

*This article examines suggestions by the General Accounting Office (GAO) to improve the rate of rehabilitation of workers on the disability rolls. It examines GAO's suggestions within the context of research by experts on return-to-work practices in Germany, Sweden, and the United States. It also discusses lessons learned from the European experiences and current and past return-to-work initiatives used in the Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) programs.*

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## ***Improving Return-to-Work Strategies in the United States Disability Programs, with Analysis of Program Practices in Germany and Sweden***

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### ***Summary***

The General Accounting Office (GAO) has made recommendations for improving the disability programs by citing practices that have been successful in Germany, Sweden, and the private sector. This issue is important in the United States because the number of disability beneficiaries is growing rapidly, program costs are increasing proportionately, and few disability recipients are leaving the disability rolls to resume work activity. GAO points out that the estimated lifetime savings for removing an additional 1 percent of the disabled beneficiaries from the rolls of the Disability Insurance (DI) and the Supplemental Security Income (SSI) programs each year will ultimately reach \$3.0 billion.

GAO cites three specific practices as showing the most promise for returning the disabled to work. They are (1) intervening as soon as possible after a disabling event to promote and facilitate return to work, (2) identifying and providing necessary return-to-work assistance and managing cases to achieve return-to-work goals, and (3) structuring cash and health benefits to encourage people with disabilities to return to work. This article examines these

suggestions to improve the rate of rehabilitation of disabled workers using research by experts on return-to-work practices in Germany, Sweden, and the United States.

Experts caution that any consideration of borrowing practices from other countries needs to take into account the unique economic, social, and political elements in each country. Although other countries appear to be very successful in their rehabilitation programs, practices that are successful in one country may not necessarily work well in another. Countries have different definitions of disability and payment structures. The existence of temporary and partial awards in Germany and Sweden may ensure a number of easily rehabilitated individuals, while the U.S. vocational rehabilitation (VR) agencies have been mandated to focus on only the most severely disabled individuals. Public expenditures for vocational rehabilitation, work for the disabled, and disability benefits are much higher as a percentage of gross domestic product in Germany and Sweden than they are in the United States. Compared with the United States, Germany spent twice as much for VR, and Sweden spent 2.6 times more.

Impediments to GAO's suggestions include divergent goals of the Social Security program and VR agencies, lack of availability of VR services, the timing of VR referral (which is significantly later than the onset of the disability), and little incentive for return to work built into the payment structure.

The Work Incentives Improvement Act of 1999 is currently being considered by a Congressional conference committee. The bill would establish a Ticket to Work and Self-Sufficiency program and would require or authorize the Social Security Administration to demonstrate and evaluate different ways of encouraging return to work. In designing these demonstrations, early intervention after a potentially disabling illness or injury is an approach that merits serious attention.

## ***Introduction***

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In the 10-year period from 1987 through 1996, the number of working-age disabled beneficiaries grew from 2.8 million to 4.4 million in the DI program and from 2.1 million to 3.5 million in the SSI program. In 1996, DI benefits cost \$39.6 billion, up from \$18.0 billion in 1987, and federal SSI benefits cost \$21.8 billion, up from \$7.8 billion in 1987.<sup>1</sup> Part of this growth has occurred because few disabled workers leave the program due to resumption of work activity. In fact, for fiscal year 1996, only 6,024 workers referred by SSA were rehabilitated by state Vocational Rehabilitation (VR) agencies.<sup>2</sup> Improving return-to-work strategies is important because the estimated lifetime savings for an additional 1 percent of the DI and SSI beneficiaries leaving the rolls is \$3 billion.<sup>3</sup> GAO has suggested that return-to-work strategies employed by Germany and Sweden hold potential for getting disabled Americans back to work. GAO recommendations are:

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

Any consideration of borrowing social insurance practices from other countries should include an analysis of the unique economic, social, and political elements in each country. Policies in any environment must be understood within that context before they are considered for use elsewhere. It is also important to recognize that all countries concede that their own social insurance programs have room for improvement. Research has shown that Germany, Sweden, and the United States have attempted to make improvements in their disability programs over the years by introducing new requirements, practices, and incentives. Some of these have proven to be successful over time and others have not. Unfortunately,

comparable data on reintegration (returning the disabled to work) from the three countries is difficult to obtain. It is also difficult to pinpoint any specific new practices that might have improved the statistics since new practices are rarely adopted in isolation. The governments of Germany and Sweden have also recently passed legislation to make incremental changes through the year 2000. The impact of these legislative changes will take years to assess.

This article examines suggestions made by GAO to improve the rate of rehabilitation of workers on the DI/SSI disability rolls. A brief discussion of some unique aspects of the European systems will provide a framework for an examination of the feasibility of GAO's suggestions. The article also discusses past lessons learned from the European experiences and current and past return-to-work initiatives used in the DI and SSI programs.

## ***Definitions of Disability***

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The U.S. national disability insurance program has the most restrictive definition of disability of the three countries. To receive benefits, an applicant must demonstrate an inability to engage in any substantial gainful activity by reason of a physical or mental medically determinable impairment that is expected to last at least 12 months or result in death. In addition, the impairment must be of such severity that the person is not only unable to do his previous work, but considering his age, education, and work experience, is unable to do any other kind of substantial work that exists in the national economy.

In Germany, disabled persons are those who are "limited in their capacity for integration into society because of the effects of a physical, mental, or psychological condition which is contrary to the norm, and where limitation of this capacity for reintegration is not merely of a temporary nature...The seriousness of limitation is expressed as a 'degree of disability' in increments of ten degrees between 20 and 100."<sup>4</sup>

In Sweden, a disability "is not looked upon as a characteristic of a person, caused by injury or illness, but as a relationship between the person and the work environment...It is only when the disability entails an impediment in relation to a certain kind of work that reference can be made to an occupational disability. A jobseeker has an occupational disability if, as a result of an impairment, medical condition or illness of a physical, mental, or intellectual or social nature, he or she has, or is expected to have difficulties in obtaining or retaining gainful employment."<sup>5</sup>

An examination of these definitions shows that the United States' definition of disability is of a full and complete disablement, whereas both Germany and Sweden recognize lesser degrees of impairment or disablement. Appropriately, those countries with definitions of disability that recognize degree of impairment award partial benefits based on degree, while the United States pays only a full benefit amount to those meeting its criteria.

## *Programs in Germany and Sweden*

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### *Guiding Policies*

Sweden's disability policy has political, economic, and social goals. The political goal, formulated by the government in 1976, is "to make society accessible for all, to provide disabled persons the opportunity to participate in the social community, and to live in a manner, to such a degree as possible, equivalent to others."<sup>6</sup> The aim is full participation and equality for all of its citizens. Responsibility for achieving this objective is shared by society as a whole. The labor market policy is based on the principle of universal entitlement to work, and an emphasis has been placed on young people, minorities, the disabled, and the long-term unemployed. Sweden's emphasis has historically been on a strong work ethic and full employment.

In Germany, there is a social right addressing the disabled: "any person who is physically, mentally or psychologically disabled, or who is threatened by such a disability, has a social right independent of the cause of disability, to the assistance which is necessary in order to avert, eliminate, or ease the disability, prevent its aggravation or to reduce its effects and to secure a place in the community, in particular in working life, in accordance with his or her inclinations and abilities." Four principles are emphasized:<sup>7</sup>

- Enabling people to live as normally and independently as possible, depending as little as possible on social benefits. This principle implies avoiding the creation of special facilities and laws targeting the rights of disabled people only;
- Offering necessary assistance to every disabled person and person threatened by disability, regardless of the cause of disability, even when responsibility for this assistance is held by a number of different funds and institutions whose eligibility requirements for the provisions of assistance vary;
- Intervening at the earliest possible stage in order to minimize the degree and effects of disability and to compensate as far as possible for unavoidable effects; and
- Tailoring individual assistance to the needs and situation of each individual disabled or threatened by disability.

### *Rehabilitation Services*

Under Sweden's General Insurance Act, employers are required to report any employee receiving more than 4 weeks of consecutive sickness benefits to the social insurance office. The employer, employee, and the social insurance office share responsibility for beginning a rehabilitation plan.

The Swedish Social Insurance Service and its regional and local offices may buy services for their clients from any

approved training service. Some rehabilitation services offer different kinds of VR programs, while others specialize in certain types of disabilities. VR providers differ greatly in terms of measures taken and results achieved, mainly because of differences in clientele due to specialized programs. Specific occupational training is conducted under the same programs for the disabled as the nondisabled.

In Germany, impaired workers are referred for rehabilitation by adjudicators of the sickness insurance system, the disability pensions, or the local employment agencies. A wide variety of programs are designed to reintegrate workers into the labor force when they are ready, including wage subsidies, job modifications, technical aids, transportation allowances, and a variety of other assistive devices. There are also provisions for part-time reintegration into the workforce while receiving partial benefits.

The physician is part of the rehabilitation process in Germany. Physicians are required to adhere to published guidelines for the treatment and rehabilitation of persons with specific illnesses and injuries. Guidelines deal with definitive treatment, recommendations for exercise and general exertion, ways to persuade the patient to apply for rehabilitation services, formulation of support groups, and the role of work in the life of a patient.

### *Trends and Program Changes*

In the 1980s, the incidence of absence from work in Sweden increased considerably. In an attempt to stop this trend in growth, benefit levels were reduced and more responsibility was placed on employers and individuals to achieve a quicker return to work. Money was diverted from funding sickness benefits to procuring rehabilitation services. During the 1990-91 period, the primary responsibility for identifying and determining the need for rehabilitation was placed on employers. Since 1990, the number of people who are compensated through the public sickness insurance system has declined almost by half due to more restrictive rules and practices. These include more restrictive requirements concerning medical documentation, sickness payments for the first 2 weeks being moved from the general social insurance system to the employer, and the compensation level decreasing from 90 percent of income to a sliding scale that decreases the benefit over time.

The role of Sweden's Social Insurance Service personnel changed in 1992. For the first time, the role of these employees was expanded to a more active role in rehabilitation. They were required to have personal contact with every workplace and play an active part in preventive measures as well as encouraging early and active rehabilitation for ill and injured workers.

Prior to 1996, all disabled persons in Germany had a legal claim to vocational rehabilitation benefits. The Growth and Employment Act (January 1997) changed this arrangement so that VR for new claims is decided on a case-by-case basis. Tighter management of claims will be pursued, and rehabilita-

tion benefits will be limited to 1993 expenditure levels.<sup>8</sup> Effective in 2000, disability pensions will no longer be liberalized or tightened based on the labor market situation. The benefit for occupational incapacity (a partial incapacity of at least 50 percent) will be removed from the pension system and privatized.

### Major Programmatic Differences

In Germany and Sweden, virtually all workers are covered by social health insurance that does not terminate with the loss of employment. This situation does not prevail in the United States. Many U.S. workers lose their medical benefits when they leave their place of employment or must pay high premiums to maintain them. When a finding of disability is made, the SSI beneficiary is automatically entitled to Medicaid coverage because of limited income and resources, and the DI beneficiary is entitled to Medicare enrollment after 24 months. Medicaid coverage can be extended indefinitely to lower income SSI workers under Section 1619 (b) of the Social Security Act, and Medicare coverage for DI workers can continue for 39 months after successful completion of the trial work period. Beneficiaries terminated from either Medicare or Medicaid may have difficulty finding coverage through private insurance companies and employer-based insurance programs that do not cover the individual for pre-existing conditions. Many researchers believe that the disabled have often been frightened of returning to work and risking the loss of Medicare or Medicaid coverage in the absence of comparable private coverage.<sup>9</sup> The Health Insurance Portability and Accountability Act of 1996 made access to health care more available to workers with pre-existing conditions by limiting insurance companies to a 12-month maximum exclusion period for these enrollees.

In Germany and Sweden, measures are in place for payment of temporary sickness benefits prior to a determination of disability. The term of these payments is flexible. Partial benefits may be paid to an individual who is still able to maintain part-time employment. The sickness benefit payment period is often used to pursue rehabilitation services prior to either a full return to work or disability pension determination. The U.S. Social Security programs do not include a partial benefit award. Instead, they grant a benefit that can be terminated for successful return to work or medical improvement, or reduced by the amount of some other benefit that is based on the same disability.

It is significant that Germany and Sweden have historically paid a higher percentage of their gross domestic product (GDP) for their programs than the United States. Expenditures for the disabled in both Germany and Sweden far exceed those of the U.S. disability program. Table 1 shows the percentage of GDP spent by each country for rehabilitation, work for the disabled (sheltered workshops and other employment programs), and disability benefits. However, it should be noted that the United States has the highest ratio of VR expenditures to disability benefits of the three countries.

Table 2 shows that Social Security contributions rates have also been much higher in the European countries. The taxation rate for U.S. workers falls considerably short of both Germany and Sweden.

Because of the differences in the programs, how they are implemented, and how success is defined, it is difficult to cite the practices or combination of practices that contribute to the success or relative failure of return-to-work practices in Germany, Sweden, and the United States. The statistics for successful return to work or reintegration for each of the countries are also difficult to compare since the definitions of success are different. The published success rates of the Rehabilitation Services Administration, the federal oversight organization for the state VR agencies in the United States, are not comparable to the published success rates of the European countries because Germany and Sweden include the unemployed, first-time workers, and those needing training in a new field as well as the disabled population. However, the rehabilitation rates of disability cases referred to the VR agencies in the United States fall far short of the national rehabilitation statistics for VR services. In 1995, approximately 1.3 million individuals were served by the state VR agencies annually, and approximately 200,000 (15.4 percent) were successfully rehabilitated,<sup>10</sup> yet only 6,238 (0.5 percent) were considered successfully rehabilitated disability claimants.<sup>11</sup>

Table 1.—Public expenditures on labor market measures for the disabled and cash benefits, as a percentage of GDP, 1991<sup>1</sup>

Country	Vocational rehabilitation	Work for the disabled	Disability benefits
Germany.....	0.13	0.09	2.0
Sweden.....	.10	.68	3.3
United States.....	.05	(2)	.7

<sup>1</sup>Leo J. M. Aarts and Philip R. DeJong, "European Experiences with Disability Policy," in *Disability, Work and Cash Benefits*, J. Mashaw; V. Reno; R. Burkhauser; and M. Barques (eds.), Michigan: W.E. Upjohn Institute for Employment Research.

<sup>2</sup>Less than 0.01 percent.

Table 2.—Social Security contribution rates for the average worker<sup>1</sup>

Country	Total	Insured person	Employer
Germany.....	20.30	10.15	10.15
Sweden.....	20.06	1.0	19.06
United States.....	12.40	6.2	6.2

<sup>1</sup>U.S. Social Security Administration, *Social Security Programs Throughout the World—1997*, Washington, DC.: U.S. Government Printing Office, 1997.

A 1998 International Labour Organization (ILO) project that studied different return-to-work strategies in several countries shows some interesting differences between countries that the statistics alone do not reflect. For instance, while the VR system in the United States concentrates on rehabilitating the most severely disabled individuals, the German system has been criticized for “creaming,” or accepting a high percentage of individuals who are skilled workers with minor health impairments while rejecting older and more severely disabled individuals.<sup>12</sup> In Sweden, disabled persons represent only 30 percent of all persons who take part in the National Labour Market Board’s range of measures.<sup>13</sup> The other participants in the range of measures receive mostly vocational training and are not disabled.

## ***A Discussion of the GAO Recommendations***

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### ***Intervene as Early as Possible After an Actual or Potentially Disabling Event***

GAO suggests that SSA should assist the applicant with access to rehabilitation as early as possible using the following practices: (1) address return-to-work goals from the beginning of an emerging disability; (2) provide return-to-work services at the earliest appropriate time; and (3) maintain communication with workers who are hospitalized or recovering at home.

The notion of early intervention has gained popularity among medical and social insurance professionals because any delay in offering rehabilitation tends to encourage applicants to focus on their disability rather than their residual ability or potential. Edward E. Palmer has noted that “time itself is a debilitating factor...As time passes individual motivation wanes and psychological barriers to returning to a normal work situation are erected, more or less subconsciously.”<sup>14</sup> In Germany and Sweden, laws and policies require that an individual’s potential for returning to work be assessed soon after the onset of a disabling condition. In Germany, early assistance in rehabilitation is a guiding principle and rehabilitation is considered before payment of benefits.<sup>15</sup> Sweden’s recent policy emphasis has been on early intervention and policy coordination of all parties involved in rehabilitation.

In Germany, physicians of the sickness insurance agency counsel and refer individuals for rehabilitation even for an emerging disability. Rehabilitation authorities have published guidelines for the treatment and rehabilitation of specific conditions. These guidelines include definitive treatment, recommendations for exercise, and ways to persuade the individual to apply for rehabilitation services. If the individual does not need to be referred immediately, the sickness insurance agency has a legal obligation to notify the pension benefit insurance agency after a worker uses 6 weeks of sick leave.

Despite Germany’s guiding principle of “rehabilitation before pension,” there is evidence of compromise in the German system. Germany has had problems supplying rehabilitation services despite promises that they are available and a priority.

Research has suggested that the principle of early intervention is not always followed. Studies conducted in 1988 and 1990 show that rehabilitation was often never begun or that measures were not undertaken for a long period of time.<sup>16</sup> Many people received pensions well before, or instead of, rehabilitation. A major reason for this problem seems to be inadequate availability of services available due to “fragmentation of authority across competing agencies.”<sup>17</sup> Funding of rehabilitation services is linked to social insurance contributions, thus the lower the employment rate, the lower the contributions and therefore the lower the rehabilitation services budget for growing numbers of the disabled.

Facilitating early return to work has become a major policy objective in Sweden. In the 1990s, the emphasis has been to give employers and employees more responsibility to achieve quicker return to work. This policy was practical because approximately 75 percent of employees either work for large companies with on-site doctors and physical therapists or for a company with an affiliation with a medical center.<sup>18</sup> The employers’ physicians monitor cases from the beginning of an illness or injury, and are therefore strategically placed to initiate any needed early intervention. Employers are now required to help create a rehabilitation plan for the employee 8 weeks into the illness or injury.

In Germany and Sweden, maintaining communication with the disabled worker during hospitalization and recovery is deemed important. This case management technique is used by private insurance companies and employers that are involved in rehabilitation efforts. Surveys have shown that participants like this personal touch feature. Case managers may actually view it as a motivational tool used to encourage the worker to get back to work.

### ***Identify and Provide Assistance Effectively***

GAO challenges SSA to address each individual’s return-to-work potential and needs, use case management techniques when appropriate to help workers with disabilities to return to work, offer transitional work opportunities that enable workers with disabilities to ease back into the workplace, and ensure that medical service providers understand the essential job functions of workers with disabilities.

One of the principles of rehabilitation policy in Germany is “individual assistance tailored to the actual needs and situation of each individual disabled or threatened by disability.” The physician in the local pension benefit agency decides the best path to be taken for each disabled person: whether he or she can be expected to recover without intervention, whether the decision should be delayed to await further developments, or whether the person should be referred for rehabilitation. If rehabilitation is chosen, a panel of doctors at the pension insurance agency decides whether medical or vocational rehabilitation is appropriate, or if a disability pension should be granted. Assessments and training generally take 6 to 12 months, but may take up to 2 years for a severely impaired individual.

Sweden began following Germany's example in 1992. Although the emphasis was to encourage earlier return to work, more responsibility was placed on social insurance officers. For the first time, they were required to coordinate rehabilitative efforts of medical and vocational professionals.<sup>19</sup> This new emphasis on case management imposed a more public role for these employees by requiring field visits to workplaces and health centers. Because the government established new cost-cutting goals for sickness and disability benefits, social insurance administrators have had to "act more as private insurers with a responsibility to contain costs."<sup>20</sup>

Another proposed focus of the disability program concerns identifying the services needed. These services, by German and Swedish examples, should be extensive and tailored to individual circumstances that help to achieve return-to-work goals for workers with disabilities while avoiding unnecessary expenditures. A mental and/or physical assessment is made for each candidate's potential to return to work, and rehabilitation services are designed to best accommodate the individual.

Germany and Sweden provide transitional work opportunities for those attempting to re-enter the workforce. In Germany, a stepwise reintegration initiative helps workers to return to their original employment.<sup>21</sup> By this plan, workers and their employers may enter into a contract that stipulates dates of the reintegration process, salary, expected progress of the workers, and any criteria for contract termination. Workers can return to their prior work at a gradual pace, allaying fears that they are ready to return to work on a full-time basis.

In the European countries, medical service providers understand the essential job functions of workers with disabilities. In Sweden, there is a close relationship between the sickness insurance agency and physicians. In Germany, education in rehabilitation for physicians has been a longstanding practice. Guidelines have been published to stress the rehabilitation aspects of medicine. By law, a physician is obliged to explain the importance of rehabilitation and explain the steps to be taken and the benefits that can be achieved.

### ***Structuring Cash and Health Benefits to Encourage Return to Work***

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GAO suggests restructuring cash and health benefits because the current structure often presents more hindrances than incentives to returning to work. It also suggests that SSA implement a contractual agreement with the disability recipient requiring complete cooperation with a return-to-work plan as a condition of eligibility for benefits. This requirement would motivate claimants to try to return to work.

As previously mentioned, a major difference between the U.S. disability programs and those of Germany and Sweden is that the European workers maintain health insurance coverage, and provisions are made for a sickness benefit prior to the determination of long-term disability. Proponents of this system argue that while receiving temporary sickness benefits, beneficiaries can focus on their efforts on rehabilitation without facing loss of income and health insurance. Since the sickness

benefit is temporary, workers know that they need to concentrate on rehabilitation. Unfortunately, empirical data supporting the notion that benefit structures in German and Swedish programs encourage or support return to work better than the U.S. programs are lacking. Also, Germany and Sweden have been just as busy as the United States in considering reform to alleviate potential crises in their programs.<sup>22</sup>

For example, beginning in 1992, Swedish workers participating in rehabilitation activities were paid an additional cash benefit allowance of 100 percent of lost earnings. This rate was eventually recognized as overly generous and not conducive to returning an individual to work. It was gradually phased out and finally abolished in 1996.<sup>23</sup> Germany is also imposing a time limited benefit to replace the existing permanent pension benefit,<sup>24</sup> thereby making automatic continuance of the benefit or rollover to a pension more difficult.

Germany and Sweden require cooperation in rehabilitation efforts by the disabled person, and GAO has suggested that a contractual provision should be made with the disabled worker to require his or her participation in return-to-work efforts. While the Social Security Act already provides for withholding of benefits for refusal, without good cause, to accept these services, there is little opportunity to enforce it since so few cases referred by SSA are accepted by the VR program.

### ***Impediments to Adopting GAO's Recommendations***

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GAO recognizes that in order to implement its proposals, SSA may need to take the lead in coordinating efforts by many agencies, including the Department of Labor, the Department of Education, the states, and the private sector. For example, it suggests that a cooperative effort to provide opportunities for transitional employment be established to assist beneficiaries in slowly moving back into the workforce. Currently, no requirements or incentives are in place to make transitional employment available in the U.S. disability programs. The Job Training Partnership Act (JTPA) has created programs available to disability recipients, but they must compete for resources with other groups of disadvantaged individuals.<sup>25</sup> The establishment of new transitional employment programs would be a major initiative and require years and special funding to initiate.

Establishing a new transitional employment program only for disability beneficiaries does not hold a great deal of promise for success. Transitional employment models tested by SSA may not be cost effective.<sup>26</sup> Germany, Sweden, and private insurers in the United States are able to capitalize on the existing employer-employee relationship, but many workers in the United States who file for disability have been away from work for an extended period of time. Any opportunities for flexible relationships with their previous employer have most likely disappeared.

The most relevant example of a partnership between governmental agencies is the relationship between the disability programs and state Vocational Rehabilitation programs.

A complicating factor in this relationship is that SSA and vocational rehabilitation have divergent definitions of successful rehabilitation: Vocational rehabilitation deems success when an individual returns to work for 60 days, but SSA has a more complex definition. SSA sees a work attempt as successful only when a claimant has “substantial” earnings for 9 months. Rehabilitation success is more difficult to achieve for disability recipients, and VR counselors “tend to shy away from them.”<sup>27</sup>

Edward Berkowitz and David Dean argue that Congress mandated a relationship between SSA and vocational rehabilitation despite divergent views of disability inherent in the programs and without serious analysis.<sup>28</sup> According to Monroe Berkowitz, “The limited effectiveness of the public VR system in taking persons off the rolls is not surprising. The VR programs have found other clientele, as Congress has asked them to concentrate on the disadvantaged, the mentally ill, persons with mental retardation, and persons with severe disabilities.”<sup>29</sup> An ILO Study Report finds that “The federal-state VR program changed its emphasis in 1974 from serving the person most likely to benefit from services to those persons with severe disabilities. As a result, states with limited funding are often forced to invoke an ‘order of selection’ which stipulated that persons with less severe disabling conditions be put on a waiting list.”<sup>30</sup>

GAO has suggested that SSA incorporate techniques used in the private sector and other countries where employers are involved in the case and have a vested interest in the worker. The structures of the private and social insurance programs in Germany and Sweden differ from those of the United States, and that difference makes borrowing their practices difficult. For instance, SSA’s disability application process provides no early rehabilitation referral, and very little subsequent referral. There is often a significant time lapse between the date that workers ended their employment and the date of filing for benefits: 42 percent of SSI applicants reported leaving their last job more than 12 months before applying for benefits and 27 percent did not know when they left their last job. Nearly half of DI and SSI applicants have not worked for more than 6 months before filing.<sup>31</sup> In some cases, the employer may have already exercised case management practices unsuccessfully before the claimant filed for disability benefits.

Currently a state VR agency screens an applicant after all evidence has been received and the claimant’s disability determination is prepared. This can occur between 30 and 180 (or more) days after an application is initially filed, and longer when the decision is appealed. The optimum period for early intervention may have already passed by the time an applicant walks into the Social Security office. The current program refers the claimant only after the lengthy wait for a decision, but only half of the workers with recently acquired disabilities who are out of work for 5 months or more will ever return to work.<sup>32</sup>

### ***Current and Future Directions***

SSA currently has initiatives in place and before Congress to improve the rate of return to work among disability recipients.

Some examples are:

- *Project ABLE* operates through the joint efforts of several federal agencies. It provides a national resume bank of qualified individuals on the disability rolls who want to work. It has provided an easily accessible applicant pool to employers through OPM (Office of Personnel Management).
- *Project RSVP* was initiated to enable an outside contractor to manage SSA’s VR referral and reimbursement system. The objective is to make services more readily available to our disabled clients and to improve the administration and cost effectiveness of the program.
- SSA has implemented the use of alternate VR providers that can supply needed employment and rehabilitation services when the state VR offices do not accept the referral. To date, over 400 providers have signed contracts to provide these services.

The Work Incentives Improvement Act of 1999 (H.R. 1180 and S 331) is currently being considered by a Congressional conference committee. The bill would establish a Ticket to Work and a Self-Sufficiency program, in which disabled beneficiaries would receive a voucher to use with any participating public or private provider of employment or rehabilitation services. The bill would also extend Medicare coverage for DI beneficiaries who return to work and would expand state options under the Medicaid program for workers with disabilities.

The bill would require or authorize SSA to conduct several evaluations and demonstrations. It would require an evaluation of the cost effectiveness of the Ticket to Work program and its effect and self-sufficiency. It would also require the agency to conduct demonstration projects providing for a gradual reduction of disability benefits based on earnings. Finally, the bill would extend SSA’s authority to conduct additional demonstrations designed to encourage rehabilitation and return to work. In designing demonstration projects under this new authority, SSA will carefully consider the recommendations made by GAO and the experiences of other countries. Both sources suggest that early intervention after a potentially disabling illness or injury is an approach that merits serious attention.

### ***What Can be Done to Increase Return to Work***

A recent survey conducted by GAO indicated that some beneficiaries felt that the 9-month trial work period was too short and the \$200 earnings level was too low to help them ease back into full-time work.<sup>33</sup> GAO has cited research to suggest that receipt of DI benefits is associated with lower success in return-to-work interventions.<sup>34</sup> Hennessey’s 1997 article also cited findings suggesting that a person with knowledge of the work incentive provisions to help transition beneficiaries to full-

time work has the same tendency to start work as someone who does not, but is less able to sustain it.<sup>35</sup> Hoynes and Moffitt<sup>36</sup> admit that the scope of empirical literature on work incentives is limited, but that more generous trial work periods and extended periods of eligibility provide a strong incentive to work at levels below substantial gainful activity (SGA).

For workers who are concerned about the availability of medical coverage for existing conditions, returning to work may be a difficult choice. Until recently, many private insurance carriers excluded pre-existing medical conditions from coverage. Even the newest laws concerning private health care coverage permit exclusion for up to 1 year. Once workers are on the disability rolls and entitled to medical coverage, they may find the security of benefits difficult to abandon. Berkowitz describes an “equilibrium” position where workers who have spent time waiting for benefits and attain them has no great incentive to change.<sup>37</sup> SSI recipients can continue Medicaid benefits without cost when they return to work, until their earnings are sufficient to compensate for the value of benefits received. DI beneficiaries must be on the disability rolls for 24 months prior to Medicare enrollment.<sup>38</sup> If they become entitled to Medicare benefits and return to work by completing the trial work period and earning over \$700 monthly,<sup>39</sup> cash benefits are suspended but health coverage continues for at least 39 months. After this, there is an option to buy continuing Medicare coverage at a rate of \$309 monthly for Hospital Insurance (Part A) and \$45.50 monthly for Supplementary Medical Insurance (Part B) (1999 rates). In the absence of available private insurance that provides comparable coverage without high premiums, beneficiaries may choose to discontinue efforts to sustain work. These factors suggest that the goal should be to make resumption of work more attractive than benefits.<sup>40</sup>

Case management techniques are embraced by the private sector and in the programs of other countries. GAO has cited favorable results found in both the private insurance sector and the social insurance programs of Germany and Sweden. Hunt et al.<sup>41</sup> have summarized essential components of successful disability management techniques identified in research literature. These components include early contact with the claimants and their doctor, early rehabilitation referral, and the use of incentives in benefit design to encourage participation.

There is evidence to support that screening criteria for VR referral developed by SSA should aim at cutting costs so that rehabilitation will not be offered to poor risk and poorly motivated individuals. Research in Germany, Sweden, and the United States on cohorts with back disorders points to certain screening criteria that lend themselves to successful rehabilitation.<sup>42</sup> They include such factors as age, sex, education, the nature of the medical problem, income, occupation, work-related demands, presence of other chronic diseases, type of medical provider, and medical interventions. Further results of the Work Incapacity and Reintegration (WIR) studies can be used as a guide to better gauge these factors for use as screening criteria on back and other impairments.

The contractual agreement for VR participation cited by

GAO could have a strong psychological effect on VR applicants. If applicants understand that they must sign a contract agreeing to mandatory vocational rehabilitation prior to receiving benefits, their energies may be more focused on the opportunity to improve their future rather than on being sustained minimally by the government.

A demonstration project conducted by SSA, Project NetWork, allowed case managers in four different models to counsel SSI applicants and DI and SSI recipients while they pursued rehabilitation services. These case managers used techniques similar to the German and Swedish models. Data from this project of volunteer applicants and awardees provides some insights but little support for the use of case management techniques.

Without the availability of VR services for all qualified applicants, the GAO suggestions would have a little chance to succeed. Fortunately, SSA has recently initiated a program to make other qualified public or private employment or rehabilitation providers available if a state VR program does not accept a referral. The inclusion of private rehabilitation providers will help overcome the problem of an overburdened state VR system.

## Notes

<sup>1</sup>U.S. Social Security Administration, *Annual Statistical Supplement to the Social Security Bulletin*, Washington, DC: U.S. Government Printing Office, 1997. Concurrently entitled beneficiaries are counted in both categories.

<sup>2</sup> Available online at <<http://www.ssa.gov/work/ssavrcpd.html>>

<sup>3</sup>U.S. General Accounting Office, *Social Security: Disability Programs Lag in Promoting Return to Work*, Letter Report to Congressional Committees, U.S. Senate and House of Representatives, United States Government Accounting Office, 1997.

<sup>4</sup>Patricia Thornton and Neil Lunt, *Employment Policies for Disabled People in Eighteen Countries: A Review*, Social Policy Research Unit: University of York, 1997, p.116.

<sup>5</sup>Ibid., pp. 241-242.

<sup>6</sup>Ibid., p. 240.

<sup>7</sup> Ibid., p. 114.

<sup>8</sup>Christiane Kuptsch and Ilene R. Zeitzer, “Public Disability Programmes under New Complex Pressures,” *International Social Security Association*, 26th Annual Assembly, Marrakech, 1998.

<sup>9</sup>Literature in the field supports the notion that the loss of health benefit coverage in addition to cash benefits provides a disincentive to returning to work. Most of the literature presents this idea as logical, but not supported by empirical evidence. Walter Y. Oi states, “It is well known that some SSDI recipients are afraid to return to work in spite of improving health because they would have to give up Medicare.” Jonathan S. Leonard states, “For many people with potentially disabling conditions (Medicare coverage) is more valuable and more difficult to replace (than cash benefits)...When (private) insurance can be bought, it sometimes costs the disabled so much that there is little financial reward to working.” Friedland and Evans contend that some people “face real and perceived disincentives for leaving public programs and seeking employment, since having a job

may mean losing needed coverage...private insurance is less likely to provide for chronic, long-term, or health-related needs.” These authors are featured in *Disability, Work and Cash Benefits*, J. Mashaw; V. Reno; R. Burkhauser; and M. Barques (eds.), Michigan: W.E. Upjohn Institute for Employment Research, 1996.

<sup>10</sup>Paul O’Leary and David Dean, “International Research Project on Job Retention and Return to Work Strategies for Disabled Workers—Study Report—USA.” International Labour Organization 1998.

<sup>11</sup> Available online at: <<http://www.ssa.gov/work/ssavrcpd.html>>

<sup>12</sup> Martin Albrecht and Hans Braun, “International Research Project on Job Retention and Return to Work Strategies for Disabled Workers—Study Report—Germany.” International Labour Organization, 1998, pp. 111-112.

<sup>13</sup> Karlsson Anders; Martin Albrecht; and Hans Braun, “International Research Project on Job Retention and Return to Work Strategies for Disabled Workers—Study Report—Germany.” International Labour Organization, p. 56, 1998.

<sup>14</sup> Edward E. Palmer, “Potential Gains from Early Intervention in Sickness Absenteeism at the Workplace: An Overview of the Current State of Knowledge and Trends in Sweden,” in *Forging Linkages: Modifying Disability Benefit Programs To Encourage Employment*, M. Berkowitz (ed.), New York: Rehabilitation International, 1990.

<sup>15</sup> See footnote 4, p. 113.

<sup>16</sup> Bernd Frick and Dieter Sadowski, “A German Perspective on Disability Policy,” in *Curing the Dutch Disease: An International Perspective on Disability Policy Reform*, L. Aarts; R. Burkhauser; and P. deJong, (eds.), Vol. 1, Avebury: Ashgate Publishing Company, p. 128, 1996.

<sup>17</sup> Ibid, p. 129.

<sup>18</sup> See footnote 14, p. 84.

<sup>19</sup> See footnote 4, p. 253.

<sup>20</sup> Leo J. M. Aarts and Philip R. deJong, “European Experiences with Disability Policy,” in *Disability, Work and Cash Benefits*, J. Mashaw; V. Reno; R. Burkhauser; and M. Barques (eds.), Michigan: W.E. Upjohn Institute for Employment Research, p. 145, 1996.

<sup>21</sup> David H. Dean, “Vocational Rehabilitation Innovations for Disabled Persons within the Federal Republic of Germany,” M. Berkowitz (ed.), *Forging Linkages: Modifying Disability Benefit Programs To Encourage Employment*, New York: Rehabilitation International, 1990.

<sup>22</sup>A reformed old-age pension system was adopted by Sweden’s Parliament in June 1998. Disability pensions will no longer be administered by the old-age pension system, but will be in a separate class of insurance. Finalization of the legislation by the spring of 1999. Available online at:

<[www.pension.gov.se/in%20English/final.pdf](http://www.pension.gov.se/in%20English/final.pdf)>

<sup>23</sup>Ewskil Wadensjo and Edward E. Palmer, “Curing the Dutch Disease from a Swedish Perspective,” in *Curing the Dutch Disease: An International Perspective on Disability Policy Reform*, L. Aarts; R. Burkhauser; and P. deJong (eds.), Aldershot: Avebury, England, pp. 137-138, 1996.

<sup>24</sup> See footnote 8.

<sup>25</sup> Burt S. Barnow, “Policies for People with Disabilities in U.S. Employment and Training Programs,” in *Disability, Work and Cash Benefits*, J. Mashaw; V. Reno; R. Burkhauser; and M. Barques, (eds.), Michigan: W.E. Upjohn Institute for Employment Research, 1996.

<sup>26</sup> Aaron J. Prero, “Quantitative Outcomes of the Transitional Employment Training Demonstration,” in *Disability, Work and Cash Benefits*, J. Mashaw; V. Reno; R. Burkhauser; and M. Barques, (eds.), Michigan: W.E. Upjohn Institute for Employment Research, 1996.

<sup>27</sup>Edward Berkowitz and David Dean, “Lessons from the Vocational Rehabilitation/Social Security Administration Experience,” in *Disability, Work and Cash Benefits*, J. Mashaw; V. Reno; R. Burkhauser; and M. Barques (eds.), Michigan: W.E. Upjohn Institute for Employment Research, p. 239, 1996.

<sup>28</sup>Ibid., p. 241.

<sup>29</sup>Monroe Berkowitz, “Improving the Return to Work of Social Security Disability Beneficiaries” in *Disability, Work and Cash Benefits*, J. Mashaw; V. Reno; R. Burkhauser; and M. Barques (eds.), Michigan: W.E. Upjohn Institute for Employment Research, p. 333, 1996.

<sup>30</sup>Paul O’Leary and David Dean, “International Research Project on Job Retention and Return to Work Strategies for Disabled Workers—Study Report—USA,” International Labour Organization, 1998.

<sup>31</sup>See U.S. Social Security Administration, Results of 1994 Two-Day Field Office Survey of Disability Applicants, agency correspondence S5H, March 22, 1994.

<sup>32</sup>General Accounting Office (GAO), *Social Security Disability: Improving Return-to-Work Outcomes Important, but Trade-Offs and Challenges Exist*, Testimony before the Subcommittee on Social Security, Committee on Ways and Means, House of Representatives, United States General Accounting Office.

<sup>33</sup>Government Accounting Office (GAO), *Social Security Disability Insurance: Multiple Factors Affect Beneficiaries’ Ability to Return to Work*, Report to the Chairman, Subcommittee on Social Security, Committee on Ways and Means, House of Representatives, United States Government Accounting Office, 1998.

<sup>34</sup>Ibid.

<sup>35</sup>John C. Hennessey, “Factors Affecting the Work Efforts of the Disabled-Worker Beneficiaries,” *Social Security Bulletin*, Vol. 60, No. 3, p. 18, 1997.

<sup>36</sup>Hilary Williamson Hoynes and Robert Moffitt, “The Effectiveness of Financial Work Incentives in Social Security Disability Insurance and Supplemental Security Income: Lessons from Other Transfer Programs,” in *Disability, Work and Cash Benefits*, J. Mashaw; V. Reno; R. Burkhauser; and M. Barques (eds.), Michigan: W.E. Upjohn Institute for Employment Research, 1996.

<sup>37</sup> See footnote 29, p. 334.

<sup>38</sup>U.S. Social Security Administration, *Annual Statistical Supplement to the Social Security Bulletin*, Washington, D.C: U.S. Government Printing Office, 1997.

<sup>39</sup>This rate is effective on July 1, 1999. The previous amount was \$500.

<sup>40</sup>Jonathan Leonard, “Disability Policy and the Return to Work,” *Disability & Work: Incentives, Rights, and Opportunities*, Carolyn Weaver, ed. Washington, DC: AEI Press, p. 47, 1991..

<sup>41</sup>H. Allan Hunt; Rochelle V. Habeck; Patricia Owens; and David Vandergoot, “Disability And Work: Lessons From The Private Sector,” in *Disability, Work and Cash Benefits*, J. Mashaw; V. Reno; R. Burkhauser; and M. Barques (eds), Michigan: W.E. Upjohn Institute for Employment Research, 1996.

<sup>42</sup>John Kearney, “The Work Incapacity and Reintegration Study:

Results of the Initial Survey Conducted in the United States,” *Social Security Bulletin*, Vol. 60, No. 3, 1997, pp. 21-32 and Frank S. Bloch and Rienk Prins, “Work Incapacity and Reintegration: Theory and Design of a Cross-National Study,” *International Social Security Review*, Vol. 50, Feb. 1997, pp. 3-23.

<sup>43</sup>Robert J. Kornfield; Michelle L. Wood; Larry L. Orr; and David A. Long “Impacts of the Project NetWork Demonstration: Final Report,” prepared for the Social Security Administration by Abt Associates, Inc., 1999.