to physical strength) or *non-exertional* (i.e., related to the senses and mental functioning). 20 C.F.R. § 416.969a(a).

73. *See id.* § 416.920(a)(4)(iv).

74. *See id.* § 416.960(b)(1); SSR 82-62, 1982 WL 31386 (Jan. 1, 1982).

75. *See* 20 C.F.R. § 416.965(a); *see also Program Operations Manual System (POMS): DI 25005.015 Determination of Capacity for Past Work—Relevance Issues*, SOC. SEC. ADMIN., https://secure.ssa.gov/apps10/poms.NSF/lnx/0425005015 [https://perma.cc/C2CM-6B28] (detailing the guidelines the SSA uses for determining whether past work is "relevant"). Once the SSA has compiled a claimant's past relevant work, it categorizes the jobs based on the skills those jobs required either as the claimant performed them, or as the jobs are currently "performed in the national economy." 20 C.F.R. § 416.960(b)(2); *see also Program Operations Manual System (POMS): DI 25005.020 Past Relevant Work (PRW) as the Claimant Performed It*, SOC. SEC. ADMIN. [hereinafter *POMS: Past Relevant Work*], https://secure.ssa.gov/apps10/poms.nsf/lnx/0425005020 [https://perma.cc/8QG9-D3GW] (detailing the procedures used by the SSA to evaluate how a claimant performed their past relevant work). The SSA uses vocational experts to categorize the job skills, as well as reference volumes such as the Dictionary of Occupational Titles ("DOT"). 20 C.F.R. § 416.960(b)(2); DICTIONARY OF OCCUPATIONAL TITLES, https://occupationalinfo.org [https://perma.cc/Z35G-GSAY]. In general, *past relevant work* is categorized using similar work criteria as was used to determine RFC (i.e., by physical and mental requirements). *See* 20 C.F.R. § 416.960(b)(2). This classification allows the SSA to do "a function-by-function" comparison of job skills between the past work and the claimant's current RFC. *See POMS: Past Relevant Work*, *supra*.

76. 20 C.F.R. § 416.960(b)(3).

77. *Id.* § 416.960(c).

78. *Id.* §§ 416.920(a)(4), 416.912(b)(3).

79. *Id.* § 416.912(a)(1)(ii)–(iv).

claimant's file is analyzed using the Medical-Vocational Guidelines (also known as the "Grid Rules").[80] The Grid Rules are a series of tables that outline disability criteria based on a claimant's age, education, past work experience, and exertional limitations.[81] A claimant who meets a Grid Rule is found to be disabled at step five.[82] If none of the Grid Rules apply to the claimant, the SSA must show there are other jobs that exist in significant numbers in the national economy that the claimant could perform based on his or her RFC.[83] If the SSA can identify three jobs from the DOT that exist in significant numbers in the national economy that the claimant could perform despite his or her RFC, the claimant receives a final adjudication of not disabled.[84]

In summary, the five-step process is a rigorous, extensive analysis of all facets of a claim. Throughout the process, the SSA is duty-bound to evaluate every piece of financial, medical, and employment history evidence a claimant submits. As was seen above, each step uses different kinds of evidence to answer the question at issue. Of particular importance to this Note are steps two, three, and the RFC determination at step four; these three steps rely exclusively on a claimant's medical evidence. Not all medical evidence is treated equally, though. As will be discussed in Part III, the rules for how the SSA assigns weight to medical evidence are now designed so the quality, and thus relative weight, of the evidence flows not from the nature or content of the evidence itself, but instead from the title of the medical provider.

Prior to any discussion of rule changes, though, it is important to understand not only what the term "mental illness" means, but also the unique hurdles Iowans and Americans in similarly-situated states face in accessing treatment—specifically, treatment that is sufficient to support a claim for disability—for mental illness.

C. *WHAT IS MENTAL ILLNESS AND HOW IS IT TREATED?*

The term "mental illness" encompasses a broad range of disorders, which range in severity from mild to debilitating, which may be manifested by a wide

80. *Id.* pt. 404, subpt. P, app. 2.

81. *Id.*

82. For example, if a claimant is of *advanced age* (i.e., over 55 years old), has an RFC exertional limitation of *light work*, graduated high school but has no college, and has only unskilled work in their past relevant work, that claimant would meet Grid Rule 202.04 and would be found disabled. *See id.* pt. 404, subpt. P, app. 2, tbl. 2.

83. 20 C.F.R. § 416.960(c)(1); *see also Program Operations Manual System (POMS): DI 25025.030 Support for a Framework "Not Disabled" Determination,* SOC. SEC. ADMIN., https://secure.ssa.gov/apps10/poms.nsf/lnx/0425025030 [https://perma.cc/59GP-FLWM] (detailing that a determination of "not disabled" must be supported by documentation that at least three occupations exist in the national economy that the claimant would be able to perform notwithstanding her limitations).

84. *See Program Operations Manual System (POMS): DI 25025.005 Using the Medical-Vocational Guidelines,* SOC. SEC. ADMIN., https://secure.ssa.gov/apps10/poms.nsf/lnx/0425025005 [https://perma.cc/KB2W-WUDY].

variety of symptoms, and for which there are a great deal of treatment options. As with a physical healthcare regimen, a mental healthcare provider works individually with each patient to develop a method of treatment that is best suited to that patient's needs.[85] While there are many methods for treating mental health, the most common can generally be grouped into two broad categories: medication and talk therapy.[86] Talk therapy can take numerous forms,[87] and many of these are designed to be successful over the course of a lengthy period of time. In general, the nature and severity of the person's mental illness will dictate for how long they must receive talk therapy before reporting improvements in symptoms or behaviors.[88] Data from July 2017 collected by the American Psychological Association ("APA") suggests that 50 percent of patients required 15–20 sessions of treatment before they self-reported positive results.[89] In addition, APA research found a correlation between longer treatment durations and positive outcomes, and especially for patients with multiple mental illnesses, treatment may be required for over a year, in order to be effective.[90]

Depending on an individual's mental healthcare regimen, there may be a variety of different mental healthcare professionals who participate in his or her treatment, with a variety of educational experiences and credentials.[91] It is helpful here to take as a baseline three of the most common classes of mental health disorders—anxiety disorders, bipolar disorder, and schizophrenia. These three classes of mental illnesses are all common impairments for which a claimant may file for disability.[92] The method used to treat a patient's mental health disorders is first and foremost dictated by the diagnosed disorder(s) from which the patient is suffering, and many

85. *See Treatments*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/About-Mental-Illness/Treatments [https://perma.cc/4VFM-V438] (describing in broad terms the possible treatment options for mental healthcare).

86. *See id.*

87. The term "talk therapy" as used throughout this Note includes a wide variety of treatment methods, all of which are based generally around conversations between patient and therapist. These methods include traditional psychotherapy (i.e., confidential individual counseling with a mental healthcare professional), cognitive behavior therapy, exposure therapy, group counseling, and even the use of therapy pets. *See Psychotherapy*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/About-Mental-Illness/Treatments/Psychotherapy [https://perma.cc/HB3N-M747].

88. *See How Long Will It Take for Treatment to Work?*, AM. PSYCH. ASS'N [hereinafter *PTSD Guideline*], https://www.apa.org/ptsd-guideline/patients-and-families/length-treatment [https://perma.cc/3KHY-RCHQ].

89. *Id.*

90. *Id.*

91. *See Types of Mental Health Professionals*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals [https://perma.cc/U5AP-XQU4] (describing the most common mental healthcare professionals).

92. 20 C.F.R. ch. III pt. 404 subpt. P, app. 1 § 12.00(A)(1) (2020). These three impairment categories are defined by SSA Rules in Listings 12.06, 12.04, and 12.03, respectively.

individuals with mental illness commonly suffer from more than one disorder.[93] The most common mental health disorders in America are part of the general classification of anxiety disorders, which affect an estimated 40 million Americans.[94] This classification includes disorders such as generalized anxiety disorder, major depressive disorder, obsessive-compulsive disorder, and posttraumatic stress disorder.[95] It is common for people with an anxiety disorder to also suffer from bipolar disorder, but bipolar disorder may be diagnosed as a stand-alone disorder.[96] Anxiety disorders and bipolar disorder vary widely in terms of severity, which can range from mild to debilitating.[97] Schizophrenia is less common than anxiety or bipolar disorders but is more likely to have a severe effect on the person.[98] All three of these common mental illnesses can be severe enough to be debilitating, and all of them use a combination of medication and talk therapy as a standard course of treatment.[99]

The two common components of a mental healthcare regimen —medication and talk therapy—may be provided by separate mental healthcare providers. This bifurcation is due both to state licensure requirements on which mental healthcare providers can prescribe mental health medication,[100] as well as a general shortage of mental healthcare providers overall—especially among psychiatrists and psychologists.[101] In Iowa, for example, the only mental health professionals that may prescribe medication are licensed psychiatrists, or licensed psychologists who have completed additional training.[102] While psychiatrists specialize in diagnosing and treating mental health disorders, the treatment they provide commonly does not include talk therapy.[103] Psychologists on the other hand, regardless

93. *See PTSD Guideline*, *supra* note 88.

94. *See Facts & Statistics*, ANXIETY & DEPRESSION ASS'N AM., https://adaa.org/about-adaa/press-room/facts-statistics [https://perma.cc/VR3U-AXV8]. Based on the estimated 2018 population, this equates to roughly 12 percent of the total U.S. population having some form of anxiety disorder. *See QuickFacts: United States*, U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/fact/table/US/PST045219 [https://perma.cc/T76V-JSRT].

95. *Id.*

96. *Bipolar Disorder*, ANXIETY & DEPRESSION ASS'N AM., https://adaa.org/understanding-anxiety/related-illnesses/bipolar-disorder [https://perma.cc/38L3-4L7R].

97. *See id.*

98. *Schizophrenia*, NAT'L INST. MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/schizophrenia.shtml#part_154881 [https://perma.cc/EA2P-6583]. Schizophrenia is one of the 15 most common causes of disability worldwide. *Id.*

99. *See supra* notes 94–98 and accompanying text.

100. *See infra* Appendix I.

101. *See infra* notes 125–29 and accompanying text.

102. *See* IOWA CODE §§ 154B.10–154B.11 (2020) (detailing procedure by which a psychologist in Iowa may obtain a prescription certificate).

103. *Types of Mental Health Professionals*, MENTAL HEALTH AM., https://www.mhanational.org/types-mental-health-professionals [https://perma.cc/Q8SD-BYY8].

of whether they prescribe medication, often do provide talk therapy.[104] Other common mental health professionals, such as Licensed Clinical Social Workers ("LCSW") and Mental Health Counselors ("MHC") can diagnose mental illnesses and provide talk therapy but can never prescribe medication.[105]

To briefly summarize, between these four common mental healthcare providers, all have state licensure requirements,[106] and all can diagnose mental illness.[107] Only psychiatrists and some psychologists can prescribe medication, but psychiatrists often do not provide talk therapy. For talk therapy, patients will typically see a psychologist, LCSW, or MHC. Talk therapy can take many forms, and depending on the nature and severity of a person's mental illness, it may take years before a patient sees results.[108] As will be seen, only two of these mental healthcare providers (psychiatrists and psychologists[109]) are acceptable medical sources under SSA Rules, only one of them commonly provides talk therapy, and depending on where a claimant lives—especially in a state like Iowa—there may not be either of them licensed or practicing within the claimant's county.

D. The State of Mental Healthcare in Iowa

Like most states, the people of Iowa are not distributed evenly throughout the state. Unsurprisingly, there are more mental health resources in areas with higher populations, and fewer in areas of sparse population. This disparity in population and resources is not inexplicable, nor is it inherently problematic; people are free to choose where they want to live, and accordingly where they want to practice their trade. Where this disparity becomes problematic, though, is in the context of claims for Social Security disability. The SSA Rules require claimants to provide evidence from certain kinds of providers; specifically, from certain enumerated providers with doctoral-level qualifications that the SSA has deemed *acceptable medical sources*.[110] But as will be seen below, there is a dramatically heightened

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104. *See What Do Practicing Psychologists Do?*, AM. PSYCH. ASS'N (Dec. 11, 2019), https://www.apa.org/topics/about-psychologists [https://perma.cc/B55N-UJBH].

105. *Types of Mental Health Professionals*, *supra* note 103.

106. *See Eligibility for Permanent Licensure*, IOWA BD. MED., https://medicalboard.iowa.gov/eligibility-permanent-licensure [https://perma.cc/QU6P-BDHZ] (detailing licensure requirements for medical doctors, which includes psychiatrists); IOWA ADMIN. CODE r. 645-240.2 (2020) (detailing licensure requirements for psychologists); *id.* r. 645-280.3(154C) (detailing licensure requirements for social workers); *id.* r. 645-31.2(154D) (detailing licensure requirements for mental health counselors).

107. *Types of Mental Health Professionals*, *supra* note 103.

108. *See supra* notes 85–87 and accompanying text.

109. *See supra* notes 101–02 and accompanying text; *see also infra* Section III.A.1 (explaining how psychiatrists and psychologists are the only two acceptable medical sources).

110. See *infra* Section III.A for further discussion of evidentiary requirements. For the purposes of this Section, "acceptable medical source" refers only to acceptable medical sources for mental health claims, which includes only psychiatrists and psychologists.

disparity between the population distribution of Iowa and the distribution of acceptable medical sources. Plainly put, nearly all acceptable medical sources in Iowa live in just a handful of population centers. In fact, an overwhelming majority of Iowa's acceptable medical sources—around 70 percent—are licensed in just *three* counties of Iowa's 99 counties.[111] In 2012, the Iowa Legislature redesigned the state's publicly-funded mental healthcare infrastructure.[112] In doing so, the Legislature had the prime opportunity to address some of these mental health provider disparities, or at the very least to bring them into closer alignment with the population disparity of the state. The disparities linger despite the redesign, though, and in some cases, they may have been made worse.

To fully understand the state of mental healthcare in Iowa, it is important first to understand how public healthcare is now administered in the state following the 2012 Act. The purpose of the 2012 Act was to shift the management and administration of public mental healthcare services from the state level to the regional level.[113] The 2012 Act divided Iowa into 14 Mental Health and Disability Services ("MHDS") Regions, each with its own management and oversight board.[114] The 2012 Act shifted both the Iowa Department of Public Health ("IDPH") and Iowa Department of Human Services ("IDHS") from management to advisory roles.[115] Under the new structure, these two state agencies provide the regions with guidelines and standards of care, under which each region determines for itself how best to administer mental health services to its residents.[116] The 2012 Act required each region to choose its own governing board and to select a regional administrator.[117] This regional administrator is the primary point of contact with the IDPH, and each region is required to enter into a performance-based contract between the state and each regional administrator, which must contain reporting and outcome requirements.[118] Funding is provided by the State in accordance with each regional administrator's performance-based contract, meaning the regions have broad authority to choose how to spend their state-allocated funds.[119] In essence, though not *legally* corporations, each region acts as its own corporation-like entity.[120]

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111. *See infra* notes 133–35 and accompanying text.

112. Publicly Funded Mental Health and Disability Services, ch. 1120, 2012 Iowa Acts 1.

113. *Id.* § 2, at 1.

114. *Id.*

115. *Id.*

116. *Id.*

117. *See id.* §§ 3, 12, at 2, 4.

118. *Id.* § 3, at 2.

119. *See id.* § 9, at 3 (detailing that funds are distributed "in accordance with performance-based contracts with the regions").

120. On its website, the IDHS itself even calls these regional administrators "Regional CEO[s]." *See Regions*, IOWA DEP'T HUM. SERVS., https://dhs.iowa.gov/mhds-providers/providers-regions/regions [https://perma.cc/GC4L-NKME].

So how does this regional redesign fit within the population distribution and mental health professional distribution of the State of Iowa? Some baseline numbers are in order. Iowa is divided into 99 counties of roughly equal size, and in 2018, the U.S. Census Bureau estimated the population of Iowa was 3,156,145.[121] The Iowa Bureau of Professional Licensure ("IBPL") is the state agency responsible for issuing licenses to healthcare professionals.[122] As of September 2019, there were 3,672 mental healthcare professionals licensed in the State of Iowa with the following breakdown: 287 psychiatrists, 520 psychologists, 1,705 LCSWs,[123] and 1,160 MHCs.[124]

While it is impossible to gauge exactly how many mental health professionals are the right number for a population such as Iowa's, the number of Iowa's acceptable medical sources[125] is objectively quite low. When divided among the population at large, there is only one psychologist for every 6,070 Iowans, and only one psychiatrist for every 10,997 Iowans.[126] Even when combined, this still means Iowa has only one acceptable medical source—who are also the only providers able to prescribe medication—for every 3,911 Iowans. Obviously, not all Iowans will need mental healthcare at any given time. That said, if the number of Iowans over age six[127] suffering from mental illness closely aligns with a recent national average,[128] then there are around

121. At the time of writing this Note, only the July 1, 2018, population estimate was available. Since then, the U.S. Census Bureau released the July 1, 2019, estimate; however, the 2019 estimate did not show a significant change in Iowa's population (specifically, the population of Iowa shrank by 1,075 people). *QuickFacts: Iowa*, U.S. CENSUS BUREAU., https://www.census.gov/quickfacts/fact/table/IA/PST045218 [https://perma.cc/PB8V-DBYH]. Accordingly, the July 1, 2018, numbers will be used throughout this Note. *See infra* Appendix I (containing a list of counties and their populations).

122. *See Bureau of Professional Licensure Home*, IOWA DEP'T PUB. HEALTH, https://idph.iowa.gov/Licensure [https://perma.cc/FUV9-DC8A].

123. Not all social workers practice in mental health, so because the IBPL does not display a social worker's field of specialty, there is no way to know what percentage of these social workers specialize in mental healthcare. This number, then, is the most optimistic projection; the actual number of social workers specializing in mental health is likely lower. Further, only social workers practicing at the *Independent Level* are included here. Practicing social work at the Independent Level in Iowa requires the most rigorous qualifications and training. Practicing at the Independent Level requires what Iowa calls the *clinical* level evaluation, which is the highest level of evaluation. IOWA ADMIN. CODE § 645-280.4(1)(c) (2020). An Independent Level social worker must have a master's or higher degree and have completed a lengthy period of supervised practice. *Id.* §§ 645-280.5(3), 645-280.6. Iowa does not use the more common term Licensed *Clinical* Social Worker, but Independent Level social workers in Iowa are equivalent to those with clinical qualifications.

124. *See infra* Appendix I.

125. Again, psychiatrists and psychologists. *See* 20 C.F.R. § 416.902(a) (2020).

126. *See supra* note 121 and accompanying text; *see infra* Appendix I.

127. *See QuickFacts: Iowa*, *supra* note 121 (showing that 70.8 percent of Iowans are adults and 23 percent of Iowans are ages 6–17). Using 2018 census data, this would mean there are 2,234,551 adult Iowans, and 725,913 Iowans ages 6–17. *Id.*

128. *Mental Health by the Numbers*, *supra* note 14 (showing that 19.1 percent of adults and 16.5 percent of youth ages 6–17 experience mental illness).

546,575 Iowans[129] suffering from some sort of mental illness, but only one acceptable medical source for every 677 of these people.

Compounding this issue is the fact that neither Iowa's population nor licensed mental healthcare providers are evenly distributed across the state. Iowa has 99 counties, but over half of its citizens—1,651,275, or 52 percent —choose to live in just ten.[130] Among those ten, the top five counties contain 37 percent of all Iowans.[131] The largest county itself, Polk, contains over 15 percent of all state residents.[132] On the other end of the spectrum, the smallest 25 counties by population contain just 191,620 citizens, which is just over six percent of the population.[133]

The distribution of mental health resources in Iowa follows the population distribution, but the degree of disparity is much higher. The ten counties mentioned above that contain 52 percent of Iowa's population[134] contain *83 percent* (237) of Iowa's psychiatrists, and *79 percent* (413) of Iowa's psychologists.[135] With psychiatrists, the disparity is even more pronounced; of Iowa's total 287 psychiatrists, *70 percent* (201) are licensed in just *three* counties.[136] More disturbing, though, is the degree to which many Iowa counties lack mental health resources. Of Iowa's 99 counties, 36 have *zero* acceptable medical sources—psychiatrists or psychologists—licensed in the county.[137] Of those 36 counties, 24 have five or fewer LCSWs—and the other nine have zero.[138] And one Iowa county—Lucas, in south-central Iowa—does not have a single mental healthcare provider licensed in the county.[139] Over ten percent of Iowans live in these 36 counties,[140] and if the number of Iowans

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129. *See supra* notes 127–28 (using the percentages from above: (2,234,551 * .191) + (725,913 * .165) = 546,575).

130. These counties are, in order: Polk, Linn, Scott, Johnson, Black Hawk, Woodbury, Dubuque, Story, Dallas, and Pottawattamie. *Iowa Counties by Population*, IOWA DEMOGRAPHICS BY CUBIT, https://www.iowa-demographics.com/counties_by_population [https://perma.cc/HH4Y-23K6] (referencing information taken from U.S. Census Bureau); *see also infra* Appendix I (compiling Iowa county populations).

131. *See infra* Appendix I. These five counties are Polk, Linn, Scott, Johnson, and Black Hawk.

132. *See infra* Appendix I.

133. *See infra* Appendix I. These counties are (arranged lowest to highest): Adams, Ringgold, Audubon, Osceola, Taylor, Wayne, Pocahontas, Ida, Fremont, Van Buren, Adair, Worth, Monroe, Decatur, Lucas, Monona, Palo Alto, Greene, Davis, Howard, Emmet, Clarke, Humboldt, Calhoun, and Sac.

134. *See supra* note 130 and accompanying text.

135. *See infra* Appendix I.

136. *See infra* Appendix I. Those counties are Johnson, Polk, and Linn. It should be noted there is a rational explanation for this distribution: Polk County and Linn County are the two counties with the highest populations (487,204 and 225,909, respectively), and despite its lower population (151,260), Johnson County is home to a large research hospital, the University of Iowa Hospitals and Clinics.

137. *See infra* Appendix I.

138. *See infra* Appendix I.

139. *See infra* Appendix I.

140. See *infra* Appendix II, specifically, the 36 counties at the end of the list.

with mental illness matches the national average from above,[141] there may be over 56,000 Iowans who have *zero* acceptable medical sources licensed in their county.[142]

To bring this disparity into the perspective of the 2012 redesign, one of the key justifications of the 2012 Act was that localized regions would be better equipped than a centralized state agency to decide how best to serve the mental health needs of their respective communities.[143] That said, if a regional, localized, *community* mindset was a motivating factor behind the 2012 redesign, one would expect at the very least that each of the 14 MHDS Regions would contain a group of counties that are by some definition a *community*, whether for geographic, economic, or other reasons. For some MHDS Regions this appears to be the case. As the simplest example, it is no surprise that Polk County, which contains Iowa's capital city of Des Moines and a population of 487,204, is its own MHDS Region.[144] Similarly, regions like the Sioux River MHDS, Northwest Iowa Care Connect, MHDS of East Central Region, Eastern Iowa MHDS, and Southeast Iowa Link all are regions that encompass relatively small geographic areas that likely share common economic resources.[145]

Two of Iowa's regions are problematic from the community standpoint, though, in that they contain a large number of counties spread across a large geographic area. One of these is Central Iowa Community Services region, which includes 11 counties in the center of the state that surround Polk County.[146] Given the layout of the region, it is unlikely the residents of all the counties share common economic resources, especially considering that to get from the southernmost county (Madison) to the northernmost (Franklin) one would need to travel through no fewer than four counties.[147] In fact, the southern two counties in this region—Madison and Warren—are completely geographically disconnected from the upper nine.[148]

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141. *See Mental Health by the Numbers*, *supra* note 14.

142. Specifically, there are 323,974 citizens in these counties: 229,374 are adults, 43,810 of whom suffer from mental illness; and 74,514 are children ages 6–17, 12,295 of whom suffer from mental illness. *See supra* text accompanying notes 135–37; *see infra* Appendices I–II.

143. *See Mental Health and Disability Redesign*, IOWA DEP'T HUM. SERVS., https://dhs.iowa.gov/mhds-redesign [https://perma.cc/T2E9-3W62] (noting the focus on services being "locally delivered").

144. For a map of the MHDS Regions, see IOWA DEP'T HUM. SERVS., MHDS REGIONS 1 (2019), https://dhs.iowa.gov/sites/default/files/MHDS-Regions-Approved-Map_0.pdf [https://perma.cc/5B46-HJFG]. The regions are not numbered; instead, each region has a distinctive name. The Polk County MHDS Region is called Polk County Health Services and is the only single-county MHDS Region. *Id.*

145. *See id.*

146. *See id.* The Central Iowa Community Services Region is lime green on this map. *Id.*

147. *Id.* The most direct route from Madison County to Franklin County would require travel through Dallas, Boone, Hamilton, and Hardin Counties.

148. *See id.*

The other problematic region is County Social Services, the largest in the state, which contains 22 counties sprawled across northern, eastern, and central Iowa.[149] It is again hard to see how counties in this region share common economic resources, considering that the easternmost county (Clayton) borders the Mississippi River in the east, while the westernmost county (Emmet) borders Minnesota to the north and is just three counties away from the Missouri River on the western border of Iowa. Just these two MHDS Regions contain a third of all counties in Iowa, and roughly a quarter of the state's population.[150] When compared with other regions, such as Heart of Iowa Community Services (three counties and 106,406 people), South Central Behavioral Health (four counties and 78,659 people), Northwest Iowa Care Connection (five counties and 62,096 people), and Southern Hills Regional Mental Health (four counties and 29,258 people), it is unclear why the legislature chose to divide 33 counties into just two omnibus regions, while in numerous other cases they created smaller, more cohesive regions.

Aside from the geographical inconsistency, the regional layout has also done little to alleviate Iowa's problems with access to mental health resources. Take two previously-mentioned regions as an example: Polk County Health Services and County Social Services. Though their populations are comparable (487,204 and 455,458, respectively), they vary widely in their available mental health resources; Polk County Health Services has 164 acceptable medical sources, while County Social Services has only 51.[151] This disparity is made more striking considering the geographic layout of the regions. The residents who live within the Polk County Health Services region all live within the same county, while those in County Social Services are spread across 22 counties that span roughly a quarter of the state.

As another example of this disparity in resources, of the three counties that contain the most acceptable medical sources,[152] two of them (Linn and Johnson) are in the same region, MHDS of East Central.[153] Because of this layout, 44 percent of the state's acceptable medical sources are licensed in just one region.[154] Conversely, other regions are left with relatively few acceptable medical sources. For example, the Southwest Iowa MHDS has nine counties and a population 188,162, but only 15 acceptable medical sources.[155] The Sioux Rivers MHDS has only three counties and a population of 71,815, but only five acceptable medical sources.[156] And the smallest region in Iowa,

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149. *See id.* County Social Services Region is blue on this map. *Id.*

150. *See infra* Appendix III. There are 33 counties and 793,966 citizens in these two regions. *See infra* Appendix III.

151. *See infra* Appendix III.

152. *See supra* text accompanying note 136.

153. *See* IOWA DEP'T HUM. SERVS., *supra* note 144.

154. *See infra* Appendix III.

155. *See infra* Appendix III.

156. *See infra* Appendix III.

Southern Hills Regional Mental Health, has four counties, a population of only 29,258, but only two acceptable medical sources.[157]

Further examples would merely belabor what should be clear at this point: Mental health resources are not spread evenly throughout the State of Iowa, and the recent mental health redesign did little to alleviate this problem. Obviously, the 2012 Act could not force mental health professionals to move to other regions or to disperse themselves evenly throughout the state. But redesigning the state's mental healthcare structure was a dramatic change, and with that dramatic change came the opportunity to address and correct one of the ongoing problems with mental healthcare in Iowa: access to services. Viewed objectively, the 2012 Act failed to address this problem. While the 2012 Act does encourage regions to pool their resources, the regions vary widely in terms of how many resources they have to begin with, so that one region has just 0.2 percent of the state's acceptable medical sources,[158] while another has 44 percent.[159] Not only that, but the regions vary widely in both population and land mass, with some regions containing only a few counties, and one containing nearly a quarter of the state. No two MHDS regions are alike, and the lack of a guiding logic behind the new regional layout makes one wonder why such striking disparities in mental healthcare access were allowed to remain—especially when certain aspects of the redesign may have made them worse.

One key takeaway is important in the following discussion of Iowans' problems with the Social Security disability application process: *it matters where you live*. Because mental healthcare services are not equally spread throughout Iowa, where Iowans live determines how easily they can access mental health resources—especially acceptable medical sources. It is naïve to say that everyone actively *chooses* where he or she wants to live; for social, economic, family, political, and myriad other reasons, people often *end up* living where they live; whether it was a choice is a matter of degrees. That said, for the 52 percent of Iowans who have ended up living in the ten most populous counties, their luck of geography gives them local access to 81 percent of Iowa's acceptable medical sources.[160] Conversely, for the 12 percent of Iowans who ended up living in the 36 least-populous counties, their misfortune of geography grants them local access to zero acceptable medical sources.[161] And even if MHDS Regions were able to efficiently pool their mental health resources, some regions—such as MHDS of East Central Region[162] and Polk County Health Services[163]—will likely be able to meet the needs of their

157. *See infra* Appendix III.
158. Southern Hills Regional Mental Health Region. *See infra* Appendix III.
159. MHDS of East Central Region. *See infra* Appendix III.
160. *See supra* text accompanying notes 134–36; *see infra* Appendix I.
161. *See infra* Appendix I.
162. *See infra* Appendix III (showing one acceptable medical source per 1,680 people).
163. *See infra* Appendix III (showing one acceptable medical source per 2,970 people).

residents, while others—such as Southwest Iowa MHDS[164] or Southern Hills Regional Mental Health[165]—will likely fall short in meeting the needs of their residents. While Iowans are free to travel between regions to receive care, for a person suffering from a serious mental impairment, who is likely also facing serious financial hardship, the burden of traveling out of county for mental healthcare may simply be too high to bear.

III. The Problem: The Evidentiary Requirements of the SSA Do Not Align with the Reality of How Iowans Receive Mental Healthcare

If an Iowan with mental illness chooses to file a claim for disability, any problems he or she has in accessing mental health resources will translate into evidentiary deficiencies in his or her application. Evidence from acceptable medical sources is required to prove a claim for disability, regardless of whether it is for a physical or mental impairment. For those Iowans living in areas with few or no acceptable medical sources, unless they chose to travel outside their county or region for treatment from a psychiatrist or psychologist, they will have deficiencies in their applications. But the problems do not end there. Even if a claimant has ample evidence from an acceptable medical source, the SSA still has broad latitude to determine how much weight to give that evidence. So even if a claimant always sought treatment from an acceptable medical source, and even if a claimant had a long treating relationship with that acceptable medical source, the SSA may still choose to give that evidence little *or no* weight.

The SSA Rules were not always designed this way. For years, the SSA gave additional weight to evidence from sources with a long treatment relationship; but recent rule changes expanded the SSA's discretion in assigning weight, removing all presumptions related to length of treatment relationship. And claims for mental impairments have an even larger problem. As mentioned above, there is only one process—the five-step process—for evaluating all claims. When viewed objectively, and despite the *special technique*,[166] the adjudication procedures are still designed to most effectively evaluate claims for *physical* impairments. This is most evident in the fact the evidentiary requirements of the five-step process align almost perfectly with how people receive treatment for physical disabilities. To wit, all possible medical sources from which a person would seek treatment for a physical impairment are *acceptable* medical sources under SSA Rules. This is not the case with mental impairments. In addition, not only does their treatment produce far less *objective* medical evidence (which is unsurprising, given the highly *subjective* nature of mental health treatment), but only two types of mental health

164. *See infra* Appendix III (showing one acceptable medical source per 12,544 people).

165. *See infra* Appendix III (showing one acceptable medical source per 14,629 people).

166. *See supra* notes 51–59 and accompanying text.

providers—psychiatrists and psychologists—are acceptable under SSA Rules. Quite simply, the SSA Rules fall short for those with mental impairments.

The SSA Rules regarding how it assigns evidentiary weight compound the problems with access to mental healthcare in states like Iowa. For background, Section III.A below will outline how the SSA defines the types of medical evidence. Next, Section III.B will discuss certain factors of the adjudication process that can compound issues of discretion. Next, Section III.C will lay out the recent rule changes that have greatly expanded the SSA's discretion in assigning weight to medical evidence. Finally, Section III.D will discuss how all of these problems have created a disconnect between the requirements of the SSA application process and the reality of how Iowans and those in similar states receive mental healthcare.

A. CATEGORIES OF EVIDENCE AND RELATIVE WEIGHT

The claimant has the burden to submit evidence sufficient to support his or her claim for disability benefits.[167] A claimant may offer any evidence he or she thinks is relevant. As mentioned above, there are three general types of evidence a claimant will submit: financial evidence (used in step one), medical evidence (used in steps two, three, and to complete the RFC), and employment history evidence (used in steps four and five). Because the problem addressed in this Note deals solely with medical evidence, financial and employment history evidence will not be discussed. Aside from one exception, the SSA considers all evidence in a claimant's file.[168] *Consideration* here means little, though, in terms of whether a claim will be approved, as the relative *weight* of each item of evidence is completely discretionary, regardless of its category.[169]

1. Evidence from Medical Sources

Evidence from medical sources is divided into three subgroups: (1) objective medical evidence; (2) medical opinions; and (3) other medical

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167. *See* 20 C.F.R. §§ 404.1512, 416.912 (2020). The claimant has the burden to submit evidence, but the actual burden of producing the evidence shifts between the claimant and SSA at different stages of the adjudication and appeal process. Despite this, there is a general understanding that regardless of who has the burden of production, claimants will do their best to assist the SSA with procuring evidence. *See id.* § 416.912(a)(1).

168. *See id.* §§ 404.1513, 416.913. SSA Rules list only one type of evidence that will not be considered: statements or analyses by a claimant's representative, regardless of whether or not the representative is an attorney. *See id.* §§ 404.1513(b), 416.913(b).

169. Prior to March 27, 2017, certain categories of medical evidence could not be given little or no weight without a statement of good cause by the administration. *See id.* § 416.927 (describing the so-called *Treating Source Rule*, which was in effect for claims filed prior to March 27, 2017). The Treating Physician Rule was eliminated on March 27, 2017. *See* SOC. SEC. ADMIN., HALLEX: HEARINGS, APPEALS, AND LITIGATION LAW MANUAL I-5-3-30 (2018) (describing the transition from the Treating Physician Rule to a discretionary system); *see infra* Section III.C.1.

evidence.[170] Objective medical evidence is considered the most reliable evidence in support of a claim under SSA Rules, and it is the only type of medical evidence that is required.[171] As will be seen, though, objective medical evidence includes only specific types of evidence from specific sources, and even the SSA Rules implicitly acknowledge that for mental health claims, objective medical evidence may be difficult to procure from a mental health professional.[172]

Objective medical evidence is defined as "[medical] signs, laboratory findings, or both."[173] SSA Rules define *signs* as "one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (symptoms)."[174] Psychiatric signs are further defined as "medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception and must also be shown by observable facts that can be medically described and evaluated."[175] Laboratory findings are defined as "one or more anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques."[176] While the section goes on to list acceptable diagnostic techniques, the only one applicable to mental impairments is "psychological tests."[177]

Evidence in the second category, medical opinions, are a middle ground between objective medical evidence and other medical evidence. These opinions take the form of "statement[s] from a medical source about what you can still do despite your impairment(s) and whether you have one or more impairment-related limitations or restrictions."[178] Generally, medical opinions are *interpretations* of the objective medical evidence that describe the limitations of the claimant's abilities despite his or her impairments, but without discussing specific diagnoses, or the nature or severity of the impairments themselves.[179] Evidence containing subjective discussions of specific diagnoses, or subjective statements regarding the nature and severity

170. *See* 20 C.F.R. § 416.913(a)(1)–(3).

171. In fact, if no objective medical evidence is provided, or if the objective medical evidence in the file is insufficient, the SSA is required to take steps to procure more. *See id.* § 416.920b(b)(2) (detailing the steps the SSA will take if the medical evidence in a claimant's file is insufficient).

172. *See, e.g.*, *id.* § 416.1017(c) (outlining the procedures a state should use in the event a qualified psychiatrist or psychologist is not available to evaluate a claimant).

173. *Id.* § 416.902(k).

174. *Id.* § 416.902(*l*).

175. *Id.*

176. *Id.* § 416.902(g).

177. *See id.*

178. *Id.* § 416.913(a)(2).

179. *See id.*

of a claimant's condition are all classified in the third category of other medical evidence.[180]

In addition to the three categories of evidence, SSA Rules categorize the medical sources themselves into two categories: *medical sources* and *acceptable medical sources*. The first category—medical sources—is broad, and includes any "individual who is licensed as a healthcare worker by a State and working within the scope of practice permitted under State or Federal law."[181] There is no degree requirement for medical sources.[182] The second category —*acceptable* medical sources—is narrower, and includes only medical providers who hold an advanced or terminal degree in their field, and are subject to state licensure requirements.[183] Acceptable medical sources under SSA Rules include physicians, psychologists, specialists (such as optometrists, podiatrists, speech language pathologists, audiologists), nurse practitioners, and physician assistants.[184] Under SSA Rules, then, LCSWs and MHCs are considered medical sources, but they are not *acceptable* medical sources. This distinction is critical, as will be seen below.[185]

2. Evidence from Nonmedical Sources

Evidence from nonmedical sources includes all other evidence the claimant submits that is not from a medical source or acceptable medical source. There are no requirements for who is considered a nonmedical source, and SSA Rules state the evidence may address "any issue in [the] claim."[186] Under this category, the claimant may offer statements from family members, friends, coworkers, educational personnel, and public or private welfare agency personnel.[187] The claimant him- or herself can also offer a statement, and this will be considered as evidence from a nonmedical source.[188]

3. Prior Administrative Medical Findings

On appeal, a prior administrative medical finding is treated as medical evidence in a claim.[189] This category is narrower, though, than the name

180. *See id.* § 416.913(a)(3). Prior to March 27, 2017, diagnoses by a claimant's treating physician were considered *medical opinions* and were given significantly more weight. *See id.* § 416.927(c). Subjective medical judgments were addressed only to note that statements on the disposition of the claim by a medical source would be ignored. *Id.* § 416.927(d).

181. *Id.* § 416.902(i).

182. *See id.*

183. *See id.* § 416.902(a).

184. *See id.*

185. *See infra* Section III.C.2.

186. 20 C.F.R. § 416.913(a)(4).

187. *Id.* § 416.902(j)(2)–(4).

188. *Id.* § 416.902(j)(1).

189. *See infra* Section III.C.1 (discussing prior administrative medical findings).

might suggest. First, only prior findings from the SSA may be considered; findings from other administrative agencies—even if they concern medical issues directly relevant to a claimant's SSI application—may not be admitted as evidence.[190] Second, only findings from the SSA at lower levels of review in the *current* claim may be considered; evidence from prior claims will not be considered.[191] Third, only specific types of medical evidence from the prior finding will be considered. These types include evidence concerning "[t]he existence and severity of . . . impairment(s)" or symptoms, statements of whether the claimant "meets or . . . equals any listing," evidence regarding the claimant's RFC, findings regarding the claimant's "failure to follow prescribed treatment," and statements concerning how drug or alcohol abuse affected the prior-level decision.[192]

Despite these restrictions, though, a prior administrative medical finding can still have a powerful impact on the success of a claim. To understand why, it is important to keep two considerations in mind. First, the only context in which the SSA would consider prior administrative medical findings is if the SSA *denied* the current claim and the claimant was appealing for further administrative review. In that regard, a medical finding from a prior denial will only work against the claimant, and never in his or her favor. Second, the SSA considers prior administrative medical findings automatically on appeal, without input or comment from the claimant.[193] A prior medical finding is functionally *res judicata* on appeal, meaning the claimant may not dispute the logic or methods of that finding. Instead, the claimant must introduce additional evidence, either to show the prior medical finding was not made with all relevant information, or that the claimant's disorder has worsened in severity.

B. The Non(?)-Adversarial SSA Adjudication Process

Though the SSA repeatedly claims the adjudication process for a disability claim is a non-adversarial process,[194] it is definitely not a *neutral* process. The evidentiary burden of proving disability begins with the claimant and remains with him or her throughout the entire adjudication process.[195]

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190. *See* 20 C.F.R. § 416.913(a)(5). For example, a medical finding from a worker compensation claim would not be considered.

191. *Id.*

192. *See id.* § 416.913(a)(5)(i)–(vii).

193. *See id.* § 416.920c (indicating that prior administrative medical findings will be considered alongside all medical evidence).

194. *See id.* § 416.1400(b) ("In making a determination or decision in your case, we conduct the administrative review process in an informal, non-adversarial manner."). Once administrative remedies are exhausted, the claimant may file a civil suit in federal court, which is a typical adversarial lawsuit. *See id.* § 416.1481.

195. *See id.* § 416.912(a)(1) ("In general, you have to prove to us that you are blind or disabled . . . . This duty applies at each level of the administrative review process . . . ."); *see also*

This naturally creates a starting presumption a claimant is *not disabled*, which the claimant carries the burden to rebut.[196] Like all adjudication procedures, a claimant's evidence must be sorted and weighed. In adversarial court proceedings, this task would fall to the factfinder, who, whether judge or jury, is inherently a neutral party to the proceedings. In disability applications, however, the factfinder is the SSA itself. Also unlike adversarial proceedings, the SSA plays the role of judge (applying the law to the facts) and of the executive (by administering the decision and preventing fraud). To say the SSA is essentially judge, jury, and executioner, though morbid, is not too far a stretch. Regardless of whether the SSA describes the adjudication process as "non-adversarial," the SSA certainly is not—and by nature, *cannot be*—neutral to a claim's outcome.

To understand why this lack of neutrality can be problematic, it is helpful to first get a sense of when throughout the adjudicative process many claims are approved or denied, and who in the SSA makes the decision at each stage. Currently about a third of applicants are approved for benefits at the administrative level,[197] with the two-thirds of denials split about evenly between medical denials (i.e., the claimant submitted a complete file, was fully considered, and was denied based on the evidence), and technical denials (i.e., the claimant failed to complete a necessary step in the application process).[198] Of the 2,467,906 claims[199] that reached a final decision in 2015, 904,240 (36.6 percent) were technical denials.[200] Of the remaining 1,642,927 claims in which a completed file was submitted, 582,135 (35.4 percent) were

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SSR 17-4p(1), 82 Fed. Reg. 46,339, 46,340 (Oct. 4, 2017) (reiterating that the claimant "has a statutory obligation to provide us with evidence to prove to us that he or she is disabled").

196. *See* 20 C.F.R. § 416.912(a)(1) ("[*Y*]*ou have to prove to us* that you are blind or disabled." (emphasis added)).

197. Note that "administrative level" means a decision from the SSA, and does not include decisions of approval made following a federal court lawsuit.

198. OFF. OF RSCH., EVALUATION, & STAT., SOC. SEC. ADMIN., ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM, 2018, at 155 (2019), https://www.ssa.gov/policy/docs/statcomps/di_asr/2018/di_asr18.pdf [https://perma.cc/L2V6-W8HV]. This report encompasses data for SSDI alone, or for claims for both SSDI and SSI. If a claimant applies for SSDI, a claim for SSI may be considered concurrently if they meet the SSI income and asset requirements. *See supra* Section II.B. The 2015 numbers will be used throughout this Section because it is the most recent year where less than ten percent of the claims filed are awaiting a final decision. OFF. OF RSCH., EVALUATION, & STAT., *supra*, at 156 tbl.60. At the time this report was published in 2019, 79,755 of the claims filed in 2015, or 3.1 percent, were still awaiting a final decision. *Id.* Also as of 2018, the most recent year with no outstanding claims is 2010. *Id.* It is important to realize that these numbers are for claims that were *completed* in 2015; it is impossible to tell when these claims were *started.*

199. *See* OFF. OF RSCH., EVALUATION, & STAT., *supra* note 198, at 156 tbl.60. Note the number of claims that reached final decision in 2015 is the number in the "Total" column (2,547,661) minus the number in the "Pending final decision" column (79,755). *See id.*

200. *Id.* At the time of writing this Note, 2015 was the most recent year with fewer than 100,000 claims pending final decision.

approved at initial determination.[201] Of those denied at initial determination, 571,979 claimants (53.9 percent) appealed for reconsideration, and 55,595 (9.7 percent) of these were approved.[202] Of those denied at reconsideration, 353,649 claimants (68.5 percent) appealed for an Administrative Law Judge ("ALJ") hearing, and 187,618 (53.1 percent) of these claims were approved.[203] The total number of approved claims filed in 2015 was 825,348 (33.4 percent)[204], which when broken down between the three levels of review, comes out to 23.6 percent approved at initial determination, 2.2 percent approved at reconsideration, and 7.6 percent approved following an ALJ hearing.[205]

These numbers show that a claimant's chance of success varies depending on the level of review. At initial application, the approval rate for claims with a complete file (35.4 percent) roughly matches the total approval rate of 33.4 percent. At reconsideration, though, the approval rate drops dramatically to only 9.7 percent, but then rises sharply following an ALJ hearing to 53.1 percent. In general, then, it appears claimants have a fair shot of success at initial determination, a low chance of success at reconsideration, but a high chance of success if they continue to an ALJ hearing. This change in approval rate is present despite the fact the same set of rules guides the entire adjudication process at the administrative level, indicating there must be some other explanation for why a claimant has such a greater chance of success at the ALJ hearing level than at reconsideration.

Given that prior administrative medical findings are used in both the reconsideration and ALJ hearing stage,[206] it seems counter-intuitive that more claimants succeed at an ALJ hearing than at reconsideration, when by ALJ hearing a claimant has two sets of negative prior administrative medical findings to overcome. So why is there such a discrepancy in success rates between these two stages of review? What may at least partially explain this discrepancy is one primary difference between reconsideration and an ALJ hearing. Though the entire adjudication process for claims is said to be non-adversarial,[207] the ALJ hearing is the first and only time during a claim when the claimant, either on her own or through a representative, will have the opportunity to actively advocate to the decisionmaker.[208] In the first two stages of review, the SSA decision is completed based solely on the papers in a

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201. *Id.* at 159 tbl.61.

202. *Id.* at 162 tbl.62.

203. *Id.* at 165 tbl.63.

204. *See supra* notes 199–203 and accompanying text. The total number of approved claims is the sum of the claims approved at initial determination, reconsideration, and ALJ hearing levels.

205. *See supra* notes 199–203 and accompanying text.

206. *See supra* Section III.A.3.

207. *See supra* Section III.B.

208. *See* 20 C.F.R. § 416.1429 (2020).

claimant's file.[209] A reconsideration is functionally the same as an initial determination, but with a different disability examiner, and possibly some updated medical information.[210] Although a claimant may submit personal statements as non-medical evidence in support of her claim at any stage of review, the only two-way dialogue between the SSA and claimant during the first two steps of the review process is regarding the *sufficiency* of the evidence; there is no two-way dialogue regarding the quality or weight of the evidence.

This changes at the ALJ hearing level. Though the ALJ hearing is still technically a non-adversarial proceeding, and is still subject to many of the same SSA Rules as the prior two levels of review, the format of the ALJ hearing is starkly different.[211] An ALJ hearing is conducted either in person or via teleconference, and is presided over by an ALJ who took no part in the previous denials.[212] Claimants may be represented by counsel at a hearing, or they may choose to represent themselves.[213] Claimants may offer new evidence into the record at a hearing, which includes bringing in witnesses or experts to offer testimony.[214] The judge will ask questions of the claimant, as will the claimant's representative, and if the claimant is unrepresented, he or she will be allowed to make a statement for the record.[215] The SSA also offers testimony from a vocational expert, and the entire proceeding is captured on an official record.[216] Plainly put, the ALJ hearing gives the claimant a chance to *advocate* on behalf of his or her claim. And the numbers show that despite the fact that these claims have been denied *twice*, and despite the fact those denials will be used against the claimant, over 50 percent of these claims are approved.[217]

What this high approval rate at the ALJ hearing level shows is that the supposedly "non-adversarial" process of review at the initial determination and reconsideration stages gets it wrong on a lot of claims. What makes this even more troubling, though, is that only a small number of claims denied at initial determination actually make it all the way to an ALJ hearing. Based on the 2015 numbers, only 19.3 percent of total denials appealed all the way to an ALJ hearing.[218] At each step of the process there is considerable drop-off;

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209. *See id.* § 416.1015 (detailing the state procedure for conducting an initial determination).

210. *See* SOC. SEC. ADMIN., THE APPEALS PROCESS 1 (2018) [hereinafter THE APPEALS PROCESS], https://www.ssa.gov/pubs/EN-05-10041.pdf [https://perma.cc/PW7K-F9NF].

211. *See generally* 20 C.F.R. §§ 416.1444–416.1465 (detailing the procedures for an ALJ review hearing).

212. THE APPEALS PROCESS, *supra* note 210, at 1; *see also* 20 C.F.R. § 416.1429 (detailing the general procedures for an ALJ hearing).

213. THE APPEALS PROCESS, *supra* note 210, at 2.

214. *Id.* at 1.

215. *See id.*

216. *Id.*

217. OFF. OF RSCH., EVALUATION, & STAT., *supra* note 198, at 165 tbl.63.

218. *See supra* notes 201–04 and accompanying text. Of the 2,467,906 claims that reached final decision in 2015, there were 1,830,176 claims denied for technical reasons and at initial

based on the 2015 numbers, only a little over 30 percent of claimants appealed their denial at all.[219] This means almost 70 percent of all claimants who were denied at initial determination simply gave up their claim.[220] When the number of claimants who give up is compared to the 53.1 percent success rate of those who continue to an ALJ hearing, one wonders how many of those who gave up their claim would have been successful if they had been allowed to *actively* advocate for their claims right from the start.

C. The 2017 Rule Changes

In any proceeding which claims to be non-adversarial, rules must be in place to prevent an imbalance of power. In SSA adjudication, there is already a high risk of imbalance in the initial determination and reconsideration stages, where the SSA acts as factfinder, judge, and program executive in an environment with only limited two-way dialogue. Of these roles, though, it is in the role of factfinder that the SSA exercises the most discretion. Therefore, any rules aimed at preventing an imbalance of power would necessarily need to define or limit the SSA's discretion in weighing evidence. Doing so would serve a similar purpose as would an advocate for the claimant, providing guardrails to prevent the SSA from giving little or no weight to potentially helpful evidence in support of a claim. As will be seen, rules limiting such boundless discretion did once exist, but were recently eliminated. Concurrently with the expansion of discretion, the SSA refused to add additional acceptable medical sources for mental health, which ushered in the current climate of boundless administrative discretion in weighing an increasingly limited scope of sufficient evidentiary sources.

1. The Elimination of the Treating Source Rule

Prior to 2017, SSA Rules contained a provision known as the Treating Source Rule.[221] The Treating Source Rule was codified in the Code of Federal Regulations as part of a broad section detailing how the SSA weighed evidence

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determination, and at reconsideration. *See supra* notes 201–04 and accompanying text. Of these denials, only 353,649 continued their claim to an ALJ hearing. OFF. OF RSCH., EVALUATION, & STAT., *supra* note 198, at 165 tbl.63.

219. *See supra* notes 201–04 and accompanying text. Of the total 1,830,178 denials, 571,979 (31.3 percent) appealed for reconsideration. OFF. OF RSCH., EVALUATION, & STAT., *supra* note 198, at 162 tbl.62.

220. Obviously, some claimants will choose to file a new claim rather than appeal a denial. This has serious consequences, though, for determining a claimant's period of disability. Very basically, a claimant who chooses to give up a claim accepts the determination he or she was not disabled for the period of disability at issue in the first claim, and this may estop him or her from claiming disability for that period in the future. *See* SSR 18-01p, 83 Fed. Reg. 49,613, 49,616 (Oct. 2, 2018).

221. *See* SSR 96-2p, 61 Fed. Reg. 34,490, 34,490 (July 2, 1996) (rescinded 2017).

in support of a claim.[222] This section laid out the process for determining whether a medical opinion would be given *controlling weight*, which was the highest level of weight the SSA could assign.[223] Generally, a treating source was an acceptable medical source who had evaluated the claimant over a long period of time.[224] The specific portion known as the Treating Source Rule stated:

> Generally, we give more weight to medical opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's medical opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight.[225]

Under this rule, the SSA would make two determinations. First, if the SSA determined that a medical opinion was from a *treating source*,[226] the SSA gave that opinion more weight than the opinions of other non-treating acceptable medical sources. Second, if the SSA determined the opinion of the treating source was well-supported by evidence in the record, that opinion received *controlling weight*.[227] If a treating source's opinion was given controlling weight under SSA Rules, then the SSA must adopt that opinion.[228]

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222. *See* 20 C.F.R. § 416.927 (2020). This section is now titled: "Evaluating opinion evidence for claims filed before March 27, 2017." *Id.*

223. *See id.* § 416.927(b), (c)(1)–(2) ("[W]e will always consider the medical opinions in your case record . . . .").

224. *See id.* § 416.927(c)(2).

225. *Id.*

226. *See id.* § 416.927(a)(2) (defining "treating source"). Generally, treating sources were acceptable medical sources who had either a long-term treatment relationship with the claimant, or who treated them as often as necessary per their specific condition. *See id.*

227. *Id.* § 416.927(c)(2).

228. *See* SSR 96-2p, 61 Fed. Reg. 34,490, 34,490 (July 2, 1996) (rescinded 2017) ("If a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record, it *must* be given controlling weight; i.e., it must be adopted.").

In early 2017, following a brief period of commentary,[229] the SSA eliminated the Treating Source Rule.[230] This not only eliminated the concept of treating source from the rules, but it also eliminated the concept of controlling weight. Following the rule changes, the SSA will still consider all medical opinions in a claimant's file, but no medical opinion *submitted by the claimant* can henceforth be given controlling weight; all final determinations on disability are now vested solely in the discretion of the administration.[231] To further drive home the point that a claimant's treating source would no longer receive any special consideration, the administration stated "that there is not an inherent persuasiveness to evidence from [medical consultants], [psychological consultants], or [consultative examination] sources over an individual's own medical source(s), *and vice versa*."[232] This language is mirrored in the relevant code provision, which states the SSA "will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources."[233]

What is more telling about the rule change is the heightened prominence the SSA now gives to its own prior administrative medical findings.[234] The comparable pre-2017 provisions mentioned prior administrative medical findings only once, and this was only to note that if controlling weight was given to a claimant's treating source, the ALJ was not required to explain what "weight he or she gave to the prior administrative medical findings."[235] Not only does the new code provision reference prior administrative medical findings *16 times*—including in the title of the provision itself—but it consistently situates prior administrative medical findings alongside the phrase *medical opinions*, so that nearly every reference to medical opinions is now phrased as "medical opinions and prior administrative medical findings."[236] Basic principles of statutory construction would indicate that, following the rule change, medical opinions and prior

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229. Commentary on this rule change was open only for two months, from September 6 to November 8, 2016. *Revisions to Rules Regarding the Evaluation of Medical Evidence*, REGULATIONS.GOV [hereinafter *Notice of Proposed Rule Making*], https://www.regulations.gov/document/SSA-2012-0035-0001 (last visited Nov. 14, 2020).

230. *See* Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. 5844, 5844 (Jan. 18, 2017) (codified at 20 C.F.R. pts. 404, 416).

231. *See id.* ("[A] statement(s) about whether or not an individual has a severe impairment(s) is a statement on an issue reserved to the Commissioner . . . .").

232. *Id.* (emphasis added). It is the "vice-versa" at the end of this statement that is the most telling. Prior to the rule change, there was no suggestion that consultative evaluations would receive higher weight than opinions from claimant's medical sources; with the "vice-versa," however, it is made clear that opinions from a claimant's medical sources are now viewed on an even footing with the administration's, regardless of length of treatment or treating relationship.

233. 20 C.F.R. § 416.920c(a).

234. *See id.*

235. *See id.* § 416.927(e).

236. *See, e.g.*, *id.* § 416.920c(a)–(b)(2).

administrative medical findings are now considered as functionally equivalent.

This change presents a conundrum: If the SSA's prior administrative medical findings are now treated as the functional equivalent of a claimant's medical sources, has the SSA made *itself* into an acceptable medical source? This seems implausible, but the rules themselves seem to imply this is true. For example, one provision states: "When a medical source provides one or more medical opinions or prior administrative medical findings . . . ."[237] From a practical standpoint, the only medical sources that *could* provide a prior administrative medical finding are whichever medical sources the SSA found most convincing at the prior levels of review and adopted as its own. And considering a prior administrative medical finding is only used upon the denial of a claim, the medical source whose opinion the SSA adopted is almost certainly going to be one who took a *negative* view of the claim. So while the SSA may not have *per se* made itself a new acceptable medical source, it certainly moved in that direction with 2017 changes. This is even suggested by the construction of a number of the new rules.[238] So while medical professionals do play a role in the SSA's determination of disability, and thus in the creation of these prior administrative medical findings, the new rules blur the lines between the medical professional who aided the SSA in making its determination and the SSA itself, addressing them consistently as if they are one entity. More disturbingly, this elevates prior administrative medical findings to an equal footing with a claimant's medical sources during the part of the process when the *correctness* of the prior medical findings of the administration is precisely at issue.

Although medical professionals are responsible for making disability determinations, the adjudication process at initial determination and reconsideration is primarily a review of the paper file; the SSA's medical professionals do not meet or personally evaluate the claimant. Claims for disability are evaluated by Disability Determination Services ("DDS") offices that are contracted by the SSA, but managed and operated by the individual states.[239] In Iowa, the DDS office is a bureau of the Iowa Vocational

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237. *Id.* § 416.920c(a).

238. *See, e.g.*, *id.* § 416.920c(c)(1) ("The more relevant the objective medical evidence and supporting explanations presented by *a medical source are to support his or her medical opinion(s) or prior administrative medical finding(s)*, the more persuasive the medical opinions or prior administrative medical finding(s) will be." (emphasis added)); *id.* § 416.920c(c)(5) ("[W]e will also consider whether new evidence we receive after *the medical source made his or her medical opinion or prior administrative medical finding* makes the medical opinion or prior administrative medical finding more or less persuasive." (emphasis added)).

239. *See* SOC. SEC. ADMIN., DISABILITY BENEFITS 5–6 (2019), https://www.ssa.gov/pubs/EN-05-10029.pdf [https://perma.cc/6C44-WXBD] (detailing how after a cursory overview of a claimant's application, the SSA forwards it to the relevant state's DDS office).

Rehabilitation Services ("IVRS").[240] The DDS assigns each disability claim a dedicated Disability Examiner whose primary responsibility is to examine the information in a claimant's file under SSA rules.[241] The Disability Examiner has the sole responsibility for determining when there is sufficient evidence in the file to begin the evaluation process, and for managing client communication.[242] Once the Disability Examiner determines there is sufficient evidence, he or she contacts medical consultants ("MC") and psychological consultants ("PC") to evaluate the medical evidence within his or her practice area.[243] These MCs and PCs are employees of the state DDS office, and they must be acceptable medical sources.[244] The MC or PC evaluates the claim based solely on the medical evidence in the file; at no point will an MC or PC have any contact with the claimant.[245]

If prior to MC or PC evaluation, however, the Disability Examiner determines there is insufficient evidence, he or she now has broad discretion from where to request more information.[246] While the SSA can request information from one of the claimant's medical sources,[247] it is under no obligation to do so.[248] If they choose, a Disability Examiner can bypass a claimant's medical sources altogether and arrange a consultative examination ("CE") with an administration-approved medical source.[249] The administration-approved medical source will be an acceptable medical source, but they will *not* be a source that has any treating relationship with the claimant.[250] Once

240. *See Disability Determination Services (DDS)*, IOWA VOCATIONAL REHAB. SERVS., https://ivrs.iowa.gov/agency-services/disability-determination-services-dds [https://perma.cc/35PF-RUHP].

241. *See Disability Determination Services: Social Security Disability Claim Process*, IOWA VOCATIONAL REHAB. SERVS., https://ivrs.iowa.gov/sites/default/files/documents/2018/09/disability_determination_services_flow_chart_text.pdf [https://perma.cc/9W4J-JWVG].

242. *See id.*

243. *See id.* This document uses the term "mental health consultant" instead of psychological consultant. For consistency with SSA rules, this Note will use the term psychological consultant ("PC").

244. *See id.* (noting that the consultants are described as "in-house"); *see also* 20 C.F.R. § 416.1015(c)(1) (2020) ("(c) Disability determinations will be made by: (1) A State agency medical or psychological consultant and a State agency disability examiner . . . ."); *id.* § 416.1016(b) (describing the qualifications for an MC, which, unlike the list of acceptable medical sources, includes only licensed physicians); *id.* § 416.1016(c) (describing qualifications for a PC, which includes only licensed psychiatrists and psychologists).

245. *See id.* § 416.1015(b) ("The State agency will make disability determinations based only on the medical and nonmedical evidence in its files.").

246. *See id.* § 404.1520b(b)(2) (noting that in the event of inconsistent or insufficient evidence, "we [the SSA] will determine the best way to resolve the inconsistency or insufficiency").

247. *Id.* § 416.920b(b)(2)(i).

248. *Id.* § 416.920b(b)(2) (noting that to resolve insufficiencies in evidence, "[w]e might not take all of the actions listed below," which includes contacting a claimant's medical sources).

249. *Id.* § 416.920b(b)(2)(iii).

250. *See id.* § 416.917 ("If we arrange for the examination or test, we will give you reasonable notice of the date, time, and place the examination or test will be given, and the name of the person or facility who will do it. We will also give the examiner any necessary background

the medical professional completes the CE and submits their finding to the administration, that finding can be given equal *or more* weight than any medical findings from a claimant's medical sources—even if the claimant's sources have long treating relationships.[251]

2. Rejection of Additional Acceptable Medical Sources for Mental Health

At the same time it expanded agency discretion in assigning weight to medical evidence, the SSA also revised the list of acceptable medical sources. What is more relevant than which sources were added, though, is which sources were *not* added. In the Notice of Proposed Rulemaking ("NPRM"),[252] the administration proposed adding both nurse practitioner and audiologist to the list of acceptable medical sources,[253] and requested commentary on whether to add Physician Assistant and LCSW.[254] The final rule change added nurse practitioner, audiologist, and physician assistant (all specialists in *physical* medicine) to the list of acceptable medical sources, but rejected the addition of LCSW.[255] While the NPRM did elicit numerous comments stressing that LCSWs play an important and crucial role in mental healthcare, as well as noting that the role of a LCSW is a corollary to that of a nurse practitioner or physician assistant,[256] the SSA rejected the LCSW primarily because of concerns about state licensure requirements.[257]

The sum effect of the 2017 rule changes was that the discretion of the agency was massively expanded, which removed one of—if not *the* —fundamental guardrail maintaining the balance of power in the non-adversarial adjudication process. Add to this the fact the SSA rejected adding LCSW as an acceptable medical source, and one is only left to wonder—*cui bono*?[258] Who benefits from these changes? Claimants with physical impairments certainly benefit from the addition of two acceptable medical sources, but that benefit is substantially outweighed by the fact that even if

information about your condition."); *id.* § 416.918(c) ("If any of your medical sources tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your medical source(s) may agree to another type of examination for the same purpose."). None of the provisions addressing CEs contain an option for the DDS to request additional information or exams from a claimant's treating source.

251. *See supra* text accompanying notes 229–32.

252. *Notice of Proposed Rule Making*, *supra* note 229.

253. *See id.*

254. *See id.*

255. *See* Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. 5844, 5847 (Jan. 18, 2017) (codified at 20 C.F.R. pts. 404, 416).

256. In their response rejecting the addition of any additional mental healthcare workers to the list of acceptable medical sources, the administration acknowledged that "many comments focused upon the prevalence of these sources [LCSWs] in the healthcare system, particularly for individuals who have mental impairments, are poor, or are experiencing homelessness." *Id.*

257. *Id.*

258. To whose benefit?

one of those two medical providers is a claimant's primary treating source, that source is no longer given preferential weight. For claimants with mental impairments, no benefits whatsoever came from the 2017 changes—only *harms*. In the end, the party that reaped the most benefits from the changes was the party that already wielded nearly all the power in the "non-adversarial" process—the SSA itself.

D. The SSA Rules Have Further Diverged From Reality

The SSA Rules prior to the 2017 changes were by no means perfect for the evaluation of disability claims for mental illness. The rules were then, and are still now, designed primarily to evaluate physical impairments. That said, the pre-2017 rules were substantially better than the post-2017 rules for claimants with mental impairments. Following the 2017 changes, the SSA rules diverged to an even greater degree from the reality of how many people receive treatment for mental health. Prior to the changes, if a claimant with mental impairments was lucky enough to live where he or she could form a treating relationship with a psychiatrist or psychologist, the opinion of that provider would receive high—or possibly *controlling*—weight in his or her disability claim. Given the nature of talk therapy, which can require months or years to be effective,[259] it was logical to give such high deference to a claimant's treating mental health provider. If changes were to be made, the most ideal change would have been to leave the treating source rule intact, but to also add talk therapy providers such as LCSWs and MHCs to the list of sources whose medical opinions could not be discounted without compelling evidence. This would have left persons suffering from mental health illness in the ideal position to prove their claims for disability; so long as they received talk therapy from licensed mental healthcare providers in their states, the evidence produced in the natural course of the treatment regimens would provide a sufficient basis for the Social Security disability claims.

The 2017 changes went the opposite way. As before the rule change, claimants for a mental impairment who receive talk therapy from a LCSW or MHC because they do not live near a psychologist or psychiatrist are still left with very little or no objective medical evidence from an acceptable medical source. To make matters worse, though, even if the claimant receives treatment from an acceptable medical source, the SSA has full discretion to give that evidence little or no weight, and to then require the claimant to submit to a CE with a provider with whom they have no treatment relationship. The findings of the CE—even if the claimant only met with the provider a single time for a period of hours or minutes—may then be given the highest weight of all evidence, and may be determinative of the claim. If the claimant chooses to appeal, they also now face the uphill battle of fighting against the weight of that prior administrative medical finding, which is

259. *See supra* notes 85–90 and accompanying text.

considered on appeal as a form of medical evidence *against* the claimant. This combination of factors makes disability claims for mental impairments under the new rules even more difficult to win for some of America's most vulnerable citizens.

The application process for disability *should* be designed so that so long as a claimant has sought regular treatment for his or her impairments, sufficient evidence to support the claim will be contained in the treatment record kept by his or her medical professionals, which can then be bolstered by testimonial statements from those treating professionals. For physical impairments, this is generally how the disability application process works. In the course of receiving treatment for a physical impairment, such as a musculoskeletal injury, the claimant will generate more than enough objective medical evidence through her regular doctor visits, which includes ample diagnostic reports (e.g., x-rays, MRIs, etc.) and physician statements. This is not the case for mental impairments, which by their nature are far more subjective, and which deal with issues that do not present themselves for diagnosis as quickly or clearly as do physical impairments. In addition, there are far fewer acceptable medical sources available from whom objective medical evidence may be provided. This is reflected both in the SSA Rules, where only two mental healthcare providers are considered acceptable medical sources, as well as in the context of the number and geographical location of mental healthcare providers, where in states like Iowa, most of the licensed acceptable medical sources in the State are located within just three geographic locations.

Quite frankly, the SSA Rules for evaluating disability claims for mental impairments do not account for the hardships many claimants face when receiving treatment for mental illness. Not only that, though, but the recent changes moved the rules further *away* from any reflection of reality. Not only are claimants with mental impairments left with as few acceptable medical sources as they had before, but the SSA now has full discretion to treat all medical evidence as equal, regardless of whether from a source who saw the claimant for an hour, a month, or a decade. The data from 2015 shows the approval rate of claims under the old rules—which recognized the importance of a claimant's treating source—was already quite low, at only around 33 percent reaching ultimate approval.[260] With the new changes removing one of the claimants' strongest tools in favor of their claims, while adding no others to their benefit, the approval rate can only go down. Add to this the fact that now on appeal claimants must fight against the weight of their former denials—which is used as medical evidence *against* them—the purpose of the rule changes becomes clear: to approve fewer claims for disability.

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260. *See* OFF. OF RSCH., EVALUATION, & STAT., *supra* note 198, at 156 tbl.60.

IV. SOLUTIONS

The current SSA Rules for evaluating all claims for disability does not allow for a fair consideration of claims for mental impairments. An ideal set of rules for evaluating mental impairments would reflect the reality of how Americans receive healthcare, and would be designed so that a claimant accumulated sufficient evidence in support of his or her claim through a regular course of treatment with licensed professionals. While it is important that a cohesive set of rules exist for a nationwide program such as SSI, none of that cohesion would be lost by modifying the current framework of the rules to add additional sections and guidance addressing the special circumstances faced by claimants suffering from mental impairments. Without changes to the current rules, Americans who need help from social programs like SSI who live in areas lacking proper mental healthcare resources—including many living in the state of Iowa—will continue to find it difficult or impossible to get the assistance they need.

Though there are many possibilities, five solutions could help alleviate this problem. First, the SSA must add more acceptable medical sources who are mental health providers. Second, the SSA should evaluate the ramifications of eliminating the Treating Source Rule, leaving open the possibility of writing that or a similar provision back into the rules if data or feedback from practitioners shows it is necessary. Third, the SSA should make accommodations for a mental impairment claimant's talk therapist, so that even if the provider is not an acceptable medical source, evidence from the claimant's talk therapist cannot be given little or no weight. Fourth, if the SSA intends to keep the rules for discretion as they are, it should either introduce adversarial testing earlier in the claim, or perhaps make the entire adjudication process adversarial from the start. Finally, and most ambitiously, the SSA should re-write and bifurcate the adjudication Rules so that claims for mental impairments are adjudicated on their own terms and in a way that more closely aligns with how Americans seek treatment for mental illness.

A. The SSA Must Add More Mental Health Providers as Acceptable Medical Sources

First, the SSA should expand the list of acceptable medical sources to include both LCSWs and MHCs. When it considered whether to add LCSWs, the SSA wrote that the primary concern was the lack of consistency in state licensure requirements for LCSWs.[261] Lack of consistency, though, does not mean there are states where an LCSW may practice without a license. Nationwide, LCSWs and MHCs—like all mental healthcare providers—are subjected to strict licensure requirements, which typically include that the provider hold a master's degree or higher and completion of specialized

261. Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. at 5846–47.

clinical training in his or her respective field of practice.[262] In this regard, the requirements mirror those of many physical medicine practitioners, including the recently-added PA.[263] In rejecting the addition of LCSW, the SSA did not enumerate what about the state licensure requirements it found objectionable beyond just inconsistency; if it so desired, the SSA would be free in future rules to define which specific requirements LCSWs or MHCs must have to be sufficiently-qualified under SSA Rules.

Furthermore, and most importantly, in states like Iowa, an LCSW or MHC may be the only option a patient has to receive talk therapy. As mentioned above, there are 24 counties in Iowa that have no licensed psychiatrist or psychologist, but do have numerous LCSWs.[264] While persons from those counties are free to go out of county to receive talk therapy from a psychiatrist or psychologist, it is more plausible that a person suffering from severe mental health issues would prefer to seek treatment close to home. This becomes even more true when considering that people who are seeking Social Security benefits in the first place are doing so precisely because they have limited financial means. It is naïve and cruel to expect someone suffering from a severe mental impairment to have both the knowledge and the resources to travel outside her county for treatment, just so their treatment is with a source acceptable to the SSA. Discounting the reliability of opinions from LCSWs by labeling them as lower-tier medical sources (as opposed to *acceptable* medical sources) allows the SSA the discretion to ignore valuable evidence—evidence which for many claimants paints the most comprehensive and accurate picture of their mental impairments.

B. The SSA Should Evaluate the Ramifications of Eliminating the Treating Source Rule

Second, the SSA should evaluate the ramifications of eliminating the Treating Source Rule. One justification for the elimination of the Treating Source Rule was to simplify the adjudication process by allowing equal treatment of all evidence at each level of review.[265] The agency stated the goal of this change was to more accurately reflect how people receive their treatment.[266] As has been shown, though, elimination of this rule in the mental health context runs flatly counter to this goal. A good first step in reviewing this change would be to open up public comment from

262. *See Social Work License Requirements*, SOCIALWORKLICENSURE.ORG (Nov. 4, 2020), https://socialworklicensure.org/articles/social-work-license-requirements/#states [https://perma.cc/6EFX-N4F4].

263. *See What is a PA?*, AM. ACAD. PHYSICIAN ASSISTANTS, https://www.aapa.org/what-is-a-pa [https://perma.cc/J4HE-56GM].

264. *See infra* Appendix I.

265. *See* Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. at 5844.

266. *See* Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62,560, 62,566 (Sept. 9, 2016) (codified at 20 C.F.R. pts. 404, 416).

practitioners on the narrow issue of whether they have seen negative effects on their mental health claimants. If so, the SSA could reinstate or create a form of treating source weight just for mental impairment claims, and in such a way that is tailored to the needs of those claimants. It is important to note that the original NPRM that contained the comments about LCSWs was primarily concerned with addressing changes in the delivery of *physical* healthcare; in fact, the request for commentary on the consideration of LCSWs was confined to a single sentence at the end of the paragraph whose purpose was to solicit comments for PAs.[267]

That said, the confidential nature of the SSI claim adjudication process may make it difficult or impossible to find data on the practical effects of the rule change so far. This complication is further exacerbated by the backlog of claims under consideration before the SSA; many claims filed after the 2017 rule changes went into effect are still in the appeals stage.[268] There are ways the SSA could collect data, though, and a valuable source of such data would be lawyers who have dealt with the effects of the rule changes in practice. Issuing a new NPRM or similar bulletin soliciting practitioners in Social Security law to offer feedback on their experiences proving claims for mental impairments under the new rules would provide much-needed feedback on this rule change. By doing so, the SSA would not only get firsthand knowledge on the effects of the rule change from those who understand the effects of rule changes the best, but it would also get the data it needs to determine whether the new rule is really effectuating its stated purpose.

C. The SSA Must Ensure Evidence from a Claimant's Talk Therapist is Considered

Third, if the SSA refuses to add LCSW or MHC to the list of acceptable medical sources, the SSA must create a pathway for claimants with mental impairments to submit evidence from their licensed mental health talk therapist in such a way it cannot be given little or no weight by the administration. The reason for this is simple; there is no possible corollary to the opinion of a claimant's talk therapist that the SSA could create on its own. While it may be possible for a CE examiner to come up with a potential diagnosis of a claimant's impairments, the knowledge garnered throughout a longitudinal course of talk therapy is not such that can be re-created in a single meeting with a CE examiner. In justifying the 2017 changes, the agency went to great lengths to articulate that *all* evidence in a claimant's file will be

267. The sole sentence soliciting comments on whether to add LCSW to the list of acceptable medical sources stated: "We are also interested in whether or not there are other professionals, such as licensed clinical social workers, who we should include on the AMS list." *Id.* at 62,569; *see also infra* Section IV.C (discussing the effect of the 2017 changes in regard to LCSWs).

268. OFF. OF RSCH., EVALUATION, & STAT., *supra* note 198, at 156 tbl.60. As of October 2019, there are still 320,565 outstanding claims filed in 2017, and it is not possible to know whether these were filed before or after March 27, 2017. *Id.*

considered, which includes evidence from both medical and nonmedical sources. This was not actually a change, though; the SSA also considered all evidence in support of a claim prior to the 2017 changes. The real change was in the elimination of the discretionary guardrails, which allows the SSA to now give evidence little or no weight for nearly any reason it chooses.

The practical effect of this rule change for mental health claimants is that evidence from long-term talk therapy providers—regardless of whether they are acceptable medical sources—may now be discounted. If additional evidence is needed—which will be likely in states with inadequate mental healthcare resources—the SSA will send the claimant for a CE with a mental health professional who will likely see the claimant only one time. With the talk therapist evidence discounted, a claim may thus rest solely upon the opinion of a CE examiner who has no treating relationship with a claimant, whose knowledge of a claimant's relevant prior medical history is confined to that which the SSA found relevant to the claim, and who may have evaluated the claimant for no more than a matter of hours. To allow such vital evidence to be discounted serves no purpose to the claimant, and has the practical effect of risking that claims will be determined based on the evidence from a single visit with a provider who knows practically nothing about the claimant. Such a rule is nearly the equivalent of allowing a court of law to create its own evidence *against* a defendant—an idea that runs counter to all notions of fairness and justice.

D. The SSA Should Remove the Reconsideration Stage from the Adjudication Process

The SSA should remove the reconsideration stage of review altogether, and move directly to ALJ hearing after denial. If one thing is clear from examining approval rates at the different stages of review, it is that a claimant's chances of success increase dramatically at the point in the review process where a claimant is able to actively advocate on his or her behalf. But as the data also shows, many claims drop off prior to the ALJ hearing, with only around 19 percent of denials continuing that far.[269] If the data suggests anything, it certainly suggests that if more claims proceeded to the ALJ hearing, more people would be approved for benefits. It takes quite a while, though, for a claim to progress all the way to an ALJ hearing. This delay itself is likely to be an enormous barrier keeping claimants from the aid they need, and it may explain why so many claimants choose to forego appeal of a claim denial. By eliminating the reconsideration stage altogether and moving forward the quasi-adversarial testing process of the ALJ hearing, claimants would be able to actively advocate for themselves much earlier in the process, both increasing claimants' chances of success and decreasing the time between initial application and final adjudication.

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269. *See supra* note 218 and accompanying text.

That said, this change would likely create a need for more ALJs to handle the increase in hearings. But it is hard to see how hiring additional ALJs would be more costly than the resources the SSA currently spends in evaluating every claim *twice* prior to an ALJ hearing. When the low success rate of claims at reconsideration (just under ten percent[270]) is taken into account, it is hard to see any purpose behind reconsideration beside adding additional and unnecessary administrative delay to adjudication of claims. In addition, at the ALJ level, as is the case in civil litigation, the bulk of the work proving a claim is done by a claimant's *attorney*, which removes a great deal of the workload from the SSA. The adversarial process is what promotes and protects fairness in civil and criminal proceedings. The interests at stake in a disability proceeding are no less important to claimants, and those interests—in addition to the interests of the SSA in cost effectiveness and reducing waste —can be best served by testing the merits of a claim in a quasi-adversarial process as soon as possible after an initial denial.

E. The SSA Should Bifurcate the Adjudication Process into Separate Rules for Physical and Mental Impairments

Finally, the SSA should take steps to bifurcate its rules so that claims for mental impairments are adjudicated on their own terms, instead of being shoehorned into a set of rules designed around physical impairments. This final suggestion is the most common-sense of all, but it is also the most difficult to implement. It would be an exhausting task to comb through the entire expanse of SSA Rules and create a mental health corollary to those rules which are tailor-made for physical impairments. Such a task is necessary, though, to ensure that claims for mental impairments are properly and fairly evaluated on terms that make sense in light of how people receive mental healthcare. Mental healthcare is already far more subjective than physical healthcare, but under the current rules, so much of the vital evidence that directly results from a claimant following his or her treatment regime is insufficient to properly support his or her claim because of rules that place the bulk of talk therapy providers on a lower-tier of medical sources.

It is important here to recognize the obvious: when a person seeks treatment for mental illness, his or her primary concern, and the concern of the treating mental healthcare professional, is improvement that person's quality of life. This means different things in the context of each person's individual needs. But creating a proper evidentiary record for a future Social Security disability claim by choosing providers who are acceptable medical sources (under rules the claimant likely does not know) and ensuring they properly document their findings is certainly the last thing on a claimant's mind. The SSA Rules should be designed around how people actually receive healthcare in America, and in full light of the fact that depending on where a

270. *See supra* note 202 and accompanying text.

claimant lives or what resources he or she has at his or her disposal, a priority for the SSA is very likely not a priority—or even a possibility—for the claimant. To best effectuate their purposes, the SSA Rules should be designed so that as long as a claimant seeks and follows through with a course of treatment for his or her illnesses, whether physical, mental, or both, the evidentiary record created by that regular course of treatment will be sufficient to support the claim. For claimants with mental impairments in Iowa, and also likely in similarly-situated states, the current rules do not reflect the reality of how they receive mental healthcare. To better serve these claimants, the current rules should be bifurcated into separate rules for mental and physical impairments, with those for mental impairments written with a compassionate acknowledgement of the unique challenges Americans face in receiving mental healthcare.

V. Conclusion

Recent rule changes enacted by the SSA have placed claimants with mental impairments at a significant disadvantage in proving their case. With both the elimination of the Treating Source Rule and with the refusal to recognize common talk therapy providers as acceptable medical sources, the SSA Rules have further diverged from the reality of how Americans receive mental health treatment. This problem is exacerbated in states like Iowa, where mental healthcare resources are scarce and unevenly distributed throughout the state. What is most important and tragic about this situation, though, is that the claimants whose cases will be hardest to prove are also those who, because of the nature of their impairment, will have the most difficulty meeting the myriad of requirements necessary to prove a disability claim. It is important not to lose sight of the very nature of mental illness and how that affects these claimants. An application for Social Security benefits is a complicated and detailed series of steps that must be precisely followed, or —as is the case 36 percent of the time[271]—the claim will be denied outright for mere technical reasons. Applying for Social Security benefits is in some ways an academic exercise, requiring a level of mental discipline and functioning that may be beyond the limits of what a person suffering from mental illness can feasibly handle. A person suffering from only a physical impairment, on the other hand, has no inherent problem completing mental tasks. Imagine, though, if a claimant with a serious back injury were required to lift heavy objects to qualify for disability. Such a requirement would be absurd, but it is the reality in which claimants with mental disorders find themselves. The administration must take steps to ensure the success of a claim does not rest upon the functioning of the object of the claimant's impairment.

271. *See supra* note 200 and accompanying text.

Efficiency and cost-effectiveness in administration must mean more than just denying more claims. Social programs such as SSI are a critical safety net for some of America's most vulnerable citizens. To function properly, all safety net programs must be thoughtfully designed and compassionately administered. These programs are useless if the benefits cannot get into the hands of those who need them because of convoluted processes or unlucky geographical distribution of resources. If we as Americans believe in the inherent value Social Security disability benefits provide to those of limited physical and mental means within our society, then we must commit to making those resources available without undue hardship or burden. The recent rule changes not only shifted the balance away from these purposes, but it also made it even more difficult for claimants with mental impairments to receive their benefits because of factors totally out of their control —namely, an unlucky geographical distribution of resources in states like Iowa. Without thoughtful and meaningful changes, the SSI program is at risk of becoming increasingly out of reach for the vulnerable Americans for whom it was designed to benefit, and who desperately need its help.

APPENDIX I: LIST OF IOWA COUNTIES WITH POPULATION AND MENTAL HEALTH SERVICE PROVIDER INFORMATION (ARRANGED ALPHABETICALLY)[272]

County	*Population*	*Psychiatrists*	*Psychologists*	*LCSW*	*MHC*
Adair	7,063	0	0	2	1
Adams	3,645	0	0	1	1
Allamakee	13,832	0	0	2	2
Appanoose	12,437	0	1	3	3
Audubon	5,506	0	0	0	2
Benton	25,642	0	0	13	3
Black Hawk	132,408	1	17	68	55
Boone	26,346	0	1	5	9
Bremer	24,947	3	2	17	19
Buchanan	21,199	3	2	17	5
Buena Vista	19,874	1	2	8	3
Butler	14,539	0	1	5	4
Calhoun	9,699	0	0	5	5
Carroll	20,154	1	2	5	4
Cass	12,930	1	2	4	5
Cedar	18,627	0	1	4	2
Cerro Gordo	42,647	2	7	34	17
Cherokee	11,321	2	1	3	2
Chickasaw	11,964	0	1	0	2
Clarke	9,423	0	0	3	1
Clay	16,134	4	2	6	7
Clayton	17,556	1	0	1	3
Clinton	46,518	2	2	15	11
Crawford	17,158	0	0	3	1
Dallas	90,180	2	19	65	45
Davis	9,017	0	0	5	1
Decatur	7,890	0	0	5	1
Delaware	17,069	0	1	5	2
Des Moines	39,138	4	3	15	14
Dickinson	17,153	0	1	3	5
Dubuque	96,854	6	17	39	54

272. Population data for all appendices taken from *Iowa Counties by Population*, *supra* note 130 (compiling data from the U.S. Census Bureau) (on file with author). Data on mental health professionals was pulled in October 2019 from public licensure searches at *Public License Search*, IOWA DEP'T PUB. HEALTH, https://ibplicense.iowa.gov/PublicPortal/Iowa/IBPL/publicsearch/publicsearch.jsp [https://perma.cc/2KSG-Z84P] (on file with author). Only professionals with an Iowa address as their primary address of licensure were included in the results; professionals with non-Iowa addresses were removed from the list.

Emmet	9,253	0	1	1	2
Fayette	19,660	0	0	4	1
Floyd	15,761	0	1	3	1
Franklin	10,124	0	1	2	1
Fremont	6,993	0	0	2	4
Greene	8,981	0	0	0	4
Grundy	12,304	0	0	5	2
Guthrie	10,720	0	1	5	5
Hamilton	14,952	0	1	4	2
Hancock	10,712	0	0	2	1
Hardin	16,868	0	0	2	6
Harrison	14,134	0	0	3	7
Henry	20,067	1	2	4	4
Howard	9,187	0	0	1	2
Humboldt	9,547	0	0	4	4
Ida	6,841	0	0	0	3
Iowa	16,141	0	0	6	5
Jackson	19,432	1	0	4	7
Jasper	37,147	0	3	7	12
Jefferson	18,381	0	3	17	7
Johnson	151,260	129	143	201	73
Jones	20,744	0	1	8	3
Keokuk	10,225	1	0	7	2
Kossuth	14,908	0	1	5	0
Lee	34,055	1	1	6	10
Linn	225,909	18	32	132	89
Louisa	11,169	0	1	2	2
Lucas	8,645	0	0	0	0
Lyon	11,811	0	0	2	0
Madison	16,249	0	2	7	6
Mahaska	22,000	1	1	12	6
Marion	33,407	2	11	22	8
Marshall	39,981	3	4	11	11
Mills	15,063	0	1	7	7
Mitchell	10,569	0	0	4	1
Monona	8,679	0	1	2	1
Monroe	7,790	0	1	2	2
Montgomery	10,003	0	0	2	0
Muscatine	42,929	0	4	7	6
O'Brien	13,840	0	0	4	6
Osceola	6,040	0	0	0	3
Page	15,249	1	1	2	12

Palo Alto	8,929	0	0	2	2
Plymouth	25,095	0	2	10	9
Pocahontas	6,740	0	0	0	1
Polk	487,204	54	110	413	254
Pottawattamie	93,533	5	1	32	47
Poweshiek	18,699	0	4	8	7
Ringgold	4,968	0	0	0	2
Sac	9,719	0	0	7	2
Scott	173,283	10	23	110	65
Shelby	11,578	0	2	1	1
Sioux	34,909	0	3	17	15
Story	98,105	5	40	48	32
Tama	16,904	0	0	4	2
Taylor	6,191	0	0	1	1
Union	12,359	1	1	4	2
Van Buren	7,020	0	0	0	1
Wapello	35,205	4	2	13	5
Warren	51,056	0	6	28	16
Washington	22,141	1	3	11	8
Wayne	6,401	0	0	0	1
Webster	36,277	4	3	20	10
Winnebago	10,518	3	1	0	5
Winneshiek	20,029	2	4	16	12
Woodbury	102,539	7	11	73	39
Worth	7,453	0	0	1	1
Wright	12,690	0	1	4	3
TOTALS	***3,145,156***	***287***	***520***	***1,705***	***1,160***

APPENDIX II: LIST OF IOWA COUNTIES WITH POPULATION AND MENTAL HEALTH SERVICE PROVIDER INFORMATION (ARRANGED BY NUMBER OF MENTAL HEALTH PROFESSIONALS, PRIORITIZING ACCEPTABLE MEDICAL SOURCES)[273]

County	*Population*	*Psychiatrist*	*Psychologist*	*LCSW*	*MHC*
Johnson	151,260	129	143	201	73
Polk	487,204	54	110	413	254
Linn	225,909	18	32	132	89
Story	98,105	5	40	48	32
Scott	173,283	10	23	110	65
Dubuque	96,854	6	17	39	54
Dallas	90,180	2	19	65	45
Woodbury	102,539	7	11	73	39
Black Hawk	132,408	1	17	68	55
Marion	33,407	2	11	22	8
Cerro Gordo	42,647	2	7	34	17
Webster	36,277	4	3	20	10
Des Moines	39,138	4	3	15	14
Marshall	39,981	3	4	11	11
Pottawattamie	93,533	5	1	32	47
Wapello	35,205	4	2	13	5
Clay	16,134	4	2	6	7
Winneshiek	20,029	2	4	16	12
Warren	51,056	0	6	28	16
Bremer	24,947	3	2	17	19
Buchanan	21,199	3	2	17	5
Winnebago	10,518	3	1	0	5
Clinton	46,518	2	2	15	11
Washington	22,141	1	3	11	8
Poweshiek	18,699	0	4	8	7
Muscatine	42,929	0	4	7	6
Cherokee	11,321	2	1	3	2
Buena Vista	19,874	1	2	8	3
Carroll	20,154	1	2	5	4
Cass	12,930	1	2	4	5
Henry	20,067	1	2	4	4
Sioux	34,909	0	3	17	15
Jefferson	18,381	0	3	17	7
Jasper	37,147	0	3	7	12
Mahaska	22,000	1	1	12	6
Lee	34,055	1	1	6	10

273. *See supra* note 272.

Union	12,359	1	1	4	2
Page	15,249	1	1	2	12
Plymouth	25,095	0	2	10	9
Madison	16,249	0	2	7	6
Shelby	11,578	0	2	1	1
Keokuk	10,225	1	0	7	2
Jackson	19,432	1	0	4	7
Clayton	17,556	1	0	1	3
Jones	20,744	0	1	8	3
Mills	15,063	0	1	7	7
Boone	26,346	0	1	5	9
Guthrie	10,720	0	1	5	5
Butler	14,539	0	1	5	4
Delaware	17,069	0	1	5	2
Kossuth	14,908	0	1	5	0
Wright	12,690	0	1	4	3
Cedar	18,627	0	1	4	2
Hamilton	14,952	0	1	4	2
Dickinson	17,153	0	1	3	5
Appanoose	12,437	0	1	3	3
Floyd	15,761	0	1	3	1
Louisa	11,169	0	1	2	2
Monroe	7,790	0	1	2	2
Franklin	10,124	0	1	2	1
Monona	8,679	0	1	2	1
Emmet	9,253	0	1	1	2
Chickasaw	11,964	0	1	0	2
Benton	25,642	0	0	13	3
Sac	9,719	0	0	7	2
Iowa	16,141	0	0	6	5
Calhoun	9,699	0	0	5	5
Grundy	12,304	0	0	5	2
Davis	9,017	0	0	5	1
Decatur	7,890	0	0	5	1
O'Brien	13,840	0	0	4	6
Humboldt	9,547	0	0	4	4
Tama	16,904	0	0	4	2
Fayette	19,660	0	0	4	1
Mitchell	10,569	0	0	4	1
Harrison	14,134	0	0	3	7
Crawford	17,158	0	0	3	1
Clarke	9,423	0	0	3	1
Hardin	16,868	0	0	2	6

Fremont	6,993	0	0	2	4
Allamakee	13,832	0	0	2	2
Palo Alto	8,929	0	0	2	2
Hancock	10,712	0	0	2	1
Adair	7,063	0	0	2	1
Lyon	11,811	0	0	2	0
Montgomery	10,003	0	0	2	0
Howard	9,187	0	0	1	2
Worth	7,453	0	0	1	1
Taylor	6,191	0	0	1	1
Adams	3,645	0	0	1	1
Greene	8,981	0	0	0	4
Ida	6,841	0	0	0	3
Osceola	6,040	0	0	0	3
Audubon	5,506	0	0	0	2
Ringgold	4,968	0	0	0	2
Van Buren	7,020	0	0	0	1
Pocahontas	6,740	0	0	0	1
Wayne	6,401	0	0	0	1
Lucas	8,645	0	0	0	0

APPENDIX III: IOWA'S 14 MHDS REGIONS (ARRANGED BY POPULATION)[274]

Name of Region	*No. Cos.*	*Pop.*	*Psychiatrist*	*Psychologist*	*LCSW*	*MHC*
MHDS of East Central	9	599,765	159	198	438	253
Polk County Health Services	1	487,204	54	110	413	254
County Social Services	22	455,458	13	38	184	131
Central Iowa Community Services	11	338,508	8	62	122	106
Eastern Iowa MHDS	5	300,789	13	30	140	91
Rolling Hills Community Services	8	197,305	11	16	104	59
Southwest Iowa MHDS	9	188,162	7	8	55	84
Southeast Iowa Link	8	162,196	8	13	62	48
Heart of Iowa Community Services	3	106,406	2	20	70	52
South Central Behavioral Health	4	78,659	5	4	33	15
County Rural Offices of Social Services	7	78,524	2	12	32	15
Sioux Rivers MHDS	3	71,815	0	5	29	24
Northwest Iowa Care Connection	5	62,096	4	3	15	23
Southern Hills Regional Mental Health	4	29,258	1	1	8	5

274. Breakdown of Iowa counties by MHDS Region taken from IOWA DEP'T HUM. SERVS., *supra* note 144, at 1; *see supra* note 272.