

Fast-Track Strategies in Long-Term Public Disability Programs Around the World

by

*David Rajnes
US Social Security Administration (ORDP/DPS)*

First Draft: September 2010

**PRELIMINARY DRAFT
DO NOT CITE OR CIRCULATE WITHOUT AUTHOR'S PERMISSION**

David Rajnes is a research analyst with the Division of Program Studies, Office of Research, Evaluation, and Statistics, Office of Retirement and Disability Policy, Social Security Administration.

Acknowledgments: The author gratefully acknowledges the invaluable assistance from many individuals at SSA while preparing this paper: L. Scott Muller (Office of Research, Evaluation, and Statistics); Nancy Schoenberg (Director, Office of Compassionate Allowances and Disability Outreach); Dalmer Hoskins (Director, Division of Program Studies); Susan Grad (Deputy Associate Commissioner, Office of Research, Evaluation and Statistics), and Barbara Kritzer (Division of Program Studies). Finally, this article benefited greatly from the feedback provided by agency staff in the several countries discussed here.

This paper explores the international experience with “fast-track” (FT) procedures in the determination process of public disability programs. FT procedures target applicants that appear likely to receive approval. Disability programs in the United States and several countries have incorporated FT procedures that share a common goal of accelerating applicants through the disability determination process—generally for those with more severe disabilities, blindness, or facing terminal illness. In expediting the application process, these procedures reduce delays, which negatively impact individuals and their families, and may help governments with disability caseload management.

In the United States, the Social Security Administration (SSA) expanded its list of FT procedures in recent years with the introduction of the Quick Disability Determination (QDD) and Compassionate Allowances (CAL) initiatives. These initiatives provide additional tools for SSA to manage the growth of disability applications from the

American baby boomer population. Complementing the more traditional “expediting” procedures operated by SSA, QDD and CAL take advantage of predictive software, which enables fast-tracking operations within an electronic disability process.

Other countries have introduced a variety of FT procedures. Like the United States, many countries in this sample are in the process of experimenting with or fine tuning recent disability reform efforts in this area. While country-specific goals and targeted medical conditions tend to be similar, the variety of disability program designs, associated claims process, and administrative arrangements give rise to subtle and some not so subtle differences.

This paper:

- Examines fast-track (FT) procedures implemented or under consideration in public long-term disability programs in the United States and several other countries;
- Compares FT procedures in these disability programs with respect to specific program features, system-wide differences for administrative components involved in the determination process, and the level of technology utilized;
- Identifies reasons why countries have considered implementing FT procedures;
- Describes how FT procedures have attempted to improve overall servicing of claims and contribute to disability case management by further refining the disability claims processing timeline.

The paper is divided into 5 sections. Part one introduces the five countries examined in this study and chronicles the methodology used in the selection process for the non-US sample. Part two documents how country-specific FT procedures operate in the context of the decision-making and application processes. Part three offers some tentative conclusions based on a data review and the country descriptions. Part four compares the operational aspects of fast-tracking disability claims across the country sample as laid out in the previous sections. Part five outlines potential areas of future research.

I. Country selection and methodological approach

This research produces a qualitative assessment of fast-track strategies using the United States as a benchmark. In addition to the U.S., four countries have been identified operating public disability programs with fast-track features inserted in various stages of the determination process.¹ These countries include Australia, Canada, Israel, and the United Kingdom. Other country programs were eliminated from consideration early in the selection process when it became apparent that sufficient detail was unavailable. Overall, efforts were made to contact 24 countries for this study, of which at least six countries were confirmed as having some type of FT process conducive for comparative purposes.² The 4-country sample represents countries with the best opportunity to date to make a comparison with the US FT processes.

Information collected in this study relies heavily on the expert knowledge and availability of staff at several national disability agencies. These country-based contacts provided much of the descriptions incorporated into this paper and verified the data collected, thus making this study possible.

Cross-country comparisons for FT processes are examined with respect to three questions:

- What is the decision process and who are the key parties responsible for administering decisions (including FT) on disability claims?
- How are FT procedures integrated into each nation's disability claims process (including technology)?
- What is the claims processing sequence for disability applications?

II. Countries with fast-track processes

This section provides the details of fast-track processes in each country surveyed. Procedures in the United States are presented first and provide a benchmark to compare FT processes in other national systems. Each national summary contains an outline of the administrative responsibilities of parties involved in the decision process, a detailed explanation of relevant fast-track procedures, a description of the evaluation procedures faced by claimants, and highlights of fast-track procedures.

Table 1 introduces the five-country sample by giving an overview of some design features in each national disability program, including how disability is defined, program

[Insert Table 1 about here]

eligibility, financing, and the treatment of work. Some significant programmatic differences can be observed, such as Israel's residency-only eligibility criteria or Australia's means-tested social programs financed by general revenues.

Another view of these countries is captured in Table 2, which highlights selected demographic and fast-track aspects of disability programs. From these data, it can be seen that self-reported disability rates range from around 5 percent of the working-age population in Australia and Israel, to higher levels as reported in multiple survey outcomes of from 6-10 percent in the United Kingdom and from 6-18 percent in the United States. More relevant for this paper are the recorded program expenditure levels

[Insert Table 2 about here]

as a percentage of GDP and the share in these disability programs of fast-track claims. Expenditure levels on disability programs range from a low of 0.22 percent of GDP in

Canada to the much higher levels found in Israel (1.07 percent) and the UK (1.27 percent), with more moderate percentages recorded for the U.S. (0.68) and Australia (0.92). The share of new claims that pass through FT processes tends to hover around the 4-6 percent range, although the share recorded for FT in Israel appears much higher.³ In general (with one exception—Israel), countries with FT processes process similar percentages of FT applicants among their claimant populations (roughly 4 to 6 percent) despite differences in overall expenditure levels on disability program or other distinguishing features.

Fast-track experience with public disability programs in the U.S.⁴

In the United States, the Social Security Administration (SSA) manages two programs that provide benefits based on disability or blindness, the Social Security Disability Insurance (DI) program and the Supplemental Security Income (SSI) program. DI provides benefits to disabled or blind persons who are insured workers who have made the required contributions⁵ to the Social Security trust fund.⁶ By contrast, SSI makes cash assistance payments to aged, blind, and disabled persons (including children) who have limited income and resources. For SSI, there is no requirement for a work history. The government funds SSI from general tax revenues. Both disability programs may utilize FT procedures.

Disability is defined in the U.S. as the inability to engage in any substantial gainful work activity (SGA) because of a medically-determinable physical or mental impairment(s) that is expected to result in death or that has lasted, or is expected to last, for a continuous period of not less than 12 months.⁷ SSA determines eligibility for both DI and SSI through a five-step sequential evaluation process used to determine whether the person is disabled (SSA 2009a; Brucker 2006; GAO 2008).⁸ This process for determining disability includes a work test, impairment severity test, medical listing test, test for ability to perform previous work, and ability to perform any type of work.

Disability assessment process. Social Security disability claims are processed initially through a network of local Social Security Administration (SSA) field offices (FOs) and state agencies (called Disability Determination Services or DDSs). Social Security representatives in the FOs obtain applications for disability benefits in person, by telephone, by mail, or online. The application and related forms ask for a description of the claimant's impairment(s), treatment sources, and other information that relates to an alleged disability. The FO is responsible for verifying non-medical eligibility requirements, which may include age, employment, marital status, or Social Security coverage information. The FO then sends the case to a DDS for evaluation of disability.

The DDSs, funded by the federal government, are state agencies responsible for compiling medical evidence and rendering the initial determination on whether or not a claimant is disabled or blind under the law. Usually, the DDS tries to obtain evidence from the claimant's own medical sources first. If that evidence is unavailable or insufficient to make a determination, the DDS will arrange for a consultative examination (CE) to obtain the additional information needed. The claimant's medical provider is preferred, but the DDS may obtain the CE from an independent source.

After completing its development of the evidence, DDS staff makes the initial disability determination. Then, the DDS returns the case to the field office for appropriate action. If the DDS finds that the claimant is disabled, SSA computes the benefit amount and begins paying benefits. If the claimant is not found disabled, the file is retained in the field office in case the claimant decides to appeal the determination. Subsequent appeals of unfavorable determinations may include the following: reconsideration by a different disability examiner in the DDS, a hearing in front of a federal administrative law judge in SSA's Office of Disability Adjudication and Review, an appeal to the Appeals Council, and appeal to the federal court system.

An important characteristic which has set the claims process in the United States apart from other countries in the sample is SSA's replacement of a traditional paper claims folder with an electronic folder (EF) to store case-related data and images.

Implementation of this technology began in 2004, and by early 2006, all DDSs had begun processing more than half of new disability claims in a completely electronic format (Green et al. 2005/2006).⁹ The Electronic Disability Collect System (EDCS) is an automated system that collects information about the claimant's disabling condition and transfers data to the EF. SSA creates the electronic folder (containing all essential documentation), which can be accessed by all case-processing agency components (FO, DDS, etc.) through an associated Electronic Folder Interface (EFI). EFI enables the downloading of the EF data as cases move from one office to another throughout the determination process. At the initial application stage, the combination of the EF and EDCS have enabled the use of a predictive model. Paper evidence, forms and case processing documents for pre-EDCS claims continue to be filed in paper folders, while new claims are handled solely by the electronic folder.¹⁰

SSA is also working on a new initiative, the Health Information Technology (HIT), designed to improve the speed and quality of the disability determination process by automating both the authorized request and receipt of data. To accomplish this, SSA has contracted with healthcare providers to participate in the Nationwide Health Information Network (NHIN),¹¹ which allow medical providers to receive a standardized electronic request for medical records and then automatically respond to SSA requests with structured medical information. SSA is the first government agency to utilize the NHIN. Since early 2009, Social Security has had instantaneous access to medical records for some disability applicants electronically through the NHIN gateway. The NHIN helps ensure that records are received in a timely fashion by making it easier and less labor-intensive for medical professionals to submit records, thus shortening the time it takes to make a disability decision and making the overall process more efficient.

Fast-track procedures. SSA uses six fast-track (FT) procedures that accelerate the claims process in the disability programs it administers. In general, one procedure only applies to claims under the SSI program, while the remaining processes fall under DI, with the possible application to both DI and SSI. However, there is a good deal of overlap in the

identification process and application. The newest procedures, Quick Disability Determination and Compassionate Allowances, are referred to as “fast-track” by SSA, while the others are generally referred to as “expedite procedures.” Recent initiatives are described first in this section.

(1) *Quick Disability Determinations (QDD)*. The Social Security Administration (SSA) began using the QDD process in August 2006 on a pilot basis,¹² issued final regulations effective September 2007, and extended the QDD process nationwide by February 2008. QDD uses a predictive model to electronically identify these claims. Cases selected for QDD processing (this step takes about a second) are forwarded to a DDS within 24 hours of receipt, and are highly likely to receive favorable determinations when objective medical information can be quickly obtained. A designated QDD examiner has to confirm that there is available medical evidence in the file to establish a chronic physical or mental disability.

(2) *Compassionate Allowances*. The Compassionate Allowance Program is another recent fast-track initiative for DI applications. Launched initially in the fall of 2008, it currently targets 25 cancers and 63 other medical conditions. The list is expected to expand in the near future. These medical conditions include adult brain disorders and other conditions so severe that they satisfy established medical criteria. All CAL-identified conditions are entered into the predicative model (PM) and selected for CAL processing based solely on the claimant’s allegations. Unlike QDD, CAL does not score the disability claim. Instead, CAL uses the PM software to quickly identify diseases and other medical conditions that invariably qualify under the Listing of Impairments based on minimal, but sufficient, objective medical information. Once an appropriate medical diagnosis is confirmed by the treating physician, the claim is approved in a matter of days compared with the several months it would take on average for a claim to be confirmed at the initial determination level. SSA developed the list of Compassionate Allowance conditions from information received at public outreach hearings, public comment from an Advance Notice of Proposed Rulemaking, comments received from the Social Security and DDS communities, and from counsel by medical and scientific experts.¹³

(3) *Terminal Illness Cases (TERI)*. Cases deemed “TERI” merit special handling, with carefully prescribed protocols for appointment setting, labeling and flagging of TERI cases, tracking, and continuous monitoring of timing to ensure fast processing. Predictive modeling software can play a role for electronic folders when a new claim is filed, although the TERI designation can be assigned to the paper folders of existing claims. Other types of cases (CAL, QDD, and PD) may be designated for processing as TERI, but cannot be formally classified as TERI unless they meet the TERI criteria. TERI cases may be identified by the telephone Teleservice Center, FO, or DDS. DDS management is responsible for tracking and controlling TERI cases through the initial and reconsideration levels of review at the DDS, 10 days following the receipt of the claim and every 10 days thereafter.

Suitable applicants with an “untreatable impairment”—which cannot be reversed and is expected to end in death—must present a credible claim from the individual, friend, family member, personal doctor or other medical source, although TERI cases can also be identified by the FO or DDS during standard processing. Qualifying claims may include a diagnosis, such as ALS (Lou Gehrig’s disease) or AIDS, or a statement that the claimant is receiving in-patient hospice care. Additional qualifying conditions include a bone marrow transplant, any malignant cancer that is metastatic (stage IV), and small cell or oat cell lung cancer, among others.

(4) *Military Casualty Cases (MC)*. The Social Security Administration expedites the processing of disability claims by military service members seriously injured while on active duty on or after October 1, 2001, with assistance from the Veterans Administration and the Department of Defense (DOD).¹⁴ In order to give priority to these cases, SSA has encouraged the identification of these “wounded warriors” claims in two ways (GAO 2009). First, since 2005, claimants can self identify under the MC program when filing for disability—SSA has added questions on its application form to help recognize military service members and veterans and their dates of service. Second, DOD agreed

(in a 2008 memorandum) to send weekly electronic updates to SSA with information about service members who become ill, wounded, or injured.

To qualify for disability benefits under MC, military personnel must be unable to do substantial work because of their medical condition (either physical or mental), and the medical condition(s) must have lasted or is anticipated to last at least one year, or expected to result in death. Service members frequently undergo a qualifying medical exam or medical test to assist in the case evaluation. FO and DDS staff are instructed to expedite processing these claims and to follow TERI procedures through all stages of case development and adjudication. Once the FO refers the application to a state DDS office for review, it follows up within 7 days to ensure receipt by the DDS system. DDS staff are required to consider “wounded warrior” cases as early as possible and explore all potential physical and mental impairments. In addition, as with critical cases, SSA staff at the hearing level are required to schedule wounded warrior cases in the first available open hearing slots.

(5) Presumptive Disability and Blindness (PD/PB) cases. PD/PB status dates back to the introduction of SSI in the 1970s; the original regulations were issued in October 1974. While all SSI claimants must establish financial need based on the income and resource requirements, certain initial (first-time) disability claimants may meet special criteria for receipt of payments in advance of the formal medical determination by the DDS. The FO is authorized to make presumptive disability (PD) or presumptive blindness (PB) determinations for special impairment categories. The DDS can make such determinations in any case with a high probability of allowance.

PD/PB disability cases must meet all non-medical factors of eligibility. Benefits begin the month after application filing, if PD/PB requirements are met. These are presumptive payments, which is a notable difference from other FT categories. Claimants may receive up to 6 months of payments based on PD or PB prior to the formal DDS determination (assuming the claimant is declared disabled and meets all other eligibility criteria).¹⁵ If

there is no initial PD/PB finding, the DDS can still make such a determination when additional evidence indicates it is appropriate.

Qualifying presumptive impairments include the amputation of two limbs; amputation of a leg at the hip; allegations of total blindness, total deafness, or a cerebral vascular accident (stroke) more than three months in the past; and continued difficulty using hands, arms or legs. Additional qualifying impairments include alleged muscular dystrophy, muscular atrophy, cerebral palsy, and even terminal illness (death within 6 months), among others.

(6) *Expedited Reinstatement (EXR) cases.* The Expedited Reinstatement provision (EXR), which became effective January 1, 2001, is considered a safety net for persons who successfully return to work and later lose their entitlement to DI or SSI payments. If a person's benefits ended because they had resumed work and received earnings, and stopped working within 5 years of when those benefits ended due to a medical condition, SSA may be able to restart benefits again without the individual filing a new application.

If a person qualifies for EXR, SSA will pay 6 months of temporary (provisional) cash payments while the DDS conducts a medical review. In addition, the person is also eligible for Medicare and or Medicaid during the six-month provisional benefit period. Provisional payments are payable beginning with the month that the claimant files the EXR request.

When someone requests EXR, claims representatives at the FO complete an EXR "package," which includes the required forms for processing. Although this process is not fully automated, SSA controls the claim in the system, using the disability control file (DCF). An EXR claim is established within the DCF and remains open until that claim is processed as either an allowance or a denial. Once the EXR package is successfully completed, SSA can initiate provisional payments through an automated post-entitlement system. Issuance of provisional payments receives priority, and controls are in place to

ensure that beneficiaries receive their temporary cash payments expeditiously should the automated action fail.

Application sequence and administration of disability claims. To apply for disability benefits in the U.S., applicants can complete an on-line application, send or bring in a completed paper disability report, or file electronically at their local Social Security office. Once a claimant's application is complete, the FO staff electronically transfer the claim to a state DDS for disability determination. At this point, a sophisticated predictive model (PM) electronically evaluates the claim, determining whether the case qualifies for processing as a QDD and/or CAL case.¹⁶ The PM rapidly searches data on the initial application, and targets certain variables such as impairment allegations, medication, age, education, and work history. The description for QDD is presented initially below.

For QDD, the screening tool sums the weighted variables and generates a likelihood score for the case becoming a QDD. More specifically, a QDD case is identified electronically by the PM as having a high degree of probability that : the claimant is disabled, evidence of the claimant's allegations is expected to be easily and quickly verified, and the case can be processed quickly by the DDS. The electronic folder applies predetermined thresholds to the score. These thresholds are determined by SSA and are unique to each DDS. If the model identifies a claim as QDD (sufficiently high score), the claim is electronically marked "QDD" and routed to the state DDSs.¹⁷ Following receipt at the DDS, a QDD case is assigned to a disability examiner (DE), also known as a disability claims adjudicator. The DE reviews the allegations and whatever medical evidence is submitted at the time of filing. If additional evidence is needed, the DE tries to obtain it. Then the DDS, in coordination with a medical consultant, prepares a determination and returns the electronic folder to the SSA Field Office.

Similar to the process for QDD cases, potential CAL cases are identified at the initial application using the PM software. CAL cases also receive expedited handling at the state DDSs. However, in contrast to QDD cases, CAL cases are not selected on the basis of a

likelihood (probability) score. Instead, medical conditions pre-identified as Compassionate Allowances are loaded into the model by impairment name, common synonyms, and abbreviations. When the PM identifies the name of a CAL condition on an application, the case is electronically marked "CAL" and routed to the state DDSs for expedited handling.¹⁸

To expedite the processing of CAL claims, SSA has provided disability adjudicators with impairment summaries for conditions identified as compassionate allowances. The impairment summaries: contain information about a disease; indicate the type of medical evidence needed to confirm a diagnosis; and suggest the Listing of Impairment criteria under which the claim may be evaluated. Similar criteria are in place to guide staff at the FO and DDS levels for assigning flags to identify cases for TERI, MC, and PB/PD handling.

Fast-Track Highlights in the U.S.

- SSA uses 6 fast-track (FT) procedures that accelerate the claims process in the disability programs it administers, including sophisticated software to enable the newest initiatives, QDD and CAL.
- The goal of QDD is to make a final, favorable disability determination within 20-30 days. Of the 2,043 QDD cases processed by DDS between November 2007 and May 2008, 87.8 percent of claims were awarded disability benefits and 92.6 percent were processed in fewer than 20 days.
- According to SSA, nearly 4 percent of all disability applications went through QDD/CAL processing in FY09, with an expectation that this share will grow to 4.5 percent by the end of FY10.
- SSA is beginning to promote Health Information Technology (HIT), an approach designed to allow medical providers to receive a standardized electronic request for medical records and then automatically respond to SSA requests with structured medical information.

Experience of Other Countries Operating Fast-Track Procedures

Other countries with FT procedures are examined in this section. The approach taken is similar to what was done earlier for the United States: short introduction followed by more detailed sections dealing with the disability claims process, an overview of FT procedures, and a discussion of what applicants experience once they submit a disability claim. Table 3 (below) gives a list of the FT procedures described in the U.S. and other

[Insert Table 3 about here]

countries examined. Of significance is the variety of procedures found in nearly every country. The U.S. complement not only contains six FT processes that address a variety of impairments, but the availability of an electronic claims process has permitted the introduction of predictive modeling software, which now dictates nearly every FT process. This innovation has the potential to lower processing times and improve impairment identification in submitted claims. As noted earlier, the QDD process selects cases based on a likelihood (probability) score, whereas CAL and other fast-track categorical cases rely on the software to identify the terms of a pre-identified medical condition. This latter CAL-style approach is used in the other countries listed in Table 3, although with less sophisticated technology. However, the situation in some of these other countries may change given announced reforms involving changes to upgrade the operational systems of their disability programs.

Two other country entries in Table 3 are significant. In Canada, FT processes target individuals in the process of submitting an application for a claim as well as those who have returned to the labor force after suffering a relapse, which is similar to EXR cases administered by SSA. Another country with an interesting FT feature is the United Kingdom, which not only has an FT process for its long-term disability program, but also

operates a supplementary program providing additional benefits for care and mobility needs, with FT features.

Table 4 allows a comparison of the general decision procedure for disability claims (column 1) with FT processing (columns 2-5), including the country-specific decision process, FT procedures, FT technology, specific timelines, and the motivation for implementing FT procedures.

[Insert Table 4 about here]

Multiple stages characterize the decision process in all countries, with the responsibility for decision-making typically conferred on a disability examiner who may share this obligation with a medical specialist. Most varied are the descriptions covering technology and time frames. U.S. innovations in software and electronic claims processing may be followed by Israel and Australia in the future, with limited changes observed in other countries sampled. The time horizons reflect similar waiting periods of 3-5 months with dramatic lower processing times established and achieved vis-à-vis fast-tracked claims procedures.

FT in Australia's public disability programs¹⁹

Australia is one of a small number of countries with social security programs based on social assistance rather than social insurance. All major support systems, including those related to disability are funded through general revenue and are based on income and asset tests (Clayton and Honeycutt 2005). Payments and services provided by public disability programs, as well as unemployment and other pensions, are the responsibility

of an agency known as Centrelink. Policy for disability programs is set by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

The primary income support program in Australia for those with disabilities is the Disability Support Pension (DSP). To qualify for DSP, an applicant must meet age, residency, disability, and employment criteria. Applicants must be between the ages of 16 and the aged pension age of 60 to 65 (depending on gender) and satisfy minimal residency criteria. An applicant can satisfy the disability requirements for DSP in two ways. The first involves a diagnosis of permanent blindness. Persons who are permanently blind may be exempt from other criteria, such as employment, for receipt of DSP. The second way is to have a physical, psychological, or psychiatric impairment that causes a serious functional incapacity and must be permanent—fully diagnosed, treated, and stabilized, that is, unlikely to show any significant functional improvement within 2 years, with or without reasonable treatment.²⁰ If functional ability is not expected to improve within the next two years, it also meets this requirement.

A major reform of Australia's disability programs was introduced as part of the 2009-10 Budget, including a new assessment process, more stringent eligibility rules, a new advisory unit to give DSP assessors independent advice, and a comprehensive revision of the tables used to measure how a person's impairment affects their ability to work. The tighter eligibility rules and new impairment tables are scheduled to be implemented in 2012.

Disability assessment process. To be eligible for DSP, a person must have a permanent physical, intellectual or psychiatric impairment assessed at 20 points or more under the Impairment Tables. These tables assess the functional capacity of body systems in relation to work capacity and have a maximum range of 40 to 50 points.²¹ The person must also be unable to do any work of at least 15 hours a week at or above the relevant minimum wage, or unable to be trained for such work for at least the next two years, as evidenced by a Job Capacity Assessment (JCA).

All DSP applicants, except for those considered as “manifestly disabled”, have to undergo a Job Capacity Assessment (JCA). The JCA has a dual role: to assess the individual’s work capacity and barriers to find work, and to refer the person to appropriate assistance when needed. For this purpose, the assessor collects medical files, employment history and other relevant information about the person. Since July 1, 2010, assessors have electronic access to the applicant’s medical information via computer.

The JCA provides Centrelink with information on the applicant's recommended impairment rating under the Impairment Tables and their work capacity. The assessor completes the JCA report electronically and this is transmitted to Centrelink and stored on the DSP claimant’s computer record. The decision to grant or reject Disability Support Pension is then made by Centrelink personnel based on all available evidence, including the information provided by the claimant and by the JCA.

Job Capacity Assessors are allied health professionals, such as psychologists, social workers, rehabilitation counselors, occupational therapists and physiotherapists. Assessors have to undertake training courses and follow service guidelines to ensure that assessments are delivered consistently across the country. Assessors are able to discuss with claimants their educational and work history, skills, qualifications and interests, as well as the effects of their medical condition including treatment history, stability and prognosis of any episodic conditions. They are also able to talk to claimants about other factors that could affect their ability to work such as language difficulties or mobility problems. This assessment provides expert advice about the impairment rating and the impact of medical condition(s) on the person's capacity to work.

Fast-track procedures. While claimants for DSP are generally required to undergo a JCA of their level of impairment and work capacity, people in select categories can be granted DSP without the need for the JCA. This occurs where the treating doctor's report clearly indicates that a person meets the eligibility criteria for DSP, and payment may be granted

without further assessment. People entering DSP in these categories are referred to as 'manifest' grants i.e. it is evidently clear that these individuals qualify for payment.

Manifest grants of DSP may only be made to claimants with one of the following conditions indicating an inability to work:

- Permanent blindness - based on the information provided in an ophthalmologist/optometrist report
- Terminal illness - current medical condition is chronic and debilitating with a prognosis that the life expectancy is 24 months or less
- Intellectual disability - supporting documentation clearly indicates an impairment rating of 20 points or more under the Impairment Tables
- Needs nursing home level care
- Has Category 4 HIV/AIDS.

Since July 1, 2010, two lists of conditions are available to help decision makers determine manifest eligibility for DSP on the grounds of terminal illness, nursing home level care requirements, and/or intellectual disability. These lists are not designed to cover manifest grants on the grounds of permanent blindness nor category 4 HIV/AIDS. They supplement, rather than replace existing manifest guidelines, so manifest grants can still be made for claimants with conditions not yet listed.

Application sequence and administration of disability claims. People claiming DSP are required to provide details about their medical condition(s) and work ability as part of the claim process. Supporting evidence must be provided (e.g., a medical or specialist report, report from special school for people with an intellectual disability). Claimants are asked to provide a report from their treating doctor, which includes information about their diagnosis, clinical features and symptoms, treatment and stability. The name of the medical condition alone is not in itself accepted as evidence of manifest eligibility. Factors to be considered in establishing if the person meets the manifest criteria include not only ensuring the condition has been clearly diagnosed, but also that there is a clear identification of the level of disability and its functional impact. Additional information

from treating specialists and other health professionals may also be provided in support of the claim.

Applicants are encouraged to register their intention to claim for the Disability Support Pension (DSP). This ensures they are paid from the earliest possible date. This step can be accomplished on line, by telephone or in person at a Centrelink Customer Service Center. Once an applicant has registered their intent to claim, a Centrelink Customer Service Officer will send them a paper claim pack. The claim forms can also be downloaded and the completed forms are sent to the nearest service center or may be submitted in person by the claimant or another person on the claimant's behalf. There are three forms that must be completed: the claim form, the income & assets form, and the medical report form. The applicant must also provide proof of identity, income, and assets.

It is up to the DSP claimant to make an appointment and arrange for their treating medical practitioner to complete the medical report. The treating medical practitioner usually gives the completed report to the DSP claimant to submit to Centrelink or the doctor may mail it to Centrelink. The medical report provides information on the diagnosis, clinical features, treatment details and the impact of the medical condition(s) on the claimant's ability to function. At present, this is a paper- based report.

Currently the paper medical reports from treating medical practitioners are stored on DSP claimant's paper-based file. Since July 2010, these paper reports and other paper-based medical information can be electronically scanned and stored on the DSP claimant's computer record. At first, this will only be done for new claimants, but it is hoped that eventually all existing medical information will be scanned and stored electronically. Centrelink decision makers and Job Capacity Assessors can access this electronically stored medical information. Once the applicant's medical practitioners are able to send electronic versions of the medical report to Centrelink, storage of this information on the DSP claimant's computer record will occur in the same manner as the scanned information mentioned above.

In addition, under the DSP fast tracking project currently being implemented, conditions listed in the DSP claimant's Medical Report will be checked against the list of conditions (currently being developed) to see if it is on one of two lists, and if so, then they will establish eligibility without the need for a Job Capacity Assessment. For example, if a Centrelink Customer Service Officer attempts to set up a JCA appointment for a DSP claimant who has a medical condition code that corresponds to a condition on list 1 or list 2, a warning will come up advising the staff person to consider whether fast-tracking is appropriate before booking a JCA appointment. Therefore, the lists assist Centrelink Customer Service Advisers (CSAs) in recognizing conditions that may deserve a DSP manifest grant under the existing guidelines, and therefore consider fast-tracking the claim. Previously, this was not always evident. The new lists are expected to be particularly useful for some of the less well-known diseases and syndromes.

These lists were developed using SSA's CAL listings as a starting point. List one includes conditions which are accepted as manifest for DSP based on diagnosis alone. The second list applies to terminal (terminal illness within two years for DSP purposes) or catastrophic cases. If the DSP claimant's Medical Report lists such a condition, then the newly-created Health Professional Advice Unit (HPAU) will provide immediate advice about a condition, treatment regime, and likely prognosis. The HPAU doctor may be able to confirm the expected prognosis i.e. whether terminal or catastrophic, or may contact the treating doctor to clarify, and thereby expedite the claim without further assessment. At the same time, treating physicians will be eligible to receive payment when they provide information on the claimant—enabling DSP assessors to make a more informed decision—at the request of the HPAU.

Fast-Track Highlights in Australia:

- A major disability reform in 2010 is expected to lead to fewer claims overall, but generate faster FT processing for “manifest grants,” including the addition of two (CAL-style listings). It also creates a new Health Professional Advice Unit to give DSP assessors independent advice, and comprehensive revision of the tables used to measure how a person’s impairment affects their ability to work.
- Since July 2010, Centrelink has access to electronic medical files for new claims.
- 6.3 percent of DSP grants in 2008-2009 were “manifest” grants (5,512 grants out of a total of 86,830), with slightly more than half being due to a terminal illness.
- While no separate statistics are kept on FT manifest grants, staff in Australia suggests the vast majority would be completed within 49 days.
- Manifest grants by category for 2008-2009, as a percentage of all successful approved grants, include: permanent blindness (0.37%); terminal illness (3.30%); intellectual/learning disability (2.12%); nursing home level care (0.54%); and HIV/AIDS (negligible).

FT in Canada’s federal disability programs²²

The Canada Pension Plan Disability (CPP-D) program provides monthly benefits to Canada Pension Plan (CPP) contributors who cannot work at any job due to a “severe” and “prolonged” physical and/or mental disability. Severe means that the applicant is incapable of regularly engaging in any substantial earnings, because the applicant's disability prevents them from doing any type of work on a regular basis. Prolonged means that: (1) the disability is of long and indefinite duration, such that the individual will not be able to work in the foreseeable future, even with medical treatment or rehabilitation or (2) the disability is likely to result in death.

Service Canada administers a range of government programs and services for Canadian citizens, including the CPP-D program, by offering access through its more than 600 points of service located across the country, call centers, and the Internet.

Disability assessment process. The CPP-D program involves a two-part test for eligibility—the earnings test and the medical requirement. To be eligible for a CPP disability benefit, an applicant (“client”) must have made enough CPP contributions in at least four of the last six years, or have contributed for at least 25 years, including three of the last six years, prior to becoming disabled. The Minimum Qualifying Period (MQP) is the minimum number of contribution years needed to be eligible for a disability benefit. Service Canada staff must calculate a claimant’s MQP before they can assess medical eligibility.

CPP looks at all information on the application form, the medical report and any other supporting documents before making the decision to grant or deny the application. A CPP-D medical report must include documentation of clinical observations, diagnosis and long-term prognosis of an applicant’s medical condition.

Medical adjudicators (MA), who are trained health care professionals (generally nurses) knowledgeable in CPP disability legislation and policies, are responsible for making a decision on a CPP-D application. They decide first whether a patient meets the “severe and prolonged” medical disability criteria. For more complex cases, adjudicators may consult with a CPP physician. Eligibility is not based on a specific medical diagnosis, but considers other factors as well, including the nature and severity of the medical condition, the impact of the medical condition and treatment on the claimant’s capacity to work at any job, personal characteristics (e.g., age, education, and work history), and the applicant’s work performance and productivity.

In addition to the detailed information provided by the applicant, CPP may consult with employers, schools and other third parties who may be able to provide additional information on the applicant’s functional capacity. The information provided by the

applicant's treating physician is also important to the adjudicators making the decision. If required, the adjudicators may also seek information from specialists or independent medical examiners. This ensures that CPP has enough information to be reasonably satisfied that the applicant meets the eligibility requirements.

CPP assesses the severity of the disability first, and if the claimant does not meet the "severe" criterion (claimant is unable to regularly pursue any "substantial gainful occupation"), then CPP does not consider the question of whether the disability is "prolonged". Once it is confirmed that the applicant has made the required contributions and has been granted a CPP disability benefit, the previous contributions are then used to calculate the monthly benefit.

Fast-track procedures.²³ A national policy, with standardized procedures for the adjudication of disability applications for clients with a terminal illness, was adopted in June 2002. It was written to ensure "compassionate; sensitive and timely" service for applicants by requiring that their disability application be adjudicated within 48 hours of receipt in the disability unit. This process was updated in March 2010 to streamline the application process at all levels for applicants whose medical condition is considered terminal.

That process begins once the application is received in the Mail Processing Center and the Program Service Delivery Clerk manually screens for one of the following terms upon receipt of an application: stage III or IV cancer, end stage, failure, malignant, metastatic/mets, palliative, terminal, carcinoma, sarcoma, and blastoma. The clerk tags terminal illness files based on the diagnosis section of the medical report—a Red Urgent tag is stapled to the folder that notes the 48-hour contact frame—requests any previous file(s), and ascertains whether there is a valid disability service benefit estimate; if there is a problem, then the clerk forwards the file to the benefits officer for an earnings re-assessment. At this point, the date of birth is also verified. Throughout this process, incomplete files will trigger a telephone call to applicants to alert them about any missing information. If everything is in order, the file is forwarded for medical adjudication. If the claim is denied on the basis of non-medical information, then a denial letter is sent out.

The medical adjudicator (MA) assesses the file for terminal illness. The MA processes the file immediately when the information clearly indicates the status is terminal, obtaining medical confirmation of the status by telephone or fax. If the assessment is negative, then the MA deactivates the terminal status indicators and returns the file to the queue for normal processing. Additional documents are added to the file throughout this step upon receipt. For terminal cases, the claimant will be notified of the decision within 48 hours from when the clerk first received the file in the mail processing center

The CPP-D program operates other FT initiatives that enhance the decision process described above, including policies for the automatic reinstatement of returning applicants to their previous CPP-D benefits and assistance to potential applicants in their document preparation prior to submitting a formal application.

(1)Fast-Track Re-Application and Automatic Reinstatement. Since January 31, 2005, former disability beneficiaries who have returned to regular employment (and whose benefits have ceased as a result) are entitled to *automatic reinstatement of benefits* if they cannot continue working due to a recurrence of their disabling condition. For CPP-D beneficiaries, this policy provides a financial safety net to encourage a return to regular employment. It is particularly beneficial for those with episodic disabilities as there is no limit on the number of times a claimant can use this provision. To use the Automatic Reinstatement provision, the claimant must have informed the Department about their return to work; their benefits have ceased and they are sent an automatic reinstatement information kit to use in the event that their disability recurs and prevents them from continuing to work. A request for Automatic Reinstatement is not a re-adjudication; there is a simple form to complete as well as a statement from a physician that they have the same or recurring medical condition. The automatic reinstatement entitlement is available for two years following the month the CPP-D benefits stopped. In addition, the request for reinstatement must be made within one year following the month in which the recurrence of the disability caused them to stop working.

Another (earlier) policy, *Fast Track Re-Application*, was introduced in 1995 to encourage CPP Disability beneficiaries to attempt a return to work. The provision allows contributors to reapply at any time within a five-year period since the termination of CPP-D benefits. This allows an additional measure of support for applicants who may not meet the timelines or medical eligibility requirement for Automatic Reinstatement of benefits. Fast Track Re-Application is available for 5 years from the date the previous disability benefit ceased, provided that valid earnings and contributions were made each year following the cessation of the previous disability benefit. The regular three-month waiting period for new claims does not apply. As with the Automatic Reinstatement provision, there is no limit to the number of times the process may be used. Claimants who reapply within five years will receive priority processing status, and approved individuals will receive a check the month following the date of application.

(2) *Terminal Illness Application (TIA) Pilot*. CPP-D has been testing an abridged format and process for terminally ill applicants. Anecdotal information has indicated that it takes approximately 4 months for claimants to complete the regular CPP-D application form (33 pages).²⁴ The TIA is a streamlined 8-page form. Service Canada has partnered with service providers—social workers, extramural nurses, cancer care “navigators” (nursing professional who helps patients and families understand cancer diagnosis, treatment and other factors), and physicians in hospitals and clinics—who work directly with terminal clients. They assist the client with the shortened form, coordinate the completion of the medical report and fax the application directly to the Mail Processing Center (MPC) to begin the formal claims process—approximately one day for processing (once it is received in the MPC) and up to 48 hours for adjudication. Pretest of the TIA, which began with 6 hospitals in the fall of 2007, has now been expanded to more than 32 agencies/hospitals. According to Service Canada, an estimated 1.8 percent of CPP-D clients may benefit from a TIA. Service Canada has received positive feedback from service providers indicating that the form and process is much easier to complete.²⁵ The next steps include further analysis of the data and lessons learned.

Application sequence and administration of disability claims. Qualified individuals wishing to apply for a CPP disability benefit may contact Service Canada to obtain the CPP disability benefit application kit. Applicants can also get an on-line version of the CPP disability benefit application kit and print it out. The kit includes: Application for Disability Benefits Form (to be completed by the applicant); Questionnaire for Disability Benefits Form (to be completed by the applicant); and the Medical Report Form (to be completed by the applicant's physician). Any additional specialists' reports are welcome and can be submitted with the application.

There is an Early Client Contact (ECC) policy active throughout the application and claims process. ECC is designed to obtain additional information from the claimant and ensure that the claimant understands the basis for the decision. Once the claimant has filed an application, they receive a call from a Service Canada representative to gather and/or provide information about the application form, timelines, and what steps to anticipate in the adjudicative process. Once a decision to grant or deny has been issued, the claimant is contacted again by Service Canada and provided with information about the decision and related matters, such as the appeals process.

Fast-Track Highlights in Canada:

- Range of FT strategies include a 48-hour processing policy for the terminally ill (introduced in 2002 and updated 2010), Fast-Track Re-Application and Automatic Reinstatement policies, and Terminal Illness Application Pilot—all assisted by an Early Client Contact (ECC) policy.
- CPP-D has been able to adjudicate 75% of initial files in 120 days, but the standard is 48 hours for fast-tracking terminal illness cases.
- TIA pilot provides a shortened and simplified application form and assists potential claimants before their application materials are submitted.
- Fast-Track Re-Application and Automatic Reinstatement help former beneficiaries who returned to work to reapply for CPPD benefits after termination.

FT in Israel's public disability programs²⁶

Disability insurance in Israel provides a minimum subsistence income for persons with disabilities. The disability pension is paid to residents of Israel between the ages of 18 and the retirement age who meet all the qualifying conditions. There are two main groups of entitled persons, according to the entitlement test: disabled persons whose earning capacity has been lost or reduced as a result of their impairment (*earners*) and disabled non-working spouses whose capacity to function in their household has been lost or reduced (referred to as *housewives*).

More specifically, the definition of a disabled earner is an individual who, as a result of a physical, mental or emotional impairment stemming from an illness, accident or birth defect, fulfills the following conditions:

- Unable to support themselves from work/occupation, or their capacity to support themselves has been reduced as a result of the impairment by 50 percent or more;

- Has no actual income from work/occupation, or such income is not above the following:
 - if entitled to pension or has a severe impairment – less than 60 percent of the average wage;
 - if not entitled to pension and does not have a severe impairment – less than 45 percent of the average wage.

For disability purposes, a “housewife” is a married woman who has not worked outside her household for a period determined in law and who, due to a physical, mental or emotional impairment stemming from an illness, accident or birth defect, does not have the capacity to function and carry out regular household chores, or her capacity for doing such work has been reduced by at least 50 percent.

The National Insurance Law was amended on August 1, 2009. The amendment encourages disability pension recipients who join the workforce and recognizes rights of those who may not work. Key provisions include the following:

1. If a degree of permanent incapacity has been established, the beneficiary will not be re-examined if they join the workforce.
2. A three-year safety net is created for beneficiaries; if they stop working or if their earnings decrease, they will be allowed to return to receiving the disability pension as before, without an additional examination.
3. A new incentive pension was created; thus the overall amount received from working and from the pension will always be higher than the disability pension alone.

Disability assessment process. There are two stages in the process of determining entitlement to a disability pension.²⁷ In the first stage, a physician on behalf of the National Insurance Institute (NII) determines the medical disability percentage. Entitlement to the pension is examined: for *earners* with a medical disability percentage

of at least 60% has been determined (or 40%, if at least 25% is determined for him from a single impairment) and for *housewives* for whom a medical disability percentage of at least 50% is determined. If the calculated degree of disability is less than the respective thresholds at this stage, then the claim is rejected, and the second stage of examining earning capacity/ household functioning is not carried out.

After the medical disability percentage is determined in stage one, the second stage involves the claims officer determining the degree of incapacity to earn/function after consultation with an authorized physician and a rehabilitation clerk. The determination of the incapacity degree is based mainly on the *earner's* personal characteristics, such as an ability to return to the previous job (on a full-time or a part-time basis), to work at a different job, or to learn a new profession (taking into account the education level, physical capacity and health condition). Under certain conditions, the opinion of the claims officer regarding the incapacity degree may be influenced by other variables such as the labor market situation in the disabled person's area of residence. Regarding *housewives*, the examination of capacity loss is based on functioning in the home.

Fast-track procedures. In the 1990s, the government decreed that decisions must be reached on claims for persons having severe disabilities within 3 weeks of the day that their claims are submitted. The NII introduced this *Green Route* to comply with the government mandate, which was enacted for humanitarian reasons, in particular to quickly process claimants (e.g., those terminally ill) with unexpectedly shorter life spans. When an authorized physician makes the decision and transfers the claim to the second stage, she/he must indicate if the claimant has one of the following cases of severe disability: cancer; ALS (being treated with RILUTEK); blindness; is incapable of working at all for at least one year from the day of the submission of the claim; the medical disability determination is at least 80%.

NII physicians may request special documents in order to make their decision.²⁸ If it is clear that the claimant has 100% disability from a single impairment, there is no need at the first stage to diagnose other impairments. Persons with severe disability are given

priority in summons before “medical committees.” In certain cases, such persons do not have to be physically present at the committee sessions, which is the stage that usually delays the determination process. If, despite all efforts, the decision on a claim of a person with severe disability is not yet made after three weeks have elapsed since the submission of the claim, and entitlement is probable, then an advance payment is made to the claimant.²⁹

Application sequence and administration of disability claims. Persons who believe they are entitled to a monthly disability pension may contact the NII branch nearest their place of residence and submit a claim for a pension. By law, the NII will consider the claim for a disability pension 90 days after the day on which the applicant lost earning capacity (or capacity to perform housekeeping tasks for spousal applicants) or when the earning’s capacity was reduced by 50 percent or more.

The claim should be submitted by the applicant, although another person may represent the claimant and submit the claim on their behalf, if they are unable to submit the claim in person due to their physical or mental condition. Medical documents, certification of employment and salary, and any other document, proving the applicant’s entitlement to a disability pension, should be attached to the claim.

The next step in the process is for the claimant to appear before a “medical committee,” composed of one doctor, who specializes in a particular medical field, and a secretary whose job is to ensure that the applicant’s rights are protected and to record the committee report. Claimants reporting a number of conditions or medical impairments may need to be examined by several specialists and if, following the examination, it is determined that an additional examination is required by another specialist, one or more additional committees may be assembled. The opinions of these specialists are then submitted to the “certified physician”.

Once the medical examination is concluded, the doctor reads the medical findings to the secretary and makes a decision in accordance with the medical documents on file, the claimant's application and the examination just concluded. The doctor determines the degree of disability according to the list of impairments in the examinations book, sets the date for the start of the medical disability percentage, and determines whether the medical disability is temporary or permanent. If the committee believes that the claimant must undergo additional medical examinations or provide additional medical documents, it will not establish a percentage of medical disability, but instead will wait for the additional material. In such cases, a letter is sent to the claimant explaining what the committee requires. Upon receipt of the requested material, the committee will determine the percentage of the claimant's medical disability. Entitlement to a pension begins 90 days after the date of commencement of incapacity to earn/perform housekeeping tasks (the "determining date"). The claim may be submitted no more than 15 months prior to the onset of the incapacity. Benefit levels are based on the percentage rating level assessed by this process.

Fast-Track Highlights in Israel:

- A 1990's government decree mandates that a decision must be reached on claims for persons with severe disabilities within 3 weeks of the day that claims are submitted. This is known as the Green Route.
- A large percentage of recipients (79%), not claims, pass through the Green Route.

FT in the United Kingdom's public disability programs³⁰

The disability benefit system in the United Kingdom is quite complex, including programs for temporary disability benefits, working tax credits, and return to work incentives (Mitra et al. 2005). There is an employer-funded and administered temporary

benefit program, Statutory Sick Pay (SSP), where employees who are unable to continue working, due to illness or non-related work injuries, can receive up to 13 weeks of benefits. An employee who has exhausted SSP and does not return to work may apply to the public contributory permanent disability program, Employment and Support Allowance (ESA). ESA, which replaced the Incapacity Benefit program for new claimants in October 2008, is designed to help those sick or disabled get back to work. In addition, the disability system in the U.K. has several noncontributory means-tested programs as well as non-means-tested programs to help meet the extra costs of living with a disability—Disability Living Allowance (DLA) for those younger than age 65 and Attendance Allowance (AA) for those aged 65 or older.

Disability assessment process. To claim ESA, individuals must be between age 16 and the normal retirement age (currently 60 for women, 65 for men), have exhausted their entitlement to SSP, and not be eligible for social assistance or unemployment benefits. After making a claim for ESA, individuals typically take part in a 13-week Work Capability Assessment (WCA) to evaluate their eligibility for ESA and capability for work. While awaiting the assessment outcome, claimants receive a basic benefit. Once a determination is made, individuals are assigned to one of two categories: a Support Group—the group in ESA that does not require the claimant to take part in any back to work activity—or a Work-Related Activity Group.

WCA may also include a medical assessment before a decision can be reached on the applicant's capability for work. An approved doctor, referred to as a healthcare professional (HCP),³¹ assesses how the illness or disability affects the applicant's capacity for work or work-related activity, and provides advice to a decision maker employed by Jobcentre Plus (part of the Department for Work and Pensions (DWP), which is responsible for administering benefit claims.

The medical input required by decision makers includes medical examinations, reports, and advice.³² The examining HCP bases their assessment on information provided by the claimant, any information available to them from the claimant's doctor, and their own

observations. After conducting the exam, the HCP completes a report for the decision maker. Somewhat differently, decisions about DLA entitlement are made by Disability and Carers Service decision makers, working from a network of 9 Disability Benefits Centres around the country. To qualify, individuals must have needed the help for three months before they claim and must show that they expect to need the help for 6 months after the claim. Decision makers examine, follow up and weigh evidence submitted as part of the claim, before issuing a decision.

Fast-track procedures. Two possible sets of assessments are relevant for fast-tracking disability benefits in the U.K.: one for ESA and another for the extra costs of disability provided by the DLA. The ESA program allows claimants with a terminal illness to be fast-tracked to the Support Group. Claimants in this group may be fast-tracked before they reach the medical questionnaire or face-to-face assessment stages, which form part of the Work Capability Assessment (WCA) that assesses ESA eligibility.

When the claimant first makes a claim to ESA, they are asked—by a call center operator over the phone or in one of the questions on the online form—whether they wish to make a claim under Special Rules. Special Rules apply to anyone who has a terminal illness, is not expected to live past six months, or who suffer from specific “deeming conditions” (kidney dialysis, double amputees, severely deaf/blind) regarded sufficient in themselves. If the claimant says she/he wishes to claim under special rules, then the case will immediately be forwarded to a HCP. If the HCP is satisfied that the claimant is terminally ill, they will advise that the claimant be placed in the Support Group and paid the highest level of ESA immediately.

The HCP can provide advice more quickly if the claimant submits a DS1500 form with their claim. By obtaining the DS1500 from their doctor, they show that they are terminally ill and are not expected to live beyond 6 months. If a HCP receives one of these with the claim, then the HCP may take this as sufficient evidence of a terminal illness. This form is used for both ESA and DLA claims. Under special rules, the DLA

(and AA) benefit will usually be awarded for a period of three years. When three years have passed, the beneficiary is asked to renew the claim.

Similar provisions apply to those claiming DLA benefits due to terminal illness. If the HCP receives a Special Rules case, and if there is no DS1500 included, they will check to see if a claim has also been submitted for DLA. If there has been a successful claim to DLA in the past 6 months, either with or without the DS1500, this information will be sufficient evidence of the claimant's terminal illness and a medical check is not repeated. The HCP advises the DWP about this. If a claimant has provided a DS1500 for a DLA claim, one is not required for the ESA claim.

If there is no DS1500 and there has been no previous claim to DLA, the HCP will contact the relevant doctor or other medical professional dealing with the claimants case to ask for further evidence. HCPs have a 48-hour target for providing advice to the Department on Special Rules cases. If a terminal illness is discovered at a later stage of the claims process—either by the claimant informing the Department or the HCP recognizing it from the medical evidence submitted—the claimant will be fast tracked to the Support Group from that point on.

Application sequence and administration of disability claims. Individuals can claim ESA in several ways. Telephone and textphone (used by those who find it hard to speak or hear clearly) are available for those requiring assistance. An adviser at the contact center can help applicants complete the application. Alternatively, applicants may complete the claim form themselves by downloading it from the internet, printing it out, filling it in manually or online, and sending it to Jobcentre Plus.

After the initial claim for ESA is filed, the applicant has to complete a questionnaire indicating how the illness or disability affects their ability to complete everyday tasks. The applicant's own doctor may be asked to provide a medical report. An approved HCP will consider the questionnaire and any medical reports, along with any other information the applicant may have provided. If the HCP needs more information to make a decision

on the benefit claim, they will recommend a face-to-face medical assessment. The medical assessment will usually take place in one of 12 Medical Centers near the applicant's residence. If the claimant is unfit to travel, the approved healthcare professional may visit the claimant at home.

The new government is looking to improve mainstream employment programs for the sick and disabled. This is still in the development phase, so details about additional FT options are not yet available. The DWP is looking to revise their specialist disability programs for the most severely disabled. A scheduled merger of several programs in October 2010 will result in a new program called Work Choice.

Fast-Track Highlights in the United Kingdom:

- Claimants who state they are terminally ill or suffer from “deeming conditions” have their case reviewed by a Health Care Professional (HCP) within 24 hours of referral.
- Approximately 5 percent of disability claims receive fast-track processing.

III. Preliminary Conclusions

The information collected from countries participating in this survey indicates that FT procedures reflect country-specific goals and standards. Although the small sample size restricts the potential for making global assertions about them, some insights into FT procedures can be made.

Among the lessons learned from this research are that:

- FT procedures do not appear widespread among public long-term disability programs throughout the world. Efforts to identify such processes identified only six potential candidate countries for this study (all OECD members), and sufficient information was available in only four cases.
- Among those countries identified as having disability programs with FT procedures, one observes a tendency to target many of the same medical conditions for accelerated processing, to emphasize similar operational guidelines, and to establish the goal of significantly decreasing processing times.

- FT procedures generally affect a relatively small proportion of the overall disability applicant pool. According to the data available, the share of cases qualifying as FT typically fall well below 10 percent (with the exception of Israel, for which there are no data available on the percentage of claims), to around 5 percent of disability claims in a given year. This may reflect a more complex national disability approach. For example, other income support programs may reduce the urgency of FT procedures (e.g., United Kingdom's 3-day waiting period and issuance of immediate issuance of benefit that can last for as long as 13 weeks until a decision is reached).
- Most countries included in this sample indicate they are considering an expansion of their use of FT procedures through pilot projects or pending reforms. SSA offers the most high-tech example, while low-tech efforts are most evident in Canada. In general, the United States is using technology to expedite disability cases, while other countries manually identify and move cases through the determination process.
- Countries desiring to use FT processes can learn from other countries what methods work and which medical conditions can be targeted. In fact, cross-country fertilization of FT practices may occur, as documented in this research, when countries take into account the relevant experiences abroad. In the process of conducting this research, for example, the author introduced FaHSCIA staff in Australia, interested in adapting SSA's CAL listings for their new DSP FT process, to SSA staff overseeing CAL. The Australian changes became effective on July 1, 2010.

IV. Aspects of Fast-Track Processes

This section discusses selected aspects of fast tracking presented earlier for the countries included in the sample. The environment in which FT procedures operate is contrasted along three dimensions: the administration of disability claims; the integration of FT (including the role played by technology) into the determination process; and claimant sequencing throughout that process.

Administration (including FT) of disability claims

Nearly two decades ago, an International Social Security Association study observed that the responsibility for both eligibility and assessing the degree of disability is generally assigned to an individual decisionmaker or to a team or committee (Bloch 1994). Based on the review of the five countries examined in the paper, this statement appears quite relevant today. However, systemic changes are evident, at least for the countries in the sample. New technology-based initiatives (QDD and CAL) in the United States, pending in Australia and under consideration in Israel, are transforming the decisionmaker's role (where FT operates), redefining responsibilities that involve more systematic verification of data rather than requiring the former top-down analysis. At the same time, the types of input required for determining disability appear to becoming more automated, which could lead to greater efficiencies. Evidence from the implementation of predictive modeling in the United States or the recent introduction of a new HPAU unit in Australia suggests these new frameworks are providing assessors with an opportunity to clarify/confirm diagnoses that allow decision makers to make more informed decisions.

At the same time, non-government involvement is evident in the private-sector medical assessment contracted out in the U.K. and the partnership arrangement that Service Canada is conducting with clinics and hospitals for the TIA pilot program, which addresses document preparation prior to the application stage in Canada. All of these characteristics may impact to some degree the potential for or operation of fast-tracking

the disability process, but it is not clear from the small 5-country sample the extent to which these features may be significant.

Integrating FT procedures into the disability claims process

FT procedures vary as far as national program-driven details are concerned, but there appears to be some convergence in terms of FT-related technology. As automation increases, we may see more of a technology-driven dichotomy consisting of claims processes that identify (flag) conditions versus a more probabilistic approach. Pending technological advances in Australia appear to be moving in the direction of SSA—both in terms of SSA’s Predictive Modeling (PM) and electronic claims processing as well as the newer Health IT initiative. The latter program seems may be a closer fit to what Australia is in the process of implementing under the new reform or what Israel is considering for implementation.

In the context of fast-tracking claims, increased automation may be expected to increase efficiency in several ways. First, it could permit better identification of an alleged or reported medical condition for screening claims when fast tracking—increasing potential for greater efficiency with the implementation of updated listings on a flow basis. Second, software innovations, similar to predictive modeling, could enable greater flexibility in disability management, as observed in the United States, with the ability to adjust criteria using FT procedures to redirect managed caseloads across the entire disability system.

This research also finds that the placement of FT in the claims process is broad-based both in terms of types of program and time horizon. This is most evident in the case of Canada (taking a relatively low-technology approach), which (like the United States) has implemented re-entitlement FT procedures, but is also currently testing an FT procedure on a pilot basis to help terminally ill individuals complete their application materials more quickly. This TIA pilot extends the time framework of the claims process forward and is indicative of what the Canadian claims process has been doing for years through

its Early Client Contact (ECC) policy. In the United Kingdom, FT processes are at work in a related Disability Living Allowance program for the additional expense associated with care and mobility of disability , which complements the standard disability benefit available through the Incapacity Benefit (IB) and (since October 2008) the Employment & Support Allowances (ESA).

Processing sequence encountered by disability applicants

Countries studied for this research differ in terms of how the disability programs approach the claimant—passive versus active perspective. At one extreme is Canada with its pre-submission pilot program, the CCE policy of walking “clients” through the entire claims process, and the post-FT options for claimants. The fact that these FT processes in the CPP-D program use relatively low-technology may not be a coincidence, since the close relationship between “customer/client” and the government delivering the service does not seem to promote a high-tech arms-length relationship. SSA is somewhat different, operating a more high-tech approach in its FT processes, but also incorporating a mixture of automation and face-to-face activities in its handling of the majority of claims at the FO and DDS levels. Meanwhile, a more centrist position appears to have been adopted by disability agencies in the U.K. and in Israel. However, the up-front availability of employer-funded and administered SSP and 13 weeks of an assessment-rate benefit in the U.K. would seem to diminish the necessity for fast-tracking claims for humanitarian reasons.

Finally, the outcomes associated with FT processes are clearly successful. Faster processing times are achieved for the most part, with overall accelerated time horizons ranging from 48 hours (Canada) to about 3 weeks (U.S., Israel). As mentioned earlier, lower processing times are attained in the UK bolstered by other income support programs. Data on lower processing times is not available for Australian manifest grants.

Insight into how to view FT procedures

The range of FT processes documented in this paper suggests that this field is not static. Rather, there is a dynamic involved with respect to the redefining of disability and processing timelines in each country examined. New or expanded impairment listings and efforts to renew older guidelines appear to be the norm in recent years for most countries in the sample. Technology is pushing the envelope as well, affecting how decision makers and medical support are able to contribute to the assessment of disability claims. Moreover, technology is becoming available to improve the identification of serious impairments both on a probabilistic and non-probabilistic basis.

V. Future considerations

The author expects to continue his efforts in this area by examining the use of technology in disability claims processing, specifically the role for electronic medical records and their potential access as evidenced by the Health IT initiative in the U.S. Electronic medical records are widespread throughout the world. However, their usage in public disability programs is relatively unknown. Based on the limited country sample examined in this paper, they do not appear to play a significant role in disability claims. Further exploration of this topic would clarify the extent of technology used in disability claims.

Another relevant area to pursue is the development of a database for the timing of benchmarks—determination date, waiting period, etc.—which could go far in helping the research community to understand the integration of fast-track processes into the determination process from a cross-country perspective. Such information would necessitate a more thorough and targeted survey of administrative outcomes in national disability programs than was conducted here.

¹ Work began in 2008 to identify countries outside the United States where fast-track disability programs operate. This activity originated with the circulation of e-mails requesting assistance from countries that had participated in previous disability studies conducted by either the Organisation for Economic Cooperation and Development (2003) or a U.S. government-funded survey (Westat 1998).

² Attempts to contact 24 countries resulted in 4 robust responses from the countries discussed here besides the United States; Norway and Germany also confirmed employing FT procedures, but insufficient detail ruled them out initially; negative responses to the survey request about the presence of FT procedures were received from Austria, Finland, Japan, Mexico, Netherlands, Portugal, Sweden, and Taiwan; attempts to contact staff with disability agencies in another 9 countries was inconclusive.

³ The 79 percent shown in Israel represents the share of recipients not claims that are fast tracked on the Green Route. Comparable data for the share of fast-tracked claims in Israel are unavailable.

⁴ The description in this section draws on SSA (2009a and 2009b), various online websites at SSA, and Szymendera (2010).

⁵ Contributions are based on employee earnings (or those of a spouse or parents). Dependents may also be eligible for benefits based on an employee's earnings record.

⁶ As a prerequisite, US applicants must also have worked for a certain period of time, or have a specified amount of covered earnings in a year as measured in quarters of coverage—depending on age—of at least 1 quarter of coverage for each elapsed year from age 22 to the age of onset (a minimum of 6 credited periods up to a maximum of 40 quarters) are required for fully-insured status. In addition, there is a recency of work test in the U.S.: the applicants must have 20 quarters of coverage in the last 40 quarters or, if age 32 or younger, one-half of the quarters elapsed since the attainment of age 22.

⁷ The term SGA describes a level of work activity and earnings. For those receiving SSDI benefits based on disability, SGA is used as a factor to determine initial eligibility and to decide if your disability continues after you return to work and complete a trial work period. Currently, SSA defines SGA as earning in excess of \$1,000 a month or, if statutorily blind, monthly earnings above \$1,640.

⁸ The evaluation is based on answers to 5 questions in order (SSA 2009a): (1) Is the individual working and earning more than the SGA amount? If the answer is no, then ask the next question. (2) Is the condition "severe" enough to interfere with basic work-related activities? If so, go to the next question. (3) Does the individual have an impairment described or that meets those listed in the published Listing of Impairments? If so, then the person is disabled. If not, then go the next question. (4) Can the individual perform the work she/he previously did? If the answer is yes, go to the final question. (5) Can the individual do any other type of work? If not the claim is approved; otherwise, the claim is denied.

⁹ Discussion of the historical background preceding SSA's launch of the electronic disability claims process in 2004 is available in GAO (2003).

¹⁰ Once SSA meets all of the requirements set forth by the National Archive and Records Administration for the retention and security of the electronic records, the electronic folder will become the official file and all information needed to document the disability case will be stored and maintained in an electronic format.

¹¹ NHIN is an initiative of the Department of Health and Human Services with support from multiple government agencies and private sector entities.

¹² In New England, where the QDD process was first tested, about 3 percent of all new disability cases were identified as QDD cases and processed in an average of 11 days.

¹³ Additional information about CAL conditions and processing cases can be found on-line at: <http://www.ssa.gov/compassionateallowances/>

¹⁴ In March 2010, the Department of Veterans Affairs (VA) proposed its own fast tracking of veterans' claims process for service-connected presumptive illnesses due to Agent Orange exposure during the Vietnam War (VA 2010). The VA hopes to migrate from the manual processing of these claims to an automated process for adjudicating the claim, involving military and private medical records and the scheduling of medical examinations. With this new approach, the VA expects to shorten the time it takes to gather evidence, which now takes an average of more than 90 days. Once the claim is fully developed and all pertinent information is gathered, the VA will be able to more quickly decide the claim and process the award, if granted.

¹⁵ The original version of the law provided for only 3 months of PD/PB payments, which changed to the current 6 months of benefits in 1991.

¹⁶ A contract was awarded to IBM in September 2004 to develop a predictive modeling (PM) tool for the QDD process, which became operational on a pilot basis in July of 2006.

¹⁷ Qualifying scores for the QDD vary across DDS jurisdictions. This arrangement helps to manage the caseload of a particular DDS.

¹⁸ While a QDD indicator cannot be manually added to a case, this is possible with CAL. The DDS, Office of Quality Performance, and the Office of Disability Adjudication and Review all have the capability to manually add cases to CAL processing.

¹⁹ The description in this section draws heavily on personal communication with Australia's Department of Families, Housing, Community Services and Indigenous Affairs (FaHSCIA) staff, online websites at fahscia.gov.au, and Clayton and Honeycutt (2005).

²⁰ This definition of permanency has three components (Clayton and Honeycutt 2005). First, a physician must diagnose the condition. Second, the condition must be "fully treated"—evaluated through a review of medical reports and other supporting information for past, current, and future treatment and whether all appropriate medical treatments have been used. If not, or if future treatments are planned, then the condition is considered as either temporary or not fully treated, and the individuals would not qualify for DSP. The "stabilization" aspect of the disability involves an assessment whether maximum medical improvement has been obtained.

²¹ Where there are multiple medical conditions that have an impact on one body system or structure, then a single score is assigned which reflects the combined functional impairment on that body system or structure. Where multiple body systems are affected by one or more conditions, ratings may be assigned on all relevant tables, and the total impairment rating should reflect the overall level of the applicant's impairment (Clayton and Honeycutt 2005).

²² The description in this section draws heavily on personal communication with Service Canada and online website descriptions at www.servicecanada.gc.ca.

²³ This section is based on CPP-D (2010).

²⁴ The national terminal illness policy (updated March 2010) did not address the complexity of the current kit (33 pages) and the amount of unnecessary information asked of a dying claimant (e.g., would they be interested in vocational rehabilitation).

²⁵ By June 2010, 309 applications were received using the new process. Evaluations indicate that it is taking approximately 1-1½ days for all sections of the TIA (including medical report) to be completed and faxed to the MPC. Once the application is received in the MPC, 81percent of all files are adjudicated in fewer than 10 calendar days, including 61percent adjudicated in fewer than 5 calendar days.

²⁶ The description in this section draws heavily on personal communication with NII staff and online websites at btl.gov.il.

²⁷ According to staff at the National Insurance Institute, a new disability system is being designed, the "tevel," which could incorporate electronic technology that would minimize the intervention of a claims officer.

²⁸ These special documents have been prepared by the Israel Cancer Association and the Atlas Association (caring for ALS patients).

²⁹ The pension may be granted later on a permanent basis, and assessments are no longer made. Under the new rules introduced August 2009, a claims officer of the NII may reopen the discussion of a disabled

person's medical degree only if the medical condition deteriorated before the end of the temporary period. A reduced medical degree may be determined after the end of the temporary period (NII 2010).

³⁰ The description in this section draws heavily on personal communication with DWP staff, Thomas (2008), Lewis (2009), Mitra et al. (2005), EUMASS (undated) and online government websites including Newcastle.gov.uk.

³¹ Schlumberger Group Medical Services, a multinational corporation, provides medical services (advice and examination reports) nationwide to the DWP, under contract for more than 200 full-time medical advisers. Due to the high workload, Schlumberger subcontracts services for another 3,000 part-time physicians (chiefly general practitioners) to conduct medical examinations (EUMASS undated).

³² The HCPs that provide these services are experienced in assessing disablement, capacity for work and care needs and mobility for such programs as ESA, Industrial Injuries Scheme Benefit, and DLA/AA.