

**STRANDED ON DISABILITY: FEDERAL
DISABILITY PROGRAMS FAILING
DISABLED WORKERS**

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED FOURTH CONGRESS
SECOND SESSION

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WASHINGTON, DC
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JUNE 5, 1996
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STRANDED ON DISABILITY: FEDERAL DISABILITY PROGRAMS FAILING DISABLED WORKERS

WEDNESDAY, JUNE 5, 1996

**U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.**

The committee met, pursuant to notice, at 8:54 a.m. in room 562, Senate Dirksen Building, Hon. William S. Cohen (chairman of the committee) presiding.

Present: Senators Cohen, Reid, Burns, and Santorum.

Staff present: Mary Berry Gerwin, Elizabeth A. Liess, Sally J. Ehrenfried, Elizabeth M. Watson, Lindsey Ledwin, Theresa M. Forster, Amy Foley, Peter Brown, Patty Deutsche, Jerry Reed, Wayne Palmer, Lori Otto, Anne McMahon, and Theresa Stathas.

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

The CHAIRMAN. We're going to do something unusual today, we're going to begin ahead of schedule rather than behind. We have about 5 minutes to go until the appointed hour of 9 o'clock but since our first panel is here and I'm advised other members will be coming in throughout the morning, we should take advantage of this moment.

Over the past 3 years, the Special Committee on Aging has examined problems in the Social Security Disability Program and how weaknesses in these programs must be addressed if we're going to undertake meaningful entitlement reform.

Today, the Social Security trustees will once again sound the alarm that we have to act now to ensure the long-term solvency of the Social Security Trust Funds. Once the baby boom generation begins to retire, the cash-flow surplus for Social Security will rapidly decline. The projections are quite bleak.

The Social Security Trust Fund will run dry in the year 2029 and the Disability Insurance Trust Fund will go broke less than 20 years from now. If we do nothing to alter this course, the shortfalls in Social Security will cause the total Federal deficit to rise enormously undermining all of our efforts to achieve a balanced budget.

At the same time that we are reassuring senior citizens that we are keeping our commitments to Social Security, a very real threat has been silently creeping up on the system, namely the uncontrolled growth of the Social Security Disability Insurance Program.

This program, which provides cash payments to disabled workers who have paid into the Social Security system and the Supplemental Security Income Program, are among the fastest growing programs of the Federal Government.

Over the past decade the number of recipients under the age of 65 on disability insurance and SSI has risen from 4.2 million to over 7 million, representing an increase of almost 70 percent.

The explosive growth in these programs has direct consequences for senior citizens and indeed, for all taxpayers. Two years ago, the Social Security Retirement Trust Fund was called upon to bail out the Disability Trust Fund to forestall its impending bankruptcy. In other words, the Social Security Retirement Trust Fund must pay out almost \$500 billion simply to keep the Disability Insurance Trust Fund afloat until the year 2016.

The big losers in the shell game are future retirees since every time we transfer money to prop up the Disability Trust Fund, we are one step closer to Social Security's insolvency. The growth in the Federal disability programs is staggering. Each week, about \$1 billion in cash payments are sent to persons on the DI and SSI programs. Despite this huge outlay of Federal dollars, we're only now just paying attention to how these tax dollars are being spent.

The burden this places on workers over the next 25 years is simply unsustainable. As this chart shows, in the year 2025, disability insurance payments will rise to over \$200 billion while the number of workers bearing the costs of these benefits is going to drop dramatically.

Investigations conducted by this committee and the General Accounting Office over the past few years have revealed some shocking abuses and weaknesses in the disability programs. We found, for example, that many drug addicts and alcoholics were using their cash disability payments to buy more drugs and more alcohol.

We also found egregious cases of abuse in which translators and other so-called middlemen would defraud the Disability Program by lying about the medical conditions of the claimants. We've also reviewed widespread allegations that some parents have coached their children to feign mental impairments and behavioral problems in order to qualify for SSI benefits.

Finally, the committee has seen how even States have found the Federal Disability Program to be a good deal. Many States have developed aggressive programs, even hiring consultants to develop them, to shift persons off their own welfare rolls onto the Federal disability rolls. This cost-shifting game has proved to be a lucrative business for disability consultants who promise States greater savings if they shift these cases from the State rolls to the Federal programs.

Through welfare reform and other legislation, the Congress has begun to address these abuses. So far, however, we've only applied Band-Aid solutions while the Disability Program is hemorrhaging out of control. We're going to hear in testimony today that major flaws still exist in the disability programs. More and more new beneficiaries are coming on the rolls, yet fewer and fewer are ever leaving.

Often getting on the disability rolls means a lifetime of benefits, even for people who could with some rehabilitation, retraining or

assistive devices, return to work, and that is the focus of this morning's hearing. Today, we're going to focus on a report of the General Accounting Office that paints a disturbing picture of the disability programs.

As we will hear in the testimony today, the GAO has found a "Meaningful and growing portion" of persons on the Federal disability rolls who may be able to return to work but the Federal disability programs have done little to identify and encourage the productive capacities of these recipients.

Instead, the structure and incentives of the disability programs encourage lifelong dependency on the Federal rolls. Appallingly, only about 1 in every 1,000 persons on the disability rolls ever gets off the program through the rehabilitation efforts of the Social Security Administration.

The bottom line is that the Federal Government is sending a very mixed message on disability. We are making the workplace more accessible to the disabled through the Americans with Disabilities Act, the so-called ADA, but the Social Security Disability Programs weave a web of dependency that undermines all these efforts toward independence.

Today's hearing is going to identify how the current Federal disability programs impede efforts to return persons to work and how strategies from other disability systems, both private sector programs and disability systems in other countries, could be used to restructure the Social Security Administration's rehabilitation and work incentive efforts.

Today, we are pleased to have with us several experts who will provide their views on the barriers that currently exist in the disability programs. These obstacles range from the Social Security Administration's work incentive rules being too complex and difficult to understand, to major disincentives to work such as the fear of beneficiaries that they will lose their health insurance coverage if they return to work.

These experts will provide us with recommendations on how to improve SSA's rehabilitation and work assistance programs. We'll also see examples of assistive technologies that can be used to help persons with disabilities return to work and hear testimony about a very successful program being used within the Department of Defense to return its employees with disabilities to work.

Unfortunately, as this committee has seen many times before, the Social Security Administration has not done a good job—has done a poor job—of managing its programs and in promoting and recommending to Congress ways that the Federal disability programs can be improved.

I had hoped that by making the Social Security Administration an independent agency, it would result in more leadership on these important issues, but that has yet to occur.

As we review major criticisms of the Federal Disability Programs today, we should keep in mind that our goal is not to unfairly or callously deny disabled persons Federal assistance. Rather, the guiding principle in our review of the disability programs is to preserve benefits for those who truly need assistance and yet not entrap those who could and want to be independent.

We must not expect miracles and believe that most persons who are now on the disability rolls could be rehabilitated, find and keep jobs. Rather, our expectations must be realistic. Even if only 1 percent of the 6.3 million working age SSI and DI beneficiaries were to leave the rolls and return to work, cash benefits would be reduced by an estimated \$2.9 billion, almost \$3 billion.

With returns and potential gains as high as these, we owe it to the American taxpayers and to those on the program to undertake true disability reform.

Our first panel this morning is Jane Ross, director for Income Security at the General Accounting Office. Ms. Ross has testified on many occasions before the Aging Committee. We are pleased to have her present GAO's findings and she'll be accompanied by Ms. Cynthia Bascetta to help answer any questions we might have. Ms. Ross, welcome once again.

STATEMENT OF JANE ROSS, DIRECTOR, INCOME SECURITY DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY CYNTHIA BASCETTA

Ms. ROSS. Thank you. Good morning, Mr. Chairman.

You asked us to come today to discuss ways to improve Social Security's disability programs by helping beneficiaries return to work.

Each week, SSA pays over \$1 billion in cash benefits to people with disabilities on DI and SSI. While these payments provide a measure of income security for these beneficiaries, they do little to enhance their work capacities and promote their economic independence. At the same time, society now places a high value on the goals of economic self-sufficiency and the rights of people with disabilities to full participation in society.

At one time, the common business practice was to encourage someone with a disability to leave the workforce. Today, however a growing number of companies in the private sector have been enabling people with disabilities to return to work. Moreover, medical and technological advances provide more opportunities for people with disabilities to engage in work.

In our report, which you released in May, we found that DI and SSI are out of sync with these private sector trends. The application process, which presumes that people with certain impairments cannot work, places a heavy emphasis on work incapacity and SSA does little to provide the support and assistance many people with disabilities need in order to be able to work.

In fact, program design and implementation weaknesses hinder maximizing beneficiary work potential and, not surprisingly, out of the millions of beneficiaries, only 6,000 left the rolls in 1994 by returning to work. As you just said, if only 1 percent of those people on the rolls, just 63,000 people, returned to work, lifetime cash benefits would be reduced by about \$3 billion. So there could be a significant savings if only 1 percent of the people go back to work.

Other work we're doing for you highlights the strategies from the private sector and other countries that SSA could actually think of using or use as models to improve their own return-to-work process.

Before turning to these strategies, let me explain why we believe there is a reservoir of untapped work potential in the current sys-

tem. The Social Security Act requires that an assessment of an applicant's work incapacity be based on the presence of medically determinable impairments, either mental or physical.

The studies that we've reviewed generally agree that medical conditions by themselves are poor predictors of work incapacity. If you rely too much on medical conditions, you tend to understate work capacity. Indeed, we know that many people with severe impairments can and do work.

Also, weaknesses in program design impede return to work. The "all or nothing" decision to award or deny benefits creates an incentive for applicants to understate their work capacities. The focus on proving incapacity creates a disability mindset, thereby weakening the motivation to work, and the sheer length of the application process further erodes the skills, the abilities, and even the habits needed in order to be able to work.

Only after this demotivating experience are work incentives and vocational rehabilitation offered, and only to those who are awarded benefits. Furthermore, the work incentives are complex, difficult to understand, and poorly implemented, and they are often not enough to overcome a very legitimate fear of losing health insurance or the prospect of a substantial drop in income for those who would only be able to earn low wages.

Regarding vocational rehabilitation, only about 70,000 beneficiaries out of 1.2 million who come on the rolls each year are even referred to VR for services. Therefore, a very small proportion are even being sent for some assessment for services in the first place.

On the other hand, the private sector's new approaches to return to work programs stand in stark contrast to SSA's management of DI and SSI. A basic premise of these private sector programs is that helping employees return to work as soon as possible is good for the bottom line.

In addition to that, social insurance programs in Germany and Sweden follow similar strategies. This demonstrates that return to work extends beyond the private sector to government-scale programs that serve people with a wide range of impairments and work experiences.

Our analysis of these other programs reveals the importance of intervening as soon as possible after a disabling event; providing necessary return-to-work services and managing the cases and structuring the cash and medical benefits to encourage work.

So early interventions, especially those tailored to individual circumstances, can minimize the adverse consequences of impairments, and case managers can provide sustained support and follow-up often needed to ensure good outcomes.

Strategies like these reflect the expectation that people with disabilities can and do return to work, and they could be used to improve return-to-work outcomes for DI and SSI beneficiaries.

Certainly no one knows how much work potential exists in the DI and SSI population and our expectations for improved outcomes are tempered for the fact that almost half of those now receiving benefits are not likely to return to work because of their age or because they have a condition so severe that they may not live more than a few more years.

For the rest, research suggests that more likely candidates for work are younger people and those with greater motivation, more education, and more work experience. In fact, we find in the DI and SSI populations a significant number of people with a high school degree or greater, and some recent work experience.

Notwithstanding these promising statistics, even those with work potential will face significant challenges. Some may need the basics such as good work habits and self esteem to be successful. Some may have impairments that limit full-time work or that cause logistical obstacles such as transportation problems.

Finally, employer resistance to hiring people with disabilities and tight labor market conditions, particularly for low wage positions, could constrain employment opportunities.

Just to conclude, we believe that a culture change may be necessary at SSA toward an agency that looks first at how to help people to work while still assuring income security for those who cannot work. Such a change is consistent with SSA's fiduciary responsibility for the \$1 billion spent each week from the Trust Fund and the general revenues.

Mr. Chairman, this concludes my remarks. I'd be happy to answer any questions you may have.

[The prepared statement of Ms. Ross follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging, U.S. Senate

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SOCIAL SECURITY

**Disability Programs Lag in
Promoting Return to Work**

Statement of Jane L. Ross, Director,
Income Security Issues
Health, Education, and Human Services Division



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Social Security: Disability Programs Lag in Promoting Return to Work

Mr. Chairman and Members of the Committee:

You asked us to discuss today ways to improve the Disability Insurance (DI) and Supplemental Security Income (SSI) programs by helping people with disabilities return to work. Each week the Social Security Administration (SSA) pays over \$1 billion in cash payments to people with disabilities on DI and SSI. While providing a measure of income security, these payments for the most part do little to enhance the work capacities and promote the economic independence of these DI and SSI recipients. Yet societal attitudes have shifted toward goals, as embodied in the Americans With Disabilities Act (ADA), of economic self-sufficiency and the right of people with disabilities to full participation in society.

At one time, the common business practice was to encourage someone with a disability to leave the workforce. Today, however, a growing number of private companies have been focusing on enabling people with disabilities to return to work. Moreover, medical advances and new technologies provide more opportunities than ever for people with disabilities to work.

We found that the DI and SSI programs are out of sync with these trends. The application process places a heavy emphasis on work incapacity, and it presumes that medical impairments preclude employment. And SSA does little to provide the support and assistance that many people with disabilities need to work. Our April 1996 report shows, in fact, that program design and implementation weaknesses hinder maximizing beneficiary work potential.¹ Not surprisingly, these weaknesses also yield poor return-to-work outcomes. Other work we are doing for you highlights strategies from the private sector and other countries that SSA could use to develop administrative and legislative solutions to improve return-to-work outcomes. Indeed, if an additional 1 percent of the 6.3 million working-age SSI and DI beneficiaries were to leave SSA's disability rolls by returning to work, lifetime cash benefits would be reduced by an estimated \$2.9 billion.²

With this in mind, today I would like to focus on how the current program structure impedes return to work and how strategies from other disability systems could help restructure DI and SSI to improve return-to-work

¹This testimony is based on SSA Disability: Program Redesign Necessary to Encourage Return to Work (GAO/HEHS-96-62, Apr. 24, 1996) and a forthcoming GAO report on return-to-work strategies in the U.S. private sector, Germany, and Sweden.

²The estimated reductions are based on fiscal year 1994 data provided by SSA's actuarial staff and represent the discounted present value of the cash benefits that would have been paid over a lifetime if the individual had not left the disability rolls by returning to work.

outcomes. To develop this information, we surveyed people in the private sector generally recognized as leaders in developing disability management programs that focus on return-to-work efforts. We also interviewed officials in Germany and Sweden because the experiences of their social insurance programs show that return-to-work strategies are applicable to a broad and diverse population with a wide range of work histories, job skills, and disabilities. We also conducted focus groups with people receiving disability benefits and convened a panel of disability experts.

Background

DI and SSI—the two largest federal programs providing cash and medical assistance to people with disabilities—grew rapidly between 1985 and 1994, with the enrollment of working-age people increasing 59 percent, from 4 million to 6.3 million, and the inflation-adjusted cost of cash benefits growing by 66 percent. Administered by SSA, DI and SSI paid over \$50 billion in cash benefits to people with disabilities in 1994. To be considered disabled by either program, an adult must be unable to engage in any substantial gainful activity because of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last at least 1 year. Moreover, 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 do any other kind of substantial work that exists in the national economy.

Both programs use the same definition of disability but differ in important ways. DI, established in 1956, is an insurance program funded by payroll taxes paid by workers and their employers into a Social Security trust fund. The program is for workers who, having worked long enough and recently enough to become insured under DI, have lost their source of income because of disability. Medicare coverage is provided to DI beneficiaries after they have received cash benefits for 24 months. Almost 4 million working-age people (aged 18 to 64) received about \$34 billion in DI cash benefits in 1994.³

In contrast, SSI is a means-tested income assistance program for disabled, blind, or aged individuals regardless of their participation in the labor force. Established in 1972 for individuals with low income and limited

³Included among the 3.96 million DI beneficiaries are 671,000 who were dually eligible for SSI disability benefits because of the low level of their income and resources.

resources, SSI is financed from general revenues.⁴ In most states, SSI entitlement ensures an individual's eligibility for Medicaid benefits. In 1994, about 2.36 million working-age people with disabilities received SSI benefits. Federal SSI benefits paid to SSI beneficiaries with disabilities in 1994 equaled \$18.9 billion.⁵

Caseloads Have Changed Since the Mid-1980s

The composition of the DI and SSI caseloads has undergone many changes during the last decade. Between 1985 and 1994, DI and SSI experienced an increase in the proportion of beneficiaries with impairments—especially mental impairments—that keep them on the rolls longer than in the past. By 1994, 31 percent of DI beneficiaries and 57 percent of SSI working-age beneficiaries had mental impairments—conditions that have one of the longest anticipated entitlement periods (about 16 years for DI). In addition, the beneficiary population has become, on average, modestly but steadily younger since the mid-1980s. The proportion of working-age beneficiaries who are middle aged (aged 30 to 49) has steadily increased—from 30 to 40 percent for DI, and from 36 to 46 percent for SSI—as the proportion who are older has declined.

Statute Provides for Returning Beneficiaries to Work

The Social Security Act states that as many individuals applying for disability benefits as possible should be rehabilitated into productive activity. To this end, people applying for disability benefits are to be promptly referred to state vocational rehabilitation (VR) agencies for services intended to prepare them for work opportunities. To reduce the risk a beneficiary faces in trading guaranteed monthly income and premium-free medical coverage for the uncertainties of competitive employment, the Congress also established various work incentives to safeguard cash and medical benefits while a beneficiary tries to return to work.

Despite congressional attention to employment as a way to reduce dependence, few beneficiaries leave the rolls to return to work. During each of the past several years, not more than 1 of every 500 DI beneficiaries has been terminated from the rolls because they returned to work.

⁴Reference to the SSI program throughout this testimony addresses blind or disabled, not aged recipients. General revenues include taxes, customs duties, and miscellaneous receipts collected by the federal government but not earmarked by law for a specific purpose.

⁵The 2.36 million SSI beneficiaries do not include individuals who were dually eligible for SSI and DI benefits. The \$18.9 billion consists of payments to all SSI blind and disabled beneficiaries regardless of age.

Technological Advances and Social Change Foster Return to Work

While DI and SSI return-to-work outcomes have been poor, many technological and medical advances have created more opportunities for some individuals with disabilities to engage in work. Electronic communications and assistive technologies—such as scanners, synthetic voice systems, standing wheelchairs, and modified automobiles and vans—have given greater independence to some people with disabilities, allowing them to tap their work potential. Advances in the management of disability—like medication to control mental illness or computer-aided prosthetic devices—have helped reduce the functional limitations associated with some disabilities. These advances may have opened new opportunities, particularly for some people with physical impairments, in the growing service sector of the economy.

Social change has promoted greater inclusion of and participation by some people with disabilities in the mainstream of society, including children in school and adults at work. For instance, over the past 2 decades, people with disabilities have sought to remove environmental barriers that impede them from fully participating in their communities. Moreover, ADA supports the full participation of people with disabilities in society and fosters the expectation that people with disabilities can and have the right to work. ADA prohibits employers from discriminating against qualified individuals with disabilities and requires employers to make reasonable workplace accommodations, unless it would impose an undue hardship on the business.

Current Program Structure Impedes Return to Work

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

Social Security: Disability Programs Lag in Promoting Return to Work

Table 1: Summary of Program Design and Implementation Weaknesses

Program area	Weakness
Disability determination	<p>"Either/or" decision gives incentive to promote inabilities and minimize abilities.</p> <p>Lengthy application process to prove one's disability can erode motivation and ability to return to work.</p>
Benefit structure	<p>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.</p> <p>People with disabilities may be more likely to have less time available for work, further influencing a decision to opt for benefits over work.</p>
Work incentives	<p>"All-or-nothing" nature of DI cash benefits can make work at low wages financially unattractive.</p> <p>Risk of losing medical coverage when returning to work is high for many beneficiaries.</p> <p>Loss of other federal and state assistance is a risk for some beneficiaries who return to work.</p> <p>Few beneficiaries are aware that work incentives exist.</p> <p>Work incentives are not well understood by beneficiaries and program staff alike.</p>
VR	<p>Access to VR services through Disability Determination Service (DDS) referrals is limited: restrictive state policies severely limit categories of people referred by DDS; 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.</p> <p>Applicants are generally uninformed about VR and beneficiaries are not encouraged to seek VR, affording little opportunity to opt for rehabilitation and employment.</p> <p>Studies have questioned the effectiveness of state VR agency services since long-term, gainful work is not necessarily the focus of VR agency services.</p> <p>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.</p> <p>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.</p>

Work Capacity of DI and SSI Beneficiaries May Be Understated

The Social Security Act requires that the assessment of an applicant's work incapacity be based on the presence of medically determinable physical and mental impairments. SSA maintains a Listing of Impairments for medical conditions that are, according to SSA, ordinarily severe enough in themselves to prevent an individual from engaging in any gainful activity. About 70 percent of new awardees are eligible for disability because their impairments meet or equal the listings. But findings of studies we reviewed generally agree that medical conditions are a poor predictor of work incapacity.⁸ As a result, the work capacity of DI and SSI beneficiaries may be understated.

While disability decisions may be more clear-cut in the case of people whose impairments inherently and permanently prevent them from working, disability determinations may be much more difficult for those 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 work.

Program Weaknesses Impede Efforts to Improve Return-to-Work Outcomes

The "either/or" nature of the disability determination process creates an incentive for applicants to overstate their disabilities and understate their work capacities. Because the result of the decision is either full award of benefits or denial of benefits, applicants have a strong incentive to promote their limitations to establish their inability to work and thus qualify for benefits. Conversely, applicants have a disincentive to demonstrate any capacity to work because doing so may disqualify them for benefits. Furthermore, the documentation involved in establishing one's disability can, many believe, create a "disability mind-set," which weakens motivation to work. Compounding this negative process, the length of time required to determine eligibility can erode skills, abilities, and habits necessary to work.

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

⁸For example, S.O. Okpaoku and others, "Disability Determinations for Adults With Mental Disorders: Social Security Administration vs. Independent Judgments," *American Journal of Public Health*, Vol. 84, No. 11 (Nov. 1994), pp. 1791-95; and H.P. Brehm and T.V. Ruzh, "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. Neither do they allay the fear of losing medical coverage and other federal and state assistance that beneficiaries who return to work may face. Studies have identified the risk of losing medical coverage as a major barrier to beneficiaries' returning to work. Beneficiaries who work and continue to earn countable income above certain amounts will eventually lose medical coverage even though they have not necessarily improved medically or obtained affordable coverage elsewhere.

Finally, VR has played a limited role in the DI and SSI programs, in part because of restrictive state VR policies and limits on alternatives to providers in the state VR system. Beneficiaries are generally uninformed about the availability of VR services and are given little encouragement to seek them. Moreover, the effectiveness of state VR services in securing long-term financial gains has been mixed at best.

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

In contrast to SSA's disability programs, which have changed little over the years, some firms in the private sector are developing new approaches to manage the size and composition of their caseloads. Known as disability management, these approaches embody a proactive strategy for controlling disability costs by helping employees with disabilities return to work as soon as possible.

Disability managers in the U.S. private sector spend money on return-to-work efforts because they believe such efforts are sound investments that reduce disability-related costs. Studies have estimated that the full cost of disability to employers ranges from about 6 to 12 percent of payroll. Such costs include insurance premiums, cash benefits, rehabilitation benefits, and medical benefits paid through workers' compensation and employer-sponsored disability insurance programs. Companies may also incur additional expenses for training and using temporary workers and retraining employees with disabilities when they return to work. When businesses help workers with disabilities return to the workplace, they are able to reduce some of these costs.

Social insurance programs in Germany and Sweden also invest in return-to-work efforts, and their experiences show that the utility of return-to-work strategies is not limited to the private sector. Our analysis of practices advocated and implemented by the U.S. private sector and other countries reveals three common strategies in the design of their return-to-work programs:

Social Security: Disability Programs Lag in Promoting Return to Work

- Intervene as soon as possible after a disabling event;
- Identify and provide necessary return-to-work services and manage cases; and
- Structure cash and medical benefits to encourage return to work.

The practices underlying these strategies are summarized in table 2.

Disability managers we interviewed emphasized that these return-to-work strategies are not independent of each other and work most effectively when integrated into a comprehensive return-to-work program. Return-to-work strategies and practices may hold potential both for improving federal disability programs by helping people with disabilities return to productive activity in the workplace and, at the same time, for reducing program costs.

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

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

Early Intervention Critical to Return to Work

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

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

Identifying and Providing Return-to-Work Services Effectively

Another common strategy is to effectively identify and provide return-to-work services. This approach involves investing in services tailored to individual circumstances that help achieve return-to-work goals for workers with disabilities while avoiding unnecessary expenditures.

In an effort to provide appropriate services, many in the private sector strive to identify the individuals who are likely to be able to return to work and then identify the specific services they need. In doing so, each individual should be functionally evaluated after his or her medical condition has stabilized to assess potential for returning to work. When appropriate, the private sector uses case management techniques to coordinate the identification, evaluation, and delivery of disability-related services to individuals deemed to need such services to return to work. Transitional work allows workers with disabilities to ease back into the workplace in jobs that are less physically or mentally demanding than their regular jobs.

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

Work Incentives Facilitate Return to Work

Finally, disability managers responding to our survey generally offered incentives through their programs' cash and medical benefit structure to encourage workers with disabilities to return to work. Disability managers believe that a program's incentive structure can affect return-to-work decisions. The level of cash benefits paid to workers with disabilities can affect their attitudes toward returning to work because, if disability benefits are too generous, the benefits can create a disincentive for participating in return-to-work efforts. Disability managers also believe employer-sponsored medical benefits can provide an incentive to return to work if returning is the way that workers with disabilities in the private sector can best ensure that they retain medical benefits.

Although the structure of benefits plays a role in return-to-work decisions, disability managers emphasized that well-structured incentives are not sufficient in themselves for a successful return-to-work program. Incentives must be integrated with other return-to-work practices. Disability managers also generally advocated including a contractual requirement for cooperation with a return-to-work plan as a condition of eligibility for benefits. They believed such a requirement helps motivate individuals with disabilities to try to return to work.

Return-to-Work Outcomes Could Be Improved Through Restructuring

Return-to-work strategies used in the U.S. private sector and other countries reflect expectations that people with disabilities can and do return to work. The DI and SSI programs, however, are out of sync with this return-to-work focus. Improving the DI and SSI return-to-work outcomes requires restructuring these programs to better identify and enhance beneficiary return-to-work capacities. While there is opportunity for improvement, it should be acknowledged that many beneficiaries will be unable to return to work. In fact, almost half of the people receiving benefits are not likely to become employed because of their age or because they are expected to die within several years. For others, work potential is unknown; but research suggests that successful transitions to work may be more likely for younger people with disabilities and for those who have greater motivation and more education.⁷

⁷For example, J.C. Hennessey and L.S. Muller, "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work," *Social Security Bulletin*, Vol. 53, No. 1 (spring 1995), pp. 15-28; R.J. Butler, W.C. Johnson, and M.L. Baldwin, "Managing Work Disability: Why First Return to Work Is Not a Measure of Success," *Industrial and Labor Relations Review*, Vol. 48, No. 3 (Apr. 1995), pp. 452-67; and R.V. Burkhauser and M.C. Daly, "Employment and Economic Well-Being Following the Onset of a Disability: The Role for Public Policy," 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. 1994).

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Studies have shown that a meaningful portion of DI and SSI beneficiaries possess such characteristics. The DI and SSI disability rolls have been increasingly composed of a significant number of younger individuals. Among working-age SSI and DI beneficiaries, one out of three is under the age of 40.⁸ In addition, in 1993, 35 percent of 84,000 DI beneficiaries expressed an interest in receiving rehabilitation or other services that could help them return to work, an indication of motivation. Moreover, a substantial portion—almost one in two—of a cohort of DI beneficiaries had a high school degree or some years of education beyond high school.⁹ The literature also suggests that lack of work experience is a significant barrier to employability.¹⁰ A promising sign is that about one-half of DI and one-third of SSI working-age beneficiaries had some attachment to the labor force during the 5 years immediately preceding the year of benefit award.¹¹

Even those who may be able to return to work will face challenges. For example, some may need to learn basic skills and work habits and build self-esteem to function in the workplace. Moreover, the nature of some disabilities may limit full-time work, while others may cause logistical obstacles, such as transportation difficulties. Finally, employer resistance to hiring people with disabilities and tight labor market conditions, particularly for low-wage positions, could constrain employment opportunities.

Nevertheless, there are compelling reasons to try new approaches. As mentioned, our review of the disability determination process shows that the work capacity of an individual found eligible for DI and SSI benefits may be understated. And this country has experienced medical, technological, and societal advances over the past several years that foster return to work. But weaknesses in the design and implementation of the DI and SSI programs mean that little has been done to identify and encourage the productive capacities of beneficiaries who might be able to benefit from these advances.

⁸Annual Statistical Supplement, 1995 to the Social Security Bulletin (Aug. 1995).

⁹J.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. 42-61.

¹⁰Berkeley Planning Associates and Harold Russell Associates, "Private Sector Rehabilitation: Lessons and Options for Public Policy," prepared for the U.S. Department of Education, Office of Planning, Budget, and Evaluation (Dec. 31, 1987).

¹¹M.C. Daly, "Characteristics of SSI and SSDI Recipients in the Years Prior to Receiving Benefits: Evidence From the PSID," presented at SSA's conference on Disability Programs: Explanations of Recent Growth and Implications for Disability Policy (Sept. 1995).

Restructuring of the DI and SSI programs should consider the return-to-work strategies employed by the U.S. private sector and social insurance programs in Germany and Sweden. Lessons from these other disability programs argue for placing greater priority on assessing return-to-work potential soon after individuals apply for disability benefits. The priority in the DI and SSI programs, however, is to determine the eligibility of applicants to receive cash benefits, not to assess their return-to-work potential. In conjunction with making an early assessment of return-to-work potential, the programs should place greater priority on identifying and providing, at the earliest appropriate time, the medical and vocational rehabilitation services needed to return to work. But under the current program design, medical and vocational rehabilitation services are provided too late in the process. Finally, the programs should be designed to ensure that cash and medical benefits encourage beneficiaries to return to work. Presently, however, cash and medical benefits can make it financially advantageous to remain on the disability rolls, and many beneficiaries fear losing their premium-free Medicare or Medicaid benefits if they return to work.

Although SSA faces constraints in applying the return-to-work strategies of other disability programs, opportunities exist for better identifying and providing the return-to-work assistance that could enable more of SSA's beneficiaries to return to work. Even relatively small gains in return-to-work successes offer the potential for significant savings in program outlays.

Conclusions

In our April 1996 report, we recommended that the Commissioner take immediate action to place greater priority on return to work, including designing a more effective means to identify and expand beneficiaries' work capacities and better implementing existing return-to-work mechanisms. In line with placing greater emphasis on return to work, we believe that the Commissioner needs to develop a comprehensive return-to-work strategy that integrates, as appropriate, earlier intervention, earlier identification and provision of necessary return-to-work assistance for applicants and beneficiaries, and changes in the structure of cash and medical benefits. As part of that strategy, the Commissioner needs to identify legislative changes that would be required to implement such a program.

Social Security: Disability Programs Lag in Promoting Returns to Work

Mr. Chairman, this concludes my formal remarks. I would be happy to answer any questions from you and other Members of the Committee. Thank you.

Contributors

For more information on this testimony, please call Cynthia Bascetta, Assistant Director, at (202) 512-7207. Other major contributors included Carol Dawn Petersen, Senior Economist; Barbara Bordelon, Brett Fallavollita, and Ira Spears, Senior Evaluators; and Kenneth Daniell and Ellen Habenicht, Evaluators.

Related GAO Products

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

PASS Program: SSA Work Incentive for Disabled Beneficiaries Poorly Managed (GAO/HEHS-96-61, 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: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).

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

Vocational Rehabilitation Program: Client Characteristics, Services Received, and Employment Outcomes (GAO/T-PEMD-92-3, Nov. 12, 1991).

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

Social Security: State Vocational Rehabilitation Agencies' Reimbursement for the Disabled (GAO/HRD-87-368R, Feb. 3, 1987).

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The CHAIRMAN. Thank you, Ms. Ross.

Before we ask you questions, I want to yield first to Senator Reid.

Senator REID. I will submit my opening statement for the record. [The prepared statement of Senator Reid follows:]

PREPARED STATEMENT OF SENATOR HARRY REID

Mr. Chairman, thank you for holding this hearing which will focus on the potential for increasing the number of the Social Security Disability Insurance and Supplemental Security Income (DI/SSI) recipients who can return to work through rehabilitation and the use of assisted devices. I am very pleased that you have elected to return to this subject once again particularly in light of the fact that, as we will learn today from the witnesses, there is still so much more that can be done. I believe we need to continue to visit with this subject until we can assure those who are entitled to disability and want to return to work that this is a worthwhile option and is readily available to them. We should also return as long as necessary to ensure the American taxpayer that these programs are effectively and efficiently managed and have a solid philosophy which supports a return to work for those eligible.

When you look at the facts we learn that currently 1 out of every 1,000 DI and SSI beneficiaries leave the rolls as a result of the Social Security Administration's return-to-work assistance. Yet, a national survey found that four out of every five persons with disabilities who are not working want to work. It is obvious that there is a disconnect between program performance and the desires of the recipients. We must find out why this disconnect exists and take appropriate steps to correct this situation. I am confident having reviewed the GAO report, and the testimony of our witnesses, that we'll make tremendous progress this morning in learning more about what needs to be done.

I believe there are number of important factors which must be examined as we discuss reasons that keep individuals from returning to work. Quite frankly, the biggest block is that we are slow in recognizing that times have changed. Our entire attitude about disabled workers has shifted and with the passage of the American's with Disabilities Act, and tremendous technological improvements in assisted devices, its time we revisit our national return to work policies and embrace the changes that have occurred instead of continuing to support a system that appears to be quite literally "behind the times." We must deal with the reality that one reason people are not returning to work is that in all candor it has not been a priority of the Social Security Administration to get people back to work and agency resources have not been directed to this option. A critical issue that must be addressed is that beneficiaries fear that by working they will lose their entitlements. We must create incentives for individuals to work and not make staying out of the workforce a more attractive option. Meaningful work which allows an individual to contribute to his or her society is so essential in the development of a strong self-esteem. I believe we owe it to the 1/3 of current beneficiaries who may be in a position to explore this opportunity to structure a system which will give them that chance.

As we continue to debate the Federal budget and continually hear threats to reduce this program, or cut this benefit, I suggest another approach might be to do exactly what we are doing here today. That is, to talk openly about ways to improve our current delivery systems and even if it means a complete redesign of the way we've been doing business, let us have the courage to do things differently. Mr. Chairman, so much of what this committee has done under your leadership is to highlight areas where, with increased emphasis, costs can be brought down without jeopardizing those who deserve assistance from receiving that assistance. I thank you once again for your keen insight.

In my State of Nevada more than 33,000 individuals receive disability support from either SSI or DI. If current estimates that between 15-30 percent of the disability rolls may be in a position to return to work, this would indicate that perhaps between 4,950 and 9,900 of Nevada SSI/DI recipients would be potentially able to return to work if the right type of assistance and support were available. We should not delay our efforts one moment as any effort to assist individuals who have the ability, the desire and the access to enter, or re-enter the workforce, should receive our full commitment immediately. Any progress made in this vein will surely contribute to a more solvent Social Security Trust Fund in the future.

Mr. Chairman, I again thank you for your leadership on this issue and your outstanding leadership of this committee. It has been an honor serving with you and as I've said so many times before, upon your departure from the U.S. Senate at the

end of this term. Americans are losing a genuine statesman. The elderly of this Nation are losing a true champion. Again, thank you Mr. Chairman.

The CHAIRMAN. Senator Burns.

Senator BURNS. I would just ask that my formal statement be made a part of the record and we can go ahead and listen to our witnesses this morning.

Thank you very much.

[The prepared statement of Senator Burns follows along with prepared statements of Senator Pryor, Simpson, Jeffords, Craig, Kohl, and Warner:]

PREPARED STATEMENT OF SENATOR CONRAD BURNS

Mr. Chairman, I thank you for holding this hearing today. I know this is an issue that is important to you and I was glad to work with you to limit the benefits for alcoholics and drug addicts. But I, too, am concerned about the growing budget for SSDI and the lack of results in returning these folks to work.

It just makes sense that if we put more emphasis on returning to work, we are all better off. It costs the government less, it restores the self-esteem of the disabled, and it benefits our economy and our communities in the long run. I would like to see all government programs reviewed to ensure that we are promoting independence and if redesigning the programs is necessary, as the GAO had recommended in the case of SSDI, then let's get to work. Government funding is only a dirty word when the money is being piled on top of a problem, not being used to solve it.

Many of these programs, SSDI included, were designed decades ago and things have changed since then. We have a new workplace, we have new technologies, we have opportunities available that we could not have even imagined when we envisioned these programs.

I have to believe that most of the folks on SSDI would rather be working, would rather be productive members of our society—whether that means in a traditional office or out of the home. Our goal then, should be to make that dream come true. We need to tear down the barriers to return to work and redesign the way we identify the beneficiaries' work capacities.

Mr. Chairman, I am looking forward to hearing from our witnesses this morning. I am especially interested to hear from those who work in rehabilitation, since their input will come from the trenches and will be focused on what is needed and what is practical.

I may have to leave for another hearing this morning, but you can bet I will work with you, Mr. Chairman, to get these folks back to work, get this program running efficiently and, hopefully, reverse the trend of out-of-control spending in this area.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, thank you for holding today's hearing on the disability portions of the Social Security (SSDI) and Supplemental Security Income (SSI) programs. Through the years, this committee has demonstrated a continuing commitment to improving these Federal disability programs, and to ensuring their availability for those citizens in need in the years ahead. It has been my great pleasure to work with you in this area and on other important aging issues.

As we have learned from previous hearings, there has been rapid growth in disability program enrollments. While there will always be a large percentage of recipients who are unable to return to work because of the nature of their physical or mental impairment, it appears that a number of them might be able to return to work had they received appropriate assistance and support. Clearly, the independence and self-esteem that can result from participating in the workforce, and the accompanying reductions in costs to the taxpayer through reduced benefit outlays, are far preferable to continuing dependence.

Our witnesses today are expected to respond to the recent GAO report which seeks to explain why few Disability Insurance (DI) and SSI adult beneficiaries with disabilities are returned to gainful employment. The report concludes that, at best, 1 of every 500 DI beneficiaries leaves the rolls by returning to work. This figure leads me to conclude that we must examine our policies for Federal disability, and perhaps need to refocus our priorities from that of the distribution of benefits to return-to-work and self-sufficiency.

In particular, I'm hopeful we will examine private sector initiatives that have helped thousands of people return to work. I feel that the public sector could learn a great deal from private sector disability managers. As we will hear today, private disability managers have had much success in moving employees back into the workforce. Furthermore, I feel it is important to ensure that DI and SSI are able to respond to the individual needs of those who are eligible for coverage, while at the same time encouraging those who can work to re-enter the workforce.

I feel it is imperative that we examine why vocational rehabilitation (VR) has played such a limited role in the DI and SSI programs. The Rehabilitation Act of 1973 provides Federal funds to a network of State agencies to operate the country's rehabilitation programs. I hope we will be able to use the findings of this report to consider what we can do to encourage States to better inform program beneficiaries about the availability of services through vocational rehabilitative agencies. If a greater number of participants would utilize the agencies' resources, they might become more self-sufficient and reenter the workforce.

I also look forward to hearing about ways in which we can restructure the program so that it creates incentives for beneficiaries to seek rehabilitation and to re-enter the workforce. The "either/or" nature of the disability determination process seems to encourage applicants to understate their work capacities. Conversely, applicants have a disincentive to demonstrate any capacity to work because doing so may disqualify them for benefits. We must ensure that obtaining employment would not result in the penalization of program beneficiaries through lost medical coverage as well as the discontinuation of other Federal and State assistance.

Mr. Chairman, I look forward to working with you and our colleagues to ensure the efficiency and viability of these important programs. I want to thank all of our witnesses for taking the time to be here with us today. By working together, I am confident that we can contribute to the strengthening of the Social Security disability programs.

PREPARED STATEMENT OF SENATOR ALAN SIMPSON

I thank our fine Chairman, Senator Cohen, for focusing attention on the need to bring disabled people into the workforce and off the disability rolls. I have a deep interest in this issue, as I also serve as Chairman of the Subcommittee on Social Security and Family Policy.

Disability Insurance (DI) is clearly an important component of the Social Security Program. The disability rolls have grown so swiftly in recent years that, in 1994, the Social Security trustees warned Congress that funds for the DI program would be exhausted by 1995. Congress responded by reallocating a portion of the OASDI payroll tax toward the DI program. According to the trustees' 1995 annual report, this action extended the solvency of the DI program through the year 2016. The 1996 report, which is scheduled for release today, may well include some "adjustment" of this date.

As we look for various ways to slow the rapid growth of both the Social Security DI program and Supplemental Security Income (SSI)—without eliminating the "safety net" for the disabled—it is quite logical that we should place a greater emphasis on bringing recipients back into the workforce wherever that is possible.

I know that the vast majority of disabled people in Wyoming would much rather work than remain on the disability rolls. Through persistence and sheer determination, some of them have reclaimed their self-sufficiency. Unfortunately, for a variety of reason, too many others are simply unable to make the transition—even though they may be very sincere about wanting to do so.

In order to respond to the needs of the disabled, we need to know more about the problems they confront and the options that exist for maximizing their potential. This morning's hearing should contribute greatly to that learning process.

PREPARED STATEMENT OF SENATOR JAMES JEFFORDS

Mr. Chairman, let me commend you on your decision to hold this hearing on the work incentives in the disability programs. This is a very complex problem that we must deal with if we ever expect to get our Federal deficit under control.

I believe that few people are returning to work after becoming eligible for Social Security Disability Income (SSDI) not because they can no longer find gainful employment, but because of a greater systemic problem we face as a Nation. What I am referring to is this country's current schizophrenic national disability policy. The laudable policy we set forth in the Americans with Disabilities Act of 1990 (ADA) which requires that resources be provided to promote functioning and work for peo-

ple with disabilities, as well as, income support for those who cannot work or whose ability to work is very limited, are not well integrated into our current SSDI and SSI programs.

I remember when we reported the ADA out of the Labor Committee. The committee made explicit that the goals of this law were to provide people with disabilities with: equality of opportunity, full participation, independent living, and economic self-sufficiency. Disability is not just a characteristic of individuals, but is a description of how well someone is able to 'fit' into our society which includes his or her capacity to work. To provide for a clear and consistent national disability policy we must make sure that the incentives and goals of our public programs, SSDI, SSI, Medicare and Medicaid work in conjunction with the private sector.

Many disabled would like to return to work, but they are heavily penalized for their efforts to do so. For example, some courts have determined that if a person qualifies for SSDI, but then wants to try to go back to work and can't find a job, they have no cause of action under the ADA.

I believe that the greatest disincentive for disabled individuals to return to work is the fear of losing their health care coverage. These individuals literally may not survive without health care coverage. Their condition often requires immediate utilization of health services and they cannot go, for, even for a short period of time, without the security of knowing they have guaranteed health coverage. It is understandable that they would prefer not to work if it will jeopardize this lifeline.

Also in the labor market, despite the ADA, there is a disincentive to hire or maintain the disabled employee. The disabled employee will likely have a chronic high cost illness and if the employer offered a health plan they would be covered under this plan. It is important to keep in mind that all employer group health plans, both insured and self-insured, are covered under ERISA. Under ERISA, the employer currently has substantial flexibility in not only the benefits it chooses to cover, but also the types of plan design features it uses. Some employers have used plan design features which will "carve out" any high cost individual from coverage under the employee benefit health plan. With no where else to turn, disabled individuals once again become dependent upon public sector health care plans.

This cost-shift from the employer health plans to the public health plans was the main argument I made during debate on the Health Insurance Reform Act when I bought my amendment on the lifetime caps to the floor. Employers, by limiting the maximum benefits they will pay for employees in a lifetime, actually set the point where their costs will end and government expenditures begin. In the private market, health plans usually decide how much risk they will assume and then they reinsure the rest. In this case, the private market uses the government run health plans as the "reinsurer of last resort".

According to previous testimony by the General Accounting Office (GAO) no more than 1 of every 1,000 SSI and DI leave the rolls for work as a result of SSA's assistance. These programs need to place a greater focus on the role the employer can play in getting people rehabilitated and back to work. Once an individual becomes disabled the link with their current employer is disrupted and often terminated. If there were incentives, particularly early in the process, for the employer to remain involved the chances of returning to work go up markedly. The employer could focus on accommodating a valuable employee rather than on replacing him.

Employers could assist their workers in getting assessed for rehabilitation services immediately instead of waiting for the SSI or SSDI programs to first complete the application process and then making a referral for such services. If the employer were to keep in closer contact it would have better opportunity to prepare for any unique assistance the individual might ultimately need like a personal assistant or other assistance technology. I look forward to hearing from Dr. Susan Miller from the National Rehabilitation Hospital to learn more about these technologies.

In conclusion, when we look at restructuring the SSI and SSDI work incentive programs we must look not only at giving incentives to the individual to return, but also for the employer to maintain a continuous link with the employee.

PREPARED STATEMENT OF SENATOR LARRY CRAIG

Mr. Chairman, thank you for holding this very timely hearing.

With Congress committed to the enactment of Welfare Reform, it is clear that we must also keep Federal disability programs in our sights. The solvency of trusts must be reviewed regularly to make certain funds like DI and SSI remain available for beneficiaries today and in the future. Return-to-work is an important aspect of those programs—not only because of the rapid growth of disability expenditures and

concern over maintaining the programs' solvency, but also because it is an important way to help disabled Americans achieve their potential and lead fulfilled lives. In the State of Idaho, 21,818 disabled residents and their dependents rely on the assistance of SSI. Many of those Idahoans genuinely want to work. Federal programs should not prevent them from doing so.

I look forward to the opportunity to hear from our witnesses on this important matter. Certainly, creating greater incentives for disabled Americans to return to work, rather than burdening them, is a necessary and correct goal.

I thank our witnesses in advance for their help in bringing this issue to the attention of the Senate, and I look forward to hearing about their findings and their recommendations for policy changes in the future.

PREPARED STATEMENT OF SENATOR HERB KOHL

Thank you, Chairman Cohen. Compared to the continuing debate on the Medicare trust fund situation, this Congress has spent relatively little time on the daunting issues threatening the solvency of the Social Security system.

The other side of the Social Security Trustees' Report released today will affirm that retirement and disability programs are also in serious trouble.

The Aging Committee has helped shed light on abuses and weaknesses in Social Security programs, particularly concerning SSI. Increased disability reviews were required under recent legislation and qualifications were tightened in relation to substance abuse.

Those efforts were a good start. But much more needs to be done to address the looming Social Security retirement and disability funding crunch.

Disability programs have seen a 70 percent increase in the number of beneficiaries over the last decade. The amount spent on the SSI and DI programs has grown 66 percent over that period, from \$23 billion in 1985 to \$53 billion in 1994. Because Federal disability beneficiaries also qualify for Medicare and Medicaid, the actual costs have hit \$101 billion.

The growth of these entitlement programs must be restrained and their focus shifted from simply handing out checks, to breaking down barriers that hinder return to work. This is not just a fiscal imperative, it is a matter of doing what's right for those challenged with functional limitations.

On the road to re-employment, people with disabilities face tremendous challenges. The mere act of qualifying for benefits means that you can't meet "substantial gainful activity" criteria. That process drives home the message that you shouldn't be working.

To make matters worse, many disability managers don't know what help is available to get people to work; or, they send beneficiaries on a confusing search for assistance and are unable to track progress. Finally, and perhaps most critical, once a person works their way into a job, they risk losing health coverage. Even though their expensive health needs remain, access to benefits is uncertain and often lost.

The social security disability programs must be reformed to maximize self-sufficiency. This hearing presents an opportunity to address, in an affirmative way, potential changes to ensure that those with disabilities have the means to get back to work.

Mr. Chairman, I would also like to take this opportunity to thank Mary Ridgely, the Executive Director of Employment Resources, Inc. of Madison, WI, who has come to testify today. I am sure the committee will benefit from her extensive experience with employment issues and work incentives.

PREPARED STATEMENT OF SENATOR JOHN WARNER

Mr. Chairman, I am pleased to join this morning's hearing as we look into the continuing challenge to our disabled population of returning to the workforce.

When President George Bush signed the Americans with Disabilities Act into law, the Nation entered a new Era of Civil Rights for the disabled. The American working environment was to become one of accommodation for the handicapped and chronically disabled as long as it did not cause undue financial hardship for the employer.

Furthermore, in the workplace we have seen the advent of supported employment, that is, the practice of local government rehabilitation agencies sending necessary financial and technical support to particular job sites to better enable individuals with disabilities to remain in their jobs.

With efforts underway to make the workplace more accommodating, our next focus must be on the individuals themselves.

It is a common occurrence that individuals who qualify for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) become so reliant on their benefits that they are reluctant to endanger their entitlement by returning to work, even though they may be physically able to perform some manner of employment.

American disability programs offer to the disabled what some have called "golden handcuffs". If a disabled individual has become eligible for SSI, it is also likely that he or she is receiving assistance through Medicaid, Food Stamps, Housing Subsidies, and other Social Welfare programs.

It is perfectly understandable that the disabled fear to lose these critical benefits, particularly Medicaid, when chronic conditions require continuing medical attention, and there is the all too real possibility that an entry level job may not have health insurance or that coverage for pre-existing medical conditions is excluded.

That is why it is vital that "back to work" programs for individuals with disabilities include flexible, transitional benefits. If we can assure people on the SSDI and SSI roles that they can continue to qualify for Medicaid for themselves and their families, childcare for those with young children, as well as nutrition and housing assistance, we will be removing the most significant obstacles to returning them to lives as productive taxpaying citizens.

No two individuals are alike. Transitional benefit programs will often have to be "hand tailored" to meet the needs of individuals and their families—some may need benefits for 6 months, others for a year. It can work, though, and it is worth the investment of government resources.

Today we are to look more closely at this program and see where the government has had some successes and where our efforts can hopefully do the most good.

I look forward to reviewing our panelists' recommendations.

The CHAIRMAN. Both of your statements will be included in the record.

Ms. Ross, it seems we're playing the same tune over again this year. I think just about a year ago we had a hearing dealing with this very subject matter. We had Mary Jane Owen who came and testified.

You may recall this was an extraordinarily talented lady who was blind and had other disabilities in terms of being able to get around and she tried for years to persuade the Social Security Administration to allow her to accumulate enough money to buy, as a I recall, a specialized computer.

Ms. ROSS. Right.

The CHAIRMAN. That would allow her to work at home. They refused and she, through the help of friends and associates, was able to accumulate enough to buy a computer, start her own business, and the fact is, the checks kept coming.

The Social Security Administration kept sending her checks—she had accumulated, as I recall, some \$16,000 in checks that she refused to cash that she presented to the committee last year saying, all I wanted was to be allowed to accumulate enough money to get a computer so I could be independent and productive. Yet, the answer was, you can't do that. She did it, and I think to the embarrassment of the Administration itself.

Here we are a year later and I was just inquiring of my staff, Mary Gerwin, didn't we cover this last year and she said, yes. But, the situation is worse now. You see that chart and those numbers and if you read today's Washington Post or any major newspaper, what's taking place with the Medicare Trust Fund: now the trustees are saying, we were off a year; it's not going to be broke in 6 years, it's going to be broke in 5 years.

We are faced with a similar situation in the Social Security Disability Trust fund, that it is the year 2016. That is not that far

away before we'll have the disability insurance fund nearly bankrupt again.

That is why we're here today to see if we can't at least call more attention to the need to reform what you call the culture.

Question, how does one reform the culture of an agency, an independent agency at this point? What more do we have to do?

Ms. ROSS. That's a tough question. I'm not entirely sure of how to do it but I do have a couple of examples of places where it's been done.

In the welfare/AFDC programs, there has been a significant transformation in the past couple of years from programs that basically provided cash benefits and had no requirement for people to go to work, to a system that now, in at least 31 States, has work incentives so that people who are coming to get cash benefits know that they are being required to return to work.

One of the issues they had to deal with in these States was changing the culture in the welfare offices. They had to move from a place where people thought about the beneficiaries as a group to whom they simply provided cash and maybe some social services to a group where the first thought was how can we put these people back to work. That kind of transformation seems to have happened in many welfare offices, although it's not complete as yet.

Also, our understanding of the situation in Sweden is that Sweden had a social security disability system that, much like ours, was pretty much focused on cash benefits. They intentionally changed from that kind of system to a much more vocationally oriented or work-oriented system. So it is clearly possible to make this transformation not just in a welfare system, but in the disability insurance system as well.

Somehow the leadership of the agency, and I suppose the administration, have to be convinced this is the direction in which to go.

The CHAIRMAN. What you're saying then is it has to be early intervention with the notion that those who are receiving disability payments also are being helped, if they can be helped, and encouraged to think about work once again after a period of training, or rehabilitation, but an early intervention.

As I understand the current system, it takes several months to even qualify for payments and then payments don't start for 5 months. You have to wait at least 5 months, so you've got several months before you even qualify and then you've got another 5-month delay. You're talking close to better than half a year, perhaps closer to a year of being unable to go to work, not encouraged to go to work before you receive the first check.

We've already built-in the mindset for people not to even think about going back to work for that first year. That's in contrast to what I think you're telling us that if you have a system whereby there's an early intervention for those who have the prospect of being rehabilitated, who want to be rehabilitated or retrained and who are physically or mentally capable of doing that, then you turn the mindset to saying, gee, I can't wait with this assistance to get back to work with a little help from my friends, as such.

Is that the essence of it?

Ms. ROSS. I think that is the essence of it. I think you captured it very well.

The CHAIRMAN. SSA gets a lot of criticism on this for not really meeting its responsibility, but it's supposed to work with other departments—the Department of Education for one. Have you seen any indication that the Social Security Administration does, in fact, coordinate with the Department of Education?

Ms. ROSS. I think we've seen evidence of very limited cooperation, but I think we're not in a position to really assess what might happen if SSA took a much more active leadership role. They're both interacting at a relatively low level at this point.

If SSA stepped out, which we think they should because they have a fiduciary responsibility to manage this program more effectively, then we could better assess how other agencies like the Department of Education might fall in line.

The CHAIRMAN. I've got one initial question for you and then I'll yield to my colleagues for some. It's puzzling to me and I'm somewhat confused by it.

In your statement, you've indicated that the current test that we have for disability today, and perhaps we should distinguish between those on SSI versus those on disability insurance, maybe you can do that in your answer, but the test we use is a medical test of impairment, either physical or mental, that would preclude that individual from engaging in any type of work not only in the job that he or she is accustomed to performing but any type of work. So it's a medical-type assessment of impairment.

You seem to criticize that as being inappropriate, that we ought to move to a more functional assessment, right?

Ms. ROSS. Yes.

The CHAIRMAN. The problem I have is that also in your statement, you've indicated we have more and more children under the age of 18 who are coming onto SSI disability rolls. There, GAO has criticized the functional assessment being used as being too subjective so that it gives those making the analysis a lot of subjective flexibility in saying whether that person is functionally incapable of performing certain tasks.

How do you reconcile, on the one hand, moving from the medical impairment phase to a functional assessment criticizing, on one hand, the children who are being evaluated saying it's too much flexibility and subjectivity. Now you want to apply that standard to those who are mature citizens, as such, over the age of 18? How do you reconcile that?

Ms. ROSS. I'm relieved to tell you I have an answer for that.

When we're talking about adults, in both the disability insurance program and the SSI program, you assess someone's disability in the same way. The first part of the assessment is to see if people have an impairment which is sufficient to meet a medical listing. If you meet a medical listing, then you're considered by SSA sufficiently impaired that you would be unable to work.

Our critique of that is that at the moment, 70 percent of the people coming onto the beneficiary rolls either meet or equal these medical listings which means that by their medical impairment alone, they're being assessed as incapable of working. That means that only about one-third of the people or a little less are actually having a full, functional assessment of their ability to work.

We think more people ought to be evaluated in terms of their functional capacity, not just on their medical condition. Everybody's medical condition certainly needs to be assessed but that determines only whether you have an impairment or some sort of a physical or mental problem that's sufficient, that impedes the way you live your life.

Then you want to specifically ask how it interacts with your work capacity and that's the part we think is missing for too many people.

You're right, when we talked last year about children and functional assessments, we came at it from a slightly different angle. When you talk about children, you can't be measuring their ability to do work; you're measuring, instead, their age appropriate behaviors, which are, I would contend, a much fuzzier kind of evaluation.

Our sense for children is that trying to assess age-appropriate behavior was something that needed to be tightened, while on the adult side, you're looking for ways to assess functionality for work which ought to be a much more concrete assessment. Functional assessments of work capacity are not easy but in the adult case, we think we need more emphasis on that.

The CHAIRMAN. Senator Reid.

Senator REID. I visited a Social Security office in North Las Vegas, NV and although they were closed, a number of them waited around to visit with me.

Without exception, they said the biggest problem was parents who say their child has learning disabilities, and they go to Social Security and automatically get so much money a month. They don't need a doctor's certificate or anything. Are you familiar with that?

Ms. ROSS. I'm familiar with that kind of accusation. I think it's not exactly accurate.

Senator REID. Why isn't it accurate?

Ms. ROSS. You need to have, as we were saying before, some significant amount of functional assessment, longitudinal data about the child's ability to function age-appropriately.

Senator REID. They said in the entire State of Nevada, all you have to do is go down and say your child has learning disabilities. How can they refute it what can they say, the social security worker? No matter what the rules might say, that's how it operates in practicality.

Ms. ROSS. There are certainly steps in the procedure that require the State Disability Determination Service, which does this evaluation, to try and get evidence from teachers and from other people who know this child and if it's the kind of impairment where there might be some objective medical or psychological tests that you can do, to conduct those tests.

Senator REID. These people told me that there are some families, all their children get this money and they have the considered opinion that there is nothing wrong with them.

Ms. ROSS. There are some families that have more than one child on the program.

Senator REID. It's tax-free money, recipients don't pay taxes on it. You don't feel that's a problem?

Ms. ROSS. We did some work on this issue of childhood disabled cases on the SSI program last year and Senator Reid, we did think

the program ought to be tightened significantly. I'm not sure how frequent it is to have the cases adjudicated the way you said but we have a general concern that is similar to yours that the program needs to be tightened.

Senator REID. They had a number of complaints about how the system was run but that was their biggest. They said that people learned how to use the system and they had a number of instances where if you have a number of children, I think it's \$250 a month or something like that you get per child?

Ms. ROSS. Over \$450 per month if you have little other income.

Senator REID. They indicated that some people just don't work and they have enough kids that they get this tax-free money.

On the Federal level, one of the problems we've had with the non-disabled in retraining programs is when people lose their jobs because of the changing workforce. We've found that one of the problems is that there are so many Federal programs to retrain, to allow people to reenter the workforce at some different level, that it's almost impossible for people to work their way through this myriad of programs.

One of the things we try to do on a bipartisan basis—we haven't been real successful—is to eliminate many of these Federal job training programs and turn it over more to the private sector with a voucher system.

In the area of disabilities, when trying to return them to the workforce, are there some of the same problems there as exist in those that aren't disabled? Do you understand the question?

Ms. ROSS. Yes, I do. I think I have two things to say about it.

I think it's a slightly different issue if you are disabled and the way you enter the disability system is to come into social security because the thing we are most concern about is not that you'll find too many programs, it's that no one will help you link to any program.

Senator REID. That's a totally different problem then.

Ms. ROSS. Well, in that dimension, I think it is different and what we think ought to happen is there ought to be a much more active involvement at the first stages of your involvement with SSA, that people direct you to these programs, any sort of retraining and rehabilitation programs.

The other part that is a concern at SSA for many of us is that to the extent people are directed to vocational rehabilitation, it tends to be just to the State VR agency. We think there is potential for a lot more private sector involvement in VR for these people particularly those with severe disabilities.

Senator REID. Have you found in your study—which I'm sorry I'm not familiar with, my staff has given me an outline of it but I have not familiarized myself with it—a priority among Social Security Administration to get people back to work who are disabled? Four out of five want to work but is it a priority of the Administration to get people back to work?

Ms. ROSS. It has not been a priority of SSA and one of the things we mean by talking about a culture change is we think the Social Security Administration ought to put much more priority on trying to return people to work, that if you're really going to manage a program like this well, one of the things you need to do is make

sure that the people on the program are the people who have to be there.

That means trying to help people who could leave the program leave, both for the program's benefit and their own. We don't see that Social Security has put nearly enough emphasis on that.

Senator REID. The last question is what could we do to create incentives either for the Administration and/or individuals to get back into the workforce?

Ms. ROSS. There are a lot of proposals that people have made for kinds of changes. One thing is, if we could all figure out how to do it is to encourage this culture shift at SSA that changes their priorities.

Beyond that, we think we ought to be looking at ways to get people involved with rehabilitation much earlier in the process, follow the cases more carefully and make sure that individuals get what they need instead of getting lost out there with all of the different service providers, and that the set of work incentives that are actually made available to people are first of all, understandable, and second, work as incentives instead of disincentives.

Senator REID. Thank you.

The CHAIRMAN. Senator Burns.

Senator BURNS. Just a couple of questions. Thank you, Mr. Chairman.

Along that same line, according to the GAO report, Ms. Ross, those people with disabilities who receive DI and SSI has nearly doubled in the last 10 years. That's an alarming figure, especially when our population hasn't doubled in the last 10 years. Can you tell me why the sudden increase or explosion in this regard?

Ms. ROSS. I think there are several reasons for the growth in the disability programs which occurred in the early 1990's.

One of the things is that there were some changes in the eligibility standards so that the mental impairment listings and the law related to mental impairments was changed in a way that more people with mental impairments came on the rolls.

There was also a poor economy and there seems to be little doubt that when the economy is in a downturn, maybe some people who are disabled who have jobs become unemployed and they find it too difficult to get another job, so they leave the workforce.

The CHAIRMAN. Could I interrupt for a second because while a dip in the economy does, in fact, increase the rolls, when the economy improves, the rolls keep increasing, so it's not a direct correlation between a poor economy and the increase in the disability rolls. When the economy is up, the rolls are still increasing, so it goes beyond that.

Ms. ROSS. It's not the only factor. There's also been a significant amount of program outreach for the SSI Program, which has encouraged people who are eligible to enroll.

There have been very few continuing disability reviews as well. Continuing disability reviews are designed to assure that if you're on the program that you're still medically eligible. Not enough of those assessments have been done so that meant that fewer people were leaving at the back end of the program.

There have been State efforts to shift cases from welfare and general assistance rolls onto the SSI rolls.

So there are a variety of factors and I've tried to touch on several of them.

Senator BURNS. We used to do a thing at the county level when I was a commissioner where we used to have a thing called foster care review. We also went with social workers and we did some review of people that were on programs there every week.

Does the SSA have, at the local level, people that visit every week and reassess situations of everybody that's on the program?

Mr. ROSS. They certainly don't have them every week.

Senator BURNS. I'm not saying we covered every one of them; we'd only take say 10 cases out of maybe 100 but we would cover a few every week. We would have a regular working lunch where we worked an hour-and-a-half on just reviewing different cases.

Ms. ROSS. We think one of the things Social Security ought to do to better manage its programs is the kind of thing you're talking about which is keep in more continuous contact with the beneficiaries.

One way you do that is through having periodic reviews of their medical status; another way is to find out something about their financial status if they're on SSI, which is a means-tested program.

There are people in the DI and SSI programs who are rarely, if ever, contacted by the Social Security Administration. There's more opportunity there, as you point out.

Senator BURNS. It looks like we should be—and maybe this is taking on too much and asking too much—how much interaction is there with your organization, say SSA and the private sector for job placement of people once they become available and should be going back into the workplace?

Ms. ROSS. Very few of SSA's beneficiaries are even referred to the Vocational Rehabilitation Service. For those that are, some of them get job referral help and most of them don't. So there's very little contact with people who might help with direct placement of jobs. We could do a lot more of that.

Senator BURNS. It just seems to me that we should work and be an advocate for the person and also set up the framework to where we might have some sort of interaction with the private sector that provides jobs.

It seems to me and it seems this is where we get into this culture thing that once we get so many people on the rolls, so to speak, then it's a make-work situation that maybe a person that's working within the Social Security organization says, pretty soon I'm going to run out of anything to do and they'll do away with my job. I think there's a little bit of make work which is done.

I would hope that we could get an advocacy program inside SSA somewhere to maintain a liaison with the private sector that when jobs come available and you have people that are ready to go into those jobs and want to do so, that we could start recommending that.

I just feel we could take a positive step in that direction because I hear the same thing that Senator Reid hears in our offices in Montana—that we are not advocate for the person to move them in, because I don't know of any of those people that when they're ready to go to work, they want to go to work. They would rather

be in the workplace than they would just standing in line and waiting for a check.

Ms. ROSS. You're talking about a cultural change. I think Social Security has been incredibly well meaning in thinking that the people that are its beneficiaries and applicants are people who are incapable of working, and I think what GAO is saying is we think you ought to take a second look.

There's no question these people are severely impaired, very severely impaired, but many severely impaired people work, especially if they get some help.

Senator BURNS. Do you have any kind of assessment of what our figure might be on how bad is fraud and abuse?

Ms. ROSS. I can't put a number on it but at GAO, we have tried to pinpoint several places where we thought the Social Security Administration ought to be paying a good deal more attention, especially to eligibility determinations. They haven't been careful enough about drug addicts and alcoholics and immigrants and some other groups where a lot of tightening is needed, especially in the SSI program.

Senator BURNS. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Santorum.

Senator SANTORUM. Thank you, Mr. Chairman.

A few years ago, we passed a law that required SSA to do more CDR's. Can you give me a report of how those have been going, if you can tell me that?

CDR's are an appropriate place to do an evaluation of whether these people should be put in some sort of program to get them back to work? Is that an appropriate point where the contact is made with the recipient to make a determination as to whether they are in fact capable of work at some level and whether a re-training program would be appropriate?

Ms. ROSS. With regard to the CDR's and the legislation, you certainly recall that one of the pieces of legislation was to require 100,000 CDR's be done on SSI beneficiaries. We've been monitoring that for the House Ways and Means Subcommittee on Human Resources where I think you helped pass that bill.

It looks at the moment as if those CDR's on the SSI cases will be done beginning this year, 1996. They're supposed to be doing 100,000 a year and Social Security plans to do them.

The one caveat they have on that is that they now have to deal with this drug addicts and alcoholics population which also will have to be reevaluated or evaluated, so they have some workload problems.

As you know, in addition, just the last couple of months, there was also a change in the way funding could be done for CDR's and SSA is at the moment trying to vastly expand the number of CDR's it's doing for both DI and still getting those SSI ones done. So we expect to see a lot more CDR's done in the next several years.

Senator SANTORUM. Can you give me any information as to what the cost benefit has been with respect to the CDR's? What are we finding out there with these CDR's?

The CHAIRMAN. Would you, for the viewing public, explain CDR?

Ms. ROSS. I'd be glad to. A CDR is a continuing disability review, which means that medical evidence is gathered again in order to

evaluate whether you still meet the standards, whether you have sufficiently improved that you ought not to be on the program.

Senator SANTORUM. What kind of results are we getting as a result of these continuing disability reviews?

Ms. ROSS. The cost benefit seems to vary between 6 to 1 and 4 to 1 depending on which groups of people you're talking about, but they're significantly cost beneficial. Certainly they will remain cost beneficial as long as you're working off this large backlog of cases where you can try and pool the cases which have the most potential for having recovered.

Senator SANTORUM. That was the argument that Social Security used, that there would not be a good cost benefit of doing these. What you're suggesting is, in fact, there is?

Ms. ROSS. Yes, there is. There still is even though they may have creamed off some of the most likely cases; there are still plenty of cases for them to examine.

They aren't finding that many people who are ineligible. By the time people go through the appeals process, it's only about 6 percent of the people they review actually come off the rolls. Nonetheless, even at 6 percent, it's still cost beneficial.

Senator SANTORUM. Can you now move to the question as to whether during the process of doing the CDR, is that an appropriate place to look at the potential for someone to go through rehab or to have some sort of training, whatever is necessary to move them into the workplace?

Ms. ROSS. You're touching on one of our recommendations, but I'll go ahead with it.

We think it is a place that we ought to talk again with beneficiaries about rehab. They've been on the program for some period of time; whether or not they come to the CDR and are found to be no longer eligible for benefits or they are eligible and will be continued for at least several more years, you have them there, you've done an assessment and it seems like a perfect time to try again to talk to them about rehabilitation.

Maybe for some people, it is an even better time than at the beginning. They've been on the rolls for a while, their lives have stabilized and they understand what this is and isn't doing for them, so maybe it would be a good opportunity to be pretty aggressive.

Senator SANTORUM. Can you tell me a little bit about the outreach program? You mentioned that as one of the reasons for continuing. I know many of us have had some concerns about the extent of the outreach. My understanding was this program was scheduled to continue to expand. Is it still expanding and what are the results? Is that one of the reasons you're seeing some of the State shift is because of the outreach? You're now seeing people on State benefits shifting to Federal benefits because of this outreach.

Ms. ROSS. Those may be two different efforts. We haven't looked in the past several months at outreach activities. We did look at it for you last year and found there had been a series of both congressional mandates and SSA initiatives to be sure that all the people who might be eligible for SSI knew about the program and it did seem to be resulting in additions to the rolls. I don't know if that's still going on.

We have tracked more recently States themselves initiating or helping people to move from the State rolls to the SSI rolls. That makes the beneficiary better off because SSI benefits tend to be more generous and it certainly makes the States better off because they pick up only the State supplemental benefit, if any, instead of the State match for AFDC or State-only general assistance.

It doesn't do a whole lot for the general revenues of the Federal Government, however. We found that a lot of States had been engaged in that kind of cost shift in order to move people to the SSI program.

Senator SANTORUM. Just to clarify your response on the outreach, you say you don't know whether it's continuing. Are you suggesting these outreach and monitoring centers are not out there anymore?

Ms. ROSS. No. I'm just saying the GAO hasn't looked at that or hasn't monitored what's going on in that area for the last several months.

Senator SANTORUM. But when you did look at it, you saw, and I found this to be somewhat incredible, that, in fact, we are out there going and in a sense recruiting them to be on this program, people who are not eligible? Is that a good way of characterizing it or am I too harsh?

Ms. ROSS. Well, people were being recruited but I think they were eligible. They were just being recruited aggressively to make sure they knew about the program.

Senator SANTORUM. Thank you, Mr. Chairman.

The CHAIRMAN. I think what we are searching for here is some kind of balance and I've been at either extreme of this particular debate. Back in the early 1980's, 1981, and 1982, you may recall that the Administration at that time had adopted a sort of computerized profile and anyone who fit the profile was automatically being notified that their disability payments were being terminated.

At that particular time, I raised serious concern that this was not a fair way to deal with people on disability, that we had to have some human contact and some process along the way from the first evaluation to either the denial or the review of that appeal of that denial. But simply relying upon a computer was not a fair way to treat people who were disabled.

Then we went to the other extreme it seems to me. There's one individual I know about in my home State who has just bought a brand new motorcycle and was out riding around on it. To my dismay, I found that he had been judged to be totally disabled because of nerves. He couldn't work because he had nerves. It occurred to me, if he's so nervous he can't work, how can he ride a large motorcycle all around town?

Ms. ROSS. That would make me nervous.

The CHAIRMAN. It would make most people nervous and it calls into question someone's judgment in terms of whether or not that individual is truly disabled.

I raise that because I believe Senator Burns raised the question about people who are severely impaired. I have a young man working in my office who was born without any arms. He handles all of my disability cases. I make everybody who comes into my office

in Bangor meet with him because he is a role model of someone who was born without either arm, he is able to drive his own vehicle, he is an archer, he is a marksman with a rifle, he pitches softball, he plays soccer, he coaches Little League, he does everything. He cuts his own meals using his feet, he is able to be totally self-sufficient and, as a result of being able to use the computer system in my office, he can talk to the computer and handle all the case work. So I make everybody who comes into my office to complain about a problem, go see him for inspiration if nothing else.

When you see someone who is disabled by virtue of "nerves" and receiving total disability and someone who has no arms fully employable, it calls into question whether or not we're seeking the appropriate golden mean.

What I've always strived for is what the ancient Greeks preached but rarely practiced and that was the golden mean. We've got to find some balance and we have yet to find that balance in the disability program.

We have people who are severely impaired and what I tried to say at the beginning of this session this morning is we are not seeking to harm people who are truly disabled, who have severe impairments. What we're looking to do is to help those who want assistance to become productive citizens.

If we have rehabilitation programs, training programs, or technology which will allow them to enter the workforce at some level, then we want to have a culture and a mindset which says we're going to encourage, we are going to embrace these individuals and bring them into the productive side of the workforce rather than simply being recipients for the rest of their lives.

So some might accuse us of being harsh or uncaring, but it's just the opposite. What we're trying to do is get a caring society which cares enough to make people feel productive throughout their remaining years.

I won't take more time, Ms. Ross. Thank you for your testimony.

One more question, Senator Santorum?

Senator SANTORUM. This is a discussion obviously of people who are eligible for work and these people out of high school and things like that, and that's what the discussion is but we're going to have a lot of "Zebley" kids moving off. Is that going to cause a spike in the number of people who are going to be on this program or is Social Security doing the disability review for these children now that they are no longer children and reevaluating them on criteria that is other than the "Zebley" criteria?

Although we passed a reform of "Zebley" here in the Congress two, three, or four times, whatever it was, it's always been vetoed by the President. The question is, since "Zebley" is still the law, what is happening to make sure that a lot of these kids who get in under the IFA, individual functional assessment—can you tell me what's happening, what's going to happen in the future if we don't change anything?

Ms. ROSS. My understanding is that Social Security right now is planning to, and are required to review people coming of age 18 each year, a third of that group each year for the next 3 years, and that they review them on a somewhat different scale than they did when they were children. I hope that part has been taken care of.

Senator SANTORUM. We don't know that though? I'd have to ask Social Security, in other words?

Ms. ROSS. I think I can say it more definitively. They have told us that they are going to do those reviews and we expect that they will. We also have a project whereby we're monitoring if they're doing them.

Senator SANTORUM. They have told you they're going to do those reviews; they have not done those reviews in the past?

Ms. ROSS. I'm not sure. I would have to give you more information for the record. I don't recall exactly how much they've done in the past, but I know they're required to do them now. In FY 1996, of the 98,360 SSI full medicals sent to the DDSS, 18,000 were 18 year old recipients and 10,500 of these have been completed as of June 1996.

Senator SANTORUM. Thank you.

The CHAIRMAN. Thank you very much, Ms. Ross and Ms. Bascetta.

Our next panel of experts will include those involved in the return-to-work programs: Mary Ridgely, executive director, Employment Resources, Inc. in Madison, WI; Barbara Otto, who is here today representing the SSI Coalition, a national resource for more than 180 organizations across the country; and Admiral David Cooney, former president and chief executive officer for Goodwill Industries of America. Goodwill is the largest private sector employer of persons with disabilities and provides vocational rehab to thousands of people worldwide.

Ms. Ridgely.

**STATEMENT OF MARY RIDGELY, EXECUTIVE DIRECTOR,
EMPLOYMENT RESOURCES, INC., MADISON, WI**

Ms. RIDGELY. Good morning, Senator.

Thank you for the opportunity to comment on return-to-work issues for SSI and DI participants.

For the past 3½ years my organization has been studying the barriers to employment for people with physical disabilities who are participating in Wisconsin's long-term support system. These are individuals who, without the aid of supportive home care or personal assistance services, would be unable to live outside of a nursing home or hospital setting.

Among the many barriers that we've identified for this group of individuals is, not surprisingly, the fear of losing benefits, particularly the health care and long-term care benefits. As far as we know, Medicaid is the only health plan that covers personal assistance services, so the loss of this benefit would be devastating to these individuals.

I'd like to outline some of the problems that we've encountered as we assist individuals who are SSI and DI participants in analyzing the impact that working will have on their lives, and suggest some solutions that are based on our research and our experience.

The problem begins with the initial claim for benefits. Not only is the definition of disability based on the presence of a mental or physical impairment, but it's also based on a person's inability to engage in substantial, gainful work. So this forces a claimant to prove that he or she is unable to work in order to get the cash ben-

efits and the medical coverage, so they are very hesitant to discuss returning to work immediately for fear that their benefits will be cutoff if the SSA thinks they can work.

An obvious solution to this problem is to change the definition of disability, and Ms. Ross referenced this, to reflect the functional limitations that are the result of the medical condition that should have been well-documented during the disability determination process.

You mentioned in your opening comments that the work incentives provisions themselves are very, very complex and we have found that very few people are even aware of them or know how to access them.

We conducted a survey in Dane County of working age adults with physical disabilities. We asked them about their familiarity with SSA work incentives. These are people who are receiving SSI and SSDI benefits.

Among both employed and unemployed respondents, we found that between one-half to three-quarters of them had never heard of the PASS Program, of 1619, of impairment-related work expenses. So we could only conclude that people are making decisions to work, or not to work, without the proper amount of information.

Of the people I meet, many of them have never seen the red book on work incentives, so they are very unlikely to call the Social Security office and ask for information about the work incentives.

Re: The new PASS Program. As someone who prepares PASS plans, I've been aware of the new PASS instructions that were issued in April to the Social Security offices.

The CHAIRMAN. Why don't you explain the PASS Program?

Ms. RIDGELY. The PASS Program is Plan for Achieving Self Support. This allows an individual to set aside some or all of their income or resources to pay for expenses that are necessary in achieving a specific vocational goal. That income might include earned income or it may include unearned income such as a SSDI benefit or a VA benefit or some other type of resource.

The PASS Program, we've put a great deal of our emphasis on helping individuals access this program to allow them to work toward a specific vocational goal. The new instructions make it even more difficult for people to access this program. The new form, for example, is 10 pages long and it's overwhelming to many claimants. Many of them will require some assistance in filling it out. In my opinion, the Social Security offices do not have the time to help every claimant who wants to submit a plan.

While I appreciate the need to ensure consistency across all States, the SSA has removed the approval process for these plans from the local offices and they are now all done in the Baltimore Headquarters. I think by removing the decisionmaking process from the local level, we've widened the gap that already exists between the claimant and this program. So as a PASS preparer, I welcome these guidelines, but I think the decision needs to be made at the local level.

Another concern I have about the PASS Program is the suggestion that DI beneficiaries should not have the option of qualifying for SSI using a PASS plan. Many of the people who have returned to work as part of our pilot project have been able to do so because

a PASS plan allowed them to qualify for SSI, SSI-related Medicaid, and eventually the 1619(b) status.

These are people who already were receiving Medicaid services as a waiver participant in our State, so they weren't asking for something they didn't already have, but access to that ongoing health care. Long-term care coverage was critical for them and the 1619(b) provision gives them that.

DI beneficiaries do not have access to that ongoing health care coverage like the SSI recipients have under 1619(b). The DI beneficiary who engages in substantial, gainful work activity is eventually going to see their Medicaid benefits stop. The loss of health care, as we've already established, is a major barrier for many people in returning to work because these are people who often cannot get insurance any other way.

Another recommendation we have is to increase the resource limit to allow the States to raise the resource limit for 1619(b) participants. There are few rewards for going to work. SSI recipients who have worked themselves off the cash payment but are maintaining Medicaid coverage under 1619 are subject to the same rules and asset limits as a SSI cash recipient.

This does not allow them, even though they're working, to save money to purchase a home, for example, or buy a new car or even save money for their child's education. So we need the flexibility to do that.

We also would recommend that the States be allowed and encouraged, in fact, to create work incentives using the Medicaid waivers and this would allow the flexibility to guarantee health care and long-term care for people who cannot work without it.

In summary of my comments, I would just suggest that what we're doing in Wisconsin is piloting the concept of providing a work incentive specialist, someone who is dedicated to offering assistance to an individual regarding the learning of the work incentives, helping them access those work incentives, and even monitoring their progress toward a specific goal.

This should be someone who is not responsible for processing claims because of the conflict of interest for both the claimant and the claims representative. We find that claims representatives in the SSA offices are simply unable to provide this kind of outreach and advocacy. A work incentives specialist could even extend his services to an employer. We found that many employers are willing and interested in helping their employee plan for the eventual termination of benefits.

By making available the assistance necessary to learn about the work incentives, to analyze the bottom line—are they going to be better off by working or worse off by working—by creating the flexibility for States to offer work incentives using Medicaid work incentives, and by changing the definition of disability to reflect the functional limitations, I am certain that we would see more people going off the rolls, the SSI and DI rolls.

Thank you.

[The prepared statement of Ms. Ridgely follows:]

TESTIMONY BEFORE THE SPECIAL COMMITTEE ON AGING

Return To Work Hearing

Mary Ridgely, M.S.

Executive Director

Employment Resources, Inc.

~~May 23, 1996~~

June 5

Good morning, and thank you for this opportunity to comment on return to work issues for SSI and SSDI program recipients. For the past three and a half years, the Wisconsin Department of Health and Social Services, in conjunction with the Dane County Department of Human Services, has funded research into the barriers to employment for people with physical disabilities who have long term care needs. Specifically, these are people who, without the aid of supportive home care and personal assistant services, would not be able to live outside of a nursing home or hospital setting. Through a series of focus groups, personal interviews, and an extensive survey, Employment Resources, Inc. has learned that among the major barriers to employment for this group is, not surprisingly, the loss of benefits, especially health benefits. There is also widespread concern that the benefits would not resume if their work attempt was unsuccessful or they were forced to stop working years later due to health issues. These are people for whom the loss of Medicaid eligibility would mean returning to a nursing home - a less than appealing option for the young, physically disabled individual.

The problem begins with the initial claim for benefits. The definition of disability is based on the claimants inability to engage in "substantial gainful activity", or SGA. This is defined as having gross monthly earnings of \$500 or more.

An initial claim may take many months to process. By the time an individual becomes eligible for cash payments, s/he has had to reduce their assets, and possibly apply for general welfare assistance in order to support themselves while they wait for an answer. In Wisconsin, once a claimant has been made eligible for benefits, they are referred to the Division of Vocational Rehabilitation (DVR). Of the approximately two hundred referrals received each month, only 10-15% actually participate in the VR program. Of that number, 30-40% are considered "rehabilitated" by SSA standards. According to state agency personnel, though every new disability program recipient is contacted and offered services, the vast majority are not interested in return to work assistance. When we force a person with a disability to prove they cannot work in order to become eligible for benefits, how can we expect them to believe that we want to help them go back to work?

In our study of the barriers to employment for people with physical disabilities, we have found that most people are unaware of the work incentives provisions or how to access them. In the survey that was conducted, respondents were asked about their experience with the SSA work incentives. One hundred and sixty four people responded to the survey: people with spinal cord injury, muscular dystrophy, multiple sclerosis, rheumatoid arthritis, etc.

Among the unemployed respondents, *more than 70% had never heard of Plan for Achieving Self Support, Impairment Related Work Expenses, and continued Medicaid coverage under Section 1619*. Even among the employed respondents, the lack of knowledge was astounding! About half had never heard of the work incentives, even though they probably could have used them to their advantage. In fact, during our interviews, we met people who had paid out-of-pocket for attendant services and did not know that they could deduct that expense as an impairment related work expense!

Currently, there is a movement to look at the vocational rehabilitation system and its lack of effectiveness in getting disability program beneficiaries to work. In our study, we met a significant number of beneficiaries who had received many years of services from the state vocational rehabilitation agency, even completing university or technical school degrees, yet never went to work because they feared the loss of benefits. To counteract this misconception, we offered benefits counseling and work incentives coordination to individuals who were interested in pursuing work. When we helped them access the work incentives provisions, some of these individuals went to work using the education and training they had previously received.

It is imperative that we focus on eliminating the disincentives to work before redesigning the system.

Our recommendations are the following:

Make a "Work Incentives Specialist" available to every SSI and SSDI recipient.

We could only conclude from our study that some people *are not working because they lack the information they need to make an informed decision*. We met Sandy, a twenty-nine year old woman with spina bifida who had never pursued paid employment after graduating from high school because she thought it would mean the loss of her SSI and Medicaid. Since she relies on Medicaid to pay for attendant services, she could not take that risk. She spent nine years in various volunteer jobs. When we told Sandy about the Earned Income Exclusion and the 1619 provision, she decided to go to work. Today, she is a successful Walmart Associate, and her earnings have reduced her federal SSI payment by more than 80%!

As an extension of our research, we decided to pilot a concept whereby we would provide education regarding work incentives to beneficiaries who were interested in working, and offer assistance in accessing the work incentives. Since January, 1994, we have helped people write and submit PASS plans, report impairment related work expenses and request the 1619(b) provisions.

In the two years since we began our pilot project:

- sixteen people have begun some type of work activity, while an additional seven have enrolled in an educational, training or internship program to get the skills needed for a particular career;

- of those whose disabilities were due to sudden onset age 16 or older, the number of years since their disability began or became severe enough to limit their work capability ranged from four to twenty-two, with an average of eleven and one-half years;
- all sixteen were receiving one or more of the following benefits or subsidies: SSI, SSDI/RSDI, VA, Medicare, Medicaid, Housing Subsidy, Home and Community Based Waiver services, Food Stamps and subsidized transportation.
- six people have seen a termination of their SSI cash payments; five of the six are eligible for continued Medicaid coverage under Section 1619(b). Four have health insurance through their employer, and only rely on Medicaid for funding for personal assistance services;
- SSDI has been terminated for three of the individuals as a result of SGA; it is expected that an additional four will be at SGA which will result in termination of these benefits in late 1996 and early 1997. The average savings in SSDI benefits for these seven individuals alone, not including cost of living adjustments, is \$53,748 per year. If they are able to continue working during their expected life span of 25+ years, the total savings is significant!

These are people who, a few years ago, were considered unemployable because of a severe, physical disability. With the technology that is available today, it is possible for anyone to work if they choose to do so. But we need to provide individual with accurate information regarding the impact that work will have on their benefits, and ongoing assistance in accessing the work incentives provisions available to them.

Dan is an example of someone who successfully used a PASS to go to work and eliminate his need for government support in the form of cash payments. Dan sustained a spinal cord injury at age sixteen. By age 42, even though he had completed a university degree, Dan had never done paid work. By using a PASS, Dan was able to acquire the necessary prerequisite training, adaptive equipment, and pay for transportation to get him to and from his job as a Geographical Information Systems (GIS) data entry specialist. Prior to working, Dan supported himself on about \$700 in Social Security and Veteran's Administration benefits drawn from his deceased father's account. Dan received Medicare benefits, and, as a home and community-based medicaid waiver participant, received funding for personal assistance services. Today, Dan earns more than \$9 per hour, with a wage increase to over \$10 expected later this year. His employer, the State of Wisconsin, provides comprehensive health care coverage. His Social Security benefits were terminated effective November, 1995, and the VA benefits stopped this month. He continues to rely on the Medicaid waiver program to provide funding for his personal assistance, but that is the only government support he requires at this time. To quote Dan, "Nothing I did entitled me to the [cash benefits]. Now, I am supporting myself through work that I enjoy doing. But I can honestly say that without the PASS, I would not have gone to work."

Allow states to increase the resource limit for 1619(b) recipients.

There are few rewards for people who do go to work and get off the rolls. Lisa is another example of who used a PASS to accomplish her goal of completing her education and going to work as an elementary school teacher. Because of a spinal cord injury at age twenty, Lisa received \$800 in Social Security benefits drawn from her retired father's account. Also reliant on the Medicaid waiver program to pay for her personal assistance services, Lisa needed to maintain MA eligibility. An approved PASS allowed her to set aside her Social Security income to save money for a van which would be modified, with funding from the VR agency, to allow her to drive. By qualifying for SSI using the PASS, not only was she able to save the money for a vehicle - but her continued eligibility for Medicaid was assured through the 1619 provision. Lisa began teaching 1st grade in the fall of 1994. As of November, 1995, her Social Security benefits were terminated. Her PASS ended several months later. The school district offers comprehensive health coverage.

Lisa would like to buy a house. Most people save for a down payment on a house, or save for that nice vacation that they have been dreaming of taking. But Lisa cannot save more than \$2,000, or she will lose her continued Medicaid eligibility under Section 1619.

We need to involve employers in planning for termination of government benefits received by their employees with disabilities.

Employers want to diversify their workforce by hiring people with disabilities. An individual who is concerned about loss of cash benefits and health coverage before they feel stable on the job is hesitant to discuss the issue with their new employer. But an employer may be able to assist in the planning by offering information regarding their company or agency health insurance plans, and by projecting the future earnings potential of an employee.

Last week, I met with a claimant and her employer for more than an hour, and together we planned her work efforts during the trial work period, looked at her earning potential and discussed her options for continued health care once her cash benefits stop. The employer had discovered that the health coverage she offers to all employees will be available to the employee with a disability if she loses Medicaid due to earnings.

Assistance with Work Incentives should be provided by staff whose time is solely dedicated to return to work for disability program recipients.

The person who advises a claimant on the use of work incentives, and the impact that work will have on their benefits, needs to have full and accurate knowledge. Unfortunately, claimants are too often given inaccurate information by the SSA office. Or, they are not given encouragement to return to work. The disability program is such a small part of what the local field office staff do, thus, they deal with so few claimants who have gone to work. (I was told a Title II CR in the Madison SSA office will see one case per year) Consequently, many do not know the rules well enough to articulate them. Unless you work with this information every day, it is too difficult to remember all of the details.

Additionally, the work incentives specialist should not be involved in processing claims or conducting continuing disability reviews. The type of advocacy that is necessary when helping someone return to work would conflict with the role of claims representative, and claimants perceive the CR as someone who is only interested in keeping them from getting the benefit.

In our experience, when DI beneficiaries do return to work and earn at the substantial gainful activity level, their benefits are not terminated in a timely manner. What results is confusion on the part of beneficiaries, who receive cash payments they are not due and eventually are required to pay back to the SSA. Staff who are dedicated to return to work could facilitate the appropriate response to beneficiaries who return to work.

Return the PASS approval process to the local SSA offices.

The new PASS guidelines will make it even harder for claimants to access this work incentive. For one thing, the new form is "overwhelming" as one claimant put it. CRs do not have adequate time to assist every claimant who wants to submit a plan. The SSA has recognized the need to ensure consistency, across all states, in the approval process. I am concerned, however, that by removing the decision making process from the local offices, they have created an even bigger rift between the claimant and the program. As a PASS preparer, I welcome the guidelines, but I think the decision should be made at the local level. One way to address the consistency concern is to implement a "PASS Committee" made up of SSI CRs in each local office. The Committee would review all plans and approve/deny based on the instructions in the POMS.

Do not eliminate the option for an SSDI beneficiary to qualify for SSI using a PASS.

Commissioner Chater's comments when the new instructions were issued described the intent to advocate for legislation which will make it impossible for a Title II beneficiary to qualify for SSI using a PASS. I would urge you to carefully review this recommendation; many of the people who have returned to work as part of our pilot were able to do so because a PASS allowed them to qualify for SSI/Medicaid. These are people who were already receiving Medicaid services as waiver participants, so we are not allowing a benefit for which they are not already eligible.

By making available the assistance needed to learn about the work incentives, analyze the "bottom line" if work is attempted, and monitor a plan or trial work period as it is ongoing, I believe we will see more beneficiaries successfully attempting work and eventually going off the rolls.

Return to work issues for recipients of disability benefits and problems with SSA work incentives provisions: A summary of recommendations.

1. ***The definition of disability is based on the inability of the claimant to work.***
This forces the claimant to prove the s/he is unable to work in order to get the cash payment and medical coverage; they will be hesitant to discuss return to work for fear the benefit may be "cut off" if the SSA thinks they can work. This may account for the lack of interest on the part of many new recipients to participate in a vocational rehabilitation program.

Solution: Change the definition of disability, now determined by the *substantial gainful activity* test, or gross monthly earnings of \$500 or more, to reflect functional limitations due to a medical condition.

2. ***The work incentives provisions, and the rules governing them, are too complex, and few people are aware of and know how to access them.***

A survey conducted in Dane County, Wisconsin of working-age adults with physical disabilities who were eligible for, or participating in, the county's long term support program found that, while only 28% of the respondents were employed at the time of the survey, nearly two-thirds of those who were not employed indicated they would like to be working. However, surprisingly few were aware of the work incentives provision available through the SSA. Most people have never seen the Red Book on Work Incentives, nor were they likely to call the SSA office to request information about work and its impact on their benefits.

Solution: Make a "work incentives specialist" available to every claimant. The WI Specialist should only deal with disability/return to work issues, and should not process claims as this would create a conflict for both the specialist and the claimant. The Work Incentives Specialist could help the claimant with understanding the work incentives, and could extend their services to employers wanting to be involved in helping the employee plan for eventual termination of benefits. Currently, Claims Representatives cannot provide this type of "advocacy".

3. ***There are few rewards for going to work.***

Solution: Raise the asset limit for SSI/1619(b) recipients, or allow the recipient to have a "special resource account" for such items as housing, vehicles, education.

4. ***The loss of health care/long term care is a major barrier for people who rely on Medicaid-type services for maintaining health and independence.***

Solution: Allow states to develop work incentives using Medicaid waivers under Section 1115. The result would be savings for the federal government as SSI/DI recipients go to work and off the rolls.

5. *The new PASS instructions increase the barriers to accessing the PASS program.*

With approvals and denials being made in the Baltimore office, the SSA has removed the decision-maker for the person submitting the plan. When reviews of previously approved plans are conducted, the SSA is, apparently, applying the new guidelines. This will inevitably result in the termination of plans which may then cause the individual to cancel their work goal.

Solution: Return the approval process to the local SSA offices. The prescriptive nature of the new POMS instructions should address the need to approve plans which are likely to succeed and that include "start-up" costs. To ensure consistency among field office staff, implement a "PASS Committees - consisting of the SSI CRs - to approve all plans for that office. The WI specialist would develop the plan with the beneficiary, with guidance from the CR, and submit it to the PASS Committee.

6. *People who are earning at the substantial gainful activity level after the trial work period continue to receive their DI benefit, often for months afterward, resulting in an overpayment of benefits which must be returned to the SSA.*

Solution: Staff who are dedicated to return to work issues should work closely with the beneficiary to plan for termination of benefits, and stop the cash payments at the appropriate time.

The CHAIRMAN. Ms. Otto.

STATEMENT OF BARBARA OTTO, EXECUTIVE DIRECTOR, SSI COALITION, CHICAGO, IL

Ms. OTTO. Thank you, Senator Cohen.

I'd like to start by thanking you for inviting us to share our experience with return-to-work issues for Supplemental Security Income and Social Security Disability Insurance.

The SSI Coalition for A Responsible Safety Net is a grassroots-based membership organization headquartered in Chicago. We're not a thinktank, we're not a direct service provider. We're focused on advocacy and policy issues around preserving the integrity of the SSI Program and related safety net programs.

I'm going to focus on job training programs for people with disabilities and some of the systemic challenges we have encountered as we kind of take our first foray into return-to-work issues.

In 1994, prior to the onset of the 1995 welfare reform debate, the SSI Coalition received a grant to explore the attitudinal and societal barriers to work for adult SSI recipients. Our key findings in that first foray into this issue found that although there were attitudinal barriers on the part of the recipient—that has a lot to do with what Mary Ridgely discussed and that is the disability standard and the eligibility criteria truly contributed to that—we also found there was an incredible lack of information available to recipients on the plans for achieving self support, SSI budgeting rules for income and resources, and the work incentives programs.

These barriers, combined with the fear of losing medical coverage, proved insurmountable for most of those we interviewed. In addition to these barriers, the SSI Coalition also found that many people with disabilities were unaware of how to access the vocational rehabilitational services or other private job training entities.

This year, we've seen Congress shift its emphasis to welfare-to-work programs and we're hearing on the House side that we may even be talking about time-limited benefits for some adults with disabilities.

The SSI Coalition feels that these initial findings really warrant further study. We raised the money to launch a multiyear employment initiative entitled "Welfare to Work for People with Disabilities Creating Opportunities for Self-Support." The Coalition is currently in the first phase of the initiative working with job training providers, SSI recipients and their families, and the Illinois Department of Rehabilitation Services, as well as disability experts on some of the systemic challenges.

In Illinois, there are 229,730 adults receiving SSI benefits. SSA has considered 159,980 to be of working age and potentially eligible for some type of VR services. In Illinois, DI working age beneficiaries number 156,990.

What we were able to find through the 1996 Federal fiscal year figures put out by SSA was that only 1,496 SSI and DI recipients were actually referred to VR training. We understand that the Illinois Department of Rehabilitation Services has the ability to track how many of those were referred and actually participated and

what services they received, but when we requested that data, that data was not made available to us.

We also requested data on how many participants in Illinois actually were matched with a job or found employment and left the rolls and we were unable to get that information in time for this testimony.

There are several systemic challenges to self-sufficiency that we have found. The SSI Coalition has identified the loss of health care coverage, as I said earlier, as the No. 1 barrier to employment. Our preliminary analysis of work incentive programs led us to make some of the following recommendations.

This is critical, especially when we're talking about Medicaid restructuring and reform, we need to ensure Medicaid and Medicare coverage and related supportive services to those individuals receiving SSI or DI that wish to return to work.

As the programs exist right now, the No. 1 barrier, as I said, is the loss of health care coverage. When asked, SSI and DI recipients state they are eager to return to work, but fear losing their health care coverage or related Medicaid-supportive services like personal attendant services.

When a recipient enters the workplace, substantial, gainful activity limits or resource limits often deter them from maximizing their ability to increase hours and their pay because of the risk of losing supportive services like Medicaid.

Another concern for many DI participants is the fear that they will not be able to work enough hours to replace the DI cash assistance, even though they could earn up to or above the SGA level. Moreover, once employed, individuals may not have the capacity to work enough hours to become eligible for employer-sponsored health care plans because of their impairment.

Beyond Federal eligibility for SSI, DI, Medicaid and Medicare, many recipients risk losing eligibility for State supplemental programs if they return to work.

I'd like to give you the example of an individual we've been working with in Chicago. I'm going to call him Matt S. Matt has severe cerebral palsy, he's technology-dependent and has a severe speech impediment. Despite his multiple barriers, Matt went through a basic skills training program and was briefly employed at a Chicago law firm.

The work was part-time and he was focused on part-time work because he feared losing his benefits and eligibility for Medicaid. Two weeks into the job, he was informed that his personal attendant services on the job would not be covered by the State. When asked why the personal attendant services would not be covered, the State correctly retorted that Matt would have to pay out of pocket for his PA services related to work since he was receiving a maximum benefit through his assisted living. Since Matt could not stay in the workplace without his personal attendant services, he had to leave his job.

So Medicaid and Medicare and these related services are critical to continued employment. There's a lot of talk about decoupling Medicare and Medicaid from SSI and DI but this doesn't necessarily address the problem because in a State like Illinois, the program is somewhat decoupled. You have to apply for Medicaid

separately from SSI. Just because you meet the SSI eligibility criteria doesn't mean you meet the Medicaid standards in the State.

It also means that you may not be eligible for maximum personal attendant services or other Medicaid-related services.

If we want to move SSI and DI recipients into the workplace, the SSI Coalition believes that we need to address the real barrier of access to health care and supportive services like PA services. Participants, we have found, may delay or postpone their entry into the workplace after their job training programs because they lack the dollars for PA services.

We're also aware that many advocates support tax credits to assist individuals as they transfer into the workplace. While we're not opposed to disability worker tax credits and personal attendant services tax credits, we've seen in nearly every case we encounter that the SSI or DI recipient's budget is so close to the bone that they cannot wait for an annual or even quarterly tax credit. Most recipients trying to enter the workforce need the financial reimbursement for outlays like personal attendant services in the month when the payment for the service is due.

A second recommendation under systemic challenges would be involving the Social Security Administration in moving people toward the workplace. We feel they must play a much more active role in introducing people, and something Ms. Ross mentioned earlier, doing some of that early intervention when people enter the rolls.

We recommend that funding be allocated to the Social Security Administration to employ dedicated staff, preferably in the field offices but at the very least, at the regional level to guide recipients through the veritable maze of the plans for achieving self support and the work incentive programs. Finding SSA staff that understands both PASS and work incentives is difficult at best.

In addition to increased funding, we recommend the following: first, revise PASS and work incentive programs to make it easier for people to understand them and access them. As Mary Ridgely mentioned earlier, the new revisions in PASS are even more complex than the prior program.

We're concerned that the complexity of these programs and how third parties such as legal representatives or case managers are often sought for their involvement in the process because it is beyond the capability of recipients or their family members. This adds considerable expense in time and resources.

Second, develop expertise on complex programs like PASS and work incentives at the local office level. Oftentimes we're finding that people are referred to the 1-800 number when they go to the local office for information on PASS and work incentives. This doesn't meet the job of helping people access return-to-work programs because they're often referred, after they hit the 1-800 number, back to the local office.

Third, promote the PASS and work incentive programs with targeted community education efforts. The SSI Coalition has actually developed, as a part of our program, training for community-based service providers and for parents and family support networks on PASS and work incentives because we're finding that as they contact SSA, they're not getting the critical information they need.

So we have actually been doing targeted community education efforts, but we can't do the bulk of that. It would be much more helpful if SSA could even provide a partnership in these efforts by community-based groups like my own.

While we can remedy some barriers to employment through revisions to existing programs and by allocating additional resources to the SSA, the fact remains that job training programs are key to moving people off the rolls and keeping them in the workplace. I don't think anybody in this room would argue that people cannot live on \$470 a month which is the highest SSI benefit for adults.

Many people want to be working and need to learn how to access job training and then be supported in that process. In Illinois, the SSI Coalition has observed little, if any, emphasis on moving SSI and DI recipients into the workplace. In fact, what we've found is if every referral sought vocational rehabilitation training, there would not be enough slots available.

The programs are not geared toward addressing a long-term employment outlook of the participant. They are most concerned about placing the participant into a job, any job rather than preparing the participant for ultimately leaving the SSI rolls through long-term employment.

The content of the training programs vary and we've looked at both VR and private sector employment training programs. They vary but once placed, participants must be employed for at least 60 days before the training provider is reimbursed. That's standard procedure.

While the Illinois Department of Rehabilitation Services has follow-up built into the job training provider's contract, preliminary inquiries in this area reveal that most of the job training providers we questioned do little more than make a phone contact with the employer and the participant once or twice after placement.

Follow-up and job retention services are not reimbursable, therefore, many job training providers are unable to provide ongoing support unless DRS identifies the individual as needing extended supportive services. Of course, we all know that costs money, so very few people are identified.

While we understand the need to focus on getting participants into the workplace, we are concerned with the lack of focus on the long-term success of the participant. Only a few of the job training providers we talked to offer more than basic skills training. Therefore, the bulk of the participants are trained for low income, low status jobs with not much of a chance for economic advancement.

With their wage-earning potential so low, few participants are able to earn wages that will move them permanently off the SSI or DI rolls. Depending upon the severity of the disability and the number of supportive services that participant is receiving, some participants the SSI Coalition has encountered feel they must earn at least \$10 to \$15 a hour working full-time to replace benefits lost due to employment.

We've also found that many job training programs are not equipped to provide general adult education services. Our experience in working with job training providers and participants has indicated that next to health care, education is a critical barrier to long-term employment.

Finally, the SSI Coalition has engaged in a study of what elements of job training promote long-term employment for SSI and DI recipients. The Coalition's preliminary work has found that the following elements are critical with long-term job retention and gains for self sufficiency.

First, we need to require a curriculum that addresses adult education deficiencies. Second, we need to create a supportive services component. Many clients need one-on-one assistance maneuvering through the SSA's work incentives and PASS programs or supplemental programs at the State level to ensure that the client complies with complex program eligibility criteria which creates or provides access to emotional and physical supportive services.

Third, require job readiness components which prepare clients for dealing with day-to-day problems associated with working. Fourth, implement a job retention or followup component which tracks the client and provides ongoing support for at least 12 months on the job.

Many of the job training providers we've been working with support these recommendations. We are currently developing a best practices report to identify job training programs that build skills and have a good track record on job placement and retention.

In conclusion, the SSI Coalition believes that to truly move recipients into long-term employment, Congress must work with the Social Security Administration to create real incentives for people to work. Beyond changing the entire premise of these disability programs, there are incremental changes that can be made to make the system more of a springboard to self-sufficiency as opposed to the poverty traps that they are today.

Thank you.

[The prepared statement of Ms. Otto follows:]

THE SSI COALITION FOR A RESPONSIBLE SAFETY NET

SUPPLEMENTAL SECURITY INCOME FOR LOW INCOME ELDERLY AND PEOPLE WITH DISABILITIES

Testimony of
Barbara Otto, Executive Director
The SSI Coalition for A Responsible Safety Net

June 5

Thursday, May 23, 1996

Senate Special Committee on Aging

Good morning. I would like to start by thanking Senator Cohen for inviting us to share our experience with return to work issues for the Supplemental Security Income (SSI) and Social Security Disability Insurance ("DI") programs. The SSI Coalition for A Responsible Safety Net is a grassroots based membership organization headquartered in Chicago, Illinois. The SSI Coalition is dedicated to improving and preserving SSI and related safety net programs.

In 1994 -- prior to the onset of the 1995 welfare reform debate -- the SSI Coalition received a grant to explore the attitudinal and societal barriers to work for adult SSI recipients. Key findings in that first foray into this issue found that although there were attitudinal barriers on the part of the recipient, the lack of information available to recipients on the Plans for Achieving Self Support, SSI budgeting rules for income and resources and the work incentives programs combined with the fear of losing medical coverage proved insurmountable for most of those interviewed. In addition to these barriers, the SSI Coalition also found many people with disabilities were unaware of how to access job training.

As Congress has shifted its emphasis to welfare to work programs and may even move toward time limited benefits for some adults with disabilities, the SSI Coalition felt that these initial findings warranted further study. We have launched a multi-year employment initiative entitled *Welfare to Work for People with Disabilities: Creating Opportunities for Self-Support*. The Coalition is in the first phase of the initiative working with job training providers, SSI recipients and their families, the Illinois Department of Rehabilitation Services and disability experts on the systemic challenges to self-sufficiency.

In Illinois there are 229,730 adults receiving SSI benefits -- 159,980 are considered to be of working age. (Illinois DI benefits numbers were not available at the time of submission of this testimony.) The 1996 Federal Fiscal year figures indicate that 1,496 SSI and DI recipients were referred to Vocational Rehabilitation (VR) training. Although we understand that the Illinois Department of Rehabilitation Services has the ability to track how many of those referred participate in VR and what services participants receive, that

data was not made available to us. Also, there is no available data on how many participants in Illinois found employment and left the rolls.

Systemic Challenges to Self-Sufficiency

The SSI Coalition has identified the loss of health care coverage as the number one barrier to employment for SSI and DI recipients. Our preliminary analysis of the work incentive programs lead us to make the following recommendations:

- ◊ *Ensure Medicaid and Medicare coverage and related supportive services to those individuals receiving SSI or DI that wish to return to work.*

As the programs exist right now, the number one barrier to employment for people is the loss of health care coverage. When asked, SSI and DI recipients state they are eager to work, but fear losing health care coverage or Medicaid related support services. When a recipient enters the workplace, substantial gainful activity ("SGA") limits or resource limits often deter them from maximizing their ability to increase hours and pay because of the risk of losing Medicaid. Another concern for many DI participants is the fear that they will not be able to work enough hours to replace the DI cash assistance, even though they could earn up to or above the SGA level. Moreover, once employed, individuals may not have the capacity to work enough hours to become eligible for an employer sponsored health care plan because of their impairment.

Beyond federal eligibility for SSI, DI, Medicaid and Medicare, many recipients risk losing eligibility for state supplemental programs. Take for example the case of Matt S..

Matt has severe cerebral palsy, is technology dependent and has a severe speech impediment. Despite his multiple barriers, Matt went through a basic skills training program and was briefly employed at Chicago law firm in the mail room shredding documents. The work was part-time, since Matt did not want to endanger his Medicaid eligibility. Two weeks into the job, Matt was informed that his Personal Attendant Services on the job would not be covered by the state. When asked why the Personal Attendant services would not be covered, the state correctly retorted that Matt would have to pay out of pocket for Personal Attendant services related to work since he was receiving the maximum Personal Attendant benefit through his assisted living. Since Matt could not stay in the workplace without a Personal Attendant he had to leave the job.

De-coupling Medicaid and Medicare from SSI and DI does not address this problem. If we want to move SSI and DI recipients into the workplace, the SSI Coalition believes that we need to address the real barrier of access to health care and supportive services, like Personal Attendant services. Participants may delay or postpone their entry into the workplace after job training programs, because of the lack of dollars for PA services.

Many advocates support tax credits to assist individuals as they transfer into the workplace. While we are not opposed to proposed disability worker tax credits and personal attendant services tax credits, the SSI Coalition sees that in nearly every case we

encounter the SSI or DI recipient's budget is so close to the bone that they can not wait for annual or even quarterly tax credits. Most recipients trying to enter the workforce need the financial reimbursement for outlays in the month when payment for the service is due.

- ◊ *The Social Security Administration must play a more active role in moving people toward the workplace.*

The SSI Coalition recommends that funding be allocated to the Social Security Administration to employ dedicated staff, preferably in the field offices, but at the very least at the regional level, to help guide recipients through the veritable maze of the Plans for Achieving Self-Support ("PASS") and the work incentives programs. Finding SSA staff that understand both PASS and work incentives is difficult.

In addition to increased funding we recommend the following:

1. Revise PASS and work incentives programs to make it easier for people to understand them, and access them. We are concerned about the complexity of these programs and how third parties (such as a legal representative or a case manager) are often sought for their involvement in the process because it is beyond the capability of recipients or their family members. This adds considerable expense in time and resources.
2. Develop expertise on complex programs like PASS and work incentives at the local office level.
3. Promote the PASS and work incentives programs with targeted community education efforts.

The SSI Coalition has a cadre of volunteers who assist with general office support. Just this year one such volunteer, Carol L., who has severe epilepsy and no prior work history, wished to enter the workplace. Of course, as a volunteer with the SSI Coalition, Carol was aware of the PASS and work incentives programs. What surprised us all was that SSA field office staff had little or no information on either program. In Carol's quest to find an SSA worker to help her wade through the complex eligibility criteria for PASS, she found that four out of the five SSA offices contacted did not know what she was talking about. The fifth office that had actually heard of the PASS program referred her to the SSA 1-800 number for more information, where she was referred back to her local office.

In week four of Carol's quest, I intervened. I contacted a colleague at the SSA Regional Office who referred Carol to field office staff on the Southwest side of the city which would have required a significant amount of travel time for Carol. Still determined, Carol pursued the contact and has had some success in getting information mailed to her and has had several phone consultations with this worker. Carol is now in the process of applying for her PASS and looking for assistance for that lengthy and complex application process.

While we can remedy some barriers to employment through revisions to existing programs and by allocating additional resources to SSA, the fact remains that job training programs are the key to moving people off the rolls and keeping them in the workplace.

Develop Standards for Job Training Programs for SSI and DI Recipients

In Illinois, the SSI Coalition has observed little, if any, emphasis on moving SSI and DI recipients into the workplace. In fact, if every referral sought Vocational Rehabilitation training there would not be enough slots available. The programs are not geared toward addressing the long-term employment outlook of the participant. They are most concerned about placing the participant into a job -- any job -- rather than preparing the participant for leaving the SSI or DI rolls through long-term employment. The content of training programs vary, but once placed, the participant must be employed for at least 60 days before the training provider is reimbursed. While the Illinois Department of Rehabilitation Services (DORS) has follow-up built into the job training provider's contract, preliminary inquiries in this area reveal that most of the job training providers we questioned do little more than make phone contact with the employer and participant once or twice after placement. Follow-up and job retention services are not reimbursable. A participant does not receive on-going support unless they are identified by DORS as needing extended supportive services.

While we understand the need to focus on getting participants into the workplace, we are concerned with the lack of focus on the long-term success of the participant. Only a few of the job training providers we talked to offer more than basic skills training. Therefore the bulk of the participants are trained for low-income, low status jobs with not much of a chance for economic advancement. With their wage earning potential so low, few participants are able to earn wages that will move them permanently off the SSI or DI rolls. Depending upon the severity of the disability, and the number of supportive services the participant is receiving, some participants the SSI Coalition has encountered feel they would have to earn at least ten to fifteen dollars an hour working full time to replace benefits lost due to employment.

The SSI Coalition has found that many job training programs are not equipped to provide general adult education services. Our experience in working with job training providers and participants has indicated that next to health care, education is a critical barrier to long-term employment.

Mary, a hearing impaired woman in her mid-forties, has been participating in sheltered workshops or similar programs for most of her adult life. Mary has an average IQ but was denied entrance into mainstream education programs when a child because of her hearing impairment. As a child, teachers believed that Mary had abnormal behavior and labelled her early on as being mentally impaired.

Had Mary been appropriately evaluated as an adult in any of the sheltered workshops or skills-based programs she has participated in, she may have received remedial education and moved onto job training which would have prepared her for long-term employment. Instead, she is relegated to sheltered workshops because she is severely limited -- not solely by her impairment -- but by her lack of general education.

The lack of education on the part of most of the adults we encounter has much to do with attitudinal as well as societal barriers. In order to make themselves eligible for SSI and/or DI, individuals -- or their families -- are forced to accept a label of severely impaired and unemployable. As a result, most adults we encounter do not feel capable of holding down a job. Worse yet, they fear entering a job training program because they believe it puts their benefits in danger. Few SSI or DI recipients are aware of PASS or the work incentives programs. When they are made aware of the existence of these programs they encounter significant problems accessing a contact at SSA to answer any questions they may have.

The SSI Coalition is engaged in a study of what elements of job training promote long-term employment for SSI and DI recipients. The Coalition's preliminary work has found the following elements critical to long-term job retention and gains for self-sufficiency:

1. Require a curriculum that addresses adult education deficiencies;
2. Create a "supportive services" component. Many clients need one-on-one assistance maneuvering through the SSA's work incentives and PASS programs, or supplemental programs at the state level to ensure the client complies with complex program eligibility criteria, and which creates or provides access to emotional and physical supportive services;
3. Require a job readiness component which prepares clients for dealing with day to day problems associated with working; and
4. Implement a job retention or follow-up component which tracks the clients and provides ongoing support for at least the first twelve months on the job.

Many of the job training providers the SSI Coalition works with support these recommendations. We are working to develop a best practices report to identify job training programs that build skills and have a good track record on job placement and retention.

In conclusion, the SSI Coalition believes that to truly move recipients into long-term employment, Congress must create real incentives for people to work. Beyond changing the entire premise of these disability programs, there are incremental changes that can be made to make the system more of a springboard to self-sufficiency as opposed to the poverty traps they are today.

The CHAIRMAN. Thank you very much, Ms. Otto.
Admiral Cooney.

**STATEMENT OF ADMIRAL DAVID COONEY (USN RET.),
FORMER PRESIDENT AND CEO, GOODWILL INDUSTRIES,
WASHINGTON, DC**

Admiral COONEY. Good morning, sir.

While I certainly agree with what you had to say about the threat of costs involved with the disability program, I would also like to add the thought that even if the Social Security Administration were funded beyond all question of size, that we should overhaul the system and get people back to work simply because it is the socially responsible thing to do. So we have two strong motives here and I think they are equal motives.

Second, I would like to point out that you are correct, I am recently retired as the CEO of Goodwill Industries but I am here because your staff felt—at least they suggested to me that, having functioned in the private sector and also in a variety of government boards and commissions and that sort of thing, perhaps I had a somewhat wider view of some of the issues than other people might. Therefore, my comments are my own, and I don't represent any particular group or organization.

The CHAIRMAN. And not that of the Navy either.

Admiral COONEY. No. Although I'd rather talk about that to a certain extent.

I have, however, over time been involved in a variety of these things, including two terms on the Disability Advisory Council for the Social Security Administration and I have come to five rather basic observations. I'd like to review those and then perhaps we can deal with some questions.

The first of them is that the desire and capacity of persons with the disability to work are consistently underestimated and they are under valued in our society.

Second, the knowledge does exist to design and operate optimal service delivery systems capable of maximizing work potential of persons with disabilities. I can talk about that a little bit.

Third, the present social security system is not that optimal system. It is actually designed to operate contrary to multiple indicators of sound rehabilitation and management practice.

Fourth, there is very little value to studying methods of improving the present social security system in my judgment. The paradigm upon which its structures are based and the operating assumptions underlying its concept of operations today are not valid in current social, medical, educational and economic circumstances.

Fifth, progress in developing new solutions to problems in the constantly changing environment is dependent on strong intellectual leadership and the structured development of information through research and testing.

Today, there is little relationship between the people who deliver services and the people in the social security system who are charged with the responsibility of gathering and analyzing information. I say charged because they have the responsibility but there's not a lot going on despite the fact that the Congress, in years past,

has not funded and authorized such research, but has urged that it take place.

I'd like to return briefly to point three which is that the Social Security system is not the optimal system. We talked a little bit about having to make a culture change. I submit for your consideration, sir, that the Social Security system was set up to pay pensions and what we're talking about is training people to go back to work. Those are two entirely different functions and, in fact, they almost conflict with each other under given sets of circumstances involving individual people.

We do have very successful, private rehabilitation programs, a lot of which are funded through a variety of private insurance companies, both short term and long term disability insurance which can be purchased by employers which guarantee that intercession for people who have been job-injured is done while the people are still in the hospital. We begin to design the rehabilitation system and the job retraining at that point rather than waiting, as you pointed out, 6 to 9 months or a year. The results are much better and the costs are much less. Yet we simply do not have that option available for a significant number of the people who are now eligible for Social Security Disability systems.

When the Social Security Disability system was created, it was mainly aimed at males who were 55 years old reaching the end of their work capacity. They were employed in jobs that literally wore their bodies out. Today, we don't have that many of those jobs. People are expected to work much longer. We have much better systems of medical practice. We do not encourage people to stay out of work, we encourage them to go back to work and reestablish those habits.

In fact, we have what's known as the "inability to work" or the "disability syndrome" which comes about in a period of about 6 months after people sit and watch soap operas on television while they're waiting to become eligible for the social security system. We are creating disabled people to consume these funds you're talking about, instead of accepting our national social responsibility of identifying the potential of those individuals.

When I say we have a system, we do. We have the capacity to measure the interest of individuals who have been disabled in a variety of ways, even those who have been born with disabilities, to determine their interests, to determine equally their skills in relationship to those interests.

We can then compare them to the physical or mental characteristics of those individuals. We can determine very accurately our market needs. The Department of Labor is very good at this sort of thing and I've sat on more than one committee for the Department of Labor involved in those kinds of measurements.

We've gone a long way with the American with Disabilities Act in providing much greater access to the workplace. It's interesting. We have established the concept, I believe, in this country that disabled people are expected to work, they are expected to compete successfully in the school system through Public Law 41-142 and a variety of other legislation. We expect them to compete successfully in the workplace where we've given them access and yet we create a disability system which actually interferes with the proc-

ess of taking those people and putting them into that working environment.

This comes about because the Social Security organization is simply not structured to do its job. Somebody has to prove they're disabled—that's the question set, that's the mental set of the intake person. Then they are referred to a State disability determination service that has a vested interest in determining only those people who will probably be the most successful in being rehabilitated.

Even when that individual gets over that hump and becomes involved in the disability system, a private sector agency like Goodwill or Easter Seal is not very anxious to get that client because they have to pay all of the expenses of training that individual. Then they have to wait until that individual has been employed for 9 months before they start getting their money back.

That's like asking Stanford to wait to collect tuition until after somebody has worked 4 years and proved the value of their degree. It just doesn't make sense, so the incentive for the private sector to be involved with these people is contra-indicated. There is no incentive at all. The system is simply not designed to work and we are not finding the agency being very aggressive about developing new means of taking care of the problem.

Even when we talk about these work incentives—which both of these ladies have been very successful at setting forth as concerns—we find that the internal education system within the Social Security Administration is so poor that most of the people at the field level aren't even aware of the programs. They don't want to answer the questions, and they aren't very helpful to the people when they come in and ask for that help. Just getting the law changed doesn't do any good.

To a great extent, that's true because the people have a vested interest in the status quo. They understand it, they are protected by sticking with what they have always done and they are not rewarded for solving problems in a new way; they are rewarded for doing things the same old way with the same old result.

I realize I sound very negative. I have a lot of hope for disabled people. I have tremendous faith in the private sector and in the government to work together to do a better job of dealing with this problem. I just don't see the solution in the Social Security Administration.

[The prepared statement of Admiral Cooney follows:]

Statement to
The United States Senate
Special Committee on Aging

By
David M. Cooney

May 23, 1996
June 5

Good morning Mr. Chairman. Thank you for inviting me to express my views and concerns about the current Social Security System disability programs. My name is David Cooney. I recently retired from the presidency of Goodwill Industries International Incorporated, a position I held for fifteen years. Prior to that time I served for 30 years as a career Naval Officer. During my time at Goodwill, I was fortunate enough to serve on many bodies, domestic and overseas, concerned with employment development and work readiness for persons with disabilities. I served those groups with enthusiasm and pride.

The thoughts I express today, however, are my own. They reflect experience gained while serving on government advisory committees, working in the private not for profit sector, and serving on the Social Security Disability Advisory Committee in two Administrations. So while I would expect no radical argument from my former colleagues, I do not suggest institutional endorsement either.

I should say, at the outset, that the report provided to you by the Government Accounting office is excellent. Any flaw is not in content, but in the basic presumption that the Social Security disability system can be repaired enough to be effective. That is not a view I share. My experience in attempting to make the vocational rehabilitation process function effectively has led me to that conclusion, based on certain salient observations. Key among those observations are the following:

1. The desire and capacity to work of persons with disabilities are consistently underestimated and undervalued.
2. The knowledge exists to design and operate an optimal service delivery system capable of maximizing the work potential of persons with disabilities.
3. The present Social Security system is not that optimal system; it is actually designed to operate contrary to multiple indicators of sound rehabilitation and management practice.
4. There is very little value to studying methods of improving the present social security disability system. The paradigm upon which its structures are based and the operating assumptions underlying its concept of operations are not valid in current social, medical, educational, and economic circumstances.
5. Progress in developing new solutions to problems in a constantly changing environment is dependant upon strong intellectual leadership and the structured development of new information through research and testing. To day there is little relationship between the people who deliver services and the people in the Social Security System who gather and analyze

information.

Because of the very short time available, I will not discuss each of these points in my statement at length, but will be happy to answer questions. However, some mention of detail is in order.

In respect to **observation 1**, there is usually little argument. The nomenclature of disability supports an assumption of reduced capacity. That assumption is correct in respect to certain limited functions defined by the person's disability, but it is not correct in respect to the individual's overall capacity and desire to do that which can be done with proper training, assistive technology, and a supportive work place environment.

In respect to **observation 2**, There are few knowledgeable persons who would argue that a systematic program involving early intervention, proper evaluation, skilled medical treatment, job skills training based on employment market requirements, placement and follow up is not effective in returning persons to work prior to their becoming involved in the DI program. Similar techniques are used by for profit insurance companies to serve customer needs and control losses.

A similar model is available and effective for individuals who have never worked or who have not worked for a long time. It is provided by many not for profit rehabilitation organizations, usually funded from their own earned resources. Payment for services to Social Security clients is never made on a real time basis. It is rarely made at all.

The most frequent criticism of this vocational rehabilitation model, interestingly enough, is not that it doesn't work. The criticism is that graduates are often placed in jobs with relatively low wages and benefits. That thought is sometimes advanced by economists, but not by employers or social scientists. In as much as most of the clients served are low functioning, inexperienced, individuals, many of whom have been neglected by a variety of government programs, this result is neither surprising nor regrettable. Nor are those factors arguments against the use of a similar system to provide services to a variety of persons with different work potential. As is true with education, the out come of training and placement should be productive employment, not perfection. Initial post rehabilitation employment is the first step in a long process, not a permanent end to occupational growth.

In **observation 3**, I assert that the present Social Security Disability System is not optimal. It is designed to operate contrary to current preferred practice. This is a serious and sweeping condemnation resulting from the fact that the Social Security System is designed to enroll applicants and to pay pensions. Its performance and the performance of its personnel are measured by criteria reflecting that reality, and its structures are designed to achieve those purposes. The involvement of the rehabilitation community comes only after a long and cumbersome intake system has functioned to determine that a person is sufficiently disabled to qualify for enrollment in DI. I suggest the following are among the most obvious faults of this system:

A. The question set employed in the application process emphasizes the person's entitlement, not the individual's residual capacities.

B. There is no positive incentive for intake persons to involve any expert assistance beyond obtaining the minimum medical documentation and work history required to complete a file. Costs of work evaluations and second opinions discourage creative inquiry.

C. The prolonged waiting period for enrollment virtually guarantees that the applicant will be work disabled because it precludes early positive intervention of medical and rehabilitation professionals while permitting the applicant to establish a pattern of life consistent with long term unemployment (sometimes called the disability syndrome).

D. The system depends on medical opinions of physicians who lack familiarity with the actual physical and mental requirements of the modern work place and who are often untrained in the practice of rehabilitation medicine.

E. The current method of reimbursing private sector rehabilitation facilities for services provided to clients sponsored by Social Security places all the risks on, and provides none of the rewards to, the service provider.

F. Dependence on state operated Disability Determination Services, rather than the private sector, allows each state to make determinations based on the ability or willingness of the state operated rehabilitation system to accept referrals instead of on the potential capacity of the individual to benefit from private sector services

Observation 4 concerns my belief that it is time to stop studying the present system for means of improvement. The paradigm upon which its structures are based and the operating assumptions underlying its concept of operations are no longer valid. It is therefore beyond repair. For example, at the beginning of the program:

A. Recipients were considered at the working age margin at 55. Today we take retirement at 65 or 70 as a normal goal to be encouraged under social security.

B. In the late 30's there were more trained employees than jobs. That is rarely true in our present economy.

C. Disabled persons were not expected to be employed in mainstream activity. Today disabled persons are expected to compete in the schools and in the work place and to earn competitive wages and contribute to their own well being and to society as a whole. The Americans With Disabilities Act gave this changed understanding the force of law.

D. Medical solutions were comparatively unsophisticated, and prolonged work absence was considered essential to the healing process for patients recovering from injury or disease. Today medical treatment has prolonged life, restored productivity and given significant residual functional capacity to individuals who once would have been invalids. Rapid return to normal activity has become a preferred method of physical and mental therapy.

E. Many persons with mental impairment were segregated from general society in the 1930s. That is no longer always true. The rehabilitation system should function to deliver care and to facilitate integration not underwrite segregation.

F. Most occupations demanded strength, flexibility, and endurance from workers. Today we are in the information age and the major portion of new jobs emphasize intellectual development, mental skills, and reasoning over strength. Such jobs lend themselves to assistive technology and work place accommodation.

G. Many persons worked for the same employer or in the same industry for most of their lives. Today it is common to change employers and career fields frequently as the economy shifts from goods to services and the U.S. competes in the world economy. Able-bodied persons require job retraining in much the same way that persons with disabilities do. Such retraining is now a normal part of remaining effective in the labor market. More opportunities for community based and campus-based training are available. That trend will continue.

H. Private pension systems, individual retirement savings programs, and short and long term disability insurance programs were uncommon. Today they are common and even a person self employed in a small business can afford to purchase a greater level of retirement security and disability protection and remedy than is available from Social Security.

I. Many chronic physical and mental conditions were not susceptible to medication or other forms of abatement or remediation. That, unfortunately is still true about some conditions, but the number is smaller. Treatment to alleviate symptoms can make work both possible and productive.

J. The primary medical delivery system emphasized the family or company doctor who often had a long term relationship with the potential applicant and some knowledge of the real capacity of the person to work. Now of course, we have care managed by strangers, a minimum of personal involvement, and physicians who may have never been employed in the competitive work place. There is a pronounced shortage of rehabilitation medicine specialists who are at the low end of the medical earning curve. Under trained and over worked physicians will be tempted to be guided by the patient's own estimate of his capacities rather than seeking to present alternative courses of action to regain the employment market. This type of medical evaluation completes the intake file. It is rare to have a medical report augmented by a full vocational evaluation.

In observation 5, I seek to connect effectiveness with knowledge gained through research of all types. Although given authority by the Congress to conduct a variety of demonstration and research projects, the Social Security Administration has been slow and largely unimaginative in the arena. Even when research has been done, results are not widely published, and little education is given to agency employees to enable application to the everyday tasks. As a result the system not only operates on an old paradigm using invalid operating assumptions, but it is making no structured effort to change these circumstances.

It is simply time to ask the basic question, "If we weren't stuck with the Social Security system, what sort of agency would we create to accomplish the tasks at hand?" The answer would certainly not be the replication or modification of the present model. We would recognize the changed role of people with disabilities in America. We would seek to solve problems of health birth defects, and trauma before they became disabling. We would assume a willingness of the

private sector to provide services paid for, in part, by employer provided disability compensation insurance, especially if there could be an offset in Social Security taxes. We would recognize the importance of the provider community in research, development, commitment and capacity to serve individuals across a wide spectrum of need. We would arrange to pay for services as they are delivered and would incent innovation and research through bonuses and other forms of recognition. We would operate on the assumption that people want to work and can work, and that should be the first goal of any system. If and when that proves to be unattainable, a proper system of support should be available.

I regret that my comments may appear to be all negative at first consideration. That is not really the case. I have a strong faith in the desire of people with disabilities to become active participants in the work of America. Further, I have considerable confidence in the leadership of the for profit and the not for profit rehabilitation communities to develop and implement current solutions to ever changing circumstances. I believe that American medicine and the insurance industry, operating independently from Social Security, have made considerable strides in developing strategic alliances to meet the needs of potentially disabled persons in a timely manner. And I believe the Congress is capable of exerting the leadership necessary to make the sweeping changes necessary to achieve work opportunities for people with disabilities without removing their income protection. Social Security is not the answer. Power and money combined with institutional lassitude will never produce quality solutions.

The CHAIRMAN. Thank you very much, Admiral.

It's not our function to be either overly negative or overly optimistic, but rather just to look at the demographics as they are coming. We have a tidal wave about to hit the United States in terms of those who are going to be drawing Social Security.

We found, as I mentioned in my opening statement, the Social Security Trust Fund is now taking money to put over in the Disability Insurance Fund which will go broke in about another 20 years or less. We have a serious, serious social problem to confront, so you can be pessimistic and express that. Hopefully, it will galvanize us to take the kind of corrective action that needs to be taken.

In view of the fact that we have two more panels, I want to try to summarize what I've heard today, and if I say anything you disagree with, just speak up.

Ms. Ridgely, in your prepared statement, you talked about environmental modifications. We're going to hear about that in the next panel but that's something we don't take into account or apparently is not being taken into account enough in making assessments as to whether someone is disabled or not.

You can make that determination of physical impairment but there might be something such as sitting in front of me here or over there that can in fact modify that individual's capabilities to become gainfully employed. So environmental modifications need to be factored into this entire equation to begin with.

Admiral COONEY. May I suggest you add to that education of the medical individuals who are making that determination? There is a very poor system of training people who are doing the medical evaluations into the reality of what modification of the work space and assistive technology can do for that person.

The CHAIRMAN. Good point. Well taken.

We need to have employer involvement. I think either Ms. Otto or Ms. Ridgely testified that you found that employers were eager to become involved to determine what were the incentives or disincentives for getting people to work.

Ms. Otto, you talked about what I would call a designated hitter at the local level, someone who is, in fact, trained and understands the 16 pages that we put together in the way of regulations. Hopefully we can simplify that even much more radically than 16 pages, but someone who understands what the programs entail and how they can be made to work.

They have sort of a rotating, designated hitter who has knowledge about the programs that exist and how they can, in fact, interface with the individual that you want to get back into the workforce.

SSA indicated that roughly 3 out of 10 of those currently on the disability rolls could be put to productive work as such. Does that sound reasonable, Ms. Ridgely, Ms. Otto, and Admiral Cooney, that 3 out of 10 could be phased back into the workforce?

Ms. RIDGELY. I think that certainly sounds reasonable. The individuals we're working with are people whose disabilities may have begun to affect their ability to work 10, 15, perhaps even 20 years ago and these individuals are returning to work with assistance in accessing the work incentives, with assurances that their benefits are going to be continued, especially the health care benefits, and

with support in accessing the assistive technology and the vocational support. So I think that's reasonable.

Ms. OTTO. I would agree with Mary. If the supportive services are available and if that threat is eliminated of losing medical coverage, I would say you could even see that increase from 3 to 10.

Admiral COONEY. I think where the real problem comes is in defining productive work. Unfortunately, each person would like to earn \$100,000 a year. There are not a lot of us who do and the same thing is true of people with disabilities.

I think sometimes the idea that people have to work in low functioning jobs is regarded as some form of punishment when the truth is there are people who are not disabled who are performing in low functioning jobs simply because that's the first step in the process of learning to work and beginning to develop a career.

I think we need to take a very good look at exactly what we're talking about when we talk about productive work. Then we can begin to figure out what it costs to subsidize people as they make growth rather than subsidizing them for not working at all.

The CHAIRMAN. In evaluating the cost benefit ratio here, we have to keep in mind the extent to which we're currently subsidizing cash benefits, plus Medicare or Medicaid, plus all of the other benefits that accrue. If you measure that against just stopping the cash benefit so that they have income coming in from a private source, that's a significant savings. Absent that, we're going to continue on the path those charts lead us to and that is complete bankruptcy.

So 3 out of 10 sounds pretty optimistic. That's getting up close to 30 percent of those on the disability rolls. We said in the beginning that about 1 percent would result in almost \$2.9 billion in savings. So if you get to 30 percent, we're talking real dollars.

Just a final comment about the conflict in mission, Admiral. You've indicated this seems to be an institutional inability to carry out both a pension benefit program and to encourage people and help move them back into the workforce. Maybe that's something we have to look at in terms of whether or not this is a conflict in mission.

We're now all focused upon FAA for the time being in terms of their dual mission of promoting air travel and also promoting air safety, as to whether or not that is an inherent conflict at some point in time, whether they should be separated. We may have to look at Social Security because the track record hasn't been admirable.

We've been talking about these issues for a long time now and they're getting worse. So we've got to perhaps look at that and see if we have to have another avenue to approach.

Admiral COONEY. For the consumer, that's a very important question. The Social Security Administration does, in my estimation, an admirable job of paying pensions. That's something that can be done in the bulk, but when you start dealing with individuals who are disabled and determining what their potential is, that has to be something that is done very specifically for the individual in the place where he lives and in the community where he has the potential to work. The Federal agency in Baltimore just can't do that. That's what you have private sector agencies to do for you.

The CHAIRMAN. Let me thank all of you for testifying. It's been very helpful and hopefully we can make some changes, certainly in the regulations and perhaps in the mission of the agency itself.

Thank you.

Our next panel consists of Dr. Mazzuchi, Deputy Assistant Secretary, Clinical Services, who is responsible for strategic planning and policy recommendations on a wide range of health-related matters and Dr. Susan Miller, director of Physical Medicine and Rehabilitation Residency Programs at the National Rehabilitation Hospital in Washington. Dr. Miller is accompanied by Mr. William Peterson who is director of Assistive Technology and Rehabilitative Engineering at the National Rehabilitation Hospital. He will coordinate the technology demonstrations.

These witnesses are going to discuss how assistive technology can help disabled individuals return to work and how the Government-sponsored Computer Accommodation Project at the Department of Defense has helped many Government employees continue to work.

Perhaps I can call initially on Dr. Miller, if you will proceed first with the demonstration, and also Mr. Peterson. Then we will come to Dr. Mazzuchi.

STATEMENT OF SUSAN MILLER, M.D., DIRECTOR OF PHYSICAL MEDICINE & REHABILITATION, NATIONAL REHABILITATION HOSPITAL, WASHINGTON, DC; ACCOMPANIED BY WILLIAM PETERSON, DIRECTOR, ASSISTIVE TECHNOLOGY AND REHABILITATIVE ENGINEERING

Dr. MILLER. Thank you, Senator.

I am a physician specializing in Physical Medicine and Rehabilitation at the National Rehabilitation Hospital here in Washington, DC. I am pleased to have been asked here today to discuss how the specialty fields of rehabilitation and assistive technology can work together to enable disabled individuals to return to our country's workforce.

I would like to begin with a basic concept, that being the reason for the existence of the medical specialty of rehabilitation. The ultimate goal of the rehabilitation process is to maximize the functional independence of persons who have experienced an impairment. An impairment is defined as a limitation resulting from a disease process, an anatomic abnormality or an injury.

In achieving the goal of maximum independence, the rehabilitation process also seeks to minimize disability, the consequence of impairment. Usually disability is measured in terms of the difficulty one has in attempting to carry out major life functions such as those pertaining to self care, mobility, communication, and employment.

In order to reduce disability and increase the independence of an individual, the rehabilitation process uses multiple interventions, among them physical therapy, occupational therapy, recreational therapy, speech therapy, various kinds of neuropsychological strategies, and vocational therapy as well as our topic today, assistive technology.

The Tech Act of 1988 defines an assistive technology device as any item, piece of equipment, or product system whether acquired off the shelf, modified, or customized, that is used to increase,

maintain or improve the functional capabilities of individuals with disabilities.

Over 2,000 resources are available worldwide which can provide assistive technology devices to those who need them. There are at least 25,000 to 30,000 products for sale in the marketplace.

Assistive technology can be applied to almost any type of workplace equipment but since it would be hard to imagine a world without computers, for today's demonstration I would like to concentrate on a few of the methods in which assistive technology can be used to obtain computer access for individuals with disabilities.

I'd like you to turn your attention now to Mr. William Peterson, director of Assistive Technology and the Rehabilitation Engineering Program at the National Rehabilitation Hospital as he demonstrates accommodations that make for more accessible input and output strategies in computer usage.

The traditional device for computer input is the QWERTY keyboard. It is named for the arrangement of the top left hand row of keys. The QWERTY keyboard can significantly impede the typing ability of an individual who types with one finger or one hand; for example, someone who has had a stroke. Therefore, keyboards now come in a variety of sizes, shapes, layouts and key types.

For example, we have mini keyboards for those whose range of motion or strength is limited. There are also expanded keyboards for those who lack fine motor control such as those individuals with cerebral palsy. For these individuals with difficulties of coordination, a plastic or metal overlay with a cutout opening can trap their finger on the correct key to help prevent mistrokes.

For those whose hand usage cannot accommodate to these keyboard alternatives, there are further options to enhance computer access. They range from different types of control switches to voice input systems.

The conditions of this room preclude our demonstration of a voice activated computer today, but we can demonstrate how a switch can be used to turn on a computer. Switches can be activated by the movements of one's head, eyes, or feet. They can also be operated by breath control.

We have an example of a chin or head switch which just needs to be activated merely by pushing your head or your chin against it. We also have a sip and puff mechanism which, for purposes of today, is connected to a call bell but can be as easily connected to the on/off switch of a computer. This might allow, for example, a quadriplegic individual to access a computer. The way to activate this sip and puff mechanism is to either blow into it or withdraw air to turn the computer on or off.

Mouse control of the computer is also frequently difficult to achieve for those with significant loss of function in their hands. Here we have a trackball which can be an adequate mouse substitution. This device looks like an upside down mouse. Instead of moving the mouse around the desktop, the computer operator uses the ball as it remains in its stationary holder. As you can see, it can be operated and manipulated by the back of one's hand, so it's useful for those individuals who have no finger dexterity.

Another mouse substitute is a digitizer which is a position sensitive tablet in which the computer operator provides input via a

stylus or a puck. These holiday cards which you see here are an example of the kind of computer-generated art work which can be produced with this type of interface.

This particular card was drawn by a 30-year-old quadriplegic individual who, after his course of rehabilitation at the National Rehabilitation Hospital, fulfilled his vocational goal of becoming a graphic artist. He now owns his own business.

Those are several of the input strategies or accommodations that we can use for computers. For those who require it, output accommodations can also be made. For example, for individuals with visual limitations, screen readers can be used to convert the text on the video display terminal to speech which is then obviously heard by the computer operator as opposed to read by them. We have an example here this morning.

Those with visual impairments can also use touch as an alternative method by which to access information on the computer. Computers can be programmed to provide braille output embossed symbols on paper, or the braille symbols can be felt as raised or vibrating pins on the keyboard itself.

The adaptations for which assistive technology can be used in the realm of computers are almost endless, and well beyond our time limitations today. However, before ending the demonstration portion of the testimony, let us show you two other types of cutting edge technologies that are available to disabled individuals in the workplace. The materials and the braces which you are being handed right now are composed of lightweight, polycarbon components which have been developed with Department of Defense funds by the aerospace industry.

With funding from the Department of Defense and private corporations, the National Rehabilitation Hospital is now developing and testing a new generation of leg braces for those with mobility impairments using these new materials. Compared to their steel equivalents which would weigh approximately 18 pounds—one of these new braces will probably weigh about 3 pounds.

Also compared to their steel equivalents, the proof of concept model composite parts are approximately 60 percent lighter, 40 percent stiffer, yet they are 200 percent stronger. By virtue of their lighter weight, these braces require their users to expend less energy while walking and that means that these braces then have the potential to give the appropriately chosen consumer extra endurance, thus reducing fatigue and increasing mobility in the workplace.

The wheelchair that you see here in front of us provides its user with the ability to stand. Developed by a paraplegic individual who wanted to dance with his wife, the standing wheelchair has successfully been used to return a paraplegic chef to work.

The standing wheelchair allows its user to position himself to reach overhead utensils such as pots and pans. While still standing, the individual can then roll through the kitchen. The particular manner in which the rear casters are made enables this chair to make very tight turns which may be necessary not only in a kitchen but in any workplace.

The assistive technology demonstrated here today represents only a fraction of the available products in the marketplace. Be-

cause of the plethora of adaptive equipment available, it is important that persons with disabilities be carefully and individually evaluated for these assistive devices.

In order to provide for an all-encompassing program that will appropriately evaluate, prescribe, and provide training for use of assistive technologies, a skilled and highly knowledgeable rehabilitation team of interdisciplinary professionals needs to be assembled.

Physicians, therapists and engineers together consider the medical, cognitive, sensory and neuromuscular status of the potential worker in order to maximize function and ensure safety. They will also make certain that the suggested equipment is compatible with the workplace as they determine how it will interface with the architecture, power sources, and space limitations of the job site.

Furthermore, the team will certify that the educational background of the disabled worker is appropriate not only for the usage of the equipment itself, but for the total workplace goals. The rehabilitation team is therefore crucial to the appropriate choice of assistive technology for disabled individuals who wish to return to work.

These two resources—assistive technology and rehabilitation—should be all that is necessary to increase the participation of disabled individuals in a return to work effort. I am sorry to say, however, that this combination of medical science and technology is not enough to wipe out what I see as the most significant obstacle to the return of the disabled individual to the workforce and that is the prejudices and the barriers which our society creates to handicap those who wish to achieve this goal.

The term handicap implies that, in addition to the disability experienced by the individual, there is also a perception of societal disadvantage attributed to that person. I think it was said best by Dr. Gale Whiteneck of Craig Hospital who suggested that most disabilities are viewed as role or activity limitations and that these perceived activity limitations are the "hallmark defining characteristic of disability in the national disability surveys in this country." Dr. Whiteneck adds that the specific notion of an individual's work limitation is an important and extremely powerful measure of the way our society regards disability.

Unfortunately, our current system of health care serves to encourage these same role and activity limitations of which Dr. Whiteneck speaks. Our current system of health care perpetuates the societal prejudices that stigmatize the disabled population in our country by limiting their access to services that would lead to employment and therefore, increased independence.

According to a 1992 study, approximately 2.5 million people in this country reported that they needed, but they could not obtain, technological devices to enhance their function. Lack of funding was the No. 1 reason to explain this problem. All too often insurers, be they government agencies or private companies, deny payment for physician-prescribed assistive technology.

The two most frequent reasons for these denials have been documented to be that the equipment is either not covered under the terms of the insurance or that the equipment is not deemed to be medically necessary by the third party payer.

Of what use is all of our technological advancement if it is not made available to those who need it? What purpose can it serve to train rehabilitation professionals to evaluate disabled individuals for the most modern and innovative assistive technology in the world if this equipment is out of the reach of those who wish to use it to return to work?

Too many, if not a majority, of persons with medical barriers to employment, the advances of assistive technology are denied and it appears that the primary obstacle standing between those with disabilities and the equipment they need to overcome them is money.

Our current medical delivery system emphasizes episodic care to restore health for acute illness or injury. Our medical health care financing mechanisms follow suit and, therefore, do not provide for the more long-term services needed to maximize the employment potential of the disabled individual.

Medicare, Medicaid, and most private insurers only reimburse for equipment that is defined as medically necessary and that equipment, by definition, is used for a medical purpose in the home. Let me repeat that because it's important. Most medically necessary equipment, by definition, is used for a medical purpose and is used in the home.

I ask again, why create assistive technology for the workplace if it is to be denied to those who wish to use it based on shortsighted, handicapping financial rules and regulations? Many insurers do not extend their coverage to any vocationally related service because they deem these services not to be medically necessary. Why then have assistive technology if you can't be evaluated for it or trained to use it?

I submit to you that one of the means to reduce the cost of disability in this country is to recognize the lifetime nature of disability and to advocate for a system of health care that does the same. We cannot allow shortsighted insurance agencies and managed care companies to penalize their patient populations by denying them access to rehabilitation services and technology.

The process of rehabilitation can rediscover the functional potential of disabled individuals and empower them to reenter this country's workforce. Disability can become capability. We need only give people the chance and the resources to achieve this goal.

Thank you.

[The prepared statement of Dr. Miller follows:]

National Rehabilitation Hospital

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REHABILITATION AND ASSISTIVE TECHNOLOGY

Testimony before the Senate Special Committee on Aging
 United States Senate
 Washington, D.C.

May 23, 1996

June 5,

Susan M. Miller, M.D.
 Director of Physical Medicine and Rehabilitation
 Residency Training Program
 National Rehabilitation Hospital
 Washington, D.C.

Staff Psychiatrist
 National Rehabilitation Hospital/
 George Washington University Hospital Affiliation Program

10th Anniversary

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Good morning. My name is Dr. Susan Miller. I am a physician specializing in Physical Medicine and Rehabilitation at the National Rehabilitation Hospital here in Washington, D.C. I am honored to have been asked here today to discuss how the fields of rehabilitation and assistive technology can work together to provide appropriate opportunities for disabled individuals to join our country's workforce.

I would like to begin with a basic concept, that being the reason for the existence of the specialty of rehabilitation. The ultimate goal of the rehabilitation process is to maximize the functional independence of persons who have experienced an impairment, which is defined as a limitation resulting from a physical or psychological disease process, anatomic abnormality, or injury. In achieving this goal of maximum independence, the rehabilitation process also seeks to minimize disability or the consequences of an impairment. Usually disability is measured in terms of an individual's inability to carry out major life functions, such as those pertaining to self care, mobility, communication and the pursuit of employment.

In order to reduce disability and increase the independence of an individual, the rehabilitation process uses multiple interventions - among them physical, occupational, speech and recreational therapies, neuropsychological strategies, vocational therapy and our topic today, assistive technology.

The Technology-Related Assistance for Individuals with Disabilities Act of 1988 defines an assistive technology (AT) device as "any item, piece of equipment or product system, whether acquired off the shelf, modified or customized, that is used to increase, maintain or improve the functional capabilities of individuals with disabilities." Over 2,000 resources are available worldwide which can provide assistive technology devices, with probably 25,000 - 30,000 products for sale in the marketplace.

Today it would be hard to imagine a world without computers. Though assistive technology can be applied to almost any type of workplace equipment, for today's demonstration, I would like to concentrate on a few of the methods in which it can be used to obtain computer access for individuals with various disabilities. Specifically, I would like to turn your attention to Mr. William Peterson, MS, Director of Assistive Technology/Rehabilitation Engineering Program at the National Rehabilitation Hospital as he demonstrates accommodations that make for more accessible computer input and output strategies.

The traditional device for computer input, the QWERTY keyboard (named for the arrangement on the top left hand row of keys) can significantly impede the typing ability of an individual who types with one finger or one hand. Therefore keyboards now come in a variety of sizes, shapes, layouts and key types. For example, there are mini-keyboards for those whose range of motion or strength is limited. There are also expanded keyboards for those who lack fine motor control. For individuals with difficulties of coordination, plastic overlays with cut out openings can "trap" a finger on a correct key and help prevent misstrokes.

For those whose hand usage can not accommodate to these keyboard alternatives, there are further options to enhance computer access that range from different types of control switches to voice input systems. The conditions of this room preclude our demonstration of a voice activated computer today, but we can show you how a switch can be used to turn on a computer. Switches can be activated by the movement of one's head, hands, feet or eyes. They can also be operated by breath control. Here is an example of a sip and puff mechanism connected to a light, but which just as easily can be connected to the on-off switch of these computers to allow quadriplegic individuals to access the machine.

Mouse control of the computer is also frequently difficult to achieve for those with significant loss of function in their hands. For some, a trackball can be an adequate mouse substitution. The device looks like an upside down mouse. Instead of moving the mouse around the desktop, the computer operator uses the ball as it remains in its stationary holder. Because the trackball may be manipulated by the back of one's hand, it is useful for those individuals with significant mobility disorders.

Another mouse substitute is a digitizer, a position sensitive tablet in which the computer operator provides input via a stylus or a puck. This "painting" is an example of the kind of computer generated artwork which can be produced with this type of interface. It was drawn by a 30 year old quadriplegic individual who after his course of rehabilitation at the National Rehabilitation Hospital fulfilled his vocational goal of becoming a graphic artist. He now owns his own business.

For those who require it, output accommodations can also be made on computers. For example, for individuals with visual limitations, screen readers can be used to convert the text on the video display terminal to speech which is then heard by the computer operator. Those with visual impairments can also use touch as an alternative method by which to access information from a computer. Computers can be programmed to provide braille output embossed symbols on paper, or as raised or vibrating pins on the keyboard itself.

The adaptations for which assistive technology can be used in the realm of computers is almost endless and well beyond our time limits today. Before ending the demonstration portion of the testimony; however, let us show you two other types of cutting edge technologies that are available to disabled individuals in the workplace.

The materials which you are being handed are lightweight polycarbon components, developed with Department of Defense funds by the aerospace industry. With funding from Department of Defense and private corporations, the National Rehabilitation Hospital is developing and testing a new generation of leg braces for those with mobility impairments, using these new materials. Compared to their steel equivalents, the proof-of-concept model composite parts are approximately 60% lighter, 40% stiffer, and 200% stronger. By virtue of their lighter weight, these braces require users to expend less energy while ambulating. These braces then have the potential to give the appropriately chosen consumer extra endurance, thus reducing fatigue and increasing mobility in the workplace.

The wheelchair you see here provides its user with the ability to stand. Developed by a paraplegic individual who wanted to dance with his wife, the standing wheelchair has successfully been used to return a paraplegic chef back to work. The standing wheelchair allows its user to position him/herself to reach overhead utensils such as pots and pans. While still standing, the individual can roll through the kitchen. The rear casters enable the chair to make the tight turns, which may be necessary in a workplace.

The assistive technology demonstrated here today represents only a fraction of the available products in the marketplace. Because of the plethora of adaptive equipment available, it is important that persons with disabilities be carefully and individually evaluated for these assistive devices. In order to provide for an all encompassing program that will appropriately evaluate, prescribe and provide training for the use of assistive technology, a skilled and highly knowledgeable rehabilitation team of interdisciplinary professionals needs to be assembled.

Physicians, therapists and engineers together consider the medical, cognitive, sensory and neuromusculoskeletal status of the potential worker in order to maximize function, ensure safety and reduce the possibility of equipment abandonment. They will also make certain that the suggested equipment is compatible with the workplace as they determine how it will interface with the architecture, power sources, space limitations of the job site. Furthermore, the team certifies that the educational background of the disabled worker is compatible with not only the equipment usage, but also the total workplace goals.

The rehabilitation team is thus crucial to the appropriate choice of assistive technology for disabled individuals who wish to return to work.

I would like to tell you that these two resources, assistive technology and rehabilitation, are all that is needed to increase the participation of disabled individuals in a return to work effort. However, I cannot. I have spoken today of impairments and of disabilities and have shown you how technologic advancements and medical knowledge together can minimize the consequences of these conditions. But I am sorry to say that this combination of science and technology is not enough to wipe out perhaps what is arguably the most significant obstacle to the return of the disabled individual to the workforce, and that is the prejudices and barriers which our society creates to handicap those who wish to achieve this goal.

The term handicap implies that in addition to the disability experienced by the individual, there also is a societal notion of disadvantage attributed to that person. At the 71st Annual Session of the American Congress of Rehabilitation Medicare, Dr. Gale G. Whiteneck of Craig Hospital, in Colorado, suggested that most disabilities are viewed as role or activity limitations and that these "perceived activity limitations are the hallmark defining characteristic of disability in the national disability surveys." According to Dr. Whiteneck, the specific notion of an individual's work limitation is an important and powerful measure of the way our society regards disability.

In my opinion, our current system of health care serves to encourage these role and activity limitations of which Dr. Whiteneck speaks and as such perpetuates the societal prejudices that stigmatize the disabled population in our country. Of what use is all of our technologic advancement if it is not made available to those that are in need of it? What purpose can it serve to train rehabilitation professionals to evaluate disabled individuals for the most modern and innovative assistive technology in the world, if this equipment remains out of reach for those who wish to use it to return to work? To many, if not a majority of persons with medical impediments to employment, the advances of assistive technology are denied - and it appears that the primary obstacle standing between those with disabilities and the equipment they need to overcome them, is money. According to a 1992 study, approximately 2.5 million people in this country reported that they needed, but could not acquire, technological devices to enhance their function. About 70% of these same people said lack of funding was the major reason for their predicament. One important explanation for this dire funding situation is that all too often insurers, be they government agencies or private companies, deny payment for physician prescribed assistive technology. The two most frequent reasons for these denials have been documented to be that the equipment was not covered under the terms of the insurance and that the equipment was not deemed medically necessary by the third party payor.

What constitutes medically necessary equipment in this country? According to Medicare, Medicaid, and most private insurances, medically necessary equipment must primarily be used for a medical purpose, must withstand repeated use, should not be useful to a person without illness or injury, and generally must be used at home. Let me repeat that - equipment deemed medically necessary by most insurers is defined as being generally used in the home. I ask, why create assistive technology for the workplace at all if it is to be denied to those who need it most based on arbitrary and handicapping financial rules and regulations?

Why have assistive technology if you can't evaluate and be trained to use it? Indeed, I am experienced with several managed care providers in our immediate geographic area alone, who do not extend their coverage to any vocationally related services because they deem these services not to be medically necessary.

Currently our country tends to focus its attention on the short term health care results that occur in a hospital, and we ignore the status of long term healthcare outcomes. I submit to you that one of the means to reduce the costs of disability in this country is to recognize the lifetime nature of this condition, and to advocate for a system of health care that does the same. We have the resources already in place to aid us in this endeavor; we just need to use them. We can not allow short-sighted insurance agencies and managed care companies to penalize their patient populations by denying them access to rehabilitation services. The process of rehabilitation can discover the functional potential in an individual with a chronic impairment and can carefully construct and encourage a long term plan of resource utilization that best serves the interests of both the consumer and society. In this way, our disabled population can be empowered to achieve their full capacity, and reenter this country's workforce. I thank the Committee for its consideration of my remarks.

Bibliography

- Blake, DJ and Scott, DD: Employment of Persons with Disabilities.
In Braddom, RL, et al. (ed): Physical Medicine and Rehabilitation,
Philadelphia, W.B. Saunders Company, 1996, 177-190.
- Britell, CW and Scott, NG: Computer Adaptive Systems and Technology for the Disabled.
In DeLisa, JA, et al. (ed): Rehabilitation Medicine, Principles and
Practice, Philadelphia, J.B. Lippincott Company, 1993, 555-562.
- Donovan, DH et.al: Profile of denials of durable medical equipment for SCI patients by
third party payers. American Journal of Physical Medicine, Vol. 66,
1987, 238-243.
- Galvin, JC and Caves, KM: Computer Assistive Devices and Environmental Controls.
In Braddom, RL, et al. (ed): Physical Medicine and Rehabilitation,
Philadelphia, W.B. Saunders Company, 1996, 493-502.
- O'Day, BL and Corcoran, PJ: Assistive Technology: Problems and Policy Alternatives.
Archives of Physical Medicine and Rehabilitation, Vol. 75, 1994, 1165-
1169.
- Whiteneck, GG: Measuring What Matters: Key Rehabilitation Outcomes.
Archives of Physical Medicine and Rehabilitation, Vol. 75, 1994, 1073-
1076.

The CHAIRMAN. Thank you very much.
Mr. Mazzuchi.

STATEMENT OF JOHN MAZZUCHI, PH.D., DEPUTY ASSISTANT SECRETARY FOR CLINICAL SERVICES, U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY DINAH COHEN, DIRECTOR, COMPUTER ELECTRONIC ACCOMMODATION PROGRAM

Mr. MAZZUCHI. Thank you, Mr. Chairman.

It is my pleasure to appear before you and the members of your committee today to present to you an overview of the Department of Defense's Computer Electronic Accommodation Program. With me today is the director of that program, Ms. Dinah Cohen, who is an expert in adaptive equipment and an enthusiastic advocate of its widespread use.

The Computer Electronic Accommodation Program, known as CAP, provides the opportunity for people with disabilities to compete in today's workforce. DOD established the CAP in fiscal year 1990 to fund the purchase of accommodations for DOD employees who required adaptive equipment to access computer or telecommunications equipment.

The CAP began as a pilot program but its success has made it a valuable, permanent component of the Department of Defense. Since its inception, the CAP has filled over 9,000 requests for accommodation. The types of accommodation and adaptive equipment supplied most frequently by the CAP Office are for people who are deaf or hard of hearing with 5,547 accommodations; people who are blind or who have low vision, 2,337 accommodations; and people with dexterity impairments, 1,252 accommodations.

Additionally, CAP funds training or support services needed to ensure that recipients become successful users of their equipment.

Major contributing factors to the success of CAP are its centralized responsibility and funding. The CAP staff has adequate equipment experts and has the ability to purchase in quantity thus streamlining our acquisition process as well as reducing costs.

A big plus for the CAP is its central funding. This factor removes budget conflicts that some DOD managers might otherwise face. When a manager has the ability to hire a person with a disability without concern for the type of accommodation needed or how to obtain it, or how much it will cost, then we have dramatically improved the employment prospects for those with disabilities.

With its successful operational experience and growing acceptance within the Department of Defense, the CAP has begun to expand its assistance efforts. We have established the CAP technology evaluation center or CAPTEC at the Pentagon where we can assist in the selection of the most workable equipment. This facility evaluates adaptive technology and showcases appropriate alternatives for demonstration to DOD employees and their managers.

CAPTEC is designed to facilitate the purchase of adaptive equipment for people with disabilities. As our experience with adaptive equipment grew, we found that we could apply the accommodation concept to employment issues other than traditional disabilities and help employees remain productive and competitive.

The members of the CAP Office now work closely with the DOD offices responsible for workers compensation and with disability re-

tirement. The CAP has provided equipment to over 60 employees who would have gone out on disability retirement. In addition, equipment provided by CAP has allowed more than 20 workers compensation recipients to return to work.

CAP is a success and what makes it so are the many employees who are working today because of the CAP Program. Let me give you just a few examples.

A senior employment specialist with a spinal cord injury depended on coworkers and secretaries to help with writing and typing tasks. Her ability to complete other jobs also depended on other employees.

After receiving accommodation from CAP, she now works independently by dictating all of her work into a voice recognition system that types everything she speaks into a computer. She produces memos, e-mails, and many other documents requiring computer equipment. In fact, her equipment is such a powerful assistant that it allows her to produce her work in final copy often quicker than many of her fellow employees.

A military officer who was diagnosed with multiple sclerosis at Walter Reed Army Medical Center developed impaired visual and dexterity problems. Walter Reed referred him to the CAPTEC for a needs assessment and evaluation. The CAP was able to identify and procure adaptive equipment to address his physical disabilities and he has now returned to work as a civilian with the Department of the Air Force.

A young summer intern in Europe was in a car accident that left her paralyzed. Since the injury occurred while at work, she could have received workers compensation for the majority of her adult life. The CAP Office worked closely with the employee, the Workers Compensation Office, and her DOD employer to set up appropriate technology in order for her to return to work where she is able to work now for many more productive years.

The last example of Cap Tech is a personal one. Born with ocular albinism and having developed glaucoma at age 40, I was unable to use the computer equipment that was absolutely required for me as a manager, especially as a senior manager in the Department of Defense. Basically, because of the tremendous assistance provided to me by Dinah and her staff, I am now able to use e-mail or any computer technology as readily as anyone else.

I am not a dutiful or bureaucratic supporter of this program, but rather a very enthusiastic personal supporter of the program and see people like Dinah and her staff as real heroes helping people with disabilities to stay on the job.

Perhaps the greatest achievement of this program is the fact that it gives the employees a level playing field to help them compete with others in today's workforce.

We don't have demonstrations available for you today but I would like to extend an invitation to you and the members of your committee and your staffs to come to the Pentagon to look at the CAPTEC. We can provide a personal tour of that facility where you will get an evaluation of how that facility reinforces what I have discussed with you today.

This completes my testimony and we'd be happy to answer any of your questions.

[The prepared statement of Mr. Mazzuchi follows:]

Department of Defense Computer/Electronic Accommodations Program

Summary Statement by

John F. Mazzuchi, Ph.D.

Deputy Assistant Secretary of Defense for Health Affairs

Before the

Special Committee on Aging

United States Senate

Second Session, 104th Congress

June 5, 1996

Mr. Chairman, Distinguished Members of the Committee, it is a privilege to appear before your Committee to present to you an overview of the Defense Department's Computer/Electronic Accommodations Program. With me today is the Director of the program, Ms. Dinah Cohen: our expert on adaptive equipment and an enthusiastic advocate for its widespread use.

The Computer/Electronic Accommodations Program, known as CAP, provides the opportunity for people with disabilities to compete in today's workplace.

DoD established the CAP in Fiscal Year 1990 to fund the purchase of accommodations for DoD employees who required adaptive equipment to access computer or telecommunications systems.

The CAP began as a pilot program, but its success has made it a valuable component of the Department of Defense. Since its inception, CAP has filled over 9,000 requests for accommodations. The types of accommodations and adaptive equipment supplied most frequently by the CAP office are for people who are deaf and hard of hearing (5,547 accommodations), people who are blind or have low vision (2,337 accommodations), and for people with dexterity impairments (1,252 accommodations). Additionally, CAP funds training or support services needed to ensure that recipients become successful users of their equipment.

Major contributing factors to the success of CAP are its centralized responsibility and funding. The CAP staff has adaptive equipment experts and has the ability to purchase in quantity, thus streamlining the acquisition process as well as reducing costs.

A big plus for the CAP is its central funding. This factor removes the budget conflict some DoD managers might otherwise face.

When a manager has the ability to hire a person with a disability without the concern for what type of accommodation, how to obtain it, or how much it will cost, we have dramatically improved the employment process.

With its successful operational experience and growing acceptance within DoD, the CAP has begun to expand its assistance efforts. We have established the CAP Technology Evaluation Center, or CAPTEC, in the Pentagon where we can assist in the selection of the most workable equipment. This facility evaluates adaptive technology and showcases appropriate alternatives for demonstration to DoD employees and their managers.

CAPTEC is designed to facilitate the process of choosing adaptive equipment for people with disabilities.

As our experience with adaptive equipment grew, we found we could apply the accommodation concept to employment issues other than traditional disabilities, and help our employees remain competitive and productive. The members of the CAP office now coordinate with DoD offices responsible for workers' compensation and disability retirement cases.

CAP has provided equipment to over 60 employees who would have gone out on disability retirement. In addition, equipment provided by CAP has allowed more than 20 workers' compensation recipients to return to work.

CAP is a success; and what makes it so are the many employees who are working today. Let me introduce you to just a few:

- A senior employment specialist with a spinal cord injury depended on co-workers and secretaries to help with writing and typing tasks. Her ability to complete job tasks also depended on other individuals. After receiving accommodations from CAP, she now works independently by dictating all her work into a voice recognition system that types everything she speaks into her computer. She can produce memos, e-mails, and any other documents by using voice recognition equipment. In fact, this equipment is such a powerful assistant that it allows her to produce work in final copy quicker than many of her co-workers.

- A military officer was diagnosed with multiple sclerosis at Walter Reed Medical Center. Due to this development, he incurred visual and dexterity impairments. Walter Reed referred him to CAPTEC for a needs assessment and evaluation. CAP was able to identify and procure adaptive equipment to address his physical disabilities and he was able to return as a civilian to his position with the Air Force.
- A young summer intern in Europe was in a car accident that left her paralyzed. Since the injury occurred at work, she could have remained on workers' compensation for the majority of her adult life. The CAP office worked closely with the employee, her workers' compensation office, and her DoD employer to set up appropriate technology in order for her to return to work and to be able to have many productive years.

In closing, Mr. Chairman, I want to address the tremendous benefits that the Computer/Electronic Accommodations Program has brought to the Department of Defense. Perhaps the greatest achievement of this program is its ability to level the playing field so that severely disabled individuals have the opportunity to compete in today's work force.

I would like to extend an invitation to the Committee and your staff members to come to the Pentagon and visit CAPTEC. A personal evaluation of this facility would reinforce what I have discussed here today.

That completes my summary, Mr. Chairman. I would be happy to respond to questions at your convenience.

The CHAIRMAN. Thank you very much, Mr. Mazzuchi.

Can you tell me, have you been approached by any of the other Government agencies for either demonstrations or explanations of how the program works?

Mr. MAZZUCHI. Yes. We put on a demonstration at the Department of Health and Human Services just recently. Dr. Joseph was so pleased with the CAP technology at the unveiling of the CAP Tech at the Pentagon that he invited Dr. Lee to have a demonstration of it and we provided that. I believe there was quite a strong acceptance by the HHS staff for what we've been able to do at the Pentagon.

The CHAIRMAN. What happens when there is a breakdown of the equipment? Who is responsible for repairs or how is that handled? Does the employee pick up part of the costs?

Mr. MAZZUCHI. No.

Ms. COHEN. We provide the equipment and with the equipment comes the warranty, the maintenance agreement, and a lot of the support services, so we provide that as backup. Once the property goes to that individual, then it stays at that activity level but we always provide the backup for any type of repairs or support they may need long term.

The CHAIRMAN. One of the things we heard in the last panel is the enormous delay involved in the Social Security Administration's handling of these issues. You must take several months simply to apply for it; there's another 5-month wait, so it's close to a year by the time you actually get payment. That, of course is a big disincentive.

You now have a mindset that gee, I can't work and shouldn't work and have got to wait until the payments start to come and if I start to do anything in between or even talk about taking advantage of programs which have never been explained to me, then that might, in fact, work against me by negating the ability to get the check in the first place.

How do you handle that situation? Do you have early involvement when someone is disabled in the Federal workforce? How do you handle that?

Mr. MAZZUCHI. I can tell you from personal experience that when I developed my problem, I was aware of the CAP Program because, fortunately for me, it was under the Health Affairs Office along with the Personnel Office, but it is so widely publicized now in the Department of Defense, I believe many managers are quite aware of what it can do.

For myself, I certainly did not need to wait very long when I identified difficulties in using the computer to Dinah. I immediately had an appointment with members of her staff who came up and assessed my personal and individual needs and provided me with the type of computer accommodation I needed. I know of several others who are hearing impaired who also had the same kind of experience.

For us, we've been very fortunate in having this program. It's been a very high visibility program for us. We briefed the program and its funding line to the Under Secretary for Personnel Readiness, Dr. Dorn, and he was an enthusiastic supporter. When the CAPTEC was opened at the Pentagon, Secretary Perry took time

out from his busy schedule to come down and tour the facility and give a presentation.

I think that kind of high visibility, high level support has really helped get word out to the Pentagon and other DOD employees of the fact that we have this accommodation program.

The CHAIRMAN. You think most DOD employees are aware of the availability of such a program?

Ms. COHEN. We're always working hard to make sure that all DOD people and managers are aware of the program, so as soon as they recognize or identify anyone who may have an accommodation requirement, they can quickly call us and we immediately start the evaluation process, the request process, and the acquisition process. The turnaround time from the time someone identifies a need to the time they get the adaptive equipment usually does not run more than a month.

The CHAIRMAN. Dr. Miller, could I ask you several questions?

We heard some testimony about the lack of flexibility, perhaps the lack of desirability of using a medical impairment standard in assessing the disability of an individual. Can you make an argument that we should retain some aspect of the medical impairment standard as opposed to a functional assessment dealing with adults?

Dr. MILLER. I think these two assessments go hand in hand. The medical impairment standard basically measures how weak a muscle is, how far a knee bends, things like that. These are very objective measurements. You should hold the physicians who are making these measurements to a scale of objectivity.

I've heard testimony today that the functional capacity evaluations that you have seen performed are somewhat subjective. But as a person who has been involved in doing these in the past, I can tell you that there are always ways of building in objectivity into some of these more subjective examinations.

For example, you can have people repeat what they think are unrelated tasks but in actuality these tasks should all be performed in a similar manner. But if people are not performing up to their full potential, voluntarily, you can catch them in the inconsistencies in which they perform these functional tests. Therefore, you can show that they are not giving a full voluntary effort. I think you have to retain both the medical impairment and functional capacities assessments because each gives you a different kind of information.

I think the key is to get physicians and therapists involved who recognize that you must show reproducibility in all of your findings. You can't just say to somebody, how far can you move your arm and have them go like that and not see if they can move their arm more.

The CHAIRMAN. What about mental impairment? About one-third of those on disability is not physical but mental. How do you make that kind of assessment?

Dr. MILLER. A mental impairment is probably a little harder to judge, but again, you can look at somebody's functional capacity. I will tell you, I was very interested in the example about the motorcycle rider who was otherwise totally, functionally impaired at least by medical definitions because of his nerves.

I will tell you that in some States, it is legal to use private investigators to follow people around and record what they do and then bring it to a physician to look at. This type of procedure has been used in the worker's compensation system with which I am very familiar in the State of Florida, when I practiced there.

I feel that kind of information is very valuable and it is only going to hurt those people who don't want that information to come into your office or the Social Security Office. I see no reason why that sort of information should not be allowed. I think it is another component of assessment exams.

Again, I have to tell you that with tough but fair impairment exams and functional capacity exams, I think you can tell a lot about a person in your office.

The CHAIRMAN. What about the cost, Mr. Peterson or Dr. Miller, of this particular piece of equipment?

Dr. MILLER. This particular piece of equipment—the standing wheelchair—is \$12,000. However, some of the environmental control units demonstrated today are less than \$25. According to the Job Accommodations Network, approximately 50 percent of the pieces of equipment that are used in the workplace to accommodate people with disabilities cost under \$500. I believe approximately 14 or 15 percent of the equipment costs between \$1,000 and \$2,000. There are other studies that agree with those figures. For the cost of a few hundred dollars, we can be putting many people back to work.

The CHAIRMAN. The cost of 1 month's check in many cases?

Dr. MILLER. Less.

The CHAIRMAN. I was intrigued with this particular piece of equipment, with something quite similar to it.

I was giving a commencement speech at the University of Maine recently and one of the young graduates was powering a chair much like this with this system just by breathing into it. He went all the way from the back of the auditorium up on the ramp, maneuvered it with a breathing technique to the standing ovation of everyone in the audience. Someone with that kind of disability was able to not only complete his studies but also to function and to get around through the use of this type of device.

Dr. MILLER. That sip and puff device can be connected to a whole panel of environmental control units so that you can operate anything in your room. You can answer a phone, you can dial a phone, you can open the curtains, close the curtains, turn on the TV, turn on your computer, et cetera, just by using that sip and puff device.

The CHAIRMAN. The other thing we have to keep in mind, just as we've seen with all technology, is that when something new arrives on the scene, it's very expensive. But if we start getting into mass production, then the cost comes down dramatically.

I don't know how many of these particular types of chairs are actually produced, but if we started out to encourage more and more people to take advantage of the technology and to turn our system so it, in fact, exploits the opportunities, as you pointed out, then I assume that chair that is \$12,000 would be substantially less.

Dr. MILLER. Right. If we could return 3 out of 10 people to the workforce, there would be more of a call for this sort of equipment and the price would go down.

The CHAIRMAN. I think also you said something very important about paradigms which is the new word we resort to, but I was thinking of Lincoln when he said, "A pessimist is someone who sees a difficulty in every opportunity and an optimist is someone who sees an opportunity in every difficulty." That is essentially what we have to engage in, that sort of mind transformation of not talking about disability but opportunity or capability.

That's why I mentioned this young Michael Noyes who works in my office. I would hope that someone might do some national television program focusing on individuals like him who were born with a tremendous "disability" and yet you stand in admiration as to what he can do. There's so many people like that if we only encourage them with the kind of supportive systems that are available and should be available.

Dr. MILLER. At the NRH, we see the courage of these people all the time and I would like to hold them up to the insurance companies who are denying them access to the equipment and to the other resources they need.

The CHAIRMAN. I thank you for coming this morning and demonstrating some of the technology available.

Dr. MILLER. Thank you.

The CHAIRMAN. Mr. Mazzuchi, I'll try to get over to the Pentagon and take a look at some of that equipment myself.

Mr. MAZZUCHI. We'd love to have you.

The CHAIRMAN. Thank you.

Our final panel today consists of Virginia Reno, project director of the Disability Project, National Academy of Social Insurance on behalf of Jerry Mashaw who is chairman of the Project.

We are also going to hear from Mr. Tony Young who is the director of Residential Services and Community Support, Government Relations Division, American Rehabilitation Association here in Washington. Mr. Young is going to be testifying in his capacity as the co-chair of the "Return To Work" Group.

Ms. Reno, would you like to begin?

STATEMENT OF VIRGINIA RENO, PROJECT DIRECTOR, NATIONAL ACADEMY OF SOCIAL INSURANCE, WASHINGTON, DC., ON BEHALF OF JERRY MASHAW, CHAIRMAN, DISABILITY POLICY PANEL

Ms. RENO. Thank you, I'm glad to be here with Tony Young as we have communicated before on some of our mutual policy proposals.

I'm here today to report to you on the work of an expert panel on disability policy that has just completed a 3-year study of the Social Security Disability Programs. The panel was convened by the National Academy of Social Insurance a little over 3 years ago in response to a request from the Ways and Means Committee.

The Academy itself is a nonprofit organization. It is made up of scholars and experts on social insurance programs; it promotes research and is a forum for exchange of ideas, but it does not take policy positions. The study groups it convenes, however, do come up with recommendations and that is what I will be reporting to you today from the Disability Policy Panel.

The list of panel members is included in our testimony and it's quite a stellar group from both the private sector and public sector and universities. They have spent much of their careers studying disability income programs and rehabilitation programs.

I would like to capsulize quickly for you the three basic questions this panel was asked to investigate. There are three short answers and then we can elaborate as needed.

The first basic question was, "are the cash benefit programs of the DI and SSI programs a strong deterrent to work?" After studying those programs and the people who receive them, and comparing these programs with others in the private sector and in other countries, the panel concluded, no. The cash benefits themselves are not.

Lack of health care is a different matter and that certainly can be an impediment to work.

The second question the group was asked is, "can an emphasis on rehabilitation be built into the disability programs of Social Security without greatly increasing the cost or weakening the right to benefits for those who cannot work?" That is a very, very hard question to answer. The panel came up with an innovative proposal that it believes has great potential for doing that. The proposal is to issue tickets, akin to vouchers, that return-to-work beneficiaries could use to get the services they need from private or public sector providers.

I would be glad to talk more about that proposal and I know that Tony and his organization have also thought a great deal about the panel's proposal.

The CHAIRMAN. Let me point out, as you heard Admiral Cooney, there are two issues involved. One is cost; second is spirit. We have to take both into account as we examine the programs.

Ms. RENO. Exactly.

The third question the group was asked is, "are there ways to restructure disability income policy that would better promote work?" The panel recognizes that any kind of income support can, to some degree, be considered a work disincentive. Income enables people to live if they are unable to work.

The panel did come up with a number of proposals that it believes will improve incentives and promote work. First, it recommends disabled workers tax credit that builds on the concepts embedded in the earned income tax credit, a way to make work pay for low income workers who have disabilities. It is designed for those who have some partial capacity to work, including young people who may be entering the workforce for the first time. It is a way to subsidize work even at low pay for people with partial disabilities.

That kind of proposal does nothing for people who are totally unable to work, and some people are in that category.

The panel also thought the disabled workers tax credit was better than trying to create some concept of partial disability in our public disability income programs. The panel considered ways to move away from the binary nature of disability in Social Security Disability Insurance by having DI pay for partial disability. That's a very costly undertaking.

Second, the panel has a recommendation for a simplified and affordable Medicare buy-in for people who work enough that they leave the disability insurance rolls and go back to work. There is a buy-in provision in the existing law; but it is so complicated and it defies explanation. If I were to try to tell you if you are contemplating going to work, what it would cost you to buy Medicare 3 years from now when you are back at work, I could not tell you, even though there is a buy-in provision.

The panel's proposal is to simplify that by saying, in effect, your Medicare premium would be 7 percent of your earnings in excess of \$15,000 a year until it reaches the full premium that is charged under the current uninsured elderly program.

Third, the panel is recommending a personal assistance tax credit under the income tax. That would enable some people who need costly personal assistance to make the transition from the public programs, mainly SSI and Medicaid, and those State programs that provide personal assistance to low income people. It would allow them to make the transition to a better-paying job where they normally wouldn't be eligible for Medicaid.

Finally, the panel believes more could be done by placing priority on implementing the existing work incentive provisions in the Social Security programs. Several players could be involved in implementing work incentives. The panel's recommendation for return-to-work tickets, and return-to-work vouchers is a way to involve the private sector and rehab providers in assisting beneficiaries return to work.

Another role those providers could play would be as an expert on the work incentive provisions so that they would know what would happen to their client when they earn specified amounts of money. They could help their client do the kind of recordkeeping that is necessary under the rules to comply with the work incentives.

The other side of administering the work incentives appears to be something that only SSA or an entity employed by SSA could do. That is, when a person does work, when they report their earnings to SSA, the changes need to be processed promptly and accurately so that the expected change in benefits actually happens, rather than waiting until long after the fact when a person may end up being overpaid or underpaid. When benefits are not adjusted promptly the kind of certainty beneficiaries need in their income doesn't happen. That uncertainty is a deterrent to work, and it can be remedied by better administration.

I would be glad to go back and elaborate on why the panel thinks that these programs, in and of themselves, are not powerful work disincentives or on any of our proposals if you wish.

[The prepared statement of Ms. Reno follows:]

**Recommendations of the Disability Policy Panel
Convened by the National Academy of Social Insurance**

**Testimony of Jerry L. Mashaw, Panel Chair
Sterling Professor of Law
Yale University**

Good Morning. I am pleased to be here today to report to you on the work of an expert Panel on disability policy that I had the privilege of chairing. The Panel was formed by the National Academy of Social Insurance a little over three years ago in response to a request from the Chairmen of the Ways and Means Committee and its Social Security Subcommittee. The Academy is a nonprofit, nonpartisan organization made up of many of the Nation's leading scholars on social insurance programs. Its purpose is to promote research and public understanding, develop new leaders and provide a forum for exchange of ideas about major issues in the field of social insurance.

To conduct the disability policy study, the Academy convened an 18 member panel from among the Nation's leading experts on disability policy. Our Panel members came from very divergent perspectives and backgrounds, including people from the private sector, public administrators, persons from the disability community and scholars from a variety of academic disciplines, including economics, law, medicine, rehabilitation and sociology. A list of Panel members follows.

The Panel issued its findings and recommendations in January and I am pleased to summarize them for you today. I should point out that the conclusions are those of the Panel. They do not represent an official position of the National Academy of Social Insurance, which does not take positions on legislative policy issues.

Jerry L. Mashaw
Senate Special Committee on Aging - ^{June 5} ~~May 23~~, 1996 1

Disability Policy Panel
National Academy of Social Insurance

THE DISABILITY POLICY PANEL
National Academy of Social Insurance

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Disability Policy Panel
National Academy of Social Insurance

The Panel's charge from the Academy was to respond to three basic questions.

- (1) Do disability cash benefits provide a strong disincentive for people to work?
- (2) Can an emphasis on rehabilitation and work be incorporated into the disability cash benefit programs without greatly expanding costs or weakening the right to benefits for those who cannot work?
- (3) Are there ways to restructure disability income policy that would encourage beneficiaries to use their residual work capacity?

Our Panel's report answers these questions, recommends a number of ways to promote work among disability beneficiaries, and explores other issues, including an assessment of the rapid growth in disability benefit programs that occurred in the early 1990s.

Benefits and Work

In answer to the first question, the Panel concluded that current benefits are not a strong deterrent to work. I should add that anyone who has studied income policy recognizes that income support can, to some degree, be viewed as a work disincentive. This is because the purpose of income support is to provide income to substitute for earnings.

- In the case of social insurance -- whether we are talking about old-age, survivors and disability insurance, or unemployment insurance -- benefits are designed to substitute for part of earnings when workers lose their jobs, lose their capacity to work, or are no longer expected to work. This is the basic purpose of social insurance.
- In the case of social assistance, such as Supplemental Security Income (SSI), benefits are designed to provide a basic minimum level of living for people who are poor and are severely limited in their ability to support themselves through work.

Our conclusion that these benefits are not a strong deterrent to work is based on our review of the strict and frugal design of these programs, our understanding of the attributes and

circumstances of the beneficiaries, and a comparison between U.S. spending on disability benefits and that in other industrialized countries.

Program Design. Social Security disability insurance (DI) and SSI use a test of disability that is the strictest used in any disability program in the United States, public or private. Under the law, benefits are paid only when a person has a medically determinable impairment of such severity that, given one's age, education and work experience, he or she cannot perform substantial gainful work (currently defined as earning more than \$500 a month) in any job that exists in significant numbers in the national economy, regardless of whether or not the person would be hired for such a job. Benefits are payable only if the impairment is expected to last 12 months or result in death within a year. This is a very stringent standard.

Second, there is a 5-month waiting period after the onset of disability before DI benefits are paid and another 24-month waiting period before Medicare coverage begins.

Finally, benefit levels are modest. DI benefit levels are evaluated in terms of replacement rates (the level at which benefits replace prior earnings). Studies find that 75 to 80 percent of workers' prior earnings are needed to maintain their prior standard of living. DI provides much lower replacement rates than these. At average earnings and above, replacement rates range from 43 percent for a person earning \$25,000 to about 26 percent for one earning \$60,000.¹ At lower earnings levels, say \$15,000, benefits replace half the worker's prior earnings, but are nonetheless below the poverty threshold.

Beneficiary Circumstances. The modest replacement rates reflect an expectation that Social Security benefits will be supplemented by pensions or savings for retired or disabled workers. When we compared the economic status of DI beneficiaries with retirees, we found that disabled workers, on average, had lower incomes and were less likely to have pensions, insurance or savings to supplement their Social Security benefits. The vastly smaller asset holdings of disabled workers is particularly striking. They are less likely to own their homes (and have smaller home equity when they do) and they have far less in savings. This, no

¹ Replacement rates can be up to 50 percent higher for the 1 in 5 beneficiaries who receive an allowance for dependents.

doubt, reflects the fact that disability occurs unexpectedly, before workers have accumulated the savings they hoped to have by retirement. Further, they are likely to have drawn on their savings to meet living expenses during the waiting period for DI benefits or to cover disability-related costs, such as health care and medications.

In short, our review led us to conclude that DI benefits are not an attractive alternative to work.

SSI benefits are even more modest. They are paid subject to the same strict test of disability and a strict means test. In 1996, the maximum federal SSI benefit is \$470 a month. While some states supplement the federal benefits, the federal guarantee, alone, amounts to about 70 percent of the poverty threshold. These benefits, too, are an unappealing alternative to work for those who can earn a living wage.

Foreign Comparisons. When we compared U.S. disability benefits with public programs in other countries, we found that U.S. expenditures are relatively low. U.S. spending for DI and SSI combined amounted to 0.7 percent of our gross domestic product (GDP) in 1991, less than half the share spent in the United Kingdom (1.9 percent) and less than a fourth of the spending in Sweden (3.3 percent of GDP).

Even Germany, which has a reputation for disability policies that are highly oriented toward work, spends far more than the United States on long-term disability benefits (2.0 percent). This is despite the Germans' emphasis on "rehabilitation before pensions" and provisions for quotas, tax penalties and subsidies for job accommodations to encourage private employers to hire disabled workers. That Germany spends more is not a criticism of the German emphasis on rehabilitation and employment. The point is only this: while these interventions may produce desirable outcomes for persons with disabilities, they do not produce lower public expenditures for long-term disability benefits than we have in the United States.

Our conclusion, therefore, is that U.S. cash benefits programs for disabled workers are strictly and frugally designed and do not provide a strong work disincentive.

Health Care Coverage and Work

While neither DI nor SSI, in and of themselves, pose strong incentives to claim benefits in lieu of working, the Panel concluded that constraints on access to health care can be a significant barrier to employment.

Persons with chronic health conditions, or disabilities, are at risk of very high health care costs. They often cannot gain coverage in the private insurance market, and even when they do have private coverage, it often does not cover the range of services and long-term supports they may need in order to live independently. Medicare or Medicaid, therefore, are crucial supports.

Furthermore, health care coverage has declined in recent years and the number of uninsured has grown, both among the entire nonelderly population and among working-age adults who have disabilities. Between 1988 and 1993, the proportion of the total nonelderly population that is covered by employment-based health insurance declined from 67 percent to 61 percent. During the same period, Medicaid coverage grew from 9 percent to 13 percent, yet the total number of persons without coverage from any source rose from 34 million to 41 million, or by roughly 1 million-a year. Adults with work disabilities also experienced a decline in employment-based coverage and an increase in Medicaid coverage between 1989 and 1993. The net result is an increase in the number of uninsured persons with work disabilities from 2.3 million to 2.9 million.²

Gaps in health care coverage limit employment among ill or disabled workers in three ways. First, gaps in coverage result in unnecessary losses in employment when uninsured people fail to get the care they need in order to treat, cure or ameliorate the disabling consequences of their conditions. Second, from the employer's perspective, firms may be reluctant to hire persons who are at risk of very high health care costs if the employer's health plan would bear that cost. Finally, from the perspective of individuals with disabilities, work may not be economically feasible if health care coverage is not available. The Panel has heard repeatedly that fear of losing Medicaid or Medicare is a major barrier to work.

² Tabulations of the March 1994 Current Population Survey provided by the Employee Benefit Research Institute, Washington, D.C.

Reforms that bring universal health care coverage would, of course, break down this barrier to work. In the absence of such reforms, the Panel is recommending a way to make Medicare coverage more affordable for DI beneficiaries who return to work, which I will describe in more detail later. We recognize that this is a piecemeal approach. The crucial point, however, is this: If we are looking for a structural problem in our benefits programs, lack of access to health care coverage is a much more important impediment to work for persons with disabilities than is the availability of cash benefits.

Beneficiaries and the Broader Population with Disabilities

Our review was also informed by a look at the prevalence of disability in the United States and how beneficiaries fit into that broader population. This "reality check" is important as we think about proposals to promote work among beneficiaries.

- Nearly 30 million working-age Americans have some type of functional impairment, which may or may not limit their ability to work, according to the Survey of Income and Program Participation.³
- Nearly 17 million working-age Americans report having a work disability: that is, they have impairments that limit the kind or amount of work they can do, according to the March 1994 Current Population Survey.
- Working-age adults who receive Social Security or SSI disability benefits -- 7.1 million people at the end of 1994 -- are a subset of the 17 million who have a work disability. They are those with the most significant and persistent work disabilities.

Many of those in the broader population are employed despite their impairments.

- About half the 30 million who have some sort of impairment are employed.

³ They include persons age 15-64 who report that they have difficulty seeing, hearing, speaking, walking, lifting or climbing stairs, those who report a limitation in performing work or housework, persons who use mobility aids such as wheelchairs, canes or walkers, and those who report limitations in activities of daily living or instrumental activities of daily living.

- About one-third of those who report work disabilities are in the labor force, either working or looking for work.

Work is far less common among those who meet the very strict eligibility requirements for Social Security or SSI benefits. A brief statistical profile of beneficiaries shows:

- About 4.0 million persons receive disabled-worker benefits from Social Security. They tend to be older workers. More than half (56 percent) are over the age of 50, while just 4 percent are under the age of 30. Many have impairments associated with aging, such as arthritis or other musculoskeletal disorders. Others have life-threatening diseases, such as AIDS, neoplasms or circulatory or respiratory diseases. Mental illness is an important cause of disability for younger workers.
- About 618,000 persons age 18-64 receive Social Security as adults disabled since childhood who are dependents of a parent who is retired, disabled or deceased. Mental retardation is by far their most common impairment, with nearly 2 in 3 recipients having that as their primary diagnosis.⁴
- Some 2.4 million disabled, working-age adults lack insured status for Social Security benefits and receive only SSI benefits.⁵ Many SSI recipients have disabilities that began in childhood or early adulthood. Nearly a quarter (24 percent) have mental retardation and another 34 percent have other mental disorders. Others have sensory disorders such as blindness or neurological or musculoskeletal disorders. Because many have conditions that began in childhood or early adulthood, SSI recipients tend to be younger than DI beneficiaries. About 35 percent of working-age SSI beneficiaries are 50-64, while about 19 percent are under the age of 30.

⁴ Another 161,000 persons age 50-64 are not insured for disabled-worker benefits, but receive Social Security as disabled widows or-widowers on their deceased spouse's work record. Their impairments are similar to those of older disabled-worker beneficiaries.

⁵ Another 1.0 million receive SSI that supplements their Social Security disability benefits.

To get beneficiaries' perspectives on their prospects for work, the Academy sponsored interviews with Social Security and SSI beneficiaries in four sites around the country. A brief summary of findings for four beneficiary groups follow.

Adults with cardiac, respiratory and other health conditions often were very ill with life-threatening conditions. They had conditions such as brain tumors, HIV, respiratory obstruction, cancer, lupus, emphysema, multiple sclerosis and cardiac conditions. They came from a range of occupations -- accountant, clerk, day care center worker, insurance representative, management secretary, nurse manager, school teacher and switchboard operator. Many had remained on their jobs months or years after the onset of their conditions, determined to "beat the odds" of their diagnosis. By the time they turned to Social Security, they had experienced the loss of their health, their livelihood, and their hopes for ending their work lives with a comfortable retirement. Their emphasis was on preserving their health, and often their lives, and finding meaning in activities without the rewards of paid employment.

Adults with musculoskeletal impairments often had back injuries and chronic pain. They reported difficulty with a broad range of physical functions: walking, standing, stooping, lifting, sitting, even sleeping, and some had difficulty with concentration due to pain or the medications used to ease it. They were disproportionately from physically-demanding blue-collar jobs -- custodian, meatpacker, construction contractor -- but included white collar workers from the service sector as well -- sales person, restaurant manager, hospital transcriber, hospital information analyst. They typically had remained on their jobs after the onset of their injuries before they or their employers determined they could no longer perform their jobs, even with accommodations. Some had aggressively sought training or other work and were still looking. They reported that their limited functional capacity and the cost to employers for health care and workers' compensation coverage made them less attractive than younger, healthy job applicants. They typically qualified for Social Security disability benefits only after lengthy appeals. The long hiatus between earnings and benefits often had wiped out their savings.

Adults with mental disorders included persons with cognitive impairments and mental illness, such as major depression or schizophrenia. Many of those with mental illness were

in treatment with costly prescription medications financed by Medicaid. If they were able to earn enough to leave the benefit rolls, continued coverage of their medication would be essential. They had held jobs as a home shopping club worker, musician and piano teacher, graphic illustrator and in sheltered employment. Some were working part-time, others looked forward to returning to work, although with some trepidation. Having an advocate -- whether a family member, therapist or community mental health clinic -- was a key link in getting connected with supports in their communities.

Young adults ages 18-25 were a highly diverse beneficiary group. Some who had high aptitude and solid support from their families and/or public agencies, such as the state commission for the blind, viewed SSI as a temporary support while they attended college to prepare for professional careers. Some beneficiaries with mental retardation had part-time jobs bagging groceries or bussing tables and typically had a social worker to help cope with problems at work or in managing their affairs. Other young beneficiaries had impairments involving head injuries and physical trauma from automobile accidents and were still recuperating. Some were completing their high school graduate equivalency degree. Many young beneficiaries hoped to work, but had not yet found a job they could do with their impairments. Interviews with parents of young adult beneficiaries included some whose children had very significant cognitive or multiple impairments that precluded competitive work or participation in a group interviews. They wanted their adult children to be treated with dignity and respect and to live with as much independence as possible.

In developing its policy proposals to promote return to work among beneficiaries, the Panel recognized that Social Security and SSI disability benefits are paid to persons who have met a very strict test of work disability, only a fraction of whom have prospects for returning to work. Nonetheless, the Panel believes there is room for improvement.

Rehabilitation and Cash Benefits

On the question of linking beneficiaries with rehabilitation services, the Panel is recommending a radical new approach.

The RTW ticket proposal is also appealing for what it does not do. First, it does not attempt to define in federal rules who should be selected for services, what services they should be provided or what is a "reasonable fee" for those services. The Panel believes these kinds of decisions are best made on a case-by-case basis between service providers and their beneficiary clients.

Second, the plan does not spend trust fund monies for services that are not effective. Because payments to providers are made only after trust fund savings accrue, providers would be paid only when they are successful. Payments might well exceed the cost of the providers' services. But they would be only a fraction of the savings to the trust funds. As such, the plan should produce net savings to the Social Security trust funds.

The exact parameters of such a proposal could take many forms. In an illustrative proposal developed by the Panel, RTW tickets would be given to all newly-awarded DI beneficiaries (other than those expected to medically recover in the near term), and providers of RTW services would be paid 50 percent of the benefit savings that would accrue over five years after a beneficiary returned to work and left the rolls. Such a plan is estimated by the Social Security actuaries to save a total of about \$440 million over a 5-year period.

We recognize that a number of details remain to be worked out. We do not know, for example, how many service providers would be willing to step forward to accept the challenge of being paid only for results. Service providers have said that they would much prefer to be paid up-front, or to receive interim payments for milestones achieved along the way toward their clients' return to work. The Panel, however, believes that the pure, incentive-based approach is worth trying. In the words of its chief architect on our Panel, Professor Monroe Berkowitz of Rutgers University and one of the nation's leading economic analysts of disability policy, "we tend to get what we pay for. If we pay for milestones, we will get milestones. If we pay only for results, then perhaps we will get results. Let's give it a try."

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Cash Benefit Policies to Promote Work

In response to the question about changes in cash benefit policies that would promote work the Panel has several recommendations. They include a wage subsidy, an improved Medicare buy-in, a tax credit for personal assistance services, and improvements in the implementation of existing work incentives.

Wage Subsidy for Low-Income Workers with Disabilities. The disabled worker tax credit (DWTC) we recommend would be separate from disability benefit programs. The wage subsidy would be paid to low-income persons not because they are unable to work, but because they work despite their impairments. Patterned after the existing earned income tax credit, it would reward work for low earners with disabilities without increasing reliance on disability benefit programs that are designed primarily for persons who are unable to work.

The Panel recognizes that work disability is a continuum and that Social Security and SSI beneficiaries are at the far end of that continuum. A DWTC would subsidize work for persons who have the residual capacity to do so. Eligibility could be based on disability findings by the Social Security administration and state VR agencies. In the illustrative plan developed by the Panel, those eligible for the DWTC would include: DI and SSI disability beneficiaries; certain applicants denied DI or SSI benefits;⁶ and persons certified by VR agencies to have impairments that are significant impediments to employment. It is designed for three groups in particular.

- First, it would encourage older workers to remain at work even though they experience a decline in hours of work or wage rates due to progressive impairments. By subsidizing low wages, it encourages older workers to delay the point at which they turn to cash benefits. The economist on our Panel who developed this plan, Richard Burkhauser, found in his research that many people spend a long time -- three to five years -- from the onset of a health problem until they ultimately leave

⁶ In the Panel's illustrative proposal, the DWTC would be available to applicants denied at the last step of the Social Security determination process. They are individuals who have severe impairments and are found unable to do their past work, but are considered able to do other work.

work. If we were to subsidize their reduced wages, some of them would be able to maintain a sufficient level of income and would not go on disability benefits.

- Second, it would ease the transition from school to work for young people with developmental disabilities whose earnings capacity is doubly limited by their youth and their impairments. By subsidizing their earnings, it encourages work even part-time or at low pay that over the long run can improve young workers' human capital through on-the-job experience.
- Finally, it would ease the transition off the DI and SSI rolls for beneficiaries who return to work. The wage subsidy would compensate for some of the loss of benefits that occurs when beneficiaries work.

The exact parameters for a DWTC will determine its cost and impact. Under the illustrative proposal the Panel developed, about 3.1 million low-income working people with disabilities are estimated to receive the credit, at a total cost of about \$3 billion in 1996. The average subsidy would be about \$1,000 per year, over any subsidy the individual might receive from the existing earned income tax credit.⁷ It is estimated that about 1 in 3 recipients of the DWTC would be working disabled individuals with tax-unit incomes below the poverty threshold, and 3 in 4 would have incomes below twice the poverty threshold.

Improved Medicare Buy-In. We have often heard that fear of losing health care coverage is a major impediment to leaving the disability benefit rolls. Our Panel is recommending an improved Medicare buy-in for DI beneficiaries who return to work. Under current law, DI beneficiaries are eligible to purchase Medicare coverage after they leave the benefits rolls because they have returned to work despite the continuation of their impairments. But, the eligibility criteria are complex, the coverage is expensive to purchase, beneficiaries appear not to know about it, and very few former beneficiaries buy it. The Panel is proposing a simplified Medicare buy-in with premiums charged on a sliding scale related to the former beneficiary's earnings. If former beneficiaries paid a premium equal to 7 percent of earnings in excess of \$15,000, capped by the full amount of the premium under current law, actuaries

⁷ Estimates are based on 1996 earned income tax credit (EITC) parameters established by the Omnibus Budget Reconciliation Act of 1993.

of the Health Care Financing Administration estimate that the buy-in would cost \$230 million over FY 1996-2000.

Personal Assistance Tax Credit. The Panel recommends a personal assistance tax credit to compensate working people for part of the cost of personal assistance services they need in order to work. Some persons require personal assistance services in order to live independently and, with those services, are able to work in the competitive labor market. Personal assistance services, however, can be very costly. They are financed by public programs in some states, but generally only for low-income persons. As such, those who need personal assistance services face a dilemma when they go to work. If they work successfully, their income may disqualify them from receiving publicly-financed services, yet they may not earn enough to pay for the services on their own. The Panel is recommending a tax credit to compensate working people for part of the cost of personal assistance services they need and pay for in order to work.

The credit would be available to persons who have a medically determinable impairment that is expected to last at least 12 months and who need personal assistance in order to engage in substantial gainful activity. The credit would be equal to one-half of personal assistance services expenses up to \$15,000 (for a maximum credit of \$7,500) and would phase out for persons with annual income between \$50,000 and \$70,000. The 5-year cost was estimated to be \$537 million for FY 1996-2000, according the Office of Tax Analysis of the Treasury Department.

Administering DI and SSI Work Incentives. The Panel believes that the most important enhancement needed in existing work incentives in DI and SSI is to improve the way in which they are implemented. Such improvements would involve both service providers who assist beneficiaries and the Social Security Administration. After in-depth analysis and extensive field research, the Panel concluded that:

- Work incentive provisions are inherently complex. Efforts to simplify them by redesigning them are not particularly promising. Therefore, beneficiaries need help to understand the rules and comply with them when they work.

- Some kinds of help could be offered by service providers who assist beneficiaries in returning to work -- such as those who accept the RTW tickets the Panel is recommending, or state VR counselors, state or local mental health or developmental disabilities agencies, independent living centers, job coaches, providers of supported employment services or those who work with recipients of private disability benefits. Such service providers would, themselves, need to understand the rules and reporting requirements of the work incentive provisions and consider it part of their job to assist their clients in complying with them.
- Some tasks necessary to make work incentives work can only be performed by the Social Security Administration or an entity it employs. These tasks include prompt processing of earnings and other reports from beneficiaries so that benefits can be adjusted promptly as their circumstances change. If benefits are not adjusted promptly, working beneficiaries are at risk of being charged with large overpayments, or of being without either earnings or benefits should their work attempt falter. If return to work is to be a priority, personnel and systems support for these functions are essential.

Work Disability, the Environment and Program Participation

Let me say a few words about how the Panel that I chaired thought about disability policy. In its analyses, the Panel emphasized that *work disability* is distinct from an impairment (such as blindness, hearing loss, or spinal cord injury). A chronic health condition, or impairment, is an essential element of work disability. But work disability occurs only when an impairment, in conjunction with the person's other abilities, the demands of work, and the broader environment, make her or him unable to perform the tasks of work. Consequently, changes in the broader environment affect the prevalence of work disability and the demands placed on disability benefit programs.

In the Panel's analysis, the environment is important in understanding causes of the growth of disability benefit programs in the early 1990s. That growth did not reflect a flaw in the basic structure of the DI or SSI programs or in the people who turn to them. While some

program criteria were modified in the 1980s, many causes of growth lie elsewhere: a growing population, the shock of an economic recession, declining demand for workers doubly disadvantaged by chronic health conditions and limited skills, and retrenchment in other parts of the support system for persons whose capacity to work is severely limited.

- The working-age population is larger and the baby boom is entering the disability-prone years. Consequently, some growth in the programs is to be expected.
- Job losses during the recession of 1990-91 brought a wave of new benefit allowances. Disability incidence rates -- new benefit awards as a percent of the insured population -- peaked in 1992 and have flattened out since then.
- Under competitive pressure to downsize and streamline their organizations, firms are less able to accommodate workers, particularly if they are doubly disadvantaged by limited skills and physical or mental impairments.
- Cut-backs in state assistance programs, constraints on access to health care, and cost controls in other wage-replacement programs increase demands on these federal programs.

Given this interpretation, what should be done? Several points stand out.

First, the very rapid growth in the early 1990s appears to be a temporary phenomenon tied to the economic recession of 1990-1991. Incidence rates have flattened out since 1992. Talk of crisis and radical remedies are not called for. Our review of the history of the disability programs over the last 25 years finds wide swings in policy responses to changes in the disability rolls. Too often "corrective" action came after problems were already being corrected, thereby fostering over-reaction in the opposite direction. The main point that I would like to make is that this is a long-term program, which is large, complex and fragile. Adjustments must be made carefully and cautiously at the margins. Thought must be given to the ripple effects over a long period of time.

We believe that a number careful changes should be made. First, the Panel's proposals are judiciously designed to promote work: the RTW tickets, the disabled worker tax credit, improved Medicare buy-in, tax credit for personal assistance service and improved implementation of work incentives.

Second, I want to emphasize the necessity of matching policy commitments with adequate resources to administer them. In cash benefit programs, for example, it is very easy for low administrative costs to translate quickly into higher program costs. This is penny-wise and pound foolish policymaking. It is noteworthy here that the 1990-91 recession, which brought rapid growth in disability workloads, came on the heels of a 25 percent reduction in Social Security Administration staff during the 1980s.

Our Panel has emphasized the point that administrative resources must be set at a level that ensures stable, effective management of the disability programs. Resources must be adequate to provide:

- (1) fair, accurate and prompt decisions on disability claims,
- (2) individualized service to beneficiaries that is contemplated under the law, including accurate information and prompt action to implement benefit adjustments when beneficiaries work, and
- (3) timely and predictable review of the continuing eligibility of those receiving disability benefits.

All of these activities are essential to ensure the integrity of and public confidence in the disability benefit system.

Third, determinations of work disability are inherently complex and the conditions that result in work disability change as medical technology changes and as the demands of work change. We concluded that the definition of disability in the Social Security Act, while very strict, is a valid statement of the nature of severe work disability. Its specific implementation is spelled out in regulations. These regulations need to be periodically updated through expert

professional review to ensure that eligibility criteria are kept current with new research and professional knowledge. These updates should be undertaken at the administrative level, through regulations, and do not require changes in the law.

In closing, I want to emphasize two theme of the Panel's report. First, many of the most promising interventions to promote employment among persons with disabilities lie outside of cash benefit programs. We need to think about changing the environment, about increasing demand for workers, about reengineering work tasks so that they can be performed by persons with physical or mental impairments, about educating future workers so they have the skills to work despite the onset of various limitations in physical functioning, and we need to think about providing basic health care. All these remedies for work disability lie outside of cash benefit policies.

Finally, *disability income* policy must strive for balance -- a balance between providing a decent and dignified level of income to workers whose careers are interrupted by disabling illness and functional loss on the one hand, and a realistic set of opportunities and supports for those who have the capacity to work, on the other. In the final analysis, the success of our disability income policy will be judged by how it achieves this balance.

Social Security Disability Benefit Levels are Modest

DI replacement rates by earnings level:

Earnings level	Replacement Rate
\$15,000	51%
\$25,000	43%
\$40,000	37%
\$60,000	26%

The Federal SSI level (\$470 in 1996) is about 70 percent of the poverty threshold.

U.S. Spends Less on Disability Benefits Than Other Countries

Share of GDP for public disability benefits

• United States	0.7 percent
• Germany	2.0 percent
• United Kingdom	1.9 percent
• Sweden	3.3 percent
• The Netherlands	* 4.6 percent

(*Includes work-injury benefits.)

The CHAIRMAN. Thank you for summarizing your statement.
Mr. Young.

STATEMENT OF TONY YOUNG, CO-CHAIRMAN, "RETURN TO WORK" GROUP, WASHINGTON, DC

Mr. YOUNG. Good morning, Mr. Chairman.

The CHAIRMAN. Sorry you had to be last. It's been a long day already.

Mr. YOUNG. I appreciate your hanging in there for us.

Thank you for this opportunity and I am pleased to be on a panel with Virginia Reno, my good friend, who has worked very hard with her panel and organization. Interestingly enough, we've come up with similar recommendations, so we hope this will be an incentive for the Congress to move forward on some of them.

I am director of Community Support at the American Rehabilitation Association. American Rehab is the largest national trade association representing providers of medical rehabilitation, vocational services, and community support to individuals with disabilities.

However, I am here today in my role as the co-chair of the "Return To Work" Group. The "Return To Work" Group is a coalition of concerned professionals and advocates who came together early in 1995 with one goal in mind, to develop an effective national strategy to return the maximum number of Social Security beneficiaries to gainful employment.

The group includes key leaders from all aspects of the national vocational-rehabilitation field, including the National Association of Rehabilitation Professionals in the Private Sector, the American Rehabilitation Association, the International Association of Business Industry and Rehabilitation, the National Council on Independent Living, and other members of the Consortium for Citizens with Disabilities.

In a recent GAO report which you heard this morning, the GAO documented the low rate of individuals leaving SSI or DI to go to work. To enable these individuals to return to or enter the workforce, public policy must address the reasons why it is so difficult for them to leave these programs. Building a bridge off cash assistance and delivering services that enable people with disabilities to cross that bridge are critical solutions.

To enable individuals to cross the bridge into employment, the Beneficiary Rehabilitation Program must be improved. We recommend Congress modify the Beneficiary Rehabilitation Program to enable beneficiaries to choose from public or private vocational rehabilitation service providers and to pay these providers based on a series of outcomes that lead directly to employment rather than the current all or nothing reimbursement mechanism.

American Rehab has learned that purely outcome-based models bring only the largest public and private providers into the service system. This will not achieve the desired results.

Our findings indicated that although only one-half of 1 percent of SSDI beneficiaries currently return to work, between 15 and 30 percent could and would work if given the opportunity. In addition, more than 5,000 private providers are ready to assist them in this effort.

The success of the Project With Industries and Worker's Compensation providers over the last few decades demonstrates that these providers are capable of meeting this challenge. By working with employers and existing incentives to hire individuals with disabilities, private providers can improve return to work rates for individuals with significant disabilities.

The "Return To Work" Group proposal, of which you have copies, is based on the principles of consumer choice and control, the use of existing administrative and direct service entities within our communities, and outcome-based payments to providers that reward successful return to work while protecting the SSDI Trust Fund. It results in substantial gains for both individuals with disabilities and the Federal Treasury.

If this proposal were implemented nationally, we estimate that over 7 years, 952,380 individuals with disabilities would return to work, resulting in \$62.2 billion in net savings to the SSI Trust Fund, a return of \$15.18 for every \$1 invested by the Federal Government.

This proposal requires expending startup costs of \$833 million over these 7 years from the Trust Fund. However, the cost of not implementing this proposal is a continuing drain on the Trust Fund, the wasting of precious human capital, and the ongoing erosion of public confidence in the SSDI Program.

However, VR services alone are not enough. The current benefit structure punishes rather than rewards people with disabilities who attempt to leave entitlement programs. The system essentially eliminates eligibility for both cash and noncash benefits such as health care and long-term services before the individual can earn a living wage. The total loss of support well known by people with disabilities as the earnings cliff is the greatest work disincentive.

A bridge that spans the chasm from dependence to economic self-reliance should be constructed. Congress should empower individuals with disabilities through these four actions.

No. 1, extend medical coverage for SSDI beneficiaries and SSI recipients after they return to work by enabling individuals with disabilities to buy into Medicare, Medicaid, or the Federal Employee Health Benefit Plan on an income-based sliding scale.

No. 2, establish a disabled worker tax credit similar to the earned income tax credit currently in law for low income workers with disabilities.

No. 3, establish a tax credit for assistive technology and personal assistance services for any individual who has a severe disability and who is working.

No. 4, create a safety net for individuals with disabilities that addresses the unique needs of these workers who, due to the nature of their disability or the effects of aging with a disability, are unable to continuously work full-time.

As a Nation, we must allow individuals with disabilities who need to leave the workforce to do so. We must also empower those who can work to accept employment. Congress has an opportunity to build an empowerment bridge from dependency to self-reliance for individuals on SSDI and SSI and to enable them to cross this bridge. I strongly urge you to take this opportunity.

Thank you for this occasion to testify. If you have any questions, I'll be happy to answer them.
[The prepared statement of Tony Young follows:]

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The Key to Self Sufficiency

TESTIMONY
OF
TONY YOUNG
DIRECTOR
AMERICAN REHABILITATION ASSOCIATION

ON BEHALF OF
THE RETURN TO WORK GROUP

BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

JUNE 5, 1996

Partnership for People with Disabilities, Employers, and Service Providers

Good morning, Mr. Chairman. I am Tony Young, Director of Community Supports at the American Rehabilitation Association. American Rehab is the largest national trade association representing providers of medical rehabilitation, vocational services and community supports to individuals with disabilities. However, I am here today in my role as a Co-Chair of the Return To Work Group. The RTW Group is a coalition of concerned professionals and advocates who came together early in 1995 with one goal in mind: to develop an effective national strategy to return the maximum number of Social Security beneficiaries to gainful employment. The Group includes key leaders from all aspects of the national vocational rehabilitation field, including the National Association of Rehabilitation Professionals in the Private Sector, the American Rehabilitation Association, the Inter-National Association of Business, Industry, and Rehabilitation; the National Council on Independent Living; and other members of the Consortium for Citizens with Disabilities.

In a recent report, the GAO documented the low rate of individuals leaving SSDI or SSI to go to work. To enable these individuals to return to or enter the workforce, public policy must address the reasons why it is so difficult for them to leave these programs. Building a bridge off cash assistance, and delivering services that enable people with disabilities to cross that bridge, are critical solutions.

To enable individuals to cross the bridge into employment, the Beneficiary Rehabilitation Program must be improved. We recommend Congress modify the Beneficiary Rehabilitation Program to enable beneficiaries to choose from among public or private vocational rehabilitation service providers, and to pay these providers based on a series of outcomes that lead directly to employment, rather than the current all or nothing reimbursement mechanism. American Rehab has learned that

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purely outcome based models bring only the largest public and private providers into the service system; this will not achieve the desired results.

Our findings indicated that, although only ½ of 1 percent of SSDI beneficiaries currently return to work, between 15 and 30 percent could and would work if given the opportunity. In addition, more than 5,000 private providers are ready to assist them in this effort. The success of Project With Industries and Workers' Compensation providers over the last few decades demonstrates that these providers are capable of meeting this challenge. Working with employers and existing incentives to hire individuals with disabilities, private providers can improve return to work rates for individuals with significant disabilities.

The Return To Work Group proposal, of which you have copies, is based on the principles of consumer choice and control, the use of existing administrative and direct service entities within our communities, and outcome based payments to providers that rewards successful return to work while protecting the SSDI Trust Fund. It results in substantial gains for both individuals with disabilities and the Federal treasury. If this proposal were implemented nationally, we estimate that, over 7 years, 952,380 individuals with disabilities would return to work, resulting in \$62.2 billion in net savings to the SSDI Trust Fund; a return of \$15.18 for every \$1 invested by the Federal government.

This proposal requires expending start up costs of \$833 million over these 7 years from the Trust Fund. However, the cost of not implementing this proposal is a continuing drain on the Trust Fund, the wasting of precious human capital, and the ongoing erosion of public confidence in the SSDI Program.

However, VR services are not enough. The current benefit structure punishes rather than rewards people with disabilities who attempt to leave entitlement programs. The system essentially eliminates eligibility for both cash and non-cash benefits, such as health care and long term services, **before** the individual can earn a living wage. This total loss of support, well-known by people with disabilities as "the earnings cliff," is the greatest work disincentive.

A bridge that spans the chasm from dependence to economic self-reliance should be constructed. Congress should empower individuals with disabilities through these four actions:

- 1) Extend medical coverage for SSDI beneficiaries and SSI recipients after they return to work by enabling individuals with disabilities to buy into Medicare, Medicaid, or the Federal Employee Health Benefit Plan on an income-based sliding scale.
- 2) Establish a Disabled Worker Tax Credit similar to the Earned Income Tax Credit for low-income workers with disabilities.
- 3) Establish a tax credit for assistive technology and personal assistance services for any individual with a severe disability who is working.
- 4) Create a safety net for individuals with disabilities that addresses the unique needs of these workers who, due to the nature of their disability or the effects of aging with a disability, are unable to continuously work full time.

As a nation, we must allow individuals with disabilities who need to leave the workforce to do so, but we must also empower those who can work to accept employment. Congress has an opportunity to build an empowerment bridge from dependency to self reliance for individuals on

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SSDI and SSI, and to enable them to cross this bridge. I strongly encourage you to take this opportunity.

Thank you for this occasion to testify. I would be happy to answer any questions you might have.

The CHAIRMAN. Thank you, very much, Mr. Young. I'm finally glad to meet someone who talks faster than I do. Just sitting here, if Federal Express ever needs a substitute, I'm going to recommend you.

Mr. YOUNG. Thank you. [Laughter.]

The CHAIRMAN. A couple of questions, Ms. Reno. When you were making your analysis or the Academy was making its analysis about cash benefits and making some comparison to other countries, did you only include cash benefits in terms of what was included and compare it to other countries or did you include the entire panoply of benefits of Medicare, Medicaid, and other types of programs?

Ms. RENO. In part of our analysis of "are these benefits a strong deterrent to work," the conclusion that they are not was based, in part, on looking at the level of DI benefits in relation to prior earnings and comparing those with replacement rates both in the private sector and in other countries.

The studies we have looked at suggest that for a person to actually maintain their prior level of living—no one is saying the public system should do that—replacement rates of 70 to 80 percent are needed.

In the private sector, private insurers typically provide 50 to 65 percent replacement, usually by supplementing Social Security up to those levels for those workers who have private insurance.

In foreign countries, they often provide 50, 60, or 70 percent replacement in their public disability programs. This was in their public disability pension systems which are like the DI program. In contrast, in the DI program in the United States, the average earner's replacement rate is 43 percent. When we say average earner, we're talking about \$25,000 a year—this is not a handsome sum of money. At higher earnings levels replacement rates decline to replacing about a quarter of your prior earnings if you earned \$60,000 and less after that because earnings above that don't count toward Social Security.

The CHAIRMAN. But if you include the cash benefits plus Medicare and Medicaid, and health programs, we're about the same, are we not, with other countries? The difference as I see it is that these other countries have early intervention and it's part of the culture, as such, to help people get back to work as quickly as possible—those who can and are desirous of doing so.

Isn't that the difference—that other countries have a different culture about utilizing the capability that exists for those who were born with or suffered a disability?

Ms. RENO. Certainly in some countries. Germany and Sweden are examples of countries that do, but in terms of their benefit structures, actually most European countries, Germany and Sweden among them, provide universal health care. It's not something you get because you're disabled; you get it because you're a German or because you're a Swede.

They also provide short-term disability benefits. These benefits are separate from, and paid prior to, a determination for disability pensions that is similar in purpose to our DI program. In Germany they pay short-term benefits that are about 80 percent of one's earnings for up to a year-and-a-half after the onset of disability

during which time efforts are made to try to intervene, to help the person find rehabilitation and get back to work.

Similarly, in the United States when private employers offer long-term disability insurance, they also generally offer health insurance, and they probably have short-term disability benefits. So, in both of these cases, there's a short-term benefit system that already is in touch with the person and there is a source of health insurance already available to the person that is not conditioned on being disabled.

When we made our national comparisons of what countries spend for public disability pension, we found that the United States spends considerably less on DI and SSI for working age adults. United States spending was 0.7 percent of gross domestic product. In Germany, they spend 2 percent. They spend more than twice as much. In Sweden, they spend 3.3 percent.

In part, this reflects the fact that, by cross-national standards, the United States has both low benefits in these programs and a very strict test of disability.

The CHAIRMAN. Again, we're talking a difference of cash benefits and reimbursement versus health care?

Ms. RENO. Yes.

The CHAIRMAN. Our health care costs are higher than Germany or Sweden or most other industrialized countries, so the benefit of having that medical care is perhaps the biggest disincentive for people in this country not to want to go back to work?

Ms. RENO. It's very important in terms of setting the incentive for people.

The CHAIRMAN. When you measure the total reimbursement available to those who are disabled, I think we're pretty high, not necessarily if you just compare cash versus cash but if you take what would be involved if you took away the medical side of things. Then you would find where the real comparison is. Our costs and reimbursement are quite significant. They're higher and, therefore, when you measure what the reimbursement levels really are, we're not that far away in terms of other countries.

What I see really is the early intervention and the availability of these vocational rehab services right away whereas we have to wait close to a year. We are afraid to even talk about rehabilitation for fear we won't qualify for the disability in the first instance, so it's really a cultural difference that we suffer.

There may be some difference in terms of total reimbursable items, but I think if you factor in all the other support services, we're not that far off. I think it's really the cultural change that makes the difference here, a personal judgment.

Let me come back to the return-to-work ticket proposal. I think that's creative, but GAO has already indicated that the success-based reimbursement policy hasn't worked well for State vocational rehabilitational agencies. How is this going to work now in terms of the small, private rehabilitation provider?

Ms. RENO. I'm glad you asked that. This proposal is very, very different from the current mechanism that is used to reimburse State agencies for VR. First, it gives consumers a choice about who they go to. In effect, the beneficiary is offered a return-to-work ticket and for them it's like a voucher. They can go and shop among

service providers to figure out who they want to work with to try to go back to work. The choice to use this ticket is also optional, voluntary!

Second, when they do deposit this ticket with a service provider it could be a VR agency or it could be one of the members of Tony's organization, or a big rehab provider, or a job placement person—this ticket then becomes a contract, an obligation for Social Security to pay that provider but only when this beneficiary is back at work and off the disability rolls. What the provider gets paid is some specified fraction of the savings to the Social Security trust fund.

You might be suspecting that this is a proposal developed by an economist. It's very much designed with incentives in mind and it's designed to provide powerful incentives for providers to produce the result we hope they will produce, to assist a beneficiary to get off the rolls and back to work.

If they are effective, the payment to them could be considerably more than what they put in if they are resourceful, careful and select their clients well.

The CHAIRMAN. How much of a time delay?

Ms. RENO. Between the time the person goes back to work and when they actually get paid. That is the primary objection we hear from providers.

Under the current scheme, there is a 9-month trial work period and a 3-month grace period after which a person's benefits would be withheld and that would be the beginning of when a provider would be paid. So, yes, they would be providing services first and being paid later.

The CHAIRMAN. How does a small outfit function in that fashion? I guess that's the question I'm asking.

Ms. RENO. I can only answer the way the proponent of this proposal, Professor Monroe Berkowitz, who defends it much more eloquently than I do.

The CHAIRMAN. Did he get paid before he made the study?

Ms. RENO. No, he didn't. He didn't get paid afterwards either. [Laughter.]

Ms. RENO. In part, it is that people sometimes borrow in order to begin a business. Not everybody gets paid up front or paid promptly, but I think the other important point is that nobody envisions that a provider would necessarily make their entire living serving only this clientele. People who receive DI benefits typically have much more significant and persistent impediments to work than is the case for people now successfully served by private providers.

There are providers out there now who apparently are not serving DI beneficiaries or at least not doing it effectively because they are not leaving the rolls. These providers, they are being paid by worker's compensation programs, by long-term disability insurers, by automobile insurers, by whoever is paying for the services they provide. So if 5 percent of their caseload were under this scheme, perhaps it could work for them.

The CHAIRMAN. Your study indicated it was important to keep the medical criteria and the vocational criteria up-to-date. Do you

have any specific areas you think we need to review there? Has the Social Security Administration been doing this, to your knowledge?

Ms. RENO. Our panel are not experts in any particular set of medical criteria. The observation they made is that the statutory definition is generic and it is flexible enough to be changed through regulatory updates as circumstances change. So the medical criteria should be kept up-to-date.

The CHAIRMAN. But has it?

Ms. RENO. I'm not sure. The two areas that our panel suggested would be good candidates for convening some experts to look at experience and new research are in the mental impairments area and in the assessment of pain. These are two of the most complicated areas to assess, whether you're the private sector or the public sector.

The CHAIRMAN. One of the problems we've had is the statistical numbers are kind of staggering, that only 1 person out of 1,000 once they get on ever gets off. It raises the question as to whether the Social Security Administration is being diligent in keeping updated review and records of medical conditions, as they improve or vocational opportunities.

We heard some testimony earlier with the availability of new technology that might assist individuals to go into the workplace, so it's very hard to come to the conclusion that these medical records or vocational opportunities are being reviewed by the agency since the record is not very good.

I'm just wondering if your panel looked at that?

Ms. RENO. They only made the observation that the criteria should be periodically updated. That is the substatutory regulatory criteria that the agency uses the panel also affirmed what others have affirmed, including the General Accounting Office, that the agency needs to have the resources and the commitment to do proper stewardship and that includes doing continuing disability reviews. It includes making prompt, accurate decisions the first time, and it includes implementing the work incentives. Those are three primary functions that have to be done.

The CHAIRMAN. Did your panel look at the availability of environmental conditions or accommodations that can now improve the opportunity for work? Did you look at some of the new technologies?

Ms. RENO. Yes. In fact, we visited the National Rehabilitation Hospital, and we had people with that kind of expertise on our panel. I'm not sure where to go with that.

The CHAIRMAN. It deals with functional assessment as we move away from the medical impairment definition or at least add to the medical impairment definition, some sort of functional assessment. When we talk about functional assessment, we've got to now start looking at the environment in which that person can operate. I see that Mr. Young operates very well in terms of his equipment that allows him to function as a very productive citizen.

We just have to see whether or not SSA is prepared to amend its focus or whether its statutory definition has to change, whether we have to add to it in order to make it more flexible to take into account advances in technology that allow people to get back into the workforce and encourage them to do so.

Mr. Young, your numbers in your proposal look pretty good on paper. Have you asked anyone at SSA to review those projections?

Mr. YOUNG. We worked with some of the actuaries at SSA to develop these numbers. There is, of course, always some flux in what happens given the environmental factors, the economic conditions when the program is implemented, and various other factors, start-up time, but we feel pretty secure that these are relatively stable numbers and if we make a national commitment to do this program, we will achieve something in this arena.

The CHAIRMAN. Has SSA aggressively pursued your proposal? What's been the reaction?

Mr. YOUNG. SSA currently doesn't have statutory authority to implement the proposal we're talking about. Their current authority allows them to pay or actually reimburse a provider, a public or private provider, for the actual cost of rehabilitation of a person after the person has completed their 9 months and their 3-month grace period but only for the actual cost of services.

What our proposal and what the National Academy's proposal says is that the payment stream is not really reimbursement; it's a payment based on savings to the Trust Fund that the individual would have received had they not gone back to work. So we would need congressional authority for them to go forward with designing this program.

I think there is a lot of interest at SSA for doing a program like this. The current Associate Commissioner has talked about this for many years now and I think, if given the green light by Congress, would move aggressively on it.

The CHAIRMAN. So you think we have to have some statutory change?

Mr. YOUNG. I believe it's necessary.

The CHAIRMAN. Mr. Young and Ms. Reno, thank you very much for your testimony and we will look very closely at those recommendations to see whether we can generate some legislative support for that. Your testimony has been very helpful.

The committee will now stand adjourned. Thank you.

[Whereupon, at 11:39 a.m., the committee was adjourned, to reconvene at the call of the chair.]

APPENDIX

WILLIAM S. COHEN, MAINE, CHAIRMAN

LARRY PRESSLER, SOUTH DAKOTA
CHARLES E. GRASSLEY, IOWA
ALAN K. SIMPSON, WYOMING
JAMES M. JEFFORDS, VERMONT
LARRY CRAIG, IDAHO
CONRAD BURNE, MONTANA
RICHARD SHELLEY, ALABAMA
RICK SANTORUM, PENNSYLVANIA
FRED THOMPSON, TENNESSEE

DAVID PRYOR, ARKANSAS
JOHN GLENN, OHIO
BILL BRADLEY, NEW JERSEY
J. BENNETT JOHNSTON, LOUISIANA
JOHN E. BREAUX, LOUISIANA
HARRY REID, NEVADA
HERB KOHL, WISCONSIN
RUSSELL D. FEINGOLD, WISCONSIN
CAROL MOSSELEY-BRAUN, ILLINOIS

United States Senate

SPECIAL COMMITTEE ON AGING

WASHINGTON, DC 20510-6400

MARY BERRY GERWIN, STAFF DIRECTOR/CHIEF COUNSEL
THERESA M. FORSTER, MINORITY STAFF DIRECTOR

April 12, 1996

VIA FACSIMILE
(Hard copy mailed)

The Honorable Shirley Chater
Commissioner
Social Security Administration
1825 Conn. Ave., N.W.
Suite 714
Washington, D.C. 20254

Dear Commissioner Chater:

In March of 1995, the Special Committee on Aging, which I chair, conducted a hearing on problems in the Social Security Disability Insurance (DI) and the Supplemental Security Income (SSI) programs. One of the issues explored at the hearing was the potential for rehabilitating and returning a larger number of recipients of DI and SSI benefits to work.

My staff and I have continued our work on this issue. My staff has been briefed by Associate Commissioner Susan Daniels on the Office of Disability's initiative: *Developing a World-Class Employment Strategy for People with Disabilities*. I would like to request an update from the Social Security Administration (SSA) on any steps that have been taken to implement employment strategies by SSA.

Specifically, I request the following information or responses to the following questions:

Questions 1 & 2

SSA has historically placed a low priority on return-to-work. For example, SSA does not routinely collect performance information on referrals to state VR agencies. Moreover, applicants are generally unaware of the programs' return-to-work provisions. Indeed, SSA's Annual Performance Plan under the Government Performance and Results Act--which includes no agency goals or performance measures for returning beneficiaries to work--underscores this lack of emphasis. If an issue is given low priority and goals do not get established, results cannot be measured or used to improve program performance.

1. Does SSA intend to place greater priority on return to work for its SSI/DI beneficiaries, and if so, how? (And if not, why not?) How does SSA intend to evaluate the effectiveness of its efforts?

(125)

2. What is the status of SSA's World class Employment Strategy for People with Disabilities? What is the status of Project Network?

Question 3

DI and SSI applicants who successfully meet the programs' definition of disability have been through a lengthy process that required them to prove an inability to work. Moreover, being out of the workforce may have degraded their marketability. These factors can reduce their receptivity to VR and work incentives, as well as their motivation to develop or regain the ability to engage in gainful employment. Furthermore, the "all-or-nothing" nature of DI cash benefits can make work at low wages financially unattractive; the risk of losing medical coverage is high for many beneficiaries; and even if they wanted to take part in VR, access to the VR system is often limited.

How does SSA suggest that these policy issues be addressed?

Question 4

The presumed link between the presence of medical condition and the inability to work establishes the basis for SSA's award of disability benefits. But concerns about the relationship between medical status and work incapacity were raised before the DI program was implemented. Indeed, physicians testified before the Congress in the deliberations leading to the establishment of the DI program that disability determination is inherently subjective. 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, several studies have shown the difficulties in accurately determining who can and who cannot work.

Could SSA comment on the basis of its disability determination in light of this? Given the changes in the labor market, medical care, and technology, does SSA believe that the presumed link between certain medical conditions and the inability to work needs to be re-examined? If not, why not? If so, what are SSA's plans?

Question 5

SSA is also responsible for administering a number of work incentive provisions under the Social Security Act:

- Section 1619 A and B for SSI recipients and the trial work period for SSDI recipients.
- Impairment Related Work Expenses (IRWEs)
- Extended Period of Eligibility
- Extended Period of Medicare Coverage
- Sec. 301 protections for recipients in Vocational Rehabilitation.

For each of these programs, please provide me with data on the number of participants; job placement rates; number of participants who have left the SSI/SSDI rolls through participation in these programs; and SSA reviews of these programs.

Question 6

Finally, the General Accounting Office recently released a report which discussed the status of the work incentive provision: Plan to Achieve Self-Support (PASS). The report indicates that SSA established its own task force to recommend changes to the administration of PASS. Please describe the changes that will be made to administer PASS and the timetable for implementation.

If you or your staff has any questions or would like to discuss this request for information, please contact me. Mary Gerwin or Liz Liess of my Aging Committee staff will be prepared to discuss this request with you.

With best wishes, I am

Sincerely,



William S. Cohen
U. S. Senator

WSC/lal



SOCIAL SECURITY

Office of the Commissioner

May 20, 1996

The Honorable William S. Cohen
United States Senate
Special Committee on Aging
Washington, D.C. 20510

Dear Senator Cohen:

Thank you for your recent letter in which you expressed concerns about the low rate of work activity among beneficiaries of the Social Security Administration's (SSA's) disability insurance and Supplemental Security Income programs.

I share your concerns, and we are working diligently to find appropriate solutions to many of the same issues raised in your letter. Enclosed is a response to each of your questions. The responses describe initiatives we are pursuing within SSA and with our other Federal, State, and private partners.

As always, my staff and I are available to provide further information on these and any other issues related to SSA's programs and policies. Please do not hesitate to contact us if you have additional concerns.

Sincerely,

Shirley S. Chater
Commissioner of
Social Security

Enclosure

RESPONSE TO SENATOR COHEN'S QUESTIONS**QUESTION 1**

Does the Social Security Administration (SSA) intend to place greater priority on return to work for its Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) beneficiaries, and if so, how? (And if not, why not?) How does SSA intend to evaluate the effectiveness of its efforts?

ANSWER

SSA is placing greater priority on helping its SSI/SSDI beneficiaries go to work. In mid-1994, the Agency began a thorough analysis of the SSA disability programs to identify barriers and disincentives to return-to-work for its beneficiaries with disabilities.

SSA began its work by meeting with a number of different groups including: SSA's beneficiaries with disabilities and their advocates, public and private providers of return-to-work services, and Federal and State officials to obtain outside views of the barriers to return-to-work in the SSI and SSDI programs. SSA also conducted a comprehensive review and analysis of the research and literature on the success or failure of return-to-work and rehabilitation efforts in the SSI and SSDI programs over the past 10 to 15 years. This information has led SSA to change its vocational rehabilitation and work incentives in various ways, explained below.

Working Towards the Goal of Expanded Employment Opportunities

SSA hopes to help people with disabilities gain independence from the disability rolls through innovative rehabilitation and employment initiatives. SSA's approach is two-pronged: (1) Making the current SSA vocational rehabilitation payment program more effective within the limits of current law; and (2) Studying new ways to increase opportunity.

To make the current vocational rehabilitation program more effective, we have:

- ◆ Published a regulation requiring the State vocational rehabilitation agencies to inform us of the SSA beneficiary referrals whom the States will serve;

- ◆ Offered the States the opportunity to enter into performance partnerships with SSA that are designed to enhance the States' rehabilitation and employment initiatives to more sharply focus on beneficiaries as vocational rehabilitation clients;
- ◆ Developed a method for re-referring beneficiaries not able to be served by the States to alternate providers of vocational rehabilitation services who sign contracts with SSA; and
- ◆ Published a new brochure informing the public how SSA can help with vocational rehabilitation.

We are presently developing and implementing enhanced methods for obtaining management information about:

- ◆ Beneficiaries who are referred to State vocational rehabilitation agencies by SSA;
- ◆ Beneficiaries who are served by the State vocational rehabilitation agencies;
- ◆ Beneficiaries who are re-referred by SSA to alternate providers of vocational rehabilitation services;
- ◆ Beneficiaries who are served by alternate providers of vocational rehabilitation services;
- ◆ The types of services provided by both State vocational rehabilitation agencies and alternate providers of vocational rehabilitation services and their cost; and
- ◆ The employment attained as a result of the vocational rehabilitation effort.

Data gathered under these enhanced referral and service opportunities will afford SSA the capability to learn more about the community of providers and services that are available to assist beneficiaries with achieving and sustaining substantive employment.

The goal for these collective efforts is to expand the number of beneficiaries who can receive quality rehabilitation and employment services in a timely, cost-effective manner and thereby afford individuals with a disability an improved quality of life and feeling of self-worth.

During fiscal year (FY) 1995, 73 State vocational rehabilitation agencies filed claims for payment from SSA. No claim is payable unless the beneficiary, on whom it is filed, has been successfully employed for 9 continuous months at earnings levels at least equal to SSA's standard for Substantial Gainful Activity (\$500 per month for nonblind individuals). In processing these claims, SSA awarded payments to the States totaling \$72.7 million for successful outcomes, the highest rate of claims allowances in the reimbursement program's history; a full 6,238 claims were paid for beneficiaries who achieved 9 months of Substantial Gainful Activity. We believe this enhanced performance is the result of continuing efforts by both the States and SSA to improve the rehabilitation and employment opportunities for our beneficiaries with disabilities.

Another key element in making the current program more effective is expanding the pool of providers who can help people with disabilities receive the vocational rehabilitation services they need to go to work. As a result of regulations published in March 1994, vocational rehabilitation service providers in the public and private sectors are now eligible to participate in SSA's vocational rehabilitation Reimbursement Program to serve SSA's beneficiaries with disabilities who are not served by the State vocational rehabilitation agencies. These providers, called alternate participants, can be paid by SSA for the costs they incur in cases where their services help SSA's beneficiaries obtain and retain jobs at certain wage levels.

SSA has received more than 4,000 requests for further information. We expect to release shortly a request for proposal (RFP) to the providers who responded to the initial notices. The RFP will provide details about SSA's vocational rehabilitation program and will invite all interested providers to submit proposals to become alternate participants. Providers will be required to submit proof of their qualifications with their proposals. Based on these proposals, SSA will enter into negotiated contracts with all qualified providers.

Finally, to improve understanding of our work incentive provisions, in July of 1995, SSA signed an interagency agreement with the Rehabilitation Services Administration for one of its grantees, Cornell University, to provide training on Social Security's

work incentives to State vocational rehabilitation professionals. This initiative is intended to increase the competencies of rehabilitation counselors in using these incentives when counseling Social Security disability beneficiaries on returning to work. With the additional sessions this agreement funded, Cornell University will be able to provide this training to all regions of the country. These sessions are scheduled to be completed by September 1996.

QUESTION 2

What is the status of SSA's World Class Employment Strategy for People with Disabilities? What is the status of Project Network?

ANSWERStatus of the Employment Strategy

We are continuing to work within SSA and with other Federal departments and agencies to find feasible solutions to the complex and often conflicting challenges inherent in encouraging work attempts by those beneficiaries who are willing to try to work. At the same time, we must protect the incomes of those who are too impaired to participate in the workforce. In this era of fiscal constraints, we are mindful of the need to minimize the work disincentives of the current disability programs and simultaneously reduce the costs of those programs. We will continue to search for solutions that can accommodate the mandates of Federal disability policy generally and, particularly, the SSDI and SSI programs.

Status of Project NetWork

SSA has contracted with Abt Associates, Inc., to perform the evaluation of Project NetWork. Project operations at the eight project sites ended in March 1995. The final report of the evaluation findings, including the cost/benefit analysis of the four models of Project NetWork, is due by March 1998.

Information on the characteristics of treatment and control cases have been summarized from the baseline survey of project participants and from data collected at the project sites during the operational phase. Some of the interesting information on participants was:

- ◆ Project participants (both treatment and control cases) were 58 percent male and were about evenly split between those under 40 years old and those who were 40-64.
- ◆ About 43 percent were high school graduates and one-third had at least some college, while a fourth were high school dropouts.

- ◆ Two-thirds of participants were white and only one-fourth were married at the outset of the project. Nearly all lived in a private residence.
- ◆ While about 40 percent were within 3 years of onset of disability, 17 percent had been disabled for 12 or more years.
- ◆ The three most prevalent impairment categories (by body system) were mental (38 percent), neurological (13 percent), and musculoskeletal (15 percent).
- ◆ Half of the participants self-rated their health to be good to excellent; about three-fourths said they could do some work; and 79 percent said their health condition limited the ability to work somewhat.
- ◆ 44 percent were disability insurance beneficiaries only, while 26 percent were receiving both SSDI and SSI disability benefits.
- ◆ About 40 percent of participants claimed transportation problems as a work limitation; 79 percent said they had received no training or rehabilitation services within the 12 months prior to entering Project NetWork.

In all, 8,241 individuals participated in Project NetWork. All participants and a sample of nonparticipants were requested to answer questions for the baseline survey of demographic, employment and earnings, health, training, and motivation characteristics. All participants who completed baseline interviews will be asked to complete a followup survey to be conducted about 30 months after the baseline interview was administered.

All participants in Project NetWork were given a waiver of trial work period (TWP) months for the first 12 months of work after entering the project. The evaluation contractor will analyze the impact of the waiver on observed work activity.

The contractor will also perform an analysis of demonstration site operations to explain outcomes and the impact of site differences in case management. The cost-benefit study will present data on outcomes of case management procedures and rehabilitation and employment services for each of the four models. The focus of that study will be whether the benefit savings attributable to case management exceeded the costs of the services provided combined with the administrative expenses of operating the case management offices.

QUESTION 3

SSDI and SSI applicants who successfully meet the programs' definition of disability have been through a lengthy process that required them to prove an inability to work. Moreover, being out of the workforce may have degraded their marketability. These factors can reduce their receptivity to vocational rehabilitation and work incentives, as well as their motivation to develop or regain the ability to engage in gainful employment. Furthermore, the "all-or-nothing" nature of SSDI cash benefits can make work at low wages financially unattractive; the risk of losing medical coverage is high for many beneficiaries; and even if they wanted to take part in vocational rehabilitation, access to the vocational rehabilitation system is often limited.

How does SSA suggest that these policy issues be addressed?

ANSWER

We believe that future solutions may be complex and multi-faceted. Therefore, solutions must be addressed in comprehensive and integrated national policy devoted to the principles of maximizing employment and self-sufficiency for people with disabilities while providing basic income and health security. The SSA disability programs are themselves 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 partners in any effort to eliminate barriers to employment and to promote return-to-work.

In addition, any Federal effort in this arena should be developed within the parameters of private sector realities. For instance, the private rehabilitation community, private insurers, employers and advocates for people with disabilities must participate in formulating new directions in the Federal sector and congressional responses to these issues.

QUESTION 4

The presumed link between the presence of medical condition and the inability to work establishes the basis for SSA's award of disability benefits. But concerns about the relationship between medical status and work incapacity were raised before the SSDI program was implemented. Indeed, physicians testified before the Congress in the deliberations leading to the establishment of the SSDI program that disability determination is inherently subjective. 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, several studies have shown the difficulties in accurately determining who can and who cannot work.

Could SSA comment on the basis of its disability determination in light of this? Given the changes in the labor market, medical care, and technology, does SSA believe that the presumed link between certain medical conditions and the inability to work needs to be re-examined? If not, why not? If so, what are SSA's plans?

ANSWER

The mere presence of a specific medical condition establishes the basis for SSA's award of disability benefits in only a relatively small portion of the cases. For most cases (including many allowed under the Listing of Impairments), the presence of a medical condition is only the beginning of the evaluation, which must progress to consider the functional consequences that result specifically from that impairment and then, for most cases, the effects of those functional limitations on ability to work.

Over the years, we have examined this listing to bring the adjudicative criteria more in line with medical findings consistent with today's medical technology. When changes are necessary, we revise the listing and publish the new listings in the *Federal Register*. Those updates are designed to reflect the advances in technology that allow a more accurate finding as to level of impairment severity, as well as a more accurate diagnosis. Some examples of updates are echocardiography for cardiac impairments; diffusion studies for lung impairments; organ transplantation; standardized measurement criteria for joint motion; visual impairments; and mental retardation;

consideration of the positive and negative effects of medication; addition of the HIV syndromes; and more numerous and detailed descriptions of the manifestations of the listed impairments.

For the remaining cases which cannot be decided at the listing step discussed above and which constitute the majority of disability decisions, we assess what the individual can still do physically and mentally despite the limitations imposed by his or her impairment. This functional assessment is quantified in work-related terms, to be compared against the duties, demands, and requirements in the world of work.

QUESTION 5

For each of the programs indicated, please provide me with data on the number of participants; job placement rates; number of participants who have left the SSI/SSDI rolls through participation in these programs; and SSA reviews of these programs.

ANSWER

	<u>Number of</u> <u>Participants</u>
SSI WORK INCENTIVES (As of December 1995)	
Section 1619(a)	28,060
Section 1619(b)	47,002
Impairment-Related Work Expenses	9,940
Blind Work Expenses	4,433
Plans for Achieving Self-Support (PASS)	10,322
SSDI WORK INCENTIVES (As of February 1996)	
Extended Period of Eligibility (EPE)	22,434
Extended Period of Medicare Coverage	141
Section 301 Protection for Beneficiaries in Vocational Rehabilitation	204

We do not have information on job placement rates or numbers of beneficiaries who have left the rolls as a result of the use of the work incentives. SSA can determine if beneficiaries have earnings for a given year from W-2 reports which employers send directly to SSA. The presence of earnings after participation in work incentives could lead one to attribute causation. If such work activity were followed by termination of benefits, we could further assume that the termination resulted from the application of work incentives. However, other explanations would also be valid, and no study has been published which clearly connects work incentives to work activity which results in termination of benefits.

As for reviews of these programs, SSA produces a report on the Section 1619 (SSI) programs each year. The December 1995 report indicates that only 5.8 percent (298,635) of SSI beneficiaries with disabilities were working. Of those, the numbers reported above show that 9.4 percent were participating in 1619(a) and 15.7 percent were using 1619(b). Also, Charles G. Scott, in an article in the Spring 1992 issue of the Social Security Bulletin (SSB), found that 20 percent of SSI beneficiaries with disabilities work

after receipt of benefits, but that only 8 percent are working at any point in time. The author concludes that this suggests that job retention is more difficult than getting a job and that work incentives should be focused on keeping beneficiaries in jobs.

Periodic reviews of the SSDI work incentives are not routinely done, but a few studies of knowledge and use of SSDI work incentives have been performed. A paper by L. Scott Muller in the Summer 1992 issue of the SSB, based on reviews of the disability folders of beneficiaries who participated in the New Beneficiary Survey (NBS), reported that only 2.8 percent of SSDI beneficiaries had a work attempt which led to benefit termination.

In another paper by John C. Hennessey and L. Scott Muller which appeared in the Fall 1994 issue of the SSB, the authors report results of the NBS indicating that only 21 percent of newly-awarded beneficiaries knew about one or more of the SSDI work incentives but not more than 2 percent said they were influenced by any single work incentive.

Hennessey and Muller also examined the role of three specific work incentives and vocational rehabilitation services in encouraging SSDI beneficiaries to return to work in another paper, published in the Spring 1995 issue of the SSB. The work incentives examined were the TWP, the EPE, and the Extended Period of Medicare Coverage. They found that knowledge of the TWP increased the tendency of beneficiaries to work but that knowledge of the Extended Medicare provisions actually decreased (statistically) that tendency. (The EPE seemed to have no effect either way.) The results suggest that when beneficiaries understand the details of the Extended Medicare provision, which specifies the conditions under which Medicare coverage ends after a continuous period of work, they are discouraged from working.

Other details reported in these three papers lead to the general conclusion that the SSDI work incentive provisions are not generally understood and are having little positive impact on work activity or reduction of benefits.

We do know with certainty that about 6,000 SSDI and/or SSI beneficiaries with disabilities are found to have worked for at least 9 continuous months of substantial gainful activity (SGA) each year. (The SGA levels for 1996 are \$500 per month for nonblind and \$960 per month

for blind beneficiaries.) These are individuals who successfully completed State vocational rehabilitation programs and the State agencies have filed claims for reimbursement of their service costs. In FY 1995, SSA reimbursed the State vocational rehabilitation agencies a total of \$72.7 million for 6,238 claims (1,869 SSDI; 2,229 SSI; and 2,140 concurrent SSDI and SSI).

QUESTION 6

Please describe the changes that will be made to administer PASS and the timetable for implementation.

ANSWER

In mid-1994 we recognized that the policies and practices relating to PASS could be improved and we initiated a full review. A workgroup was established that included policy, field operations staff and Inspector General staff. Based on the workgroup's interim findings and recommendations, we issued improved instructions in December 1994. When the workgroup made its final recommendations in 1995, it recommended, and I approved, major changes to strengthen the integrity of PASS, minimize abuse, improve cost-effectiveness and strengthen administrative control of the program.

We are well on our way to implementing improvements under the provision. The field offices were instructed to forward all pending PASS applications to headquarters for decision. We have established a new cadre of PASS specialists. They have received intensive training on PASS policy as well as vocational assessment. This cadre of specialists will be in a better position to make decisions on PASS objectives and appropriate expenditures. The interim cadre has been in place since April 2, 1996; revised field instructions were issued during the week of April 8.

We have made significant progress on our PASS improvement strategy. The changes we have made will ensure that PASS continues to be useful while we minimize potential abuse.

SSA procedures on PASS now require the following:

- ◆ There must be a realistic expectation that the PASS will lead to reduced dependence on SSI (either reduced or terminated benefits).
- ◆ Each plan must specify an occupational objective, a particular job or profession the person wants to attain through the PASS.
- ◆ The occupational objective must be feasible for the individual given the nature of impairments and prior work history and training.

- ◆ Allowable expenses must be necessary to attain the work goal and of a reasonable cost; expenses may only reflect start-up costs.
- ◆ Allowable transportation expenses must be directly related to the job goal and must be the lowest-cost alternative. Costs of luxury cars will never be regarded as necessary or appropriate PASS expenses.
- ◆ No expenditures will be approved that were in existence prior to the initiation of a PASS (e.g., existing car or other loan payment).

STATEMENT FOR THE RECORD ON

**SOCIAL SECURITY ADMINISTRATION'S
PROGRESS ON RETURNING
BENEFICIARIES TO WORK**

By

**DR. SHIRLEY S. CHATER
COMMISSIONER
OF SOCIAL SECURITY**

**BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING**

June 5, 1996

Statement Submitted for the Record
by Dr. Shirley S. Chater
Commissioner of Social Security
Before the Senate Special Committee on Aging
June 5, 1996

Mr. Chairman and Members of the Committee:

I share your concern that SSA's current rehabilitation program serves only a very small percentage of Social Security Disability Insurance (DI) beneficiaries. In mid-1994, SSA began a thorough analysis of the disability program to identify barriers and disincentives faced by beneficiaries in their attempts to return to work.

First, however, I must emphasize that in the last year, the Social Security Administration has returned more beneficiaries to work—over 6,000—than ever before. In addition, SSA has promulgated regulations which will allow us to refer beneficiaries to private vocational rehabilitation providers for the first time if that individual has been denied State service. Request for Proposals have been issued for this private participation and we anticipate full implementation within the next few months.

Accomplishments

Despite rising initial claims workloads, SSA has been working to help people with disabilities gain independence from the disability rolls through innovative rehabilitation and employment initiatives. Mr. Chairman, you have expressed a perceived lack of effort on our part to help disabled beneficiaries return to work since the hearing you conducted on March 2, 1995. However, we have:

- o Reimbursed State vocational rehabilitation (VR) agencies \$72.7 million in fiscal year 1995 for the successful rehabilitation of 6,238 beneficiaries.
- o Received input from advocates, experts, and other stakeholders on removing the barriers to return to work in the Supplemental Security Income (SSI) and DI programs.
- o Published regulations which: (1) require the State VR agencies to inform us

of those SSA-referred beneficiaries that they are able to serve; and (2) permit us to re-refer individual beneficiaries to an alternate provider when the State VR agency is unable to provide services.

- o Developed a method for re-referring beneficiaries not able to be served by the States to qualified, alternate VR service providers that have entered into negotiated contracts with SSA.
- o Requested that States enter into performance partnerships with SSA to enhance the States' rehabilitation and employment initiatives to better focus on beneficiaries as VR clients.
- o Published a new brochure to inform the public about how SSA can help with VR services.
- o Signed an interagency agreement with the Rehabilitation Services Administration for Cornell University to provide training on our work incentives to State VR professionals in all regions of the country.
- o Let a contract for a complete, comprehensive evaluation of Project NetWork, a major SSA research effort that tested four models for delivering alternative employment and rehabilitation services.

As a result of regulations published in March 1994, VR service providers in the public and private sectors are now eligible to participate in SSA's VR reimbursement program to serve our beneficiaries who are not served by State VR agencies. After receiving nearly 4,000 requests for further information, we released a request for proposal to each responder. Based on proposals received, we will enter into negotiated contracts with all qualified VR providers.

In addition, we have been expanding Project ABLE (Able Beneficiaries' Link to Employers), a joint Federal-State initiative to develop a database linking disabled job-ready beneficiaries with Federal, State and local agencies and private sector employers that need their skills and abilities. Project ABLE is a cooperative effort of the Office of Personnel Management in conjunction with SSA, the Rehabilitation Services Administration and participating State VR agencies.

Project ABLE has been recognized as a National Performance Review 'Reinvention Lab.' I am pleased that it has proven to be an excellent example of Federal and State agencies collaborating to give world class service to our joint customers.

We will continue to work with our State partners, other public agencies, and

private organizations that serve people with disabilities to bring together the interests of employers, private insurers, and rehabilitation service providers to more efficiently serve people who are able and willing to return to the workplace.

Continuing Disability Reviews

SSA looks for every opportunity to convey information about VR services to our beneficiaries. During the continuing disability review (CDR) process, SSA conveys information about VR services to beneficiaries who have been on the rolls. Our CDR mailer questionnaire, which we implemented nationally in 1993, contains a question asking if the beneficiary is interested in receiving rehabilitation or other services that could help him/her get back to work. SSA initiates a referral to the State VR agency for each beneficiary who responds affirmatively to the question. In addition, at the time the CDR medical determination is prepared, the State disability determination services (DDSs) consider if a beneficiary should be referred for VR services and initiate appropriate referrals to the VR agencies.

Each CDR determination notice which informs the beneficiary that their entitlement to benefits will continue also states that SSA can help the individual go to work by offering to contact the State VR office to arrange for training and employment assistance and answering work-related questions.

We are committed to ensuring that individuals remain on the disability rolls only if they continue to be disabled. The more efficient CDR mailer process, which is also twice as cost-effective, has allowed us to significantly increase the number of CDRs we conducted in the past few years.

In addition, Public Law 104-121, enacted on March 29, 1996, provides for an adjustment in the discretionary spending caps for increased funding for CDRs for fiscal years 1996 through 2002. Funds have been appropriated for processing CDRs for fiscal year 1996. However, further congressional action is necessary each year to make additional funds available to us. If additional funds are appropriated each year as projected in the authorizing legislation, we should be able to eliminate the current backlog of DI cases requiring a CDR by the year 2002 and to stay current with our legally mandated DI and SSI disability review workloads.

Need for Intergovernmental Coordination

We recognize that we must provide real options for those beneficiaries who can return to work. However, we have found that piecemeal solutions applied to the problems faced by our disability beneficiaries would have only limited

success. We 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, Health and Human Services, and the Internal Revenue Service, as well as the Social Security Administration, 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 developing a process for enhancing the productive capabilities of disabled beneficiaries.

Conclusion

SSA will continue to work with all interested public and private stakeholders to develop new and innovative methods of encouraging return-to-work efforts by our beneficiaries. We will also continue to evaluate our current work incentives to ensure that all beneficiaries have access to the information they need to determine how returning to work would affect their benefits.

Task Document

REPORT FOR THE RECORD

HEARING OF THE U. S. SENATE SPECIAL COMMITTEE ON AGING

**STRANDED ON DISABILITY:
FEDERAL PROGRAMS FAILING DISABLED WORKERS**

JUNE 5, 1996

The Council of State Administrators of Vocational Rehabilitation (CSAVR) is comprised of the chief administrators of the public agencies providing rehabilitation services to persons with disabilities in the fifty (50) states, the District of Columbia, and the territories.

These Agencies constitute the State partners in the State-Federal Program of Rehabilitation Services for persons with mental and/or physical disabilities, as authorized by the Rehabilitation Act of 1973, P.L. 93-112, as amended.

The State Vocational Rehabilitation (VR) agencies have provided VR services to persons with disabilities for more than 75 years. During this period, more than nine million persons with disabilities were assisted to enter or return to work. The State VR agencies have worked with the Social Security Administration (SSA) for more than thirty years to assist persons with disabilities who also received benefits from the Social Security Disability Insurance (SSDI) program or from the Supplemental Security Income (SSI) program to return to work. Over this thirty-year period, the eighty-two State VR agencies funded by the Rehabilitation Services Administration (RSA) have responded to SSA referrals, solicited beneficiary participation, and delivered VR services in an almost infinite variety of ways. Based on this experience, the State VR agencies and RSA have some insight into the issues and problems of achieving return to work outcomes.

THE CURRENT SSA/STATE VR AGENCY VOCATIONAL REHABILITATION PROCESS

In simplified form, the SSA VR process has operated as follows. The person with a disability applies for benefits at a local SSA office. After meeting requirements, including a minimum period of disability, the claim is sent to an SSA funded but State (often State VR) operated Disability Determinations Services (DDS) office for initial determination of eligibility for disability payments. Around the time of the disability determination decision, the DDS refers both persons allowed and denied disability benefits to the State VR agency based on a set of criteria for referral. The DDS notifies the beneficiary by letter that a VR referral has been made and the State VR agency attempts to contact the beneficiary to offer rehabilitation services.

If the beneficiary responds to State VR agency contacts and wishes to apply for services, a VR counselor is assigned to work with the individual. The VR counselor makes a

determination of eligibility, and if the individual is found eligible, an individual rehabilitation plan of services, including a specific vocational goal, is developed with the agreement and informed choice of the beneficiary.

Since March of 1994, SSA has the authority to refer any person who has not been accepted for services by the State VR agency within four months of referral by SSA to an alternative provider of rehabilitation services.

From the State VR agency program perspective, persons with disabilities may choose any vocational outcome and level of work and income they desire as long as the outcome is consistent with the unique strengths, resources, priorities, concerns, abilities and capabilities of the individual. Employment outcomes are considered successful if the person maintains the chosen outcome for sixty days.

From the SSA perspective, the State VR agency is reimbursed for an employment outcome only if the person completes a nine-month trial work period and earns an amount that exceeds the level of Substantial Gainful Activity (SGA), currently \$960 per month for persons with visual impairments and \$500 per month for persons with all other disabilities. True success in SSA terms occurs at the end of an extended period of eligibility (about two years) when the person is no longer able to return to the benefit rolls.

ISSUES AND PROBLEMS IN THE SSA VOCATIONAL REHABILITATION PROCESS

Simply reporting the results of SSA rehabilitation efforts as "less than one-half of one percent leaving the rolls through return to work" implies that the system has failed where it should have succeeded with the remaining 99.5 percent. It does not illuminate the factors involved in creating such a low rate of benefit termination due to return to work.

Disability Program Disincentives and Administrative Barriers

Disincentives inherent in the SSA disability program structure are the most significant barriers to return to work. These include:

- loss of medical insurance and particularly loss of Medicaid coverage with its unique benefits related to long-term care;
- loss of cash support (which in addition to the actual SSDI or SSI payment could include additional earnings up to certain limits without loss of the total benefit package);
- loss of other benefits such as housing subsidies or food stamps;
- fear that the benefits seemingly hard won through a lengthy application process could be removed forever if the individual proves capable of some work;

- fear that the work outcome will not be sufficient to replace benefits lost; and
- the possibility that the physical and emotional effort required for some persons with severe disabilities to perform the daily activities to prepare for and get to work may be so great as to offset the perceived benefit of higher income.

The SSA disability program procedures and structure contribute to the low number of persons returned to work in significant ways:

- Referrals are made to State VR agencies without any personal contact with the beneficiary regarding the purposes of VR referral and the beneficiary's responsibilities regarding referral.
- No explanation of the benefit eligibility protections and work incentives available is given to beneficiaries prior to or concurrent with VR referral.
- State VR agencies come in contact with many beneficiaries whom State VR agency staff believe could be returned to work. Individuals often refuse to apply for services, fail to cooperate, or choose outcomes that result in retention of benefits because of the understandable fear of the loss of critical benefits. Further, the beneficiary is not provided a personal explanation of the statutory obligations with regard to participation in VR efforts or the statutory sanctions which are possible.

Disability program statutory benefit disincentives and administrative issues combine to produce a number of problems during the vocational rehabilitation process.

Referral Issues

There are several factors that require mention related to State VR agency practices with regard to SSA referrals. Most important is that large numbers of persons were referred who did not want to participate in VR services. In one agency, only 6 out of every 100 SSA referrals were willing to complete an application and only four out of 100 were willing to begin a rehabilitation plan. Reasons for lack of interest included beneficiary beliefs that they were too disabled to work, desire to maintain SSA disability benefits, lack of understanding of work incentives, and lack of understanding that they might risk losing benefits if they did not participate in VR efforts.

Many State VR agencies at some time in the last thirty years attempted to emphasize outreach to SSA referrals. When persons who appeared to be good prospects for rehabilitation did not apply, the State VR agency reported this decision to SSA in accordance with SSA statutory requirements with the expectation that SSA would contact the beneficiary, let him or her know that they risked benefit suspension or termination according to SSA statutes, and if the refusal persisted, apply statutory sanctions. According to SSA, no one has had benefits terminated or suspended because he or she refused to apply for VR services. Since 1965, only about 100 persons have been

sanctioned and all of these were situations where persons withdrew after beginning a rehabilitation plan. The overhead cost of opening files, conducting interviews, and closing cases of a large number of persons referred by SSA who refused services discouraged State VR agencies from pursuing outreach programs.

Another referral barrier was that many persons denied disability benefits and referred for VR services by SSA were still involved in SSA appeals processes to receive disability awards. This meant that the beneficiary was being contacted about VR services while still actively engaged in an appeals process designed to show that the beneficiary was incapable of working at any job found in significant numbers in the national economy. Again, refusal to apply for rehabilitation services was the overwhelming response.

Rehabilitation Planning and Vocational Outcomes

Some SSA beneficiaries who are capable of earning more than the SGA level of earnings may only work enough to supplement SSA benefits, in order to maintain essential medical and other benefits. For other beneficiaries, part-time or low wage jobs may be the only appropriate outcomes.

State-federal VR program rules allow for individual choice in vocational goals and in services to the extent that the choices are achievable and in accordance with State VR agency policy. In the absence of SSA policy and support for requiring beneficiaries to make choices that lead to outcomes where earnings are sufficient to result in benefit termination, some SSA beneficiaries may choose to design a rehabilitation program that maximizes employment skills but work only enough to maximize earnings while retaining benefits.

State VR agencies rehabilitate by RSA standards about 48,000 (out of 200,000) SSA disability program beneficiaries per year. Of those, only 6,200 (12.9%) make enough money for nine months to qualify for reimbursement from SSA. Most of the 39,000 beneficiaries who do not qualify for SSA reimbursement do not qualify based on earnings. Further, about 3,200 of the 6,200 persons who qualify for reimbursement do not leave the rolls at the end of the two year extended eligibility period. SSA reports a significant number leave work and return to the rolls just prior to the end of medicaid eligibility.

Persons with severe disabilities who are not SSA disability program beneficiaries appear to make twice the earnings at successful employment outcome (non SSA \$237.32, SSA \$118.11 weekly) and exceed the SGA requirements for benefit termination at approximately five times the rate of SSA beneficiaries (non SSA 62%, SSA 12.9%).

These differences maintain in spite of preliminary data showing that the State VR agencies commit significant resources to SSA recipients needing services. SSA recipients receive more services at greater cost, receive more training services, job referrals and job placement assistance than do non SSA beneficiaries.

How could the current SSA Vocational Rehabilitation Program be Improved?

- Change the disability programs disincentive structures, particularly with regard to medical insurance and long-term assistance for personal assistance and supports for independent living along the lines of the testimony heard in the June 5, 1996 Hearing.
- Require SSA to support State VR agencies by requiring beneficiaries to participate in VR programs.
- Require the national use of standard but fairly broad criteria for selection of beneficiaries for referral by SSA to State VR agencies.
- Require a personal contact by SSA with each referral to explain the requirements for participation and the work incentives available prior to or concurrently with referral to the State VR agency.
- Require a personal contact by the State VR agency with each beneficiary to explain the VR process and the VR services available to them.
- Require some level of ongoing communication between SSA and State VR agencies regarding individuals receiving rehabilitation services as the rehabilitation process continues. Such contact could include feedback about results of individual referrals, help for individuals to understand SSA work incentives, and informal problem resolution.
- Provide funding either through SSA or State VR agencies to provide contact with beneficiaries through the trial work period and the extended eligibility period to explain concerns about changes in benefit eligibility and to assist in maintaining employment.

Comments on Privatization of SSA Vocational Rehabilitation Program Proposals

Disincentives and policy and procedural issues have been the primary causes of the low rate of benefits terminations due to return to work outcomes. Following are some preliminary thoughts on the alternative rehabilitation program proposals presented on June 5, 1996. It is clear that:

- Changes in the SSA benefit structure must be made regardless of who provides rehabilitation services.
- SSA must decide to support the vendor by requiring participation regardless of who provides rehabilitation services.

Without the two changes above, the private sector seeking to provide direct services to

SSA disability beneficiaries under any of the proposed plans for payment based only on success as defined by SSA would face high overhead for relatively few reimbursable results. It is questionable whether private vendors would spend the staff time to process 100 referrals to find four who will participate.

- Two proposals for allowing direct service provision to SSA beneficiaries, the National Academy of Social Insurers (NASI) proposal and the Return to Work Group (RTWG) proposal, base payment to vendors only on success by SSA standards. These proposals do not consider how costly services will be provided.

The NASI proposal reimburses providers for outcomes as a percentage of savings to the Trust Fund over a period of years. It is not a cost reimbursement proposal. For example, some of the work-related assistive devices demonstrated in the hearing cost over \$10,000. If the average return on a successful outcome is \$10,000 to \$26,000 as indicated in the proposals and in the testimony, does this mean that a private provider might not offer these services because it cuts into profit or administrative cost reimbursement? Or would the private provider offer them to only those beneficiaries whose net return to the vendor would be enough to cover the costs, but not to others? What about costly training services? These proposals need to address these issues. As currently proposed, the NASI scheme reinforces low cost strategies such as direct job placement at low wage jobs that require few expensive accommodations, leaving the beneficiary with limited vocational choice.

- The RTWG identifies the State VR agency as a source of funds for payment for costly services. A beneficiary chooses a rehabilitation service provider by depositing a "return to work ticket" with the private vendor. The private vendor would then be entitled to payment from SSA after successful termination of benefits due to the provider's services and a return to work outcome at or above the level of SGA for a specified period of time. The RTWG proposal states that the private provider, (who is entitled to the payment from SSA) could refer beneficiaries to the State VR agency for payment of expensive services. In such a situation, the cost to public funds could increase if full payment was given to the private vendor and the State VR agency also provided expensive services from public VR funds.
- Consumer choice of vendor is a point made by these proposals.

The discussion of client choice in the NASI and RTWG proposals appears to be a choice of first vendor. How can the individual make a choice to go to another vendor if the relationship deteriorates? Are there subsequent vendor choices? If so, who repays the first vendor for costs incurred? And what if the consumer needs the services of several vendors?

- What about consumer choice of vocational goal and vocational services?

What are the consumer entitlements as regards choice in these areas, given that the costs

are presumably coming from the private sector vendor?

- How will due process for resolution of disputes be provided for both beneficiaries and vendors?

SSA has said it does not want disputes and appeals over the provision of rehabilitation services by alternative participants (private providers of rehabilitation services) clogging its own internal appeals processes and currently proposes buying these services from existing protection and advocacy services. However, after providing nonbinding mediation services, how does an advocacy service provider force a private vendor under the NASI or the RTWG proposal to spend its own money? Or require a beneficiary to take a job? Or handle a vendor dispute when the vendor has expended its own funds and SSA will not support the vendor by requiring participation or benefit suspension, thereby making the vendor recovery of the expended funds and any profit impossible? It is not clear how SSA will be able to enforce a vendor spending their own funds even if the dispute is handled through its own appeals process, much less empower a protection and advocacy organization to do so.

- There is always the cost of administration to consider.

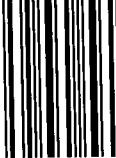
What is being proposed is the establishment of a new VR services delivery system. The new system proposals emphasize that such a system is made up of existing providers, and assume that this means no new administrative structure. However, there has been no other administrative structure comparable to RSA and the State VR agencies, which SSA has in effect borrowed to coordinate the provision of rehabilitation services to beneficiaries. The new proposals require a new administrative structure to replace RSA and the State VR agency administrative functions. Whether this is contracted services, payments to private agency staff who act as alternative participant network administrators or network coordinators, or actual SSA agency staff positions, there will be an additional administrative cost to the SSA and the public.

CSAVR continues to develop information about SSA beneficiary rehabilitation outcomes from its various data bases. CSAVR will also continue to study the various proposals for SSA rehabilitation program restructuring and will gather information about ways in which State VR agencies have pursued initiatives with the SSA beneficiary population.

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