United States General Accounting Office

GAO

Report to the Chairman, Special Committee on Aging, U.S. Senate

April 1996

SSA DISABILITY

Program Redesign Necessary to Encourage Return to Work

GAO
75 years
1921 - 1996

GAO/HEHS-96-62

GAO

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

Health, Education, and
Human Services Division

B-256285

April 24, 1996

The Honorable William S. Cohen
Chairman
Special Committee on Aging
United States Senate

Dear Mr. Chairman:

This report responds to your request for information on why few Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) adult beneficiaries with disabilities are returned to gainful employment. The report discusses weaknesses in the design and implementation of the DI and SSI programs that impede the Social Security Administration from identifying and expanding the productive capacities of beneficiaries. The report also presents information on key program trends.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to the Commissioner of Social Security, the Secretary of Education, the Secretary of Health and Human Services, and other interested parties. We will also make copies available to others upon request.

Please contact me on (202) 512-7215 if you or your staff have any questions concerning this report. Other GAO contacts and contributors to this report are listed in appendix VII.

Sincerely yours,

Jane L. Ross

Jane L. Ross
Director, Income Security Issues

Executive Summary

Purpose

The Disability Insurance (DI) and the Supplemental Security Income (SSI) programs are the two largest federal programs providing assistance to people with disabilities. The two programs served 7.2 million people in 1994 and provided $53 billion in cash benefits. The Social Security Administration (SSA) administers DI and SSI and makes benefits determinations using a common definition of disability for both programs. SSA is also responsible for encouraging DI and SSI beneficiaries to return to work whenever possible. To this end, DI and SSI applicants are to be referred to state vocational rehabilitation agencies. The Congress has enacted various work incentive provisions that are designed to safeguard beneficiaries' cash and medical benefits to encourage them to test their ability to engage in work.

Despite these statutory provisions, as well as medical and technological changes that have afforded greater potential for some beneficiaries to work, not more than 1 of every 500 DI beneficiaries has left the rolls by returning to work. For this reason, the Chairman of the Senate Special Committee on Aging asked GAO to

- describe changes in the number and characteristics of DI and SSI program beneficiaries over time and the implications of these changes for returning beneficiaries to work;
- analyze the disability determination process to assess whether it can accurately distinguish between applicants who can work and those who cannot; and
- evaluate the effect of the disability determination process, work incentives, and vocational rehabilitation on returning DI and SSI beneficiaries to work.

Background

Working-age adults with disabilities can obtain benefits in the form of services and cash assistance from a number of public and private programs. After the onset of a disabling condition, a worker with a temporary work incapacity may receive short-term cash benefits from an employer, a private insurer, or a workers' compensation program. The last resort for many people who cannot return to the workplace is long-term cash benefits provided by workers' compensation, private disability insurance, and DI. Long-term cash benefits, available through SSI, are the last resort for people with disabilities who have low income and limited assets.

DI provides cash benefits for people with disabilities covered under Social Security who have been found to be unable to work at gainful levels. After receiving DI benefits for 24 months, DI beneficiaries also become eligible for Medicare. In 1994, there were 3.3 million DI beneficiaries. SSI provides cash benefits for the aged, blind, and disabled whose income and resources are below a specified amount. In most cases, SSI beneficiaries are also eligible for Medicaid coverage. In 1994, there were 2.4 million blind and disabled SSI beneficiaries of working age. Additionally, in 1994 671,000 adult beneficiaries received both DI and SSI benefits because they met requirements for both programs, and 841,000 children with disabilities received SSI benefits.

To be considered disabled by either program, an adult must be unable to engage in any substantial gainful activity (SGA) because of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last 12 months or longer. Once a person is on the rolls, benefits continue until death; until SSA determines that the beneficiary no longer meets the eligibility requirements; or, in the case of DI beneficiaries, until their benefits are converted to Social Security retirement benefits at age 65.

Results in Brief

Over the last decade, the number of DI and SSI beneficiaries increased 70 percent because of program changes and economic and demographic factors. By 1994, 31 percent of DI beneficiaries and 57 percent of the adult SSI beneficiaries had mental impairments—conditions that have one of the longest anticipated entitlement periods (about 16 years for DI). During the past decade, the proportion of adult beneficiaries who were middle aged steadily increased as the proportion who were older than middle aged declined, although data on recent years suggest that this trend may reverse.

Almost one of every two beneficiaries may not be realistic candidates for return to work because of their age or because they are expected to die within several years. The ability to find and maintain employment may be challenging for others because some beneficiaries have a very limited work history, even low-wage positions may be limited, and people with certain impairments may appear less attractive to employers. On the other hand, advances in technology—like standing wheelchairs and synthetic voice systems—and the medical management of some physical and mental impairments have created potential for some people with disabilities to engage in work. Furthermore, there has been a trend toward greater

inclusion of and participation by people with disabilities in the mainstream of society.

SSA is required to assess an applicant's work incapacity on the basis of the presence of medically determinable physical and mental impairments. However, evidence indicates that, except in cases of very severe disabilities, making an "either/or" disability determination based on medical condition is very difficult. Other factors—psychosocial, environmental, and economic—also influence work incapacity.

Weaknesses in the design and implementation of DI and SSI program components have limited SSA's capacity to identify and assist in expanding beneficiaries' productive capacities. Eligibility requirements and the application process encourage people to focus on their inabilities, not their abilities; work incentives offered by the programs do not overcome the risk of returning to work for many beneficiaries, and the complexities of work incentives can make them difficult to understand and challenging to implement; and beneficiaries receive little encouragement to use rehabilitation services, which are relatively inaccessible to beneficiaries seeking them.

SSA identified key return-to-work issues in mid-1994 and has developed a draft internal document laying out four initiatives that could be used to increase return-to-work outcomes. SSA will need to develop an integrated approach to help more beneficiaries join the workforce.

Principal Findings

Current Caseload Poses Challenges Yet Advancements Increase Potential for Return to Work

Between 1985 and 1994, the number of people with disabilities who received DI and SSI benefits increased from 4.2 million to 7.2 million. Program growth has been attributed to factors that increased the number of people who came onto the rolls—for example, eligibility expansion, program outreach, and national economic factors—and decreased the rate at which people left the rolls through death and retirement.

During this period, the programs experienced an increase in the portion of beneficiaries with longer-lasting impairments, particularly mental impairments. By 1994, mental impairments, which are associated with the

longest entitlement periods, accounted for 57 percent of the SSI beneficiary population aged 18 to 64, and 31 percent of the DI beneficiary population.

The DI and SSI adult beneficiary populations became somewhat younger during this period. The proportion of DI beneficiaries who were middle aged (aged 30 to 49) increased from 30 percent in 1986 to 40 percent in 1994; the proportion of SSI beneficiaries who were middle aged increased from 36 percent in 1986 to 46 percent in 1994.

The current caseload presents challenges to developing effective return-to-work strategies. Almost half of a cohort of beneficiaries who entered DI in 1988 had died or reached age 65 within almost 6 years; and about the same proportion of adult DI and SSI beneficiaries were aged 50 or older in 1994. Assisting those individuals who can return to work will require varying approaches and levels of support. Beneficiaries with little work history, and perhaps some people with mental impairments, may have additional challenges in finding and maintaining employment. Also, economic trends, labor market competition, and welfare reform may limit the availability of full-time employment in the future for beneficiaries who are low-wage earners.

However, advances in medicine and assistive technologies and a trend toward greater inclusion of and participation by people with disabilities in the mainstream of society have created more work potential for people with disabilities than in the past. Further, the 1990 Americans With Disabilities Act (ADA) supports the full participation of people with disabilities in society and fosters the expectation that people with disabilities can work.

Determining Who Can and Who Cannot Work Is Difficult

SSA is required to assess an applicant's work incapacity on the basis of the presence of medically determinable physical and mental impairments. However, while decisions may be more clear cut in the cases of people whose impairments inherently and permanently prevent work, disability determinations may be much more difficult in the cases of people with disabilities who may have a reasonable chance to work if they receive appropriate assistance and support. Research studies suggest that making accurate decisions about who can and cannot work is difficult.

Program Components Undermine Return to Work

The "either/or" nature of the disability determination process encourages applicants to focus on their inabilities. The documentation involved in

establishing one's disability can, many believe, create a "disability mindset" that erodes motivation to work, and the length of time required to determine eligibility can weaken skills, abilities, and habits necessary to work.

Despite providing some financial protection for those who want to work, work incentives do not appear to be sufficient to overcome the prospect of a drop in income for those who accept low-wage employment; neither do they allay the fear of losing medical coverage and other federal and state assistance that beneficiaries who return to work must face. Work incentive provisions are complex and difficult to understand, making implementation a challenge. Few beneficiaries are aware that work incentives exist, and SSA does not promote them extensively.

Vocational rehabilitation (VR) has also played a limited role in the DI and SSI programs, in part, because of restrictive state VR policies and limited alternatives to the state VR system. As with work incentives, beneficiaries are generally uninformed about the availability of VR services and are given little encouragement to seek them.

Program Redesign Is Necessary to Better Identify and Expand Beneficiary Return-to-Work Potential

Although a sizable portion of the disability rolls may not be realistic candidates for returning to work, there is a meaningful and growing portion who can be expected to survive for many years and who may be able to return to work. Although no solid evidence is available, some information from SSA indicates that up to one-third of the beneficiary population may have rehabilitation potential. Weaknesses in the design and implementation of the DI and SSI programs, however, have done little to identify and encourage the productive capacities of beneficiaries who might be able to benefit from rehabilitation and employment assistance. In this context, SSA needs to take major action, which may require proposing new legislation, to create and implement effective, integrated, and consistent return-to-work strategies.

Recommendation

GAO recommends that the Commissioner of SSA take immediate action to place greater priority on return to work, including designing more effective means to more accurately identify and expand beneficiaries' work capacities and better implementing existing return-to-work mechanisms. As part of this effort, the Commissioner of SSA should develop a legislative package for those areas in which SSA does not

currently have legislative authority to enact change in order to position the agency to expeditiously redirect its emphasis on return to work.

Agency Comments

In commenting on a draft of this report, the Commissioner of SSA concurred with GAO's findings and conclusions (see app. VI), but did not indicate whether or not action would be taken to implement GAO's recommendation. The Commissioner also made a number of technical comments, which GAO incorporated where appropriate.

Contents

Abbreviations

ADA	Americans With Disabilities Act
CDR	continuing disability review
CRS	Congressional Research Service
DDS	Disability Determination Service
DI	Disability Insurance
FICA	Federal Insurance Contributions Act
GA	general assistance
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IRWE	Impairment-Related Work Expenses
OIG	Office of Inspector General
PASS	Plan for Achieving Self-Support
RFC	residual functional capacity
SGA	substantial gainful activity
SSA	Social Security Administration
SSI	Supplemental Security Income
VR	vocational rehabilitation

Introduction

Advances in technology and medicine and economic changes have created more potential for people with disabilities to engage in employment. Moreover, there has been a trend toward greater inclusion of and participation by people with disabilities in the mainstream of society. These changes have sparked an increased interest in public policy on the employment of people with disabilities.

In this report, we focus on Disability Insurance (DI) and Supplemental Security Income (SSI)—the two largest federal programs providing assistance to people with disabilities. Provisions contained in the legislation that created DI and SSI focus on returning people with disabilities to self-supporting employment whenever possible. Yet, very few people have left the disability rolls to return to work.[1]

DI is the nation's primary source of income replacement for workers with disabilities who have paid Social Security taxes and are entitled to benefits. SSI provides federal and state assistance to people who are aged, blind, or disabled, regardless of Social Security coverage, whose income and resources are below a specified amount.[2] DI and SSI are administered by the Social Security Administration (SSA) with the assistance of state agencies.

The Number of People With Disabilities Depends on the Definition of Disability

Estimates of the number of people with disabilities in the United States depend on the definition of disability. The Survey of Income and Program Participation—an ongoing study by the U.S. Census Bureau of the economic well-being of the civilian noninstitutionalized population—reports about 51.5 million people with some type of work or functional limitation.[3] Approximately 43 million people are reported as having disabilities when using the definition of disability in the Americans With Disabilities Act of 1990 (ADA). According to ADA, having a physical or mental impairment substantially limiting one or more major life activity, having a record of such an impairment, or being regarded as having such an impairment constitutes disability.

When disability is defined by inability to work or perform other major activities, the size of the population with disabilities is much smaller. For

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

[2]Reference to the SSI program throughout the remainder of the report addresses blind or disabled, not aged, recipients.

[3]U.S. Census Bureau, unpublished data collected at the end of 1993 and the beginning of 1994.

instance, about 16 million persons are work disabled according to the U.S. Census Bureau's 1993 Current Population Survey, which defines work disability as a self-reported limitation in the type or amount of work a person is able to perform because of chronic illness or impairment.

Services Range From Return-to-Work Assistance to Long-Term Cash Benefits

Working-age adults with disabilities can obtain benefits in the form of services and short- and long-term cash assistance from a number of public and private programs (see app. I). After the onset of a disabling condition, workers may be eligible for return-to-work services, such as rehabilitation. The aim of such return-to-work services is to maintain workers in their current work setting. These services are provided through various means, including employers, private disability insurers, state or private nonprofit vocational rehabilitation programs, and workers' compensation programs.

If, however, a worker is temporarily unable to work while recovering from an illness or injury but is expected to recover, the worker may turn to short-term cash benefits to replace lost wages. To illustrate, in the case of a temporary inability to work caused by an illness or an off-the-job injury, a person might be eligible for short-term cash disability benefits from state temporary disability insurance. Five states provide this type of benefit.[4] Or, a worker might be eligible for paid sick leave or sickness or accident insurance benefits if a policy is provided by the employer or purchased by the worker. If the worker is injured on the job but is expected to recover, he or she may be eligible for temporary workers' compensation benefits. Once the worker recovers and returns to the workplace, temporary cash benefits end.

Those who do not return to work may seek long-term cash benefits to replace lost wages. They may be eligible for private disability insurance benefits—either employer-provided or from a personal policy—or, if injured on the job, for workers' compensation. In some cases, workers can supplement DI coverage—the country's long-term public disability insurance program for workers—with cash benefits from private long-term disability insurance. But a worker who is not eligible for cash benefits from either private insurance or workers' compensation and is unable to be accommodated in the workplace may discover that DI offers the only potential for wage replacement.

Long-term benefits may also be sought by people with disabilities who have low income and limited assets, regardless of their work histories.

[4]States that provide this benefit are California, Hawaii, New Jersey, New York, and Rhode Island.

Individuals with little or no work history are unlikely to be covered by employer-provided disability insurance. Moreover, it is unlikely that such individuals could afford to purchase a private disability policy. These individuals may apply for SSI benefits. SSI provides income support at the national level regardless of work connection for low-income people with disabilities.

DI and SSI Program Design

DI and SSI are the two major public programs serving people with disabilities. In 1994, 3.3 million disabled workers were enrolled in DI and received, on average, about $660 a month; 2.4 million adults aged 18 to 64 were enrolled in SSI and received, on average, about $360 a month (beneficiaries in the 48 states plus the District of Columbia that provided a monthly SSI supplement in 1994 received, on average, an additional $103). In addition, 671,000 more people were concurrently enrolled in both programs,[5] and 841,000 children with disabilities received SSI benefits.[6]

DI is designed to insure covered workers against loss of income due to a disabling condition. The program was established in 1956 under title II of the Social Security Act. At that time, its primary purpose was to prevent "loss or reduction of benefit rights" for wage earners who became disabled and were considered unable to continue paying Social Security taxes. The program provided payment of cash benefits to disabled workers aged 50 or older. Benefits for dependents of disabled workers were provided by the 1958 Social Security Amendments, and benefits to disabled workers under age 50 were provided by the 1960 amendments. The Congress authorized Medicare coverage for DI beneficiaries in 1972, making it available to beneficiaries after they have received cash benefits for 24 months.

Those who have worked long enough and recently enough become insured for DI coverage,[7] but there is no requirement that a disabling impairment happen on or because of the job. The DI program is funded through

[5]Individuals insured under Social Security who meet SSI's income and resource requirements qualify for both DI and SSI benefits.

[6]SSA, Annual Statistical Supplement to the Social Security Bulletin (Washington, D.C.: SSA, Aug. 1995); HHS, State Assistance Programs for SSI Recipients, SSA Pub. No. 17-002 (Washington, D.C.: Office of Program Benefits Policy, SSA, Jan. 1995).

[7]Workers earn up to four credits per year, and the amount of earnings required for a credit increases each year as general wage levels rise. In 1995, one credit was received for every $630 of earnings. The number of work credits needed for DI benefits depends on the worker's age when he or she becomes disabled. For instance, a person who becomes disabled before age 24 needs six credits in the 3-year period ending when the disability starts; a 50-year-old person needs 28 credits, 20 of which must have been earned in the 10 years immediately before becoming disabled.

Federal Insurance Contributions Act (FICA) taxes paid into a trust fund by employers and workers.[8]

The SSI program was authorized in 1972 under title XVI of the Social Security Act as a means-tested income assistance program for the aged, blind, or disabled. In most cases, SSI beneficiaries are eligible for Medicaid coverage. SSI raised to the federal level preexisting federal/state welfare programs authorized under various provisions of the Social Security Act. Unlike DI beneficiaries, SSI disabled recipients do not need to have a work history to qualify for benefits, but they must have low income and limited assets. The SSI program is funded through general revenues.[9]

Disability Determination Process Decides Eligibility

The Social Security Act defines disability as the inability to engage in any substantial gainful activity (SGA)[10] because of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last 12 months or longer.[11] Moreover, the act states that the impairment must be of such severity that a 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 engage in any other kind of substantial work that exists in the national economy.

To apply for DI or SSI benefits, a person must file an application at any one of 1,300 SSA field offices or other authorized locations. For SSA to determine whether an applicant qualifies for disability benefits, the application proceeds through a five-step evaluation process (see app. II). In step one, an SSA field office determines if an applicant is currently engaged in SGA. If an applicant is found not to be engaged in SGA, the field office forwards the application to a state Disability Determination Service (DDS) office for processing through the remaining four steps until a

[8]FICA payroll taxes are allocated among the Disability Insurance Trust Fund, Old Age and Survivors Trust Fund, and the Medicare Trust Fund.

[9]General revenues include taxes, customs duties, and miscellaneous receipts collected by the federal government that are not earmarked by law for a specific purpose.

[10]Regulations currently define SGA as employment that produces countable earnings of more than $500 a month for disabled individuals and $960 a month for individuals who are blind. SSA deducts from gross earnings the cost of items a person needs in order to work and the value of support a person needs on the job because of the impairment before deciding if work is SGA.

[11]SSA uses a different definition of disability for children than for adults. Generally, the Social Security Act defines a disabled child as a person under age 18 who suffers from any medically determinable physical or mental impairment of comparable severity to one that disables an adult. For a complete description of the specific criteria, see Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations (GAO/HEHS-94-225, Sept. 9, 1994). When we refer to SSA's definition of disability in this report, we are referring to the definition applicable to adults.

determination of disability or no disability is reached. A DDS office develops medical, functional, vocational, and other necessary evidence; evaluates it; and determines whether the applicant meets the disability criteria set forth in SSA regulations. Once the DDS has determined that the applicant meets the criteria, SSA calculates the benefits payable and makes the award.

SSA pays the costs incurred by DDSs in evaluating applications, including the expense of collecting medical evidence they request from hospitals, clinics, or other institutions. There are 54 DDSs throughout the country employing about 12,000 full-time and 2,000 part-time employees. SSA reported that in fiscal year 1994 the DDSs processed about 2.6 million initial claims, and the total DDS budget was about $1.1 billion.

Applicants denied benefits after the initial DDS review may request a reconsideration by the DDS office. If still not satisfied, they can appeal to an administrative law judge. If denied again, they may appeal to the SSA Appeals Council and, later, to the federal district courts.

Once a person is on the disability rolls, disability benefits continue until one of three things happens: the beneficiary dies; SSA determines that the beneficiary is no longer eligible for benefits; or, for DI beneficiaries, benefits convert to Social Security retirement benefits at age 65. Generally, a beneficiary loses eligibility for benefits under one of two conditions: (1) a beneficiary earns more income than allowed by program rules (the monthly ceiling is $500 for disabled DI beneficiaries and $960 for blind DI beneficiaries; for SSI, the ceiling varies from state to state—for example, $1,464 in Pennsylvania and $1,855 in California) or (2) SSA decides that a beneficiary's medical condition has improved to the point that he or she is no longer considered disabled and can now perform work at the SGA level. In order to make this latter determination, SSA periodically performs continuing disability reviews.[12] The law requires SSA to conduct such a review at least once every 3 years on DI beneficiaries whose medical improvement is possible or expected. When medical improvement is not expected, SSA is required to schedule a continuing disability review at least once every 7 years.

[12]For a more complete discussion of SSA's performance in conducting continuing disability reviews, see Disability Insurance: Broader Management Focus Needed to Better Control Caseload (GAO/T-HEHS-95-164, May 23, 1995).

Statute Provides for Returning Beneficiaries to Work

The Social Security Act states that people applying for disability benefits should be promptly referred to state vocational rehabilitation (VR) agencies for services in order to maximize the number of such individuals who can return to productive activity. However, the act does not require that all applicants be referred to VR agencies because doing so would not be useful in many circumstances (for example, a 62-year-old person who experienced an accident resulting in total paralysis would be unlikely to benefit sufficiently from VR to return to work). DDS offices decide whether or not to refer applicants to state VR agencies. DDS offices make referral decisions using SSA's recommended criteria and additional criteria developed in consultation with state VR agencies to screen out applicants who are not considered to be reasonable candidates for rehabilitation.

Once a referral has been made, a state VR agency weighs the candidate's potential for rehabilitation against that of other VR applicants. If the VR agency decides to offer services to the applicant, it contacts the applicant directly. State VR agencies also provide rehabilitation services to people not involved with the DI and SSI programs. VR services include, for example, guidance, counseling, and job placement, as well as therapy and training. State VR agencies are reimbursed by the federal government for the rehabilitation cost of each DI/SSI client who is returned to employment at the SGA level for 9 continuous months. The Social Security Act provides for withholding benefits from beneficiaries for refusal, without good cause, to accept rehabilitation services offered to them.

A beneficiary who engages in work encounters additional challenges, however. By returning to work, a beneficiary trades guaranteed monthly income and premium-free medical coverage for the uncertainties of competitive employment. To reduce this risk, the Congress has established program provisions, referred to as work incentives, to safeguard cash and medical benefits while a beneficiary tries to return to work. For example, DI provisions allow beneficiaries to engage in a trial work period during which they can earn any amount without affecting their benefits.[13] Beneficiaries who complete a trial work period but who do not medically recover can retain Medicare coverage for at least an additional 39 months. In addition, cash benefits can be reinstated for any month within a 36-month period following the end of a trial work period if a beneficiary's earnings drop below the SGA level. Under SSI provisions, beneficiaries whose impairments continue are allowed to earn above the SGA level and

[13]The trial work period allows beneficiaries to work for 9 months (not necessarily consecutively) within a 60-month rolling period and earn any amount without affecting benefits. After the trial work period, cash benefits continue for 3 months and then stop if countable earnings are greater than $500 a month.

to continue to receive reduced cash benefits indefinitely. Also, SSI beneficiaries whose earnings eliminate eligibility for cash benefits can continue to receive Medicaid coverage if their incomes remain within certain limits.

Despite congressional interest in helping return DI and SSI beneficiaries to employment, few beneficiaries engage in work while on the rolls and fewer still leave the rolls to return to work. In a recent month, for example, about 8 percent of SSI recipients aged 18 to 64 reported any earnings, and about 1 percent of DI beneficiaries reported earning $500 or more. Moreover, during each of the past several years, about 6,000 of the more than 3 million DI beneficiaries have been terminated from the rolls because they returned to work. Although SSA does not count the number of SSI beneficiaries terminated because of return to work, it has estimated that few are terminated for this reason.

The proportion of beneficiaries who return to work (1 in 500 for DI) would be higher if candidates unlikely to obtain gainful employment were excluded from the equation. Such candidates include, for example, beneficiaries who are expected to die or to reach retirement age within a few years following benefit award. SSA research findings provide some estimate of the size of these groups. Among a cohort of beneficiaries who entered DI in 1988, 28 percent died and 17 percent reached 65 within 5-1/2 years. Also, among cohorts of recipients who entered SSI between 1974 and 1982, 28 percent died or reached 65 within 10 years. Moreover, 46 percent of all working-aged DI and SSI beneficiaries are 50 or older.[14] While age alone may be neither an accurate nor appropriate predictor of return-to-work potential, older workers who become disabled generally are less likely to recover functioning and return to work than younger workers.

Objectives, Scope, and Methodology

The Chairman of the Senate Special Committee on Aging asked us to examine trends in the DI and SSI programs and determine why few beneficiaries are returned to substantial gainful employment. On the basis of subsequent discussions with his office, we designed our study to do the following:

- describe changes in the number and characteristics of DI and SSI program beneficiaries over time and the implications of these changes for returning beneficiaries to work;

[14]Annual Statistical Supplement to the Social Security Bulletin, multiple years.

- analyze the disability determination process to assess whether it can accurately distinguish between applicants who can work and those who cannot; and
- evaluate the effect of the disability determination process, work incentives, and vocational rehabilitation on returning DI and SSI beneficiaries to work.

To do this work, we reviewed the extant literature and synthesized our prior work and reports published by SSA, the Congressional Research Service (CRS), and others; analyzed information from SSA; interviewed federal and state agency officials, experts, and advocates; observed DDS operations; and conducted six focus groups around the country with people receiving federal disability benefits. We also convened a panel of disability experts (see app. III) to review our findings and comment on the report's accuracy, completeness, objectivity, and soundness. A bibliography of the literature we used in our analysis and a list of related GAO products are presented at the end of this report.

We did not independently verify the accuracy of the data used in the analysis of this report. Our work was performed between February 1994 and December 1995 in accordance with generally accepted government auditing standards.

Current Caseload Poses Challenges Yet Advancements Increase Potential for Return to Work

The number of beneficiaries and the cost of program benefits have grown rapidly since the mid-1980s. Program growth is attributed to factors that increased the number of people coming onto the rolls and decreased the number leaving. As the beneficiary population has grown, a greater portion of beneficiaries now have impairments—especially mental impairments—that are likely to keep them on the rolls for longer periods than in the past. Also, the beneficiary population has proportionately more middle-aged adults and fewer older beneficiaries, although trends in recent years suggest that the relative numbers of older beneficiaries may increase in the years ahead.

For the current beneficiary population, there are challenges to develop effective return-to-work strategies that will recognize and flexibly respond to individual differences. However, while economic changes may have had a mixed impact on work opportunities for people with disabilities, technological and medical advances—along with a trend toward inclusion of and participation by people with disabilities in mainstream society—have created more potential for some people with disabilities to engage in gainful work.

Caseloads Have Grown Rapidly and Changed Since the Mid-1980s

Between 1985 and 1994, the combined DI and SSI beneficiary population increased 70 percent and the inflation-adjusted cost of cash benefits grew 66 percent. Although the reasons for growth are not fully understood, a number of factors are believed to have increased the number of people who entered the programs and decreased the number who were terminated. These factors include eligibility expansion; program outreach; fewer continuing disability reviews; and occurrences external to the programs, for example, a downturn in the business cycle and demographic changes.

At the same time, the portion of the adult beneficiary population with longer-lasting impairments has increased since the mid-1980s. This trend has been driven especially by increases in the proportion of beneficiaries with mental impairments. In 1994, more people qualified for disability benefits because of mental retardation and mental illness than any other impairment category. Compared with beneficiaries with shorter-term impairments, a lower proportion of beneficiaries with longer-term impairments are terminated from the rolls each year because of death. The growing proportion of beneficiaries with longer-lasting impairments means that the beneficiary population, on average, is likely to spend more time on the rolls before reaching age 65.

In addition, the beneficiary population has become, on average, modestly but steadily younger since the mid-1980s. The proportion of adult beneficiaries who are middle-aged has steadily increased as the proportion who are older has declined. However, this trend reversed slightly between 1992 and 1994. Coupled with the aging of the "baby boom" cohort, this suggests that the age of the beneficiary population may increase in the years ahead.

Size and Costs of Caseloads Are Rising

DI and SSI caseloads and expenditures increased dramatically between 1985 and 1994, and the pace of this growth accelerated in the early 1990s. As a result of this rapid growth, concern arose regarding the adequacy of the DI Trust Fund. Responding to estimates that the DI Trust Fund would be depleted in 1995, the Congress reallocated payroll tax receipts in 1994 from the Social Security Old Age and Survivors Trust Fund into the DI Trust Fund. SSA has estimated that by the end of 2016 this measure will have transferred $499 billion from the Old Age and Survivors Insurance Trust Fund into the DI Trust Fund.

In 1985, 4.2 million blind and disabled persons under age 65 received DI or SSI benefits: 2.3 million received DI benefits, 1.6 million blind and disabled adults and children received SSI, and about 324,000 people received both DI and SSI benefits. By 1994, the number of blind and disabled people under age 65 receiving DI or SSI benefits reached 7.2 million. The DI beneficiary population increased 41 percent, the SSI beneficiary population increased 105 percent, and the number of people receiving both DI and SSI increased 107 percent. (See table 2.1.) Moreover, 37 percent of the growth between 1985 and 1994 in the overall size of the disability rolls occurred between 1992 and 1994 (see fig. 2.1). Appendix IV presents information on the entire 1985 to 1994 period.

Table 2.1: Increase in Number of Beneficiaries and Cash Benefits, 1985-94

Beneficiary categories	1985	1994	Percent increase
Number of beneficiaries (in thousands)			
DI[a]	2,332	3,292	41
SSI adults[b] (aged 18 to 64)	1,333	2,362	77
SSI children[b] (under age 18)	227	841	270
DI/SSI (dual eligibility)	324	671	107
Total	**4,216**	**7,166**	**70**
Cash benefits (in billions, percent increase adjusted for inflation)			
DI[a]	$16.5	$33.7	49
SSI[c]	6.6	18.9	109
Total	**$23.1**	**$52.6**	**66**

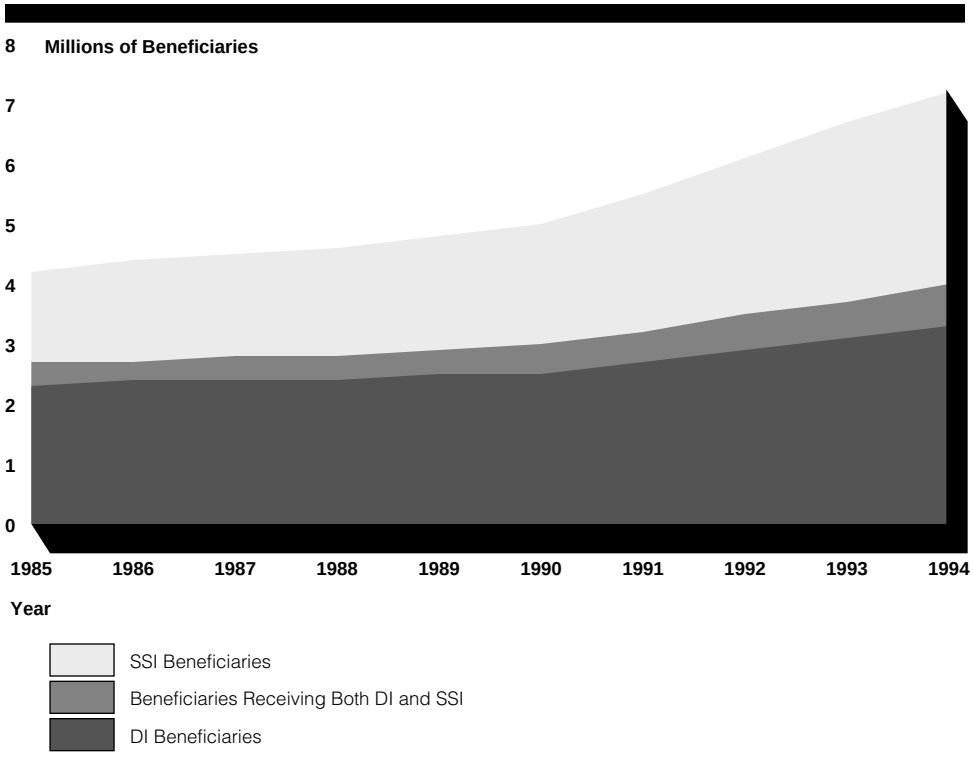
[a]Includes only disabled workers aged 18 to 64.

[b]Includes people with a federal SSI payment and/or federally administered state supplementation.

[c]Includes federal-only (not state supplementation) SSI payments to SSI adults aged 18 to 64; SSI children under age 18; and people dually eligible for SSI and DI payments who are disabled workers. Also includes federal-only SSI payments to SSI beneficiaries aged 65 or older and people dually eligible for SSI and DI who are not disabled workers.

Source: Annual Statistical Supplement to the Social Security Bulletin, multiple years.

Figure 2.1: Growth in the DI and SSI Programs, 1985-94



Note: SSI beneficiaries include all people with a federal SSI payment or a federally administered state supplementation. DI beneficiaries include disabled workers aged 18 to 64.

Source: Annual Statistical Supplement to the Social Security Bulletin, multiple years.

As the number of DI and SSI beneficiaries increased, so did the amount paid in cash benefits. In 1985, SSA paid $17 billion in DI cash benefits and $7 billion in SSI cash benefits. By 1994, cash benefits reached $34 billion for DI and $19 billion for SSI. Overall, the combined DI and SSI cash benefits increased from $23 billion to $53 billion in 10 years (adjusted for inflation, the increase in the value of cash benefits was 66 percent). Moreover, the cost of DI and SSI benefits nearly doubles when including the cost of health care coverage. In 1994, the cost of providing Medicare and Medicaid to

beneficiaries was about $48 billion,[15] bringing the federal cost of cash benefits and health care coverage for disabled beneficiaries in that year to about $101 billion.

More People Entered the Programs and Fewer Left

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

Eligibility Expansion

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

Program Outreach

The purpose of SSA's outreach efforts has been to reduce the barriers that prevented or discouraged potentially eligible individuals from applying for SSI benefits. SSA has conducted several outreach efforts since program authorization in 1972. Around the late 1980s, congressional and agency actions were taken to ensure that all segments of the potential SSI population were made aware of their potential eligibility. For instance, a permanent outreach program for disabled and blind children was established by the Omnibus Budget Reconciliation Act of 1989; SSA made SSI outreach an ongoing agency priority in 1989; and, in 1990, the Congress mandated that SSA expand the scope of its SSI outreach efforts. Since 1990, the Congress has appropriated $33 million for SSA to complete a series of outreach demonstration projects.

[15]The $48 billion includes $19.7 billion in Medicare disbursements for 4.3 million disabled Medicare enrollees during 1994, according to Health Care Financing Administration (HCFA) Office of the Actuary estimates. Disabled enrollees include disabled workers who are DI beneficiaries; disabled railroad retirement system annuitants; people suffering from end-stage renal disease; and federal, state, and local employees receiving Medicare benefits who are not DI beneficiaries. Although HCFA told us they could not identify the specific amount of this disbursement made on behalf of DI beneficiaries, according to SSA, there were about 4 million DI beneficiaries (including 671,000 disabled workers dually eligible for DI and SSI benefits) in 1994, or about 93 percent of disabled Medicare enrollees during that year. The $48 billion figure also includes $28.4 billion in Medicaid vendor payments, premiums, and other capitation payments made on behalf of SSI blind and disabled beneficiaries in 1994, as estimated by the HCFA Office of the Actuary.

Economic Factors

Economic factors play an important role in the decisions of people with disabilities to seek disability benefits, particularly DI benefits, according to an SSA-sponsored study on the demographic and economic determinants of growth in SSA disability programs.[16] Factors that reduce the rewards of participating in the labor force for people with disabilities, such as downturns in the business cycle, make leaving the labor force and applying for benefits more attractive to people with disabilities. However, while economic downturns contribute to program growth, no evidence exists that there has been a concomitant exit from the DI rolls when the economy has improved.

State Cost Shifting

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

Lack of Affordable Health Insurance

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

Demographics

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

Also, the growing number of immigrants admitted annually for legal residence in the United States may have contributed to SSI growth. In 1993, 880,00 immigrants were admitted to the United States, compared with 570,000 in 1985. In addition, nearly 3 million formerly illegal immigrants

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

attained legal residence status under the Immigration Reform and Control Act of 1986. This increased immigrant population is likely to have contributed to the rising portion of disabled immigrants on SSI, which increased from less than 2 percent of the SSI disabled population in 1982 to about 6 percent in 1993.

DI Termination Rate Decreased; SSI Rate Remained Stable

As more people were enrolled, the DI termination rate decreased and the SSI termination rate remained stable, thereby resulting in a net increase in DI and SSI program size. The DI termination rate decreased from 13.1 percent in 1985 to 10.8 percent in 1992 (between 1970 and 1984, the DI termination rate fluctuated between 14 and 19 percent). The termination rate for each of the major reasons for exiting DI—conversion to retirement benefits at age 65, death, failure to meet medical criteria, and return to work—decreased during this period (reaching age 65 and dying accounted for the vast majority of instances of termination from 1985 to 1992). Between 1988 and 1993, the SSI termination rate for adults with disabilities remained around 16 percent.

A factor contributing to the decrease in DI terminations due to medical recovery (which was relatively low from 1985 to 1992) may have been the reduction in the number of continuing disability reviews (CDR) performed by SSA.[17] In the early 1990s, because of SSA resource constraints and increasing initial claims workloads, the number of DI CDRs declined dramatically. In 1995, the backlog of CDRs for DI beneficiaries was about 1.5 million cases, with about 500,000 additional cases coming due each year.[18]

[17]The purpose of a CDR is to verify that an individual on the rolls still has a disability that prevents that person from working. The Social Security Independence Act (1994) directed SSA to perform a minimum number of CDRs for SSI beneficiaries. As now required, SSA plans to conduct 100,000 CDRs on SSI adults and on one-third of SSI children turning age 18 for each of the 3 fiscal years beginning in 1996. Conducting the appropriate number of CDRs has significant implications for expenditures. For example, in 1994, SSA determined that 17,000 DI beneficiaries were no longer eligible for benefits on the basis of information gathered from CDRs. These results are subject to appeal; SSA estimates that 65 percent of the ineligibilities will be upheld and that terminations will save an average of $90,000 in lifetime DI and Medicare benefits costs per person. As a result, total savings from these CDRs could be almost $1 billion.

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

Proportion of Beneficiaries With Longer-Lasting Impairments Grew

SSA researchers have found that the types of impairments that qualify people for benefits are associated with different lengths of entitlement.[19] The researchers calculated average length of stay on the disability rolls for DI and SSI cohorts who were awarded benefits ("awardees") from 1975 through 1993. For DI awardees, on average, mental impairments (16 years); diseases of the nervous system (13 years); and musculoskeletal impairments (10 years) lead to the longest entitlement periods. Between 1986 and 1994, the proportion of DI beneficiaries with any one of these three impairment types increased from 54 percent to 62 percent (see table 2.2). Most of this growth occurred within the category of mental impairment, which increased from 24 percent of the DI beneficiary population in 1986 to 31 percent in 1994. The trend toward a greater portion of beneficiaries with longer-lasting impairments signifies lengthy stays on the rolls for some.

Table 2.2: Percentage Distribution of DI Beneficiaries With Diagnosis Available by Selected Impairment Categories, 1986-94

	Percentage of total DI beneficiary population with selected impairments			
Year	Mental impairment[a]	Disease of nervous system[b]	Musculoskeletal condition	Total
1986	24.4	11.0	18.2	**53.6**
1987	26.1	11.0	18.2	**55.3**
1988	26.7	11.0	18.5	**56.2**
1989	27.7	10.9	18.9	**57.5**
1990	28.5	10.7	19.1	**58.3**
1991	29.2	10.6	19.4	**59.2**
1992	29.8	10.4	20.0	**60.2**
1993	30.6	10.2	20.5	**61.3**
1994	30.9	10.0	20.9	**61.8**

[a]Includes mental illness and mental retardation.

[b]Includes diseases of the nervous system and sense organs.

Source: Annual Statistical Supplement to the Social Security Bulletin, multiple years.

[19]K. Rupp and C.G. Scott, "Determinants of Duration on the Disability Rolls and Program Trends," a paper presented at the Social Security Administration's conference on Disability Programs: Explanations of Recent Growth and Implications for Disability Policy (Washington, D.C.: July 20-21, 1995). We exclude congenital disease (14 years' average length of entitlement) because of this category's low prevalence among the DI population (0.4 percent).

For SSI adult awardees, on average, mental impairments and diseases of the nervous system also lead to the longest entitlement periods.[20,21] The proportion of adult SSI beneficiaries with either of these impairment types increased from 60 percent in 1986 to 65 percent in 1994. In 1994, about 57 percent of adult SSI beneficiaries had a mental impairment, up from 50 percent in 1986. (See table 2.3.)

Table 2.3: Percentage Distribution of SSI Adult Disabled Beneficiaries by Selected Impairment Categories, 1986-94

	Percentage of beneficiary population aged 18 to 64 with selected impairments[a]		
Year	Mental impairment[b]	Disease of nervous system[c]	Total
1986	49.7	10.4	**60.1**
1987	51.4	10.2	**61.6**
1988	52.2	10.0	**62.3**
1989	53.1	9.9	**63.0**
1990	53.7	9.5	**63.2**
1991	54.2	9.2	**63.4**
1992	54.7	8.7	**63.5**
1993	55.9	8.7	**64.6**
1994	56.7	8.5	**65.2**

[a]Includes people receiving federally administered payments; excludes people transferred from prior state programs.

[b]Includes psychiatric impairments and mental retardation.

[c]Includes diseases of the nervous system and sense organs.

Source: Annual Statistical Supplement to the Social Security Bulletin, multiple years.

Proportion of Middle-Aged Beneficiaries Grew While Proportion of Older Beneficiaries Declined

Between 1986 and 1994, the proportion of adult beneficiaries who were middle aged steadily increased as the proportion who were older than middle aged declined. Although this trend signified that the beneficiary population had become younger, it did not signify that the population was

[20]Although musculoskeletal conditions lead to one of the longest entitlement periods for DI, these conditions are associated, on average, with moderate lengths of entitlement for the SSI population. While congenital diseases lead, on average, to the longest entitlement periods for SSI, we excluded this condition from our analysis because of its low prevalence (2 percent) among the SSI population under age 65.

[21]According to SSA researchers, the mean duration on the rolls for SSI awardees with a psychiatric impairment is 20 years for adults aged 18 to 34, 14 years for adults aged 35 to 49, and 6 years for adults aged 50 to 61 years. The mean duration on the SSI rolls for beneficiaries with mental retardation is 23 years for adults aged 18 to 34, 15 years for adults aged 35 to 49, and 7 years for adults aged 50 to 61 years.

young, as only 10 percent of the adult DI/SSI disability rolls consisted of persons aged 18 to 29 in 1994. Moreover, the proportion of older new awardees increased slightly in recent years, suggesting that the beneficiary population will become older in the years ahead if this trend persists.

Among the DI population, the proportion of beneficiaries aged 30 to 49 steadily increased from 30 percent in 1986 to 40 percent in 1994. While the proportion of DI beneficiaries who were younger remained around 4 percent during this time, the proportion of older DI beneficiaries steadily decreased from 66 percent in 1986 to 56 percent in 1994. Likewise, within SSI, the proportion of beneficiaries who were middle aged increased as the proportions of beneficiaries who were older or younger decreased. The proportion of SSI beneficiaries aged 30 to 49 increased from 36 percent in 1986 to 46 percent in 1994. During this time, the proportion of beneficiaries who were older decreased from 40 percent to 35 percent, and the proportion of beneficiaries who were younger decreased from 23 percent to 19 percent. (See table 2.4.)

Table 2.4: Percentage Distribution of Adult DI and SSI Beneficiaries by Age Group, 1986-94

	Percentage of beneficiary population aged 18 to 64					
	18-29		30-49		50-64	
Year	DI	SSI[a,b]	DI	SSI[b]	DI	SSI[b]
1986	4.4	23.4	29.5	36.3	66.0	40.3
1987	4.3	23.1	31.4	37.7	64.3	39.2
1988	4.2	22.6	32.7	38.9	63.1	38.5
1989	4.1	21.9	34.2	40.2	61.6	37.9
1990	4.3	21.2	35.8	41.6	60.0	37.2
1991	4.4	20.2	37.2	43.1	58.4	36.8
1992	4.6	19.3	38.6	44.5	56.8	36.2
1993	4.6	19.8	39.2	45.0	56.2	35.3
1994	4.2	19.2	39.8	45.9	56.0	34.9

[a]Excludes blind and disabled children aged 18 to 21 as defined by the program.

[b]Includes all people receiving federally administered payments.

Source: Annual Statistical Supplement to the Social Security Bulletin, multiple years.

The trend toward serving a greater proportion of beneficiaries who were middle aged was also generally evident among new awardees. While the proportion of DI awardees who were under 35 fluctuated somewhere around 17 percent between 1986 and 1994, the proportion of DI awardees who were middle aged steadily increased from 25 percent to 31 percent;

the proportion of DI awardees who were older than middle aged steadily decreased, except in 1994, from 55 percent to 51 percent. Between 1993 and 1994, however, the proportion of DI awardees who were between 50 and 64 increased nearly 3 percentage points (an increasing proportion of DI awardees who are older may continue into the future as the baby boom cohort turns 50 and older). Likewise, the proportion of SSI middle-aged awardees increased modestly between 1986 and 1992; between 1992 and 1993, the proportion of middle-aged awardees decreased as the proportion of older awardees and, to a lesser extent, younger awardees increased. Overall, the proportions of younger, middle-aged, and older SSI awardees in 1993 were roughly equal. (See table 2.5.)

Table 2.5: Percentage Distribution of Adult DI and SSI Awardees by Age Group, 1986-94

	Percentage of awardee population					
	Under 35		35-49		50-64	
Year	DI	SSI	DI	SSI	DI	SSI
1986	19.8	33.5	25.4	26.9	54.8	39.7
1987	17.9	31.4	26.5	28.0	55.6	40.6
1988	17.6	30.3	27.1	31.0	55.3	38.7
1989	16.6	30.3	28.0	30.7	55.4	39.0
1990	17.3	29.0	28.7	31.8	54.0	39.2
1991	17.4	29.1	30.2	33.2	52.4	37.7
1992	18.5	30.9	30.7	34.3	50.8	34.8
1993	17.5	31.9	31.7	32.1	50.8	36.0
1994	15.8	[a]	30.5	[a]	53.7	[a]

[a]1994 data not reported in source document.

Source: DI figures from SSA, Annual Statistical Supplement to the Social Security Bulletin, multiple years; SSI figures from Rupp and Scott, "Determinants of Duration on the Disability Rolls and Program Trends."

Beneficiary Population Presents Return-to-Work Challenges

Developing effective return-to-work strategies for people with disabilities presents challenges to policymakers. For example, strategies need to recognize individual differences and abilities and should have the flexibility and capacity to provide varying levels and types of assistance. Some people may require a one-time medical intervention, while others may need ongoing and changing levels of medical support; some individuals may require remedial retraining, and others may need education and job coaching.

Moreover, beneficiaries with limited work histories present particular challenges in finding and maintaining employment.[22] In addition to needing to learn basic skills and work habits, some beneficiaries, for example, may need to overcome social isolation and low self-esteem in order to function at the workplace. Also, even jobs that pay low wages may not be widely available for some beneficiaries and may become more scarce in the future. Real wages for the least skilled workers have declined since the late 1970s. Current welfare reform proposals call for sending low-skilled people into the labor market, so competition for low-wage jobs may increase.[23] Also, the U.S. economy may be moving toward more temporary or part-time work (which generally offers little if any health care coverage and other benefits). While this trend would match the needs of some beneficiaries who cannot or do not want to work full-time, it would also make the road to economic self-sufficiency more difficult and less attractive than public support for others, particularly for those who earn low wages.

In addition, employment may be more easily disrupted for some people with disabilities, thereby creating additional challenges to developing successful return-to-work mechanisms. For instance, people with visual impairments who work in office settings may undergo more adjustment than other workers if an office converts from a text- to a graphics-mode of communication. At a more basic level, some people with disabilities may experience difficulty in getting to work in the event of inclement weather or changes in public transportation schedules. Moreover, the nature of some disabilities may make it difficult for some workers to engage in full-time work while other disabilities may stigmatize individuals and perhaps make them appear less attractive to employers. Finally, a shift in the U.S. economy from labor/manufacturing to skill/service-based jobs may have had a negative impact on the job opportunities for some people with mental impairments.

[22]SSI beneficiaries do not need to have any work history to qualify for benefits. Social Security field offices surveyed applicants for disability benefits on 2 days during 1994. Field office staff administered the survey after completion of the initial claims interview. SSA found that 42 percent of applicants for SSI benefits reportedly left their last job more than 12 months before applying for benefits; 27 percent said they did not know when they left their last job. See Associate Commissioner for Research and Statistics, SSA, memo to Associate Commissioner for Disability regarding results of the 1994 2-day field office survey of disability applicants (Mar. 22, 1994).

[23]Some similarities exist between the return to work of people on disability rolls and employment of people on welfare rolls. For a discussion of GAO's work on the latter, see JOBS and JTPA: Tracking Spending, Outcomes, and Program Performance (GAO/HEHS-94-177, July 15, 1994) and Self-Sufficiency: Opportunities and Disincentives on the Road to Economic Independence (GAO/HRD-93-23, Aug. 6, 1993).

Advances Increase Return-to-Work Potential

Although efforts to maximize the work potential of people currently on the disability rolls face many challenges, numerous technological and medical advances and economic changes have created more potential for some people with disabilities to engage in work. Electronic communications and assistive technologies—such as synthetic voice systems, standing wheelchairs, and modified automobiles and vans—have given greater independence and more work potential to some people with disabilities. Advances in the management of disability—like medication to control mental illness or computer-aided prosthetic devices that return some functioning to the impaired—have helped reduce the severity of some disabilities. Also, the shift in the U.S. economy toward the service industry may have opened new opportunities for some people with physical impairments.

Moreover, over the last several decades, there has been a trend toward greater inclusion of and participation by people with disabilities in the mainstream of society. For instance, over the past 2 decades people with disabilities have sought to remove environmental barriers that impede them from fully participating in their communities. Additionally, the ADA supports the full participation of people with disabilities in society and fosters the expectation that people with disabilities can work. The ADA prohibits employers from discriminating against qualified individuals with disabilities and requires employers—without undue hardship—to make reasonable workplace accommodations.

Current DI and SSI Program Structure Impedes Return to Work

The Social Security Act requires that the assessment of an applicant's work incapacity be based on the presence of medically determinable physical and mental impairments. The findings of the studies we reviewed generally agree that difficult measurement and conceptual issues complicate the use of medical conditions as the basis for decisions on work incapacity. Indeed, making valid decisions about who can work and who cannot is very difficult. While decisions may be more clear cut in the case of people whose impairments inherently and permanently prevent work, disability determinations may be much more difficult concerning people who may have a reasonable chance of work if they receive appropriate assistance and support. Nonmedical factors may play a crucial role in determining the extent to which people in this latter group can engage in substantial gainful activity.

Compounding decision-making difficulties are program features that, taken together, can undermine the incentive to attempt work. First, the "either/or" focus of the disability determination process encourages applicants to concentrate on their inabilities. Moreover, people who have successfully established their disability to SSA staff may have little reason or desire to attempt rehabilitation and competitive work. Second, the benefit structure can provide disincentives to low-wage workers. Third, work incentives, which few beneficiaries take advantage of, are generally ineffective in encouraging return to work. Finally, VR plays a limited role in the disability programs because beneficiaries have poor and untimely access to services, and the long-term gains for people who receive VR services are generally lacking. As a result, the design and implementation of DI and SSI undermine the ability of SSA to identify and expand work capacities of beneficiaries and return them to substantial gainful employment. Table 3.1 summarizes these program weaknesses.

Table 3.1: Summary of DI and SSI Program Design and Implementation Weaknesses

Program area	Weakness
Disability determination	"Either/or" decision gives incentive to promote inabilities and minimize abilities. Lengthy application process to prove one's disability can erode motivation and ability to return to work.
Benefit structure	Cash and medical benefits themselves can reduce motivation to work and receptivity to VR and work incentives, especially when low-wage jobs are the likely outcome. People with disabilities may be more likely to have less time available for work, further influencing a decision to opt for benefits over work.
Work incentives	"All-or-nothing" nature of DI cash benefits can make work at low wages financially unattractive. Risk of losing medical coverage when returning to work is high for many beneficiaries. Loss of other federal and state assistance is a risk for some beneficiaries who return to work. Few beneficiaries are aware that work incentives exist. Work incentives are not well understood by beneficiaries and program staff alike.
VR	Access to VR services through DDS referrals is limited: restrictive state policies severely limit categories of people referred by DDSs; the referral process is not monitored, reflecting its low priority and removing incentive to spend time on referrals; VR counselors perceive beneficiaries as less attractive VR candidates than other people with disabilities, making them less willing to accept beneficiaries as clients; and the success-based reimbursement system is ineffective in motivating VR agencies to accept beneficiaries as clients. Applicants are generally uninformed about VR and beneficiaries are not encouraged to seek VR, affording little opportunity to opt for rehabilitation and employment. Studies have questioned the effectiveness of state VR agency services, since long-term, gainful work is not necessarily the focus of VR agency services. Delayed VR intervention can cause a decline in receptiveness to participate in rehabilitation and job placement activities, as well as a decline in skills and abilities. The monopolistic state VR structure can contribute to lower quality service at higher prices, and recent regulations allowing alternative VR providers may not be effective in expanding private sector VR participation.

Determining Who Can and Who Cannot Work on the Basis of Medical Condition Is Imprecise

The Social Security Act defines disability as the inability to engage in any SGA because of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last 12 months or longer. A physical or mental impairment is one that results from anatomical, physiological, or psychological abnormalities that are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. The statutory requirement for disability presumes that some medical conditions are sufficient, in themselves, to prevent individuals from engaging in substantial gainful employment. The presumed link between inability to work and presence of a medical condition establishes the basis for SSA's award of disability benefits.

SSA maintains a Listing of Impairments containing medical conditions that are, according to SSA, ordinarily severe enough in themselves to prevent an individual from engaging in any SGA. About 70 percent of new awardees are eligible for disability because their impairments meet or equal the listings.[24] Applicants whose impairments do not meet or equal the medical listings are further evaluated on the basis of nonmedical factors, including residual functional capacity (RFC), age, education, and vocational skills.[25]

Weak Scientific Basis Makes Disability Determinations Inherently Difficult

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

[24]An impairment or combination of impairments is said to "equal the listings" if the medical findings for the impairment are at least equivalent in severity and duration to the listed findings of a listed impairment.

[25]SSA reports that "some, but not all, of the Listings consider functional consequences of an impairment; however, functional considerations vary significantly among the Listings. Additionally, in assessing an individual's functional abilities at the later steps in the sequential evaluation, adjudicators collect and analyze evidence from a multitude of different, and often conflicting, sources including: objective clinical and laboratory findings; treating source opinions and other third-party statements considered to be consistent with the objective evidence; and the individual's descriptions of his or her limitations." See HHS, Plan for a New Disability Claim Process (Washington, D.C.: HHS, SSA, Sept. 1994, p. 11).

motivational—are often considered to be more important determinants of work capacity.

Concerns about the relationship between medical status and work incapacity were raised before the DI program was implemented. In deliberations leading up to the establishment of the DI program, the 1948 Advisory Council on Social Security recommended that compensable disabilities be restricted to those that can be "objectively determined by medical examination or tests." However, physicians testified before the Congress that disability determination is inherently subjective and they could not provide the kind of objective determination that policymakers desired. According to this view, physicians can attest to the existence of medical impairments but they cannot quantify inability to work, and they cannot certify that the impairments render a person unable to work.

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

"information about a claimant's medical condition and vocational background cannot conclusively demonstrate that he or she cannot work. Except in the case of very severe disabilities and relatively minor disabilities, the current state of knowledge and technology does not enable the quantification of disabilities or the definition of categories of disability which reliably correlate an impairment with a particular individual's capacity to work."[26]

Studies Show Difficulties in Accurately Determining Who Can and Who Cannot Work

Studies we reviewed show that sorting people into two mutually exclusive categories—either not having the ability to engage in SGA or having the capacity to do so—can lead to questionable decisions. Many people with disabilities may have some capacity to work, especially if given appropriate treatment and support, and these cases are likely to be the ones that result in different decisions by different decisionmakers. Using medical criteria as the basis for these decisions attempts to impose precision on an imprecise process. Decision-making as implemented under current law involves significant judgment, which may result in some applicants' receiving benefits while others with similar limitations in their capacities are denied benefits. Such a disparity illustrates the inherent subjectivity of making disability determinations; it does not imply that

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

DDSs could make more accurate decisions under current decision-making procedures.

Two of the studies we reviewed compared disability decisions made by DDS/SSA with nonbinding decisions on the same cases made by independent decisionmakers. In one study, a team of vocational and health care professionals reached decisions opposite from those reached by DDS/SSA in 30 percent of cases: DDS/SSA approved 37 percent of the cases denied by the teams and denied 27 percent of the cases approved by the teams.[27] The other study found that a team of mental health workers could not agree on a disability decision in 47 percent of DI/SSI cases involving people with mental impairments. Among the cases allowed by the team, 88 percent were also allowed by the DDS; but of the cases denied by the team, 55 percent were allowed by the DDS (overall, the team reached conclusions opposite from those of the DDS in about one out of every four cases).[28]

The findings of one other study and a survey we conducted suggest that disability decisions are not accurate predictors of work capacity. The study found that, among a sample of people who had physical impairments that met or equaled the listings but who were not enrolled in DI or SSI, about 61 percent of men and 32 percent of women were employed 2 years after being diagnosed with their physical impairment.[29] The survey we conducted showed that about 58 percent of DI applicants who were denied benefits in 1984 and who were not receiving DI benefits as of 1987 reported that they were not working (over two-thirds of these nonworking applicants had been out of the workforce for at least 3 years).[30] Moreover, the self-reported functional and health status of the nonworking denied group was nearly indistinguishable from the status of a sample of DI beneficiaries accepted into the program in 1984. Appendix V contains more details on the studies cited.

[27]S.Z. Nagi, Disability and Rehabilitation: Legal, Clinical, and Self-Concepts and Measurement (Columbus: Ohio State University Press, 1969).

[28]S.O. Okpaku and others, "Disability Determinations for Adults with Mental Disorders: Social Security Administration vs. Independent Judgments," American Journal of Public Health, Vol. 84, No. 11 (Nov. 1994), pp. 1791-95.

[29]H.P. Brehm and T.V. Rush, "Disability Analysis of Longitudinal Health Data: Policy Implications for Social Security Disability Insurance," Journal of Aging Studies, Vol. 2, No. 4 (1988), pp. 379-99. Employment figures exclude the 27 percent of adults who died during the 2-year period.

[30]Social Security Disability: Denied Applicants' Health and Financial Status Compared With Beneficiaries' (GAO/HRD-90-2, Nov. 6, 1989).

Disability Determination Process Encourages Work Incapacity

Two aspects of the disability determination process—the disability decision itself and the application process—may promote inability to work. Eligibility for disability benefits is an "either/or" decision. The Social Security Act characterizes individuals as either unable to engage in any substantial gainful employment or having the capacity to work. Because the decision is a dichotomy—the result is either full award of benefits or denial of benefits—applicants have a strong incentive to promote their limitations in order to establish their inability to work and thus qualify for benefits. Conversely, applicants have a disincentive to demonstrate any capacity to work at all.

Moreover, the process of applying for disability benefits has been characterized in the literature we reviewed as long, cumbersome, and possibly debilitating in itself because of the certification and labeling of the individual as disabled. The length of the determination process ranges from a minimum of several months to 18 months or longer for individuals who are initially denied benefits and appeal. During this time, an applicant meets with his or her physician, SSA staff, and others in an attempt to establish disability. Some individuals completing the process may become entrenched in their perceived inability to work, which can possibly lead to a gradual decrease in actual work ability.

SSA survey results indicate that nearly one-half of DI and SSI applicants with a work history reported being out of the workforce for more than 6 months in the period immediately preceding application for benefits.[31] Consequently, their skills and work habits may have declined prior to application. And, since these individuals are unlikely to participate in any substantial gainful employment during the application process, the erosion of skills may be exacerbated, further contributing to a decline in their motivation or ability to work.

Applicants who successfully meet the programs' definition of disabled may be poor candidates for attempting a return to work. They have been through a lengthy process that required them to prove an inability to work. They have provided information about their disabilities before program officials and the health care community, and family and friends may have helped to demonstrate their work incapacity. Moreover, being out of the workforce may have degraded their marketability. The literature suggests that these factors can reduce receptivity to VR and work incentives as well as the motivation to develop or regain the ability to engage in gainful

[31]Memo from SSA's Associate Commissioner for Research and Statistics to the Associate Commissioner for Disability, March 22, 1994.

employment. The degree to which this may occur, however, will vary among beneficiaries. A small portion of people do, in fact, leave the rolls by returning to work.

Benefit Structure Provides Disincentive to Low-Wage Work

Cash and medical benefits themselves are another factor that can reduce beneficiaries' motivation to work and receptivity to work incentives and VR. The average monthly benefit value in 1994 for DI and SSI beneficiaries was about $1,050 and $930, respectively.[32] As part of their consideration of whether to undergo rehabilitation, attempt work, or both, beneficiaries may weigh the financial gains of working against the value of their monthly cash and medical benefits. On the one hand, rehabilitation and work require significant time commitment and the chance of success is unknown; on the other hand, program benefits are secure and free individuals from having to devote time to secure economic stability. Some people may opt to live at a lower income level rather than at a marginally higher income level if the latter requires a major commitment of time and energy.

Some people with disabilities commit significant amounts of time to performing daily activities (bathing, dressing, and eating), self-managing their impairments or receiving medical treatment, or meeting their transportation needs. The time required to perform these and other activities can reduce the time available for work and influence an individual's decision to opt for benefits over work.[33] People who have less time available for full-time work may see some value in part-time work. However, if part-time work pays less than the value of lost benefits, then a person would actually be financially better off to receive benefits rather than to work.

Work Incentives Ineffective in Motivating People to Work

From our fieldwork and analysis of several studies, we identified weaknesses in the design and implementation of work incentive provisions. While some provisions effectively reduce the risk of returning to work, others do little to remove work disincentives. Studies conducted by SSA researchers and others have questioned the effectiveness of the work incentive provisions and have cited many of the same design and

[32]Average monthly medical benefit values are based on estimates from HCFA, Office of the Actuary.

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

implementation problems raised during our discussions with disability advocates and program and rehabilitation officials.

DI and SSI Work Incentives Provide Different Benefit Protections

The DI and SSI programs offer a number of work incentives to encourage beneficiaries to return to work. For both populations, work incentive provisions safeguard cash and medical benefits and retain beneficiaries' program eligibility during work attempts. However, work incentive provisions differ significantly between the two programs, providing differing levels of benefit protection for DI and SSI beneficiaries. One significant difference between the two programs is that a DI beneficiary's cash benefit stops completely after the trial work period (if it is determined that work is at the SGA level), while an SSI recipient's cash benefit is gradually reduced to ease the transition back to work. Another difference is that a DI beneficiary can purchase Medicare coverage as an ex-beneficiary, although it is expensive for lower-wage earners to do so, but an SSI recipient may lose Medicaid coverage once he or she exceeds a certain income level.[34]

A number of work incentive provisions exist within each program, and, depending upon an individual's particular situation, certain provisions may be more useful than others. If, for example, a DI beneficiary engages in work and earns more than $500 a month but needs a wheelchair and special transportation in order to work, the beneficiary may use the Impairment-Related Work Expenses (IRWE) provision to maintain eligibility while working. This provision allows a DI or SSI beneficiary to deduct work expenses that are related to the impairment from gross earnings, which are used to determine continuing eligibility. Without this provision, someone with high disability-related work expenses could be financially harmed by returning to work. On the other hand, a beneficiary such as a construction worker who became eligible due to blindness may need to acquire new skills in order to return to work. The Plan for Achieving Self-Support (PASS) provision allows DI beneficiaries to become eligible for SSI, or SSI beneficiaries to increase the amount of their monthly cash benefits, by excluding from the SSI eligibility and benefit calculations

[34]The earned income threshold is the first item considered in determining whether eligibility for Medicaid should continue. If an individual's earnings exceed the threshold level, SSA performs an individualized calculation to determine if the earnings are sufficient to replace SSI, Medicaid, and publicly funded attendant care that would otherwise be lost due to earnings. Also, the individual must continue to meet all other SSI disability and nondisability requirements to continue Medicaid coverage.

income or resources set aside to pursue a work goal.[35] Table 3.2 highlights each program's work incentive provisions.

Table 3.2: Highlights of DI and SSI Work Incentive Provisions

Program	Provision
Income safeguards	
DI	Trial work period: Allows beneficiaries to work for 9 months (not necessarily consecutively) within a 60-month rolling period during which they may earn any amount without affecting benefits. After the trial work period, cash benefits continue for 3 months, then stop if countable earnings are greater than $500 a month. Extended period of eligibility: Allows for a consecutive 36-month period after the trial work period in which cash benefits are reinstated for any month countable earnings are $500 or less. This period begins the month following the end of the trial work period.
SSI	Earned income exclusion: Allows recipients to exclude more than half of earned income when determining the SSI payment amount. Section 1619 (a): Allows recipients to continue to receive SSI cash payments even when earnings exceed $500 a month. However, as earnings increase the payment decreases. Plan for Achieving Self-Support (PASS): Allows recipients to exclude from their SSI eligibility and benefit calculation any income or resources used to achieve a work goal.
DI and SSI	Impairment-related work expenses: Allows the costs of certain impairment-related items and services needed to work to be deducted from gross earnings in figuring SGA and cash payment amount. For example, attendant care services received in the work setting are deductible while nonwork-related attendant care services performed at home are not. Subsidies: Allows the value of the support a person receives on the job to be deducted from earnings to determine SGA. An example of such support is the value of supervision provided to a worker with a disability that is in addition to that provided to other workers receiving the same pay.
Medical coverage safeguards	
DI	Continued Medicare coverage: Allows for continued Medicare coverage for at least 39 months following a trial work period as long as one continues to be medically disabled. Medicare buy-in: Allows beneficiaries to purchase Medicare coverage after the 39-month premium-free coverage ends. Beneficiaries pay the same monthly cost as uninsured retired beneficiaries pay.
SSI	Section 1619 (b): Allows recipients to continue receiving Medicaid coverage when earnings become too high to allow a cash benefit. Coverage continues until earnings reach a threshold amount, which varies in every state. For example, the threshold amount in 1994 was $17,480 in Pennsylvania and $22,268 in California.

(continued)

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

Program	Provision
Eligibility safeguards	
DI	Reentitlement to cash benefits and Medicare: After a period of disability ends, allows beneficiaries who become disabled again within 5 years (7 years for widow(ers) and disabled adult children) to be reentitled to cash and medical benefits without another 5-month waiting period.
SSI	Property essential to self-support: Allows recipients to exclude from consideration in determining SSI eligibility the value of property that is used in a trade or business or for work. Examples include the value of tools or equipment.
DI and SSI	Continued benefit while in an approved vocational rehabilitation program: Allows a person actively participating in a vocational rehabilitation program to remain eligible for cash and medical benefits even if he or she medically improves and is no longer considered disabled by SSA.

Work Incentives' Design Weaknesses Diminish Their Effectiveness

Despite the ways in which work incentive provisions can provide some financial protection for those who want to return to work, work incentive provisions do not appear to be appropriately designed to motivate beneficiaries to work. In fact, from an SSA survey of DI beneficiaries, it was found that only about 2 percent said that their decision to attempt work was influenced by the work incentive provisions.[36] Our review, as well as other studies, identified a number of design weaknesses that diminish the work incentives' intended benefit safeguards.

"All-or-Nothing" Nature of Cash Benefits for DI Beneficiaries Makes Work Financially Unattractive

Research conducted by SSA researchers and others suggests that DI work incentive provisions are actually disincentives. DI work incentives provide for a trial work period in which a beneficiary may earn any amount for 9 months (which need not be consecutive) within a 60-month period and still receive full cash and medical benefits. At the end of the trial work period, if a beneficiary's countable earnings are more than $500 a month, cash benefits continue for an additional 3-month grace period and then stop. For 36 months after the trial work period ends, referred to as the extended period of eligibility, cash benefits will be reinstated for any month in which the person does not earn more than $500 a month in countable income. After the completion of the trial work period, a beneficiary's countable earnings in excess of $500 a month cause a precipitous drop in monthly income—from full benefits to no cash benefit. SSA researchers have noted that such a drop in income is a considerable

[36]J.C. Hennessey and L.S. Muller, "Work Efforts of Disabled-Worker Beneficiaries: Preliminary Findings From the New Beneficiary Followup Survey," Social Security Bulletin, Vol. 57, No. 3 (fall 1994), pp. 42-51. These findings should be interpreted with caution, since SSA gathered retrospective data on event histories over a 10-year period.

disincentive to finishing the trial work period as well as to beginning work.[37]

Cash and medical benefits continue indefinitely for a DI beneficiary as long as the beneficiary does not earn more than $500 a month in countable income or does not medically recover. Especially for beneficiaries with low earnings, it may be more financially advantageous to quit work, or work part time, and continue to receive disability payments than to earn more than $500 a month in countable income. As illustrated in table 3.3, some beneficiaries would be making a rational economic decision to limit work in order to continue receiving benefits.

Table 3.3: The Impact of Benefit Cessation for Some DI Beneficiaries

	Earnings	Cash benefit	Total monthly income
Beneficiary earning no more than $500 a month	$500	$660	$1,160
Beneficiary earning more than $500 a month	501	0	501

Table 3.3 presents a simplified scenario illustrating the financial disincentive to work for some DI beneficiaries. If a beneficiary works and earns $500 a month in countable income and continues to receive the average DI cash benefit, his or her total monthly income would be $1,160. At minimum wage ($4.25 an hour), the beneficiary would need to work 27 hours a week to earn $500. But, if that same beneficiary earned $1 more, so that earnings were greater than $500 a month, cash benefits would stop, and the $1 additional earnings would cost the beneficiary $659 in monthly income. To maintain a monthly income of $1,160, the beneficiary would have to work 63 hours each week in a minimum-wage-paying job.

A review of the effectiveness of DI work incentive provisions performed by the Office of Inspector General (OIG) at HHS found that some beneficiaries who had completed a trial work period subsequently reduced their earnings so they could continue to receive the full cash benefit amount, causing their total monthly income (wages plus cash benefit) to be higher than it would have been from earnings alone.[38] The OIG observed that these beneficiaries were making "financially correct decisions," a conclusion

[37]J.C. Hennessey and L.S. Muller, "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work," Social Security Bulletin, Vol. 58, No. 1 (spring 1995), pp. 15-28. These findings should be interpreted with caution, since SSA gathered retrospective data on event histories over a 10-year period.

[38]HHS, Audit of the Effectiveness of Title II Disability Work Incentives, A-13-92-00223 (Washington, D.C.: HHS, OIG, Feb. 1993).

that table 3.3 supports. Of 63 cases reviewed, 9 beneficiaries—or 14 percent—had reduced their earnings in order to continue to receive cash benefits. Although it is uncertain whether this behavior is widespread, data from a study of beneficiary participation in DI work incentive provisions indicate that only 6 percent of the beneficiaries successfully completed a trial work period, and more than half of those never left the program.[39]

Beneficiaries Fear Losing Medical Coverage

In addition to losing cash benefits, beneficiaries who work and continue to earn countable income above certain amounts will eventually lose medical coverage even though they have not necessarily medically improved or obtained affordable coverage elsewhere. Disability advocates and VR counselors that we spoke with believe that the fear of losing medical coverage is one of the most significant barriers to the participation of SSI and DI beneficiaries in a VR program, their return to work, or both.

DI work incentive provisions provide up to 4 years of premium-free Medicare coverage when a person who continues to be medically disabled goes to work and earns more than $500 a month in countable income. When premium-free coverage ends, these individuals may purchase Medicare coverage at the same monthly premium paid by uninsured retired beneficiaries. However, the monthly premium—exceeding $300 for full coverage in 1996—may be a hardship for some beneficiaries, especially individuals with low earnings. In a study of DI beneficiary work attempts, SSA researchers noted that "the eventual loss of Medicare coverage which, for some beneficiaries, is worth as much as cash benefits, adds to a feeling of future financial insecurity and discourages work."[40]

SSI beneficiaries who lose medical coverage because they exceed the earnings limit do not have the option of purchasing Medicaid. In most states, section 1619 work incentives allow beneficiaries to keep Medicaid coverage even when earnings exceed $500 a month. SSI beneficiaries may keep their Medicaid coverage until earnings increase to a point—referred to as the threshold amount—that SSA considers high enough to replace SSI cash and Medicaid benefits.[41]

[39]L.S. Muller, "Disability Beneficiaries Who Work and Their Experience Under Program Work Incentives," Social Security Bulletin, Vol. 55, No. 2 (summer 1992), pp. 2-19.

[40]Hennessey and Muller, "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work."

[41]The threshold amount is based on the amount of earnings that would cause cash payments to stop in the person's state of residence and the annual per capita Medicaid expenditure for that state. As discussed earlier, the earned income threshold is followed by an individualized assessment to determine whether eligibility for Medicaid should continue.

Beneficiaries who lose Medicaid could be uninsurable or face prohibitively high premiums. It may matter little how much a beneficiary can earn by returning to work if he or she cannot buy health insurance because of a disabling condition. Even if a beneficiary is able to obtain health insurance, he or she may still be subject to a waiting period and exclusion for preexisting conditions.

Other studies have also identified the risk of losing medical coverage as a major barrier to beneficiaries' returning to work. For example, the fear of losing Medicaid and Medicare was identified as perhaps the single greatest barrier to employment by the President's Committee on Employment of People With Disabilities. Its study reportedly included the views of more than 1,200 leaders of every major disability constituency in every state.[42] In a recent OIG/HHS survey of disability program applicants, 75 percent of the DI applicants and 79 percent of the SSI applicants rated continued medical coverage as very important to encouraging work.[43]

Beneficiaries Who Return to Work Risk Losing Other Federal and State Assistance

Beneficiaries with low income may be receiving benefits from other programs—for example, food stamps, housing assistance, and energy assistance. SSI and DI work incentives do not protect beneficiaries from losing benefits from other programs. During our visits with disability advocates and rehabilitation counselors, we were told of instances in which beneficiaries had little option other than to quit work because they could not afford to lose their housing assistance. Thus, beneficiaries faced with losing their medical benefits and benefits from other programs if they return to work have an incentive to forgo work in order to continue receiving cash, medical, and other types of assistance.

Work Incentives Are Poorly Implemented

Implementation problems further limit the effectiveness of work incentive provisions in two ways. First, beneficiaries are generally unaware of the work incentive provisions. Second, if beneficiaries are aware of the provisions, they generally do not understand their complexities.

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

[43]HHS, Disability Applicants' Responses to Vocational Rehabilitation Issues: A Mail Survey (draft report) OEI-07-90-00830 (HHS, OIG, Mar. 1995). The OIG selected a random sample of 600 applicants whose claims had been adjudicated. SSA awarded benefits to half the applicants and denied benefits to the other half.

Beneficiaries Are Generally Unaware of Work Incentive Provisions

For work incentives to influence behavior, beneficiaries need to be aware of the work incentive provisions. Disability advocate groups and VR counselors told us, however, that beneficiaries generally are unaware of the work incentive provisions. SSA researchers have found that, among a sample of DI beneficiaries, 80 percent were unaware of the work incentive provisions at the time they returned to work.[44] This lack of knowledge of work incentives is due, in part, to SSA's emphasizing disability determination over encouraging or helping beneficiaries to work. SSA claims representatives told us that they devote most of their time to assisting beneficiaries to apply for benefits, leaving little time to inform them of work incentive provisions. When work is discussed, it is generally in the context of the application process and how earnings may result in lower benefits or no benefits at all.

Although some claims representatives do spend time discussing the work incentive provisions, they recognize that time spent on work incentives is quite brief and that it occurs at the end of a lengthy application process in which they have already provided beneficiaries with a large amount of information. Further, the evidence we reviewed indicated that, at the time of application, individuals are focused on establishing their inability to work and not on initiating efforts to obtain employment. Other claims representatives told us that they discuss work incentive provisions only if the beneficiary expresses a desire to work, while still others said they provide brochures describing work incentive provisions or rely on SSA headquarters to provide this information.

Beneficiaries Generally Do Not Understand Complex Work Incentives

Claims representatives, disability advocates, and VR counselors told us that most beneficiaries who are aware of the work incentive provisions do not understand them. In fact, counselors and advocates who help beneficiaries return to work are not always able to explain how work incentives apply to a person's particular situation, because they are not fully aware of or do not understand all the provisions themselves. Claims representatives, who spend most of their time processing claims, are not always familiar with work incentive provisions, either. During group discussions with claims representatives, we found that although some appeared to have a good working knowledge of the work incentive provisions, some were not aware of certain provisions while others appeared to be confused by them.

The difficulty in understanding work incentives is heightened for the 11 percent of the beneficiary population who receive both DI and SSI. For

[44]Hennessey and Muller, "Work Efforts of Disabled-Worker Beneficiaries: Preliminary Findings From the New Beneficiary Followup Survey."

these concurrent beneficiaries, the SSI work incentive provisions apply to the SSI portion of their cash benefit and the DI provisions apply to the DI portion of their cash benefit. In some SSA district offices, concurrent beneficiaries must go to two different claims representatives to handle their cases. In addition, when reporting earnings to SSA, these beneficiaries must report their earnings to both programs, each of which has its own reporting requirements and processes. For example, DI requires that reported earnings reflect when the income was earned, while SSI requires that reported earnings reflect when the income was received.

Some beneficiaries who receive DI and SSI benefits do not understand the different reporting requirements. If these beneficiaries report earnings only to one program, for example, they may be overpaid by the program that does not receive the earnings data. Beneficiaries can become even more confused and anxious about working when they later receive a notice of overpayment.

Studies have also found that beneficiaries generally do not understand work incentive provisions. For example, one study concluded that DI and SSI work incentive policies and procedures were neither well understood nor operating smoothly administratively.[45] Another study noted that DI beneficiaries who were aware of work incentive provisions were unfamiliar with the details and had conflicting interpretations. The study also found that claims representatives had a large number of responsibilities and used very little of their time advising beneficiaries about return to work. Moreover, the claims representatives said that the complexity of the work incentives made the provisions hard for even them to master.[46] The Disability Advisory Council also concluded that beneficiaries did not understand the work incentive provisions. The Council stated that better understanding of the provisions would help beneficiaries dispel their fears and encourage them to test their work capacity.[47]

[45]A.C. Jensen, Consumers' Experiences with Work Incentive Policies in the Supplemental Security Income and Social Security Disability Insurance Programs: An Exploratory Study (Elmhurst, Ill.: National Foundation for People With Disabilities, June 1990).

[46]Portfolio Associates, Inc., for the Office of Disability, Division of Disability Program Information and Studies, SSA, HHS, Work Incentive Marketing Project (final report) (Washington, D.C.: HHS, Jan. 1989).

[47]Report of the Disability Advisory Council, HHS.

VR Plays Limited Role in Disability Programs

The application process and weak DI and SSI program work incentive provisions can discourage a beneficiary from attempting to return to work. Structural weaknesses in the VR system—spanning SSA, the DDSs, and the state VR agencies—further diminish the chances that a beneficiary will return to work.

The Social Security Act established the policy that the maximum number of individuals applying for disability benefits should be rehabilitated into productive activity. People applying for disability benefits are to be promptly referred to state VR agencies for rehabilitation services.[48] VR services are intended to prepare individuals with disabilities for work opportunities. However, VR has a limited impact on DI and SSI, as state agencies successfully rehabilitate only about 1 out of every 1,000 beneficiaries, on average, each year.[49]

Access to VR Services Through DDS Referrals Is Limited

With few beneficiaries referred by DDSs for VR services, and fewer still accepted by VR agencies as clients, access to VR services through the DDS referral process is limited.[50] DDSs refer for VR services, on average, only about 8 percent of DI and SSI applicants awarded benefits. And although less is known about how many DDS referrals are accepted by state VR agencies, previously we estimated that less than 10 percent of beneficiaries referred by DDSs were accepted by VR agencies as clients.[51] Several factors contribute to limited access.

[48]The Rehabilitation Act of 1973, as amended, authorizes the Department of Education's VR program, which provides federal funds to a network of state VR agencies, to operate the country's public VR program. The federal share of funding for these services is about 80 percent; the states pay the balance.

[49]The DI and SSI programs' standard of successful rehabilitation is limited to cases in which the beneficiary is returned to SGA for at least 9 continuous months (which we refer to as "SSA-defined success"). In contrast, state VR agencies' standard of successful rehabilitation is met if the agency places the individual in suitable employment (paid or unpaid) for at least 60 days (which we refer to as "VR-defined success"). In this case, we are referring to an SSA-defined success.

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

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

Restrictive State Policies Limit VR Referrals

SSA's national screening guidelines are intended to ensure that all disabled applicants with rehabilitation potential are given the opportunity to receive services. The national guidelines counsel DDSs to refer all applicants for VR services except those with terminal illnesses, severe or rapidly progressive impairments not responding to treatment, or other characteristics that make rehabilitation and sustained work unlikely. Using SSA's national guidelines as a basis, however, some DDSs, working in conjunction with state VR agencies to reflect state agency priorities, have developed additional criteria for the DDSs to apply in screening out certain categories of beneficiaries for referral. In this way, some VR agencies have limited the types of referrals they receive to those they consider to be the best VR candidates.

These added criteria are more restrictive than SSA's national guidelines. For example, California's state VR agency and state DDS have agreed to limit referrals to beneficiaries who are high-school-educated (or the equivalent), 18 to 45 years old, and have an orthopedic or visual impairment (if a DI beneficiary) or an orthopedic, visual, or mental retardation impairment (if an SSI beneficiary). California developed its criteria to overcome problems encountered with large numbers of unevaluated referrals that it considered too time consuming and unproductive to deal with. These criteria, if strictly applied, would preclude from referral for VR services, for instance, a DI beneficiary with a mental impairment.

Some state policies also restrict VR services to people capable of working a minimum number of hours per week. This restriction, according to the President's Committee on Employment of People With Disabilities, blocks people with disabilities who can work fewer than a prescribed minimum number of hours per week from VR services that could help them become more employable.[52]

[52]Operation People First: Toward a National Disability Policy, President's Committee on Employment of People With Disabilities.

SSA Does Not Routinely Monitor the Referral Process

Although SSA monitors the volume, timeliness, and quality of the benefit application process, little information is routinely collected on the referral process. To illustrate,

- although SSA began early in 1996 to track the number of DDS-referred beneficiaries accepted for VR services,[53] SSA does not track the number of DDS-referred beneficiaries successfully rehabilitated (SSA-defined success);[54]
- SSA does not collect information on the reasons that some DDS referrals are not accepted for services or successfully rehabilitated; and
- the DDSs do not review the referral process as part of the DDS quality assurance process.

Information such as this could help evaluate and improve the referral process, including the quality of the referrals, and also reward employees for their accomplishments in referral activities. Nevertheless, the Joint VR Referral Task Force, a multiagency group that sought to improve the VR referral process, reported that no work credit or other recognition was associated with the referral process in SSA's field offices.[55]

By not routinely monitoring the performance of the referral process, SSA and DDSs tell their employees that referring beneficiaries for VR has relatively low priority compared with claims processing tasks. A message of low priority greatly diminishes the incentive for SSA field office and DDS employees to spend time informing individuals about the referral process and assessing beneficiaries' potential for referral, thereby negatively affecting the number of referrals.

Beneficiaries Are Perceived as Less Attractive VR Candidates

Not all people referred to state VR agencies are accepted for VR services. State VR agencies use their own selection processes to identify individuals they believe will be best served by VR services. Some state VR agency counselors view DI and SSI beneficiaries as relatively less attractive candidates for VR services than VR candidates who are not beneficiaries, thereby reducing the number of DDS referrals that they accept. When

[53]SSA began early in 1996 to collect information on the number of DDS referrals accepted for VR services by the state VR agencies. This was the first step in the agency's implementation of new regulations that allow it to use providers for VR services other than state agencies.

[54]SSA tracks successful rehabilitations but cannot distinguish these cases by referral source.

[55]HHS, Final Report and Recommendations Resulting from the Joint Vocational Rehabilitation Referral Task Force (Washington, D.C.: Office of Disability, SSA, May 16, 1994). The task force included representatives from state VR agencies, DDSs, the Department of Education's Rehabilitation Services Administration, and SSA. The task force reviewed the existing VR referral process and recommended improvements.

choosing between DI and SSI beneficiaries and others, for example, some counselors are influenced by two different perceptions of beneficiaries: they are seen either as less needy than other potential VR candidates who are unemployed and lack disability benefits or as more difficult to rehabilitate because they are more severely disabled and less motivated to participate in rehabilitation than other persons referred for VR services. In either case, some VR counselors are less willing to accept DI and SSI beneficiaries as clients.

Moreover, no follow-up exists between the DDS examiner who refers the beneficiary and the VR counselor who receives the referral, unlike other sources of referrals for the VR agencies. In light of the evidence that beneficiaries are sometimes perceived as less attractive VR candidates than non-SSA clients, lack of a support network to advocate personally on behalf of beneficiaries may mean that beneficiaries will be at a disadvantage in the selection of people served by VR agencies when this type of support exists for referrals from other sources.

However, attitudes held by some VR counselors toward beneficiaries may not be unrealistic. For instance, the average cost of VR services for a beneficiary who was successfully rehabilitated (VR-defined success) was about $4,000 in fiscal year 1992; in comparison, the cost of services for a successfully rehabilitated nonbeneficiary was about $2,500.[56] Disincentives discussed above can impede beneficiaries' motivation to return to work and may cause beneficiaries to be unreceptive to VR. Clients with poor motivation to seek and gain employment can prevent VR agencies from achieving a high rate of success.

Rehabilitation Reimbursement System Is Ineffective in Motivating VR Agencies

Studies have questioned whether the VR reimbursement system motivates state VR agencies to accept DI and SSI beneficiaries. Through 1981, SSA allocated funds to state VR agencies to finance VR services provided to beneficiaries regardless of rehabilitation outcome. Under the current VR reimbursement program established by the Congress in 1981, SSA reimburses state VR agencies only for costs incurred in successfully rehabilitating DI and SSI beneficiaries (SSA-defined success).[57] The Congress intended this "success-based" reimbursement system to provide state VR agencies with an incentive to rehabilitate beneficiaries to SSA's standards.

[56]These cost figures include only purchased VR services, such as training, not VR agency salaries and administrative expenses.

[57]SSA's reimbursement is in addition to the funding provided to state VR agencies by the federal (80 percent) and state (20 percent) governments, which covers costs for both successful and unsuccessful cases.

We reported previously that VR agencies became more cautious about accepting DI beneficiaries for services following implementation of the current reimbursement system.[58] They were more cautious because of (1) the perceived lower likelihood of success with DI beneficiaries and (2) the uncertainty of getting SSA reimbursement for the cost of VR services because SSA had a considerable backlog of claims for VR reimbursement at the time. The HHS/OIG found little evidence in 1990 that the reimbursement system was inducing states to increase the number of SSA clients served.[59] With two exceptions, the sampled states had made no special efforts to enroll SSA beneficiaries in VR programs, and none had established any special rehabilitation activities for them. In spite of the Congress' intent to motivate state agencies to rehabilitate beneficiaries, the OIG found that, because of implementation problems, states had little incentive to rehabilitate SSA clients. Problems included, for example, delays in receiving reimbursements from SSA and policies in some states that required reimbursements to be deposited into a state's general fund rather than into a VR agency's operating budget. Thus, problems in implementation have hampered testing the full potential of the success-based reimbursement system.

Beneficiaries Are Unaware of VR Services and Are Not Encouraged to Use Them

SSA field office employees are required by agency regulations to inform applicants for disability benefits that they may be contacted by a state VR agency about an opportunity for rehabilitation. Employees also are required to inform applicants that refusal to accept rehabilitation services offered to them, without good cause, can result in the withholding of benefits. Moreover, employees are expected to give written materials about VR services to anyone who inquires about disability benefits.

In spite of these policies, a 1995 HHS/OIG survey of DI and SSI applicants found that respondents were generally uninformed about VR.[60] More than two-thirds of the respondents said that they had not been told or did not recall having been told that they might be contacted about VR services. Three out of every four respondents said that they had not been told or did not recall having been told that benefit payments might stop if they refused to participate in VR. Moreover, three out of every four respondents said they had not received or did not recall having received materials

[58]Social Security: State Vocational Rehabilitation Agencies' Reimbursement for the Disabled (GAO/HRD-87-36BR, Feb. 3, 1987).

[59]HHS, Social Security Administration Payments for Vocational Rehabilitation, OEI-07-89-00950 (Washington, D.C.: OIG, HHS, Apr. 1990).

[60]Disability Applicants' Responses to Vocational Rehabilitation Issues: A Mail Survey, HHS.

about VR services. If not informed about VR services, the chances of beneficiaries' becoming rehabilitated and returning to the workforce may be reduced.

Responding to findings by the Joint VR Referral Task Force that beneficiaries lacked awareness about rehabilitation opportunities, SSA has recently developed and distributed a brochure on VR for its field offices to disseminate to beneficiaries.[61] The availability of updated materials on VR, however, does not guarantee that a beneficiary will be thoroughly familiar with VR services, as SSA and DDS employees generally lack incentives to educate beneficiaries about VR.

In addition to the lack of awareness and support, beneficiaries generally lack encouragement to take part in VR services. For example, some state VR agencies make little or no attempt to contact beneficiaries and involve them in their VR programs or actively encourage them to become interested in VR. Additionally, fewer than half the applicants surveyed by the OIG in 1995 reported that someone had encouraged them to participate in VR.[62] And only one out of every four applicants surveyed reported having received encouragement from SSA employees to take part in VR services. Since beneficiaries' initial exposure to the possibility of VR occurs at the same time that they are trying to establish inability to work, limited encouragement can further distance them from seeking VR services.

Long-Term Gains From State VR Services Are Generally Lacking

Even if a beneficiary is referred for VR services and accepted by a VR agency, studies have questioned the effectiveness of VR services. In 1993, we evaluated the long-term results of state VR services by examining the employment status of VR clients (including SSA beneficiaries) over an 8-year period following receipt of services.[63] We found that gains in employment and earnings of clients who had been successfully rehabilitated (VR-defined success) faded after about 2 years, with earnings for many returning to near or below the pre-VR program level after 8 years. Clients who had been successfully rehabilitated had better work and earnings histories than clients who had dropped out of the VR program.

[61]Final Report and Recommendations Resulting from the Joint Vocational Rehabilitation Referral Task Force, HHS.

[62]Disability Applicants' Responses to Vocational Rehabilitation Issues. A Mail Survey, HHS.

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

However, clients who had not been rehabilitated, but had received many of the services that rehabilitated clients had received, did no better in later employment and earnings than VR dropouts who had received no services after an initial VR evaluation.

Obtaining sustained, gainful work for clients is not always the focus of state VR agencies, which may be one reason that long-term gains are limited. Each client served works with the state VR agency to establish an individual rehabilitation plan. The plan includes an achievable vocational goal considered to be "suitable employment" for the client. The VR agency considers a client to be successfully rehabilitated following 60 days of suitable employment (VR-defined success). Suitable employment need not involve wages or salary and may include, for example, working as an unpaid homemaker or family worker.[64] The suitable employment found for about 10 percent of state VR agencies' successful cases in fiscal year 1992 was as unpaid homemakers. Moreover, more than one of every four DI beneficiaries rehabilitated in fiscal year 1992 was an unpaid homemaker.

The VR 60-day measure of success is less rigorous than SSA's criterion of employment at SGA for 9 continuous months. State VR agency employees, accountable to their states for success according to the 60-day measure, may not necessarily be geared toward providing beneficiaries with services oriented toward achieving and maintaining long-term gainful employment. Strong organizational incentives—pay, promotion, and recognition—may incline VR counselors toward providing services suitable for short-term employment or homemaker activity rather than for longer-term competitive employment.

Moreover, studies show that few beneficiaries receive VR services that are associated with returning beneficiaries to work. SSA researchers reported that certain VR services—job placement, vocational training, and general education—had a significant and positive effect on the tendency for DI beneficiaries to return to work.[65] This finding is supported by another study of the same population, in which about one-half to two-thirds of DI beneficiaries who received these types of VR services indicated that the

[64]The Department of Education defines "unpaid homemaker" as someone who is able to keep house for oneself, if living alone, or for self and others, if living in a family setting. An unpaid family worker is someone who works without pay on a family farm or in a family business.

[65]Hennessey and Muller, "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work."

services helped them return to work or continue working.[66] The latter study found, however, that these VR services were offered to a small segment of the relatively few DI beneficiaries who received VR: only 6 percent received job placement services, 12 percent received vocational training, and 7 percent received general education.[67] A similar message was reported by the 1988 Disability Advisory Council.[68] The Council heard testimony that some state VR agencies did not provide adequate job placement and job retention services, and it recommended that VR programs for beneficiaries be geared toward these services.

Timing of Referral Can Diminish Its Effectiveness

Findings from research we reviewed generally agreed that rehabilitation, including treatment, offered close to the onset of disabling impairments has the greatest likelihood of success. In fact, the literature emphasizes that "early" intervention for disabled workers is "not a question of months, but of days or even hours."[69] However, by the time a person applies for DI or SSI benefits, in many cases the chance for early work-site intervention has been lost. SSA survey results indicate that nearly 40 percent of DI/SSI applicants with a work history reported being out of the workforce for more than 12 months in the period immediately prior to applying for disability benefits.[70]

The application process further delays the provision of VR services. The period during which applicants are being certified and labeled as disabled is generally a lengthy one during which applicants risk becoming entrenched in their self-perceived inability to work. According to SSA's Associate Commissioner for Disability, "DDSs refer some individuals...to the state [VR agencies] at the same time we notify these individuals of [our] disability decisions. Arguably, this is the least appropriate time to discuss VR or employment."[71]

[66]Hennessey and Muller, "Work Efforts of Disabled-Worker Beneficiaries: Preliminary Findings From the New Beneficiary Followup Survey."

[67]Just over one-half of DI beneficiaries who received VR services received physical therapy. Physical therapy was found to have a positive and significant effect on the tendency to return to work.

[68]Report of the Disability Advisory Council, HHS.

[69]W.A. Hunt and others, "Disability and Work: Lessons from the Private Sector," paper presented at the National Academy of Social Insurance and the National Institute for Disability and Rehabilitation Research Workshop on Disability, Work, and Cash Benefits (Santa Monica, Calif.: Dec. 8-10, 1994), p. 32.

[70]Memo from SSA's Associate Commissioner for Research and Statistics to the Associate Commissioner for Disability, HHS.

[71]HHS, Associate Commissioner, Office of Disability, Developing a World-Class Employment Strategy for People with Disabilities, A Briefing for Commissioner Chater and Principal Deputy Commissioner Thompson (Washington, D.C.: SSA, HHS, Aug. 1994).

The timing of the referral can diminish the effectiveness of VR in rehabilitating individuals and encouraging them to return to work. Extended absence from the workplace reinforces a person's self-perceived inability to work and drains one's motivation to work. As a consequence, receptiveness to participate in rehabilitation and job placement activities can decline.

Overall Service Delivery Structure May Limit Quality of Services

The VR service delivery structure may contribute to the limited gains in employment and earnings derived from state VR services. DDSs refer beneficiaries to the state VR agency network for services. Since state VR agencies select the service providers, little competition exists in this network to help ensure that beneficiaries receive high-quality, cost-effective services. Beneficiaries cannot choose among public and private service providers operating in a competitive market to find the one that provides the services they believe are most valuable.

New authority in SSA's regulations allows SSA to refer people to private VR providers when the state VR agencies refuse or are unable to serve referrals. SSA put into place the information system needed to begin implementation of these regulations early in 1996 and expects to have some private entities providing VR to its referrals by the summer of 1996. Although the regulations introduce limited competition in providing VR services to DI and SSI beneficiaries, two factors may limit participation by private VR providers. First, state VR agencies have 4 months to accept or reject a referral before beneficiaries can receive services from private providers. This first right of refusal may result in state agencies' selecting beneficiaries who are the easiest to rehabilitate and employ, thereby leaving the most difficult cases for the private market to serve. Second, some private providers have criticized the practice of reimbursing for services only after clients have been employed at SGA for 9 continuous months. A representative of these providers calls the timing of this payment mechanism "unworkable" for the private sector because of the financial burden and risk it imposes on providers.

In effect, allowing private sector providers access to beneficiaries only after the public sector rejects them means that private sector providers will continue playing a secondary role in the market. Consequently, choice and competition will remain curtailed, and the quality of VR services is not likely to change.

Conclusions, Recommendation, and Agency Comments

Conclusions

In recent years, the potential for some DI and SSI beneficiaries to engage in substantial gainful employment has increased because of advances in assistive technologies and the medical management of disabilities, as well as an increasing trend toward the integration of people with disabilities into society. The Congress has signaled an interest in taking advantage of these changes to enhance the employment opportunities for DI and SSI beneficiaries.

A significant portion of people receiving disability benefits may not be likely candidates for rehabilitation and return to work, however. For instance, almost one-half of a cohort of beneficiaries who entered DI in 1988 died or reached the age of 65 in less than 6 years. Furthermore, almost one-half of the adult DI and SSI beneficiary population was aged 50 or older in 1994.

On the other hand, there is a meaningful portion of working-age beneficiaries who can be expected to survive for many years, and who may be candidates to return to work. SSA testified before the House Committee on Ways and Means in 1990 that almost one-third of DI and SSI beneficiaries are very good candidates for VR.[72] Furthermore, 35 percent of the 84,000 DI beneficiaries who responded to a questionnaire in May 1993 that asked if their medical conditions had changed indicated an interest in receiving rehabilitation or other services that could help them get back to work.

Weaknesses in the design and implementation of the DI and SSI programs, however, mean that little has been done to identify and encourage the productive capacities of beneficiaries who might be able to benefit from rehabilitation and employment assistance. The disability determination process encourages applicants to focus on their incapacities and, coupled with a strong financial incentive to retain benefits, may create little interest in returning to work. Work incentives may not overcome the risk of lost income faced by beneficiaries attempting trial work or the risk of losing medical coverage when successfully employed. SSA does not adequately promote work incentives, and the complexities of the work incentives—especially in the absence of clear guidance from SSA staff—are difficult for beneficiaries to understand. Also, state VR services do not appear to be accessible to many beneficiaries, and their effectiveness in securing long-term financial gains for beneficiaries has been called into

[72]"Proposals to Improve the Effectiveness of the Social Security Administration's Vocational Rehabilitation Program," testimony given by Louis D. Enoff, Deputy Commissioner for Programs, before the Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, serial 101-94, Apr. 19, 1990.

question. The cumulative effect of these weaknesses is diminished capacity of the DI and SSI programs to return people to work. Indeed, we testified in May 1995 that SSA required a broader management focus to do more to improve the productive capacity of DI and SSI beneficiaries.[73]

In light of these weaknesses, SSA needs to place much greater emphasis on achieving return-to-work outcomes. Doing this will require SSA to restructure its existing strategies for identifying and enhancing the productive capacities of beneficiaries. SSA's success in restructuring is likely to be dependent upon a multifaceted approach. For instance, expanding VR opportunities may not facilitate long-term employment among beneficiaries if people continue to fear that working their way off the rolls will lead to loss of health insurance. Also, educating beneficiaries about work incentives and VR services may have little impact if beneficiaries are better off financially not working than attempting to work. Examples such as these suggest that the full impact of restructuring return-to-work efforts may be limited unless these efforts are integrated into a unified and consistent strategy.

As an initial step in restructuring its return-to-work strategy, SSA needs to identify the size and characteristics of the beneficiary population that has a reasonable chance of achieving gainful employment. SSA also needs to identify how the design and implementation of the DI/SSI application process, benefit structure, work incentives, and VR service provider system can be restructured to facilitate employment opportunities. Throughout such efforts, special attention should be given to developing data on the costs and benefits of various return-to-work strategies, as this will be essential input for policymakers considering redesign options. Finally, success in improving return-to-work rates will be likely to extend beyond the control of SSA alone to other federal agencies—such as the Department of Education and the Department of Labor, which have jurisdiction over issues affecting the rehabilitation and employment of people with disabilities—and to the private sector as well.

SSA may find that restructuring its return-to-work strategies requires legislative action. For instance, the experts we interviewed, as well as much of the literature we reviewed, underscored the influence of treatment, supports, and services on the work capacities of people with disabilities. However, current law does not require the evaluation of an individual's capacities to consider such enabling supports and services. Thus, to the extent that decisions on work capacity and successful

[73]GAO/T-HEHS-95-164, May 23, 1995.

return-to-work outcomes depend upon such supports and services, SSA may wish to propose legislative reform to the disability determination process, benefit structure, and other areas of program design.

Recommendation

We recommend that the Commissioner of SSA take immediate action to place greater priority on return to work, including designing more effective means to more accurately identify and expand beneficiaries' work capacities and better implementing existing return-to-work mechanisms. As part of this effort, the Commissioner of SSA should develop a legislative package for those areas in which SSA does not currently have legislative authority to enact change, in order to position the agency to expeditiously redirect its emphasis on return to work.

Agency Comments

In commenting on a draft of this report, the Commissioner of Social Security concurred with our findings and conclusions (see app. VI) but did not indicate whether or not she would take action to implement our recommendation. The Commissioner agreed that DI and SSI beneficiaries face a number of barriers and disincentives that impede entry into the workforce. She also agreed that many current beneficiaries have the potential to return to work and that making program improvements will involve input from a network of federal, state, and private sector players. The Commissioner made a number of technical comments, which we have incorporated where appropriate.

Range of Public and Private Disability Benefit Types for Working-Aged People With Disabilities

Cash Benefit

Public/Private Insurers

Long-Term Disability

A worker covered under Social Security and unable to work because of a severe long-term disability could be eligible for cash benefits from DI—the country's long-term public disability insurance program. Workers can supplement DI coverage with cash benefits from private long-term disability insurance or pensions if their employers provide such plans or if the workers have purchased supplemental insurance on their own.

Short-Term Disability

In case of illness or injury resulting in a temporary inability to work, a person might be eligible to receive short-term cash disability benefits from state temporary disability insurance programs.[74] However, only five states currently provide this type of benefit.[75] Outside these states, workers may be eligible for paid sick leave or sickness or accident insurance benefits if provided by the employer or purchased on their own.

Compensation

Individuals can receive compensation for injuries sustained on the job, during active duty with the Armed Services, and in nonjob-related accidents. Workers injured on the job can receive cash benefits through their states' employer-financed workers' compensation programs. An individual can receive workers' compensation benefits and DI simultaneously, although the DI cash benefit generally is reduced by workers' compensation. An injured worker can receive compensation for temporary total disability—meaning that the worker is unable to work but expected to fully recover—or for being permanently and totally disabled for any employment. If, however, the permanent disability is partial, the injured worker can receive compensation whether or not the disability lessens work ability. Also, a member of the Armed Services who becomes permanently disabled because of injuries or disease incurred or aggravated by active duty is compensated based on the percentage of normal functioning that is lost, ranging from partial to total (10 percent to 100 percent). Finally, an individual injured in an automobile accident or suffering other nonjob-related injuries in which another party is at fault can also receive compensation payments.

[74]These programs are integrated with sick leave in varied ways.

[75]California, Hawaii, New Jersey, New York, and Rhode Island.

Income Support

A person with severe disabilities who has low income can receive means-tested cash benefits from SSI regardless of workforce connections. Similarly, a veteran with wartime service who has low income and a disability unrelated to active military duty can be eligible for a veterans' pension.

Services

A myriad of federal, state, and local disability programs provide services for working-aged people with disabilities. For instance, each state has one or more agencies that provide VR services to eligible individuals under a joint federal/state VR program administered by the Rehabilitation Services Administration in the Department of Education. State workers' compensation also pays for rehabilitation; veterans have a separate VR program as well as other programs administered by the Department of Veterans Affairs that supply, for example, prosthetics and housing assistance. The Department of Transportation grants funds from earmarked revenues to support transportation projects and programs that benefit people with disabilities. And people with disabilities who have low income may be eligible for food stamps, housing, and employment assistance administered, respectively, by the Departments of Agriculture, Housing and Urban Development, and Labor. An array of federal agencies also funds services for people with specific impairments, including visual, hearing, and mental impairments, as well as developmental disabilities.

Health Care

Eligible working-aged individuals with disabilities benefit from publicly provided health insurance. Medicaid provides federal funds to states to help pay for health care for people who are eligible for SSI. The Medicare program provides hospital and medical insurance protection for disabled individuals who have qualified for DI benefits. Additionally, a person can defray the costs of disability-related medical expenses by purchasing private medical insurance or participating in an employer-provided insurance program.

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

To determine whether an applicant qualifies for DI or SSI disability benefits, SSA uses a five-step sequential evaluation process. In the first step, an SSA field office determines if an applicant is working at the level of substantial gainful activity (SGA) and whether he or she meets the applicable nonmedical eligibility requirements (Social Security insured status, income and resources, residency, and citizenship, for example).[76] An applicant found to be not working or working but earning less than SGA (minus allowable exclusions), and who meets the nonmedical eligibility requirements, has his or her case forwarded to a Disability Determination Service (DDS) office. Applicants who do not meet these requirements, regardless of medical condition, are denied benefits.

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

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

[76]To be eligible for DI benefits, individuals must have worked long enough and recently enough under Social Security. To be eligible for SSI benefits, individuals must not have countable monthly income (earned and unearned income, as defined by the SSI program, minus allowable exclusions) higher than the federal benefit rate, nor countable real and personal property (including cash) worth more than $2,000.

evaluated further to determine whether he or she has vocational limitations that, when combined with the medical impairment(s), prevent work.

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

In the fifth and last step, the DDS office determines if an applicant who cannot perform work done in the past can do other work that exists in the national economy.[77] Using SSA guidelines, the DDS considers the applicant's age, education, vocational skills, and RFC to determine what other work, if any, the applicant can perform. Unless the DDS office concludes that the applicant can perform work that exists in the national economy, benefits are allowed.

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

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

List of Expert Reviewers

Deborah R. Becker, M.Ed.
Research Project Director
New Hampshire-Dartmouth Psychiatric Research Center
Concord, New Hampshire

Sharon Bonney, M.A.
Assistant Director
Executive Office
World Institute on Disability
Oakland, California

Henry P. Brehm, Ph.D.
Professor
Department of Sociology
University of Maryland, Baltimore County
Catonsville, Maryland

Richard V. Burkhauser, Ph.D.
Professor
Center for Policy Research
The Maxwell School
Syracuse University
Syracuse, New York

Admiral David M. Cooney (ret.)
Karalekas & Noone
Washington, D.C.

David H. Dean, Ph.D.
Associate Professor of Economics
Robins School of Business
University of Richmond
Richmond, Virginia

Donald E. Galvin, Ph.D.
President and Chief Executive Officer
Commission on Accreditation of Rehabilitation Facilities
Tucson, Arizona

Allen Jensen
Intergovernmental Health Policy Project
George Washington University
Washington, D.C.

Arthur T. Meyerson, M.D.
Professor and Vice Chairman of Psychiatry
Department of Psychiatry
University of Medicine and Dentistry of New Jersey
Newark, New Jersey

Virginia Reno
Project Director
National Academy of Social Insurance
Washington, D.C.

Kenneth J. Shaw
Director
Program Development and Research Division
Goodwill Industries International, Inc.
Bethesda, Maryland

William E. Shelton
Director
Disability Determination Bureau
Department of Health and Social Services
Madison, Wisconsin

Jenifer Simpson
Policy Associate
Governmental Activities Department
Community Services Division
United Cerebral Palsy Associations
Washington, D.C.

Deborah A. Stone, Ph.D.
David R. Pokros Professor of Law and Social Policy
Heller Graduate School
Brandeis University
Waltham, Massachusetts

Size of Disability Rolls and Amount of Cash Benefits, 1985-94

Table IV.1: DI Beneficiary Population and Cash Benefits, 1985-94

Year	Beneficiaries[a] (in thousands)	Annual percentage increase in beneficiaries	Benefits (in millions)	Annual percentage increase in benefits
1985	2,332		$16,483	
1986	2,371	1.7	17,409	5.6
1987	2,396	1.0	18,053	3.7
1988	2,419	1.0	19,165	6.2
1989	2,452	1.3	20,314	6.0
1990	2,547	3.9	22,113	8.9
1991	2,686	5.4	24,738	11.9
1992	2,900	8.0	27,856	12.6
1993	3,100	6.9	30,913	11.0
1994	3,292	6.2	33,711	9.1

[a]Includes only disabled workers aged 18 to 64.

Source: Annual Statistical Supplement to the Social Security Bulletin (Aug. 1995).

Table IV.2: SSI Beneficiary Population and Cash Benefits, 1985-94

	Beneficiaries[a] (in thousands)				Benefits[b]	
Year	Adults (aged 18-64)	Children (under age 18)	Total	Annual percentage increase	Amount in millions	Annual percentage increase
1985	1,333	227	1,561		$6,575	
1986	1,466	241	1,707	9.4	7,308	11.2
1987	1,488	251	1,739	1.9	7,830	7.1
1988	1,544	255	1,799	3.5	8,457	8.0
1989	1,615	265	1,880	4.5	9,244	9.3
1990	1,728	309	2,036	8.3	10,372	12.2
1991	1,866	397	2,263	11.1	12,073	16.4
1992	2,064	556	2,620	15.8	15,346	27.1
1993	2,230	723	2,953	12.7	17,624	14.8
1994	2,362	841	3,204	8.5	18,910	7.3

[a]Includes all people with a federal SSI payment and/or federally administered state supplementation.

[b]Includes federal-only (not state supplementation) SSI payments to SSI adults aged 18 to 64; SSI children under age 18; and people dually eligible for SSI and DI payments who are disabled workers. Also includes federal-only SSI payments to SSI beneficiaries aged 65 or older and people dually eligible for SSI and DI who are not disabled workers.

Source: Annual Statistical Supplement to the Social Security Bulletin (Aug. 1995).

Table IV.3: Concurrent DI and SSI Beneficiaries, 1985-94

Year	Number of beneficiaries in thousands[a]	Annual percentage increase
1985	324	
1986	357	10.1
1987	390	9.2
1988	411	5.5
1989	444	7.9
1990	465	4.7
1991	509	9.7
1992	568	11.5
1993	626	10.3
1994	671	7.2

[a]Includes only disabled workers under age 65 who also receive SSI.

Source: Annual Statistical Supplement to the Social Security Bulletin (multiple years).

Table IV.4: DI and SSI Beneficiaries and Cash Benefits, 1985-94

	Beneficiaries[a]		Benefits[b]	
Year	Number in thousands	Annual percentage increase	Amount in millions	Annual percentage increase
1985	4,217		$23,058	
1986	4,435	5.2	24,717	7.2
1987	4,525	2.0	25,883	4.7
1988	4,630	2.3	27,622	6.7
1989	4,776	3.2	29,558	7.0
1990	5,047	5.7	32,485	9.9
1991	5,458	8.1	36,811	13.3
1992	6,088	11.5	43,202	17.4
1993	6,679	9.7	48,537	12.3
1994	7,166	7.3	52,621	8.4

[a]Includes DI disabled workers aged 18 to 64. Also includes the following groups who receive a federal SSI payment and/or federally administered state supplementation: SSI adults aged 18 to 64, SSI children under age 18, and people dually eligible for SSI and DI who are disabled workers.

[b]Includes DI payments to disabled workers aged 18 to 64 and federal-only (not state supplementation) SSI payments to SSI adults aged 18 to 64; SSI children under age 18; and people dually eligible for SSI and DI payments who are disabled workers. Also includes federal-only SSI payments to SSI beneficiaries aged 65 and older and people dually eligible for SSI and DI who are not disabled workers.

Source: Annual Statistical Supplement to the Social Security Bulletin (Aug. 1995).

Summary of Studies on Accuracy of Disability Determinations

Evidence from four empirical studies shows that accuracy is limited in a disability determination system designed to sort people with disabilities into categories of either not having the ability to engage in any substantial gainful employment or having the capacity to do so (see table V.1). The studies indicate that

- independent decisionmakers often make different disability decisions than DDS/SSA offices on the same cases and
- meeting or equaling SSA's listings for physical impairments may not be a good predictor of an inability to work.

As independent decisionmakers often disagreed among each other or had difficulty in deciding whether to accept or deny cases, the findings do not demonstrate that DDS/SSA should be making more accurate decisions, but that disability decisions involve a high level of judgment in many cases. Indeed, SSA has reported some inconsistency between DDS decisionmakers themselves. In one study, SSA found that there was about one chance in eight that two DDS examiners selected at random in a state would reach opposite decisions on the same case using the same decision-making criteria; there was about one chance in six that opposite decisions would be reached by examiners chosen from two different states.[78]

[78]HHS, Consistency of Initial Disability Decisions Among and Within States, No. 13-11869 (Washington, D.C.: SSA, HHS, July 1980).

Table V.1: Summary of Studies on Validity of SSA Disability Determinations

Study	Principal findings
Nagi (1969)[a]	Overall level of disagreement between DDS/SSA and independent clinical teams was 30%: 37% of cases denied by independent teams were approved by DDS/SSA, and 27% of cases approved by the teams were denied by DDS/SSA.
Okpaku and others (1994)[b]	An independent team of mental health workers could not reach a decision on 47% of cases (most of these cases—79%—were approved by DDSs). Of cases on which a decision was reached, there was a 24% level of disagreement with DDSs: 88% of cases approved by the team were approved by DDSs; 55% of cases denied by the team were approved by DDSs.
Brehm and Rush (1988)[c]	Of a sample of adults from the Framingham Heart Study, about 60% of men and 32% of women who met or equaled SSA medical listings—in other words, individuals who would have been considered too disabled to work had they applied for disability benefits—were employed at 2-year and 4-year follow-ups (excluding the 27% of adults who died before the first 2-year period and an additional 12% who died before the second 2-year period). Among adults 54 years of age or younger, employment rates were 83% for men and 42% for women.
GAO (1989)[d]	Nearly 60% of applicants who were denied DI benefits in 1984 were not working 3 years later (over two-thirds of this group had been out of work throughout this period). When the self-reported functional and health status of nonworking, denied applicants was compared with the status of beneficiaries who entered DI in 1984, little difference was found. On the basis of self-reporting, GAO classified about three-fourths of each group as having severe functional limitation.

[a]Nagi, Disability and Rehabilitation: Legal, Clinical, and Self-Concepts and Measurement.

[b]Okpaku and others, "Disability Determinations for Adults With Mental Disorders: Social Security Administration vs. Independent Judgments."

[c]Brehm and Rush, "Disability Analysis of Longitudinal Health Data: Policy Implications for Social Security Disability Insurance." Percentages exclude the 27 percent of adults who died during the 2-year period.

[d]GAO/HRD-90-2, Nov. 6, 1989.

Independent Decisionmakers Often Disagree With DDS/SSA About Awards and Denials

Two of the four studies compared SSA disability decisions with nonbinding disability decisions made by independent decisionmakers. In one comparative study (Nagi, 1969), teams of clinicians (each team was composed of a social worker, a physician, a psychologist, an occupational therapist, and a vocational counselor) used professional judgment to rate

2,454 applicants for disability benefits along a continuum from "fit for work under normal conditions" to "not fit for work." The decisions were categorized into "disabled" and "nondisabled" and compared with decisions made by DDS/SSA offices.[79]

The findings indicated that 30 percent of team decisions were opposite from DDS/SSA decisions and that discrepancies were somewhat more likely to result from DDS/SSA's approving an application denied by the teams rather than DDS/SSA's denying an application approved by the teams. Of the cases denied by the teams, 37 percent were allowed by DDS/SSA; of the cases allowed by the teams, 27 percent were denied by DDS/SSA.

In a second and more recent study, researchers compared disability decisions made by DDS offices for claims relating to mental impairments with independent judgments of a team of mental health workers (Okpaku and others, 1994). Both groups used SSA criteria to make determinations on a sample of 158 adults who were receiving or applying for disability benefits on the basis of mental disorders. DDS offices, using normal operating procedures, either accepted or denied claims. A decision from the team of mental health workers was made for each case by tallying individual votes: team members could vote to "allow" or "deny" a case, or vote "maybe." Whichever decision received the most votes was the team decision; a case was "undecided" if a plurality did not exist.

The team voted "maybe" or was undecided on 47 percent of all cases. Among these, 79 percent were approved by the DDSs. Among the cases for which the team reached a decision to allow or deny benefits, the team reached opposite conclusions from the DDSs in 24 percent of cases. Of the cases allowed by the team, 88 percent were allowed by the DDSs; of the cases denied by the team, 55 percent were allowed by the DDSs. The researchers concluded that the team was more conservative than the DDSs in determining who should receive benefits and who should not.

The fact that the team could not decide whether to allow or deny an applicant benefits in almost half of all cases reflects, we believe, the difficulty in deciding who is unable to engage in any gainful activity. Interestingly, team members whose professional work involved much direct observation of the work behavior of severely impaired adults were more likely to vote against approval for disability than other team members. In attempting to explain this finding, the researchers suggested

[79]At the time of the study, as part of the usual disability determination procedure used by SSA, SSA staff reviewed all DDS decisions before issuing a final determination.

that "staff who work directly on getting clients employed and are trained to focus on their strengths may view them as less disabled."[80]

Medical Criteria as Basis for Decisions May Poorly Predict Work Potential

Research suggests that SSA's Listing of Impairments overestimates inability to work and has limited capacity to distinguish accurately between people who can work and people who cannot work. Using data from the Framingham Heart Study population cohort, researchers identified a sample of adults living in the community who had physical impairments that met or equaled those in the listings (Brehm and Rush, 1988). The study tracked the adults' work histories and found that after 2 years of being diagnosed with an impairment, about 61 percent of men and 32 percent of women were employed.[81] Moreover, employment rates for adults aged 54 or younger were even higher: 83 percent for men and 42 percent for women. After an additional 2 years, almost identical rates of employment were found (excluding an additional 12 percent of adults who died between the examination periods).

While findings from the Brehm and Rush study suggest that the listings may overestimate work incapacity in some cases, findings from our earlier study suggest that the disability determination process may result in the denial of benefits to people who may have low capacity to work and function without support and services (GAO, 1989). In the study, we contacted a sample of people whose applications for DI benefits had been approved and a sample of people whose DI applications had been denied. About 3 years after their cases had been decided, we asked about their employment and health status. Fifty-eight percent of applicants who were denied benefits reported that they were not working at the time of the study (of this group, over two-thirds reported being out of work for at least 3 years). We then compared the self-reported functional and health status of people accepted into DI against the status of the nonworking-denied group and found the two groups to be nearly indistinguishable.

[80]Okpaku and others, "Disability Determinations for Adults With Mental Disorders: Social Security Administration vs. Independent Judgments."

[81]These percentages exclude the 27 percent of adults who died during the 2-year period.

Comments From the Social Security Administration

SOCIAL SECURITY

Office of the Commissioner

March 4, 1996

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

Dear Ms. Ross:

Thank you for the opportunity to comment on the draft report, "SSA Disability: Program Redesign Necessary to Encourage Return-to-Work" (GAO/HEHS-96-62).

I share your concern that people with disabilities who receive Social Security Disability Insurance and Supplemental Security Income disability benefits face a number of barriers to entering or reentering the workforce. As you know, SSA conducted an indepth analysis of the SSA disability programs to identify barriers and disincentives to return-to-work for beneficiaries of those programs. We found the following:

- Federal disability policy needs to clearly articulate goals that are reflective of the desire of most disabled Americans to work;
- Beneficiaries face loss of financial security and health care by choosing to work;
- Current return-to-work strategies need improvements;
- Young people with disabilities have little exposure to the world of work or skills training, yet they are treated the same as retirees; and
- Because SSA's work incentive provisions are so complex, they discourage work.

Our work corroborates many of the findings in your report, as do the findings of the Disability Policy Panel of the National Academy of Social Insurance. I believe that we need to continue to embrace the original intent of the Social Security disability programs, that is, to provide a floor of basic income security for people with very severe disabilities and at the same time search for avenues of opportunity for them to reenter the economic mainstream.

I also agree with your conclusions that piecemeal solutions to this problem will have limited success, and that we must provide real return-to-work options for those who, with our help, can return to work. I believe that solutions should address, in a comprehensive and integrated manner, the principles of maximizing employment and self-sufficiency for people with disabilities while providing basic income and health security. The SSA disability programs are only one piece of a vast network of Federal, State and private sector systems influencing the independence and economic self-sufficiency of persons with disabilities. At the Federal level alone, the Congress, the Departments of Education, Labor, and Health and Human Services, and the Internal Revenue Service must be key players in any effort to eliminate barriers to employment and to promote return to work.

In addition, any Federal effort in this arena should also incorporate the private sector. The private rehabilitation community, private insurers, consumers, employers and advocates for people with disabilities can greatly assist us in recognizing, and developing a process for enhancing, the productive capabilities of disabled beneficiaries.

Enclosed are our specific comments on the report. If you have any questions, please call me or have your staff contact Susan Daniels at (410)965-3424.

Sincerely,

Shirley S. Chater
Commissioner
of Social Security

Enclosure

Major Contributors to This Report

Cynthia A. Bascetta, Assistant Director, (202) 512-7207
Brett S. Fallavollita, Evaluator-in-Charge
Barbara H. Bordelon, Senior Evaluator
Susan Y. Higgins, Senior Evaluator
David F. Fiske, Senior Evaluator

Bibliography

Akabas, Sheila H., and others. Disability Management: A Complete System to Reduce Costs, Increase Productivity, Meet Employee Needs, and Ensure Legal Compliance. New York: American Management Association, 1992.

Beedon, Laurel E. Changing Social Security Disability Insurance. No. 9302. Washington, D.C.: American Association of Retired Persons, Public Policy Institute, July 1993.

Berkeley Planning Associates. Operations of the Special SSDI and SSI Vocational Rehabilitation Programs: Eight Case Studies. Report to the Assistant Secretary for Planning and Education, U.S. Department of Health, Education and Welfare. Berkeley, Calif.: Berkeley Planning Associates, Feb. 1980.

_____. Establishing Policy in the Special SSDI and SSI Vocational Rehabilitation Programs. Report to the Assistant Secretary for Planning and Education, U.S. Department of Health, Education and Welfare. Berkeley, Calif.: Berkeley Planning Associates, Feb. 1980.

_____. The Client Perspective on Performance in the Special SSDI and SSI Vocational Rehabilitation Programs. Report to the Assistant Secretary for Planning and Education, U.S. Department of Health, Education and Welfare. Berkeley, Calif.: Berkeley Planning Associates, Feb. 1980.

_____ and Harold Russell Associates. Private Sector Rehabilitation: Lessons and Options for Public Policy. Report to the Office of Planning, Budget, and Evaluation, U.S. Department of Education, Dec. 31, 1987.

Berkowitz, Edward, and David Dean. "Lessons From the VR/SSA Experience." Paper presented at the National Academy of Social Insurance and the National Institute for Disability and Rehabilitation Research Workshop on Disability, Work, and Cash Benefits, Santa Monica, Calif., Dec. 8-10, 1994.

Berkowitz, Monroe. "Improving the Return to Work of Social Security Disability Beneficiaries." Paper presented at the National Academy of Social Insurance and the National Institute for Disability and Rehabilitation Research Workshop on Disability, Work, and Cash Benefits, Santa Monica, Calif., Dec. 8-10, 1994.

Brehm, Henry P., and Thomas V. Rush. "Disability Analysis of Longitudinal Health Data: Policy Implications for Social Security Disability Insurance." Journal of Aging Studies, Vol. 2, No. 4 (1988), pp. 379-99.

Chirikos, Thomas N. "Accounting for Population Heterogeneity in the Design of Disability Policy." Paper presented at the National Academy of Social Insurance and the National Institute for Disability and Rehabilitation Research Workshop on Disability, Work, and Cash Benefits, Santa Monica, Calif., Dec. 8-10, 1994.

U.S. Department of Education, Office of Special Education and Rehabilitative Services, Rehabilitation Services Administration. Annual Report to the President and to the Congress—Fiscal Year 1992—On Federal Activities Related to the Rehabilitation Act of 1973, as Amended. Washington, D.C.: U.S. Government Printing Office, 1992.

U.S. Department of Health and Human Services, Office of Inspector General. Audit of the Effectiveness of Title II Disability Work Incentives. A-13-92-00223. Washington, D.C.: HHS, Feb. 1993.

_____. Disability Applicants' Responses to Vocational Rehabilitation Issues: A Mail Survey. Draft report. OEI-07-90-00830, Mar. 1995.

_____. Missing Data Hinders Vocational Rehabilitation Referrals. OEI-07-90-00831. Washington, D.C.: HHS, Feb. 1995.

_____. Social Security Administration Payments for Vocational Rehabilitation. OEI-07-89-00950. Washington, D.C.: HHS, Apr. 1990.

U.S. Department of Health and Human Services, Social Security Administration. 1992-1994 Interim Report of Demonstration Activities under Public Law 96-265, Section 505 (a) (as Amended) and Related Activities. Washington, D.C.: HHS, Nov. 1994.

_____. Consistency of Initial Disability Decisions Among and Within States. No. 13-11869. Washington, D.C.: HHS, July 1980.

_____. Developing a World-Class Employment Strategy for People With Disabilities. A Briefing for Commissioner Chater and Principal Deputy Commissioner Thompson. Washington, D.C.: HHS, Aug. 1994.

_____. Plan for a New Disability Claims Process. Washington, D.C.: HHS, Sept. 1994.

_____. Proposals to Improve the Effectiveness of the Social Security Administration's Vocational Rehabilitation Program. Written statement of Louis D. Enoff, Deputy Commissioner for Programs, before the Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, 101st Congress, 2nd Session, serial 101-94. Washington, D.C.: Apr. 19, 1990.

_____. Report of the Disability Advisory Council. Washington, D.C.: HHS, Mar. 11, 1988.

_____. The Social Security Administration's Annual Performance Plan for Fiscal Year 1995 as Required of Pilot Agencies Under the Government Performance and Results Act of 1993. Washington, D.C.: HHS, Sept. 1994.

_____, Associate Commissioner for Research and Statistics. Memo to Associate Commissioner for Disability regarding results of 1994 2-day field office survey of disability applicants. Mar. 22, 1994.

U.S. Department of Health and Human Services, Social Security Administration, Office of Disability. Final Report and Recommendations Resulting From the Joint Vocational Rehabilitation Referral Task Force. Washington, D.C.: HHS, May 16, 1994.

U.S. Department of Health and Human Services, Social Security Administration, Office of Program Benefits Policy. State Assistance Programs for SSI Recipients. SSA Pub. No. 17-002. Washington, D.C.: HHS, Jan. 1995.

U.S. General Accounting Office. Disability for Addicts. GAO/HEHS-94-178R, June 8, 1994.

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

_____. JOBS and JTPA: Tracking Spending, Outcomes, and Progam Performance. GAO/HEHS-94-177, July 15, 1994.

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

_____. Self-Sufficiency: Opportunities and Disincentives on the Road to Economic Independence. GAO/HRD-93-23, Aug. 6, 1993.

_____. Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed. GAO/T-HEHS-94-121, Mar. 10, 1994.

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

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

_____. Social Security: Little Success Achieved in Rehabilitating Disabled Beneficiaries. GAO/HRD-88-11, Dec. 7, 1987.

_____. Social Security: Major Changes Needed for Disability Benefits for Addicts. GAO/HEHS-94-128, May 13, 1994.

_____. Social Security: Most of Gender Difference Explained. GAO/HEHS-94-94, May 27, 1994.

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

_____. Social Security: State Vocational Rehabilitation Agencies' Reimbursement for the Disabled. GAO/HRD-87-36BR, Feb. 3, 1987.

_____. Social Security Disability: Denied Applicants' Health and Financial Status Compared With Beneficiaries'. GAO/HRD-90-2, Nov. 6, 1989.

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

_____. Social Security Disability: SSA Quality Assurance Improvements Can Produce More Accurate Payments. GAO/HEHS-94-107, June 3, 1994.

_____. SSA's Rehabilitation Programs. GAO/HEHS-95-253R, Sept. 7, 1995.

_____. Supplemental Security Income: Growth and Changes in Recipient Population Call for Reexamining Program. GAO/HEHS-95-137, July 7, 1995.

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

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

_____. Vocational Rehabilitation: Clearer Guidance Could Help Focus Services on Those With Severe Disabilities. GAO/HRD-92-12, Nov. 26, 1991.

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

Hennessey, John C., and L. Scott Muller. "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work." Social Security Bulletin, Vol. 58, No. 1 (spring 1995), pp. 15-28.

_____. "Work Efforts of Disabled-Worker Beneficiaries: Preliminary Findings From the New Beneficiary Followup Survey," Social Security Bulletin, Vol. 57, No. 3 (fall 1994), pp. 42-51.

House of Representatives, Committee on Ways and Means, 103rd Congress, 2nd Session. Overview of Entitlement Programs, 1994 Green Book, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means. WMCP: 103-27. Washington, D.C.: U.S. Government Printing Office, July 1994.

Hunt, H. Allan, and others. "Disability and Work: Lessons From the Private Sector." Paper presented at the National Academy of Social Insurance and the National Institute for Disability and Rehabilitation Research Workshop on Disability, Work, and Cash Benefits, Santa Monica, Calif., Dec. 8-10, 1994.

Jensen, Allen C. Consumers' Experiences With Work Incentive Policies in the Supplemental Security Income and Social Security Disability Insurance Programs: An Exploratory Study. Elmhurst, Ill.: National Foundation for People With Disabilities, June 1990.

Koitz, David, and others. CRS Report for Congress, Status of the Disability Programs of the Social Security Administration, 1994. Washington, D.C.: Library of Congress, Congressional Research Service, June 1994.

LaScola Qualitative Research. Disabilities and Work: Perspectives of Disability Benefits Recipients. Focus group report prepared for the Disability Panel, National Academy of Social Insurance. Washington, D.C.: Nov. 1994.

Muller, L. Scott. "Disability Beneficiaries Who Work and Their Experience Under Program Work Incentives." Social Security Bulletin, Vol. 55, No. 2 (summer 1992), pp. 2-19.

Nagi, Saad Z. Disability and Rehabilitation: Legal, Clinical, and Self-Concepts and Measurement. Columbus: Ohio State University Press, 1969.

National Academy of Social Insurance. Preliminary Status Report of the Disability Policy Panel. Rethinking Disability Policy: The Role of Income, Health Care, Rehabilitation and Related Services in Fostering Independence. Washington, D.C.: Mar. 1994.

National Performance Review, Vice President Al Gore. From Red Tape to Results. Creating a Government That Works Better and Costs Less. Washington, D.C.: Sept. 7, 1993.

Okpaku, Samuel O., and others. "Disability Determinations for Adults With Mental Disorders: Social Security Administration vs. Independent Judgements," American Journal of Public Health, Vol. 84, No. 11 (Nov. 1994), pp. 1791-95.

Portfolio Associates, Inc. Work Incentive Marketing Project—Final Report. Washington, D.C.: Office of Disability, Division of Disability Program Information and Studies, Social Security Administration, Department of Health and Human Services, Jan. 1989.

President's Committee on Employment of People With Disabilities. Operation People First: Toward a National Disability Policy. Washington, D.C.: Mar. 28, 1994.

Rupp, Kalman, and C.G. Scott. "Determinants of Duration on the Disability Rolls and Program Trends." Paper presented at the Social Security Administration's conference on Disability Programs: Explanations of Recent Growth and Implications for Disability Policy, Washington, D.C., July 20-21, 1995.

Rupp, Kalman, and others. "Design of the Project NetWork Return-to-Work Experiment for Persons With Disabilities." Social Security Bulletin, Vol. 57, No. 2 (summer 1994), pp. 3-20.

Social Security Administration. Annual Statistical Supplement to the Social Security Bulletin. Washington, D.C.: SSA, multiple years.

_____, Office of Supplemental Security Income, Office of Disability. Red Book on Work Incentives—A Summary Guide to Social Security and Supplemental Security Income Work Incentives for People With Disabilities. SSA Publication No. 64-030. Washington, D.C.: SSA, Aug. 1995.

Stapleton, D.C., and others. "Demographic and Economic Determinants of Recent Application and Award Growth for SSA's Disability Programs." Paper presented at the Social Security Administration's conference on Disability Programs: Explanations of Recent Growth and Implications for Disability Policy, Washington, D.C., July 20-21, 1995.

Stone, Deborah A. The Disabled State. Philadelphia: Temple University Press, 1984.

Weaver, Carolyn L. Disability and Work: Incentives, Rights, and Opportunities. Washington, D.C.: American Enterprise Institute for Public Policy Research, 1991.

_____. "Privatizing Vocational Rehabilitation." Journal of Disability Policy Studies, Vol. 5, No. 1 (1994), pp. 53-76.

Related GAO Products

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

SSA's Rehabilitation Programs (GAO/HEHS-95-253R, Sept. 7, 1995).

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

Supplemental Security Income: Growth and Changes in Recipient Population Call for Reexamining Program (GAO/HEHS-95-137, July 7, 1995).

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

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

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

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

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

Disability Benefits for Addicts (GAO/HEHS-94-178R, June 8, 1994).

Social Security: Most of Gender Difference Explained (GAO/HEHS-94-94, May 27, 1994).

Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS-94-128, May 13, 1994).

Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994).

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

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (301) 258-4066, or TDD (301) 413-0006.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested