CHALLENGES FACING SOCIAL SECURITY DISABILITY PROGRAMS IN THE 21ST CENTURY

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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CHALLENGES FACING SOCIAL SECURITY DISABILITY PROGRAMS IN THE 21ST CENTURY

THURSDAY, JULY 13, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SOCIAL SECURITY,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:07 a.m., in room B–318, Rayburn House Office Building, Hon. E. Clay Shaw (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
July 6, 2000
No. SS–20

CONTACT: (202) 225–9263

Shaw Announces Hearing on Challenges Facing Social Security Disability Programs in the 21st Century

Congressman E. Clay Shaw, Jr., (R–FL), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing to examine the challenges facing the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs in the 21st century. **The hearing will take place on Thursday, July 13, 2000, in room B–318 Rayburn House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives of the U.S. General Accounting Office, disability experts, and advocates for people with disabilities. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The SSDI and SSI programs provide cash benefits to individuals who are unable to work because of severe disabilities. In 1999, nearly five million disabled workers and their families received more than $50 billion from the SSDI program, and four million low-income disabled adults received $24 billion from SSI. Most of these beneficiaries also received health insurance through Medicare and Medicaid because they qualified for this cash assistance.

The Social Security Act first addressed the issue of disability in 1952 by excluding income earned while disabled from the computation of retirement benefits. The 1954 amendments provided cash benefits, but only for disabled individuals who were at least age 50. The lower age limit was removed in 1960. The definition of disability has remained essentially unchanged since the beginning of the SSDI program, and the same definition was adopted for the SSI program when it began providing benefits for low-income people with disabilities in 1974.

In recent years, numerous technological and medical advances, coupled with a growing economy, have created the potential for more people with disabilities to achieve independence. In addition, the “Americans with Disabilities Act of 1990” (P.L. 101–336), has helped promote the full participation of people with disabilities in society and has fostered the expectation that people with disabilities can work and have the right to work. The “Ticket to Work and Work Incentives Improvement Act of 1999” (P.L. 106–170), provided new opportunities for adults receiving public benefits to pursue work without fear of losing all benefits.

The safety net provided by the Social Security disability program is critically important for individuals with disabilities and their families. Maintaining the safety net will be particularly challenging in coming decades, when, like Social Security, the disability program faces financial challenge. According to the 2000 Annual Report of the Board of Trustees, beginning in 2007, the Disability Insurance Trust

Fund is projected to run cash deficits and by 2023, the trust fund assets will be exhausted.

In announcing the hearing, Chairman Shaw stated: “Social Security’s disability programs have provided vital assistance for people with disabilities for nearly 50 years. Fortunately, today individuals with disabilities have opportunities and support never imagined in years past. As we enter the 21st century, we need to ensure Social Security disability programs continue to meet the changing needs of people with disabilities.”

FOCUS OF THE HEARING:

The hearing will focus on the characteristics of people with severe disabilities and will identify the supports needed to achieve independence. The hearing will also examine how disability systems in other countries as well as in the private sector have adapted to meet the changing needs of people with disabilities.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the *close of business*, Thursday, July 27 , 2000, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Social Security office, room B–316 Rayburn House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at ‘http://waysandmeans.house.gov’.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

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Chairman SHAW. Today we will explore the challenges facing Social Security disability programs in the 21st century. Like Social Security retirement and survivor programs, the disability program has been remarkably successful in providing financial and health care support of those unable to work because of their disabilities. Yet, this vital program faces more immediate financial challenge than that faced by the retirement program.

Beginning in just 7 years, disability program outlays will exceed income. By the year 2023 the trust fund will no longer be able to pay full benefits. Securing the financial future of this essential safety net is paramount as we begin the 21st century. Much has changed over the nearly 50 years of history of this program. This month we are celebrating our 10th anniversary of the Americans with Disabilities Act.

This landmark legislation has helped to change the expectations for work for many people with disabilities as well as expand the consciousness of Americans to view people with disabilities in terms of their abilities, not their disabilities. Medical and technological advances have made it possible for many individuals to achieve independence even though it is independence that they never thought was possible.

The Ticket to Work and Work Incentive Improvement Act of 1999 developed in large part by this Subcommittee and signed into law last December removed barriers preventing individuals from becoming self-sufficient by providing extended health care coverage and providing more choice and opportunities to obtain needed rehabilitation and support services. These are important achievements but we must do more. Today we will begin our work by learning more about the characteristics of people with severe disabilities today and the support that they need to achieve independence.

We also examine how disability systems in other countries as well as in the private sector have adapted to meet the changing needs of people with disabilities. I look forward to hearing the advice and suggestions of the experts that we have assembled in this room today. Mr. Matsui.

Mr. MATSUI. Thank you, Mr. Chairman. As many members in this room are aware, one of our successes in this Congress was enacting the Ticket to Work and Work Incentives Improvement bill last year. The Ticket to Work Act when fully implemented will help disabled Social Security beneficiaries receive the rehabilitation services they need to return to the labor force. The Ticket to Work Act also provides disabled beneficiaries who return to work with extended health care coverage to increase the likelihood that they will be able to remain in the work force.

The Ticket to Work Act represents a great step forward in helping people with disabilities to participate in our Nation's economy and to share in the prosperity of recent years. However, we should not consider it the end of our journey. We still have much further to go before we can call our efforts complete. Consequently, I would like to thank Chairman Shaw for holding today's hearing for I think it is vitally important to examine new ideas for helping people with disabilities realize their goals to participate in the work force.

During today's hearing, we will hear testimony about the different approaches foreign countries and private insurance utilize to help people with disabilities and enhance their ability to return to work. While I am sure we can learn a number of lessons from these countries and private insurers, we do need to keep several things in mind as we explore new ways to help people return to work.

We must be aware that many differences may exist between populations and that the disability programs abroad and private insurers serve populations that may differ somewhat than ours. For instance, private insurance have the luxury of deciding their risk pools while SSA does not. We must also recognize the differences that exist between the United States and other industrialized nations in terms of the delivery of social services and the implications that those differences have for the disabled community.

Health insurance is the prime example. In crafting the Ticket to Work Act last year, we went through a major struggle for relatively modest extensions of health care coverage for those disability beneficiaries returning to work. Indeed, in the end the Congress agreed to a Ticket to Work Act providing 8.5 years of Medicare coverage for disabled beneficiaries rather than the full 10 years in the original House bill. This aspect of the debate would not be of great concern abroad because of universal health care coverages in those countries.

In addition, we must be clear that our goal is not simply to move people with disabilities off the beneficiary rolls but to help them secure a job with salaries that can be supportive to them. One of our witnesses today will testify about a study that he recently conducted that reveals that people with severe mental impairments who are gainfully employed are still frequently poor and are likely to remain so because most of their jobs are low wage, entry level positions.

Finally, we should expect Social Security to maximize the effectiveness of its resources for helping people to return to work but we should also be realistic. We cannot delude ourselves and think that with a few shifts in policy we can do the job and Social Security can do the job on its own within its current budget. Further progress in assisting people with disabilities to return to work will require a sustained commitment from across the Federal bureaucracy and may well require dedication of additional resources. So, Mr. Chairman, again I want to thank you for calling this hearing and obviously thank all the witnesses as well.

Chairman SHAW. Thank you, Bob. Our first panel this morning is a friend of this Committee, Barbara Bovbjerg, who is the Associate Director, Education, Workforce and Income Security Issues, Health, Education and Human Services Division of the United States General Accounting Office, and she has with her Carol Petersen, who is the Assistant Director, Education, Workforce, and Income Security Issues. Welcome, both of you.

As other panels, we have your full statement which will be placed in the record, and we invite you to proceed as you see fit. Ms. Bovbjerg.

STATEMENT OF BARBARA D. BOVBJERG, ASSOCIATE DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION; ACCOMPANIED BY CAROL PETERSEN, ASSISTANT DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION

Ms. BOVBJERG. Thank you, Mr. Chairman. Mr. Chairman, Mr. Matsui, I am pleased to be here to discuss practices that help people with severe disabilities return to work. The Disability Insurance and Supplemental Security Income Programs administered by the Social Security Administration provide benefits to millions of people with long-term disabilities. Although many of these programs' beneficiaries want to work and technological and medical advances have increased the potential for them to do so, less than 1% of SSA's disabled beneficiaries successfully return to work each year.

Disability systems in the private sector and other countries have designed programs to help disabled workers who can work, do so. Although measures taken by these other systems may not translate directly to SSA's disability programs their practices and experiences may provide approaches for SSA to draw upon. My testimony is based on our ongoing review of these practices for this Subcommittee in which we have interviewed managers of three private sector disability insurers and disability program officials in Germany, Sweden and the Netherlands.

Today I would like to focus my remarks in two areas. First, how disability systems in the private sector and three other counties facilitate and encourage return to work, and, second, how these practices compare with the DI program. I make this distinction, DI/SSI, because DI beneficiaries' work experience is more comparable to that of employees with private disability insurance, but many of the comparisons we will discuss apply to the SSI Program as well.

First, the systems in the private sector and other countries. These systems integrate return-to-work considerations early after disability onset and continue them throughout the eligibility assessment process. With the initial reporting of a disability claim, these disability insurers immediately set up the expectation that the claimant will return to work, and collaborate closely with the claimant, the treating physician, and the employer to assess what support is needed.

These systems also provide incentives for claimants to take part in individualized return-to-work programs and to receive appropriate medical treatment. They also provide incentives for employers to offer work to claimants. Claimants with work potential are required to participate in individualized programs that may include vocational rehabilitation. Claimants are also assessed medically and required to obtain appropriate medical treatment. Insurers offer assistance in obtaining such treatment where necessary.

Employer incentives involve paying for employee accommodation, subsidizing wages, or reducing premiums for employers who re-employ disabled workers.

Managers of these other systems also explained to us that they match appropriately trained staff with different types of claims to provide cost-effective return-to-work assistance. Both the insurers and other countries triage claims by the claimant's work potential. They have access to staff with a range of skills and expertise and they apply this expertise where it could be most effective to assess and enhance claimant's capacity to work.

Let me now turn to SSA's approach. Historically, the agency has placed little emphasis on helping beneficiaries return to work. More recently, however, the agency has begun placing a greater priority on this area. For example, the Office of Employment Support Programs has been established to promote employment of disabled beneficiaries through a variety of means including sponsoring research and working to remove employment barriers.

Moreover, the new Ticket to Work Act, by expanding access to vocational rehabilitation services, is also expected to enhance work opportunities for people with disabilities.

But despite these advances, fundamental policy weaknesses in the DI program remain. These weaknesses include an eligibility determination process that concentrates on applicants' incapacities, an all or nothing benefit structure and return to work services offered only after a lengthy determination process.

This is not to say that SSA could effectively engage in all the practices that private insurers and other countries have adopted. Little hard data exist on the effectiveness of return-to-work approaches used in these other systems and even less information is available with regard to cost. Furthermore, it is unclear that successful practices in other countries would succeed in another sociopolitical environment or that private sector policies could prove directly adaptable to public sector priorities.

Nonetheless, as we have recommended in the past, SSA needs to adopt a comprehensive strategy for returning beneficiaries to work and could usefully draw upon the approaches of other systems in so doing. Because such a strategy may require fundamental changes to the underlying philosophy and direction of the disability programs, policymakers would need to weigh carefully the implications of such changes.

However, the prospect of helping individuals improve their productive potential should provide ample reason to consider the experiences of these other systems. Mr. Chairman, that concludes my statement and I welcome your questions.

[The prepared statement follows:]

Statement of Barbara D. Bovbjerg, Associate Director, Education, Workforce, and Income Security Issues, Health, Education, and Human Services Division

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to discuss the practices of the private sector and other countries in helping people with severe disabilities return to work. Each month the Social Security Administration's (SSA) Disability Insurance (DI) program pays over $4 billion in cash benefits to people with disabilities. The DI beneficiary population has grown significantly over the past 15 years, increasing by 67 percent, while benefit payments have nearly tripled. This growth has contributed to the DI Trust Fund's projected insolvency in 2023. Yet, during this period of program growth, numerous technological and medical advances, combined with changes in society and the nature of work, have increased the potential for some people with disabilities to return to, or remain in, the labor force. Many beneficiaries with disabilities indicate that they want to work and be independent, and many can work if they receive the supports they need, yet fewer than one-half of 1 percent of DI beneficiaries leave the rolls each year to return to work.

The U.S. private sector, as well as other countries, has designed disability systems to help disabled workers return to work. In recent years, a growing number of private insurance companies have been focusing on developing and implementing strategies for controlling disability costs by enabling people with disabilities to return to work. Disability programs financed by social insurance systems in other countries also focus on return to work and have implemented practices similar to those in the U.S. private sector.

Today I would like to discuss how disability systems in the private sector and other countries encourage and facilitate return to work in three key areas: (1) the eligibility assessment process, (2) work incentives, and (3) staffing practices. I will describe these three elements for U.S. private sector disability insurers and for other countries' social insurance systems and compare the practices of both with those of the DI program. We are comparing these practices with those of the DI program because the work experience of the DI population is most comparable to that of employees covered under private disability insurance. However, many of the comparisons discussed would be applicable as well to SSA's other disability program, Supplemental Security Income (SSI).

To develop this information, we conducted in-depth interviews and reviewed policy documents and program data at three private sector disability insurers: UNUMProvident, Hartford Life, and CIGNA.[1] We also interviewed program officials and other experts on the disability systems of Germany, Sweden, and The Netherlands and reviewed policy documents and studies of these programs. This work updates and expands on our previous work in this area.[2]

In summary, the disability systems of the private insurers and the countries we reviewed integrate return-to-work considerations early after disability onset and throughout the eligibility assessment process. This involves both determining—as well as enhancing—the ability of each claimant to return to work. In addition, these systems provide incentives for claimants to take part in vocational rehabilitation programs and to obtain appropriate medical treatment and for employers to provide work opportunities for claimants. Managers of these other systems also explained to us that they have developed techniques—such as separating (or "triaging") claims—to use staff with the appropriate expertise to provide return-to-work assistance to claimants in a cost-effective manner. Although these practices are common to the private sector insurers and the countries whose systems we examined, limited data exist on the cost-effectiveness of these approaches.

SSA may face greater difficulty in returning some of its beneficiaries to work than the private sector insurers, since DI covers a broader population than the private insurers. Nevertheless, opportunities exist to help disabled workers remain at or return to the workplace. In recognition of these opportunities, SSA has recently begun placing greater priority on returning beneficiaries to work. Moreover, the new Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket to Work Act), by expanding access to vocational rehabilitation services, is expected to enhance work incentives for people with disabilities. However, fundamental policy weaknesses in the DI program remain unchanged. As we have reported in the past, these weaknesses include an eligibility determination process that concentrates on applicants' incapacities, an "all-or-nothing" benefits structure, and return-to-work services offered only after a lengthy determination process.

To address these policy weaknesses, we continue to believe—as we recommended in 1996—that SSA should develop a comprehensive return-to-work strategy. In de-

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[1] Taken together, these three insurers have experience not only in long-term, stand-alone disability insurance, but also in integrating short-and long-term disability insurance with workers' compensation and, in one instance, with health care. These insurers are also among the largest long-term disability insurers in the country, together covering about 52 percent of the long-term U.S. private disability insurance market in 1997. We focused our analysis on the population of applicants and beneficiaries whose disabilities are of such severity that they would likely qualify for SSA's disability benefits. In addition, we focused our review on private insurers' group disability insurance policies, which contain return-to-work incentives.

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

veloping the strategy, SSA can draw upon the experiences of other systems to identify elements of a new federal disability system that could help each individual realize his or her productive potential without jeopardizing the availability of benefits for people who cannot work. Having identified these elements, SSA would then be in a position to determine the legislative and regulatory changes needed to test and evaluate the effectiveness of these practices in the federal disability system.

BACKGROUND

DI provides monthly cash benefits to workers who are unable to work because of severe long-term disability. Established in 1956, DI is an insurance program funded by payroll taxes paid by workers and their employers into a Social Security Trust Fund. Workers who have worked long enough and recently enough become insured for DI coverage. In addition to cash assistance, DI beneficiaries receive Medicare coverage after they have received cash benefits for 24 months. In 1999, 4.9 million disabled workers received DI cash benefits totaling about $46.5 billion, with average monthly cash benefits amounting to $755 per person.[3]

To meet the definition of disability under DI, an individual must have a medically determinable physical or mental impairment that (1) has lasted or is expected to last at least 1 year or to result in death and (2) prevents the individual from engaging in substantial gainful activity. Individuals are considered to be engaged in substantial gainful activity if they have countable earnings at or above a certain dollar level.[4] Moreover, the statutory definition 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. SSA pays state disability determination service (DDS) agencies to determine whether applicants are disabled. The program offers people on the DI rolls incentives that are intended to encourage beneficiaries to return to work—and, potentially, to leave the rolls. For example, the DI work incentives provide for a trial work period in which a beneficiary may earn any amount for 9 months within a 60-month period and still receive full cash and medical benefits.

Historically, SSA has given little emphasis to assisting beneficiaries in returning to work, and we have made a number of recommendations for improvement. For example, in 1996, we identified weaknesses in SSA's return-to-work efforts and recommended that SSA intervene earlier to foster a greater emphasis on assisting disabled applicants and beneficiaries in returning to the workforce.[5] We also reported that the disability determination process encourages work incapacity because applicants have a strong incentive to emphasize their limitations in order to qualify for benefits. In addition, we observed that the often lengthy and cumbersome application process may itself reinforce applicants' perceptions of their inability to work.[6]

SSA has recently begun to place higher priority on emphasizing return to work for DI beneficiaries. For example, SSA recently established the Office of Employment Support Programs to promote the employment of disabled beneficiaries. In addition, the Ticket to Work Act is expected to enhance work opportunities for people with disabilities. For example, this new act expanded eligibility for Medicare for DI beneficiaries and created a "Ticket to Work" voucher program that will allow beneficiaries a greater choice of vocational rehabilitation and employment service providers. SSA has also funded partnership agreements in 12 states that are intended to help the states develop services to increase the employment of DI beneficiaries.

Private Disability Insurers Implement Return-to-Work Practices to Control Costs

Private insurers provide disability insurance to a selected portion of the U.S. working population. Unlike SSA, private sector insurers are able to choose the industries to which they market their policies. The characteristics of the private insurers' beneficiaries can also differ from those of SSA's beneficiaries because private in-

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[3] In the same year, DI also paid about $4.9 billion in cash benefits to about 1.7 million spouses and children of disabled workers.

[4] Regulations currently define substantial gainful activity (SGA) as employment that produces countable earnings of more than $700 a month for nonblind disabled individuals. The SGA level for individuals who are blind is set by statute and indexed to the annual wage index. Currently, the SGA for blind individuals is $1,170 of countable earnings. SSA deducts from gross earnings the cost of items a person needs in order to work and the value of support a person needs on the job because of the impairment before deciding if work is considered SGA.

[5] See GAO/HEHS–96–133, July 11, 1996.

[6] See SSA Disability: Program Redesign Necessary to Encourage Return to Work (GAO/HEHS–96–62, Apr. 24, 1996).

surers can allow employers who purchase their disability policies to vary coverage by type of impairment or by class of employee. For example, employers generally choose to limit coverage for mental impairments to a maximum of 24 months.[7] Employers may also choose to provide long-term disability coverage for only their white collar employees, rather than for all their employees.

The private disability insurance industry, moreover, provides benefits to many individuals who are not as severely disabled as the beneficiaries of the DI program. However, for the insurers reviewed, almost two-thirds of those receiving private long-term disability benefits also received DI benefits.[8] This group of beneficiaries, in the cases of the two insurers that provided us with comparable data, was composed of a slightly higher proportion of female and older beneficiaries than the overall DI population. All the insurers had a lower proportion of beneficiaries with mental impairments than the DI population.

Some private sector organizations have recognized the potential for reducing disability costs through an increased focus on returning people with disabilities to productive activity. To accomplish this comprehensive shift in orientation, the private disability insurers have begun developing and implementing strategies for helping claimants return to work as soon as possible, when appropriate. Although the private sector insurance companies expect a positive effect on return-to-work outcomes from these strategies, it is too early to fully measure the effect of these changes. In many cases, return-to-work processes have only recently been implemented. Moreover, although the private insurers are now including return-to-work provisions in the standard contracts that they are writing, a large number of employees are still insured under prior contracts that lack these provisions. While the insurers could not provide us with comprehensive cost-effectiveness studies, their initial return-to-work rates are promising. The private insurers reported that, in 1999, between 2 and 3 percent of their long-term disability beneficiaries who also received DI benefits returned to work or were terminated from the private sector disability benefit rolls because they were assessed as having the capacity to work.

Other Countries Also Invest in Return-to-Work Efforts

In contrast to the private sector, which covers a selected portion of the U.S. working population, the experiences of Germany, Sweden, and The Netherlands show that return-to-work strategies are applicable to a population with a wide range of work histories, job skills, and disabilities. However, these disability systems operate in a somewhat different social and political context than the DI program. For example, 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. In addition, disability systems in these countries offer short-term as well as long-term benefits, which provides an important basis for comprehensive disability case management.

The social insurance disability programs in these countries have invested in return-to-work efforts and have implemented practices similar to those in the U.S. private sector. While the German social insurance system has had a long-standing focus on the goal of "rehabilitation before pension," the reorientation of Sweden and The Netherlands toward a return-to-work focus has occurred mostly within the past decade. Although rigorous studies demonstrating the cost-effectiveness of German, Swedish, or Dutch programs generally do not exist, some limited studies and data indicate positive results from the return-to-work approach in these disability insurance systems.[9]

The Eligibility Assessment Process Integrates Return-to-Work Considerations Throughout

All the private disability insurers and the countries we reviewed have developed an eligibility process that includes assessing and enhancing the ability of claimants to work throughout the process. To enable claimants to return to work as quickly as possible, insurers incorporate return-to-work considerations early in the assess-

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[7] The 24-month limitation on mental impairments does not include time spent in a hospital or mental institution. Also, the three insurers vary in their descriptions of the types of mental illness that are covered under this special limitation. One insurer excludes bipolar affective disorders, psychotic disorders, and schizophrenia from this limitation. In contrast, the DI program does not have time-limited benefits for beneficiaries with mental impairments. In 1999, 26.8 percent of DI disabled workers with an available diagnosis had mental disorders.

[8] For claimants who receive both private and DI benefits, the private insurers reduce their disability payments by the amount of the DI payment.

[9] For example, a 1990–92 study of certain return-to-work practices used by Sweden's social insurance offices concluded that social insurance costs had been reduced by returning people to the workplace sooner. Practices assessed included early screening and contact with disabled individuals.

ment process and throughout a customized evaluation of each claimant's initial and continuing eligibility for benefits. In contrast, SSA's return-to-work efforts occur after its eligibility assessment process. (See Table 1.)

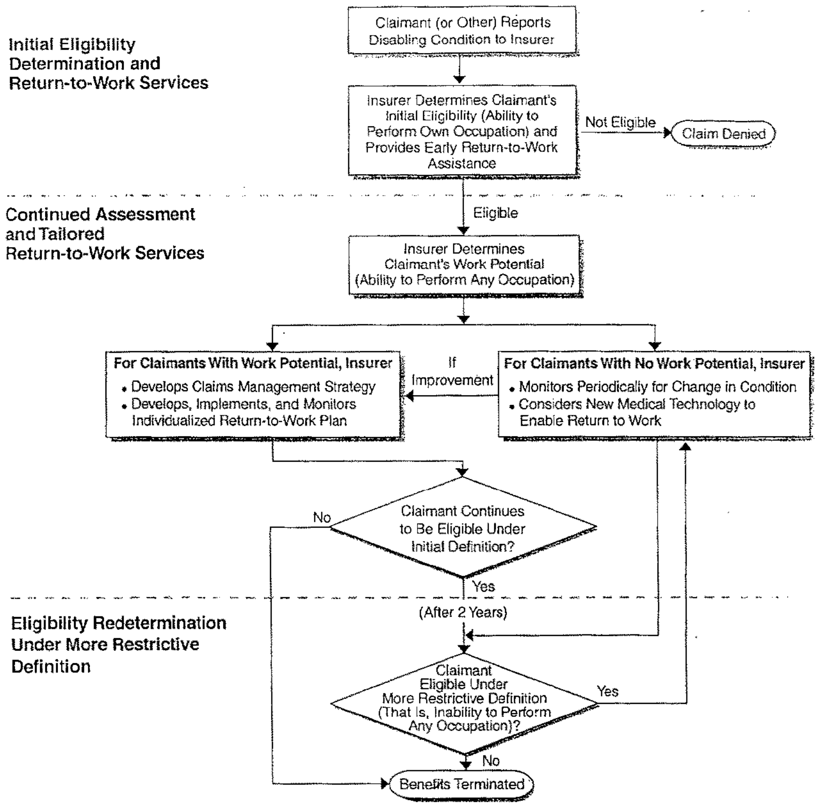
Table 1:—Comparison of Eligibility Assessment Process Features of Private Insurers and Other Countries With Those of SSA

Process feature	Private insurers and other countries	SSA
Disability definition	Definition of disability shifts over specified time period from less to more restrictive, recognizing the possibility of improvement in the capacity to work through provision of supports and services, such as retraining..	"All-or-nothing" definition characterizes individuals as either unable to work or having the capacity to work..
Early intervention	Intervention occurs soon after disability onset to identify return-to-work needs..	There is a long delay in providing services because only individuals who have been awarded benefits—following an often lengthy assessment process—are eligible for return-to-work services..
Ongoing assessment of work potential	Work capacity is periodically monitored and reassessed, focusing on returning those with work potential to work..	There is no integration of return-to-work considerations into either the initial or the continuing eligibility assessment process..

Private Insurers Incorporate Return-to-Work Efforts From the Beginning of the Assessment Process

All the private insurers we observed incorporate return-to-work considerations early in the assessment process to assist claimants in their recovery and in returning to work as soon as possible. With the initial reporting of a disability claim, these insurers, when appropriate, immediately set up the expectation that the claimant will return to work. The insurers' process for assessing and assisting a claimant's ability to work is illustrated in Figure 1.

Figure 1: Private Disability Insurers' Eligibility Assessment Process



After receiving a claim, the private insurers' assessment process begins with determining whether the claimant meets the initial definition of disability. In general, for all the private sector insurers we studied, claimants are considered disabled when, because of injury or sickness, they are limited from performing the essential duties of their own occupation, and they earn less than 60 to 80 percent of their predisability earnings, After receiving a claim, the private insurers' assessment process begins with determining whether the claimant meets the initial definition of disability. In general, for all the private sector insurers we studied, claimants are considered disabled when, because of injury or sickness, they are limited from performing the essential duties of their own occupation, and they earn less than 60 to 80 percent of their predisability earnings, depending upon the particular insurer.[10] As part of determining whether the claimant meets this definition, the insurers compare the claimant's capabilities and limitations with the demands of his or her own occupation and identify and pursue possible opportunities for accommodation—including alternative jobs or job modifications—that would allow a quick and safe return to work. A claimant may receive benefits under this definition of disability for up to 2 years.[11]

As part of the process of assessing eligibility according to the "own occupation" definition, insurers directly contact the claimant, the treating physician, and the employer to collect medical and vocational information and initiate return-to-work efforts, as needed. Insurers' contacts with the claimant's treating physician are aimed at ensuring that the claimant has an appropriate treatment plan focused, in many cases, on timely recovery and return to work. Similarly, early contact with the claimant's employer is used to encourage the employer to make accommodations for claimants with the capacity to work.

If the insurers find the claimant initially unable to return to his or her own occupation, they provide cash benefits and continue to assess the claimant to determine if he or she has any work potential. For those with work potential, the insurers focus on return to work before the end of the 2-year period when, for all the private insurers we studied, the definition of disability becomes more restrictive: after 2 years, the definition shifts from an inability to perform one's own occupation to an inability to perform any occupation for which the claimant is qualified by education, training, or experience. Claimants may be found ineligible for benefits under the more restrictive definition.[12]

The private insurers' shift from a less to a more restrictive disability definition after 2 years reflects the changing nature of disability and allows a transitional period for insurers to provide financial and other assistance, as needed, to help claimants with work potential return to the workforce. During this 2-year period, the insurer attempts to determine the best strategy for managing the claim. Such strategies can include, for example, helping plan medical care or providing vocational services to help claimants acquire new skills, adapt to assistive devices to increase functioning, or find new positions. For those requiring vocational intervention to return to work, the insurers develop an individualized return-to-work plan, as needed. Basing the continuing receipt of benefits upon a more restrictive definition after 2 years provides the insurer with leverage to encourage the claimant to participate in a rehabilitation and return-to-work program. Indeed, the insurers told us that they find that claimants tend to increase their efforts to return to work as they near the end of the 2-year period.

If the insurer initially determines that the claimant has no work potential, it regularly monitors the claimant's condition for changes that could increase the potential to work and reassesses after 2 years the claimant's eligibility under the more restrictive definition of disability. In addition, the insurer looks for opportunities to assist these claimants when changes in medical technology, such as new treatments for cancer or AIDS, may enable them to work.

The private insurers that we reviewed told us that they customize their assessment and enhancement of a claimant's ability to work throughout the duration of

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[10] The private insurers generally define one's "own occupation" as the occupation a person is routinely performing at onset of disability. They generally assess how the claimant's own occupation is performed in the national economy, rather than how the work is performed for a specific employer or at a specific location. Two insurers have expanded their "own occupation" definition of disability to include a reasonable alternative position. These insurers require that a claimant who is judged able to do so accept a reasonable alternative position—a job in the same general location offered by the claimant's current employer—or risk losing cash benefits. The claimant must be qualified to perform this alternative position—which must pay the claimant more than 60 to 80 percent of predisability earnings, depending upon the insurer—given his or her education, training, or experience.

[11] Our review of group disability insurance policies focused on those with an "own occupation" definition of disability that changes to an "any occupation" definition after 2 years.

[12] The private insurers generally use the same "own occupation" definition for short-and long-term disability benefits. However, in the case of long-term benefits, the definition shifts to the "any occupation" definition after 2 years. When applying the "any occupation" definition, private insurers generally try to identify several occupations that exist locally that could provide a sufficient salary for the claimant. However, the insurer is obligated only to identify occupations with a sufficient salary in the national economy and not to find specific job openings or place the claimant in a new position.

the claim. To do this, disability insurers use a wide variety of tools and methods when needed. Some of these tools, as shown in tables 2 and 3, are used to help ensure that medical and vocational information is complete and as objective as possible. For example, insurers consult medical staff and other resources to evaluate whether the treating physician's diagnosis and the expected duration of the disability are in line with the claimant's reported symptoms and test results. Insurers may also use an independent medical examination or a test of basic skills, interests, and aptitudes to clarify the medical or vocational limitations and capabilities of a claimant. In addition, insurers identify transferable skills to compare the claimant's capabilities and limitations with the demands of the claimant's own occupation. This method is also used to help identify other suitable occupations and the specific skills needed for these new occupations when the claimant's limitations prevent him or her from returning to a prior occupation. Included in these tools and methods are services to help the claimant return to work, such as job placement, job modification, and retraining.

Table 2:—Tools and Methods Used to Provide Medical Assessment

Task	Tools and methods
Assess diagnosis, treatment, and duration of the impairment and begin developing a treatment plan focused on returning the claimant to work promptly and safely.	Consultation of medical staff and other resources, including current medical guidelines describing symptoms, expected results from diagnostic tests, expected duration of disability, and treatment.
Assess the claimant's cognitive skills.	Standardized mental tests.
Validate the treating physician's assessment of the impairment's effect on the claimant's ability to work and the most appropriate treatment and accommodation.	Review of the claimant's file, generally by a nurse or a physician who is not the claimant's treating physician.
Verify diagnosis, level of functioning, and appropriateness of treatment.	Independent medical examination of the claimant by a contracted physician.
Evaluate the claimant's ability to function, determine needed assistance, and help the claimant develop an appropriate treatment plan with the physician.	Home visits by a field nurse or investigator or accompanied doctor visits.
Assess the claim's validity.	Home visits and interviews with neighbors or others who have knowledge of the claimant's activities.

Table 3: Tools and Methods Used to Provide Vocational Assessment and Assistance

Task	Tools and methods
Identify transferable skills, validate restrictions on and capabilities for performing an occupation, and identify other suitable occupations and retraining programs.	• Test basic skills, such as reading or math. • Determine interests and aptitudes. • Evaluate functional capacities associated with an occupation, such as lifting, walking, and following directions. • Compare functional capacities, work history, education, and skills with the demands of an occupation.
Enhance work capabilities and help develop job-seeking skills.	• Provide resume preparation, development of job-seeking skills, and help with job placement. • Assist in obtaining physical, occupational, or speech therapy and access to employee assistance, support groups, or state agency vocational rehabilitation or other community services. • Identify and fund on-the-job training or other educational courses.

Task	Tools and methods
Assess ability to perform own or any occupation, assess potential for accommodation, and determine whether sufficient salary is offered locally or nationally for a suitable occupation.	• Observe and analyze the essential duties of the claimant's own occupation, another occupation for the same employer, or an occupation of a prospective employer. • Determine the general availability and salary range of specified occupations. • Identify for a specified occupation the potential employers and related job descriptions, salary range, and openings.
Reaccustom claimant to a full work schedule and enable claimant to overcome impairment and return to work.	• Provide work opportunities for the claimant to gradually resume his or her job duties. • Procure devices to assist with work or otherwise help to modify the job.

Other Countries Also Provide Return-to-Work Assistance Early After Disability Onset and Throughout the Assessment Process

The countries we studied also begin assessing return-to-work needs soon after the onset of a disabling condition and integrate return-to-work assistance that is tailored to meet individual needs throughout the assessment process. These countries also provide short-term benefits on the basis of a person's inability to perform his or her current job because of illness or injury. These short-term disability benefits—which may be granted for a year or more—are similar to the private insurers' provision of benefits during the 2-year "own occupation" period of disability in that they provide a transitional period for assessing an individual's work potential and providing treatment and rehabilitation.

For example, German laws and policies require that all applicants for disability benefits be evaluated for rehabilitation and return to work. Based on the principle that intervention should occur at the earliest possible stage of disability to minimize the degree and effect of the impairment, intervention in Germany often begins when the health insurance agency urges a disabled worker receiving short-term benefits to apply for medical rehabilitation. In addition, vocational counselors often discuss rehabilitation and return-to-work plans with disabled workers while they are still in the hospital. The social insurance office then evaluates the person's capacity to work and, if necessary, refers the applicant to vocational rehabilitation or other types of return-to-work services and assistance. These return-to-work measures may include assistance in retaining or obtaining a job or in selecting an occupation. They may also involve providing basic training or retraining to prepare for an occupation and developing workplace accommodations. As long as the person continues to receive short-term disability benefits, the social insurance office will monitor the case and periodically reassess the person's work capacity and need for return-to-work assistance. The office will award long-term disability benefits only after it determines that a person's earning capacity cannot be restored through return-to-work interventions.

Under Swedish laws and policies, both the private and public sectors are responsible for the early identification of candidates for rehabilitation and return to work. After an employee has been on sick leave for 4 weeks, employers are responsible for determining whether the employee needs some type of rehabilitation and are required to report this information to the social insurance office. Social insurance offices closely monitor the use of short-term benefits and intervene when employers disregard their early intervention responsibilities.[13] The social insurance office then begins the process of determining whether the person will need vocational rehabilitation to return to work. The office arranges for an assessment of the disabled employee's rehabilitation needs and works with the employer and employee to develop a rehabilitation plan. Rehabilitation in Sweden is not meant to be a lengthy process, but rather a short, intensive period of medical and vocational training to help the individual return to work as soon as possible. As in Germany, the social insurance offices in Sweden periodically monitor and reassess the rehabilitation needs of individuals receiving short-term disability benefits and, after the first year of benefits,

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[13] Social insurance offices in Sweden have no mechanisms or sanctions to force employers to comply with their rehabilitation responsibilities. We reported in 1996 that, according to social insurance office surveys, employers do not arrange for rehabilitation examinations in about 40 to 50 percent of the cases.

consider granting long-term benefits if the person's rehabilitation potential has not improved.

In The Netherlands, the employer has had increasing responsibility for efforts to return the employee to his or her current job or a comparable job within the company since the mid–1990s. This shift of responsibility from the public to the private sector is intended to encourage greater responsibility on the part of employers in the prevention and prompt amelioration of employee health impairments. Under this policy, within about 3 months of the onset of the disability, the employer must submit to the social insurance agency a preliminary plan to return the disabled worker to the workforce. A final plan must be submitted within about 9 months. If the employer determines that the disabled worker cannot return to the workplace, or if the disabled worker has not returned to work after 1 year of receiving short-term benefits, the social insurance agency assesses the person's condition to determine eligibility for long-term disability benefits. The assessment involves evaluations of the applicant's physical and mental capabilities, which are then matched against different occupations to determine whether the person is capable of performing any work.

SSA Does Not Incorporate Return-to-Work Efforts Into Its Eligibility Assessment Process

Unlike the private sector and foreign countries, SSA does not integrate efforts to return individuals to work into either its initial or continuing eligibility assessment process. To be considered initially eligible for DI benefits, applicants must meet the Social Security Act's definition of disability—an "all-or-nothing" definition that characterizes individuals as either unable to work or having the capacity to work.[14] Because the result of the decision is either full award or denial of cash benefits, applicants have a strong incentive to emphasize their limitations to establish their inability to work and a disincentive to demonstrate any capacity to work. The act's definition of disability—under which a person is unable to do any substantial work in the national economy—is comparable to the private sector's most restrictive definition.

In recent years, SSA has piloted numerous initiatives to redesign and thereby improve its disability determination process. But while an internal SSA evaluation recently recommended that the agency "create an awareness and attitudinal change to accept employment support as a core SSA mission," the agency has not yet integrated return-to-work considerations into its efforts to redesign its disability determination process.[15] Moreover, the recently enacted Ticket to Work Act was intended to increase beneficiary access to vocational services but does not change the point in the process at which beneficiaries may receive assistance. Only those individuals who have met the Social Security Act's definition of disability and are approved for DI benefits will, under the Ticket to Work Act, receive a ticket entitling them to receive return-to-work services. There can be a long delay in receiving services: SSA's eligibility determination process ranges up to 18 months or longer for individuals who are initially denied benefits and who then appeal. Since many applicants have been unemployed before applying and remain unemployed during the eligibility determination process, it is likely that their skills, work habits, and motivation to work deteriorate during this wait, thus decreasing their readiness to work[16] However, the Ticket to Work Act authorizes SSA to carry out a demonstration project to test the advantages and disadvantages of earlier referral of applicants and beneficiaries for rehabilitation.[17] SSA may also gain additional insights into early intervention approaches through its funding of demonstration projects in 12 states.[18]

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[14] There are also distinct differences between the methods used by SSA and the private insurers to determine a level of earnings beyond which an individual no longer qualifies for benefits. SSA regulations, on one hand, apply a standard level of countable monthly income for all people other than the blind (currently $700), regardless of predisability earnings. In contrast, the private insurers we studied establish an individualized level that is a proportion of each person's predisability earnings. For disabled beneficiaries with high predisability earnings, the private sector's individualized level represents a much greater incentive to work than does SSA's standard level. However, the private sector's individualized level may provide less of a barrier to qualify for benefits and thus may encourage more people to apply for disability benefits.

[15] Social Security Administration, Employment Support Concept Development Plan, Apr. 12, 1999.

[16] See GAO/HEHS–96–62, Apr. 24, 1996.

[17] SSA has not yet designed such a project, and it is unclear how early SSA will be intervening after onset of disability in this demonstration.

[18] For example, one state is testing the provision of short-term vocational services to DI applicants with recent work histories, with an emphasis on early intervention and quick employment.

Other Systems Provide Incentives for Claimants and Employers to Encourage and Facilitate Return to Work

To facilitate return to work, all of the insurers and the countries we studied employ incentives both for claimants to participate in vocational activities and receive appropriate medical treatment, and for employers to accommodate claimants. For claimants who could benefit from vocational rehabilitation, insurers and the countries we studied require participation in an individualized return-to-work program. They also provide financial incentives to promote claimants' efforts to become rehabilitated and return to work. To better ensure that medical needs are met, the insurers and the countries we studied require that claimants receive appropriate medical treatment and assist them in receiving this treatment. In addition, they provide financial incentives to employers to encourage them to provide work opportunities for claimants. Although these practices are common to the private sector insurers and the countries we examined, limited data exist to determine whether these incentives for claimants and employers yield positive outcomes. In contrast to the practices of other systems, the Ticket to Work Act makes participating in rehabilitation and return-to-work services voluntary for DI beneficiaries. In addition, under law and SSA regulations, receiving appropriate medical treatment is not a prerequisite for award or continuing receipt of DI benefits. Moreover, DI applicants and beneficiaries may not have access to appropriate medical care.

Private Insurers Offer Incentives to Claimants and Employers to Promote Return to Work

All the private insurers we reviewed require claimants who could benefit from vocational rehabilitation to participate in a customized program or risk loss of benefits. As part of this program, the return-to-work plan for each claimant can include, for example, adaptive equipment, modifications to the work site, or other accommodations. All the private insurers mandate the participation of claimants whom they believe could benefit from rehabilitation, because they believe that voluntary compliance has not encouraged sufficient claimant participation in these plans.[19]

These insurers also make special financial incentives available to claimants who participate in rehabilitation programs, as appropriate. All insurers may defray costs associated with rehabilitation, such as child care expenses. For example, one insurer may pay $250 a month per child, up to $1,000 per month. This insurer also increases claimants' benefit payments by 10 percent, up to a maximum of $1,000 a month, for those who participate in rehabilitation.

In addition, all of the insurers told us that they encourage rehabilitation and return to work by allowing claimants who work to supplement their disability benefit payments with earned income.[20] During the first 12 or 24 months of receiving benefits, depending upon the particular insurer, claimants who are able to work can do so to supplement their benefit payment and thereby receive total income of up to 100 percent of predisability earnings.[21] After this period, if the claimant is still working, the insurers decrease the benefit amount so that the total income a claimant is allowed to retain is less than 100 percent of predisability income.

However, when a private insurer determines that a claimant is able, but unwilling, to work, the insurer can reduce or terminate the claimant's benefits. Moreover, to encourage claimants to work to the extent they can, even if only part-time, two of the insurers may reduce a claimant's benefit by the amount the claimant would have earned if he or she had worked to maximum capacity. One insurer uses the claimant's physician or three independent experts qualified to evaluate the claimant's condition to determine a claimant's maximum capacity to work. One of the insurers may also reduce a claimant's monthly benefit during the first year by the amount that the claimant could have earned if he or she had not refused a reasonable job offer—that is, a job that was consistent with the claimant's background, education, and training. Claimants' benefits may also be terminated if claimants

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[19] Although claimants may be involved in the development of the individualized rehabilitation plans, the insurers make the final decision as to the types of rehabilitation services claimants will receive.

[20] The private disability insurers we reviewed told us that their benefits generally replace 60 percent of predisability earnings, depending upon the insurer.

[21] To illustrate, assume that Ms. Jones is a claimant with predisability earnings of $1,000 per month and an insurance policy that replaces 60 percent of her predisability earnings. She is currently not working. Under this scenario, her income would be limited to $600 per month in disability benefits. However, if she returned to work, even part-time, she would have the opportunity to increase her total income to 100 percent of her predisability earnings or, in this instance, $1,000. If she returned to work and earned $500 per month, the insurer would reduce her benefit payment from $600 to $500 per month, so that her combined earnings and benefit payment would provide a total monthly income equal to her predisability income of $1,000.

refuse to accept a reasonable accommodation that would allow them to work. For example, if a claimant with impaired vision refuses the offer of a large-screen terminal that would allow the claimant to work, the insurer can terminate his or her benefits.

Since medical improvement or recovery can also enhance claimants' ability to work, the private insurers we studied not only require, but also help, claimants to obtain appropriate medical treatment. To maximize medical improvement, private insurers require that the claimant's physician be qualified to treat the particular impairment. Additionally, two insurers require that treatment be provided in conformance with medical standards for type and frequency. Moreover, to help ensure that a claimant is receiving appropriate treatment, the insurers' medical staff work with the treating physician as needed to ensure that the claimant has an appropriate treatment plan. The insurers may also provide funding for those who cannot otherwise afford treatment.

All private sector insurers we studied may also provide financial incentives to employers to encourage them to provide work opportunities for claimants. By paying for accommodations and offering lower insurance premiums to employers, private insurers encourage employers to become partners in returning disabled workers to productive employment. For example, to encourage employers to adopt a disability policy with return-to-work incentives, all the insurers offer employers a discounted insurance premium that they can continue to receive if their disability caseload declines to the level expected for those companies that assist claimants in returning to work. To this end, these insurers fund accommodations, as needed, for disabled workers at the employer's work site.[22]

Other Countries Also Provide Incentives to Claimants and Employers to Encourage Return to Work

Germany and Sweden also require participation in rehabilitation. Individuals there may be denied benefits for not participating in rehabilitation when it is recommended by the social insurance offices. Both these countries, as well as The Netherlands, also provide financial incentives to encourage participation in rehabilitation. For example, they provide supplementary benefits to cover rehabilitation-related expenses, such as transportation and housing costs and the cost of educational courses, books, and study aids.[23] Germany and Sweden also offer transitional work opportunities that enable people with disabilities to return to work part-time while earning disability benefits. These individuals can gradually increase their daily work hours, and thus their earnings, until they reach their maximum work capacity, with a corresponding decrease in benefits.[24] Similarly, The Netherlands provides a supplemental wage to beneficiaries who work, allowing them to earn a wage equal to their predisability earnings. The countries we studied also provide appropriate medical treatment and rehabilitation services to disabled individuals, and social insurance offices in Germany and Sweden may terminate the disability benefits of individuals who refuse to follow such medical recommendations.

In addition, Germany, Sweden, and The Netherlands provide financial assistance to employers for the purchase of workplace accommodations needed by disabled employees. For example, such assistance may pay for technical aids, special staff or personal assistants to help a disabled worker perform various work functions, or adaptations of the work environment to meet the special needs of a disabled worker. These countries also offer financial incentives for the employment of disabled individuals by subsidizing the wages that employers pay them. Wage subsidies are provided for a time-limited period of 3 to 4 years, with the amount of the subsidy declining each year.[25] Furthermore, in The Netherlands, employers have an additional incentive to assist employees in returning to work because the employers' contribu-

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[22] Educating employers about the size and extent of disability costs is an important element in motivating the employer to promote efforts to return claimants to work. For example, private insurers educate employers about the direct and indirect costs of not controlling lost time associated with disability, which was estimated by one insurer to be 4 to 6 percent of an employer's payroll.

[23] Germany and Sweden also promote disabled workers' efforts to return to work by providing them with financial assistance to purchase technical aids; workplace adaptations; and other work-related needs, such as personal assistants or payment of transportation costs. Additionally, Sweden provides grants to subsidize the purchase or modification of a vehicle if it is considered necessary for vocational training or for traveling to work.

[24] In Sweden, individuals with reduced work capacity may work full-time and still take part in the transitional work program.

[25] In Sweden, wage subsidies may be maintained at the same level and extended beyond the 4-year period if authorities determine it is appropriate.

tions to the disability insurance fund are partially determined by the number of their employees who became disabled in the prior year.

SSA's Return-to-Work Incentives Are More Limited Than Those Used in Other Systems

In contrast to the private sector and the countries we studied, SSA's disability programs do not require rehabilitation for beneficiaries, regardless of their capacity to work. Instead, the recently enacted Ticket to Work Act establishes a voluntary system that depends upon the beneficiary's motivation to pursue rehabilitation services. Thus, a beneficiary who could benefit from rehabilitation might not choose to seek such services. Further, in contrast to the private sector requirement that an individual work to his or her maximum capacity, the Social Security Act does not have such a requirement, which may act as a disincentive to work. In particular, beneficiaries with low earnings may find it more financially advantageous to periodically stop working, or work part-time and continue to receive disability payments, than to earn more than SSA's limit of $700 a month in countable income and lose all cash benefits after completing a trial work period. In recognition of the potential work disincentive from this all-or-nothing benefit structure, the Ticket To Work Act requires SSA to conduct demonstration projects under which benefits are reduced by $1 for each $2 of a beneficiary's earnings above a level determined by SSA.

SSA also differs from the private sector and the countries we studied in requiring medical treatment. The Social Security Act, along with SSA regulations, requires that benefits be denied when an individual fails, without good cause, to follow treatment prescribed by his or her physician.[26] However, if an applicant is not receiving treatment, SSA still assesses the applicant's eligibility for benefits and—if the applicant qualifies—awards benefits, even if the applicant would not qualify for benefits if treated. And unless medical treatment is prescribed, it is not a prerequisite for continued receipt of benefits once they have been awarded. Indeed, SSA found in 1999 that some beneficiaries with affective disorders—who constitute one of the fastest-growing groups on the DI rolls—were receiving no medical treatment. However, SSA has recently begun a demonstration project to determine whether providing access to the right medical treatment for beneficiaries with affective disorders will enable them to return to work.[27] Nevertheless, access to medical treatment may be limited for many DI applicants and beneficiaries.[28]

In contrast to the private sector and The Netherlands, SSA does not have the legal authority to use financial incentives to encourage employers to assist those with disabilities to return to work, thus limiting the agency's ability to influence employers. SSA, however, is currently funding demonstration projects in 12 states to develop ways to increase employment of DI beneficiaries and other people with disabilities and is looking to employers for help. For example, a goal of one state project is to solicit employer views on barriers to hiring DI beneficiaries and identify strategies for, and educate employers about, increasing employment opportunities for DI beneficiaries. In addition, the federal government provides tax incentives, and states may provide other assistance to employers to encourage them to return people with disabilities to work.[29]

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[26] For benefits to be denied, treatment must be prescribed by the individual's treating physician (the licensed physician who attends to an individual's medical needs). When an individual has no attending physician, the treating physician is the hospital or clinic where the individual goes for medical care.

[27] In addition, many beneficiaries with affective disorders were not being treated by mental health professionals. Yet, research suggests that as many as 60 percent of affective disorder cases can be controlled with appropriate treatment, and SSA believes that providing appropriate medical treatment to beneficiaries with affective disorders could help them return to work. Outside of the ongoing demonstration project, SSA does not routinely intervene in the delivery of medical services for its beneficiaries.

[28] DI applicants may not be covered by health insurance. In addition, new DI beneficiaries have a 24-month waiting period before Medicare eligibility. Moreover, Medicare generally does not cover the costs of certain treatment—such as prescription drugs—that may be necessary to improve functioning for a return to work.

[29] For example, small businesses may take an annual tax credit for a variety of costs incurred in providing employee accommodations, such as readers, sign language interpreters, and adaptive equipment Also, all businesses may take an annual deduction for the expense of removing physical, structural, and transportation barriers to disabled workers Further, state vocational rehabilitation agencies can provide various services to employers, such as rehabilitation engineering services for architectural barrier removal and work site modifications.

Other Systems Strive to use Appropriate Staff to Achieve Accurate Disability Decisions and Successful Return-to-Work Outcomes

Officials of each of the disability insurers and countries that we studied told us that they have developed techniques for using the right staff to assess eligibility for benefits and return those who can to work. Both the insurers and the countries have access to individuals with a range of skills and expertise. Moreover, officials told us that they selectively apply this expertise as appropriate to cost-effectively assess and enhance claimants' capacity to work. In contrast, SSA's DDS teams of medical and psychological consultants and disability examiners are hired and trained to assess eligibility of applicants to receive cash benefits rather than to enhance claimants' capacity to work. As a result, the staff of SSA and the DDSs do not have the expertise to carry out the role of returning disabled workers to productive employment.

Private Insurers Seek to Use Appropriate Staff to Assess Eligibility and Provide Return-to-Work Services

Each of the private disability insurers that we studied has access to multidisciplinary staff with a wide variety of skills and experience who can assess claimants' eligibility for benefits and provide needed return-to-work services to enhance the work capacity of claimants with severe impairments. The private insurers' core staff generally include claims managers, medical experts, vocational rehabilitation experts, and team supervisors.[30] The insurers explained that they set hiring standards to ensure that these multidisciplinary staff are highly qualified. Such qualifications are particularly important because assessments of benefit eligibility and work capacity can involve a significant amount of professional judgment when, for example, a disability cannot be objectively verified on the basis of medical tests or procedures or clinical examinations alone.[31] Table 4 describes the responsibilities of this core staff of experts employed by private disability insurers, as well as its general qualifications and training.

Table 4: Responsibilities and Qualifications of Staff Employed by Disability Insurers to Assess and Enhance a Claimant's Work Potential

Type of staff	Responsibilities	Qualifications and training
Claims managers	• Determine disability benefit eligibility.. • Develop, implement, and monitor an individualized claim management strategy.. • Serve as primary contact for the claimant and the claimant's employer.. • Focus on facilitating the claimant's timely, safe return to work.. • Coordinate the use of expert resources..	One insurer gives preference to those with a college degree and requires insurance claims experience and specialized training and education. Another requires a college degree, a passing grade on an insurer-sponsored test, and specialized training and coaching..
Medical and related experts [a]	• Collect and evaluate medical and functional information about the claimant to assist in the eligibility assessment and help to ensure that claimants receive the appropriate medical care to enable them to return to work.. • At one insurer, physicians also help train company staff..	Medical staff include registered nurses with case management or disability-related experience and experts in behavioral and mental issues, such as psychologists, experienced psychiatric nurses, and licensed social workers. Two insurers also employ board-certified physicians in various specialties.[b].

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[30] The insurers also employ disability income specialists to assist claimants in applying for DI benefits.

[31] According to one insurer, disabilities with subjective diagnoses include certain types of mental illness, fibromyalgia, chronic pain (often back pain), and chronic fatigue syndrome.

Type of staff	Responsibilities	Qualifications and training
Vocational rehabilitation experts	• Help assess the claimant's ability to work.. • Help overcome work limitations by identifying needed assistance, such as assistive devices and additional training, and ensuring that it is provided..	Rehabilitation experts are masters-level vocational rehabilitation counselors. In addition, one insurer requires board-certification and 5 years of experience..
Supervisors	• Provide oversight, mentoring, and training..	One insurer gives preference to those with a college degree and requires 3 years' disability experience, some management experience, and specialized training. Another insurer require's a college degree, more than 12 years' disability claims experience, and completion of courses leading to a professional designation..

[a] In one company, the medical expert is an employee of a company subsidiary but is often colocated with the insurers' employees.

[b] One company, for example, employs 85 part-and full-time physicians, including psychiatrists, doctors of internal medicine, orthopedists, family practice physicians, cardiologists, doctors of occupational medicine, and neurologists.

The disability insurers we reviewed use various strategies for organizing their staff to focus on return to work, with teams organized to manage claims associated either with a specific impairment type or with a specific employer (that is, the group disability insurance policyholder). One insurer organizes its staff by the claimant's impairment type—for example, cardiac/respiratory, orthopedic, or general medical—to develop in-depth staff expertise in the medical treatments and accommodations targeted at overcoming the work limitations associated with a particular impairment. The other two insurers organize their staff by the claimant's employer, because they believe that this enables them to better assess a claimant's job-specific work limitations and pursue workplace accommodations, including alternative job arrangements, to eliminate these limit ations.[32] Regardless of the overall type of staff organization, each of the insurers facilitates the interaction of its core staff—claims managers, medical experts, and vocational experts—by pulling these experts together into small, multidisciplinary teams responsible for managing claims. Additionally, one insurer engenders team interaction by physically colocating core team members in a single working area.

The disability insurers expand their core staff through agreements or contracts with subsidiaries or other companies to provide a wide array of needed experts. These experts—deployed both at the insurer's work site and in the field—provide specialized services to support the eligibility assessment process and to help return claimants to work. For instance, each insurer we studied contracts with medical experts beyond its core employee staff—such as physicians, psychologists, psychiatrists, nurses, and physical therapists—to help test and evaluate the claimant's medical condition and level of functioning. In addition, the insurers contract with vocational rehabilitation counselors and service providers for various vocational services, such as training, employment services, and vocational testing.[33]

All of the private insurers we examined told us that they strive to apply the appropriate type and intensity of staff resources to cost-effectively return to work claimants with work capacity. The insurers described various techniques that they use to route claims to the appropriate claims management staff, which include separating (or "triaging") claimants with work potential and directing their claims to staff with the appropriate expertise. According to one insurer, the critical factor in increasing return-to-work rates and, at the same time, reducing overall disability

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[32] All three insurers, however, have behavioral care specialists specifically for managing psychiatric claims.

[33] Two insurers also contract with investigators and surveillance personnel to investigate potential inconsistencies between the claimant's statements and actual activities. One company employs field-based investigators who verify claimant information and assess the conformance of the claim to observed claimant activities. These investigators usually have prior investigative experience and receive ongoing training on current medical issues and other professional education.

costs is proper triaging of claims. In general, the private insurers separate claims by those who are likely to return to work and those who are not expected to return to work. The insurers told us that they assign the type and intensity of staff necessary to manage claims of people who are likely to return to work on the basis of the particular needs and complexity of the specific case. This selective staff assignment is shown in Table 5.

Table 5: Triage of Claims and Illustrations of Selective Staff Assignment for Claims Management

Triage category	Staff assigned	Types of return-to-work services provided
Likely to return to work		
• Condition requires medical assistance and more than 1 year to stabilize medically.	Medical specialist	• Recommend improvements in treatment plan to treating physician.. • Refer claimant for more specialized or appropriate medical services.. • Ensure frequency of treatment meets standards for condition..
• Condition requires less than a year to stabilize.	Claims manager	• Monitor medical condition. • Maintain contact with employer and physician to ensure return to work.. • Obtain input from medical and vocational specialists as needed..
• Condition is stabilized and claimant needs rehabilitation or job accommodation to return to work.	Multidisciplinary team including • Vocational expert • Medical expert • Claims specialist • Specialists as needed	Evaluate claimant's functional abilities for work.. • Customize return-to-work plan. • Arrange for needed return-to-work services.. • Monitor progress against expected return-to-work date..
Unlikely to return to work		
• Claimant is determined unable to return to work.	Claims manager	• Review medical condition and level of functioning regularly..

As shown in Table 5, claimants expected to need medical assistance, such as those requiring more than a year for medical stabilization, are likely to receive an intensive medical claims management strategy. A medical strategy involves, for example, ensuring that the claimant receives appropriate medical treatment. Claimants who need less than a year to stabilize medically are managed much less intensively. For these claims, a claims manager primarily monitors the claimant's medical condition to assess whether the claimant has stabilized sufficiently medically to begin vocational rehabilitation, if appropriate. Alternatively, claimants with a more stable, albeit serious, medical condition who are expected to need vocational rehabilitation, job accommodations, or both to return to work might warrant an intensive vocational strategy. The private disability insurers generally apply their most resource-intensive, and therefore most expensive, multidisciplinary team approach to these claimants. Working closely with the employer and the attending physician, the team actively pursues return-to-work opportunities for claimants with work potential.

Finally, claimants who are likely not to return to work (or "stable and mature" claims) are generally managed using a minimum level of resources, with a single claims manager responsible for regularly reviewing a claimant's medical condition and level of functioning.[34] The managers of these claims carry much larger caseloads than managers of claims that receive an intensive vocational strategy. For example, one insurer's average claims manager's caseload for these stable and mature claims is about 2,200 claims, compared with an average caseload of 80 claims in the same company for claims managed more actively.

Regardless of the category into which a claim is placed, the claims manager is responsible for identifying the appropriate experts and involving them in the management of the claim as an essential element of developing and implementing a cus-

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[34] One of the insurers reviewed cases of claimants who were not expected to recover medically and to remain work-disabled for the duration of the policy every 12 to 36 months.

tomized claims management strategy. The claims manager may informally use the assistance of experts or hold an interdisciplinary team meeting, including clinical and rehabilitation experts, to obtain advice on developing the claims management strategy and help in determining which specialized experts need to be deployed to manage the claim. Further, if the claims manager refers the claim to a specialist, that specialist may determine that additional expertise is required as well. But the insurers told us that they escalate a claim to staff with progressively more training and specialization, and thus higher cost, only if needed to resolve increasingly complex claims management issues. To ensure that staff are utilized cost-effectively, the private insurers said that they compute the return-on-investment accruing from investing in return-to-work resources for a particular claimant.

Other Countries Also Selectively Apply Specialized Staff to Return Claimants to Work

Other countries' social insurance offices also call upon various specialists, such as physicians, vocational experts, and psychologists, in the process of evaluating and enhancing a person's ability to work. If the needed expertise is unavailable in-house, the social insurance agency may purchase the necessary services from other organizations. The expertise applied is decided on a case-by-case basis depending on the case's complexity. For example, the social insurance offices in Sweden are responsible for working with the regional and local employment and rehabilitation offices to determine the appropriate types of rehabilitation services for a claimant. Medical assessments of work capacity in Germany and The Netherlands may also be supplemented by advice from vocational or other experts.

Social insurance offices in Germany and Sweden select the appropriate staffing and services to dedicate to particular cases on the basis of the likelihood of a successful outcome. The staff assignments made and the return-to-work actions taken by the social insurance offices depend on an assessment of each applicant's potential for returning to work. In complex cases of potential long-term disability, more extensive evaluations involving psychologists and vocational specialists may be conducted to assess the work capacity of an applicant. In Germany, medical rehabilitation is provided before an applicant's condition is assessed to determine whether vocational rehabilitation is necessary. Only if successful rehabilitation seems unlikely, or if rehabilitation has been provided without success, will the social insurance offices in Germany and Sweden typically grant the person long-term disability benefits. But, in contrast with the private insurers we examined, once an individual is granted long-term benefits and therefore considered too severely disabled to benefit from services, the social insurance offices rarely reassess the person's return-to-work potential and generally do not offer any return-to-work services or benefits.

The Netherlands also dedicates resources to evaluating return-to-work potential and providing rehabilitation services on the basis of the particular return-to-work potential and needs of individuals. But unlike Germany and Sweden, The Netherlands offers vocational rehabilitation to disability beneficiaries who choose to pursue a work goal even after they are granted long-term benefits.

SSA Staff Are Not Focused on Returning Claimants to Work

In contrast to the private insurers and the foreign social insurance offices, the focus of DDS staff who make determinations for SSA is to assess the eligibility of applicants to receive cash benefits. The DDSs do not assess what is needed for an individual to return to work or help an individual with work capacity to return to work. Neither do they ensure that DI applicants or beneficiaries receive medical treatment. To make initial benefit eligibility determinations, DDSs rely on teams comprising a disability examiner and a medical or psychological consultant. Since the DDS teams do not carry out the variety of roles related to return to work, they do not include staff with the vocational skills and expertise who are incorporated in teams used by the private and foreign disability systems. However, under the Ticket to Work Act, beneficiaries who voluntarily choose to attempt a return to work may tap into vocational expertise outside SSA that could provide the additional services, expertise, and supports to help them in their effort, but only after benefit award.

Moreover, while SSA funds the state DDSs, SSA's regulations delegate authority to each DDS to set hiring policies and determine how to organize staff charged with carrying out the eligibility assessment function. Consequently, in contrast to the standardized hiring practices used by the private insurers, considerable variation can exist among the states in the requisite qualifications for hiring key staff. For example, among the DDSs, the required educational background for disability examiners ranges from a high school diploma to some college to a college degree.

In addition, SSA separates beneficiaries into groups according to their likelihood of medical improvement for the purpose of assessing continuing eligibility for benefits, in accordance with law and regulation. The agency invests greater staff resources in reviewing beneficiaries who are most likely to medically improve than in reviewing those with less likelihood of improvement. In contrast to practices of the private insurers and foreign social insurance offices, SSA uses its resources to determine continuing eligibility on the basis of medical improvement and does not separately evaluate whether a beneficiary has the potential to return to work[35]

CONCLUDING OBSERVATIONS

Return-to-work practices used in the U.S. private sector and in other countries reflect the understanding that people with disabilities can and do return to work. In 1996, we recommended that SSA place greater priority on helping disabled beneficiaries return to work. We also recommended that the agency develop a comprehensive strategy for this effort. While SSA has begun to focus more on return to work, it has yet to adopt a comprehensive strategy for implementing this new approach. For example, it has yet to integrate its return-to-work efforts with its initiatives to improve the disability decision-making process. In short, we continue to believe SSA is still not placing enough priority on identifying and enhancing the work potential of its beneficiaries with disabilities. We also continue to believe that SSA could do this more effectively without jeopardizing the availability of benefits for people who cannot work.

We acknowledge that limited data exist on the cost-effectiveness of the return-to-work approaches used in the other systems we examined. In addition, SSA may face greater difficulty in returning some of its beneficiaries to work than private sector insurers do, since DI covers a broader population than the private insurers. Moreover, significant differences exist between SSA's disability programs and those of private sector disability insurers and social insurance programs in other countries. Some of these differences can be attributed to the particular laws and regulations governing the programs. Although SSA would face substantial constraints and challenges in applying the return-to-work practices of other programs, we believe 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.

The Congress recognized the need to focus more on return to work when it passed the Ticket to Work Act, which authorizes and requires SSA to conduct return-to-work demonstration programs. Program managers and policymakers will be able to learn from the experiences of these demonstrations, and they can also draw upon the approaches of the other systems to further strengthen and enhance a comprehensive return-to-work focus. Adopting such a focus will, however, require fundamental changes to the underlying philosophy and direction of the disability programs, including the determination of disability. Policymakers will need to carefully weigh the implications of such changes, but compelling reasons exist to try new approaches. Current estimates project that the DI trust fund will become insolvent in 2023. This financial strain, along with advances in technology and medicine that can help individuals improve their productive potential, provides ample reason for examining how practices from other systems could be applied to improve SSA's return-to-work outcomes.

Mr. Chairman, this concludes my prepared statement. I would be pleased to respond to any questions you or Members of the Subcommittee may have.

GAO CONTACT AND STAFF ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Barbara D. Bovbjerg at (202) 512–7215. Carol Dawn Petersen, Barbara H. Bordelon, Kelsey M. Bright, Julie M. DeVault, William E. Hutchinson, and Mark Trapani also made key contributions to this testimony.

RELATED GAO PRODUCTS

Social Security Disability Insurance: Raising the Substantial Gainful Activity Level for the Blind (GAO/T–HEHS–00–82, Mar. 23, 2000).

Social Security Disability: Multiple Factors Affect Return to Work (GAO/T–HEHS–99–82, Mar. 11, 1999).

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[35] The law contains several exceptions that allow benefits to be terminated even when a person's medical condition has not improved. For example, benefits may be disallowed when new or improved diagnostic techniques reveal that the impairment is less disabling than originally determined.

Social Security Disability Insurance: Factors Affecting Beneficiaries' Return to Work (GAO/T–HEHS–98–230, July 29, 1998).

Social Security Disability Insurance: Multiple Factors Affect Beneficiaries' Ability to Return to Work (GAO/HEHS–98–39, Jan. 12, 1998).

Social Security Disability: Improving Return-to-Work Outcomes Important, but Trade-Offs and Challenges Exist (GAO/T–HEHS–97–186, July 23, 1997).

Social Security: Disability Programs Lag in Promoting Return to Work (GAO/HEHS–97–46, Mar. 17, 1997).

1SSA 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).

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Chairman SHAW. Thank you, Ms. Bovbjerg. Ms. Petersen, do you have something to add to the remarks?

Ms. PETERSEN. No, I do not.

Chairman SHAW. Mr. Matsui.

Mr. MATSUI. Thank you, Mr. Chairman. Thank you very much, Barbara, for your testimony. You indicated in your actual written report that it is difficult to ascertain the cost that is expended on the various programs that you just mentioned for the disabled in terms of job retraining programs and obviously others. Is that part of your conclusion that there is not a lot of transparency in what the expenditures are in some of the European and other countries?

Ms. BOVBJERG. Well, we could not get cost information from the other countries and frankly, were we to get that, it would be difficult to know how we could translate it into a projection for SSA if SSA were to do these things. We did get cost information from private insurers and, as you might expect, they told us that the cost ranged depending on the intensity of the intervention. If a claimant was assessed as being very unlikely to be able to work it cost them $100 a claim.

On the other end of the spectrum, if they are working with someone who they think really has a very good shot at going back to their job, they might spend $2,300 a claim. So there is a wide variation and it is unclear when you look at it in the aggregate how this would translate to the Social Security system because as you have pointed out there are some differences in client populations.

Mr. MATSUI. So for the foreign countries it is just difficult to get information from them in terms of what the actual overall cost is in terms of comparison with the U.S., our Social Security system, unemployment system, and obviously other aspects of the Federal Government, state government in terms of cost that goes into it. Then on the private side they could give you the numbers but because each individual case differs so much it is hard to make an evaluation as to the effectiveness of the programs. Is that kind of what you are concluding or part of the summary?

Ms. BOVBJERG. It was hard to know whether those costs predict what SSA would experience if they were to do similar things. I think in terms of effectiveness the private sector was uniform in saying that these measures they took were not only effective but they were cost-effective or they wouldn't do them.

Mr. MATSUI. OK, good. Have you in your studies brought together unemployment insurance, the health policies, you know, health care coverage, and rehabilitation services, did you use all those different aspects that are outside of the Social Security Administration and compare it to the private sector plus the foreign countries?

Ms. BOVBJERG. Well, when we looked at private sector and foreign countries, we noticed that they did take quite an integrated approach—

Mr. MATSUI. Right.

Ms. BOVBJERG [continuing]. In their return-to-work strategy. That they do work with medical providers. In the private sector they are often working with people who have health insurance and if they are unable to get access to the kind of treatment that the insurer thinks they need some, insurers will help assure that that happens. That would be harder for the Social Security Administration. We have a different system. And in other countries it is much more integrated, with fewer separate agencies.

Mr. MATSUI. It is hard to make comparisons. What about the earlier intervention by some of these other countries as well? I mean obviously there is Sweden and a few others, they move very quickly when it comes to the disabled compared to in our country, is that correct as well?

Ms. BOVBJERG. Private insurers and the other countries all move quickly. They intervene very early. They assess work capacity, work potential right away. After that assessment they then work with the claimants who have potential to try to see what kinds of support they need and to try to plan an individualized approach for each of them.

In Social Security the claimant goes through the process, which may be lengthy as you know, for determining eligibility and it is only at that point now under the Ticket to Work Act that they will be offered vocational rehabilitation services, so it is quite a different approach.

Mr. MATSUI. One of the problems that I am having is I think we need to re-examine all of this. I think it really has to be done but in a very comprehensive way. And I am afraid—this Subcommittee can only take so much and then you have labor and education, you have other Committees that are involved in this as well.

And somehow we have to find a way to integrate this because I think the next major step is obviously to provide full services and quick early services, early intervention, and obviously universal coverage indefinitely while the need is there, but, you know, how do we go about that? And the comparisons are very difficult now because we don't have that unified approach in this country.

Ms. BOVBJERG. But I think that what we tried to point out in our statement is that these other systems offer ideas to draw upon. They are doing these things. They think they are effective. It becomes up to us in the Federal Government to think about how do we select the things that are going to work best for us and create a comprehensive strategy?

Mr. MATSUI. Right. And I guess what I want to make sure is that we get the overall cost comparisons so that we don't mislead ourselves to think that, well, we can do this with the same dollars that we have or the same resources that we have and expect the same results because I don't know if that is necessarily the case. And your studies cannot give me, and it is not your fault, but your studies cannot give me any assurance that we are moving in that direction because you can't get information from the foreign countries and obviously the private insurers are a much different situation.

And somehow we need to—and again I am suggesting that the next step may be to try to get a more comprehensive idea of what the overall cost is in these other studies that are being done and compare them to ours and then see how we can reallocate our resources but also find additional resources should they become necessary.

Ms. BOVBJERG. And to think about what we need, what fits in with our policy priorities for disability.

Mr. MATSUI. Exactly. Thank you.

Chairman SHAW. Barbara, to follow up on what Mr. Matsui was talking about, I want to talk about the fragmented services across many governmental agencies. I assume that other countries have the same problem and perhaps even in the private sector. How would you compare that as far as the expeditious nature of the handling of these to go ahead and process all these things together so that the disabled get the help that they need, how can that be rearranged or arranged?

Ms. BOVBJERG. Carol knows a great deal about how some of these things work in foreign countries.

Ms. PETERSEN. Well, in the foreign countries, in some instances, services will be provided within an agency and in other instances there may be services that they need to draw upon from another agency. For example, in Sweden you have a social insurance board that handles everything from sickness benefits to long-term disability but when it comes to assessing work capacity, that is done in the labor ministry and in the agencies that are run under that ministry.

And in that country and similarly in Germany there seems to be very well-developed interagency coordination and cooperation. The agencies work very closely with one another. They are all operating with the same mission and goal to return people to work—for those that can—and so there are strong linkages between the agencies. The private sector relies on contractual agreements with other firms to provide it with services that it does not provide in-house.

Chairman SHAW. Contrast that with our government services.

Ms. PETERSEN. I am sorry?

Chairman SHAW. Contrast that with our government delivery system.

Ms. PETERSEN. Our Federal agencies could contract for some of these services as well but I think they would need to put them together.

Chairman SHAW. Contrast it with existing—with the way we do it now.

Ms. PETERSEN. Oh. Again, you would need to examine what type of new system you would want, what elements you wanted in place and then see whether the existing agencies provide those services or could provide those services or whether you would want to contract some of that with the private sector. This would have to be part of a comprehensive strategy that would be developed.

Chairman SHAW. What I would like to see is sort of walk us through the process that somebody with a disability goes through when they come in trying to seek some assistance. Maybe that would be helpful to us.

Ms. BOVBJERG. To seek return to work assistance or to the application process?

Chairman SHAW. The whole thing, just very, very briefly.

Ms. BOVBJERG. Well, when someone comes to SSA and says that they are disabled the first thing SSA has to do is determine whether they are eligible for the program, you know, are they a citizen, do they have 20 of the last 40 quarters in covered employment. Once they do that the person's disability claim is then referred to the state-run Disability Determination Service, under contract with Social Security and that is where the claim is evaluated for whether it meets SSA's standards for disability.

At this point they were looking at what the nature of the impairment is, does it fit with their medical listings and if the person has been working. The person cannot be able to earn above substantial gainful activity. And at various points in the process maybe Social Security tells them, yes, you are disabled and they put them on the rolls. At that point under Ticket to Work, they can be offered vocational rehabilitation services but at no point is the person evaluated for work capacity.

We did a report a couple of years ago where we talked to about 70 DI recipients who had returned to work and we asked them what were the things that were most important to them, why could they return to work when maybe other people with similar disabilities couldn't do that. Clearly personal motivation is a factor. They talked about how they couldn't possibly have done it without the support of their family, their friends, their employer, without medical insurance, without the support of their physician.

And virtually everyone said they didn't get much support from Social Security but that these supports were really important and it would have been helpful to have gotten more from the Social Security Administration. So I think if you are someone who wants to return to work, you can avail yourself of the ticket to get vocational rehabilitation but you are not getting the kind of help that I think we see in some of these other systems, where the program really focuses on individual needs and capacity.

Chairman SHAW. How would that affect cost containment or cost efficiency? Are we utilizing our dollars to our best ability?

Ms. BOVBJERG. I think that if there are people who can work and who want to work who are on the disability rolls and we are not helping them work, then we are not spending that money wisely. I will say that I think as Mr. Matsui points out, this is not necessarily a small expenditure. We don't know what it would cost to try to do some of these earlier interventions. That is something that I think we might know more about once the Social Security Administration embarks on their demonstration projects that are authorized under Ticket to Work.

They are considering an early intervention demonstration which under a mandate under Ticket to Work we will be looking at once they start it and that may provide some of the information that we would need to make these decisions.

Chairman SHAW. Thank you. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. This is a very interesting hearing because as Members of Congress we become involved trying to help constituents qualify, in essence, for Social Security disability benefits and we become kind of with tunnel vision just looking to get them on the program, you know, if they are qualified and make sure they don't slip through the cracks and we often don't become involved in their efforts to return to work so this is a very, I think, worthwhile hearing and subject for us to get into.

You mentioned, Ms. Bovbjerg, that an individual's motivation is obviously important in whether he or she returns to work. I am wondering if in your analysis of other countries' programs or even in private sector programs what incentives you found in those programs for either the individuals or maybe the individual's former employer to get that individual back to work.

Ms. BOVBJERG. The incentives that insurers provide were among the most important things that we thought we saw. Insurers begin working with claimants really early in the process to make sure that they get vocational rehabilitation. Insurers also review the medical treatment that they are getting, and make sure that they get the right medical treatment, help them with a second opinion, another physician, whatever is necessary.

In terms of employers, the private insurers have the ability to set the premium that the employer pays, so they are almost uniquely able to create some direct incentives. They can set premiums to be lower if the employer is re-employing disabled workers, and they can subsidize the wages of the disabled worker, and that is also true in the other countries.

There are a number of things that are done both on the employer's side and on the individual's side but I did want to make the comment about motivation, that what we see is that motivation is higher the sooner that the disability insurer or the agency works with the claimant; the longer the claimant is not involved in a return-to-work strategy or is not getting vocational rehabilitation, the less motivation they have.

Mr. MCCRERY. And you mentioned the pilot programs that SSA can do under the Ticket to Work Act. Do you think that one or more of those pilot programs will include this early intervention? Is there anything that we can do, Mr. Chairman, as a Committee to encourage SSA to include those types of activities in their pilot programs?

Ms. BOVBJERG. I believe that SSA is considering that. We are hopeful that they will look at early intervention because that would be another source of information and experience.

Mr. MCCRERY. Yeah, I mean the evidence that you brought to us certainly seems to indicate without any doubt that early intervention is very important but Mr. Matsui and the Chairman have both raised the question of cost and we don't have any answers for that so it seems to me that if we know it is effective in getting people back to work but we don't know the cost, we ought to encourage SSA to utilize some of the money under Ticket to Work that they are authorized to use to discover what in fact the costs are and the benefits are of early intervention.

It is a rather novel concept in this country, as you know, for SSA to get involved with rehab before the person is even qualified for benefits. I mean that is—and sometimes as you know it takes months and even years for somebody to qualify for disability benefits so there could be a lot of intervention in that interim but for us to pay for early intervention before the person is even qualified is a novel concept so I think we need some evidence as to the effectiveness of that and whether it would in the end or in the long run actually save us money or at least break even. Thank you, Mr. Chairman.

Chairman SHAW. Yes. Mr. Matsui. Mr. Weller, do you have any questions at this point? Mr. Matsui.

Mr. MATSUI. Thank you, Mr. Chairman. I just have a few more questions and I am sorry I didn't get to them in the first part of when I asked you. In terms of the private insurance side of it, it is hard to make comparisons I would imagine because private insurers can actually, and correct me if I am wrong, but can pick and choose the various industries in which they seek to make coverage so they don't have to get, for example, mine workers if they choose not to but they could go to lawyers, for example, and so they have a little more opportunity, I don't want to use the word cherry pick, but at least selectively pick cases in which it might be a little easier. So your studies are based upon that first premise, is that correct?

Ms. BOVBJERG. In talking to private insurers, we really talked about people with severe disabilities in their group so I don't want you to think we are talking about returning people with broken legs to work.

Mr. MATSUI. No, no, I am not saying that, but I am just saying that overall they can survive and make a profit because their universe is one in which they decide who they are going to cover.

Ms. BOVBJERG. Yes. That is correct. And I think a big difference or the most significant difference between the caseload in the private sector and the caseload under DI is mental impairment.

Mr. MATSUI. That is why to me it is a difficult thing to make comparisons because if I can select the people I want to cover, I could probably pick folks that I—you know, it would be severe disabilities in some cases but on the other hand, you know, just in terms of the overall efficiency of what I can do is probably much better than Social Security which has to take all comers. That is the only thing I am suggesting.

Ms. BOVBJERG. Although I would think that because there is this triaging concept in the private sector that even with a different population you wouldn't expend significant return-to-work resources on claimants who were judged unable to work.

Mr. MATSUI. And the second point I would like to just explore with you is that in your document you indicate that of those that are insured and receiving benefits from the private sector two-thirds of those same people receive Social Security disability benefits as well. And as a result of that it is really hard then to make a comparison as to how they are getting along, these people that are disabled, because they still are receiving SSI, Social Security disability benefits, is that correct?

Ms. BOVBJERG. Yes, that is right.

Mr. MATSUI. And so it makes it difficult then to—you know, quality of life issues. Is that correct?

Ms. BOVBJERG. It is difficult.

Ms. PETERSEN. Well, I was going to add that because there is such a high proportion of people on the private rolls, that also qualify for DI that we felt that helped us in some ways make comparisons between the two insurers, the public SSA and the private sector, because at least for a very large portion of people the degree of impairment severity was comparable, although as you point out there are some differences in terms of occupations and the types of impairments. The biggest one, as you mentioned, is that the private insurers do not have the same proportion of people with mental impairments.

Mr. MATSUI. Thank you. Thank you, Chairman.

Mr. WELLER. Thank you, Mr. Chairman. I got a couple questions I would like to direct to Ms. Bovbjerg. In your testimony you stated that you believe that SSA should intervene earlier to foster a greater emphasis on assisting disabled applicants and beneficiaries in returning to the work force. How do you believe this should work? What would you recommend?

Ms. BOVBJERG. Our recommendation for SSA is actually a little bit of a step back from that; it is to develop a comprehensive strategy for return-to-work. Part of that might include earlier intervention because, as Mr. McCrery mentioned, earlier action is really so central to what is done in these other systems and the people we spoke to seem to believe that that is crucial to their success.

But I think that SSA really needs to consider how they would integrate this within their current policies—what would be most effective, what would have to change, how does it work with the process that is now in place or with a redesigned disability process. So I would be very reluctant to recommend just taking what one of the private sector companies does and dropping it into SSA because I think it is much more complex than that. And as we have discussed earlier, we are not at all clear on what these things would cost and what the benefits would be.

Mr. WELLER. Also in looking at your testimony you of course focused attention on the less stringent definition of disability that was used initially by private sector companies. How would it work if SSA departed from its current all or nothing definition disability and shifted it to recognize the possibility of improvement in the capacity to work through the provisions of supports and services such as retraining?

Ms. BOVBJERG. That is one way that other systems address early intervention. They have this transitional period where they help people return to work before a more rigorous definition of disability is applied. That would require a change in law and that would be something that you would want to look at in light of this comprehensive strategy, and you might want to consider things that could be done within current law first. I just wouldn't think about these things in isolation.

Mr. WELLER. Ms. Petersen, do you have anything to add?

Ms. PETERSEN. Well, it is true that the private sector and the other countries start off with a less restrictive definition and they move to the more restrictive definition but even when they are assessing their applicants against the more restrictive definition their determination process looks very different from that of SSA.

Again, SSA's process of determination focuses on an applicant's ability to prove incapacity to work, to focus on the degree of impairment severity, whereas the private sector's and the other countries' determination processes focus on an approach to determine what type of work capacity exists, the potential that the claimant has to return to work, and what types of supports and accommodations and other types of assistance, whether it be medical or vocational, could be put in place to facilitate a person returning to the workplace. So even under more restrictive definitions, the process looks very, very different.

Mr. WELLER. OK, thank you. Thank you, Mr. Chairman.

Chairman SHAW. Thank you, and I thank the panel. Thank you very much.

Ms. BOVBJERG. Thank you, Mr. Chairman.

Chairman SHAW. We now have a rather large panel, Dr. Edward Berkowitz, Professor and Chair, Department of History at George Washington University; Donald Lollar, Chief, Disability and Health Branch, National Center for Environmental Health, Center for Disease Control and Prevention, Department of Health and Human Services, from Atlanta, Georgia; Richard Baron, who is the Project Director of the Pew Fund for Health and Human Services for Vulnerable Adults, OMG Center for Collaborative Learning in Philadelphia, Pennsylvania; Dr. Richard Burkhauser, Sarah Gibson Blanding Professor of Policy Analysis and Chair of the Department of Policy Analysis and Management, Cornell University; Ralph Mohney, who is the Senior Vice President, Customer Care Center; and Tony Young, who is Co-Chair, Social Security Taskforce, Consortium for Citizens with Disabilities and Director of governmental Affairs, NISH, Vienna, Virginia.

Welcome, gentlemen. We have each of your full statements, which will be made a part of the record and you may proceed as you see fit. Dr. Berkowitz.

STATEMENT OF EDWARD D. BERKOWITZ, PH.D., PROFESSOR AND CHAIR, DEPARTMENT OF HISTORY, GEORGE WASHINGTON UNIVERSITY

Mr. BERKOWITZ. Thank you. I believe that history provides the best means of explaining why our disability programs have the structures that they do. Once we know why something was done in the first place, we can begin to decide whether it is worth changing. Planners in the Social Security Administration wrote a tough definition of disability into their proposals so as to distinguish sharply between unemployment and disability but they knew that if the program were administered in too severe a manner then the courts and the Congress would force Federal officials to admit more people to the rolls.

They realized that disability was an elastic concept. By 1949 the opponents of SSDI had begun to argue that people with disabilities should receive rehabilitation rather than a pension that allowed them to retire from the labor force for life. Conferees considering disability legislation in 1952 came up with the idea of letting the states rather than the Federal Government make the initial determinations of disability, a feature of the program that survives to the present day and which can only be explained by understanding the historical context in which it arose.

In 1954 officials in the Eisenhower administration argued that rehabilitation should be expanded rather than passing a disability insurance program. They wanted to limit tickets out of the labor force and instead encourage people to enter the labor force. The Secretary of Health, Education and Welfare recommended, for example, that Social Security trust fund money be used to provide rehabilitation services but not cash benefits to insured people who became disabled.

Congress passed SSDI in 1956 but in its formative years between 1956 and 1960 SSDI paid benefits only to workers who were 50 years of age or older. That meant that the linkage between applicants for disability benefits and vocational rehabilitation never took hold since older individuals were not good candidates for rehabilitation. The SSDI program became, like Social Security itself, a retirement program. SSI arose as part of a discussion of welfare reform that began in 1969.

But policy makers failed to anticipate important trends. Few people thought to ask what effect the new law would have on disability. Instead, Congress reflexively assigned welfare beneficiaries to the administrative apparatus already established to administer SSDI benefits. In thinking about SSI, policy makers envisioned that it would apply mainly to the elderly who had traditionally dominated the adult welfare categories. At the beginning, people with disabilities made up less than half of the SSI caseload.

But when Congress was considering SSI the incidence of disability was growing at a unprecedented rate; hence, circumstances that could have been foreseen favored a rise in the disability categories of SSI. Armed with that knowledge, policy makers might have designed SSI differently. As things turned out, adults and children who were either blind or disabled represented nearly two-thirds of the SSI caseload by 1994.

That meant that just as disability was grafted onto a retirement program for the elderly in the SSDI program so it was added to a welfare measure that Congress intended primarily as a means of serving the elderly. Another anomaly in SSI was that the entire discussion focused on the so-called adult welfare categories but many SSI recipients turned out to be children. That meant that a disability determination system intended to serve people who had been in the labor force was forced to handle many claims for children.

It shouldn't be surprising that a disability system developed in the thirties and created during the political conflicts of the fifties and seventies should expenience strains after nearly a half century of operation, but as we modernize the system we might want to keep in mind that things seldom work out as planned. If we restrict benefits, for example, we have to be careful to avoid the situation that occurred after 1981 in which policy makers sought to tighten the rolls but ended up greatly increasing the size of the rolls.

As we modernize, we shouldn't be blinded by false hopes as I think have arisen in the implementation of the Americans with Disabilities Act. The ADA has not led to the substitution of jobs and independent living for cash disability benefits despite the hopes of those who lobbied for the law's creation. In the field of welfare, we should remember that the SSI Program was itself an attempt to modernize the system but because policy makers failed to spot emerging trends the new program developed its own problems.

So I would end by saying that sometimes the only explanation for a particular policy is historical but even if we know that we are not ourselves immune from historical forces. Thank you.

[The prepared statement follows:]

Statement of Edward D. Berkowitz, Ph.D., Professor and Chair, Department of History, George Washington University

I am Edward Berkowitz, and I am the chair of the Department of History at George Washington University. Much of my research has focused on disability policy and on Social Security policy.

My job today consists of providing a historical overview of Social Security Disability Insurance and Supplemental Security Income. My hope is that by observing these programs with a historical eye, members of this committee, who have inherited the present system, will be able to see just why our disability income policy has the structure that it does. Armed with this information, policymakers can begin to decide which aspects of the system are worth changing. In the process of making those changes, I would hope that Congressmen would attempt to spot emerging trends of the sort that have so often have caused outcomes to diverge from expectations in the field of disability policy. Because this hearing marks a step in that direction, I applaud its intent.

Social Security Disability Insurance

Although Social Security Disability Insurance did not become law until July, 1956, a long period of discussion both in the executive agencies and in Congress preceded its passage. Planners in the Social Security Administration began their consideration of this measure in 1936. They devised a program that they felt could withstand the pressures of the depression. In particular, they wrote a tough definition of disability into their proposals so as to distinguish sharply between unemployment and disability. Instead of adopting a definition similar to the ones in the existing workers' compensation and veterans pension laws, they chose to define disability as "an impairment of mind or body which continuously renders it impossible for the disabled person to follow any substantial gainful occupation," and was likely to last for "the rest of a person's life."

Even with this tough definition, which is similar to the one in the present law, many doubted the ability of federal officials to administer a disability program. As an actuary who served on the 1938 Social Security Advisory Council put it, "You will have workers like those in the dust bowl area, people who have migrated to California and elsewhere, who perhaps have not worked in a year or two, who will imagine they are disabled." The actuary warned that unless a highly qualified medical staff examined each applicant, the cost of the program would be higher than "anything that can be forecast."

Although the Social Security officials sought a strict definition of disability, they knew that, if the program were administered in too severe a manner, then the courts and the Congress would act to make federal officials admit more people to the disability rolls. One of the principal Social Security researchers thought of disability as an elastic concept. "Too strict a system invites pressure to swing in the opposite direction," he said. His remarks foreshadowed the volatility that would accompanied disability insurance after 1956 and in particular the sequence of rapidly expanding rolls in the 1970's, attempts to stop the growth of the rolls in the early 1980's, and the rise in the rolls in the later 1980's and early 1990's.

Much of the conceptual work that underpinned Social Security Disability Insurance took place in the 1930's and early 1940's. Passage of the measure did not occur until the 1950's. The delay reflected the understandable lack of attention to domestic policy during the years of World War II and the reality that public assistance paid higher benefits and reached more people than did Social Security between 1935 and 1950. Members of Congress who represented constituents in areas that contained few industrial and commercial workers had no reason to wish to expand Social Security, much less to acquiesce to the passage of Social Security Disability Insurance.

Social Security Disability Insurance did not receive serious attention from Congress until the Committee on Ways and Means held hearings on this topic, and other topics related to Social Security, in 1949. By this time the depression was over, and wartime conditions had helped to bring rehabilitation medicine to maturity. As a consequence, the opponents of Social Security Disability Insurance argued that people with disabilities should receive rehabilitation, rather than a pension that allowed them to retire from the labor force for life. Social Security officials conceded the importance of rehabilitation and even gave serious consideration to recommending that applicants to the disability rolls should receive rehabilitation services and interim payments before they entered the rolls on a permanent basis. They managed to persuade the Committee, however, that, important as rehabilitation was, it did not supersede the need for cash benefits. As a consequence, the Committee included a disability insurance program in the bill that the House of Representatives passed in 1949.

The Senate chose to emphasize rehabilitation, rather than cash benefits, and did not include disability insurance in its version of the Social Security bill that was passed in 1950. The House receded in conference, and as a compromise measure Congress adopted a new public assistance category, Aid to the Permanently and Totally Disabled. Up until 1950, Aid to the Blind had stood alone as a federally assisted public assistance program that reached people with disabilities.

After 1950 Social Security became a popular program that received bipartisan support, both within the Committee on Ways and Means and in Congress itself. Social Security Disability Insurance, by way of contrast, remained a controversial measure, and the Senate Finance Committee, in particular, refused to recommend it to Congress. A series of incremental, compromise laws in 1952 and 1954 paved the way for the final passage of SSDI in 1956.

The 1952 legislation introduced the idea of a disability freeze, in which a person could receive Social Security benefits at the normal retirement age, even if he or she dropped out of the labor force for a substantial period of time because of a disability. This measure passed Congress only after the conferees considering the legislation agreed to the unusual step of letting the disability freeze expire before it could take effect. More importantly, the conferees came up with the idea of letting the states, rather than the federal government, make the initial determinations of disability—a feature of the program that survives to the present day and which can be explained only by understanding the historical context in which it arose.

In 1954, as part of the Eisenhower administration's plan to expand the vocational rehabilitation program and to use the Social Security program as a means of identifying candidates for rehabilitation, Congress passed a disability freeze measure. At this time, Secretary Oveta Culp Hobby, the second female cabinet officer in the nation's history, recommended that Social Security trust fund money be used to provide rehabilitation services, but not cash benefits, to insured people who became disabled. She argued that the investment of OASI funds would be small but "no accountant can estimate the physical rewards, the sense of independence, pride and usefulness and the relief from family strains which accrue to one of the disabled when he returns to his old job or to a newly learned job suited to his limitations." Her sentiments reflected the feelings of many within the Eisenhower administration such as those of Assistant Secretary of Health, Education, and Welfare Roswell Perkins who said that the administration's philosophy was that "the first line of attack on disability should be rehabilitation, in order that people be restored to useful and productive lives."

In 1955 the House once again passed a disability insurance measure and in 1956 the Senate Finance Committee once again opposed it. That set up a dramatic fight on the floor of the Senate that resulted in the passage, by the barest of margins, of Social Security Disability Insurance. As a means of gathering support, the proponents of the legislation limited benefits to those fifty or older and did not include benefits for the dependents of disabled workers.

In its formative years between 1956 and 1960, therefore, SSDI paid benefits only to workers who were fifty years of age or older. That meant that the linkage between applicants for disability benefits and vocational rehabilitation never took hold, since everyone agreed that older individuals made the worst candidates for rehabilitation and the state vocational rehabilitation agencies were simply unable to cope with the large numbers of people who applied for disability benefits. It also meant that the caseload contained a disproportionate number of people with impairments that affected older individuals, such as heart disease and arthritis, rather than people with impairments or conditions that affected younger individuals, such as mental disorders. In effect, despite the eventual use of trust fund money to pay for the rehabilitation of people on the SSDI rolls, the SSDI program became, like the Social Security itself, a retirement program.

At the time, policymakers tended to think of the system for caring for people with mental illness, who occupied the majority of the beds in the nation's hospitals, as a state responsibility. There was little desire to use Social Security money to subsidize state mental health hospitals. In the earliest drafts of the disability insurance legislation, prepared in the 1930's and 1940's, the planners specified that no benefits were to be paid to those with mental disabilities. In defense of this position, they argued that most people with mental disabilities were already taken care of in state hospitals, that mental disabilities were difficult to diagnosis, and that mental disabilities had created problems in foreign disability insurance programs, such as the one in Sweden. They worried that benefits for people with mental disabilities would result in malingering. This suspicion of mental illness as a basis for disability benefits persisted in the program that was passed in 1956 and made it difficult for the system to cope with the revolution in social policy unleashed by the deinstitutionalization movement in the 1960's.

Supplemental Security Income

Supplemental Security Income, the other pillar of our modern disability system, arose as part of a discussion of welfare reform that President Richard Nixon initiated in 1969. Here, as with SSDI, historical particulars mattered. As it became clear that the President's comprehensive plan to change the Aid to Families with Dependent Children Program would not pass Congress, attention shifted to the reform of what policymakers called the adult welfare categories. In particular, the notion arose that the administration of Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to the Elderly should be federalized and run by the Social Security Administration.

Because policymakers did not engage in the sort of oversight (that, for example, the present hearing represents), they failed to anticipate important trends. At the time people pointed to more adequate benefits as a reason for the creation of the program. In particular, Congress hoped to do away with such things as lien laws and to model the new law on practices in the more progressive states. Social Security Administration officials supported the law because they hoped it would take away some of the pressure to raise the minimum benefit under Social Security and hence strengthen the relationship between contributions and benefits. Few people thought to ask what effect the new law would have on disability. Instead, policymakers reflexively assigned welfare beneficiaries to the administrative apparatus already established to administer SSDI benefits. Hence, states made the initial disability determinations under SSI, just as they did under SSDI, and the two programs used a common definition of disability.

In thinking about the new program, policymakers envisioned that it would apply mainly to the elderly, who had traditionally dominated the adult welfare categories. Social Security officials believed that many SSI recipients would be people already receiving Social Security benefits but who found that these benefits were not enough to bring them out of poverty. At first these assumptions proved to be correct. When SSI began in 1975, blind and disabled adults and children represented only 42% of the caseload. At the same time that Congress considered SSI, however, the incidence of disability was growing at an unprecedented rate. The highest rates of growth of the SSDI rolls, for example, occurred between 1971 and 1975. Hence, circumstances favored a rise in the disability categories of SSI. Furthermore, in the same year that Congress created SSI, it also provided a 20% increase in Social Security benefits and indexed benefit levels to the rate of inflation. This action had the effect of raising replacement rates under Social Security and lessening the chance that an elderly Social Security recipient might also need to receive SSI. As a result of these two forces, adults and children who were either blind or disabled represented nearly two thirds of the SSI caseload by 1994.

That meant that just as disability was grafted on to a retirement program for the elderly in the Social Security Disability Insurance program so it was added to a welfare measure that Congress intended primarily as a means of serving the elderly.

Another anomaly in Supplemental Security Income was that the entire discussion focused on what nearly everyone called the "adult welfare categories." As things worked out, however, many SSI recipients turned out be children. By 1992, for example, 16 percent of SSI beneficiaries under age 65 were children. That meant that a disability determination system intended to serve people who had been in the labor force was forced to handle many claims from children. Friction developed between the courts and other overseers of the disability determination process and the Social Security Administration, leading to such cases as the 1990 *Sullivan* v. *Zebley* decision.

Conclusion

It should not be surprising that a disability system developed in the 1930's and created during the political conflicts of the 1950's and 1970's should experience strains after nearly half a century of operation. Still, the warnings of the system's founders remain relevant Simply put, things do not always work out as planned in disability policy. Correcting the system's flaws by restricting benefits can, for example, lead to a reaction of the sort that occurred between 1981 and 1984. By the time that Congress acted in 1980 in response to rising disability rolls, the disability incidence rate was already heading down. After the administration moved to implement the new law in an aggressive manner beginning in 1981, the system nearly fell apart, as governors ordered their state disability determination offices not to cut people from the rolls and administrative law judges and the courts reversed many of the policies of the Social Security Administration. The ultimate result was that more people, rather than less, entered the rolls.

Similarly, the creation of important civil rights laws such as the Americans with Disabilities Act has failed to have an immediate impact on the disability rolls. The ADA has not led to the substitution of jobs and independent living for cash disability benefits, despite the hopes of those who lobbied for the law's creation.

In the field of welfare, the SSI program, because policymakers failed to spot emerging trends, developed in ways unanticipated by its founders.

As my testimony has demonstrated, outcomes do sometimes diverge from expectations. It seems to me that fact only increases the responsibility of this subcommittee to survey the landscape and identify emerging trends. As it does so, the subcommittee should realize that sometimes the only explanation for a particular policy is historical.

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Chairman SHAW. Thank you. Dr. Lollar.

STATEMENT OF DONALD LOLLAR, ED.D., CHIEF, DISABILITY AND HEALTH BRANCH, NATIONAL CENTER FOR ENVIRONMENTAL HEALTH, CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ATLANTA, GEORGIA

Mr. LOLLAR. Mr. Chairman, Members of the Committee, I appreciate having the opportunity to speak to the Committee today. I am Dr. Don Lollar, Chief of the Disability and Health Branch in the National Center for Environmental Health at the Centers for Disease Control and Prevention. The mission of the CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability.

We do this by identifying public health problems, determining the scope of these problems, conducting research to identify their preventable causes and then implementing public health interventions. The Disability and Health Branch's mission at CDC is to promote the health and well being of all people with disabilities. Our branch is currently supporting both research to better measure the disabling process and we support state programs to improve the health of people with disabilities.

I want to focus on two primary areas. First, I will describe how the social and physical environment plays a vital role in either inhibiting or encouraging people with a disability to participate fully in society. Second, I will describe in broad terms how an emerging World Health Organization (WHO) classification system can influence how society better defines and meets the needs of people with disabilities.

Typically when a person with a physical, intellectual or emotional impairment is not participating in society the way other people do, we assume that it is because the person's disabling condition itself prevents them from doing so. In reality, disability is a complex interaction of the person with their environment. Some factors that influence participation are within a person, including medical conditions, personal strength and limitations, but other factors are outside a person including the physical and social environments. Advances in technology and changes in attitudes have made it clear that people with disabling conditions are capable of doing many things. Technology has provided the tools to help people with disabilities perform daily life tasks vital to their autonomy such as personal care, mobility, communication and even learning.

Assistive devices and technologies that allow more personal autonomy include power chairs, voice synthesizers and special telephones and computers; but, in addition, factors such as accessibility to buildings or transportation and acceptance by others also influence participation at work or school. Unfortunately, not all people with disabilities have access to these technologies nor have all attitudes in our society changed. As a result, the opportunities for complete participation that are possible have not been extended to all persons with a disability.

To describe these various disability dimensions, the World Health Organization has developed the International Classification of Functioning and Disability, the so-called ICIDH–2. This classification is a way to understand and communicate more clearly about the disabling process. The system describes the various dimensions of the disabling process, which includes physical or body functions, everyday personal activities, societal participation, and the environmental factors.

ICIDH-two can enable society to better define and meet the needs of people with a disability. The advantages of this system are that it combines an understandable framework, which includes environmental factors, and provides a classification system as the basis for future research. While the concepts of ICIDH–2 are useful its implementation is just beginning. The future utility of the system will depend on how widely it is used and how well users are able to apply it.

A useful system of classifying disability elements needs to recognize the complexity of the interactions between people with disabilities and their physical and social environments. Disability policy should more broadly address the various environmental barriers that restrict full participation by people with disabilities. CDC would be pleased to work with this Committee, with other Federal and state agencies and researchers in the private sector to improve the health and participation of people with disabilities. Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of Donald Lollar, Ed.D., Chief, Disability and Health Branch, National Center for Environmental Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Atlanta, Georgia

Mr. Chairman, Members of the Committee.

I appreciate being given the opportunity to speak to the Committee today. I am Dr. Donald Lollar, Chief of the Disability and Health Branch in the National Center for Environmental Health at the Centers for Disease Control and Prevention. The mission of the CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability. We do this by identifying emerging and reemerging public health problems, determining the scope of these public health problems, conducting research to identify preventable causes of public health problems, and developing and evaluating public health intervention programs. Since 1988, the mission of the Disability and Health Branch has been to promote the health and well being of all people with disabilities in the U.S. including the millions of people served by Supplemental Security Income and Social Security Disability Insurance. The Disability and Health Branch is currently supporting both research to better measure the disabling process and state programs to improve the health of people with disabilities.

I will focus on two primary areas. First, I will describe how the social and physical environment plays a vital role in either inhibiting or encouraging people with a disability to participate fully in society. Second, I will describe in broad terms how an emerging World Health Organization classification system might influence how society better defines and meets the needs of people with disabilities.

Typically, when a person with a physical, intellectual, or emotional impairment is not participating in society the way other people do, one assumes that it is because the person's disabling condition prevents them from doing so. In reality, disability is a complex interaction of a person with their environment. Some factors that influence participation are within a person, including medical conditions, personal strengths and limitations. Other factors are outside a person, including the physical and social environments. Advances in technology and changes in attitudes have made it clear that people with disabling conditions are capable of doing many things.

Technology has provided the tools to help people with disabilities perform daily life tasks vital to their autonomy such as personal care, mobility, communication, and learning. Assistive technologies that allow more personal autonomy include power wheelchairs, voice synthesizers, and special telephones and computers. In addition, factors such as accessibility to buildings or transportation and acceptance by others also influence participation at work or school. Unfortunately not all people with disabilities have access to these technologies, nor have all attitudes in our society changed. As a result, the opportunities for complete participation that are possible have not been extended to all persons with a disability.

Let me give you an example. Jonathan is a young 21 year old with cerebral palsy. Without assistance, he is substantially limited in personal activities, such as mobility and communication. With the aid of a power wheelchair and a voice synthesizer, he can move around and communicate with others. His family has purchased an adapted van that allows him to travel.

Jonathan faces several types of barriers to his full participation, some at the person-level and some at a broader societal level. Technology has removed several of his person-level limitations, such as in the areas of freedom of movement and accessibility. If, however, Jonathan wants to participate more fully in society, such as by working or developing friendships, other environmental factors must be addressed. In addition to matching his abilities with potential jobs he might consider, the work place must be accessible for his wheelchair and, not unlike many of us, his work setting may need to be adapted to accommodate his needs. Coworkers' attitudes toward Jonathan—both positive and negative—also impact his participation.

To assess the various disability dimensions, the World Health Organization (WHO) has developed the International Classification of Functioning and Disability (ICIDH–2). The ICIDH–2 is a way to understand and communicate more clearly about the disabling process. The system describes the relationships between the various parts of the disabling process—the physical or body functions, the personal everyday activities, participation in society, and environmental factors. ICIDH–2 provides a common language that allows us to talk with one another about the different life dimensions people with disabilities experience. The language describes each individual dimension separately and then focuses on how they may interrelate with each other. Jonathan, for example, experiences impairments of various body systems, has difficulty with everyday activities of moving around, personal care, and communication. With the intervention of assistive technology, his activity limitations are reduced. Even with greater performance in personal everyday activities, however, he may still be restricted from participating in work, recreation, or even social relationships. This restriction in participation is, in this case, not associated with his impairments or his personal activity limitations, but rather due to environmental factors, such as architectural barriers, social program guidelines, or attitudes toward people with disabilities.

The ICIDH–2 may enable society to better define and meet the needs of persons with a disability. The advantages of ICIDH–2 are that it combines an understandable framework, which includes environmental factors, addresses the interaction of the person and the environment on participation in society, and creates a commonly used classification system for future research. While the concepts of ICIDH–2 are useful its implementation is just beginning. The future utility of the system will depend on how widely it is used and how well users are able to apply it.

To put it another way, participation in work, school, or any other area of daily life depends on both the individual and their environment. As their circumstances or situations change, an individual with an impairment or disability who was not previously able to do so may be able to attend school or work.

A useful system of classifying disabilities needs to recognize the complexity of the interactions between people with disabilities and their physical and social environments. Disability policy should more broadly address environmental barriers, which restrict full participation by people with disabilities. CDC would be pleased to work with this Committee, other federal and state agencies, and researchers to improve the health and participation of people with disabilities.

Thank you, Mr. Chairman and members of the Committee, for the opportunity to come before you today. I will be happy to answer any questions you have about CDC's Disability Program or any other areas of my remarks today.

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Chairman SHAW. Thank you, Dr. Lollar. Mr. Baron.

STATEMENT OF RICHARD C. BARON, M.A., PROGRAM DIRECTOR, PEW FUND FOR HEALTH AND HUMAN SERVICES FOR VULNERABLE ADULTS, OMG CENTER FOR COLLABORATIVE LEARNING, PHILADELPHIA, PENNSYLVANIA

Mr. BARON. Good morning. My name is Richard Baron, and I want to focus today on the sometimes surprising results of a research project I recently completed, and the implications of those results for the Social Security disability program's dramatically large number of beneficiaries and recipients who have a serious mental illness. Let me tell you the gist of my comments first. The vast majority of people with serious mental illness are desperately poor, and are likely to remain at or near the poverty level for the remainder of their lives, whether they work or not.

It is time that the country and SSA commit itself not merely to getting people back to work or off the SSA rolls, but more significantly to helping people with serious mental illness who work to claim a fair share of the nation's prosperity. Although I have recently taken a job at the OMG Center in Philadelphia, where I direct the Pew Fund's Health and Human Services grant making program for vulnerable adults, for the past 2 years I have been engaged in an independent research project funded by a Switzer Fellowship from the National Institute on Disability and Rehabilitation Research, exploring the long-term career patterns of people with serious psychiatric disabilities.

In extensive, qualitative interviews people with serious mental illness talked with me about their attitudes toward work, the many jobs they had held in the past, their employment aspirations, and the impact of the Social Security disability program on their careers. This research offers some surprisingly encouraging news. First, the people I interviewed were overwhelmingly enthusiastic about working. They readily understood the financial, psychiatric, and social benefits that work provides.

There is no great value divide between the rest of us and those with disabilities. Nearly everyone wants a good job. Second, most of those I talked to had worked a great deal and had worked successfully, both before and after their diagnosis and before and after their eligibility for Social Security. Those I interviewed had each held many jobs with an average job tenure at each job of 18 to 24 months. Interviewees reported that they had been both productive and personable on the job. They had been well worth their paychecks and they had gotten along with their colleagues.

Third, the people I interviewed reported that they were only rarely fired. Indeed, about half of my interviewees left jobs for reasons that had nothing at all to do with mental illness: a company closed down or left town, elderly parents got sick or moved, the boss made unreasonable demands, or the salary was just too low. Almost no one had the kind of on-the-job meltdown our rehabilitation programs dread although people sometimes did lose jobs because they were too depressed to get out of the house, too manic to resist an adventure or too paranoid to face co-workers.

Fourth, I want to underline that people did not receive their first diagnosis of serious mental illness and grab the next cab for the local Social Security office. Despite mounting psychiatric problems people often worked for years trying to avoid a life of public dependency before turning to SSA. And, as you know, many continue to work after SSA eligibility but only at levels that would allow them to sustain their critical life line to consistent medical support.

However, beneath these positive notes about the work motivation and work success of people with serious mental illness lies a harsh reality. Most people with serious mental illness who have worked in the past or are working now are employed in entry level, low wage, minimal benefit, and part-time jobs that do not provide them access to prosperity. More than 75% of the job placements made by rehabilitation agencies only help people toward the kinds of secondary labor market jobs that they have already proven fairly adept at obtaining for themselves.

Thus, there is often little discernible economic difference for people with serious mental illness between working and not working. Such limited outcomes are unfortunate not only because those jobs simply do not provide living wages that lift people out of poverty but also because such jobs no longer serve as stepping stones to permanent full-time jobs with decent benefits, and those I interviewed were acutely aware of how unlikely it was that they would be able to find good jobs in the future.

Many understood that this had as much to do with their lack of educational qualifications as it did with their psychiatric disability. Their work prospects today are similar to those of many working class people without disabilities. The gap between the rich and the poor is widening most often because good jobs are beyond the grasp of poor people. Either they cannot manage the full-time demands of the careers emerging in the new economy or they haven't the college degrees, technical skills, or work histories these jobs demand.

We ought not to delude ourselves that helping someone with a serious psychiatric disability, or with any serious disability or educational disadvantage, to obtain an entry level part-time or even full-time job is enough. Our economy does not provide the right kinds of opportunities for the typical SSA client to make real economic progress in the secondary labor market. We have to establish longer term programs that genuinely help people to move into the economic mainstream, and this means that we have to make more substantial educational, training and other investments in beneficiaries and recipients themselves.

It is clearly a failure of public policy to pretend that getting off the SSA rolls or extending medical eligibility is enough to escape poverty. It is just not so. I was struck in the course of these interviews by how many women talked about wanting a decent place of their own and how many men talked about their longing to own a used car. These are not elaborate delusions or self-indulgent ambitions for today's Americans but they remain at present completely beyond the grasp of most people with serious mental illness. This should not be so. Thank you.

[The prepared statement follows:]

Statement of Richard C. Baron, M.A., Program Director, Pew Fund for Health and Human Services for Vulnerable Adults, OMG Center for Collaborative Learning, Philadelphia, Pennsylvania

Good morning. My name is Richard Baron, and I want to talk to you today about the sometimes surprising results of a research project I have recently completed, and the implications of those results for the Social Security disability program as it continues to work toward meeting the changing needs of people with disabilities, particularly the large number of individuals on the SSA rolls who have a serious mental illness.

Let me tell you the gist of my comments before I fill in some of the details: the vast majority of people with serious mental illness are desperately poor, and are likely to remain at or near the poverty level for the remainder of their lives, and will do so—unless there are significant changes in our national policies—whether they work or not. It is time that the country commit itself not merely to getting people 'back to work' or 'off the SSA rolls,' but, more significantly, to helping people with serious mental illness who work to claim some fair share of the nation's remarkable prosperity.

Although I have recently taken a job at the OMG Center for Collaborative Learning, in Philadelphia, where I direct the Pew Fund's Health and Human Services grant making program for vulnerable adults, from 1973 to 1998 I worked at Matrix Research Institute, a private nonprofit research and training center, also in Philadelphia, with a focus on improving rehabilitation and employment services for people with serious mental illness.

For the past two years, however, I have been engaged in an independent research project, funded by a Switzer Fellowship from the National Institute on Disability and Rehabilitation Research, in which I explored the long term career patterns of individuals with substantial and sustained psychiatric disabilities, through in-depth qualitative interviews with individuals across the Eastern half of the United States. In these interviews, people with serious mental illness talked at length about their attitudes toward work, each one of the many jobs they had held in the past, their employment aspirations for the future, and the impact of the Social Security disability program on all of this.

First, then, this research has some surprisingly encouraging news. The people I interviewed were overwhelmingly enthusiastic about working: they understood all too well the financial, psychiatric and social benefits that work provides, and although they report that neither their clinicians nor their rehabilitation programs are very encouraging with regard to work, they long for the sense of independence and normalcy that working offers. There is no great 'value divide' between the rest of us and those with disabilities: nearly everyone wants a good job.

Second, most of those I interviewed had worked a great deal, and had worked successfully, both before and after their diagnosis, and before and after their eligibility for the Social Security disability program. Those I interviewed had each held 6 −8 jobs, and their average job tenure was around 18 months. They reported that they had been both productive and personable on the job: they had been well worth their paychecks, and they had gotten along with their colleagues. They knew full well that they both should and could work in the competitive labor market.

Third, the people I interviewed reported that they had left far more jobs than they had been fired from. About half of the reasons people left jobs had nothing at all to do with mental illness: a company closed down or left town; elderly parents got sick or moved; their boss made unreasonable demands or their salary was just too low—all the kinds of reasons you hear from people without psychiatric disabilities in a turbulent job market. While the other half of job losses were indeed related to their psychiatric disabilities, almost no one had the kind of on-the-job meltdown our rehabilitation programs dread: most people lost their jobs because they were too depressed to get out of the house, too manic to resist an adventure, too paranoid to face coworkers, or too quickly hospitalized to open up the shop that morning.

Fourth, people did not receive their first diagnosis of serious mental illness and grab the next cab for their local Social Security Office: despite their mounting psychiatric problems, people often worked on and off for years before entering the SSA rolls, trying to avoid a life of public dependency. And, as you know, many continue to work after SSA eligibility, walking the fine line that the system of disincentives forced them to walk in order to sustain their critical lifeline to consistent financial and medical support.

However, beneath this positive news about their motivation and relative success at work lies a harsh reality. Most people with serious mental illness who have worked in the past or are working now are employed in those entry-level, low-wage, minimal-benefit, and part-time secondary labor market jobs that do not provide them access to any reasonable measure of prosperity. More than 75% of the job placements made from the state/federal vocational rehabilitation system or the nation's critically-needed network of psychosocial rehabilitation agencies—including those that are part of the nation's supported employment initiatives—help people toward the kinds of jobs that they had already proven themselves fairly adept at obtaining for themselves.

Such limited outcomes are unfortunate not only because those jobs simply do no provide a 'living wage' that lifts people out of poverty, but also because such jobs no longer serve as a stepping stone to permanent full-time jobs with decent benefits. There was, among the people I interviewed, a pattern of significant gaps in their work histories. Some of these gaps were no doubt due to prolonged psychiatric hospitalizations and post-hospital recovery periods, but it was clear to me that a good percentage of unemployment was due to the fact that there is little discernible economic difference for them between working and not working.

Those I interviewed were acutely aware of how unlikely it was that they would be able to substantially improve upon their current lifestyles, whether they worked or they did not, and that this 'parchment ceiling' had as much to do with their lack of educational qualifications as it did with their psychiatric disability. Their work prospects, like their work histories, are similar to those of many working class people without disabilities in the current economy, in which the gap between the rich and the poor is widening: the 'good jobs' are often beyond their grasp. Either they cannot manage the full-time ongoing demands of the careers emerging in the 'new economy,' or they haven't the college degrees, technical skills, or work histories these jobs demand. Like other's in the secondary labor market, they are often working very hard and getting nowhere, and now they are not even getting by.

We ought not to delude ourselves that helping someone with a serious psychiatric disability—or anyone with any kind of disability, or educational disadvantage—to obtain an entry-level, part-time job is enough. It is not. The economy of prosperity in which we live does not provide enough opportunities for the typical SSA disability beneficiary or recipient to make progress: people do not move readily from part-time to full-time employment, because the jobs are not there for them. People do not move from jobs with few benefits to jobs with full benefits because employer based health care systems are seeking to diminish rather than expand employee benefits, particularly in the secondary labor market. People do not move from minimal responsibilities to major assignments because they lack the educational qualifications to do so.

We have to begin to think about longer term programs that help people to move into the economic mainstream, and this means that we have to think in terms of more substantial investments in SSA beneficiaries and recipients. My research doesn't allow me to presume that I can readily suggest the public policy alternatives that address the problem of desperate poverty among people with serious disabilities, but stronger economic support for people with the most severe and medically demanding disabilities, rehabilitation programs that provide people with access to a job with a living wage, and a stronger support for educational programs, certainly would seem to move us in the right direction.

But, it is clearly a failure of public policy to pretend that simply getting off the SSA rolls or extending medical insurance eligibility is enough to escape poverty. It's just not so. I was struck in the course of these interviews by how many women talked about wanting a decent home of their own and how many men talked about their longing to own a car. These are not overly-elaborate delusions or self-indulgent ambitions for Americans at the beginning of this new century, but they are, at present, completely beyond the grasp of most people with serious mental illness. This should not be so. Thank you.

Chairman SHAW. Thank you, Mr. Baron. Dr. Burkhauser.

STATEMENT OF RICHARD V. BURKHAUSER, PH.D., SARAH GIBSON BLANDING PROFESSOR OF POLICY ANALYSIS, AND CHAIR, DEPARTMENT OF POLICY ANALYSIS AND MANAGEMENT, CORNELL UNIVERSITY, ITHACA, NEW YORK

Mr. BURKHAUSER. Thank you. My name is Richard Burkhauser. Before I became a university professor, I taught every grade from kindergarten through high school and that experience has made me a show and tell speaker. So I would like to confine my remarks to three tables that are at the end of my written statement and are samples of the cross national research that I have done on disability programs over the last couple of years.

Table one looks at disability transfer recipients per thousand workers by age in the four countries that the GAO report talked about. There are some similarities in the four countries: the United States, the Netherlands, Sweden and Germany. That is, the ratio of people on the disability transfer rolls rises with age in all four countries. That is to be expected because the onset of a disability is much higher at older ages. But there are also tremendous differences in these ratios across countries and across time that clearly can't be driven by differences in underlying health conditions. My research suggests that there differences are really driven by policy decisions, decisions that you, Mr. Shaw, and others in Congress must make as leaders of our country.

In the Netherlands the transfer recipient rates increase from 55 per 1000 to 138 per 1000 in the seventies, a 151% increase in beneficiaries. In the eighties this enormous growth slowed down in the Netherlands and in the other countries in Table 1. However but it wasn't until the nineties that the Dutch made a concerted effort to contain their program growth. Consequently, the ratio of people on the rolls per 1000 workers between 1990 and 1998 actually fell by 10% in the Netherlands.

How did this happen? Benefit levels were cut and a legal basis for disentangling the risks of disability and employment were introduced. In 1993 periodic reviews of those on the disability rolls were made part of the system. All beneficiaries younger than age 45 received elegability reviews based on these new standards. In contrast, the United States had the highest growth in their disability rolls in the nineties, a 63% increase, and most disturbing there was an 87% increase in the ratio of younger workers on the rolls.

We have long known that disability programs serve as an early retirement program for folks with disabilities who would like to get out of the labor force but are too young for early Social Security benefits. Table two shows how dramatic the differences are in the way the Netherlands and the United States provide benefits to such workers. If you look at the employment rate of men aged 51, 52 and 53 in the United States and the Netherlands they are about the same in the two countries. Labor force participation rates then fall gradually in the United States to about 67% by age 60.

In contrast, the Dutch go from 82% at age 53 to 21% at age 60. Fully 33% of men in the Netherlands receive disability transfers at age 60. This suggests that if there is a will, there is a way to put as many people on the disability rolls as policymakers desire and the Dutch have succeeded in demonstrating this point. You might argue that this is appropriate social policy for older people. However, it is not so clear that it is appropriate social policy for younger people.

Table 3 looks at the United States employment rates of men and women with and without disabilities and their median household incomes between 1982 and 1998. What it shows is that business cycles affect all of us in about the same way. Growth is good for everyone. Recessions are bad for everyone. If you look at employment rates from 1982 to 1989, which is the growth period of the Reagan boom of the 1980s, you will see that employment of both those with and without disabilities increased between 1982 and 1989 as did their median household income.

We had a recession between 1989 and 1993 in which employment fell and median household income fell for both groups. Now here is the most serious news about what is going on in the 1990s in the United States for folks with disabilities. After 1993, we have had stupendous economic growth in this country which has led to increases in employment for men and women without disabilities, and has led to substantial increases in their real median household income.

In contrast, the employment rates of men and women with disabilities are actually lower in 1998 than they were in 1993, the employment trough of the last business cycle. Real employment of men with disabilities has fallen about 25% since the last business cycle peak of 1989. (For women it is about 24%.) Median household income of men with disabilities has fallen by about 5%. What is going on? In my view, there has been a major shift from work to the disability rolls, both Disabilities Insurance and Supplemental Security Income, by folks with disabilities in the 1990s.

Let me conclude by saying that the lesson of the Netherlands is that the disability transfer population can be quite large if disability transfer rolls are used as an alternative to long-term unemployment or welfare programs. But the experience of Germany and Sweden suggests that these rolls can be kept within socially acceptable limits, if a work force strategy of accommodation, rehabilitation, and integration of people with disabilities in the labor market is implemented.

The recently implemented Ticket to Work Act is certainly a step in the right direction but future legislation is likely to be needed to shift United States disability policy toward more work-orientated outcomes. Thank you.

[The prepared statement and attachment follow:]

Statement of Richard V. Burkhauser, Ph.D., Sarah Gibson Blanding Professor of Policy Analysis, and Chair, Department of Policy Analysis and Management, Cornell University, Ithaca, New York

LESSONS FROM EUROPEAN DISABILITY POLICY EXPERIENCE

Work in the marketplace is the principal source of income in modern industrial societies, and ameliorating economic risks associated with exits from the labor force due to health problems or "old age" is a fundamental goal of all modern social welfare systems. Yet the mix of private and public insurance against such risks varies greatly across countries, and the resulting structure of retirement and disability programs and the signals they send with respect to how and when to leave the labor market are more likely to explain the dramatic differences in across country disability rolls and in employment at older ages than differences in underlying health conditions in those countries.

International evidence suggests that public policies are the most important factor in determining the relative size of the disability-transfer population. Over time, countries have used different eligibility criteria to define this protected population and different processes to implement this protection. Table 1 shows that the percentage of the working age population receiving disability transfers in the United States, The Netherlands, Sweden, and the western states of Germany varies across age groups and over time. As would be expected, since the prevalence of health-related impairments increase with age, disability transfers among working age people increase at older ages in all four countries. Past that similarity, dramatic differences are observed across countries and within each country over time.

No country demonstrates the power of policy to affect the rate of growth in the disability-transfer population better than The Netherlands. No one would suggest that the underlying health of the Dutch working age population has deteriorated at a more rapid pace than that of the other countries in Table 1. Yet the growth in the prevalence of the Dutch working age population receiving disability transfers in the 1970s far exceeded those of other countries. Policy changes in the 1980s slowed that growth, and dramatic policy changes in the 1990s have turned it around. Benefit levels were cut and a legal basis for disentangling the risks of disability and unemployment were introduced. But real changes in the rolls only began in 1993 when eligibility standards and the process for continuing benefits were dramatically tightened. In 1993, periodic review of those on the disability rolls was made a part of the system. All beneficiaries younger than age 45 were reviewed based on the new standards.

As can be seen in Table 1, as a result of these reforms and others, the prevalence of disability transfer recipients per 1000 workers fell by 10 percent between 1990 and 1998. While the ratio of disability transfer recipients to workers in 1998 is still higher in The Netherlands than in the other countries, it is the United States which experienced the greatest growth in its disability rolls among the four countries in Table 1 in the 1990s. Most ominously, the fastest growth in the United States disability transfer rolls was among younger persons aged 15 to 44.

It has long been recognized that disability transfer programs act as a form of early retirement for older workers with some level of disability. Hence transfer payments rather than rehabilitation or integration into the workforce via job creation or quotas, have dominated policy in all four countries for this older age group. Table 2 compares the age specific employment rates of men aged 51 through 61 in The Netherlands and the United States in 1992 and shows how disability transfers and private employer pensions are used as a bridge to the earliest social security retirement age in these two countries.

But the rapid increase in the disability rolls among younger workers is a much more controversial policy outcome and one that has already pushed the United States ahead of Sweden and Germany in the prevalence of disability transfers in this age group. The rapid increase in the SSI-children program population in the early 1990s is a major example of the increased use disability based transfers to provide a minimum income level to younger persons. In contrast, both Swedish and German policies are much more focused on integrating younger workers with disabilities into the labor market than is United States disability policy.

One possible consequence of the relaxation of eligibility standards for SSI-disability and SSDI benefits in the late 1980s in the United States is that while the disability transfer rates have been rapidly rising, the employment rates of men and women with disabilities in the United States have been falling. As Table 3 reports, not only did the employment rates of men and women with disabilities fall as the country moved from a business cycle peak in 1989 to a business cycle trough in 1992 but they continued to decline thereafter despite six consecutive years of economic growth.

The lesson of The Netherlands suggests that the size of the disability transfer population can be quite high if disability transfer rolls are used as an alternative to long term unemployment or welfare programs. But experience in Germany and Sweden suggests that these rolls can be kept within socially acceptable limits if a "work first" strategy of rehabilitation and integration of people with disabilities into the labor market is implemented. The recently implemented Ticket to Work/Work Incentives Improvement Act is certainly a step in the right direction, but future legislation is likely to be needed to shift United States disability policy toward more work orientated outcomes.

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Table 1.—Disability Transfer Recipients Per Thousand Workers by Age in Four OECD Countries, 1970 to 1998

Age	1970	1975	1980	Growth Change 1970–1980 (percent)	1985	1990	Growth Change 1980–1990 (percent)	1995	1998 [a]	Growth Change 1990–1998 (percent)
Aged 15 to 64 Years										
United States	27	42	41	52	41	43	5	64	70	63
The Netherlands	55	84	138	151	142	152	10	142	137	− 10
Sweden	49	67	68	39	74	78	15	106	27	
Germany	51	54	59	16	72	55	− 7	57	60	9
Aged 15 to 44										
United States	11	17	16	45	20	23	44	39	43	87
The Netherlands	17	32	57	235	58	62	9	57	59	− 5
Sweden	18	20	19	6	20	21	11	32	34	62
Germany	7	6	7	0	8	5	− 29	6	8	60
Aged 45 to 59										
United States	33	68	83	151	71	72	− 13	103	104	44
The Netherlands	113	179	294	160	305	339	15	271	241	− 29
Sweden	66	95	99	50	108	116	17	151	145	25
Germany	75	64	84	12	103	75	− 11	87	81	8
Aged 60 to 64										
United States	154	265	285	85	254	250	− 12	314	329	32
The Netherlands	299	437	1,033	245	1,283	1,987	92	1,872	2025	2
Sweden	229	382	382	67	512	577	51	716	709	23
Germany	419	688	1,348	222	1,291	1,109	− 18	1,347	1,020	− 8

(a) U.S. data are from 1997.

Source: Derived and updated from Aarts, Burkhauser, and De Jong (1996), Table 1.1.

Table 2.—Prevalence of Work and Transfer Benefits for Men by Age in The Netherlands and in the United States

Age	United States				The Netherlands			
	Working[a]	Disability Transfers[b]	Not Working Employer Pension[c]	Other[d]	Working[a]	Disability Transfers[b]	Not Working Employer Pension[c]	Other[d]
51	82.6	4.1	0.9	12.4	83.3	13.7	0.0	3.0
52	84.9	3.0	2.4	9.9	87.5	8.1	1.9	2.5
53	82.8	3.5	0.5	13.2	81.9	14.1	1.7	2.3
54	84.6	2.9	2.7	9.8	74.6	17.2	1.9	6.2
55	78.5	4.5	1.8	15.3	72.2	16.7	3.5	7.5
56	76.9	5.0	6.3	11.8	59.0	23.9	10.2	6.8
57	80.3	4.6	7.0	8.0	58.7	17.4	15.6	8.3
58	71.5	7.5	9.2	12.0	49.0	25.0	19.0	7.0
59	68.9	6.5	9.3	15.3	44.1	23.2	27.5	5.2
60	67.9	6.1	12.6	13.3	20.9	33.3	42.3	3.5
61	65.9	5.6	16.0	12.5	16.8	26.9	50.5	5.8

[a] Those who are working at the time of the interviewC1993 in The Netherlands and 1992 in the United States.

[b] Those who are not working and are receiving disability transfers at the time of the interview.

[c] Those who are not working or receiving disability transfers but who are receiving private pension benefits at the time of interview.

[d] Those who are not working and receiving neither disability transfers nor private pension benefits at the time of interview.

Source: Burkhauser, Richard V., Debra Dwyer, Maarten Lindeboom, Jules Theeuwes, and Isolde Woittiez.(1999) Data from The Netherlands are weighted values of the 1993 Wave 1 CERRA Household Survey. Data from the United States are weighted values of the 1992 Wave 1 Gamma Release of the Health and Retirement Survey.

Table 3.—Employment Rates and Median Household Size-Adjusted Income of Civilian Aged 25 through 61 by Gender and Disability Status in 1982, 1989, 1992, and 1998[a]

Groups[b]	Employment Rate[c]				Percentage Changed		
	1982	1989	1993	1998	1982–89	1993–98	1989–98
Men without Disability	95.1	96.1	94.5	95.1	1.0	0.6	−1.0
Men with Disability	41.7	44.0	37.2	34.4	5.4	−7.8	−24.5
Women without Disability	69.3	77.0	78.3	80.8	10.5	3.1	4.8
Women with Disability	29.3	37.5	33.4	29.5	24.6	−12.4	−23.9

Groups[b]	Median Income[e]				Percentage Change[d]		
	1982	1989	1993	1998	1982–89	1993–98	1989–98
Men without Disability	27,399	31,888	30,076	33,486	15.1	10.7	4.9
Men with Disability	13,948	16,477	14,490	15,717	16.6	8.1	−4.7
Women without Disability	24,486	28,841	27,512	30,384	16.3	9.9	5.2
Women with Disability	13,200	14,789	13,061	14,173	11.4	8.2	−4.3

Source: Burkhauser, Daly and Houtenville (2000) calculations based on the March Current Population Survey, 1981–1999.

[a] Those less than age 25 or more than age 61 or in the Armed Force are excluded. In our study, persons are considered to have a disability if they report having a health problem or disability, which prevents them from working or limits the kind or amount of work they can do.

[b] Disability status is for year following income year. Beginning in survey year 1994, computer assisted interviews were used which slightly modified the question we use to define disability.

[c] Includes as employed only those who work 52 hours or more in a given year and have positive earnings.

[d] When calculating percentage change, we use the average of the two years as the base.

[e] All dollar amounts are in 1998 dollars. Income is household size-adjusted by dividing income by the square root of household size. Negative sources of income were converted to zero. In addition, the bottom and top 5 percent of the household size-adjusted income distribution are excluded from the analysis.

Richard Burkhauser, Ph.D.

Department of Policy Analysis and Management, Cornell University

The experiences of other countries can shed some light on the search for appropriate Social Security Disability Insurance (SSDI) and Social Security Income (SSI) program eligibility criteria for people with disabilities. This discussion focuses primarily on experiences with disability-transfer programs in four countries—the Netherlands, Germany, Sweden, and the United States (Aarts et al., forthcoming).

Before recommending dramatic changes in our current SSDI and SSI eligibility criteria, one has to ask several questions. Is the current system sufficiently in trouble to warrant such changes? If so, what is the evidence of the failure of the current system to achieve its objectives, and what criteria were used to determine the size of this failure? Without answers to these questions, it is difficult to either put a new system into place or to determine whether or not the new system is superior to the current system.

International evidence suggests that public policies are the most important factors in determining the relative size of the disability-transfer population. Over time, countries have used different eligibility criteria to define their protected population and different processes to implement this protection. Described below are some of the differences across countries and over time in these criteria and processes as well as an overview of the tradeoffs that should be considered in establishing them.

Table 5–1 shows that the working age population receiving disability transfers in the Netherlands, Germany, Sweden, and the United States varies across age groups and over time. As would be expected, since the prevalence of health-related impairments increases with age, disability transfers among working age people increases at older ages in all four countries. Past that similarity, dramatic differences are observed across countries and within each country over time.

Table 5.1 Disability Transfer Recipients per Thousand Workers by Age, in Four OECD Countries, 1970 to 1995

Age	1970	1975	1980	Growth Change 1970–1980 (percent)	1985	1990	Growth Change 1980–1990 (percent)	1995	Growth Change 1990–1995 (percent)
Aged 15 to 64 Years									
United States	27	42	41	52	41	43	5	64	49
The Netherlands	55	84	138	151	142	152	10	142	−7
Sweden	49	67	68	39	74	78	15	106	36
Germany[a]	51	54	59	16	72	55	−7	47	−15
Aged 15 to 44									
United States	11	17	16	45	20	23	44	39	70
The Netherlands	17	32	57	235	58	62	9	57	−8
Sweden	18	20	19	6	20	21	11	32	52
Germany	7	6	7	0	8	5	−29	6	8
Aged 45 to 59									
United States	33	68	83	151	71	72	−13	103	43
The Netherlands	113	179	294	160	305	339	15	271	−20
Sweden	66	95	99	50	108	116	17	151	30
Germany[a]	75	64	84	12	103	75	−11	87	16
Aged 60 to 64									
United States	154	265	285	85	254	250	−12	314	26
The Netherlands	299	437	1,033	245	1,283	1,987	92	1,872	−6
Sweden	229	382	382	67	512	577	51	716	24
Germany[a]	419 s	688	1,348	222	1,291	1,109	−18	890	−20

[a] German data refer to the population in the states in the former Federal Republic of Germany.

Source: Derived and updated from Aarts, Burkhauser, and de Jong (1996), Table 1.1.

USE OF MEASURES IN PUBLIC AND PRIVATE PROGRAMS

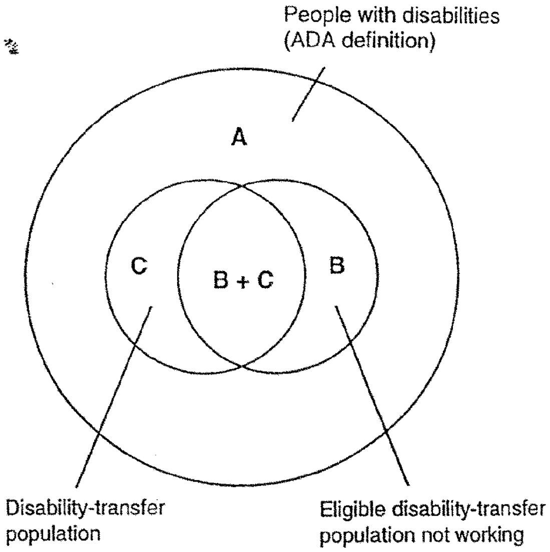

FIGURE 5–1.—Targeting social policies on the working age population with disabilities. SOURCE: Burkhauser, 1997. Reprinted with permission of Dr. Richard V. Burkhauser, Cornell University.

Those differences have more to do with the policies that govern the disability eligibility determination process than with changes in the underlying health and disability patterns of those populations.

The preponderance of evidence to date suggests that overall health in each of these countries, measured either by morbidity or mortality scales, has improved significantly over the last 25 years. Yet the number of people on disability-transfer programs relative to the working population has increased in all four countries.

No country demonstrates the power of policy changes to affect the rate of growth in the disability-transfer population better than the Netherlands. No one would suggest that the underlying health of the Dutch working age population has deteriorated at a more rapid pace than that of the other countries in Table 5–1. Yet the growth in the prevalence of the Dutch working age population receiving disability transfers in the 1970s far exceeded that of the other countries. Policy changes in the 1980s slowed this growth, and dramatic policy changes in the early 1990s have turned it around. (See Aarts et al. [forthcoming], for a fuller discussion.)

The dramatic differences in disability-transfer populations seen in Table 5–1 can be explained using Figure 5–1. Circle A represents the entire working age population with disabilities, using the Americans with Disabilities Act of 1990 (ADA) definition, namely, working age people who have a physical or mental impairment that substantially limits one or more major life activities, or a record of such impairments, or who are regarded as having such impairments. This definition is more all-encompassing than that of Nagi or the World Health Organization, since it includes people who have limitations, but may or may not be failing in some socially expected role. Previous studies applying this broader definition to the United States have found that from 8 to 12 percent of the total working age population would be included in the population with disabilities depending on the data set and questions used (Bound and Burkhauser, forthcoming).

When the ADA definition is applied across countries or over time in the same country, the size of the overall population in circle A does not dramatically change. However, two subsets within this population, circle B—the eligible disability-transfer population—and circle C—the actual disability-transfer population—will change dramatically.

Circle A is more or less invariant to policy decisions. It is a function of demographic characteristics, such as age and gender. But it is also affected by the quantity and quality of medical care, the wealth of the country, and the education of the population with regard to their personal health. In the long run, circle A can increase or decrease as a result of medical innovations. It decreased when polio was eradicated and will do so again if a cure is found for AIDS. But circle A can also increase. If medical innovations prolong life but do not offset ensuing impairments and functional limitations, then circle A would increase, as, for instance, it did in the case of advancements in medical care for severe spinal cord injuries.

By contrast, the size of the population in circle B has historically been a reflection of public policy in all four countries in Table 5–1. Eligibility rules vary across the countries. Only in the United States is eligibility limited to those who are totally disabled. In the other three countries, eligibility is offered to those who are partially disabled. The criteria for failure to perform work are also important in determining the size of the circle B population. In the United States, the definition is strict and relates to any substantial gainful employment, while Sweden and Germany use a commensurate work definition. That is, if the impairment prohibits a person from doing the kind of work the person has been doing in the past, this is sufficient to become eligible for disability-transfer benefits. In 1993, in an effort to reduce system growth, the Netherlands abandoned its definition of commensurate work and adopted a "substantial gainful employment" criterion like the one used in the United States. This change in eligibility criteria is one of the reasons for the reduction in the relative size of the disability-transfer population in the Netherlands in the 1990s seen in Table 5–1.

A major distinction between the United States disability-transfer program and that of other countries in Table 5–1 is the availability of immediate benefits. The United States has a five-month waiting period and no universal short-term disability program, although many individual employers have short-term disability benefits programs. Sweden, Germany, and the Netherlands all have sickness benefits that can continue for several years. Since 1993, however, the Netherlands has required employers to pay for the first six weeks of sickness benefit. When that policy was imposed, the proportion of workers receiving sickness benefits declined.

Labor market considerations affect the size of the eligible population. Prior to 1987, the Netherlands had an elaborate procedure to measure earning capacity in which officials looked at the characteristics of a person's past jobs. They tried to link the characteristics of these jobs to their measure of the person's impairments. They also had a very intricate six-category system of partial disability, starting at the 15 percent disability level. However, if a person was declared to be partially disabled, even if only at the 15 percent level, but was not currently employed, the person received a full disability benefit unless the government could show otherwise. Hence while the Netherlands had an elaborate system of trying to assign a share of disability to each individual, the overriding importance of labor market considerations effectively meant that very few people actually got partial benefits.

Circle C represents the population currently receiving disability benefits. The size of the circle C population depends on application decisions by the potentially eligible as well as on acceptance decisions by program gatekeepers. Applications are sensitive to general economic conditions. They rise in bad economic periods and fall when the economy improves. For individuals, the size of their benefits and their ease of access to them relative to other alternatives is an important factor in their decision to apply. In disability systems that emphasize work through rehabilitation and quotas, such as in Germany and Sweden, even though disability-transfer benefits are relatively generous, transfer rolls remain relatively low because many in the transfer-eligible population work.

The relative size of disability-transfer benefits compared to those offered by other government programs also makes a difference. For instance, transfer benefits in the German disability system are not much different from the benefits offered by other German transfer programs. By contrast, relatively easy access and high benefits relative to other transfer programs in the Netherlands and in the United States have meant that during the trough period of the business cycle, much greater pressure is put on their disability-transfer programs.

Circle B and C populations do not necessarily have to coincide. Some in circle B work and therefore do not apply for benefits, while others in circle B do not know they are eligible and therefore do not apply. Finally, some in circle B have applied for benefits and are eligible, but they are mistakenly denied benefits. This is known as type–2 error.

Circle C is not a subset of circle B, because some of the circle C population are awarded benefits even though they are not truly eligible. This is Type–1 error. These people are currently unemployed and have disabilities, but they are capable of substantial gainful employment and hence do not actually meet circle B eligibility criteria.

Policy choices make a difference in the size of the two circles and in the degree that they coincide. In its effort to redesign the disability decision process, SSA must decide what it is trying to achieve—for example, reduce the size of circle C, insure that circle B and circle C coincide, insure that circle C is a subset of circle B, minimize Type–1 error, or minimize Type–2 error. If SSA is interested in reducing errors, which is more important—reducing false eligibility or false ineligibility? The discussion at this meeting suggests that we are primarily focusing on reducing Type–1 error. But in making judgments about what we are trying to achieve, it is important to think about the social costs of both types of error when discussing the tradeoffs between added administrative costs and the reduction of such errors.

One important criterion that could be used in any evaluation of a redesigned system is its ability to reduce the uncertainty of outcomes on the part of all parties involved. Ex ante the system should provide better information about the likely outcome for people with disabilities who are required to make the difficult choice of if and when to apply for benefits.

Half of the people with disabilities who have gone through this process and have been denied benefits never work again. There are two reasons why they never work again: (1) the system mistakenly denied them benefits, and (2) the scarring effect of the system itself. If a person invests in trying to get on the program, the rational way to do so is to do everything possible to diminish the possibilities of being judged capable of performing any substantial gainful activity. A person with disabilities planning to apply for benefits has to be unemployed for six months prior to application and during the determination process. Obviously, people out of the workforce for two years are much less likely to get back into the labor force, regardless of their initial condition, than those who try to get back to work before applying for benefits. Therefore, it is possible that a more complex method of reducing errors could lead to worse outcomes, if that system increased the uncertainty of the final outcome to the applicant. Rather than searching for a system that reduces errors based on some gold standard, which in the end will be to some degree arbitrary, a redesigned system should reduce the uncertainty of the process and hence the social costs associated with the disruptions in the lives of people with disabilities.

Chairman SHAW. Thank you. Mr. Mohney. Watch your cord there.

STATEMENT OF RALPH MOHNEY, SENIOR VICE PRESIDENT, CUSTOMER CARE CENTER, UNUMPROVIDENT CORPORATION, PORTLAND, MAINE

Mr. MOHNEY. Thank you, Mr. Chairman, Members of the Committee. My name is Ralph Mohney and I am Senior Vice President for the Customer Care Organization of UnumProvident Corp. I appreciate this opportunity to testify about UnumProvident's roll as the world's leading provider of disability insurance. First, however, I would like to commend this Congress for passing the return-to-work legislation that was enacted last year.

Your efforts eliminated two significant return-to-work barriers by continuing government health insurance and by setting up trial return to work opportunities. My comments will focus on how to build upon this landmark legislation. UnumProvident is a publicly traded insurance holding company. We provide insurance solutions to a wide clientele ranging from individuals to small employers to several of the nation's largest industrial companies and internationally in Japan, Europe and Canada. We are the world's leading provider of disability insurance.

UnumProvident's disability claim organization, which we call Customer Care, provides critical support for very diverse customers. The organization fulfills this traditional roll of thoroughly, fairly, and objectively evaluating claims, paying legitimate claims promptly and with a high level of service, and defending against those few claims that are not legitimate. But our claim management employees then go beyond the traditional role to proactively assist insureds in their return-to-work efforts.

This involves providing specialized resources when appropriate to help each individual regain the ability to earn an income and become self-sufficient once again. The UnumProvident claim management model is driven by four important elements, triage, early intervention, impairment-based claim management, and face-to-face interaction provided by our GENEX subsidiary. Nearly half of our new long-term disability claimants are able to return to work within 6 months of receiving benefits.

For our claimants who are also receiving Social Security benefits, we experience a recovery rate that is roughly six times the reported Social Security recovery rate. As stated in the Ticket to Work legislation, one-half of 1% improvement in Social Security disability recovery rates would yield $3.5 billion of savings for the program. Social Security can improve its experience if the logical next steps of last year's legislation are adopted.

I recommend that this Subcommittee explore the following four key areas based on our experience in the private sector. The first area is triage. Over one million new claims are received for Social Security disability payments each year. The conditions of these individuals range widely from situations involving permanent and total disability to shorter term disability where recovery can be expected. An appropriate triage system applying the right resource to the right claim at the right time will enhance return-to-work effectiveness and insure appropriate use of resources.

The second area is early intervention. For claimants with recovery potential early and ongoing clinical intervention is essential to return-to-work success. We have found that face-to-face personal attention, particularly our expert GENEX resources, are invaluable in terms of evaluating appropriateness of care. The third area is continual claim management. Social Security policy should go beyond simply determining initial eligibility and focus more on the ongoing eligibility for benefits and more continual review of claims.

Again, we return 50% of long-term disability claimants to work within the first year. Ongoing management is essential for this success and it is important to integrate medical advances into the continual review process. The fourth area is adaptable benefits and incentives. Recovering from disability really is an incremental process and adaptable benefits are essential to address the stages of disability. Features such as transitional work funding and partial payments, as well as assistance through vocational training.

In addition, legislation could provide more incentives for employers who return employees to work. These recommendations will create financial value for the individuals and for the Social Security program. While there will be initial cost, the long-term savings will prove significant. In conclusion, let me say that there is dignity associated with a person's ability to work and great value in the ability to live a full and independent lifestyle. This philosophy and its focus on abilities is behind all of the customer care resources of UnumProvident. Thank you once again for allowing me this opportunity.

[The prepared statement follows:]

Statement of Ralph Mohney, Senior Vice President, Customer Care Center, UnumProvident Corporation, Portland, Maine

My name is Ralph Mohney, and I am the Senior Vice President for the Customer Care organization of UnumProvident Corporation (UnumProvident). I appreciate this opportunity to share our corporate best practices through testimony about UnumProvident's role as the world's leading provider of disability insurance.

First, however, I would like to commend this Congress for passing the return-to-work legislation that was enacted last year. Your efforts eliminated two significant return-to-work barriers by continuing government health insurance and by setting up opportunities for trial return to work without forfeiting Social Security disability benefits if the process is not successful. My comments will focus on how to build upon this landmark legislation.

Corporate Background and Philosophy

UnumProvident is a publicly traded insurance holding company formed by the merger of Unum Corporation of Portland, Maine, and Provident Companies, Inc., of Chattanooga, Tenn.

UnumProvident has major centers of operation in Chattanooga, TN; Portland, ME; Columbia, SC; and Worcester, MA. Our international presence includes disability operations in the United Kingdom, Canada and Japan. In addition, the company utilizes the resources of its subsidiaries, GENEX and OCI, headquartered in Pennsylvania and Wyoming respectively. The single largest functional area within UnumProvident is our unique Claims Management area, which we have named Customer Care. It is an area of rapid growth—we recently held a ribbon-cutting ceremony for a new claim management operation in Glendale, CA to serve the West Coast market.

UnumProvident provides insurance solutions to a wide clientele, ranging from individuals through small employers to several of the nation's largest industrial companies. UnumProvident reported total revenue of $9.4 billion for the twelve months ending March 31, 2000. The company holds the following industry-leading positions:

Individual income protection	#1
Long-term disability income protection	#1
Short-term disability income protection	#1
Group long-term care	#1

We strive to deliver on our customer commitment through our integrated product solutions, return-to-work expertise, and responsive service. We are dedicated to our purpose, "protecting everything you work for."

Having built the premier leadership position in the insurance industry's strongest growth markets, we are deploying our people, technology, integrated product and service offerings, and multiple channel network to deliver the value the marketplace demands. UnumProvident serves many customers. For this discussion, I will focus on the group long-term disability insurance solutions we provide to employers to assist their employees during times of disability.

Meeting Customer Needs

UnumProvident is in the business of protecting our customers' income. Disability insurance is not a mandated form of financial protection. It is a choice. Therefore, we are committed to educating consumers about the value of disability insurance as an essential and necessary form of financial protection. The statistics clearly support this need. Approximately 54 million Americans (1 in 5) have a disability. This represents 21 percent of the total population of the United States.[1] To place that in an employer perspective, in 1995, 120,000,000 workdays were lost because of work injuries.[2]

We recognize that disability affects all walks of life, and our comprehensive and affordable income protection portfolio addresses this spectrum. Our company seeks opportunities to position our three leading product platforms—individual, group and voluntary benefits—to appropriately cover the continuum of life needs that are experienced by our customers.

UnumProvident's product strategy is designed to fit the industries for which we write business. We recognize that today's consumer marketplace has a multitude of different needs, many of those being nontraditional. For example, we do not automatically exclude high-risk industries such as trucking or high-rise construction from insurance coverage; if otherwise eligible, they have the option to purchase catastrophic disability coverage. For customers who have suffered disability and wish to reenter the workforce in a self-employed fashion, we offer financial support they can use to start their own business. UnumProvident also participates in the important long term care market, leading the industry in providing group long term care. Our product pays benefits for the loss of two or more "Activities of Daily Living" or severe cognitive impairment. A simplified indemnity model pays the full monthly benefit amount selected, regardless of the actual expenses incurred.

Through special risk coverages such as these, UnumProvident is able to help answer non-traditional financial needs through creative solutions.

Customer Care Background

UnumProvident's disability claims organization provides critical support for these diverse customer needs. The organization fulfills the traditional role of thoroughly, fairly and objectively evaluating claims, paying legitimate claims promptly and with a high level of service, and defending against those few claims that are not legitimate. Our claim management employees then go beyond the traditional role to proactively assist insureds in their return-to-work efforts. This involves providing specialized resources when appropriate to help each individual regain the ability to earn an income and become self-sufficient once again.

UnumProvident terms its claims management organization the Customer Care Center. This name was chosen because it truly reflects the department's mission—serving customers, protecting them against loss of income, and caring enough about our customers to assist them in return-to-work efforts when disability strikes. We believe that our success lies not just in how we manage claims, but in the policies and procedures that form the basis of our organization. Through appropriate contracts and service, we ensure that our customers are receiving the benefits for which they have paid. In 2000, we expect to manage more than 400,000 new disability claims across our six Customer Care Centers in the United States.

The Claim Management Model

The response to our interpretation of marketplace needs has been the creation of a Customer Care organization focused on assuring that every income protection claim receives the most effective early intervention and the most appropriate management possible. The UnumProvident claim management model is driven by these four important elements:

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[1] McNeil, J.M. (1997) Americans with Disabilities: 1994–95. U.S. Bureau of the Census Current Population Report P70–61. Washington, DC: U.S. Department of Commerce.

[2] National Safety Council, Accident Facts, 1996 Edition.

Triage: During triage, each claim is examined and the appropriate resources are assigned to meet the specific claim criteria. Claims are channeled to one of five different claim management pathways, depending on the level of clinical and other resources which would be appropriate for the claim. Detailed evaluation occurs within five days of claim receipt.

Early intervention: An emphasis on early intervention speeds recovery and return to work. For claims with clinical issues, nurse case managers make contact with the attending physician, employer and insured within 48 hours of claim receipt. The purpose of this contact is to evaluate appropriateness of care, to develop treatment plans geared toward return to work, and to ensure that employers are willing to make reasonable accommodations.

Duration-and impairment-based management: The state-of-the-art initial triage process speeds claims to the most appropriate care pathway. In addition to duration-based units, our impairment-based specializations include cardiac, orthopedic, psychiatric, and general medical claims. This month, we will be staffing our newest impairment-based unit at all sites—the cancer unit.

This approach is driven by teamwork and expertise. For example, in the psychiatric unit, a claim is received and evaluated by a consultant. After review, the consultant channels the claim to the appropriate claim specialist based on level of difficulty or complexity. The specialist builds a claim action plan and brings the claim to a roundtable that includes a psychiatrist or psychologist. The roundtable may refer the claim to an addictionologist or neurologist, or may seek external expert input. These experts will examine appropriateness of care as well as expected duration of the claim. Such teamwork allows us to place specific focus on the impairment in a way that promotes knowledgeable service and increased return-to-work potential.

GENEX: When more personal face-to-face interaction is appropriate, field-based case managers and vocational rehabilitation specialists with our GENEX subsidiary work directly with the employer, employee, treating physician and customer care specialist to ensure that medical care and treatment are directed toward return-to-work goals.

UnumProvident has invested significantly in medical and rehabilitative resources to support the claim management model. They include:

- Nearly 100 physicians and several hundred nurse case managers and vocational rehabilitation counselors;
- More than 700 nurse case managers and vocational rehabilitation professionals within our GENEX subsidiary, located in over 100 offices across North America; and
- 3,000 Customer Care Center employees organized around specific durations and impairments.

The claim management model is an important factor in UnumProvident's ultimate goal to offer a quality customer experience. By building a strong level of expertise in each duration-and impairment-based medical area, the company offers improved specialization, individualized customer service, and significantly improved return-to-work experience.

Nearly half of our new claimants are able to return to work within six months of receiving benefits. For claimants who are also receiving Social Security benefits, we experience a recovery rate that is roughly six times the reported Social Security recovery rate. As stated in the return-to-work Ticket to Work legislation, a one-half of one-percent improvement in Social Security disability recovery rates would yield $3.5 billion over the work life of such individuals. Social Security can improve its experience if the logical next steps are adopted to build on progress made by the legislation.

Return-to-Work Emphasis

UnumProvident understands that the best insurance against unnecessary work disruption is the ability to return an employee to a productive lifestyle in a timely fashion. Each year, more than 750,000 Americans experience injuries or illnesses that keep them out of work for five months or longer.[3] For the employer, this may mean absorbing extensive and unnecessary lost time costs. Employee replacement and retraining costs become an additional, unexpected expense.

Some large and small employers have corporate health and return-to-work practices and policies that are clear, comprehensive and coordinated—actively inviting employees back to work. Most employers, however, randomly tend to the work dis-

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[3] Annual Review of Disability Management, 1992, The Washington Group/Health Institute for Rehabilitation and Disability Management.

ruption in their work force. They may provide unclear or competing expectations about returning to work through their organizational policies and practices.

The employers who demonstrate the greatest success in controlling the impact of work disruption and lost time are those who incorporate formal return-to-work strategies within their employee relations activities and benefit plans. At UnumProvident, our corporate Return to Work Dividend Program is a consultative service offered to employers to structure policies and procedures to achieve return-to-work success. The program offers a unique blend of policy and staff development opportunities through:

- Return-to-work programs that assist employers in defining the impact of lost time and creating practical return-to-work strategies;
- Integrated disability management that assists organizations in determining its readiness and capacity to integrate the wide range of its disability insurance, workers' compensation, lost time and healthcare programs;
- Absence management strategies to evaluate, select and develop programs that manage FLMA, intermittent and casual lost work days; and
- Assistance that enhances the employer's capacity to apply computer-based assistive technology.

Another important element of UnumProvident's return-to-work commitment is an understanding of the science of disability. The company is a leading proponent of disability research, with groundbreaking work based on the realization that disability management goes far beyond simply verifying and paying claims. We continually make investments in understanding both the scientific and human aspects of disability at every stage of life so we can offer more than just a benefit check to our customers.

A core part of this commitment to understanding disability is the work done by our Disability Research Alliance. Current initiatives include active physician education and employer education programs. The Alliance is also partnering with the Washington Business Group on Health and Watson Wyatt Worldwide in the "Progression of Disability" study. This study, conducted with Virginia Commonwealth University, addresses the variables that occur in the progression from short-term disability to long-term disability to Social Security benefits.

Visible Impact

I would like to illustrate the information I've shared with you about our claim process and philosophy through several return-to-work success stories. Increasingly, we are finding that some claims thought to be long-term in nature actually have the potential for recovery. These stories demonstrate the impact that return-to-work support and medical advances can have on claim results.

- A 48-year old Virginia AIDS claimant who stopped working in March 1996 saw his condition begin to improve in May 1999 as a result of new drug therapy. A UnumProvident vocational rehabilitation counselor discovered in phone discussions with the claimant that he was interested in returning to work full-time. The outcome is shown in this letter from the claimant to the counselor:
- "It was very nice to talk to you on the phone about the happy news of my new job. You were the first person with whom I shared this good news. I am thankful to you for your counseling and consultation. You gave me the inspiration and courage to stand once again on my own feet. It was very encouraging when you told me that I have the skills and potential, that I just needed to polish my skills and my résumé. On a regular basis, you were in touch with me, asking how I was doing. By your blessings, I finally achieved my destination. I got a job in________International, Inc. Thank you very much once again for the blessings, inspiration, support and courage you gave me for the last nine months."
- Kevin Bibeau was involved in a car accident that left him severely disabled. At the time of his accident, Kevin knew very little about his employer-provided disability insurance. He found that his UnumProvident coverage enabled him to meet his living expenses and allowed him to go back to work part-time and receive a continuous salary. UnumProvident then collaborated with his employer, helping him return to his full-time job as an engineer sooner than originally expected. Kevin's experience with UnumProvident has caused him to encourage others to consider the value of long-term disability insurance. According to Kevin, "Long-term disability insurance is the best-kept secret. . . I don't think people believe anything is going to happen to them that will cause them to go on long-term disability. It's nice to know it exists and that you have it just in case."
- A North Carolina claimant has been physically disabled under our policy for 12 years and has been denied benefits by Social Security three times. After 12 years out of the workforce, she wants to move on with her life and find a way to rejoin

the workforce. UnumProvident is now working to provide her a lump sum amount that will allow her to purchase a small franchise business that will allow her to actively return to work.

These stories demonstrate creative solutions, as well as the honorable purpose and potential impact shared by all providers of disability insurance.

The Millennium Workforce

Over the past 100 years, it is estimated that there have been more than 250,000 pieces of state and federal legislation defining and reforming the nature and scope of our response to work place injury and illness. In spite of these efforts, the fundamental nature of injury and illness in the work place remains the same. To address the challenges at hand, we must alter the basic concepts of disability.

As we move ahead and form a new understanding of disability, research shows us several critical points about the work force of the new millennium:

Impairment does not equal disability. Impairment is objective. Disability is subjective and is created by the benefit plan design. The plan determines how long someone stays out of work, not how long they suffer from the impairment.

Ambiguity limits recovery and return to work. All too often, the employer fails to define the expectations for an individual to return to work. Clear corporate policies supported by well-defined work prescriptions reduce the incidence of lost time.

Corporate policies sometimes disable employees. Corporate policies can be the greatest contributor to employee disability. The most common disabling corporate policy is the “100% or nothing” threshold. This policy says that an employer is willing to wait until the employee is cleared of all impairment before coming back to work. In fact, the employee will regain functional capacity incrementally.

In the case of Social Security, current policies encourage individuals to argue they are fully disabled and can not return to work. Otherwise, they are not eligible for benefits. In convincing the system, they also convince themselves.

Physicians are not HR managers. Physicians are not prepared as HR managers. They understand impairments but not the occupation requirements of specific jobs. They need to be trained to be able to define the conditions under which an employee can resume a safe transition back to full work.

Disability cloaks performance problems. Some supervisors use a disability program to solve job performance problems. This is a very expensive practice and reflects an inadequate human resource program.

Return-to-work best practices. Proven strategies that reduce lost time and prevent extended disability are:

- Create clear, consistent and early return-to-work expectations;
- Implement a formal planning process;
- Provide formal supervisor training on the process; and
- Establish transitional return-to-work pathways based on job demands and worker functional capacities.

These key points should serve as instruction for disability insurers as they craft programs and implement solutions for the marketplace.

Recommendations

Based on the experience and expertise of UnumProvident, I would like to provide recommendations to the Subcommittee on Social Security for consideration as the Subcommittee considers challenges in the 21st century.

Let me reiterate, last year’s Ticket to Work legislation removed important return-to-work barriers that were contributing to the historical less than one-half of one-percent recovery rate of Social Security recipients. Now we need to take the next steps and change the infrastructure to facilitate return to work for Social Security disability claimants. Also it will require that the concept of disability be altered—disability does not mean inability, it means experiencing and recovering from disability in stages.

I recommend that the Subcommittee explore the following four key areas based on our experience in the private sector:

- *Triage:* Approximately three million new claims are received for Social Security disability payments each year. The conditions of these individuals range widely from situations involving permanent and total disability to shorter-term disability where recovery can be expected. An appropriate triage system applying the right resources to the right claim at the right time will enhance return-to-work effectiveness and ensure appropriate use of resources.
- *Early intervention:* For claimants with recovery potential, early and ongoing clinical intervention is essential to return-to-work success. At UnumProvident, this intervention takes the form of three-point contact with the attending physician,

claimant and employer. We have found that face-to-face personal attention, specifically, our expert GENEX resources are invaluable in terms of evaluating appropriateness of care.

- *Continual claim management:* It is recommended that Social Security policies go beyond simply determining initial eligibility to achieve more focus on ongoing eligibility for benefits and more continual review of claims.

It is important to maximize the level of expertise applied to claims, and to integrate medical advances into the continual review process. The impairment-based model used by UnumProvident has already resulted in a significant increase in applied expertise and medical resources, therefore better meeting the customer's needs. We feel this is the best way to leverage and apply specialized care.

- *Adaptable benefits and incentives.* UnumProvident's plan designs include return-to-work features such as transitional work funding and partial payments, as well as assistance through vocational training. It is recommended that Social Security continue to align its government assistance in a similar manner to encourage return-to-work efforts. Recovering from disability is an incremental process and these types of adaptable benefits are essential to address the stages of disability.

In addition, legislation could provide more economic incentive for the employer to entice employees to return to work. It would also prove helpful to quantify ratings experience by industry to encourage employers to visualize how disability can drive up costs. With ratings as reference, employers will have more incentive to be actively involved in the disability management process, as has been the case in terms of worker's compensation management.

These recommendations will create financial value for the individuals and for the Social Security program. While there will be initial costs incurred, the long-term savings will prove significant.

Conclusion

There is dignity associated with a person's ability to work and great value in the ability to live a full and independent lifestyle. This philosophy—and its focus on abilities—is behind all the Customer Care resources of UnumProvident.

Quite simply, we believe that the general population does want to be active in society and part of the workforce. Statistics support this belief—sixty percent of Americans not working say that they would like to if the opportunity were made available.[4]

For those of us in the disability insurance industry, it is both our job and responsibility to ensure we make that opportunity a reality. In closing, I would like to thank you once again for offering me this opportunity to testify. I would now be happy to answer any questions.

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Chairman SHAW. Thank you, sir. Mr. Young.

STATEMENT OF TONY YOUNG, CO-CHAIR, TASKFORCE ON SOCIAL SECURITY, CONSORTIUM FOR CITIZENS WITH DISABILITIES; AND DIRECTOR, GOVERNMENTAL AFFAIRS, NISH, VIENNA, VIRGINIA

Mr. YOUNG. Thank you, Mr. Chairman, for this opportunity to testify on behalf of the Consortium of Citizens with Disabilities Taskforce on Social Security. Federal disability programs were created assuming that people with disabilities would remain unable to work throughout their lives. This static view of disability meant that little thought was given to what might happen if people returned to work after receiving benefits.

However, we now know that disability is not static but a dynamic condition. Medical advances, new technologies, improvements in services and supports, along with enhanced expectations of people with disabilities, have all conspired to change the very definition

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[4] Richardson, Mary, 1994. The Impact of the Americans with Disabilities Act on Employment for People with Disabilities. Annual Reviews, Public Health. 15:91–105.

of disability. The consequences of this new disability dynamic have rippled through the Federal disability system, revealing that it is not ready to meet the challenges ahead.

Many people are surviving injuries, disabling diseases, or traumatic accidents to live with significant disabilities. Some have access to the latest technology, medications, surgeries, therapies, and other disability management procedures. However, many do not have access to these state-of-the-art services nor will they have access to potential advances in genetic treatments. This opportunity gap will widen the discrepancy in work opportunities for those in SSA disability programs.

The changing demographics of individuals on the SSA disability programs, the nature of their disabilities, the age of onset, the length of time in the programs, and related factors has had and will have a profound impact on SSDI and SSI. We offer some brief statistics on page two of our written statement. It must be noted that people on Federal disability programs are markedly different than those on private disability or those on disability programs in other countries.

What works for one population may or may not work for others, yet while there is much diversity among disability beneficiaries they share common concerns including an easy transition from benefits to personal support rather than a sudden cutoff of benefits, easy re-entry to benefits if work is not successful, no total cutoff of benefits until reaching a living wage with comparable health coverage, and a flexible benefit for individuals who can only work episodically such as those with mental illness.

While Federal disability programs provide needed cash assistance and supports there are weaknesses in these programs we wish to discuss. These include Social Security's definition of disability which continues to focus on near complete inability to work, the unrealistically low substantial gainful activity level, the poor coordination among programs providing Federal assistance to people with disabilities, the poor integration of SSI with work programs for older, disabled children, the ineffective tracking of earnings, and the remaining work disincentives not addressed by the Ticket to Work and Work Incentives Improvement Act.

In addition, SSA is facing complex future work challenges. During the next 20 years, the number of people who reach full retirement and early retirement ages will increase substantially and this will have an enormous impact on SSI's operations. The SSA customer population has changing expectations about technology and it has more claimants that are non-English speaking or limited English speaking.

Further, SSA must provide increased employment services for people with disabilities, must maintain an aggressive schedule of continuing disability reviews, and other eligibility reviews, and must implement new approaches to prevent fraud and abuse all while operating a disability determination process that remains complicated and lengthy. These problems are aggravated by SSA's own aging work force which soon will lose significant numbers of experienced staff including senior leadership personnel.

The task force recognizes no single hearing can capture all the questions that need to be addressed about the future of Federal disability programs and that this is just the beginning of an exploration of ways to modernize the disability program. We also recognize that some of these questions fall under other Committees' jurisdictions, which may indicate a need for greater coordination for disability programs within Congress.

We offer several other issues in our written statement that the Committee should examine as it continues its investigations, including SSA policies on technology acquisition, CDRs under Medicaid section 1619(b) or Medicare, Medicaid's 209(b) provisions, and the Medicaid 1619(b) formula for individual determinations among others. We appreciate the Subcommittee's interest in these issues and look forward to continuing to work with you in modernizing the disability programs. I would be happy to answer any questions you have.

[The prepared statement follows:]

Statement of Tony Young, Co-Chair, Task Force on Social Security, Consortium for Citizens with Disabilities, and Director, Governmental Activities, NISH, Vienna, Virginia,

ON BEHALF OF

American Association on Mental Retardation
American Council of the Blind
American Network of Community Options and Resources
American Occupational Therapy Association
Brain Injury Association
Easter Seals
Epilepsy Foundation
International Association of Psychosocial Rehabilitation Services
InterNational Association of Business Industry Rehabilitation—INABIR
National Association of Developmental Disabilities Councils
National Association of Protection and Advocacy Systems
National Association of Social Security Claimants Representatives
National Mental Health Association
National Multiple Sclerosis Society
NISH—Creating Employment Opportunities for People with Severe Disabilities
Paralyzed Veterans Of America
The Arc of the United States
Title II Community AIDS National Network

Chairman Shaw, Mr. Matsui and members of the subcommittee, thank you for the opportunity to testify today on the Future of SSA Disability Programs. I am Tony Young, Director of Government Activities for NISH and Vice Chair of the Consortium for Citizens with Disabilities. CCD is a coalition of nearly 100 national organizations advocating on behalf of people with all types of physical and mental disabilities. I am testifying today in my role as a Co-Chair of the CCD Task Force on Social Security.

INTRODUCTION

We appreciate having this opportunity to examine the needs of persons with disabilities who are on, or who will be participants in, the SSA disability programs—Social Security Disability Insurance [SSDI] and Supplemental Security Income [SSI]. SSDI began in 1956 as an early retirement program for injured workers who could not struggle through to the regular retirement age of 65. SSI, created in 1972, was a program intended to supply a minimum level of economic support to the elderly, blind or persons with disabilities whose work history was insufficient to qualify them for SSDI.

Since their inception, these disability programs have evolved unevenly whereby individual problems in the programs were identified and partially solved, not always with a comprehensive view or purpose. Changes have come only when program parameters have been found to be grossly out of line with reality. For instance, the substantial gainful activity [SGA] level was finally raised in 1999 to $700 per month after having been set at $500 per month since 1990. Some program criteria, such as the SSI earned income disregard, has not been changed since the program began in the early 1970s.

Federal disability programs, as originally envisioned, were based on the assumption that people who became disabled would remain disabled throughout the rest their lives. This static view of disability meant that little thought was given to what might happen if people returned to work after becoming eligible for benefits. However, disability is not static. Disability is a dynamic condition. Medical advances, new technologies, improvements in rehabilitation services, and the expectations of people with disabilities have all conspired to change the meaning of disability, the very definition of disability. The consequences of this new disability dynamic have rippled through the federal disability system, revealing a system that has not adapted to meet the challenges ahead.

DEMOGRAPHICS, SOCIETY AND THE ROLE OF PEOPLE WITH DISABILITIES

The changing demographics of individuals who might benefit from the SSA disability programs—the nature of their disabilities, the age of onset, the length of time in the programs, and related factors—has had and will have a most profound impact on SSDI and SSI. Some brief statistics provide a snapshot of Americans with disabilities and the circumstances in which they live.

In 1996, the Government Accounting Office [GAO][1] reported that, during the period 1985 to 1994, the number of people with disabilities on SSI and SSDI increased from 4.2 million to 7.2 million. By 1994, 57% of people on SSI aged 18 to 64 were those with mental impairments. For those on SSDI the percentage was 31% of the DI population. The DI and SSI populations became somewhat younger during that time period: DI beneficiaries in "middle age' [30 to 49] increased from 30% in 1986 to 40% in 1994; for SSI beneficiaries the increase was from 36% in 1986 to 46% in 1994.

The majority of Americans with disabilities are of working age [57.6%]. Native Americans have the highest disability rate of all racial groups [17.6%]; Asians and Pacific Islanders have the lowest rate [7.2%]. For whites and African Americans, the rates are 15.3 and 15.9 percent respectively but Hispanics report a disability rate of only 10.5%. Disability rates are highest in rural areas [although most people with disabilities live in metropolitan areas (74.8%)]. Disability rates are 3 times higher among people who did not finish high school than among those with college degrees. People with disabilities, according to a 1992 National Health Interview Survey, include 4 million Americans with heart disease, 3.7 million with arthritis, 1.5 million with mental disorders, 1.4 million with mental retardation or learning disabilities. There are over half a million Americans with spinal cord injuries or dysfunction and 654,000 with hearing impairments.[2] Another 1.4 million individuals have visual impairments.[3]

Only 3 in 10 working-age adults with disabilities are employed full or part time, compared with 8 in 10 non-disabled adults. This low rate of employment has led to an income gap not reduced since 1986. One in 3 disabled adults, compared to 1 in 8 non-disabled adults, live in households with incomes below $15,000.[4]

Any examination of federal disability programs must be viewed in light of the evolving societal factors surrounding people with disabilities—such as the Individuals with Disabilities Education Act [IDEA] and Americans with Disabilities Act [ADA]—and the shifting expectations of the role that individuals with even the most severe disabilities can play in the lives of our communities and economy. Among the most exciting advances have been our expectations for individuals with the most significant support needs. For example, over the past twenty years we have moved from building institutions to creating individualized living arrangements in the community for individuals who have been labeled with a significant cognitive disability. Well over 200,000 individuals who once were never expected to spend their days beyond the protective walls of congregate settings such as sheltered workshops or adult day activity centers are now working in the community in real, competitively paid jobs through supported employment. They now do what the rest of us do: go to a wide array of jobs, collect their paychecks, and go home, many with supports, some with none.

The nation will celebrate the tenth anniversary of the Americans with Disabilities Act later this month. That Act recognized what the disability community has known for years, that "disability is a natural part of the human experience." The protections afforded by the ADA have opened the windows on the disability experience

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[1] GAO/HEHS–96–62, SSA Disability Program Redesign Necessary to Encourage Return to Work, April 1996

[2] Disability Watch, Disability Rights Advocates, Volcano Press, Volcano, CA, 1997

[3] American Council of the Blind

[4] 1998 N.O.D./Harris Survey of Americans with Disabilities

and revealed a myriad of individual skills and capacities that very closely parallel those of people without disabilities. This exposure, along with an explosive growth of technology, research and training, best practice services and supports, individual awareness and self-determination have changed forever the way that we approach disability in this country from public policy to practice.

NEW TECHNOLOGIES, MEDICAL ADVANCES AND IMPROVEMENTS IN SUPPORTS AND SERVICES

Much of the changing attitudes toward people with disabilities and their capabilities have been driven by the transformation of the workplace and the environment through technology, breakthroughs in medical science, and innovations in supports and services used to enhance the independence of individuals with disabilities. Four years ago, the GAO noted that, despite poor return-to-work outcomes under SSI and SSDI, "many technological and medical advances have created more opportunities for some individuals with disabilities to engage in work. Electronic communications and assistive technologies—such as scanners, synthetic voice systems, standing wheelchairs and modified autos and vans—have given greater independence to some people with disabilities, allowing them to tap their work potential. 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 opportunities, particularly for some people with physical impairments, in the growing service sector of the economy."[5]

Finally, the development and replication of new supports and services has made it possible for many more people with disabilities to receive the rehabilitation and on-going supports they need to work. Psychosocial rehabilitation, occupational therapy, and job coaching are just some of the services now available to people with severe mental and physical disabilities. These services help people assume and maintain work and also include services to develop or enhance self-care skills so that the individual can function in society.

Many people with significant disabilities are surviving injuries at birth, disabling diseases, or traumatic accidents. Some of these survivors are living longer, more healthy lives. Some, however, are not. Some of these survivors have access to the latest technological aides that make them productive and independent. Many other survivors do not have access to this technology. Some individuals have access to the latest prescription medications, surgical techniques, intervention therapies, and other modern disability management procedures. Most people with severe disabilities do not. The future holds potential for remarkable advances in gene therapy and similar genetic treatments that some will have access to, but many still will not. This opportunity gap will widen the discrepancy in work opportunities for those who might qualify for SSA disability programs.

Different types of supports and expectations are needed and appropriate for people of different ages and with different types of disabilities. Disability is as individual as the person who experiences it. Each disability has its own personality, with strengths, weaknesses, and even quirks. Each must be treated appropriate to its own personality in order for the individual with the disability to be successful at whatever they might attempt to do.

Clearly, age and disability are interrelated when it comes to work aspirations. A young adult who has never worked will have greatly different aspirations than an individual in mid-work life with several years of work experience, and that individual will have different aspirations than an older individual who has many decades of work experience.

Their needs for income and supports will vary greatly as well. To treat everyone equally is to mistreat the majority of those on the program. Individualized assessments of needs and services are essential to successfully assisting people with disabilities to work. There must be incentives for people to encourage them to risk leaving the benefit program, and there must be an easy transition from benefit support to personal support. It is essential that all persons be allowed to seamlessly reenter the benefit program should they fail in the effort to work.

It is possible to identify common concerns for all as well as particular concerns of subgroups. Common concerns include: 1) an easy transition from benefits to personal support rather than a sudden cutoff of benefits; 2) easy reentry to benefits if work is not successful; 3) no total cutoff of benefits until one reaches a living wage with comparable health coverage; and 4) a flexible benefit for individuals who can only work episodically, such as those with mental illness.

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[5] GAO/HEHS–96–147, Social Security: Disability Programs Lag in Promoting Return to Work

WEAKNESSES OF FEDERAL DISABILITY POLICY

Definition of Disability—In a 1996 report, the GAO identified at least "fourteen different definitions of disability used by federal programs alone, and many of these definitions provided considerable agency and state discretion in eligibility determinationa. . . For example, programs administered through the Department of Education, such as VR, defined eligibility in terms of physical or mental impairments, whereas the programs administered through SSA defined disability in terms of the inability to work."[6]

One of the most serious problems with current disability program design and policy derives from the fact that Social Security's definition of disability continues to focus on near-complete inability to work. Furthermore, the measure for ability to work is set at a level of income that does not provide even a base of support necessary for most people to live. Many of the policies that penalized people with disabilities for working have been addressed through last year's Ticket to Work and Work Incentives Improvement Act. Yet, the retention of the unrealistically low substantial gainful activity [SGA] level continues to punish rather than reward people who attempt to leave entitlement programs through work. We recognize that considerable debate has already occurred on this subject. However, we reiterate once again our firm belief that federal disability programs must respond to modern reality rather than remain mired in the mind-set of the last century.

In the past, CCD has recommended changes in the definition of disability that would: retain the criterion of mental or physical impairment [or combination of both] verifiable by accepted clinical methods; replace the concept of SGA with an assessment of functional limitations in all areas of life activities; and consider vocational, medical and other factors in an overall assessment of an individual's functioning in areas of major life activity. Furthermore, attention must be paid to how temporary, recurring/intermittent, or partial disability is addressed by federal disability programs.

Whatever future steps Congress may take in this regard, CCD urges you to proceed with caution. Any proposals to revise the definition of disability, whether through statute or regulation, should be subjected to careful analysis of the effects on people with disabilities and a realistic assessment of the true meaning of disability, including for those who are able to work with necessary, on-going supports.

Multiplicity of Federal Disability Programs—In 1996, the GAO found that federal assistance to millions of people with disabilities was provided through 130 programs in 19 federal agencies.[7] Very often, service delivery is performed through numerous public and private agencies at the state and local level. In the fiscal year studied [1994], GAO revealed that the federal government spent over $60 billion on 69 programs targeted exclusively to people with disabilities. In addition, people with disabilities benefited from between $81 billion and $184 billion in spending through 61 partially targeted programs. This list of programs did NOT include AFDC, the forerunner of Temporary Assistance to Needy Families [TANF]—as GAO eliminated programs not specifically intended to address disability. How well these programs coordinate with one another and how well they serve the people they were created to help are questions worth considering.

Interaction with Other Governmental Programs—As noted above, SSA disability programs do not exist in a vacuum. There are over 100 federal programs that affect people with disabilities. It is imperative to examine how the SSA disability programs interact with other poverty programs, e.g., job training, Food Stamps, housing subsidies, transportation supports, long-term supports, and similar programs. A major issue for individuals with severe disabilities concerns the need to stitch together a patchwork quilt of income, and in-kind supports in order to live. Too often, taking a job unravels this quilt in ways that undermine the work effort and trap them in poverty and government cash assistance.

For example, Medicaid policy allows some states to have stricter Medicaid income levels, asset levels, income disregards and even medical disability definitions than SSI. This means that incentives for SSI recipients to return to work are seriously undermined because the Medicaid needed to support work attempts is not always available if Medicaid rules are not the same as those of SSI. In addition, continuing disability reviews [CDRs] that find people "no longer disabled" not only deprive them of cash benefits but they cost such persons continued Medicaid and Medicare which, under current law, are supposed to be available to those who leave the SSI and SSDI rolls to work. Furthermore, the Medicaid formula for determining medical

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[6] GAO/HEHS–96–126, People with Disabilities: Federal Programs Could Work Together More Efficiently to Promote Employment, September 1996

[7] Ibid.

expenses used for individualized computations of earnings thresholds in determining continued eligibility under Section 1619(b) now only recognizes publicly-provided attendant care costs and fee-for-service per capita Medicaid expenditures on behalf of that particular patient. Accounting for the true costs of supports becomes an issue when states' Medicaid reimbursements are only recorded as capitations to managed care contractors—-and do not, therefore, fully recognize the high costs of services actually rendered to particular disabled individuals.

HUD housing programs do not have earnings disregards. Local public housing authorities do have authority to institute earnings disregards for public housing units—-but NOT for Section 8, vouchers, Section 212, Section 811 or the special subsidies for people with disabilities established by Congress in the late 1990s. And even this limited authority has so far been largely directed at helping TANF mothers in public units return to work.

A growing body of research indicates that a large proportion of parents receiving TANF [or who have left TANF] have disabilities or health conditions that may affect their ability to succeed in the workforce if they are not provided with the appropriate supports and services to help them succeed.[8] In addition, many families who are eligible for Medicaid or other publicly funded health insurance coverage are not enrolled in those programs, due to the de-linking which has occurred.

These are but a few of the complexities of the social security disability programs' interactions with other government programs.

Integrating SSI with work programs for older disabled children—Children in the IDEA era have, generally speaking, been entitled to a free and appropriate public education and, theoretically, have had access to an array of services while in school. However, they lose these supports upon attaining a certain age and often fail to advance into the world of adult employment as a result. Children and their families need the services accorded by IDEA in order for them to perform at satisfactory levels to achieve their educational goals. These same or similar services may be required for them to then meet their vocational goals. In addition, there is the need to eliminate the penalties built into the current system for young people who need ongoing supports even while working.

Work Incentives—The Ticket to Work and Work Incentives Improvement Act, in reality a major achievement in addressing certain deficiencies in federal disability programs, is placed here to draw attention to remaining hurdles confronting people on SSI and SSDI. Furthermore, because PL 106–170 has yet to be implemented, we cannot predict how successful it will be in eradicating barriers it was created to remove.

A major problem with the SSDI program has been its eligibility determination system that forces applicants to assert that they have no residual work capacity in order to qualify for benefits. Then, if someone attempted to work, the system abruptly withdrew all supports that individual needed to survive. The Ticket to Work and Work Incentives Improvement Act took significant steps toward eliminating this bias through its provisions assuring extended Medicare coverage for workers with disabilities and the easier return to benefits should a work attempt fail. However, SSDI retains the assumption that work beyond a very modest, less-than-minimum wage level of earnings means that a person is no longer "disabled".

The concept of appropriate supports means the elimination of all financial and psychological disincentives to work. In the past, applicants for SSDI had to undergo months of review in which they had to assert no capacity for work. They waited months for benefits, often after months of appeals, and waited again to qualify for Medicare coverage. Only recently, did they have the presumptive eligibility for entrance into the vocational rehabilitation system and, even if they did receive VR services, they were warned not to earn too much, lest they lose all of their benefits.

If implemented properly, the Ticket to Work and Work Incentives Improvement Act could address many of these disincentives. The extension of Medicare will assure continued health care coverage for SSDI recipients. Depending on how and whether they are adopted by states, the Medicaid buy-in provisions have the potential to provide more complete health care supports to beneficiaries going to work. Again, depending on how SSA implements the Ticket to Work program, beneficiaries should have greater choice in provider and type of vocational rehabilitation services. And, the benefits outreach, counseling and assistance, if done properly, can offer beneficiaries clearer road maps to navigate the consequences of going to work. For those with a recently acquired disability, early intervention of the type envisioned through the counseling and assistance planners may mean the difference between returning to work and languishing on the disability rolls for years. Finally, the expe-

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[8] Center for Budget and Policy Priorities, Feb. 2000, "Recent Studies Indicate that Many Parents who are current or former welfare recipients have disabilities or other medical conditions"

dited reentry provisions offer some measure of reassurance that benefits will not be difficult to obtain should a work attempt fail.

However, while the system manages to make initial disability determinations, it is totally inadequate at tracking income and earnings as people take advantage of the aforementioned services. This inadequacy will become more apparent as people take advantage of the recently enacted work incentives legislation. For example, while overpayments to beneficiaries who work have always been problematic, they promise to become catastrophic if left unchecked. Beneficiaries will more deeply mistrust the program, providers won't get paid under the Ticket if the benefits continue unnecessarily, the fiscal strain on the program will continue, and other parts of the disability program will suffer as SSA struggles to correct the problem without adequate resources. Congress must address the need for systems improvement and modernization.

CHALLENGE OF THE BABY BOOM

It is no secret that during the next twenty years, there will be a large increase in the number of people who reach both retirement and early retirement ages. Strategies must be explored to help individuals reaching early retirement age, who lose their ability to perform their existing jobs, to remain in the workforce for as long as possible. Currently, the SSA disability programs only respond once someone's disability has reached the acute stage in which an individual is driven out of the workforce entirely.

The sheer number of baby boomers will have an enormous impact on SSA's operations. According to SSA's Office of the Actuary, by 2010, SSDI applications will increase by 54% and SSI disability applications by more than 10%.[9] Over the same period, the increase in the normal retirement age also will affect the number of disability applications.

In addition, SSA has been faced with more complex and changing work challenges. The disability determination process is complicated and lengthy. The SSA customer population has changing expectations about technology. More claimants are non-English speaking or limited-English speaking, leading to a need for more bilingual staff. Recent legislation requires SSA to provide increased rehabilitation and employment services for people with disabilities, to maintain a schedule of continuing disability reviews and other eligibility reviews, and to implement new approaches to prevent fraud and abuse.

The problem is aggravated by the fact that SSA's workforce also is aging and will begin to lose significant numbers of experienced staff, including senior management and leadership personnel. More than one-half of SSA's 63,000 employees will be eligible to retire by 2009 or leave government service after twenty years with pension rights.[10] Between 2007 and 2009, about 3,000 employees are expected to retire per year. The service delivery problems have been exacerbated by SSA's prolonged period of downsizing—since 1982, SSA's workforce has declined by 27%. At Subcommittee hearings earlier this year, the Social Security Advisory Board, the Commissioner of Social Security, and the General Accounting Office raised the issue of how SSA should plan to retain experienced staff and train new managers to meet these needs.

The CCD Social Security Task Force has voiced concern for some time over the continued long-term downsizing of the SSA workforce and believes that failure to conduct appropriate and timely CDRs and other eligibility reviews could lead to decreased trust in the integrity of the Social Security and SSI programs. In addition, the new efforts to assist people with disabilities to go to work, through the Ticket to Work and Work Incentives Improvement Act of 1999, will require new and expanded approaches for SSA interaction with beneficiaries. Adequate staffing levels are critical for these and other efforts to be successful, especially given the coming disability and retirement years of baby boomers.

The independent, bipartisan Social Security Advisory Board has unanimously urged that SSA's "administrative budget, like its program budget, be explicitly excluded from the statutory cap that imposes an arbitrary limit on the amount of discretionary government spending."[11]

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[9] Testimony of Cynthia Fagnoni, Director, Education, Workforce and Income Security Issues, General Accounting Office, to the Ways and Means Social Security and Human Resources Subcommittees, Hearing on Social Security's Readiness for the Impending Wave of Baby Boom Beneficiaries, Feb. 10, 2000

[10] Ibid.

[11] Testimony of the Honorable Stanford Ross, Chair, Social Security Advisory Board, before the House Subcommittee on Social Security, Committee on Ways and Means, February 10, 2000

We believe that the entire Limitation on Administrative Expenses [LAE] should be removed from under the domestic discretionary spending caps so that SSA's administrative functions can continue to operate smoothly for beneficiaries. [For background, see CCD statement for the record, March 16, 2000]

ISSUES FOR THE FUTURE

No single hearing can capture the entire range of questions that need to be asked about the future of federal disability programs. The CCD Social Security Task Force recognizes that this is just the beginning of an exploration of ways to modernize SSDI and SSI. We also recognize that some of these questions fall under other committees' jurisdictions. That, however, may indicate a need for greater coordination among Congressional bodies responsible for programs affecting people with disabilities. Based on our testimony, we would like to offer several issues that the committee should examine as it continues its investigations.

- Does the definition of disability under social security adequately capture the spectrum and continuum of disability today? Does it reflect the interaction of vocational, environmental, medical and other factors that can affect the ability of someone on SSI or SSDI to attain a level of independence?
- Do current SSA program policies foster or hinder acquisition of technology that will lead to greater independence? Are these technologies covered under impairment related work expenses? Would someone acquiring necessary supports to go to work encounter problems with asset and resource limits imposed under federal disability programs. Should tax credits or other incentives be provided for people to obtain these supports to go to work?
- How competent is SSA at communicating with its SSI and SSDI beneficiaries with visual impairments? Frequent failure of SSA to produce notices and documents in accessible formats lead to penalties imposed on such beneficiaries and increased administrative expenses in dealing with the consequences.
- Should CDRs be reevaluated for those covered under Medicaid Section 1619(b) or individuals still relying on Medicare to prevent denial of the very health care coverage offered to encourage people to work?
- Can the stricter income, asset levels allowed under Medicaid's 209[b] provisions undermine promotion of Medicaid buy-ins and other initiatives designed to assure continued health care coverage for individuals on SSI and SSDI going to work?
- Are changes needed in the current Medicaid 1619[b] formula for individualized determinations to allow for other medical costs of working disabled persons met by other programs? [e.g. Medicare, state pharmacy assistance, AIDS Drug Assistance Programs, WIC, public maternal and child health programs, cash medical purchases and private health insurance.]
- Why are earnings disregards recognized for SSI, SSDI, Medicaid and Medicare purposes not so honored by housing subsidy programs as well? Income and assets excluded by the PASS program are excluded under the housing statutes. The HUD programs should similarly recognize other disability-related disregards.
- How well do veterans' programs interact with and serve veterans with disabilities who rely on SSDI and/or SSI?
- Can steps be taken to replicate the earnings disregards and work incentives of the SSI and SSDI programs in Medicaid and the AIDS Drug Assistance Programs? This is important for individuals dependent for drugs on non-SSI-based Medicaid (e.g., TANF-related cases) and the AIDS Drug Assistance Programs rely for essential pharmacy coverage on programs which currently have NO meaningful earnings disregards or other work incentives.
- Should state standards for exemption from welfare time limits and work/training requirements make allowances for families in which either a primary or secondary parent cares for a child with a disability? Studies suggest that at least 20% of TANF cases have disabled primary caretakers, children or second parents (since many states can and do now include two parent families).

Again, these are but a few questions that arise when considering the array of federal programs affecting Social Security beneficiaries with disabilities. We appreciate the subcommittee's attention to these issues and look forward to continuing to work with the members in examining the future of the disability programs.

Chairman SHAW. Thank you, Mr. Young. Mr. McCrery.

Mr. MCCRERY. Professor Berkowitz, having been a history major in undergraduate school, I welcome the opportunity to grill a professor of history. I found your testimony very interesting and as was sometimes the case though in my history classes, I learned a lot of facts but I am not sure the point that I learned. So I am going to ask you, if you would, to describe for us any of these emerging trends that you cautioned us to be aware of. Can you identify any of those for us that you discovered in your research?

Mr. BERKOWITZ. Yes, sir. I guess the most important one is simply that we should recognize that when you try to tighten the rolls as one might want to do in pursuing a work strategy then you have the risk always of expanding the rolls and what I meant to say by that is that this was tried in the eighties in a bipartisan way. Congress passed a law in 1980 which encouraged the Social Security Administration to periodically re-examine people who were on the disability rolls and in 1981 aided by a GAO report the new administration decided to do that and to pursue that policy aggressively.

What in fact happened though was that this policy was pursued so aggressively that administrative law judges who were part of the system of disability determination and the courts, which are part of this disability determination system, and ultimately the Congress itself, including this Subcommittee, but many others throughout Congress cautioned the Social Security Administration not to move aggressively on this matter. Too many people were being dropped from the rolls, and new legislation was passed in 1984 at the end of a very long process. As Professor Burkhauser pointed out, the disability rolls went up a great deal in the long run.

So in trying to cut the rolls we can make the mistake sometimes of actually defeating our objective. That would be lesson number one.

Lesson number two might simply be that when we pass a new law like as we did in 1972 with the creation of the Supplemental Security Income Program, we should try very hard to look at prevaling trends. What happened in the case of SSI, I think, is that the discussions that began in 1969 were all centered on President Nixon's welfare reform proposals.

People didn't think much about the so-called adult welfare categories, and they failed to see that, just as the discussion was maturing over several Congresses, the disability incidence was going up. So by the time the law was passed and by the time it was put in place there was a tremendous rise in the disability rolls. This is an example of not looking at the trends in the middle of trying to put together a very delicate political deal, another lesson that we have to look at.

I guess a third and final lesson is that I think we should emphasize here as we think about interventions on the disability rolls that the person who is trying to apply for disability benefits is facing a great deal of uncertainty. He doesn't know whether he is going to get benefits, and so therefore he is very reluctant to engage in rehabilitation. I am put in mind of a description from the thirties from Harry Hopkins' WPA and other welfare programs of how hard it was for someone in the thirties to actually go in and ask for help from the Federal Government. It was the last thing they wanted to do.

Many of these people that are entered on the disability rolls are in similar positions and therefore as we think about our interventions we should think about the uncertainty that they face. These are all lessons I draw.

Mr. MCCRERY. So are you suggesting that we should be more aggressive, the government should be more aggressive in getting individuals into rehabilitation from the outset rather than having this lingering doubt about whether they are going to qualify for benefits.

Mr. BERKOWITZ. Well, I have suggested in the past that there might be an interim benefit status that we might call rehabilitation status which would precede full benefits. But there is a very delicate question of policy that you would have to consider at some length. The other thing that you might think about is that we have always put SSDI together with Social Security, just as we do in this Subcommittee.

Maybe that is not the right way to think about disability policy. I think we have seen in the last 10 years or so, sort of a separation between the notion of retirement and Social Security and SSDI. Maybe we need to look at SSDI as a somewhat different program. Maybe there needs to be—the same way there is a Committee to consider the problems of the aging in Congress—some sort of oversight Committee that looks at disability. But these are all big changes that you would have to consider for a great deal of time before making.

Mr. MCCRERY. Thank you, Mr. Chairman. I see my time has expired. I may want to come back after you all have finished and ask a couple more questions.

Chairman SHAW. Mr. Tanner, do you have any questions?

Mr. TANNER. Mr. Chairman, I apologize for being late. I have been unavoidably detained by about three other—this is the only job that I have ever had where one thinks nothing of it to be scheduled to be in three different places all at the same moment, and so I apologize and I am looking forward to reading through the record. Thank you.

Chairman SHAW. OK. Mr. Baron. You indicated that a majority of the people with a serious mental illness are desperately poor and likely to remain at or near the poverty level for the remainder of their lives and will do so whether they work or not unless there are significant changes in our national policies. What changes would you want us to consider?

Mr. BARON. I would want to consider a fairly broad range of changes. There are certainly a great many people in the disability community generally and among people with mental illness who have the capacity to go on to higher education and post-graduate degrees, who have the capacity to reach on any levels of professional engagement. We need to invest more heavily in making sure people have access to and financial support to increase their education. It is a commonplace observation that the higher your educational level the more substantial your income is likely to be.

We need to help more people with disabilities and certainly more people with serious mental illness to get the educational qualifications that they need and to place a much greater emphasis on education. We need to place a much greater emphasis on specific skill training for those who are not going on to college educations so that they have a set of skills that make them much more likely to work. But I also think we need to take a look at those people who are not likely to go on to college educations, who are not likely to benefit from technological skilled training programs, and think clearly about how we provide greater financial and other sources of support to people who are, like many Americans, working to make a living within the working class in our country.

We need to find a way to help people grab hold of prosperity in a job market that makes it very difficult for them. Further, we have among disabled populations in general, but certainly within the population of people with serious mental illness, a number of people who are not going to be able to work full time. Their disability is going to preclude full-time work.

I don't want to presume to suggest the specific policies that we need to mount to address those problems but we do need to find a way to make it possible for people whose optimal vocational level is at part-time to earn a decent living and to combine that living with disability payments and social supports that make it possible for them to go beyond the poverty level.

Anybody who is working, full time or part time, and is dependent upon secondary labor market jobs lives at or near the poverty level. I am not sure that we want serious disability of any kind to relegate people to a poverty level existence.

Chairman SHAW. Mr. Mohney—by the way your name tag there is misspelled. It is spelled with an A instead of an O. You reported a recovery rate among your clients, who are also Social Security beneficiaries, of roughly six times that of Social Security. Do all these recoveries represent successful return to work and what aspect of your claim management do you believe is most responsible for this success, which is rather startling?

Mr. MOHNEY. I would say that the vast majority of these recoveries reflect successful return-to-work. In terms of the aspects of the claim management process clearly it is the things we talked about. It is triage, recognizing that different claims are different and have different recovery potential matching up the right types of resource with the right claim on a very individualized basis to understand and promote return to work.

It involves continuing review. Disabilities, again our experience is that most disabilities do not last a long period of time and so we need to work with our insureds to focus on their abilities to focus on opportunities to provide vocational rehabilitation services that might benefit them. Early intervention is key and one of the problems with the length of time associated with the approval process for Social Security is that we find that many times insureds have to fight so hard to be accepted that they accept a disability mindset and that once that mindset has been accepted it is very difficult to get them to think in terms of return to work and be as interested in vocational rehabilitation.

Motivation is key and I think we need a system that is fair on the front end in terms of the approval process and very interactive throughout the process geared toward return-to-work.

Chairman SHAW. Well, are you—compare that with the Federal system.

Mr. MOHNEY. My impression of the Federal system is that there is opportunity for improvement, particularly along the lines of the ongoing claim management particularly in the areas of early intervention having clinical resources review the situations, look at the appropriateness of care, looking at whether treatment plans are developed toward returning the person to work versus simply getting them out of the hospital. I believe that there is tremendous opportunity there as it relates to the continual review and as it relates to getting individuals focused on their abilities and their potential for return to work and supporting that.

Mr. TANNER. Mr. Chairman.

Chairman SHAW. Yes. Mr. Tanner.

Mr. TANNER. The thought occurred to me, in this system does it make sense to look at the definition of disabled—is the definition of disabled adequate or would a less restrictive definition be of any—make any sense?

Mr. MOHNEY. Mr. Tanner, I clearly think that would be and we talked earlier about a comprehensive strategy and review of the situation. I believe the definition of disability needs to be revised. In particular, we find on the private side real benefit where individuals are able to return to work gradually and that is typically how return-to-works occur. It does not occur all at once but it occurs gradually with a buildup in time and hours. And on the private side we do provide partial benefits such that they are not simply dropped from our roll. I think that that would be a significant incentive that would be beneficial in the program, yes, sir.

Mr. TANNER. Does anyone else have a comment about that?

Mr. BERKOWITZ. May I, sir?

Mr. TANNER. Yes.

Mr. BERKOWITZ. Even if we did have a change in definition, it would be important to remember that the original system was created as a reaction against the workers' compensation program, which those of you who have served in state legislatures know is still a major concern in states today.

The problem in the workers' compensation program in the states has been permanent partial disabilities, partial disabilities that prove to be a major problem, and if you were to move in a direction of some sort of partial disability definition, you would be opening up many problems for potential expansion of the rolls so that would have be looked at very carefully.

Mr. TANNER. I understand that but I am talking about making sense as to the goal of helping people achieve independence. Yes, sir. Mr. Young.

Mr. YOUNG. CDC has long advocated for a modification of the way we look at disability, something that looks more at functional limitations and functional abilities and then uses those results to help serve people in the best way possible. What we do right now is just determine whether people are making $700 a month or not and that tells you something but it doesn't tell you a lot more.

And that next look, the functional abilities, impairments, barriers, between that person and the job are the questions that need to be asked and the solutions that need to be determined for where a new definition of ability to really be effective and for us to really make progress on transforming the current early retirement program into a full support program for those who need to retire but a support program for those who want to work as well.

Mr. BURKHAUSER. Mr. Tanner, my grandmother used to say that the road to hell is paved with good intentions. The Dutch had a partial disability program and the reason that their disability transfer rolls are so high today is that they had an elegibility test which if you were judged to be 15% disabled but weren't employed meant you were eligible for full disability benefits unless it could be shown by the agency that it was unemployment and not disability that was causing the problem.

This type of entry into their system was probably the major reason why the Dutch rolls are twice the size of the United States or any other country in the world. We need to take serious the notion that folks with disabilities can work and change our policy goals so that our first priority is to get folks with disabilities into employment.

That is what Sweden and Germany do. Even though they have very high replacement rates, much higher than we have in the United States, they have a view that no one can get onto the disability benefit rolls unless they have gone through a year or two of rehabilitation and it is shown that they can't work. Hence income benefits are definitely a second round program in those countries.

Mr. TANNER. So the problem is not necessarily definitions but more execution of rehabilitation.

Mr. YOUNG. No, the problem is both. The definition does feed into the problem because you come into the system and you spend at least 5 months and maybe 2 years proving you have not a bit of residual work capacity. And then the next thing you get that happens is you get a letter saying would you like to go to voc rehab. And the disconnect in people's minds is just phenomenal.

If we are serious about supporting people with severe disabilities who want to work, we have to change the way we start that mind process going and support people right up at the front but then recognize that no matter what you do, what supports you provide, what training, what technology, some people will not be able to work. Find those folks, give them what they need, find the folks who can work, support them as they need, and then let the process go on.

Chairman SHAW. Mr. McCrery.

Mr. MCCRERY. Professor Burkhauser, you mentioned just now again your work first strategy. In your testimony you said that in order to keep rolls at socially acceptable levels a work first strategy must be employed. Leaving aside the question of what is a socially acceptable level, could you expound a little on the work first strategy? What are some of the tools that we should look at to implement a work first strategy?

Mr. BURKHAUSER. In both Sweden and Germany you go on a temporary disability benefits program before you go into the permanent system and every worker who comes onto the temporary rolls in Sweden and Germany is given rehabilitation that connects them to the work force. It is only after that has proven unsuccessful that people are allowed onto the permanent rolls.

Mr. MCCRERY. Excuse me. Is this done prior to a determination of disability? In other words, is it done upon application of the individual for benefits or how does that work?

Mr. BURKHAUSER. One of the things that goes on in these countries that is different than here is that each has a sickness benefit so people receive this benefit almost immediately and can be on that program for a couple of months. At that time employers are involved with the social agencies to see whether the worker needs rehabilitation. In addition there are in Sweden, jobs targeted for folks with disabilities. In Germany there are quotas. Firms with 16 or more workers are required to employ a worker with a disability for every 16 workers.

In Sweden and Germany firms are not allowed to fire a worker based on health conditions, so there are all sorts of firm level programs that are institutionalized that make it more likely than in the United States that firms will accommodate their employees who experience the onset of a disability. In our country, as Tony Young was saying, there is a long period following the onset of a disability before you are entitled to disability benefits and it is only after you get the benefits that there is some effort to do some rehabilitation.

The key is to put the rehabilitation effort up front. One possibility would be to have a system where you pass an initial screen that is sufficient to get you into a rehabilitation program and possibly a temporary benefit. But this would strictly be a temporary benefit to go along with rehabilitation. The determination for permanent benefits would then occur after 6 months or even a year or 2 years.

Mr. MCCRERY. OK. Thank you. Thank you, Mr. Chairman.

Chairman SHAW. Thank you. I will throw this out to anyone who would like to take it. What are we doing here with regard to taking someone who may be physically impaired so that they cannot be rehabbed to get back into being a carpenter, an electrician or a plumber, but they are not mentally impaired, so that they can get into another field through advanced education. What are we doing about that?

Mr. YOUNG. We have the Rehabilitation Act that is supposed to address those issues and in fact.

Chairman SHAW. How is that operating?

Mr. YOUNG. Well, there is a hearing in itself, sir. The Work Force Investment Act, which has lots of money for job training in there that I guess is part of what we need to talk about as far as coordination of disability programs and what Social Security can do and what the Rehabilitation Services Administration can do and what the Department of Labor can do as far as retraining people. But there are lots of people who do to rehab every year and I think about 200,000 or so get placed in new jobs.

Of course, the demand is much greater than the number of people who actually go through the process and end up with jobs and that is the end of the story.

Chairman SHAW. Do we need three agencies doing that or would it be better to try to focus on one agency?

Mr. YOUNG. Again, sir, I think that is a hearing of itself. I think we very well don't need three agencies doing that.

Chairman SHAW. Maybe we ought to look into that next year.

Mr. YOUNG. I think that would be a good idea.

Mr. BERKOWITZ. Mr. Chairman, there was a period when we spent a substantial amount of trust fund money essentially subsidizing the vocational rehabilitation program in an effort to get people rehabilitated. I think it is fair to say that that was not a particularly strong success and we changed it and no one is that sad that we did.

The other thing that I might add is that over time as we have tried to organize the government, we have created a lot of distance between vocational rehabilitation and our SSDI program. Vocational rehabilitation is one of the bargaining chips in the creation of the Department of Education and so it went over there when it was created. And of course SSA is now an independent agency but that bureaucratic distance and indeed rivalry between vocational rehabilitation and SSA has been a factor in the historical record and that hasn't helped coordinate efforts between the two agencies.

Mr. MOHNEY. Mr. Chairman, I would add that on the private side we have had great success in focusing on retraining and focusing on labor market surveys and functional capacity assessments to match up individuals who perhaps have some impairment, some restrictions and limitations, but are interested in working and finding other occupations that they can be successful in. It has been cost effective. It must be applied selectively. I don't think there is a broad, one category fits all approach, but when applied selectively to individuals it can be highly cost effective.

Mr. BARON. Could I?

Chairman SHAW. Yes, sir.

Mr. BARON. Just one other observation that in thinking through how to better utilize government dollars to retrain and re-educate people, I would want to caution us to think as closely as we can about the kinds of jobs we want to train and educate and prepare people for and to be clear that the kinds of jobs that are going to be developing over the next decade or two are quite different than the kinds of jobs that we might have prepared people for a generation or even a decade ago and that if we want to provide people with retraining and re-education for new careers it ought to be for new careers that lead them toward prosperity and do not lead them back into jobs that it is going to be hard for people to make economic progress through. And that is a different kind of investment and probably a much greater investment than many of us have currently been thinking about.

Chairman SHAW. Well, thank you all very much. They called the vote at just the right time. I was afraid they were going to call it around 11 and we were going to have to make you gentlemen wait but I appreciate your time and I appreciate your testimony. It has been very helpful. Thank you. We are adjourned.

[Whereupon, at 11:42 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Kenneth Nibali, Associate Commissioner for Disability, Social Security Administration

Mr. Chairman and Members of the Subcommittee:

Thank you for providing me the opportunity to discuss initiatives to ensure that the Social Security Administration's beneficiaries with disabilities receive the supports needed to achieve independence. This is an important issue, and the Social Security Administration (SSA) has placed a high priority on helping its Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) beneficiaries return to work.

I will discuss SSA's disability process, the current work incentives available to individuals with disabilities and the Ticket to Work legislation that will provide more opportunities for individuals with disabilities to return to work. I will also discuss some of the differences between SSA's programs and private insurer programs.

Social Security Disability

Generally, when people think about Social Security, they think about retirement benefits. Nearly one third of Social Security beneficiaries, however, are the surviving family members of workers who have died or are severely disabled workers or their wives and children. The protection provided by the SSDI program is extremely important, especially for young families. For a young, married, average income worker with two children, Social Security is the equivalent of a $223,000 disability income insurance policy. In the event of severe disability, the SSDI program stands between these families and poverty. Additionally SSI serves the most economically vulnerable population with disabilities, most of whom are living in poverty.

In June 2000, 5,884,200 beneficiaries were receiving Social Security benefits on the basis of disability—4,959,500 disabled workers, 724,400 disabled adult children, and 200,300 disabled widows and widowers. In addition, 170,800 spouses and 1,419,800 minor and student children of disabled workers were receiving benefits. Further, 5,304,324 blind or disabled individuals received SSI benefits. About 30 percent of these individuals received both SSDI and SSI benefits. Thus, in June, SSA sent benefits to over 9.5 million individuals on the basis of disability. In fiscal year 1999, disabled workers and their dependents received over $50 billion in cash benefits under the SSDI program and disabled individuals received over $24 billion in cash benefits under the SSI program.

Furthermore, SSDI benefits are the gateway to the Medicare program to those individuals who have been eligible for disability benefits for 24 months. These benefits provide health care coverage that to many SSDI beneficiaries is simply irreplaceable, since many would not be able to obtain insurance in private markets simply because they are disabled. The Medicare program paid over $24 billion in benefits in fiscal year 1999 to individuals whose entitlement to Medicare is based on their SSDI benefits. Thus, almost $75 billion was paid in fiscal year 1999 from the Social Security and Medicare programs on behalf of disabled workers and their families.

As with the retirement program, SSDI is funded through a payroll tax on covered earnings, paid by employees, their employers, and the self-employed. The current DI payroll tax on earnings is 0.9 percent for employees and employers, each, and 1.8 percent for the self-employed.

SSDI is designed to protect workers covered under the Social Security program who become severely disabled, with applicants judged on the basis of a uniform set of standards. The criteria we use to award disability benefits requires that the condition either be expected to result in death or last at least 12 months. To qualify, the individual must be unable because of a medical condition to perform any substantial work in the national economy. Thus, the inability to do one's own past work or the inability to find suitable employment are not a sufficient basis for meeting the definition of disability. Our regulations provide for a five-step sequential evaluation based on the statutory definition of disability, and require that a claimant not currently be engaging in substantial gainful activity (SGA)—a level of work currently set at $1,170 per month for blind beneficiaries and $700 per month for nonblind beneficiaries, a level recently proposed to be adjusted annually to the national average wage index. Additionally, applicants must have worked 20 quarters during the 40 quarter period ending with the quarter in which disability began (special provisions apply for workers who are under age 31), and they must complete a 5-month waiting period after the onset of the disability.

After a claim is taken in one of Social Security's field offices, it is forwarded to one of the State Disability Determination Services. These State employees are responsible for following up on at least one year's worth of medical evidence in support of the claim, scheduling consultative examinations if necessary, and making the disability determination at the initial and reconsideration (the first level of appeal of an adverse initial determination) levels. The States are fully reimbursed for making these determinations. The process of evaluating an individual's disability accounts for the administrative costs for the disability program being somewhat higher (3.0 percent of benefits) than those for the retirement and survivor program, largely because of the cost of obtaining medical evidence and the need for a thorough evaluation by a physician or other highly trained professional reviewer.

While the Social Security eligibility criteria are very strict, we also have a very structured system to ensure that applicants' rights are protected and that those applicants who are eligible actually get their benefits. Currently, a physician must be part of the decision-making team, although we are testing a system where certain claims, generally the most severe and obvious cases, would be decided by a trained layperson. After a reconsideration denial, a claim can be appealed to an administrative law judge, then the Appeals Council and up to a federal court. We also are testing a model that would streamline the process by eliminating the reconsideration step. While the primary purpose of SSDI is to replace a portion of income, the program also includes provisions designed to encourage beneficiaries to return to work.

Current Work Incentive Provisions

Work incentives assist beneficiaries with disabilities to enter or reenter the workforce by protecting entitlement to cash payments and/or health care until this goal is achieved. Some work incentives are common to both the SSDI and SSI programs, while some are unique to one program or the other. Because even the common work incentives may be treated differently by either program, I would like to briefly discuss work incentives as each program treats them.

SSDI Work Incentives

There are several work incentives for SSDI beneficiaries built into the Act, most notably impairment-related work expenses (IRWE), the trial work period (TWP), the extended period of eligibility for reinstatement of benefits (EPE), and continuation of Medicare. The availability of these incentives is dependent upon the disabled beneficiary continuing to have a disabling impairment.

Certain impairment-related work expenses may be deducted from gross earnings when determining SGA. An expense qualifies as an IRWE during a period of work when:

- The item or service enables them to work;
- They need the item or service because of their disabling impairment;
- They pay the cost and are not reimbursed by another source (e.g., Medicare, Medicaid, private insurance);
- The expense is "reasonable"—that is, it represents the standard charge for the item or service in their community.

The TWP enables disabled beneficiaries to test their ability to work by allowing them to receive full benefits regardless of how high earnings might be. The TWP continues until the accumulation of 9 months (not necessarily consecutive) of "services" performed within a consecutive 60-month period. We use this "services" rule only to control when the TWP stops. "Services" means any activity in employment or self-employment for pay or profit or of the kind normally done for pay or profit (whether or not it is SGA). We currently consider work to be services if earnings are more than $200 a month (or more than 40 self-employed hours in a month). SSA recently proposed this level be increased to $530 per month.

Following the end of the TWP, beneficiaries have a 3-month grace period before beginning the 36-month extended period of eligibility. During the EPE, the beneficiary does not receive a cash benefit in any month earnings exceed SGA. Cash benefits can be reinstated anytime during this 36-month period that the beneficiary earns less than SGA and continues to meet the definition of disability. Currently, Medicare coverage continues during this period and for three additional months. At that point, individuals with disabilities can buy Medicare coverage. Effective October 1, 2000, based on the new Ticket to Work Incentives Improvement Act, premium-free Medicare is extended an additional 4 years.

In addition to providing incentives to work, we also refer beneficiaries with disabilities to their local State Vocational Rehabilitation (VR) agency, or to other service providers in the public and private sector who try to help beneficiaries return to work. In fiscal year 1999, SSA paid State VR agencies about $120 million for their services provided to over 11,000 beneficiaries with disabilities who worked at least 9 months at the substantial gainful activity level. Although this was a record year for reimbursements, we look forward to much more progress in this area.

Under the *Ticket to Work and Work Incentives Improvement Act of 1999* (TWWIIA), disabled beneficiaries will receive a ticket that they may use to obtain employment services, vocational rehabilitation services, or other support services from an employment service network (EN) or a State VR agency. The ticket will be assigned to the participating employment network of the beneficiary's choice, assuming the EN is willing to accept the assignment. Under the TWWIIA, the number and scope of available "rehabilitation" options for beneficiaries was expanded to include public and private VR services, including employment services and assistive technology. All ENs must meet the qualifications set by the Commissioner.

A purpose of the TWWIIA is to provide disabled beneficiaries more supports to test their ability to work. In addition to improving access to services, a disabled beneficiary using the ticket is not subject to continuing disability reviews. Thus, disabled beneficiaries receive a greater opportunity to become self-sufficient without losing their benefits.

SSI Work Incentives

Some general information about the SSI program is useful to explain the work incentive provisions as they apply to that program. The SSI program differs from Social Security in that the monthly Federal benefit standard (currently, $512 for an individual and $769 for an eligible couple) is reduced dollarfordollar by the amount of the individual's "countable" income—i.e., income less all applicable exclusions. The result of this computation determines whether the individual (or couple) is eligible and the amount of the benefit payable.

SSI law defines two kinds of income: earned and unearned. Earned income is wages, net income from selfemployment, remuneration for work in a sheltered workshop, royalties on published work, and honoraria for services. All other income (including income received in kind) is unearned.

When determining an individual's countable income, exclusions are taken for various types of income. There is a general $20 exclusion, applied to an individual's unearned income. In the case of earned income, we exclude a portion of the $20 general exclusion that has not been used, and then exclude the first $65 and one-half of the remainder of the earnings. This greater exclusion for earned income acts as a work incentive for all SSI recipients.

In determining the benefits of individuals with disabilities, we exclude IRWEs. For these individuals, we exclude work expenses directly related to the individual's disability, such as attendant care services, assistance in travelling to and from work and personal assistance related to work.

Under SSI we also exclude income saved or being used to pursue a plan for achieving selfsupport (PASS) that has been established by a disabled or blind person. These plans are established to help blind and disabled individuals become self-supporting by excluding income that is set aside to help the individual reach a specific occupational goal. In December 1999, there were 1,045 SSI recipients with a PASS established, although not all of those individuals reported earnings for that month.

We also encourage self-sufficiency among SSI recipients who are under the age of 22. Under the Student Earned Income Exclusion, students can exclude up to $400 of earned income per month when determining their eligibility. The maximum yearly exclusion is $1,620. Recently, President Clinton proposed raising the monthly and yearly exclusions to $1,290 and $5,200, respectively.

Finally, the laws governing SSI contain provisions that enable blind and disabled individuals to continue working and receiving income beyond the limit that would normally result in ineligibility.

Under section 1619(a) of the Social Security Act, a disabled beneficiary who would cease to be eligible because of earnings over the SGA limit (currently $700 a month) can continue to receive cash benefits until the amount of earnings would cause him or her to be ineligible for benefits under SSI income counting rules. Being a recipient of this special benefit equals being an "SSI recipient" for Medicaid eligibility purposes.

Section 1619(b) provides "SSI recipient" status for Medicaid eligibility purposes for certain SSI recipients. These individuals have earnings that preclude the continued payment of an SSI benefit but are not sufficient to provide a reasonable equivalent of the SSI, social services, and Medicaid benefits that the individuals would have in the absence of earnings. For these individuals, the loss of the social service and Medicaid benefits would seriously inhibit their ability to continue working.

According to SSA's Office of Research, Evaluation and Statistics, there were approximately 340,000 SSI disability beneficiaries (or 6.4 percent) who were working in December 1999. About 70,000 of these individuals were receiving benefits under section 1619(b). These beneficiaries do not receive an SSI payment but retain their Medicaid coverage. Almost three-fourths of those who received this type of SSI benefit had amounts of earned income below the substantial gainful activity level.

Ticket to Work and Work Incentives Improvement Act of 1999

Last December the President signed the TWWIIA into law. I want to express again my thanks to the Chairman and the members of the Subcommittee for your support in getting the "Ticket" passed. This legislation will help individuals with disabilities who want to work by lessening their fears about losing health care coverage and income during attempts to work.

It improves and expands their VR choices, providing enhanced work incentives, outreach activities and new service structures. Ever since the TWWIIA was enacted, we have been actively engaged in the hard work of implementing its various provisions. We again look forward to working with you as the different provisions take shape and begin to show the results we anticipate—more people with disabilities entering or reentering the workforce.

We will be reporting to Congress regularly about the progress of the TWWIIA program. By December 2002, we must report to Congress on the adequacy of our payment rates to employment networks. Over the next six years we must make three separate reports to the House Committee on Ways and Means and Senate Committee on Finance evaluating the progress of program activities, as well as conclusions on whether or how the program should be modified.

Currently, we are preparing an NPRM package to implement these provisions. We plan to begin implementing the ticket provisions in some States in January 2001, distributing tickets in a staged process through May 2001, with the remaining States phased-in by January 2004. We are currently accepting applications from those who want to serve as employment networks.

The new law requires SSA to conduct demonstration projects to evaluate the effects of reducing benefits $1 for every $2 of earnings over a certain limit. Beginning in December 2001, annual reports to Congress are required on the projects, with a final report due no later than one year after the project is complete. Currently, we are in the process of designing the parameters of the $1 for $2 demonstration projects. Additional legislation would be required before implementation of these projects may begin.

Additionally, Congress extended SSA demonstration authority until December 2004 to allow SSA to explore various projects that will enable more individuals to return to work. We are assessing which experiments and projects we shall pursue.

Private Insurance vs. Social Security Administration's Disability Programs

The SSA disability programs differ from other insurance programs offered through the private sector in a number of ways ranging from the definition of disability to beneficiary characteristics and timing of benefits. However, SSA can still benefit from lessons learned by these alternate insurance providers in determining how to further improve its programs.

Private systems often use a less restrictive definition of disability. Generally, the first definition for disability in private insurance is the inability to do the person's own occupation; this makes for a quicker and easier determination. After six months to two years, the definition extends to any occupation. SSA must make a long-term, broad-ranging entitlement determination. Favorable SSDI determinations normally cannot be changed without demonstrating medical improvement, while a private insurance determination can be reversed or discontinued without determining that the individual's disabling condition has medically improved. Furthermore, SSA must meet strict requirements for providing claimants legal due process and for ensuring uniformity across its national program.

SSA's beneficiaries are on average more severely and permanently disabled than workers in those other systems and have significantly lower expected return to work rates. Private insurers often target policies and services to relatively low-risk clients such as professional or technical employees. Some insurers may not offer individual disability insurance to people in higher risk jobs, or may offer it at a cost to the employee that is prohibitive. SSA provides benefits to any eligible disabled worker or low income disabled person and must accept disabled individuals with high-risk as well as low-risk profiles for high lifetime disability costs.

SSA tends to serve on average a less affluent and less educated population than private disability insurance providers do. As such, applicants under the SSA-administered disability programs often require greater assistance with the disability application and adjudication process than do applicants for private insurance disability benefits especially since the latter may receive employer assistance in pursuing their claims. The SSDI and SSI programs must cover individuals with all types of impairments (pre-existing conditions, mental impairments, etc.) while private insurers can choose what conditions they will cover.

One-half of SSDI claimants have been out of work for over a year before applying for benefits. This is due to a combination of reasons, such as the availability of short-term insurance from the employer, the claimant's decision to wait for the termination of sick leave and Worker's Compensation benefits, or the claimant's reliance on COBRA coverage. The current connection with the employer is often broken and sometimes health insurance lapses. Therefore, some SSDI applicants do not have complete and current medical documentation of their disability. Private insurance is frequently associated with an employer-based benefit program, and documentation of the medical condition is often available through the employee's employer-provided health insurer. In some cases, the employer will assist the claimant in obtaining evidence under the terms of their insurance coverage. Additionally, there is typically not an extended period during which the applicant does not have health insurance coverage.

SSA agrees that earlier intervention, and earlier identification and provision of necessary return-to-work assistance for applicants and beneficiaries should be researched and considered as part of an overall return-to-work strategy. However, applications for SSDI and SSI are often months after the onset of the episode. Other than through our new demonstration project authority, SSA cannot refer disability claimants for reimbursable VR services until they are awarded benefits. We agree that earlier intervention to assist presumably disabled applicants with securing appropriate return to work services should be researched and considered as part of an overall return-to-work strategy. How best to coordinate this with State unemployment insurance, State temporary disability benefits, and State workers compensation programs are just some the details that will need to be worked out.

Conclusion

We want to build on the momentum provided by the enactment of the TWWIIA and to increase incentives to work for all people with disabilities. Our commitment is to make every effort to enrich the lives of *all* people with disabilities and to help *all* those who want to work do so. One of the best ways for SSA to do this is to continue its active implementation of the TWWIIA program, including the evaluation of its progress and our reports to Congress.

We know that return to work efforts must include coordination with other Federal departments and agencies as well as the private sector to find new and innovative ways to encourage work. Solutions to the redesign of the Federal disability programs require the active involvement of several Federal agencies, including the Departments of Education, Labor, the Treasury, and Health and Human Services. On March 13, 1998, President Clinton signed Executive Order 13078, establishing the Presidential Task Force on Employment of Adults with Disabilities. The mandate of the Task Force is to evaluate existing Federal programs to determine what changes, modifications, and innovations may be needed to remove barriers to employment opportunities faced by adults with disabilities. The work of the Task Force will help ensure that national initiatives identified will receive high priority within respective departments and agencies.

The private rehabilitation community, private insurers, consumers, employers and advocates for people with disabilities can greatly assist SSA in implementing the TWWIIA. We will continue to look for ways to further enhance the productive capabilities of disabled beneficiaries with our private sector business partners.

We look forward to working with the Subcommittee and Congress to achieve our mutual goal: removing as many barriers to work as possible and providing as many incentives and supports as possible to enable people with disabilities to participate in the workforce.

Statement of American Occupational Therapy Association, Inc., Bethesda, Maryland

The American Occupational Therapy Association (AOTA) submits this statement for the record for the hearing on July 13, 2000. AOTA commends the Subcommittee for holding this hearing in its ongoing efforts to address the challenges facing the social security disability programs and its recipients.

AOTA supports the notion put forth by the Consortium of Citizens with Disabilities (CCD) that the original assumption of federal disability programs was that people who become disabled would remain so throughout the remainder of their lives, and that little thought was given to what would happen if these individuals returned to work after becoming eligible for benefits. We agree with CCD that disability is a dynamic condition, evolving in response to advances in technology and medical intervention, improvements in services and the expectations of persons with disabilities. Many individual and policy barriers continue to prevent persons with disabilities from achieving economic independence through work and work-related rehabilitation services (such as occupational therapy).

What is Occupational Therapy?

Occupational therapy is a health and rehabilitation service reimbursed under Medicare, Medicaid, health insurance policies, the Rehabilitation Act, worker's compensation, and other programs. Occupational therapy services can help individuals with disabilities desiring to enter or return to the workforce to assess their capabilities, to learn skills, and to achieve success in the work place. Using purposeful activity (or "occupations"), such as work simulation and conditioning activities, occupational therapists assess and intervene with individuals whose ability to function in a competitive work environment is affected due to physical or emotional illness, injury or condition. Occupational therapy intervention includes assessment of functional limitations and capabilities needed to perform meaningful, productive work.

Occupational therapy practitioners are licensed or otherwise regulated in every state and territory. They use their knowledge of the structure and function of the human body, the effects of illness and injury, and the components of activity to achieve recovery, to improve functioning and to increase clients' involvement in productive and other activities.

Performance areas, performance components, and performance contexts are the parameters of occupational therapy's domain of concern.

- Performance areas are broad categories of human activity that are typically part of daily life. For occupational therapy, these are activities of daily living (ADLs), including instrumental activities of daily living (IADLs), work and other productive activities, and play or leisure activities.
- Performance components are fundamental human abilities that, to varying degrees and in differing combinations, are required for successful engagement in desired performance areas. These components are sensorimotor, cognitive, psychological, and psychosocial.
- Performance contexts are situations or factors that influence an individual's engagement in desired and/or required performance areas.

Occupational therapy assessment involves examining abilities in and the relationship between performance areas, components and contexts. Intervention may be directed toward elements of performance areas (e.g. dressing, vocational options), performance components (e.g. strength, endurance, problem solving) or the environment.

Occupational Therapy and Work Rehabilitation

Occupational therapy contributes to the promotion and management of productive occupation as well as the prevention and treatment of work-related disability. Through skilled observation and evaluation of a person's performance, occupational therapists can identify a person's interests, abilities, and needs as they related to general work performance and to specific job and workplace design. Appropriate intervention strategies are developed based on the evaluation results, and are designed to explore and expand work options, to enhance or develop work-related capacities, and to obtain or retain employment.

In providing work-related services, including workplace redesign, work disability prevention, and management programs, occupational therapy performs several tasks including:

- Evaluating the client's work roles and work performance and the impact of their abilities on performance
- Analyze work tasks and the work environment
- Collaborate with other team members in coordinating occupational therapy services
- Provide recommendations about adapting work tasks or environments for the worker and/or employer

When developing interventions, occupational therapists consider the client's age, interests, values, culture, skills and abilities, motivation, and psychological and psychosocial status as well as work role, task demands, work environment, and available resources. Intervention strategies may include direct services or consultation to individuals and groups.

Successful return to work can be dependent on many issues that an occupational therapist is qualified to address, including looking at the individual's physical and psychological tolerances essential to appropriate fulfillment of the vocational planning process, and development of appropriate work behaviors that will improve retention and reduce recidivism. For example:

Conclusion

Occupational therapy can be an important component of a program to enable individuals to return to work, tailoring rehabilitation, work training, and job modifications and placement. AOTA stands ready to assist the Subcommittee in its efforts to improvement federal disability programs to enable persons with disabilities to have the opportunity to work. Congress has begun this work by passing the Ticket to Work and Work Incentives Improvement Act (TWWIIA) last year (P.L. 106–17). TWWIIA is a major step toward eliminating many of the existing barriers to work in federal disability programs. We applaud the Subcommittee for taking the next step and looking at other barriers to work for persons with disabilities.

Statement of Terri Spurgeon, President, National Association of Disability Examiners, Lansing, Michigan

Mr. Chairman and Members of the Subcommittee, on behalf of the members of the National Association of Disability Examiners (NADE) I want to take this opportunity to thank you for holding this series of hearings on the problems and challenges facing the Social Security and Supplemental Security Income (SSI) disability programs today. Our membership is committed to the preservation of the disability program and deeply concerned about the problems we encounter in the administration of these programs. Those concerns have been described in earlier testimonies before this Subcommittee and will not be reiterated here. We would, however, like to address those issues involving the solvency of the disability trust fund and return to work barriers and incentives.

The Social Security and SSI disability programs play a vital role in the lives of millions of Americans. Disability benefits provide an important safety net for disabled individuals and their families. However, we believe that the majority of those who apply for these benefits would prefer to remain in the workforce. We welcomed the recent efforts of the Congress and of the Social Security Administration (SSA) to facilitate and encourage a beneficiary's efforts to return to work by removing barriers such as loss of medical coverage and by authorizing and establishing return—to-work demonstration projects.

Individuals who understand that their claims will be reviewed at the appropriate time are much more likely to take advantage of return to work initiatives. We strongly support SSA's focus on continuing disability reviews (CDRs) and we appreciate the Congressional initiatives to provide the necessary funding to conduct these reviews. The public should be able to expect that the Social Security Administration (SSA) will administer the disability program in a cost-effective manner. We believe it is vital that sufficient resources continue to be made available to permit to become-and remain-current on these reviews. These reviews are vital because of the importance they have on the economic security of the disability trust fund and on the public's confidence in the disability program. However, while we support the present CDR initiative, we believe this process would be more effective if the current Medical Improvement Review Standard (MIRS) were revised. (A copy of NADE's analysis of this subject is attached for your review.).

Although time-limited benefits are common in many private disability programs, and have been proposed as one means to encourage claimants to obtain appropriate treatment and rehabilitation to re-enter the work force, we do not advocate such a proposal for the Social Security or SSI disability programs at this time. Unlike private insurers and other disability programs, the programs administered by Social Security do not award benefits for partial or short-term disability. By definition, individuals who are awarded Social Security or SSI disability benefits are unable to engage in any substantial gainful activity for a period of not less than 12 months. These individuals should be able to expect that SSA will not terminate those benefits unless there is a change in their condition that would warrant termination. At the same time, however, we believe that disability benefits should be paid only to those who meet the statutory definition of disability and that individuals who are capable of returning to the workforce do so. **This requires an efficient and effective CDR process.**

The CDR process has not been utilized in the way it was envisioned. SSA's need to utilize limited funds for more pressing needs have made it impossible to pursue the CDR process without the recent special appropriations from the Congress. NADE firmly believes that if CDRs can be conducted timely, if genuine errors in decision-making can be corrected at the CDR level by changes in the MIRS, and if additional disincentives to return to work can be eliminated, then a medical review standard can serve both the disabled population and the general public better than the wholesale changes that time-limited benefits would entail.

The General Accounting Office, in their July 13, 2000 testimony, noted that, "In recent years, SSA has piloted numerous incentives to redesign and thereby improve its disability determination process." NADE has supported these efforts and many of our members are, or have been, involved in piloting and prototyping this new process. We would hope that simplifying and streamlining the process would enhance and support the current return to work initiatives.

While NADE supports efforts to make the decision making process more efficient, we do not support change for the sake of change. It appears that SSA is planning to go forward with national roll-out of the new disability claims process before data—including the impact this new claims process has had on both administrative costs and program costs—has been fully assessed. Earlier we contacted Commissioner Apfel expressing both our concerns with and suggestions for national roll-out. A copy of that correspondence accompanies this testimony.

We would also like to take this opportunity to express our concern that several of the states involved in the prototype of the new disability claims process are reporting that hundreds of claims have been received for which they have yet to initiate any case development. These claims are sitting untouched, filed away, until such time that the DDS has sufficient staff to initiate the required development. This backlog of cases was created as the DDS's made the required adjustments to begin processing claims in the new manner prescribed by the prototype. The DDS's were not given sufficient lead time or training to prepare for the new process. These backlogs do not serve the public interest, improve a claimants potential for return to work, or enhance the public's confidence in the disability program.

NADE is concerned about the viability and stability of the Social Security and SSI disability programs and the integrity of the disability trust fund. We appreciate your willingness to solicit a wide range of viewpoints and suggestions for improving these programs. NADE feels honored to be invited to submit our views and we offer the expertise of our members, working with the Subcommittee, as a means to achieve that goal.

[Attachments are being retained in the Committee files.]

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