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Disability Programs Lag in Promoting Return to Work

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Chairman
The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Bill Archer
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House of Representatives

Each week the Social Security Administration (SSA) pays over $1 billion in cash benefits to people with disabilities who are beneficiaries of Disability Insurance (DI) and Supplemental Security Income (SSI). The size of the working-age beneficiary population has grown rapidly over the past decade, increasing by 65 percent. However, not more than 1 in 500 DI beneficiaries, and few SSI beneficiaries, have left the rolls to return to work. Therefore, although they may provide a measure of income security, DI and SSI do little to enhance work capacities and promote economic independence.

Yet societal attitudes, as reflected in the Americans With Disabilities Act (ADA), have shifted toward goals of economic self-sufficiency and the right of people with disabilities to full participation in society. Moreover, medical advances and new technologies provide more opportunities than ever for people with disabilities to work. Although at one time the common business practice was to encourage someone with a disability to leave the workforce, today a growing number of private companies have been focusing on enabling people with disabilities to return to work.

In testimony before the Senate Special Committee on Aging on June 5, 1996, and in two reports to the committee issued in April and July 1996,[1] we discussed why so few DI and SSI adult beneficiaries with disabilities

[1]Social Security: Disability Programs Lag in Promoting Return to Work (GAO/T-HEHS-96-147, June 5, 1996); SSA Disability: Program Redesign Necessary to Encourage Return to Work (GAO/HEHS-96-62, Apr. 24, 1996); and SSA Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs (GAO/HEHS-96-133, July 11, 1996).

return to work[2] and how strategies from other disability systems could help restructure DI and SSI to improve return-to-work outcomes. This report updates the information in those previous reports that was based on surveys of private sector leaders in developing return-to-work programs; interviews with federal and state agency officials, experts, and advocates and officials in Germany and Sweden; analysis of SSA's administrative data; and focus groups with beneficiaries.[3] Although we did not independently verify the data used in the analysis of this report, the data cited came from either U.S. government data systems or issue area experts. Except for this, our work was performed in accordance with generally accepted government auditing standards in November and December 1996.

Results in Brief

Design and implementation weaknesses in the DI and SSI programs hinder maximizing beneficiary work potential. The application process places a heavy emphasis on work incapacity and presumes that many medical impairments preclude employment. And SSA does little to provide the support and assistance that many people with disabilities need to work. Not surprisingly, these and other program weaknesses yield poor return-to-work outcomes and mean that DI and SSI have not kept pace with societal trends toward the economic self-sufficiency of people with disabilities.

Lessons learned from return-to-work strategies and practices now used in the U.S. private sector and in other countries may hold potential for improving federal disability programs by helping people with disabilities return to productive activity and at the same time reduce cash benefits. SSA serves a population with a wide range of disabilities that often may be more severe than the disabilities of the average person served by U.S. private sector programs. Therefore, SSA may face greater difficulty in returning some of its clients to the workplace. The experiences of the social insurance programs of Germany and Sweden, however, show that return-to-work strategies are applicable to government-scale programs serving a broad and diverse population with a wide range of work histories, job skills, and impairment types.

Our analysis of practices advocated and implemented by the private sector in the United States and by social insurance programs in Germany and

[2]By return to work, we refer to both the reentry into the labor force of people with work experience and the initial entry of people with no work history.

[3]See GAO/HEHS-96-62 and GAO/HEHS-96-133 for a more detailed discussion of the scope and methodology of these analyses.

Sweden revealed three common strategies in the design of their return-to-work programs:

- Intervene as soon as possible after an actual or potentially disabling event to promote and facilitate return to work.
- Identify and provide necessary return-to-work assistance and manage cases to achieve return-to-work goals.
- Structure cash and health benefits to encourage people with disabilities to return to work.

Disability managers emphasize that these return-to-work strategies are interrelated and work most effectively when integrated into a comprehensive return-to-work program. They spend money on return-to-work efforts because they believe these efforts are sound investments that reduce disability-related costs.

Although SSA faces constraints in applying these strategies, opportunities for better identifying and providing assistance to enable more of SSA's clients to engage in work could be created. The portion of DI and SSI beneficiaries that could return to work if given the appropriate supports and services is unknown. But if an additional 1 percent of the 6.6 million working-age SSI and DI beneficiaries were to leave SSA's disability rolls by returning to work, lifetime cash benefits would be reduced by an estimated $3 billion.[4] These reductions, however, would be offset, at least in part, by rehabilitation and other costs that may be necessary to return a person with disabilities to work.

Background

Working-age adults with disabilities can obtain benefits in the form of services and cash assistance from a number of public and private programs. After the onset of a disabling condition, a worker with a temporary work incapacity may receive short-term cash benefits from an employer, a private insurer, one of the few states providing temporary disability insurance, or a workers' compensation program. Those who do not return to the workplace may seek long-term cash benefits to replace lost wages.

A worker covered under Social Security and unable to work because of a severe long-term disability could be eligible for cash benefits from DI—the country's long-term public disability insurance program. Workers can

[4]Our estimate is based on fiscal year 1995 data provided by SSA's actuarial staff and represents the discounted present value of the cash benefits that would have been paid over a lifetime if the individual had not left the disability rolls by returning to work.

supplement DI coverage with cash benefits from private long-term disability insurance or pensions if their employers provide such plans or if the workers have purchased supplemental insurance on their own. Moreover, workers injured on the job can receive cash benefits through their states' employer-financed workers' compensation programs. An individual can receive workers' compensation benefits and DI simultaneously, although the DI cash benefit generally is reduced by workers' compensation. But a worker who is ineligible for cash benefits from either private insurance or workers' compensation[5] and who is unable to be accommodated in the workplace may discover that DI offers the only potential for wage replacement.

Long-term cash benefits may also be sought by people with disabilities who have low income and limited resources, regardless of their work histories. SSI provides income support at the national level regardless of work connection for low-income people with disabilities. Similarly, a veteran with wartime service who has low income and a disability unrelated to active military duty can be eligible for a veteran's pension.

DI and SSI are the two largest federal programs providing cash assistance to people with disabilities. DI, established in 1956, is an insurance program funded by payroll taxes paid by workers and their employers into a Social Security trust fund. The program is designed to insure covered workers against loss of income due to a disabling condition. Workers who have worked long enough and recently enough become insured for DI coverage. In addition to cash assistance, Medicare coverage is provided to DI beneficiaries after they have received cash benefits for 24 months. In 1995, about 4.2 million working-age people (aged 18 to 64) received DI cash benefits.[6] DI cash benefits in that year totaled about $36.6 billion, with average monthly cash benefits amounting to $680 per person.[7] In 1994, the Congress reallocated payroll tax receipts, estimated to total almost $500 billion by the end of 2016, from the Social Security Old Age and Survivors Insurance Trust Fund to the DI Trust Fund to prevent impending insolvency.

In contrast, SSI is a means-tested income assistance program for disabled, blind, or aged individuals regardless of their prior participation in the

[5]Individuals can also receive compensation for injuries sustained during active duty with the armed services or for non-job-related injuries in which another party is at fault.

[6]Included among the 4.2 million DI beneficiaries are about 694,000 beneficiaries who were dually eligible for SSI disability benefits because of the low level of their income and resources.

[7]The $36.6 billion includes benefits paid to all DI disabled workers, regardless of age.

labor force. Established in 1972 for individuals with low income and limited resources, SSI is financed from general revenues.[8] In most states, SSI entitlement ensures an individual's eligibility for Medicaid benefits.[9] In 1995, about 2.4 million working-age people with disabilities and 917,000 children under 18 received SSI benefits. In the same year, federal SSI cash benefits paid to SSI beneficiaries with disabilities equaled $20.6 billion, and average monthly SSI cash benefits amounted to about $365 per beneficiary.[10]

The DI and SSI programs use the same statutory definition of disability. To meet this definition, an adult must be determined to be unable to engage in any substantial gainful activity because of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last at least 1 year.[11] Moreover, the statutory definition further specifies that, for a person to be determined to be disabled, the impairment must be of such severity that the person not only is unable to do his or her previous work, but, considering his or her age, education, and work experience, is unable to do any other kind of substantial work that exists in the national economy. (See app. I for a more complete description of the five-step process used to determine DI and SSI eligibility.)

Once a person is on the disability rolls, disability benefits continue until one of three things happens: the beneficiary dies; SSA determines that the beneficiary is no longer eligible for benefits; or, for DI beneficiaries, benefits convert to Social Security retirement benefits at age 65. Generally, a beneficiary loses eligibility for benefits for one of two reasons: the beneficiary earns more income than allowed or SSA decides that the beneficiary's medical condition has improved to the point that he or she is

[8]References to the SSI program throughout this letter refer to blind or disabled, not aged, recipients. General revenues include taxes, customs duties, and miscellaneous receipts collected by the federal government but not earmarked by law for a specific purpose.

[9]States can opt to use the financial standards and definitions for disability they had in effect in January 1972 to determine Medicaid eligibility for their aged, blind, and disabled residents, rather than making all SSI recipients automatically eligible for Medicaid. Often the Medicaid financial standards used by states are more restrictive than SSI's.

[10]The 2.4 million SSI beneficiaries do not include individuals who were dually eligible for SSI and DI benefits. The $20.6 billion consists of payments to all SSI blind and disabled beneficiaries regardless of age.

[11]SSA uses a different definition of disability for children than for adults. Generally, the Social Security Act defines a disabled child as a person under age 18 who suffers from a medically determinable physical or mental impairment that results in marked and severe functional limitations.

no longer considered disabled. To make this latter determination, SSA periodically performs continuing disability reviews.[12]

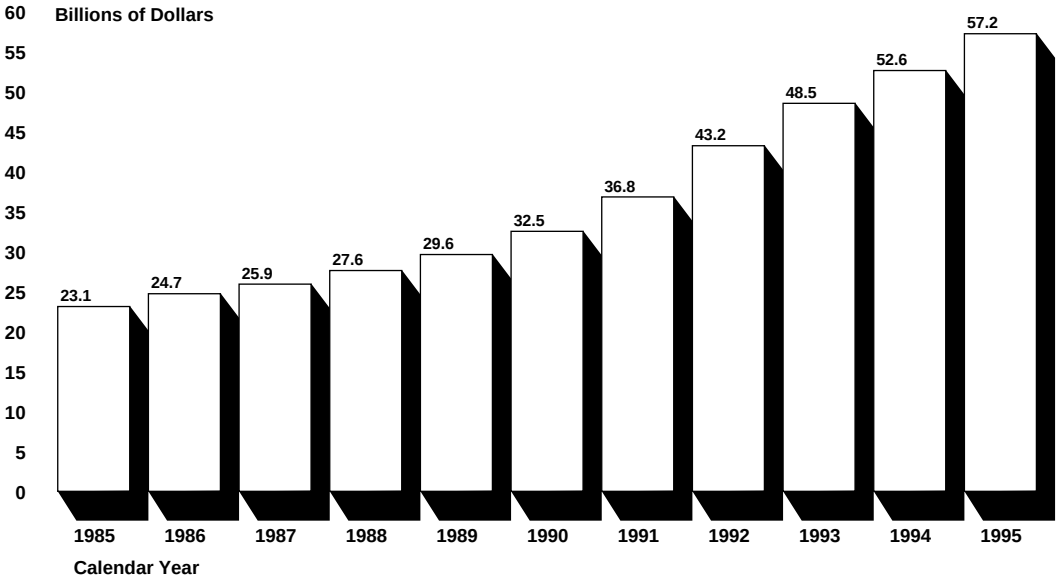
Multiple Factors Contribute to Rapid Program Growth

DI and SSI grew rapidly between 1985 and 1995. During this period, cash benefits to adults and children with disabilities increased from about $23.1 billion to $57.2 billion, with the inflation-adjusted cost of cash benefits growing by 75 percent.[13] (See fig. 1.) At the same time, while the number of working-age beneficiaries who received disability benefits increased from 4.0 million to 6.6 million, DI and SSI experienced an increase in the proportion of adult beneficiaries with the types of impairments that lead to the longest entitlement periods, signifying lengthy stays on the rolls for some. Individuals with mental impairments accounted for most of this growth. (See app. II for an overview of the reasons for program growth.)

[12]SSA is to conduct a continuing disability review (CDR) at least once every 3 years on DI beneficiaries whose medical improvement is possible or expected. When medical improvement is not expected, SSA is to schedule CDRs at least once every 7 years. SSA is to conduct CDRs on one-third of SSI beneficiaries reaching age 18 and a minimum of 100,000 additional SSI beneficiaries annually in fiscal years 1996 through 1998. SSA is to conduct CDRs (1) at least every 3 years for children under age 18 who are likely to improve or, at the option of the Commissioner, unlikely to improve and (2) on low-birth-weight babies within their first year of life. Disability eligibility redeterminations, instead of CDRs, are required for all 18-year-olds beginning on their 18th birthdays, using adult criteria for disability. See Social Security Disability: Improvements Needed to Continuing Disability Review Process (GAO/HEHS-97-1, Oct. 16, 1996) and Social Security Disability: Alternatives Would Boost Cost-Effectiveness of Continuing Disability Reviews (GAO/HEHS-97-2, Oct. 16, 1996).

[13]SSA issued its Report on Rising Cost of Social Security Disability Insurance Benefits to the Congress on Feb. 14, 1996.

Figure 1: Growth in DI and SSI Cash Benefits, 1985-95



Note: Includes DI benefits to disabled workers and federal-only SSI benefits to all SSI blind and disabled beneficiaries regardless of age.

Source: Annual Statistical Supplement to the Social Security Bulletin (Sept. 1996).

The number of children receiving SSI has more than tripled since 1990, from about 300,000 to more than 900,000 in 1995.[14] A number of factors have contributed to the growth in children's awards, including outreach efforts by SSA and child advocates, rising numbers of children in poverty, and major changes in the criteria for determining whether children are disabled. Growth has been especially rapid in awards to children with mental impairments. SSA researchers estimate that SSI awardees ages 1 to

[14]We have issued several products recently on children with disabilities, including Children Receiving SSI by State (GAO/HEHS-96-144R, May 15, 1996); SSA Initiatives to Identify Coaching (GAO/HEHS-96-96R, Mar. 5, 1996); Social Security: New Functional Assessments for Children Raise Eligibility Questions (GAO/HEHS-95-66, Mar. 10, 1995); and Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations (GAO/HEHS-94-225, Sept. 9, 1994).

17 with mental impairments will stay on the rolls nearly 27 years on average.[15]

Statute Provides for Returning Beneficiaries to Work

The Social Security Act states that people applying for disability benefits should be promptly referred to state vocational rehabilitation (VR) agencies for services so that as many applicants as possible can return to productive activity. State Disability Determination Service (DDS) offices, which act for SSA in making disability evaluations, decide whether to refer applicants to the state VR agencies.

Furthermore, to reduce the risk a beneficiary faces in trading guaranteed monthly income and subsidized health coverage for the uncertainties of competitive employment, the Congress has established various work incentives intended to safeguard cash and health benefits while a beneficiary tries to return to work. Nevertheless, few beneficiaries leave the rolls to return to work.

Beneficiaries Face Return-to-Work Challenges, Yet Some Have Characteristics Associated With Work

Many DI and SSI beneficiaries will be unable to return to work, while others present challenges to developing effective return-to-work strategies. Almost half of the people receiving benefits are not likely to become employed because of their age or because they are expected to die within several years. For other beneficiaries, the ability to find and maintain employment may be challenging because they need to learn basic skills and work habits and build self-esteem to function in the workplace. Some may lack access to the assistive technologies that could enhance their work potential. Still others might face tight labor market conditions, particularly for low-wage positions, that could constrain employment opportunities. Moreover, the nature of some disabilities may limit full-time work, while others may result in logistical obstacles such as transportation difficulties. And despite antidiscrimination laws, some disabilities may stigmatize individuals, making them appear less attractive to employers and less likely to be hired.

While beneficiaries may face many challenges in attempting to return to work, research suggests that successful transitions to work may be more likely for younger people with disabilities and for those who have greater

[15]K. Rupp and C.G. Scott, "Determinants of Duration on the Disability Rolls and Program Trends," a paper presented at SSA's conference on Disability Programs: Explanations of Recent Growth and Implications for Disability Policy (Washington, D.C.: July 20, 1995). In an effort to stem the increase in the number of children receiving SSI, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) changed initial and continuing eligibility requirements for children with disabilities. The effect of these changes on the size of the rolls is as yet unknown.

motivation to work and more education.[16] Studies have shown that a significant number of DI and SSI beneficiaries possess these characteristics. The DI and SSI disability rolls increasingly are composed of a significant number of younger individuals. Among working-age DI and SSI beneficiaries, one out of three is under the age of 40.[17] In addition, in 1993, 35 percent of the 84,000 DI beneficiaries who responded to an SSA questionnaire in May 1993 expressed an interest in receiving rehabilitation or other services that could help them return to work, an indication of motivation. Moreover, a substantial portion—almost one in two—of a cohort of DI beneficiaries had a high school degree or some years of education beyond high school.[18]

Changes Create Return-to-Work Opportunities

The percentage of beneficiaries that could return to work if given the appropriate supports and services is unknown, in part, because employment depends upon a multitude of complex, interrelated factors. The data suggest, however, that a meaningful proportion of beneficiaries could potentially benefit from return-to-work assistance. In addition, many technological and medical advances have created more opportunities for some individuals with disabilities to work. Electronic communications and assistive technologies—such as scanners, synthetic voice systems, standing wheelchairs, and modified automobiles and vans—have given greater independence to people with some disabilities. Advances in the management of disability—like medication to control mental illness or computer-aided prosthetic devices—have helped reduce the functional limitations associated with some disabilities. These advances may have opened new employment opportunities for people with disabilities in the growing service sector of the economy.

Social change has also promoted the goals of greater inclusion of and participation by people with disabilities in the mainstream of society, including children in school and adults at work. For instance, over the past 2 decades, people with disabilities have sought to remove environmental barriers that impede them from fully participating in their communities.

[16]For example, J.C. Hennessey and L.S. Muller, "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work," Social Security Bulletin, Vol. 58, No. 1 (Spring 1995), pp. 15-28; R.J. Butler, W.G. Johnson, and M.L. Baldwin, "Managing Work Disability: Why First Return to Work Is Not a Measure of Success," Industrial and Labor Relations Review, Vol. 48, No. 3 (Apr. 1995), pp. 452-67; and R.V. Burkhauser and M.C. Daly, "Employment and Economic Well-Being Following the Onset of a Disability: The Role for Public Policy," in Jerry L. Mashow, Virginia Reno, Richard V. Burkhauser, and Monroe Berkowitz, eds., Disability, Work, and Cash Benefits (Kalamazoo, Mich.: W.E. Upjohn Institute for Employment Research, 1996), pp. 59-101.

[17]Annual Statistical Supplement to the Social Security Bulletin (Sept. 1996).

[18]J.C. Hennessey and L.S. Muller, "Work Efforts of Disabled-Worker Beneficiaries: Preliminary Findings From the New Beneficiary Followup Survey," Social Security Bulletin, Vol. 57, No. 3 (Fall 1994), pp. 42-51.

Moreover, the ADA supports the full participation of people with disabilities in society and fosters the expectation that people with disabilities can work and have the right to work. The ADA prohibits employers from discriminating against qualified individuals with disabilities and requires employers to make reasonable workplace accommodations unless it would impose an undue hardship on the business.

Current Program Structure Impedes Return to Work

Despite advances in technology and medicine that have increased the potential for some beneficiaries to work, the DI and SSI disability programs have remained essentially frozen in time. Weaknesses in the design and implementation of the DI and SSI programs, summarized in table 1, have impeded identifying and encouraging the productive capacities of those who might benefit from reasonable and appropriate rehabilitation and employment assistance. The cumulative effect of these weaknesses is to understate beneficiaries' work capacity and hinder efforts to improve return-to-work outcomes.

Table 1: Summary of Program Design and Implementation Weaknesses

Program weakness	Description of program weakness
Work capacity of DI and SSI beneficiaries may be understated.	Medical conditions alone are generally a poor predictor of work incapacity. While impairment has some influence over capacity to work, other factors—vocational, psychological, economic, environmental, motivational—are often considered to be more important determinants of work capacity.
Disability determination process may encourage work incapacity.	"All-or-nothing" decision gives incentive to promote inabilities and minimize abilities. Lengthy application process to prove one's disability can erode motivation and ability to return to work.
Benefit structure can provide disincentive to low-wage work.	The prospect of losing cash and health benefits themselves can reduce motivation to work and receptivity to VR and work incentives, especially when low-wage jobs are the likely outcome. People with disabilities may be more likely to have less time available for work, further influencing a decision to opt for benefits over work.
Work incentives are ineffective in motivating people to work.	Work incentives are complex, difficult to understand, and poorly implemented. Few beneficiaries are aware that work incentives exist. Work incentives do not overcome the prospect of a drop in income for those who accept low-wage employment. Risk of losing health coverage is a major barrier to returning to work.
VR plays limited role in disability programs.	Access to VR services through DDS referrals is limited: restrictive state VR policies limit categories of people referred by DDSs; the referral process is not monitored (reflecting its low priority and removing incentive to spend time on referrals); and the success-based VR reimbursement system is ineffective in motivating VR agencies to accept beneficiaries as clients. Applicants and beneficiaries are generally uninformed about VR and are not encouraged to seek VR, affording little opportunity to opt for rehabilitation and employment. Studies have questioned the effectiveness of state VR agency services.

Work Capacity of DI and SSI Beneficiaries May Be Understated

The current disability determination process may understate the work capacity of DI and SSI beneficiaries, thereby lowering expectations for return-to-work outcomes. The Social Security Act requires that the assessment of an applicant's work incapacity be based on the presence of medically determinable physical and mental impairments. SSA maintains a Listing of Impairments (usually referred to as "the listings") for medical conditions that are presumed to be, according to SSA, ordinarily severe enough in themselves to prevent an individual from engaging in any gainful activity. About 70 percent of new awardees are eligible for disability

benefits because their impairments meet or equal the listings.[19] But findings of studies we reviewed generally agree that medical conditions are a poor predictor of work incapacity.[20]

Relevant studies indicate that the scientific link between work incapacity and medical condition is a weak one. While it is reasonable to expect that some medical impairments prevent individuals from engaging in work (for example, people who are quadriplegic with profound mental retardation), it is less clear that some other impairments that qualify individuals for disability benefits prevent individuals from engaging in any substantial gainful activity (for example, people who are missing both feet). Moreover, while most medical impairments influence the extent to which an individual is capable of engaging in gainful activity, other factors—vocational, psychological, economic, environmental, and motivational—are often considered to be more important determinants of work capacity.

Concerns about the relationship between medical status and work incapacity were raised before the DI program was implemented. In deliberations leading to the establishment of the DI program, the 1948 Advisory Council on Social Security recommended that compensable disabilities be restricted to those that can be "objectively determined by medical examination or tests." Physicians, however, testified before the Congress that disability determination is inherently subjective and they could not provide the kind of objective determination that policymakers desired. According to this view, physicians can attest to the existence of medical impairments, but they can neither quantify inability to work nor certify that the impairments render a person unable to work.

Since then, some experts have contended that the scientific community is unable to reliably predict the work capacity of people with disabilities. The 1988 Disability Advisory Council to the Department of Health and Human Services (HHS), citing testimony by medical experts, researchers, rehabilitation providers, advocacy groups, and beneficiaries, concluded that

[19]An impairment or combination of impairments is said to "equal the listings" if the medical findings for the impairment are at least equivalent in severity and duration to the listed impairment. Applicants whose impairments do not meet or equal the medical listings are further evaluated on the basis of nonmedical factors, including residual functional capacity, age, education, and vocational skills.

[20]For example, S.O. Okpaku and others, "Disability Determinations for Adults With Mental Disorders: Social Security Administration vs. Independent Judgments," American Journal of Public Health, Vol. 84, No. 11 (Nov. 1994), pp. 1791-95; and H.P. Brehm and T.V. Rush, "Disability Analysis of Longitudinal Health Data: Policy Implications for Social Security Disability Insurance," Journal of Aging Studies, Vol. 2, No. 4 (1988), pp. 379-99.

"information about a claimant's medical condition and vocational background cannot conclusively demonstrate that he or she cannot work. Except in the case of very severe disabilities and relatively minor disabilities, the current state of knowledge and technology does not enable the quantification of disabilities or the definition of categories of disability which reliably correlate an impairment with a particular individual's capacity to work."[21]

Disability Determination Process May Encourage Work Incapacity

The "all-or-nothing" nature of the disability determination process creates an incentive for applicants to overstate their disabilities and understate their work capacities. Because the result of the decision is either full award or denial of benefits, applicants have a strong incentive to promote their limitations to establish their inability to work and thus qualify for benefits. Conversely, applicants have a disincentive to demonstrate any capacity to work because doing so may disqualify them for benefits. Furthermore, the documentation involved in establishing one's disability can, many believe, create a "disability mind-set," which weakens motivation to work. The effects of this process are compounded by the length of time required to determine eligibility—from a minimum of several months to 18 months or longer for individuals who appeal—during which skills, abilities, and habits necessary to work can erode.

Benefit Structure Can Provide a Disincentive to Low-Wage Work

The prospect of losing cash and health benefits themselves is another factor that can reduce beneficiaries' motivation to work and their receptivity to work incentives and VR. The average monthly cash and health benefit value in 1994 for DI and SSI beneficiaries was about $1,050 and $930, respectively.[22] As part of their consideration of whether to undergo rehabilitation, attempt work, or both, beneficiaries may weigh the financial gains of working against the value of their monthly cash and health benefits. On the one hand, rehabilitation and work require significant time commitment and the chance of success is unknown; on the other hand, program benefits are secure and free individuals from having to devote time to obtaining economic stability. Some people may opt to live at a lower income level rather than at a marginally higher income level if the latter requires a major commitment of time and energy.

Some people with disabilities commit significant amounts of time to performing daily activities (bathing, dressing, and eating), self-managing their impairments, receiving medical treatment, or meeting their

[21]HHS, Report of the Disability Advisory Council (Washington, D.C.: HHS, SSA, Mar. 11, 1988).

[22]Average monthly health benefit values are based on estimates from the Health Care Financing Administration, Office of the Actuary.

transportation needs. The time required to perform these and other activities can reduce the time available for work and influence an individual's decision to opt for benefits over work.[23] People who have less time available for full-time work may see some value in part-time work. If part-time work pays less than the value of lost benefits, however, then a person would actually be financially better off receiving benefits rather than working.

Work Incentives Ineffective in Motivating People to Work

Work incentive provisions that are complex, difficult to understand, and poorly implemented further impede return-to-work efforts. Because SSA does not promote them extensively, few beneficiaries are aware that work incentives exist. Despite providing some financial protection for those who want to work, work incentives do not appear to be sufficient to overcome the prospect of a drop in income for those who accept low-wage employment.

For example, DI work incentives provide for a trial work period in which a beneficiary may earn any amount for 9 months (which need not be consecutive) within a 60-month period and still receive full cash and health benefits. At the end of the trial work period, if a beneficiary's countable earnings are more than $500 a month, cash benefits continue for an additional 3-month grace period and then stop, causing a precipitous drop in monthly income from full benefits to no cash benefits.[24] SSA researchers have noted that such a drop in income is a considerable disincentive to finishing the trial work period as well as to beginning work. Especially for beneficiaries with low earnings, it may be more financially advantageous to continue to receive disability payments by not working or by limiting earnings than to earn more than $500 a month in countable income.

Beneficiaries Fear Losing Health Coverage

The work incentive provisions also do not allay the fear of losing health coverage that beneficiaries who return to work may face. Studies have identified the risk of losing health coverage as a major barrier to

[23]W.Y. Oi, "Disability and a Workfare-Welfare Dilemma," in C.L. Weaver, ed., Disability and Work: Incentives, Rights, and Opportunities (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1991), pp. 31-45.

[24]For 36 months after the trial work period ends, cash benefits will be reinstated for any month in which the person does not earn more than $500 a month in countable income; this is referred to as the extended period of eligibility.

beneficiaries' returning to work.[25] Beneficiaries who work and continue to earn countable income above certain amounts will eventually lose health coverage even though they have not necessarily improved medically or obtained affordable coverage elsewhere.

DI work incentive provisions provide up to 4 years of Medicare coverage when a person who continues to be medically disabled goes to work and earns more than $500 a month in countable income. When this coverage ends, these individuals may purchase Medicare coverage at the same monthly premium paid by uninsured retired beneficiaries. But the monthly premium—exceeding $300 in 1996—may be a hardship for beneficiaries, especially individuals with low earnings. In a study of DI beneficiaries' work attempts, SSA researchers noted that "the eventual loss of Medicare coverage which, for some beneficiaries, is worth as much as cash benefits, adds to a feeling of future financial insecurity and discourages work."[26]

Moreover, SSI beneficiaries who lose health coverage because they exceed the earnings limit do not have the option of purchasing Medicaid. Work incentives allow beneficiaries to keep Medicaid coverage until earnings increase to a point—referred to as the threshold amount—that SSA considers high enough to replace SSI cash and Medicaid benefits.[27] Beneficiaries who lose Medicaid could be uninsurable or face prohibitively high premiums. It may matter little how much a beneficiary can earn by returning to work if he or she cannot buy health insurance because of a disabling condition. Even if a beneficiary is able to obtain health insurance, he or she may still be subject to a waiting period and coverage exclusions for preexisting conditions.

VR Plays Limited Role in Disability Programs

Access to VR services through the DDS referral process is limited, because DDSs refer few beneficiaries for VR services and state VR agencies accept

[25]For example, see the President's Committee on Employment of People With Disabilities 1993 teleconference project report, Operation People First: Toward a National Disability Policy (Washington, D.C.: President's Committee on Employment of People With Disabilities, Mar. 28, 1994).

[26]Hennessey and Muller, "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work." These findings should be interpreted with caution, because SSA gathered retrospective data on event histories over a 10-year period.

[27]The threshold amount is based on the amount of earnings that would cause cash payments to stop in the person's state of residence and the annual per capita Medicaid expenditure for that state.

fewer still as clients.[28] DDSs refer for VR services, on average, only about 8 percent of DI and SSI applicants awarded benefits. And, although less is known about how many DDS referrals are accepted by state VR agencies, previously we estimated that less than 10 percent of beneficiaries referred by DDSs were accepted as clients.[29] Several factors contribute to limited access, including restrictive state VR policies that limit categories of people referred by DDSs, a referral process that is not monitored (reflecting its low priority and removing the incentive to spend time on referrals), and a success-based VR reimbursement system that is ineffective in motivating VR agencies to accept beneficiaries as clients. In addition, applicants and beneficiaries are generally uninformed about the availability of VR services and are given little encouragement to seek them.

Even if a beneficiary is referred for VR services and accepted by a VR agency, the effectiveness of state VR services in securing long-term financial gains for rehabilitants has been mixed at best. In 1993, we evaluated the long-term results of state VR services by examining the employment status of clients (including SSA beneficiaries) over an 8-year period following receipt of services.[30] We found that gains in employment and earnings of clients who had been successfully rehabilitated—that is, placed in suitable paid or unpaid employment for at least 60 days—faded after about 2 years, with earnings for many returning to near or below the pre-VR program level after 8 years. Clients who had been successfully rehabilitated had better work and earnings histories than clients who had dropped out of the VR program. Clients who had not been rehabilitated, however, but who had received many of the services that rehabilitated clients had received, did no better in later employment and earnings than VR dropouts who had received no services after an initial VR evaluation.

[28]Public and private entities, such as educational institutions, welfare agencies, hospitals, and other health organizations, as well as DDSs, refer beneficiaries to state VR agencies. In discussing access to VR services, we have limited our analysis to access through the DDS referral system. Our findings, therefore, cannot be generalized to referrals from other sources.

[29]Social Security: Little Success Achieved in Rehabilitating Disabled Beneficiaries (GAO/HRD-88-11, Dec. 7, 1987). We reviewed the referral outcomes of DI beneficiaries in 10 states. Approximately 90 percent of the referrals were not considered feasible prospects by the agencies, did not respond to the agency contact, were uninterested in VR, or were already known to the agencies. These data should be interpreted with caution because they were collected in 1986, and changes over time in DDS and VR agency procedures, priorities, and resource levels, and in beneficiary characteristics, could have altered acceptance patterns.

[30]Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27, 1993). We examined the program's long-term results by computer-matching a database on nearly 900,000 VR applicants whose cases were closed in 1980 with SSA wage records on these individuals from 1972 through 1988—both before and after their VR program experience.

SSA Efforts to Improve Return-to-Work Outcomes Likely to Have Only Marginal Effect

SSA's efforts to improve return-to-work outcomes are focused in the right direction but are likely to have limited impact. SSA began an analysis of barriers and disincentives to employment in its disability programs in 1994 and has undertaken several related return-to-work efforts. These include publishing regulations permitting SSA to refer beneficiaries to an alternate provider when the state VR agency is unable to provide VR services and publishing a brochure to inform the public about how SSA can help with VR services. Additionally, SSA has signed an agreement with the Department of Education's Rehabilitation Services Administration to provide training on SSA's work incentives to state VR professionals and contracted for an evaluation of Project NetWork, an SSA research effort testing different methods to deliver employment and rehabilitation services.

Although important, these efforts do not constitute a comprehensive strategy that fundamentally redirects the disability programs' current focus on an individual's limitations to a focus on identifying and encouraging the productive capacities of those who might benefit from employment assistance. For example, expanding VR opportunities may not facilitate long-term employment among beneficiaries if people continue to fear that working their way off the rolls will lead to loss of health insurance. Also, educating beneficiaries about work incentives and VR services may have little effect if beneficiaries are better off financially not working than attempting to work.

Return-to-Work Strategies From Other Systems Contrast Sharply With Federal Disability Programs

In contrast with SSA's disability programs, which have retained their core design over the years, some firms in the private sector are developing new approaches to manage their disability caseloads. Collectively known as disability management, these approaches embody a proactive strategy for controlling disability costs by helping employees with disabilities return to work as soon as possible. Social insurance disability programs in Germany and Sweden also invest in return-to-work efforts, and their experiences show that return-to-work strategies can be applied to government-scale programs that serve people with a wide range of work histories, job skills, and disabilities.[31]

Disability managers in the U.S. private sector spend money on return-to-work efforts because they believe such efforts are sound

[31]Although rigorous studies demonstrating the cost-effectiveness of German and Swedish programs generally do not exist, we included these countries in our analysis because their disability programs apply principles—such as early intervention and rehabilitation—that have been identified by the U.S. private sector and other experts as being key to disability management. Application of these principles to DI and SSI would need to be tailored to the U.S. political system and budget realities.

investments that reduce disability-related costs. Studies have estimated that the full cost of disability to employers ranges from about 6 to 12 percent of payroll. Such costs include insurance premiums, cash benefits, rehabilitation benefits, and health benefits paid through workers' compensation and employer-sponsored disability insurance programs. Companies may also incur additional expenses for training and using temporary workers and retraining employees with disabilities when they return to work. When businesses help workers with disabilities return to the workplace, they are able to reduce some of these costs.

Our analysis of practices advocated and implemented by the U.S. private sector and other countries reveals three common strategies in the design of their return-to-work programs. These strategies, and their underlying practices, are summarized in table 2.

Table 2: Strategies and Practices in the Design of Return-to-Work Programs of the U.S. Private Sector and Other Countries

Strategy	Practices
Intervene as early as possible after an actual or potentially disabling event.	Address return-to-work goals from the beginning of an emerging disability.
	Provide return-to-work services at the earliest appropriate time.
	Maintain communication with workers who are hospitalized or recovering at home.
Identify and provide necessary return-to-work assistance effectively.	Assess each individual's return-to-work potential and needs.
	Use case management techniques when appropriate to help workers with disabilities return to work.
	Offer transitional work opportunities that enable workers with disabilities to ease back into the workplace.
	Ensure that medical service providers understand the essential job functions of workers with disabilities.
Structure cash and health benefits to encourage return to work.	Structure cash benefits to encourage workers with disabilities to rejoin the workforce.
	Maintain health benefits for workers with disabilities who return to work.
	Include a contractual provision that can require the worker with disabilities to cooperate with return-to-work efforts.

Disability managers emphasized that these return-to-work strategies are not independent of each other and are most effective when merged into a comprehensive return-to-work program. Return-to-work strategies and practices may potentially enhance federal disability programs by enabling beneficiaries to work and by helping to reduce program costs.

Intervene Early to Facilitate Return-to-Work

Disability managers we surveyed in the private sector stressed the importance of early intervention in returning workers with disabilities to the workplace. Advocates of early intervention believe that the longer an individual stays away from work, the less likely return to work will be. Studies show that only half the workers with recently acquired disabilities who are out of work 5 months or more will ever return to work. Disability managers believe that long absences from the workplace can reduce motivation to attempt work.

In Germany and Sweden, laws and policies require that an individual's potential for returning to work be assessed soon after the onset of a disabling condition. Consequently, people with disabilities are generally considered for rehabilitation and return to work at relatively early stages in their contacts with social insurance offices. For example, everyone applying for a disability pension in Germany is considered for rehabilitation and return to work before being determined eligible for permanent benefits.[32]

Setting return-to-work goals soon after the onset of disability and providing timely rehabilitation services are believed to be critical in encouraging workers with disabilities to return to the workplace as soon as possible. Moreover, maintaining communication with a disabled worker is also important. For example, disability managers believe that contacting a hospitalized worker soon after an injury or illness, and then continuing to communicate with the worker recovering at home, helps reassure the worker that there is a job to return to and that the employer is concerned about his or her recovery.

Provide Necessary Return-to-Work Services, Manage Cases

In an effort to provide appropriate services, many disability managers strive to identify the individuals who are likely to be able to return to work and then identify the specific services they need. This approach involves investing in services tailored to individual circumstances that help achieve return-to-work goals for workers with disabilities while avoiding unnecessary expenditures. As part of this approach, individuals are functionally evaluated to assess their potential for returning to work. When appropriate, the private sector uses case management techniques to coordinate the identification, evaluation, and delivery of disability-related services for individuals deemed to need such services to return to work.

[32]Disability pensions in Germany are not awarded until it has been determined that the person's earning capacity cannot be restored through rehabilitation.

Transitional work allows employees to ease back into the workplace in jobs that better accommodate their disabilities than their regular jobs.

In Germany and Sweden, return-to-work services and assistance are fairly extensive and tailored to meet individual needs. An individual may receive a combination of different benefits and services—such as medical or vocational rehabilitation, employment or social assistance—as well as cash assistance while applying for or participating in rehabilitation. In addition, both countries offer transitional work opportunities to people with disabilities.

The private sector also stresses the need to ensure that physicians and other medical service providers understand the essential job functions of workers with disabilities. Without this understanding, an individual's return to work could be delayed unnecessarily. Also, if an employer is willing to provide transitional work opportunities or other job accommodations, the treating physician must be aware of and understand these accommodations.

Provide Incentives to Engage in Return-to-Work Efforts

Finally, disability managers responding to our survey generally offered incentives through their programs' cash and health benefit structure to encourage individuals with disabilities to return to work. These managers believe that a program's incentive structure can affect return-to-work decisions. As a result, their companies structure cash benefits to make returning to work more financially attractive than remaining away from work. Disability managers also believe retention of health insurance can be an important work incentive.

Although the structure of benefits plays a role in return-to-work decisions, disability managers emphasized that well-structured incentives are not sufficient in themselves for a successful return-to-work program. Rather, incentives must be integrated with other return-to-work practices.

Conclusions

Return-to-work strategies used in the U.S. private sector and other countries reflect the expectation that people with disabilities can and do return to work. But the DI and SSI programs are not placing enough priority on tapping the work potential of beneficiaries. We believe SSA could do this more effectively without jeopardizing the availability of benefits for people who cannot work.

Compelling reasons exist to try new approaches. In 1994, the Congress reallocated payroll tax receipts, estimated to total almost $500 billion by the end of 2016, from the Social Security Old Age and Survivors Insurance Trust Fund to the DI Trust Fund to prevent impending insolvency. This financial strain, along with advances in technology and medicine that could reduce functional limitations posed by certain impairments, provides ample reason for examining how strategies from other systems could be applied to improve return-to-work outcomes. If even an additional 1 percent of the 6.6 million working-age beneficiaries were to leave SSA's disability rolls by returning to work, lifetime cash benefits would be reduced by an estimated $3 billion. These reductions, however, would be offset at least in part by rehabilitation and other costs that may be necessary to return a person with disabilities to work.

Developing an integrated, comprehensive return-to-work strategy is likely to extend beyond SSA to include programs in other federal agencies, such as the Department of Labor and the Department of Education, the states, and the private sector. But, as the primary manager of multibillion-dollar programs and as the entity with fiduciary responsibility for the trust funds, SSA has a critical role to play as the catalyst in forging the partnerships and cooperation that will be needed to redesign federal disability programs. Although SSA faces constraints and challenges in applying the return-to-work strategies of other programs, opportunities exist for providing the return-to-work assistance that could enable more of SSA's beneficiaries to reduce or eliminate their dependence on cash benefits.

In earlier reports, we recommended that SSA place greater priority on helping DI and SSI beneficiaries go back to work. We further recommended that SSA develop a comprehensive return-to-work strategy integrating, as appropriate, earlier intervention and provision of return-to-work assistance as well as changes in the structure of cash and health benefits. Recognizing that new legislation may be required to implement such a strategy, we also recommended that SSA identify needed legislative changes to make such a return-to-work focus a reality. SSA agreed that beneficiaries face a number of barriers and disincentives that impede entry into the labor force and that many current beneficiaries have the potential to return to work. SSA expressed an interest in determining whether the return-to-work practices of other systems could be useful in improving beneficiary return-to-work rates and emphasized that making program improvements would involve input from a myriad of relevant federal, state, and private sector stakeholders.

Agency Comments

In commenting on a draft of this report, the Commissioner of Social Security shared our concern that beneficiaries face a number of barriers to entering or reentering the workforce and agreed that compelling reasons exist to try new return-to-work approaches. (See app. III for the full text of SSA's comments.) SSA is seeking statutory authority to create a voucher-type system that beneficiaries could voluntarily use to obtain rehabilitation and employment services from a participating public or private provider of their choice. Additionally, provision of extended medical coverage for beneficiaries who return to work is also being sought. These initiatives, reflected in the President's 1998 budget, attempt to place greater emphasis on return to work and to providing alternatives to the state VR agency structure. Although not specifically mentioned by SSA in its comments, given this increased priority we would expect to see SSA set explicit performance measures under its Government Performance and Results Act strategic plan regarding its return-to-work efforts.[33]

In its proposed initiatives, SSA recognizes that extending medical coverage can be an important factor in reducing the perceived risks a beneficiary faces in returning to work. But other weaknesses in the DI and SSI programs—including a determination process that concentrates on applicants' incapacities and work incentives that act as disincentives—remain unchanged, suggesting that the impact of SSA's initiatives may have a more limited effect than desired. A new VR service delivery system would be likely to have the greatest effect if it were integrated into a comprehensive return-to-work strategy that incorporates earlier intervention, a focus on developing productive capacity, and changes to the structure of benefits. Such a strategy would encourage beneficiaries to take advantage of rehabilitation services and provide incentives for beneficiaries to return to work.

In addition, while we firmly advocate the critical importance of evaluation, the proposed 7-year pilot period for the new VR service delivery system apparently focuses on one system to the exclusion of other alternatives. If SSA tests only one type of service delivery system, the agency will forego the opportunity to compare the results of the proposed outcome-based payment system with those of alternative systems, such as combining

[33]The Government Performance and Results Act of 1993 created requirements for agencies to generate the information congressional and executive branch decisionmakers need in considering ways to improve government performance and reduce costs. It requires that agencies consult with the Congress and other stakeholders to clearly define their missions, establish long-term strategic goals and annual goals, measure performance against the goals they have set, and report publicly on how well they are doing.

outcome-based payments with reimbursements to providers based on milestones reached prior to the beneficiary leaving the rolls.

SSA also made some technical comments, which we incorporated where appropriate.

We are sending copies of this report to the Commissioner of the Social Security Administration and other interested parties. Copies also will be available to others on request. If you or your staff have any questions concerning this report, please call me at (202) 512-7215 or Cynthia A. Bascetta, Assistant Director, at (202) 512-7207. Other major contributors include Barbara H. Bordelon, Brett S. Fallavollita, Michele Grgich, Susan Y. Higgins, and Ira B. Spears, Senior Evaluators; Kenneth F. Daniell, Evaluator; and Carol Dawn Petersen, Senior Economist.

Jane L. Ross
Director, Income Security Issues

Contents

Abbreviations

ADA	Americans With Disabilities Act
CDR	continuing disability review
DDS	Disability Determination Service
DI	Disability Insurance
HHS	Department of Health and Human Services
SSA	Social Security Administration
SSI	Supplemental Security Income
VR	vocational rehabilitation

Five-Step Sequential Evaluation Process for Determining DI and SSI Eligibility

To determine whether an applicant qualifies for DI or SSI disability benefits, SSA uses a five-step sequential evaluation process. In the first step, an SSA field office determines if an applicant is working at the level of substantial gainful activity and whether he or she meets the applicable nonmedical eligibility requirements (for example, residency, citizenship, Social Security insured status for DI, and income and resources for SSI). An applicant who is found to be not working or working but earning less than the substantial gainful activity level (minus allowable exclusions), and who meets the nonmedical eligibility requirements, has his or her case forwarded to a state Disability Determination Service (DDS) office. Applicants who do not meet these requirements, regardless of medical condition, are denied benefits.

DDS offices gather medical, vocational, and other necessary evidence to determine if applicants are disabled under the Social Security law. In step two, the DDS office determines if the applicant has an impairment or combination of impairments that is severe and could be expected to last at least 12 months. According to SSA standards, a severe impairment is one that significantly limits an applicant's ability to do "basic work activities," such as standing, walking, speaking, understanding and carrying out simple instructions, using judgment, responding appropriately to supervision, and dealing with change. The DDS office collects all necessary medical evidence, either from those who have treated the applicant or, if that information is insufficient, from an examination conducted by an independent source. Applicants with severe impairments that are expected to last at least 12 months proceed to the third step in the disability determination process; applicants without such impairments are denied benefits.

At step three, the DDS office compares the applicant's condition with the Listing of Impairments (the "listings") developed by SSA. The listings contain over 150 categories of medical conditions (examples of conditions include the loss of both feet or an IQ score below 60) that, according to SSA, are severe enough ordinarily to prevent an individual from engaging in substantial gainful activity. An applicant whose impairment is cited in the listings or whose impairment is equally as severe or more severe than those impairments in the listings, and who is not engaging in substantial gainful activity, is found to be disabled and awarded benefits. An applicant whose impairment is not cited in the listings or whose impairment is less severe than those cited in the listings is evaluated further to determine whether he or she has vocational limitations that, when combined with the medical impairment(s), prevent work.

In step four, the DDS office uses its physician's assessment of the applicant's residual functional capacity to determine whether the applicant can still perform work he or she has done in the past. For physical impairments, residual functional capacity is expressed in certain demands of work activity (for example, ability to walk, lift, carry, push, pull, and so forth); for mental impairments, residual functional capacity is expressed in psychological terms (for example, whether a person can follow instructions and handle stress). If the DDS office finds that a claimant can perform work done in the past, benefits are denied.

In the fifth and last step, the DDS office determines if an applicant who cannot perform work done in the past can do other work that exists in the national economy.[34] Using SSA guidelines, the DDS considers the applicant's age, education, vocational skills, and residual functional capacity to determine what other work, if any, the applicant can perform. Unless the DDS office concludes that the applicant can perform work that exists in the national economy, benefits are allowed.

At any point in the sequential evaluation process, an examiner can deny benefits for reasons relating to insufficient documentation or lack of cooperation by the applicant. Such reasons can include an applicant's failure to (1) provide medical or vocational evidence deemed necessary for a determination by the examiner, (2) submit to a consultive examination that the examiner believes is necessary to provide evidence, or (3) follow a prescribed treatment for an impairment. Benefits are also denied if the applicant asks the DDS to discontinue processing the case.

[34]By definition, work in the national economy must be available in a significant amount in the region where the applicant lives or in several regions of the country. It is inconsequential whether (1) such work exists in the applicant's immediate area, (2) job vacancies exist, or (3) the applicant would actually be hired.

Reasons for Program Growth

Although the reasons for growth and their relative effects are not fully understood, multiple factors contributed to the increase in SSA's disability program growth. The following factors affected program growth by bringing more people into the programs and lowering the rate at which some beneficiaries left the programs.

Eligibility Expansion

The eligibility standards, especially for mental impairments (which include mental retardation and mental illness), were expanded in the mid- to late 1980s largely as a result of the effects of legislative, regulatory, and judicial action. For example, additions were made to the listing of medical criteria used by SSA to determine program eligibility, which gave greater weight to evidence gathered from an applicant's own physician, and more consideration was granted to pain and functional deficits in social relations and in concentration.

Program Outreach

The purpose of SSA's outreach efforts has been to reduce the barriers that prevented or discouraged potentially eligible individuals from applying for SSI benefits. SSA has conducted several outreach efforts since program authorization in 1972. In the late 1980s, congressional and agency actions were taken to ensure that all segments of the potential SSI population were made aware of their potential eligibility. For instance, a permanent outreach program for disabled and blind children was established by the Omnibus Budget Reconciliation Act of 1989; SSA made SSI outreach an ongoing agency priority in 1989; and, in 1990, the Congress mandated that SSA expand the scope of its SSI outreach efforts.

Economic Factors

Economic factors play an important role in the decisions of people with disabilities to seek disability benefits, particularly DI benefits, according to an SSA-sponsored study on the demographic and economic determinants of growth in SSA disability programs.[35] Factors that reduce the rewards of participating in the labor force for people with disabilities, such as downturns in the business cycle, make leaving the labor force and applying for benefits more attractive. But, while economic downturns contribute to program growth, no evidence exists that there has been a concomitant exit from the DI rolls when the economy has improved.

[35]D.C. Stapleton and others, "Demographic and Economic Determinants of Recent Application and Award Growth for SSA's Disability Programs," a paper presented at SSA's conference on Disability Programs: Explanations of Recent Growth and Implications for Disability Policy (Washington, D.C.: July 20-21, 1995).

State Cost-Shifting

Many state and local governments actively encouraged and assisted disabled recipients of state-funded general assistance to apply for SSI benefits when general assistance was cut in these jurisdictions. These state and local efforts to shift public assistance recipients with disabilities onto the SSI rolls appeared to increase the number of SSI (and, to a lesser extent, DI) applications and awards, according to the SSA-sponsored study on growth in the disability programs.

Lack of Affordable Health Insurance

An increase in the number of people without affordable health insurance may have affected the size of the DI and SSI program growth. The uninsured population under age 65 in the United States grew by 5 million between 1988 and 1992.[36] In addition, limitations in employment-based health care coverage for chronic conditions may have prompted some individuals to apply for DI or SSI for health care protection.

Demographics

Demographic changes have played a role in program growth. For example, the aging baby boom cohort born between 1946 and 1964 (which increased the number of people in middle age during the late 1980s and early 1990s), greater labor force participation among women (which increased the number of women insured for disability benefits), and declines in marriage rates (which may have limited the income support provided by spouses of people with disabilities) have been associated with increases in program applications and awards.

Also, the growing number of immigrants admitted annually for legal residence in the United States may have contributed to SSI growth. In 1993, 880,000 immigrants were admitted to the United States, compared with 570,000 in 1985. In addition, nearly 3 million formerly illegal immigrants attained legal residence status under the Immigration Reform and Control Act of 1986. This increased immigrant population is likely to have contributed to the rising portion of disabled immigrants on SSI, which increased from less than 2 percent of the SSI disabled population in 1982 to about 6 percent in 1993.[37]

[36]The Environment of Disability Income Policy: Programs, People, History and Context, National Academy of Social Insurance, Disability Policy Panel Interim Report (Washington, D.C.: 1996), p. 93.

[37]Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns (GAO/T-HEHS-95-67, Jan. 27, 1995). Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the income and resources of an immigrant's sponsor and an immigrant's spouse are counted in determining eligibility for SSI benefits. The effect on future growth in the rolls of SSI by provision is unknown.

DI Termination Rate Decreased; SSI Rate Remained Stable

As more people were enrolled, the DI termination rate decreased and the SSI termination rate remained stable, thereby resulting in a net increase in DI and SSI program size. The DI termination rate decreased from 13 percent in 1985 to 10 percent in 1993 (between 1970 and 1984, the DI termination rate fluctuated between 14 and 19 percent). The termination rate for each of the major reasons for exiting DI—conversion to retirement benefits at age 65, death, failure to meet medical criteria, and return to work—decreased during this period (reaching age 65 and dying accounted for the vast majority of instances of termination from 1985 to 1992). Between 1988 and 1993, the SSI termination rate for adults with disabilities remained around 16 percent.

A factor contributing to the decrease in DI terminations due to medical recovery—which, at below 0.5 percent, were at an all time low from 1991 to 1993—may have been the reduction in the number of continuing disability reviews (CDR) performed by SSA.[38] In the early 1990s, because of SSA resource constraints and increasing initial claims workloads, the number of DI CDRs declined dramatically. In fiscal year 1996, about 4.3 million DI and SSI beneficiaries were due or overdue for CDRs.[39]

[38]The Environment of Disability Income Policy: Programs, People, History and Context, p. 65.

[39]Social Security Disability: Improvements Needed to Continuing Disability Review Process (GAO/HEHS-97-1, Oct. 16, 1996).

Comments From the Social Security Administration

SOCIAL SECURITY
Office of the Commissioner

February 6, 1997

Ms. Jane L. Ross
Director, Income Security Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Ross:

Thank you for the opportunity to comment on the draft report, "Social Security: Disability Programs Lag in Promoting Return to Work" (GAO/HEHS-97-46).

We agree that compelling reasons exist to try new return-to-work approaches for people with disabilities who receive Social Security Disability Insurance and Supplemental Security Income disability benefits. Medical advances, new technologies, and shifts in societal attitude provide added impetus for examining how new strategies could be applied to improve return-to-work outcomes. The Social Security Administration (SSA) shares your concern that these beneficiaries face a number of barriers to entering or reentering the workforce. SSA has placed a high priority on the development of return-to-work initiatives.

The President's 1998 Budget reflects major initiatives that I believe will create new opportunities for our beneficiaries to return to work. SSA is seeking statutory authority to provide disabled beneficiaries with a rehabilitation and employment services "ticket" that they may voluntarily use to obtain rehabilitation and/or employment services from any participating public (including a State Vocational Rehabilitation agency) or private service provider of their choice. Payments to service providers would be made when beneficiaries have returned to work and have left the cash benefit rolls. We are proposing a pilot test of this concept, which will begin in 5 to 10 states. We will carefully monitor the cost and effectiveness of these activities during this pilot period, with rigorous evaluations conducted at 3, 5 and 7 years of operation. We will add more states, at the appropriate time, if the program proves effective.

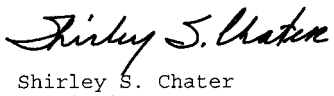
The President's 1998 Budget also seeks to make changes in Medicare and Medicaid to provide extended medical coverage for disability beneficiaries who return to work. There is general agreement that access to health care is one of the most significant considerations for these beneficiaries. We are optimistic that more beneficiaries will attempt to return to work

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

if they have greater confidence that their health care will continue for a substantial period of time.

A summary of other employment initiatives is attached. If you have any questions, please call me or have your staff contact Susan Daniels at (410) 965-3424.

Sincerely,



Shirley S. Chater
Commissioner
of Social Security

Attachment

COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION (SSA) ON THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT, "SOCIAL SECURITY: DISABILITY PROGRAMS LAG IN PROMOTING RETURN TO WORK" (GAO/HEHS-97-46)

In addition to the initiatives described in our cover letter, we are providing a summary of employment initiatives that were reported in agency comments to two earlier GAO reports on return-to-work issues, "Social Security Disability: Program Redesign Necessary to Encourage Return to Work" (GAO/HEHS-96-62), and "Social Security Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs" (GAO/HEHS-96-133). The high priority SSA has placed on these initiatives emphasizes the Agency's commitment to finding new and innovative ways to encourage return to work.

Employment initiatives reported earlier:

- We awarded $65.5 million to State VR agencies in fiscal year 1996 for the successful rehabilitation of over 6,000 beneficiaries.

- We have received input from advocates, experts, and other stakeholders on removing barriers to return to work in the SSI and SSDI programs. We have also conducted a comprehensive review and analysis of the research and literature on the success or failure of return to work and rehabilitation efforts in the SSI and SSDI programs over the past 10 to 15 years.

- We have published regulations that permit us to refer beneficiaries to an alternate provider when the State VR agency is unable to provide services. This is the first time SSA has worked with private providers of VR.

- We have requested that States enter into performance partnerships with SSA to enhance the States' rehabilitation and employment initiatives to better focus on beneficiaries as VR clients.

- We have signed an interagency agreement with the Department of Education's Rehabilitation Services Administration to have Cornell University provide training on our work incentives to State VR professionals in all regions of the country.

- We have let a contract for a complete, comprehensive evaluation of Project NetWork, a major SSA research effort that tested four models for delivering alternative employment and rehabilitation services.

- We have improved management information to more thoroughly evaluate the results of our efforts.

Success in assisting persons with disabilities to re-enter the workforce requires the active involvement of many Federal agencies. SSA's disability programs are only one piece of a vast network of Federal, State and other systems influencing the independence and economic self-sufficiency of people with disabilities. In addition, any Federal effort in this arena must also include the private sector. The private rehabilitation community, private insurers, consumers, employers and advocates for people with disabilities can greatly assist us in recognizing, and developing, a process for enhancing the productive capabilities of disabled beneficiaries.

Related GAO Products

Social Security Disability: Improvements Needed to Continuing Disability Review Process (GAO/HEHS-97-1, Oct. 16, 1996).

SSA Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs (GAO/HEHS-96-133, July 11, 1996).

Social Security: Disability Programs Lag in Promoting Return-to-Work (GAO/T-HEHS-96-147, June 5, 1996).

SSA Disability: Program Redesign Necessary to Encourage Return to Work (GAO/HEHS-96-62, Apr. 24, 1996).

PASS Program: SSA Work Incentive for Disabled Beneficiaries Poorly Managed (GAO/HEHS-96-51, Feb. 28, 1996).

Social Security Disability: Management Action and Program Redesign Needed to Address Long-Standing Problems (GAO/T-HEHS-95-233, Aug. 3, 1995).

Disability Insurance: Broader Management Focus Needed to Better Control Caseload (GAO/T-HEHS-95-164, May 23, 1995).

Supplemental Security Income: Recipient Population Has Changed as Caseloads Have Burgeoned (GAO/T-HEHS-95-120, Mar. 27, 1995).

Social Security: New Functional Assessments for Children Raise Eligibility Questions (GAO/HEHS-95-66, Mar. 10, 1995).

Social Security: Federal Disability Programs Face Major Issues (GAO/T-HEHS-95-97, Mar. 2, 1995).

Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns (GAO/T-HEHS-95-67, Jan. 27, 1995).

Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations (GAO/HEHS-94-225, Sept. 9, 1994).

Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).

Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27, 1993).

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