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OPERSource

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AN OVERVIEW OF THE OPERS DISABILITY PROGRAM PROCESS

The OPERS disability program is another valuable service we provide to our members who suffer a disabling condition while contributing to the system or as a result of contributing service. In order to ensure that only eligible individuals are granted an OPERS disability benefit, we have developed a thorough process that identifies our members who meet the disability requirements. With the passage of S.B. 343, the Ohio General Assembly approved several significant changes to the OPERS disability program. As a result, we thought it would be helpful to explain our disability review process and describe the recent legislative changes.

The disability program remains an important part of the OPERS retirement plan. For eligible members who become disabled and are unable to perform the duties of their particular job, OPERS administers two disability plans – the **original plan** and the **revised plan**. Both of these plans are described below, but it is helpful to note at the outset that all employees hired after July 29, 1992, are covered under the revised plan, and the changes included in S.B. 343 became effective this year (Jan. 7, 2013) and apply to any disability applications received after Friday, Jan. 4, 2013.

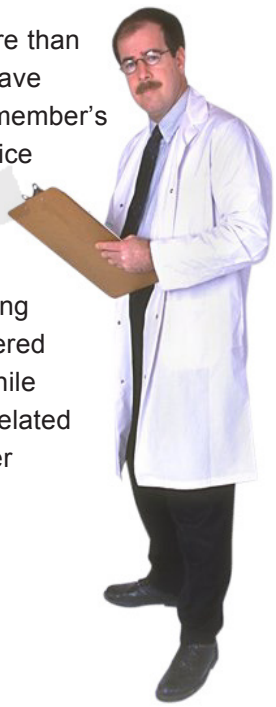
> "The OPERS disability program is another valuable service we provide to our members who suffer a disabling condition while contributing to the system or as a result of contributing service."

Based on medical information provided by the member and an OPERS-appointed medical examiner, an eligible member may qualify for a disability benefit. In 2012, OPERS paid out more than $603 million in disability benefits and an additional $413 million in health care benefits for disabled workers and their dependents.

Who is eligible?

OPERS members who participate in the Traditional Pension or Combined Plans may be eligible for disability benefits based on date of hire.

Both before and after S.B. 343, members must have at least 60 months of contributing service credit – unless they are covered under the law enforcement division and become disabled due to an on-duty illness or injury – in order to be eligible to receive an OPERS disability benefit. Under the **original plan**, a member in transition groups A or B must file a disability application before age 60, members in transition group C must file before age 62; under the **revised plan**, they may apply at any age. Additionally, the member must have been removed from the payroll because of a presumably permanent disabling condition, either mental or physical, which prevented the member from performing their particular job duties. A disability benefit cannot be given due to a temporary illness or temporary disability. It is important to remember that a disabling condition does not have to have occurred on the job, only that the disabling condition makes the member either physically or mentally incapable of performing their duties of their public employment position.



To apply, no more than two years may have passed since a member's contributing service terminated. A new provision under S.B. 343 requires that an application made in the two-year period after the member's contributing service ceases may only be considered if the condition became disabling while the member was contributing or is related to work performed while the member was contributing.

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Application process for disability benefits

OPERS' disability process requires the completion of three separate forms (described below). Each form must be completed by the appropriate parties and sent to OPERS when a member applies for a disability benefit. Proof of date of birth must be provided before payment may be issued, assuming that the application is approved by the OPERS Board of Trustees.

1. *The Disability Benefit Application* (DR-1) must be completed by the **member** and notarized.

2. *The Report of Physician* (DR-APS) is to be completed by the **member's physician**. It must describe in detail the disability on which the application is based, certify the member is permanently disabled, and provide the date on which the condition became permanently disabling.

3. *Report of Employer for Disability Benefit Applicant* (DR-4) is to be completed by the **member's employer** and the **employer's fiscal officer**. The employer may certify either an exact final date of compensation, or that the final date will be provided pending the OPERS Board approval of the Application.

Once OPERS receives all three forms and proof of date-of-birth, the materials are transferred to our third-party administrator, the Managed Medical Review Organization (MMro), which is primarily responsible for overseeing the medical review process, including clinical triage services, medical assessment determinations, and recommendations.

MMro also reaches out to the member's physician to gain further insight into the disabling condition.

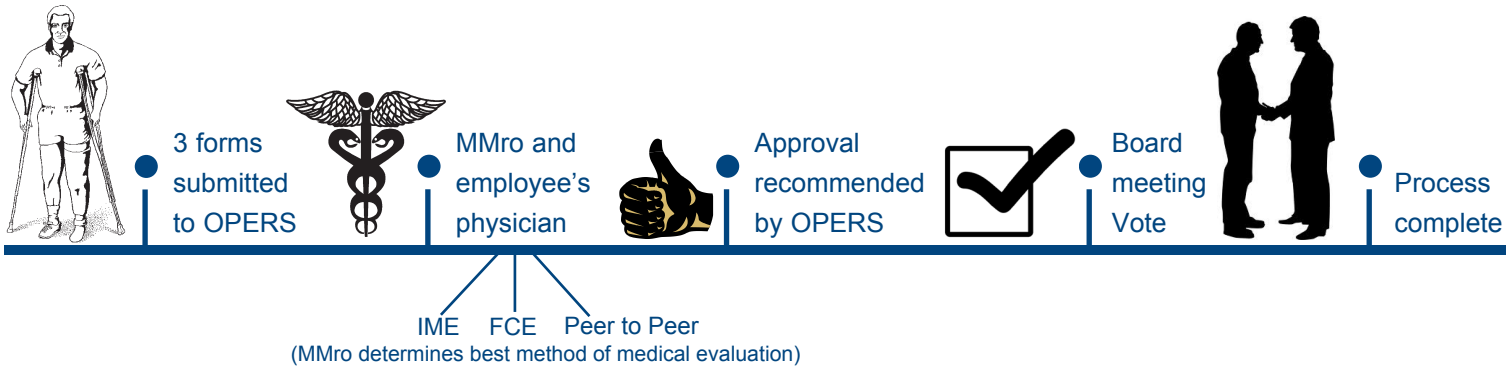
In sum, MMro provides OPERS with more clinical professional expertise and experience in the medical review process.

MMro reviews applications and determines the best method for medical evaluation. Some applicants are directed to an Independent Medical Evaluation (IME), others, a Functional Capacity Evaluation (FCE) or Peer to Peer (physician to physician) evaluation.

Following its review, MMro will recommend to OPERS whether a member's disability application should be approved. The OPERS Medical Advisor will review MMro's information and make his or her own recommendation. The OPERS Medical Advisor's recommendation is final and, depending on when the recommendation is received, will be added to the consent agenda of the next OPERS Board meeting.

Upon approval by the OPERS Board, a disability benefit becomes effective the later of either the first day of the month following termination of contributing service (employment) or the attainment of eligibility. The benefit payable is set forth in statute and is based on final average salary (FAS) and years of service. It is important to remember that the entire application process may take 3 to 4 months to complete.

Unless it has been decided that a member's disability is permanent, the member may be required to undergo medical examinations at least once a year to determine if his or her condition is improving. The member also has the option of participating in rehabilitative services. If it is determined the member is no longer disabled, his or her benefits will be terminated within three months of the Board's official decision – subject to appeal.



The total application process takes 3 to 4 months.

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Own occupation vs. any occupation standard evaluation change

Members who applied for a disability benefit prior to the effective date of SB 343 will continue to be evaluated under the "own occupation" standard, which means the member is physically or mentally incapable of performing the duties of their last public position.

Under the provisions of SB 343, members applying for a disability benefit on or after the effective date (all applications received after Friday, Jan. 4, 2013) will be evaluated under the "own occupation" standard during their first three years receiving a disability benefit. At the end of the third year and thereafter, these members will be evaluated under a new "any occupation" standard. The OPERS Board may extend the "own occupation" standard for up to five years if the member is receiving rehabilitative services acceptable to the Board's physician. (Under SB 343, Law Enforcement division members are exempt from this change.)

> "OPERS strongly encourage members to check with the Center for Medicare and Medicaid Services (CMS) regarding potential eligibility for continued health care coverage."

The "any occupation" standard considers whether a member is no longer physically or mentally incapable of performing the duties of **any position** that meets the following criteria:

a. The salary of the position replaces at least 75 percent of the member's inflation-adjusted FAS;

b. The position is reasonably found in the member's regional job market (75 miles); and

c. A position the member is qualified to perform based on his/her education and experience.

Benefit termination options, including return to prior public employer

A disability benefit terminates if (A) the member is no longer disabled, (B) they return to public service, (C) they choose to begin receiving an age and service pension, or (D) at their death. Prior to SB 343, if a member receives disability benefits for **less than five years**, OPERS will certify to their previous employer they are no longer incapable of returning to work. The employer should restore the member to their previous, or a similar, position and salary unless they were dismissed or resigned in lieu of dismissal for dishonesty, misfeasance, malfeasance, or conviction of a felony.

Members who applied for disability benefits on or after the effective date of SB 343 retain OPERS membership status and are considered on leave of absence during their **first three years** receiving a disability benefit or **up to five years** for members who are receiving rehabilitative services acceptable to the Board's physician.

Health care coverage under the OPERS disability program

Health care coverage for disability recipients is available through the OPERS Health Care Plan effective the first day of the month in which OPERS receives a disability benefit application or the disability benefit effective date, whichever is later. Please refer to the *Health Care Coverage Guide* on the OPERS website (www.opers.org) for more detailed information. Eligibility for health care coverage may be limited to the first five years of a disability benefit. Therefore, OPERS strongly encourage members to check with the Center for Medicare and Medicaid Services (CMS) regarding potential eligibility for continued health care coverage. A member may qualify for coverage through CMS even if not eligible to apply for Social Security Disability Insurance (SSDI).

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How can a member appeal if their disability application is denied or their benefit is terminated?

Members who wish to appeal an OPERS Board decision regarding their disability benefits can utilize the *Disability Benefits Appeal Request Form*. This form is mailed to members with OPERS' letter of denial or termination. Failure of a member to submit an appeal request within 30 days of the notice of denial or termination will render the Board's action final.

Next, members must submit a completed *Report of Physician* form within 45 days of the date OPERS received the written notice of intent to appeal. Appeal requests must include additional objective medical evidence, including current medical evidence documented by a licensed physician specially trained in the field of medicine covering the illness or injury for which the disability is claimed.

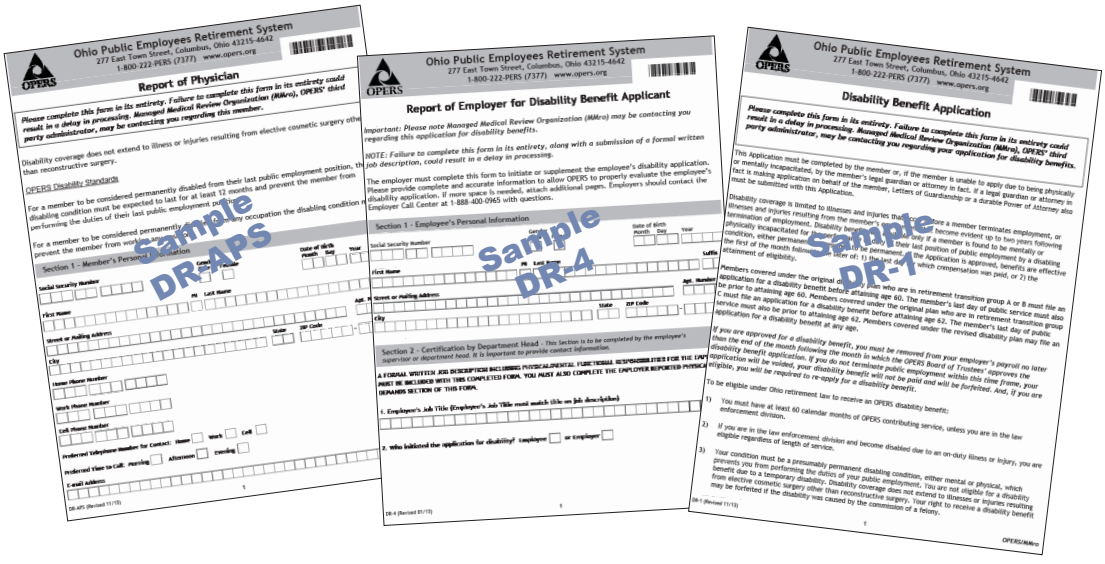
This is **additional** evidence, and thus, cannot have been submitted previously.

Failure to provide the additional medical evidence within forty-five days of the member's appeal request will render the Board's action final. If additional time is required to submit additional evidence a member can request an extension using a *Disability Benefits Appeal Request form*. Only one extension, not to exceed forty-five days, may be granted. During this time, the member pays all costs related to the appeal.

The additional evidence is reviewed by MMro and the Board's medical advisor who will make a recommendation to the Board. The member will be notified by regular mail of the Board's decision.

FEDERAL ISSUES UPDATE

OPERS Government Relations continues to monitor important federal issues that could impact the retirement system. For the latest updates on these and other issues, be sure to check out the OPERS Government Relations webpage at https://www.opers.org/about/government/index.shtml.



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