The American Disability Insurance Program

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THE AMERICAN DISABILITY INSURANCE PROGRAM

A SENIOR HONORS THESIS

SUBMITTED TO

THE HONORS PROGRAM

OF THE

DEPARTMENT OF POLITICAL SCIENCE

BY

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Introduction

On August 1, 1956, President Eisenhower officially signed off on disability insurance. The first seeds for this legislation were planted 45 years prior in New Jersey and Wisconsin, the first states to pass workers’ compensation laws. Looking back on that 1911 legislation, one can see the early forms of a disability program. Many states soon followed the example set by New Jersey and Wisconsin, and by 1948 all states had workers’ compensation laws. The purpose of these laws was to compensate employees who were physically injured while on the job. Prior to the enactment of this legislation, employees’ only redress for injuries suffered at the workplace was suing their employer in court, an experience that could eventually get them fired. The new workers’ compensation laws did away with this precarious position that injured employees found themselves in and instead allowed them to collect benefits from their state governments.

While the workers’ compensation laws were a nice first step for the disabled, the laws left many disabilities unprotected. Only physical disabilities suffered on the job received compensation. This type of disability represented only a tiny sliver of the many existing impairments that Americans struggled with on a daily basis. The laws did not protect mental disabilities or physical disabilities that were not caused by one’s place of employment. This phenomenon soon received attention from the U.S. president. After signing the original Social Security Act in 1935, President Franklin D. Roosevelt soon began to ponder the future expansion of the act, wondering whether he could eventually include disability benefits that would cover all severely disabled workers as part of the social security legislation. With this thought in mind, an Advisory Council was formed in 1937 to examine “the feasibility of
disability insurance.” The council’s initial opinion was that while disability benefits would certainly be welcomed by the public, and would be socially responsible, a great deal of planning, spanning many years, was necessary before such legislation could be passed due to the expensive, administrative nightmare that disability insurance would pose.

After disappearing from Congress’ legislative agenda for six years, disability insurance resurfaced in 1943. During that year, the Social Security Board wrote to two senators and one representative—Senator Robert Wagner (D.-New York), Senator James Murray (D.-Montana), and Representative John Dingell (D.-Michigan)—asking them to consider a piece of legislation that would enact “permanent disability, temporary disability, and national health insurance all under federal control.” Congress quickly rejected the bill. A similar one that appeared in May of 1945 was also voted down.

The year 1946 was a gloomy one for disability insurance. The 1946 elections saw the first Congress with a Republican majority since Herbert Hoover was president. With Republicans generally much less open to the idea of disability benefits, disability insurance likely would not be passed in the near future. Despite this sentiment, another Advisory Council convened in 1947 to discuss a future disability program. The main focus of this gathering was to find ways around the massive expenses a disability insurance law would almost definitely engender. The debate quickly centered on the definition of disability, with all the council members realizing that the size and expense of the program depended directly on the definition of who is considered disabled. This idea reassured many on the council for they realized that as long as disability insurance legislation was narrowly crafted, the program did not have to be as expensive as many first thought.
The following year, 1948, was a very good year for disability insurance. Another Advisory Council convened and the liberals soon began making concessions that led disability insurance to become more of a realistic possibility. One of these concessions included a work requirement that made disability insurance only available to “those who had worked for at least a year and a half in the three years before they became disabled.” This would make sure that only those who had legitimately contributed to society prior to their disability would receive financial support. Following further debate, the Advisory Council fully endorsed disability insurance. Soon after this endorsement, the Republicans lost their congressional majority, making disability insurance even more of a likely possibility: “Almost as soon as Congress convened, ‘Muley’ Doughton, a veteran Democrat from North Carolina reclaiming his place as chairman of the Committee on Ways and Means announced the beginning of a legislative drive to expand social security.” Disability insurance—the status of which had recently looked bleak—now appeared to be a realistic piece of legislation.

The year 1950 saw the enactment of a form of disability benefits—a welfare program for the disabled called Aid to the Permanently and Totally Disabled—but not what disability insurance advocates had hoped for. This program had more of a welfare slant and left out many disabled Americans. It was a small victory for disability benefits but was not even close to the end result disability advocates sought. The debate over disability insurance continued in Congress and it soon became clear that the House would vote for a disability insurance law but the Senate was still firmly against it at this point.

The Republicans regained control of the government in 1953 and they collectively decided that they wanted to do something for the disabled. In their minds, they would be
happier if they, and not the Democrats, were the ones who crafted disability legislation since they would approach the matter more cautiously and in more of a fiscally responsible manner. What was eventually settled on, after much disagreement in the Senate, was a disability freeze: “The freeze preserved a disabled worker’s rights to social security at age sixty-five. Under its terms, persons who became disabled had their benefit records ‘frozen.’ If they qualified for benefits when their records were frozen, they received them when they reached retirement age, even though they had been out of the labor force and paying nothing into the social security trust fund.” The idea behind the disability freeze was that when a social security retirement benefit was calculated it was based on the average earnings a worker had over his lifetime. A long period of disability would undoubtedly reduce a person’s average earnings. In order to protect against this, the disability freeze only averaged a worker’s salary during the years he was not disabled. President Eisenhower signed off on the disability freeze in the summer of 1954.

What was so revolutionary about this “freeze” (and why the Senate had such a problem with the idea of a disability freeze) was that it essentially set the ground work for disability insurance. The disability freeze set up a system in which the states had to examine and verify that people were disabled in order to grant them a disability freeze. Doling out cash benefits would not be any more administratively difficult; just more expensive. Hence, the disability freeze was really a test-run for disability insurance.

The argument for disability insurance gained further steam two years later: “By 1956, the states had already made 106,130 determinations under the disability freeze program without the sky falling in…This bit of information greatly strengthened the argument that disability insurance was administratively feasible.” Despite the increasingly positive feeling
about disability insurance, there were still many detractors. One of the more interesting
opponents of disability insurance was the American Medical Association. The AMA “took
the lead in opposing disability insurance, arguing that it would perpetuate the condition of
sickness and would work against rehabilitation.” They were also afraid that disability
insurance would lead to socialized medicine.

While disability supporters essentially ignored the pleas from the American Medical
Association, they did not ignore the lukewarm feeling resonating in the Senate concerning
disability insurance. In an effort to reach out to those still on the fence, the Ways and Means
Committee “made a significant concession to the forces of incrementalism by proposing
disability insurance only for those over the age of fifty. In the past, the Social Security
Administration had vigorously opposed this kind of age limitation on disability insurance.
Now, in the interest of making some headway, it endorsed it eagerly.” This was a gigantic
concession by disability supporters—it sectioned off disability insurance for only a select
group of Americans. The potential cost of the program was greatly reduced by this
compromise.

The existence of this new cooperative mood soon inspired Congress to organize a
vote on disability insurance. After much debate and lobbying aimed at gathering a majority,
disability supporters finally got their wish: “The amendment, with its provision for disability
insurance, obtained the vote of forty-one Democrats and six Republicans, carrying 47-45.
One change of vote would have created a tie that Nixon would have broken.” It was a
narrow victory to say the least, but undoubtedly a monumental one. Beginning in October of
1956, the Social Security Administration began accepting applications for disability benefits.
The first payments occurred in July of 1957. The disability program was officially underway.

Never again would the disability landscape be the same in America.
Chapter 1: The Disability Insurance Law

The Original Disability Insurance Legislation

Having detailed the events leading up to the passing of disability insurance, it is imperative that we now examine the law itself. The disability insurance law of 1956 states that in order to obtain benefits, “a person needed to demonstrate that he was unable to engage in [substantial] gainful activity by virtue of a medically demonstrable impairment.” Many aspects of this disability definition need further clarification. For starters, we must discuss the term *disability* itself. Many times when the word disability is used, people think of a physical or mental injury. This encompasses only half of the definition of disability. The disability insurance legislation classifies mental and physical injuries as impairments or function losses. It is important to note, however, that only impairments that affect working capabilities are classified as disabilities: “There may be a decrease in the range of motion of a joint, in visual acuity, or in respiratory capacity as compared with the functions of a ‘normal’ or ‘standard’ person—but again, not all of them are significantly related to working ability.” Only impairments that sever a person from the ability to participate in the labor market are deemed disabilities that are worthy of benefits.

The second thing that needs illumination is the term *substantial gainful activity*, or SGA. SGA refers to any job in the national economy. In other words, if a person’s mental or physical condition prevents them from continuing their current job but would not prevent them from working at another type of job, then this person is not disabled. Even if a person
cannot gain employment in another field of work because there are no jobs available, the fact that he has the potential to be employed prevents him from being classified as disabled. Furthermore, as the law is written, if potential jobs that a person can do are located in another state or even distant part of the country, a person must pursue them and cannot gain disability insurance just because he is unable to be employed in his current setting.

Another part of the disability insurance law that needs further explanation is the time frame of disability. In the original legislation, only people who have permanent disabilities that are not projected to ever heal are granted disability benefits. Under the disability insurance law of 1956, no partial disabilities receive compensation. This is a very important point to focus on for two reasons. The first is that focusing solely on permanent disabilities drastically narrows the scope of the disability insurance law. Many people suffer short-term disabilities, but the disability insurance law is not meant for them. A second important point to focus on is that deciding whether a disability is temporary or permanent can be very arbitrary. Some conditions may clearly be permanent, but what about someone suffering from a mental illness? Most doctors cannot predict whether the disease will last a year or two or an entire lifetime. This definition definitely allows for a liberal interpretation of the law—it could turn out to be very restrictive or it could allow many borderline cases to be classified as permanent disabilities.

A final thing about the disability insurance law that needs highlighting is the age requirement. The original disability insurance legislation restricted disability benefits to those 50 years of age and older. While almost everyone realized how arbitrary this age choice was it came about as a way to restrict the disability program to a number that was acceptable to
the legislation’s opponents. Those under 50 years old were eligible for the disability freeze but not for full disability benefits.

The Democrats may have won by getting disability insurance passed into law but, as the definition of disability demonstrates, their victory was a narrow one. At least on paper, disability benefits were restricted to those 50 years and older with a mental or physical injury that is permanent and keeps a person from being employed by most jobs in the national economy. This is a victory for some of America’s disabled, but it definitely leaves many of them out. Disability advocates felt, however, that if they could aid some of the disabled, while putting a program on the table that was open to later expansion, it was at least better than the pre-1956 world.

Changes to the Original Legislation

Between 1956 and the current time, disability insurance has undergone drastic changes, most of which have been liberalizations of the original legislation. The first major change to the disability insurance legislation of 1956 occurred four years after Eisenhower signed off on the original law. In 1960, following much congressional debate, amendments were passed into law which abolished the restriction that a person must be 50 years of age in order to receive disability benefits. The fact that the 50 year old age restriction had been an arbitrary number to begin with was a motivating factor for this legislation. A further influential factor was studies which showed “more than half of all permanent disability cases occurred among workers under fifty-five.” The original legislation simply was not reaching many worthy disabled people.
A second extremely important change to the original disability insurance law occurred in 1965. Amendments passed during this year “changed the definition of ‘permanent disability’ from a condition with a ‘long, continued, and indefinite duration’ to one ‘expected to continue for at least 12 months.’” This amendment made disability insurance available to so many more disabled people. Before the amendment, a very select few could objectively be classified as permanently disabled. Countless disabilities, however, fall in between the 12 month time frame and the permanent designation. Mental disabilities in particular usually last at least a year, but it is almost impossible to determine if they are permanent. The 1965 amendments eliminated much of this problem, making disability insurance available to more of the mentally disabled community. Overall, the 1965 amendments simply made sense. If a disability cannot be expected to last at least for a full year, there is really little need to provide extensive disability benefits. Perhaps a small check might be humane but someone with such a short-term disability really should not expect much governmental aid. On the other hand, only allowing the permanently disabled to have access to benefits was too harsh because countless extremely disabling conditions last longer than one year without being permanent.

During the same time the 1965 amendments became law, other parts of the disability insurance legislation were also being liberalized. Throughout the early to mid-1960s, the courts engaged in a process of expanding the definition of disability with respect to substantial gainful activity. While the original law had stated that SGA meant any job in the national economy, the courts claimed that this was unreasonable and there was no way Congress really meant that. They insisted on taking into account a person’s education, past job experience, and the current job market within a reasonable domain.
The first case in which the courts made a major stand on this issue occurred in 1960 in what has been called the Kerner case. Many have blamed this particular case for “changing disability insurance from a strict medically based program to a limited unemployment compensation program.” Here is what transpired:

The case was brought by a man who had held a variety of jobs as a carpenter, mechanic, furniture repairman, and salesman, and who suffered from a cardiac condition, diabetes, and anxiety. Although he acknowledged that he was able and willing to do light sedentary work, he was unable to obtain a job. The case thus turned on his employability. The SSA denied his claim on the grounds that he was in fact able to engage in “substantial gainful employment.” The appeals court saw the issue differently. It ruled in 1960 that “mere theoretical ability to engage in substantial gainful employment is not enough if no reasonable opportunity for this is available.”

This ruling drastically changed the landscape of disability insurance policy. It allowed those with impairments to be classified as disabled if they could not find work. This completely violated the sentiment of the original legislation.

By the year 1967, Congress had had enough of the court’s liberalization of its SGA terminology. The courts were expanding disability benefits to way too many Americans and Congress was prepared to “reassert control by specifying a strict definition to make disability independent of job availability.” Congress soon passed amendments that clarified its original legislation: “The law requires that a person have an impairment of ‘such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience engage in any kind of substantial gainful work which exists in the immediate area in which he lives or whether a specific job vacancy exists for him or whether he would be hired if he applied for work.’” In other words, Congress said that in order for a person to be deemed disabled, he must show that he cannot do his previous work and cannot do any other realistic job.
Congress obviously did not expect a person that lacked an education to apply for a job as a rocket scientist, but it did expect a person to be able to do a job that he had the skills for or could easily learn. Furthermore, just because there was not an opening for one of these potential positions did not mean a person was disabled, but simply unemployed. With the passing of the 1967 amendments, Congress also clarified that it did not expect a person to move across the country for a job, but it was reasonable to expect a person to have to drive a decent distance for one. Despite all of these clarifications, the courts continued to apply a fairly liberal definition to the SGA terminology. Many believe that the “Kerner doctrine” did not take a drastic hit from the 1967 amendments.

The year 1972 saw the introduction of three additional major reforms to disability insurance. The first change was that people now only had to wait five months (instead of six) after being diagnosed as disabled for their benefits to be paid. The idea behind the original legislation was to make sure that disability benefits were not paid toward short-term disability but were for the severely disabled. While not a big change, shortening the waiting period from six months to five helped people gain access to benefits sooner. A second amendment to disability insurance that was passed in 1972 was a bill that extended Medicare coverage to those deemed disabled after they had been on disability insurance for 24 consecutive months. This benefit was in addition to the cash benefits and served as a way to financially aid those who were the most disabled and had a disability that spanned over two years.

These two reforms coupled with a general increase in the level of disability benefits made 1972 a very expensive year for Congress. Hoping to avoid a further costly increase in disability benefits, the Republicans in Congress succeeded in indexing future benefit
increases to the inflation rate. While this sounded alright in theory, it turned out to be a disaster: “The rate of inflation rose in the 1970s and carried social security benefits along with it. At the same time, average wages and employment rates failed to increase as rapidly as expected. As a result, the social security program had less money coming in and more going out than anticipated.” This situation was eventually rectified but it is representative of the 1970s—nothing could stop the growth of disability benefits.

As the 1970s progressed, the size and cost of the disability insurance program grew by so much that it soon became a political liability: “The growth of disability insurance put pressure on the entire social security system, which faced a series of financial crises in the mid-1970s and early 1980s…In actual dollars, program expenditures doubled between 1967 and 1971, between 1971 and 1975, and between 1975 and 1980.” By 1980, politicians were determined to trim down disability insurance to a level that was fiscally responsible. One important bill that was passed by the Carter Administration in 1980 limited the number of “drop-out” years for those who were young and disabled. In the original legislation, those applying for disability benefits were allowed to drop out their lowest five years of earnings when calculating their average yearly salary in order to decide how much disability benefits they deserved. The new 1980 amendment did not allow those under age 28 to drop out any years of employment. Those 45 and older were allowed to drop out the usual five years. Men and women in between 28 and 45 were able to drop out between one and five years depending on their age and years of work experience. This amendment was a logical reform—before its enactment young men and women who applied for disability benefits could likely take their best year of earnings and have that serve as their average annual salary, while older employees had to average in their up and down years. The end result was
a fair policy that managed to cut down on the amount of disability benefits younger employees received.

Jimmy Carter’s Administration cut back on the cost of disability insurance in a few additional ways. One change involved decreasing the percentage of a person’s income that they could receive in disability cash benefits. The purpose of this amendment was to decrease the cost of the disability insurance program and also reduce the incentive for a person that was only mildly disabled to enter the disability rolls. Along these same lines, Carter’s Administration also “made it easier for a disability insurance beneficiary to work.”12 The greatest fear that disabled people had about returning to work was leaving the disability rolls and losing their medical benefits. A new law passed in 1980 relaxed this fear by allowing “a handicapped person to continue receiving Medicare for up to four years, after he returned to work.”13 Getting people off the rolls and back in the labor force was presumably best for them, and of course less people on the disability rolls meant less money spent on disability insurance.

The final amendment to the disability insurance legislation that occurred in 1980 turned out to be the most controversial. When disability insurance was expanded from permanent disability to disability lasting at least one year, it was assumed that those not deemed permanently disabled would be reevaluated after several years. This rarely happened. During the 1970s in particular, an extreme amount of people were added to the disability rolls and yet very few of them ever had to undergo reevaluation. In fact, “of the people who came onto the disability rolls during the 1970s, 72-82 percent were never looked at again.”14 In order to rectify this issue, and make sure only those who are truly disabled receive benefits, Carter’s Administration passed a law that “mandated review of a disability
beneficiary’s status once every three years to ascertain whether he remained disabled.” At the time of its passing, this law was not controversial in the least. Ironically, it would later be a part of the greatest crisis in the history of disability insurance.

While Carter’s disability review legislation helped set the stage for the greatest catastrophe in the history of the disability program, it was Reagan’s actions that brought the crisis to fruition. When President Reagan took office in 1980, the rapid growth in disability benefits that had transpired in the 1970s had begun to subside:

As Reagan prepared to take office in 1980, the number of new disability awards, which had reached a peak of 592,000 in 1975, were expected to drop to 390,000. The number of workers on the disability rolls appeared to be stable, having leveled off at about 2,837,432 in 1977; a month after Reagan took office, the number stood at 2,854,519. The program cost more but only because inflation continued to drive up the average benefit a worker and his family received. For the first time in many years, the program appeared to be under control.

But Reagan was not satisfied. His goal was to cut back on the budget as much as possible. Disability insurance soon became a prime target. First of all, the Democratic Carter Administration had even said that more people on the disability rolls should be reviewed in order to remove those who did not deserve cash benefits. Secondly, a nonpartisan study done by the General Accounting Office in 1980 showed that “perhaps 20 percent of the caseload did not meet the eligibility standard in April 1979; Social Security could have paid more than $2 billion a year to people who were not eligible.” Finally, “a follow-up study conducted by the Social Security Administration, now intent on weeding out corruption, showed an even greater percentage of the caseload to be ineligible for benefits. The new study, of those on the rolls in July and September 1980, concluded that 26 percent—more than one-quarter of the caseload—should not have been on the disability rolls.” Armed with this empirical support, Reagan quickly became determined to pare down the disability rolls.
Carter’s 1980 law had advised that disability reviews not begin until 1982. The reasoning for this was that the administrative process for the reviews needed time to be set up. Reagan decided to ignore this order and begin disability reviews as early as 1980 with the hope of paring down the disability rolls as quickly as possible. The Social Security Administration warned Reagan that aggressively removing people from the disability rolls without a great deal of planning could lead to a catastrophe. Reagan did not heed this advice. Instead, he rushed into the disability review process in 1980, forcing the states to review a countless number of disability patients without the proper training or resources.

Many horror stories soon arose concerning severely disabled people that had their benefits taken away. Public opinion quickly blasted Reagan and the disability reviews. One major controversy involved the question of whether “a person whose condition had not improved could be removed from the rolls. The Social Security Administration thought it could do so, but many of the courts, such as the one in the Ninth Circuit, disagreed.” In order to better understand this debate, we must discuss the events of the mid-1970s. During this time, disability benefit standards were extremely relaxed, much more so than in 1980. An issue arose when the tougher standards of the early-1980s were used to judge those who received disability benefits during a time when the definition of disability was more expansive. This led to many people being removed from the rolls and a great deal of controversy.

Four years after Reagan’s disability review began, over 40% of those who had their cases reviewed had their benefits revoked: “By fall 1984, the administration had reviewed about 1.2 million disability beneficiaries and informed about 490,000 of them that they would lose their benefits.” The mentally disabled took the brunt of many of the disability
benefit revocations: “On January 11, 1984, District Judge Jack B. Weinstein ruled that the Social Security Administration had implemented ‘a fixed clandestine policy against those with mental illness.’” There was a lot of truth to this claim. Those in charge of the disability reviews concentrated the most time on younger disability beneficiaries who would stay on the disability rolls much longer than older folks. The mentally ill made up a solid majority of this younger disabled group, and were therefore targeted more than any other sub-group.

To make matters worse for the mentally disabled, they were judged by a very strict standard:

A schizophrenic, for example, needed to demonstrate “marked restriction of daily activities and constriction of interest and seriously impaired ability to relate to other people.” Those capable of watching television might not meet the standard of a “marked restriction of daily activities.” One medical consultant noted that it was “practically impossible to meet the listings...for any individual whose thought processes are not completely disorganized, is not blatantly psychotic, or is not having a psychiatric emergency requiring immediate hospitalization.”

Because many of the mentally ill were targeted by the disability reviews and because the mentally disabled were judged by an extremely restrictive standard, many people who were truly mentally disabled had their benefits taken away. This led to many regressions in treatment and a number of suicidal deaths.

Eventually, as the political nightmare from the disability reviews continued, Reagan decided he had to act in order to avoid further crisis. Reagan’s 1984 Disability Benefits Reform Act tried to rectify the situation. The law stated that the only way a person could be taken off the benefits list was if they showed signs of improvement or new evidence or technological equipment emerged which demonstrated that the person’s original condition did not meet the necessary disability criteria. The enactment of this law made clear the fact that the legal issues of entitlement had undoubtedly trumped the economic issues that the
disability insurance program faced. The 1984 legislation ignored the work incentives posed by Carter’s 1980 bill, and instead made it much more difficult for those entrenched on the disability rolls to ever be removed.

The next major piece of legislation to affect disability insurance did not occur until 2006, over two decades after Reagan curtailed the disability reviews. The 2006 legislation, called the Disability Service Improvement Act, represented the greatest change in the administrative aspect of disability insurance. The Disability Service Improvement Act created five new developments in the disability benefit process. First of all, a quick disability determination process was created in order to expedite the time in which those who are clearly disabled receive disability benefits: “Favorable decisions would be made in such cases within 20 days after the claim is received by the state disability determination agency.”23 This reform was very necessary, since some people wait up to three years for the entire appeals process to sort itself out and benefits to be paid. Those who are clearly disabled to the naked eye should be allowed to bypass this long stretch and receive the care they need more quickly.

The Disability Service Improvement Act also included a provision that provided for a great deal of further training for disability examiners. The purpose of this training was to make both more accurate disability determinations and more rapid decisions, so there wasn’t such an extensive backlog of disability applications. In addition, the new service improvement act did away with the second stage of the disability determination process. Prior to 2006, when a case was rejected by the initial disability examiner, the applicant appealed to the reconsideration official. The new law does away with this reconsideration position and instead creates a Federal Reviewing Official that will examine the initial
rejection on request. One of the main purposes of this switch from reconsideration to the Federal Reviewing Official was to eliminate unnecessary steps. Since the reconsideration official and the disability examiner both worked in the same department, it was no surprise that appeals brought before the reconsideration official were almost always denied.

The last two changes that the Disability Service Improvement Act engendered also involved additions and deletions to the administrative process. The law eliminated the Appeals Council and essentially made the Administrative Law Judge’s decision final, barring an appeal to the federal courts. The Appeals Council would be replaced in part by the Decision Review Board whose job was to make sure no errors or injustices were made in disability determination. On the whole, this reform was very logical because statistics showed that the Appeals Council almost never overturned the ALJ’s decision.

The Disability Service Improvement Act is so new that it has not yet spread throughout the United States: “The Commissioner stated that the new disability determination process will be rolled out gradually, beginning in the Boston Region on August 1 of this year and that it will not be extended to another region until at least a year after that.” It will be interesting to keep tabs on these recent changes and observe how they affect the disability process.
Chapter 2: The Disability Benefits Process

The Current Disability Process

Armed with an understanding of the entire history of disability insurance, let’s now take a look at the current disability process and how people actually go about getting benefits. The first step in this process is to fill out a disability application. In order to qualify for disability benefits, a person must suffer from an impairment that either does not allow them to work or does not allow them to earn above $900 a month: “This amount is referred to by the social security administration as SGA, or substantial gainful activity. It is important to note that this amount is before taxes.” In addition to meeting the SGA requirement, a person’s impairment must have lasted or be projected to last at least one full year. If a person does not meet these very basic requirements, he should not waste his time filling out a disability application. If these requirements are met, a person should definitely file an application for disability insurance.

There are three main ways for potential claimants to file a disability application: “filing for disability online, calling the social security office to set up an appointment to apply, and walking into the social security office without an appointment.” It is usually recommended that people call to file a disability application. The reasoning for this is people who file online applications do not get to interact with a disability representative and ask questions; people who file in person at the social security office usually have to wait a few hours before being seen. Calling is the easiest and most effective method of the three.
After a disability application is filed it is sent to the Disability Determination Services (DDS) division where a DDS examiner will review the case. People should expect to hear back with the initial decision on their application after three to four months. In the hands of a DDS examiner, one of the first parts of the disability application that will be considered is the applicant’s medical records. If medical records were not submitted as part of the original application, or the DDS examiner believes more records are necessary, he or she will request them. The medical records are an extremely important aspect of the disability application. Without them, benefits will not be rewarded.

The medical records that have the most influence on the eventual decision are ones submitted by an applicant’s personal doctor or treating physician. These individuals should know a person’s medical condition better than any other medical professional. When a doctor submits a report he should provide a detailed summary of “a patient’s symptomology, restriction in range of motion, muscular strength, and the ability to sit, stand, walk, crouch, bend, and reach.” A doctor’s report should also detail the patient’s “diagnosis, prognosis, and the functional restrictions that result from a patient’s impairment(s), i.e. why the patient is unable to return to work.” The doctor’s report should stick as much as possible to facts and stray away from personal declarations that a patient should definitely be granted benefits.

After initially examining an applicant’s medical records, the DDS examiner generally follows a four-step plan for the rest of the disability evaluation process. The first step is to examine an applicant’s work experience. If an applicant is currently working and making over $900 a month—the designated SGA amount—the person cannot gain access to disability benefits. If a person is either unemployed or making below the SGA amount, then the next thing to consider is whether the condition is severe enough to be considered a
disability. In order to meet the standards set by the Social Security Administration, an applicant’s impairment(s) must be on the SSA’s List of Impairments or be equivalent in severity to one of the conditions on the list. If a person’s condition either matches or equals an impairment on the list, he is classified as disabled and receives benefits.

An applicant whose condition does not meet the severity level of those on the List of Impairments next faces a determination of whether his condition hinders him so much that he cannot do his past work. If the DDS examiner decides that a person can do his past work despite the impairment, disability benefits are denied at this point. If, however, it is decided that the impairment is enough to prevent a person from doing his past work, the next question becomes whether an applicant has the ability to do any other work considering his “medical conditions, age, education, work experience, and any transferable skills.” If the DDS examiner concludes that a person can do other work, the disability claim is rejected. If, however, the examiner decides that a person does not have the capability to do anything besides his former job that he now cannot do, disability benefits will be granted.

Applicants should keep in mind that on average 70% of initial claims are rejected. If denied on the first try, applicants should definitely request an appeal within the 60 day deadline. Ironically, most people who have their initial attempt at disability denied by the DDS examiner do not appeal. Some give up hope while others make uninformed mistakes like forgetting to fill out an appeal on time or filing a brand new claim instead of an appeal. All of these circumstances are unfortunate mistakes: “A failure to appeal timely or filling a brand new claim will have the same end result: a loss of all appeal rights and starting over at the very beginning, with a new Social Security Disability application.” People should always appeal the initial decision because over half of the initial applicants who are rejected
eventually receive disability benefits. The appeals process certainly can be a long nightmare, stretching sometimes for almost two and a half years if the appeal makes it all the way to the last review. Nonetheless, benefits are obviously preferred over not receiving anything for one’s condition.

Provided one appeals the initial disability determination, the next step used to be Reconsideration—a review of the DDS examiner’s decision and sometimes a granting of benefits. In 2006, this step was eliminated by the Disability Service Improvement Act (It must be noted that this stage has only been eliminated in the Boston region so far, with other regions to follow suit in the coming years.) The main reason why this Reconsideration stage was phased out is because it was essentially an extra, unnecessary step. The reconsiderations were done by the same DDS agency that did the initial reviews and only resulted in reversals of the initial decision about 15% of the time.9 It was common knowledge that an initial rejection meant that a person would almost always have to come before an Administrative Law Judge. So in an effort to expedite the disability benefit process, the Reconsideration phase was eliminated.

With the Reconsideration stage being phased out, the next step after the initial disability determination is the hearing in front of an Administrative Law Judge. This hearing is the only stage in the disability process in which the decision-maker and the disability applicant meet one another in person. It is also the stage in which applicants have the greatest chance of having their denial reversed. On average, 50% of people who appeal to an ALJ win their case and are granted disability benefits.10 The reason for this high number of reversals has a lot to do with the more lenient standards the ALJs apply to disability review. Over the years, ALJs have been known to be very lenient on people with impairments that have caused
them to be unable to work at their current job. The SSA has continually stressed that those who can work another job, no matter whether an opening exists or if they would be accepted if they applied for an opening, are not considered disabled. ALJs are much more likely to take extenuating circumstances into account when deciding on disability.

After filing an appeal following the initial disability determination, it takes between six months and a year and a half to receive a hearing before an ALJ. In very serious cases, an applicant can file a dire need letter to speed up the process of gaining a hearing:

For the most part, a hearing office will only consider a dire need situation to be one in which a disability claimant is in danger of becoming homeless… Bringing a dire need situation to the attention of the Office of Hearings and Appeals (via a detailed and well-written dire need letter) can, in some cases, have the effect of shaving months away from the time it ordinarily takes to get a hearing scheduled.

Unfortunately, it takes a very serious situation in order for a person to have their ALJ hearing moved up. For those denied a dire need petition, a year wait for a hearing is not uncommon.

An ALJ hearing has three different outcomes. The first two outcomes are different forms of acceptances: “Favorable hearing notices can be either fully favorable or partially favorable, the difference between the two being determined by whether or not an ALJ grants a claimant benefits beginning with the disability onset date they allege, or grants benefits in accordance with a later date of onset (based on the medical evidence).” The only difference between the two favorable outcomes is how much backpay in benefits disability applicants’ receive. For example, a person may claim that they first became disabled in January and that is when their benefits should have begun. The ALJ examines all of the medical and employment records and either agrees that January was in fact the start date of disability or decides on another start date.
The third option that the ALJ declares half of the time is a denial of benefits. This leaves applicants with two main routes: “In some instances, it will make perfect sense to file a brand new claim. In other instances, a judge’s decision will seem so inappropriate to the evidence that was presented that an appeal will be the better route.” At this point, a lawyer or someone else with knowledge of the disability system would be a great asset. If an ALJ neglected an important piece of evidence, an appeal would be a valid choice. Unless there is something major an ALJ overlooked, however, the chances of receiving a positive decision after an ALJ rejection are very slim.

The next step after an appeal of the ALJ decision now varies. In the past, before the enactment of the Disability Service Improvement Act in 2006, the stage after the ALJ hearing was the Appeals Council. The Appeals Council usually takes between three months and a year and a half to review the ALJ’s decision. There are three possible results of an Appeals Council review: “the AC will issue a statement that the request for review has been denied, the AC will overturn the ALJ’s decision, [or] the AC will determine that the ALJ erred in some fashion and will remand the case. Option 1 is usually the answer a claimant can expect to get. Option 2 rarely ever happens. And Option 3, the remand, happens often enough to make an appeal to the AC something to consider.” The chances of the ALJ decision being overturned are so slim that as part of the 2006 bill, the Appeals Council was scheduled to be slowly phased out of existence. While this initially seems to be bad news for disability applicants since it takes away one of their chances for reversal, in reality eliminating this stage helps applicants appeal their cases to the federal courts more quickly—their best bet for reversal after an ALJ denial: “It is possible for a claimant to file a civil action in the United States District Court, requesting review of Social Security’s decision. A Social Security
disability claim can go all the way to the Supreme Court. Perhaps once every year or two
years, the United States Supreme Court actually hears an appeal about a Social Security
disability case.”16 Once a disability benefit appeal reaches the federal courts and is denied,
there is nothing else to do besides file another application and begin the process anew.

Provided disability benefits are eventually granted, a person will usually receive them
within 60 days, “though waits of several months are not unheard of.”17 It will be helpful to
examine the way these benefits are calculated. The main focus is on an applicant’s average
indexed monthly earnings, or AIME:

The period used to calculate the AIME equals the number of full calendar
years elapsing between age 21 and the year of first eligibility. The actual years
used in the computation are the years of highest earnings minus dropout years
equal to one-fifth of the number of elapsed years rounded to the next lowest
integer (to a maximum of 5 dropout years)…Disabled workers who receive
fewer than 3 dropout years under the one-fifth rule may be credited with
additional dropout years based on child care, up to a total of 3 dropout years.
To receive this credit, a worker must have had no earnings in that year and
must have been living with a child under age 3.18

While seemingly complicated, what this method boils down to is this: people’s monetary
level of benefits is determined by their prior earnings. Depending on applicants’ ages and
years of work experience, disability insurance law allows some of the years in which
applicants earned the least to be dropped when calculating the AIME. Special provisions also
exist for those who had to tend to childcare and were not able to work as many hours.

Another aspect of disability benefit payments that warrants discussion is the issue of
backpay. Because disability cases drag on for so long, disability insurance law grants people
benefits starting from when they were first disabled (even though this was before the
disability benefits process began). The maximum amount of backpay that is usually granted
is 12 months: “Bear in mind, this is the maximum and the actual amount received will
depend on the onset date (when a claimant’s disability is decided to have begin) and the date of entitlement (which is, due to the five month waiting period, a claimant’s first month of eligibility to receive benefits).” Nonetheless, backpay can often be thousands of dollars. It will often take longer to receive backpay than the original monthly benefits, but the existence of backpay is usually enough in itself to satisfy disability applicants.

Two years after disability is established, people receive full-paid Medicare. The idea behind the two-year wait is to make sure that only those who are severely disabled are granted additional benefits. The one draw-back of these Medicare benefits is that often times it deters people from ever attempting to reenter the workforce. The reasoning for this is because people are afraid to return to work, forgo their Medicare and disability benefits, and then not be able to make enough money to make up for the loss of them. Recent legislation has made this dilemma less of an issue: “Full benefits may continue for a year after an individual returns to work. Even thereafter, an individual who has to stop work in the following three years can get back on Social Security disability benefits immediately without having to file a new claim.” In addition, a law passed in October of 2000 “expands Medicaid and Medicare coverage to more people with disabilities who work. It extends Medicare Part A premium-free coverage for 93 months after the trial work period for most disabled beneficiaries who work.” As a result of this legislation, people can return to work with the knowledge that they have a safety net available for the next few years to catch them if things go awry.

One of the last parts of the disability benefits process that should be examined is disability review. Every so often, a person who is not originally classified as permanently disabled is reviewed by the social security office: “If medical improvement can be predicted
when benefits start, the first review will be 5 to 18 months later. If medical improvement is possible but cannot be predicted, the case will be reviewed about every 3 years. If medical improvement is not likely, the case will be reviewed about once every 5 to 7 years.”22 The following is a good description of the disability review examination:

During a review, the disabled beneficiary is asked to provide information about any medical treatment he or she has received and any work he or she might have done. An evaluation team, which includes a disability examiner and a doctor, then requests the individual’s medical records and carefully reviews his or her file. If the team decides a person is still disabled, benefits will continue. If they decide that the person is no longer disabled, the individual can file an appeal if he or she disagrees with the determination. Otherwise, benefits stop 3 months after the beneficiary is notified that his or her disability ended.23

Typically, very few disability review cases result in the removal of benefits. Only those original cases that were extremely borderline or dealt with very short-term disability usually result in an elimination of benefits. The current standards, unlike those used during the 1980s, are very pro-patient. Unless a person’s medical records show enough improvement to demonstrate that SGA is a distinct possibility, benefits will continue.

Having detailed the entire disability process, two general pieces of advice for disability applicants emerge. The first piece of advice is that a claimant would be wise to hire a lawyer to guide him through the process. Not only will a lawyer help translate the law for the applicant and keep him updated on all of his deadlines and hearings, a lawyer also is an authority figure in court and can be of great use at the ALJ hearing. Most people who hire lawyers do so after being rejected in the initial review by the DDS examiner. Very few of these people fail to secure benefits at the ALJ stage. In addition, an attorney comes cost-free if an applicant fails to gain benefits. If an applicant succeeds in the disability process, the average lawyer fee is one-quarter of the backpay benefits—not a large fee to pay if a victory provides a person with access to monthly benefits for many years.
The second piece of advice is to be proactive when dealing with the disability process. People need to stay positive throughout the process in order to aid their cases. They cannot allow rejections to frustrate them so much that appeal deadlines pass without filing anything. Applicants should also remain up-to-date on their applications. Calling the social security office to update them on informational changes—“a change in treatment sources, diagnoses, or simply a change of residence or contact numbers”—is a must.24 Enlisting the help of a state congressman to help speed along the process is also a wise idea. The disability benefits process may certainly be a long one, but the end result will likely be worth the wait.

The Inherent Dilemma

Having detailed the disability benefits process, I would be remiss if I did not highlight some of its inherent difficulties that have caused problems over the years. While there have been many amendments to the 1956 disability insurance legislation, no law has been able to fix the inherent dilemma that originally was one of the leading factors in holding up the passing of disability insurance—How can you tell someone is disabled? Unfortunately, there is often times no simple way to decide for sure whether a person is disabled or not: “Most people who are disabled suffer from pain. There is no way of determining whether or not another individual is in pain, much less how much pain they are in.”25 Measuring disability is downright difficult.

Assessing physical disabilities is a challenging enough task: “One brave soul, at the risk of making his profession look somewhat foolish, cited a poll of heart specialists about whether Eisenhower was ‘physically able’ to serve as President after his heart attack: 114 specialists had said ‘yes,’ but 93 said ‘no.’ Such disagreement, even among specialists, was
typical in all fields of disability determination, the doctor asserted.” Mental disability is a
Totally different animal. Less physical evidence can be studied and medical professionals
have to rely more on signs and symptoms, which can be very subjective.

Prior to 1956, while disability insurance was still being debated in Congress,
countless physicians testified before Congress and stressed that there was no way they could
provide the kind of objective disability evaluation politicians were asking for: “Physicians
asserted that disability determination is inherently subjective, and, that honest physicians
could legitimately disagree about whether a person is disabled. Over and over again they told
Congress that ‘medicine is not an exact science.’” Physicians regularly disagree over
physical diagnoses. Agreeing on mental illness diagnoses is that much more difficult.

Even if doctors could all agree on the exact severity of physical and mental illnesses,
no doctor that testified before Congress was willing to claim that he could accurately decide
the amount of work a person with a certain condition was capable of: “[Physicians] were
adamant that extrapolating from the impairment to a person’s work capacity was an entirely
different matter and one beyond their field of expertise.” One must keep in mind that there
are so many different variations and intensity levels of every disease. Factor in the idea that
every person has a different tolerance for pain and the issue becomes even cloudier. Even if
we could objectively measure anxiety, for example, there is no existing scale that will tell us
how much work someone could perform under a certain level of anxiety: “Even so staunch a
defender of the idea of objective measurement of impairment as Henry Kessler says that his
practical experience has taught him ‘there is no great correlation between physical injury and
ability to earn a living.’” According to many social workers, the idea of temporary vs.
permanent disability makes the issue even more confusing: “Efforts to distinguish between
employable and nonemployable applicants and between temporary unemployables and permanent unemployables had proved ‘impossible.’”30 The Social Security Administration definitely launched itself into a very subjective realm when disability insurance was passed in 1956. When medical professionals cannot even agree on definitions for what should be classified as a disability, how can we expect disability examiners to?

In addition to the murky issues of diagnosing impairments and assessing which impairments create disabilities, a third major obstacle for disability policy is mental and physical illness in children. Non-existent in the past, disability benefits for children have become a more recent controversial issue. In the past two decades, the number of children receiving disability benefits has risen dramatically: “Between 1989 and 2001, the proportion of children with a mental impairment grew more than fivefold.”31 The same issue of disability determination that plagues general disability policy is even more apparent in childhood disability. The Social Security Act states that children are entitled to disability benefits if they are “judged to have an impairment of ‘comparable severity’ to one that would disable an adult.”32 An immediate problem with this definition is that in most cases, it is not readily apparent how severe an impairment is and so the case turns on past employment. In only a small percentage of cases are people deemed disabled without an examination of past work experience. Kids, however, don’t work, and this obviously makes disability determination much more difficult.

While these three dilemmas are the major problems inherent in the disability insurance law, many other issues abound when the disability process is dissected in closer detail. In order to facilitate a discussion on the entire spectrum of disability policy dilemmas, it will be helpful to examine the issues bipolar disorder causes for disability insurance.
Mental disabilities pose the greatest problems for disability examination, and bipolar disorder, due to its very nature, is one of the more difficult to properly assess.
Chapter 3: An Examination of Bipolar Disorder

Bipolar Disorder Diagnosis

Bipolar disorder (BD) is a mental illness that is characterized by significant changes in mood and energy. Those with BD cycle back and forth between manic states, depressive states, and sometimes hypomanic states. During a manic phase, a person exhibits euphoria, irritability, high self-esteem, high energy, hyperactivity, and poor judgment. He or she is impulsive, makes poor judgments, needs less sleep, and has many racing, crowded thoughts. A person experiencing a depressive state has low energy, low self-esteem, and slow thoughts. He or she is constantly sad, needs more sleep than usual, lacks interest in all things, and consistently procrastinates due to the desire to complete nothing.

Hypomania is a much more pleasant experience. In fact, it usually has such a pleasurable nature that few people ever see a doctor about it: “Hypomania is a heightened experience—a drug you want more of. One is fascinated by the world, and sometimes it seems that the world falls in love with you, too.” There are two main types of hypomania—euphoric and dysphoric. Euphoric hypomania is by far the most common:

During euphoric hypomania, the patient feels well and is able to function well (or even better than usual). Often, the patient’s mood is jovial or euphoric. Energy and self-esteem are increased; mental acuity and creative abilities are heightened and are accompanied by a feeling of well-being. There may be increased talking (chatty) and, sometimes, a decreased need for sleep…Many patients do not see hypomania as a problem and actually resist being treated for it. For the most part, they want to extend, or increase, their hypomania, and seek help only when it comes to an end and depression sets in.
While there are some negative aspects to euphoric hypomania like impaired judgment and lack of insight, generally the positives heavily outweigh the negatives. This, coupled with the fact that the symptoms are usually short-lived, makes successful diagnosis of hypomania extremely challenging.

Those suffering from dysphoric hypomanic symptoms are less pleased with their condition: “During dysphoric hypomania, the mood is not euphoric; rather it is irritable, anxious, unpleasant, or depressed. In these cases, the patient will be disturbed by irregular or interrupted sleep, inability to focus or relax, angry outbursts, constant worrying, and endless complaints.” We must keep in mind, however, that dysphoric hypomania is a much rarer condition. Overall, hypomania is a very pleasant experience for the “sufferer.” This begs the question—why does the medical community even worry about hypomania? The answer is that even if hypomanics experience only pleasurable symptoms, hypomania cannot last forever and after it concludes depression usually follows: “Hypomania cannot be sustained; when it subsides, depression often sets in, as if the system was compensating for the enormous expenditure of energy with a general slowdown, or even a complete shutdown (depression).” In other words, hypomania is an overt sign that a person’s condition is going to quickly worsen. People who experience hypomania should visit a doctor immediately instead of basking in the uplifting nature of the illness. Unfortunately, this is not the common reaction.

Having detailed the three major phases of bipolar disorder, we must now examine the different variations they produce. While bipolar disorder is characterized by significant changes in mood and energy, there is not an exact template that these mood transformations take. Some people suffer through a sluggish depression state and then quickly transition into
a hypomanic state in which they gain a burst of energy and are over-active. Others experience a manic state first, in which they are over-active but less positive than when they are hypomanic; later, depression sets in. In addition to the different orders in which bipolar patients experience their symptoms, there is also a great variation in the length of the cycles: “Some [people] move quickly from episode to episode, with virtually no period of mood stability in between significant ups and downs. Others may be relatively stable between discrete episodes of mania or depression for longer periods.” All of these countless variations mean that physicians cannot focus in on one particular form of bipolar disorder. Instead, they must be on the look-out for a variety of different “cycling combinations.”

The American Medical Association’s DSM-IV defines four major types of bipolar disorder. In BD type I, people experience varying degrees of depression and have had at least one manic episode. Those with BD type II experience hypomania but not mania. The main symptom of BD-II is depression: “In BD-II disorder, depressive symptoms are the most prominent clinical manifestation. It is not surprising that these depressions are often confused with major depressive disorder. Depressive episodes draw attention from patients and their families, as well as doctors, because depressive symptoms tend to be more disabling and more disturbing.” The next two types of bipolar disorder are much rarer and also much more controversial. BD type III is “a pharmacologically induced mania or hypomania that was not present before it was induced by medication.” BD type IV is “an agitated depression that predominantly affects people over 50 with ‘extroverted personalities.’” Before BD-IV was part of the DSM, people with this condition were usually labeled narcissistic.

In addition to these four main types of BD, there is another form called the mixed state. A person suffers a mixed state “when symptoms of mania/hypomania and depression
occur at the same time.” In the past, this condition was viewed as very rare, but it is now being diagnosed more frequently in adults and young children. A major problem with the mixing of the bipolar states is that the illness becomes more difficult to treat with medicine. For example, when anti-depressants are prescribed for patients suffering a mixed state in order to keep their depression in check, the medication will exacerbate hypomania symptoms and cause patients to be much more agitated.

Having five major forms of bipolar disorder, in addition to many less frequent variations, is a considerable challenge for the medical world. Childhood bipolar disorder makes BD diagnosis and treatment a legitimate nightmare. On average, children have shorter mood cycles than adults: “Children’s moods seem to flip on and off like a stoplight throughout the day.” Instead of clear periods of mania, depression, and sometimes hypomania, the constant switching in children’s moods makes it appear as if they are always irritable and moody: “In adults, symptoms of mania and depression…tend to last for weeks, months, and sometimes years. In younger patients, during the early course of the illness and in some forms with rapid cycles, the symptoms may last only for minutes, hours, or days.” On the whole, children’s symptoms are also not as severe as adults. While this is a good thing in many respects, it also means that symptoms are more subtle and this can lead to bipolar disorder going awhile without being detected. The longer the disease lasts before being treated, the less chance the symptoms will respond positively to medicine.

Let’s take a closer look at the various manic and depressive symptoms that children with BD suffer. Manic children demonstrate a variety of the following characteristics: binge eating, increased activity, increased sexual drive, restlessness, impulsivity, increased speech, hard time getting to sleep, and hard time staying asleep. In addition, manic children often act
giddy for no reason, laugh excessively, always complain, fall into fits of anger and rage, and in general simply suffer unstable moods. Other symptoms include racing and crowded thoughts, inability to handle change, delusions, hallucinations, paranoia, and inability to complete tasks because there are too many stimulating things to choose from. Symptoms of depressive stages include—decreased energy, increased sleep, passivity, appetite disturbances, decreased speech, low self-esteem, feelings of worthlessness, thoughts of suicide, and cognitive dulling (which begins to shut down short and long-term memory and can temporarily lower one’s IQ by as much as 30 points).

Overall, childhood bipolar symptoms are fairly similar to adult bipolar symptoms. The main difference is that adult cycles typically last longer than children’s cycles and adults suffer more intense levels of the symptoms—compared to adults with BD, children are not quite as happy and energized during a hypomanic stint but they also do not suffer as devastating a depressive state. Both of these differences make diagnosing bipolar disorder more difficult in children. Rapid cycle changes and less severe symptoms make doctors’ jobs much more challenging. The longer bipolar goes undiagnosed in a child, the worse the symptoms will become and the more irreversible they will be.

An even more daunting problem than shorter cycles and less severe symptoms is distinguishing between abnormal childhood behavior that signals mental illness and normal, childish and immature behavior. Many children who do not have bipolar disorder have trouble sleeping, speak too rapidly when they get excited, and are hyperactive one minute and lazy the next. Children frequently binge-eat, laugh uncontrollably for little or no reason, and display intense fits of anger and frustration when they do not get their way. Does a child who is constantly moody have bipolar disorder or is he constantly angry and depressed
because everyone at school makes fun of him? Are kids sluggish in doing their homework because they have BD or because there are so many other more enjoyable temptations to engage in—friends, video games, the internet, etc.? The fact that the more severe childhood BD symptoms, which are easier to classify as abnormal, occur less frequently does not help the situation. Hypersexual behavior, psychoses, and self-harm occur in less than 35% of childhood cases while less than 10% of children attempt suicide.12

Faced with this challenge of differentiating normal and abnormal behavior, the best approach is to judge children’s actions according to their normal course of behavior: “Thus, changes in mood, activity, sleep, and ability to concentrate should be compared to your child’s own baseline, rather than to that of peers or siblings.”13 Of course with children, a severe change in behavior cannot always be attributed to the onset of a disorder. Children suffer through a tumultuous world of changing friendships, differing levels of academic work, hormones, etc. This all makes diagnosis of childhood bipolar disorder all the more difficult. Another complication for using this “baseline” method is the fact that children under three years old have been diagnosed with bipolar disorder. In these cases, parents will likely never notice a change in behavior; the BD behavior will be the way their child has always acted.

The more severe cases of childhood bipolar disorder allow for easier diagnoses. Even healthy children sometimes throw long, angry temper tantrums. When children become violent, however, it may be a sign that they have bipolar disorder: “The child’s reaction can be violent, with a rapid escalation to rage, sometimes including verbal or physical abuse. Some of these rages can last for hours (even days).”14 Parents of bipolar children have been
beaten and even had kitchen knives thrown at them over a dispute as small as turning off the television and doing homework instead.

As difficult as it may be to successfully diagnose bipolar disorder in children, a quick diagnosis is crucial. The longer the illness goes undetected, the worse it will become. Adults who suffer bipolar disorder are already fully grown by the time their illness begins. Children with bipolar disorder are forced to struggle with the illness during a crucial time in their mental and emotional development. This creates a devastating cycle: “In a child with BD, the progression of the illness runs parallel to ongoing development. The two are closely intertwined, influencing each other in complex and unpredictable ways. On one hand, the unfolding of BD can cause delays or deficits in several areas. On the other hand, problems in one or more developmental areas can exacerbate emotional instability”15 For example, bipolar disorder negatively affects children’s learning ability and this can frustrate a child so much that it is often a stressor that exacerbates BD. In addition, children who only experience hypomania before reaching puberty may find themselves burdened by intense manic periods during and after puberty due to puberty’s many complex hormonal changes.

If the challenge of diagnosing bipolar disorder in children wasn’t difficult enough, it now needs to be mentioned that childhood BD closely resembles and is often confused with attention deficit hyperactivity disorder (ADHD). The reason for this is because the manic and/or hypomanic states of bipolar disorder are very similar to ADHD. The depression phase in children with BD is not as noticeable or intense as it is in adults; as a result, it is often ignored and the manic and/or hypomanic states receive the most attention. It is not hard to see why people confuse mania/hypomania with ADHD. Both often involve rapid speech, racing thoughts, inability to concentrate on one thing, overstimulation, and many other
symptoms. To further complicate the issue at hand, sometimes children actually have both bipolar disorder and ADHD. The real problem occurs, however, when a person just has bipolar disorder and it is treated like ADHD. The treatment for ADHD is a stimulant called Ritalin. This stimulant is not only the wrong treatment for bipolar disorder, it can actually harm people with bipolar disorder by deepening their current cycle or triggering a new one. The end result of this far too common misdiagnosis is a patient that is wrongly medicated and more volatile.

While on the topic of misdiagnoses, let’s examine some other conditions that closely resemble bipolar disorder. One condition that mirrors the depressive phase of bipolar disorder is hypothyroidism. This condition can cause “decreased energy, sluggish mental functioning, and increased sleep, all of which can look like depression.” Another condition that demonstrates similar symptoms as bipolar disorder is temporal lobe epilepsy which is “associated with many of the same symptoms that can be seen in bipolar disorder—no coincidence since one of the main brain structures implicated in bipolar disorder is the brain’s temporal lobe.” Finally, various neoplastic or cancer syndromes also exemplify symptoms similar to those of BD.

As if BD diagnosis was not difficult enough with five major adult variations, childhood BD, and illnesses that closely resemble but are not BD, many people with bipolar disorder also have other illnesses. This phenomenon, known as comorbidity, is actually the norm for BD sufferers and not the exception. The most common comorbid disorders that people with bipolar also possess are ADHD, as was previously mentioned, and a number of anxiety disorders. Research has shown that nearly all people with bipolar disorder also have another mental disorder. For example, “Borderline Personality Disorder [is] a condition that
research reveals affects 40% of all bipolars (research continually shows that in addition to their Bipolar Disorder most bipolars will have some other personality disorder, be it obsessive-compulsive or anxiety-based).” This makes successful diagnoses extremely challenging. With many different symptoms blending together it is certainly possible that a successful diagnosis will not be made. With bipolar symptoms not uniform or clear in all cases, the added challenge of spotting bipolar disorder among a host of other conditions makes physicians’ jobs incredibly challenging.

**Bipolar Treatment**

The first thing to keep in mind when examining BD treatment is the origin of the illness. Bipolar disorder is first and foremost a genetic disease: “Family, twin, and adoption studies show that hereditary genetic factors are extremely important. For instance, BD occurs at a rate of 50 to 67 percent in identical twins, whose genetic makeup is exactly the same, compared with a rate of 17 to 24 percent in nonidentical or fraternal twins, who have about half of their genetic makeup in common.” Frequently, a bipolar child’s parent (or both parents) has bipolar disorder. This makes diagnosis much easier. Unfortunately, it is often the case that “a relative with BD was misdiagnosed as schizophrenic or depressed, or as having a substance abuse problem.” This takes away that crucial link that otherwise might serve as a warning sign that a child has a genetic susceptibility to bipolar disorder.

While bipolar disorder results from a genetic transmission, it is often exacerbated by environmental factors. In fact, “some theorists suggest that patients may carry the genetic predisposition to bipolar disorder, but not develop symptoms unless exposed to significant stress, especially during developmental periods. For example, extensive use of illegal
substances or early physical or sexual trauma could trigger this stress vulnerability.”22

Children, in particular, are very vulnerable to environmental stressors: “Changes in the environment can have a profound effect on a child with BD. The birth of a sibling, the separation or divorce of parents, relocation and/or a change of school, recent losses (illness/death of a relative or friend, school failure), or trauma and/or abuse can trigger the onset of BD in genetically vulnerable, that is, predisposed children.”23 The school day in general can also be an extremely stressful time: “Many aspects of a school day (completing tests or assignments on time, being called upon to answer questions, fitting in socially, being teased and bullied) can function as environmental stressors.”24 Children are definitely not the only ones who have their BD exacerbated by environmental stressors. A demanding work environment can often times tear apart adults with BD. They cannot handle all of the commands and time constraints; they falter under the pressure. In addition to employment, BD in adults can even worsen because of changes in temperature or the amount of light.25

Armed with the understanding of the origin of bipolar disorder, we must now focus on ways to contain the symptoms and eventually force them into remission. Because of BD’s genetic nature, various medicines have the ability to keep bipolar symptoms in-check and eventually allow for a remission. The challenge is finding the right medicine. One of the more popular recent drugs used to treat bipolar disorder is an anticonvulsant called Lamictal. Doctors have also been prescribing antipsychotic medications like Risperdal, Seroquel, Symbyax, and Abilify more frequently: “[Jennifer] DeWeese said her daughter, who has tried more than half a dozen drugs, some of which made her like ‘a raging maniac,’ currently takes Abilify, an antipsychotic primarily used to treat schizophrenia in adults.”26 Unfortunately, medications may often need to be adjusted after people switch BD phases. In addition,
current medications may include significant side effects for children who use “the powerful mood stabilizing drugs adults take for bipolar disorder.” People with BD who also have other comorbid disorders should not use antidepressant drugs because they will worsen a BD’s manic stage.

While medications can eventually aid bipolar symptoms more than anything else, their inconsistency and side effects make it necessary to try another form of treatment in conjunction—avoiding stressors that trigger bipolar cycles or make them worse. The main goal of this method is to prevent mania and hypomania because they trigger the rest of the cycle:

The main treatment target is mania, hypomania, or any excitatory state. Depression is viewed as the result of an excitatory phase. Our focus is on treating, or better yet, preventing mania as a way to avoid the whole cycle. Too much stimulation usually leads to manic excitement and mood instability; therefore, we make an effort to identify all possible sources of stimulation, and we discuss how to reduce their negative effects. The most common causes of instability are drugs, certain medications, lack of sleep, and environmental overstimulation.

While drugs should be an obvious thing to avoid, lack of sleep and environmental overstimulation can sometimes be difficult to evade. If an adult has a demanding job, it may certainly overstimulate him during the day and also cause him to forgo the necessary amount of sleep. On the whole, stressful jobs are a very poor choice for those with bipolar disorder.

**Prevalence of Bipolar Disorder**

When people ask how widespread bipolar disorder is they often get many different answers. Some of the more extreme responses are five million Americans suffer from bipolar disorder, no child in the U.S. suffers from BD, and 13% of Americans have some form of
hypomania. The majority of responses are between 2 and 3.5 million Americans. Not surprisingly, this discrepancy has caused a great debate to ensue over the prevalence of bipolar disorder.

Many of the voices heard in this debate are critical of the rising number of bipolar diagnoses. Some experts think that bipolar disorder has become a new fad: “one critic called it ‘psychiatry’s flavor of the month’—a decision too often based on skimpy evidence, cursory evaluations and incorrect assumptions about genetic risk.” Many others echo this sentiment: “As much as depression was the illness of the nineties, mild bipolarity has become the new diagnosis for a slice of society that includes hard-to-treat depressives and some with a personal disposition that perhaps hedges into ordinary moodiness.”

Childhood bipolar disorder has drawn the greatest ire. Jon McClellan, a Psychiatry professor at the University of Washington, is particularly incensed by childhood BD: “Labeling severe tantrums in toddlers as a major mental illness lacks…validity and undermines credibility in our profession.” Others question the accuracy of childhood diagnoses in general: “With kids, especially little kids, all disorders pretty much look alike. Kids tend to behave by lashing out and acting out.”

There are of course those that disagree strongly with the critics who claim that BD is over-blown. Joseph Biederman, a Harvard Psychiatry professor, has been one of the strongest supporters of treating children as young as preschoolers for bipolar disorder. Biederman is convinced that BD had been “severely under-diagnosed in children.” He believes that the only reason why childhood bipolar diagnosis is a hot-button issue is because “it has been assumed not to exist.” Biederman is referring to the fact that years ago it was believed by
almost all that only adults suffered bipolar disorder. He believes that despite new evidence, too many doctors are unwilling to budge from that original assumption.

With all of these differing opinions, it seems like the most responsible decision is to acknowledge that in the United States there exists a bipolar spectrum—“It’s a rainbow that includes highly functional people as well as those with powerful psychoses.”36 While treating the people with the most severe bipolar disorder should be the first priority, we must not allow critics to convince us that because there are so many new bipolar cases, those with minor BD should be overlooked. The reasoning for this is because “the absence of vigorous treatment for several years can lead to serious consequences, such as self-harm, resistance to treatment, and comorbidity.”37 Because of the nature of bipolar disorder, people with a minor form of the illness can have their conditions quickly worsen.
A Case Study

If we learned anything from the last chapter, we now know how difficult it is to successfully diagnose bipolar disorder. Unfortunately, there exists no specific test that can diagnose BD without error: “There is no blood test or brain scan, as yet, that can establish a diagnosis of bipolar disorder.” To make matters worse, instead of doctor’s focusing on one bipolar illness, they must focus on all of the many “cycling combinations” of BD, as well as the many comorbid disorders and illnesses that appear like BD but are not.

The Social Security Administration has tried as much as possible to simplify the diagnosis of bipolar disorder. The SSA regulations that a disability examiner must follow ignore the various labels—BD type I, BD type II, BD type III, BD type IV, mixed state, etc.—and instead focus on the symptoms. This approach significantly simplifies the problem of comorbid disorders. The disability examiner does not have to worry about whether a person has bipolar disorder and anxiety disorder; their only focus is on whether the symptoms are severe enough to meet the SSA List of Impairments’ criteria.

The one problem with the SSA Regulations on comorbidity occurs when people possess some bipolar symptoms and some symptoms of another disorder but not enough of either one to qualify for disability benefits under a single diagnosis. The Social Security Administration’s rulings on this phenomenon are very unclear. On the one hand, they say that the doctor’s report, which is submitted to the disability examiner, must consider the combined impact of the multiple impairments: “When assessing the severity of multiple
impairments, the adjudicator must evaluate the combined impact of those impairments on an individual’s ability to function, rather than assess separately the contribution of each impairment to the restriction of function as if each impairment existed alone.” However, shortly afterward, the regulations state that different impairments cannot be combined to collectively make up the necessary 12 months needed for disability benefits:

Severe impairments lasting less than 12 months cannot be combined with successive, unrelated impairments to meet the duration requirement. For example, if an individual had two unrelated incapacitating impairments, one lasting for only 9 months and the other developing 6 months after onset of the first and lasting for only 7 months, the duration requirement is not met since neither impairment lasted at least 12 months even though the individual’s inability to work lasted for a total of more than 12 months.

This seems very contradictory. The SSA wants peoples’ conditions to be combined for the sake of determining functioning ability, but at the same time one of these conditions by itself must last at least twelve months.

Having exhausted the topic of comorbidity, let’s now take a closer look at the Social Security Administration’s list of bipolar symptoms. According to the SSA, in order for an applicant’s BD to be severe enough to earn disability benefits, a person must suffer four depression symptoms from the following list—loss of interest in almost all activities, appetite disturbance, sleep disturbance, decreased energy, feelings of guilt or worthlessness, difficulty thinking, paranoia, hallucinations, delusions, or thoughts of suicide. If the patient does not suffer four depression-like symptoms, he must possess three of the following manic symptoms: hyperactivity, rapid speech, flighty ideas, inflated self-esteem, decreased need for sleep, easily distractible, or risky behavior. In addition to either the four depression symptoms or the three manic symptoms, the patient’s symptoms must result in at least two of the following: marked restriction of daily activities, marked difficulty in social functioning,
marked difficulty in concentration, or repeated decompensation. Childhood and adolescent bipolar disorder criteria are essentially identical with the addition of irritable mood and depressed mood as options under the depression symptoms, and a necessary five depression symptoms to qualify for disability benefits.

While these regulations serve as helpful guidelines for bipolar determination, and eliminate some of the confusing labels, so many questions still remain. For example, what factors are taken into consideration when judging the severity of symptoms? How severe do symptoms have to be? What if a patient has a very severe symptom that is similar to one listed but not exactly the same? Another problem that the SSA’s symptom examination often struggles with is the issue of bipolar cycling. The disability examiner’s main reference for medical evidence comes from the doctors that have seen the applicant. Unless multiple appointments have been scheduled with these doctors, it is likely that applicants’ manic, hypomanic, and depressive stages have not all been observed. One of the phases will be on display at the time of the appointment. The manic/hypomanic stage poses particular problems for successful bipolar diagnosis if it is the one on display: “If manic, the bipolar can have an unrealistic positive attitude about every issue.” Bipolars in the manic stage may appear overly upbeat during an interview with a doctor and may leave him thinking there is absolutely nothing wrong with the patient. Debra Meehl provides an excellent example of this in her “Friends and Family Bipolar Survival Guide” when she describes the process she went through with her bipolar husband, Mark:

Mark would step into his calm and well-ordered ‘Dr. Jekyll’ persona and everything would be fine, leaving our counselor confused as to what was going on. Only when “Mr. Hyde” finally showed up for a therapy session did she finally understand…until she could see Mark in his full form, she had no idea what I was facing. Mark always had a “good story” on how I just needed to get onboard and should be more positive in life. It sounded
great to the counselor and, of course, she always wanted to know ‘why’ I
was not being positive.

Of course if a doctor cannot observe the full form of the illness with the patient while face to
face, how is a disability examiner who only has a medical record to work with supposed to
successfully decide a disability case?

Even if a person is diagnosed correctly with bipolar disorder, there is no one model
that can predict when a person will undergo a manic phase, hypomanic phase, depressive
phase, or relapse phase. Some people have long phases of each, some have short ones, and
others have mixtures of both. In addition, all people are different and deal with varying
degrees of pain uniquely. Many people with bipolar disorder can be fairly incapacitated. On
the other hand, there are many famous and accomplished men and women who had
symptoms of the illness, including—Abraham Lincoln, Alexander Hamilton, Beethoven,
Goethe, Hemingway, Isaac Newton, Mark Twain, Ralph Waldo Emerson, Theodore
Roosevelt, Virginia Woolf, William Faulkner, and Winston Churchill. These people
definitely accomplished a great amount of work in their respective professions throughout
their lives. The possible scale of peoples’ working capacity with bipolar disorder is clearly
vast. Successfully diagnosing someone with BD is only the tip of the iceberg since the goal
in the disability process is not diagnosis but qualification for disability benefits, which is
based on working capability.

Having said this, it is clear that while medical diagnosis can be very helpful, disability
examiners need an additional method in order to properly decide disability cases. The method
that has been settled on one might call a functionalist approach. Instead of just examining the
applicant’s symptoms, the applicant’s past work experience and functioning capability is
given great weight: “You could interview an employer who could say, ‘Yeah, Howard was a
great employee. He was very motivated, but then he got depressed, then went into the hospital and hasn’t been the same since.” This approach takes into consideration the context of an applicant’s life and is often times more revealing than a medical evaluation.

This functionalist approach helps determine working capability much better than trying to decide working ability based solely on medical diagnosis. The method can also, however, be used for medical diagnosis itself. The functionalist approach to mental disability determination enables certain signs of bipolar disorder to be viewed that otherwise would not have been if a strict clinical approach was used: “The ability to function depends substantially on such abstractions as motivation, tolerance for pain, and energy levels. These are not testable characteristics of persons in the way that blood type is, yet they may be highly relevant to the question of a claimant’s functional capacity.” The functionalist approach does a much better job than a strict clinical approach at keying in on a bipolar’s various cycles. Hypomania provides a helpful example here. Bipolars’ hypomanic cycles typically feel good to them: “Hypomanic individuals report feeling on top of things, productive, sociable, and self-confident. They feel excited, energized, creative, active, intelligent, and sometimes, more sexual. They may say that they feel better than at any other time in their lives.” If this is the only cycle that doctors observe, there is a good chance that they will see nothing very serious with the patient. A functionalist approach that encompasses all past behavior, and does not rely on a one time examination, will allow for a much more accurate diagnosis.

This functionalist approach to medical diagnosis can be utilized in two main ways for disability determination. The first way is for a patient’s close family members to keep a report of their symptoms and present it to the doctor every time the patient is seen for a visit.
This will help provide the doctor with a more thorough picture of the illness being examined. This will also allow a doctor to send a more accurate medical diagnosis to the disability examiner. The second way the functionalist approach can be utilized is for a patient’s friends and relatives to send letters with background information on the patient directly to the disability examiner. The Social Security Administration’s regulations often allow statements from these familiar sources to carry much weight:

An opinion from a “non-medical source” who has seen the claimant in his or her professional capacity may, under certain circumstances, properly be determined to outweigh the opinion from a medical source, including a treating source. For example, this could occur if the “non-medical source” has seen the individual more often and has greater knowledge of the individual’s functioning over time.11

Input from these familiar sources can help neutralize the difficulties that a bipolar patient’s cycling causes. Close friends and family can detail for doctors the extent of the other phases the patient is experiencing but perhaps not displaying during examinations. One issue with this approach, however, is that there is no guideline that states when the opinion of a non-medical source vaults into greater importance than other sources. According to the regulations, it appears as if the disability examiner or ALJ should know when to value the word of non-medical sources over medical sources. This provides the disability examiner with a great amount of freedom which can be good because every case is different but also bad due to too much ambiguity.

While the functionalist approach works well with adults, it is also very helpful in childhood disability determination. During their hypomanic phases, doctors usually observe children who are very happy and upbeat. This can easily confuse successful diagnosis. Statements from parents about the entire spectrum of their child’s behavior help shed a lot of light on a child’s true condition. Since children do not work, the best environment to observe...
their functionality in school. The SSA Listings suggest that observations made about kids’ behavior at school can be very useful in diagnosing mental disability symptoms. One of the first signs of bipolar disorder that teachers notice quickly is “problems in social functioning, especially in the area of peer relationships.” Drastic differences in test scores can also be a sign of bipolar disorder since the depressive stage can dull one’s IQ by up to 30 points. While watching how children interact with others and handle specific situations at school may be a better indicator of their mental health than a simple medical evaluation, we must be careful here. The average child is very up-and-down. They have good days and bad days. Even healthy children may seem bipolar when they are struggling through a rough day.

**Bipolar Disorder in the Workplace**

With our discussion of bipolar disability determination complete, let’s now focus on employment guidelines for people with BD. The first thing that must be taken into consideration is that all people with bipolar disorder have certain stressors that augment their symptoms: “Bipolar Disorder often hides behind life’s ordinary experiences, emerging only when certain environmental ‘triggers’ or ‘stressors’ cause it to manifest itself.” Without stressors, people with bipolar disorder would suffer much less: “If you were a Buddhist monk and lived your entire life in the temple, you might not ever experience the intense mood swings that are caused by the stressors of daily living in our society.” Unfortunately, the workplace is practically the opposite of living in a monastery: “The constant pressure to conform and to scratch and claw one’s way to the top is usually a pressure cooker for the bipolar.” Working in an intense environment, the bipolar is bound to crumble under the pressure and enter a free fall of intense mood swings.
Another problem bipolars generally have in the workplace is adjusting to other peoples’ ways of doing things. Bipolars have a desperate need to do things their way: “Many of us live under the burden of many ‘absolutes’ and in the black-or-white world of the bipolar there are even more.” When events transgress this “necessary path,” bipolars have a much greater chance of experiencing a dramatic mood swing. People with bipolar disorder necessitate a work environment that is willing to be flexible to their needs. Jobs that are flexible by nature, and which bipolars should drift toward if at all possible, include artwork, consulting, and sales. Studies have shown the bipolars that adjust the best to their work environment are those who work for small companies or start their own company: “Small companies, in our experience, also tend to be a good deal more understanding of the bipolar’s needs. Therefore, it is often possible to arrange to allow the bipolar to work alone and to control the amount of stress present at any given time, or to surround themselves with a supportive group of co-workers.”

Many times, however, despite generous accommodations, people with bipolar disorder just don’t make good employees. In particular, bipolars have very bad relationships with co-workers. They also exhibit extremely poor judgment during their manic phase. It is not uncommon for a manic bipolar to spend an extravagant amount of money in a few hours: “[Couples] find themselves thousands of dollars in debt as a result of uncontrolled spending during a manic episode.” Of course it is possible to deny bipolar employees access to the company’s finances, but nonetheless someone who is so irresponsible during a manic episode can be a dangerous person to employ.

Having said this, often times the best option for a bipolar is to be self-employed. The majority of the famous people with bipolar disorder have been self-employed—authors like
Hemingway and Faulkner, composers like Beethoven, etc. There are also a lot of very successful bipolar entrepreneurs: “History bears out that most bipolars who find success in the work world are entrepreneurs. They often don’t make good employees, but they do make great leaders. Some of the most gifted, intelligent and talented people in business today are bipolar.” Whether bipolars work for themselves, a small company, or an understanding larger firm, it remains that in order to be solid contributors they need to have more control than the average employee over their work environment, tasks, and schedule.
Chapter 5: Disability Insurance Abroad

Disability Benefits—A Comparative Perspective

In order to gain a better perspective of the United States’ disability insurance program, it will be helpful to consider similar programs in other countries. This will provide us with a context for what is transpiring in the U.S. program and perhaps offer important changes that should be implemented in the United States. On average, other countries spend more money on disability than the United States, focus more on rehabilitation, have more extensive anti-discrimination employment laws that allow a greater number of disabled people to be employed, and offer various types of disability benefits.

Before delving into a multi-national comparison of disability programs, it will be helpful to first consider a comparison between the United States and Germany. This will provide us with a general understanding of how the United States differs from other countries with respect to their disability program. In the United States, the main focus, as we’ve discussed, is on disability benefits. While these benefits can pay for healthcare, and eventually Medicare is also granted once a person has been on the disability rolls for two years, it remains that the U.S. program is not very focused on rehabilitation: “In the United States, rehabilitation and job programs are secondary to transfer payments as a means of helping people with disabilities.”. Return to work programs have only become more popular in the United States in the past few years.

The focus of the German disability program is entirely different: “The goal of the German system is to provide early detection, rehabilitation, job retraining, and employment
whenever possible and to award transfers only when other mechanisms fail.”: In fact, Germany has enacted laws that require a quota of disabled employees at almost all businesses: “The government has a quota system mandating all public and private enterprises to employ a handicapped worker for every 16 employees or about 6 percent of their workforce. A fine of [approximately $125] per month per unfilled quota position is charged to employers who do not comply.” Of course this is a small fine to pay for most companies, but it definitely relays the message that employment for the disabled is an important priority in Germany.

The United States’ and Germany’s different approaches to disability have predictably led to dissimilar results: “In the United States, the percentage of younger men with a disability is much higher and the percentage of older men with a disability much lower than is the case in Germany.” The reason for this trend is because German disability policy stresses rehabilitation and full-time employment for younger workers with impairments, while acting more leniently toward older workers, providing many of them with disability benefits. On the contrary, the United States hands out disability benefits more evenly which leads to them having more younger workers receiving disability benefits than in Germany but fewer older workers.

A final major difference between the United States and Germany is the ability disabled workers have to earn a substantial living. On average, disabled German workers receive a much greater salary than disabled workers in America: “Men with disabilities in the United States on average received only 49 percent of the labor earnings of men without disabilities. In Germany, men with disabilities on average received 65 percent of the labor
earnings of men without disabilities.” This data is certainly representative of Germany’s greater focus on the reemployment of the disabled.

Having grasped some of the differences between disability programs in the United States and Germany, let’s now take a closer look at how the U.S. compares to a variety of other countries. In almost all circumstances, the United States spends less money on disability benefits than other countries. Denmark, Finland, Norway, Sweden, and the United Kingdom all spend much more on disability cash benefits than the United States. Greece, Italy, Portugal, and Spain spend less than these countries but still more than the United States. All of these countries spent considerably more than the U.S. on measures to help the disabled return to the workplace. According to data collected between 1996 and 2000, “The United States spent a lower percentage of its GDP on disability programs than did all other countries under study except Canada, Korea, and Mexico. Norway, Sweden, and the Netherlands spent three times as much on their disability programs as did the United States.” The reason for this is because the definition of disability is much narrower in the United States. In general, disability in the U.S. means a severe impairment in which the person is incapable of work for a substantial period of time. The United States also has refrained from using their disability benefits process as an early retirement program for the elderly, contrary to many other countries.

One major difference between the United States and many other countries is in the level of disability benefits. In the U.S., there is only one level of disability benefits: “There is no opportunity to negotiate a middle ground or alternative arrangement that would suit the interests and understanding of both parties. The game is zero-sum. Either the claimant gets payments and the government is out the money or the government keeps the money and the
claimant gets nothing.” This is not the case in many other nations. In Germany, for example, “there are two levels of disability protection: one covers an inability to perform any occupation and pays a benefit of approximately 100% of the standard old-age pension, and the other covers an inability to carry out 50% of the tasks of one’s own or similar occupation and pays 66% of the old-age pension.” The French system possesses even more innovation. There are three categories of French disability:

The first class applies to disabled persons who are still able to perform any gainful activity. The pension is calculated according to the following formula: Average Annual Wages x 30%. The average annual wages represents the wages accrued during the 10 best years, adjusted and divided by 10, if there were 10 years. The second class applies to disabled persons who are unable to perform any gainful activity. The third class applies to disabled persons who belong to the second class, but need a constant attendance for daily activities.

For each progressive category, the disability is worse and the corresponding benefits are higher.

There are both positives and negatives about offering different disability levels. The main positive of this format is that countries are able to aid a greater amount of people with impairments and at the same time focus more resources on the severely disabled. In the United States, those that are not severely disabled are borderline candidates for disability—they will either get accepted and gain more benefits than they likely merit or they will be denied and gain less benefits than they deserve. Differing levels of disability help provide people with the amount of benefits that their specific condition warrants. A negative aspect of these different levels of disability insurance is the administrative aspect. As we saw with the United States, it is incredibly difficult to decide whether people are disabled or not. Figuring out percentage-wise how much disability a person possesses is even more arbitrary.
The German system that is split into two categories is fairly manageable, but some other systems are downright confusing.

Another major difference between U.S. disability insurance and programs in other countries is that other countries offer temporary disability insurance. The only countries to have a lower number of disabled people than the United States are Italy, Korea, and Mexico. Yet the number of severely disabled people in the U.S. is not too far behind other countries; the difference lies in the fact that other countries offer temporary disability to those who are less severely disabled. Temporary disability benefits in Europe are usually called sickness benefits and are a part of countries’ national health insurance: “The insured person draws sickness benefits for a period of one or two years, and if his disability has not been eliminated within the specified time, he is switched into a permanent pension program.” In France, people can begin collecting these sickness benefits after the fourth day in a row they are absent from work due to an illness.

Temporary disability benefits also have positives and negatives to them. A major positive is that they help make reemployment extremely easy. In the United States, by the time a disability application has worked its way through the U.S. system, a couple years may have passed and by that time a person may be better off settling for the disability benefits and backpay rather than reentering the workforce. In countries with temporary disability, a person can exercise these benefits, get well again, and then reenter the workforce quite easily. The main negative associated with temporary disability benefits is that they can often be very expensive. The fact that the French allow sickness benefits to be drawn after the fourth day of missed work is absurd.
Along these same lines of making a return to work easier, another difference between many European countries and the United States is that many European countries offer universal healthcare: “Public health care programs in these countries ensure that the retention of health insurance is not an issue in a worker’s decision on whether to apply for benefits, participate in rehabilitation, or attempt returning to work.” Many Americans on the disability rolls believe they have little incentive to attempt a return to the workforce because they are afraid of losing healthcare benefits that come with being disabled for two years. Recent amendments to the disability insurance program have allowed these healthcare benefits to continue for a few years after a person has reentered the workforce. This should allow disabled Americans to become more like their European counterparts and seek reemployment more often than in the past. With the enactment of the Americans with Disabilities Act, the United States has also tried to emulate the Europeans who have even set up quotas for the number of disabled employees a business must possess: “In 1990 the United States moved closer to this two-pronged European approach of transfers and employment protection by enacting the Americans with Disabilities Act…One of the hopes underlying the ADA is that accommodation at the onset of a health impairment will delay job exit and subsequent movement onto the disability rolls.” While still trailing the Europeans, the United States has begun to focus more on employment accommodations for the disabled.

A final thing that warrants discussion is medical treatment and rehabilitation. In the United States, rehabilitation is not a primary goal. This is very different in many European countries, especially Germany and France. The French provide their disabled citizens with first-class medical coverage: “Hospital costs are covered to the amount of 80%. In some cases, customers are reimbursed to the amount of 100% (as from the 31\textsuperscript{st} day of hospital stay
or for particular medical services such as surgery). When reimbursed to the amount of 100%, the patient had to pay a [small] flat rate per day towards the hospital costs.”14 In addition, the French pay close attention to the medical treatment that disabled patients receive. They want to make sure that people are really being rehabilitated. In order to achieve this, the French charge an extra fee to those people who receive medical treatment from unassigned government sources:

Every patient over 16 years of age has to choose a treating doctor who will refer him to the appropriate doctor or hospital and will coordinate the private medical record…The treating doctor keeps up to date the medical record and prescribes the further medical investigations or refers to another doctor. All medical procedures carried out or advised by the treating doctor will be refunded at normal rate, for the concerned person is following the course of coordinated care. But if the patient has not given the name of a treating doctor or if he goes directly to see a specialist doctor, he is no longer within the course of coordinated care, the refund will be lower and the amount he will be responsible to pay will be higher.15

The French clearly have a better system of rehabilitation than the Americans who provide mainly cash benefits and do not follow a person’s rehabilitation.
Chapter 6: Future Improvements

What Now?

Now that we have examined the disability insurance program in the United States, and compared it to similar programs throughout the world, it is time to make further suggestions about how the American disability process can be improved. The first thing we should focus on is the recurring issue of deciding disability cases that are not immediately obvious. The program does not struggle with cases in which a clearly severe impairment is on display. The borderline cases are where the difficulties lie. Despite the use of the functionalist method, these cases have still been decided so inconsistently by different parties: “The [General Accounting Office]…circulated descriptions of some two hundred cases to ten state agencies and asked them to adjudicate the claims. The study found that there was complete agreement among the agencies in only 22 percent of the cases.” Another study found that in the same year, the state of Alaska denied disability benefits to 63% of its cases while Iowa rejected only 37% of its applicants. Less severe disability cases are just really difficult to judge. No matter the standards set by the federal government, there is always going to be a lot of leeway in disability decision-making, and accordingly a lot of inconsistency.

Another problem with the American disability insurance program is its lack of attention to medical care and rehabilitation. As was seen in our comparison of the United States to other countries, medical care and rehabilitation are not focal points of the American disability program. From a goodwill standpoint, the United States should really try to aid disability patients in eradicating their illnesses. It is odd that rehabilitation, which many
would think should be the natural target of disability insurance, is a long afterthought in the American system. Obviously some people may be beyond assistance, but those who are reachable and can be rehabilitated should be; that needs to be one of the most important goals of the program. Interestingly, studies in the past have shown that focusing on rehabilitation actually saves the Social Security Administration money in the long run. During the 1950s, “the federal government spent $19.7 million on rehabilitation and rehabilitated 64,000 people. Within a year, these people paid more than $10 million in federal income taxes, and within a few more years they repaid the government’s investment ten times over.” Another study done in 1981 demonstrates a similar conclusion: “The agency’s annual report for fiscal 1981 made the same claims, estimating a return of ten dollars for every one dollar spent on the program and substantial savings in public assistance costs.” These studies really beg the question—if money is not the reason rehabilitation has not become more of a vital focus of the U.S. disability insurance program, then what is? It is inexcusable that rehabilitation remains such a low priority in the American disability program.

With borderline disability cases causing so much inconsistency and rehabilitation an ideal goal of any disability policy, the best route the United States can take is providing disability cash benefits and medical care to the severely disabled and rehabilitation and employment programs for those less severely disabled. While this approach seems very similar to the European model, I would not recommend that the United States allow their program to mushroom into what the Europeans have. France, in particular, is fiscally irresponsible in providing benefits after just four days absent from the office. Instead, the United States should keep their numbers about where they are but try to rehabilitate the less severely disabled who currently meet the disability standards and aid their return to the
workplace. For those who are even less severely impaired than the current disability benefit recipients, but impaired nonetheless, they will benefit from more forgiving work environments similar to those of the Europeans. If universal healthcare is ever passed in the United States, the disability program can be solely for the severely disabled, with the less severely impaired able to take advantage of universal healthcare and specially structured work programs.

All signs point to the American public approving of this new approach to disability. Americans do not strongly support cash hand-outs, as can be seen by how unpopular welfare has been throughout our country’s history. Many Americans are wary of the increase in taxes that more monetary support of disability will cause. Overall, however, Americans do support anti-discrimination laws that help provide jobs for those with disabilities. Not all people are completely in favor of these measures, specifically business owners and wealthier Americans. What is significant, however, is that those who have worked with disabled individuals are the greatest supporters of disability rights: “Participants with prior work experience with people with disabilities (defined as prior work or volunteer experience in the disabilities field or having employees with disabilities) expressed more positive attitudes toward disability rights than those who did not have this experience.” It is interesting to note that those who have worked with people who are disabled have an even higher opinion of disability rights than those who have friends or family with disabilities. Clearly, the disabled have proved themselves in the workplace.

With the goal in mind of establishing more forgiving environments for disabled workers, let’s examine what the United States has done so far toward this endeavor. The first major law to make accommodations for disabled Americans was the Rehabilitation Act of
1973, and in particular Section 504: “[The regulations]—which applied to all hospitals, schools, local governments, or other institutions that received funds from the Department of Health, Education, and Welfare—required that all new buildings be barrier-free, that all activities be made accessible to the handicapped, that all handicapped children be given a free public education, and that all colleges and universities modify their academic requirements and provide auxiliary aides to allow the handicapped to participate.” The next major act, and the most important American legislation of its kind, was signed into law on July 26, 1992 and called the Americans with Disabilities Act (ADA).

The ADA originally applied to all employers with 25 or more workers. Two years after its original passage, “the standards of antidiscrimination were extended to all employers of 15 or more workers.” This far-reaching law consists of five main sections:

Title I prohibits discrimination against qualified persons with disabilities in the realm of employment. Title II ensures that eligible individuals are not denied state or local government services, programs or activities because of their disabilities. Title III prohibits private establishment and places open to the public from discriminating against people with disabilities in the full and equal enjoyment of goods, services, and facilities. Title IV ensures that telecommunications relay services are available for people with speech, hearing, and voice disabilities. Lastly, Title V of the ADA consists of miscellaneous provisions that cover an array of issues, such as the nonprotection of the ADA for those actively using illegal drugs.

One of the greatest positives about the ADA legislation is that it aids all people with impairments, not just those who are considered eligible for disability benefits. This allows for the extension of at least some form of aid to those with impairments that do not meet the SSA criteria for disability. An additional positive of the Americans with Disabilities Act is that it provides students with “the right to specialized training and programs designed to make the education process easier. With an Individualized Education Plan (IEP) in place, accommodations can be made to help with testing and issues relating to behavior and the
individual needs of the student.” This will allow children with impairments to learn as much as they can on their own special terms.

One sign that the United States is trending more towards encouraging the reemployment of the disabled is the 1999 Ticket to Work and Work Incentives Improvement Act: “The goal of this landmark legislation is to remove barriers and increase incentives for individuals with disabilities to seek work…Prior to enactment of the bill, less than 1 percent of the individuals with disabilities receiving Social Security Disability Insurance left the rolls to return to work.” The focus of the program is in providing a ticket to those with disability benefits which can be used to obtain a job from various Employment Networks: “Employment Networks can be a single entity, a partnership or alliance of entities (public and/or private), or a consortium of organizations collaborating to combine resources to serve ticket-holders.” In addition to providing a job network in which disabled employees can find jobs the easiest, the Ticket to Work and Work Incentives Improvement Act also “allows people with disabilities who return to work to continue their premium-free Medicare Part A coverage for an additional 4 years beyond the 4 years previously provided.” At this point, there are more than 11 million ticket-holders in this program with an average return to employment cost of $15,819. While the United States still has not made a concerted effort toward rehabilitation of the disabled, it clearly is showing signs of trying to move the disabled back into the workforce and, at the same time, crafting work environments that are disability friendly.

One important question that still lingers is whether the United States is prepared for a change in their disability program. The last major change in the disability program—the disability reviews of the early 1980s—was a political nightmare. First of all, there was much
public outrage. All of the major newspapers ran stories about deserving people who were rashly removed from the disability rolls: “The Wall Street Journal reported on a Vietnam war veteran whose jaw was wired shut and who had lost a leg and two fingers; part of his stomach was gone. Although he had been on the disability rolls for seven years, he was cut off. By the time the Social Security Administration restored his benefits, he was dead.”15 The public quickly became angry that the Social Security Administration would leave severely disabled patients to fend for themselves.

In addition to the public, the Administrative Law Judges also rebelled against the 1980 disability reviews: “At least 200,000 of the approximately 490,000 people whose benefits had been terminated had their benefits restored…By August 1982, for example, the Social Security Administration had terminated 31,700 people with mental impairments. Of those, 13,400 requested a reconsideration. Although the states sustained the decisions in 76 percent of the cases, the administrative law judges reversed 91 percent of the mental impairment cases that reached their hearing rooms.”16 This defying of the federal government soon led to subtle sanctions against judges with high reversal rates, including mandatory courses to reeducate them about disability determination as well as decreases in their secretarial help. ALJs soon saddled the federal government with a lawsuit, and the mess continued.

Fortunately, I do not see the public or administrative agencies becoming nearly as incensed about my new proposed disability policy. There are a number of reasons for this. First of all, the severely disabled would continue to receive their regular benefits. Nothing would change there. The less severely disabled who still qualify for disability would be given short-term disability benefits, placed in a rehabilitation program, and eased back into the
workforce. Unlike the disability review where people were dropped without notice or benefits to hold them over until they found a job, this new proposed policy would provide people with temporary benefits that would only expire after they had been rehabilitated and returned into an understanding work environment. The disability rolls may shrink in size because of this policy, but more people will receive the medical attention they need and the rehabilitated should have much greater earning potential once healthy and working rather than sick and receiving disability benefits.
Epilogue

While focusing more on rehabilitation and reemployment will make the American disability program much more effective, one thing that will certainly improve the disability insurance process is new scientific knowledge, specifically regarding the ever-difficult mental disabilities. Fortunately, many important discoveries are being made every day. For example, researchers have begun to discover that “during depression, the frontal cortex will show decreased activation; during mania, temporal lobe regions will show increased activation.” By examining blood flow and brain activity, doctors should eventually be able to diagnose bipolar disorder by objective means: “We can expect important new findings in the next 10 years on fundamental brain processes and underlying mechanisms of major psychiatric illnesses.” In the meantime, we are stuck with an inexact, subjective way to measure bipolar disorder and many other mental disabilities.

Luckily, another positive development is also on the horizon—the American Psychiatric Association’s new DSM-V is slated to be finished by 2011. According to updates from the APA, the DSM-V may greatly aid disability determination in at least three main ways. First of all, the DSM-V will concentrate on finding more objective tests for mental illnesses:

Essential elements of a research agenda that would elucidate an etiology-based system include genetic studies, brain imaging, post-mortem studies, and animal studies. Genetic studies, despite several decades of effort, have not yet identified with certainty any bona fide psychiatric disease gene, although the field is getting closer and new advances in genetics portend rapid progress. Brain imaging studies in humans promise, for the first time, to provide detailed information about molecular and cellular substrates of the brain involved in psychiatric disorders.
Secondly, the DSM-V is considering a new dimensional approach toward symptom analysis that “would describe the patient’s psychopathology in terms of where the symptomatology falls along a number of dimensions, for example, low on depression, high on psychosis, etc. Although the categorical approach more closely conforms to the way clinicians think, a dimensional approach without discreet boundaries more closely conforms to clinical reality.” If this change occurs, the DSM-V will begin to look a lot more like the list of symptoms disability examiners consult.

A final improvement the DSM-V plans to make is improving the methods used in disability examination:

As greater emphasis is placed on detection and early intervention for mental disorders in settings other than traditional psychiatric clinics and practices, there is a need to define or operationalize diagnostic criteria using methods other than the traditional psychiatric interviews which require considerable training and clinical judgment. Strategies to reduce reliance on clinical judgment include increased use of laboratory tests, psychological testing, and standardized self-report rating scales.

With these changes in the DSM-V making a disability examiner’s job easier, along with new scientific knowledge being discovered daily, disability examination will continue to become more accurate. This positive outlook, coupled with a new policy stressing rehabilitation and reemployment in a well-suited work environment, could transform the United States’ disability program into one of the best in the world.
Endnotes

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Bibliography


17. Esther U. Schutz and Friedrich Muller, “Disability Schemes in Germany and the Netherlands,” GeneralCologne Re.


