#426

Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

A Review of the Public Employees' Retirement System's Disability Determination Process

The Public Employees' Retirement System (PERS) serves over 150,000 state and local government employees in Mississippi. PERS provides regular service benefits and disability benefits to qualified applicants. State law provides three mechanisms by which PERS may make initial disability determinations: through a medical board, through the Social Security Administration (SSA), or through contracting with another governmental or non-governmental entity to make determinations. The PERS Board currently requires that a medical board appointed by the PERS Board make all PERS disability determinations.

PEER compared PERS's and SSA's disability determination processes to determine whether it would be advisable for the state to rely on the SSA's process as the sole and final determinant of disability for PERS members or whether PERS should continue to make its own disability determinations.

Because both PERS's and SSA's processes have weaknesses, neither option emerges as clearly superior. However, by leaving the determination process at PERS, the Legislature could mandate and oversee implementation of improvements to the process, which it could not do with SSA. Also, moving the process to SSA would require adopting SSA's definition of disability, a tougher standard than the current definition of disability contained in state law. PEER outlines the steps that should be taken under each option to increase the objectivity, fairness, and consistency of the disability determination process.

November 13, 2001

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The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

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On November 13, 2001, the PEER Committee authorized release of the report entitled **A Review of the Public Employees' Retirement System's Disability Determination Process.**

Representative Herb Frierson, Chairman

This report does not recommend increased funding or additional staff.

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A Review of the Public Employees' Retirement System's Disability Determination Process

Executive Summary

Introduction

In response to a legislative request prompted by citizens' complaints of disability claims being unfairly denied, the PEER Committee conducted this review of the Public Employees' Retirement System's (PERS's) disability determination process. The purpose of the review was to determine:

- the legal authority and rationale for PERS's disability determinations;
- costs associated with PERS's disability determination process;
- how PERS's disability determination criteria and process compare to that used by the federal Social Security Administration (SSA) in making its disability determinations; and,
- whether it would be advisable for the state to rely on the Social Security Administration's determination of disability as the sole and final determinant of disability for members of PERS (as permitted under MISS. CODE ANN. Section 25-11-113 [1] [a] [1972]) in lieu of PERS making its own disability determinations.

Background

Determination of Disability Benefits under Mississippi's Public Employees' Retirement System

The Mississippi Public Employees' Retirement System is the retirement system for nearly all non-federal public employees in the state. Regular service retirement benefits are available to members with at least four years of membership service.

There is no length of service requirement for PERS members applying for duty-related disability. PERS members applying for a non-duty-related disability must have four years of credit in the state retirement system. For non-duty-related disability,

applicants (that were approved for benefits) are under the age-limited plan or the tiered plan. The plans differ in that mainly the age-limited plan applicants must be fifty-nine or younger to apply, and with the tiered plan there is no age limit.

Also, inactive applicants (i.e., those individuals who are no longer employed by the state) are eligible for disability benefits provided they have four years of credit in the system and can prove that the disability occurred within six months of termination of active service. The applicant must also have medical evidence to prove that the disability was the reason for withdrawal from state service.

State law provides three mechanisms for PERS in making initial disability determinations: determination by a medical board, determination by the Social Security Administration, or contracting with another governmental agency or non-governmental disability determination service to make disability determinations. The PERS Board currently requires all of its disability determinations to be made by a medical board composed of three physicians whose terms are not limited by state law or board policy.

Prior to 1995, PERS frequently accepted SSA certifications of disability in awarding disability benefits under PERS. According to PERS's Executive Director, PERS no longer accepts SSA certifications because PERS is not confident that SSA uses sufficient expertise of medical professionals in making its disability determinations. The PERS Executive Director also disagreed with SSA's inclusion of non-medically documented information in the decision making process (e.g., an applicant's description of pain).

For the period 1990 through 1994, when PERS accepted SSA certifications of disability as automatic proof for disability at PERS, the costs averaged $38,266 per year. From 1995 through 2000, after PERS decided to no longer accept SSA certifications as automatic proof for the allowance of PERS disability, PERS spent an average of $269,904 per year on disability determinations.

According to PERS, the cost to administer the disability program has increased because of increases in full-time staffing, the change in the number of physicians that review the disability cases, and the number of appeals that have been filed.

Determination of Disability Benefits under the Social Security Administration

The federal government provides benefits to disabled workers through the Social Security Administration. To become eligible for SSA disability benefits, the applicant must have worked a certain amount of time in a recent time frame and earned a specified minimum level of covered earnings.

Responsibility for SSA disability determinations is divided between the Social Security Administration, and under contract, the Office of Disability Determination Services (DDS) of Mississippi's Department of Rehabilitation Services.

The national average cost of processing an SSA disability case in FY 2000 was $383. According to the Social Security Advisory Board, Mississippi's DDS has the lowest reported cost in the nation for processing a case ($244 per case).

Comparison of PERS's and SSA's Disability Determination Criteria and Processes

The Exhibit, page x of this summary, compares basic elements of PERS's and SSA's disability determination criteria and processes. Overall, SSA's process for making disability determinations is the more objective of the two processes because it is based on detailed written criteria, procedures, and policy interpretations governing case disposition, whereas PERS's process has no written criteria, policies, or procedures governing how its physicians make disability determination decisions.

PERS and SSA differ in terms of how "inability to work" and permanence of the disability are defined. PERS has a less stringent "inability to work" requirement than SSA (i.e., inability to perform a similar job at similar pay under PERS versus inability to perform any job paying at least $740 per month under SSA), but has a more stringent requirement regarding the permanence of the condition (i.e., permanent under PERS, versus ongoing for at least twelve months under SSA).

With respect to evidence, PERS and SSA use similar medical evidence in reaching their determinations, but differ in that SSA allows the admission of non-medical evidence--e.g., an applicant's statement of pain that is not substantiated by objective medical evidence. The SSA adjudicator then makes a finding on the credibility of the applicant's statements based on a consideration of the entire case record.

With regard to qualifications of adjudicators, PERS uses physicians to make its initial determinations and uses physicians to review all of its appeals. In contrast, under the SSA system, trained non-medical disability examiners initially review each applicant's file using detailed criteria. In complex cases, physicians assist in the initial review and in all cases, a physician reviews the work of the disability examiner before the initial determination decision is finalized.

Exhibit: Comparison of Determination Processes of PERS and SSA

	PERS	SSA
Definition of disability	condition must be permanent	condition must be expected to last at least one year or result in death
Inability to work	at the job retiring from or a similar job with similar pay	at any job earning at least $740 per month
Length of service to qualify	4 years for non-duty-related disability (tiered and age-limited plans)	determined by work credits
	no service length requirement for duty-related disability	determined by work credits
Age to qualify	59 years or less for non-duty-related disability under age-limited plan but no age requirement under tiered plan	determined by work credits
	no age requirement for duty-related disability	determined by work credits
Qualifications of case reviewers	licensed medical doctors	disability examiners and licensed medical doctors
Type of evidence used in determination process	medical evidence	medical evidence and consideration of claimant's symptoms
Written criteria for determination process	none	SSA's Listing of Impairments and SSA's policy interpretations
Frequency of re-exams	annually for the first 5 years then once every 3 years	once a year if improvement expected and if unsure about improvement every 3 years and if no improvement expected every 7 years
Appellate levels	2 levels of appeal	4 levels of appeal
Average cost to make a determination (in FY 2000)	$586	$244 (in Mississippi)

SOURCE: PEER

Both PERS's and SSA's processes consist of the initial determination, re-examination, and appeals phases. However, in the second phase, frequency of re-exams differs between PERS and SSA. PERS requires disability recipients under the age of sixty to be re-examined each year during the first five years and once every three years thereafter. SSA requires disability recipients to be re-examined at least once every three years, unless the disabling condition is permanent. In the appeals phase, PERS provides one level of review before the appeals route to the court system, while SSA provides three levels of internal review of the decision.

Conclusions Regarding Whether PERS Should Rely on Social Security Administration Determinations to Establish Eligibility for Disability Benefits

In considering whether to rely on SSA determinations to establish eligibility for disability under PERS, the Legislature should consider several important issues, summarized below in question and answer format.

- Would all PERS members applying for disability benefits under PERS qualify to apply for disability benefits under SSA?

  No.

- Do all PERS members applying for disability benefits also apply for disability benefits under SSA?

  No.

- For those cases that have been considered by both PERS and SSA over the past eleven years, have the outcomes been similar?

  No.

- How much would PERS save if SSA handled the disability determination function?

  PERS would recognize minimal savings.

- Would determinations under SSA be more fair and uniform than under PERS?

  Some subjectivity is inherent in the process of making disability determinations. The SSA's Advisory Board, in a recent report on its own disability program, stated that "the perception is that determinations of eligibility are not being made in a uniform and consistent manner." However, the SSA

system does have written criteria and formal rules and regulations.

- What changes would have to be made in state law in order to require PERS to accept SSA determinations?

  The Legislature would have to amend state law to abolish adjudicatory and reexamining functions within PERS's disability program and delete references to interaction between the PERS Board, the Disability Appeals Committee, and the medical board. The Legislature would have to adopt the SSA's definition of "disability" and require that PERS disability applicants first apply with the SSA and that SSA's rules, policies, and procedures govern determinations for PERS.

- What would be the advantages of PERS's reliance on SSA disability determinations?

  The advantages would be that PERS applicants would be adjudicated by written criteria, applicants would have access to more appeal stages, and that the duplication of having both state and federal determination processes would be eliminated.

- What would be the disadvantages of PERS's reliance on SSA disability determinations?

  The primary disadvantage would be that the disability determination process could take longer than it presently does.

Options and Recommendations

Because both PERS's and SSA's disability determination processes have weaknesses, neither option (leaving the determination process at PERS or moving it to SSA) emerges as clearly superior in terms of yielding consistent, objective, and fair disability determinations. However, one could make an argument to leave the determination process at PERS because the Legislature can mandate and oversee implementation of improvements to PERS's process, while it cannot mandate and oversee changes to SSA's process. Further, moving the process to SSA would require adoption in state law of SSA's definition of disability, which is on paper a tougher standard to meet than the current definition of disability contained in state law.

The following options outline steps that should be taken under either option. Under Option 1, keeping the determination process at PERS, PEER has listed recommended steps that PERS should

take to increase the objectivity, fairness, and consistency of its disability determination process.

Under Option 2, moving the process to SSA, PEER recommends changes that the Legislature would have to make in state law to accomplish the move. Under this option, while PERS would discontinue its function of making disability determinations, it would continue to ensure that the applicant qualified to apply for disability benefits under state law and calculate and pay out the benefits due to the PERS member following a certification of disability by SSA.

Option 1: Keep the Disability Determination Process at PERS

If the Legislature chooses to keep the disability determination process at PERS, the agency should take the following actions.

1. PERS should develop written criteria for what constitutes a disabling condition, similar in detail to SSA's Listing of Impairments.

2. PERS should issue formal, written policy interpretations in response to questions/issues arising from implementation of the written criteria developed in response to Recommendation 1.

3. For each case that it considers, PERS should require its medical board to explain in writing the reason for its determination, in sufficient detail that an outside reviewer could understand the rationale for the decision.

4. PERS should develop a checklist of required medical tests for the types of disabling conditions contained in the listing discussed in Recommendation 1. PERS should require that results from the tests be placed in the applicant's file prior to the PERS medical board's consideration of the case.

5. PERS should provide ongoing training to its physicians on implementing specific policies and procedures for the disability determination process.

6. PERS should cease its practice of disclosing the estimated amount of an applicant's disability benefits to those who are making the disability determinations, as this information is irrelevant to a determination of disability and by its presence in the file could influence the outcome of the determination.

Option 2: Require PERS to Rely Totally on SSA's Disability Determinations

If the Legislature chooses to rely on the SSA's disability determinations, the Legislature should make the following changes in state law to reflect such.

7. The Legislature should amend MISSISSIPPI CODE ANNOTATED Sections 25-11-113, 25-11-119, and 25-11-120 to:

    - require that SSA disability determinations be accepted as the only form of proof of disability at PERS;
    - delete PERS's definition of disability and substitute SSA's definition of disability;
    - reflect that all policies, procedures, rules, and regulations of SSA will govern PERS's disability determinations;
    - require that all PERS disability applicants first apply for disability benefits at the SSA;
    - delete the adjudicatory functions of PERS (e.g., abolish the medical board and the Disability Appeals Committee, PERS Board of Trustees' powers relating to disability determinations);
    - have all reexaminations made by SSA rather than by PERS; and,
    - require that all administrative functions (e.g., determining PERS eligibility) relating to PERS's disability benefits program remain a responsibility of PERS.

8. In cases where applicants do not have Social Security coverage, PERS should contract with Disability Determination Services (DDS) to secure its services to perform disability determinations for PERS using DDS's criteria. Furthermore, the Legislature should enact legislation that provides that when any individual who is not a participant in Social Security coverage and seeks disability benefits from PERS through any procedure established by law and rule, that applicant should have a right to appeal any adverse administrative decision made by the SSA to the First Judicial District of Hinds County Circuit Court.

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A Review of the Public Employees' Retirement System's Disability Determination Process

Introduction

Authority

The PEER Committee authorized a review of the Public Employees' Retirement System's (PERS's) disability determination process. PEER conducted the review pursuant to the authority granted by MISS. CODE ANN. Section 5-3-57 et seq. (1972).

Scope and Purpose

In response to a legislative request prompted by citizens' complaints of disability claims being unfairly denied, the PEER Committee conducted this review of PERS's disability determination process. The purpose of the review was to determine:

- the legal authority and rationale for PERS's disability determinations;
- costs associated with PERS's disability determination process;
- how PERS's disability determination criteria and process compare to that used by the federal Social Security Administration (SSA) in making its disability determinations; and,
- whether it would be advisable for the state to rely on the Social Security Administration's determination of disability as the sole and final determinant of disability for members of PERS (as permitted under MISS. CODE

ANN. Section 25-11-113 [1] [a] [1972]) in lieu of PERS making its own disability determinations.

Method

In conducting this review, PEER:

- reviewed state law and regulations governing disability determinations of PERS;
- reviewed federal law and regulations governing determinations for disability benefits from the Social Security Administration (SSA);
- reviewed disability determination case files, personnel costs, and administrative costs of PERS;
- conducted a case study of 164 PERS disability applications randomly selected from approximately four thousand disability applications received by PERS from 1990 through 2000 to compare the actual dispositions of these cases under PERS to the actual dispositions under the Social Security Administration;
- interviewed staff of the federal Social Security Administration and the state Disability Determination Services (DDS) unit of Mississippi's Department of Rehabilitation Services, the state agency under contract with SSA to perform its disability determinations; and,
- interviewed staff of PERS's disability unit and physicians on contract who make disability determinations for PERS.

Background

Determination of Disability Benefits under Mississippi's Public Employees' Retirement System

Legal Authority for Disability Determination under PERS

PERS serves employees of the state, public school districts, municipalities, counties, community colleges, state universities, and such other public entities as libraries and water districts.

During the 1952 Regular Session, the Mississippi Legislature passed Senate Bill 273, which established Mississippi's Public Employees' Retirement System, hereinafter referred to as PERS. PERS is the retirement system for nearly all non-federal public employees in the state. With 156,894 active members as of June 2001, PERS serves employees of the state, public school districts, municipalities, counties, community colleges, state universities, and such other public entities as libraries and water districts. Membership in PERS is a benefit accorded to covered full-time public employees of member agencies and is financed by contributions made by the employees and their employers and the earnings on these contributions. Regular service retirement benefits are available to members with at least four years of membership service.

Section 16 of Senate Bill 273 (1952) established disability benefits for all members of the Public Employees' Retirement System (MISS. CODE ANN. Section 25-11-113). There is no length of service requirement for PERS members applying for duty-related disability.

In addition to duty-related disability, members may also apply for non-duty-related disability. All employees who became members of PERS after July 1, 1992, receive non-duty-related disability benefits under a tiered plan. The tiered plan has no age requirements and allows recipients to choose from several disability benefit payment options.

Prior to July 1, 1992, all PERS members applied for non-duty-related disability under an age-limited disability plan, which required members to be fifty-nine years of age or younger and provided only one method of paying disability benefits. MISS. CODE ANN. Section 25-11-113 allowed employees who were members of the PERS system

when the plan change went into effect (i.e., members prior to July 1, 1992) to make a one-time choice between the age-limited plan and the tiered plan. As a result, some PERS members continue to apply for and receive disability benefits under the age-limited disability plan instead of the tiered disability plan.

Also, inactive applicants (i.e., those individuals who are no longer employed by the state) are eligible for disability benefits provided they have four years of credit in the system and can prove that the disability occurred within six months of termination of active service. The applicant must also have medical evidence to prove that the disability was the reason for withdrawal from state service.

Under PERS's regulations, a PERS member cannot apply for disability benefits and regular service retirement benefits at the same time. However, if an individual who could qualify for regular retirement benefits applies for disability benefits and is denied, that applicant may then apply for regular service retirement.

If an applicant receives disability benefits instead of regular service retirement, the disability retirement amount is generally higher than regular benefits because the disability retirement formula allows for a greater service credit factor.

If an applicant receives disability benefits instead of regular service retirement, the disability retirement amount is generally higher than regular benefits. This is because the disability retirement formula allows for a greater service credit factor, which yields more compensation. This does not occur in the formula for regular service retirement. (See Appendix A, page 45, for examples of differences in regular service retirement allowances versus disability retirement allowances.)

According to unaudited figures provided by PERS, as of June 2001, of the 53,229 total PERS retirees, 3,654 (6.8%) were receiving disability benefits.

Determination of Eligibility to Receive Disability Benefits

State law provides three mechanisms for PERS in making initial disability determinations:

- determination by a medical board;
- determination by the Social Security Administration; or,
- contracting with another governmental agency or non-governmental disability determination service to make disability determinations.

The PERS Board of Trustees currently requires all of its disability determinations to be made by a medical board.

Since 1995, the PERS Board of Trustees has required that a medical board make all of its disability determinations.

Prior to 1995, PERS utilized the second mechanism noted above for making disability determinations, available under MISS. CODE ANN. Section 25-11-113 (1972), and accepted most of SSA's disability determinations in cases in which the applicant had applied for disability benefits with the SSA. Specifically, CODE Section 25-11-113 (1) (a) states, in pertinent part, "the board of trustees may accept a disability medical determination from the Social Security Administration in lieu of a certification from the medical board."

According to PERS's Executive Director, PERS no longer relies on the SSA's determinations because PERS is not confident that SSA uses sufficient expertise of medical professionals in making its disability determinations (see page 18 for a discussion of qualifications of individuals responsible for making SSA disability determinations). The Executive Director also disagreed with SSA's inclusion of non-medical information that is not clearly documented by test results (e.g., applicant's description of pain) in the decisionmaking process.

PERS's Executive Director stated that in 1993 the PERS Board of Trustees attempted to exercise the third mechanism for making disability determinations by trying to negotiate a contract with the State Department of Rehabilitation Services' Disability Determination Service to make disability determinations for PERS *using PERS criteria* as required by law. It is important to note that this attempt was different from the option of PERS's accepting SSA certifications of disability because the proposed contract involved additional work on the part of DDS. DDS declined entering into the contract, reportedly because it did not have the staff to handle the additional workload involved.

Organizational Responsibility for Disability Determination Benefits under PERS

Responsibility for processing and disposition of disability benefit applications is divided between full-time PERS staff and contract physicians.

On average, PERS receives 400 new applications for disability benefits each year. Responsibility for the processing and disposition of PERS's disability benefit applications is divided between full-time PERS staff and physicians who serve the board under contract.

The number of full-time staff assigned to the PERS disability unit has increased from 0.25 full-time

equivalents (FTEs) in 1990 to 4.14 FTEs as of June 2001. The primary functions of this staff are to:

- verify the applicant's eligibility to apply for disability benefits (e.g., verify years of service);
- compile the application information that the contractual physicians will use to make their disability determinations (e.g., completed application form, copies of physicians' notes, and medical test results); and,
- estimate the benefits that the applicant would receive if he or she were approved to receive disability benefits.

As noted on page 4, the PERS Board currently requires all of its determinations to be made by a medical board. CODE Section 25-11-119 (7) describes the composition of this board as follows: "The [PERS] board may designate a medical board to be composed of three (3) physicians." Neither state law nor PERS's board policy sets limits on the number of years that a physician may serve on the medical board.

The three physicians currently serving on the medical board practice in the following areas of medicine: physical medicine and rehabilitation, psychiatry, and internal medicine and gerontology.

Cost of PERS's Disability Determination Process

PEER reviewed the unaudited costs of PERS's disability determination process during the decade of the 1990s. Because PERS frequently accepted SSA disability certifications between 1986 and approximately 1994, the following cost discussion is broken into two sections: costs during the period when PERS accepted SSA certifications of disability in most cases and costs during the period when PERS no longer accepted SSA certifications.

The specific time frames that will be examined are from 1990 through 1994 and 1995 through 2000. These periods were chosen because from 1990 through 1994, PERS typically accepted disability certifications from the SSA. Yet, this practice ended in 1995.

Beginning in 1995, PERS began making all of its determinations and not relying on the SSA's determinations as automatic proof of disability for PERS disability benefits. Due to this major change in PERS's disability program's policy, PERS's expenses related to

disability determinations are examined separately (e.g., 1990-1994 and 1995-2000) below.

Cost of Disability Determination Process when PERS Accepted SSA Determinations (1990-1994)

The average annual cost of making disability determinations from 1990-1994 was $38,266.

From 1990 through 1994, when PERS frequently accepted SSA certifications of disability as automatic proof for disability at PERS, the costs for this period totaled $191,334. These costs include salary and fringes, contractual services, commodities, and capital outlay. The average annual cost for this period was $38,266.

At the beginning of the period, in FY 1990, the total amount expended on PERS's disability program was $18,228, with the PERS medical board deciding 289 cases. By FY 1994, the total amount expended on PERS's disability program had increased to $73,920, with the medical board deciding eight fewer cases than in FY 1990.

Cost of Disability Determination Process when PERS No Longer Accepted SSA Determinations (1995-2000)

The average annual cost of making disability determinations from 1995-2000 was $269,904.

From 1995 through 2000, after PERS decided to no longer accept SSA certifications as automatic proof for the allowance of PERS disability, PERS spent a total of $1,619,427. These costs include salary and fringes, contractual services, commodities, and capital outlay. The average annual cost during this period was $269,904.

More specifically, in FY 1995 the total amount expended for disability determinations in PERS was $164,257, with the medical board making 548 decisions. In FY 2000, PERS spent $365,593 on its disability program, with the medical board making 624 initial determinations.

Exhibit 1, page 8, illustrates the increasing costs of PERS to administer the disability program from fiscal years 1990 through 2000. Generally, the increasing costs can be attributed to the addition of more physicians in the determination process over the years and the increase in the number of appeals filed by applicants.

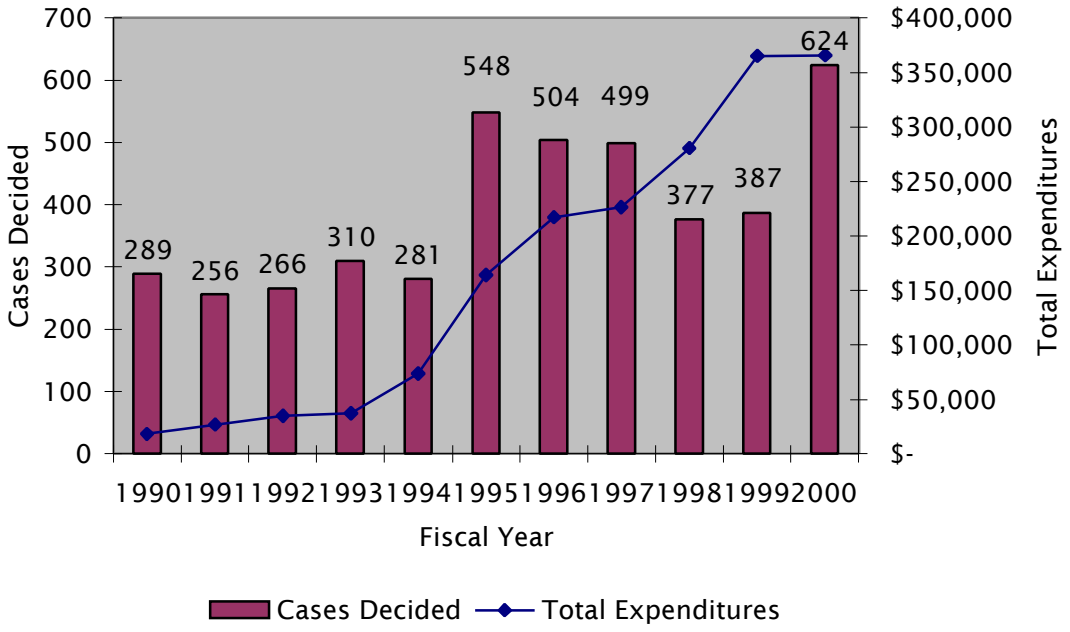
Reasons for Increases in Costs for Disability Determination

According to PERS, the cost to administer the disability program has increased for at least three reasons:

- an increase in full-time personnel;
- an increase in the number of physicians involved in the process; and,
- an increase in the number of appeals filed.

One reason for the increase is the cost of full-time personnel. In FY 1990, no full-time positions at PERS were dedicated to the disability unit; only 25% of one employee's time was needed to administer the program. However, in FY 2000, four-full time positions were dedicated to the disability unit.

Exhibit 1 : Cases Decided and Total Expenditures for FY 1990 through 2000



SOURCE: PERS

According to PERS, disability determination costs have increased because of increases in full-time personnel, the number of physicians involved in the process, and the number of appeals filed.

Another reason that the cost for PERS's disability unit has increased is the change in the number of physicians that review the disability cases. During the mid-1990s, three physicians (medical board members) were involved in the disability determination process and one physician (who was also from the medical board) was involved in the appeal process.

However, in 2000 and currently, five physicians are involved in the disability determination process if an applicant appeals a denial; if there is no appeal, three physicians are involved in the process. The five physicians in the determination process are three medical board members and two Disability Appeals Committee (DAC) members. (See page 30 for the role of DAC in the disability determination process.)

The current compensation rates for the medical board and the DAC are as follows:

- Medical board members are paid $750 per month plus the costs of any medical evaluations that they may conduct. In FY 2001, one medical board member received a total of $700 for conducting psychiatric medical evaluations for applicants.

- DAC members are paid $250 for each appealed case that they review.

A final reason that costs have increased, according to PERS, is the number of appeals that have been filed in the court system. For example, in FY 1990 no appeals were filed. However, in FY 2000, 94 appeals (which include circuit and Supreme Court case remands to PERS) were filed. Due to the growth in the number of appeals that have been filed, the legal costs have increased, which has contributed to the rise in costs to administer PERS's disability program.

Breakdown of Recent Costs of Disability Determination

In FY 2001, PERS spent a total of $419,845 on disability determinations.

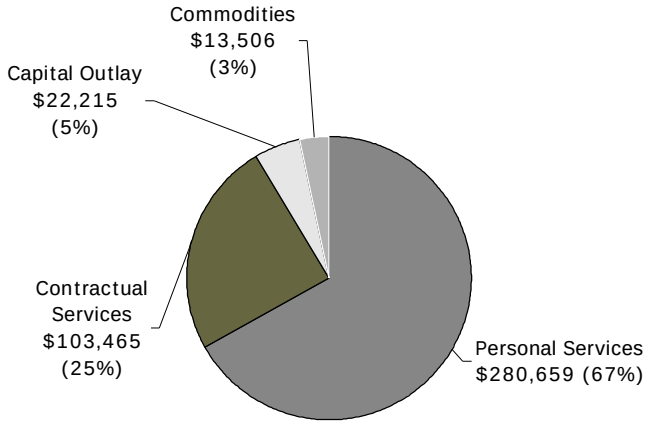
The most current information for costs associated with PERS's disability program is presented in Exhibit 2, page 10, which details PERS's major objects of expenditures in FY 2001. In FY 2001, PERS spent a total of $419,845 on its disability program.

The greatest portion of PERS's major objects of expenditure is salaries, wages, and fringe benefits. Specifically, in FY 2001, PERS spent $280,659 on salaries related to administering the disability program.

The next most costly area under major expenditures for PERS came from contractual services. PERS contracted for medical and legal services for a total of $103,465. Specifically, these contractual services were for compensation of the medical board, DAC, and costs for medical evaluations that were needed for applicants (see discussion of compensation rates above). The legal services that were contracted were for the attorney from the Attorney General's Office who sits on the DAC and the staff attorney who represents the agency. (See page 30 for the role of DAC in the disability determination process.)

The least costly major expenditures are for capital outlay and commodities. For FY 2001 PERS spent $22,215 for capital outlay followed by $13,506 for commodities.

Exhibit 2 : Major Expenditures in FY 2001 for Administering the PERS Disability Program



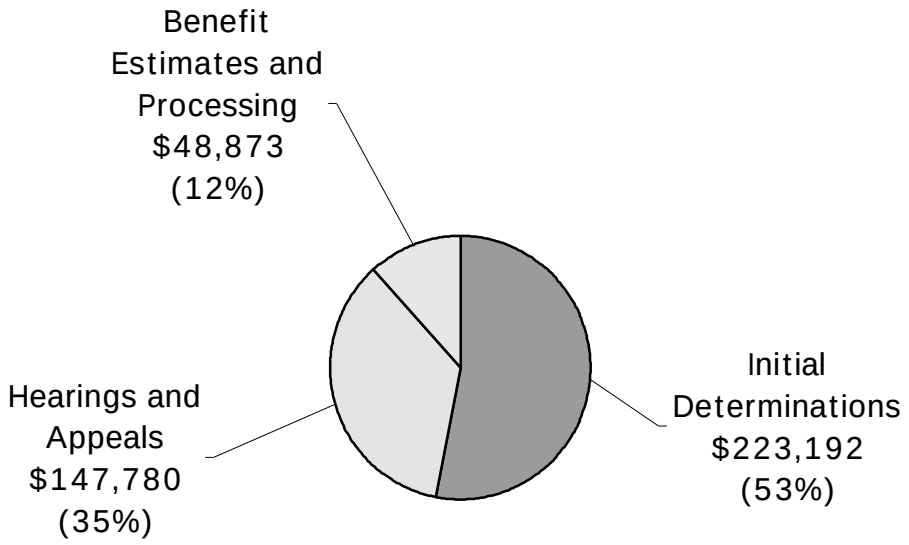
TOTAL FY 2001 Expenditures $419,845

SOURCE: PERS

Within the major objects of expenditures, PERS has three areas of activity of its disability program: initial

determinations, hearings and appeals, and benefit estimates and processing. The total cost in FY 2001 associated with initial determinations was $223,192, followed by hearings and appeals at $147,780, and benefit estimates and processing at $48,873. Exhibit 3, below, illustrates the percentages of the total spending by activity.

Exhibit 3: Expenditures by Activity for PERS's Disability Program for FY 2001



TOTAL FY 2001 Expenditures $419,845

SOURCE: PERS

Determination of Disability Benefits under the Social Security Administration

Legal Authority for Disability Determination under the Social Security Administration

Under 42 USC § 421, the federal government provides benefits to disabled workers through the Social Security Administration (SSA). The SSA provides disability benefits through its Social Security disability insurance program. According to the Social Security Advisory Board, more than 135 million employees across the nation are insured through the SSA's disability insurance program. Of this number, approximately 6.6 million individuals (4.8%) are receiving disability benefits.

To become eligible for SSA disability benefits, the applicant must have worked a certain amount of time in a recent time frame and earned a specified minimum level of covered past earnings. The required level of earnings varies by the age when the applicant became disabled, ranging roughly from an accumulated total of $16,000 for an individual who becomes disabled between the ages of 30 and 42 to an accumulated total of $32,000 for an individual who becomes disabled at the age of 62 or older.

Organizational Responsibility for SSA Disability Determinations

Responsibility for SSA disability determinations is divided between the Social Security Administration and Mississippi's Department of Rehabilitation Services' Office of Disability Determination Services.

Responsibility for SSA disability determinations is divided between the Social Security Administration, and under contract, Mississippi's Department of Rehabilitation Services' Office of Disability Determination Services (DDS). The Social Security Administration is responsible for calculating an individual's eligibility to apply for disability benefits, based upon his or her past earnings as noted above. The Social Security Administration contracts with state agencies such as the Department of Rehabilitation Services to perform its disability determinations based on federal criteria, policies, and procedures.

DDS is not under the administrative control of the SSA and is therefore responsible for hiring its own personnel for disability determinations. In FY 2000, Mississippi's DDS had approximately 148 disability examiners on its staff who processed 79,768 cases (including initial

determinations and continuing disability reviews). In FY 1999, the DDS staff processed 74,768 cases.

Cost for SSA Determinations

According to the Social Security Advisory Board, Mississippi's Office of Disability Determination Services has the lowest reported cost in the nation for processing a case ($244 per case).

SSA's disability insurance program is funded through payroll taxes. The national average cost of processing a disability case in FY 2000 was $383. According to the Social Security Advisory Board, Mississippi's DDS has the lowest reported cost for processing a case at $244 per case. The advisory board calculated this cost by taking the total funding that Mississippi's DDS had obligated and dividing it by the total number of cases processed.

Comparison of PERS's and SSA's Disability Determination Criteria and Processes

The Social Security Administration's process for making disability determinations is the more objective of the two processes because it is based on detailed written criteria, procedures, and policy interpretations governing case disposition. PERS's process has no written criteria, policies, or procedures governing how its physicians make disability determination decisions.

Exhibit 4, page 15, compares basic elements of PERS's and SSA's disability determination criteria and processes.

From a definitional standpoint, PERS and SSA differ in terms of how "inability to work" and permanence of the disability are defined.

With respect to evidence, PERS and SSA use similar medical evidence in reaching their determinations, but differ in that SSA allows the admission of non-medical evidence--e.g., an applicant's statement of pain that is not substantiated by objective medical evidence. The adjudicator then makes a finding on the credibility of the applicant's statements based on a consideration of the entire case record.

With regard to qualifications of adjudicators, PERS uses medical doctors to make its initial determinations and uses medical doctors to review all of its appeals. In contrast, under the SSA system, trained non-medical disability examiners initially review each applicant's file using detailed criteria. In complex cases, physicians assist in the initial review and in all cases, a physician reviews the work of the disability examiner before the initial determination decision is finalized.

While both processes include re-exams and appellate stages, the frequency of the re-exams and the number of appellate stages differ, as shown in Exhibit 4, page 15.

A comparison of the PERS and SSA disability determination criteria and processes, presented in question and answer format, follows the exhibit.

Exhibit 4: Comparison of Determination Processes of PERS and SSA

	PERS	SSA
Definition of disability	condition must be permanent	condition must be expected to last at least one year or result in death
Inability to work	at the job retiring from or a similar job with similar pay	at any job
Length of service to qualify	4 years for non-duty-related disability (tiered and age-limited plans)	determined by work credits
	no service length requirement for duty-related disability	determined by work credits
Age to qualify	59 years or less for non-duty-related disability under age-limited plan but no age requirement under tiered plan	determined by work credits
	no age requirement for duty-related disability	determined by work credits
Qualifications of case reviewers	licensed medical doctors	disability examiners and licensed medical doctors
Type of evidence used in determination process	medical evidence	medical evidence and consideration of claimant's symptoms
Written criteria for determination process	N one	SSA's Listing of Impairments and SSA's policy interpretations
Frequency of re-exams	annually for the first 5 years then once every 3 years	once a year if improvement expected and if unsure about improvement every 3 years and if no improvement expected every 7 years
Appellate levels	2 levels of appeal	4 levels of appeal
Average cost to make a determination (in FY 2000)	$586	$244 (in Mississippi)

SOURCE: PEER

Comparison of PERS's and SSA's Definitions of Disability

PERS has a less stringent "inability to work" requirement than SSA (i.e., inability to perform a similar job at similar pay under PERS versus inability to perform any job paying at least $740 per month under SSA), but has a more stringent requirement regarding the permanence of the condition (i.e., permanent under PERS, versus ongoing for at least twelve months under SSA).

How does state law define disability under PERS?

State law defines disability as a permanent condition that prevents the individual from performing his or her job, or a similar job with a comparable pay rate that is offered by the state.

MISS. CODE ANN. Section 25-11-113 (1) (a) (1972) defines "disability" as follows:

> *. . .the inability to perform the usual duties of employment or the incapacity to perform such lesser duties, if any, as the employer, in its discretion, may assign without material reduction in compensation, or the incapacity to perform the duties of any employment covered by the Public Employees' Retirement System that is actually offered and is within the same general territorial work area, without material reduction in compensation.*

Further:

> *. . .the medical board, after a medical examination, shall certify that the member is mentally or physically incapacitated for the further performance of duty, that such incapacity is likely to be permanent, and that the member should be retired.*

Essentially, four elements must be met to fulfill the statutory definition of disability under PERS:

- the applicant must have a permanent disabling medical condition; and,
- the applicant does not have the ability to do the job at which he or she ceased working due to the medical condition; and,

- the applicant cannot perform a job that entails lesser duties with similar pay as prior to the disabling condition; and,

- the applicant cannot perform any job that is offered by the state in the applicant's general field without having a material decrease in pay.

How does federal law define disability under SSA?

Federal law defines disability as a condition expected to result in death or to last for a continuous period of not less than twelve months and that prevents the individual from holding any job paying $740 or more per month.

The SSA's definition of disability is found in 42 USC § 423 (d) (1) (2) and reads as follows:

> *(1) The term "disability" means-*
>
> *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 which has lasted or can be expected to last for a continuous period of not less than 12 months.*
>
> *(2) For purposes of paragraph (1) (A)-*
>
> *An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of such of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.*

The SSA's definition of disability consists of the following requirements:

- the medical condition must be expected to last for at least a year or result in death; and,

- the person must be unable to work in any occupation--not just the occupation in which

the applicant was employed before the alleged onset of the medical condition; and,

- the applicant must not be able to perform any substantial gainful employment (i.e., which is on average no more than $740 per month, according to the SSA).

Comparison of PERS's and SSA's Processes for Determining Disability

Both PERS's and SSA's processes for determining disability consist of three primary phases: initial determination, reexamination, and appeals. This section discusses the primary differences within each phase.

What are the differences in PERS's and SSA's processes at the initial determination phase?

SSA's criteria and processes are written and standardized and are applied by trained disability professionals and a trained medical professional, which comprise the adjudicative team. PERS's criteria and processes are not in written form; they are left to the judgment of the three physicians on the medical board.

One of the main differences between the two systems at the initial determination phase is that SSA's criteria and processes are standardized in the form of detailed criteria manuals (the Listing of Impairments) and written policy interpretations which trained disability examiners apply under the oversight of a physician, whereas PERS's criteria and processes are not in written form. Instead, PERS's decisions are left completely to the judgment of the three physicians who make the determination. SSA's detailed written standards provide for greater uniformity and fairness in disability determinations.

Also, PERS and SSA differ in the qualifications and training of those who make initial disability determinations. The initial determinations at PERS are made by the medical board, composed of physicians who are engaged in active practice. While SSA uses physicians in a consultative decisionmaking capacity, disability examiners (who must have a four-year degree from an accredited college or university) conduct the primary review of the case records for initial determination and refer all cases to medical professionals for review prior to the cases' final clearance.

With respect to the role that pain has in the disability determination process, PERS takes the position that if pain

is not medically documented (i.e., in medical test results), it is not given much weight. However, the SSA considers the applicant's complaint of pain by balancing what the applicant says about the pain, along with the applicant's personal physician's statements relating to the pain, and other evidence in the file.

Initial Determinations by PERS

Physicians on the PERS medical board review medical documents in an applicant's file to make an initial disability determination. However, these physicians have no formal, written policies, procedures, or criteria to use in making their evaluations and they have received no formal training relating to criteria that should be used in making disability determinations.

PERS has no formal, written policies and procedures governing initial determinations. When making the initial determinations, the medical board reviews the retirement benefit application forms packet. The PERS benefit analyst makes sure that the application packet contains the following documents for review:

- employer's certification of job requirements (The applicant's employer is required to provide detailed information of the applicant's job and what specific duties that job entails. Also, the employer must show whether alternative jobs have been offered to the applicant, if any jobs were available.);
- medical information form (includes applicant's medical history and treatments the applicant may have received);
- statement of examining physicians (applicant's personal physician);
- all medical office notes, medical reports, medical test results and or discharge summaries (PERS advises applicants to submit medical information that has been completed within the last three to five years. For physical impairments, the board may ask the applicant to provide the results of a Functional Capacity Examination [FCE]. This examination, which is conducted by a physical or occupational therapist, requires the applicant to complete physical maneuvers to determine if the applicant has the ability to perform physical duties related to his or her job.)

Also the applicant's file may contain the following additional documents, if applicable:

- Social Security award letter (for Social Security disability benefits), along with all supporting documentation; and,

- a copy of the worker's compensation report and/or hurt-on-the-job report completed by the employer.

Although PERS asks that the applicant provide medical reports and notes, it does not give the applicant specific guidance as to what tests or medical evidence should be present in order to assist those who are making disability determinations. If PERS created a checklist for specific medical evidence that is needed for disability determination, it would help the applicant know what is needed to prove disability, as well as formalize the basis upon which PERS adjudicators base their determinations.

PERS does not give applicants specific guidance as to what tests or medical evidence should be in their files in order to assist those who are making disability determinations.

Also, when reviewing the applicant's file, the medical board is aware of the amount of disability benefits the applicant would receive. This irrelevant information is provided to the medical board although it should have no bearing on whether the applicant is in fact disabled and therefore should receive disability benefits.

Based on its review of a case, the medical board may approve, deny, or defer the claim for disability. The medical board states that it makes its disability determinations by using its medical training and practice experience to evaluate the information contained in the applicant's file. According to PERS doctors, the objective medical evidence (e.g., medical test results) contained in the applicant's file is PERS's stated standard for making disability determinations. However, PERS provides no formal training to its physicians relating to criteria that should be used in making disability determinations.

PERS does not require that the medical board describe how it reaches its determinations.

There is no requirement that the medical board describe how it reached its determination. While there is a place in the file for such a record (on the medical board review summary sheet), PEER's review of a random sample of 164 files showed that the place in the record for explanation of the determination was left blank. A description of how the documentation contained in the file led to the disposition of the medical board is essential to ensuring the consistency and, hence, fairness of PERS's disability determinations.

In the event the applicant's claim is denied, the applicant is sent a Notice of Appeal of the decision. If the applicant decides to appeal, he or she has sixty days to file the appeal from the date the applicant received the medical board's denial.

PERS has no standard checklist of specific medical tests that must be performed to document specific conditions.

The medical board defers the decision if it decides that there is not enough evidence in the applicant's file to make a determination. However, PERS has no standard checklist of specific medical tests that must be performed to document specific conditions.

In the event the medical board defers an applicant's case, the PERS disability analyst who is the case manager (i.e., responsible for gathering documents) schedules an evaluation by a physician of the medical board's choosing. PERS pays for any evaluation that the medical board may order. Once the additional medical evidence is received, the board makes a decision to either deny or approve the claim for disability.

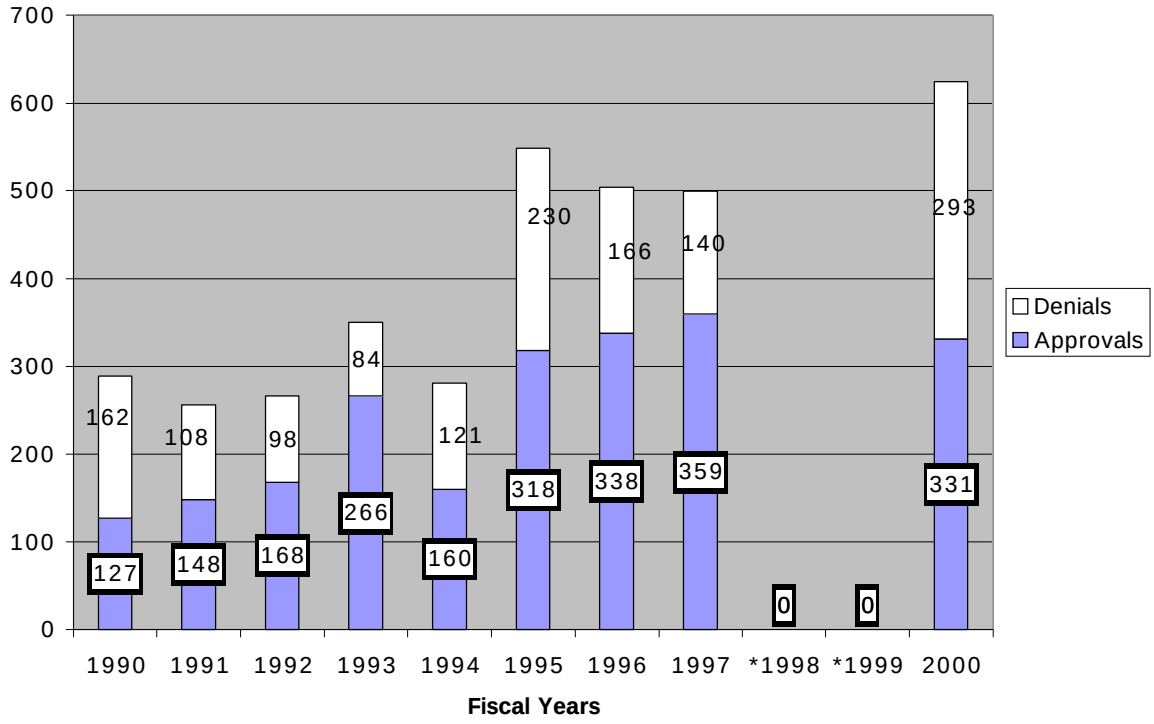
Exhibit 5, page 22, illustrates the outcomes of the medical board's initial determinations of disability claims from fiscal years 1990 through 2000. (Fiscal years 1998 and 1999 include the results of initial determinations, as well as re-exams, because PERS was unable to distinguish between the two in its records for those years).

Initial Determinations by SSA

SSA's disability examiners, specifically trained in making disability determinations, utilize a five-step screening procedure as the foundation of the disability determination process. This five-step procedure includes use of the SSA's Listing of Impairments, a detailed medical reference guide that lists and defines mental and physical impairments that are expected to prevent an individual from working.

Each SSA case is assigned to a disability examiner for review. The examiner participates in an eight- to ten-week training course in which medical staff and supervisors instruct them on making disability determinations. Along with the training course, examiners are trained an additional minimum of two years up to a maximum of four years. Training includes information on advanced medical issues, as well as procedural issues and policy updates. The disability examiner may make initial determinations either alone or in conjunction with a medical consultant, depending on the complexity of the case. However, all cases are reviewed by a medical consultant before the initial determination is finalized.

Exhibit 5: Approvals and Denials of Disability Claims for FY 1990 through FY 2000



SOURCE: PERS
*PERS could not provide the number of initial determinations exclusively for FYs 1998 and 1999. The data also included re-exams, which PERS could not differentiate from initial determinations in its records for those years.

The medical consultant works with the disability examiner, and may either be a licensed physician, qualified speech language pathologist (if the case involves language impairments), or a psychologist who evaluates disability claims involving mental impairments, including cases where a mental impairment is present with another disability but the mental impairment is so significant that it alone would be a basis for the disability claim.

Criteria for SSA Determinations

Robert M. Ball, who was the Commissioner of the Social Security Administration from 1962 to 1973, described the philosophy of how determinations are made at the SSA in the following manner:

> *The key administrative decision, which was made in the early days of the disability program, and which has governed disability determinations since, was to adopt what may be called a 'screening strategy.' The idea was to screen quickly the large majority of cases that could be allowed on reasonably objective medical tests and then deal individually with the troublesome cases that didn't pass the screen.* ***What is wanted from a physician is not his opinion as to whether someone is 'disabled' or whether he 'can work' but objective evidence about a condition.*** [emphasis added]

Utilization of a screening strategy and compilation of objective evidence about the alleged disabling condition provide the foundation of SSA disability determinations.

Although the previously mentioned philosophy dates back nearly twenty years, the utilization of a screening strategy and the compilation of objective evidence about the alleged disabling condition still provide the foundation of SSA disability determinations.

SSA follows a five-step sequential evaluation, based on the following questions, to arrive at an initial determination:

- Is the applicant engaged in substantial gainful activity?
- Is the applicant's condition severe enough to prevent him or her from performing gainful employment?
- Is the applicant's condition found in the SSA's list of disabling conditions?
- Is the applicant able to do the work he or she previously had done?
- Does the applicant have the ability to do any other type of work?

The following paragraphs briefly discuss each of these steps.

Is the applicant engaged in substantial gainful activity?

If an applicant for SSA disability benefits is earning $740 or more a month, then the claim is automatically denied without considering medical factors.

This first step simply evaluates whether the applicant is working and earning an average of $740 or more per month. If the applicant for SSA disability benefits is earning $740 or more a month, then the claim is automatically denied without considering medical factors. This limit is based on SSA's definition of disability (see page 17), which requires that the individual be unable to perform any type of gainful work. If the applicant is not engaged in substantial gainful activity, then the next step in the evaluation is considered.

Is the applicant's condition severe enough to prevent him or her from performing gainful employment?

SSA considers a condition "severe" when it has more than a minimal effect on the applicant's ability to perform basic work activities.

Once the applicant has shown that he or she is not engaged in substantial gainful activity, the applicant must have a medically determinable impairment "of such severity" that the person cannot perform gainful employment. The severity requirement for the impairment is also a part of the SSA's definition of disability (see page 17).

SSA considers a condition "severe" when it has more than a minimal effect on the applicant's ability to perform basic work activities.

In the event the adjudicator determines that the condition is severe (by reviewing medical information of the applicant), then the next step in the screening process is followed.

Does the applicant have an impairment that meets or is equivalent to an impairment that is described in the SSA's Listing of Impairments?

According to the SSA, the third step in the sequential evaluation process requires precise and objective medical evidence. If a person is not working and his or her disability meets the severity threshold (e.g., when a condition has more than a minimal effect on the applicant's ability to perform basic work activities) and the condition is found in the SSA's Listing of Impairments, the applicant may be awarded SSA benefits.

SSA's Listing of Impairments contains specific criteria that indicate the presence and severity of an impairment.

SSA's Listing of Impairments, which is divided into fourteen body areas, is a detailed medical reference base listing and defining mental and physical impairments that are expected to prevent any individual from working. The Listing of Impairments is continuously updated to reflect

medical advances. The listing contains criteria that indicate the presence and severity of an impairment. The SSA uses the Listing of Impairments for the following reasons:

- as a screening device for conditions that are obviously disabling;
- as a method to inform the public about what the SSA considers disabling;
- as a benchmark for severity for those who have the responsibility of deciding disability cases;
- as a method to promote uniformity and consistency in cases that come before the SSA for disability determinations.

Using the Listing of Impairments in combination with the objective evidence contained in the applicant's file (e.g., applicant's allegations, the applicant's treating physician's examination, laboratory findings, test results) the adjudicator is normally able to make a decision as to whether the applicant is disabled. (Refer to Appendix B on page 46 for an example of how a disability examiner would use SSA's Listing of Impairments to make a disability determination.)

If an applicant's impairment is not found in the Listing, he or she may still be granted disability benefits if the medical consultant makes an equivalency ruling or if the impairment is documented through a Residual Functional Capacity assessment.

However, an applicant is not automatically denied benefits if his or her impairment is not found in the Listing. An applicant whose impairment or combination of impairments is equal in severity to those conditions listed in the Listing of Impairments can be granted disability benefits. By SSA policy, only SSA's medical consultants can make an equivalency ruling. Even if the applicant does not have an impairment contained in the Listing or an equivalent impairment, he or she may still receive disability benefits if the impairment is documented through a Residual Functional Capacity (RFC) assessment. When conducting an RFC assessment, SSA's medical consultants examine the evidence contained in the case file to determine the most the applicant can do (in a work context) based on the applicant's medically documented impairments in combination with the applicant's education, work experience, and age.

For example, if an applicant's RFC indicates that he or she is able to perform sedentary work and his or her experience and education allow him or her to perform sedentary work, the adjudicator would move to the next step.

Can the applicant perform work that he or she has done in the past despite functional limitations that are caused by a severe impairment?

If the adjudicator concludes that the applicant has the ability to do any work that he or she has done within the past fifteen years despite the limitation, then the applicant will not be determined disabled.

In this step the adjudicator determines if the applicant has the ability to perform any work that he or she has done within the past fifteen years. If the adjudicator concludes that the applicant has the ability to do any work that he or she has done within the past fifteen years despite the limitation, then the applicant will not be determined disabled.

However, if the adjudicator determines that the applicant does not have the ability to perform any previous work duties, then the final step in the sequential evaluation process is reached.

Can the applicant do any other type of work?

SSA primarily uses the Medical-Vocational Guidelines, also known as Vocational Grids, for determining whether an applicant can do any other type of work.

In determining whether the applicant can do any other type of work, the primary tool SSA uses is the Medical-Vocational Guidelines, also known as Vocational Grids. Also, SSA uses the completed RFC for this step.

The Vocational Grids were developed so that the SSA could tally the number of unskilled jobs that exist in the national economy at the sedentary, light, medium, heavy, and very heavy levels. This was needed because at the final stage of the sequential evaluation process, the burden of proof is no longer on the applicant but on the SSA to show that the applicant can perform other gainful employment (earning $740 or more per month) that is present in significant numbers in the national economy.

In this final stage of the process, the vocational gridlines and the RFC, along with the applicant's age, education, and work experience, determine if the applicant can perform any other work. This can be complicated, and sometimes disability examiners seek help from vocational specialists when making such determinations.

SSA Policy Interpretations Further Guide Disability Decisions

In addition to detailed written criteria such as the Listing of Impairments and Vocational Grids, SSA also issues written policy interpretations that explain in detail how adjudicators should handle specific disability issues. An example of such a ruling is SR-96-9p, entitled "Policy Interpretation Ruling Titles II and XVI: Determining Capability to do Other Work-Implications of a Residual

Functional Capacity for Less than a Full Range of Sedentary Work."

SSA's written policy interpretations assist adjudicators in ensuring that difficult areas relating to a decision have a feasible solution.

The ruling gives specific alternative accommodations that the adjudicator should consider in determining whether an applicant can perform sedentary work. For instance, if an applicant complains of back pain, one accommodation would be to allow the applicant to stand or walk periodically in a sedentary job. The standing or walking (periodically) would be used to relieve the individual from the sitting position.

Overall, policy interpretations assist the SSA's adjudicators in ensuring that difficult areas relating to a decision have a feasible solution. In turn, this allows the adjudicator to be more neutral in the decisionmaking process.

What are the differences in PERS's and SSA's processes with respect to re-exams?

PERS requires disability recipients under the age of sixty to be re-examined once each year during the first five years following disability retirement and once every three years thereafter. SSA requires disability recipients to be re-examined at least once every three years, unless the disabling condition is considered to be "permanent."

PERS Re-Exams

If PERS determines a person to be disabled, the applicant, with the exception of those who are not expected to improve, must submit to "re-exams." Re-exams are the procedures used to ensure that disability retirees are still disabled and therefore should continue to receive disability benefits.

MISS. CODE ANN. Section 25-11-113 (3) (1972) gives the requirements for re-exams:

> *. . .once each year during the first five (5) years following retirement of a member on a disability retirement allowance, and once in every period of three (3) years thereafter, the board of trustees may, and upon his application shall, require any disability retiree who has not yet attained the age of sixty (60) years . . . to undergo a medical examination, such examination to be made at the place of residence of said retiree or other place mutually agree upon by a physician or physicians designated by the board. The board, however, in its discretion, may authorize the medical board to establish reexamination schedules appropriate to*

the medical condition of individual disability retirees.

The PERS medical board decides whether a disability recipient still has the inability to work.

After a re-exam, if an individual is determined to still have the inability to work, the individual will continue to receive disability benefits. The medical board makes this decision. However, if the individual is determined to no longer have a disabling condition, disability benefits are discontinued after approximately three months. If the applicant is denied he or she may appeal to the DAC. (Refer to page 30 for DAC's role).

SSA Re-Exams

Federal law also provides for periodic reexaminations of certain individuals receiving disability benefits under SSA. 42 USC § 421 (i) states:

> *In any case where an individual is or has been determined to be under a disability the case shall be reviewed by the applicable state agency or the Commissioner of Social Security (as may be appropriate), for purposes of continuing eligibility, at least once every 3 years, subject to paragraph (2); except that where a finding has been made that such disability is permanent.*
>
> *(2) The requirement of paragraph (1) that cases be reviewed at least every 3 years shall not apply to the extent that the Commissioner of Social Security determines, on a State-by-State basis, that such requirement should be waived to insure that only the appropriate number of such cases are reviewed.*

SSA has a policy that disability recipients must submit to re-exams once a year if they are expected to improve. However, if the person is not expected to improve, the reexamination may be scheduled for every three years or every seven years. DDS makes the recommendation of whether improvement is expected.

A DDS disability examiner and physician decide whether a recipient should continue to receive disability benefits.

The decision of whether an individual should continue to receive disability payments is made by a disability examiner and a physician or psychologist within DDS. This is strictly a paper review in which the disability benefits recipient supplies DDS with medical reports and information on any changes that have occurred in the recipient's condition.

If it is determined that a recipient has not improved, he or she will continue to receive disability benefits. If it is

determined that the recipient has improved, and therefore can work, disability benefits will cease. However, this decision may be appealed to a hearing officer where the individual can present evidence to DDS's hearing officer in person. DDS hearing officers are experienced disability examiners who have not been involved in the cases that are on appeal.

What are the differences in PERS's and SSA's processes at the appeals phase?

While both systems have a mechanism for appealing an initial determination, SSA provides three levels of internal review of the decision, while PERS only provides one level of review before the appeals route to the court system.

Appeals under PERS

If an applicant is denied benefits by the PERS medical board, the applicant has sixty days to request a hearing. The Disability Appeals Committee serves as the hearing officer for this appeal and makes a recommendation to the PERS Board of Trustees to either deny or approve an appealed case. If the applicant is denied benefits by the Board of Trustees, he or she may appeal the decision to the courts.

State law specifies the process and timelines for PERS disability appeals.

If an applicant has applied for PERS disability benefits and the PERS medical board has decided that the applicant should not receive disability benefits, the applicant has the option to appeal the medical board's decision. MISS. CODE ANN. Section 25-11-113 (1) (c) sets out the process and time lines for an applicant to appeal the PERS medical board decision. Specifically, this section states, in pertinent part, "If the medical board certifies that the member is not mentally or physically incapacitated for the future performance of duty, the member may request, within sixty (60) days, a hearing before the hearing officer as provided in Section 25-11-120."

MISS. CODE ANN. Section 25-11-120 (1972) allows the PERS Board of Trustees to set the rules and regulations for the appeals hearing. Specifically, this section states:

> *(1) Any individual aggrieved by an administrative determination, including a determination of the medical board, relating to the eligibility for or payment of benefits, or the calculation of creditable service or other similar matters relating to the Public Employees' Retirement System or any other retirement system or program administered by the board, may request a hearing before a hearing officer designated by the board. Such hearings shall be conducted in accordance*

with rules and regulations adopted by the board and formal rules of evidence shall not apply.

. . . . . .

(3) The board is authorized to appoint a committee of the board to serve as hearing officer or to employ or contract with qualified personnel to perform the duties of hearing officer and court reporter as may be necessary for conducting, recording and transcribing such hearings.

The Disability Appeals Committee

The PERS Board has appointed the Disability Appeals Committee, consisting of four physicians and an attorney, to serve as the disability appeals hearing officer.

The committee that the PERS Board of Trustees has appointed to serve as the hearing officer for medical board appeals is the Disability Appeals Committee (DAC). The DAC consists of four physicians (who are appointed with no specific term limits by the PERS Board of Trustees) and an attorney that is assigned from the Attorney General's Office.

PERS's policy is to schedule two to three hearing dates per month. However, for the hearings that take place, only two of the four physicians hear the cases at a time, along with an attorney.

In FY 2000, approximately one third of the medical board's decisions were appealed.

When the DAC has a hearing, committee members have all of the case file information that the medical board had. However, the DAC does not know the reasons the medical board decided not to grant the applicant disability benefits. The DAC essentially hears the case as if the medical board had not made a decision. In FY 2000, 32%, or 94, of the medical board's decisions, were appealed. The appealed cases include circuit court and Mississippi Supreme Court remands. The remanded cases were sent back to PERS so that corrections could be made based on rulings that were made by the courts in FY 2000.

The DAC, unlike PERS's medical board, has the opportunity to observe the applicant in person. According to committee members of the DAC, observing the applicants assists them in deciding whether to reverse or affirm the medical board's decision. However, the physical observation of the applicant alone is not the deciding factor when deciding a case.

The DAC, unlike PERS's medical board, observes the applicant in person.

When a case is heard by the DAC, the applicant has the option to have an attorney present at the hearing. PERS has its own attorney, along with a benefit analyst who represents PERS's position by introducing evidence and summarizing the information contained in an applicant's file.

During the hearing the DAC may ask the applicant questions directly to determine whether the applicant is disabled. Examples of questions that the DAC may ask are how long the applicant has been disabled or how the disabling condition occurred. Also, the DAC may ask the applicant about specific medical information that is in the applicant's file.

If the DAC disagrees with the medical board and decides to grant the applicant disability benefits, the applicant will begin receiving disability benefits. However, if the DAC agrees with the medical board, the applicant will once again be denied disability benefits.

Judicial Appeal

If the applicant is denied by the DAC, the applicant may appeal to the Hinds County Circuit Court.

If the applicant is denied by the DAC, the applicant still has the option to appeal the DAC's decision to the Hinds County Circuit Court, where a circuit court judge will decide the case.

When the circuit court judge makes a decision and if either the applicant or PERS is not satisfied with the judgment, the decision may then be appealed to the Mississippi State Supreme Court.

Appeals Under SSA

If an applicant is denied benefits by the SSA, the applicant has sixty days to file a written notice of appeal for reconsideration by a disability examiner and medical consultant who were not involved in the initial determination review. The second level of appeal is a hearing by an administrative law judge, who may consider any new evidence. The third level of appeal is review by an Appeals Council consisting of administrative appeals judges. Beyond this point, the applicant may appeal to the courts.

Just as with PERS, if an applicant who has applied for SSA disability benefits is denied disability benefits at the initial determination stage, the applicant may appeal the decision. SSA has three internal levels of appeal before a case may be appealed to the federal courts:

- reconsideration by DDS;
- hearing by an administrative law judge; and,
- review by the Appeals Council.

In order for an applicant to appeal a decision, he or she must inform the SSA in writing within sixty days of the notice of denial of benefits. If the applicant fails to file a timely notice of appeal, the applicant loses the right to appeal, unless good cause is shown.

Reconsideration

At the first level of appeal, a disability examiner and medical consultant who were not involved in the initial determination review the evidence.

At the federal level, the first level of appeal under SSA is the reconsideration level. At this level of appeal, a disability examiner and medical consultant who were not involved in the initial determination review the evidence in the applicant's file, along with any other evidence that the applicant wishes to submit.

If the disability examiner and medical consultant agree with the initial determination and in turn deny the claim, the applicant may then take his or her case to the next level of appeal, before an administrative law judge.

Review by Administrative Law Judge

The next level of appeal is a face-to-face hearing with an administrative law judge.

The primary difference between SSA's reconsideration level of appeal and the administrative law judge hearing is that the applicant has the option of having a face-to-face hearing with the administrative law judge, whereas reconsideration is strictly a paper review. Another difference in the reconsideration level of appeal and review by an administrative law judge is that administrative law judges use the *Hearings, Appeals, and Litigation Law* manual and adjudicators at the reconsideration level do not. The use of the manual allows the administrative law judge to have more latitude when applying Social Security rules and regulations.

At the hearings the administrative law judge considers new evidence (if any), reviews the evidence used in making the decision under review, and may question witnesses. Further, the administrative law judge may ask the applicant to undergo a consultative medical examination to gain more evidence prior to making a decision.

Review by Appeals Council

If the Appeals Council agrees to hear the appeal, the council may decide to uphold, modify, remand, or reverse the decision rendered by the administrative law judge.

If the administrative law judge agrees with those who made the decision at the reconsideration level and decides not to award benefits, the applicant may then request that the Appeals Council hear his or her case. The Appeals Council consists of administrative appeals judges. If the Appeals Council chooses to deny an applicant's request to have his or her case reviewed, the administrative law judge's decision would stand.

If the Appeals Council agrees to hear the appeal, the council makes a decision based on the evidence of record. The council may decide to uphold, modify, remand, or reverse the decision that was rendered by the administrative law judge. When a decision to deny the applicant benefits is rendered by the council, the applicant may then make a judicial appeal.

Judicial Appeal

SSA applicants' judicial route of appeal is through the federal courts.

The judicial appeal consists of the applicant filing a claim with a federal district court. In Fiscal Year 2000, applicants (nationwide) appealed approximately 16% of the Appeals Council's denials. If the federal court still denies the applicant benefits, the applicant may then appeal to the U.S. Circuit Court of Appeals and finally to the United States Supreme Court.

Conclusions Regarding Whether PERS Should Rely on Social Security Administration Determinations to Establish Eligibility for Disability Benefits

MISS. CODE ANN. Section 25-11-113 already allows PERS to accept federal certification of disability. As discussed on page 5, between 1987 and 1994 PERS followed SSA's determinations, but in 1995 stopped this practice by official PERS Board policy. Currently, while PERS's medical board asks for evidence of federal certification as part of its application package, such evidence is only part of the record and is not a deciding factor in making a PERS disability determination.

In considering whether to rely on SSA determinations to establish eligibility for disability under PERS, several important issues must be considered. A discussion of these issues, presented in question and answer format, follows.

Would all PERS members applying for disability benefits under PERS qualify to apply for disability benefits under SSA?

No.

A small percentage of PERS members are not covered by Social Security. Specifically, according to unaudited figures provided by PERS, approximately 1,481 firefighters and police officers are members of PERS but have no Social Security coverage. These firefighters and police officers are employed in the following cities: Biloxi, Jackson, Laurel, Natchez, Vicksburg, and Tupelo.

In addition to the 1,481 firefighters and police officers who have no Social Security coverage, sixty-seven other active employees who are members of PERS also do not have Social Security coverage. These sixty-seven members are employed by the following entities: Town of Sebastopol, Town of Lena, Town of Puckett, Town of Crawford, Laurel-Jones County Library, Itta Bena Housing, Claiborne County Human Resources Agency, and Cleary Water and Sewer District.

Further, some political subdivisions also do not have Social Security coverage for certain classes of employees,

but yet are members of PERS. An example of such an entity is the Town of Beaumont, which elected to exclude elected officials from Social Security coverage. PERS was unable to quantify the number of political subdivisions who may have elected to exclude certain categories of employees from Social Security coverage.

Social Security does not cover all the previously mentioned employees because the entities did not adopt a Section 218 Agreement. Section 218 Agreements, which are authorized under Section 218 of the Social Security Act, are voluntary agreements between a state and the SSA to provide employees of state and local governments with either Social Security or Medicare or both. Section 218 Agreements cover positions and not individuals. They are adopted after a referendum is held and the majority votes to have Social Security coverage. If the Section 218 Agreement is adopted, then employees' positions are subject to either Social Security or Medicare taxes or both.

In the event the referendum is not passed by a particular entity, the state and local government employees' positions will not be taxed. As a result, those positions will not have coverage under SSA or Medicare. This occurred in the reported small percentage of PERS's active employees that are discussed above.

Do all PERS members applying for disability benefits also apply for disability benefits under SSA?

No.

SSA does not currently review all PERS cases, reportedly because all individuals do not apply under both systems. Also, not all PERS members have Social Security coverage (see discussion in previous section relating to Section 218 Agreements). In PEER's case study, approximately thirty percent that applied for PERS disability did not apply for SSA disability.

For those cases that have been considered by both PERS and SSA over the past eleven years, have the outcomes been similar?

No.

PEER conducted a case study analysis of 164 cases that had determinations made in PERS from 1990-2000. The method in which the case study was conducted was that PEER randomly selected case determinations from PERS

and forwarded those same cases to DDS to determine how DDS made determinations on those cases.

Since PEER conducted a case study analysis rather than a random statistical sample, no general conclusions should be drawn relating to all determinations made at PERS and DDS. It should be noted that PEER attempted to conduct a random statistical sample with some 600 cases in the sample; however, due to DDS's workload, DDS was able to assist PEER with only 164 cases in the case study.

Of the 164 cases sent to DDS, DDS did not have 50 of the cases in its database, presumably because the individuals did not apply for SSA disability benefits. A comparison of the remaining 114 cases that were reviewed by both PERS and SSA follows in Exhibit 6, below.

Exhibit 6: Profile of Results of Case Study of PERS and SSA Determinations

	PERS	DDS
Approvals	74%	53%
Denials	26%	46%
Miscellaneous*	-0-	1%

* One case did not have information available at DDS.

SOURCE: PEER analysis of PERS and DDS information.

As seen above in Exhibit 6, PERS has a higher approval rate for the same cases, with 74% as compared to DDS's 53% approval rate. This illustrates that for these cases the final determinations at DDS and PERS are quite different.

How much would PERS save if SSA handled the disability determination function?

PERS would recognize minimal savings.

Savings would be minimal because most staff involved in PERS disability determinations have other responsibilities and the benefits calculation function and benefits eligibility functions would remain at PERS.

Savings to PERS would occur only in the contractual services area (i.e., the medical board and DAC.) For example, in FY 2001 contractual services composed only $103,465, or 25% of PERS's disability program's major objects of expenditures.

Would determinations under SSA be more fair and uniform than under PERS?

Although some subjectivity is inherent in the process of making disability determinations, SSA's system has written criteria and formal policies and procedures.

According to internal reviews conducted by SSA, it is subject to the same criticism regarding fairness as PERS.

While SSA has a more objective system on paper, no guarantee exists that the system would be more fair and consistent in practice. Internal reviews conducted by SSA indicate that it is subject to the same criticism regarding fairness as PERS. Specifically, SSA's Advisory Board reported that there is inconsistency in determinations throughout the regions of the U.S. (Refer to Appendix C, page 48, for criticisms.)

Some element of subjectivity is inherent in the process of making disability determinations. While it is beneficial to minimize the subjectivity through written policies and procedures, it is impossible to have a definitive policy and criteria governing every aspect of every case.

What changes would have to be made in state law in order to require PERS to accept SSA determinations?

The Legislature would have to amend state law to abolish adjudicatory and reexamining functions within PERS's disability program and delete references to interaction between the PERS Board, the Disability Appeals Committee, and the medical board. The Legislature would have to redefine "disability" and to require that PERS disability applicants first apply with the SSA and that SSA's rules, policies, and procedures govern determinations for PERS.

While MISS. CODE ANN. Section 25-11-113 makes accepting SSA disability determinations an option, it is not a requirement. If PERS were required to accept the SSA's disability determinations, several changes in state law would be required.

State law would have to be amended to abolish all adjudicatory functions that reside with PERS's disability program. For example, the PERS medical board would have to be abolished, as well as the DAC. These adjudicatory bodies of PERS would no longer be needed because all disability determinations would be made with the SSA. In addition, powers relating to the PERS Board of Trustees (e.g., accepting or rejecting the DAC's findings on appeal) would have to be abolished for the reasons mentioned above for the medical board and the DAC.

State law would have to be amended to require that all PERS disability applicants must first apply with the SSA. This will be a necessity because only SSA would make the disability determinations if it were to make the determination for PERS. Also, state law would have to be changed relating to PERS's definition of disability. This change is needed because PERS and SSA have different definitions (refer to page 15 for definitions).

Further, state law would have to be amended to state that all rules, policies, and procedures of SSA would govern PERS's disability determinations. This amendment is needed because the SSA would use its own written criteria if PERS were to adopt SSA determinations.

The law would also need to be amended to have the reexamining responsibility for PERS to be abolished. This PERS function would no longer be needed because the service is already done at SSA (refer to page 28).

The administrative responsibility should remain at PERS because the eligibility requirements for PERS and SSA are different. The only amendments that would be needed relate to the actual function of determining disability, which is currently duplicated between PERS and the SSA.

What would be the advantages of PERS's reliance on SSA disability determinations?

The advantages would be that PERS applicants would be adjudicated by written criteria, applicants would have access to more appeal stages, and that the duplication of having both state and federal determination processes would be eliminated.

If PERS were to rely on the SSA's disability determinations, there would be several advantages. First, PERS applicants would be adjudicated by written criteria. The written criteria are regulations as well as SSA's policy rulings. As a result, there should be more consistency and fairness in the determination process, because the decisionmaking process would be more standardized as compared to PERS's current system.

Another advantage of PERS following SSA disability determinations would be that the applicant would have access to more appeal stages. As a result, the PERS applicant would be afforded the opportunity to exercise three levels of appeal before going to the court system, rather than one route of appeal as with the PERS system.

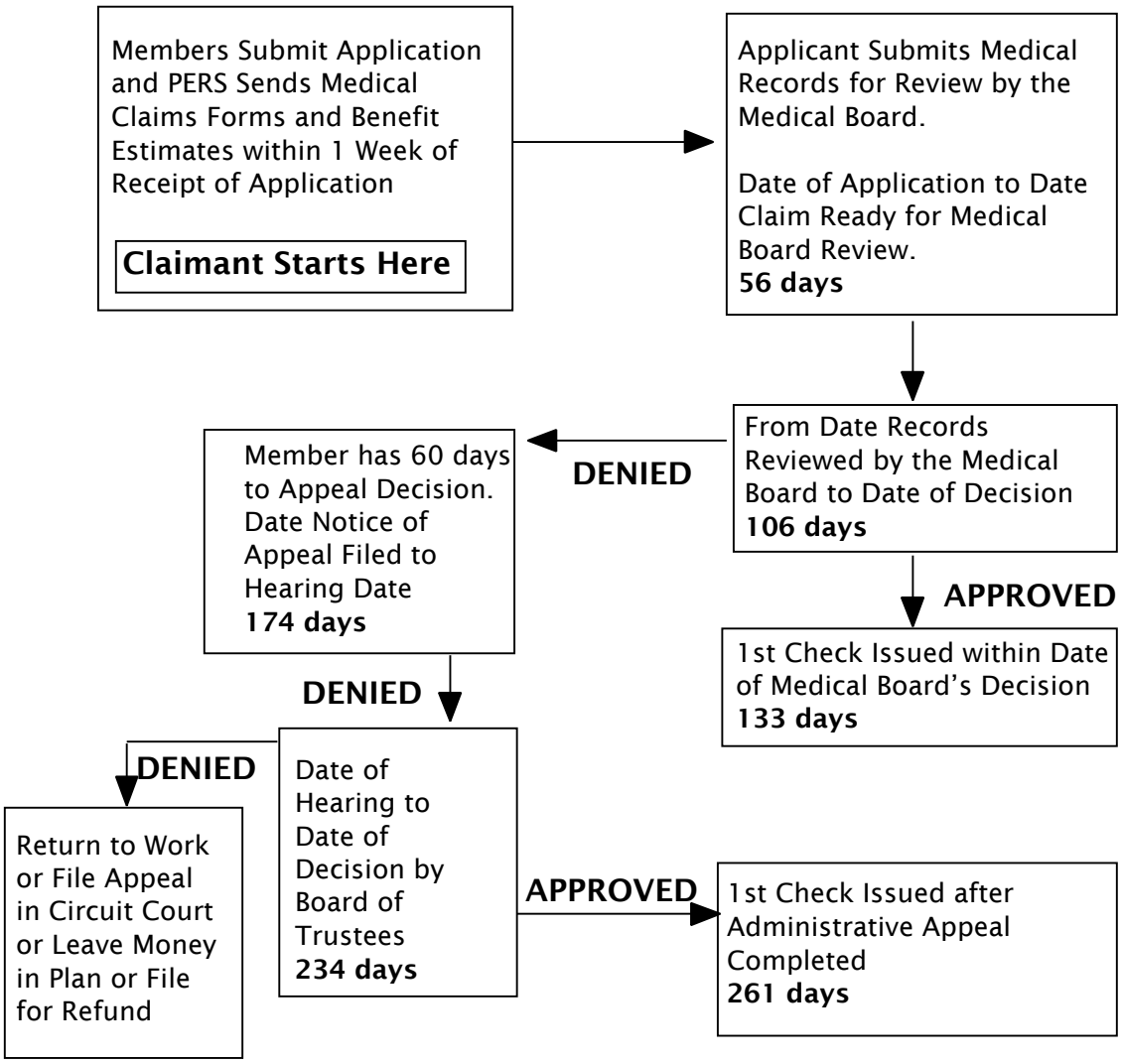
Finally, by relying on the SSA's disability determinations the duplication that is present by having both state and federal determination processes would be eliminated. The purposes of PERS's and SSA's disability programs are to provide disability coverage for those who are unable to work due to a disability. If the SSA is able to provide the means to make the decision as to who is disabled, there is no need to have the state perform the same service.

What would be the disadvantages of PERS's reliance on SSA disability determinations?

The primary disadvantage would be that the disability determination process could take longer than it presently does.

The primary disadvantage of PERS's reliance on SSA disability determinations would be the amount of time that it would take for a final adjudication to be rendered by the SSA. As shown in Exhibits 7 and 8, pages 40 and 41, PERS renders final determinations more rapidly than SSA, in part because there are fewer levels of administrative appeal (e.g., PERS has one level whereas SSA has three) and PERS handles fewer cases than the SSA.

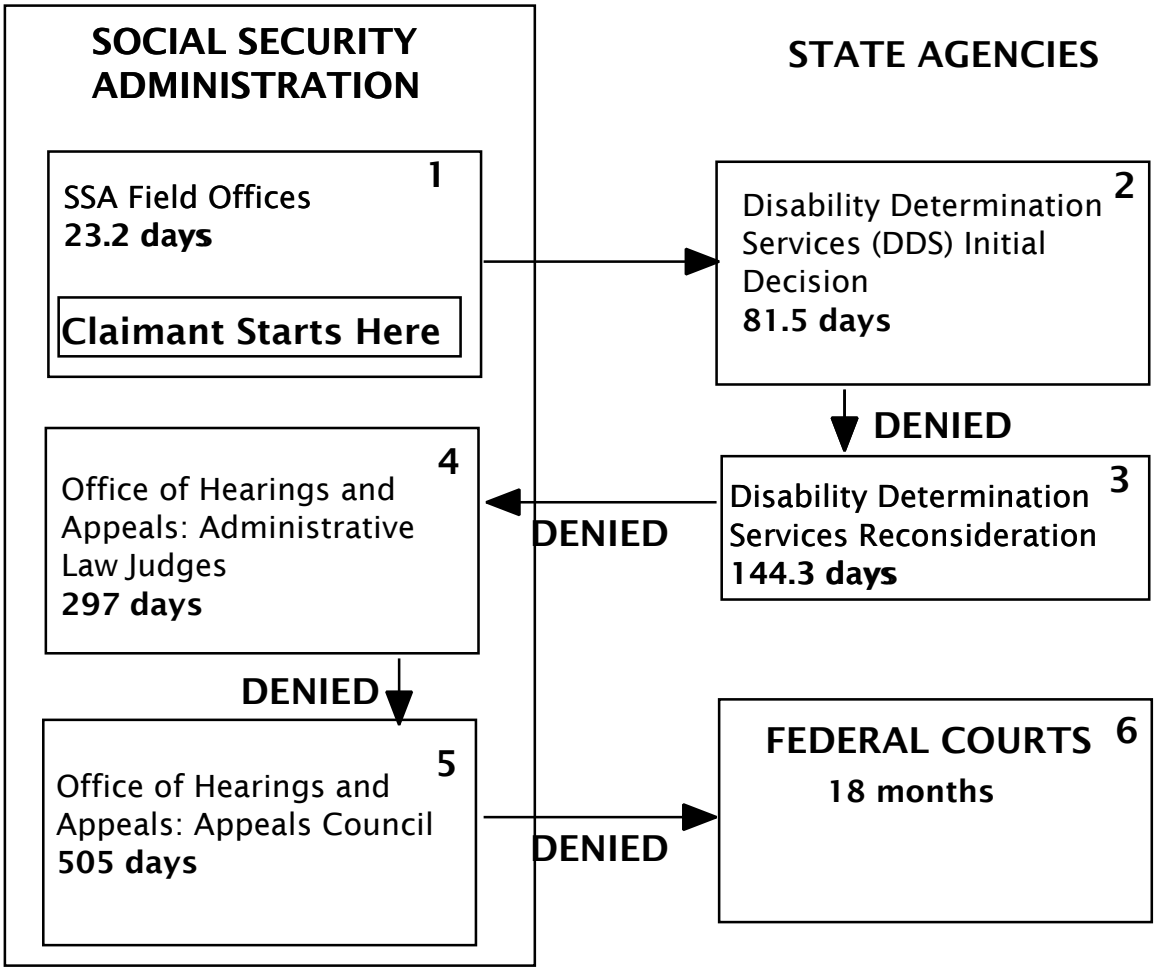
Exhibit 7: PERS Disability Claims Process: Steps and Average Processing Times,* FY 2001



*PERS average processing times shown above are cumulative.

SOURCE: Compiled from information provided by PERS.

Exhibit 8: SSA Disability Insurance Claims Process: Steps and National Average Processing Times,* FY 2000



*SSA average processing times shown above are cumulative.

SOURCE: Social Security Advisory Board

Options and Recommendations

Because both PERS's and SSA's disability determination processes have weaknesses, neither option (leaving the determination process at PERS or moving it to SSA) emerges as clearly superior in terms of yielding consistent, objective, and fair disability determinations. However, one could make an argument to leave the determination process at PERS because the state Legislature can mandate and oversee implementation of improvements to PERS's process, while it cannot mandate and oversee changes to SSA's process. Further, moving the process to SSA would require adoption in state law of SSA's definition of disability, which is on paper a tougher standard to meet than the current definition of disability contained in state law (see discussion beginning on page 16).

The following options outline steps that should be taken under either option. Under Option 1, keeping the determination process at PERS, PEER has listed recommended steps that PERS should take to increase the objectivity, fairness, and consistency of its disability determination process.

Under Option 2, moving the process to SSA, PEER recommends changes that the Legislature would have to make in state law to accomplish the move. Under this option, while PERS would discontinue its function of making disability determinations, it would continue to ensure that the applicant qualified to apply for disability benefits under state law and calculate and pay out the benefits due to the PERS member following a certification of disability by SSA.

Option 1: Keep the Disability Determination Process at PERS

If the Legislature chooses to keep the disability determination process at PERS, the agency should take the following actions.

1. PERS should develop written criteria for what constitutes a disabling condition, similar in detail to SSA's Listing of Impairments.

2. PERS should issue formal, written policy interpretations in response to questions/issues

arising from implementation of the written criteria developed in response to Recommendation 1.

3. For each case that it considers, PERS should require its medical board to explain in writing the reason for its determination, in sufficient detail that an outside reviewer could understand the rationale for the decision.

4. PERS should develop a checklist of required medical tests for the types of disabling conditions contained in the listing discussed in Recommendation 1. PERS should require that results from the tests be placed in the applicant's file prior to the PERS medical board's consideration of the case.

5. PERS should provide ongoing training to its physicians on implementing specific policies and procedures for the disability determination process.

6. PERS should cease its practice of disclosing the estimated amount of an applicant's disability benefits to those who are making the disability determinations, as this information is irrelevant to a determination of disability and by its presence in the file could influence the outcome of the determination.

Option 2: Require PERS to Rely Totally on SSA's Disability Determinations

If the Legislature chooses to rely on the SSA's disability determinations, the Legislature should make the following changes in state law to reflect such.

7. The Legislature should amend MISSISSIPPI CODE ANNOTATED Sections 25-11-113, 25-11-119, and 25-11-120 to:

   - require that SSA disability determinations be accepted as the only form of proof of disability at PERS;

   - delete PERS's definition of disability and substitute SSA's definition of disability;

   - reflect that all policies, procedures, rules, and regulations of SSA will govern PERS's disability determinations;

- require that all PERS disability applicants first apply for disability benefits at the SSA;

- delete the adjudicatory functions of PERS (e.g., abolish the medical board and the Disability Appeals Committee, PERS Board of Trustees' powers relating to disability determinations);

- have all reexaminations made by SSA rather than by PERS; and,

- require that all administrative functions (e.g., determining PERS eligibility) relating to PERS's disability benefits program remain a responsibility of PERS.

8. In cases where applicants do not have Social Security coverage, PERS should contract with Disability Determination Services (DDS) to secure its services to perform disability determinations for PERS using DDS's criteria. Furthermore, the Legislature should enact legislation that provides that when any individual who is not a participant in Social Security coverage and seeks disability benefits from PERS through any procedure established by law and rule, that applicant should have a right to appeal any adverse administrative decision made by the SSA to the First Judicial District of Hinds County Circuit Court.

Appendix A: Examples of Comparisons of PERS Disability Allowances and Regular Service Retirement Allowances for FY 2001 Cases*

Disability Retirement Allowance (Monthly)	Regular Service Retirement Allowance (Monthly)
$1,586.40	$1,245.65
$3,189.37	$2,339.66
$1,980.46	$1,509.21
$1,509.97	$1,194.87
$883.24	$622.68
$1,977.51	$1,410.99
$937.55	$830.45
$1,023.05	$901.42
$1,852.36	$1,420.94
$1,990.89	$1,806.92
$2,446.85	$1,811.84
$2,003.03	$936.04
$2,111.57	$1,543.59
$2,386.99	$1,762.82
$917.47	$202.94
$503.79	$257.21
$2,265.85	$1,884.90
$1,710.20	$1,631.99
$1,099.47	$1,072.55
$1,092.06	$981.88
$2,402.27	$2,015.69
$1,128.93	$929.13
$4,056.43	$3,132.19
$1,674.85	$1,196.30
$899.96	$528.35
$940.32	$797.37
$2,469.20	$1,797.30
$2,199.10	$1,601.97
$1,630.07	$1,269.97
$1,880.03	$1,681.83
$2,254.04	$1,794.14

*These are actual calculations of allowances of individuals who have applied for disability benefits and the amount they would receive if they were to retire under disability or regular service retirement.
SOURCE: PERS

Appendix B: Example of How an SSA Disability Examiner Would Use the Listing of Impairments to Document a Disability

If an applicant stated that he or she could not work due to problems with his or her respiratory system, the adjudicator would consult the Listing of Impairments related to the applicant's complaint.

Some of the claimant's allegations could be as follows:

-trouble breathing, smothering; short of breath

-lung infections, frequent colds, cough, spitting up mucous, blood

-wheezing; tired

-frequent attacks requiring hospitalization

-bronchitis; emphysema; asthma; tuberculosis

The adjudicator would then look in the file for clinical signs. Clinical signs are proven by what the applicant's treating physician has observed while examining the applicant.

Some of the clinical signs associated with problems with the respiratory system could be the following:

-height/weight

-poorly nourished

-acute or chronic stress

-wheezes in lungs

-abnormal lung sounds

-barrel-chested

-cyanosis

-clubbing of finger

-hemoptysis

-productive cough

-shortness of breath

According to the clinical signs, the adjudicator would then look for test results or laboratory findings that support the applicant's claims along with the physician's observations.

Some of the test results could come from the following:

-chest x-ray

-bronchoscopy

-biopsy

-sputa cultures

After the adjudicator has reviewed all of the information relating to symptoms, clinical signs, and laboratory findings and compared them to the Listings requirement for disability, a decision is made.

Appendix C: Summary of Findings of Social Security Advisory Board's 2001 Report Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change

In January 2001, the Social Security Advisory Board released a report entitled **Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change**. The report was the result of an extensive study of the nation's two primary disability programs: Social Security Disability Insurance (an insurance program that provides disability benefits based on previous employment covered by Social Security) and Supplemental Security Income disability (a means-tested income assistance program for aged, blind, and disabled individuals regardless of prior workforce participation).

The need for the study was driven by growth trends in these two programs. The Social Security Administration's actuaries project that with the aging of the baby boomers, between 2001 and 2010, the number of Social Security Disability Insurance beneficiaries will increase by nearly 50% and the number of SSI disability beneficiaries will increase by 15%. The introduction to the report notes, "This projected growth in the number of disability claimants threatens to overwhelm a policy and administrative infrastructure that is already inadequate to meet the needs of the public."

The report focused on four major issues:

- Are disability decisions consistent and fair?
- Is disability policy being developed coherently and in accord with the intent of Congress?
- Can today's administrative structure support future program needs?
- Is Social Security's definition of disability appropriately aligned with national disability policy?

A summary of the conclusions reached in each section follows.

Are disability decisions consistent and fair?

The study notes that while consistency and fairness should be fundamental goals of the disability programs, "the perception is that determinations of eligibility are not being made in a uniform and consistent manner." Despite the board's conclusion, the board did admit that there was a lack of data because of state agencies' inability to give data needed to understand the degree to which the agencies are causing inconsistent outcomes. As a result, the board's criticisms should be taken with caution.

The board's data showed "striking" differences among state agencies in the percentage of DI applicants whose claims were allowed (e.g., in Fiscal Year 2000 the percentages ranged from 31% in Texas to 65% in New Hampshire, with a national average of 45%), as well as major differences between levels of adjudication for both programs (66% of DI and SSI claims denied at the state agency level in 2000 were reversed and approved at the administrative law judge hearing level).

Among the reasons offered for these differences were economic and demographic differences among regions, the fact that the claimant does not meet with the decisionmaker until the face-to-face hearing at the administrative law judge level, and reasons relating to program policy, procedures, and structure, including inconsistencies in quality assurance reviews from region to region. The section concludes with the observation "as long as variations in decision making remain unexplained, the integrity and fairness of the disability programs are open to question."

Is disability policy being developed coherently and in accord with the intent of Congress?

The study noted that although Congress has not changed the statutory definition of disability for thirty years, "the determination of what constitutes disability has changed in fundamental ways. . . .For example, there has been a gradual but persistent trend away from decisions based on the medical listings to decisions that increasingly involve assessment of function. Since 1983, the percentage of DI claimants awarded benefits by State agencies on the basis of meeting or equaling the medical listings has declined from 82 percent to 58 percent, while the percentage awarded on the basis of vocational considerations has more than doubled."

Also, mental impairment has become the largest single reason for state agency DI awards (22% of total in 1999). Further, the study found that "disability decision making

by both state agency examiners and administrative law judges has become considerably more subjective and complex." The study notes that none of these changes have been reviewed by Congress and there is a question as to whether the SSA has adequately analyzed the changes.

Can today's administrative structure support future program needs?

The study notes that when the Disability Insurance program was enacted in 1956, the expectation was that the program would be relatively small. At present, "all parts of the applications and appeal structure are experiencing great stress." According to the study, SSA field office personnel are no longer able to provide the kind of assistance that applicants need to file a properly documented claim.

State agency examiners are having to make increasingly complex and subjective decisions. State agencies often "lack the ability to hire and retain qualified staff and to provide the training they need." Because most denied cases are appealed given the public's perception that most appeals are won by the claimant, many hearing offices are struggling to keep up with their workloads. Decisionmaking at the appeals level differs from the state agency level, due in part to court rulings affecting the appeals process.

For example, as the result of court decisions, administrative law judges in some parts of the country make their decisions only after seeking the opinion of a vocational expert on whether an individual can perform work in the national economy. Vocational experts are not used at the state agency level, where the greater reliance is on medical listings. Also, at the hearing level, nearly all claimants have a representative. In the midst of the greater complexity and subjectivity, there is far less policy guidance from SSA than was the case in the earlier years of the program.

Is Social Security's definition of disability appropriately aligned with national disability policy?

Many believe that the SSA's definition of disability, which requires claimants to prove that they cannot work and has an "all-or-nothing" benefits structure, is inconsistent with the Americans with Disabilities Act. The study notes that "with the many accommodations that exist today it is possible to fit many individuals with disabilities into a satisfying job. . . .The Ticket to Work legislation enacted last year authorizes SSA to conduct experiments and

demonstration projects related to encouraging rehabilitation and employment, including earlier referral of individuals for rehabilitation."

Overall Conclusions of the Board

As a result of its in-depth study of the disability programs, the board concluded that fundamental changes in policy, procedure, and structure were necessary in order to address the specific problems noted above.

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County Employees

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State Employees

PROGRAMS ADMINISTERED

Public Employees' Retirement System of Mississippi

Mississippi Highway Safety Patrol Retirement System

Government Employees' Deferred Compensation Plan

Mississippi Municipal Retirement Systems

Supplemental Legislative Retirement Plan

Retiree Group Life & Health Benefits

Optional Retirement Plan for Institutions of Higher Learning

November 7, 2001

Mr. Max Arinder, Executive Director
Performance Evaluation Expenditure Review Committee
501 N. West Street
3rd Floor, Woolfolk Building
Jackson, MS 39201

Dear Mr. Arinder:

Attached is the Public Employees' Retirement System's response to the PEER review entitled, "A Review of the Public Employees' Retirement System's Disability Determination Process."

Please contact this office if the Committee has any questions regarding our response.

Sincerely,

Frank Ready

Frank Ready
Executive Director

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Executive Summary

A Review of the PERS Disability Determination Process
PERS Response: Executive Summary
November 6, 2001

The PEER Review has compared the disability determination process used by the Social Security Administration (SSA) and that utilized by the Public Employees' Retirement System (PERS). The conclusions drawn from this review support a move to either make PERS' determination process more like that of Social Security or alternatively, to change the law to require that SSA make the determinations of disability for all members of systems administered by PERS using the SSA definition of disability. PERS disagrees with a proposal of this nature given the fact that the SSA disability program has identified significant program issues it needs to address before they themselves would propound to serve as a model for the best method of disability determination. In reports issued by the Social Security Advisory Board in January and February of 2001, significant weaknesses in the SSA process are enumerated with regard to consistency, objectivity, equity and fairness. There are a number of major issues which should be addressed before policymakers commit to changing the PERS disability determination process and the PERS benefit structure.

1) **The following quotes from Social Security Advisory Board reports issued in 2001,** Disability Decision Making: Data and Materials, January 2001; Agenda for Social Security. Challenges for the New Congress and the New Administration, February 2001; Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change, January 2001, **speak to the issues and concerns of PERS in considering the recommendation that PERS use SSA's program as a model for disability determination:**

   - *"The development of sound disability policy requires far greater medical and vocational expertise than the agency currently has. Over the years, SSA has lost many of its skilled medical and vocational specialists that have not been replaced with sufficient rapidity. As a result, important medical listings have not been kept up to date to reflect advances in medical diagnosis and treatment and vocational guidelines do not take into account the changes that have occurred in the workplace. Of perhaps even greater concern is the fact that the Department of Labor's Dictionary of Occupational Titles is no longer being updated. This document, which describes the types of jobs that are available in the national economy has long served as a primary tool for adjudicators in determining whether a claimant has the capacity to work. SSA currently has no replacement for the Dictionary of Occupational Titles, leaving a critical policy vacuum at a time when program rules require more and more decisions to be made on the basis of vocational factors."*

   - *"As the GAO recently testified, fundamental weaknesses remain. These include an eligibility determination process that concentrates on applicants' incapacities rather than their capacities, return-to-work services offered only after a lengthy determination process, and an "all-or-nothing" benefits structure that characterizes individuals as incapable of work."*

   - *"The infrastructure is weak. There are too many voices articulating disability policy. Adjudicators in different parts of the system are bound by different sets of rules. Important policy elements are out of date. As the result of downsizing and lack of new staff to replace those who have left the agency through retirement or otherwise, the level of expertise in areas such as medical and vocational factors has declined."*

   - *"The Administrative Law Judges (ALJ) have been required to balance three roles. They are obligated to protect the interests of both the claimant and the government and to serve as an objective adjudicator. But as attorney and other third party representation on behalf of claimants has increasingly become the norm, ALJs are finding it difficult to maintain the balance. Nationally, about 80 percent of Disability Insurance Claims are now represented by an attorney, a situation that many believe has made the process too one-sided."*

   - SSA is initiating steps to eliminate the input of the physician in the decision making process. *"The single decision maker is a position which would give the disability examiner authority to make disability determinations without requiring physician input."*

2) **There are significant differences in the PERS and SSA benefits. Accepting the SSA definition of disability would significantly reduce the value of the disability benefit available to members of systems administered by PERS. The PERS benefit is based on an employee's "own occupation" standard and the SSA benefit is based on an "any occupation" standard.**

3) **The reason there are differences in the outcome of the disability determination process between PERS and SSA are related to the following reasons:**

- The PERS review is made by trained medical doctors on the basis of objective medical evidence.
- The SSA review relies heavily on the judgement of lay evaluators, using outdated guidelines, with minimal involvment of physicians. Subjective information is increasingly relied on by SSA as a primary basis for disability determination.
- PERS gives no special consideration to the age, education or experience of the member at the time of application. All claimants are on equal footing.
- SSA may allow disability benefits to be paid if a medical condition is expected to last for a period no less than twelve months, while PERS requires the condition to be permanent.

4) **Clearly, PERS is far ahead of SSA is the development of its appeal process in that PERS has already eliminated unnecessary review levels to expedite the final disposition of the case. SSA is proposing to eliminate and streamline the multiple levels of review in the appeals process.**

5) **The recommendation to make statutory changes to require that the policies, procedures, rules and regulations of SSA govern the PERS disability determinations, would result in the Legislature separating from itself and the Board of Trustees the power to maintain control over the program thus, resulting in improper delegation of the Board's duty and fiduciary responsibility for the administration of the Trust Fund.**

6) **PERS agrees to eliminate the inclusion of the benefit estimates in the record to prevent the appearance that such might be a basis for a medical determination or that a review of such information may result in a bias on the part of a physician.**

7) **PERS staff of physicians would not only appreciate any training opportunities provided by PERS but could and would be willing and able to provide training in the field for other physicians interested in this area of medical expertise.**

Given the impact of having an increased number of people out of the work force due to the retirement of the aging baby boomers and the fact that they will be reaching an age of increased likelihood of disability, significant economic and social challenges loom before policymakers, the medical community as well as employers. These challenges particularly relate to issues involving disability determination, rehabilitation and vocational training/retraining. Given the dramatic administrative and fiscal impact disability issues may have on the trust fund, it is imperative that the disability program remain under the control of the MS Legislature and PERS.

Comprehensive Response to the PEER Committee Investigation Report

REVIEW AND DISCUSSION OF PEER COMMITTEE'S ANALYSIS AND RECOMMENDATIONS REGARDING THE PERS DISABILITY DETERMINATION PROCESS
November 6, 2001

The Social Security Administration administers a huge nationwide plan that differs from PERS in many respects. Its benefit structure is designed to provide a minimal replacement income to those who can no longer be gainfully employed in any occupation due to a disability, where such disability can be expected to result in death or last for a period of at least one year. The program is structured to provide a greater percentage of replacement income for lower paid employees than for higher paid employees. A member who is engaged in substantial gainful activity is one who, under SSA rules, is performing substantial services and who earns more than an average of $700 per month. The SSA benefit is equal to that which would be paid as if the member had reached age 65 and more favorable consideration for awarding benefits is given to SSA benefit applicants over the age of 55. SSA benefits are available to any participant who has contributed for the necessary period of time regardless of whether he or she is actively employed at the time a claim for disability benefits is filed. SSA disability benefits are coordinated with (reduced by) any Worker's Compensation benefit received by the disability benefit recipient.

The Public Employees' Retirement System awards benefits to applicants who are permanently disabled from performing their own occupation. The benefit is designed to provide an adequate replacement income, regardless of the applicant's economic income level or age. PERS benefits are designed to provide income replacement to actively contributing members who become disabled prior to termination of covered service. An inactive member applying for disability benefits from PERS must prove the reason for terminating covered service was a direct result of the medical condition for which a claim is filed. That is, the member must prove he or she was disabled at the time of termination. The PERS benefit is no longer coordinated with the Worker's Compensation benefit received by a member.

Social Security Administration benefits are funded by taxes levied on all wage earners in the country versus the PERS benefits which are funded by contributions from participants in the PERS Trust Fund. The geographical and logistical issues of administering a program in 50 states with thousands of employees presents different challenges and requires different solutions to meet economic limitations and consistency goals than the administration of a one state program run with less than 10 employees, including benefit analysts and physicians.

Social Security Administration is believed to do an admirable job administering the disability insurance program, given the challenges, goals, and environment in which it must operate. However, many of the characteristics, tools and processes of the SSA which have been devised for administering a program which is "behemoth" in comparison to PERS and which has different resources and accountability, are not best suited for administering the PERS plan.

PERS Evaluation Process Using an Interdisciplinary Team of Physicians

In the early 1990's, PERS recognized a need to further develop the disability determination program. Initially, PERS sought to have the MS Disability Determination Service (DDS) review all disability claims using the PERS standards for disability. DDS was unable to meet the service delivery needs required by PERS due to the numerous problems identified in the SSA disability determination and

reexamination process and the program as a whole. Therefore, PERS went about implementing initiatives to enhance the PERS disability determination process, gradually increasing resources dedicated to the program. The primary goal was to attract and retain highly qualified physicians to evaluate claims for disability benefits. PERS has been very selective in its recruiting of physicians to serve in the disability determination process. Recognizing the significant advances in the field of medicine taking place every day, it became imperative for PERS to insure that the physicians reviewing disability claims be in active practice. Disability determination by PERS is based on objective medical evidence, using a medical model, with an interdisciplinary team of physicians. Each claim is initially reviewed by a group of three physicians with training and specialized knowledge in gerontology, physical medicine and rehabilitation, and psychiatry. Prior to denial of a claim, the majority of applicants are currently required to undergo a physical examination conducted by a medical doctor, psychological testing conducted by a psychologist or psychiatrist or a Functional Capacity Evaluation conducted by a physical therapist. The results of this testing are again reviewed by the team of physicians. If denied, the disability claim is reviewed by the Disability Appeals Committee consisting of two more physicians and a presiding hearing officer who is an attorney and nurse, by profession. There are four physicians serving on two teams of hearing officers of the Disability Appeals Committee. These physicians are internists. One specializes in gerontology, a second specializes in endocrinology, the third has over 15 years of experience and a focused practice in disability benefit evaluations, and the fourth is an internist.

Collection and Evaluation of Medical and Employment Information by PERS

Determining whether an individual's medical condition results in functional limitations, thereby preventing performance of job requirements and thus, whether this condition meets the statutory definition of disability, is an inexact scientific process. Therefore, the approach taken by PERS, using highly trained medical practitioners to evaluate medical and vocational documentation, is believed to be much more desirable than the approach utilized by SSA. It is believed that the determination method utilized by PERS does, in fact, result in more objective, medically sound decision making than that used by SSA.

It is the responsibility of the PERS benefit claimant to obtain and submit medical records from treating physicians for review by the PERS Medical Board. The PERS Benefit Analysts are responsible for conducting personal interviews with the claimants in person and over the telephone. They also communicate regularly in writing, to ensure the claimant provides a complete listing of medical information to be submitted in support of his or her claim for benefits. The claimant must provide a history of the treatment received during the course of his or her illness. The PERS Benefit Analysts monitor receipt of the medical documentation on an ongoing basis and notify the claimant in writing when information is received. The claimant is also notified in writing on a regular basis that information listed in the medical history has not been received and is required prior to review by the Medical Board. The treating physician(s) must provide a diagnosis and a listing of any limitations or restrictions related to the applicant's medical condition. The treating physicians are asked to certify whether the claimant has reached maximum medical improvement.

In addition, since the criteria for disability determination with PERS is based on a permanent inability to perform one's own occupation, regardless of the age, education or experience of the claimant, knowing the claimant's job requirements is critical to the determination process. Therefore, PERS provides a form for completion by the employer in describing the functional requirements of the job. The employer also provides his or her evaluation of how the claimant's medical condition limits or restricts adequate performance of the stated job requirements. This form provides the basis for the

Medical Board's determination as to whether the performance requirements of the job are sedentary, light, medium or heavy.

The objective medical evidence in the record describing the severity of the condition and revealing the claimant's physical and mental limitations and restrictions is then compared to the requirements of the job. If the functional abilities of the claimant are not clearly and objectively defined in the medical records, the Medical Board may request the claimant to consent to what is called a Functional Capacity Evaluation (FCE). The FCE is used to objectively measure a claimant's physical abilities and limitations. The FCE is conducted by trained physical therapists in a medically safe and controlled environment. Using equipment, as well as a knowledge and understanding of body movement, the physical therapists ask the claimants to perform certain tasks to simulate the functional requirements of the job, as certified by the employer. The claimant's heart and pulse rates are monitored by the physical therapists during the entire process. Through the use of scientific methodology, the physical therapists are able to formulate a conclusion about the claimant's functional abilities. Through the use of the FCE, objective evidence can be also be obtained as to the existence of pain resulting from physical exertion as measured by increased heart rate, pulse and/or other physically observable responses.

Assessing subjective complaints of impairments or dysfunction can be a challenging undertaking, especially with regard to mental problems or complaints of pain. Applicants presenting claims based on mental conditions, requiring objective evidence of functional limitations are often referred for a neuropsychiatric evaluation, conducted by a psychologist or a psychiatrist. This evaluation requires a personal interview in order to conduct a thorough history of the patient. A series of psychological tests are then administered to determine the applicant's current level of functioning. The psychiatrist or psychologist will then review the functional requirements of the job and draw conclusions as to the applicant's ability to perform the job requirements using the testing results as the basis for the conclusions.

The PERS physicians, in evaluating claims for benefits, look to see whether or not reasonable accommodations could be made in the work place to allow or make it easier for a member to perform his or her job. The physicians seek information about the various types of treatments tried by the claimant and his or her physicians as well as the treatment that is being considered to improve the claimant's functional ability and/or medical condition.

The PERS physicians make efforts to document the existence of debilitating pain, as well as the existence of a medical condition of sufficient severity to result in debilitating pain, through the use of independent medical evaluations or through the use of Functional Capacity Evaluations. However, allowing the use of self-reported pain by individuals with conditions such as fibromyalgia (as allowed by SSA), in which pain is the primary and predominant symptom, while requiring patients with other medical problems where pain is a predominate factor such as Rheumatoid Arthritis, Lupus, Low Back Pain, etc., to have objective evidence of their disability is believed to be intrinsically unfair. It is therefore the belief of the PERS Medical Board, that the standard of requiring objective medical evidence should be applied in all cases for the sole purpose of ensuring uniformity, objectivity, equity and fairness in the determination process.

The PEER Review noted that PERS should develop a checklist of required medical tests for types of disabling conditions and require that the results be placed in the file prior to review by the PERS Medical Board. PERS would note that if the checklist is for the Medical Board's use or for use by the applicant's treating physician, then such would be unnecessary as they themselves know the kind of

test that might provide information necessary for documentation in support of a particular diagnosis. If the checklist is for the applicant so that he or she can have medical tests performed before applying for benefits based on certain medical conditions or diagnoses, then such might lead to unnecessary expense or physical risk for the claimant.

Collection and Evaluation of Medical and Employment Information by SSA

The SSA definition of disability requires that a claimant be disabled from performing "any occupation" in the economy for which, he or she, by virtue of age, education and/or experience, could perform. While SSA's standard for disability does require the disabling medical condition be permanent; the term "permanent" is operationally defined as resulting in death or lasting for a period of at least one year.

SSA, through each State's Disability Determination Service (DDS), relies on the use of lay evaluators to obtain medical information from claimants, evaluate the data and determine eligibility for benefits using a five step sequential evaluation process. These lay evaluators are individuals who work for DDS, have college degrees and are required to participate in an **8 to 12 week course** in the SSA disability decision-making process. The **lay evaluators** are given the responsibility to determine what and how much medical documentation is to be obtained for use in decision making.

Physicians and psychologists, hired by the State DDS, are available on a part time basis to sign off on the review and decisions as to benefit eligibility made by the lay evaluators. These physicians also serve as consultants to the lay adjudicators involved in the determination process. A physician's input is currently required with two disability evaluation tools which are unique to SSA. These evaluation tools include the Residual Functional Capacity Evaluation (RFC) and the Listing of Impairments.

The Residual Functional Capacity Evaluation (RFC) consists of an **administrative paper review** of the medical and vocational information contained in the record for the purpose of delineating physical or mental functional abilities and requirements. A medical doctor performs the RFC for physical impairments and a psychologist performs a specialized form of the RFC in cases of mental impairment claims. The claimant is the sole source for information about the job he or she performed. The employer is not contacted for information about the job requirements. Furthermore, while the employee may be a reliable source of information about his or her job requirements, his or her information is not required to be substantiated by a third party, such as an employer. A physical examination is not required for completion of the RFC. That is, no personal contact is required at the initial decision making level. There is no requirement for gathering objective, measurable, reproducible evidence or information. The functional requirements of a job for which a claimant is trained or could be trained, based on functional abilities as measured by the RFC, as well as the claimant's age, education and job experience, is then evaluated against the requirements of jobs as they exist in the economy. If the applicant has no transferable skills or there are insufficient jobs in the economy available to the applicant and/or the RFC reveals significant limitations, the claim may be approved. The Dictionary of Occupational Titles and vocational grid are used to identify the job requirements of the applicant as well as the availability of jobs in the economy. The DOT is a publication of the Department of Labor and focuses on the **physical requirements** of a job without consideration for non-physical or mental requirements of many sedentary jobs in today's economy.

The third step of the sequential evaluation process which currently requires the use of physicians, involves the use of the Listing of Impairments. This Listing of Impairments attempts to address or list the medical documentation i.e., test results, including documented, observable symptoms, and

complaints within fourteen different body systems, required for a determination of disability. However, if the medical documentation does not "meet" the Listing of Impairments, the adjudicator may conclude that while no one medical condition meets the Listing of Impairments, the combination of medical conditions documented may "equal" the Listing of Impairments and thus, result in a determination of disability.

It is important to note that SSA recognizes the problems inherent in its adjudication process for disability benefit determination. In a recent report issued by the Social Security Advisory Board, Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change, published in January 2001, page 14, the following comment is made about SSA's approach: ***"The development of sound disability policy requires far greater medical and vocational expertise than the agency currently has. Over the years, SSA has lost many of its skilled medical and vocational specialists that have not been replaced with sufficient rapidity. As a result, important medical listings have not been kept up to date to reflect advances in medical diagnosis and treatment and vocational guidelines do not take into account the changes that have occurred in the workplace. Of perhaps even greater concern is the fact that the Department of Labor's Dictionary of Occupational Titles is no longer being updated. This document, which describes the types of jobs that are available in the national economy has long served as a primary tool for adjudicators in determining whether a claimant has the capacity to work. SSA currently has no replacement for the Dictionary of Occupational Titles, leaving a critical policy vacuum at a time when program rules require more and more decisions to be made on the basis of vocational factors."***

The above discussion involved the role of SSA physicians in Step 3, 4 and 5 of SSA's five step sequential evaluation process. However, SSA decisions are made on a vast number of benefit claims without going further in the sequential evaluation process than steps one and two. That is, determinations are made as to whether the claimant is engaged in or is able to engage in substantial gainful activity, step one, and whether or not the medical condition is "severe" or "non-severe," step two. Both Steps 1 and 2 are completed by the lay evaluator.

It is the lay evaluator's responsibility for determining whether or not additional testing is requested or whether an independent medical evaluation is to be requested. The evaluator is also responsible for determining the type of evaluation to be performed and may reference a testing guide or the Listing of Impairments for determining what tests to require.

While SSA has implemented a process of quality assurance, the process, overseen by quality assurance personnel, is open to criticism because of the apparent broad based authority resting with these employees. Those staff members responsible for quality assurance are not physicians. Rather, they normally have training, background and experience as lay evaluators. It is within the authority of these quality assurance personnel to challenge a physician's decision and to document errors of evaluators who have incorporated a physician's opinion in the disposition of a case.

The SSA process, as documented in publications issued by the Social Security Advisory Board, relies heavily upon the use of subjective information. SSA appears to place increasingly more weight on the **opinions** of treating physicians as well as the self-report of claimants as to the existence of disabling conditions. Decision-making based upon the use of subjective data, by its very nature, results in inconsistencies. SSA may accept a self report of pain as a credible basis for decision-making. However, PERS, while not discounting the opinion of the treating physician or the existence of pain, does require objective indicators for use in decision making.

Quoting the Social Security Advisory Board report, Charting the Future of Social Security: The Need for Fundamental Change, page 5, ***"Although Congress has not changed the law for more than 30 years, the determination of what constitutes disability has changed in fundamental ways. For example, there has been a gradual but persistent trend away from decisions based on the medical listings to decisions that increasingly involve assessment of function. Since 1983, the percentage of Disability Insurance claimants awarded benefits by State agencies on the basis of meeting or equaling the medical listings has declined from 82 percent to 58 percent, while the percentage awarded on the basis of vocational consideration has more than doubled."***

In the same report on page 9, the Social Security Advisory Board notes, ***"As the GAO recently testified, fundamental weaknesses remain. These include an eligibility determination process that concentrates on applicants' incapacities rather than their capacities, return-to-work services offered only after a lengthy determination process, and an "all-or-nothing" benefits structure that characterizes individuals as incapable of work."***

And on page 11, the report states, ***"The infrastructure is weak. There are too many voices articulating disability policy. Adjudicators in different parts of the system are bound by different sets of rules. Important policy elements are out of date. As the result of downsizing and lack of new staff to replace those who have left the agency through retirement or otherwise, the level of expertise in areas such as medical and vocational factors has declined."***

Currently, SSA uses physicians in the disability decision making process. SSA has plans to implement numerous dramatic changes with respect to the use of physicians on a nationwide basis over the next five years. As noted in the report issued by the Social Security Advisory Board in January 2001, Disability Decision Making: Data and Materials, page 105 – 106, SSA is committed to ***"eliminating the input of the physician in the decision making process."*** SSA refers to this initiative as part of the "Full Process Model" of decision making. This initiative was undertaken in response to the diminishing availability of medical and vocational expertise. A major goal of SSA is to move to what is called the "single decision maker." According to SSA, **"the single decision maker is a position which would give the disability examiner authority to make disability determinations without requiring physician input."**

Documenting the Decision to Deny a Claim for Benefits

The burden of proof that a medical condition with corresponding functional limitations and/or restrictions which meet the definition of disability rests with the PERS disability applicant during the initial review by the PERS Medical Board. If a claim is denied, the applicant is sent a letter notifying of the decision to deny, stating there was insufficient objective medical evidence to support the finding of a medical condition which prevents further performance of his or her job. In addition a list of the records reviewed by the Medical Board in making this determination is attached to the letter. The decision to deny a claim is written in very broad terms, similar to the letter sent by SSA at the initial review level. However, if the claim is appealed to the Disability Appeals Committee, the claimant is allowed to introduce additional medical evidence and testimony. The PERS process allows the DAC to hear the claim with an unbiased view of the medical evidence and testimony. If the Board of Trustees accepts the DAC recommendation to deny the claim then, like SSA, a detailed statement is prepared outlining the information reviewed and detailing the reasons for denial. PERS has recognized a need to improve this notification process and has recently taken steps to ensure the notice of decision document prepared by the Disability Appeals Committee and provided to the applicant by the Board of Trustees provides the details needed to fully explain the reason for the decision. This detailed notice is

provided for the benefit of the applicant, his or her legal counsel and an appellate judge, should the case be appealed to Circuit Court.

Conclusions Regarding PERS' Use of SSA Evaluation Process

While the Listing of Impairments is beneficial to lay decision makers and may be helpful to applicants and the representatives of applicants, it is no substitute for medical knowledge and expertise available through the use of physicians evaluating a claim. The physician evaluation allows for consideration of unique, individual symptoms and responses to conditions that are not otherwise addressed in an Impairment Listing. The Listing of Impairments, by design, represents the norm with little or no consideration for deviation from the norm. It is the position of PERS that the use of lay decision makers with no more than 8 to 12 weeks of training as a substitute for decisions of physicians is also irresponsible. PERS believes the members of the retirement systems administered by PERS deserve to have decisions regarding the use of their funds for the purpose of paying disability benefits be made by experts who are trained physicians. The benefit applicants deserve to have their medical conditions reviewed by those trained in medicine. PERS would compare this to turning over the investments of our trust funds to employees with 8 to 12 weeks of investment training. Such action would justifiably result in public outrage. Just as with the investment of PERS funds, PERS has the responsibility to bring the best suited and best trained resources to the process – and in this case, it is 3 to 5 practicing physicians versus lay persons. Because of the fiduciary responsibility and moral obligation PERS has to its members, acceptance of or modeling of the SSA approach to disability determination is not a reasonable recommendation.

The Appeals Process

PEER has compared the PERS appeal process to Social Security's appeal process. The implication is that because the PERS process only has only two levels of review before a denied claim can be taken into court and the SSA process has 4 levels of review before going to Court, that the SSA process is superior. This is a fallacy. First, in the past, PERS had multiple appellant processes. Statutory changes have been sought by the PERS administration to shorten the appeal process. Previously, the PERS process tracked very closely with that currently maintained by SSA.

The Social Security Advisory Board, in a January 2001, publication, Charting the Future of Social Security's Disability Program: The Need for Fundamental Change, page 105 – 106, recommends ***"elimination of the "reconsideration process" in order to shorten the time necessary for disability adjudication."***

Further, SSA is recommending reduction in the levels of appeals and has specifically requested consideration for establishment of a SSA Appeals Court. It has been recommended that in the appeals process, the agency's (DDS) position with regard to the decision to deny the claim, be represented by counsel. According to SSA in the January 2001, publication, Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change, page 18, ***"the Administrative Law Judges (ALJ) have been required to balance three roles. They are obligated to protect the interests of both the claimant and the government and to serve as an objective adjudicator. But as attorney and other third party representation on behalf of claimants has increasingly become the norm, ALJs are finding it difficult to maintain the balance. Nationally, about 80 percent of Disability Insurance Claims are now represented by an attorney, a situation that many believe has made the process too one-sided."***

SSA currently allows claimants to submit new or additional medical or vocational information in support of their claim at any time. New information may be introduced at any level of the adjudication process, including the hearing before the Administrative Law Judge. SSA is recommending that claimants be required to submit all information during the initial evaluation process and that the record be closed at that time.

Clearly, PERS is far ahead of SSA is the development of its appeal process in that PERS has already eliminated unnecessary review levels to expedite the process. As stated earlier, PERS recognized the need to streamline the appeals process. PERS requires all medical information be submitted for review by the PERS Medical Board, prior to a final determination being made. Appellants are asked to sign a form prior to the Disability Appeals Committee hearing that all information for consideration has been submitted. Additional information may be submitted at the DAC hearing but only after a ruling by the DAC presiding hearing officer. Once the case has been decided by the DAC, the claimant's record is closed. A formal appeals procedure was implemented and for disability cases, the appeals process has been revised numerous times in an effort to appropriately meet the special needs of this benefit population. The Special Assistant Attorney General assigned to PERS sits in on the Disability Appeals Committee Hearings to see that the record of the hearing is properly introduced and to address any administrative or statutory issues should the need arise. Unlike what is mentioned in the PEER Review, the DAC process is NOT an adversarial process and the attorney does not serve in an adversarial capacity. However, if the case is denied by the Board of Trustees and is appealed by the claimant to the Circuit Court of Hinds County or the Supreme Court, the PERS attorney is responsible for representing the interest of PERS and defending the decision of the Board in denying benefits. PERS also has legal representation of the agency's medically-based decision making throughout the judicial process.

Understanding The Impact Of Requiring PERS To Use The SSA Definition Of Disability

There are two primary types of disability benefits offered in the public and private sector. These disability benefit types differ in the criteria used to determine disability. One's limitations and impairments are measured against one's "own occupation" or against "any occupation" for which a claimant is trained. The PERS benefit is based on the inability to perform one's "own occupation" while the SSA benefit contains an "any occupation" standard. The "own occupation" standard used by PERS and the systems administered by PERS is a far more valuable benefit to the individual member.

The impact of PERS relying on SSA for disability determination as suggested in the PEER Review, presents significant problems because of the differences in the benefits and the groups of workers covered by SSA and PERS. PERS administers a retirement plan for classes of individuals not covered by Social Security. These classes of individuals include certain firemen and policemen, as well as some elected officials, primarily employed in municipalities. These classes of employees represent a small but important percentage of individuals who do not have SSA coverage and could be adversely impacted by changes in the current PERS disability program. In addition, PERS provides disability benefit protection to individuals who earn less than that recognized by SSA as "substantial income from gainful activity." In the first step of SSA's sequential evaluation process, the SSA adjudicator will determine whether or not an individual is engaged in gainful activity earning more than $700 per month. PERS currently has 10,565 contributing members earning less than $700 per month.

An example of how these opposing standards create conflict between the PERS and SSA benefit is a follows:

> *An elected alderman who is not contributing to SSA but pays PERS contributions on his $200 per month municipal job, applies for PERS disability benefits. The alderman job is the only job for which PERS disability benefits are extended. However, this same person is also a construction worker and pays social security taxes on his earnings as a construction worker. The gentleman injures himself, preventing performance in his job as a construction worker. The injury was not so severe as to prevent performance in his sedentary job as an alderman. This gentleman applied for disability benefits from PERS and SSA. SSA receives the claim and knows nothing about the alderman job. However, even if information was known about the alderman job, because the gentleman is earning less than $700 per month, it is uncertain as to whether this job would be considered in SSA's determination process. If SSA made the determination on this claim on behalf of PERS, as recommended in the PEER report, using SSA standards, the gentleman would receive PERS disability benefits simply because he could not perform a job unrelated to his public service. Applying the PERS disability standard, the gentleman would be entitled to disability benefits from SSA for the construction job but would not meet the standard for disability under PERS for this sedentary position.*

Conversely, following is an example of where an employee covered under PERS for disability benefits would be adversely affected by adoption of the SSA definition of disability.

> *A fireman contributes to PERS but does not pay SSA taxes on his fireman's earnings. However, the same fireman works part time in a job, i.e., a cashier's job, at a local convenience store. The fireman pays SSA taxes on earnings as a cashier. The fireman injures his arm thus, preventing further performance as a fireman who is required to lift 50 to 100 pounds. The "own occupation" disability standard used by PERS would allow for benefits to be awarded in this case. However, since no such lifting requirement exists with his SSA covered position, he would not qualify for SSA benefits. The SSA "any occupation" benefit would not extend benefit protection to the fireman's job, whether or not SSA taxes had been paid on the job. The reason SSA benefits would not be paid is that the fireman is able to perform other jobs in the economy, for which he is trained.*

A final example where the use of the two different disability eligibility definitions used by PERS and SSA would result in opposite outcomes involves an individual under age 50 performing a light to medium job and who is participates in PERS and pays into Social Security:

> *The job of teacher is classified as a light to medium job. In the event a teacher, under age 50, develops a medical condition which prevents standing for long periods of time and prevents lifting more than 10 pounds, he or she would be considered disabled when applying the PERS "own occupation" definition of disability. Because the individual was of a younger age (under age 50), college educated, and because there are sufficient jobs in the economy which are sedentary, that is, do not require prolonged standing or lifting more than 10*

pounds, this condition would not meet SSA's definition of disability and the SSA claim would be denied.

The PERS disability benefit providing protection to members in the event of a disability preventing performance in one's "own occupation" is extremely valuable. Acceptance of the SSA definition of disability would significantly reduce the disability protection currently available to members.

SSA's definition of disability allows approval of claims where the medical condition is expected to last for one year. Such standard requires a committed approach to reexamination of disability retirees as to continued eligibility for benefits. Because of the growth of the claimants over the years, SSA has been backlogged as much as seven years in reexamination of benefit recipients.

The standard applied by PERS in allowing payment of disability benefits requires the disability to be permanent. However, there are some claims approved for benefits which are subject to reexamination by the PERS Medical Board. The PERS Reexamination Review is now based on whether or not the disability retiree's condition has improved thus allowing a return to performance of the job from which retired. Many claimants are approved for benefits with no reexam requirement, i.e., patients with terminal illnesses.

All PERS disability benefit recipients are allowed to work while receiving disability benefits. Such work must be in a position with functional requirements different from the job for which disability benefits were approved. The income that can be earned by a PERS disability retiree is limited to no more than the difference in the benefit paid, exclusive of the Cost of Living Adjustment and the average compensation used in calculating the benefit. The income of disability retirees is monitored by PERS on an annual basis. Because the PERS disability program is smaller and under direct control of the agency, PERS is able to maintain its reexamination process without significant backlog.

The Cost to Administer the PERS Disability Program

The SSA has noted the cost for the State of MS Disability Determination Service (DDS) to make disability determinations is quoted as $224 per case. This cost does not appear to include the cost of the SSA hearings and appeals process nor does it include the benefit eligibility screening, estimates and processing or benefit payroll services rendered by non-DDS employees. In reviewing the cost of the PERS process it is important to realize the cost for making the "right decision" is directly related to the cost of the benefit should a member be processed to payroll who does not meet the PERS disability benefit eligibility criteria using objective medical evidence. The cost for the initial stage of the disability determination process is consistent with the cost for similar services rendered by DDS. PERS' cost for initial determinations during FY 2001 is $290 per case. However, the cost for this service is expected to rise with increased cost for the medical services, i.e., independent medical evaluations and functional capacity evaluations. During this fiscal year, PERS has made a commitment to require that the majority of claims, prior to issuing a denial of benefits, must first be evaluated by a physician or be scheduled for neuropsychiatric testing or a functional capacity evaluation. The cost for such evaluation services as well as the additional cost to defend the decision to deny benefits is minimal when compared to the cost to provide benefits over the lifetime of the applicant should he or she be inappropriately granted disability benefits.

During Fiscal Year 2001, an analysis was done to determine what the cost of certain benefits would have been had they been approved. In addition, PERS staff reviewed the cases that were denied by

PERS but approved by SSA. Of the 88 cases denied by PERS, 70 had applied for SSA. Of these 70 cases, denied on the basis of objective medical evidence, 20 were denied by PERS but approved by SSA. The average benefit of these claimants was $12,150 per year. The present value of the benefits was $2.7 million.

Concern has been expressed that PERS disability allowances are inconsistent with those of SSA. Unlike the results of the data comparison between SSA and PERS decisions reflected in the PEER Review, SSA reports significantly higher rates of claims approval than documented by PERS over the last ten years. In fact, taking into consideration the initial, reconsideration and ALJ hearing process, the statistical data presented in the Social Security Advisory Board's Report, Disability Determination: Data and Materials, pages 21 and 22, during Fiscal Year 2000, **approximately 89 percent of the claims for disability were approved. The data reflected a 45% approval rate at the initial level of review, an 18% approval rate at the reconsideration level and a 75% approval rate during the hearing before the Administrative Law Judge.** Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change, page 3, states, ***"Claims denied by State agencies and appealed to the administrative law judge (ALJ) hearing level are more likely than not to be approved at the hearing level."***

Over the last ten years, PERS' approval rates have varied over the years. In PERS' opinion, this variation in approval rates reflects the validity of the claims rather than a pattern of errors and bias in evaluation. The PERS approval rates, over the period of 1990 through 2001, are as follows: **1990** – 44%; **1991**- 58%; **1992** – 63%; **1993** – 73%; **1994** - 57%; **1995** – 58%; **1996** – 67% ; **1997** - 72%; **1998** – 65%; **1999** – 70%; **2000** – 53% ; **2001** – 72% approved.

Because the SSA and PERS disability programs are so different, it is difficult to draw a true comparison as to whether one organization is doing a better job than the other in the area of disability determination. It is hoped that this review has explained the differences between PERS and SSA in the coverage groups, benefit structures, evaluation methods, definitions of disability, and differences in what is viewed as substantial gainful activity. PERS gives no special consideration to the age, education or experience of the member at the time of application. SSA may allow disability benefits to be paid if a medical condition is expected to last for a period no less than twelve months. PERS, however, allows benefits be paid only in cases where the condition is expected to be permanent. The PERS review is made by trained medical doctors. The SSA review relies heavily on the expertise of lay evaluators, under the supervision of physicians and subjective information is increasingly relied on by SSA as the basis for disability determination. Each program has its own unique set of rules and each benefit is very valuable to the members. The two benefits are not coordinated and are separate components of a member's retirement income planning.

Inequities in the PERS Service and Disability Benefit Structure

During the analysis of the FY 2001 data, PERS administration reviewed the outcome of those claims where the applicants were eligible for service retirement benefits. A total of 34 members applied for disability benefits who were eligible for service retirement. PERS approved 22 of these claims. A total of 12 claims were denied. Of the 12 denied claims, 5 were approved by SSA. The average age of these 5 members was age 49. The average PERS disability benefit was $13,458 per year and the average service retirement benefit was $8,234 per year. These members will receive a benefit from SSA equivalent to that which they would receive at age 65. This SSA benefit, when combined with the PERS disability benefit, in many cases, results in an income exceeding that which was earned prior to retirement. This presents a strong incentive for members to apply for disability benefits

Whether a person is eligible for service retirement under PERS is not considered by the PERS Medical Board in determining disability benefit eligibility. Clearly, whether or not a person is eligible for service retirement is in no way whatsoever correlated with the existence of a disabling condition. As recommended by PEER, PERS agrees to eliminate the inclusion of the benefit estimates in the record to prevent the appearance that such might result in a bias on the part of a disability determination process. However, for PERS administration, the fact that a member may receive more in disability income than from service retirement is troublesome, as is the fact that a disability retiree may receive an increase in overall income over that which was received while actively employed.

The purpose of the retirement system is to provide retirement income to those individuals who have worked in public service and contributed to the retirement plan over a period of years. The retirement system has a responsibility to provide an adequate replacement income to participants and/or their families should a participant become unable to work or should a participant die before reaching retirement age. A primary goal of PERS is to provide a retirement plan that rewards employees for dedicated service. The longer a participant works in public service, the greater the benefit should be when applying the benefit formula.

PERS sees the need to adjust this inequity in the service and disability benefit payments. Consideration is being given as to how benefits could be restructured or what services could be added to not only address the problem with the benefit structure but provide added value to the disability benefit. Whether the disability benefit should be capped at no more that what could be earned under service retirement as it is with SSA, is an issue being considered by PERS administration.

Conclusion

PERS is very proud of its disability program. The disability applicants and retirees are viewed as a very special population deserving of the most professional and efficient service possible. PERS is committed to improving any deficiencies in program operations. PERS is constantly striving to reduce the turnaround time in its process, taking care to maintain the integrity of the process.

The PEER Review suggested PERS provide training to its evaluating physicians. This suggestion is felt to be most appropriate. PERS selects physicians for the Medical Board and Disability Appeals Committee who are actively practicing and engaged in ongoing training. In addition, PERS seeks out physicians who are trained and who practice in disability determination and rehabilitation specialties. As a result, these physicians stay up to date on the latest developments in the field of disability and rehabilitative medicine. In fact, current and former members of the Medical Board and Disability Appeals Committee author papers on topics concerning disability and rehabilitative medicine for review by other physicians. PERS staff of physicians would not only appreciate any training opportunities provided by PERS but could and would be willing and able to provide training in the field for other physicians or lay persons interested in this area of medical expertise.

Given the fact that the disability population is projected to grow tremendously with the aging of the baby boomers, the issues surrounding disability benefit determination should be a basic information and training topic for all practicing physicians and employers in the State of Mississippi and the country.

During Fiscal Year 2001, the SSA's Disability Insurance Program and the Supplemental Security Insurance Program are expected to account for $90 billion in federal spending, or nearly five percent of

the Federal Budget. By 2010, SSA disability insurance recipients are projected to increase by fifty percent. There were 5 million adult workers receiving disability insurance benefits as of February 2001. In 2001, about two-thirds of SSA's $7.1 billion administrative budget, nearly $5 billion, is expected to be spent on disability program administration. SSA states that, ***"this projected growth in the number of disability claimants threatens to overwhelm a policy and administrative infrastructure that is already inadequate to meet the needs of the public."*** In Fiscal Year 2001, PERS paid $41,196,470 in benefits to 3,531 disability retirees, representing approximately 6% of the total PERS retiree payroll. These figures do not include benefits paid out under other systems administered by PERS such as Ms Highway Patrol Retirement System, the Supplemental Legislative Plan and the 19 separate Fire and Police Disability and Relief Funds (Municipal Retirement Plan). PERS also expects an increase in the disability retirees over the next several years. Given the impact of having an increased number of people out of the work force due to the retirement of the aging baby boomers and the fact that they will be reaching an age of increased likelihood of disability, significant economic and social challenges loom before policymakers, the medical community as well as employers. These challenges particularly relate to issues involving disability determination, rehabilitation and vocational training/retraining. Given the dramatic administrative and fiscal impact disability issues may have on the trust fund, it is imperative that the disability program remain under the control of the MS Legislature and PERS.

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