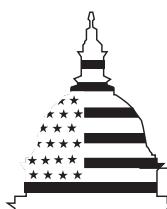


January 2001

SSA DISABILITY

Other Programs May Provide Lessons for Improving Return-to-Work Efforts



G A O

Accountability * Integrity * Reliability

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Abbreviations

DDS	disability determination service
DI	Disability Insurance
SGA	substantial gainful activity
SSA	Social Security Administration
SSI	Supplemental Security Income



United States General Accounting Office
Washington, D.C. 20548

January 12, 2001

The Honorable E. Clay Shaw, Jr.
Chairman
The Honorable Robert T. Matsui
Ranking Minority Member
Subcommittee on Social Security
Committee on Ways and Means
House of Representatives

The Honorable Benjamin L. Cardin
Ranking Minority Member
Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives

The Honorable Nancy L. Johnson
House of Representatives

Each month, the Social Security Administration (SSA) pays nearly \$6 billion in cash benefits to people with disabilities who are beneficiaries of the Disability Insurance (DI) and Supplemental Security Income (SSI) programs.¹ The size of the working age beneficiary population has grown significantly over the past 10 years, increasing by 65 percent to its current size of 7.5 million. This growth has contributed to the DI trust fund's projected insolvency in 2023 and a significant increase in expenditures for SSI benefits, which are financed by general revenues.² Although technological and medical advances and societal changes have increased the potential for some people with disabilities to participate in the labor force, fewer than one-half of 1 percent of DI beneficiaries, and about 1 percent of SSI beneficiaries, leave the rolls each year because they are working. As we have reported in the past, the U.S. private sector and social insurance systems of other countries are adjusting to this increased work

¹This figure is for 1999.

²DI is funded by payroll taxes paid by workers and their employers into the Social Security DI trust fund.

potential more quickly than SSA.³ Although at one time the common business practice was to encourage someone with a disability to leave the workforce, in recent years the private sector in this country and social insurance systems overseas have been developing and implementing strategies for helping people with disabilities to return to work as quickly as possible.

We have testified on the practices of the private sector and other countries for helping people with disabilities return to work and, at your request, are now providing a report on these issues.⁴ We focused our work on three key areas: (1) the eligibility assessment process, (2) work incentives, and (3) staffing practices. In this report, we describe these three elements for three U.S. private sector disability insurers and for three other countries' social insurance systems and compare the practices of both with those of the DI and SSI programs. The DI program covers a broader population than the private insurers, but employees covered under private disability insurance generally have work experience that insures them for coverage under DI. Although SSI beneficiaries, unlike DI beneficiaries, are not required to have worked in covered employment to be eligible for benefits, we extended our comparison to the SSI program because relatively large numbers of SSI beneficiaries have also worked at some point, either prior to benefit receipt or while on the disability rolls.⁵ Nonetheless, particular return-to-work practices may not be the same for the two programs because of the differences, beyond work history, in the beneficiary populations that each program serves. For example, the DI beneficiary population is generally

³See *SSA Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs* (GAO/HEHS-96-133, July 11, 1996).

⁴See *SSA Disability: Other Programs May Provide Lessons for Improving Return-to-Work Efforts* (GAO/T-HEHS-00-151, July 13, 2000).

⁵See Mary C. Daly, "Characteristics of SSI and DI Recipients in the Years Prior to Receiving Benefits: Evidence From the PSID," in Kalman Rupp and David C. Stapleton, eds., *Growth in Disability Benefits: Explanations and Policy Implications* (Kalamazoo, Mich.: W.E. Upjohn Institute for Employment Research, 1998), pp. 190-94. Daly found that about 30 percent of a sample of SSI recipients reported having been employed during the 5 years prior to benefit receipt. Daly defined employment as having worked 52 hours or more, or as having wage earnings, in the previous year. See also L. Scott Muller, Charles G. Scott, and Barry V. Bye, "Labor-Force Participation and Earnings of SSI Disability Recipients: A Pooled Cross-Sectional Times Series Approach to the Behavior of Individuals," *Social Security Bulletin*, Vol. 59, No. 1 (spring 1996). The authors found that, among individuals entering the SSI rolls after 1976 and spending at least 1 full year in benefit status, nearly one-fourth had earnings in at least 1 year while on the rolls. Average annual earnings for all SSI recipients who worked, indexed to 1989 levels, were \$2,075.

older and has a higher proportion of males and beneficiaries with a musculoskeletal diagnosis, and a lower proportion of beneficiaries with a mental impairment, than the SSI disabled beneficiary population of working age adults.

To do this work, we conducted in-depth interviews and reviewed policy documents and program data at three private sector disability insurers: UNUMProvident, Hartford Life, and CIGNA.⁶ 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. Our review of these disability systems updates and expands on our previous work in this area.⁷ Although we were able to compare the return-to-work practices of the different disability systems, we were unable to obtain from the private insurers or other countries complete, comparable data on the costs and benefits of their return-to-work practices. We performed our work in accordance with generally accepted government auditing standards between February and December 2000.

Results in Brief

The disability eligibility assessment process of the U.S. private insurers and the countries we reviewed focuses on returning people with disabilities to work. The assessment process both evaluates a person's potential to work and assists those with work potential to return to the labor force. This process of identifying and providing services intended to enhance a person's productive capacity occurs early after disability onset and continues periodically throughout the duration of the claim. This ongoing process is closely linked to a definition of disability that shifts over time from less to more restrictive—that is, from an inability to perform one's own occupation to an inability to perform any occupation. Both the definitional shift and the ongoing assessment process recognize the possibility for improvement in an individual's capacity to work through

⁶Taken 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 these individuals would likely qualify for SSA's disability benefits. In addition, we focused our review on private insurers' group disability insurance policies that contain return-to-work incentives.

⁷See GAO/HEHS-96-133, July 11, 1996.

early provision of supports and services, such as workplace adaptations or training. In contrast, SSA does not incorporate efforts to return individuals to work into its eligibility assessment process. SSA's return-to-work efforts occur only after the agency's often lengthy process of determining whether an individual meets its statutory definition of disability. Moreover, the "either/or" nature of this definition encourages applicants to focus on their inabilities by characterizing individuals as either able or unable to work.

Work incentives are an important feature of the strategy that the private insurers and other countries we reviewed use to encourage and facilitate a person's return to work. These incentives include requirements for obtaining appropriate medical treatment and participating in a return-to-work program, if such a program would benefit the individual. To support these requirements, these disability systems help the individual obtain the appropriate medical care and provide financial incentives to promote participation in rehabilitation, such as reimbursement for family care costs. In contrast, although SSA's claimants must follow medical treatment that a provider has prescribed for them, they are not required to seek treatment to be eligible for initial award or continuing receipt of SSA disability benefits. Indeed, many disabled DI and SSI applicants and beneficiaries may not have access to the appropriate medical care. Additionally, rehabilitation in DI and SSI is optional and depends upon the beneficiary's motivation to pursue such services. Thus, a beneficiary who could benefit from rehabilitation might not choose to seek it.

Appropriate staffing is a third key component of the return-to-work strategy implemented by the private insurers and the countries we studied. These disability systems have access to staff with a wide range of expertise not only in making eligibility decisions, but also in providing return-to-work assistance. The three private disability insurers told us that they select the appropriate type and intensity of staff resources to return individuals with work capacity to employment cost-effectively. For example, while the three private insurers generally assign minimal staff resources to periodically monitor the status of individuals who are unlikely to return to work, they usually apply their most resource-intensive, multidisciplinary teams to assist those who are assessed as being likely to work. In comparison, staff who make eligibility decisions for the DI and SSI programs focus on assessing eligibility of applicants to receive cash benefits, not on helping them return to work. However, under the new Ticket to Work and Work Incentives Improvement Act (Ticket to Work Act), SSA's disabled beneficiaries who choose to pursue rehabilitation are to be given a voucher (or "ticket") to gain access to specialists who can assist them in returning to work.⁸

While the Ticket to Work Act and other initiatives are beginning to focus more on returning DI and SSI beneficiaries to work, we believe that SSA is not placing enough priority on enhancing the productive potential of its disabled beneficiaries and needs to develop a comprehensive return-to-work strategy. In commenting on a draft of this report, SSA agreed that the return-to-work practices that other disability programs follow provide useful information and that emphasis should be placed on helping beneficiaries with disabilities return to work. But SSA disagreed on the need to develop a comprehensive return-to-work strategy for its disability programs, stating that it is already devoting substantial resources to return to work. The agency also stated that changing the DI and SSI policies discussed in the report would require new legislation, and that differences between SSA's programs and those of the other systems we reviewed might limit the application of other systems' practices to the DI and SSI programs. With regard to these concerns, we believe that SSA's return-to-work initiatives do not constitute the comprehensive strategy necessary to address fundamental program weaknesses and reorient the agency's policies and practices to focus on work while not jeopardizing benefits for people who cannot work. Moreover, while some aspects of the current disability programs are based in law, others are set forth in regulation; thus,

⁸P.L. 106-170, Dec. 17, 1999.

important aspects of the programs could be modified by the agency without legislation. Finally, the existence of differences between SSA's disability programs and those of the other systems we examined should not be construed to imply that our federal programs have little to learn from the approaches of these other systems. Indeed, although limited data exist on the cost-effectiveness of the practices of other disability systems, the initial return-to-work rates of the three private insurers show promise. SSA should build on the experiences of other disability systems and the results of the Ticket to Work demonstrations to identify the elements of a model disability system and then determine the legislative and regulatory changes needed to test and evaluate the effectiveness of these elements. Because adopting a comprehensive strategy will require fundamental changes to the underlying philosophy and direction of the DI and SSI programs, which are embedded in both law and regulation, policymakers will need to carefully weigh the implications of such changes.

Background

DI and SSI are the two largest federal programs providing cash assistance to people with disabilities. Established in 1956, DI is an insurance program that provides monthly cash benefits to workers who are unable to work because of severe long-term disability. Workers who have worked long enough and recently enough are insured for coverage under the DI program. After becoming disabled, individuals have a waiting period of 5 months before receiving cash benefits. In addition to cash assistance, DI beneficiaries receive Medicare coverage after they have received cash benefits for 24 months. Beneficiaries' DI benefits convert to Social Security retirement benefits when beneficiaries reach age 65. 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.⁹

⁹Included in the 4.9 million DI disabled workers are about 735,500 beneficiaries who were also eligible for SSI disability benefits because of the low level of their income and resources. In 1999, DI also paid about \$4.9 billion in cash benefits to about 1.7 million spouses and children of disabled workers.

SSI, created in 1972, is a means-tested income assistance program that provides a financial safety net for disabled, blind, or aged individuals who have low income and limited resources. Unlike the DI program, SSI has no prior work requirement and no waiting period for cash or medical benefits. Eligible SSI applicants generally begin receiving cash benefits immediately upon entitlement and, in most cases, receipt of cash benefits makes them eligible for Medicaid benefits. In 1999, about 2.6 million working age people with disabilities received SSI benefits.¹⁰ In the same year, federal SSI cash benefits paid to SSI beneficiaries with disabilities equaled \$22.9 billion, and average monthly federal SSI cash benefits amounted to about \$364 per person.¹¹

The DI and SSI programs use the same statutory definition of disability. To meet the definition of disability under these programs, 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 (SGA). Individuals are considered to be engaged in SGA if they have countable earnings above a certain dollar level.¹² Moreover, the 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 contracts with state disability determination service (DDS) agencies to determine whether applicants are disabled.

¹⁰The 2.6 million beneficiaries received federally administered SSI payments based on disability. This number does not include disabled workers who were dually eligible for DI and SSI benefits.

¹¹The \$22.9 billion in federal SSI cash benefits was paid to SSI disabled beneficiaries of all ages, including working age adults aged 18 to 64, as well as disabled beneficiaries under age 18 and over age 65. These benefits were also paid to disabled workers dually eligible for DI and SSI benefits. The \$22.9 billion does not include SSI supplemental payments made by the states.

¹²Regulations currently define SGA for both the DI and the SSI programs as employment that produces countable earnings of more than \$700 a month for nonblind disabled individuals. The SGA level for DI blind individuals, set by statute and indexed to the annual wage index, is currently defined as monthly countable earnings that average more than \$1,170. 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 a person is working at the SGA level.

The DI and SSI programs offer various incentives that are intended to encourage beneficiaries to work—and, potentially, to leave the rolls.¹³ 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 benefits. After the trial work period, cash benefits continue for 3 months and then are terminated completely if countable earnings are greater than SGA. The SSI work incentives, among other features, allow beneficiaries to earn more than the SGA level and retain part of a cash benefit. As a beneficiary's earnings increase, the SSI benefit payment gradually decreases until earnings become too high to allow a cash benefit.¹⁴

Despite these work incentives, however, few DI and SSI beneficiaries return to work. Therefore, we have recommended in previous reports that SSA place greater priority on helping disabled beneficiaries return to work. 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.¹⁵ We 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.

SSA has recently begun to increase its emphasis on helping its DI and SSI beneficiaries return to work. 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 the availability of health care services and created a "Ticket to Work" voucher program that will allow beneficiaries a greater choice of vocational rehabilitation and employment service providers. SSA

¹³See *Social Security Disability: Improving Return-to-Work Outcomes Important, but Trade-Offs and Challenges Exist* (GAO/T-HEHS-97-186, July 23, 1997) for a more complete explanation of DI and SSI work incentives.

¹⁴To calculate the monthly SSI benefit amount, SSA excludes \$20 of a beneficiary's monthly general income, \$65 of his or her monthly earned income, as well as \$1 for every \$2 of the remaining monthly earnings.

¹⁵See GAO/HEHS-96-133, July 11, 1996, and *SSA Disability: Program Redesign Necessary to Encourage Return to Work* (GAO/HEHS-96-62, Apr. 24, 1996).

has also funded partnership agreements with 12 states. These agreements are intended to help the states develop services to increase the employment of beneficiaries with disabilities.

Private Disability Insurance

Employers may choose to sponsor private disability insurance plans for employees either by self-insuring or by purchasing a plan through a private disability insurer. These disability plans can provide short- or long-term disability insurance coverage, or both, to replace income lost by employees because of injuries and illnesses. The private insurers generally reduce the disability benefit payments of individuals who receive both private disability and DI benefits by the amount of the DI benefit payment. The Department of Labor's Bureau of Labor Statistics estimates that, of the approximately 100 million employees who work in the private sector, only a portion—about 36 percent—are covered by employer-sponsored short-term disability insurance, and a smaller portion—about 26 percent—have long-term coverage.¹⁶

¹⁶See *Private Disability Insurance: Employer-Sponsored Plans* (GAO/HEHS-00-18R, Nov. 5, 1999). Bureau of Labor Statistics estimates are for the 1996-97 period. These estimates include part- and full-time employees. (Employees were classified as either full- or part-time workers in accordance with their employers' practices.) These estimates do not include data on agricultural employees or disability provisions of defined benefit pension plans. (In a defined benefit plan, the employee's benefit at retirement can be specifically determined using such factors as salary and number of years of service.) Data on short-term coverage include state temporary disability insurance plans in New York, New Jersey, and Hawaii funded, at least in part, by employee contributions. Data exclude such plans in California and Rhode Island, where benefits are wholly financed by employees. The estimates cannot be summed to calculate the total number of employees with private disability insurance because some employees may have either short-term coverage or long-term coverage—or both.

The characteristics of the portion of the U.S. working population that is covered by employer-sponsored private disability insurance differ from those of SSA's covered population. For example, unlike SSA, private insurers vary the employer's premium cost on the basis of various risk factors, such as the type of work and the general health of the workers. Thus, employers in higher risk industries may choose not to purchase private disability insurance for their workers because of the cost of coverage. Moreover, in contrast to SSA, private insurers allow employers who purchase their disability policies to vary coverage by type of impairment or by class of employee. For example, because the disability insurance industry generally charges much higher premiums for full mental health coverage, employers in general limit coverage for mental impairments to a maximum of 24 months.¹⁷ Employers may also choose to provide long-term disability coverage for only their white collar employees, rather than for all their employees.¹⁸

The private disability insurance industry, moreover, provides benefits to many individuals who are not as severely disabled as the beneficiaries of the DI and SSI programs. However, almost two-thirds of those receiving private long-term disability benefits from the three private insurers we reviewed also received DI benefits. 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, and a lower proportion of female and younger beneficiaries than the SSI disabled population. The three insurers reviewed had a lower proportion of beneficiaries with mental impairments than the DI and SSI disabled populations.

¹⁷For the three insurers we reviewed, 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 such conditions as psychotic disorders and schizophrenia from this limitation. In contrast, the SSA disability programs do not have time-limited benefits for beneficiaries with mental impairments. In 1999, 26.8 percent of DI disabled workers and 33.8 percent of SSI disabled individuals between the ages of 18 and 64 had mental disorders other than mental retardation.

¹⁸White collar jobs fall into two categories: managerial and professional occupations and technical, sales, and administrative support occupations.

Similar to the private sector organizations we assessed in our previous work in this area, the three private disability insurers we reviewed for this report have recognized the potential for reducing disability costs through an increased focus on returning people with disabilities to productive activity.¹⁹ To accomplish this comprehensive shift in orientation, these insurers have begun developing and implementing strategies for helping people with disabilities return to work as soon as possible, when appropriate. Although the insurers 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 three private insurers are now including return-to-work provisions in the standard disability contracts that they are writing, a large number of employees are still insured under prior contracts that lack these provisions. While only partially indicative of the results of these strategies, the three insurers' initial return-to-work rates are promising, showing greater success than SSA's DI program in returning the disabled to work. The three insurers reported that, in 1999, between 2 and 3 percent of their long-term disability beneficiaries who also received DI benefits either returned to work or were terminated from the private sector disability benefit rolls because they were assessed as having the capacity to work. However, the groups covered by SSA and the private insurers are not fully comparable. Although both groups of individuals receive DI benefits, as described previously, the private insurers cover a selected portion of the U.S. working population and, therefore, of DI beneficiaries.

Other Countries' Disability Systems

Like SSA's disability programs, disability systems in Germany, Sweden, and The Netherlands cover a broad population with a wide range of work experiences, skills, and disabilities. However, these disability systems operate in a somewhat different social and political context than DI and SSI. For example, the availability of universal health insurance in these countries ensures that the receipt of health insurance is not an issue in a worker's decision about whether to apply for benefits, participate in rehabilitation, or attempt returning to work, as it can be in the United States. 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.

¹⁹See GAO/HEHS-96-133, July 11, 1996.

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. Some limited studies and data indicate positive results from the return-to-work approach in these disability insurance systems.²⁰

Return-to-Work Efforts Are Integral to Eligibility Process in Selected Private and Foreign Systems

In the disability systems of the private disability insurers and the countries we reviewed, identifying and providing services intended to enhance the claimants’ capacity to work are central to the process of deciding eligibility for benefits.²¹ To enable claimants to return to work as quickly as possible, these disability systems begin assessing each claimant’s potential to rejoin the labor force shortly after disability onset. Further, these systems continue to periodically monitor work potential and provide return-to-work assistance to claimants as needed throughout the duration of the claim. This ongoing process is closely linked to a definition of disability that shifts over time from less to more restrictive—that is, from an inability to perform one’s own occupation to an inability to perform any occupation. Both the definitional shift and the ongoing assessment process recognize the possibility for improvement in an individual’s capacity to work. In contrast to the efforts of the private insurers and other countries we reviewed, the efforts that SSA makes to return claimants to work occur only after an often lengthy review of eligibility. (See table 1.)

²⁰For 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 the social insurance offices’ early screening and contact with disabled individuals.

²¹Throughout this report, we use the term “claimant” to refer to both a person who submits a claim for disability insurance and a person who receives disability benefits for the lifetime of a claim.

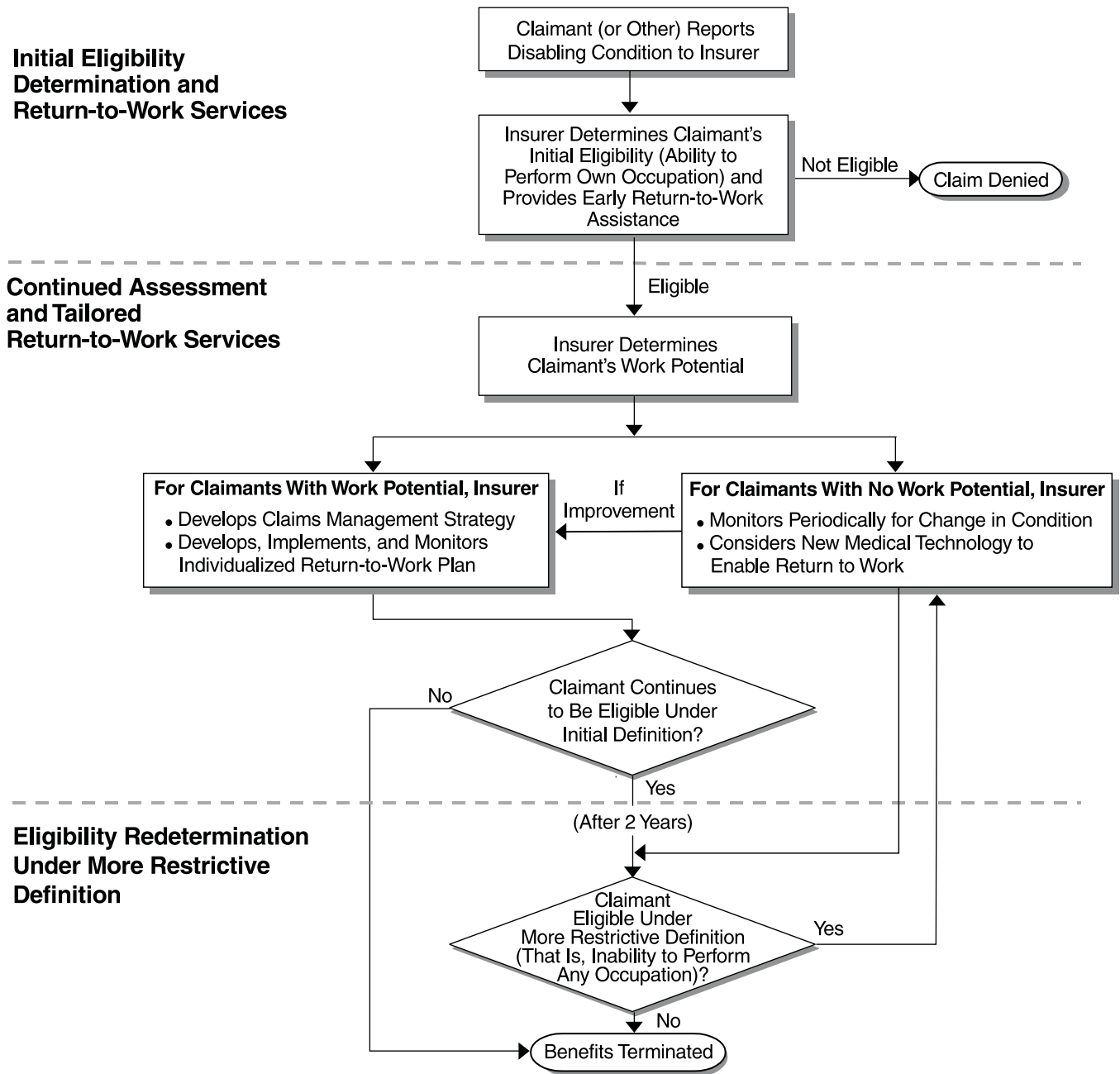
Table 1: Comparison of Eligibility Assessment Process Features of U.S. Private Insurers and Other Countries With Those of SSA

Process feature	Private insurers and other countries	SSA
Disability definition	Definition of disability shifts over a specified time period from less to more restrictive, allowing a transitional period of eligibility under a less restrictive definition for providing financial and other work assistance, such as retraining. This transitional period recognizes the possibility of improvement in an individual's capacity to work.	"Either/or" 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 eligibility 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 who can work to the labor force.	There is no integration of return-to-work considerations into the eligibility assessment process.

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

The three 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 immediately set up the expectation that claimants with the potential to do so will return to work. The insurers' process for assessing and enhancing 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 the three private sector insurers we studied, claimants are considered disabled when, because of injury or sickness, they are limited in 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.²² 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.²³

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, insurers use early contact with employers to encourage them to provide workplace accommodations for claimants with the capacity to work.

²²The 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. Moreover, two of the insurers have expanded their “own occupation” definition of disability to include a reasonable alternative position. These two insurers require that a claimant who is judged able to do so accept a reasonable alternative position—a job in the same general location as that offered by the claimant's current employer—or risk losing cash benefits. The claimant must be qualified to perform the work of 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.

²³Our 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.

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 initially found eligible for benefits may be found ineligible under the more restrictive definition.²⁴

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 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. The insurer continues to look for opportunities to assist claimants who qualify under this definition of disability in returning to work. Such opportunities may occur, for

²⁴The three 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, these private insurers generally try to identify several occupations that exist locally that could provide a sufficient salary for the claimant. However, the insurers are 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.

example, when changes in medical technology—such as new treatments for cancer or AIDS—may enable claimants to work, or when claimants are motivated to work. To illustrate, one insurer told us of a 57-year-old, college-educated manager who sustained severe injuries, including the amputation of a leg, as the result of a car accident. The private insurer initially found the claimant unable to perform any occupation and awarded him private disability benefits. (SSA, under its own eligibility determination process, also awarded the claimant DI benefits.) However, because the claimant wanted to work, the private insurer, employer, and claimant collaborated in developing and implementing a return-to-work plan. After 1 month of computer training, the claimant returned to a new position with the prior employer at his predisability salary.

The private insurers that we reviewed told us that, throughout the duration of the claim, they tailor the assessment of work potential and development of a return-to-work plan to the specific situation of each individual claimant. 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: Medical Assessment: Tasks, Tools, and Methods

Task	Tools and methods
Assess the 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 the 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: Vocational Assessment and Assistance: Tasks, Tools, and Methods

Task	Tools and methods
Identify transferable skills, validate restrictions on and capabilities for performing an occupation, and identify other suitable occupations and retraining programs.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • Provide resume preparation, help develop 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.
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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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 three 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. Consistent with the principle that intervention should occur at the earliest possible stage of disability to minimize the degree and effect of the impairment, program officials told us that 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, they said that 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 monitors the case and periodically reassesses the person's work capacity and need for return-to-work assistance, according to program officials. The office awards long-term disability benefits, officials said, 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, program officials told us.²⁵ 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 services 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, consider granting long-term benefits if the person's rehabilitation potential has not improved, program officials explained.

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.

²⁵Social 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.

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 its eligibility assessment process.²⁶ To be considered eligible for long-term cash benefits, applicants are characterized as either having the capacity to work or being unable to work, according to the Social Security Act's definition of disability. But this dichotomous choice does not recognize that many people with disabilities fall on a continuum between being able to work full-time and being unable to work at all. These individuals may have a variety of needs for shorter-term supports and services other than permanent cash payments to help them make the transition to the workforce, such as assistive devices and medical treatment. Yet, to obtain any services through DI and SSI, individuals who might have been able to remain at or make the transition to work with shorter-term services have no choice but to emphasize their limitations and de-emphasize any work capacity in order to establish their inability to work. In other words, eligibility for noncash services that are needed in order to work is, paradoxically, linked to proving one's inability 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.

²⁶There 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 to both the DI and the SSI programs 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.

In recent years, SSA has piloted numerous initiatives to redesign and thereby improve its disability determination process. But while an 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.²⁷ 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. Under the Ticket to Work Act, only those individuals who have met the Social Security Act’s definition of disability and are approved for benefits will receive a ticket entitling them to receive return-to-work services. Because SSA’s eligibility determination process can take up to 18 months or longer for individuals who are initially denied benefits and who are then deemed eligible on appeal, there can be a long delay in receiving services. Since many applicants have been unemployed before applying for benefits and remain unemployed during the eligibility determination process, their skills, work habits, and motivation to work are likely to deteriorate during this wait.²⁸ However, the Ticket to Work Act authorizes SSA to carry out a demonstration project to test the advantages and disadvantages of earlier referral of DI applicants and beneficiaries for rehabilitation.²⁹ SSA may also gain additional insights into early intervention approaches for both DI and SSI through its funding of demonstration projects in 12 states.³⁰

²⁷SSA, *Employment Support Concept Development Plan* (Baltimore, Md.: SSA, Apr. 12, 1999).

²⁸See GAO/HEHS-96-62, Apr. 24, 1996.

²⁹SSA has not yet designed such a project, and it is unclear how early SSA will be intervening after onset of disability in this demonstration.

³⁰For example, one state is testing the provision of short-term vocational services to DI and SSI applicants with recent work histories, with an emphasis on early intervention and quick employment.

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

To facilitate return to work, 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. Insurers and the countries we studied require claimants who could benefit from vocational rehabilitation to participate 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 obtaining 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 they 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 beneficiaries. In addition, under law and SSA regulations, although SSA's claimants must follow medical treatment that has been prescribed for them, they are not required to seek treatment as a prerequisite for award or continuing receipt of benefits. Moreover, access to medical treatment may be limited for many DI and SI applicants and beneficiaries, whose medical costs may not be covered.

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

The three private insurers we reviewed require claimants who could benefit from vocational rehabilitation to participate in a customized rehabilitation program or risk loss of benefits. As part of this program, a return-to-work plan for each claimant can include, for example, adaptive equipment, modifications to the work site, or other accommodations. These 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.³¹

These insurers also make special financial incentives available, as appropriate, to claimants who participate in rehabilitation programs. For

³¹Although claimants may be involved in the development of the individualized rehabilitation plans, the insurers make the final decision about the types of rehabilitation services claimants will receive.

example, one insurer told us that claimants receive an additional benefit equal to 10 percent of their disability payment for participating in rehabilitation. The insurer caps these additional benefits at \$1,000 a month. In addition, the insurers may defray costs associated with rehabilitation, such as child care expenses. To this end, one insurer reported that it may pay \$250 a month per child, up to \$1,000 per month.

In addition, 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.³² 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.³³ 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 may reduce or terminate the claimant's benefits. To encourage claimants to work to the extent they can, even if only part-time, two of the insurers told us they may reduce a claimant's benefit by the amount the claimant would have earned if he or she had worked to maximum capacity.³⁴ The other insurer may reduce a claimant's monthly benefit 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 refuse to accept a

³²The private disability insurers we reviewed told us that their benefits generally replace 60 percent of predisability earnings, depending upon the insurer.

³³To 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.

³⁴One 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.

reasonable accommodation that would enable them to work. For example, if a claimant with impaired vision refuses the offer of a large-screen computer terminal that would enable 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, these 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 treatment type and frequency. Moreover, the insurers' medical staff work with the treating physician as needed to ensure that the claimant has an appropriate treatment plan. The insurers told us they may also provide funding for those who cannot otherwise afford treatment.

The three private sector insurers we studied may also provide financial incentives to employers to encourage them to provide work opportunities for claimants. By offering lower insurance premiums to employers and paying for accommodations, these 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, the three insurers offer employers a discounted insurance premium: if their disability caseload declines to the level expected for those companies that assist claimants in returning to work, the employers may continue to pay the discounted premium amount. These insurers also fund accommodations, as needed, for disabled workers at the employer's work site.³⁵

³⁵Educating employers about the size and extent of disability costs is an important element in motivating employers to promote efforts to return claimants to work. For example, one of the private insurers we reviewed educates employers about the direct and indirect costs of not controlling lost time associated with disability, which this insurer estimated to amount to 4 to 6 percent of an employer's payroll.

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

In Germany and Sweden, individuals may also 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.³⁶ 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.³⁷ 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 rehabilitation services and medical treatment to disabled individuals, and social insurance offices in Germany and Sweden may terminate the disability benefits of individuals who refuse to follow 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 employing 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.³⁸ Furthermore, in The Netherlands, employers have an additional incentive to assist employees in returning to work because the employers' contributions to the disability insurance fund are partially determined by the number of their employees who became disabled in the prior year.

³⁶For example, 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.

³⁷In Sweden, individuals with reduced work capacity may work full-time and still take part in the transitional work program.

³⁸In Sweden, wage subsidies may be maintained at the same level and extended beyond the 4-year period if authorities determine it is appropriate.

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

In contrast to the practices of 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, the Social Security Act does not require that an individual work to his or her maximum capacity, which may act as a disincentive to work. In particular, DI 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 DI benefits are reduced by \$1 for each \$2 of a beneficiary's earnings above a level determined by SSA. Such a phased reduction in benefits is currently used in the SSI program, in which benefits are reduced by \$1 for each \$2 in earnings above the beneficiary's first \$65 in monthly earnings and \$20 in monthly general income.

The DI and SSI programs also differ from the private sector and the countries we studied in their requirements for 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.³⁹ However, if an applicant is not being treated by a physician, SSA is still required to assess his or her eligibility for benefits. If an applicant qualifies, SSA is required to award benefits, even if the applicant would not qualify for benefits if following treatment prescribed by a physician. And unless medical treatment is prescribed, it is not a prerequisite for continued receipt of benefits once they have been awarded.

³⁹42 U.S.C. secs. 423(f) and 1382c(a), and 20 C.F.R. secs. 404.1530, 404.1594(e) (4), 416.930, and 416.994(b) (4) (iv). 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.

Indeed, SSA found in 1999 that some beneficiaries with affective disorders were receiving no medical treatment. Affective disorders are the primary diagnosis of about one in every nine DI beneficiaries, according to SSA. This diagnosis is characterized by a disturbance in mood—for example, depression, mania, or both—and includes such diagnoses as major depressive disorder and bipolar disorder. In addition, SSA found that many beneficiaries with affective disorders who were receiving treatment were not being treated by mental health professionals. Research cited by SSA suggests that as many as 60 percent of affective disorder cases can be controlled with appropriate treatment.⁴⁰ SSA believes that providing access to the right medical treatment for DI beneficiaries with affective disorders could help them return to work and has recently begun a demonstration project to test this assumption.⁴¹ Nevertheless, access to medical treatment may be limited for many DI and SSI applicants and beneficiaries, for whom medical costs may not be covered.⁴²

In addition, 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. However, SSA is currently funding demonstration projects in 12 states to develop ways to increase employment of beneficiaries and other people with disabilities and is looking to employers for help. For example, the goals of one state project are to solicit employer views on barriers to hiring beneficiaries and to identify strategies for, and educate employers about, increasing employment opportunities for beneficiaries. In addition, the federal government provides tax incentives, and states may provide other

⁴⁰The extent to which these data apply specifically to DI and SSI disabled beneficiaries is unknown.

⁴¹Outside of the ongoing demonstration project, SSA does not routinely intervene in the delivery of medical services for its beneficiaries.

⁴²For example, DI and SSI applicants may not be covered by health insurance before or during the application for benefits process. In addition, new DI beneficiaries have a 24-month waiting period before Medicare eligibility begins. Moreover, Medicare and Medicaid often severely restrict funding for assistive technologies that improve function or help prevent secondary disabilities, and Medicare generally does not cover the costs of prescription drugs. Lack of coverage for medications can limit the ability of some people with disabilities to return to work in cases in which drugs are essential to improving functioning.

assistance, to employers to encourage them to return people with disabilities to work.⁴³

Other Systems Use Staff With a Wide Range of Expertise to Assess and Enhance Claimants' Work Potential

The private disability insurers and social insurance systems in the other countries we studied have developed techniques for using the right staff to assess eligibility for benefits and return those who can to work. Officials of the three private insurers and the social insurance systems told us that they have access to individuals with a range of skills and expertise, including medical experts and vocational rehabilitation experts. Private disability insurers told us that they 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

The three private disability insurers that we studied have 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 includes claims managers, medical experts, vocational rehabilitation experts, and team supervisors.⁴⁴ 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

⁴³For 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 equipment modifications. 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 may provide various services to employers, such as rehabilitation engineering services for architectural barrier removal and work-site modifications.

⁴⁴The insurers also employ disability income specialists to assist claimants in applying for DI benefits.

examinations alone.⁴⁵ 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 Private Disability Insurers to Assess and Enhance a Claimant’s Work Potential

Type of staff	Responsibilities	Qualifications and training
Claims managers	<ul style="list-style-type: none"> • 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. 	<p>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.</p>
Medical and related experts ^a	<ul style="list-style-type: none"> • 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. 	<p>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</p>
Vocational rehabilitation experts	<ul style="list-style-type: none"> • 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. 	<p>Rehabilitation experts are master’s-degree-level vocational rehabilitation counselors. In addition, one insurer requires board certification and 5 years of experience.</p>
Supervisors	<ul style="list-style-type: none"> • Provide oversight, mentoring, and training. 	<p>One insurer gives preference to those with a college degree and requires 3 years’ disability experience, some management experience, and specialized training. Another insurer requires a college degree, more than 12 years’ disability claims experience, and completion of courses leading to a professional designation.</p>

^aAt one company, the medical experts are employees of a company subsidiary but are often colocated with the insurer’s employees.

^bOne 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 three disability insurers we reviewed use various strategies for organizing their staff to focus on return to work, with teams organized to

⁴⁵According to one insurer, disabilities with subjective diagnoses include certain types of mental illness, fibromyalgia, chronic pain (often back pain), and chronic fatigue syndrome.

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 limitations.⁴⁶ Regardless of the overall type of staff organization, each of the three insurers facilitates the interaction of its core staff—claims managers, medical experts, and vocational rehabilitation experts—by pulling these experts together into small, multidisciplinary teams responsible for managing claims. Additionally, one insurer engenders team interaction by physically collocating core team members in a single working area.

To provide a wide array of needed experts, the three disability insurers expand their core staff through agreements or contracts with subsidiaries or other companies. 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, these insurers contract with medical experts beyond their 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.⁴⁷

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

⁴⁶All three insurers, however, have behavioral care specialists specifically for managing psychiatric claims.

⁴⁷Two insurers also contract with investigators and surveillance personnel to investigate potential inconsistencies between claimants' 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.

management staff, which include separating (or “triaging”) different types of claims and directing them 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 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 (see table 5).

Table 5: Staff Assignment for Claims Management by Triage Category

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Vocational expert • Medical expert • Claims specialist • Other specialists as needed 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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, a claimant with a more stable, albeit serious, medical condition who is 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.⁴⁸ 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.

Mirroring this wide difference in caseload size, administrative costs for managing claims increase as the intensity of resources dedicated to claims management increases.⁴⁹ Thus, one private insurer told us that its annual average administrative costs for managing stable and mature claims equaled about \$100 per claim. In contrast, the same insurer reported annual average costs for claims managed more actively to be about \$2,400 per claim, with claims managed through the multidisciplinary team approach

⁴⁸The insurers review these claims on a regular basis, ranging from every 6 months to every 3 years, depending upon the insurer and the characteristics of the claim.

⁴⁹Administrative costs include salaries and overhead expenses, such as legal fees, telephone and computing services, and rent. These costs do not include, however, some costs of returning a claimant to work, such as costs of return-to-work services provided by vendors. For example, one insurer told us that its average cost per claim for using vendor services to return an employee to work was about \$470. Included in this calculation are individuals with disabilities that are less severe than those of individuals who qualify for SSA disability benefits. The insurer told us that the average cost of returning an employee to work could be higher for individuals with disabilities severe enough to qualify for SSA disability benefits.

focusing on return to work costing even more to manage.⁵⁰ Similarly, another insurer told us that it spent 10 times more to manage claims that required an active intervention strategy than it did to manage stable and mature claims.

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 customized 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.

Moreover, to ensure that staff are utilized cost-effectively, the private insurers said that they compute the return accruing from investing in return-to-work resources for a particular claimant. For example, for claimants who were successfully returned to work, one insurer reported realizing a return of \$90 in benefit savings for each dollar invested in vendor services for rehabilitation.⁵¹ Another insurer estimated that it invests on average between about \$60 and \$1,900 to successfully return a

⁵⁰In addition, the same company reported that the annual administrative cost for intake and triage of claims to the correct staff for claims management was about \$18 per claim.

⁵¹These data, however, are incomplete because they do not include the costs associated with claimants who received assistance but were unable to return to work. In addition, the data reflect costs for some claimants whose disabilities are less severe than those of SSA's disabled beneficiaries. The insurer told us that the cost for returning claimants with more severe disabilities to work might be higher.

claimant to work.⁵² In addition, the insurers compare the amount invested in staff resources with the estimated gross savings they expect to accrue over the life of the claim from returning an average claimant to work, which range from \$25,000 to \$40,000.⁵³

Other Countries Also Use 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. Officials explained that, in Germany, medical rehabilitation is provided before an applicant's condition is assessed to determine whether vocational rehabilitation is necessary. Officials also said that only if successful rehabilitation seems unlikely, or if

⁵²The insurer bases the costs on the average hourly salary for a vocational rehabilitation expert and the average amount of time this expert spends in returning a claimant to work in the following situations: (1) return to work with the same employer, with job modifications—\$58.90; (2) return to work with the same employer and an alternative job—\$106.02; and return to work with a different employer, with or without retraining—\$1,884.80. These costs are only for those claimants who were successfully returned to work. If claimants who did not return to work were included in the cost estimate, the cost would increase. Moreover, the cost might also increase if the claimants considered were only those with severe disabilities.

⁵³Two insurers calculated average savings from returning a claimant to work as, respectively, nearly \$34,000 and about \$40,000. The third insurer calculated the average savings in lifetime benefits for returning to work a 55-year-old private disability beneficiary who also receives DI to be about \$25,000.

rehabilitation has been provided without success, will the social insurance offices in Germany and Sweden typically grant the person long-term disability benefits. Moreover, officials told us that once an individual is granted long-term benefits because he or she is 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 Resources Are Not Focused on Returning Claimants to Work

In contrast to the private insurers and the foreign social insurance offices, SSA requires staff who make determinations only to assess the eligibility of applicants to receive cash benefits and not to assess what is needed for an individual to return to work or to help an individual with work capacity to return to work. Neither does SSA provide staff to monitor applicants' or beneficiaries' medical treatment. To make initial benefit eligibility determinations, SSA relies on teams comprising a disability examiner and a medical or psychological consultant. Since SSA's teams do not carry out the variety of roles related to return to work that teams in the private and foreign disability systems do, SSA does not require that these positions be staffed with individuals with vocational skills and expertise. 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 DDS agencies that perform eligibility determinations under contract with SSA, 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.⁵⁴ In contrast to practices of the private insurers and foreign social insurance offices, SSA does not separately evaluate whether a beneficiary has the potential to return to work.

Conclusions

Return-to-work practices used in the U.S. private sector and in other countries reflect the understanding that some 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. Moreover, although the Ticket to Work Act is expected to enhance work incentives for people with disabilities, fundamental policy weaknesses in the DI and SSI programs 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" DI benefits structure, and return-to-work services offered only after a lengthy determination process.

We continue to believe that opportunities exist for enabling more of SSA's disabled beneficiaries to reduce or eliminate their dependence on cash benefits, and that SSA could do this without jeopardizing the availability of benefits for people who cannot work. We also continue to believe SSA still is not placing enough priority on identifying and enhancing the work potential of its beneficiaries with disabilities and needs to develop a comprehensive return-to-work strategy. In developing such a strategy, SSA can supplement what it learns from the experiences of the Ticket to Work demonstrations with the return-to-work approaches of other disability systems to identify elements of a new system that could help each individual realize his or her productive potential. Having identified these elements, SSA would then be in a position to determine the legislative and regulatory changes needed to test and evaluate their effectiveness.

⁵⁴The 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.

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 its programs cover 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. Many of these differences can be attributed to the particular laws and regulations governing the programs. Despite the data limitations and the differences between disability systems, initial return-to-work rates of U.S. private insurers are promising, and the experiences of the other countries show that return-to-work strategies can apply to a broad population with a wide range of skills and disabilities. Nevertheless, adopting a comprehensive return-to-work strategy will require fundamental changes to the underlying philosophy and direction of the DI and SSI programs, including the determination of disability. Policymakers will need to carefully weigh the implications of such changes.

Agency Comments and Our Response

In commenting on a draft of this report, SSA agreed that the return-to-work practices that other disability programs follow provide useful information and that emphasis should be placed on helping beneficiaries with disabilities return to work. However, the agency had three concerns with the report. First, it disagreed with our assertion that it needs to develop a comprehensive return-to-work strategy for its disability programs, stating that it is already devoting substantial resources to return to work. For example, SSA cited a number of activities that it has under way or is planning to implement, including working with the Congress to develop and implement the Ticket to Work Act. Second, the agency stated that the DI and SSI policies discussed in the report are specified by the Social Security Act and that changing them would require new legislation. Finally, SSA said that differences between its programs and those of U.S. private insurers and other countries' social insurance agencies might limit the extent to which specific practices of these disability systems are transferable to the DI and SSI programs. SSA also made a few technical comments, which we incorporated where appropriate. (SSA's comments appear in app. I.)

We acknowledge throughout this report SSA's return-to-work activities and the potential for improvements under the Ticket to Work Act, such as expanding the availability of vocational rehabilitation. Although these are steps in the right direction, fundamental policy weaknesses—particularly

at the front end of the eligibility assessment process—remain unchanged by the act and SSA's activities. These weaknesses include, as we explain in the report, an eligibility assessment process that encourages applicants to focus on their incapacities and return-to-work assistance that occurs only after an often lengthy eligibility process, if at all. Indeed, although SSA stated that the Social Security programs are programs of last resort, for some applicants and beneficiaries these programs are the sole option for return-to-work assistance and medical care. Although these individuals may have a variety of needs for supports and services other than permanent cash payments to help them make the transition to the workforce, eligibility for noncash services is, paradoxically, linked to emphasizing one's limitations and de-emphasizing any work capacity. Because of the continuing existence of such structural program weaknesses, we believe, as we have concluded in this and earlier reports, that SSA's return-to-work activities do not constitute the comprehensive strategy necessary to reorient the agency's policies and practices to focus on work, while not jeopardizing benefits for people who cannot work. Absent a comprehensive strategy, SSA lacks a road map for enhancing the productive capacity of its applicants and beneficiaries and thus risks spending substantial resources in a piecemeal fashion with little likelihood of significantly improving outcomes.

With regard to the concern about the need for legislative change, we have always recognized that new legislation may be in order to reorient the DI and SSI programs toward return to work and have called for SSA to identify the legislative changes needed to implement such a reorientation. While some aspects of the current program are based in law, however, others are set forth in agency regulations. For example, the sequential process used by SSA to determine whether applicants meet the Social Security Act's definition of disability is set forth in regulation—not in law. Important aspects of the program could, therefore, be modified by the agency without legislation.

Regarding SSA's third concern, we have long acknowledged, in this and other reports, that the DI and SSI programs differ in a number of ways from those of private insurers and social insurance programs in other countries. For example, SSA's programs cover a broader population than the private insurers do. Although a significant portion of the long-term disability beneficiaries of the private insurers we examined also received DI benefits, we sought to compensate for the differences between SSA's beneficiaries and those of the private sector by examining the return-to-work approaches of other countries' disability systems as well. These systems,

like SSA's disability system, cover a broad population with a wide range of work experiences, skills, and disabilities. We have also acknowledged that other significant differences exist between SSA's disability programs and those of the other systems we examined, such as the availability of universal health insurance in some countries. But the existence of these and other differences among the systems should not be construed to imply that our federal programs have little to learn from the approaches of other systems. Indeed, SSA itself has long had an interest in disability programs in other countries and their rehabilitation and return-to-work efforts.

SSA, in its March 11, 1999, strategic plan for the disability programs, said that many beneficiaries with disabilities want to work and become independent and many can work despite their impairments if they receive the supports they need.⁵⁵ To tap this potential, we believe that a comprehensive return-to-work strategy addressing the fundamental policy weaknesses in the DI and SSI programs is needed. But, in developing such a strategy, we do not advocate either wholesale or immediate adoption of these systems' approaches. Rather, we suggest a carefully managed approach, in which SSA builds on the experiences of other disability systems (while considering the differences among the systems) and the results of the Ticket to Work demonstrations to identify elements of a new system that will help each person realize his or her productive potential. In thinking through such a system, SSA should first identify the elements of a model system and then determine the legislative and regulatory changes needed to test and evaluate effectiveness of these elements. Through such testing and evaluation, SSA, as the primary manager of multibillion-dollar programs and as the entity with fiduciary responsibility for the trust funds, could take the lead in developing the evidence it needs to suggest legislative and regulatory changes necessary to develop a disability system for the 21st century.

We are sending copies of this report to the Honorable Kenneth S. Apfel, Commissioner of Social Security; appropriate congressional committees; and other interested parties. We will also make copies available to others on request.

⁵⁵SSA, *Social Security and Supplemental Security Income Disability Programs: Managing for Today; Planning for Tomorrow* (Baltimore, Md.: SSA, Mar. 11, 1999).

If you or your staff have any questions concerning this report, please call me at (202) 512-7215 or Carol Dawn Petersen at (202) 512-7066. Another GAO contact and staff acknowledgments are listed in appendix II.

A handwritten signature in black ink that reads "Barbara D. Bovbjerg". The signature is written in a cursive style with a large, stylized initial "B".

Barbara D. Bovbjerg
Director, Education, Workforce,
and Income Security Issues

Comments From the Social Security Administration



SOCIAL SECURITY

Office of the Commissioner

December 6, 2000

Ms. Cynthia M. Fagnoni
Director, Education, Workforce, and
Income Security Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Fagnoni:

Thank you for the opportunity to review the draft correspondence report, "Social Security Disability: Other Programs May Provide Lessons for Improving Return-to-Work Efforts" (GAO-01-153). Our comments on your report are enclosed. If you have any questions, please have your staff contact Sandy Miller at (410) 965-0372.

Sincerely,

A handwritten signature in black ink that reads "Kenneth S. Apfel".

Kenneth S. Apfel
Commissioner
of Social Security

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

**COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION (SSA) ON THE
GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT, "SOCIAL
SECURITY DISABILITY: OTHER PROGRAMS MAY PROVIDE LESSONS
FOR IMPROVING RETURN-TO-WORK EFFORTS"**

General

We appreciate GAO's time and effort on this and other reports on this issue. We also appreciate the opportunity to review the subject draft report. The report makes no recommendations, but we do have the following comments.

This report is similar to GAO reports of 1996 and 1999, which focused on the structure and practices of private disability insurance programs in the United States and those of European countries. The current report provides useful information about practices that other disability programs follow to help their beneficiaries return to work. SSA agrees that emphasis should be placed on helping beneficiaries with disabilities return to work and has been working to adapt the underlying principles of many of these practices to its Disability Insurance (DI) and Supplemental Security Income (SSI) programs.

We agree with GAO's conclusion that "policymakers will need to carefully weigh the implications of such changes" when considering "fundamental changes to the underlying philosophy and direction of the DI and SSI programs." However, we disagree with GAO's conclusion that SSA should have adopted such changes as part of a "comprehensive return-to-work strategy." In fact, SSA is devoting substantial resources to a return-to-work strategy. The agency was very active in working with Congress in developing the Ticket to Work and Work Incentives Improvement Act (TWWIA), and has already started implementing it. As part of TWWIA, SSA awarded grants to 43 non-profit organizations and/or State agencies in 26 States to provide benefit planning, assistance and outreach for persons with disabilities who are attempting to return to work. We believe that SSA is taking the appropriate, statutorily based approach of implementing the Ticket to Work program over a number of years, while concurrently testing demonstration projects.

With regard to other aspects of our strategy, SSA currently has, or is planning, several research projects that focus on issues highlighted in the report. Principal among these are the Affective Disorders Treatment demonstration, the State Partnership Initiative cooperative agreements and a \$1-for-\$2 benefit offset demonstration. In addition, SSA is currently developing an early-intervention demonstration project. These projects will help SSA to better understand and facilitate effective ways of encouraging disability beneficiaries to return to work. We think this measured approach is preferable to making immediate changes to the fundamental principles of such important programs.

It is important to bear in mind, however, that the DI and SSI programs differ in a number of ways from the programs that the GAO report describes. These differences may limit the extent to which the specific practices of the other programs are transferable to the DI and SSI programs. In particular, as discussed below, the DI and SSI programs have a unique statutory basis as well as a beneficiary population that is not necessarily mirrored in the private sector.

Basis of DI and SSI Policy

When citing DI and SSI policies, the report often describes a policy or procedure as though it were a matter of agency discretion when it actually is prescribed or directed by the Social Security Act. On page 11, for example, the report notes that "...the efforts that SSA makes to return claimants to work occur only after an often lengthy review of eligibility." GAO should give more emphasis to the fact that SSA's administrative eligibility process is driven by the statutory definition of disability as the "inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months."

On pages 5 and 40, the report states that SSA needs to adopt a return-to-work strategy that would include "fundamental changes to the underlying philosophy and direction of the DI and SSI programs, including the determination of disability..." That philosophy, however, is embedded in the legislation that authorizes the program. Moreover, even if some of the recommended changes could be implemented without affecting the definition of disability, nearly all the changes being suggested would require new legislation.

Although the Conclusions section of the report mentions that legislation would be needed for these fundamental changes, the report should make this clear at the outset. The Executive Summary should state that the DI and SSI policies discussed in the report are prescribed or directed by the Social Security Act and that changing them will require legislation.

Comparability of Beneficiary Populations

While the report acknowledges a number of differences between the DI and SSI disability beneficiary populations and the other populations that were examined, it does not give weight to the fundamental differences between Social Security's disability programs and those of the private insurance companies. Since programs in other countries are in the context of social welfare systems that feature universal health care, the differences are even more pronounced.

The Social Security programs are programs of last resort, intended to replace income lost due to inability to work. While we agree that early intervention is extremely important and are looking for ways to provide it, the nature of our programs and those of the private sector are different. Individuals get on the SSDI and SSI rolls after other alternatives are exhausted. Consequently, the beneficiary populations are also different. Therefore, it is

Now on p. 14.

Now on pp. 8 and 40.

**Appendix I
Comments From the Social Security
Administration**

Now on p. 34.

not clear that the practices that appear promising for some beneficiaries of the other programs would hold similar promise for DI and SSI beneficiaries. Indeed, the report notes that only 2 to 3 percent of private insurers' long-term disability beneficiaries who also received DI benefits either returned to work or were terminated as having the capacity to work. While this percentage is greater than the approximately one-half-of-one-percent rate for DI, it does demonstrate that the private sector success is more modest for Social Security beneficiaries in comparison to their other beneficiaries and that the populations are different.

Moreover, table 5 on page 34 of the report shows that the other programs divide claimants into six triage categories for the purpose of targeting their return-to-work efforts toward those beneficiaries who can benefit most from them. The table shows that the other programs devote almost no return-to-work resources to two of the six categories: "unlikely to return to work" and "unable to return to work." While we believe that many DI and SSI disability beneficiaries could benefit from early return-to-work interventions, it is also true that many are individuals who fall into these two categories.

GAO Contact and Staff Acknowledgments

GAO Contact

Barbara H. Bordelon, (202) 512-4427

Staff Acknowledgments

Kelsey M. Bright, Julie M. DeVault, William E. Hutchinson, and Mark Trapani made key contributions to this report.

Related GAO Products

SSA Disability: Other Programs May Provide Lessons for Improving Return-to-Work Efforts (GAO/T-HEHS-00-151, July 13, 2000).

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

Private Disability Insurance: Employer-Sponsored Plans (GAO/HEHS-00-18R, Nov. 5, 1999).

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

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).

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

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

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

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