BARRIERS PREVENTING SOCIAL SECURITY DISABILITY RECIPIENTS FROM RETURNING TO WORK

HEARINGS

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

JULY 23 AND 24, 1997

Serial 105–61

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
55–046 CC WASHINGTON : 1999

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
WES WATKINS, Oklahoma
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. McNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
KAREN L. THURMAN, Florida

A.L. SINGLETON, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON SOCIAL SECURITY

JIM BUNNING, Kentucky, *Chairman*

SAM JOHNSON, Texas
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
JON CHRISTENSEN, Nebraska
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri

BARBARA B. KENNELLY, Connecticut
RICHARD E. NEAL, Massachusetts
SANDER M. LEVIN, Michigan
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

Page

Advisories announcing the hearings 2

WITNESSES

Social Security Administration, Hon. John J. Callahan, Acting Commissioner; Accompanied by Susan Daniels, Associate Commissioner, Office of Disability 8
U.S. Department of Education, Judith E. Heumann, Assistant Secretary, Office of Special Education and Rehabilitative Services; Accompanied by Mark Shoob, Deputy Assistant Secretary 13
U.S. General Accounting Office, Jane L. Ross, Director, Income Security Issues, Health, Education, and Human Services Division; Accompanied by Cynthia Bascetta, Assistant Director 33

Abilitech, Suzanne Erb 106
American Rehabilitation Association, Mary Gennaro 153
Arc of the United States, Lorraine Sheehan 98
Arizona Bridge to Independent Living, Susan Webb 80
Arthritis Foundation, Brenda Crabbs 102
Baron, Richard C., Matrix Research Institute, and International Association of Psychosocial Rehabilitation Services 54
Berkowitz, Monroe, Rutgers University 44
Christman, Rick, Metro Industries, and Kentucky Association of Community Employment Services; as presented by Mary Gennaro, American Rehabilitation Association 153
Connecticut Bureau of Rehabilitation Services, John Halliday 124
Consortium for Citizens with Disabilities Vocational Working Group, Tony Young 88
Council of State Administrators of Vocational Rehabilitation, John Halliday 124
Crabbs, Brenda, Arthritis Foundation 102
Erb, Suzanne, Abilitech 106
Gennaro, Mary, American Rehabilitation Association; presenting statement of Rick Christman, Metro Industries, and Kentucky Association of Community Employment Services 153
Growick, Bruce, Ohio State University 41
Halliday, John, Connecticut Bureau of Rehabilitation Services; and Council of State Administrators of Vocational Rehabilitation 124
Hessellund, Thorv A., National Association of Rehabilitation Professionals in the Private Sector 157
International Association of Psychosocial Rehabilitation Services, Richard C. Baron 54
Kentucky Association of Community Employment Services, Rick Christman 153
Kregel, John, Virginia Commonwealth University 51
Matheson, Leonard N., Washington University School of Medicine 57
Matrix Research Institute, Richard C. Baron 54
Metro Industries, Rick Christman 153
National Academy of Social Insurance, Virginia P. Reno 44
National Association of Rehabilitation Professionals in the Private Sector, Thorv A. Hessellund 157
National Council on Disability, Bonnie O'Day 86
National Council on Independent Living, Susan Webb 80
O'Day, Bonnie, National Council on Disability 86
Ramstad, Hon. Jim, a Representative in Congress from the State of Minnesota 5
Reno, Virginia P., National Academy of Social Insurance 44
Return-to-Work Group, Stephen L. Start 164

Page
Sheehan, Lorraine, Arc of the United States 98
S.L. Start & Associates, Inc., Stephen L. Start 164
Southwest Business Industry and Rehabilitation Association, Fred E. Tenney 161
Start, Stephen L., S.L. Start & Associates, Inc., and Return-to-Work Group 164
Tenney, Fred E., Southwest Business Industry and Rehabilitation Association 161
United Cerebral Palsy Associations, Inc., Tony Young 88
Webb, Susan, Arizona Bridge to Independent Living; and National Council on Independent Living 80
Young, Tony, United Cerebral Palsy Associations, Inc.; and Consortium for Citizens with Disabilities Vocational Working Group 88

SUBMISSIONS FOR THE RECORD

American Occupational Therapy Association, Inc., Bethesda, MD, statement and attachments 205
Association for Persons in Supported Employment, Richmond, VA, Celane M. McWhorter, letter 215
Becklund Home Health Care, Inc., Golden Valley, MN, T. Jeff Bangsberg, and Courage Center, Golden Valley, MN, Anita Boucher, joint letter and attachments 220
Center for Career Evaluations, Inc., Oakland, CA, Thomas P. Yankowski, statement 224
Corp, Elizabeth A., Metropolitan Life Insurance Co., Met DisAbility Division, statement 242
Courage Center, Golden Valley, MN, Anita Boucher, and Becklund Home Health Care, Inc., Golden Valley, MN, T. Jeff Bangsberg, joint letter and attachments 220
EXCEL! Networking Group, Inc., Merrifield, VA, Robert Rudney, statement ... 228
Hurt, Jerald L., NovaCare, Inc., King of Prussia, PA, statement 255
Isernhagen and Associates, Duluth, MN, Susan J. Isernhagen, statement and attachments 230
Kalix Group, L.L.C., Pasadena, CA, Robert L. Sniderman, statement 240
McWhorter, Celane M., Association for Persons in Supported Employment, Richmond, VA, letter 215
Metropolitan Life Insurance Co., Met DisAbility Division, Elizabeth A. Corp, statement 242
National Alliance for the Mentally Ill, Arlington, VA, Annie V. Saylor, statement 249
NovaCare, Inc., King of Prussia, PA, Jerald L. Hurt, statement 255
Rudney, Robert, EXCEL! Networking Group, Inc., Merrifield, VA, statement .. 228
Saylor, Annie V., National Alliance for the Mentally Ill, Arlington, VA, statement 249
Sniderman, Robert L., Kalix Group, L.L.C., Pasadena, CA, statement 240
Yankowski, Thomas P., Center for Career Evaluations, Inc., Oakland, CA, statement 224

BARRIERS PREVENTING SOCIAL SECURITY DISABILITY RECIPIENTS FROM RETURNING TO WORK

WEDNESDAY, JULY 23, 1997

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

The Subcommittee met, pursuant to notice, at 10:16 a.m., in room 1100, Longworth House Office Building, Hon. Jim Bunning (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearings follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
July 15, 1997
No. SS–8

CONTACT: (202) 225–9263

Bunning Announces Hearing on Barriers Preventing Social Security Disability Recipients From Returning to Work

Congressman Jim Bunning (R–KY), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on barriers preventing Social Security disability recipients from returning to work. The hearing will take place on Wednesday, July 23, 1997, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Between 1985 and 1994, the number of working-age recipients on the Social Security and Supplemental Security Income disability rolls increased 59 percent. In addition, disabled recipients are staying on the rolls longer than in the past because of increased life expectancy, a lower average age of disability recipients due to the baby boom cohort, and an increase of awardees with disabling mental impairments who tend to be younger and physically healthier.

In 1996, fewer than 6 percent of new disability recipients were referred to State vocational rehabilitation agencies for services, and historically, less than of 1 percent of disabled recipients leave the rolls because of successful rehabilitation. These facts underscore the need for initiatives designed to encourage disabled recipients to receive rehabilitation services and to enter the workforce.

To help Social Security and Supplemental Security Income disability recipients who want to return to a life of financial independence and self sufficiency, Chairman Bunning introduced H.R. 4230, the Rehabilitation and Return to Work Opportunity Act of 1996, last Congress. Since then, similar legislation (H.R. 534, Transition to Work Act of 1997) has been introduced by ranking member Rep. Barbara Kennelly (D–CT), and the Administration has included a related proposal in the President's fiscal year 1998 budget.

In announcing the hearing, Chairman Bunning stated: "Social Security disability recipients are not getting the rehabilitation services they deserve. It isn't fair for anyone to face a life of dependency and denied opportunities unnecessarily. It's time to remove the barriers and provide real rehabilitation assistance for those who want to return to work."

FOCUS OF THE HEARING:

During the hearing, the Subcommittee will receive the views of various agencies, experts, consumers, and providers regarding the barriers which prevent Social Security disability recipients from returning to work, and will hear recommendations on what changes in the law are needed to remove those barriers.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-space legal-size copies of their statement, along with an IBM compatible 3.5-inch diskette in ASCII DOS Text format only, with their name, address, and hearing date noted on a label, by the close of business, Wednesday, August 6, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Social Security office, room B–316 Rayburn House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

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

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on an IBM compatible 3.5-inch diskette in ASCII DOS Text format.

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

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

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

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

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

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

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
July 16, 1997
No. SS–9

CONTACT: (202) 225–9263

Bunning Announces Continuation of Hearing on Barriers Preventing Social Security Disability Recipients From Returning to Work

Congressman Jim Bunning (R–KY), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee's hearing on barriers preventing Social Security disability recipients from returning to work will be continued on Thursday, July 24, 1997. The second day of the hearing will begin at 1:00 p.m. in room B–318 Rayburn House Office Building.

On July 23, the Subcommittee will receive testimony from various agencies and rehabilitation experts, and on July 24, will receive the views of consumers and providers regarding the barriers which prevent Social Security disability recipients from returning to work, and will hear recommendations on what changes in the law are needed to remove those barriers.

(For further details see Subcommittee press release No. SS–8, dated July 15, 1997.)

Chairman BUNNING. The Subcommittee will come to order. I thank the Members for being here.

This morning we begin the first day of a 2-day hearing about the barriers preventing disabled Social Security recipients from returning to work. We will also hear recommendations on what changes in the law are needed to remove those barriers.

We are all too familiar with the huge increases in the Social Security disability and the Supplemental Security Income disability rolls. There seems to be no end in sight to this alarming trend. In fact, new disability awardees are, on average, coming on the rolls at a younger age and staying on the rolls longer than in the past. This means recipients will spend more of their lives dependent on Social Security or SSI benefits.

In 1996, fewer than 6 percent of new disability recipients were even referred to State vocational rehabilitation agencies for service. And historically, fewer than one-half of 1 percent of disabled recipients leave the rolls because of successful rehabilitation. Social Security and disability recipients are just not getting rehabilitative services they need. This isn't right, and it certainly isn't fair.

Congress must give recipients with disabilities the opportunity to obtain the tools and training they need to return to productive and

self-sufficient lives. That is why in the last Congress I introduced H.R. 4230, the Rehabilitation and Return to Work Opportunity Act of 1996. I am happy to say that since then, Ranking Member Kennelly has introduced similar legislation, and the administration has included a related proposal in the President's 1998 budget.

Today we will hear the views of one of our own colleagues, Jim Ramstad, from Minnesota, followed by the Social Security Administration, and the Department of Education, and then we will hear from GAO and experts in the field of rehabilitation.

I am very pleased that tomorrow we will hear from consumers, those individuals who are closest to the issues surrounding return to work. I believe that they will give us valuable insight into what is working, what isn't working, and offer suggestions for improvement.

Finally, we will hear the views of those who work day to day providing rehabilitation services. As we will hear over the next 2 days, these issues are complex, and finding real answers will not be easy. Still, I remain optimistic that Mrs. Kennelly and I, along with the Subcommittee Members and the administration, can work together to craft legislation that provides real opportunities to people with disabilities.

In the interest of time, it is our practice to dispense with opening statements, except for the Ranking Democratic Member, and we will allow her to put her statement in the record when she arrives.

I would like to begin with our testimony today from our Ways and Means colleague Congressman Jim Ramstad from Minnesota.

STATEMENT OF HON. JIM RAMSTAD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. RAMSTAD. Thank you, Mr. Chairman and colleagues. I am here today to thank you and the Subcommittee for your important efforts on return to work issues for people with disabilities. I applaud you for calling this hearing to discuss those barriers which deter eager, hardworking, productive people with disabilities from working.

When I first came to Congress in 1991, Mr. Chairman, I was very surprised to learn that among the multitude of caucuses and task forces in Congress, there was no group specifically focused on issues affecting people with disabilities. That is why I started our Conference Task Force on Disabilities.

Under the purview of the task force, I held a field hearing in Minnesota on the work disincentives in those Federal programs, particularly SSI and SSDI, to which the Chairman alluded, which are supposed to assist people with disabilities. I continue to work in Minnesota with my own Disabilities Advisory Committee on these and many other issues affecting people with disabilities. Virtually every member of that task force, were they here today, would cite the work disincentive issue as a top priority.

I have witnessed firsthand countless stories of frustrated individuals who desperately want to work and contribute to society, but are literally prohibited from doing so because of confusing Federal programs and rules which make working too difficult or expensive. Of course, we must take steps to prevent abuses in the system, but in doing so, we must make sure our efforts do not prohibit Ameri-

cans with disabilities from living up to their full potential. We should not have a system of laws that provide a built-in disincentive to people from working.

Mr. Chairman, preventing people from working runs counter to the American spirit, a spirit that thrives on individual achievements and societal contributions. In addition, discouraging people with disabilities from working, earning a regular paycheck, paying taxes and moving off public assistance of course results in reduced Federal revenues.

Creating incentives for people with disabilities is not just humane public policy, it is sound fiscal policy. Eliminating the current barriers to work that so many people face is not just a smart thing to do, Mr. Chairman, it is the right thing to do.

Let me give you one example. A good friend, since 1981, his name is Tom Haben. I met him when he was president that year of the Metropolitan Handicapped Coalition in the Twin Cities of Minnesota. Tom happens to be a person with quadriplegia; very bright, hard working, productive, just a great guy, and as I said, one of my best personal friends.

Tom went to work, in fact, went to work for me, but it became counterproductive for him to work. We couldn't pay him what he was worth. He couldn't take that because he would start losing his benefits. Therein lies the problem. He had a disincentive to work. Ultimately, he left the office and has not been employed in the marketplace since because he can't afford to lose those benefits at the pay level he was being paid.

As you know, Mr. Chairman, in 1993, I worked with our colleague, Representative Stark, on legislation to address the disincentives people with disabilities face in Federal programs. We weren't successful in the 103d Congress to pass the legislation to help get people back to work, but I appreciate so much your commitment and other Members of the Subcommittee, and I am confident that we can untangle this complicated web and get something done soon.

Your leadership, Mr. Chairman, in this area deserves high praise. I followed with great interest the hearings the Subcommittee held last session on these issues and appreciate your efforts to deal with this in a comprehensive way very much.

I see that my time has elapsed, and I don't want to violate anyone's time. I know we have many other people here to testify today, but I ask unanimous consent that the rest of my testimony be entered into the record.

Again, I want to thank you and the Subcommittee staff. You have been very helpful and very sensitive to the needs of people with disabilities. Working together, I am absolutely confident that we can untangle this web, this maze of Federal laws that provide a built-in disincentive to people with disabilities from working. We can change the system so the people can be gainfully employed and truly enjoy the dignity of independent living which they so deserve.

Thank you, Mr. Chairman.

Chairman BUNNING. We will allow your complete statement to be put into the record.

[The prepared statement follows:]

Statement of Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

Mr. Chairman, I am here today to thank you and the Subcommittee for your important efforts on "return to work" issues for people with disabilities. I applaud you for calling this hearing to discuss those barriers which prevent eager, hard-working intelligent people with disabilities from working.

When I came to Congress in 1991, I was surprised to find that among all the caucuses and task forces on the Hill, there was no group specifically focused on issues affecting people with disabilities. That's why I started the Republican Task Force on Disabilities.

Under the purview of the task force, I held a field hearing in Minnesota on the work disincentives in those federal programs—particularly SSI and SSDI—which are supposed to assist people with disabilities. I continue to work with my own Disabilities Advisory Committee back in Minnesota on these and many other issues facing people with disabilities.

I have heard countless stories of frustrated individuals who desperately want to work and contribute to society but are literally prohibited from doing so because confusing federal programs and rules make working too difficult or expensive. Of course, we must take steps to prevent abuse of the system, but in doing so, we must make sure that our efforts do not prohibit Americans with disabilities from living up to their full potential.

Mr. Chairman, preventing people from working runs counter to the American spirit—a spirit that thrives on individual achievements and societal contributions. In addition, discouraging people with disabilities from working, earning a regular paycheck, paying taxes and moving off public assistance results in reduced federal revenues.

Creating work incentives for people with disabilities is not just humane public policy, it is sound fiscal policy. *Eliminating the current barriers to work that so many individuals face is not just the smart thing to do, it is the right thing to do.*

As you know, in 1993 I worked with our esteemed colleague on the Ways and Means Committee, Representative Stark, on legislation to address the disincentives people with disabilities face in federal programs. While we were not successful in the 103rd Congress to pass legislation to help people get back to work, I remain hopeful that we will get something done soon.

Your leadership in this area deserves high praise. I followed with great interest the hearings this Subcommittee held last session on these issues and was very interested in the legislation you introduced last year. I realize that some of the elements of comprehensive reform in these areas fall outside the jurisdiction of this Subcommittee, but I want to publicly and personally thank you for looking at those issues within your jurisdiction.

Specifically, when I hear that in 1996, fewer than 6% of new disability recipients were referred to state vocational rehabilitation agencies for services and less than ½ of 1% of disabled recipients leave the rolls because of successful rehabilitation, I know something must be done to open up the vocational rehabilitation process.

In my home state of Minnesota, the State Vocational Rehabilitation Program administrators do a good job in meeting the needs of many Minnesotans, but I am also aware of experienced, successful private groups in Minnesota that can also provide these services. Many private rehabilitation groups in Minnesota have been involved in SSA demonstration programs and can greatly contribute to the efforts of the state VR and help even more people get back to work. In addition, people with disabilities should have the ability to seek rehabilitation and choose the provider they feel will best help them achieve their goal of employment.

Like everyone else, people with disabilities have to make decisions based on financial reality. Should they consider returning to work or even make it through vocational rehabilitation, the risk of losing vital federal health benefits often becomes too threatening to future financial stability. As a result, they are compelled not to work. Given the sorry state of present law, that's generally a reasonable and rational calculated decision.

I appreciate the attention in your legislation to Medicare coverage for those who work. It is my sincere hope that the Commerce Committee will also consider proposals to allow individuals with disabilities who return to work access to Medicaid.

I am currently seeking Medicaid proposals from my state Department of Human Resources and others that will hopefully compliment any legislation you introduce this year so we can comprehensively knock down all the barriers preventing people from working.

Mr. Chairman, thanks again for your leadership on these important issues and for letting me come before the Committee today. Your Subcommittee staff has been

very gracious in allowing me and my staff to work with you on these important issues and I look forward to continuing to work with you on our shared goal of helping people with disabilities return to work.

Chairman BUNNING. And Mr. Collins, do you have any questions?

Mr. COLLINS. I have no questions.

Chairman BUNNING. We thank you, Jim, for your interest, and your determination to do something about this, and we appreciate your testimony.

Mr. RAMSTAD. Thank you, Mr. Chairman.

Chairman BUNNING. If the next panel will come forward. Acting Commissioner of Social Security, Hon. John Callahan, accompanied by Susan Daniels, Associate Commissioner at the SSA Office of Disability. Testifying on behalf of the U.S. Department of Education is Judith Heumann, Assistant Secretary for Special Education and Rehabilitative Services.

Dr. Callahan, if you would begin, we would appreciate it.

STATEMENT OF HON. JOHN J. CALLAHAN, ACTING COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; ACCOMPANIED BY SUSAN DANIELS, ASSOCIATE COMMISSIONER, OFFICE OF DISABILITY

Mr. CALLAHAN. Thank you very much, Mr. Chairman, for inviting us here today. We would like to commend you and Congresswoman Kennelly and other Members of the Subcommittee for holding these hearings. They are very, very important hearings, and I think we are all starting down this road of dismantling barriers for return to work. So my commendation to you and the Ranking Member.

Today, too few of our approximately 8 million Social Security and Supplemental Security Income recipients leave the disability rolls each year to work. Many more of our customers with disabilities tell us they want to work, and they will do so, if the incentives are right and the services they need are available. We look forward to working with this Subcommittee to turn their dreams of economic independence into a reality.

I am enthusiastic about the possibilities for the future, particularly the President's Ticket to Independence Proposal, which we have sent forward to the Congress. The Ticket to Independence is a good public-private partnership. The partnership would give people receiving disability payments what they want and what they need: The control and flexibility to secure services tailored to their individual requirements, from their choice of providers. The Ticket Program is also, I would add, fiscally responsible, since providers would only be paid for results, that is, placing individuals in a job and eliminating Federal cash assistance.

The Ticket to Independence is grounded on four principles. The first is customer choice. SSA's customers desire and need maximum flexibility and choice in pursuing services that will help them become gainfully employed. Beneficiaries with disabilities will receive this Ticket to Independence to use with a participating public or private employment or rehabilitation provider of their choice.

The second principle is innovation. The employment strategy in our proposed legislation encourages widespread innovations in the public and private sectors by providing opportunities for State agencies, local nonprofit and for-profit providers and employers to work with willing beneficiaries.

Third, paying for results. This is very important. The focus on outcomes, we believe, is best achieved by linking it to financial rewards. The provider will be paid only when the beneficiary's earnings from work result in benefit savings.

And finally, health care incentives. We all know that one of the key barriers to returning to work is fear of losing health care. Opportunities to obtain employment should be as health-care-neutral as possible.

The Senate reconciliation bill does contain a proposal similar to that proposed by the President that would allow workers with disabilities to buy into Medicaid. We urge the conferees to adopt the President's proposal in that regard. The President's proposal for a 4-year demonstration to extend premium-free part A Medicare benefits beyond the current period of Medicare eligibility is not included in reconciliation. We believe that is still important and would want to pursue that demonstration authority in the future.

Very quickly, this is how the ticket will work. After SSA determines that individuals are eligible for benefits, it will issue them tickets. A beneficiary may give the ticket to his or her provider of choice in exchange for rehabilitation and employment services. We expect to select between 5 and 10 States to begin our pilot. Tickets will be issued and providers will be solicited for participation. State vocational rehabilitation agencies and alternate participants will also have an option to participate in either the Ticket Program or the current program.

Providers must satisfy certain criteria to be enrolled and be eligible to receive payments from SSA: They must be able to conduct business in the State where they enroll by whatever criteria are used in that State.

Very quickly, I see the light is running here, the beneficiary may have a ticket for up to 2 years. They may be able to renew it for another 2 years. Payments will be made to providers once these individuals terminate their cash benefits and become permanently employed.

We feel as a starting payment point that we will be prepared to pay 50 percent of the cash benefit, up to 5 years of gainful employment. We will select a contract administrator to administer this program, and we will report back to Congress on the 3d, 5th, 7th and 10th year of the pilot.

In conclusion, the Ticket to Independence is a very frugally designed, results-oriented innovation that can, first of all, create a public-private partnership between us and public and private providers, obtain significant savings to the SSA Trust Funds, give beneficiaries what they want, which is a choice to find a willing provider and minimize bureaucracy in the administration of this program.

We believe these hearings are a starting point on a long road to fashioning constructive legislation, and we are committed to work-

ing with the Subcommittee and the administration to get legislation that will remove the disincentives to go back to work.

[The prepared statement follows:]

Statement of Hon. John J. Callahan, Acting Commissioner, Social Security Administration

Mr. Chairman and Members of the Subcommittee:

A large and growing number of people with disabilities can work, and want to work. With the Americans With Disabilities Act, changes in societal attitudes, and advances in technology, it is clearer than ever that being disabled does not mean that you can't contribute to our nation's economy. However, people with disabilities face a variety of complex barriers to work. Now is the right time to launch new initiatives to help break these barriers.

Today, too few of our approximately 8 million Social Security and Supplemental Security Income (SSI) disability recipients leave the disability rolls each year because of work. In fiscal year 1996, SSA paid State vocational rehabilitation (VR) agencies about $65.5 million for their services provided to approximately 6,000 beneficiaries with disabilities who worked at least 9 months earning more than $500 per month. However, many State VR agencies have waiting lists for services, and many more of our customers with disabilities tell us they want to work and will do so if the incentives are right and the services they need are available. We look forward to working with Congress, the Rehabilitation Services Administration, and other Federal agencies to turn our customers' dreams of economic independence into reality. I am enthusiastic about the possibilities for the future, particularly the President's "Ticket to Independence" proposal.

This plan creates new ways to help people find work and achieve their goals. The Administration looks forward to working with the Hill to enact these proposals. Since there are members of Congress from both sides of the aisle who are also working to solve this problem, we are looking forward to a constructive dialogue with you on this issue that will lead to the enactment of legislation, and we believe that our proposal merits your support.

The "Ticket to Independence" is a public-private partnership designed to expand opportunities for individuals with disabilities, including individuals who are blind. This partnership would give people receiving disability payments what they want and need—the control and flexibility to secure services tailored to their individual requirements from their choice of providers. The Ticket is fiscally responsible, since providers would be paid only for results, i.e., placing individuals in jobs and eliminating Federal cash assistance.

Some have been critical of the current system for not improving the work capacity of our beneficiaries. We know that many highly skilled, outcome-focused agencies and professionals could be successful in assisting our diverse beneficiaries to return to work and that individualized planning and support is essential to successful work re-entry. The President's proposal builds on this knowledge.

We believe that the "Ticket to Independence" proposal will result in more opportunities for our beneficiaries to receive the services they need in order to work. We must keep in mind, however, that many of our beneficiaries have disabilities so severe and permanent that they will be unable to work even with the best VR services.

THE "TICKET TO INDEPENDENCE" PROPOSAL

Included in the President's fiscal year 1998 budget is a historic proposal to help more beneficiaries achieve their goals of obtaining a job and leaving the benefit rolls. This is the first time that a President has submitted a proposal to significantly expand return to work efforts. The "Ticket to Independence" is grounded in a four part vision.

• Customer Choice: SSA's customers desire and need maximum flexibility and choice in pursuing services which will help them to become gainfully employed. Beneficiaries with disabilities will receive a "Ticket to Independence" to use with a participating public or private employment or rehabilitation provider of their choice. Our experience indicates that customer choice is a key element in their decision to seek services.

• Encouraging Innovation: The Administration's proposal seeks to encourage widespread innovations in the private and public sectors by creating opportunities for Federal and State agencies, local non-profit and for-profit providers, employers, and beneficiaries to work together.

• Paying for Results: Beneficiaries and providers alike should focus on the goal of stable employment. The provider will be paid only when the beneficiary's earnings from work result in benefit savings. The "Ticket to Independence" rewards success and frugally uses public funds in an accountable and targeted way. And, since stable employment is the only goal that reaps a financial return, fewer resources are needed to monitor methods, expenditures, case files, etc.

• Health Care Incentives: Health care security is viewed by beneficiaries as an essential factor in deciding whether or not to try to work. Opportunities to obtain employment should be as health-care neutral as possible for individuals with disabilities. As you know, the President's Budget proposal included two new approaches to removing disincentives to returning to work.

We are pleased that the Senate Reconciliation bill includes a proposal similar to that proposed by the President that would permit states to allow workers with disabilities to buy into Medicaid. The Administration has urged the Conferees to adopt the President's version which would not limit eligibility for this program to people whose earnings are below 250 percent of poverty.

Unfortunately, the Administration's proposal for a 4-year demonstration to extend premium-free Part A Medicare eligibility for beneficiaries who leave the cash benefit rolls and continue working beyond the current period of Medicare eligibility (39 months) was not included in Reconciliation. The Administration continues to believe—that such a demonstration, coupled with the "Ticket to Independence," is good policy and continues to support changes in Medicare to reduce disincentives to return to work.

How the Ticket Will Work

After SSA determines that individuals are eligible for benefits, we will issue them tickets. The beneficiary may still apply to the State VR agency for services regardless of whether it is participating in this program, or give the ticket to another participating provider of his/her choice in exchange for rehabilitation and employment services. If the beneficiary returns to work and benefits cease due to earnings, the provider holding the ticket will receive a portion of the savings for a fixed period of time.

Phased Roll-Out

SSA will select 5–10 States to begin. Tickets will be issued and providers will be solicited for participation. State VR agencies will have the option to participate in either the "Ticket to Independence" or the current SSA VR Reimbursement Program.

For State VR agencies or alternate providers which choose to participate in the pilot, claims filed under the current program prior to the start of the pilot will continue to be processed under that program. Also, the State VR agencies in pilot States will not have first priority access to referrals of beneficiaries who have tickets.

Eligibility

All disability beneficiaries in roll-out States, except those whose medical conditions are expected to improve, will be eligible to receive a ticket. Beneficiaries who are expected to improve will be eligible for a ticket if their benefits are continued as a result of a continuing disability review.

Providers

Providers must satisfy certain criteria to be enrolled and eligible to receive payments from SSA. Providers must be eligible to conduct business in the State where they enroll by whatever criteria are used in that State. SSA will not certify, license or regulate organizations or businesses.

Using the Ticket

A beneficiary may activate a ticket at any time by giving it to an enrolled provider, who then registers it for 1 or 2 years, at the beneficiary's discretion. The ticket can be transferred to another provider only if the original ticket holder agrees (except in situations where disputes between a beneficiary and a provider are resolved by withdrawing the ticket). The terms of transfer of the ticket from one approved provider to another, with the beneficiary's consent, are entirely up to the respective parties. Providers receiving tickets from other providers must notify SSA of the change to be eligible for payment. At the end of the period of registration,

if no provider is being paid under the expired ticket, the beneficiary may request a renewed ticket and that ticket may be registered for 1 or 2 years with the same or a different provider. Only one ticket will be issued to a beneficiary at a time and only one provider may hold a beneficiary's ticket at a time.

PAYING THE PROVIDER

When SSDI benefits or an SSI beneficiary's federally administered benefits stop due to earnings, the provider is paid a portion of each monthly benefit not paid to the beneficiary during a specified continuous period.

The provider payments begin with the first month that Social Security disability insurance benefits or Federally administered SSI payments are reduced to zero, due to earnings, after the ticket is registered.

ADMINISTERING THE TICKET

SSA will award a contract to an administrator to manage the enrollment of providers, the system of referrals, ticket registration, and to assist in paying providers. The administrator will also develop a data collection system incorporating information required for management reports, a beneficiary tracking system, and the evaluation of the impact of the "Ticket to Independence."

EVALUATION AND EXPANSION

The Commissioner of Social Security will report to the Congress on the operations of the "Ticket to Independence" Program. At the end of the 3rd, 5th, 7th, and 10th year of the pilot, the Commissioner will evaluate and report on the impact of the program and work activity of beneficiaries with disabilities. Based on the results of the evaluation, the Commissioner will determine whether to continue and expand to other States (if the ticket system has been sufficiently successful), to modify aspects of the models to gain better results (such as the payment formula or the length of the payment period), or to discontinue the project.

PROTECTION AND ADVOCACY

SSA will supplement the funding of the existing State Protection and Advocacy (P&A) system with funds specifically designated for assisting SSA beneficiaries when disputes with providers occur. The State P&A System is a long established federally mandated system operating in each State and territory that investigates, negotiates and mediates solutions to problems that certain persons with disabilities cannot resolve on their own.

CONCLUSION

The "Ticket to Independence" is a cost effective, results oriented innovation that can:

- Create a public-private partnership between Social Security and public and private providers with the goal of supporting beneficiaries who want to work.
- Offer potentially significant savings to the SSA trust funds by helping persons with disabilities to work.
- Give beneficiaries the control and flexibility they need in securing services they want.
- Minimize bureaucratic involvement.

Mr. Chairman, let me reiterate. We want to work with you to design new programs that can result in jobs for persons with disabilities who would otherwise remain dependent upon disability benefits. We believe the President's "Ticket to Independence" begins a deliberate process to roll out a federal initiative to achieve that end. I thank you for your attention and would be happy to answer any questions.

Chairman BUNNING. Thank you, Dr. Callahan.

Testifying on behalf of the U.S. Department of Education is Judith Heumann. If you will begin, please.

STATEMENT OF JUDITH E. HEUMANN, ASSISTANT SECRETARY, OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES, U.S. DEPARTMENT OF EDUCATION; ACCOMPANIED BY MARK SHOOB, DEPUTY ASSISTANT SECRETARY

Ms. HEUMANN. Thank you, Mr. Chairman, Mrs. Kennelly and other Members of the Subcommittee. Thank you very much for inviting us to speak with you on the issue of barriers that prevent disabled Social Security, disabled insurance and Supplemental Security Income beneficiaries from engaging in or returning to work.

As the Department of Education's Assistant Secretary for the Office of Special Education and Rehabilitative Services, I am responsible for providing leadership to the Rehabilitation Services Administration, the Federal agency that provides support to State vocational rehabilitation agencies and other service providers to assist individuals with disabilities to achieve employment and to live independently. Since my childhood, we as a country have made significant strides in improving educational and employment opportunities for individuals with disabilities. The Congress' recent bipartisan reauthorization, strengthening the Individuals with Disabilities Education Act, and the coming reauthorization of the Rehabilitation Act, will lead to significant progress in furthering opportunities for education, employment, and independent living.

It is estimated that approximately 800,000 individuals with disabilities are now working because of the antidiscrimination protections provided by the 1990 Americans with Disabilities Act. But significant barriers remain to achieving the goals of independence, inclusion and empowerment for all individuals with disabilities. Federal policy aimed at assisting individuals with disabilities has created disincentives for many with disabilities.

For example, the potential loss of health care coverage represents a significant barrier to employment for SSDI and SSI recipients. In order to address this disincentive, the President's budget proposes to help people with disabilities work without losing their health care coverage.

Federal income policy regarding disability payments may also create disincentives through employment. Our data suggests many beneficiaries are well aware of the substantial gainful activity threshold and earnings limits and, as they approach them, tend to limit their hours of work or earnings so as to remain eligible. Ultimately these barriers must be addressed if we were to achieve successful employment outcomes for many more individuals with significant disabilities.

The programs I administer at the Department of Education have played a significant role in our overall efforts to help individuals to be prepared for and engage in gainful employment and must continue to be part of a comprehensive strategy. The Vocational Rehabilitation State Grants Program provides $2.2 billion in formula grant assistance to 82 State-operated VR service programs. These programs provide consumers with choices among a wide range of specialized services that include, but are not limited to, job development, job training and placement, counseling and guidance, assisted technology, personal assistance services, physical and mental restoration services, reader services, interpreter services, supported employment services and school-to-work transition services.

The essence of the VR Program is to provide services that meet the aspirations, needs, abilities and priorities of each individual, consistent with the individual's informed choice. A VR counselor works as a partner with a person with disability to design a rehabilitation program that matches the individual's strengths and interests to a vocational outcome, and they jointly develop an employment plan. In fiscal year 1996, 213,500 individuals who exited the VR system after receiving services achieved an employment outcome and showed notable gains in their economic status.

The State VR agencies and the Social Security Administration have a long history dating back to 1954 of working together to assist SSDI and SSI beneficiaries to return to work. In order to examine the success of the VR Program in assisting individuals with disabilities to achieve sustainable improvement in employment, earnings and independence, the Department is currently conducting a major longitudinal study. The study which is being conducted by Research Triangle Institute follows approximately 8,000 current and former VR consumers over a 3-year period and examines services and post-VR earnings, employment and community integration of VR consumers. Information obtained from this study will enable the Department to conduct specific analysis relative to SSDI and SSI beneficiaries receiving VR services.

Some of the preliminary data regarding the rehabilitation of SSI and SSDI beneficiaries may be of interest to you. This data shows 28 percent of all active VR clients are, in fact, SSDI and SSI beneficiaries who have been receiving benefits for an average of 55 months. SSI/DI beneficiaries referred to the VR Program directly by SSA or SSA's Disability Determination Service represent only 3.6 percent of all beneficiaries who, in fact, are applying for services. Beneficiaries enter the VR system far more often through self-referral, community health and rehabilitation programs and schools, after a period of receiving SSA benefits.

SSA beneficiaries tend to have higher percentages of some significant disabilities. These include higher percentages of visual disabilities, significant mental disabilities, mental retardation and prelingual deafness.

Chairman BUNNING. Are you close to being finished?

Ms. HEUMANN. Yes.

The Department is committed to closely monitoring program outcomes, improving performance and developing evaluation standards and performance indicators for the VR Program in order to improve program performance. We recognize that Education's Vocational Rehabilitation Programs are only part of the solution to the unemployment of individuals with disabilities, and we support other options to maximizing return to work opportunities, including the Social Security's Ticket to Independence. We must continue to explore ways to address the broad range of factors contributing to the high unemployment of individuals, and we are committed to working with you on this process. Thank you.

[The prepared statement follows:]

Statement of Judith E. Heumann, Assistant Secretary, Office of Special Education and Rehabilitative Services, U.S. Department of Education

Chairman Bunning and members of the Subcommittee, thank you very much for inviting me to speak with you on the issue of barriers that prevent disabled Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) beneficiaries from engaging in or returning to work.

As the Department of Education's Assistant Secretary for the Office of Special Education and Rehabilitative Services (OSERS), I am responsible for providing leadership to the Rehabilitation Services Administration (RSA), the Federal agency that provides support to State vocational rehabilitation (VR) agencies and other service providers to assist individuals with disabilities to achieve employment and to live independently. My leadership also extends to the National Institute on Disability and Rehabilitation Research which—through research, demonstration, and dissemination and utilization programs—identifies those best practices in technology, rehabilitation, and independent living that result in greater independence and productivity of individuals with disabilities.

My appointment as Assistant Secretary and my ability to live independently would not have been possible without the broad array of rehabilitation and independent living services from which I have benefited along with my personal determination and family's support.

When I was one and a half years old, I developed polio. When I was five, the public school officials would not allow me to enroll. They told my mother that because of my wheelchair, I was a fire hazard. Instead, the school system sent a tutor to my house. When I was nine, I finally got to go to school, but I was placed with other disabled kids in a room hidden in the school basement.

I was the first student in my class to go on to high school—but not until my mom and dad fought for this right.

After graduating from high school, I went to college. I wanted to become a teacher, but the agency financing my education believed that people who use wheelchairs could not teach, so they refused to let me major in education. But I did manage to minor in it.

When I graduated, I applied for a teaching license in the New York City school system. I passed the written test and the spoken test. But I failed the medical test because I used a wheelchair. The school officials would not give me a license to teach. But I knew I could be a good teacher. With the support of my parents, I challenged the school system, obtained my license, and finally got a job teaching.

During this time, I became aware that other disabled people from all over the nation—in fact, from around the world—were also advocating for equal rights. These people, and many other disabled people and their families, became part of the growing movement for the rights of the disabled.

This broader movement enabled me to go on to graduate school, and to be a leader in the then new independent living movement. I helped found the first Center for Independent Living in Berkeley, California.

Since my childhood, we, as a country, have made significant strides in improving educational opportunities for individuals with disabilities, particularly with the enactment of the Individuals with Disabilities Education Act (IDEA) in 1975. In addition to Congress' recent bipartisan reauthorization that further strengthened IDEA, we have also made significant progress in furthering opportunities for employment and independent living for individuals with disabilities through a broad range of programs that support both rehabilitation and independent living services and research and demonstrations and programs that protect the rights of individuals of disabilities from discrimination in employment, housing, and transportation. It is estimated that approximately 800,000 individuals with disabilities are now working because of the anti-discrimination protections provided by the Americans with Disabilities Act. But significant barriers remain to achieving the goals of independence, inclusion, and empowerment for all individuals with disabilities. Despite the opportunities afforded by the Individuals with Disabilities Education Act, the Rehabilitation Act, and the Americans with Disabilities Act, nearly half of working-age persons with disabilities are unemployed.

These barriers include environmental barriers such as the lack of transportation and lack of affordable and accessible housing. Individuals like myself need access to personal assistance services in order to work. Many individuals need accommodations on the job such as assistive technology to perform effectively in the workplace. Despite the promise of the ADA, negative employer and individual attitudes regarding the employability of individuals with disabilities persist.

Notably, federal policy aimed at assisting individuals with disabilities is also creating disincentives to work for many individuals with disabilities. For example, the

potential loss of health care coverage represents a significant barrier to employment for SSDI and SSI recipients. Medicare for disabled SSDI beneficiaries and Medicaid for SSI recipients provide the majority of health care coverage for these groups. While there are provisions that extend these benefits once an individual returns to work, Medicare coverage is time limited and SSI recipients who go to work lose Medicaid if their earnings exceed caps that vary by State. As a result, it's possible that people who are eligible for SSI "mangage" their income to ensure that they keep Medicaid—by stopping work when they hit the caps, or even turning down promotions. In addition to primary health care services, the Medicaid program also offers a variety of optional services essential to the needs of severely disabled individuals that are both costly and difficult to obtain even if traditional employer-based health care coverage can be secured.

In order to address this disincentive, the President's budget proposes to help people with disabilities work without losing their health care coverage. The President's proposal would create a new State option that would allow SSI beneficiaries with disabilities who earn more than those State caps to keep Medicaid by contributing to the cost of their coverage as their income rises. The President's budget also includes a proposal for a 4 year demonstration project to extend Medicare coverage for SSDI recipient who return to work.

Federal income policy regarding disability payments may also create disincentives to employment. SSDI benefits can continue for up to nine months after an individual attempts to return to work. At that point, SSA must determine if the SSDI beneficiary has achieved substantial gainful activity (SGA), which is a trigger for termination of cash benefits. SSI recipients can continue to receive their SSI checks while they work. As long as they remain disabled, they will continue to receive their SSI check until they reach a certain level of earnings. Our data suggest that many beneficiaries are well aware of the SGA threshold and earnings, and, as they approach them, tend to limit their hours of work or earnings.

Ultimately, these barriers must be addressed if we are to achieve successful employment outcomes for many more individuals with disabilities.

The programs I administer at the Department of Education have played a significant role in our overall efforts to help individuals to be prepared for and engage in gainful employment and must continue to be part of a comprehensive strategy. One of the biggest programs is the Vocational Rehabilitation State Grants programs, which provides $2.2 billion in formula grant assistance to 82 State-operated VR service programs. These programs provide consumers with a wide range of specialized services that include, but are not limited to, job development, job training and placement, counseling and guidance, assistive technology, personal assistance services, physical and mental restoration services, reader services, interpreter services, supported employment services, and school-to-work transition services. The essence of the VR program is to provide services that meet the aspirations, needs, abilities and priorities of each individual, consistent with the individual's informed choice. A VR counselor works as a partner with an individual with a disability to design a rehabilitation program that matches the individual's strengths and interests to a vocational outcome, and they jointly develop an employment plan.

Since its creation seventy-seven years ago by the Smith-Fess Act, the VR State Grants program has assisted some nine million individuals with disabilities to achieve gainful employment. Presently, there are over 1.25 million eligible individuals receiving VR services, 77.5 percent of whom have significant disabilities. In FY 1996, 213,500 individuals who exited the VR system after receiving services achieved an employment outcome and showed notable gains in their economic status.

The State VR agencies and the Social Security Administration have a long history, dating back to 1954, of working together to assist SSDI and SSI beneficiaries to return to work. The Social Security Amendments of 1965 authorized the use of Social Security trust funds to pay for VR services for beneficiaries. The goal of the Beneficiary Rehabilitation Program is to return the maximum number of disabled beneficiaries to work so that savings in reduced benefit payments and the Social Security contributions of the rehabilitated beneficiaries would equal or exceed the amount paid for rehabilitation services.

Since 1983, VR agencies have been reimbursed by SSA only for beneficiaries who are terminated from benefits following a determination that the beneficiary has achieved substantial gainful activity. Payment is made to the VR agency only when savings to the trust fund are anticipated.

In order to examine the success of the VR program in assisting individuals with disabilities to achieve sustainable improvement in employment, earnings, and independence, the Department is currently conducting a major longitudinal study. The study, which is being conducted by Research Triangle Institute, includes a sample

of approximately 8,000 current and former VR consumers at 37 VR offices over a three-year period. The time frame permits tracking of services and post-VR earnings, employment, and community integration of VR consumers.

Specifically, the study investigates:

- short and long-term outcomes achieved by VR consumers;
- characteristics of consumers that affect access and receipt of services and outcomes;
- how receipt of specific services contributes to successful outcomes;
- how local environmental factors influence services and outcomes;
- what about the VR agency influences services and outcomes; and
- the extent of return on the VR program's investment.

Information obtained from this study will also enable the Department to conduct specific analysis relative to SSDI and SSI beneficiaries. Some of the preliminary data regarding the rehabilitation of SSI and SSDI beneficiaries may be of interest to you. These data show that 28 percent of all active VR clients are SSDI and SSI beneficiaries who have been receiving benefits for an average of 55 months and include recipients who have initiated contact with the VR program or who have self-referred. SSI/DI beneficiaries referred to the VR program directly by SSA or SSA's Disability Determination Service represent only 3.6 percent of all beneficiaries who apply for services because these referrals are made much earlier in the process, e.g., when they first start to receive benefits and are not yet ready to return to work. Beneficiaries entered the VR system far more often through self-referral, community health and rehabilitation programs, and schools. One implication of these data is that a majority of beneficiaries who elect to enter the vocational rehabilitation system do so after a period of receiving SSA benefits, rather than concurrent with the initiation of the receipt of benefits.

The data also show some significant differences between the SSA beneficiary population and the general population served by the VR program. Beneficiaries tend to have higher percentages of some severe disabilities. These include higher percentages of visual disabilities, severe mental illness, mental retardation, and prelingual deafness. One result of the more severe disability mix is higher cost of services. For example, in 1995, the average cost of purchased services for beneficiaries was 49 percent higher than for non-beneficiaries ($4,724 compared to $3,168).

The Department is committed to closely monitoring program outcomes to improve performance and is also in the process of developing evaluation standards and performance indicators for the VR program in order to improve program performance.

The 1992 amendments to the Rehabilitation Act made a number of important changes to the VR State Grants program that will enhance employment opportunities for individuals with disabilities. For example, the amendments modified the criteria for determining eligibility for services to streamline the process and set forth the policy that individuals with disabilities are to be active participants in their own rehabilitation programs.

In preparing for the pending reauthorization of the Rehabilitation Act, we have invited input from a broad range of groups and individuals to get their ideas for further improving the Act, and we are prepared to make a number of specific recommendations for changes that are aimed at improving results for individuals with disabilities in the areas of employment and independent living. These include further streamlining the eligibility determination process to establish presumptive eligibility for VR services for recipients of disability benefits under Titles II and XVI of the Social Security Act, and streamlining the Individualized Written Rehabilitation Plan (renamed the Individualized Employment Plan) to eliminate unnecessary process requirements and give consumers who want to take responsibility for developing their plan the option of doing so. We also support an amendment that clarifies that consumers have the right to choice in regard to the selection of their employment goal, the services needed to reach their goal, the providers of such services, and the methods to be used to procure the services.

At the same time, we recognize that vocational rehabilitation is only part of the solution to the unemployment of individuals with disabilities, and we support other options to maximize return-to-work opportunities. For example, the Social Security Administration has recently transmitted its Ticket to Independence proposal, which would authorize a new public-private partnership to assist individuals who receive SSDI or SSI benefits on the basis of disability to return to work. We look forward to working with the Social Security Administration on this effort.

We must continue to explore ways to address the broad range of factors contributing to the high unemployment of individuals with disabilities. I am convinced that by working together, the Administration, Congress, individuals with disabilities and their advocates, service providers, and employers can turn the wasted talents of disabled people into an important resource for securing our nation's future.

I want to assure the Subcommittee of my sincere desire to work with you and our partners at SSA to achieve our common goal of assisting individuals with disabilities to achieve gainful employment and to become contributing members of our society.

Chairman BUNNING. Thank you.

Let me start the questioning with Dr. Callahan. The legislative language for the Ticket to Independence Proposal is somewhat vague regarding payment to providers. Please describe your proposal payment system.

Mr. CALLAHAN. The proposal payment system—I would like to answer this question, and Associate Commissioner Daniels may want to amplify—we would first of all seek to pick 5 to 10 States to pilot this program.

Chairman BUNNING. Five pilot States.

Mr. CALLAHAN. Five to ten pilot States. We would make sure the States were a diverse group of States throughout the country, large, small, with various characteristics. Right now, we have 65 alternate providers nationwide that would be ready to serve current beneficiaries. We expect more providers to come online. The disabled individuals in those States would be given tickets, and they would be able to take those tickets to any provider that was willing to provide Ticket to Independence services. They would register with those providers for up to 1 or 2 years, which could be renewable for an additional 1 or 2 years. We expect during that process that the provider would help them obtain stable employment. Once they go into stable employment and their cash assistance ends, the provider of those services would receive up to 50 percent of the estimated cash benefit, possibly up to 5 years.

Chairman BUNNING. In their report of March 1997, GAO suggests that SSA compare the results of the proposed results-based payment system with those of alternate systems. Does SSA intend to pilot more than one payment system? If not, why not; if so, would you please describe it?

Mr. CALLAHAN. Let me ask Associate Commissioner Daniels to comment on that, if I may.

Ms. DANIELS. Our original plan is to start with one payment system, as Mr. Callahan has described. Fifty percent of the benefit for every month the individual is not in cash status for 5 years. However, the language is flexible enough to allow us to determine if that needs to be adjusted in any way, and we will be collecting data to see if any particular group of beneficiaries are not being served and take a look at maybe changing or modifying that formula.

Chairman BUNNING. Would SSA administer payments to providers directly or use a contractor?

Mr. CALLAHAN. We would use a contractor, sir.

Chairman BUNNING. I understand SSA's proposal only pays providers when the recipient comes off of the rolls; is that correct?

Mr. CALLAHAN. Yes, that is correct.

Chairman BUNNING. How would smaller providers, who may have limited capital, be able to participate in the program then?

Mr. CALLAHAN. Let me say, our assessment is that the alternate providers, which have come to us to seek to provide vocational rehabilitation services, range from large to small enterprises. We think there are a lot of innovative small enterprises that would be willing to participate in this program.

One of the things I think you allude to is the issue of paying for milestones. One of the things we have to be——

Chairman BUNNING. I am alluding to the fact that a small provider couldn't carry this program very long.

Mr. CALLAHAN. The providers will assess their own internal capacities, and they will look at the various beneficiaries that are out there, and——

Chairman BUNNING. What I am alluding to is the fact that some of the younger, smaller and best providers may have the best ideas on how to do it, and we may miss those ideas if we are only contracting with larger providers.

Mr. CALLAHAN. Well, you are presuming when we put the ticket stick out that no smaller providers will come forward.

Chairman BUNNING. No, I am worried about their financial ability to carry it.

Mr. CALLAHAN. Well, I think it is like everything else, Mr. Chairman. Individuals and enterprises with good ideas and good innovation oftentimes can get capital from a variety of sources. So we believe that they would be able to do that and that the better ones would enter into the process.

Chairman BUNNING. My time has expired, and I want to question the next witness, but I will yield to Mrs. Kennelly.

Mrs. KENNELLY. I thank the panel for being with us this morning.

I have introduced legislation on the issue we are talking about this morning, and I have to say to you there was a certain amount of skepticism when I was putting my legislation together that, in fact, it would increase the number of people taken off the disability rolls. So what I would ask you, Dr. Callahan, considering only 1 percent or less are leaving the rolls, is there anything we can do to increase that number? Have you got numbers you can give us on how this proposal would increase the numbers going off disability?

Mr. CALLAHAN. Obviously we would shoot for at least initially a 30-percent increase of people going off the rolls in the pilot States. One of the things we are encouraged about is that by paying providers for results, we will increase the capacity of public and private providers to provide the appropriate services. So we would hope to increase it at least initially by 30 percent.

Mrs. KENNELLY. That would be wonderful, and I think it is going to take a great deal of work.

Mr. CALLAHAN. That is right.

Mrs. KENNELLY. We are talking about people who get off disability and enter into a situation where they have a provider. How does that save the trust fund money if we are only talking about those who are already off, and we know so few go off? When you put forth your proposals, what are the savings?

Mr. CALLAHAN. Well, as you probably know, there are at least three cost estimates of this proposal. SSA's actuaries have costed

it out, OMB has costed it out, and CBO has costed it out. All three components indicate a fair amount of cost neutrality in the first stages; that is, savings. We indicate that we will have savings over the full 10 years of the pilot, the OMB indicates less savings in the last 5 years, and CBO has a different alternative.

I think one thing to be aware of is that some people say we will just be paying for people who are going back to work anyway. I think that is something that has to be looked at and studied, but the key thing here is to increase the capacity of the overall system to provide these services, bring more providers online, and provide the best incentive we know, which is paying for results.

Mrs. KENNELLY. Well, that is something that both the Chairman and I are concerned about.

Mr. CALLAHAN. Let me add one point, if I may. I understand the desire for cost savings for the trust funds, but we also are looking at a goal of putting disabled individuals back to work. I mean, we shouldn't forget that goal. That is a very important goal.

This Subcommittee has a difficult task. You have to look at all the issues that affect disabled workers. It is not just Social Security, it is Medicare, Medicaid, sometimes assisted housing, transportation services, and so forth, and I think this will be a benefit to us as you look to that as well.

Mrs. KENNELLY. But, Doctor, with less than 1 percent going back to work, we are all going in the same direction on that, we have to increase that number, and to take that one step further, Ms. Heumann, everything I read tells me early intervention is the key. What does this proposal do to get the intervention earlier than it is now?

Mr. CALLAHAN. That is already on a separate track. You passed legislation here, I believe it is H.R. 1048. It is pending in the Senate. We would support getting that enacted into law as soon as possible, rather than tying that back to this particular proposal. So in one sense, you are already ahead of the game on early intervention with your other legislation.

Mrs. KENNELLY. A proposal this size, we have to all be on the same track.

Ms. Heumann.

Ms. HEUMANN. I was just going to say, some of the State rehabilitation agencies have already been working in a proactive way with employers, so as individuals are becoming injured on the job, they can come in and try to maintain people on the work force, which we believe is critically important.

In addition to that, as I was discussing in my presentation, the study being done by Research Triangle is, in fact, showing that one of the difficulties is that individuals are being given determinations of disability and at the same time are being told about their ability to go get jobs. The data are showing people enter into the system as much as 40 to 55 months after they have been on benefits, so it does seem to say a number of things. For some individuals, capturing them early, if their disability is not necessarily significant enough, may be able to keep them in the work force. Changing employers' attitudes so employers welcome workers and to keep them in the work force is something we also know is positive.

But I think what everyone has been saying this morning is people have more significant disabilities. There is a time period for some in which they are going to have to adjust to their disabilities, as well as the other issues we laid out around health care benefits, which is a very big issue. Congressman Ramstad raised that issue earlier with his former employee who was a quadriplegic who couldn't maintain employment. I assume because he was at risk of not only losing his Medicaid, but in the State of Minnesota, they have good programs for personal assistance services.

This is a complex issue. We agree with you that early interventions are critically important for some, and then a collaborative approach of services that come from Social Security, rehabilitation agencies and many other programs can also potentially help move people back into work; plus the removal of the disincentives, which we all believe is one of the biggest problems of getting people back into the work force.

Mrs. KENNELLY. Thank you for that excellent answer.

Chairman BUNNING. Thank you.

Mr. Collins will inquire.

Mr. COLLINS. Thank you, Mr. Chairman.

Mr. Callahan, I want to kind of clear up this 30 percent. You say you are hoping to increase by 30 percent the number who leave the rolls of disabled back into the workplace.

Mr. CALLAHAN. Over the current baseline, yes, sir.

Mr. COLLINS. Not 30 percent of a half percent, then, that Mrs. Kennelly spoke of, is now currently leaving the rolls, because that wouldn't be much of an increase, would it? That would get us up to about two-thirds of 1 percent.

Mr. CALLAHAN. State vocational rehabilitation agencies are our primary provider of services right now. We referred last year 60,000 individuals to State vocational rehabilitation agencies for services.

Mr. COLLINS. According to our numbers, that was about 6 percent.

Mr. CALLAHAN. Right. But let me, if I could, just pursue this for 1 minute. Of the 60,000 we referred, we reimbursed the States for their services to 6,000 disability beneficiaries; that is, those who were substantially gainfully employed for 9 months or more.

Now obviously, we would like to increase the number. First of all, we would like to get more of those 60,000 beneficiaries we referred for services back to work. Additionally, we would like to get more beneficiaries referred for services. The Ticket to Independence, at the very least, will enable us to list more individuals on the electronic billboard, that is, advise all the providers participating in the Ticket Program that these individuals have tickets, and to marry the individuals with a provider of services, whether that be a State VR agency if they choose to participate in the Ticket Program, or some other public or private service provider. So it is in essence trying to achieve a market solution, if you will; that is, marry the individuals with the service providers and get them back into the work force.

Mr. COLLINS. Well, good. You know, I think the best place for rehabilitation is the workplace, and you suggested that, hopefully, you think there are people in the private enterprise, small business

area that would be willing to take this task on and hire people with disabilities, and I agree with that. I think they will, too. But you say you think they are. Have you actually inquired with small business people, entrepreneurs, employers as to where the stumbling blocks are in hiring people with a disability, because there are some there. I am a small business person, and I know where they are, and I know where the disincentives are because of a long-range liability that that employer is going to pick up. Have you been to the workplace and talked to people about it?

Mr. CALLAHAN. If I may, Congressman, let me defer to Associate Commissioner Daniels, who has dealt with that in more detail than I have.

Ms. DANIELS. As we were developing the proposal, we had an opportunity to talk with employers, some of them large, some of them small. One of the things they indicated to us is they are in the business of their business, and that when it comes to hiring people with disabilities, they are generally willing to hire people who can help them do their business. They need help sometimes in figuring how to make the best accommodations or how to provide the best workplace, but they don't want, themselves, to become experts in that. We believe that the providers who take our tickets will be willing to work with employers to make those kinds of transitions happen for our beneficiaries, without asking the employer to become an expert in rehabilitation or workplace accommodations.

Mr. COLLINS. Well, the incentive to me to hire anyone is productivity, and the disability should not be a question as to whether they are productive or not, unless it is a job where they just actually physically can't handle it.

But there are some problems in the area of insurance, problems in the area of workers' compensation, and problems in the area of entrance to the facility, and all of these things are regulated very heavily by the Federal Government that puts the roadblock up that I don't want to deal with. But I would deal with them if I were not afraid of the punishment that I might receive of attempting to try to deal with it. I think you need to go to the marketplace and talk to people and talk to them in a real sense, not a bureaucratic sense.

Thank you, and thank you, Mr. Chairman.

Ms. HEUMANN. Mr. Collins, could I just say one thing?

Mr. BUNNING. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Since I was a junior in high school, Dr. Callahan, you have been testing a pilot program and going through a demonstration project. I believe it has been about 17 years. From that pilot program, since I was a junior in high school, what have you learned that you incorporated into the Ticket to Independence Program?

Mr. CALLAHAN. Well, I will defer to Associate Commissioner Daniels on this because she has worked on it for the past several years, but I will say we also have a study, called Project Network, for which we expect an evaluation report by the end of this year. We are going to fully report to the Subcommittee, which will shed light on this. But, I think what we have learned is that a disabled individual wants to go back to work. I think the testimony from all the panelists today suggests there are a lot of disabled people who

want to go back to work, but are concerned about disincentives, and finding a willing provider of services that tailors the program with the disabled individual, and provides the various things that are helpful to that individual in order to return to work.

I mean, my colleague here, says we have had 800,000 people go back into the workplace since the ADA was passed. We find that our customers tell us they want to go back to work. We are seeking here, as a result of that, to put providers together with the disabled individuals and try to get them back to work. It is a very complex and a time-consuming process.

Mr. CHRISTENSEN. I guess what I question is the fact that after 17 years of a pilot program, roughly $30 million in taxpayers' money, the Ticket to Independence Program that you are rolling out is still yet another pilot program; that after 17 years of studies and pilot programs and demonstration projects, you don't have enough confidence in the program to roll it out as a permanent program rather than another pilot program which will last, I think, 10 years.

Ms. DANIELS. Let me say that many of the previous demonstrations have given us a lot of useful information. They were not wasted. One of the most important things——

Mr. CHRISTENSEN. I have never heard of a government program that wasted money.

Ms. DANIELS. One of the most important things we learned, and you probably will learn from some of our colleagues on the other panel, is we found that there is a broad network of very able, highly skilled, results-oriented professionals out there who are willing to work with our beneficiaries. We structured the Ticket to Independence, as you see, to start slowly, 5 to 10 States, but it gives us the flexibility, if the program is successful, to continue to roll it out even faster, to encompass as many States as possible as our capacity increases to manage the program and as it remains successful.

So I would think this is not as limiting a rollout pilot as you might be thinking. It starts small, but it can grow rapidly if it is successful.

Mr. CALLAHAN. If it works, we are probably going to come back and ask for permanent legislation. If it doesn't, we will come back and tell you why it didn't work.

Mr. CHRISTENSEN. When do you think it will come back?

Mr. CALLAHAN. The legislation provides that I am supposed to report back to the Congress within 3, 5, 7 and 10 years—I am sure I will be reporting back before then—so we will be reporting back as quickly as we can on this, but we don't want to start a permanent program that doesn't have a chance of success.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. HULSHOF. Mr. Christensen, I can't wait to see the headline back in your hometown paper that you have never heard of a government program that wasted money.

Ms. Heumann, I wanted to give you the opportunity to respond to Mr. Collins' question, but I think you did want to share with us some opinions.

Ms. HEUMANN. I just would like to put a face on the people we are talking about, and I think the issue Mr. Collins raised is very

important, the need for agency—Social Security and rehabilitation agencies and others to be working face to face with employers to understand those programs. I think really the reforms that have been going on in programs around the United States in the last 8 to 10 years have definitely been linking rehabilitation agencies with employers to understand their real needs.

I also think we can't avoid the discussion which deals with the disincentives, because just improving employers' opportunities to bring disabled people in will not address the issues of individuals who have significant disabilities. I mean, people like myself, that are right now spending $3,500 a month for rent and attendant services; the person that Congressman Ramstad spoke about earlier, who I am sure has a comparable level of expense. So we have to, as we all work forward with the mutual goal of getting disabled people to work, which is what we want to do, we have to realize that we have to make some of these systemic changes if we are going to allow people opportunities.

The approach Social Security is taking is one more approach to assist disabled people to moving into the work force, but if we don't seriously address these other issues, we are not going to be able to move the number of people who could move into the work force into the work force.

Mr. HULSHOF. Let me ask you about the SSA Ticket Proposal. Specifically, Ms. Heumann, let me ask you to comment on right of first refusal, because as I understand, the Ticket Proposal allows the State VR agencies to opt into the Ticket Program in the States participating in the pilot, but then the State VR agencies in the States would then no longer enjoy the right of first refusal as currently provided for in current law. Would you expect States to opt into this program? And what is the Department of Education's view about losing right of first refusal?

Ms. HEUMANN. We anticipate some States would participate in the program. What our hope is, and we have obviously been working very closely with Social Security, is as the program moves forward, individuals with disabilities are given significant information so they understand what the ticket is going to mean. They have a better understanding of the various providers that are going to be there, the kinds of services that rehabilitation is legally required to offer people versus the services that agencies that make—become ticketholders are not obligated to provide people, and that individuals also are aware of what protections they have, if there are differences in the beliefs of the purchaser, as the disabled individual, and the provider.

I think those are criteria we think are critically important as the program moves forward.

Mr. HULSHOF. You mentioned information about the new pilot program, and, Dr. Callahan, as you know, we have split this hearing up into two sessions. Tomorrow we are going to hear from many in the disabled community; also some from the consumer panel tomorrow. And maybe it is unfair of me to ask you to comment, but, for instance, I think Mr. Halliday is testifying tomorrow on behalf of the Council of the VR—State VR Administrators. He talks about the lack of understandable information on what would happen to cash benefits and medical coverage when a person at-

tempts to work, and he calls it; the Twilight Zone, I think, in his testimony.

In addition to the pilot program, what is SSA doing to educate those presently trying to move into the work force?

Mr. CALLAHAN. We have a number of initiatives underway that Dr. Daniels has spearheaded, and I think she would like to comment.

Ms. DANIELS. We realize the work incentives are very complex and, in fact, we have become students of some colleagues from the Virginia Commonwealth University who have created a computer program to show us and others what happens to income and net income when individuals work, and how it affects their benefits. I think you may have a chance to hear from those individuals. We have invested heavily in that program, and we think it holds promise of being available to our beneficiaries to help them and their providers figure out the real impact of the work incentives.

Additionally, we developed a package for young people called, "Graduating to Independence," that focuses on families and young people. Counselors teach them about work incentives and teach them how to prepare for a transition to work. We have publications that we deliver, and we have a continuing and ongoing dialog with our customers about what makes sense and how we can best administer the work incentives. All of the things are leading us in a good direction, we hope.

Chairman BUNNING. The gentleman's time has expired.

Mr. Johnson.

Mr. JOHNSON. Thank you, Kenny. Thank you, Mr. Chairman.

Dr. Callahan, the National Council on Disability appointed by the President has some recommendations in it to improve the Social Security's ability to return disabled to work, and some of our witnesses will be reviewing those details, but one of the recommendations is to reduce the monthly SSDI benefits $1 for every $2 of earnings over $500 a month, similar to the SSI Program. What are your views on that, and isn't that a possibility, and why aren't those two programs the same anyway?

Mr. CALLAHAN. I haven't seen that proposal in all its detail. We would obviously have to understand the cost ramifications of it. Clearly, we would like to see some comparability among all our programs, but, Mr. Johnson, what I would like to do is provide our answer for you on that one for the record because I would like to take the time to study the National Council on Disability's recommendations.

[The following was subsequently received:]

A disability benefit offset provision for Social Security disability insurance (SSDI) beneficiaries, similar to that proposed by the National Council on Disability, has been considered several times over the years. For example, both the 1988 Disability Advisory Council and the 1996 Disability Policy Panel of the National Academy of Social Insurance (NASI), considered, but rejected, a disability offset proposal. Although the measure may encourage more beneficiaries to work, it also raises a number of concerns:

- Beneficiaries would continue to be eligible for cash payments despite earning comparatively large incomes. For example, NASI reported that an individual with monthly DI benefits of $1,100 could earn more than $32,000 per year and still collect a partial DI benefit.

- A disparity would occur between SSDI applicants and beneficiaries. In order to qualify for benefits, applicants would have to be unable to perform substantial gainful activity (SGA), while beneficiaries could remain on the rolls while earning well in excess of the SGA level, currently $500 per month. Thus, a benefit offset could be seen as establishing a different, less strict definition of disability for those individuals receiving disability benefits versus those applying for such benefits.

- A disability offset provision may induce many people with disabilities who work despite their impairments to stop working long enough to apply for and become entitled to cash disability benefits (and eventually Medicare), thereby increasing both SSDI program costs and administrative costs. In 1996, SSA's Office of the Actuary estimated that a proposal to reduce SSDI benefits by $1 for each $2 in excess of $500 per month would result in an increase in SSDI benefit payments totaling $5.1 billion over a 5-year period.

- The proposed $500 per month SSDI beneficiary earnings disregard is almost 8 times greater than the $65 per month disregard applied to a Supplemental Security Income (SSI) disabled recipient's earnings under the SSI disability offset provision under section 1619 of the Social Security Act.

Mr. JOHNSON. You haven't looked at the President's recommendations then?

Mr. CALLAHAN. I don't have that right in front of me, sir, no, I don't.

Mr. JOHNSON. One other question. When people get out of disability, they lose Medicare; is that true?

Mr. CALLAHAN. I am sorry?

Mr. JOHNSON. They lose Medicare—or Medicaid, maybe.

Mr. CALLAHAN. It depends. They can lose it to some degree or another. Let me ask Ms. Daniels.

Ms. DANIELS. The Social Security Disability Insurance Program allows beneficiaries to keep their Medicare part A premium free for their trial work period, which is 9 months, and then to continue to keep that premium free for the extended period of eligibility, which is another approximate 3 years, and at the end of that period the beneficiary may purchase part A, with a premium. It is a little over $300 a month.

So there are transitions currently in the Disability Insurance Program that allow the beneficiary to keep the Medicare that they have while they are beginning to work and get stabilized, and, at the end of that, to purchase it.

Mr. JOHNSON. So that is not an obstacle to them getting work then, is it?

Ms. DANIELS. Some of our beneficiaries say that the premium itself, at a little over $300 a month, is a substantial premium, given their ability to earn after they have become disabled.

Mr. JOHNSON. But you said they get it for 9 months, in the interim, free.

Ms. DANIELS. That is right, part A.

Mr. JOHNSON. I understand.

Well, is it working or not?

Ms. DANIELS. Certainly for people on their trial work periods or in their extended period of eligibility, it is a fabulous coverage for them to have and something for them to depend upon. Whether or not they can afford to keep it after they finish that period is really uncertain. We have only had approximately 600 people since this provision was put in law to ever use it; in other words, purchase their Medicare part A.

Mr. JOHNSON. Six hundred out of how many?

Ms. DANIELS. Out of several thousand. I would have to look at my book here, but several thousands of people have left the rolls over the years, and very, very few people have ever bought Medicare.

Mr. JOHNSON. Thank you very much.

Thank you, Mr. Chairman. I yield back to you.

Chairman BUNNING. I would like to ask Ms. Heumann your comments on the Council, National Council on Disability, employment recommendations, if you know about them.

Ms. HEUMANN. I am sorry, I haven't seen them in detail either.

Chairman BUNNING. You don't have any idea whether you agree or disagree with the recommendations?

Ms. HEUMANN. I think the thrust of the Council's recommendations we support because it is the same thrust we are all discussing. What they have been doing is convening meetings around the country and bringing together disabled experts who are both knowledgeable about disability from a personal perspective and knowledgeable about the laws.

Chairman BUNNING. I want to assure all of the witnesses that I am going to submit questions in writing to you for answers for the record.

Mr. CALLAHAN. Yes, sir.

Chairman BUNNING. Ms. Heumann, in your testimony you state the Department of Education supports consumers' choice in the selection of their employment goals. Would you like to expand on that for me?

Ms. HEUMANN. Well, we believe it is important for anyone in this country to be able to have the opportunity to talk about what their work objectives are, not for someone to say that this is the job you should do. Historically, and if I could just talk personally, when I was in high school, what my disabled friends told me in high school was when you went to rehabilitation many years ago, you could

only tell them you wanted to do a job where you could demonstrate that another disabled person had a job like that. So when I was interested in becoming a teacher, I knew not to tell anybody I wanted to be a teacher because they would not help me go to school to become a teacher. So I said instead I wanted to be a speech pathologist, which I never really wanted to be.

Today, because of many of the pieces of legislation that are out there, disabled individuals have options like other people, but we need to make sure that no one is saying to any disabled person, you should do *x* job when, in fact, they want to do *y* job. So choice means that we have to be able to sit down with the disabled individual and allow the person to say what they are interested in, what kind of adaptations they need for the job, types of technology they may need, where they may have to live in order to get to and from the job, to look at other disability-related issues as they make their determinations.

Chairman BUNNING. I don't want to interrupt you. Mr. Collins brought up some of the barriers that exist for industry and small businesses when trying to hire people with disabilities. Disincentives include health care and liability insurance and more. So is that in an educational process being brought up to those that are seeking to hire the disabled?

Ms. HEUMANN. Well, what we would be talking to a disabled person about is if they are interested in certain types of jobs where there are risks in the jobs, what kind of accommodations could be provided for the individual to remedy the risk issue.

Chairman BUNNING. Well, that is very important, obviously, for the disabled person to be able to choose any job they want. The reality is that there are barriers that prevent employment. We are seeking to get a handle on the big picture. We can't write a bill to handle SSDI and SSI without the complete picture on subsidized housing, on all the other things that go with it.

Ms. HEUMANN. Mr. Chairman, I think it is important to give that information to disabled individuals, but I also think we need to do a continued job at working with employers, because there are still employers—and I am not talking about Mr. Collins—who are unaware of what disabled people can do. And so I think we need to have a partnership with the provider, with the disabled individual and with the potential employer to be able to look at what they perceive as barriers to see if, in fact, the barriers can be removed. We don't want to limit disabled individuals' options in the world of work based on their disability.

Chairman BUNNING. We want to make sure they have an opportunity to do a better job at rehabilitating more than 1 percent of those on SSDI. That is our job and what we are trying to accomplish in any kind of legislation we would propose.

Ken, do you have any other questions?

Mr. HULSHOF. No.

Chairman BUNNING. I would like to thank the panel for their testimony, and we will be submitting questions to you. Thank you.

[The following was subsequently received:]

Questions received from Hon. Jim Bunning, and Subsequent Responses from Hon. John J. Callahan, Acting Commissioner of Social Security

1. You indicated that, under the Administration's Ticket to Independence proposal, providers are not paid for services until the recipient no longer receives benefits. What about an individual who is only able to work part-time? Is there nothing that can be done, in your view, to reward this progress?

First, we would like to emphasize that the Ticket to Independence Program (TIP) is intended to be a voluntary addition to all the VR programs currently available to SSA's beneficiaries. As such, a beneficiary can get services from the State VR agencies in their respective States. Second, the essence of the TIP is that savings to the SSDI Trust Fund or the general revenues is a prerequisite for payment to a provider. One could make milestone payments, but that would not be consistent with the approach we have proposed. The TIP (and any savings-based payment system) is designed to encourage aggressive pursuit of employment outcomes for as many beneficiaries as can be efficiently returned to work. Other beneficiaries, who need more extensive services in order to return to work full time, will be served by existing systems such as the State VR agencies.

2. In your testimony, you mention the Administration's proposal for a four-year demonstration to extend premium-free Medicare health insurance for recipients who leave the cash benefit rolls because of work. You also state that the Administration believes such a demonstration, along with the "Ticket to Independence," is good policy and constitutes an incentive to return to work. Why, then, did the Administration not include this proposal in its 1998 budget?

The President's 1998 budget did include a proposal for a demonstration which would have permitted certain title II disability beneficiaries to have their Medicare coverage continued, premium-free, for an extra 4 years after their Medicare coverage would have terminated under present law. While the President's proposal was, unfortunately, not included in the Balanced Budget Act of 1997, the Administration plans to continue to pursue such demonstration authority.

3. All disability recipients, except those whose medical conditions are expected to improve, will be eligible to receive a ticket. Recipients who are expected to improve will be eligible for a ticket after their benefits are continued as a result of a CDR. Since an extensive CDR backlog still exists, why not issue a ticket to those whose medical conditions are likely to improve, as it seems that those recipients would benefit from rehabilitation services early in the process?

We intend to issue tickets at the time of award to new beneficiaries who are not considered "high profile" in SSA's CDR profile system. Those considered high profile would be eligible for a ticket after a CDR results in a finding that their disability condition has not improved. All beneficiaries currently on the rolls who are not classified as "high profile" cases will also be eligible to receive tickets. Initially, it may be necessary to phase in the profile system, if it appears that too many beneficiaries would be excluded from receiving a ticket or phase in the beneficiaries on the rolls, if the workload appears too large in the first year. In addition, we will evaluate the CDR backlogs at the time legislation is enacted and reassess our position, if necessary, at that time.

4. Basically, under your proposal most new recipients and individuals who are continued benefits after a CDR are issued a ticket. Is their use of a ticket mandatory?

The Social Security Administration has a duty, obligation, and responsibility to protect the Social Security trust funds and the general funds of the treasury from being used to pay benefits to individuals who are not entitled to them. Therefore, the "Ticket to Independence" proposal provides that the benefits of beneficiaries who (1) either do not cooperate in a rehabilitation program designed by the provider to which they assigned their ticket, to get them off the disability rolls, or (2) refuse to assign their ticket to a provider which has developed a rehabilitation program which is likely to get them off the disability rolls, may be withheld or terminated. These sanctions are consistent with long-standing Social Security policy.

5. Social Security law requires suspension of benefits for those SSDI and SSI recipients who refuse to accept vocational rehabilitation services. How many SSDI and SSI recipients have had their benefits suspended because they refused to accept services?

Benefit suspension can occur when an individual, without good cause, refuses to continue to accept VR services or fails to cooperate in such a manner as to preclude their successful rehabilitation. Before a suspension occurs, SSA and the State VR agency make every possible effort to encourage the individual to participate in their

program of VR services. Additionally, SSA independently evaluates if good cause exists in those cases where nonparticipation is reported. During the last three years, SSA has reimbursed a State VR agency in fewer than 10 cases where benefit suspension was linked to a refusal situation.

6. State VR agencies are reimbursed by SSA for services when SSA recipients engage in substantial gainful employment for nine months. In 1996, SSA reimbursed State VR agencies for about 6,000 recipients. How many recipients actually left SSA disability rolls because of VR services?

To assess the effectiveness of successful State rehabilitations, SSA periodically evaluates the number of months successfully rehabilitated individuals stay off the disability rolls. Although we do not presently have longitudinal data on 1996 successful rehabilitations, prior analyses indicate that over a 5 year (60 month) period, successfully rehabilitated SSDI beneficiaries will be out of benefit status for an average of 46 months (i.e., collect checks in only 14 months in 5 years following successful rehabilitation).

The months an individual is in benefit status include all 60 months for the few individuals who never leave the rolls, any new reentitlements based on new applications within the following 5 year period, and any months during the extended period of eligibility an individual received benefits because their earnings fell below the substantial gainful activity level. This information confirms that, on average, SSA is getting a good payoff from successful rehabilitations. As it is not currently available, we will provide the number requested under separate cover.

7. Most of the return-to-work proposals focus on the back end of the disability program, in other words, once individuals are allowed benefits. However, many people think the front end of the disability program needs to be brought up to date. Do you believe that the current law definition of disability is still appropriate for the program? Should it be changed?

Many people, both in government and the private sector have mixed opinions about this issue. It is true that the current implementation of the definition of disability, which is defined in broad terms in the Social Security Act, was written into regulation and established in State agencies across the country nearly 40 years ago. Much has changed since then. However, fundamental changes to that process would have far-reaching consequences for current beneficiaries and individuals who are insured for disability, for disability advocates, for the larger disability and health insurance systems in America, and for the federal government. We are willing to work with the Congress to identify changes that all agree would be desirable and to test those changes, to the extent possible, in controlled field experiments before attempting to implement a different definition nationwide.

As you know, we have a review of the entire disability decision process on-going under the Disability Process Redesign Project. Part of that redesign effort includes research into alternate ways to implement the functional evaluation of the severity and consequences of physical or mental impairments. We plan to field-test any feasible alternate processes which are identified by the research. Any of these alternate processes would have to be proven to be cost-effective in terms of decision accuracy and administrative efficiency. It is not clear that the current system would turn out to be less effective than any proposed alternative.

8. Why are so few disabled recipients (6%) referred to State VR agencies for services?

We too are concerned that relatively few beneficiaries are referred for VR services. While the national rate of referral is below 10 percent, the rate does show a wide variance from State-to-State. Some factors influencing this variance are the individual States' use of local criteria for selecting referrals and the fact that some beneficiaries are already VR clients (due to a referral from another source) before the SSA medical determination is completed.

To help address the overall rate of referrals and wide State-to-State variance, we are working with both the Council of State Administrators of Vocational Rehabilitation and the Rehabilitation Services Administration. Through this joint effort, we are seeking ways to implement a more uniform and broader selection of quality referrals.

9. In March 1994, SSA issued regulations allowing public and private providers to provide services to SSA's disabled recipients who are not served by the State VR agencies. Currently, how many recipients are actually receiving services from alternate providers? Why has it taken so long to get this program up and running?

Developing a process within SSA for working with alternate providers of VR services has never before been done. The process required considerable original and

imaginative work to establish. Over 4,000 separate public and private VR providers expressed an interest in the new process and received the agency's solicitation for a proposal. Over 500 actually submitted proposals to become alternate participants. The first contract was awarded in the Spring of 1997. Since then, nearly 100 additional contracts have been negotiated and awarded. More are expected from those for whom additional information has been requested.

Several of those awarded contracts are already accessing our listings of available beneficiaries. The contractors are free to choose which beneficiaries are contacted and to independently negotiate a plan of services with a beneficiary. We are very early in the period where alternate participants have begun outreaching to available beneficiaries. Therefore, the results are limited. We do know, however, that some services are being provided and at least one individual has begun workibg.

10. One of the SSI program's work incentive is the PASS program. We are hearing from many consumers, including panelists who testified in Day 2 of this hearing, regarding their concerns over SSA's administration of the PASS program. Since many SSI recipients also receive SSDI benefits, please explain what SSA is doing to ensure that the PASS program is being effectively administered.

PASS allows the Social Security Administration, in determining eligibility and payment amount for SSI, to exclude income and resources an individual sets aside in order to pursue an occupational goal. The purpose of this provision is to help disabled and blind individuals who want to work obtain items or education that will help them to work. For example, funds set aside under a PASS can be used for tuition, training, transportation, supplies, and computers.

We feel strongly that PASS is an important work incentive for highly motivated disabled SSI recipients. However, recent evaluations of the provision by us and by the General Accounting Office (GAO) revealed that there are some aspects of the PASS that are vulnerable to misuse. We want to make sure that PASS continues to be available for moving individuals from dependency to independence. Our goal in recent months has been to improve management of the provision while reducing opportunities for misuse.

To improve adjudication accuracy, and to achieve consistency in decisionmaking, we recently centralized the processing of all PASS applications. We are currently evaluating options for achieving further improvements in the adjudication of this sensitive and important workload.

SSA instituted a comprehensive review of policies for the PASS provision. Our review began this past spring in keeping with commitments we had made to study the first year impact of changes in the way PASS requests are processed.

We cannot at this point specify the precise nature of any future proposals for PASS changes resulting from our review.

Question received from Hon. Jim Bunning, and Subsequent Response from Judith Heumann

Question: State VR agencies are reimbursed for services when an SSA recipient engages in substantial gainful activity for nine consecutive months. State VR agencies were reimbursed for only about 6,000 SSA beneficiaries last year. Why are so few SSA recipients served by State VR agencies?

Answer: In FY 1995, SSA reimbursed State vocational rehabilitation (VR) agencies a total of $65,480,627.30 for the rehabilitation of 6,026 SSDI and SSI beneficiaries. While this figure represents only a small percentage of individuals on the disability rolls, it also reflects only a small number of beneficiaries who requested, and were provided, VR services from the State VR program.

In FY 1995, 607,195 individuals requested services from State VR agencies. Of these, 143,298, or about 28%, were SSDI or SSI beneficiaries. 130,343 were accepted for VR services, 97,363 received services under an Individualized Written Rehabilitation Program (IWRP), and 53,877 exited the VR system, having met the programs criteria for an employment outcome.

It is important to point out that the criteria under which SSA reimburses VR agencies for their services differs considerably from the standards by which the VR program determines a successful employment outcome. In order for VR agencies to be reimbursed by SSA, it must be established that a beneficiary has engaged in substantial gainful activity (SGA) for nine months. The SGA earnings level is set at $500 per month for disabled non-blind beneficiaries, and $1,000 per month for blind beneficiaries.

Criteria established by the Rehabilitation Act of 1973, as amended, require that in order for a State VR agency to claim an employment outcome, it must be determined that: VR services have contributed to the employment outcome; the employment outcome is consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; the employment be in the most integrated setting possible; the employment must have been at least 90 days in duration; and, the individual and VR counselor agree that the employment is satisfactory and progressing well. While VR agencies strive to assist individuals in obtaining the best paying jobs possible, as long as these criteria are met, it is acceptable, and appropriate, for the individual to be "rehabilitated" in employment that may be part-time employment, supported employment, or employment at earnings less then SGA. In FY 1995, 38,629, or 71.1% of all SSA beneficiaries closed after achieving an employment outcome, were working in the competitive labor market. Preliminary data suggest that this percentage increased to about 84% in FY 1996.

Data, obtained from the Rehabilitation Services Administration's (RSA) Case Service Report System (RSA–911), indicate that when SSA beneficiaries choose to apply for VR services, they are more likely than non-beneficiaries to be accepted by the program. In FY 1995, 90.1% of beneficiaries who applied for VR were accepted, compared with 76% of non-beneficiaries. Preliminary FY 1996 data are similar, but with decreases in the percentage of non-beneficiary acceptances (90.4% of beneficiaries compared to 72% of non-beneficiaries).

SSA beneficiaries have ample opportunity to access the VR system. Current law requires, that upon initial adjudication for benefits, they be referred to the VR program. There are strong indications that this may not be the most appropriate time for such a referral, as most beneficiaries who participate in VR services have been on the benefit rolls for several years (40–55 months). Further, the 1995 data show that a large percentage, over 24%, have accessed VR through self-referral. Currently, SSA, OSERS(through RSA), and State VR agencies are working cooperatively to improve the referral system.

It is clear from the information presented above that SSA beneficiaries represent a significant percentage of the VR caseload. Further, many beneficiaries do enter employment in the competitive labor market. However, what is also clear is that many beneficiaries who attempt work do not earn enough to be terminated from benefits. Disincentives inherent in the present benefit structure, have been cited as reasons why more beneficiaries do not attempt work. These include: loss of essential medical coverage, fear that earnings alone will not be sufficient for self-support, and difficulties associated with re-entry into the benefit system.

Finally, it appears that in FY 1996, State VR agencies will be reimbursed over $90 million for their services to SSA beneficiaries. As of July 31, 1997, SSA reported that over 6,700 cases have been processed for reimbursement. State VR agencies consider these reimbursements to be a valuable source of program income and are working cooperatively with SSA and RSA to improve the reimbursement system.

The vocational rehabilitation of individuals with significant disabilities is a priority of the Rehabilitation Act. SSA beneficiaries, almost without exception, are included in this group, and VR agencies are committed to working with them towards achievement of meaningful employment outcomes.

Chairman BUNNING. Panel number two, if they will come forward, we will hear from Jane Ross, Director, accompanied by Cynthia Bascetta, Assistant Director of Income Security Issues at the Health, Education, and Human Services Division of the U.S. General Accounting Service; Dr. Bruce Growick, professor of rehabilitation services at Ohio State University; Dr. Monroe Berkowitz, professor of economics at Rutgers University, accompanied by Virginia Reno, director of research at the National Academy of Social Insurance; John Kregel, research director at the Rehabilitation Research Training Center at Virginia Commonwealth University; Richard Baron, director of the Matrix Research Institute in Philadelphia; and Dr. Leonard Matheson, director of the Work Performance Laboratory and section chief of the Occupational Competence and

Ergonomics Section at the Washington University School of Medicine Program in Occupational Therapy in St. Louis, Missouri.

Chairman BUNNING. Ms. Ross, when you are ready, you can begin with your testimony

STATEMENT OF JANE L. ROSS, DIRECTOR, INCOME SECURITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY CYNTHIA BASCETTA, ASSISTANT DIRECTOR

Ms. ROSS. Mr. Chairman, thank you for inviting me to testify on issues facing Social Security as it tries to increase the work effort of disabled people.

As you know, we have recommended that SSA place much greater priority on improving its return to work efforts. With cash payments now exceeding $1 billion a week, SSA has a powerful incentive to take such actions as the ones they have just described.

Experts have told us that effective strategies to encourage disabled people to work must include three types of initiatives. Thus, we believe that SSA should develop a strategy that includes intervening earlier in a person's disability experience, providing vocational rehabilitation services to help applicants and beneficiaries become ready for employment, and encouraging work by guaranteeing medical coverage or assuring increased income as a result of working.

Today I would like to emphasize two points. First, although preparing people for work is important, beneficiaries are likely to return to work only if they perceive they will be better off financially. Second, although no one knows which strategies might yield the best results, the high opportunity costs of both inaction and choosing options that may not work well strongly indicate that testing more than one approach is appropriate.

On the first point, while the administration has proposed the Ticket to Independence Program, they haven't yet made a proposal to ensure people will be better off financially if they return to work. SSA should test work incentive reforms that address the risks that beneficiaries face when they give up benefits and medical coverage for the uncertainties of employment.

The two charts that I have with me today over here show the financial risks that face DI beneficiaries when they work. The white bars on each chart show how the current law works. You can see that the individual's net income is at $1,000 when he or she has about $500 of earnings. Well, when the benefits are terminated, he or she doesn't get back to the same net income level until earnings are almost $1,800. So when a beneficiary considers his options about returning to work, he has to assess how long it is going to take to get back to the same income position as when he was receiving benefits.

These two charts also show how a tax credit and a gradual benefit reduction proposal could cushion the drop in an individual's income when benefits stop. The tax credit would provide additional income through a refundable income tax credit and would be linked to the amount a person earned. The gradual benefit reduction could cut benefits by, say, 50 cents for every dollar of earnings.

While the choices that an individual faces are illustrated in charts like this and could be individualized for any particular person, the total costs of proposals like these are uncertain, because we don't have sufficient information on how individuals will change their work effort in response to program changes; For people that are already on the program, will they respond to the earnings benefit decision by increasing their earnings or not? Also, allowing people to keep more of their earnings may cause people who are currently not on the program to apply for benefits.

We believe that SSA should test and evaluate at least a few work incentive options. Also, while we agree in principle for paying for vocational rehabilitation based on outcomes, as SSA has proposed, we believe SSA should test and evaluate other reimbursement mechanisms for vocational rehabilitation, such as a milestone-based reimbursement system.

Before I summarize, I want to point out that most of the proposals under discussion would affect beneficiaries who are already on the rolls. But, we have also urged SSA to work with other agencies on strategies to intervene before people with disabilities even apply for benefits. By not offering vocational rehabilitation earlier, we could be missing a chance to help people stay off the DI rolls. With about 2 million people applying for benefits each year, this fundamental redirection could be even more fruitful than trying to help beneficiaries reduce their reliance on benefits once it has begun.

Just to summarize, we know that intervening earlier, vocational rehabilitation, and cash and medical work incentives are all important parts of a strategy to ease the transition back to work. However, it is not clear how to package all these components so they work in concert, and make work more financially attractive without increasing caseloads or program costs. We have a lot to learn about the work responses of people with disabilities to changes in the programs. We owe it to the beneficiaries and taxpayers alike to move forward expeditiously and judiciously in reforming the programs.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of Jane L. Ross, Director, Income Security Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to testify on return-to-work issues facing the Disability Insurance (DI) and Supplemental Security Income (SSI) programs and to discuss various alternatives the Social Security Administration (SSA) could use in developing strategies to help more people with disabilities to work. Each week, SSA pays over $1 billion in cash payments to DI and SSI beneficiaries. While providing a measure of income security, these payments, for the most part, do little to enhance work capacities and promote beneficiaries' economic independence. Yet, as embodied in the Americans With Disabilities Act (ADA), societal attitudes have shifted toward goals of economic self-sufficiency and the right of people with disabilities to full participation in society. Moreover, medical advances and new technologies now provide more opportunities than ever before for people with disabilities to work.

The DI and SSI programs, however, have not kept pace with the trend toward returning people with disabilities to the work place: Fewer than 1 percent of DI beneficiaries, and few SSI beneficiaries, leave the rolls to return to work each year. Yet, even relatively small improvements in return-to-work outcomes offer the potential for significant savings in program outlays. For example, if an additional 1 percent of the 6.6 million working-age SSI and DI beneficiaries were to leave SSA's dis-

ability rolls by returning to work, lifetime cash benefits would be reduced by an estimated $3 billion.[1]

Because the current structure of DI and SSI does not encourage return to work, many proposals are being discussed to address this problem. Over the past few years, we have issued a series of reports that have recommended that SSA place much greater priority on helping DI and SSI beneficiaries maximize their work potential—whether part- or full-time—and we continue to urge SSA to act expeditiously in developing an integrated and comprehensive strategy to do so. Our work has demonstrated that SSA's success in redesigning the disability programs is likely to require a multifaceted approach, including earlier intervention, providing return-to-work supports and assistance, and structuring benefits to encourage work.

At the same time, we recognize the dearth of empirical analysis with which to predict outcomes of possible interventions. In particular, because measures of work responses to changes in work incentives and other return-to-work measures are unknown, any estimates of the net effect on caseloads and taxpayer costs are likely to involve a high degree of uncertainty. Moreover, our analysis of some of the proposed changes to the work incentives illustrates the difficult trade-offs that will be involved in any attempt to change the work incentives. With this in mind, today, I would like to discuss the challenges and trade-offs faced in redesigning the disability programs. We strongly encourage testing and evaluating alternatives to determine what strategies can best tap the work potential of beneficiaries without jeopardizing the availability of benefits for those who cannot work. My testimony is based on our published reports and prior testimonies and our recent analysis of work incentives conducted for Representative Kennelly. (A list of related GAO products appears at the end of this statement.)

BACKGROUND

DI and SSI—the two largest federal programs providing cash and medical assistance to people with disabilities—have grown rapidly between 1985 and 1995, with the size of the working-age beneficiary population increasing from 4.0 to 6.6 million. Administered by SSA and state disability determination service (DDS) offices, DI and SSI paid cash benefits approaching $60 billion in 1995. 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.

Established in 1956, DI is an insurance program funded by Social Security payroll taxes. The program is for workers who, having worked long enough and recently enough to become insured under DI, have lost their ability to work—and, hence, their income—because of disability. Medicare coverage is provided to DI beneficiaries after they have received cash benefits for 24 months. About 4.2 million working-age people (aged 18 to 64) received about $36.6 billion in DI cash benefits in 1995.[2]

In contrast, SSI is a means-tested income assistance program for disabled, blind, or aged individuals regardless of their prior participation in the labor force.[3] Established in 1972 for individuals with low income and limited resources, SSI is financed from general revenues. In most states, SSI entitlement ensures an individual's eligibility for Medicaid benefits.[4] In 1995, about 2.4 million working-age people with dis-

[1] The estimated reductions are based on fiscal year 1995 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. These reductions, however, would be offset, at least in part, by rehabilitation and other costs that might be necessary to return to a person with disabilities.

[2] Included among the 4.2 million DI beneficiaries are about 694,000 beneficiaries who were dually eligible for SSI disability benefits because of the low level of their income and resources.

[3] References to the SSI program throughout the remainder of this testimony address blind or disabled, not aged, recipients.

[4] States can opt to use the financial standards and definitions for disability they had in effect in Jauary 1972 to determine Medicaid eligibility for their aged, blind, and disabled residents, rather than making all SSI recipients automatically eligible for Medicaid. Often, the Medicaid financial standards used by states are more restrictive than SSI's.

abilities received SSI benefits; federal SSI cash benefits paid to these and other beneficiaries amounted to $20.6 billion.[5]

The Social Security Act states that people applying for disability benefits should be promptly referred to state vocational rehabilitation (VR) agencies for services in order to maximize the number of such individuals who can return to productive activity.[6] Furthermore, to reduce the risk a beneficiary faces in trading guaranteed monthly income and subsidized health coverage for the uncertainties of employment, the Congress has established various work incentives intended to safeguard cash and health benefits while a beneficiary tries to return to work.

CURRENT PROGRAM STRUCTURE DOES NOT ENCOURAGE WORK

In a series of reports, we have discussed how the DI and SSI programs' design and operational weaknesses do not encourage beneficiaries to maximize their work potential.[7] The lengthy disability determination process, which presumes that certain medical impairments preclude employment, requires applicants to emphasize their work incapacities. To address the erosion in motivation to work that could result from applying for benefits, we have recommended that SSA develop strategies to intervene earlier in the application process. For example, before awarding benefits, SSA could help applicants assess their work capacity and, in turn, their ability to maintain economic independence or delay their application for benefits. This would likely involve SSA's collaboration with other federal agencies, such as the Departments of Labor and Education. Significant savings could be achieved by reducing the need for people with disabilities to rely on DI and SSI. Although full-time work may not be achievable, even part-time work could reduce their reliance on benefits.

Regarding those people currently on the rolls, we have also reported that SSA has done little to promote return-to-work measures, such as VR and economic incentives to work. VR services include, for example, guidance, counseling, and job training and placement. VR can help beneficiaries return to work by improving their skills and making them more marketable and competitive. A beneficiary who engages in work encounters additional challenges, however. By returning to work, a beneficiary trades guaranteed monthly income and premium-free medical coverage for the uncertainties of employment. Work incentives, such as access to medical coverage or retention of a portion of their cash benefits while working, are intended to encourage beneficiaries to return to work—and, possibly, leave the rolls—by making work more financially attractive.

In the last couple of years, numerous changes to the work incentives and to the delivery of and payment for VR services have been proposed in legislation and by various interest groups. Most recently, SSA has proposed a VR system emphasizing provider choice. Beneficiaries would get a voucher, usually referred to as a "ticket," which they could use to obtain services from public or private VR providers and which would be reimbursed on the basis of outcomes. In our March 1997 report, we advocated the critical importance of testing and evaluating new measures to return beneficiaries to work. We also cautioned against focusing on one option to the exclusion of alternative measures. We noted, for example, that if SSA tests only one type of VR service delivery system, the agency will forgo the opportunity to compare the results of the proposed outcome-based payment system with those of alternative plans, such as combining outcome-based payments with reimbursements to providers on the basis of milestones reached before the beneficiary leaves the rolls.

In addition, others have proposed changes to financial incentives, including making DI similar to SSI by reducing benefits $1 for every $2 in earnings and revising the deduction of impairment-related expenses. New tax incentives have also been proposed, including tax credits to individuals—making work more financially attractive—and tax credits to employers—encouraging them to hire people with disabilities. Proposed changes to medical benefits include extending premium-free Medicare coverage, scaling Medicare buy-in premiums to earnings, expanding Medicare and Medicaid eligibility, and creating a Medicaid buy-in.

---

[5] The 2.4 million SSI beneficiaries do not include individuals who were dually eligible for SSI and DI benefits. The $20.6 billion represents payments to all SSI blind and disabled beneficiaries regardless of age.

[6] State VR agencies also provide rehabilitation services to people not involved with the DI and SSI programs.

[7] *SSA Disability: Program Redesign Necessary to Encourage Return to Work* (GAO/HEHS–96–62, Apr. 25, 1996); *SSA Disablity: Return-to-Work Strategies From Other Systems May Improve Federal Programs* (GAO/HEHS–96–133, July 11, 1996); and *Social Security: Disability Programs Lag in Promoting Return to Work* (GAO/HEHS–97–46, Mar. 17, 1997).

Our work has called for SSA to develop a comprehensive, integrated return-to-work strategy that includes (1) intervening earlier, (2) providing return-to-work supports and assistance, and (3) structuring benefits to encourage work. SSA has agreed that compelling reasons exist to try new return-to-work approaches and, as mentioned, has proposed the creation of a VR ticket to expand beneficiaries' access to VR providers. We believe a successful strategy would incorporate all three components, working in concert, and that beneficiaries are likely to return to work only if it is financially advantageous for them to do so. The remainder of this testimony focuses on the work incentives, the proposed changes to them, and the difficulties and trade-offs involved in their reform.

DI AND SSI WORK INCENTIVES PROVIDE DIFFERENT BENEFIT PROTECTIONS

The work incentive provisions of the two programs differ significantly, providing very different levels of benefit protection for DI and SSI beneficiaries. One significant difference is that a DI beneficiary's cash benefit stops completely after a period of time, if earnings exceed a specified level, while an SSI recipient's cash benefit is gradually reduced to ease the transition back to work. The gradual reduction in SSI cash benefits yields savings to the government, even if recipients work part time. In contrast, DI beneficiaries who work yield no program savings unless they leave the rolls, because their benefits are not offset. Another difference is that a DI beneficiary can purchase Medicare coverage after premium-free coverage ends (although lower-wage earners may find it too expensive to do so), but an SSI recipient loses Medicaid and is unable to purchase further coverage once he or she exceeds a certain income level. Table 1 highlights each program's work incentive provisions.

WORK INCENTIVES ARE INSUFFICIENT AND DIFFICULT TO UNDERSTAND

Despite providing some financial protection for those who want to work, the DI work incentives do not appear to be sufficient to overcome the prospect of a drop in income for those facing low-wage work. Moreover, the work incentives do not allay DI or SSI beneficiaries' fear of losing medical or other benefits, which could accompany return to work. In addition, the current package of work incentive provisions is complex and difficult to understand, which further discourages work effort. This difficulty in understanding the work incentives is heightened for the 694,000 beneficiaries (11 percent of the beneficiary population) who are dually eligible for DI and SSI. For these concurrent beneficiaries, SSI work incentive provisions apply to the SSI portion of their cash benefit and DI provisions apply to the DI portion of their cash benefit. This adds administrative complexities to the system because earnings must be reported to both programs, each of which has its own reporting requirements and processes. Because SSA does not promote the work incentives extensively, few beneficiaries are even aware that these provisions exist.

WORK INCENTIVES ILLUSTRATE DIFFICULT TRADE-OFFS IN DISABILITY REFORM

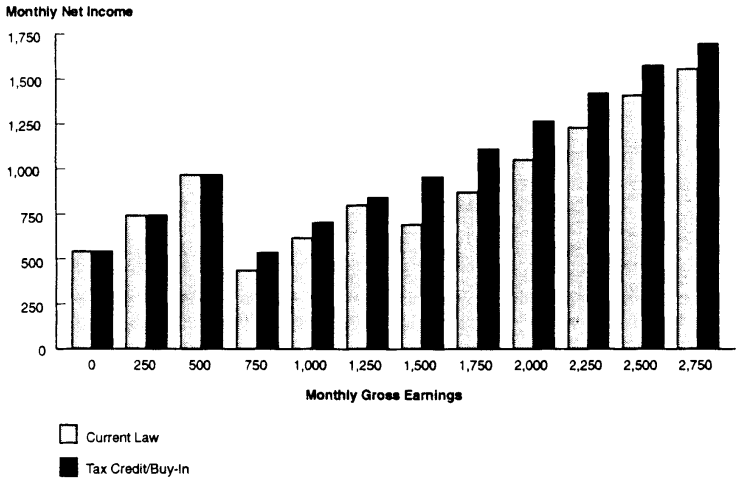
Some work incentive changes may help some beneficiaries, or some groups of beneficiaries, more than others. Data from Virginia Commonwealth University's Employment Support Institute illustrate this point.[8] For example, figure 1 shows that under current law, a DI beneficiary's net income may drop at two points, even as gross earnings increase. The first "income cliff" occurs when a person loses all of his or her cash benefits because countable earnings are above $500 a month and the trial work and grace periods have ended. A second income cliff may occur if Medicare is purchased when premium-free Medicare benefits are exhausted. Figure 1 also illustrates what happens to net income when a tax credit is combined with a Medicare buy-in that scales premiums to earnings. In this particular example, although the tax credit may cushion the impact of the drop in net income caused by loss of benefits, it does not eliminate the entire drop. However, as figure 2 shows, this income cliff is eliminated when benefits are reduced $1 for every $2 of earnings above SGA.

[8] The Employment Support Institute at Virginia Commonwealth University developed WorkWORLD software, which allows one to compare what happens to an individual's net income (defined as an individual's gross income plus noncash subsidies minus taxes and medical and work expenses) as earnings levels change under current law and when work incentives are changed.

Table 1: Highlights of DI and SSI Work Incentive Provisions

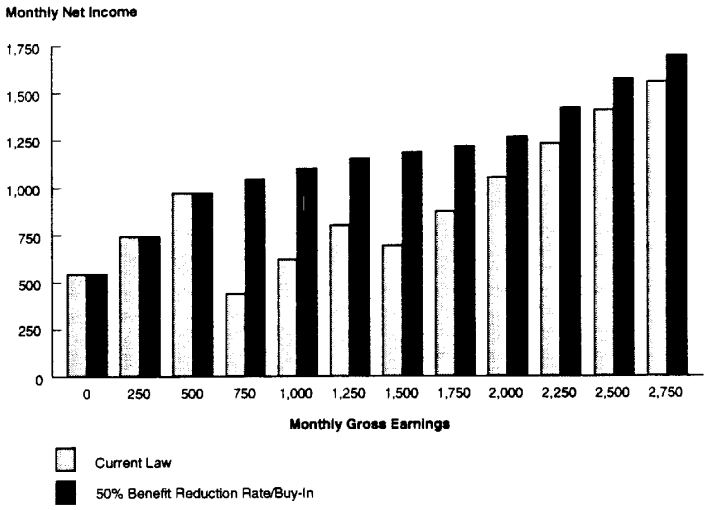
Program	Provision
Income safeguards	
DI	*Trial work period*: Allows beneficiaries to work for 9 months (not necessarily consecutively) within a 60-month rolling period during which they may earn any amount without affecting benefits. After the trial work period, cash benefits continue for 3 months and then stop if countable earnings are greater than $500 a month.
	Extended period of eligibility: Allows for a consecutive 36-month period after the trial work period in which cash benefits are reinstated for any month countable earnings are $500 or less. This period begins the month following the end of the trial work period.
SSI	*Earned income exclusion*: Allows recipients to exclude more than half of earned income when determining the SSI payment amount.
	Section 1619 (a): Allows recipients to continue to receive SSI cash payments even when earnings exceed $500 a month. However, as earnings increase the payment decreases.
	Plan for Achieving Self-Support (PASS): Allows recipients to exclude from their SSI eligibility and benefit calculation any income or resources used to achieve a work goal.
DI and SSI	*Impairment-related work expenses*: Allows the costs of certain impairment-related items and services needed to work to be deducted from gross earnings in figuring substantial gainful activity (SGA) and the cash payment amount. For example, attendant care services received in the work setting are deductible, while nonwork-related attendant care services performed at home are not.
	Subsidies: Allows the value of the support a person receives on the job to be deducted from earnings to determine SGA.
Medical coverage safeguards	
DI	*Continued Medicare coverage*: Allows for continued Medicare coverage for at least 39 months following a trial work period as long as medical disability continues.
	Medicare buy-in: Allows beneficiaries to purchase Medicare coverage after the 39-month premium-free coverage ends. Beneficiaries pay the same monthly cost as uninsured retired beneficiaries pay.
SSI	*Section 1619 (b)*: Allows recipients to continue receiving Medicaid coverage when earnings become too high to allow a cash benefit. Coverage continues until earnings reach a threshold amount, which varies in every state.
Eligibility safeguards	
DI	*Reentitlement to cash benefits and Medicare*: After a period of disability ends, allows beneficiaries who become disabled again within 5 years (7 years for widow(ers) and disabled adult children) to be reentitled to cash and medical benefits without another 5-month waiting period.
SSI	*Property essential to self-support*: Allows recipients to exclude from consideration in determining SSI eligibility the value of property that is used in a trade or business or for work. Examples include the value of tools or equipment.
DI and SSI	*Continued benefit while in an approved VR program*: Allows a person actively participating in a VR program to remain eligible for cash and medical benefits even if he or she medically improves and is no longer considered disabled by SSA.

Figure 1: Comparison of Net Income for DI Beneficiaries Under Current Law and Under Proposed Tax Credit and Sliding Scale Medicare Buy-In



Source: Employment Support Institute, Virginia Commonwealth University.

Figure 2: Comparison of Net Income for DI Beneficiaries Under Current Law and Under Proposed 50-Percent Benefit Reduction Rate and Sliding Scale Medicare Buy-In



Source: Employment Support Institute, Virginia Commonwealth University.

NET EFFECT OF PROPOSALS ON WORK EFFORT AND PROGRAM COSTS IS UNKNOWN

Because there are complex interactions between earnings and benefits, changing the work incentives may or may not increase the work effort of current beneficiaries, depending on their behavior in response to the type of change and their capacity for work and earnings. But, even if the changes in the work incentives increase the work effort of the current beneficiaries, a net increase in work effort may not be achieved. This point is emphasized by economists who have noted that improving the work incentives may make the program attractive to those not currently in it.[9] Allowing people to keep more of their earnings would make the program more generous and could cause people who are currently not in the program to enter it. Such an entry effect could reduce overall work effort because those individuals not in the program could reduce their work effort in order to become eligible for benefits. Moreover, improving the work incentives could also keep some in the program who might otherwise have left. Allowing people to keep more of their earnings would also mean that they would not leave the program, as they once did, for a given level of earnings. Such a decrease in this exit rate could reduce overall work effort because people on the disability rolls tend to work less than people off the rolls. The extent to which increased entry occurs and decreased exit occurs will affect how expensive these changes could be in terms of program costs.

However, determining the effectiveness of any of these proposed policies in increasing work effort and reducing caseloads requires that major gaps in research be filled. The economists considered entry and exit effects in their analysis by using economic theory and numerical simulations of how net income (earnings plus benefits plus earnings subsidies) is affected when individuals work for different numbers of hours at different wage rates. But the economists were not able to simulate changes in work effort in response to program changes because that would require information that is not currently available from the literature. Such information would measure how beneficiaries' work efforts change in response to changes in income, including the value of noncash benefits, resulting from program changes.

The costs of the proposed reforms are difficult to estimate with certainty because of the lack of information on entry and exit effects. SSA has tried to account for potential entry and exit effects when estimating the cost of various proposed reforms. But the agency has noted that such estimates are subject to significant uncertainty because of the lack of information on changes in work effort.

Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or the other Subcommittee Members may have.

RELATED GAO PRODUCTS

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

People With Disabilities: Federal Programs Could Work Together More Efficiently to Promote Employment (GAO/HEHS–96–126, Sept. 3, 1996).

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

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

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

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

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).

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

[9] See Hillary 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*, edited by Jerry L. Mashaw, Virginia Reno, Richard V. Burkhauser, and Monroe Berkowitz (Kalamazoo, Michigan: W.E. Upjohn Institute for Employment Research, 1996) and Hillary Williamson Hoynes and Robert Moffitt, "Tax Rates and Work Incentives in the Social Security Disability Insurance Program: Current Law and Alternative Reforms," May 1997, unpublished.

Chairman BUNNING. Thank you very much.
Dr. Growick.

STATEMENT OF BRUCE GROWICK, PH.D., ASSOCIATE PROFESSOR, REHABILITATION SERVICES PROGRAM, COLLEGE OF EDUCATION, OHIO STATE UNIVERSITY

Mr. GROWICK. Thank you. It is a pleasure to be here to present before your Subcommittee.

My name is Bruce Growick, associate professor in the College of Education at Ohio State University, where I teach classes, conduct research and advise students in the discipline of rehabilitation counseling. I am also a past president and an active member of the National Association of Rehabilitation Professionals in the Private Sector. On a part-time basis, I am also a vocational expert for the Social Security Administration, and I partake in a daily decision-making process of deciding who is disabled and who is not.

Chairman BUNNING. Are you a Buckeye fan though?

Mr. GROWICK. Of course. Ranked number 2 last year, of course.

The training program at Ohio State has graduated over 120 students at both the doctoral and master's level since I have been there, and Ohio State is only 1 of 70 to 80 rehabilitation training programs nationally. An interesting trend has emerged over the last few years. More and more of our graduates are obtaining employment in the private sector of rehabilitation, rather than the public sector, rather than the State and Federal rehabilitation system. Many graduates are employed by private, nonprofit and for-profit agencies and companies, helping individuals with disabilities either enter or return to employment. Most of these entities in the private sector counsel individuals who are covered by personal injury, workers' compensation or Social Security insurance.

In the area of private sector rehabilitation, counselors who can help people obtain work are valuable because they remove an outstanding portion of liabilities that are covered by the insurance policy. The insurance industry has discovered it is cheaper and better to help beneficiaries return to work than it is to pay off a claim. This is especially true in workers' compensation where employers are clearly liable for wages lost by individuals who are injured on the job.

Many of our graduates prefer this kind of work in the private sector because they are unencumbered by unnecessary paperwork. They often feel they can help people quicker and more easily, and their beginning salary is higher.

In contrast to the public sector of rehabilitation, the world of private sector rehabilitation is relatively new, but has been growing rapidly over the last several years. As with most services starting in the public sector, like health care and education, rehabilitation has seen a transformation from the monopolistic domination of the public sector to the healthy addition of the private sector and competition. Nothing improves on the delivery of a service or development of a product like competition, and the United States is a com-

petitive society, and policies that spur competition are clearly healthy and good.

During a 2-year leave of absence from Ohio State, I also had the opportunity and honor of being director of the rehabilitation division of the Bureau of Workers' Compensation. That bureau is quite similar to the State/Federal rehabilitation system.

Ohio, under Governor Voinovich, has undergone a transformation over the last couple years in moving rehabilitation services from the public sector to the private sector, and an analogy may be appropriate here that the State/Federal system of rehabilitation services might be more efficient and effective if it were not the sole provider of rehabilitation services to the beneficiaries of Social Security.

A critical component of any new legislation should be provisions for informed choice throughout the rehabilitation process. In addition to consumers having the right to select an employment goal and their choice and services; they should no longer be limited to just a State/Federal rehabilitation system. Individual choice, by competition, simply increases involvement in the quality of services provided. The Social Security Subcommittee should codify the need for and value of allowing private sector rehabilitation professionals to compete in the area of rehabilitating Americans with disabilities, based on cost, quality, and outcome.

There have been many successful cooperative partnerships between State governments, Federal Governments and the private sector in the areas of welfare, workers' compensation and unemployment. The role of government should be to assist and encourage persons with disabilities toward employment, but by the same token, the system should include the private sector as an expanded and successfully proven option. A good mechanism for referral of Social Security beneficiaries to the private sector needs to be developed as soon as possible.

In conclusion, I would like to say more and more of my students have been taking advantages of the benefits of employment and private sector rehabilitation. Now it is time to give Social Security beneficiaries the same choice. The private sector has a proven history of providing cost-effective and successful return to work outcomes for the insurance industry, and Social Security should be the same. In fact, return on investment in private sector rehabilitation is so good that our industry continues to grow, and in private sector rehabilitation, we like to say we operate under earned dollars rather than appropriated dollars. If we are to reduce the disability rolls, we must provide true consumers with their choice, and that choice needs to include private sector rehabilitation.

Thank you, your Honor.

[The prepared statement follows:]

Statement of Bruce Growick, Ph.D., Associate Professor, Rehabilitation Services Program, College of Education, Ohio State University

Chairman Bunning and members of the Subcommittee, thank you very much for this opportunity to share with you both my professional experiences in the field of vocational rehabilitation, and my personal suggestions and recommendations for improving on the delivery of rehabilitation services in America.

My name is Bruce Growick, and I am an Associate Professor in the College of Education at The Ohio State University (OSU) where I teach classes, conduct research, and advise students in the Rehabilitation Services program. I am also a

past-president and active member of the National Association of Rehabilitation Professionals in the Private Sector (NARPPS). However, I am here today in my capacity as an Associate Professor of rehabilitation.

The training program at OSU has graduated over 120 students at both the master's and doctoral level over the last fifteen years. Many, if not most, of these graduates have obtained employment in our field, and are contributing to the rehabilitation of individuals with disabilities. In addition, we at OSU have also conducted federally-funded research on different aspects of the rehabilitation system including predictors of rehabilitation success, counselor satisfaction and performance, and the Americans with Disabilities Act.

An interesting trend has emerged over the last few years. More and more of our graduates are obtaining employment in the private-sector of rehabilitation rather than the public-sector. Many of our graduates are now employed by private, nonprofit and for-profit, agencies and companies helping individuals with disabilities either enter or return to employment. Most of these entities in the private-sector counsel individuals who are covered by personal injury, workers' compensation, and/or Social Security insurance. In the area of private-sector rehabilitation, counselors who can help individuals obtain work are valuable because they remove an outstanding portion of the liability that is covered by the insurance policy. The insurance industry has discovered that it is cheaper and better to help their beneficiaries return to work than it is to pay off a claim. This is especially true in workers' compensation cases where employers are clearly liable for wages lost by individuals who are injured on the job.

Many of our graduates prefer this kind of work because, unlike the public state/federal rehabilitation system, they are unencumbered by unnecessary paperwork, they often feel they can help people quicker and more easily, and their salary is higher. In contrast to the public-sector, the world of private-sector rehabilitation is relatively new, but has been growing tremendously over the last ten years. As with most services which start in the public-sector like health care and education, the field of rehabilitation has seen a transformation from the monopolistic domination of the public-sector to the healthy addition of the private-sector and competition. Nothing improves on the delivery of a service or the development of a product like competition. The United States is a competitive society and policies that spur competition are healthy and good.

During a two-year leave of absence from The Ohio State University (1989–1990), I also had the honor of being the Director of Rehabilitation for the Ohio Bureau of Workers' Compensation. As Director, I had responsibility for twelve field offices located throughout the State of Ohio, two rehabilitation Centers (Columbus and Cleveland), and over 400 employees with an annual budget of $48 million dollars. During 1990, the Rehabilitation Division of the Ohio Bureau of Workers' Compensation returned to work over two thousand injured workers. Ohio is somewhat unique in that it offers industrial rehabilitation services directly to injured workers by a separate state agency. As you can see, this agency is quite similar to the public rehabilitation system.

Over the last five years in Ohio, more and more of the delivery of industrial rehabilitation services have been provided by the private-sector. Our state agency is no longer both the regulator and the sole provider of rehabilitation services. An analogy may be appropriate here that the state/federal system of rehabilitation services might be more efficient and effective if it were not the sole provider of services to beneficiaries of Social Security. A critical component of any new legislation should be provisions for informed choice throughout the rehabilitation process. In addition to consumers having the right to select an employment goal, and a choice in services needed to reach their goal, consumers should be able to choose from whom they would like to receive services, no longer being limited to just state Vocational Rehabilitation agencies. Individual choice simply increases involvement and the quality of services provided. The Social Security Subcommittee should codify the need for and value of allowing the private-sector to compete in the area of rehabilitating Americans with disabilities based on cost, quality, and outcome.

Changes are necessary in the way in which beneficiaries of Social Security can receive rehabilitation services and return to work. The current climate represents a historic opportunity to instill needed change into a system that has, to date, been inefficient and insufficient in its provision of vocational rehabilitation to persons with disabilities. A recent GAO study documented the unacceptable return to work rate of the state/federal system. In contrast, the private-sector has a proven history of providing cost-effective and successful return to work outcomes within the insurance industry. In fact, the private sector continues to exist and prosper specifically because of its ability to return individuals with disabling conditions to gainful employment for a sustained period of time and resolve outstanding liabilities.

There have also been many successful cooperative partnerships between state governments and the private sector in the areas of welfare, workers' compensation, unemployment, etc. The role of government should be to assist and encourage persons with disabilities towards employment, but by the same token, the system should include the private sector as an expanded and successfully proven option. A good mechanism for the referral of SSA beneficiaries to the private sector needs to be developed as soon as possible.

In conclusion, more of my students have been taking advantage of the benefits of the private-sector. Now it is time to give SSA beneficiaries that same choice. The private sector has a long and proven history of providing cost effective and successful return-to-work outcomes within the insurance industry. In fact, return on investment in private-sector rehabilitation is so good that our industry continues to grow. In the private-sector, rehabilitation providers operate under earned dollars, not appropriated dollars. If we are to reduce the disability rolls than we must provide true consumer choice for SSA beneficiaries, and that choice needs to include private-sector rehabilitation services.

I respectfully offer the following five recommendations as you consider new legislation in this area:

- Reduce the disincentives for return-to-work for SSA beneficiaries by providing a means to continue medical coverage upon return to work.
- Include choice of the private-sector for return-to-work services with a payment model for providers that is viable and realistic.
- Avoid increasing the work load of SSA; this new return-to-work system should be as streamlined and efficient as possible.
- Develop an incentive for employers to hire SSA beneficiaries, such as a FICA Tax Credit.
- And that you and your staff feel free to call on me as a valuable tool in your efforts to improve the state/federal vocational rehabilitation system.

Again, Mr. Chairman, thank you for the opportunity to present today before the Subcommittee, and I am happy to answer any questions that the Subcommittee might have.

Chairman BUNNING. Thank you very much.

Dr. Berkowitz.

STATEMENT OF MONROE BERKOWITZ, PROFESSOR OF ECONOMICS EMERITUS, RUTGERS UNIVERSITY, NEW BRUNSWICK, NEW JERSEY; ACCOMPANIED BY VIRGINIA P. RENO, DIRECTOR OF RESEARCH, NATIONAL ACADEMY OF SOCIAL INSURANCE

Mr. BERKOWITZ. With your permission, may I ask for Ms. Reno from the National Academy of Social Insurance to say a word of introduction?

Chairman BUNNING. Without objection. Go right ahead, Ms. Reno.

Ms. RENO. Thank you, Mr. Chairman. We commend you and Mrs. Kennelly on the leadership you have given in this very important area of return to work and barriers to work. Our academy completed a study recently that we began over 3 years ago to look at the Social Security Program and barriers to work. Our expert panel came out with both findings and recommendations. Professor Berkowitz was a member of the panel, and he will speak about our most innovative recommendation.

In brief, when the panel looked at the Social Security Program in comparison with private disability insurance and with foreign disability programs, it had several findings. First, the test of disability in these programs is among the strictest found anywhere. Second, by these comparisons, the benefits are modest. The benefits

alone are not a strong deterrent to work, in the panel's view, but lack of health care coverage can be.

The panel had five recommendations: First, a better Medicare buy-in for those who return to work, and similar provisions in Medicaid; second, a tax credit to make work pay; third, better implementation of existing work incentives to get the best we can out of current law; fourth, a personal assistance tax credit for people with extraordinary work expenses; and finally, a return to work ticket.

Professor Berkowitz designed the Ticket Proposal, and he is an expert on the thinking behind it. It rests on a few very simple ideas of consumer choice, innovation through voluntary market-based arrangements, and, finally, paying for the result you want, which, out of Social Security funds, means the person back at work and off the Social Security rolls.

[The prepared statement follows:]

Statement of Virginia P. Reno, Director of Research, National Academy of Social Insurance

Mr. Chairman, we commend you and Representative Kennelly for your leadership on the important issue of Social Security and return to work. We appreciate the opportunity to report to you on key findings and recommendations of the Academy's Disability Policy Panel. With me today is Monroe Berkowitz, Professor of Economics, Emeritus of Rutgers University who served on the Panel.

I will briefly summarize the Panel's findings and recommendations. Professor Berkowitz will spend most of our time discussing the return-to-work ticket proposal. Summaries of the Panel's report, Balancing Security and Opportunity: The Challenge of Disability Income Policy, are available here today.

The Academy is a nonprofit, nonpartisan organization made up of many of the Nation's leading scholars on social insurance. Its purpose is to promote research and to be a forum for exchange of new ideas in social insurance.

The Academy convened a panel of 18 of the Nation's leading experts on varied aspects of disability policy to conduct its analysis. The list of panel members is on page 2.

The findings and recommendations we are presenting 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 legislation.[1]

[1] The Disability Policy Panel's work was funded from private sources—The Pew Charitable Trusts, the Robert Wood Foundation, and by corporate members of the Health Insurance Association of America that offer long term disability insurance. It also received an in-kind contribution from the Social Security Administration in the loan of an employee under an Intergovernmental Personnel Act (IPA) assignment.

THE DISABILITY POLICY PANEL, NATIONAL ACADEMY OF SOCIAL INSURANCE

Jerry L. Mashaw, Chair, Sterling Professor of Law, Institute of Social and Policy Studies, Yale University Law School, New Haven, CT
Monroe Berkowitz, Professor of Economics, Emeritus, Rutgers University, New Brunswick, NJ
Richard V. Burkhauser, Director, Center for Policy Research, Maxwell School, Syracuse University, Syracuse, NY
Gerben DeJong, Director, National Rehabilitation Hospital-Research Center, Washington, D.C.
James N. Ellenberger, Assistant Director, Department of Occupational Safety and Health, AFL–CIO, Washington, D.C.
Lex Frieden, Senior Vice President, The Institute for Rehabilitation and Research, Houston, TX
Howard H. Goldman, M.D., Professor of Psychiatry, University of Maryland School of Medicine, Baltimore, MD
Arthur E. Hess, Consultant, Former Deputy Commissioner of Social Security, Charlottesville, VA
Thomas C. Joe, Director, Center for the Study of Social Policy, Washington, D.C.
Mitchell P. LaPlante, Associate Adjunct Professor, Institute for Health and Aging, University of California, San Francisco
Douglas A. Martin, Special Assistant to the Chancellor, University of California, Los Angeles
David Mechanic, Director, Institute for Health, Health Care Policy and Aging Research, Rutgers University, New Brunswick, NJ
Patricia M. Owens, President, Integrated Disability Management UNUM America, Brooklyn, NY
James M. Perrin, M.D., Associate Professor of Pediatrics, Harvard Medical School, Massachusetts General Hospital, Boston, MA
Donald L. Shumway, Co-director, RWJ Project on Developmental Disabilities, Institute on Disabilities, University of New Hampshire, Concord, NH
Susan S. Suter, President, World Institute on Disability, Oakland, CA
Eileen P. Sweeney, Director of Government Affairs, Children's Defense Fund, Washington, D.C.
Jerry Thomas, President, National Council of Disability Determination Directors, Decatur, GA

The Panel was asked to answer to three basic questions.

(1) Do disability cash benefits provide a strong deterrent to work?

(2) Can an emphasis on rehabilitation be built into the Social Security disability insurance (DI) program without greatly expanding costs or weakening the right to benefits?

(3) Are there ways to restructure disability income policy to better promote work?

The short answers are no, yes, and yes. The reasons for these answers and the Panel's recommendations follow.

BENEFITS AND WORK

First, the Panel concluded that current benefits are not a strong deterrent to work.[2] That conclusion is based on the Panel's review of the strict and frugal design of the DI and Supplemental Security Income (SSI) programs, the attributes of beneficiaries, and a comparison of U.S. disability spending with that in other Western countries.

The strict and frugal design of DI and SSI is evident in three ways: First, the test of disability is among the strictest used in any disability program in the United States, public or private. And it is stricter than in most European countries.

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. Virtually all private systems, and most foreign systems, assure short-term benefits before long-term benefits are paid. And virtually all are accompanied by secure health care coverage before and after disability.

Third, the benefits are modest. Replacement rates in DI are lower than those provided by U.S. private disability insurance or in the public systems in other countries. Those systems typically pay between 50 and 70 percent replacement rates. DI in contrast, pays replacement rates ranging from 43 percent for a person earning

[2] In reading this conclusion,t he Panel recognized that any income support can, to some degree, be viewed as a work disincentive. This is because the purpose of income support is to provideincome to substitute for earnings when that is warranted.

$25,000 to about 26 percent for one earning $60,000.[3] At lower earnings levels, say $15,000, benefits replace half the worker's prior earnings, but are nonetheless below the poverty threshold.

The modest replacement rates from Social Security reflect an expectation that benefits will be supplemented by pensions or savings. When compared with retirees, disabled workers had lower incomes and less often had pensions, insurance or savings to supplement their Social Security. Their vastly smaller asset holdings is particularly striking. Their modest savings no doubt reflect the fact that disability occurs unexpectedly, before they have completed saving for retirement; and the unexpected costs of disability eroded their savings.

SSI benefits are more modest. They are paid subject to the same strict test of disability and a strict test of means. In 1997, the maximum federal SSI benefit is $484 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 the Panel compared U.S. disability spending with that in other countries, it found that U.S. spending is 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 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.

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

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, 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 among the entire working-aged population and among those with disabilities. Between 1988 and 1993, the number of persons with work disabilities who lacked health coverage from either private insurance or public programs grew from 2.3 million to 2.9 million.[4]

The Panel recommended a way to make Medicare coverage more affordable and secure for DI beneficiaries who leave the rolls because of work. It also urged States to adopt similar arrangements in their Medicaid programs.

RETURN TO WORK TICKETS

On the question of linking beneficiaries with rehabilitation services, the Panel recommended a radical new approach. Beneficiaries would receive a return to work (RTW) ticket, that they could use to shop among providers of rehabilitation or RTW services in either the public or private sector. Once a beneficiary deposited the ticket with a service provider, the Social Security Administration would have an obligation to pay the provider, but only after the beneficiary returned to work and left the benefit rolls. A provider whose client successfully returned to work would, each year, receive in payment a fraction of the benefit savings that accrue to the Social Security trust funds because their customer—the former beneficiary—is at work and not receiving benefits.

This market approach rests on a few basic principles:

• Beneficiary choice. For the market approach to work, the beneficiary's choice to use the ticket has to be voluntary. And the provider's choice to accept the ticket has to be voluntary.

---

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

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

• Innovation. Beneficiaries and providers would decide on a case-by-case basis, the approach that will work to get the desired result.

• Paying for the result you want—beneficiaries in long-term jobs and off the benefit rolls.

The Panel concluded that each of these principles is essential to the overall effectiveness of the proposal. And, with these features, it can be effectively administered by the Social Security Administration. To deviate from these basic principles—choice, innovation and paying for results—means a much greater role of government in decisions that the Panel believes are most effectively made directly between customers and providers. If choices are not made voluntarily, the government inevitably must be involved in deciding who is obligated to do what for whom; who has "good cause" for not doing what the other party wants; and so forth. Professor Berkowitz will elaborate on the Return-to-Work ticket developed by the Panel.

OTHER POLICIES TO PROMOTE WORK

In response to the question about changes in cash benefit policies that would promote work the Panel recommended a wage subsidy, 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) the Panel recommended would be separate from the Social Security system. It would be paid to low-income persons, not because they are unable to work, but because they work despite their impairments. Patterned after the 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. It is designed for three groups in particular.

• Older workers who experience a decline in hours of work or wage rates due to progressive impairments.

• Young people with developmental disabilities who are entering the work force for the first time.

• People who leave the DI or SSI rolls because they return to work. The wage subsidy would ease the income "cliff" that DI beneficiaries now face.

Personal Assistance Tax Credit.

The Panel recommended 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 people who require personal assistance services are able to work in the competitive labor market. But they face a dilemma. If they work successfully, their income may disqualify them from receiving publicly-financed services, yet they do not earn enough to pay for the services on their own. The Panel recommended a tax credit to compensate working people for part of the cost of personal assistance services people need and pay for in order to work.

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 recommends. They would need to understand the rules and consider it part of their job to assist their clients in complying with them.

• Some tasks can only be performed by the Social Security Administration or an entity it employs. These include prompt processing of earnings reports so that benefits are adjusted promptly as beneficiaries' circumstances change. If return to work is a priority, personnel and systems support for these functions are essential.

CONCLUSIONS

In closing, I want to the emphasize two themes of the Panel's report. First, many of the barriers to employment for persons with disabilities lie outside cash benefit programs. Consequently, many of the promising interventions also lie outside of

cash these programs—in health care, the structure of jobs, education and training. The Panel focused its recommendations only on federal benefit and tax policy.

Finally, as indicated in the title of their report, Balancing Security and Opportunity, the Panel concluded that disability income policy must strive for balance—between providing secure and dignified income benefits to benefits to those who are unable to work, on the one hand, while providing realistic opportunities and supports for those who have the capacity to work, on the other. In the final analysis, our nation's disability policies will be judged by how well they achieve this balance.

Ms. RENO. Professor Berkowitz.

Mr. BERKOWITZ. Let me just say that the views I express here are mine and not necessarily endorsed by the panel, and certainly not by the Social Security Administration.

I would heartily endorse a simple return to work program for persons on Social Security rolls for the following reasons: First, the system is broke, and if it is broke, it needs fixing. Once on the rolls, people leave only as they die or they transfer to the old-age system, and we have already had testimony about the number, the pitifully small number of people that go to work.

Second, persons on the roll are a diverse lot. Some are mature persons with work experience who can no longer carry on. Others have never worked and are now preparing themselves for a life of benefits. This heterogeneous population needs a variety of services, and it clearly is not a case of one size fits all.

Third, how we can get more people back to work. This is the narrow issue with which we are concerned. I don't want to reform the system, I don't want to make things better for everyone. I want to find a way to get people off disability rolls and back at good competitive jobs. The Social Security Administration can't do the job. We made that decision way back in 1956. We decided that the SSA ought not get into the rehabilitation business. The joint Federal/State Vocational Rehabilitation Program is doing a fine job addressing the priorities Congress assigned to them. They may have a role to play here; they may not. They ought to be given a chance.

Fourth, we are fortunate, as Dr. Growick just said, in having in this country a thriving private sector rehabilitation industry. It is flexible and adaptive. I don't think we have gone far enough in involving the private sector providers.

How can we bring the energies of those people into this business? To go down the road of having the Social Security Administration negotiate fee schedules, utilization protocols and other rules would provide jobs for the Federal bureaucracy, but very few for persons on the disability rolls.

The conviction that there has to be a better way led to this ticket plan. Here is simplicity itself. Here is a plan that gives disabled persons a choice. People entering the rolls are issued a ticket. They need not do anything with the ticket. The system has to be voluntary. That is the essence of the plan. However, if they choose to deposit the ticket with a provider—and visualize, if you will, a whole wide variety of providers to match the variety of problems, then the ticket allows the provider to begin services.

We don't know that there is any one way to take people off the rolls and to rehabilitate them. We don't know that there is one way

to motivate people. Let 1,000 flowers bloom here, and allow a variety of providers to get into this act.

Once deposited with a provider, the ticket becomes a contract with the Social Security Administration to pay the provider a percentage of the benefits that would have been paid once the person goes back to work and off the rolls. Nothing gets paid until the beneficiary is back at work, and then only after savings are realized.

We debated this proposal for many, many sessions, and all kinds of issues arise. I do not have the time to get into them. But let me conclude by noting that although there are many details, the essence of the plan is contained in two essential principles. The plan must be voluntary. Years of experience in workers' compensation in this and other countries in the world convinces me a compulsory plan will not work.

Second, all risks must be borne by the provider. If we pay for milestones, we will get milestones. We will get what we pay for. Milestones are not what we want. We want return to work, and that is what we ought to pay for.

Pick up any newspaper and look at the ads for lawyers who want to get people on the rolls. They receive no interim payments, they do not get paid for milestones. They are on a contingency-fee basis. It is the one part of Social Security that works, unfortunate though that may be. Let's use the same idea and the same creativity and move people into the world of work. Thank you.

[The prepared statement follows:]

Statement of Monroe Berkowitz, Professor of Economics Emeritus, Rutgers University, New Brunswick, New Jersey

My name is Monroe Berkowitz. I am professor of economics emeritus at Rutgers University. For over four decades, I have been concerned with research in the area of economics of disability with emphasis on return to work. I am a member of the National Academy of Social Insurance and served on its Disability Panel. The views I express are my own and not necessarily endorsed by the Panel. I am most grateful for the opportunity to appear before the committee.

I heartily endorse a simple return to work program for persons on the Social Security Disability benefit rolls for the following reasons:

• The system is broke and needs fixing. Once on the rolls, persons leave only as they die or become old enough to switch to old-age benefits. Less than one half of one percent of the persons on the rolls return to work. We should be able to improve that record.

• Persons on the rolls are a diverse lot. Some are mature persons with work experience who can no longer carry on. Others are persons who have never worked and who are consigned to a life of benefits. This heterogeneous population needs a variety of services. Clearly this is not a case of one size fits all.

• How can we get more people back to work? Social Security cannot do the job. We made the decision back in 1956, that Social Security should not get into the rehabilitation business. The joint federal-state vocational rehabilitation programs are doing a fine job addressing the priorities Congress has assigned to them. They may have a role to play in returning beneficiaries to work, but it is increasingly evident that they cannot do the job alone.

• We are fortunate in having in this country a thriving industry of private sector rehabilitation providers. These are imaginative hard working people who have years of experience in helping injured workers return to the job. They can provide the flexible, adaptive type of services that can return SSA beneficiaries to work.

• How can we bring the energies and creativity of the private sector to bear on this problem? It is my judgment that Social Security cannot do a very good job of negotiating with private providers. To go down the road of negotiating fee schedules and utilization protocols is to end up providing jobs for the federal bureaucracy but not for persons on the disability rolls.

• The conviction that there has to be a better way led to the development of the ticket plan. Here is simplicity itself that takes into account the heterogeneity of persons on the rolls and that enlists the creativity and energies of providers.

—Persons entering the rolls are issued a ticket. They need not do anything with the ticket. The essence of the plan is that it is voluntary in all of its aspects.

—They may choose to deposit the ticket with a provider. Visualize a wide variety of providers. The variety of problems should be matched with a variety of providers offering a medley of approaches and services.

—Once deposited with the provider, the ticket becomes a contract between the provider and the Social Security Administration to pay the provider a percentage of the benefits that would have been paid once the person goes back to work and is off the rolls. Nothing gets paid until the beneficiary is back at work, and then only after the savings are actually realized.

• The Panel debated the ticket proposal for many sessions. I have had the advantage of discussing it before many groups of persons working for the government, persons drawn from the disability community and private and public sector providers. In the course of these discussion, I believe we have touched on each of the issues and the possible problem areas and I would be happy to discuss these if there are any questions.

Let me conclude by noting that details can differ, but the essence of the plan is contained in these essential principles.

—The plan must be voluntary. Years of experience in workers' compensation in this and other countries in the world convinces me that a compulsory plan will not work.

—All risks must be borne by the providers. If we pay for milestones, we will get milestones. That is not what we want. We want return to work and that is what we should pay for.

Pick up any newspaper and note the ads for lawyers who are soliciting clients to get them *on* the disability rolls. These lawyers are working on a contingency fee basis and no one is offering them interim payments. They get paid once the person is on the disability rolls. Why cannot we enlist that same entrepreneurial energy to get people off the rolls and back to work?

Thank you Mr. Chairman. I appreciate the opportunity to present my views on this important subject and will be happy to answer any questions.

Chairman BUNNING. Thank you for your testimony.

Mr. Kregel.

STATEMENT OF JOHN KREGEL, ED.D., RESEARCH DIRECTOR, REHABILITATION RESEARCH AND TRAINING CENTER ON SUPPORTED EMPLOYMENT, VIRGINIA COMMONWEALTH UNIVERSITY

Mr. KREGEL. It is an honor for me to be with you this morning.

The suggestions and recommendations I will share over the next few minutes are the results of research activities completed by the Rehabilitation Research and Training Center at Virginia Commonwealth University in 1995 and 1996, through the joint funding provided by NIDRR and the Social Security Administration.

As a part of this research effort, we conducted focus groups comprised of representatives of local provider agencies and completed over 300 structured telephone interviews with directors of local agencies in 40 different States. Questions focused on the agencies' perceptions of potential effectiveness of various provider incentive proposals.

I would like to briefly share with you recommendations in three areas: First, the perceived need for milestone payments; second, strategies to enhance the ability of smaller agencies to participate in the program; and third, the need for strong programmatic management structures, external to SSA.

First the need for milestone payments. While the notion of paying providers for results is logically and physically sound, in practice this approach will greatly reduce the number of agencies that will participate in the program and limit the overall size of the return to work initiative. Participation will likely be limited to large, highly capitalized agencies which receive sizable amounts of support from charitable organizations, or which are able to generate revenue through various enterprises.

Lack of milestone payments limit the participation of various categories of provider agencies, including smaller agencies, which don't have the fiscal resources to provide resources for long periods of time without some reimbursements for incurred cost, and programs in rural communities which are generally small and face additional costs associated with providing employment services in rural areas.

In addition, it should be anticipated that individuals who are either viewed as too challenging, that is, costly, to serve, or too poor a risk for meeting success criteria for the program, such as individuals with persistent mental illness or brain injuries, will have extreme difficulties locating providers willing to assist them.

Second, strategies for promoting participation of smaller agencies. Return to work programs should be designed so that payments to providers are viewed as a premium resulting from savings to the trust fund or general fund, rather than as a cost reimbursement mechanism. Provider incentive proposals should carefully consider dual funding arrangements as a mechanism for encouraging the participation of small- and medium-sized agencies.

For example, agencies should be allowed to serve as both the employer and the provider agencies for individuals who select them for service provision. This will allow agencies providing employment opportunities through JWOD or other similar programs to focus their efforts on serving individuals participating in the return to work program.

In addition, local employment agencies should be allowed to seek reimbursement from other funding agencies for services provided to individuals participating in the return to work program. For example, agencies should be able to receive funding from a local mental health or mental retardation authority, State rehabilitation agency or other funding entity which would partially or fully reimburse agencies for the cost of providing services. Payments provided to the agencies through the return to work program would be a premium over and above those received from other funding agencies.

Third, the need for a strong external management structure. A strong management structure, external to SSA, is required to resolve the numerous issues that will inevitably arise in the implementation of the return to work program. The programs being considered will dramatically change the relationship between consumers and employment service agencies. While this change is highly desirable, it cannot be assumed that numerous implementation issues will be quickly or automatically resolved.

Consider, for example, the following scenarios. An individual attempts to resign from an unsatisfactory employment situation 7 months after initially entering the job. The provider agency, having already expended extensive resources, places undue pressure on

the individual to remain in an unsatisfactory employment setting rather than jeopardize the agency's potential reimbursement. Or an individual who has been working for 5 months becomes dissatisfied with the services delivered by the provider agency. The individual changes to a different provider agency and remains in employment until ultimately leaving the disability rolls. To what extent does the first provider agency have a legitimate claim to subsequent payments from SSA?

These are but two of a myriad of implementation issues which will eventually arise as the return to work program evolves. Many of the issues have only been marginally recognized in the development of the proposed plans. Management structures, external to SSA, are needed that would coordinate implementation policies and guidelines across the country, while allowing flexibility to address regional and local needs.

Thank you very much.

[The prepared statement follows:]

Statement of John Kregel, Ed.D., Research Director, Rehabilitation Research and Training Center on Supported Employment, Virginia Commonwealth University

It is an honor for me to be with you this morning. The suggestions and recommendations I will share in the next few minutes are the result of research activities completed by the Rehabilitation Research and Training Center at Virginia Commonwealth University in 1995–96 through joint funding provided by NIDRR and the Social Security Administration.

As a part of this research effort, we conducted focus groups comprised of representatives of local provider agencies and completed over 300 structured telephone interviews with directors of local agencies from 40 different states. Questions focused on the agencies' perceptions of the potential effectiveness of various provider incentive proposals.

I would like to briefly share with you recommendations three areas: (1) the perceived need for milestone payments; (2) strategies that will enhance the ability of smaller agencies to participate in the program; and (3) the need for strong program management structures external to SSA.

NEED FOR MILESTONE PAYMENTS

While the notion of paying providers only for results is logically and fiscally sound, in practice this approach will greatly reduce the number of agencies that will participate in the program and limit the overall size of the return to work initiative. Participation will likely be limited to large, highly capitalized agencies which receive sizable amounts of support from charitable organizations, or which are able to generate revenue through various enterprises. Lack of milestone payments will limit the participation of various categories of provider agencies, including:

- smaller agencies which simply don't have the fiscal resources to provide services for prolonged periods of time without some reimbursement for incurred costs; and
- programs in rural communities, which are generally small and face additional costs associated with providing employment services in rural areas.

In addition, it should be anticipated that individuals who are either viewed as too challenging (i.e. costly) to serve or too poor a risk for meeting the success criterion of the program, such as individuals with persistent mental illness or brain injuries, will have extreme difficulties locating providers willing to assist them.

STRATEGIES FOR PROMOTING THE PARTICIPATION OF SMALLER AGENCIES

Return to work programs should be designed so that payments to providers are viewed as a premium resulting from savings to the Trust Fund or General Fund, rather than as a cost reimbursement mechanism. Provider incentive proposals should carefully consider "dual funding" arrangements as a mechanism for encouraging the participation of small and medium-sized agencies.

For example, agencies should be allowed to serve as both the employer and the provider agency for individuals who select them for service provision. This will allow agencies providing employment opportunities through JWOD or other programs to

focus their efforts on serving individuals participating in the return to work program.

In addition, local employment agencies should be allowed to seek reimbursement from other funding agencies for services provided to individuals participating in the return to work program. For example, agencies should be able to receive funding from a local mental health/mental retardation authority, state rehabilitation agency, or other funding entity which would partially or fully reimburse agencies for the costs of providing services. Payments that are provided to the agency through the return to work program would then be a premium over and above those received from other funding agencies.

NEED FOR A STRONG EXTERNAL MANAGEMENT STRUCTURE

A strong management structure, external to SSA, is required to resolve the numerous issues that will inevitably arise during the implementation of the return to work program. The programs being considered will dramatically change the relationship between consumers and employment service agencies. While this change is highly desirable, it cannot be assumed that numerous implementation issues will be quickly or automatically resolved. Consider the following scenarios.

- An individual attempts to resign from an unsatisfactory employment situation seven months after initially entering the job. The provider agency, having already expended extensive resources, places undue pressure on the individual to remain in an unsatisfactory employment setting rather than jeopardize the agency's potential reimbursement.
- An individual who has been working for five months becomes dissatisfied with the services delivered by the provider agency. The individual changes to a different provider agency and remains in employment until ultimately leaving the disability rolls. To what extent does the first provider agency have a legitimate claim to subsequent payments from SSA?

These are but two of a myriad of implementation issues which will eventually arise as the return to work program evolves. Many of these issues have only marginally been recognized in the development of the proposed plans. Management structures external to SSA are needed that will coordinate implementation policies and guidelines across the country while simultaneously allowing flexibility to address regional and local needs.

Chairman BUNNING. Thank you very much.

Mr. Baron.

STATEMENT OF RICHARD C. BARON, DIRECTOR, MATRIX RESEARCH INSTITUTE, PHILADELPHIA, PENNSYLVANIA, ON BEHALF OF INTERNATIONAL ASSOCIATION OF PSYCHOSOCIAL REHABILITATION SERVICES, COLUMBIA, MARYLAND

Mr. BARON. Thank you. Good morning. I want to thank the Subcommittee for the opportunity to testify today. I am director of Matrix Research Institute and its Research and Training Center on Vocational Rehabilitation Services for Persons with Mental Illness. I will be speaking today also as a representative of the International Association of Psychosocial Rehabilitation Services.

A staggering 90 percent of Americans who struggle with a serious mental illness are unemployed, the vast majority of whom rely on SSA or SSDI for cash assistance and medical coverage. The largest group of SSA recipients are those with mental illness, and they are the group currently most likely to remain on the rolls for their entire adult life. Although the symptoms of serious mental illness are considerable barriers to job performance, a wide array of transitional and supportive rehabilitation programs have been proven to be dramatically effective in helping people to work, but such programs remain in short supply.

More importantly, the barriers to employment, implicit in our public policies, dissuade many people who should be working to opt instead for dependency, and both the President and the Congress are to be congratulated for the recent initiatives to reshape the Nations's approach; however, I want to note a few of the most critical barriers that new public policy will need to address.

First, the longstanding public policy preoccupation with getting people off the SSA rolls is, in my opinion, an inappropriate goal and its own barrier. What we need instead is legislation that encourages more people to work at their individual capacity as frequently and as often as they can, even if that employment is less than full time, or is only intermittent. The vast majority of people with serious mental illness can build substantial careers if we encourage both part-time and full-time options, and we believe financial savings from such policies, because of the widespread and sustained reductions in cash assistance that will follow, will be dramatic and far more effective than concentrating our rehabilitation efforts on the relatively limited number of people who can afford to escape the SSA rolls because they have the capacity to return to full-time jobs in white collar professions. Both groups of people deserve the attention of this Subcommittee.

Second, any new system must address the barrier represented by the potential loss of medical insurance for those who work, limiting access to the very supports that make work possible in the first place. Although I know Medicaid and Medicare provisions are beyond the purview of this Subcommittee, because people with serious mental illness use SSI and/or SSDI eligibility as the portal to medical support, any program that seeks to offer new incentives for employment must find a way to ensure enrollees' access to Medicaid and Medicare if they need it.

A third barrier has been a presumption that mental health professionals or SSA personnel can accurately assess rehabilitation potential. Any system that attempts to determine at the outset which clients do and do not have the capacity for employment is wrongheaded. There is no evidence that we have the tools to make accurate prognostications of this sort, and forcing rehabilitation professionals to pretend to do so will only result in eliminating from potential employment all but a few higher functioning clients. New approaches must encourage each client to reach his or her vocational potential.

A fourth barrier has been a tendency to assume that rehabilitation is a straight-line process. Many people will need to be assured they can try once, fail, and then try again, and yet again. Many of us would hate to see a ticket or voucher program that provided only a one-point-in-time opportunity for people to enter the working world, or one that placed arbitrary time limits on needed support.

Fifth, delaying payment to vocational rehabilitation agencies until the end of the process, when the client has achieved prescribed goals—such as leaving the SSA rolls or remaining employed consistently for 12 months—only creates new barriers. The agencies will want to serve only those clients who will appear, often erroneously, to be good bets. The new system will need to offer payments at various milestones in each client's progress, and then pro-

vide for the ongoing occasional assistance some will need to build lifetime careers.

Sixth, the complexities of the current work incentive provisions are considerable barriers as well. Although not perfect, the current work incentives are quite positive, yet they are largely unknown or unutilized by most consumers, and are largely ignored or misunderstood by mental health, vocational rehabilitation and Social Security staff. Any future changes to incentives must be accompanied by a financial commitment to provide expertise at the local level that consumers need to manage these complicated systems.

Finally, let me say a word about the consequences of continuing to ignore the vocational potential of persons with serious mental illness, people who should be working because it is in their own best interest, people who could be working because rehabilitation programs do make it possible, and people who would be working because work, in fact, endures as a primary goal for the majority of those now completely dependent on SSA. To fail to offer new opportunities and new incentives is to risk the loss of yet another generation of disabled people who are prepared to face the challenges of work, a loss neither they nor the Nation can afford.

Thank you.

[The prepared statement follows:]

Statement of Richard C. Baron, Director, Matrix Research Institute, Philadelphia, Pennsylvania, on Behalf of International Association of Psychosocial Rehabilitation Services, Columbia, Maryland

Good morning. My name is Richard Baron, and I want to thank the Subcommittee for the opportunity to testify today. I am the Director of Matrix Research Institute and it's Research and Training Center on Vocational Rehabilitation Services for Persons with Mental Illness. I'll be speaking today also as a representative of the International Association of Psychosocial Rehabilitation Services.

A staggering 90% of Americans who struggle with a serious mental illness are unemployed, the vast majority of whom rely on SSI and SSDI both for cash assistance and medical coverage. The largest group of SSA recipients are those with mental illness, and they are the group currently most likely to remain on the rolls for their entire adult lives. Although the symptoms of serious mental illness are considerable barriers to effective job performance, a wide array of transitional and supported rehabilitation programs have been proven to be dramatically effective in helping people to work, but such programs remain in short supply.

More importantly, the barriers to employment implicit in our public policies dissuade many people who should be working to opt instead for dependency, and both the President and the Congress are to be congratulated for their recent initiatives to reshape the nation's approach; however, I want to note a few of the most critical barriers that new public policies will need to address.

First, the long-standing public policy pre-occupation with "getting people off the SSA rolls" is its own barrier. What we need instead is legislation that encourages more people to work at their individual capacity as frequently and as often as they can, even if that employment is less than full-time or is only intermittent. The vast majority of people with serious mental illness can build substantial careers if we encourage both part-time and full-time options, and we believe that financial savings from such policies—because of widespread and sustained reductions in cash assistance—will be dramatic, and far more effective than concentrating our rehabilitation efforts on the relatively limited number of people who can afford to escape the SSA rolls because they have the capacity to return to full-time jobs in white collar professions. Both groups of people deserve the attention of this Subcommittee.

Second, any new system must address the barrier represented by the potential loss of medical insurance for those who work, limiting access to the very supports that make work possible in the first place. Although I know that Medicaid and Medicare provisions are beyond the purview of this Committee, because people with serious mental illness use SSI and/or SSDI eligibility as the portal to medical support, any program that seeks to offer new incentives for employment must find a

way—as in a national health care program or the states' 1115 waiver programs—to insure enrollees' continued access to Medicaid and Medicare.

A third barrier to employment has been a presumption that mental health or vocational rehabilitation professionals—or SSA personnel—can accurately assess 'rehabilitation potential:' any system that attempts to determine at the outset which clients do and do not have a capacity for employment is wrong-headed: there is no evidence that we have the tools to make accurate prognostications of this sort, and forcing rehabilitation professionals to pretend to do so will only result in eliminating from potential employment all but a few higher functioning clients. New approaches must encourage each client to reach for his or her vocational potential.

A fourth barrier has been our tendency to assume that rehabilitation is a straight-line process; many people will need to be assured that they can try once, fail, and then try again, and yet again. Many of us would hate to see a 'ticket' or 'voucher' program put in place a system that only offered one-point-in-time opportunity for people to enter the working world, or one that placed arbitrary time limits on needed support.

Fifth, delaying payment to vocational rehabilitation agencies until the 'end' of the process—when the client has achieved a prescribed goal such as leaving the SSA rolls or remaining employed consistently for 12 months—only creates new barriers: the agencies will want to serve only those clients who will appear—often erroneously to be 'good bets'. The emerging system, to encourage agency engagement, will need to offer payments at various milestones in each client's progress toward employment, and then provide for the ongoing occasional assistance some will need to build lifetime careers.

Sixth, the complexities of the current work incentive provisions are considerable barriers as well. Although not perfect, the current work incentives are quite positive, yet they are largely unknown or unutilized by most consumers, and are largely ignored or misunderstood by mental health, vocational rehabilitation, and Social Security staff. Any future changes to incentives must be accompanied by a financial commitment to provide expertise, at the local level, that consumers need to manage these complicated systems.

Finally, let me say just a word about the consequences of continuing to ignore the vocational potential of persons with serious mental illness, people who should be working because it is in their own best interest, who could be working because rehabilitation programs make it possible, and who would be working because work endures as a primary goal for the majority of those people now completely dependent on SSA. To fail to offer new opportunities and new incentives is to risk the loss of yet another generation of disabled people who are prepared to face the challenges of work, a loss neither they nor their nation can afford.

Chairman BUNNING. Thank you very much.

Mr. Matheson.

STATEMENT OF LEONARD N. MATHESON, PH.D., CVE, DIRECTOR, WORK PERFORMANCE LABORATORY; AND SECTION CHIEF, OCCUPATIONAL HEALTH AND ERGONOMICS, PROGRAM IN OCCUPATIONAL THERAPY, WASHINGTON UNIVERSITY SCHOOL OF MEDICINE, ST. LOUIS, MISSOURI

Mr. MATHESON. Thank you, Mr. Chairman.

In 1970, I began to work with a young man named Paul who was a teenager at Rancho Los Amigos Hospital; he was a client of mine. He had a serious head injury, resulting in hemiplegia and very bad paralysis on one side of his body. Eventually I helped him get a job as a spray painter at a furniture plant. Twenty years later he is still a spray painter, he is married for the second time, he has three kids and a wife living in a mortgaged home in southern California. He has claimed his occupational birthright as an American, despite the fact that he easily qualifies for SSDI benefits.

I have worked with several thousand people with disabilities, approximately half of whom have been able to get back to work. For

all of them, functional capacity evaluation, which we call FCE, guided rehabilitation and was a key to their success. FCE is a systematic process of measuring and developing an individual's ability to perform meaningful tasks on a safe and dependable basis. It addresses functional limitations, which is a bridge between medical impairment and ability to work. This addresses the most important defect in the design of SSDI, the attempt to predict disability from impairment. In order to manage the issues that limit the potential to work, it is necessary to move beyond impairment to address functional limitation to address performance on job tasks.

It was proposed in your Rehabilitation and Return to Work Opportunity Act of 1996 that the assessment of capability for vocational adjustment be undertaken on a broad basis. This was well-intended but would have resulted in a wasteful application of resources. It would be much better to evaluate the occupational potential of a person with a disability on a progressively constricting basis. This would allow the process to be halted before it consumes too many resources. FCE can provide objective information necessary to achieve effective gatekeeping to screen out those who are not likely to benefit while boosting the opportunities for those who can benefit based on adherence to three indicators of success, the first being the ability to maintain focus on meaningful work goals; second being the ability to maintain focus on function rather than impairment; and third, the willingness to stick with it. This is the single most important multiplier of ability.

Rehabilitation requires 110-percent effort. In order to take advantage of FCE strengths and not waste resources, the process must be undertaken in steps. At each step, recipients who do not meet criteria for success must be excused from the program in an ever-constricting funnel that preserves resources so that meaningful rewards in terms of rehabilitation benefits are provided to those that persevere.

In step one, we must identify causes. In step two, we must minimize disablement. In step three, we must identify the person's ability factors. In step four, get into vocational exploration to help the person identify goals, interests and possible vocational targets. We wind up at step five with a rehabilitation plan that has prepared the person to be an excellent candidate for a return to work program.

The hallmarks of this process is that it is driven by demonstrated recipient effort and guided by objective information about work performance.

I have three policy recommendations, the first having to do with standardization, and I ask SSA pay only for FCE services which are provided by programs that are accredited by an independent agency.

The second has to do with science and technology, and I would recommend SSA only pay for services which adhere to standards for technology development, which can be developed by a national interdisciplinary committee of experts.

The third has to do with cost efficiency. I have cost estimates in a supplemental report I provided this morning, predicated on a policy in which the SSA pay only for FCE services which address

questions pertinent to that step in the process at which the client is found.

To conclude, the successful return to work of SSDI recipients benefits all Americans. The GAO has estimated if only 73,000 of the 6.6 million Americans of working age who received SSDI and SSI benefits were to return to work, $3 billion could be saved. It seems to me this is aiming far too low, given the need and potential we find in these people.

My supplemental report looks at lifetime cost savings. I see FCE as a gatekeeper, something that could be used as a supplement to the Bunning bill, and would be a transition to work program tickets, which will make it more likely that small providers will take on these clients.

Thank you for your time.

[The prepared statement and attachment follow:]

Statement of Leonard N. Matheson, Ph.D., CVE, Director, Work Performance Laboratory; and Section Chief, Occupational Health and Ergonomics, Program in Occupational Therapy, Washington University School of Medicine, St. Louis, Missouri

In 1970, I began to work with a teenager named Paul who came to me as a client with a severe head injury at Rancho Los Amigos Hospital in Downey, California where I worked as a pre-vocational counselor in the pediatrics unit. I helped Paul get a job as a spray painter in a furnitue plant. I still hear from Paul occasionally during the Holiday season. Paul is a grandfather, married for the second time, has three children who live with him and his wife in a mortgaged home, and is still employed as a spray painter. He has claimed his occupational birthright as an American, in spite of the fact that he easily qualifies for SSDI based on the severity of his impairments, including a seizure disorder, complete hemiplegia which stops him from using his left hand and causes difficulties with standing and walking, swallowing, speech, memory, and reading.

More than 6.6 million Americans of working age are SSDI and SSI recipients who have impairments that limit their potential for competitive employment. Some have functional limitations that make work impractical while others are limited by disabilities that can be overcome with proper identification and management. Since I had the opportunity to work with Paul, I have assisted more than 7,000 persons with severe disabilities to attempt to enter the work force. Approximately 50% of these people have been successful. The patterns of success are apparent, and stem both from characteristics of the person served and characteristics of the services each received.

I am here today to discuss the importance of functional capacity evaluation (FCE) as a key service that can help the Pauls and Paulas of this country retrieve what I believe is every American's birthright, the opportunity to work and demonstrate occupational competence. I will present FCE as a process of measurement and development which can be used to improve the Social Security Administration's disability determination process as well as to increase the likelihood that occupationally disabled SSDI beneficiaries will return to work. In my testimony, I will be describing a vision of FCE that can be used as a model of service to improve the health and function of our citizens so that they can return to work, resume full-fledged participation in the economy, restore dignity to themselves and to their families, and improve the overall financial and emotional health of the nation.

FUNCTIONAL CAPACITY EVALUATION

We should begin with a definition. Functional capacity evaluation (FCE) is a systematic process of measuring and developing an individual's ability to perform meaningful tasks on a safe and dependable basis (1).

Brief History

The scientific underpinnings of FCE stem in large part from the research efforts of industrial and human factors psychologists in World War II and thereafter, supported by federal defense funding. The idea of matching the person to the task was extended from this work to the Rehabilitation community in the 1950's with early centers of excellence at the University of Wisconsin, the University of Arizona and

at rehabilitation centers such as Rancho Los Amigos. In those days, we assumed that persons with severe disabilities who wanted to work probably could be assisted to work and we developed procedures to achieve such goals. From the first, we recognized that the evaluation of work capacity was a key to success for people like Paul. This early experience evolved into formal procedures for evaluating functional capacity as a subset of work capacity and marrying that to work-oriented treatment programs (2, 3), which will be described later. The use of FCE in Rehabilitation has continued to develop over the intervening years. At its present level, FCE is able to offer assistance to American society to match a wide variety of persons with chronic disabilities [1] to a wide variety of meaningful jobs. How it can accomplish this requires that we consider FCE in more detail.

Functional

The term "functional" is intended to connote performance of a purposeful, meaningful, or useful task that has a beginning and an end with a result which can be measured. Several authors (4–7) have described current models of disablement (8–10) and the rehabilitation process (11). My testimony today references a model of rehabilitation depicted in Figure One (below), the Stage Model of Occupational Rehabilitation, in which functional limitations hold a translational role between the individual's impairment and his or her occupational disability. This key segment of the process of the occupational rehabilitation process is the focus of FCE (12, 13). It is important to focus on functional limitations because they bridge between impairment which is assessed by medical means and disability which is assessed my non-medical means (14). More to the point, occupational disability predicts employability better than does impairment (15–17), as Paul's case and hundreds of others in my direct experience indicate. This may be the single most important defect in the design of SSDI; the attempt to predict disability from impairment. In order to manage the issues that limit potential to work, it is necessary to move beyond impairment and functional limitation to address performance on job tasks. The impairment-centered model must not continue to be used for this purpose.

Figure One. Stage Model of Occupational Rehabilitation.

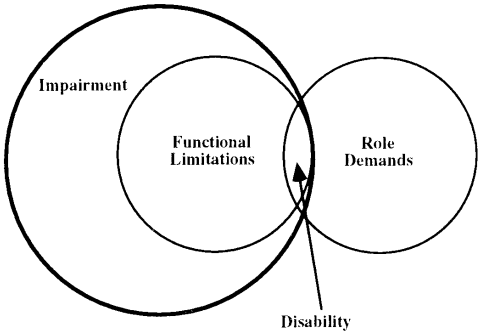
Stage	Issue Addressed	Measured by or in terms of ...	Measurement Professionals
One	Pathology	Cells, tissue and bone	All appropriate medical diagnosticians.
Two	Medical Impairment	Anatomic, physiologic, psychologic system health.	All appropriate health care providers.
Three	Functional Limitation	Task performance	FCE-trained MDs, OTs, PTs, PhDs.
Four	Occupational Disability	Role consequences of functional limitations.	Occupational Therapists, Vocational Evaluators.
Five	Vocational Feasibility	Acceptability of the evaluee as an employee.	Vocational Evaluators, Occupational Therapists.
Six	Employability	Ability to become employed.	Vocational Evaluators, Rehabilitation Counselors.
Seven	Vocational Handicap	Ability to perform a particular job.	Occupational Therapists, Ergonomists.
Eight	Earning Capacity	Earned income over expected worklife.	Economists.

This model describes pathology and impairment as factors that, taken within the context of the individual's environmental and personal resources (12–18), are the precursors of functional limitation. If the impairment is sufficiently severe, functional limitations can result. If the functional limitations are sufficiently severe and are pertinent to role tasks, occupational disability will be the result. Occupational disability can be thought of as the summation of the role consequences of functional limitations (6, 7) and recently has been the focus of governmental attention (19). Another useful definition of occupational disability is that it is the individual's uncom-

[1] The word "disabilities" is plural because most people who are chronically disabled have more than one cause of disablement.

pensated shortfalls in responding to role demands (13). Figure Two represents this definition in graphic terms.

Figure Two. Disability occurs at the interface of functional limitations and role demands.

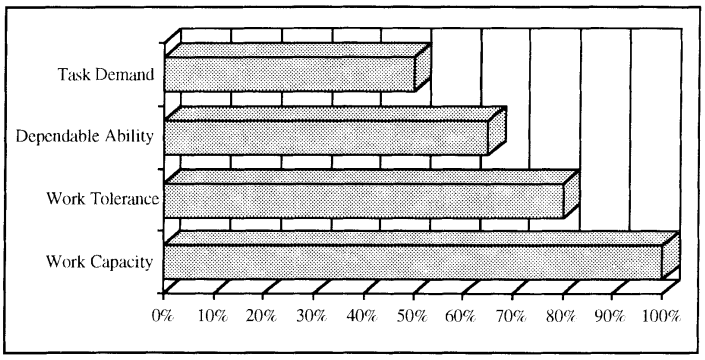


Evaluation of disability is based on the measurement of the functional consequences of impairment in tasks that are pertinent to the particular role under consideration (6, 9). Individuals assume several roles in society, such as spouse, parent, neighbor, worker, team mate or customer. If the functional consequences are significant and occur in tasks which are critical to the performance of the job, the evaluee can be described as having a compensible occupational disability (COD). When the emphasis is on determining the presence or degree of occupational disability, the focus must be on tasks in the worker role and work environment (20). The extent and type of the COD is dependent on the evaluee's ability to perform these work-relevant tasks.

Capacity

The term "capacity" connotes the immediate potential of the evaluee, what the person can possibly do at that point in time. The use of the term capacity is somewhat misleading because it rarely is measured directly unless the evaluee is highly trained and motivated, such as when an experienced athlete competes. Work capacity is less than "work tolerance" and can be inferred somewhat from evaluation of an individual's response to exhaustive demands. However, exhaustive demands are inappropriate when the focus of the evaluation is on a worker (impaired or healthy). In this circumstance, the evaluation may be concerned with the individual's "maximum dependable ability," what he or she can do on a regular basis in hallmark tasks such as lifting and carrying. This information allows us to identify occupations in which there are jobs the person may be able to perform, based on the assumption that the demands of these jobs are less than the evaluee's maximum dependable ability. If we can, in turn, evaluate a person for a particular job, we can focus on ability to handle that job's task demands. Knowing the SSDI recipient's maximum dependable ability places us in the ballpark; assignment to a particular position on the team depends on the recipient's ability to handle the tasks that are found in that position. A typical relationship among these variables is described in Figure Three.

Figure Three. The ideal relationship among work capacity, work tolerance, dependable ability, and task demand when the evaluee is found to be capable of work.



Evaluation Compared with Assessment

Functional capacity evaluation should be distinguished from functional assessment (21). Although the terms sometimes are used interchangeably and some functional assessment instruments are used in FCE, they describe different processes. Generally, FCE is based on performance measurement while functional assessment is based on expert ratings from observation or on the evaluee's self-report (22–25). FCE employs structured performance protocols using test equipment or simulated activities to measure functional performance while functional assessment employs structured behavior rating scales to rate observations of the evaluee made by trained observers or self-perceptions made by the evaluee. Thus, FCE is much more likely to identify work tasks that can be performed by SSDI recipients. Additionally, FCE is much more likely to identify problems with motivation or less than full effort performance because it actively engages the evaluee in challenging tasks and records the evaluee's behavioral response.

Because functional capacity evaluation involves measurement of the evaluee's ability to perform work, it involves the interface between both the person and the job. At this interface are tasks that have complex physiological, psychological, musculoskeletal and environmental bases. To evaluate the individual without impairment and achieve a safe and dependable match to job demands is difficult; to do so with a person who has an impairment is more difficult; to do so with many people who have a wide variety of impairments is daunting. For SSDI recipients, there is often not a job to return to or a job available to allow a focus on certain job demand factors, further broadening the scope of FCE.

Numerous FCE Providers

Many professional disciplines provide FCE services. In fact, all of the major disciplines involved in FCE today have legitimate claims in that each has been interested to greater or lesser degrees in matching the person to the task. FCE is taught in many colleges and universities and postgraduate seminars and is provided by a wide range of professionals:

Occupation	Estimated U.S. Providers
Occupational Therapists	10,000
Physical Therapists	10,000
Physicians	5,000
Psychologists	5,000
Vocational Evaluators	5,000

Each discipline has developed its own approach to FCE, dependent on factors which differentiate one discipline from the other. In recent years, professionals from the fields of exercise physiology, kinesiology, nursing, chiropractic medicine, and speech pathology have developed additional approaches to FCE. Most SSDI recipi-

ents will require the services of more than one discipline, both during the FCE and once the rehabilitation plan begins in order to maximize their potential for gainful work.

Specific Purposes of FCE

Beyond the general purpose of measuring an individual's ability to perform meaningful tasks on a safe and dependable basis, functional capacity evaluation as practiced in the United States has three specific purposes:

Disability Determination

Determines the presence (and, if present, the level) of occupational disability so that the evaluee's case can be bureaucratically or juridically concluded (1, 26). In practice, disability determination is the most simple of the three, because it is only necessary to identify one factor (or a small group of factors) to confirm that a person is disabled and to measure the extent of disability with various rating schemes, while many factors must be evaluated to determine whether a person is able to fulfill an occup ational role. The efficiency that can be obtained when a circumscribed question is posed for FCE to answer is realized in this type of evaluation, which may be demonstrated in the future as the SSA Disability Determination reengineering process continues to unfold. HR 4230, introduced in the last Congressional session, recognized that something more was possible and held the promise of much greater fiscal and human savings.

Rehabilitation Planning

Assists a medically impaired person to improve role performance through identification of occupationally-relevant functional limitations so that these decrements may be resolved or managed (2, 13, 27). Health care professionals use this information for many purposes, including the triage of patients into proper treatment programs, to provide the basis for remediation, and to measure treatment progress. Many times, recipients have disabilities which can be eliminated through aggressive rehabilitation or the use of technological assists.

Job Matching

Measures the individual's ability compared to task demands to determine whether he or she will be competent in a job (10, 21). Routinely, the comparison of an individual's capacity to a job's demands is made to diminish the risk of re-injury that is associated with a mis-match as well as to improve the individual's productivity. Numerous researchers (28–33) point to the importance of properly matching the worker's capacity to the job's demands. Shortfalls in the relationship between the individual's resources and the environment's demands will result in decreased performance (34) and increased risk for injury (35, 36).

Legislative Initiatives

It was proposed in the "Rehabilitation and Return to Work Opportunity Act of 1996" (HR 4230), that the assessment of capability for vocational adjustment be undertaken on a broad basis, with mandated assessment of work and educational history, abilities and limitations, and interests and aptitudes. This was well-intended but would have resulted in wasteful application of resources. It would be much better to evaluate the occupational potential of a person with a disability on a progressively constricting basis. This would allow the process to be halted before it consumes too many resources so that the downstream benefits can be made sufficiently supportive that success will be a likely consequence of full-effort participation. This can be accomplished and will result in much greater efficiency and success. FCE can provide the information necessary to achieve effective "gatekeeping" to screen out those who are not likely to benefit while boosting the opportunities provided to those who can truly benefit.

Context of Practice

The FCE process should have a strong therapeutic orientation and should always have a focus on achieving productivity that enlists the individual's goals, motivation and attitudes toward success. This context of practice has been described as "work hardening," a treatment program which was developed at Rancho Los Amigos Hospital in the 1970's (2, 3) and has been shown to be effective in many settings throughout the United States. Each step of the FCE process should be presented within such a context. Key indicators of success in this process include:

- The ability to maintain a focus on meaningful work goals. Goals such as improvement in fitness, decrease or control of pain, alleviation of depression, improved

sleep, and many others which will be identified in these types of cases must always be considered secondary to return to meaningful work as the primary goal.

• The ability to focus on function rather than impairment. The medical impairment aspects of the case should be handled in a way that facilitates maintaining a focus on the development of the recipient's work behaviors. Many of these people have not benefited from medical care; some of them can be vocational successes in spite of their medical circumstances. This will be most difficult and important with regard to pain control. For the person who is disabled by pain, this approach may greatly increase discomfort on a temporary basis. If this temporary increase is not able to be tolerated without strong medication, it is unlikely that the person will be able to work in a competitive market place. However, appropriate medical support to manage benign disabling pain can be accomplished and should be provided.

• The willingness to stick with it. At each step of the evaluation process, the recipient must be expected to "pay the price of admission" to the next step by demonstrating a strong willingness to participate, in spite of his or her circumstances. Less than full effort participation should be cause for suspension or cessation of the return to work program. Conversely, full effort participation which demonstrates a high level of motivation must be reinforced tangibly and recognized as the single most important multiplier of ability.

Step-Wise Service Delivery

FCE is a developmental process (13) in which the experiences of the recipient lead to improvement in performance through learning, adaptation, and changes in the supporting environment. It also can have immediate therapeutic effect (37, 38) based on development of self-efficacy as a consequence of feedback concerning functional abilities which are uncovered or affirmed (39). Finally, it can greatly improve the likelihood that an SSDI recipient will benefit sufficiently from rehabilitation to achieve a return to work. In order to take advantage of these benefits and to maintain the highest level of cost efficiency and not waste resources, the FCE process for SSDI and SSI recipients must be undertaken in steps. At each step, recipients who do not meet criteria for success must be excused from the program in an ever-constricting funnel that preserves resources so that meaningful rewards in terms of rehabilitation benefits are provided to those who persevere.

Step One.—The evaluation must identify the causes of disablement, through the active involvement of the recipient in a simulated work environment, including the implementation of normal work hours, work rules and procedures. The questions to be addressed at this step center around, "What are the functionally limiting factors which have created this occupational disability?" Issues which identify good candidates for return to work include the degree to which the individual demonstrates a strong work ethic, is safe in the work place, and is able to get along with fellow workers and supervisors. Recipients will be excused for problems with safety and interpersonal behavior. Recipients with problems with productivity will be retained and move to Step Two.

Step Two.—The evaluation must begin to minimize disablement by answering the question: "For the functionally limiting factors, are there rehabilitation services which will be likely to improve ability to work?" This is best addressed within a simulated work environment to provide an appropriate context of treatment. This is the step at which work hardening and work conditioning occur (2, 3, 40–42). Issues which identify good candidates for return to work include full-effort performance, the demonstrated ability of the individual to negotiate with disabling factors such as pain and fatigue, and his or her effective use of work aids, modifications and productivity enhancement strategies. Recipients will be excused for inability to push through pain to improve function, maintain a conditioning regimen, or participate daily. As recipients plateau, they will move to Step Three.

Step Three.—If the recipient is to enter the work force, we must identify his or her person-centered ability factors. This process should be structured by a work demands taxonomy[2] such as that developed by Fleishman and his colleagues (44) which can be matched to an occupational database in Step Four. This is a broad-based approach to evaluation which will be necessary if the full spectrum of occupationally disabling functional limitations is to be addressed. Using a variety of standardized procedures, the recipient's aptitudes, abilities, and transferable skills are identified and measured. Issues which identify good candidates for return to work include the identification of resources which can be developed to a level that will

[2] Based on factor analysis research of the abilities requirements of numerous jobs, Fleishman and Reilly describe 52 different abilities that are pertinent to job tasks. Nine of these abilities involve strength, while an additional ten are psychomotor abilities which involve response speed and precision, and other factors involve verbal skills, reasoning, and social skills.

be valued by employers, coupled with a positive response to the identification of these resources (45). Recipients will be excused for levels of aptitudes or abilities which are below a threshold for competitive employment at a level of remuneration that is likely to make the available benefits package unattractive. As a feasible occupational profile is developed, recipients will move to Step Four.

Step Four.—The collection of work relevant ability information will provide the recipient with information which will be used in vocational exploration to identify goals, interests, and possible vocational targets if a rehabilitation program were to be undertaken. Issues which identify good candidates for return to work include the identification of occupations which use selected personal resources which can be developed into salable skills, the key to sustainable employment (46) over the next 20 years. Recipients who are unable to identify occupations which have jobs in their geographic area which will provide adequate remuneration will be excused. After an acceptable occupational target is identified, recipients will move to Step Five.

Step Five.—Finally, the evaluation will conclude with rehabilitation plan development. If the recipient has progressed successfully through each of the earlier steps, he or she will be an excellent candidate for a return to work rehabilitation program focused on a particular vocational target, the likely outcome of which will be sustainable employment.

The hallmarks of the FCE process described above are that it is driven by continuing demonstration of the recipient's effort and is guided by objective information about his or her work performance. These are the keys to return to work for a person with a chronic disability. The consequence of this process should be a recipient who is ready to begin a focused rehabilitation program that often will involve services such as occupational therapy, rehabilitation counseling, and both formal education and on the job vocational training. These are services that should only be undertaken if objective data have been used to develop information about the person with disabilities that makes it likely that he or she will benefit and the outcome will be sustainable employment.

POLICY RECOMMENDATIONS

Standardization

FCE is practiced by professionals from many different disciplines, none of which can lay sole claim. As a consequence, FCE is not formally governed and lacks consistency, resulting in less efficient use of resources and less than optimal outcome for service recipients. The field needs cross-disciplinary standards of practice. Programs in which FCE is often found have accreditation available through the Commission on Accreditation of Rehabilitation Facilities (CARF),[3] although accreditation is voluntary and often is not pursued because of expense, inconvenience, and marginal applicability.

Policy recommendation: Pay only for FCE services which are provided by programs accredited by an independent agency, using new FCE standards for service delivery which are developed by a national interdisciplinary committee of experts.

Science and Technology

In the past 20 years, FCE technology has outstripped its scientific underpinnings, resulting in problems with the utility of many of the FCE applications that are in use today (47).

Policy recommendation: Require adherence to standards for technology development, including both test protocols and equipment, which are developed by a national interdisciplinary committee of experts, such as those first published by the EEOC in 1978 (48) which guide employee selection procedures, the American Physical Therapy Association guidelines, and those published by the American Psychological Association (49–51) which currently are under revision.

Cost Efficiency

This is the most subtly difficult problem. FCE easily can be too expensive for the utility which is derived. An FCE only has utility to the degree it assists in the resolution of a problem and adheres to the "evaluation factors hierarchy" (47). To maximize cost effect, data which relate to the likelihood of return to work should be collected using procedures which maintain a reasonable balance among safety, reliabil-

[3] The American Psychological Association, American Physical Therapy Association, American Occupational Therapy Association, American College of Physical Medicine and Rehabilitation, and most of the other professional associations in Rehabilitation underwrite CARF and have representation on its Board of Trustees and nominate members of its specially-convened national standards committees.

ity, validity and practicality after developing a sharp focus on the question, "To what purpose will the information be put?"

Policy recommendation: Pay only for FCE services which address questions which are pertinent to that step in the evaluation process at which the client is found, based on a classification of types of services which normally are appropriate. Such a classification scheme can be developed by a national interdisciplinary committee of experts.

The successful return to work of SSDI recipients is a cause for celebration because it benefits all Americans in both tangible and spiritual ways. These people have the need and many have been found to be amenable to rehabilitation. The General Accounting Office has estimated that if only 73,000 of the 6.6 million Americans who receive SSDI and SSI benefits were to return to work, $3 billion could be saved in subsequent years. It seems to me that this is aiming far too low, given the need and potential that we find in these people. I have presented an approach which will be much more effective.

We are on the verge of a great opportunity that needs only to be captured and managed with resolve. FCE is an important component of an effective return to work strategy which can be implemented on a national basis. The costs of not making the attempt have become unbearable. Responsible and innovative leadership is required.

Thank you.

REFERENCES

1. Matheson L. Functional Capacity Evaluation. In: Andersson G. Demeter S, GH S, eds. Disability Evaluation. Chicago, IL: Mosby Yearbook, 1996:
2. Ogden-Niemeyer L, Jacobs K. eds. Work hardening: State of the art. Thorofare, NJ: Slack, 1989.
3. Matheson L, Ogden L, Violette K, Schultz K. Work hardening: occupational therapy in industrial rehabilitation. The American Journal of Occupational Therapy 1985;39(5):314321.
4. Nagi S. An epidemiology of disability among adults in the United States. Health and Society 1976(Fall):439–467.
5. Nagi S. Disability concepts revisited: implications for prevention. In: Pope A, Tarlov A, eds. Washington, DC: National Academy Press, 1991:309–327.
6. NCMRR. Report and research plan for the National Center for Medical Rehabilitation Research. National Advisory Board on Medical Rehabilitation Research. National Institute of Child and Human Development. Bethesda, MD: National Institutes of Health, 1992:
7. WHO. International classification of impairments, disabilities and handicaps. Geneva: World Health Organisation, 1980:
8. Granger C. A conceptual model for functional assessment. In: Granger C, Gresham G. eds. Functional assessment in rehabilitation medicine. Baltimore, MD: Williams and Wilkins, 1984:14–25.
9. Jetté A. Physical disablement concepts for physical therapy research and practice. Phys Ther 1994;74(5):380–386.
10. Mathiowetz V. Role of Physical Performance Component Evaluations in Occupational Therapy Functional Assessment. AJOT 1993;47(3):225–230.
11. Baum M, Law M. Occupational therapy practice: Focusing on occupational performance. American Journal of Occupational Therapy 1997;51(4):277–288.
12. American Occupational Therapy Association I. Uniform Terminology for Occupational Therapy: Application to Practice. (3rd ed.) 1994.
13. Matheson L. Work capacity evaluation for occupational therapists. Rehabilitation Institute of Southern California, 1982.
14. AMA, ed. American Medical Association guides to the evaluation of permanent impairment. 3rd ed. Chicago: American Medical Association, 1988.
15. Commission EEO. Equal employment opportunity for individuals with disabilities; final rule. Federal Register, July 26 1991;56(14):1–32.
16. Gebhardt D, Crump C. Recent developments in the design of pre-employment medical standards. Bethesda, Maryland: ARRO, 1983. vol Aug).
17. Nygård C, Eskelinen L, Suvanto S. Tuomi K. Ilmarinen J. Associations between functional capacity and work ability among elderly municipal employees. Scand J Work Environ Health I 991;17(1):122–127.
18. AMA. American Medical Association guides to the evaluation of permanent impairment. (4 ed.) Chicago: American Medical Association, 1993.
19. EEOC. Equal Employment Opportunity Commission rules and regulations. Federal Register 1991;56(144):35726–35756.
20. Velozo C. Work evaluations: Critique of the state of the art of functional assessment of work. Am J Occup Therapy 1993;47(3):203–209.
21. Hart D. Test and measurements in returning injured workers to work. In: Isernhagen S, ed. Work injury management: the comprehensive spectrum. Rockville, MD: Aspen Publishers, 1994:
22. Deyo R, Centor R. Assessing the responsiveness of functional scales to clinical change: an analogy to diagnostic test performance. J Chron Dis 1989;39(11):897–906.
23. Fairbank J, Couper J, Davies J, O'Brien J. The low back pain disability questionnaire. Physiotherapy 1980;66(8):270–272.

24. Dodds T. Martin D, Stolov W, Deyo R. A validation of the functional independence measurement and its performance among rehabilitation inpatients. Arch Phys Med Rehabil 1993;74(May):531–563.
25. Granger C, Wright B. Looking ahead to the use of the functional status questionnaire in ambulatory physiatric and primary care: The functional assessment screening questionnaire. Philadelphia: W.B. Saunders, 1993. (Granger C, Gresham G. eds. Physical Medicine and Rehabilitation Clinics of North America: New Developments in Functional Assessment;
26. Matheson L, Mooney V, Grant J, Leggett S, Kenny K. Standardized evaluation of work capacity. Journal of Back and Musculoskeletal Rehabilitation 1996;6:249–264.
27. Isernhagen S. Functional capacity evaluation and work hardening perspectives. In: Mayer T, Mooney J, Gatchel R, eds. Contemporary conservative care for painful spinal disorders. Philadelphia: Lea & Febiger, 1991:328–345.
28. Abdel-Moty E, Fishbain D, Khalil T, et al. Functional capacity and residual functional capacity and their utility in measuring work capacity. C1 J Pain 1993;9(3):168–173.
29. Ayoub M, Mital A, Asfour S. Bethea N. Review, evaluation, and comparison of models for predicting lifting capacity. Human Factors 1980;22(3):257–269.
30. Fleishman E. On the relation between abilities, learning, and human performance. Am Psych 1972(Nov):1017–1032.
31. Fraser T. Fitness for work. Bristol, PA: Taylor & Francis Inc. 1992.
32. Snook S. Irvine C. Maximum acceptable weight of lift. Am Ind Hyg Assoc J 1967;28:322–329.
33. Waters T. Revised NIOSH equation for the design and evaluation of manual lifting tasks. Ergonomics 1993;36(7):749–776.
34. Welford A. Skilled performance: perceptual and motor skills. Glenville, IL: Scott, Foresman and Company, 1976.
35. Ayoub M. Control of manual lifting hazards: I. Training in safe handling. J Occup Med 1982;24(8):573–577.
36. Chaffin D, Andersson G. Occupational Biomechanics. New York: John Wiley & Sons, 1984:
37. Isernhagen S. Functional capacity evaluation: rationale, procedure, utility of the kinesiophysical approach. J Occup Rehabil 1992;2(3):157–169.
38. Matheson L, Matheson M, Grant J. Development of a measure of perceived functional ability. J Occup Rehab 1993;3(1):15–30.
39. Bandura A. Human agency in social cognitive theory. Amer Psychologist 1989;44(9):1175–1184.
40. Darphin L, Smith R, Green E. Work conditioning and work hardening. In: Isernhagen S. ed. Orthopaedic Physical Therapy Clinics of North America: Industrial Physical Therapy. Philadelphia: W. B. Saunders Company, 1992:105–124. vol 1).
41. Hart D, Berlin S, Brager P, et al. Standards for performing functional capacity evaluations, work conditioning and work hardening programs state of Maryland. Annapolis, Maryland: Joint Committee on Industrial Services, 1993:
42. Lechner D. Work hardening and work conditioning interventions: Do they affect disability? Phys Ther 1994;74(5):471–493.
43. Fleishman E, Reilly M. Handbook of human abilities. Palo Alto, CA: Consulting Psychologists Press, Inc, 1992.
44. Fleishman E, Quaintantce M. Taxonomies of human performance: the description of human tasks. Orlando, FL: Academic Press, 1984:461–464.
45. Matheson L, Matheson M, Grant J. Reliability of a measure of functional self-efficacy. J of Occupational Rehab 1993;3(1).
46. Kiplinger. A special Kiplinger report: The next 20 years, how you can profit. Washington, DC: Kiplinger Washington Editors, Inc., 1996:
47. Matheson L. Basic requirements for utility in the assessment of physical disability. APS Journal 1994;3(3):193–199.
48. EEOC. Equal Employment Opportunity Commission uniform guidelines on employee selection procedures (1978). Federal Register. Washington, DC: United States Congress, 1990:216–243. vol 1).
49. AERA, APA, NCME. Standards for educational and psychological testing. Washington, DC: American Psychological Association, Inc, 1986.
50. APA, AERA, NCME. Standards for educational and psychological tests and manuals. Washington, DC: American Psychological Association, 1966.
51. APA, AERA, NCME. Standards for educational and psychological tests and manuals. Washington, DC: American Psychological Association, 1974.

Effect of optional vs. mandatory participation in RTW program.

Step	Cost*	Optional	Cost	Mandatory	Cost
1	$500	156,464	$ 78,232,167	400,549	$ 200,274,348
2	$2,000	125,171	$ 250,342,936	200,274	$ 400,548,697
3	$1,500	100,137	$ 150,205,761	100,137	$ 150,205,761
4	$1,000	90,123	$ 90,123,457	90,123	$ 90,123,457
5	$500	81,111	$ 40,555,556	81,111	$ 40,555,556
Total	$5,500	73,000	$ 609,459,877	73,000	$ 881,707,819
Voc Prep**	$10,000		$ 730,000,000		$ 730,000,000
Total VR Costs			$ 1,339,459,877		$ 1,611,707,819

Lifetime Roll Costs (73,000/yr. successful at RTW)***

Psych	$ 228,000				
Musculoskeletal	$ 126,000				
Average	$177,000				
SSDI Costs			$ 12,921,000,000		$ 12,921,000,000
Savings Potential			$ 11,581,540,123		$ 11,309,292,181

Additional SSDI savings to SSA through shared private-public partnership (LTD)

Step	Cost	Optional	Cost	Mandatory	Cost
1	$250	23,470	$ 5,867,413	60,082	$ 15,020,576
2	$1,000	18,776	$ 18,775,720	30,041	$ 30,041,152
3	$750	15,021	$ 11,265,432	15,021	$ 11,265,432
4	$500	13,519	$ 6,759,259	13,519	$ 6,759,259
5	$250	12,167	$ 3,041,667	12,167	$ 3,041,667
Total	$2,750	10,950	$ 45,709,491	10,950	$ 66,128,086
Voc Prep	$5,000		$ 54,750,000		$ 54,750,000
Total VR Savings			$ 100,459,491		$ 120,878,086

* anticipated average costs per step
** average training and counselor expenses subsequent to plan development
*** assumes 10 years of SSDI and Medicare benefits for musculoskeletal impairment allowances and 16 years for psychological impairment allowances.

Chairman BUNNING. Thank you all for your testimony. I want you to know we will submit questions for the record in writing to you, but we want to do some individual questioning.

Ms. Ross, in your testimony, you advocate the importance of testing and evaluating new measures to return beneficiaries to work and caution against focusing on one option to the exclusion of alternative measures. Do you think that return to work legislation should authorize the testing of various alternatives, rather than a full implementation of one measure?

Ms. BASCETTA. Yes, Mr. Chairman, we do prefer testing various alternatives. Because our analysis shows——

Chairman BUNNING. Would you please bring the mike closer so everyone can hear you.

Ms. BASCETTA. We do prefer testing more than one alternative, and the reason is that our analysis has shown there are many interrelated problems. So we think we could obtain richer information about what might work best if we test at least a few ideas in a couple of areas. For instance, we would want to know before full implementation how different changes in work incentives might affect caseload growth and work effort, and we would also like to know how many VR providers might participate and who they might serve under different reimbursement mechanisms.

Chairman BUNNING. Do you have any recommendations who should monitor return to work alternatives, given SSA's record on managing demonstration projects?

Ms. BASCETTA. We don't have a specific recommendation about who might monitor, but we would anticipate that SSA's Office of Research, Evaluation, and Statistics would hire specialized expertise, you know, a nationally known researcher, or a firm with a track record in conducting social experiments. And, we would also strongly advocate peer review, outside peer reviewers, particularly during the design of the study, and also at important points during the analysis of the data.

Chairman BUNNING. I think Mr. Christensen mentioned the fact that there have been pilot programs in existence for over the last 17 years, and we are having the administration recommend another pilot program.

Let me ask all of the participants on this panel, if the fear of losing a medical card or medical insurance is one of the principal barriers to returning to work for people with disabilities? In other words, if we could provide in a piece of legislation the fact that they are going to be covered by Medicaid or Medicare, and have it reasonably priced—by that I don't mean the current $300 plus after 9 months—would that address the main barrier right now from returning people from the SSDI and SSI rolls to the work force?

Mr. MATHESON. It is an important barrier. I think the main barrier is motivation on the clients' parts. The most important——

Chairman BUNNING. Please repeat that. I didn't understand.

Mr. MATHESON. I think the absence of a medical care card would be a very important barrier. It is with my clients. I think the most important barrier has to do with a person's motivation.

Chairman BUNNING. Anyone else care to respond.

Mr. KREGEL. I would like to comment on that. There are provider agencies, both public and private, in operation this morning, in which people are meeting with the consumers with disabilities, who are coming with them, expressing an interest to return to work. What these professionals are doing in collaboration with the consumer is not figuring out how they can get off the SSDI rolls, but rather how to maximize their earnings while retaining their SSDI eligibility, so that they can maintain their eligibility for Medicare services.

Chairman BUNNING. What if we took that factor out though?

Mr. KREGEL. Then the issue becomes whether the individual is financially better off as a result of returning to work, and by maintaining Medicare eligibility you eliminate a major, major factor of that cost equation for the individual, because of the special types of expenses that they are going to have related to their medical expenses.

Chairman BUNNING. Also, in regard to the employment in the private sector, there is the barrier that the liability assumed by the employer is so high.

Is there someone else?

Mr. Baron.

Mr. BARON. In that regard, a number of States have begun to experiment through the 1115 waiver program with various kinds of

sliding scale programs, as well as wraparound coverage, and either of those, in addition to full continued coverage through Medicaid and Medicare, are possibilities that need to be considered. I don't think we have much evidence yet of which of those is going to be most effective, but it is a major barrier in terms of the culture of unemployment and the lack of motivation that exists in the community of people I am most familiar with.

Chairman BUNNING. I think there could be a sliding scale built in according to the amount of earnings as to how much you might be offered in medical coverage.

Would anyone else like to comment?

Ms. RENO. If I may, Mr. Chairman, that was the thinking behind the panel's recommendation for an affordable and understandable Medicare buy-in. There are two problems with the Medicare buy-in. First, it is very, very difficult to explain to a beneficiary what the price of it is, so the price needs to be both affordable and understandable. Scaling it to their earnings is an idea that our panel thought would work. That is understandable.

The second point the panel recognized is that for many people on the disability rolls, prescription medications are needed in order for them to function. They need it while they are disabled and not working, they need it while they are working, and that is not covered by Medicare, which is why Medicaid often is very important.

Chairman BUNNING. Anyone else?

Ken, go ahead.

Mr. HULSHOF. Thanks.

Ms. Ross, this first one is for you. Dr. Growick, maybe you can also comment on this particular question, but, Ms. Ross, you mentioned that you recommended to SSA they should develop strategies to help intervene earlier in the application process, maybe even prior to awarding benefits, to help applicants assess work capacities. Would SSA have to actually advance screen for those who would somehow presume to be disabled, and are there some problems along with that?

Ms. ROSS. Well, you are certainly right in pointing out that it is not easy to figure out how you would have a whole set of applicants move into the vocational rehabilitation world. There are some possibilities for something that a lot of beneficiaries say they really would like, such as one-stop shopping. This could happen in some SSA offices, where you could have vocational rehabilitation people and other kinds of employment and training facilities there. Without its being at all involved with SSA, you could make some of these referrals before people began applying for benefits. Maybe there is a possibility for limited screening, that is another way to look at it.

The major point is that we know what we have now is too late for many people; that by the time you have had an award, it could be at least 1 year, and sometimes many years, after you have started to experience this physical or mental impairment. So while the precise solution isn't obvious, it seems like an area where we ought to grapple some more.

Mr. HULSHOF. Doctor, you mentioned the insurance industry has discovered it is cheaper and better to help beneficiaries return to work than it is to pay off a claim. Are there any lessons we can

learn in terms of early intervention from the insurance industry that might be included in some sort of reform proposal?

Mr. GROWICK. Yes, sir. Obviously earlier rehabilitation is better rehabilitation. The sooner you can get to an individual before they are disenfranchised from the workplace, the better off and research has shown that, some of my own research in terms of prediction of outcome. Within the workers' compensation arena, it is even paramount that that happens. The reason is that claimants are receiving TT, temporary total disability payments, so the clock is ticking. Rehabilitation professionals, graduates of my training program, will go into the private sector, work with workers' compensation claimants, know that time is their enemy, so they have to enter the process as soon as possible.

There is another fiat they use in that whole process in workers' compensation rehabilitation, and that is something we call a hierarchy of return to work, and it is codified in some workers' compensation systems nationally, hierarchy, return to work, meaning when you work with somebody with a disability, especially if it is work-related, you go back to the same employer and try to get the person back to work in the same job with the same employer. For some reason, they don't have the functional capabilities to do their previous work, you then move down the hierarchy to a different job, same employer, see what else can be done at the worksite with modifications, what other essential functions the person can perform for that employer. Then you could go to a different employer, same job, down this hierarchy.

Early rehabilitation is crucial. That is part of the problem with bureaucracy that is government run. You have to employ the free-enterprise system, have private providers out there who are going to respond quickly and fast, and also know how to talk to employers and get the job opportunities that are necessary.

Chairman BUNNING. Doctor Berkowitz, you want to comment, and let me even ask you as sort of an introductory question because my time is limited, do you believe personally that SSA should manage a return to work program, Dr. Berkowitz?

Mr. BERKOWITZ. Do I believe they should manage a return? No, no, I don't. I recognize that the GAO recommends we ought to intervene early. Do we really want the Social Security Administration to pay trust fund money to persons not on benefits? Do we want to turn SSA into a rehabilitation agency? We are lucky SSA can pay checks on time. The Social Security Administration is not set up to accomplish these functions.

The essence of the ticket plan is that SSA is relieved of these functions and responsibilities.

I don't know whether any particular rehabilitation scheme will work. The advantage of having a variety of private providers is that each can do their own thing. Best of all there are no risks. We pay them only if the beneficiary goes back to work.

Why am I so against milestones? It is not that I wouldn't love to reward providers. It is because I have no confidence in the ability of SSA to negotiate fee schedules. The minute you begin to pay for milestones, you are creating a new bureaucracy, and I don't think that is necessary. I want to pay people only for what we want. We want people back at work, in good productive jobs. I don't

think anybody around this table knows of any one way to do that. There are just a variety of ways to do it and the Ticket Proposal allows all of them an opportunity to demonstrate their utility.

Chairman BUNNING. The gentleman's time has expired.

Let me ask Dr. Growick, you recommended an incentive for employees who hire SSA recipients, such as a FICA tax credit. What data is there to support that kind of tax credit, and is it really needed?

Mr. GROWICK. The data is mostly personal experience.

Chairman BUNNING. No studies, just your own experience and your own students' experiences?

Mr. GROWICK. Correct. In terms of working with employers, our experience is that you need some sort of leverage when you go to an employer to try to get them to accept individuals with limitations because of some of the potential liabilities down the road. Anything we can do to help the rehabilitation industry work with employers, you know, helps the entire process, and there is some, you know, tax credits with the general rehabilitation field that have been tried over the years that have been successful in terms of opening doors to employers that otherwise might not be so receptive.

Chairman BUNNING. Dr. Berkowitz, unfortunately, or fortunately, the SSA is in the SSDI business right now. What makes you think that the ticket model that we are talking about will work?

Mr. BERKOWITZ. They are in the DI business; they pay benefits.

Chairman BUNNING. That is correct, they are in the business—there is a law on the books right now, right now, that requires a review of everyone on SSDI over a 3-year period. Obviously they are not complying with the law. That is the law. So let's move on from there, and I want to know your opinion on why you think your Ticket Program will work.

Mr. BERKOWITZ. I don't know whether it will work or not. All I am saying is it is a risk-free method of trying it. Now, you seem to be concerned, or someone on the panel seems to be concerned, about the fact that this is going to disenfranchise certain providers out there.

Chairman BUNNING. I am not concerned about any of that. I am concerned about getting answers.

Mr. BERKOWITZ. I think this is a good way to try. Let's unleash all of the creativity that Bruce has talked about in regard to the Workers' Compensation Program. We know a lot of exciting things are happening in the private sector. Now insurance carriers are continually hiring people to aid people to get back to work. They have no prescribed protocol. They do it in 100 different ways. And I say here is a marvelous opportunity to try at no cost to the U.S. Government.

Chairman BUNNING. Well, you also really emphasize the fact it has to be voluntary.

Mr. BERKOWITZ. I am sorry?

Chairman BUNNING. That it has to be voluntary.

Mr. BERKOWITZ. Yes.

Chairman BUNNING. That you can't mandate it. Tell me the reason that it has to be voluntary. Why is that so important?

Mr. BERKOWITZ. I have looked at these programs in this country and abroad in many different countries, and I have never seen compulsory provisions work. We are confronted with the atomic bomb dilemma. If the only penalty is cutting people off the rolls, administrators are hesitant to use it. The essence of this plan is to get the disabled person together with a provider so that they can work together to get the person back to work. The whole idea of compelling people, or penalizing them, is contrary to the whole spirit and philosophy of this plan.

Chairman BUNNING. Mr. Kregel, let me ask you one question. You mentioned in your statement that a strong management structure, external of SSA, is needed to effectively implement the return to work program, much like Dr. Berkowitz. Can you elaborate on why a return to work program should be administered outside of SSA, other than the bureaucratic maze that we have?

Mr. KREGEL. There are functions that are required, such as expertise in the design and management and evaluation of employment programs and return to work programs; and there is also a function relating to consumer advocacy, consumer assessment, and building consumer protections into the delivery of services. Both of those are unique areas of expertise, and it seems to me that those types of functions should be identified outside the Social Security Administration.

Specifically, there are some issues—that were alluded to in an earlier panel—about information that would be provided to individuals who need to make a decision; first, should I participate in the Ticket Program, and then second, what agency should I select to deposit my ticket with? Now, who should provide that information? Should it be that the provider agencies themselves recruit and market their services to individuals? Is that exclusively SSA's responsibility because of what we know about prior efforts in terms of promoting work incentives and other factors; or is there a need for a management structure that can give information to people in the best way that will work in their particular locale?

Mr. HULSHOF. Mr. Chairman, I would be extremely remiss if I didn't lob at least one softball to a fellow Missourian.

So, Dr. Matheson, you make some very strong points in support of the functional capacity evaluation, and I appreciate the supplemental, because rather than bog down with some of the costs of it, is a functional capacity evaluation needed in every case; and if not, in what types of circumstances would it be most useful?

Mr. MATHESON. I think it is going to be something that could be mandated as a screening process for the subsequent voluntary participation and the ticket. I think it is going to bring about such great savings, identifying those people who are good candidates, that it ought to be used widely.

Mr. HULSHOF. Are there certain industries that have utilized a similar type of evaluation that we can look to to say that this is a good model for us to follow?

Mr. MATHESON. This model began at Rancho Los Amigos Hospital, and if you look at the large rehabilitation centers that have the full range of capabilities, from physicians, PTs and OTs down to rehabilitation counselors, you find this is a stepwise model that is interdisciplinary. I think its application on a wide basis is new

and in some ways revolutionary, but the model itself is one that is grounded in quite a bit of experience.

Mr. HULSHOF. Last question. Since I haven't had a chance to digest some of the numbers, is there an average cost of a functional capacity evaluation?

Mr. MATHESON. The process we have projected is $5,500 before we get to something that we would say is a ticketed sort of benefit, of vocational preparation, and that $5,500, it would only be a $500 cost if the person only makes it through step one. It would be an aggregate of $4,000 if the person makes it through step three and so forth.

Mr. HULSHOF. Thank you, sir.

Mr. MATHESON. You're welcome.

Chairman BUNNING. Ms. Reno, you mentioned one of the panel's conclusions was that current benefits are not a strong deterrent to work. Are current benefits, in your view, a strong deterrent to people coming on the rolls?

Ms. RENO. The panel's conclusion was that for people who had a choice to work or to turn to benefits, the benefits themselves are a very poor second choice to having and remaining in a job.

Chairman BUNNING. I apologize, I have to go to the floor, and if my colleague has no further questions, we will submit to you in writing those questions that we have failed to ask you today in person. Thank you for your cooperation.

[The following was subsequently received:]

Questions received from Hon. Jim Bunning, and Subsequent Responses from Dr. Bruce Growick

1. In your testimony, you said that a critical component of any new legislation should be provisions for informed choice throughout the rehabilitation process with a payment system that is viable and realistic. What are the key components, in your view, of a viable and realistic payment model for providers?

The development of a payment system should focus on providing the consumer with choice. That means developing a system that will enable and encourage all qualified providers, both large and small, to participate in the program. In order for this to occur, a payment model must contain milestone payments so that small providers can remain financially viable during the long process of consumer job placement and retention. Also, a larger reimbursement target must be established to encourage providers to have a vested interest in long-term job retention by the consumer. The most viable reimbursement option appears to be a percentage of the savings realized to the Social Security fund from having the individual being self sufficient and off the roles.

2. You recommend that a new return-to-work system be as streamlined and efficient as possible and avoid increasing SSA's workload. Do you have any specific recommendations for designing such a system?

The Social Security Administration (SSA) is a government agency that was established to provide retirees, the disabled and the poor with financial aid. The SSA is not in the business of rehabilitating its recipients with disabilities. Therefore, a system should be developed that allows SSA to retain oversight over payments but establishes a governing body that will regulate the delivery of services by taking into account the needs of consumers and the qualifications of providers.

Questions received from Hon. Jim Bunning, and Subsequent Responses from John Kregel

[At the time of printing, no responses had been received from Mr. Kregel.]

You mention that individuals viewed as too challenging to serve, or too poor a risk for meeting the success criteria of the program (such as individuals with persistent mental illness or brain injury), will have extreme difficulties locating providers willing to serve them. Can you envision any type of incentive or special provision which might be included in legislation to help ensure these individuals do receive services?

SSA's proposal contains a provision for protection and advocacy funding designed to assist SSA recipients with any disputes with providers that may occur. What are your views regarding a protection and advocacy system? Do providers need a system to address disputes that they may encounter?

I understand that you are a vendor of supported employment services for persons with severe disabilities. Could you describe the services that you provide and the process for placing individuals with severe disabilities into the workplace?

Questions received from Hon. Jim Bunning, and Subsequent Responses from Richard Baron

Chairman Bunning's Question #1: Your testimony focused on the unique challenges faced by individuals with mental impairments. If a ticket-type approach isn't the best option for these individuals, what other options do you envision working?

Response. While the 'ticket approach'—which emphasizes empowering consumers to choose their providers and rewarding those providers on the basis of specific outcomes—is a reasonable way in which to structure Social Security's response to meeting the needs of persons with serious mental illness, the development of a ticket approach must avoid a number of operational problems that, unless addressed, will limit the rehabilitation opportunities available to people who are often quite eager to enter the competitive labor market. To avoid some of the problems that can be anticipated, we would suggest building into the 'ticket approach' a number of key operational principles. Along these lines, the 'ticket approach' to insure that the tickets are:

Accessible. Because we believe that there are no effective means to accurately predict which SSA recipients or beneficiaries are most likely to succeed at working in the competitive labor market, access to the ticket should be universal, and not involve testing and screening out possible candidates for rehabilitation and employment programming.

Renewable. Persons with serious mental illness will often need to be engaged in the process of rehabilitation several times in their lives in order to establish a long-term relationship with the labor market: for this reason, the 'ticket' system cannot be a 'one-time-only' offer on the part of the Social Security Administration.

Divisible. Rehabilitation providers will need to be reimbursed at various milestones—on the basis of specific achievements at points along the client's progress toward economic independence—if the ticket approach is to avoid encouraging agencies to work only with those most readily employed and avoid those clients who will take longer or may choose to drop out mid-process.

Transferable. To maximize client choice, the ticket must be transferable, at the client's request, from provider to provider: some clients may be dissatisfied with the services they receive; others may choose to leave an area or a state to make a new life for themselves elsewhere, and others may believe better employment prospects will be in other settings.

A ticket approach that embodies these principles is far more likely to be able to meet the needs of persons with serious mental illness, maximizing both their choice of providers and their choice of the type, pace, and outcomes of the rehabilitation program they may find most helpful, at the various points in their lives. It must be emphasized that persons with mental illness often have a long-term disability, and this will require a long-term commitment to provide rehabilitation services if the nation is going to encourage them toward long-term careers. A ticket approach can and should respond to these unique needs.

Chairman Bunning's Question #2. Various proposals create a system under which an SSA recipient would be given a ticket which they could use to obtain vocational rehabilitation and employment services from a public or private provider. In your view, will the majority of SSA recipients be able to make informed decisions on how best to assign their ticket? How can consumers best make informed choices regarding provider services?

Response. There is no question but that people with serious mental illness and others with serious disabilities will be able to make informed decisions on how best to assign their ticket if they are provided with the kind of information on which informed decisions are made. To insure that such information is available to consumers, Social Security will need to insure that:

—*information about the operations and outcomes of provider agencies will be accessible.* SSA will need to support the collection of both outcome data and consumer assessments of the various provider agencies they may want to use. Much of this information can be gathered by consumer organizations themselves.

—*'vocational case management' resources will be accessible to help clients make choices.* In addition to providing the information, consumers will need access to guidance—from either professional or consumer organization—to help them determine goals, assess the offerings from various providers, and make choices on an ongoing basis throughout the rehabilitation process.

Finally, many consumers are likely to face very few choices in their communities: in many parts of the country—in both urban and rural communities—there may only be a single provider of work oriented rehabilitation services, in which case 'choosing' between depositing their ticket with their local Office of Vocational Rehabilitation (which will contract with the provider for service delivery anyway) or contracting directly with the same provider agency is really no choice at all. Social Security—to make their reliance on 'client choice' more real—will need to explore varied means for promoting the development of a far richer array of rehabilitation program.

Chairman Bunning's Question #3. You mentioned in your testimony that SSA's current work incentives are largely unknown. Do you have recommendations on ensuring that SSA recipients are informed and knowledgeable on current or future work incentives?

Response. The Social Security Administration will indeed need to make a substantial commitment to ensure that information about the work incentives are available. Two major activities need to be undertaken. First, a much greater effort must go toward informing the Social Security Administration's own field staff about the usefulness and details of existing and emerging work incentives: it is now commonplace to hear complaints from vocational rehabilitation counselors, consumers of disability services who are back at work, and employers that local Claims Representatives are either unaware of or misinformed about the work incentives within their own systems.

Second, there will need to be a comparable effort to provide local provider agencies with similar information, so that persons with disabilities are informed—as early as possible and with absolute accuracy—about the impact of work (and the work incentives) on their financial lives. The Matrix Research Institute/University of Pennsylvania Research and Training Center on Vocational Rehabilitation Services for Persons with Mental Illness, supported under a grant from the National Institute on Disability and Rehabilitation Research, is currently exploring two different modalities in providing such information to consumers:

—*internal advocacy* involves the development of 'in-house' expertise, in which each provider agency is funded to support a half-time or full-time position to provide vocational rehabilitation clients with information about work incentives. Those who fill such positions will need both initial training and ongoing support.

—*external advocacy* involves the establishment of a regional center (on a statewide or citywide basis) to be used by both rehabilitation staff and clients, where their questions about the work incentives can be answered authoritatively—by telephone and fax and E-mail, or in training programs and in-person presentations—by trained full-time staff.

Again, many of these advocacy programs can be staffed and run by consumer organizations themselves: here at MRI we have successfully operated a Work Incentives Advocacy (WIA) program that has been entirely consumer staffed, which has allowed the WIA advocates both to speak with great authority and to gain the trust of their audience...

Again, let me thank you for your interest in our views. We would be delighted to have the opportunity to answer any further questions on these critically impor-

tant matters as the Subcommittee on Social Security moves forward. The Subcommittee's efforts are especially encouraging to those of us in the field: there is a growing conviction that people with all kinds of serious disabilities have enormous but largely unrealized vocational potential, and that the current economic climate offers an unparalleled chance to seek to define a new role for people with disabilities in the competitive labor market.

Questions received from Hon. Jim Bunning, and Subsequent Responses from Leonard Matheson

[At the time of printing, no responses had been received from Mr. Matheson.]

What is the difference between a functional assessment and a functional capacity evaluation? How does a functional capacity assessment measure motivation or less than full effort performance?

You recommend evaluating the occupational potential of a person with a disability on a "progressively restrictive basis." What exactly does this mean and how would such an evaluation serve as a gatekeeper to the process?

Chairman BUNNING. The Subcommittee stands adjourned.
[Whereupon, at 12:09 p.m., the hearing was adjourned.]

BARRIERS PREVENTING SOCIAL SECURITY DISABILITY RECIPIENTS FROM RETURNING TO WORK

THURSDAY, JULY 24, 1997

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

The Subcommittee met, pursuant to notice, at 1 p.m., in room B–318, Rayburn House Office Building, Hon. Jim Bunning (Chairman of the Subcommittee) presiding.

Chairman BUNNING. The Subcommittee will come to order. Today we will continue with part II of our hearing on barriers preventing Social Security disability recipients from returning to work. My formal statement was made yesterday, so my remarks this afternoon will be very short.

During part I of the hearing we heard from the Social Security Administration, the Department of Education, the General Accounting Office, and experts in the field of rehabilitation.

Today I look forward to hearing from consumers, those individuals who are closest to the issues surrounding return to work, and from those who work day to day providing rehabilitation services.

I am confident that each of you will provide important insight for the Subcommittee to carefully consider. In addition, I want to thank each of you for your tireless advocacy and commitment.

Many of you have provided your counsel to both my staff and Mrs. Kennelly's staff, and I want you to know how much we appreciate your help.

In the interest of time, it is our practice to dispense with opening statements, except from the Ranking Democratic Member. All Members are welcome to submit statements for the record. I yield to Mrs. Kennelly for any statement she would like to make.

Mrs. KENNELLY. Thank you, Mr. Chairman. Mr. Chairman, the testimony we received yesterday was useful in setting out some of the work disincentives which the disabled face in attempting to return to work. I am sure we will find today's testimony equally as helpful.

I am pleased the administration has now submitted to us a plan for returning more beneficiaries to the workplace. I hope that you and I, Mr. Chairman, together with the administration can work on a bipartisan solution to this problem, and I look forward to today's hearings.

Thank you.

Chairman BUNNING. Thank you, Barbara.

Testifying on the first panel today are Susan Webb, executive director of the Arizona Bridge to Independent Living in Phoenix, and board member of the National Council on Independent Living; Bonnie O'Day with the National Council on Disability; Tony Young, cochair of the Consortium for Citizens with Disabilities Vocational Working Group; Lorraine Sheehan, chairperson of the Governmental Affairs Committee of The Arc of the United States, accompanied by Marty Ford, assistant director of the Governmental Affairs Office; Brenda Crabbs, a current SSDI beneficiary testifying on behalf of the National Arthritis Foundation; and Suzanne Erb, a former SSDI beneficiary from Philadelphia, Pennsylvania.

Ms. Webb, if you would start the testimony please.

STATEMENT OF SUSAN WEBB, EXECUTIVE DIRECTOR, ARIZONA BRIDGE TO INDEPENDENT LIVING; AND BOARD MEMBER, NATIONAL COUNCIL ON INDEPENDENT LIVING

Ms. WEBB. Thank you, Mr. Chairman. Members of the Subcommittee, thank you very much for the opportunity to be here with you today.

My name is Susan Webb. I am executive director of the Arizona Bridge to Independent Living, and I am also a board member of the National Council on Independent Living, or NCIL, and I chair NCIL's Subcommittee on Social Security issues.

Representative Bunning, on the last day of the 104th Congress, you presented a statement before the House floor that gave a very deplorable statistic: That 1 in 1,000 people who ever get onto SSDI voluntarily leave those rolls.

And I guess my purpose here today is I am the 1 in 1,000 who made it.

Chairman BUNNING. Congratulations.

Ms. WEBB. Thank you. Twenty-three years ago I fell off a motorcycle at a company picnic. It happens. And I woke up 2 days later, having permanently and irreversibly lost the use of 60 percent of my body.

For the next 3 years I took advantage of the SSDI Program, and it was my safety net that enabled me to live independently in the community while I rehabilitated both physically, medically and vocationally.

Now, at the end of that time, I used the trial work period to return to work. I have been gainfully employed full time without interruption for the past 20 years.

Now, as near as I can figure, the American taxpayer spent about $29,000 on SSDI benefits to me and vocational rehabilitation services. I am very proud to tell you today that in 1 of those 20 years that I have been employed, I paid back every penny of that $29,000 in taxes. Admittedly, it was a good year.

The other 19 years I did not make quite that much, but I figure that still as an employed person I was making a personal investment in the greatest country in the world.

Now, you might assume that if I can do it, why are not all the other millions of people that are receiving SSDI doing the same thing. Well, the fact is that I was very, very lucky.

Everything fell into place for me. My medical care issue was not a problem, because I was insured by two different private health care coverers at the same time.

A key issue was that the Social Security Administration did not hassle me. I went through the 5-month waiting period. I got into the system. I did not have lengthy appeals. I did not have to get an attorney. While I was on the system, they did not hassle me. They did not overpay me.

And so when it was time to go back to work it was not a fear for me. I did not fear going back to work, that the SSA was going to come and beat up on me over it. So it seemed the logical thing to do to try work, because I felt that if it did not work out for whatever reason, I would still be able to use the SSA as my safety net.

I had a car that was paid for. Transportation was not an issue. My family was supportive. My uncle built a ramp and put in grab bars so I did not have to go into expensive—well, I do not know what the euphemism is, but we call them nursing homes where I live. I was able to stay and rehabilitate in the community.

And the fact was that my disability was not that severe. Quite frankly, I do not need help with toileting, dressing, bathing, meal preparation. I do not need help on the job in terms of personal assistance services, sign language interpreters or job coaches. People who need those kinds of things need extra support, and those things are not available to you today to any appreciable extent if you do in fact work.

The other factor was that jobs were available, just like today. We are in a really good economy. This is the best time right now for people, in a post-ADA era, in a strong economy to return to work. We are there now to where I think we can do some of the things that I availed myself of back in the seventies.

Today my colleagues and I come to you with a proposal. This proposal was developed in Houston, Texas, this year where 40 consumers from around this Nation who had lived it—had been there—who had been on the system, got together in a room, and answered one fundamental question: What is it going to take for people with disabilities on SSI and SSDI to return to work?

We believe, Mr. Chairman, and Members of the Subcommittee, we have answered that question. We believe that it is a reasonable and it is a cost-effective proposal. But I am here to tell you I am not an economist. I do not have a Ph.D. in anything.

All I know is that I lived with this, and I got off the system because the system was there for me when I needed it in a rational way. Today it is not for most beneficiaries.

Our proposal fixes that, because it is finally the consumer voice from people who really know what needs to be done.

I caution you that we cannot take a piecemeal approach. This has got to be comprehensive, and I applaud your leadership and I look forward to your leadership in taking it beyond the jurisdiction of this Subcommittee, and taking it to a massive, comprehensive solution.

No more studies. No more demonstration projects. No more Band-Aids. No more delays. Millions of people are counting on you to be an integral part of Workforce 2000.

That completes my comments, Mr. Chairman. I welcome any questions.

[The prepared statement follows:]

Statement of Susan Webb, Executive Director, Arizona Bridge to Independent Living; and Board Member, National Council on Independent Living

Mr. Chairman, members of the subcommittee, thank you for your interest in disability-related issues. Thank you for inviting me to be with you today. My name is Susan Webb, and I am the Executive Director of the Arizona Bridge to Independent Living (ABIL), Board Member of the National Council on Independent Living (NCIL), and chair of NCIL's Social Security subcommittee.

Representative Bunning, on the last day of the 104th Congress you delivered a statement from the House floor that included a deplorable statistic: 1 in 1,000 SSDI beneficiaries voluntarily leave the rolls to return to work. I am here today is as a representative of that statistic. I am the 1 in 1,000 who did so. Twenty three years ago I fell off a motorcycle while attending a company picnic. I woke up two days later with 60% of my body permanently and irreversibly paralyzed. After three years of physical and vocational rehabilitation I used the SSDI Trial Work Period to return to work. I have worked full-time without interruption for the last 20 years.

As near as I can estimate, the American people provided me with approximately $29,000 in SSDI and Vocational Rehabilitation Services (allowing 20% for administrative overhead). I am proud to say that in one year during the last twenty (admittedly a good year!) I paid back every cent of that $29,000 in taxes. As for the taxes I paid during the other 19 years, well, I figure that's an investment in the greatest country in the world. Clearly, my returning to work was far more cost-effective for our Nation than if I had not returned to work. And, of course, my lifestyle is far closer to the American Dream as a result.

Now, you might be inclined to assume that if I did it, so can the millions of other SSDI recipients. Unfortunately, I am the exception rather than the rule because I was very, very lucky. Many components involved in my achieving this goal happened to fall perfectly into place for me. It obviously does not happen that way for the vast majority of SSDI beneficiaries. For example:

1. My medical expenses were completely covered as I was dually insured by an employer-provided healthcare policy and as a dependent on my husband's policy. Although they did not cover all the cost of assistive technology (formerly called durable medical equipment), my employer had purchased short-term disability insurance which provided me with $100 per week for 26 weeks. I used this income to purchase the additional equipment I needed to achieve independence.

2. The Social Security Administration didn't hassle me about eligibility for benefits. After the five-month waiting period I began receiving cash benefits without lengthy appeals. I received accurate information on options available to me including the Work Incentives. I received no threats or letters of "overpayments." In short, I was not afraid to leave the rolls as I had not had a threatening experience with the SSA to begin with. It never occurred to me to worry about what would happen if for some reason I found I did not have the endurance to work successfully. I assumed the safety net of the SSA would be there for me if I needed it.

3. I owned an automobile that was fully paid for. Having transportation that enabled me to come and go whenever and wherever I needed allowed much greater opportunity to continue with outpatient therapy, attend college and ultimately return to work.

4. State Vocational Rehabilitation was relatively new as the Rehabilitation Act of 1973 had just been adopted. My VR counselor was focused on counseling rather than the professionalized, process-oriented, bureaucratic system we have today. She was actually helpful in advice and guidance while I made my own decisions about the direction of my life.

5. My family was supportive. I went to live with an aunt and uncle for six months. My uncle built a ramp and installed grab bars. They had two children living at home with disabilities. They knew I needed time to practice independent living skills to become completely independent and avoid institutionalization in expensive nursing homes. I have never been institutionalized due to the support available to me that enabled me to adjust while living and functioning in the community.

6. My disability is not as severe as that of many others. I was young, healthy and strong when my accident occurred. I do not need personal assistance for bathing, dressing, toileting, meal preparation or housekeeping. I do not need personal assistance on the job such as job coaches, sign language interpreters, readers, etc. For those who need these services, working is only possible when such services are available, preferably on a co-pay or tax credit basis.

7. When I started back to work, the economy was good, jobs were available. My employer, Michigan Bell, had just been selected by the President's Committee on Employment of the Handicapped (now the President's Committee of Employment of People with Disabilities) as "Handicapped Employer of the Year." I had marketable skills and training. I worked for the Bell System/AT&T for 12 years in two states. Accommodations, when I needed them, were made willingly. I was part of the team and considered a valuable employee.

My colleagues and I come to you today with a proposal developed by those of us who have "been there." On January 31 and February 1 of this year, 40 consumers with disabilities, most of whom have been on SSI or SSDI, assembled in Houston, Texas to answer one fundamental question: What will it take so that SSI/SSDI beneficiaries can reduce our dependency on these systems by starting or returning to work? We believe that finally a comprehensive proposal from those of us whose very lives depend on this system have come forward with a document demonstrating a cost-effective, reasonable answer to that question.

As NCIL's representative at the Houston conference, I was one of the five steering committee members facilitating the position development. NCIL's Board of Directors formally adopted the position at our Board meeting in March, 1997. It is important to note, however, that this position is representative of people across the Nation representing a cross-disability, cross-country, multi-cultural perspective. It stands on its own merit as a comprehensive document that should be used as a jumping-on point to other stakeholders as partners in a cohesive, bipartisan movement toward successful (re)entering the workforce for millions of Americans with disabilities.

The National Council on Disability plans to issue a report to you within a week that details all of the provisions of the position. For the sake of brevity, however, I offer you the following summary of our position:

THE PROBLEM:

- Only 1 in 500 [1] DI beneficiaries voluntarily leave the rolls.
- Few beneficiaries know of or use the current work incentives.
- Linkage between benefits perpetuates "all-or-nothing" focus (e.g. beneficiaries lose healthcare coverage if they leave the rolls)
- State VR system is the only option for SSA referrals for return-to-work services. VR serves only a small percentage of these referrals.
- SGA earnings cliff discourages work.
- Lengthy eligibility determination, lack of consistent information by SSA, and lack of confidence in SSA disincents work attempts.

GUIDING PRINCIPLES FOR PROPOSED SOLUTION:

- System change must include incentives for all stakeholders: beneficiaries, employers, insurers, public and private vocational providers, taxpayers, SSA.
- SSI and DI programs need to be simplified/consolidated.
- Changes must be comprehensive. Piecemeal solutions have never worked.
- Focus must be on reduction of dependency on the system rather than whether an individual fully leaves the rolls.
- Proposed solutions must be revenue neutral or demonstrate savings to the trust fund and/or general fund.
- Systems must focus on the relationship between beneficiaries and employers. SSA should not be gatekeeper or be in the business of vocational services. Beneficiaries must control and be primarily responsible for the own return-to-work plan.

HIGHLIGHTS OF POSITION:

Increase Choice in Employment Services and Providers:

- Consumers/beneficiaries take responsibility for choosing among providers of return-to-work employment services, both public and private.
- Providers of employment services are reimbursed upon attainment of milestone outcomes, e.g., after completing training, after job placement, after a period of time on the job.

[1] According to a General Accounting Office report submitted to the Ways and Means Subcommittee on Social Security Disability in 1996. Representative Bunning's statement from the House floor used a 1 in 1,000 statistic.

Streamline SSI/SSDI Work Incentives:

• SSI and SSDI benefits should be reduced $1 for every $2 earned above $500 in earned income. Reductions should be made in $50 and $100 increments. This would allow low wage earners or those only able to work part time to work as much or as little as their disability allows but would still reduce dependency on the system. The incremental offsets would reduce the accounting burden and the historical inaccuracy of determining benefit reductions monthly.

• Eliminate existing complexities: e.g., Trial Work Period and Extended Period of Eligibility. The offsets described above would achieve the safety net needed to encourage return-to-work attempts but would do so in a manner more consistent with transitioning rather than reaching an "earnings cliff" associated with the existing TWP and EPE.

• Eliminate Substantial Gainful Activity (SGA) except as it relates to initial SSDI eligibility. We understand that an earnings benchmark is needed to identify when an individual is considered "employed" by the very nature of SSDI being an income replacement program when loss due to disability occurs. However, beyond initial eligibility, it serves as an earnings cliff and bears no relevance on ability or inability to work, especially if the 2:1 offset proposed above is adopted.

• Retain the Plan to Achieve Self-Support (PASS) Program and apply it to SSI and SSDI beneficiaries. The PASS Program has been criticized recently for being underutilized, poorly managed by the SSA and used by beneficiaries with little successful outcome. We believe the PASS program represents a viable means for beneficiaries to ease back into the workforce by setting aside earned income for pre-employment expenses, such as specialized transportation, job coaching, sign language interpreters, personal assistance services, assistive technology and specialized transportation. We believe that the lack of usage and questionable success of the PASS Program is directly related to the fact that other barriers described in this proposal have not been addressed simultaneously. We believe the PASS Program would be immensely successful if implemented as part of a comprehensive public policy around (re)entering the workforce.

• Improve SSA accountability by establishing an independent, federally-funded oversight body that includes all stakeholders (51% consumers) who approve employment-related regulations and monitor their implementation. As evidenced in recent history by such progressive endeavors as the Americans with Disabilities Act, public policy should be shaped by the Americans whose lives are affected. Personal accountability and responsibility can only be achieved when those expected to be accountable and responsible have the major voice in the programs imposing the expectation. A consumer-controlled oversight entity will achieve this goal.

Remove Financial Disincentives to Work:

• Establish an Impairment Related Work Expense Tax Credit for SSI/SSDI beneficiaries who work to cover 75% of the cost of impairment related expenses up to a maximum of $15,000 per year. Phase out at an income level of $50,000 and end at $75,000. Individuals with the most severe disabilities (e.g. needing attendant services, sign language interpreters, job coaches) are the most difficult to employ because these expenses are rarely considered a "reasonable" accommodation for an employer to provide. Further, expenses for assistive devices such as motorized wheelchairs, lift-equipped vans, prosthetic limbs, etc. that make some individuals more employable are expensive and often not considered "medically necessary" such that health insurance would pay for these items. A tax credit would offset these expenses only when the individual is employed, thereby providing an incentive to actually go to work. Tax credits also apply only to actual disability-related expenses rather than "one-size fits all" cash benefits that offer no incentive to work.

• Current IRWE tax deductions should be extended to include expenses related to preparation for and traveling to and from work. The need for in-home personal assistance services and specialized transportation are a major barrier to employment. Tax deductions for these expenses would help offset these costs.

Enhance Employer Incentives:

• Implement a FICA exemption (50% first year, 75% second year and 100% third year). This incentive would be attractive to small and medium sized businesses whose fear of hiring persons with disabilities might be willing to give it a try in order to reap the FICA savings. The proposal assumes that after the third year, the employee will have become an indispensable part of the team.

• Implement a tax credit for true expenses such as increased workers' compensation costs, healthcare insurance, worksite modifications, sign language interpreters, print materials in alternative formats, on-the-job personal assistance, job coaches,

etc. Although numerous studies conducted over the years by corporations such as McDonald's and Dupont demonstrate that the cost of accommodations is minimal, many employers still fear that one-in-a-million case where the costs are extraordinary. This provision is to allay that fear but still provide a safety net for the rare circumstance where an employer is extraordinarily burdened.

• Establish an insurance fund that would cover employers' extraordinary expenses. Premiums could be taken as a tax credit. This would be an added benefit to allay employer fears.

Extend Medical Services:

• Establish a Medicaid buy-in to allow consumers to buy Medicaid on a sliding scale according to adjusted gross income after deductions for Impairment Related Work Expenses.

• Establish a Medicare buy-in after current coverage ends. Premium should be 10% of adjusted gross income in excess of $15,000. Current Medicare premiums are typically considered too expensive by most beneficiaries, especially those unable to work full time.

• Encourage states to provide personal assistance services to workers with disabilities on a co-pay or premium basis similar to the Medicare buy-in.

• Include a wrap-around provision in Medicare and Medicaid to fill gaps in employer-provided health insurance.

• Encourage states to provide equal access to psychiatric services including co-pays.

We realize that at first blush these recommendations might lead you to ask: "After all these benefits, what would be leftover from earnings to add to the tax base? Isn't this a little excessive? How will this possibly save the trust fund and/or general fund?" We are in the process of developing a means to cost-out this proposal. However, it is important to recognize these proposal provisions in the context of a large consumer base. No one consumer or employer would use all of them. The proposal is designed to offer the widest latitude to pick and choose those provisions that will incent a particular individual or employer. Our goal was to develop a proposal that would include all the flexibility needed to anticipate the characteristics of a broad base of consumers and employers. For example, the 2:1 offset would be attractive to a consumer who is only able to work part time or sporadically. For a consumer who begins work at a high wage, he/she will not be eligible for the offset. For those consumers whose accommodation needs are minimal, the employer would absorb the cost as a reasonable accommodation and, therefore, the consumer would not claim a tax credit.

By having the courage to make the massive changes envisioned here people with disabilities will gain a significant foothold on realizing the full promise of the Americans with Disabilities Act of 1990 by finally achieving equality with our non-disabled peers in achieving full economic independence and inclusion in the mainstream of American life. Not only will we the people with disabilities benefit but so, too, will those who provide employment services to us, those who employ us, those who insure us, and most importantly, the taxpayers who unwillingly financially support us.

We recognize this is a massive undertaking. We applaud this committee's leadership in bringing this issue to the forefront. We ask for your continued leadership in shaping an effort that will go beyond the jurisdiction of this committee to encompass both sides of the aisle and both houses of Congress. Anything less than a complete solution will only be a Band-Aid that WILL NOT WORK. If, however, we wage a massive systems change, millions of Americans with disabilities, hopelessly living in poverty today, will be successful, contributing members of Workforce 2000.

Chairman BUNNING. Thank you very much for your statement. Ms. O'Day.

STATEMENT OF BONNIE O'DAY, MEMBER, NATIONAL COUNCIL ON DISABILITY

Ms. O'DAY. Good afternoon, Mr. Chairman and Members of the Subcommittee. My name is Bonnie O'Day, and I am a member of the National Council on Disability. I was listed as chair in your program. I am not chair. I am chairperson of a Subcommittee that deals with Social Security return to work issues.

The National Council on Disability is a 15-member body appointed by President Clinton and confirmed by the Senate to advise Congress and the President on disability issues. We are an independent Federal agency that offers such advice and counsel.

And today we are here to reflect the thousands of voices of individuals with disabilities throughout this country who want to work. These individuals are anxious to reap the gains of the Americans with Disabilities Act passed by Congress in 1990, and also to increase the tax base by paying taxes because they have returned to work.

However, we have found that individuals with disabilities face tremendous financial barriers if they want to achieve this goal.

We are here today as the culmination of an intensive effort to reflect the voices and gain the input of individuals with disabilities. This input started when we convened a summit last year of over 400 people which culminated in a report entitled "Achieving Independence."

The employment recommendations from that report were the basis of the meeting that the National Council pulled together in Houston that Ms. Webb alluded to. These individuals were people who had been on SSI and SSDI but had made themselves experts in the system, and they assisted the Council by coming up with a list of proposals which you will hear about in just a moment.

We took those proposals out to the community to obtain some grassroots support and input. We are subsequently going to revise our original recommendations and would like to submit a final report for the record as soon as it is completed—probably sometime in August.

The primary finding from the hearings is that for many participants it does not pay to go to work. The barriers that individuals face are extremely complex, and a holistic, non-Band-Aid approach solution will be needed to assist individuals in overcoming those barriers.

There are many of those barriers for which this Subcommittee does not have jurisdiction. However, we are asking you, Mr. Chairman, and Members of your Subcommittee, to provide leadership among your colleagues in the House on addressing such issues.

As you said yesterday, health care is probably the number one barrier for individuals with disabilities who wish to return to work. The administration and Members of Congress are working to try to address this issue during the budget reconciliation discussions and we would ask for your support in this endeavor.

Additionally, we ask your support in providing tax incentives for employers, so that individuals with disabilities will not face discriminatory barriers and other barriers as they return to work.

But I would like to spend most of my time today talking about work incentives that are within the jurisdiction of your Subcommit-

tee that you can help us address. First of all, with regard to the SSDI system, when an individual goes to work, once they earn $500, they face what we call an income-earnings cliff.

They lose their entire benefit package as soon as they make that first $500. According to an individual from Minnesota named Maynard Bostrom, you either stay under $500, or you earn enough money to make it worthwhile. According to statistics out of Virginia Commonwealth University that's about $24,000.

Additionally, we believe that the $500 income exclusion needs to be indexed to inflation, and that individuals should be able to keep $50 of benefits for every $100 earned, to provide a ramp, rather than a cliff off the system.

We believe that eliminating this work incentive will drastically improve the number of individuals with disabilities who can return to work. If 5 percent of individuals return to work, this will make this a cost neutral proposal.

Additionally I would like to spend just a moment addressing the Ticket Proposal submitted by the administration. We do support the Ticket Proposal, but believe that individual milestones should be considered during the payment mechanism.

We also believe that an independent evaluation needs to be funded by a certain percentage of the Social Security Trust Fund that allows organizations to be able to evaluate the programs and obtain consumer input on the programs and their services.

Chairman Bunning, thank you very much for allowing us to testify today. We look forward very much to submitting our final report for the record. Thank you.

[The prepared statement follows:]

Statement of Bonnie O'Day, Member, National Council on Disability

Thank you Mr. Chairman and distinguished Members of the Subcommittee, for this opportunity to testify on barriers preventing Social Security disability recipients from returning to work. I am Bonnie O'Day, a member of the National Council on Disability (NCD), a fifteen-member Council appointed by the President and confirmed by the U.S. Senate to advise Congress and the President on matters affecting people with disabilities. As an independent federal agency, our purpose here today is to reflect the voices of hundreds of consumers around the country who wish to work. They want to fully reap the gains made during the last several years resulting from the Americans with Disabilities Act by contributing their talents to the economy and paying taxes, but they face tremendous financial barriers to realizing this goal.

NCD's Action Proposals are the culmination of an intensive campaign to hear from beneficiaries, advocates and grassroots leaders. We began in 1996 with a summit of approximately 300 people with disabilities, which generated Achieving Independence, a policy roadmap for the 21st Century. The employment recommendations from this report served as the springboard for a 2½ day working conference of 40 consumer/advocates, most of whom had direct experience with SSI DI, and all of whom are very knowledgeable about disability employment issues. The group generated a series of proposals for overcoming those barriers. NCD subsequently took those proposals to the community through a nationwide series of 13 public hearings, and received oral and written testimony from people with disabilities, their advocates and service providers.

The primary finding of the hearings is that, for many people, it doesn't pay to work. The barriers to work are extremely complex, and a holistic, system-wide approach is needed to eradicate these barriers. While we realize that many of our proposed solutions lie outside the jurisdiction of this committee, we request that you play a leadership role in assuring that health care coverage, SSI work incentives, tax credits for personal disability-related expenses, and employer tax credits, are addressed by your colleagues. Those recommendations, along with those within your purview, are detailed in a soon to be released report which the Council would like

to submit for the record. Today, I will address those recommendations within the purview of this Subcommittee.

SSDI WORK INCENTIVES:

Existing SSDI work incentives themselves are a major employment barrier, especially for part-time workers who can't earn enough to make up for loss of their entire benefit package. People with disabilities who earn $500 per month face a sudden loss of benefits: a cliff. According to Maynard Bostrom from Minnesota, "Now, you either stay under $500 or get a position that pays high enough to make it work it," over $24,000 per year, according to the Employment Support Institute at Virginia Commonwealth University. NCD recommends that the current level of Substantial Gainful Activity (SGA) be indexed to inflation, and that SSDI cash benefits be reduced $50 for every $100 of earnings above the SGA level to provide a "ramp" rather than the current "cliff" off the benefit rolls. Individuals eligible for the $1,000 Blind SGA amount could choose either to remain under current rules or switch to the $500 SGA and $50/$100 reduction. This recommendation would eliminate the need for the nine month Trial Work Period, which is confusing to beneficiaries, complex to administer, and generally results in SSDI overpayments. Preliminary estimates show that a mere five percent of DI beneficiaries must return to work, earning more than $500 per month, for this proposal to be cost neutral.

We further recommend that Congress ensure continued eligibility for both SSI and DI as long as the individual remains disabled. Beneficiaries would receive cash benefits only when their income was low enough to qualify. This would allow people whose disabilities permit only intermittent employment, such as people with MS or psychiatric disabilities, to work to their capacity, without the need to reapply for benefits during periods of symptom exacerbation. The process of Continuing Disability Review (CDR) should be based upon SSA's established schedule, rather than precipitated by the individual's attempts to work.

CHOICE IN REHABILITATION PROVIDERS

A substantial portion of SSDI beneficiaries could work if they had informed choices and access to training programs, employment counseling, adaptive equipment and transportation, or resources needed to start their own businesses. We support the "Ticket to Independence" proposal, but suggest that providers be reimbursed based upon milestones, e.g., after a consumer has completed training, after job placement, and after a period of employment.

To ensure success of the ticket proposal, Congress should designate a certain percentage of the Trust Fund for a competitive grant program for information dissemination about return-to-work options and incentives. Independent evaluations of rehabilitation providers should be funded, to give potential workers consumer-based information to aid in their decision making. The funding should also provide for advocates to assist in resolving disputes between consumers and providers.

Congressman Bunning, thank you for the leadership that you and your colleagues on the Subcommittee on Social Security have shown in helping people with disabilities return to work. Your leadership on this issue will allow thousands of citizens with disabilities to become taxpayers, and realize the ADA's promise of independence and full productivity. We look forward to submitting our Barriers to Work: Action Proposals for the 105th Congress report into the record.

Chairman BUNNING. Thank you, Ms. O'Day.

Mr. Young, if you would be so kind as to testify.

STATEMENT OF TONY YOUNG, PUBLIC POLICY ASSOCIATE, UNITED CEREBRAL PALSY ASSOCIATIONS, INC.; AND COCHAIR, CONSORTIUM FOR CITIZENS WITH DISABILITIES VOCATIONAL WORKING GROUP

Mr. YOUNG. I am Tony Young, public policy associate with the United Cerebral Palsy Associations, and a former SSDI beneficiary. Today I speak on behalf of the Consortium for Citizens with Disabilities Vocational Working Group.

Recent reports cite five interdependent barriers to work for SSDI beneficiaries and SSI recipients. CCD recommends solutions that extend health benefits for working beneficiaries, streamlines work incentives, makes work pay, enhances consumer choice of providers, and researches ways to increase work opportunities.

As you have heard, the all or nothing design of the SSDI Program prevents most beneficiaries from working. Unlike the SSI Program, where recipients who work lose $1 in cash assistance for every $2 earned, DI beneficiaries lose all cash assistance after $500 per month.

This working beneficiary falls off a net income cliff when earning only $6,000 a year, and does not recover the same net income until earnings reach $24,000 annually. An SSI recipient's net pay increases until they hit their income cliff as they reach their State Medicaid threshold and attempt to purchase medical coverage.

Ironically, most beneficiaries who attempt to work find it so costly that they cannot afford to continue. They feel they are financially and medically supported for remaining on benefits, yet financially and medically penalized for working.

If a work incentive similar to the SSI Program was instituted for SSDI, including a buy-in to medical coverage, beneficiaries would work to the maximum extent possible. This would mean savings to the trust fund as they began to forgo all or some of their cash assistance.

We know this solution has been determined by CBO to have high costs. We respectfully yet strongly disagree with the assumptions underlying these results. CCD urges the Subcommittee to work with us to develop state-of-the-art computer models for anticipating work efforts and the resulting benefit savings.

Consumers must be able to choose from among all public and private providers of employment services, paid using an outcome-based milestone payment system. Limiting choice to vocational rehabilitation agencies will quickly overwhelm a system that is already struggling to serve only some of the individuals with disabilities who request their assistance.

In addition, the range of SSDI and SSI beneficiaries in the system now demands that we focus the full capacity of the Nation's employment and training resources on assisting them to work.

Implementing choice is a critical component. CCD recommends a commission with equal representation from consumers, providers and employers be appointed to assist SSA in this effort. It should research, model, test and recommend the structure of the program to SSA and the Congress by a date certain.

Work in the information age recognizes that technology can enhance the abilities of all workers. A work disability exists when a person with an impairment does not have all the supports needed to work. Medical rehabilitation, assistive technology, and employment training when combined with work incentives that accommodate lifelong physical or mental disabilities can open many employment opportunities to beneficiaries.

Some of these solutions lie beyond this Subcommittee's jurisdiction. We discussed them because a comprehensive solution is required that engages each of the stakeholder groups on this issue—

consumers, providers, employers, policymakers, and taxpayers—in reducing cash assistance for beneficiaries through work.

We seek opportunity, employment and freedom, rather than dependence. Sometimes we will attain self-sufficiency and require only opportunity and accommodations from society. Many times we will earn most of our support, but will need help to ease the extraordinary expense of working with disabilities.

More than occasionally, even our maximum work effort will require some ongoing cash assistance, and inkind support from society. In all instances, we are highly motivated to be working members of society, contributing what we can, and taking only that which we need to survive and prosper.

In all instances, the opportunity exists to reduce the dependence of beneficiaries on cash assistance, and to minimize public expenditure on inkind support.

Thank you for your attention. I will be happy to answer any questions you might have.

[The prepared statement follows:]

Statement of Tony Young, Public Policy Associate, United Cerebral Palsy Associations, Inc.; and Cochair, Consortium for Citizens with Disabilities Vocational Working Group

These Signatory Organizations Support This Statement in Principle

Alliance for Rehabilitation Counseling (NRCA/ARCA)
American Network of Community Options and Resources
American Rehabilitation Association
American Association on Mental Retardation
Bazelon Center for Mental Health Law
Goodwill Industries International
International Association of Psycho-Social Rehabilitation Services
Inter-National Association of Business, Industry, and Labor
National Association of Developmental Disabilities Councils
National Association of Protection and Advocacy Systems
Paralyzed Veterans of America
The Arc of the United States
United Cerebral Palsy Associations, Inc.

Thank you, Mr. Chairman and distinguished Members of the Subcommittee, for this opportunity to testify on Barriers Preventing Social Security Disability Recipients From Returning to Work. I am Tony Young, a Public Policy Associate with the United Cerebral Palsy Associations, Inc., and a former SSDI beneficiary. Today I appear before you representing the Consortium for Citizens with Disabilities Vocational Working Group. Reflecting the complex interrelations between Social Security and employment, the Vocational Working Group consists of expert members from the CCD Task Force on Social Security and the CCD Task Force on Employment and Training. CCD is a coalition of almost 100 national disability organizations working together to advocate for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities into all aspects of society. The CCD Social Security Task Force monitors federal policy that impacts upon SSDI beneficiaries and SSI recipients. The Employment and Training Task Force monitors federal policy that effect employment of people with disabilities.

Recent reports from sources as varied as the General Accounting Office (GAO), the National Academy of Social Insurance (NASI), the National Council on Disability (NCD), the Consortium for Citizens with Disabilities (CCD), the Employment Support Institute at the Virginia Commonwealth University (ESI) and the Return To Work Group (RTW) all demonstrate that there are five principal barriers to the employment of individuals with significant disabilities who are SSDI beneficiaries and SSI recipients (SSDI/SSI beneficiaries).

The barriers are:

1. The loss of health benefits; 2. The complexities of current work incentives; 3. Financial penalties of working; 4. Lack of choice in employment services and providers; and, 5. Inadequate work opportunities.

The solutions are:

1. Extend Health Benefits; 2. Streamline Work Incentives; 3. Make Work Pay; 4. Enhance Consumer Choice of Services and Providers; and, 5. Help Employers to Employ Individuals with Significant Disabilities.

It is generally agreed that all of these barriers must be solved in order to empower individuals with significant disabilities to go to work. We recognize that some of these solutions lie beyond the jurisdiction of the Subcommittee on Social Security, and even beyond that of the Committee on Ways and Means. Nonetheless, while we will focus our testimony on issues under the Subcommittees' jurisdiction, we chose to discuss the full range of these solutions with this Subcommittee for three important reasons:

1. All of these barriers must be resolved in order to empower individuals with significant disabilities to go to work. The major studies of the disincentives to work done by the General Accounting Office, the National Academy of Social Insurance, and the Employment Support Institute all agree that to truly solve this problem, a comprehensive solution is required.

2. It is important to note that these solutions address issues faced by not only people with disabilities. There are five stakeholder groups with a direct interest in this issue: individuals with disabilities; providers of employment services; employers; policymaker, especially the US Congress, and, taxpayers. Each of these stakeholders holds a portion of the answer to the puzzle of employment for SSDI/SSI beneficiaries. Without the willing participation of each stakeholder to implement the solutions, there is no hope of achieving the desired outcome of reducing cash assistance payments for SSDI/SSI beneficiaries through work.

3. The Subcommittee, especially through its Chairman and Ranking Member, has demonstrated leadership and strong interest in crafting solutions to barriers to employment for SSDI/SSI beneficiaries. We strongly encourage the Subcommittee to carry on in its leadership role on this issue in the areas under its jurisdiction, and continue to work in a bipartisan, cooperative mode with other Committees and Subcommittees, and the Administration, as appropriate, to enact a comprehensive solution to these barriers. Our goal is to work with the Subcommittee on Social Security, along with other partners, to create an effective system that both supports employment for those who can work and early retirement for those who, due to the severity of their disabilities, cannot work.

Scope of the Barriers

The solutions outlined above reflect the desire of many individuals with significant disabilities to change the way SSDI responds to the needs of persons with work disabilities. In the beginning SSDI was designed as an early retirement program to provide income support for injured or ill workers who could no longer perform Substantial Gainful Activity in a post World War II Industrial economy. In the four decades that have elapsed since the inception of SSDI, the economy has changed substantially, perceptions of individuals with significant disabilities have changed substantially, and even the nature of work has changed substantially. SSDI has only experienced technical modifications that have left it struggling to cope with a new generation of workers with disabilities trying to obtain employment in a booming Information Economy.

In essence, individuals with significant disabilities want to benefit from taxpayer dollars spent on assisting our efforts to seek opportunity, employment, productivity, and freedom rather than for dependence on cash assistance. We want to work to the maximum of our physical and mental capacities, fully understanding that even if we do so, some of us will not earn enough income to be economically self sufficient, and some of us who are terminally ill or similarly substantially impaired will be unable to work at all. Nevertheless, we want to engage in work the most essential of all societal activities to the greatest extent possible.

In some instances we will attain economic self sufficiency and require only opportunity and accommodations from society. In other instances we will be capable of earning a substantial portion of our support but will require ongoing in-kind support (e.g., primarily health care, personal assistance, and housing subsidies) from society to help with the extraordinary expense of living and working with disabilities. In some instances, even our maximum work effort will still require both some cash assistance and in-kind support from society. In all instances, we want to be active members of society, contributing what we can and taking only that which we need to survive and prosper. In all of these instances, the real opportunity exists to reduce the dependence of SSDI/SSI beneficiaries on cash assistance and to minimize direct public expenditures on in-kind support.

However, the current all-or-nothing design of the SSDI program prevents most beneficiaries from attempting to go to work. Unlike the SSI program, where recipi-

ents who attempt work lose only $1 in cash assistance for every $2 in earned income and can continue receiving Medicaid acute medical care, personal assistance, and prescription medication coverage (up to State limits), SSDI beneficiaries lose all cash assistance after earnings reach $500 per month (assuming in this example that the Trial Work Period has expired). Further exasperating the situation, SSDI beneficiaries receive free Medicare (which, because it does not cover personal assistance and prescription medications is a lesser benefit than Medicaid) for only 36 months. After then, they pay the full Part A premium, currently $330 monthly, to continue coverage.

The result is that the vast majority of DI beneficiaries find that working to their maximum capacity under the current SSDI work incentives rules is so costly that they financially cannot afford to work. They feel that they are financially and medically rewarded for remaining on benefits and punished for attempting work.

An analysis of these "work incentives" by the Employment Support Institute is enlightening. They have designed a software program that can demonstrate the impact on the net income of an individual receiving SSDI, SSI, or both when they attempt to work. Under current rules, an SSDI beneficiary receiving the average amount ($704 per month DI check in 1997) who attempts work falls off a net "income cliff" after earning $600 per month ($7,200 per year) and does not recover the same net income level until earnings reach $2,000 per month ($24,000 annually). An SSI recipient in a similar circumstance can continue earning more income and take home more net pay after passing $600 per month because of the Sec. 1619 two for one offset of cash assistance they have available to them. SSI recipients do not experience the "income cliff" until they reach their State Medicaid threshold and attempt to purchase medical coverage.

These are only two examples of the unfortunate situations (visit the ESI Web page at http://www.vcu.edu/busweb/esi to review other scenarios, all of which are significant barriers to employment for SSDI/SSI beneficiaries) that are an unintended result of Federal and State social policies that were developed without a coordinated purpose. The result is a conflicting maze of work incentives that all too often rewards SSDI/SSI beneficiaries who try to work with the receipt of an over payment letter from SSA rather than income security. No wonder less than one-half of 1% of SSDI beneficiaries leave the rolls to work.

If a work incentive similar to the SSI Sec. 1619 program were instituted for SSDI beneficiaries, and combined with extended health coverage, tax incentives, and choice in providers, DI beneficiaries could work to the maximum extent that their disabilities and other personal circumstances allowed. This would result in savings to the SSDI Trust Fund as beneficiaries entered the workforce and began to forego all or some of their DI cash assistance. These cash savings would grow over time as SSDI beneficiaries gained skills and confidence. The following section discusses a comprehensive package of changes required to implement these solutions.

BARRIERS AND SOLUTIONS

Barrier 1: Health Benefits. Access to private health insurance is increasingly cited as the key obstacle to employment, particularly in light of the increase in part-time work, which rarely brings access to health insurance. With underwriting practices and limits on benefits acting as critical disincentives, many people with disabilities must seek Social Security benefits in order to gain access to public health insurance.

Solution 1: Extend Health Benefits. An individual who is an allowed SSDI/Medicare or SSI/Medicaid beneficiary who returns to work, should remain in a continuing disability status unless medical recovery is determined. Health coverage should be maintained for SSDI/SSI beneficiaries going to work in three ways: 1) Continue Medicare free until $15,000 of earned income, then with a buy-in at 10% of earned income capped at the full Part A Medicare premium amount; 2) Establish a Medicare-only buy-in similar to number one above for individuals with disabilities who would be DI eligible except for earning above SGA, capped at the full Part A Medicare premium amount; and, 3) Create an optional state Medicaid buy-in for working SSDI/SSI beneficiaries.

Barrier 2: Complexity of Work Incentives. The SSDI and SSI programs both have work incentives that are designed to assist beneficiaries and recipients to leave the rolls by going to work. These work incentives have the potential to be effective but they complex and incomplete and therefore are underutilized. In addition, they are not coordinated for people who receive both SSDI and SSI. Despite intense efforts by SSA and advocacy groups to publicize and educate SSDI/SSI beneficiaries about these benefits, they are used by only a small fraction of those eligible. They also are very expensive to administer and too often result in benefit overpayments that must be returned by the payees.

Solution 2: Streamline Work Incentives. The "work incentives" in current law must be renamed and simplified so that SSDI/SSI beneficiaries can understand and utilize them, and so there is a decrease in the expense of their administration. The goal should be to modify them into easily understood and usable work facilitators that encourage the transition from sole reliance on public benefits to economic security primarily through employment.

Barrier 3: Financial Penalties. Enabling individuals who have been unable to afford to enter or re-enter the workforce due to the economic disincentives inherent in the current system requires the redesign of the program. This should be done in a way that facilitates former SSDI/SSI beneficiaries to earn an income that enables them to survive. The current SSDI structure punishes rather than rewards people with disabilities who attempt to leave entitlement programs to work. The SSDI system eliminates eligibility for both cash assistance and in-kind support (e.g., health care) before the individual can earn a living wage. Whie the SSI program has Sec. 1619, SSDI has no similar work incentives. This sudden loss of support is known as the "income cliff" and represents a significant disincentive to work.

Solution 3: Make Work Pay. A combination of declining cash assistance similar to the SSI Sec. 1619 program, disability expense related tax credits, and tax deductions will enable individuals with significant disabilities to work. We also recommend a change in the asset limitations for SSI recipients who work to facilitate savings and investment. This recognizes that some individuals with the most significant disabilities will need ongoing support due to their limited earning capacities.

Declining cash assistance. An allowed SSDI/Medicare beneficiary who goes to work should have their DI cash assistance reduced by $50 for every $100 earned beginning at $500 of monthly earned income. The $50/$100 sliding scale offset would replace Substantial Gainful Activity (SGA) measures only for allowed SSDI beneficiaries who attempt to work. SGA, defined as earnings from wages or salaries that equal or surpass $500 monthly (for non blind disabled beneficiaries) would remain a principal criteria for establishing a work disability at initial eligibility.

CCD recognizes that this provision has been analyzed by CBO and determined to have high costs. We respectfully disagree with the assumptions underlying these results. We urge the Congress to work with CCD and the Employment Support Institute at VCU in developing state-of-the-art computer models for anticipating work efforts. The financial barriers to work for SSDI/SSI beneficiaries are real. As a nation we must afford these individuals every opportunity to work; we certainly cannot afford to trap them in a lifetime of poverty on government cash assistance payments.

Disability Expense Tax Credits. The vast majority of working Americans have their wages supported by tax breaks, either through personal exemption; standard or itemized deductions; or tax credits. Individuals with disabilities should be rewarded for working through the alleviation of their extraordinary expenses of living and working with a disability. A tax credit of one-half of all disability related expenses, including personal assistance services, of up to $15,000, should be provided for SSDI/SSI beneficiaries who are working. Costs for disability related work expenses beyond those applied to the Disability Expense Tax Credit should be deductible as Impairment Related Work Expenses.

Personal assistance is defined as one or more persons or devices assisting a person with a disability with tasks which that individual would typically do if they did not have a disability. This includes assistance with dressing, bathing, getting in and out of bed or one's wheelchair, toileting (including bowel, bladder and catheter assistance), eating (including feeding), cooking, cleaning house, and on-the-job support. It also includes assistive technology devices and services, assistance with cognitive tasks like handling money and planning one's day, and fostering communication access through interpreting and reading services.

Impairment Related Work Expense Tax Deductions. A modification of the existing Impairment Related Work Expense tax deduction available to workers who itemize deductions on their tax returns would enhance long term employment for individuals with significant disabilities. This modification would allow former SSDI/SSI beneficiaries to deduct costs of disability related work expenses beyond those covered by the proposed disability expense tax credit.

Facilitate Savings and Investment. SSDI/SSI beneficiaries who work should have their unrestricted asset limitation raised to $5,000 (indexed to inflation). "Super IRA's," "qualified plans" and medical savings accounts should be exempted from this resource limitation. These plans allow savings for education, medical emergencies or retirement.

Barrier 4: Consumer Choice of Services and Providers. People with disabilities who are SSDI beneficiaries or SSI recipients have no choice in the providers of their services. Consumers are assigned to a service provider, which by law must be a state vocational rehabilitation agency, usually by type of disability rather than type

of services required. Consumers who determine that they are not receiving appropriate or high quality services generally have no recourse other than to purchase services themselves from private vendors. Given the cost of private services and the state of most consumer's finances, this is an option very few can afford.

Solution 4: Enhance Consumer Choice of Services and Providers. Active participation in the rehabilitation process is a proven method for increasing the chances of a successful outcome. Enabling consumers to choose their services and providers gives the individual a feeling of ownership in the process. This choice of services and providers treats the beneficiary as an adult, capable of making significant life choices, thereby enhancing the individuals self-esteem and confidence. Choice eliminates the conflicting signals currently sent by the referral system, which tells beneficiaries they are capable enough to work, but they are not capable to select by themselves where to go for employment and related vocational services. Choice is also important for those individuals with cognitive impairments who may need assistance in exercising choice.

Consumers must be able to choose from among the many thousands of public and private rehabilitation, employment service, and related providers in the nation. Limiting the choice of SSDI/SSI beneficiaries who want to work to only the network of State Vocational Rehabilitation Agencies (SVRA's) will quickly overwhelm a system that is already struggling to serve some of the individuals with disabilities who request their assistance to prepare for and enter the work force. In addition, the sheer magnitude of SSDI/SSI beneficiaries who may want to access services to prepare for and go to work demands that we focus the full capacity of the nation's employment and training resources on assisting them to work.

Consumer choice will only work if there are a wide range of high quality, effective public and private providers available. This means that an infrastructure that enables providers to contact, recruit, serve, and to receive timely payment for having served consumers must be designed from the ground up to be effective in this outcome-based system.

Since 1981, Congress has required the only authorized provider of employment services to SSDI/SSI beneficiaries SVRA's to share the risk of assisting them to work by reimbursing relevant service costs only after the attainment of a measurable outcome: returning to work at or above the SGA level. This strategy has reduced expenditures from the SSDI Trust Fund without significantly reducing the numbers of those who reach SGA. It is time to modernize this risk based payment system so that all public and private employment service providers have an incentive to assist SSDI/SSI beneficiaries to work.

The updated payment system should encourage work by all SSDI/SSI beneficiaries, regardless of their ultimate work capacity. Instead of rewarding providers only for removing people from the rolls, it should reward providers for assisting people to minimize their dependancy on cash assistance programs. Paying providers a portion of the savings realized by the Federal Government will enable many more people to work to their full capacity and result in greater savings than only paying for those attaining SGA.

Payment should be made through a milestone approach. Providers should receive partial payments at three points: When a consumer and provider agree on an employment plan; 60 days after the consumer begins employment; and when the consumer completes 9 months of employment. Subsequently, providers should receive quarterly payments equal to a portion of the savings the Government realizes due to the reduction of the cash assistance paid to the consumer for five years. Milestone amounts should be limited so that no more than one-third of the total payment made to providers are received before the consumer achieves the third milestone.

Designing and implementing this program will be a significant challenge to SSA. CCD recommends that a Commission with equal representation from consumers and their self-selected representatives, providers, and employers be appointed and charged with responsibility to assist SSA in this endeavor. The Commission should have broad authority to research, model, test, and recommend the final structure of the program to SSA and the Congress by a date certain. It is imperative that the missteps that occurred during implementation of the Alternate Participant program be avoided.

In any system involving negotiations between parties there will be disagreements. Therefore, funding for advocacy services specifically designated to assist SSA's beneficiaries to resolve disputes with providers should be made available. It should protect their legal and human rights, and assist and advocate for such individuals in their relationship with public and private providers through alternative dispute resolution means as necessary.

Finally, the management of the new program should be contracted to a private sector firm on a competitive bid similar to the arrangement in the current Alternate

Participant program. This will minimize the administrative burden of the program on SSA.

Barrier 5: Inadequate Work Opportunities. Individuals with significant disabilities face competition from many directions in their efforts to work. Individuals who are leaving welfare, those who are graduating from schools and colleges, and those who are dislocated due to corporate down-sizing and economic restructuring all are competing for a limited pool of jobs.

Solution 5: Help Employers to Employ Individuals with Significant Disabilities. The Committee should study the impact of an expansion of the Work Opportunity Tax Credit to employers for hiring and retaining former SSDI/SSI beneficiaries. It should also study other ADA and disability related employment incentives already available to employers.

WORK IN THE INFORMATION AGE

The new definitions generally accepted for work in the Information Age recognize that the creative application of technology can enhance the inherent skills, abilities, and talents of all workers. A work disability now exists as a point in time when an individual acquires a physical or mental incapacity and can no longer perform SGA, rather than a lifelong incapacity to do any work. However, only the application of new techniques in medical rehabilitation, assistive technology, and employment training, when combined with the employment supports that we discussed today which accommodate the lifelong physical or mental disability, can open this unprecedented array of employment opportunities to individuals with significant disabilities.

Most of us languish behind a wall of barriers made up of all the best intentions of the policy makers who have gone before us. Only those most fortunate among us have been able to use our unique personal circumstances to go to work. My rehabilitation and work experience is an example of this serendipity.

I became a C–4 quadriplegic in 1970 as a result of a body surfing accident. I was 18 years old, and just graduated from high school. My work skills and experience included mowing lawns, raking leaves, washing cars and dishes, and three summers as a life guard, swimming instructor and swim team coach. These jobs are not exactly what you need to prepare for working in an economy of high skill, high wage jobs, especially with a disability as severe as mine. After medical rehabilitation, I was evaluated by the Virginia Department of Rehabilitative Services in 1971, determined to have no work potential, and sent home to live with my parents.

In 1975, I was again connected with the Virginia Department of Rehabilitative Services and evaluated for work potential. In the few years between 1971 and 1975, the expectations of the potential of severely disabled persons changed substantially, mainly due to the emergence of the Independent Living Movement. I was determined to have work potential under these new expectations. I wanted to earn a college degree, and agreed to a program of study to become a computer programmer. After one year of study, during which I demonstrated a complete and utter lack of talent or aptitude for programming computers, I realized that I could be successful not by accomplishing tasks directly, but by managing human and other resources to accomplish tasks, so I changed my major to Business Administration and completed my degree program.

I initially went to work at the US Department of Agriculture as a Budget Analyst under a Schedule A appointment which paid a salary but did not provide health coverage. The only reasons why I was able to accept this opening was the fact that I was covered under my Mother's employer sponsored health insurance, and that as a GS–7, I was, at that time, able to pay for some of my personal assistance services. Without a personal assistant to help me shower, get dressed, and prepare for work, I would have been unable to even consider working. I relied on family and friends for the balance of my needs, such as grocery shopping, doing laundry and house keeping, taking medications, going to the doctor, and other routine activities of life.

My next job was as the Executive Director of a Center for Independent Living. As the boss, I could decide who to cover under our health plan and chose to cover my entire staff as a group. Mixing employees with and without disabilities under a small group plan was difficult even 15 years ago, but that coverage and my ability to pay for more of my personal assistance expenses made it possible for me to continue to work.

A few years later I experienced some significant health problems that forced me to retire from the active workforce for a time and left me with a secondary disability and a propensity for decubitus ulcers (pressure sores or bed sores). When I recovered, I worked part-time as a consultant in public policy for persons with disabilities. I worked part-time because I could no longer sit in my wheelchair for the full

amount of time required for a full time job due to the decubitus ulcer problem. I worked as much as I could, relying once again on my Mother's family health coverage, along with Medicare, SSDI, and volunteer personal assistance. I was reviewed by a Continuing Disability Review once during this period and determined not to be performing SGA. This was a difficult and extremely trying time for me and my family.

In 1990, technology, workplace theory and civil rights for individuals with disabilities began to catch up with my disability. The introduction of the personal computer and telecommuting, along with the passage of the Americans with Disabilities Act, enabled me to accept a full-time position with the American Rehabilitation Association at an excellent salary and with health and retirement benefits. The state-of-the-art working environment at American Rehab, including job-related personal assistance at work, flexible working schedule, telecommuting, and accessible personal computers, enabled me to significantly advance my career. The knowledge and experience I obtained there led me directly to the position I currently hold at UCPA.

I have been able to build some personal financial stability. This "personal safety net," as I call it, consists of personal savings, retirement savings, and an investment plan for building my personal wealth. This means that I have the personal resources to weather a financial setback without needing to immediately return to public support, and to look forward to retirement without the prospect of relying solely on Social Security retirement checks. Federal policy should encourage everyone to build this type of "personal safety net" as soon as possible. We recommend a change in the asset limitations for SSI recipients who work to facilitate savings and investment.

None of this would have been possible without a series of fortunate circumstances. My Mother was working, and I was covered under family health insurance that allowed me to ignore the number one barrier to work: fear of losing health coverage. I lived in my parents' home (after accessibility adaptations) rent free, which allowed me to afford to pay for the extraordinary expenses of living and working with a disability, thus avoiding barriers two and three: the complex work incentives and the earnings cliff. I was not able to choose my rehabilitation provider, which meant that I had to wait until the changing attitudes of the work capacity of individuals with significant disabilities permeated my sole mandated service provider before I could receive services; I might have been working years earlier had I been able to choose other provider options. Finally, my first employer had an internal incentive to hire me: as a Schedule A appointment, I did not count against the Branch's FTE limit, thus boosting the productivity of the unit substantially.

It is not in the best interests of society, either from a fiscal standpoint or from a humanistic view, to force SSDI/SSI beneficiaries to rely on luck as a means to opportunity, employment, productivity, and freedom. It is certainly not in the best interests of SSDI/SSI beneficiaries, as analysis clearly shows. These barriers that were inadvertently built into the system must be removed; the physical, mental, and financial health of SSDI/SSI beneficiaries depends upon the timely enactment and full implementation of effective, comprehensive solutions. The financial health of the nation demands the full participation of all of its citizens to the maximum extent of their capabilities. The Congress has an historic opportunity to use the full range of tools at its disposal to meet the converging needs of SSDI/SSI beneficiaries, providers of rehabilitation services, employers, and taxpayers. We are ready, willing, and able to assist the 105th Congress to achieve this important goal.

Endnotes

1. SSA Disability Program Redesign Necessary to Encourage Return to Work, GAO/HEHS 96-62, April, 1995.

2. Findings and Recommendations of the Disability Policy Panel, National Academy of Social Insurance, January, 1996

3. Achieving Independence, National Council on Disability, July, 1996.

4. Testimony before the House Subcommittee on Social Security, Consortium for Citizens with Disabilities, August 3, 1995.

5. Draft Recommendations to the Work Incentive Redesign Task Force, Ruth, D and M. Hill, Virginia Commonwealth University Employment Support Institute, June, 1996.

6. Developing Choices For People On The Disability Rolls to Return-To-Work and Self-Sufficiency, The Return To Work Group, June, 1996.

7. SSA Disability Program Redesign Necessary to Encourage Return to Work, GAO, April, 1996, pg 58.

8. Scrutinizing Policy Options II The NCD Recommendations: Consequences for Individuals, Ruth, David , Mark Hill, Simone Jones, Robert Carlson and Alice Watts, Virginia Commonwealth University Employment Support Institute, May, 1997.

9. SSA Disability Program Redesign Necessary to Encourage Return to Work, GAO, April, 1996, pp 44-45.

10. SSA Disability Program Redesign Necessary to Encourage Return to Work, GAO, April, 1996, pp 45-46.

11. Unpublished research by O'Day, B. Personal communication, 1997.

12. SSA Disability Program Redesign Necessary to Encourage Return to Work, GAO, April, 1996, pp 42-44.

13. SSA Disability Program Redesign Necessary to Encourage Return to Work, GAO, April, 1996, pp 48-56.

14. SSA Disability Program Redesign Necessary to Encourage Return to Work, GAO, April, 1996, pg 31.

Mr. HAYWORTH [presiding]. Mr. Young, thank you very much for your testimony. As you see I have some big shoes to fill. The Chairman's been called away to speak on the floor, and so I am pleased to be sitting here with my dear friend from Connecticut and hearing all of your testimony.

Let's move along now. Lorraine Sheehan, chairperson of the governmental affairs committee of The Arc of the United States, accompanied by Marty Ford, assistant director of governmental affairs.

Ms. Sheehan.

STATEMENT OF LORRAINE SHEEHAN, CHAIRPERSON, GOVERNMENTAL AFFAIRS COMMITTEE, ARC OF THE UNITED STATES; ACCOMPANIED BY MARTY FORD, ASSISTANT DIRECTOR, GOVERNMENTAL AFFAIRS OFFICE, ARC OF THE UNITED STATES

Ms. SHEEHAN. Mr. Acting Chairman, and Members of the Subcommittee, thank you for the opportunity to testify. We appreciate the leadership of Chairman Bunning and Representative Kennelly in taking a serious and long overdue look at the work incentive and barrier issues in the Social Security Disability Program.

I want to focus on issues and problems facing people with mental retardation. I am testifying as chairperson of the governmental affairs committee of The Arc of the United States, and also as the mother of my son, John.

John is 31 years old, has mental retardation. He works in groundskeeping, in a Maryland State park during the summer, and has been receiving SSI benefits since 1984. During the school year, he works for the Marriott Corp. in the cafeteria at St. John's College in Annapolis.

His work is known as supported employment because he has a job coach to assist him with job-related issues. I also want you to know that he is well-known in his neighborhood and he is good looking.

Many people with mental retardation receive title II Social Security benefits as adult dependents of their parents who have retired, become disabled or died. In addition, a growing number receive SSDI benefits as a result of their own work history and disability.

People with mental retardation have a lifelong disability. Although most can work, those who are severely disabled enough to qualify for SSDI or SSI benefits are likely to need lifelong support of some sort, even if they are working.

Success for many people with mental retardation must be measured in decreasing dependence, increasing productivity and community participation. It should not be measured solely in terms of elimination of benefits. The fact that many people continue to use section 1619 of the SSI Program without moving off should not be viewed as a failure.

In my son's situation, the SSI exclusion for impairment-related work expense makes work pay. Transportation to and from work absorbs half his earnings. The IRWE helps cover those expenses before SSI benefits are reduced on the basis of earnings.

Due to the nature of the disability and the nature of job opportunities traditionally open to people with mental retardation, many will start as low-wage workers and will remain at lower levels of income most of their lives, often in jobs which do not provide health or other benefits. Many will be the last hired, the lowest paid, and the first to be fired in any restructuring or downsizing.

While my son has been working at St. John's College for 4 years, previous to that he had a series of four or five jobs that lasted between 1 and 5 months. Even with the additional support of a job coach it was, and can be, very hard to find jobs which are an appropriate match for the individual with mental retardation and the employer.

Sometimes fitting in with untrained or uninterested managers and coworkers can be an insurmountable hurdle. In spite of that fact, my son clearly wants to work, as others do like him. And in spite of the Americans with Disabilities Act, and the Rehabilitation Act it can be very difficult to find jobs which provide the right match for people with significant cognitive limitation.

It is even more difficult to find those jobs which provide long-term stability and support needed by an individual with significant impairment over a lifetime. John's two jobs are considered part time, and do not provide health or retirement benefits.

The cash cliff of title II and the cost of continuing Medicare are very real barriers to work. In the SSI Program, sections 1619 (a) and (b) allow for gradual decline in cash benefits and continuing Medicaid coverage if the person needs continuing Medicaid in order to work.

The Social Security Disability Program does not have similar work incentives.

In addition, there are very significant complications for people who move from SSI 1619 to the title II disability programs, and for those who receive benefits from both title II and SSI. Typically, when a child reaches 18, the family will sign them up for SSI, and then the parent retires or becomes disabled, and then the individual becomes eligible for SSDI.

But the major change comes when we die, when parents die. Believe me when I say this, our greatest fear as parents of children and adults with mental retardation, is what is going to happen to our kids when we die. It is a thought constantly on our minds.

And in today's world, with the title II benefits, my son could actually lose the stability of a job, as well as wondering who is going to care for him, and all of the rest.

For my son and others like him, loss of meaningful work also means loss of part of your identity, as for many of the rest of us.

The Arc would like to work with the Subcommittee on all of these incentive issues. Our goal is to really make it work. And I hope that you will be sensitive to the different needs of different people with different strengths and limitations, and we look forward to working with you.

Thank you.

[The prepared statement follows:]

Statement of Lorraine Sheehan, Chairperson, Governmental Affairs Committee, Arc of the United States

Thank you, Mr. Chairman and Members of the Subcommittee, for this opportunity to testify on the barriers to employment for Social Security disability beneficiaries. The Arc of the United States has joined in the statement of the Consortium for Citizens with Disabilities. We appreciate the leadership of Chairman Bunning and Representative Kennelly in taking a serious and long overdue look at the work incentive and barrier issues in the Social Security disability programs. I will use this opportunity to highlight and discuss in further detail the issues and problems facing people with mental retardation.

I am testifying in my capacity as Chairperson of the Governmental Affairs Committee of The Arc of the United States and also as mother of my son John. John is 31 years old, has mental retardation, works in groundskeeping at Sandy Point State Park during the summer, and has been receiving SSI benefits since 1984. During the school year, he works for the Marriott cafeteria at St. John's College in Annapolis. His work is known as supported employment because he has a job coach to assist with transitional and other job-related issues.

TITLE II AND PEOPLE WITH MENTAL RETARDATION

Before I make certain basic points about the experience of people with mental retardation in the Title II program, let me explain why Title II is important to people with mental retardation. Many people with mental retardation receive "Title II" Social Security benefits as adult dependents of their parents who have retired, become disabled, or died. To qualify in this way for benefits based upon a parent's work history, the adult "child" must have been disabled during childhood. This group of eligible adults disabled during childhood are often referred to as "DACs" (disabled adult child).

In addition, a growing number of people with mental retardation receive Title II disability insurance benefits as a result of their own work history (quarters of coverage) and disability.

Since the eligibility criteria and work incentive provisions of the disability insurance program are applied to all of these categories of adults, the term SSDI (Social Security Disability Insurance) is often used in references to encompass all of the Title II disability programs (even though it is technically incorrect for encompassing all). It is important that improvements in any of the work incentives be applied to all people who receive Title II benefits on the basis of disability, not just those who are technically in the SSDI program.

THE LESSONS OF SECTION 1619 AND TITLE II WORK INCENTIVES

I would now like to highlight a number of key issues regarding work incentives for people with mental retardation, based on the experiences of people with mental retardation as reported to us over the years by themselves, their parents, and service providers.

• People with mental retardation have a life-long disability. Although most can work, those who are severely disabled enough to qualify for SSDI or SSI benefits are likely to need life-long support of some sort even if they are working. That need for support will vary with the individual, depending on circumstances including age, health, skill development, and family and community support, to name a few.

• Success for many people with mental retardation must be measured in decreasing dependence (financial or otherwise) and increasing productivity and community participation; success should not be measured solely in terms of elimination of benefits. The fact that many people continue to use Section 1619 of the SSI program without "moving off" should not be viewed as failure. For the people with mental retardation involved, they have increased their own financial stability while reducing the amount of cash benefits paid out of the general treasury.

• In my son's situation, the SSI exclusions for impairment related work expenses make work pay. Transportation to and from work absorbs half of his earnings; the IRWE helps cover those expenses before SSI benefits are reduced on the basis of earnings.

• Due to the nature of the disability and to the nature of job opportunities traditionally open to people with mental retardation, many will start as low-wage workers and will remain at lower levels of income most of their lives, often in jobs which do not provide health or other benefits. Many will be the last hired, lowest paid, and the first to be fired in any restructuring or downsizing. While my son has been working at St. John's College for 4 years, previous to that he had a series of 4 to 5 jobs which lasted from 1 to 5 months. Even with the additional support of the job coach, it was and can be very hard to find jobs which are an appropriate match for the individual with mental retardation and the employer. Sometimes, fitting in with untrained or uninterested managers or co-workers can be an insurmountable hurdle. In spite of the fact that my son clearly wants to work, as do others like him, and in spite of the Americans with Disabilities Act and the Rehabilitation Act, it can be difficult to find jobs which provide the right match for people with significant cognitive limitations. It is even more difficult to find those jobs which provide the long term stability and support needed by an individual with significant impairment over a lifetime. John's summer job does not provide health or retirement benefits; his school-year job is also considered part-time and does not cover benefits.

• Therefore, the "cash cliff" in Title II (the loss of all cash benefits after reaching the substantial gainful activity (SGA) level of earnings for the 9 months of the trial work period (TWP)) and the cost of continuing Medicare are very real barriers to work. In the SSI program, Sections 1619(a) and (b) allow for a gradual decline in cash benefits as earned income increases beyond the SGA level and for continued Medicaid coverage, even beyond the cash break-even point, for as long as the person needs continued Medicaid in order to continue working. The Social Security disability program does not have similar work incentives. There, people lose all cash after 9 months of trial work and Medicare is very expensive for lower income earners

when the extended period of eligibility (EPE) is exhausted. It is important to note that, when the Section 1619 program was made permanent in 1986, the TWP and EPE were eliminated in SSI; with the gradual cash offset and the availability of continued Medicaid, TWP and EPE were no longer necessary.

• In addition, there are very significant complications for people who move from SSI Section 1619 work incentives to the Title II disability programs and for those who receive benefits from both Title II and SSI.

• We strongly believe that a parallel program to Section 1619 should be established in Title II, including elimination of the confusing TWP and EPE.

• In our experience, there is a very typical scenario for people with mental retardation and their attempts to work despite severe, life-long disability. Of course, there are innumerable variations, but the basic scenario is repeated over and over again across the country in family after family.

—First, the young person, often upon becoming 18 years old, becomes eligible for SSI based on disability and low income and resources. The individual is able to increase income to the best of his/her ability using the Section 1619 program. This is where my son fits into the scenario.

—Then the individual's parent retires or becomes disabled. The individual becomes eligible to receive a benefit of 50 percent of the parent's benefit. This will happen to my son John soon. As you know, an SSI beneficiary must apply for and accept all other sources of income or benefits he/she is entitled to, because of the nature of the SSI program as supplemental income.

—As a result of this increase in unearned income, the individual may lose SSI completely OR may receive both SSI and SSDI simultaneously. It is at this step that it becomes clear that the work incentives in SSI and SSDI are not at all coordinated.

—The next major change comes when the parent dies. As parents, our greatest fear is not for our own futures, but for the future of our sons and daughters, particularly when they have significant limitations in their ability to anticipate and care for their own needs. At this point, the individual becomes eligible for a Title II benefit equal to 75 percent of what the parent's benefit was. Once again, the individual may lose SSI altogether and move completely into Title II, OR may continue to receive SSI and SSDI simultaneously.

—Throughout all of this, the individual has not changed at all. There may have been no change in job status, no change in job or income, no promotion. Yet, the person, through no action of his/her own, may become ineligible for basic safety net support and is forced to choose between that critical support or work which cannot meet his/her needs.

—The loss of SSI benefits and the loss of those work incentives which make it possible to improve financial stability, therefore, may also mean the loss of work and the loss of an important factor in quality of life. The individual with a significant impairment and the need for some level of life-long support simply cannot afford to work at this point unless potential income is high enough to skip over the cliffs and canyons created by the loss of the Title II cash benefit and medical coverage. For the individual whose income is likely to start and remain low, including most people with mental retardation, the loss of work is likely.

—For my son and others like him, loss of meaningful work also means loss of part of your identity. As for many of us, your work is who you are.

• The movement between programs requires other trade-offs also. In SSI, the Sec. 1619 work incentives encourage work. However, a person cannot save meaningfully for the future because of the limits on resources. While in SSDI, the work incentives do not encourage work, so a person cannot earn. However, there are no restrictions on savings for the future. Both programs require that the individual give up one or the other of these essential components for future financial security, if not total financial independence. Families helping a person with significant cognitive impairment, like mental retardation, must be concerned for the future and the long-term.

• In designing a series of changes for Title II and/or SSI, remember that, for people with mental retardation, work is often for the first time and may require different approaches than for people who are "returning" to work.

• Finally, I would like to make a comment on SGA. The substantial gainful activity level needs an increase and should be indexed for inflation. Rep. Phil English has introduced a bill which is long overdue. We urge the Committee to address it as part of its work incentive improvement efforts. However, caution will be necessary to ensure that it works in the overall context of work incentives addressed here this week.

The Arc would like to work with the Committee on all of these work incentive issues. Our goal is to make work incentives really work, to make them sensitive to the different needs of people with different strengths and limitations, and to have

them incorporate the need to potentially support some people over a lifetime. We look forward to working with you.

Mr. HAYWORTH. Ms. Sheehan, thank you very much for your testimony. Now we will hear from Brenda Crabbs, a current SSDI beneficiary who is here to testify on behalf of the National Arthritis Foundation.

Ms. Crabbs.

STATEMENT OF BRENDA CRABBS, CURRENT SOCIAL SECURITY DISABILITY INSURANCE BENEFICIARY, BALTIMORE, MARYLAND, ON BEHALF OF THE ARTHRITIS FOUNDATION

Ms. CRABBS. Thank you, Mr. Chairman. Ladies and gentleman, my name is Brenda Crabbs, and I am here today on behalf of the Arthritis Foundation, and I am also an SSDI recipient.

Forty million Americans have arthritis, and it is the number one cause of disability in America, and the second leading cause of disability payments. Overall, the impact of arthritis and related diseases on the economy amounts to more than $149.8 billion, approximately 2.5 percent of the gross national product.

Women under the age of 65 with musculoskeletal diseases represent 7.3 percent of all SSDI recipients, and I am one of those women. I have rheumatoid arthritis. I was diagnosed 34 years ago, and stopped working 5 years ago, so I made it longer than most with my problem. But I have had three operations in the last 4 years and there is more to come.

There is no expectation that I am going to experience a medical recovery, so the question becomes who would want to employ me, and, more importantly, who would want to insure me? I do not need referral to vocational rehabilitation. I have skills, but there is no expectation that I will ever get better, only worse.

As a self-employed person who works on a contract basis, Social Security regulations subject me to an ever higher standard of substantial gainful activity when determining SGA for me, and the Social Security Administration considers the value of my work to the business that I am contracting with, and evaluates whether I provide significant services to that business.

In terms of my self-employment, I am the business. And the hours I can work each month are restricted. This higher standard, combined with the current SGA level of $500 per month, requires me to give away my skills if I want to have something to do.

The $500 cap needs to be adjusted to keep pace with economic growth. In addition, I constantly worry about inadvertently violating a rule which would cause me to lose my health benefits. I am even concerned about being here today, frankly.

Existing work incentives are extremely complex and hard to understand. Adequate and well-trained administrative resources are absolutely essential to serve beneficiaries. The booklets are hard to understand. I could not figure them out, and I consider myself an educated person.

So I went to the Social Security office and met with an employment representative. His main advice to me was do not make more than $500 under any circumstances.

I was never told that I could buy into Medicare. I was given a form to fill out, and told to mail it in, and to continue to report any work experience that I had.

I could not get the form through the mail. I have to go to the office to get the form. This is not a user-friendly system, and part of the disincentive to try working is the lack of faith in the predictability of the system's response.

Once on Medicare, the loss of those health benefits is a major disincentive to returning to work. Part-time employment does not provide health benefits, and private health insurance is not available to those with difficult medical backgrounds.

Current underwriting practices, and limits on benefits are critical disincentives. Employers do not want a disabled person on their health plan, because it pushes up their insurance rates.

After being disabled for 2 years, a person is offered Medicare, and the information states that if he does not take it then, the premium will increase by 10 percent for each year he waits.

When I accepted Medicare assignment, I thought that if I did not take it then I would not have another opportunity until age 65, which at the time was a long way away for me.

Once a person signs on, Medicare becomes the primary coverage, and private insurance drops you, even as a secondary insurer. The only secondary coverage available is a Medigap policy.

For people who are under 65 who are disabled, there are very few Medigap insurance products available nationwide. None provide prescription coverage.

So for the people who need the coverage most, there is the least available.

As a divorced woman, I have had firsthand experience of the dilemma of choosing between Medicare or health care provided through my ex-husband as part of the divorce agreement. His plan provided excellent benefits, and included prescription coverage. But I chose to take Medicare because I simply could not afford to risk the loss of health benefits if something happened to his job.

In choosing Medicare, I lost his plan, even as a secondary insurer, and had to take a Medigap policy, which, of course, forced me to absorb the expense of prescription drugs.

In order to be self-supporting and get off of SSDI, a person has to be able to work on a regular basis a substantial amount of time for good wages. part A costs $4,000 a year. part B adds another $500. Prescription costs are $3,600.

A Medigap policy premium is $1,200. That is over $9,000 in basic medical costs before a doctor is visited or a procedure completed.

Then there are the rest of living expenses, food, clothing, rent, transportation, and so forth. When you are disabled, it costs more to do everything, whether it is choosing a place to live, or pumping gas.

Congresswoman Kennelly's Transition to Work bill brings the Medicare buy-in program into the real world, and would enable me to work when I can without limits on the amount I can make, but still have the safety net when I need it. This would go a long way toward helping me maintain financial independence, and would enhance the quality of my emotional and psychological well-being.

In conclusion, the system badly needs reform. There is sometimes an attitude in society that individuals on disability are derelict and do not want to work. Not only is that picture unfair. It is simply inaccurate.

Many people on the SSDI roles are educated and have skills that make them employable in spite of their disability. They need help simply because life has dealt them a different hand. They want to work.

The potential loss of Medicare, and complicated rules for returning to work serve as a deterrent for even attempting to leave Social Security rolls.

Help people work with their disabilities and remain productive members of society. One set of rules does not fit all circumstances. The system needs flexibility to deal with different types of disability.

Some consideration should be given to differentiating between individuals who are likely to recover from their illness and those who are chronically ill and have no chance of medical improvement.

Thank you very much for this opportunity to appear.

[The prepared statement follows:]

Statement of Brenda Crabbs, Current Social Security Disability Insurance Beneficiary, Baltimore, Maryland, on behalf of the Arthritis Foundation

Good afternoon Mr. Chairman, ladies and gentleman.

My name is Brenda Crabbs and I am here today on behalf of the Arthritis Foundation to speak about Social Security disability reforms and back to work incentives. I am the chair of the Public Policy and Advocacy Committee for the Maryland Chapter, a member of the Foundation's national Public Policy and Advocacy Committee and an SSDI beneficiary.

Arthritis, one of the oldest diseases known to man, is a major factor in the economic and social fabric of the United States. Each year, 40 million Americans with arthritis and other musculoskeletal conditions make 315 million physician visits, have 8 million hospital admissions and experience approximately 1.5 billion days of restricted activity. Arthritis is the number 1 cause of disability in America and the second leading cause of disability payments. Overall, the impact of arthritis and related diseases on the economy of the United States amounts to more than $149.8 billion, approximately 2.5% of GNP.

The economic realities of the graying of the baby boomers and increased longevity of the American population cannot be ignored as you consider reforms to the SSI and SSDI programs. The size of the Social Security disability rolls will mushroom in the next two decades and serious changes need to be made to minimize the strain to the disability system. By the year 2020, the number of Americans with arthritis will jump to 60 million. When combined with other chronic diseases, the potential cost to the Social Security disability system is staggering.

Of the 40 million Americans of all ages with some form of arthritis, nearly two-thirds of them are women. These diseases destroy joint tissue, damage internal organs, shorten life expectancy, weaken the spine, make bones brittle and in many cases, deprive individuals of physical and financial independence. Osteoarthritis and rheumatoid arthritis are leading causes of work limitation among women. Patients with rheumatoid arthritis have a one in three chance of becoming disabled and 50% of patients with rheumatoid arthritis stop working within 10 years of diagnosis, 60% within 15 years.

Some facts related to Social Security Disability Payments

- One in ten of all women under 65 receiving SSI payment is a woman disabled by musculoskeletal disease: the fourth largest category after mental disorders, retardation and diseases of the nervous system.
- Within the age group 60 to 64, the proportion rises to one in 5, only slightly lower than the leading category.
- Women under the age of 65 with musculoskeletal diseases represent 7.3% of all SSDI beneficiaries.
- Lifetime costs of lost earnings because of rheumatoid arthritis are close to heart disease and stroke.

I, unfortunately, am one of the 7.3% of women under 65 who has had to stop working because of rheumatoid arthritis. I was diagnosed 34 years ago and stopped working 5 years ago. Because of excellent medical care, advances from research and a lot of determination, I beat the odds and was able to work longer than most, but I miss working. There is no expectation that I am going to experience a medical recovery. My ability to work is limited by significant loss of function in many joints, and multiple operations (three in last four years with more to come). So the question becomes who would want to employ me? And more importantly, who would want to insure me? I don't need referral to vocational rehabilitation because there is no expectation that I will ever get better. And yet, it would certainly be better for my mental and emotional health if I felt like I was able to be productive.

Perhaps a tax credit should be considered for disabled persons who try to work despite their disabilities and, or a personal assistance tax credit to compensate working people for the help they need to work. These tax credits would provide an additional incentive for people to leave the Social Security disability rolls by compensating them for additional expenses such as transportation and health care costs incurred by returning to work.

In addition, a tax credit for employers might make them more receptive to hiring persons with disabilities who want to return to work. The credit would make up for additional expenses that an employer would have to absorb for any changes in the workplace that would be required to accommodate a person with a disability.

Because of my background, I occasionally have the opportunity to use my skills working from home at my own pace, but I am limited by the $500 cap or "substantial gainful activity" definition. If I exceed that amount, I not only lose my benefits, I lose my health insurance. The $500 figure does not fit with today's cost-of-living and needs to be adjusted to keep pace with economic growth.

As a self-employed person who works on a contract basis, Social Security regulations subject me to an even higher standard of Substantial Gainful Activity. When determining SGA for me, SSA considers the value of my work to the business and evaluates whether I provide significant services to the business. The hours I can work each month are restricted. This higher standard combined with the current SGA level of $500 per month requires me to give away my skills. In addition, I constantly worry about inadvertently violating a regulation which would cause me to lose my benefits.

Existing work incentives are extremely complex and hard to understand. Adequate and well-trained administrative resources to serve beneficiaries are essential. The booklets put out by the Social Security Administration are confusing. I went to my local Social Security office and met with a representative. His main advice was not to make more than $500. He never told me I could buy into the Medicare system. I was given a form to fill out and told to mail it in. The form is not available by mail and yet the Social Security Administration wants recipients to report earned income on a continuing basis. This is not a user friendly system and part of the disincentive to try working is the lack of faith in the predictability of the system's response.

Once on Medicare, the fear of losing Medicare benefits is a major disincentive to work. Part-time employment does not provide health benefits and private health insurance is not available to those with difficult medical backgrounds. Current underwriting practices and limits on benefits are critical disincentives. Employers don't want a disabled person on their health plan because it pushes up their rates.

After being disabled for 2 years, a person is offered Medicare and the information states that, if he doesn't take it then, he won't have another opportunity until age 65. Once a person signs on, Medicare becomes primary coverage and private insurance drops an individual even as a secondary insurer. The only secondary coverage available is a medigap policy. For people under 65 who are disabled, there are very few medigap insurance products available nationwide. None provide prescription coverage. So for the people who need coverage the most, there is the least available.

As a divorced women, I have firsthand experience of the dilemma of choosing between Medicare or health coverage provided through my ex-husband as part of the divorce agreement. His plan provided excellent benefits and included prescription coverage but I chose to take Medicare because I simply couldn't afford to risk the loss of health benefits if something happened to his job. In choosing Medicare, I was forced to absorb the expense of prescription drugs.

In order to be self supporting and get off of SSDI, a person has to be able to work on a regular basis a substantial amount of time for good wages. Currently, I believe the Medicare buy-in cost is $332 per month or $4000 per year for Part A. Part B premiums add another $500 per year. In addition, my prescription costs are approximately $300 per month or $3600 per year. A medigap policy premium is another $1200 per year. This is over $9000 in basic medical costs before a doctor is visited

or a procedure is completed. Then there are the rest of living expenses—food, clothing, rent, transportation, etc. When you are disabled, it costs more to do everything from cleaning your house to pumping gas.

A simplified, well advertised and affordable Medicare buy-in should be established. Congresswoman Kennelly's Transition to Work bill brings the Medicare buy-in program into the real world and would enable me to work when I can without limits on the amount I can make, but still have the safety net when I need it. This would go a long way toward helping me maintain financial independence and would enhance the quality of my emotional and psychological well-being.

In conclusion, the system badly needs reform. There is sometimes an attitude in society that individuals on disability are derelict and simply do not want to work. Not only is that picture unfair, it is simply inaccurate. Many people on the Social Security disability rolls are educated and have skills that make them employable in spite of their disability. They need help simply because life has dealt them a different hand. They want to work. The potential loss of Medicare and complicated rules for returning to work serve as a deterrent for even attempting to leave the Social Security rolls.

Help people work with their disabilities and remain productive members of society. One set of rules does not fit all circumstances, the system needs flexibility to deal with different types of disability. Some consideration should be given to differentiating between individuals who are likely recover from their illness and those who are chronically ill and have no chance of medical improvement.

Thank you for this opportunity to appear before you. I would be happy to answer any questions you may have.

Mr. CHRISTENSEN [presiding]. Thank you.

Ms. Erb.

STATEMENT OF SUZANNE ERB, FORMER SOCIAL SECURITY DISABILITY INSURANCE BENEFICIARY; AND MANAGER, STUDENT SERVICES, ABILITECH, PHILADELPHIA, PENNSYLVANIA

Ms. ERB. Good afternoon ladies and gentlemen of the Subcommittee. Thank you very much for the opportunity to have the pleasure of providing my testimony for you this afternoon.

As you can tell, I am using an instrument that I bought as a result of being on Social Security disability. My computer that I have here is something that I was able to purchase while I was still on SSDI.

I am here representing not only myself, but I work for an agency called Abilitech, and we provide services for people with disabilities who want to return to work. We provide training for people in the computer fields, so they can then go out and get meaningful and viable jobs with their disabilities.

As manager of student services at Abilitech, I help people with all sorts of disabilities who sincerely want to return to work, especially people with severe physical disabilities, mental disabilities, drug and alcohol issues—all sorts of disabilities.

And we help them learn to develop the skills they need as well as to write good resumes, interviewing skills—all that sort of thing. We work very closely—we are a project with industry, and we work very closely with private industries in the Philadelphia area to work specifically on people's needs.

We draw from the expertise of these business leaders, rehabilitation specialists, and the Federal Government to provide people with disabilities gainful employment. At Abilitech not only do we help people get jobs, but we also have a component that enables people

with disabilities to provide services to local businesses in the form of training people to use equipment, and so forth.

We work with the advisory committee in our admissions process. During our admissions process they help us to provide services for the people, and they help us to determine some of our admissions criteria, in our selection of students, in our curriculum development. They serve as advisors in helping us to decide what courses to teach.

And in our internship and placement phases, they also serve as potential internship host sites, and sometimes even as actual placements in jobs.

I, myself, have been on both sides of the desk. I was born blind, so I have been educated as a blind person. I attended the Overbrook School for the Blind as a blind youngster. So the State has actually invested a lot of money in me. That's true.

When I was in senior high school, I went on to the local high school, and this was just before 94–142, so the public school still did not have to accept me, but they did. And I hope that they were glad that they did, because I certainly was. I had a good time in high school.

And I actually graduated from the Shipley High School, which is a private high school outside of Philadelphia. I studied at Bryn Mawr College. I received a bachelor of arts degree from Bryn Mawr, and I received some rehabilitation services while I was in school.

I received help with readers, and I also got lots of student loans. And then after I finished my schooling, I was very lucky. I was able to get a job right away out of going from college.

I worked for many of the agencies serving blind people in Philadelphia, and then I took a civil service job. I said, Well, I want to broaden my horizons, and get out into the "mainstream society," and so I took a civil service job, and went into child welfare for several years.

And that was really exciting, because I got to travel all over the city, and work in foster care. And that was really exciting and challenging work.

However, the demands of the job were such, the unpredictable nature of the job, led me to consider going back to school, which I did. I went back to the University of Pennsylvania and received my master's degree.

During this time, I went on disability. Had it not been for SSDI, I would not have been able to return to school. I would not have been able to take advantage of the opportunity that I had to go back to school and to live while I was going back to school.

After I graduated, however, it was difficult for me to find employment. So I really did still continue to need SSDI benefits while I was working part time. I was under the threshold, so fortunately for that threshold, I was able to work part time, and still continue to receive benefits.

Mr. CHRISTENSEN. Ms. Erb, Mr. Hayworth has to go to the floor, and he wants to ask a couple questions before he leaves, and your time is also expired, and I want to ask you some questions as well. So if it is OK, we would like to go to some questioning.

Ms. ERB. Sure.

Mr. CHRISTENSEN. Good job. I enjoyed your testimony.

Mr. HAYWORTH. Yes, I would like to thank Ms. Erb, and all of the panelists here today who are on the frontlines, living this challenge, wanting to be part of the work force.

Now, for purposes of full disclosure, as many who join us here today might ascertain, representing the State of Arizona, I have a previous acquaintanceship with Ms. Webb. And we had a chance to sit down a few weeks ago and talk. Weeks turned into months, but to me it just seemed like a twinkling of an eye.

Not to get scriptural or anything, Susan. But we are glad you are here today. But your story is very, very compelling. And I want to talk about the Arizona Bridge to Independent Living. I love the acronym—ABIL.

I would like you to share with my colleagues here some of the intricacies of what you have done with ABIL that you shared with me previously, and how you have been able to address and deal with some of these challenges that you and the other panelists have pointed out where it appears that there are actually disincentives to try and return to the work force.

Ms. WEBB. I think that the proposal that we brought forward details the solutions, and I think we need to focus on those solutions. But I think that ABIL represents one of 400 independent living centers around the Nation, established by title VII of the rehabilitation act.

And what that started out as was finally those of us who live with disabilities have our own voice. If there is anybody who knows what these solutions are, it is those of us who have lived them.

And I think that is the basic point that we are trying to make today, that finally we are very grateful that you folks within Congress recognize that we are professional people, credible people, who can develop our own proposals, who know what it is like, and who can come up with solutions using a reasonable and cost-effective approach.

I had a meeting with one of your former staff folks on this Subcommittee about a year and a half ago, and she shared with me that the feeling among many Congressional Members is that people with disabilities are still entitlement mongers. That's really all we want, is to live on all these marvelous benefits that keep us clothed and fed and housed. And that is not what we want.

And that is what independent living centers were formed to create, was a way to help people be part of the community, not institutionalized, to make our choices, and accept responsibility for those choices that we make.

Bonnie O'Day talked about the summit in Dallas, and I was one of the participants in that as well. And at that summit, with 400 people who represented consumers, the overriding final frontier for us was economic independence.

The ADA has been a marvelous tool. It has given us that boost, but the fact is that we still have a deplorable unemployment rate. That is because we are still trapped in these systems.

You have the leadership and the ability on this Subcommittee to get that ball rolling, to get other Members of the Legislature, other Committees involved in a comprehensive solution to this.

Accept our proposal as that. The things you have heard on this panel today represent divergent views of people who can get off the system entirely. But some cannot. And the system needs to be seamless in terms of health care, transportation, being able to move in and out of it when you need to.

And again, I am not an economist, but that has just got to be healthy for our country. Reducing dependency means dollars in the taxpayer's pocket. Sorry. That is just pure and simple.

Mr. HAYWORTH. Susan, the thing I found gratifying was the whole notion of getting people together in Houston and trying to hammer out policies. Not totally unlike what happens in this institution, although we come from a variety of different backgrounds, and do not have as intimate a knowledge of what you face every day.

With that in mind, and certainly we want to take the Houston blueprint, and I think Members on both sides of the aisle think that is a good working document, but with what is in the hopper today, have there been specific legislative proposals in the 104th Congress, or now in the 105th Congress that you think line up with some, or perhaps all of the goals established in Houston?

Ms. WEBB. Mr. Chairman, and Representative Hayworth, I am really enthusiastic and excited about what I have seen so far. The bill that Representative Bunning introduced last session, the bill that Representative Kennelly has introduced this session, the bill that Senator Jeffords has introduced last session, and I believe is drafting again—we are going in the right direction.

I think we just need to continue going where we are going. Providers have come forward with an excellent proposal. I am not sure about the Ticket to Independence issue from my own personal perspective. I like more of a consumer control/provider partnership.

As a provider myself I know that there is no way that I can keep people on my service system for a year or more without being paid for the services I provide. That is not realistic, especially for smaller providers.

But I think that we can form a partnership that includes all the stakeholders, and I think you are going in that direction. I am very encouraged.

And I guess you cannot do it. I know you cannot do it without our input. That is the way the system works. So what we are here today saying to you is thank you for that opportunity, and we are here to work with you, to give you the ammunition that you need to go to the floor and fight for us.

Mr. HAYWORTH. Ms. Webb, thank you very much. To my colleague from Nebraska, the Acting Chairman—well, our Chairman has arrived again. I thank you very much, and I yield back the time.

Chairman BUNNING [presiding]. Mrs. Kennelly.

Mrs. KENNELLY. Thank you, Mr. Chairman. Ms. O'Day, Ms. Webb just referred to the ticket approach, and we had some discussion on it yesterday as you know, and in some of our proposals we addressed using that kind of a method.

I am going to ask you, from what our discussions have been, if you would add to it. Should the Social Security Administration give

tickets to only those they think will use the ticket, or should everybody get the ticket and decide if in fact they want to use the ticket?

And the second question is, if a beneficiary is participating in a Vocational Rehabilitation Program, and they are in fact offered a job, should they be made to take that job, and possibly lose their benefits? How would you see this playing out if we do use this new system?

Ms. O'DAY. Well, I am a very firm believer in the concept of choice, whether that refers to choice in the marketplace as to what kind of car you want to drive, or choice in the marketplace as to where you receive your rehabilitation services.

Twenty years ago I think choice meant not being pushed into the kind of job that was a stereotyped position. For example, a sheltered workshop, or some other position that would be "appropriate" for a blind person.

But I think today we are seeing choice as much broader—we are looking at it in a much broader way. And we are seeing that choice needs to be what kind of provider, whether public or private, do you want to go to as a consumer, and what kind of information can you get as a consumer?

Sometimes people say I went to agency *x* and they told me about a particular training program. If they did not provide any other options, then the person is going to be likely to say yes to that training program.

So along with the Ticket to Independence Proposal, we believe there needs to be some kind of mechanism, perhaps using the private nonprofit network, perhaps funded with a percentage of dollars from the trust fund, that educates people about what their choices are, and evaluates those choices based on outcomes.

Now, to answer your question. I do not believe that anyone at the Social Security Administration with all due respect has the expertise to determine when someone walks in the door whether or not they can work.

I believe that individuals if provided the opportunities and the options and the supports who are able to work will be able to work.

There are no ways that I have seen that can adequately predict who can and who cannot work. Based on stereotypes, those of us sitting at this table would be deemed unable to work.

So I believe that the ticket should be offered to anyone who applies for SSDI, perhaps within a particular age range, and that they then should be given the choice of what provider they should go to.

I also believe that there do need to be safeguards so that individuals are not forced into taking a particular job if they do not want to. I believe that most private agencies, private for-profit and nonprofit operate like businesses, and they have more of a business mentality than those of us within government may have, and they understand that if you force someone to do something they do not want to do, eventually it is not going to work out.

An individual who takes a job that they do not want or do not like is not going to be able to stay there. They are going to find some way to leave that job, whether it is poor performance, or moving someplace else, or what have you.

So I do not believe that most private agencies will force individuals to take jobs. I do not believe that that is an appropriate approach. I hope that answers your questions.

Mrs. KENNELLY. And I would like to comment. Was it Ms. Webb that said some staffer said that the only thing that people wanted was the benefits? I certainly hope it was nobody on this Subcommittee. But I think I can speak for the Chairman and myself, that we understand what people want. People want to live as normal a life as possible, work, take care of themselves.

But the problem we are having is that less than 1 percent of those who go on disability get off disability. So we have to be very frank in how we talk about it, because the successes are not as many as many of us who want to have people get off disability would hope for.

And that is why we are doing exactly what we are doing. Let me ask one more question of Mr. Young, Mr. Chairman.

There are several possible types of tax incentives—and as you know, we are the tax committee, and that is how we are going to get from here to there—which one might adopt. My bill offers an incentive directly to the disabled person, through a disabled worker tax credit.

Mr. Bunning's bill provides an incentive to the employer by reducing the FICA tax. And then you have suggested a tax credit for disability related expenses, and obviously we cannot finance them all.

If you had to pick one, what would your druthers be? I ask you that question, but it is probably the one you suggested. [Laughter.]

Choose between us.

Mr. YOUNG. I guess I did not get the southpaw question. Actually, Mrs. Kennelly, the tax credit that we proposed, the disabled worker tax credit, that is aimed at persons with disabilities who have extraordinary work expenses, is sort of the migration from your tax credit that came from the NASI proposal for a tax credit above and beyond EITC.

What we wanted to try and do was focus the tax credit toward those individuals who actually have extraordinary expenses of working, so that we get, if you will, the most bang for the buck.

Instead of just giving it to a person, because they have a disability, or because they were a former beneficiary, we aim it toward people who were former beneficiaries or even current beneficiaries who are trying to work their way off, so that the persons with the most severe disabilities and who have the most intense expenses in going back to work can get some relief through the Tax Code, keep some more of their income, and be more self-sufficient.

So we kind of chose you, only you differently.

Mrs. KENNELLY. We had someone in here yesterday who had, I think, $36,000 in expenses per year for work.

Mr. YOUNG. Yes. Not unusual.

Chairman BUNNING. Thank you. Now that I have returned, I get a chance to ask questions. Both Ms. O'Day and Ms. Webb said one size does not fit all. And I think that you will not have any disagreement up here.

In your testimony, Ms. Webb, you recommended that SSDI and SSI benefits be reduced one dollar for every two earned above $5,000 in earned income.

Ms. O'DAY. $500.

Chairman BUNNING. Is that what I said?

Ms. O'DAY. You said $5,000.

Chairman BUNNING. Excuse me. $500. You also mentioned that such an offset would not be available for consumers who begin working at a high wage.

At what earnings level would you suggest that the two for one offset not apply?

Ms. WEBB. The NASI information that they provided says that—I think the threshold there is $32,000. That when a person earns $32,000, that is when the offset would work itself out. And the NASI recommendation was that that was too high.

I do not have any particular recommendation because my thinking on that is that if I am working and paying taxes, if I am losing one dollar for every two dollars I earn regardless of what my income is, I'm still taking less from the taxpayer than I would otherwise be if I were not working.

So I do not think that the threshold is the issue. The issue is reducing dependency, rather than getting off the rolls.

Chairman BUNNING. OK. Let me talk to you about CBO, and their problem. When we put a bill in, we have to get it scored by CBO, unfortunately—or fortunately.

CBO says that the more we allow individuals with disabilities to earn once they are allowed benefits, the more individuals with disabilities will be enticed to enter the program.

So it's kind of a catch-22 for CBO. How do we get by that? In other words do you have a suggestion on how we can get by that scoring? Because if we did what you suggested, they would score it in a negative way, and therefore we would have to go find some money to offset that CBO scoring.

Ms. O'DAY. I understand. I am a bit familiar with this issue, so if it is all right with you, Mr. Chairman, I would like to go ahead and answer.

Chairman BUNNING. And anyone else that would like to do it in a short period of time, I would appreciate that.

Ms. O'DAY. Thank you. First of all, in looking at the two for one, the benefits will actually zero out at about $15,000, based on some statistics that come from the Employment Support Institute at Virginia Commonwealth University.

If you are losing a dollar for every two dollars you earn, that is the approximate—using averages—that is the approximate place where you will then be receiving zero benefits.

In terms of the CBO scoring, I would say a couple of things. There are two issues here. First of all, there are some individuals who leave the system who earn less than $15,000. And the second issue is the issue of individuals being enticed onto the program.

My sense is that CBO did not consider the 5-month waiting period, the lack of medical benefits for 2 years, and other issues that are endemic to this program when they came up with those figures.

However, the statistics that we have show that if 5 percent, only 5 percent of all the individuals with disabilities on SSDI go to

work, even considering those CBO cost figures, that this will be a cost neutral proposal.

Chairman BUNNING. That would be a very good goal for us to have, when we do some kind of legislation. Let me ask Mr. Young, you recommend making work pay through a variety of measures, including a disability expense tax credit. Would you like to elaborate on that for us?

Mr. YOUNG. As we were discussing just a minute ago, the disability expense tax credit will kick in, hopefully when the two for one kicks out.

So that when people go to work and have expenses for personal assistance services, so they can get up in the morning and get ready to go to work, for transportation—an adapted van or adapted car, for adapted computer equipment or a job coach, or some of those expenses that a person without a disability does not have to incur when they go to work.

The person would be enabled through working at a high enough level and being able to keep a bit more of their—the money they would pay in taxes, Federal taxes, to be able to afford to pay for those things themselves, as opposed to being dependent upon another Federal or State program for inkind supports, as we call them, or either personal care services or public transportation or van service or something like that.

Chairman BUNNING. My time is almost expired, but I want to ask Ms. Sheehan, you raise a number of very good points regarding the unique challenges disabled adult children face in trying to work. The impaired-related work expenses, as I understand them, are the costs of certain impaired-related items and services that persons need to work, which are deducted from the gross earnings in figuring SGA.

They are in essence allowing individuals to keep more of what they earn.

In your view, are the impaired-related work expenses understood by families, and are they being utilized?

Ms. SHEEHAN. In my experience, and that may be limited, although I think I have talked to numbers of people on this, I do not think that people are using it as much as they could. And the reason for that is, and I hate to dump on Social Security, but often these things are not explained.

The view of parents with kids is, if my kid goes to work, I am going to lose the SSI and he is going to lose his medical insurance, and even though that is not true, you hear that.

So that we do not have——

Chairman BUNNING. Are you saying that SSA is discouraging——

Ms. SHEEHAN. No. I am not saying they are discouraging. I am saying that they are just not helpful. And it varies from office to office.

Chairman BUNNING. In other words, they do not explain the ramifications of what you——

Ms. SHEEHAN. Right. And I think that the provider community does not know enough about it, and so forth.

But once you get on it, and once you understand it, I mean, it is really making all the difference in the world for John and for

others, I know. And, of course, the SSDI does not allow this type of thing at all.

So in that case, people are correct in saying I am going to lose my benefits if I go to work.

Chairman BUNNING. OK.

Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Ms. Erb, thank you for your testimony. I appreciate hearing that. You made a comment that I want to have you elaborate on a little bit. You said something about being lucky, and that you were lucky to get a job.

Well, I do not believe you are lucky. You went out there, and you got that job. You worked hard. You worked hard through school.

And I do not believe in luck, and I do not think you were lucky. So I give you all the compliments in the world for making it happen on your own initiative.

I do want to ask you about your computer, though. Can you explain to me, when you were typing there a bit ago, were you—what were you doing? Were you inputting, or were you taking out a script that was already put in your computer. Explain to me what you were doing?

Ms. ERB. Well, I was doing a little bit of both. I had to type in to retrieve the file. Part of my testimony was written, and part of it was not. I was doing some reading from the computer while I was sitting here.

I use this—this is actually a braille output device. I type the braille into it, and braille comes out. And I can also use speech output with this computer.

This computer can hook up to a print printer, and print out print or it can be hooked up to a braille printer and print out braille.

Mr. CHRISTENSEN. So you were doing a little bit of reading as well as just on your own.

Ms. ERB. Right.

Mr. CHRISTENSEN. OK. And I cut you off during your testimony, so if you have full testimony within your computer that you would like to have printed out and inserted into the record, make sure we get that done before you leave today.

I have a question though for you concerning your experience as far as working with outside employers. What do outside employers see as the barrier to hiring people as yourself, and other people with disabilities?

Ms. ERB. I think some of the barriers they see are having to provide what they consider to be perhaps expensive equipment, assistive technology, for example, for blind workers, for example, speech output for computers, other kinds of assistive technology.

I think also sometimes people are afraid that people with disabilities just are not going to be able to perform competitively, and yet we have, as disabled workers, we have very good records in terms of our productivity, and in terms of our absenteeism. We are very reliable workers, generally speaking.

I think that especially today, because of so many advances in technology, for example, to provide speech or braille output for people with disabilities on the job, the expenses are far lower than they used to be.

I think especially in my case, where I as the disabled worker obtained much of the equipment for myself, and the Bureau of Blindness and Visual Services also helped provide with some of it, and the employer helped, but all three, working in concert with each other enabled me to perform my job, I think, satisfactorily.

And I think as the ADA becomes more ingrained in our minds and hearts as a country, that perhaps this will turn out to be the model that will eventually work into the system, I hope.

But I do think that many employers are afraid of what they consider to be the expenses involved, and I think they are afraid, they do not necessarily know how to work—they are afraid, what if the disabled person does not do the job well, how can I fire them?

Instead of looking at the positives, it is like any other unknown. People just do not know. So I think education for people is probably one of the best things that we can do.

Mr. CHRISTENSEN. Thank you very much. Thank you, Mr. Chairman.

Chairman BUNNING. Ken, would you like to inquire?

Mr. HULSHOF. Thank you, Mr. Chairman.

Chairman BUNNING. We have two votes on the floor, and after your inquiry we will recess and go vote, and then we will come back and continue the questions, if you will be so kind as to be patient with us as we vote and come back.

Mr. HULSHOF. Thank you, Mr. Chairman.

Mr. Young, this is an extraordinary Committee, the Ways and Means Committee, with the jurisdiction over so many different issues. And I want to compliment you on how you deflected that very tough question by Mrs. Kennelly. [Laughter.]

One of the solutions that you propose, and one that I am very intrigued by, is your suggestion that in discussing the solution to the barrier of health benefits, to create this optional State Medicaid buy-in for working SSDI and SSI recipients. Medicaid is not within the jurisdiction of this Committee.

Have you shared your proposal with the Commerce Committee, that does have jurisdiction? And if so, can you just tell us briefly what reaction you have had?

Mr. YOUNG. We have just begun to work with the Commerce Committee to share our ideas. We have not yet had a chance to have a formal dialog with them to the extent that we have been working with this Committee on that issue.

We think that the way we want to present this, and the way of moving people off of other Federal benefits, and allowing us a wraparound, if you will, with the Medicaid Program providing vital services, particularly personal assistance, and durable medical equipment and prescription medications to the Medicare Program will be something that the Commerce Committee we hope will see as fruitful as we think this Committee sees the other work incentives.

Mr. HULSHOF. Good luck in that endeavor. Ms. Crabbs, let me ask you a question. You mentioned in your testimony that some consideration should be given to differentiating between individuals that are likely to recover from their illness and those who are chronically ill and have no chance of medical improvement.

What are the issues that you think are the most important for us to address in terms of differentiating programs or changes in these programs for the chronically ill?

Ms. CRABBS. Well, in my situation, just in comparison to the other things we have heard here, and I do not mean to disparage anybody's disability, not at all. But someone who is blind, she has learned to deal with that. She was born that way, and she does not have a different challenge every day.

Likewise, Ms. Webb, who was injured a long time ago and is not experiencing any additional injuries. For people with arthritis, it changes from day to day. I could get up and get myself organized to come here today. Tomorrow, I might not be able to get out of bed.

And that is not unusual. My situation changes from day to day, from week to week. But when I am able I would like to be able to work. And it is that irregularity, I guess, of my problem that makes it very hard to deal with the rules as they are.

And that is why I think we need some sort of flexibility in the system.

Mr. HULSHOF. I certainly appreciate you sharing your very personal aspects of your life and your story with us. Recognizing the amount of time we have left, I will yield back, Mr. Chairman.

Chairman BUNNING. Well, we will recess for two votes, and we will return as quickly as possible, so please be patient.

[Recess.]

Chairman BUNNING. The Subcommittee will come to order. I have some general questions for this panel, and I would like to proceed, and when my colleagues return from their second vote, they can do whatever they like as far as asking their questions.

First of all, I am impressed by all of you, and commend you for the extreme hurdles you have overcome and the great achievements you have made in becoming self-sufficient and productive in the workplace.

But tell me one thing: Are you all exceptions? Or can we expect to have a significant number of recipients with similar disabilities to become as successful as yourselves? Who would like to start?

Ms. O'DAY. I would like to respond, sir. The National Council has conducted a series of thirteen public hearings around the country for the specific purpose of hearing from individuals with disabilities about what their experiences are with return to work.

While there were many people that we heard from who were not able to work because of the tremendous barriers that they faced in terms of medical coverage and financial disincentives, and so forth, we also did hear from many, many people with disabilities who are working.

There are many people—I think there is a stereotype that individuals with disabilities do not work. And we certainly do. The impetus, I think, of this panel is that we feel that with a holistic and comprehensive approach to changing some of the structures that really inhibit work, that many, many more people right now could work.

I think there are a couple of things you could do that would really make a huge difference. One is to increase the opportunities for health coverage, so that individuals who work do not lose their

health benefits. We heard over and over that that was the major barrier.

And the second thing I think you could do is to deal with the $500 income cliff, so that individuals are not induced to work below the poverty level and below poverty level wages to be able to keep their benefits.

Chairman BUNNING. Mr. Young.

Mr. YOUNG. Mr. Chairman, what has been extraordinary or lucky or fortunate or whatever term you might like to choose among many of us here on this panel is that we were in a position as we were trying to go back to work where the systemic disincentives in the program, we can ignore them. They did not apply to us.

I had family medical coverage. Susan had family medical coverage. We were able to get away with going on that coverage until the time that we got our own job and were able to get employer-mandated coverage. I was able to live at home and cut my expenses way, way down, so that the jobs that I got could cover the expenses that I had.

The problem is that we cannot—a large group of people will not move off the rolls unless they have something more reliable to depend on than just fortunate family circumstances or other kinds of circumstances that happened into their lives.

What we want to do is make sure that everyone has the same opportunities that we have been able to have over the last few years so that we can move large numbers of people into the work force as productively as possible.

Chairman BUNNING. Ms. Webb.

Ms. WEBB. Chairman Bunning, Members of the Subcommittee, there is something that we have not addressed today. And we were talking about it while you were out voting.

And that is that those of us who you see here today represent persons with very significant disabilities, but the rolls are growing because of disabled workers that are coming off of the workers' compensation system.

At my agency we run an employment program where we place people back into the work force in community-based and integrated jobs. It amazes me in all of the many hundreds of people that have gone through my program, generally speaking, I think it is a fair statement to say, that the things that are keeping them from working have very little to do with their disability.

We work with every major employer in Phoenix. We work with the American Expresses, the Motorolas, the Honeywells, on and on. And employers, and maybe it is our economy in Phoenix, but employers are dying for good workers, and they really do not care if a person has a disability. They want somebody with the skills they need to get the job done.

People with disabilities for whatever reason are out of work for the same kinds of reasons that other people on other welfare programs are out of work. They are trapped in systems. The systems, transportation, health care, child care, job training and work force development, the big four.

If we can solve those problems, people with disabilities will in fact—and I will come back here 5 years from now and tell you I was right.

Chairman BUNNING. You won't tell me. I won't be here. [Laughter.]

You can tell Barb. She will be here.

Ms. WEBB. I will tell somebody.

Chairman BUNNING. All right.

Ms. WEBB. Anybody will listen, that people with disabilities can in fact be very, very vital working members of this community. It is not our disabilities that keep us unemployed, and I think you have heard it across this panel today.

The other issue, as was brought out very eloquently, is this is always an all or nothing thing for us today. We are either all on benefits, or we are all not. We have got to have a seamless system that allows people whose disabilities might be episodic to move in and out without penalty. And that we do not do today.

So those two factors, I think, are the critical pieces in this.

Chairman BUNNING. Would someone else like to add something?

Ms. SHEEHAN. Just briefly, Mr. Chairman. Thank you for your comments. I consider my son, John, a very successful human being. He is working as hard as he can and using every ounce of his energy, and whatever he has in making himself successful.

But I want to make the point again that success for people with mental retardation might not necessarily be getting off the rolls, but rather a lesser dependency on the public system, with a little bit of both, with their work, and with public assistance.

And that can be a measure of success.

Chairman BUNNING. Anyone else? Do you have anything you would like to add?

Mrs. KENNELLY. No, Mr. Chairman, but I would like to thank the panel for their exceptional testimony and ask them if they would continue to work with us as we try to get to the same goals that we all want.

Chairman BUNNING. I appreciate all of your testimony, obviously, and it seems to me that if there is a middle ground that we can come to, where the disincentives are weighted against the incentives to the point where they are not a barrier for work, I think we can expect to increase the return to work rate to 30 or 40 percent of the people, if we can find middle ground.

Such middle ground would be where workers with disabilities do not lose their health care, and where there is some kind of incentive program for employers to offset the expense of new technology and equipment that is needed to accommodate more disabled workers.

And mental health is a very, very critical area. And the fact of the matter is, if we can get people with mental illness back to work sometime, it is better than not working at all. And that gives them added meaning to their lives.

I have some grandchildren that fall under that category, so I am very familiar with it. I thank you all for your testimony.

[The following was subsequently received:]

Questions received from Hon. Jim Bunning, and Subsequent Responses from Susan Webb

1. In your testimony, you summarize a number of recommendations involving work incentives, removing financial incentives, enhancing employer incentives, and extending medical services. You do point out that the National Council on Disability pro-

posal is designed so consumers have wide-latitude to pick and choose. So, in fact, are you advocating a type of menu-driven approach, where one size does not fit all? How would you see such a program being administered, and what role would SSA play?

1. My testimony on behalf of the National Council on Independent Living (NCIL) does advocate a menu-driven approach so that consumers of SSI and SSDI benefits can choose from an array of options to fit his/her individual circumstances. We believe this approach has several advantages:

A. By increasing consumer choice, the consumer also accepts personal responsibility and accountability for those choices. Typically, a case management approach that focuses on process, procedures and one-size-fits-all regulations relieves the individual from decisionmaking on his or her own life. Consumers are then lulled into a dependent posture where it is easy to claim he or she is a "victim" of the system and, therefore, can pass the blame to someone else.

B. Consumer choice by default achieves a consumer "buy-in" to the plan rather than merely a sign-off role as exists today. Greater likelihood of success occurs when the consumer truly buys in.

C. In the current system a consumer typically has several gatekeepers, each of whom have some level of expertise (e.g. vocational rehab counselor, SSA caseworker, medical practitioners, independent living specialist, etc.) Each of these gatekeepers specializes in a particular aspect of a consumer's life. However, the only member of the team who truly has firsthand knowledge of all aspects of the consumer's life is the consumer him/herself. Shouldn't the one person who knows the most about the consumer as a whole be the primary decisionmaker about his/her life?

D. NCIL's (and NCD's) proposal moves a consumer away from receiving cash benefits simply for being disabled and moves toward public money being used specifically for those services and technologies that directly represent actual costs of work barriers and disincentives specifically related to disability. The costs associated with an individual's disability are very specific to that individual. Not every individual who is blind, for example, has the same costs associated with working simply because he or she is blind. A menu-driven approach, then, provides for that individual to take total charge of his or her start/return-to-work effort but only pays for actual expenses. Those individuals who are blind and live in rural communities, for example, may have a much higher transportation cost than those who live in an urban area with good public transportation. A totally blind individual may have a higher cost to acquire computer technology with voice synthesis software than will a person who is partially sighted who may only need less-costly large-print software.

The administration of such a program should be consumer-controlled and market-driven. Consumers should be able to choose among existing public programs such as State Vocational Rehabilitation, Job Training Partnership Act, Personal Responsibility Work Opportunity Restoration Act, Job Corp, etc. using a voucher or similar method. In addition, a consumer should be able to purchase services (including personal assistance and assistive technology) from the private sector just as he or she would purchase other goods and services in the community. Several concerns immediately come to mind with this model:

A. How do we ensure that consumers have access in the private sector to all the types of services needed all across the country, especially in rural communities?

B. How do we ensure that consumers receive quality services and avoid "fly-by-nights"?"

C. How do we pay providers in a way that enables them to provide comprehensive, ubiquitous services while still only paying for outcomes?

D. How do we ensure that providers are not "creaming," that is, only serving those who are easier and less costly to place, while those with the most significant disabilities or harder to place get inadequate or no services?

E. How do we ensure that consumers use their vouchers for realistic services with high potential for positive outcomes? What do we do if consumers purchase services and then do not reduce reliance on SSI/SSDI?

Admittedly, our position is weak on this issue. The Return-to-Work Group, the National Academy of Social Insurance and other private provider-based organizations probably can answer these concerns better than we. However, a mechanism for consumers to evaluate providers and report problems to a consumer-controlled protection and advocacy entity is a checks and balances approach that is highly recommended. Protection and advocacy entities exist today around the country to ensure that consumers can report problems with existing State VR and Independent Living programs. Such a methodology could be applied to private providers also. Current P&A agencies should be changed, however, to require that they be

consumer-controlled; at least 50% of their Board of Directors and staff should be individuals with disabilities.

A comprehensive, compensable consumer training and program orientation should be included in the reforms being proposed. NCIL members and consumers report that consumers receive little or no information today about work incentives and the information they do receive is often inaccurate. If consumers are expected to control their own lives and start/return-to-work activities, they MUST have access to accurate, timely information about their options.

NCIL's Social Security Subcommittee has yet to address the issue of potential consumer fraud or misuse of vouchers. Consumers with disabilities are like every other segment of the population who pursue training and employment. If barriers and disincentives are reduced, most will succeed and some will fail. The NCIL subcommittee will take up this issue in the near future and report back to you on our position. Current welfare reform efforts under the Temporary Assistance to Needy Families (TANF) programs include sanctions of individuals who do not achieve work outcomes. Perhaps a similar methodology could be deployed in the start/return-to-work of individuals with disabilities at some point in the future. However, given the deplorable unemployment statistics among SSI/SSDI beneficiaries, we believe that such a significant number of individuals with disabilities could and would return to work if the disincentives were removed from the system that directing much attention to fraud and sanctions at this time is premature.

The role SSA should play in the whole start/return-to-work effort is, with all due respect, to just get out of the way. Susan Daniels, Associate Commissioner of the Office of Disability Policy at the Social Security Administration, is right on target. She has said many times that the SSA is a safety net there to provide cash benefits to people who simply cannot work at some point in their life. They are not qualified to be traffic cops or vocational providers. Yet the current system puts the SSA in a position to determine whether an individual has the capacity to work, whether an individual's work goal is realistic and can only refer an individual with a work goal to the State VR system that can serve only a limited number of these beneficiaries. SSA caseworkers are not qualified to make these decisions nor does such a system empower the person who knows most about capacity to work—the consumer him/herself. The SCI's role should be as it was intended originally: determine whether an individual is eligible for cash benefits based on inability to perform substantial, gainful activity. Provide the safety net needed by such individuals until such time as they determine they no longer need them in whole or in part. Although we know that today only a tiny percentage of beneficiaries voluntarily leave the rolls, this situation should automatically correct itself by removing the barriers and disincentives. In particular, de-linking availability of healthcare coverage from SS and SSDI is critical to allowing beneficiaries to reduce their dependency. Likewise, a system that allows for gradually leaving the rolls and reduced dependency by those who can work part-time or episodically would greatly impact the likelihood of more beneficiaries starting or returning to work.

2. Some individuals are so severely disabled that they may not have any remaining capacity to work. Although no one should be prevented from trying to work, we wouldn't necessarily expect all disabled recipients to work. But, there are some disabled individuals who would be good candidates for rehabilitation services. Yet, we know that Social Security law requires suspension of benefits for those SSDI and SSI recipients who refuse to accept vocational rehabilitation services. Should legislation require that recipients with potential for work take advantage of return-to-work services?

2. At this time NCIL's position is that beneficiaries found to be eligible for SSI/SSDI benefits should not be required to start or return to work. Since the overwhelming majority of current beneficiaries are not starting or returning to work, it is intuitively obvious that something is wrong with the current approach. We believe that millions of current beneficiaries could start or return to at least part-time or temporary work. However, most are fearful to even try to do so because those who have tried have experienced such punitive attitudes and outcomes by the SSA's inefficiencies and errors, that they never try again and advise others not to try. Further until the current disincentives and barriers are removed and we have some data on the results (qualitative as well as quantitative), a system that REQUIRES a return to work will be more punitive than is justified at this time. Discussion of such a requirement also poses the $64,000 question: Who determines "potential for work" and how is that determined? We need only look at the "medicalized" Workers' Compensation system with its "100% recovered" approach to know how that would end up.

3. Do we need to provide additional incentives in the law for employers to hire individuals with disabilities?

3. Employers hire qualified individuals to get the job done. Our proposal includes employer incentives we believe to be useful. However, the most important issue for employers is not the "incentives" but rather a "reduction of perceived risk." Employers, especially small employers, want to be assured that they will not increase their liability and costs. Our proposal includes exemptions of the employer's FICA match. However, allowing employers to take tax credits when they actually incur additional expenses directly related to an employee's disability makes sense. We know from data published over the years by employers that the average employee with a disability is not expensive in terms of accommodations. However, have we done an adequate job of employing pepsins with the most significant disabilities? We do know that only a tiny percentage are returning to work so what would the actual costs be for these workers? Employers need an assurance that they can recoup extraordinary costs when those occur. Job coaches, sign language interpreters, on-the-job personal assistance can be costly. Yet we know that an employer tax credit would rarely cost more than keeping that individual with the most significant needs out of the workforce and totally dependent upon public entitlements.

4. If only one tax credit could be implemented for disabled Social Security recipients, would you recommend a personal assistance tax credit or a disabled worker tax credit? Please explain.

4. We highly recommend tax credits for personal assistance but that includes a broad definition of personal assistance. For example, attendant care in preparation for and returning from work in addition to on the job, personal assistance on the job such as sign language interpreters, readers, job coaches, etc. and assistive technology such as voice synthesis software, hand controls, home modifications, etc. should all be available with a tax credit where it is not employer-provided. The disabled worker tax credit is designed for low wage earners and serves a very different purpose. We are proposing both but believe the personal assistance credit is critical. The personal assistance credit also removes those types of services from the typical "medical" category, which we believe is more of 90's concept! Personal assistance is a lifestyle issue rather than a medical issue but is just as necessary to the independence and well-being of a person with a disability as medical services.

Questions received from Hon. Jim Bunning, and Subsequent Responses from Bonnie O'Day

1. Have you discussed your recommendations with SSA? And if so, what has been their reaction? I recognize that your forums have been ongoing over the last few months and your report is about to be finalized, however many of the issues you have raised have been around for a long time. Why, in your view, are only a few of the NCD's recommendations included in the Administration's ticket proposal?

• The NCD recommendations have been informally shared with Social Security personnel during the development and public hearing stages. Additionally, Social Security officials attended several of the public hearings held by NCD. While the SSA has provided technical information and support during proposal development, SSA has not formally responded to NCD's proposals.

• SSA's Ticket proposal is budget neutral. In contrast, the NCD believes that some up-front expenditure of funds is essential for the ticket program's success, and did not limit itself to "no-cost" approaches. We do believe, however, that over time, the NCD proposals will prove to be cost effective by returning recipients of SSI and SSDI to work.

2. You suggest that Congress should designate a certain percentage of trust fund monies for a competitive grant for information dissemination about return-to-work incentives. How do you envision such a program working?

• Our intention is that centers for independent living, employment agencies, disability organizations, and other local agencies be offered the opportunity to submit grant applications to SSA through an RFP process to provide employment counseling services to SSI/DI applicants and beneficiaries. SSI/DI applicants should immediately be referred to such services. Employment counselors located at these agencies would explain how to use the SSI/DI work incentives, inform applicants of the vocational training and other supports available to them through vocational rehabilitation and other agencies, and help applicants negotiate through the bureau-

cratic maze so that they can make full use of the work incentives and employment services available.

3. How important to a successful return-to-work program are rehabilitation provider evaluations?

• To maximize choice of rehabilitation providers, consumers must have concrete, performance based information about rehabilitation providers. This information should be based primarily upon outcome measures such as numbers and types of placements, wages, types of disabilities served, and consumer satisfaction. This information should be widely disseminated, since independently gathered, outcome-based information is crucial to consumers in making informed decisions. If this information is lacking, consumer choice will be based largely upon public relations materials distributed by agencies, relating choice to the size of agency advertising budgets rather than consumer outcomes.

4. Some individuals are so severely disabled that they may not have any remaining capacity to work. Although no one should be prevented from trying to work, we wouldn't necessarily expect all disabled recipients to work. But, there are some disabled individuals who would be good candidates for rehabilitation services. Yet, we know that Social Security law requires suspension of benefits for those SSDI and SSI recipients who refuse to accept vocational rehabilitation services. Should legislation require that recipients with potential for work take advantage of return-to-work services?

• During the Houston meeting, where the first draft of the NCD proposals were drafted, consumers held a heated discussion about whether recipients should be required to use the work incentive and vocational services. Consumers felt strongly that a far greater number of SSI/DI recipients could return to work, and that the culture of lack of expectation of work prevalent in the Social Security system should be altered. However, there is no fail-safe evaluation mechanism that can accurately assess an individual's likelihood of successful employment. Much depends upon the local economy, education, skill, age, level of disability, and motivation of the recipient. Additionally, a holistic rather than piecemeal approach, which includes vocational training, medical insurance, cash or other assistance and employer incentives may be needed to enable recipients to return to work. Until all of these elements are in place, a punitive system which coerces beneficiaries to use return-to-work services is likely to result in waste of effort for the rehabilitation agencies, complex administrative enforcement procedures for SSA, and significant anxiety for consumers.

5. Do we need to provide additional incentives in the law for employers to hire individuals with disabilities?

• The NCD believes that employers should receive a tax credit for any additional costs incurred for hiring someone with a disability. For example, employers are currently required to offer the same level of health coverage to employees with disabilities that they offer to other employees. Under our proposal, the employer would receive a credit only for any additional health care expenses resulting from the individual's disability. The NCD also supports a tax credit for employers who provide disability diversity training to employees.

Several hearing participants also testified about the devastating impact of employer discrimination on their efforts to find employment. While not contained in this proposal, the NCD strongly supports the provision of additional resources to the Equal Employment Opportunity Commission and the Department of Justice for ADA education, mediation and enforcement.

6. If only one tax credit could be implemented for disabled Social Security recipients, would you recommend a personal assistance tax credit or a disabled worker tax credit? Please explain.

The NCD supports a Disability Work Expense (DWE) tax credit that would reimburse 75 percent of an individual's expenses related to preparing for, traveling to and from work, and any expenses incurred at work. The reimbursement could not exceed the individual's gross earnings, and would be capped at expenses of $15,000 per year.

The DWE Tax Credit would include any personal assistance services (PAS) expenses in preparing for work, traveling to and from work, and during the work day. Additionally, it would benefit SSI/DI recipients who do not use personal assistance by covering other disability-related items used for work, such as adaptive equipment, readers or drivers for blind persons, or other supports.

Questions received from Hon. Jim Bunning, and Subsequent Responses from Tony Young

1. In your testimony, you mention that SSA's current work incentives are expensive to administer and too often result in benefit overpayments that recipients must pay back. Since SSA's payment system is not able to compute monthly accounting for earnings, it seems to me that the $1 for $2 offset would result in multiple overpayments for those recipients attempting to work. Are you concerned at all about this?

Yes, this does present a concern. However, we propose several changes to the procedure through which the current $1 for $2 offset for SSI recipients is administered that would mitigate this problem. First, we recommend that the offset be calculated on a Quarterly rather than a monthly basis. This would avoid the common problem of the five pay check month that pushes recipients into an overpayment problem. Second, we recommend that the offset be administered in $100 increments; that is, for every $100 earned, a recipient foregoes $50 in benefits. This would level out many small changes in income that would require a minor adjustment in benefit payments. These changes to the way benefit offsets are administered, if applied to the current SSI offset and the proposed SSDI offset, would save SSA millions of dollars in administrative costs over the next five years. In addition, we recommend that SSA be directed in legislation that it should work with the IRS to begin accessing quarterly IRS earnings statements electronically to facilitate the processing of any benefits offset. There should be an interagency working agreement between SSA and IRS to facilitate the administration of the offset. SSA should electronically access the quarterly earnings reports submitted by employers to ascertain the earnings levels of beneficiaries participating in the offset program, calculate the correct offset amounts, and distribute the change equally over the next three monthly benefit checks.

2. Some individuals are so severely disabled that they may not have any remaining capacity to work. Although no one should be prevented from trying to work, we wouldn't necessarily expect all disabled recipients to work. But, there are some disabled individuals who would be good candidates for rehabilitation services. Yet, we know that Social Security law requires suspension of benefits for those SSDI and SSI recipients who refuse to accept vocational rehabilitation services. Should legislation require that recipients with potential for work take advantage of return-to-work services?

The legislation should not require recipients to take advantage of return-to-work services. We know that there are SSI/DI beneficiaries who are good candidates for potentially returning to work or entering the workforce for the first time. What we do not know with any certainty is which SSI/DI beneficiaries are those who can successfully enter or reenter the workforce. There is no proven technique or test that can accurately, reliably predict success in employment based upon disability status. If there was, it is uncertain whether or not the benefits of such screening would outweigh the administrative cost of testing SSI/DI beneficiaries for work potential and tracking their participation. We recommend that every beneficiary be given a ticket and allow the providers in the free market system to use its marketing tools to entice beneficiaries to access employment services.

3. Do we need to provide additional incentives in the law for employers to hire individuals with disabilities?

No. Given the current economic demand for workers and the recent questions regarding the effectiveness of incentives for employers to hire workers from targeted populations, it is inappropriate to provide additional incentives in this law for employers to hire individuals with disabilities. If the Subcommittee wishes, it may consider studying the potential to expand WOTC to SSDI beneficiaries as well as SSI beneficairies and make it permanent.

Chairman BUNNING. We have a second panel. John Halliday, director of the Bureau of Rehabilitation Services in Windsor, Connecticut, and chairman of the Council of State Administrators of Vocational Rehabilitation, Social Security Relationship Committee;

Richard Christman, from Metro Industries, from my home State, Lexington, Kentucky and reading his testimony will be Mary Gennaro, from the American Rehabilitation Association; Dr. Thorv Hessellund, president of the National Association of Rehabilitation Professionals in the Private Sector, from Pleasant Hill, California; Fred Tenney, president of Southwest Business Industry and Rehabilitation Association in Scottsdale, Arizona; and Stephen Start, chief executive officer and president of S.L. Start & Associates in Spokane, Washington.

And Barb would like to introduce her constituent.

Mrs. KENNELLY. Thank you, Mr. Chairman. I am delighted that Mr. Halliday from Connecticut is able to be with us. As a public servant dedicated to helping individuals return to the workplace, I think he is eminently qualified to talk about the barriers to employment for people with disabilities, and I thank him very much for coming to Washington today to share his knowledge with us.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Halliday, would you like to begin, please?

STATEMENT OF JOHN HALLIDAY, DIRECTOR, CONNECTICUT BUREAU OF REHABILITATION SERVICES, ON BEHALF OF COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

Mr. HALLIDAY. Thank you, Mr. Chairman. Mrs. Kennelly, thank you very much for your kind remarks.

It is a pleasure and an honor to have the opportunity to address this Subcommittee on behalf of the Council of State Administrators of Vocational Rehabilitation.

As you are aware, the public vocational rehabilitation system has been providing services to SSDI and SSI recipients since the beginning of those programs, and continues to do so. We have demonstrated, through our partnership with consumers, families, other government agencies and the private sector, success in assisting individuals on SSI and SSDI to enter employment.

Over 45,000 people a year who are SSI and SSDI recipients are entering employment as a result of that effort. The challenge before us is to increase both the number entering employment and the earnings of those individuals.

The association provided, I believe, a white paper to the Members of the Subcommittee.

[The information follows:]

COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

PRESS RELEASE

FOR IMMEDIATE RELEASE

CONTACT: Jack Duncan
General Counsel
CSAVR
202-638-4634

CSAVR WHITE PAPER ON SSA DISABILITY BENEFITS

(Washington D.C.) In an effort to break the cycle of dependency and put more people with disabilities now receiving Social Security Disability benefits to work, the Council of State Administrators of Vocational Rehabilitation (CSAVR) has produced a White Paper offering some necessary solutions and recommendations.

The Council noted that each week, the Social Security Administration (SSA) pays more than $1 billion to people with disabilities on Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Under the current Social Security Disability Income programs, fewer than 1.5 percent of those beneficiaries return to work annually and cease to receive benefits. Meanwhile, the Social Security disability rolls have increased by at least 13 percent since 1991.

The Council further noted that many of these beneficiaries can work, and want to work, but are prevented from doing so because of the manner in which the SSA disability income programs are structured. Beneficiaries fear the loss of the financial security of regular monthly income payments as well as loss of associated medical benefits.

Solutions proposed in the White Paper include:

1. Increase financial incentives to work and reduce the risk of losing benefits, particularly for SSDI recipients.

2. Increase the involvement of the Public Vocational Rehabilitation Program to prepare SSA Disability recipients for competitive employment.

3. Change the current work incentive structure from negative to positive.

4. Form a partnership of the SSA, the Rehabilitation Services Administration and the CSAVR to work toward getting people with disabilities out of the Social Security disability dependency loop and giving them a stake in their future.

John Halliday, Director of the Connecticut Bureau of Rehabilitation Services, testifying on Thursday, July 24, before the House Subcommittee on Social Security, at which time the White Paper was made public, said: "All parties agree that the current Social Security Disability Income Program does not work. Better use of the Federal-State Public Vocational Rehabilitation Program, coupled with improved incentives for people with disabilities to go to work, would significantly reduce the SSI/SSDI roles."

The Council is an organization comprised of the chief executive officers of the eighty-one (81) State Vocational Rehabilitation Agencies responsible for the administration of the Federal-State program designed to assist persons with disabilities to become employed.

VOCATIONAL REHABILITATION AND SOCIAL SECURITY

A WHITE PAPER - JUNE, 1997

COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

SOCIAL SECURITY RELATIONS COMMITTEE
Charles LaRosa, Chairperson

HIGHLIGHTS OF CSAVR WHITE PAPER: VR AND SOCIAL SECURITY

HISTORICAL PERSPECTIVE

- **1970'S - SSA/VR Program, Forward Funding**
- **1980's - Legislative Changes, Reimbursement Program**
- **SSA's Dual Strategy**
  - Alternative Programs,
    - *Short Term Demonstration Projects*
    - *Private Providers*
    - *In-house Program*
    - *Cost of over $30 million dollars*
    - *Results never released*
  - Trust Fund Reimbursements
    - *Under-funded*
    - *Extensive time delays*
    - *Structural Flaws*
      - Referral at time of Cash Award
      - Two year delay in reimbursement
      - Poor Communication
      - Referral at time of award/denial of cash benefits
      - Delay in Reimbursement payments
      - Poor communication

THE PROBLEM

- **Current System Does Not Work**
- **Fewer than 1.5% of beneficiaries return to SGA long enough to get off benefits**
- **Structural Disincentives vs. service delivery as the Primary Issue**
- **SSA Issue is twofold:**
  - Provide a benefit and work incentive package to assure that beneficiaries will not avoid the risk of work return;
  - Create a partnership with the Public VR Program
- **Structural Disincentives**
  - Increase in initial DDS allowances, only 5% increase in referrals to VR
  - For every $100 SSA spends on cash benefits, it spends little more than $.10 on VR
  - Decline in Reimbursement Money to states (FY96 $65 million should have been $84 million)
  - Decline in Claims Processing (lowest in 7 years)
  - Backlog in Claims and Reimbursements (7570 claims pending as of 9/30/96, with a total dollar amount of $84,264,158)
  - SSA Capacity Issue

- **Work Disincentives**
  - Recipients do not continue work at SGA
  - SSA Analysis of the Issues
    - *Loss of security of regular monthly payments*
    - *Young people have no opportunity to develop job skills*
    - *Complexity of system*
  - CSAVR Analysis of the Issues
    - *Loss of Cash Benefits*
    - *"all or nothing" approach*
    - *No gradual phase-down of benefits*
    - *Loss of Medical Benefits*

RECOMMENDED SOLUTIONS

- **Overhaul of work incentives, particularly for SSDI**
- **Proactive engagement of the Public VR Program**
- **Recommended Changes to the Current Work Incentive Structure**
  - Sliding scale system for reduced cash benefits for SSDI with protection of medical coverage
  - Immediate Medicare coverage
  - Unlimited Extended Period of Eligibility
  - Simplify and fully explain existing work incentives
  - Assign responsibility for development and approval of PASS Plans to Public VR Program counselors
- **Recommended Changes for the Relationship Between SSA and VR**
  - SSA/RSA/CSAVR Agreement
  - Routine invitations to VR by SSA to assist applicants to develop employment goals as part of the disability determination process
  - More timely funding of Rehabilitation Costs
- **Long Term Recommendations for the SSDI/SSI Disability Program**
  - Temporary Total Disability
  - Temporary Partial Disability

CONCLUSION

- **Public VR is the single source dedicated to returning SSA Disability beneficiaries to work**
- **Streamlining**
- **Legislative Proposals**
- **New Benefit and Work Incentive Package**
- **Partnership between SSA and VR**

VOCATIONAL REHABILITATION AND SOCIAL SECURITY
A WHITE PAPER
EXECUTIVE SUMMARY

HISTORICAL PERSPECTIVE

Through the 1970's and 1980's, the Social Security Administration (SSA) and the Public Vocational Rehabilitation Program (VR) attempted different strategies to return SSDI/SSI beneficiaries to work. In the early 1980's, Congress changed the law by which VR agencies were reimbursed for services from forward funding to a service based reimbursement program. The SSA implemented these changes without addressing work disincentives and other system barriers, and began a process of disengagement from the Public VR Program.

THE PROBLEM

The current SSA return to work programs for beneficiaries are not working. The General Accounting Office (GAO) reported that "...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." (GAO/T-HEHS-96-147, June 5, 1996).

Structural Disincentives

The SSA's rehabilitation and employment efforts for its beneficiaries have not kept pace with the growth of the Disability Program. Although there has been a staggering increase in allowances for SSDI/SSI benefits, this has not been reflected in referrals to the Public VR Program for employment services. Despite the lack of referrals directly from SSA, the Public VR Program continues to work with SSDI/SSI beneficiaries. In fact, states continue to increase the number of claims submitted and continue to increase the efficiency and accuracy of these claims. This has created a backlog of reimbursement

claims pending decisions, compounding an already threatening issue of capacity for SSA.

Work Disincentives

The experience of the Public Vocational Rehabilitation Program over time has demonstrated that the greatest barriers to return to work for beneficiaries are the disincentives connected to loss of medical and cash benefits. The SSA Disability Program in many ways is designed to discourage attempts at work return by its beneficiaries. Barriers identified have included the "all or nothing" approach to employment and public insurance for persons with disabilities, disincentives for individuals who have had no previous opportunity to develop job skills, and a complex system of work incentives which seems to dissuade many individuals with disabilities from even attempting work return.

RECOMMENDED SOLUTIONS

Change the Current Work Incentive Structure by providing:

- sliding scale system for reduced cash benefits for SSDI beneficiaries, with protection of medical coverage,
- immediate Medicare coverage similar and equal to SSI under Medicaid,
- unlimited extended period of eligibility, and
- simplified work incentive program.

Change the Relationship Between the Social Security Administration and the Public Vocational Rehabilitation Program:

- continue developing and implementing the SSA/RSA/CSAVR Agreement,
- institutionalize the connection between VR counselors and SSA District Offices in order to assist applicants to develop employment goals as part of the disability determination process, and
- more timely funding of rehabilitation costs.

Fix the SSDI/SSI Disability Programs over the long term by creating a system of:

- Temporary Total Disability, and
- Temporary Partial Disability

CONCLUSION

The Public VR Program is the one single employment program dedicated to returning Social Security Disability Program beneficiaries with all types of disabilities to work on a national basis. The State VR Agency utilizes a process

of individualized vocational services that has recently undergone substantial streamlining.

It is now time for the SSA to re-engage in a partnership with the Public VR Program, make use of this information, and get down to work in order to improve the employment programs for disabled beneficiaries of the Social Security Disability Programs.

HISTORICAL PERSPECTIVE:

As the Social Security Disability rolls continue to rise dramatically, it becomes increasingly important to evaluate the effectiveness of the current system for supporting individuals with disabilities in their efforts to return to work. There is widespread agreement that the disability system in its current form has many structural flaws preventing individuals with disabilities from returning to work.

This situation, with all of its complexities, has taken a long time to develop. In the 1970s, SSA and State Vocational Rehabilitation Agencies developed a program to return SSDI/SSI beneficiaries to work. This effort included forward funding by SSA to VR to provide dedicated vocational rehabilitation services to beneficiaries, referred at the point of allowance/ disallowance for benefits. Although mechanisms have been in place to pursue individuals not cooperating with VR, in practice such pursuit has never been followed or sustained, mainly due to political pressures. There are no known cases of beneficiary status being terminated by SSA, and SSA has actively discouraged the Public VR Program from identifying beneficiaries who refuse employment opportunities. Additionally, work disincentives inherent in the SSA disability system were so powerful as to essentially dissuade many potential workers from risking employment.

. . work disincentives inherent in the SSA disability system were so powerful as to essentially dissuade many potential workers from risking employment.

Much attention was given to this system in the late 1970's and early 1980's, resulting in legislative changes in 1981. The Omnibus Reconciliation Act of 1981 changed the way that vocational rehabilitation agencies were

reimbursed for services to help beneficiaries to go to work. The change from forward funding to a reimbursement system was a significant systemic change which had a negative impact on cooperative efforts. State VR agencies were no longer funded to designate specialty counselors to exclusively serve SSA beneficiaries. SSA shifted to a system of reimbursement for success, rather than engaging in a cooperative ongoing process designed to address the structural flaws within the disability programs. For much of the last decade, SSA has employed a dual strategy to address the problems in the disability programs:

1. Exploring a variety of alternative programmatic solutions to employment of beneficiaries, by funding a series of short-term demonstration projects, such as:

- funding private providers for VR services,
- running an in-house VR program,
- vouchering employment and training services, and
- developing enhanced referral systems.

The demonstration projects have cost the SSA over $30 million dollars and have duplicated rehabilitation resources in an effort to re-invent the case management model originally developed by the Public Vocational Rehabilitation Program. Despite this expenditure, the SSA has never released the results of the various studies it has undertaken to look at alternatives to the current system. For this reason, the CSAVR cannot comment on the findings.

2. Maintaining a Trust Fund Reimbursement System for services rendered by the State VR Agencies over the last ten years, resulting in payment at least nine months after beneficiaries leave benefits and, now under new regulations, allowing for "alternative providers" to the State VR Agencies to operate under the same reimbursement system.

The reimbursement program has been examined on a yearly basis by both CSAVR and SSA jointly. The program started with tremendous obstacles, including inadequate funding of the Trust Funds dedicated to the program. Advocacy on the part of the CSAVR in the

mid-1980's resulted in increased funding. However, the following structural flaws have never been adequately addressed:

- Referral from SSA to State VR Agencies occurring at the point of award/denial of SSDI/SSI Benefits, despite data that this is the time least likely to result in engagement by the individual in a process resulting in a return to work.

  The DDS referral process often operates to discourage, rather than encourage, appropriate and effective vocational rehabilitation outcomes. Currently, the DDS refers 10-15% of their applicants to the Public VR Program at the time of disability determination, immediately following the completion of a complex process to prove their inability to work at the SGA level. As a result, only a very small percentage of the people referred actually follow through and apply for VR services. As discussed further in the recommendations that follow, VR needs to be involved early in the process so that a proactive stance can be taken to help the applicant understand that SSI/SSDI should be viewed as a resource providing financial security during the rehabilitation process to develop new work skills.

- Reimbursement occurring often more than two years after initial expenditure by the State Agency. This delay is caused by service time, the time taken in the trial work period, and SSA time in processing reimbursement claims.

- Poor communication between SSA and the State VR Agencies, particularly in the area of follow-along of a beneficiary's earning status, due to overly complex regulations on the release of such information by SSA. This has resulted in a lower than necessary claims award rate to State VR Agencies.

The Public Vocational Rehabilitation Program stands ready to address these issues in partnership with Social Security. National forward funding strategies and/or a more timely reimbursement process could be put in place by SSA, as part of an overall cooperative effort to address the identified barriers to better performance outcomes within the system. Regrettably, the result of SSA's lack of a coherent strategy on employment, along with the on-going problems of work disincentives, has been a de-emphasis of the relationship between State VR Agencies and SSA. This situation must be turned around if any improvements in the overall system are to occur.

THE PROBLEM:

The current Social Security Disability Programs and related employment programs for beneficiaries are not working. The Social Security Administration's (SSA) employment data shows that fewer than 1.5% of beneficiaries return to substantial gainful employment long enough to get off benefits. The General Accounting Office (GAO) reported that "...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." (GAO/T-HEHS-96-147, June 5, 1996).

"...Each week the (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." (GAO)

Although Social Security Disability Programs are still based on the premise that persons with severe disabilities are unable to work, the goals of the Public Vocational Rehabilitation Program are consistent with society's attitudinal shift. The Rehabilitation Act of 1973, as amended, provides flexibility for persons with disabilities to choose their vocational outcome and level of work and income. National data clearly demonstrates the Public VR Program's emphasis on competitive employment. Of the more than 200,000 individuals who were rehabilitated by the Public Vocational

Rehabilitation Program in 1996, over 87 percent were placed in integrated, competitive employment.

It is clear that there are both structural disincentives and work disincentives preventing Social Security Disability Program beneficiaries from returning to meaningful employment. The only national program that addresses the employment needs of all persons with disabilities through direct service is the Public Vocational Rehabilitation Program. For this reason, CSAVR does not accept the position as "one of the stakeholders," but instead believes that the Public Vocational Rehabilitation Program should be a true partner in this overall effort. State Vocational Rehabilitation Agencies have implemented significant service improvements which directly impact on the ability to meet the employment needs of SSDI/SSI beneficiaries, including streamlining programs, providing more focused attention to the employment needs of people with the more severe disabilities, and the development of new technologies and strategies resulting in greater employment outcomes. The Public VR Program assists employers and employees in identifying and arranging for reasonable accommodations, provides technology to assist persons in reaching their employment goals, and serves persons with disabilities holistically.

The only national program that addresses the employment needs of all persons with disabilities through direct service is the Public Vocational Rehabilitation Program. For this reason, CSAVR does not accept the position as "one of the stakeholders," but instead believes that the Public Vocational Rehabilitation Program should be a true partner in this overall effort.

The General Accounting Office Report from June of 1996 concluded that "In line with placing greater emphasis on return to work, [the GAO] believes that the [SSA] 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 [SSA] Commissioner needs to identify legislative changes that would be required to implement such a program." (GAO/T-HEHS-96-147, June 5, 1996)

The recommendations outlined in this Paper are consistent with the GAO's findings. The Public Vocational Rehabilitation Program has been requesting for many years that Congress evaluate the importance and potential effectiveness of work incentive changes such as those outlined in this Paper. The findings of the GAO Report also support the CSAVR's belief that it is the disincentives in the current SSA Disability Program, not the service delivery system, that keep people from entering or maintaining employment. Most of the recent proposed legislation targeting change within the Social Security Disability Program focuses primarily on the service delivery system for vocational rehabilitation services. Most studies on the Social Security Disability Program demonstrate that disincentives are the primary barrier keeping beneficiaries from work, and virtually all studies of the Public Vocational Rehabilitation Program show it to be highly cost-effective. In light of these two clearly demonstrated facts, it seems that the approach the Social Security Administration needs to take is twofold:

. . . it is the disincentives in the current SSA Disability Program, not the service delivery system, that keep people from entering or maintaining employment.

1) Provide a benefit and work incentive package that assures that beneficiaries will not avoid the risk of return to work, including a redesigned SSDI Program and a comprehensive health care package.

2) Create a partnership with the Public Vocational Rehabilitation Program to provide the most effective and efficient services to Social Security Disability Program beneficiaries, rather than risking Trust fund dollars on the implementation of costly experimentation with an untried new service delivery system.

STRUCTURAL DISINCENTIVES

The SSA's rehabilitation and employment efforts for its beneficiaries have not kept pace with the growth of the SSDI Program. National statistics (1991 - 1994) show a staggering increase of 13% in initial allowances for the SSI and SSDI programs. For the same period, there was only a 5% increase in referrals to the Public Vocational Rehabilitation Program for employment services, and in the current system, referral decisions are controlled by the SSA. These circumstances begin to demonstrate how the system of national Social Security Disability Programs has cost the Social Security Trust Funds and the American economy hundreds of millions of dollars each year in cash and related health benefits. On analysis, this situation is the result of an overall web of law, regulation, policy and practice based on the out-dated concept that persons with severe disabilities are, by definition, unable to work.

The SSA's rehabilitation and employment efforts for its beneficiaries have not kept pace with the growth of the SSDI Program.

In 1993, the GAO reported: ". . . Helping people with disabilities return to work has been a low priority of SSA and the Congress for both the SSI and DI programs, and, in fact, SSI and DI return virtually no one to work . . . for every $100 SSA spends on cash benefits, it spends little more than $.10 on VR, and few recipients are referred for VR services . . . " (GAO/PEMD-93-19, Aug. 27, 1993).

The SSA attributes "static" reimbursement figures to a capacity issue on the part of the Public VR Program, even though they have never surveyed state agencies to determine their capacity level. Recent reimbursement program

statistics, however, demonstrate that the capacity issue is not on the part of the Public VR Program, but rather on the part of the SSA. For Federal Fiscal Year 1996, the Public VR Agencies increased the number of claims submitted for reimbursement by eleven percent, while increasing their allowance rate by seven percent. For the same year, SSA decreased their processing of claims by eleven percent. If SSA had processed claims at the same rate in FFY96 as FFY95, rather than processing the lowest number of claims in seven years, the Public VR Program would have received $84,147,798 for vocational rehabilitation services instead of $65,480,627. This would have been the highest reimbursement amount ever (16% increase over FFY95).

As states continue to increase the number of claims submitted and continue to increase the efficiency and accuracy of claims, it becomes clear that the backlog of claims pending decisions (7,570 claims pending as of September 30,1996 with a total dollar amount of $84,264,158) will continue to grow, thus compounding the already threatening issue of capacity for the SSA.

WORK DISINCENTIVES

The experience of the Public Vocational Rehabilitation Program over time has demonstrated that the greatest barriers to return to work for beneficiaries are the disincentives connected to loss of medical and cash benefits. These fears are compounded by the complexity of the work incentive structure itself. A 1994 Lou Harris Poll found that 80% of people with disabilities who were unemployed said they wanted to return to work. However, 54 percent said they could not work full time, because they would lose their benefits.

As a conservative estimate, about 40 percent of the 1.2 million people with disabilities served annually by the Public Vocational Rehabilitation Program are SSI/DI recipients. Of the 209,000 people with disabilities who go to work from the Public VR Program annually, approximately 45,000 are SSI/DI recipients. Of that, 6,000 become recipients for whom the states are reimbursed as having achieved 9 months of work, or longer, at or above Substantial Gainful Activity (SGA - $500 in earnings per months). After receiving vocational rehabilitation services and achieving work status, 30,000-40,000 SSI/DI recipients did not continue to work at a Substantial Gainful Activity (SGA) level. These figures lend support to the notion that it is not a lack of motivation that prevents individuals with disabilities from working, but rather a result of systemic flaws in the disability program.

. . . the greatest barriers to return to work for beneficiaries are the disincentives connected to loss of medical and cash benefits.

The SSA Disability Program in many ways is structurally designed to discourage attempts at employment by beneficiaries, regardless of their current capacity. In fact, the leadership of the SSA has acknowledged the problems and barriers related to returning persons with disabilities to employment in its report titled "Defining a Work Employment Strategy for People With Disabilities (September, 1994). These barriers include:

- The loss of security of regular monthly payments from the SSA in contrast to uncertain, unstable employment prospects which often do not provide medical benefits and that pay relatively low wages.

- Young people coming onto benefits have no opportunity to develop job skills and are, therefore, likely to stay on benefits.

- The complexity of the system makes it difficult for people with disabilities to understand, and makes it complex for the SSA to administer.

Although SSA acknowledges that these issues are barriers to employment, CSAVR's analysis is that the barriers are more extensive. The two primary issues in looking at disincentives to employment revolve around loss of cash benefits and loss of medical benefits as a result of work activity.

These issues affect both SSDI and SSI beneficiaries, but the disincentives are greater for SSDI recipients, where benefits awarded are often equal to or exceed the value of past or potential earnings, particularly when medical benefits are considered. There is no gradual phase-down of benefits when SSDI beneficiaries attempt work return, as is available to SSI beneficiaries. This "all or nothing" approach to employment and public insurance for persons with disabilities, young or old, does not work, and often results in the under-employment of persons receiving SSDI benefits. The gradual phase-down of benefits based on earnings, as available to SSI recipients, is widely held as a stronger work incentive than the trial work period.

Loss of medical benefits is another critical issue in the return to work efforts for individuals receiving benefits from the SSA Disability Programs. Recent proposed legislation has attempted to address the issue of medical insurance, but the scope of the legislation is not sufficient to alleviate the fears of beneficiaries faced with the loss of medical coverage. (Specific recommendations are discussed further, p. 13). Until significant changes are made to address these issues, the numbers of beneficiaries leaving the Social Security rolls will not rise dramatically.

The tragedy of thousands of beneficiaries out of work on a chronic basis is compounded by the fact that, despite SSA's years of research about these systemic barriers, little has been done, legislatively or otherwise, to fix the system. We believe that a fundamental change at the Federal level is needed to promote interaction and collaboration between the Social Security Administration, the Rehabilitation Services Administration (RSA), and Public State Vocational Rehabilitation Agencies.

RECOMMENDED SOLUTIONS:

When State VR counselors incorporate discussions about benefits planning into vocational rehabilitation planning, the counselors are met with skepticism and fear, based on a past history of inconsistent information. The CSAVR recommends that the numbers of re-employed SSDI beneficiaries and the employed persons on SSI could be immediately improved through the following steps:

- An overhaul of the available work incentives for both SSDI and SSI beneficiaries, and, particularly DI.

- Proactive engagement of vocational rehabilitation programs that have demonstrated an ability to put beneficiaries back to work through forward funding and coordinated service delivery between SSA disability programs and State VR Agencies in SSA District Offices across the country.

RECOMMENDED CHANGES TO THE CURRENT WORK INCENTIVE STRUCTURE:

- Include a sliding scale system for reduced cash benefits for SSDI beneficiaries, with protection of medical coverage similar to the SSI 1619 A and B program. SSDI benefits should be gradually reduced based on income instead of providing full benefits until date of termination.

- Immediate Medicare coverage similar and equal to SSI under Medicaid. SSA should recognize that for many individuals, a potential loss of medical benefits is their biggest worry. The current 24 month waiting period for Medicare forces people to become dependent on Medical Assistance, a system that does not promote employment because of the "spend-down" provisions. Medical coverage should include personal

attendant care services and prescription drugs needed to maintain employment (e.g., psychotropic medications for serious mental illness). Medical benefits should continue (through a sliding fee scale based on earnings) after cash benefits end to allow people to consider employment opportunities that may not include adequate health insurance coverage.

- Provide an unlimited extended period of eligibility. As long as an individual's medical condition exists, s/he would not have to go through a new eligibility determination for SSDI if their earnings decreased.

- Simplify and fully explain existing work incentives. Many beneficiaries referred to VR are unaware of, or do not understand, the work incentives currently provided by SSA. Brochures and other forms of communication must be simplified so that people understand the intent of the program. If an earlier intervention strategy is developed between the SSA and the Public VR Agencies, VR counselors could fully explain the incentives at the time of application for SSA/VR benefits and then incorporate them into the rehabilitation plan. Furthermore, the SSA has been reluctant to provide information in writing as to what will happen to an individual's benefit if they go to work. For some people, having the information in writing reduces their anxiety to return to work.

- Assign responsibility for development and approval of PASS plans to Public Vocational Rehabilitation counselors. The GAO report on the SSA's PASS Program (GAO/HEHS-96-51, pages 22-24) indicates that Social Security District Office staff do not have sufficient vocational expertise to adequately assess PASS plans. Public VR Program counselors possess the necessary education, training and experience to assist individuals in developing vocational goals which will lead to employment through PASS plans. They should, therefore, be given the responsibility for PASS plan approval. The result would be increased collaboration between the front line Public VR counselors and the SSA district staff and therefore, an increased number of employment outcomes resulting from PASS plans.

RECOMMENDED CHANGES FOR THE RELATIONSHIP BETWEEN THE SOCIAL SECURITY ADMINISTRATION AND THE PUBLIC VOCATIONAL REHABILITATION PROGRAM:

- The SSA and the Rehabilitation Services Administration (RSA) need to continue with developing and implementing the SSA/RSA/CSAVR Agreement to promote employment opportunities for people receiving SSDI/SSI benefits.

- The CSAVR recommends that Public VR counselors routinely be invited by SSA District Offices to assist applicants to develop employment goals as part of the disability determination process. This proactive stance would promote rehabilitation and employment over a person's remaining on the SSDI/SSI rolls permanently.

- Provide more timely funding of rehabilitation costs. More timely reimbursement of expenditures would allow the Public VR Program to expand services to SSA beneficiaries.

LONG-TERM RECOMMENDATIONS FOR THE SSDI/SSI DISABILITY PROGRAMS:

- Introduce a Temporary Total Disability from Work Award as an alternative to the current permanent benefit and Continuing Disability Review (CDR) system. Combined with the proactive engagement of Vocational Rehabilitation at the point of first contact with the SSA, a temporary total award determination would stress that SSI/SSDI should not be viewed as a permanent lifelong benefit.

  Individuals should apply with the SSA and VR concurrently, and the two agencies should share medical records and other applicable information. If the applicant is determined eligible for both programs, cash benefits should be tied to active participation in a

rehabilitation program that will lead to employment within a specified time frame. Instead of a CDR review date, benefits would cease at the end of the specified time frame and the person would need to reapply for SSA benefits if he or she has not achieved employment.

It is recognized that some people may not benefit from VR services. Participation in VR for people with rapidly progressively or catastrophic disabilities, and people over the age of 60, should be voluntary. Permanent disability benefits should be awarded to these individuals with no medical review date.

- Further, the CSAVR recommends the introduction of "Temporary Partial Disability" for persons with stable conditions who are able to work, (albeit not at SGA), instead of requiring the person to stop working in order to maintain eligibility for full SSDI benefits. This could be designed on a sliding scale for reduced cash benefits based on income, similar to the SSI system. These changes would reduce the "all or nothing" aspects of the current system for SSDI recipients. Also, such a system would reward initial attempts at part-time work, which is very often possible and available to beneficiaries early after benefit award.

CONCLUSION:

The Public VR Program is the one single source dedicated to returning Social Security Disability Program beneficiaries with all types of disabilities to work on a national basis. The State VR Agency utilizes a process of individualized vocational services that has recently undergone substantial streamlining. The changes brought on by the Rehabilitation Act Amendments of 1992 dovetail in many ways with the needs and expectations of the SSA and beneficiaries who are seeking to return to work. If systemic disincentives are addressed, a newly streamlined State VR system that utilizes an existing Public/Private service delivery system is poised to address the return to work effort for SSDI/SSI beneficiaries.

Many legislative proposals targeted at SSA system redesign have recently surfaced. A few of the proposals support a competitive referral model, opening up referrals of Social Security Disability program beneficiaries to alternate providers. The CSAVR believes that disincentives and policy and procedural issues, not choice of service provider, have been the primary causes of the low rate of benefits termination due to return to work outcomes. It is clear that changes in the SSA benefit structure must be made regardless of who provides rehabilitation services. The Public VR Program has much to offer in terms of history and experience supporting individuals with disabilities in their return to work efforts, and would welcome the opportunity to be involved in discussions relevant to legislative changes.

As outlined in the Problem Statement, there is clearly a twofold approach for the SSA to take to address the structural and work incentives inherent in their current Disability Program:

1) Provide a benefit and work incentive package that assures that beneficiaries will not avoid the risk of return to work. To be effective, it would need to include a redesigned SSDI Program, similar to the current SSI structures, as well as including comprehensive health care benefits.

This package should be readily understandable and accessible nationally to SSDI/SSI beneficiaries.

2) Develop a partnership with the Public Vocational Rehabilitation Program to provide the most effective and efficient services to Social Security Disability Program beneficiaries, rather than risking Trust fund dollars on the implementation of costly experimentation with private providers. The SSA should serve as the primary referral base to established Public VR Agencies with expertise in meeting the employment needs of persons with disabilities.

It is now time for the SSA to re-engage in a partnership with the Public VR Program, make use of this information, and get down to work in order to improve the employment programs for disabled beneficiaries of the Social Security Disability Programs.

Mr. HALLIDAY. I will not go through all of that. I would like to focus on a couple of key barriers and our main recommendations if I may.

The barriers we see come in three main areas: One is disincentives. And the panel before us did an outstanding job of identifying the major ones there.

Clearly the availability of medical coverage is a key factor in preparing for and maintaining employment.

It is the advances in treatment and rehabilitation that allow people to function at work and to increase their employment levels.

The other disincentives are the structural ones, and those are the ones I would like to spend the most time talking about. They fall into the following areas.

We need to become much more effective in identifying those on disability who are involved in rehabilitation activities. In order to do this, we need to work very closely with the Social Security Administration so that I could come here and say, of the approximately 7,000 people in Connecticut who are active participants in vocational rehabilitation, *x* number are on SSI and SSDI.

Today I cannot do this because we have been unable to get the necessary information from Social Security.

We have to be able to give recipients fast, clear, accurate, and, most of all, predictable information regarding work incentives. Like all of us, if I cannot get clear answers in a very complex matter, and the decisions I make will have direct impact on what my in-

come is, what my benefits are, and it is fuzzy and it is unclear—I am not going to act.

We are concerned and scared by contradictory information. We need to provide consumers clear, understandable information so that they can make decisions that will hold up over time.

The other structural barrier is the impact of reimbursement on benefit systems. As I come here before you today, the latest figures I have show 87 million dollars' worth of potential reimbursable costs sitting in Baltimore. These are reimbursement claims the public vocational rehabilitation agencies are asking Social Security to consider for people who have gone to work for a minimum of 9 months.

These funds need to be turned around more quickly so that they get back into the VR system, where they will be spent in returning individuals to work.

I think one of the things you heard the panel before say, and we have talked about in our report, is clearly people need work incentive education. Much of the information they get, unfortunately, is from hearsay, and off the street. It is inaccurate, and does not contribute to their being able to make timely decisions.

Those kinds of changes in that kind of system can be done without adding cost.

The other point that we are deeply concerned with is that we do not spend our scarce resources on building infrastructure and competing systems. We need cooperation and collaboration between the public and private sectors to maximize our financial resources.

Many recipients of SSDI are also receiving services from private programs such as workers' compensation or disability insurance. We need to look at jointly working toward the common goal of employment.

Thank you for this opportunity. We are available to work with you, and look forward to doing so. Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of John Halliday, Director, Connecticut Bureau of Rehabilitation Services; and Chair, Council of State Administrators of Vocational Rehabilitation, Social Security Relationship Committee

Chairman Bunning and distinguished members of the Subcommittee, it is a privilege to have the opportunity to provide testimony on behalf of the Council of State Administrators of Vocational Rehabilitation (CSAVR) regarding the barriers facing Social Security Disability recipients in their efforts to return to and maintain employment.

The CSAVR is composed of 81 state officials who administer the Public Vocational Rehabilitation program in the 50 states, the District of Columbia and the territories. This program has a history of providing vocational rehabilitation services to recipients under the various Social Security Disability Programs since the inception of the SSDI and SSI programs. Our goal today is to share with your our understanding of the factors that impact individuals receiving Social Security Disability Benefits as they consider active participation in our national economy.

We are proud of the history and achievement of the Public Vocational Rehabilitation Program in assisting annually thousands of recipients of Social Security Disability to prepare for, enter, and maintain employment. Of the 1.2 million people served annually by the Public Vocational Rehabilitation Program, 40% are conservatively estimated to receive SSI and SSDI when they enter or participate in the Vocational Rehabilitation System. Over 200,000 individuals enter work annually through their efforts with the Public Vocational Rehabilitation Program. Approximately 45,000 of these individuals are also SSI and SSDI recipients. The level of partnership with consumers, families, and other public and private rehabilitation programs exhibited in the delivery of services through the Public Vocational Reha-

bilitation Program is exemplary and this partnership has brought about the success of the Program. It is through the continued growth and development of such partnerships that our efforts to assist increased numbers of individuals with SSI and SSDI need to be based.

The mandate of the Public Vocational Rehabilitation Program is to assist eligible individuals with disabilities to enter and maintain competitive employment in the full range of economic activities that our society offers.

The barriers to Social Security recipients entering and maintaining employment fall into three categories: disincentives, structural issues and resource issues.

In the area of disincentives, the barrier is the availability of continued Medicare and Medicaid eligibility to cover the costs of treatment, medicine and other necessary services that in fact, enable people with significant impairments to enter and maintain employment. These barriers are well documented and widely agreed to. The other major disincentive is the loss of income, both perceived, and in some cases real, resulting in individuals finding themselves in severe economic crisis. There is broad agreement that we need to continue to work on various modifications to the Medicare and Medicaid structures in order to enable persons with disabilities to continue to have access to necessary medical and rehabilitation treatments.

One of the greatest disincentives to Return-to-Work is the lack of understandable information on what will happen to both cash benefits and medical coverage. I refer to this as the twilight zone, in that one feels lost in a fog of confusion with contradictory messages often being received. Beneficiaries are frequently told to just go ahead and take a job, so that they then, only after taking it, will be informed as to what will happen to their benefits. The system must be simplified to encourage persons to return to work. The redesign of this system should be focused on a customer service orientation which would result in people having confidence around returning to work. We must decrease the great unknown that we ask people to leap into when we ask them to consider return to work.

In the area of structural barriers, it is clear that the timing of outreach to encourage beneficiaries to return to work is poor. It is poor because it occurs at a time when persons with disabilities are either trying to prove they cannot work or when they have just been allowed benefits. Also complicating the matter is the lack of a joint method between the Public Vocational Rehabilitation Program and the Social Security Administration to determine who is receiving benefits.

It gets worse when you look at the reimbursement process where bureaucracy, in terms of paper, is extremely time consuming to the Public Vocational Rehabilitation Agency. Then, as if this frustrating process is not enough, there is the unpredictability of response and reimbursement of funds in a timely fashion.

The impact of these two structural areas can be seen clearly when the Public Vocational Rehabilitation Agency tries to set up a process to check with Social Security on the status of applicants or eligible individuals. There is no easy and consistent way we can do this nationally. This leaves states in the situation of having to try to get the information directly from consumers who are often receiving services from numerous programs and are somewhat confused as to exactly which they are receiving and why. In addition, at the time of placement into employment, there is no easy way to identify whether or not an individual was, and still is, receiving Social Security Benefits. This clearly impacts on the reported effectiveness of the Public Vocational Rehabilitation Program. An example in Connecticut: For a short period of time we were able to access information and, as a result, identified an increase in a three month period of 30 percent of the cases we could identify who were in employment above the Substantial Gainful Activity level who were on SSI and SSDI and therefore would qualify under the Reimbursement Program. If this is an indication of the true impact Public Vocational Rehabilitation has on employment outcomes for beneficiaries, clearly improvements in identifying those receiving Social Security would show that, in fact, the Public Vocational Rehabilitation Program is even more effective than the present data shows.

Due to the lack of predictability around the timeliness of reimbursements, State Vocational Rehabilitation Agencies find themselves unable to determine funding levels and, thus, unable to commit more funds to the delivery of services to SSI and SSDI recipients. The current structure of the Return-to-Work Program costs the Social Security Administration no money since the full up front costs for services administration collection is borne by the Public Vocational Rehabilitation Program. Even under these conditions, Social Security, apparently, has been unable to design an effective, efficient and timely reimbursement structure. One must, therefore, raise the question of what will happen with a wider, more complex system of reimbursement that is contained in many of these proposals.

A third barrier is the area of resources. It is interesting that one of the general assumptions behind many of the Return-to-Work proposals is the idea that access

to services through the Public Vocational Rehabilitation Program and other rehabilitation agencies is problematic for individuals on SSI/SSDI. I must say that I have never heard this as a complaint from consumers. We may have heard of individuals who did not get a particular service, but we have never heard that they can not get into an agency, make application or have their eligibility determined, develop plans, etc. If there are limitations on services, it is due to the lack of actual funding available to the agencies rather than lack of access or openness to serving SSI and SSDI recipients. These individuals would be placed on a waiting list until funds become available. In fact, the priority set by the Rehabilitation Act as amended in 1992, matches perfectly with the priority of returning individuals on SSI and SSDI to employment.

The Rehabilitation Act ensures that Public Vocational Rehabilitation Program funding and the reimbursements received through the Social Security Reimbursement Program go back into vocational rehabilitation services and, thus, those resources are available to serve more individuals. Proposals we have reviewed, to this point, seem to have no assurances that the funds reimbursed or paid out through various schemes would, in fact, add any new capacity to provide vocational rehabilitation services at the community level. Many of the proposals suggest that there might be considerable pitfalls in them, such as the shifting of costs to public programs by creating potential windfalls in private for-profit programs. This would happen as a result of most of the proposals allowing for-profit programs to serve only those individuals who are already involved with them due to their agreements under insurance and other programs. In these situations, there would be no new capacity created and no incentive to expand funds to serve more individuals beyond those already receiving services. Furthermore, these proposals lack any appeal process or fair hearing for individuals who would receive services.

I have seen some references to private disability programs having higher percentages of success in terms of Return-to-Work figures. It would be interesting to do some real demographic studies on the populations served by private disability programs. In general, one could assume that they would probably be individuals who have attained much higher levels of education, job training and income who have the resources and perceive the risk to protect their present income levels. If such individuals require disability, they clearly have numerous options for employment that would not be available to the full range of individuals served by Social Security who do not possess these advantages. One might then ask, is this really a fair comparison or are we looking at a population with specific characteristics that is served primarily by private disability programs?

I would like to discuss, for a moment, some of the main recommendations that the CSAVR has made regarding the Social Security Program. We are presenting to you today a Paper which we have developed outlining our concerns and recommendations.

First, we must eliminate what we call the "leap of faith" or the "all or nothing approach," whereby recipients must be either on or off benefits with no sliding scale, etc. We recommend for SSDI that consideration be given to some type of sliding scale benefit rather than the "trial work period" approach. There must be continued eligibility for Medicare coverage and the type of community health services provided under Medicaid. We realize that in both of these areas there are cost concerns which must be projected and considered for possible financial impact.

We recommend simplification of the Work Incentives Program, including employment related work expenses, 1619 A&B provisions, PASS Programs, etc. We further recommend that the Committee consider these programs being administered by the Public Vocational Rehabilitation Program rather than by the present system of trying to deal with the Social Security Administration structure. The Social Security Administration does many functions extremely well, particularly the issuing of checks and determining of financial disability eligibility. It does not, however, have the expertise nor the structure to administer incentive programs which help people deal with planning beyond just the Social Security Programs. Consideration must also be given to the various other Federal, State, Local resources and programs available in order to complete and implement a successful Return-to-Work effort.

We strongly urge continued joint effort based on the Agreement that now exists between the Social Security Administration, the Rehabilitation Services Administration, and the CSAVR. In terms of identifying effective and specific plans for outreach, it is important to provide education and information to Social Security recipients regarding Return-to-Work opportunities. Secondly, we must work to simplify the reimbursement program so that this can be done quickly with the minimum of paperwork.

The cooperation of the RSA, the SSA, and the CSAVR will help us begin to chip away at the mixed message we give our citizens and our communities regarding dis-

ability. On the one hand, under Social Security, we identify people as totally disabled, unable to be involved in any economic activity in their community, and in fact, so disabled that their impairment may result in death. On the other hand, under Title I of the Rehabilitation Act and the Americans with Disabilities Act, we assume that persons with disabilities, regardless of their impairment, have the capacity to work, and should have that opportunity. We cannot underestimate the impact of having to implement these paradoxical messages. For example, we ask treating physicians and other health professional to, on the one hand, describe the significant level of impact of impairment such that it prevents the person from doing any work in the community for at least a year in order for them to be eligible for Social Security. A short time later, we turn around and ask those same people to describe what functional strengths and potential for employment the Social Security recipient has. This double message impacts the individual with the disability, all the individuals who interact with him or her, and the community at large, creating a sense of confusion around what potential individuals with disabilities have and what our public policy is toward disability.

In order to address these larger public policy issues, we have suggested a long term consideration of a temporary disability program for some groups. For example, individuals who acquire a disability at a young age could be granted a fixed period of financial eligibility for benefits, combined with ongoing availability of medical coverage. They would be required to be involved in Vocational Rehabilitation to continue their education and/or development of vocational skills to enter the workforce. Another way of addressing this would be the consideration of a temporary, partial disability program which would provide for the needs of individuals who require Disability after they have developed job skills and have been in the labor market. This approach would allow them to continue to participate in the labor market rather than having to make the decision to describe themselves as either totally unable to work or able to work, with nothing in between.

In conclusion, we believe that the Public Vocational Rehabilitation Program is effective in providing vocational rehabilitation services to SSI and SSDI recipients. Thousands of these individuals enter employment each year. We have streamlined the Public Program and have reached out to the Social Security Administration. The Public Vocational Rehabilitation Program has greatly increased its flexibility. We are working in partnership with Social Security and other public and private agencies, particularly in researching ways to effectively simplify incentives to "Return-to-Work."

This partnership must continue. In addition, there are critical questions which we must ask:

Do we want to take our precious limited resources and invest them in competing publicly administered structures which do nothing to increase the resources available?

Is it our goal to create more levels of public programs and greater confusion on the part of recipients and providers in the community as to who is doing what?

Does it make sense to set up public and private agencies as competitors and risk damaging the good collaborative efforts which currently exist within the Vocational Rehabilitation Community?

Our answers to these questions must be "No" if we believe those with disabilities should be offered the same choices as others to fully participate in the economic activity of their communities.

I wish to thank you on behalf of CSAVR. We stand ready to actively participate in the development and continued evolution of an effective coordinated employment program for Social Security Disability recipients.

Chairman BUNNING. Ms. Gennaro, would you read Mr. Christman's statement?

STATEMENT OF RICK CHRISTMAN, EXECUTIVE DIRECTOR, METRO INDUSTRIES, LEXINGTON, KENTUCKY; AND KENTUCKY ASSOCIATION OF COMMUNITY EMPLOYMENT SERVICES; AS PRESENTED BY MARY GENNARO, AMERICAN REHABILITATION ASSOCIATION

Ms. GENNARO. Thank you, Mr. Chairman. Rick Christman was honored to have been given the opportunity to testify here today,

and I know as a fellow Kentuckian he was thankful for your leadership. And unfortunately weather kept him in Kentucky. All his flights to try to get here were canceled. So thank you for your kindness in letting me read his testimony.

I am the executive director of Metro Industries, a not-for-profit community rehabilitation program in Lexington, Kentucky. Metro Industries provides employment, occupational skills training and job placement to people with a variety of barriers to employment, including persons with disabilities.

I am representing today a group of like organizations in Kentucky known as the Kentucky Association of Community Employment Services. Metro Industries is also a member of the American Rehabilitation Association.

As you are already aware, the state of affairs for persons with disabilities relative to employment is sad. According to a survey conducted by Lou Harris for the National Council on Disability in 1994, only 68 percent of persons with disabilities in the United States are unemployed, an actual increase in unemployment for this population, compared to 1986.

This disturbing phenomenon has worsened despite our Nation's passage of the Americans with Disabilities Act in 1990. While not all persons with disabilities are SSDI or SSI recipients, this statistic serves to underscore the problem of the explosion in beneficiary rolls.

Accordingly, in addition to rights and public access for persons with disabilities, policymakers should equally focus on programmatic innovation and the elimination of work disincentives.

The current system for delivery of employment-related services to beneficiaries can be improved. What is necessary is a choice-based market-driven service delivery system which will drive effectiveness and innovation. And, second, the alleviation of risk of loss of health insurance.

With regard to the implementation of a market-driven service delivery system, and the correct assumption that SSDI/SSI beneficiaries would benefit from having a much larger pool of service providers from which to select, we know that a provider pool will not have to be developed from scratch.

In addition to public providers, there already exists in every community providers known as community rehabilitation programs. In fact, some 6,700 organizations exist to provide employment-related services to persons with disabilities.

Unfortunately, only a fraction of beneficiaries are referred to these organizations. By creating a workable payment mechanism, and directly linking beneficiaries to service providers, the underutilized potential of these organizations will be unleashed.

In the State of Kentucky, members of our association worked in cooperation with Kentucky's Department of Vocational Rehabilitation to develop a highly accountable fee for service outcome-based funding mechanism.

Taking a page from the farsighted vision of Kentucky DVR, a similar mechanism could also be fashioned for the Social Security Administration. Because of the 9-month trial work period necessary for beneficiaries to demonstrate their job placement success, and the investment needed to prepare someone for employment, a fee

system based on the attainment of certain milestones will be necessary.

These milestones would include completion of a rehabilitation plan, 60 days of employment, and 9 months of employment. Then continued payment based on savings will support ongoing maintenance of the former recipients' employment status.

Without these milestones, too many providers will find it impossible to participate.

Now, to the issue of work disincentives. Over the course of my 20-year career in vocational rehabilitation, one of the prime fears I have encountered among recipients and their families is health care. Most people are far more concerned about loss of Medicaid or Medicare than of cash benefits.

Because of this fear, when vocational rehabilitation professionals work with recipients job placement into truly self-sufficient employment is seldom attained. Too frequently, we professionals assist persons with disabilities to obtain positions below their abilities and earning capacity simply to preserve health benefits.

The problem of the medical insurance disincentive is a complex one to be sure. However, our agency has found that the SSI Program and its graduated reduction of cash benefits against earned income, with the recipient maintaining medical coverage, to be much more conducive to employment than the structure of the SSDI system.

A means of allowing recipients to purchase Medicare and Medicaid coverage after attaining self-sufficient employment is certainly an idea worth serious consideration.

Thank you, Mr. Chairman for the opportunity to comment.

[The prepared statement follows:]

Statement of Rick Christman, Executive Director, Metro Industries, Lexington, Kentucky; and Kentucky Association of Community Employment Services

Thank you Mr. Chairman, and distinguished Members of the Subcommittee, for the opportunity to testify on the important issue of assisting beneficiaries of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits to increase their self-sufficiency through employment.

I am the Executive Director of Metro Industries, a private, not-for-profit community rehabilitation program in Lexington, Kentucky. Metro Industries provides employment, occupational skills training and job placement to persons with disabilities and other individuals with a variety of barriers to employment. Today, I am representing a group of similar organizations in Kentucky known as the Kentucky Association of Community Employment Services (KACES). Metro Industries is also a member of the American Rehabilitation Association.

The state of affairs for persons with disabilities relative to employment is unsatisfactory. 1994 U.S. Census Bureau data indicates that 73.9% of persons with severe disabilities, age 21 to 64, were not employed. It has been estimated that only about one out of every 1,000 beneficiaries is rehabilitated each year (GAO/HEHS–96–62). More people can and must be assisted to work or "return to work." More that $57 billion in cash benefits was paid out to people with disabilities in 1995 through the Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) programs. The United States General Accounting Office reports that if an additional 1% of the 6.6 million working-age SSI and SSDI beneficiaries were to "leave the rolls," by returning to work, lifetime cash benefits would be reduced by an estimated $3 billion (GAO/HEHS–97–46, March 17, 1997). Guaranteeing rights and public access has increased the ability of, and opportunity for, persons with disabilities to become employed. Now we must also focus on programmatic innovation and the elimination of work disincentives to increase employment.

The current system for delivery of vocational rehabilitation services to SSDI/SSI beneficiaries has assisted people to become employed, but many more people with

disabilities want to work and need access to the services which will enable them to do so. A key element in helping them move into employment, and off of benefits, is already in place, namely, the estimated 6,700 community rehabilitation programs throughout the country. These community based organizations provide directly, or facilitate the provision of, vocational rehabilitation services to individuals with disabilities. They work with countless businesses across the country. Through quality evaluation, training, placement and support, they assist people with disabilities to work to their highest potential. We must expand access to rehabilitation services and allow consumers to choose their providers from among the many public and private providers available. This will enable more people with disabilities to receive the services they need to participate in the workforce.

A combined outcome-based, milestone payment system is a necessity. An outcome-based system will help ensure quality results, but milestone payments are also essential for quality. If milestone payments are not available, too many community rehabilitation providers will find it financially impossible to bear the risk of participating. The program must attract an adequate supply of diverse providers in small and large communities alike. Providers should receive milestones payments at completion of an employment plan, after 60 days of employment, and after nine months of employment. This essential for success of the program. Once a person with a disability is working and no longer eligible for benefits, the provider should receive a percentage of the monthly benefit until five years post employment, while the person continues to remain off of benefits.

The Alternate Participant Program illustrates the problem posed by an inadequate payment system. This program is likely to be little utilized because it only reimburses for actual costs and payment is only made after a person has completed nine months of work at the "substantial gainful activity" level or higher. For non-blind individuals with disabilities this would be earnings of $500 a month or higher. There must be a sharing of risk, otherwise participation will be limited to only a few large providers who have the cash flow necessary to serve a substantial case load with only the possibility of future payment.

Lack of access to adequate and affordable health care coverage is a significant barrier to employment for persons with disabilities, which we must address in any "return to work" effort. Over the course of my 20-year career in vocational rehabilitation and other disability-related positions, one of the prime fears I have encountered among persons with disabilities and their families is loss of health care coverage, so much so, that the risk of the potential loss of one's Medicaid or Medicare coverage is often the primary impediment to work. Persons receiving SSDI and/or SSI, who become employed, should be able to maintain their health care coverage. Eligibility for Medicare and Medicaid should be maintained up to a certain level of earnings at which point a person with a disability should be able to pay for continued coverage under these programs. The need for personal assistance and long-term supports must also be addressed and Medicaid is virtually the only source of reimbursement for long-term services and supports.

We should also attempt to address the current economic disincentive to work which exists for SSDI beneficiaries. In the current system persons face a sudden lose of benefits after achieving a certain level of earnings over a period of time. This loss of support occurs before the individual is earning enough to support him or herself, and acts as a financial disincentive to working.

Participation in the program should be voluntary, at least until the program is in place for a period of time. It should also be fairly simple for a provider to be "certified" to provide services. Quality assurance should be built into the program. Providers should provide information on their services and outcomes in order to facilitate consumer choice. At the same time, providers should not be ranked or graded, because this would involve comparisons which cannot be made fairly.

A "ticket" approach presents many concerns for providers. It will make the payment system difficult and uncertain. If a consumer needs more than one provider at the same time, how will the funding represented by the ticket be disbursed? If a consumer decides to change providers, how will payment be made?

To enhance the design and implementation of the program, a commission with representation by consumers, providers and employers should be appointed. Working with the Social Security Administration, such a commission will ensure the development of a program that, from the onset, has the input of all the parties most critical to its success.

A system which provides for consumer choice, expands access to services, addresses disincentives to work, provides for an adequate payment system, assures quality, and includes key stakeholders in its design and implementation, will work. We need to create such a system. Many, many people with disabilities who seek greater independence and wish to more fully utilize their skills and abilities will benefit. The

country as a whole will benefit as more of its citizens are able to more fully contribute to the community, lessening their dependence on government and contributing to the tax rolls. Metro Industries, along with community rehabilitation providers in Kentucky and throughout the country, stand ready to help create such a system and work within it to assist more people with disabilities to increase their independence and self-sufficiency through employment. Thank you Mr. Chairman, and members of the Subcommittee, for the opportunity to comment.

Chairman BUNNING. Thank you very much. Next would be Dr. Hessellund, please.

STATEMENT OF THORV A. HESSELLUND, ED.D., CRC, PRESIDENT, NATIONAL ASSOCIATION OF REHABILITATION PROFESSIONALS IN THE PRIVATE SECTOR, FRAMINGHAM, MASSACHUSETTS

Mr. HESSELLUND. Thank you, Mr. Chairman. My name is Thorv Hessellund. Today I am here as president of the National Association of Rehabilitation Professionals, NARPPS, to provide our recommendations on Social Security reform.

I will cite how private sector can enhance the current system and return those Social Security recipients with disabilities back to the job market. In addition to being president of NARPPS, my education is in rehabilitation counseling. I am a certified rehabilitation counselor and have been in the field 31 years, 22 of those years as a private case practitioner and businessowner in the State of California.

I also serve as vice chair of the Washington, DC-based group, Mainstream, a nonprofit group dedicated to creating jobs for individuals with disabilities.

NARPPS' members, approximately 3,200 strong, are located in every State in the country. Our organization represents private sector members who could be either a solo practitioner, a businessowner, or a member of a regional or national organization. But we all have one goal in mind.

And that is to take every referral we receive back to the maximum level of productive activity, with the most preferable outcome being a return to suitable gainful employment.

NARPPS has formed many strategic alliances with this goal in mind with other organizations, with the goal of providing high quality rehabilitation services. Some of these organizations include NASPPR, the National Association of Service Providers in Private Rehabilitation; Vocational Evaluation and Work Adjustment Association, which is VEWAA; Mainstream, Inc.; the National Management Alliance, based in Cornell; Return-to-Work Group Coalition; as well as the Case Management Association Coalition.

Who are we? Who are the service providers? Educationally we are most likely to have a master's degree in rehabilitation counseling or a related field, a bachelor's degree or higher in nursing or it could be a registered occupational or physical therapist.

Our certifications include certified rehabilitation counselor, certified case manager, certified disability management specialist, certified rehabilitation nurse, certified vocational evaluator.

In some States, we must be licensed, depending on the State requirements. Our referrals most commonly come from workers' com-

pensation carriers, long-term disability insurers, health insurers, managed care companies, employers, attorneys and persons with disabilities.

We have a proven history of effectiveness of providing savings to the insurance industry by enhancing the functional levels of the clients we serve. We also must abide by a professional code of conduct, both set by our organization, NARPPS, as well as other organizations we belong to.

We are subject to peer review and malpractice if we do not adhere to these codes.

Our members have been following closely the dialog on Social Security reform. Privatization of vocational rehabilitation services for Social Security beneficiaries is a huge potential referral source if set up correctly.

The current system was established with good intention, and public vocational rehabilitation professionals are some of the most dedicated. Many of our members got our start there. I worked for the State agency for 3 years myself.

However, due to the sheer scope and magnitude of the issue, the public sector cannot do it alone. In fact, the private sector continues to exist and prosper, specifically because of our ability to return individuals with disability to gainful employment over a substantial period of time.

We would now like the opportunity to apply the success rate to SSA beneficiaries.

What do we need in order to return SSA beneficiaries with disabilities to gainful employment? The consumer group, the previous panel, did an excellent presentation, and it was informative to hear we are on the same page along these lines.

First, to minimize the disincentives beneficiaries have that impede them from returning to gainful employment. First and foremost is to protect the beneficiaries' health insurance, and in this regard, we are in support of the 5-year continuation of Medicare coverage that is currently in the Rehabilitation Return to Work Act of 1996.

Second, to tie beneficiary and service provider incentives to benchmark outcomes. Third, to give the beneficiary an informed choice through an option to select the rehabilitation service provider from a number of prequalified public and private sector service providers.

Fourth, to establish benchmark milestone payments for services rendered. We are in support of the milestone payment system as proposed by the Return-to-Work Group in concept, and Return to Work Act. Quite simply, our members would not be able to provide services if we had to wait for 9 months or longer before we would be paid for our services. There just would not be a market for us.

Five, the first milestone that we are recommending in terms of payment is the point of termination of vocational feasibility. This could be much the same as done by an independent screener, as now exists with the Department of Labor, Federal Employee Compensation Act.

Sixth, the higher service provider payments come at the point of completion of an individual employment plan, and ultimately upon return to work.

On behalf of NARPPS, and myself, I want to thank you for the opportunity to provide this testimony. And we remain available to work further with the Subcommittee. I would be happy to answer any questions at the appropriate time.

[The prepared statement follows:]

Statement of Thorv A. Hessellund, Ed.D., CRC, President, National Association of Rehabilitation Professionals in the Private Sector, Framingham, Massachusetts

INTRODUCTION

Good afternoon, my name is Thorv Hessellund. Today, I am here as President of the National Association of Rehabilitation Professionals in the Private Sector (NARPPS) to provide our recommendations on how to reform Social Security. More specifically, I will cite how the private sector can enhance the current system and return those Social Security beneficiaries with disabilities to gainful employment.

In addition to being President of NARPPS, I have a Doctorate in Rehabilitation Counseling, I am a certified Rehabilitation counselor, a certified Case Manager with 31 years experience in the field of vocational rehabilitation, and for the last 22 years I have been a California based private sector vocational case management business owner and practitioner. I am also a current Vice Chair of Washington, D.C.-based Mainstream, Inc.—a national non-profit organization dedicated to improving competitive employment opportunities for individuals with disabilities—and a Director of Vocational Programs for Paradigm, Inc.—a company that provides national catastrophic injury case management services.

NARPPS members, approximately 3200 strong, are located in every state in the country. The number of medical and vocational rehabilitation professionals that NARPPS actually reaches is much larger. Many organizations with multiple offices and employees often take on limited membership and distribute our Newsletter, Journals, and other communications internally once received. Our organization represents private sector members who may either be a solo practitioner, member of a regional or national company, or a business owner. Whether the emphasis of the company is medical or vocational case management or both, we all have one goal in mind which is to take every referral to the maximum level or productive activity with the most preferable outcome being the return to suitable gainful employment.

We are not alone in our dedication and proven results, NARPPS has engaged in many strategic alliances and partnerships with other organizations united in the cause of providing high-quality rehabilitation services to individuals with disabilities. Some of these prestigious organizations are:

- National Association of Services Providers in Private Rehabilitation (NASPPR)
- Vocational Evaluation and Work Adjustment Association (VEWAA)
- Mainstream, Inc.
- National Management Alliance (Headed by Cornell University)
- The Return-To-Work Group Coalition
- Case Management Association Coalition

WHO ARE PRIVATE SECTOR REHABILITATION SERVICE PROVIDERS?

Educationally, we are likely to have master's degrees in rehabilitation counseling or a related field, a Bachelors degree or higher in nursing, or could be registered an occupational or physical therapist. Our national certifications include Certified Rehabilitation Counselor, Certified Case Manager, Certified Disability Management Specialist, RN, BsN, Certified Vocational Evaluator, OTR, RPT are the most common designations. In some states, we must be licensed. Our referrals commonly come from workers' compensation carriers, long term disability insurers, health insurance companies, managed care companies, employers, attorneys, and persons with disabilities. We serve several masters—our referral source, the payer, who is not always one in the same, as well as the beneficiary of services. These referral sources engage the services of private rehabilitation professionals in order to enhance the quality of life of the individual needing rehabilitation services, but also to minimize the costs and long-term expense and liability involved in settling a claim or caring for the long-term needs of individuals with disabilities, especially in workers' compensation cases.

Private sector rehabilitation professionals have a proven history of providing savings to the insurance industry by enhancing the functional levels of the clients they serve. We adhere to the NARPPS professional code of conduct as well as those of our particular certification(s). We are subject to peer review and malpractice if we

do not adhere to these codes of conduct. We remain employed and/or in business only if we achieve results. We are generally perceived only as good as most recent referral. Though we have generally been paid on a fee for service basis, flat rate billing for pre-agreed services is becoming more common place.

WE CAN APPLY OUR DESIRE AND ABILITY TO RETURN INDIVIDUALS WITH DISABILITIES TO GAINFUL EMPLOYMENT TO SSA BENEFICIARIES

Our members have been following closely the dialogue on Social Security reform. Privatization of vocational rehabilitation services for Social Security beneficiary is a huge potential referral source. If properly structured, there is opportunity for creative and productive rehabilitation for those recipients who are able and desirous of benefiting from return-to-work services. In many, if not most states, our members are becoming increasingly handcuffed by regulations, such as workers' compensation; managed care, which limit achievable outcomes. We are looking for new markets to utilize our proven capabilities. With Social Security reform, there remains an opportunity to establish a results based system where the private sector works in sync with the public sector toward one common goal, to return Social Security beneficiaries to productive activity and thus taking them off the disability rolls. In this way, we can work to bring our experience in delivering cost-effective, outcome oriented services to Social Security beneficiaries with associated benefits of minimizing cost and long-term expense to the Trust Fund.

The current system was established with good intention and public vocational rehabilitation professionals are some of the most dedicated. In fact, many of our members got their start with State VR agencies. However, due to the sheer scope and magnitude of the issue, the public sector cannot do it alone. The private sector has a long and proven history of providing cost effective and successful return-to-work outcomes within the insurance industry. In fact, the private sector continues to exist and prosper specifically because of its ability to return individuals with disabilities to gainful employment over a sustained period of time. We would now like the opportunity to apply this success rate to SSA beneficiaries.

WHAT WE NEED IN ORDER TO RETURN SSA BENEFICIARIES WITH DISABILITIES TO GAINFUL EMPLOYMENT

1) Minimize the disincentives beneficiaries have that impede them from returning to gainful employment. First and foremost is to protect the beneficiaries' health insurance. In this regard, we are in support of the five year continuation of Medicare coverage following return to work as proposed in the Rehabilitation and Return to Work Act of 1996.

2) Tie beneficiary and service provider incentives to benchmark outcomes.

3) Give the beneficiary an informed choice through an option to select their rehabilitation service provider from a number of pre-qualified private and public sector rehabilitation professionals.

4) Establish benchmark/milestone payments for services rendered. We are in support of the milestone payment system as proposed by the Return-To-Work Group and as incorporated in concept in the Rehabilitation and Return to Work Act. Simply stated, our members will not become alternate providers under the current system where payment is not available until after the beneficiary has maintained suitable gainful activity for nine months. The nine months could be reached anywhere from one year to two or more years following referral, depending on the rehabilitation services provided, and only the largest of national providers would have the necessary cash flow to wait so long for compensation for their work.

5) The first milestone should be at the point of determination of vocational feasibility. That is, a determination as to the likelihood of the beneficiary benefiting from vocational rehabilitation services now or in the future. This is to performed either by an independent screener(such as now exists with the Department of Labor FECA referrals) or by the long term service provider.

6) The higher service provider payments come at the points of completion of an individual employment plan and ultimately upon return to suitable gainful activity for the full nine months.

CONCLUSION

For myself and on behalf of NARPPS, I want to thank you for the opportunity to provide this testimony. We remain available if needed to work further with the Subcommittee on legislation to return SSA beneficiaries to gainful employment.

I would be happy to answer any questions the Subcommittee may have for me as a rehabilitation professional in the private sector.

Chairman BUNNING. Thank you very much, Doctor. The next person to testify is Fred Tenney, from Scottsdale, Arizona.

STATEMENT OF FRED E. TENNEY, PRESIDENT, SOUTHWEST BUSINESS INDUSTRY AND REHABILITATION ASSOCIATION, SCOTTSDALE, ARIZONA

Mr. TENNEY. Chairman Bunning, and Members of the Subcommittee on Social Security, it is with a great deal of pleasure and optimism that I reappear before this Subcommittee. I would like to commend the Chairman and the Ranking Minority Member for maintaining the momentum on this issue in a bipartisan manner.

I would also be remiss if I did not compliment the Subcommittee staff on their endeavors and their similar commitment to this very important goal. My principle reason for testifying here today is to answer the question, Can this be done?

I offer to you that not only can it be done, but that it has been done. My experience in more than a half dozen research and demonstration projects dealing with SSI and SSDI recipients, including the often referenced Project Network, demonstrated beyond any doubt that success in utilizing private sector rehabilitation providers is successful.

Here I must acknowledge the cooperation and professional approach of such people as Dr. Thomas Rush and Ms. Natalie Funk and others from Social Security in creating a professional environment to implement these projects.

The case management approach to rehabilitating the SSI recipients is a valid approach. While some changes are necessary, I feel that this prescriptive approach not only works but maintains the sense of continuity and consistency, and, more importantly, avoids being another bureaucratic handoff.

The advent of computerized technology and the ongoing medical and rehabilitation achievements have led many U.S. taxpayers to question the deep pockets of their Federal and State governments. Civilized individualism has replaced the cradle to grave social contract that arose early in the 20th century.

Educational institutions, social and religious organizations, health care vendors and their respective funding sources have been called upon to provide a system that allows all citizens to be full participants in the economic achievements the world over.

Critical to the successful implementation of any return to work program is inherent in the main premises of Project Network: The case management concept that was able to provide ongoing continuity and coordination in the process of assisting people; a resource management component that insures adequate reimbursement to providers of quality services, and management of those resources to assure availability of services to clients as heeded; and client empowerment in the whole decisionmaking process, not only because it is right and reasonable, but because it creates vestitures.

I would like to drone on for a couple of hours, enthusiastically describing the process and the success that we have had, but I

would refer you to an article in the upcoming NARPPS Placement Journal which documents this information.

The commission referenced in our proposal and the bill Chairman Bunning introduced last year is essential. Regardless of the well meaning attacks, this is not another layer of bureaucracy. Rather, an oversight commission compiled of all interests looking out for the welfare of everyone.

It is a venue for all interests to give input outside the bureaucracy. This is a much needed and extremely valuable resource to all concerned.

In addressing the State/Federal rehabilitation system, the facts are indisputable. They have been less than responsive to this target population. It is recognized this is a rehabilitation program meeting the needs of many in the community.

The sometimes heard concern that this bill would eliminate VR rings hollow when they currently serve less than one-tenth of 1 percent of those SSA beneficiaries referred.

Again, as in the testimony I gave this Subcommittee 2 years ago, I suggest keeping them in the system, and encouraging them to participate as any other vendor. But please, keep the playingfield level.

VR can and will be our partners in this process. We look forward to our continued close relationship.

There are those who suggest this bill will promote creaming. You bet it will. The question that goes begging is what is the definition of creaming? The conventional definition has been serving only the less disabled. Not so in my world.

Creaming to us in the private sector is serving those who want to go to work. The severity of the disability has little to do with our ability to get a person a job. In short, bring us someone who wants to go to work, and we will almost without fail see that they are employed in the shortest amount of time.

Incentives is a term that seems to be on everyone's lips. The only incentive we found to be critical is the ability to get medical insurance. I urge you to facilitate a system that allows access to health insurance as part of any bill you pass. Medical insurance has become critical to all Americans.

There will be others who suggest that tax credits for extraordinary expenses associated with employment are important. I have no dispute with them, but I cannot testify to the critical need.

Employer incentives is a term that I have heard discussed most often by people who are not in the actual job placement business. Let me comment on a couple of issues relating to employer incentives.

In the early fifties, this Nation embarked on a hire the handicapped campaign. It must have worked. There is little resistance to hiring the disabled, and it's getting better daily.

In short, businesses hire the disabled because it is in their best interest, and, thankfully, socially accepted, not because of incentives, but because it is the right thing to do.

Frankly, there are more jobs than there are people to fill them. Demand exceeds supply.

And I will submit the rest of my testimony in written form to the Subcommittee. In anticipation of Mr. Collins being here, I had 1 page prepared for him from the last testimony.

[The prepared statement follows:]

Statement of Fred E. Tenney, President, Southwest Business Industry and Rehabilitation Association, Scottsdale, Arizona

Chairman Bunning, members of the Subcommittee on Social Security, it is with a great deal of pleasure and optimism that I appear before this Subcommittee. I would like to commend the Chairman and the Ranking Minority Member for maintaining the momentum on this issue and in a bi-partisan manner. I would also be remiss if I didn't compliment the Subcommittee staff on their endeavors and for their similar commitment to this very important goal.

My principal reason for testifying here today is to answer the question, "Can the private sector return SSDI recipients with disabilities to work?" I offer to you that not only can it be done . . . but that it has been done. My experience in more than a half dozen research and demonstration projects dealing with SSI/SSDI recipients, including the often referenced Project Network, demonstrated beyond any doubt the success of using private sector rehabilitation providers. Here I must acknowledge the cooperation and professional approach of such people as Dr. Thomas Rush, Ms. Natalie Funk and others from SSA in creating a professional environment to implement these projects.

The "case management" approach tested in Project Network was successful in rehabilitating SSA recipients and would be a valid approach on a larger scale. While some changes are necessary for full national implementation, I feel that this tested prescriptive approach not only works but maintains a sense of consistency, and more importantly avoids being another bureaucratic hand out.

The advent of computerized technology and the ongoing medical and rehabilitation advancements have led many U.S. taxpayers to question the "deep pockets" of their federal and state governments. "Civilized individualism" has replaced the "cradle to grave" social contract that arose earlier in the Twentieth Century. Educational institutions, social and religious organizations, health care vendors, and their respective funding sources have been called upon to provide a system that allows all citizens to be full participants in the economic advancements occurring the world over.

Critical components to any successful return to work program are: 1) a case management component to provide ongoing continuity and coordination to the process of assisting people, 2) adequate reimbursement to providers of quality services, and 3) client empowerment in the whole decision making process. I would love to drone on for two hours and enthusiastically describe the process and our successes but I will refer you to an article to be published in an upcoming NARPPS placement journal which details the results of this approach. Instead I will touch on some areas of concern I have which have grown out of a year and a half of reviews of the recommendations of the Return-To-Work (RTW) Group, of which I am a member.

The Commission as referenced in our proposal and the bill Chairman Bunning introduced last year would be effective, regardless of the well meaning criticism. This is not another layer of bureaucracy, rather an oversight commission compiled of all interests looking out for the welfare of everyone. It's a venue for all interests to give input outside the bureaucracy. This is a much needed and extremely valuable resource to all concerned. In addressing the state/federal voc rehabilitation system, the facts are indisputable, they have been less than responsive to this target population. It is recognized this is a rehabilitation program meeting the needs of many of the community. The sometimes heard concern that this will eliminate VR rings hollow when they currently serve less than one tenth of one percent of those SSA beneficiaries referred. Again as in the testimony I gave before this Subcommittee two years ago, I suggest keeping them in the system and encourage them to participate as any other vendor. But please keep the playing field level. VR can and will be our partners in this process. We look forward to our continued close relationship.

There are those who are concerned that the Chairman's bill of last year would promote "creaming." You bet it will! The question that goes begging, "what's the definition of creaming?" The conventional definition has been, serving only the least disabled. Not so in my world!! "Creaming" to us in the private sector is serving those who want to go to work. The severity of the disability has little to do with our ability to get a person a job. In short, bring us someone who wants to go to work and we will almost without fail see that they are employed in the shortest amount of time.

"Incentive" is a term that seems to be on everyone's lips. The only incentive we found to be essential is the ability to get medical insurance. I urge you to facilitate a system that allows access to health insurance as part of any bill you pass. Medical insurance has become critical to all Americans. There will be others who suggest tax credits for extra ordinary expenses associated with employment. I have no dispute with them but I can't testify to the critical need. Employer incentives is a term I hear discussed most often by people who are not in the actual job placement business. Let me comment on a couple of issues related to employer incentives. In the early 1950's this nation embarked on a "hire the handicapped" campaign. It must have worked. There is little resistance to hiring the handicapped and it's getting better daily. In short, businesses hire the handicapped because it's in their best interest and thankfully socially accepted, not because of incentives but because it is the right thing to do. Frankly there are more jobs than people to fill them. Demand exceeds supply. There are probably companies with noble usage of the incentives, we just haven't encountered them to any significant degree. That's not unusual because most of our placements are with small businesses who don't want to be bothered by "government red tape." Others see this as a civic responsibility.

I earlier mentioned Project Network. Let me share some salient facts.

- 16% of all benefices who received a solicitation notice from SSA called to find out about the project.
- 38% agreed to an interview with a case manager.
- 66% of all referenced interviewees agreed to participate in the project.

157 clients were placed during the project.

100 clients remained working at projects end.

It would be difficult to establish the exact cost effectiveness of the project until the 9 month trial work period expires. However, a glimpse into the future will likely show $539 a month or $6,470 a year in benefits will be replaced by $881 pr month in wages. If only 100 clients remain working (without benefit of follow-up) $647,000 in benefit saving per year will be realized. Over a normal 20 year work span without any added inflationary factors the savings on this one little project in AZ will be in excess of $13 Million dollars.

In summation I have asked myself why am I here today? Why have I worked so hard for these recommendations to become a reality? In all likelihood I'll be retired before it's implementation. My answer is simple. It's the same answer you give every day. Because it's right for the taxpayers, it's right for the consumers, it's right for our economy and finally it's just plain right for America.

Mr. Chairman and members of the Subcommittee, thank you for allowing me to appear before you today.

Chairman BUNNING. We appreciate your testimony, and sorry Mr. Collins is not here, but I would be more than happy if we could send off and find him somewhere.

Stephen Start, please.

STATEMENT OF STEPHEN L. START, CHIEF EXECUTIVE OFFICER, S.L. START & ASSOCIATES, INC.; AND COCHAIRMAN, RETURN-TO-WORK GROUP, SPOKANE, WASHINGTON

Mr. START. Mr. Chairman, and Members of the Subcommittee, I would like to thank you for the opportunity to discuss ways to increase the number of individuals that leave the SSDI rolls to return to work.

My name is Steve Start. I am cochairman of the Return-to-Work Group, and chief executive officer of S.L. Start & Associates. S.L. Start is one of the largest providers of residential and return to work services for people with disabilities in the Northwest.

We have served as one of the original Social Security return to work demonstration projects, and have been involved in the national Projects with Industries effort for the past 20 years.

Our Project with Industries has returned over 2,000 people to work.

A successful return to work program must address the needs of beneficiaries, employers, and providers. Studies indicate that 15 to 40 percent of the people on disabilities rolls would like to return to work if given the opportunity. Many, however, are highly fearful of losing their medical benefits. You have heard it 20 times today.

Chairman BUNNING. Not to disrupt you, but we heard it 20 times yesterday, too.

Mr. START. Extension of the benefits is essential for an effective return to work program.

Chairman BUNNING. I think that's pretty well the consensus.

Mr. START. Yes. Consumers want a choice of providers, control in developing their return to work plan, and economic gain as an outcome. They need knowledge of the job market, and access to employers with jobs that match their skills and abilities.

Employers are concerned about economic survival and getting the job done. The key qualities they look for in hiring employees are people who display positive attitudes, work habits, and a willingness to learn.

Some critical factors about jobs: Over 75 percent of the net job activity in our country occurs in small, middle and startup companies. Less than 12 percent of the job openings nationally are posted with public employment agencies, such as employment security agencies.

Approximately 80 percent of the jobs filled nationally are through word of mouth or personal relations in the local community. Employment experts dub this phenomenon the hidden job market.

Employers provide more training to more people than all the trade schools and universities combined. The employment rate for employment-based training is higher than any other training method. The use of OJT and tax incentives can increase access to jobs, especially those that require more than entry-level skills.

Projects with Industries, vocational rehabilitation firms and rehabilitation facilities exists in virtually every community in this country. They are directly tied to the hidden job market. They understand the needs of beneficiaries, are accomplished at matching job candidates' abilities with local employers, and many are highly interested in serving people on the rolls.

Unfortunately, neither current alternative provider program being implemented by SSA, nor the proposed Ticket for Independence Program will take full advantage of this vast resource.

The provision of both programs to pay providers only after people have come off the rolls is financially impossible for the vast majority of providers. This approach will produce very limited choice for consumers, and will fail to effectively access the hidden job market.

It is an attempt to totally eliminate the risk of investing in a viable return to work effort that will essentially guarantee that billions will continue to be wasted on people who want to return to work.

Many providers will actively participate in a program that shares some risk by paying outcome-based milestones, combined with long term, keeping people off the rolls.

We have recommended three simple outcome-based milestones. An initial $300 payment for a return to work plan signed and committed to by both the beneficiary and the provider. The plan would

contain as a minimum employment goal, the method to obtain employment, resources to be used, and a financial analysis of the benefit upon successful completion for that beneficiary.

A second milestone would include the individual obtaining and retaining employment for 60 days, with a third being leaving the rolls.

The total cost for the proposed outcome-based milestone program is $2,700 for persons coming off the rolls. Historically State VR agencies have been reimbursed in the neighborhood of $10,000 to $12,000 depending on the year per person coming off the rolls to cover their agency's cost of rehabilitation.

Pricing the milestone level below cost forces providers to produce long-term savings to stay in business. The return to work group has designed a program model to implement such a national scale return to work program. We have also developed a computer simulation model to assess risk, cost/benefit, and output performance for a wide variety of programs.

Using even very conservative historically-based performance assumptions that come directly from SSA research and demonstration projects, our simulation indicates that a milestone approach would produce a low risk and highly cost-effective program.

During initiative 7-year implementation, it predicts over 144,000 people would come off the rolls at a total savings to the taxpayers of $12.3 billion. The program would pay for itself in 4 years.

A cost/benefit of the program would be 13.9 cents saved for every dollar invested. A simulation that assumes even very modest impacts from the implementation of medical benefit extensions, worker incentives, or employer incentives increases the number of people coming off the rolls to 264,000.

We recommend that such a program be initiated during this Congress, and that a bipartisan commission made up of consumers, providers and employers be appointed to oversee such a program's refinement, implementation and outcome reporting back to Congress.

Refinement of incentive programs or provider reimbursement can be tested in various regions during the 7-year rollout.

Chairman BUNNING. Mr. Start, your time has expired.

Mr. START. I am finished. Every day we waste lives and money. Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of Stephen L. Start, Chief Executive Officer, S.L. Start & Associates, Inc.; and Cochairman, Return-to-Work Group, Spokane, Washington

Mr. Chairman and Members of the Subcommittee:

Thank you for providing me the opportunity to discuss with you today the development of a RTW program that will assist individuals on the social security disability rolls in returning to substantial gainful employment. I have been involved in the provision of vocational rehabilitation, employment placement, and supported residential living services for people with disabilities for the past 25 years. My company provides services in the states of Washington, Oregon, and Idaho. I have managed in excess of 350 grants and contracts focused on developing and providing innovative approaches to assist individuals with significant barriers to employment and to maximize their ability to engage in employment activities that will provide a stable and desirable standard of living. I have also designed, developed, and operated numerous programs to assist disabled people to leave institutional settings and live independently in their communities. Services we have provided have been funded through a wide range of contract relationships with a broad array of government agencies. A small sample includes the Social Security Administration (SSA), the Re-

habilitation Services Administration (RSA), the Department of Labor, and the Department of HEW at the federal level. Many of our contracts are with agencies of state and local governments. A project that I am especially proud of and from which we have learned many lessons about RTW practices is the Inland Empire's Projects With Industry (PWI). Our PWI is part of a national initiative funded under the RSA that has resulted in the development of a national network of projects that represent an activity partnership between rehabilitation, RTW organizations, and employers. For the past 20-plus years, PWIs across the country have provided the most cost-effective, outcome-based, RTW effort of any initiative in our nation that I am aware of which has been undertaken by the public sector. My firm participated very actively in the Research and Demonstration Project (RDP) funded by SSA. As a result of these activities, my company has worked with several thousand disabled individuals and hundreds of employers throughout the Pacific Northwest. Later in my testimony, I will share with you some important lessons that we have learned from PWI experience and participation in the RDP process.

In testimony today, I want to focus on what we in the field of RTW have learned over the years about the four stakeholders in this process; namely, employers, people with disabilities, providers of service, and SSA. I will then focus on the implications of those lessons for policy and program development, and finally outline for you a cost-effective approach to a national RTW effort that draws on the lessons that we have learned from the stakeholders.

WHAT WE HAVE LEARNED

About People with Disabilities in Relation to the Job Market:

Many disabled individuals (even those with severe disability) sincerely want to return to work, take control of their own lives, and be productive, self-sufficient citizens. Various studies have indicated that from 15 percent to as high as 40 percent of those on the social security rolls would like to return to employment.

- Consumers want to have a choice of providers, methods of returning to work, and the type of occupation they pursue.
- They want to be able to exert real and meaningful control over their RTW effort and their lives.
- A significant percentage of people on the rolls cannot return to full-time employment and desperately need income and medical support provided by SSDI and SI programs.

Many are very fearful of losing their medical support. This fear transmits into placement counselors, mental health professionals, and social workers who interact with these individuals to such a degree that the service community will often help disabled people strategize ways to maximize their personal income while avoiding the loss of benefits. Counseling staff are placed in the untenable situation of asking someone to essentially risk their life to pursue employment that may turn out to be temporary under the current eligibility guidelines.

Most individuals with disabilities lack the specific skills and knowledge necessary to adequately seek out and obtain employment in the competitive workplace. The behaviors and attitudes that are required for an individual to secure social security benefits are the exact opposite of the behaviors and attitudes required to convince an employer that the individual is the right person for a job. The current eligibility system requires a focus on disability, inability, and dependency to gain access to benefits. Employers are looking for independent, positive, and upbeat employees who focus on what they can do, not what they can't do.

Without RTW assistance, the employment rate for people coming off the rolls will continue to be incredibly low. The onset of disability and the system to access benefits is often demoralizing and inadvertently takes away from the individual his sense of self-confidence and focus on goal-oriented, productive behavior that is essential to obtaining and retaining employment.

Some individuals believe that, as a result of the Americans with Disabilities Act (ADA) and Affirmative Action, employers have an obligation to employ them and that fear of government intervention will motivate employers. It is our experience that using the ADA as a threat to gain access to employment for a specific individual virtually guarantees that an employer will not hire that person.

Many people believe that in order to compensate for their disability they must have highly developed, specific vocational skills to compete effectively in the work force. Our experience indicates this is not necessarily true.

Many people with disabilities tend to believe that employers basically do not like people with disabilities, are concerned only about the bottom line, and require significant financial incentive to motivate them to employ people with disabilities.

While placement professionals know this is not true with the majority of employers, this fear serves as a barrier to return to work.

THINGS WE HAVE LEARNED ABOUT EMPLOYERS

The primary motive or objective of most employers is to get the job done: operate a healthy, positive work environment and produce a reasonable return on investment. While profit is an important consideration and essential to survival, many businesses (especially smaller businesses) were started because of the employer's personal attachment to the profession or interest in producing particular goods or services.

Employers primarily want to hire employees who display a positive attitude, have good, dependable work habits, have the ability to work as a team player, and display a willingness to learn. Individuals (whether disabled or not) who appear to be litigious in their approach are avoided at all cost. Some employers are willing to make significant levels of accommodation to facilitate the productivity problem encountered by a person with a disability, if the employee displays the work habits previously mentioned. Many employers take pride in their corporate citizenship and their ability to assist disabled people to become productive and gain independence from the tax dole.

Many employers are highly intimidated by and afraid of large government agencies such as Employment Security, the Department of Labor, and Vocational Rehabilitation, etc. Employers feel such organizations do not understand, value, or appreciate the private sector and stand ready at a moment's notice to trigger legal action if something goes wrong with the employment of a disabled individual or other protected classes of employees. The various programs and laws we have created to help individuals with significant barriers to employment gain acceptance into employment have created what is perceived as an immense threat to business. This phenomenon may explain why, since the enactment of the ADA, there has been essentially no net gain in employment in our country for people with disabilities.

Some policy makers and advocates believe that the key to employment is targeting large Fortune 500-style companies. The reality is that over 75 percent of the net job activity in the United States comes from small-and medium-sized employers. Employment experts have dubbed this the hidden job market. Eighty percent of those jobs are filled by informal word-of-mouth and through personal relationships within a local community. Less than 15 percent of the job openings available nationally are posted with public employment agencies. This, coupled with fear of government agencies, may, in part, explain why the public vocational rehabilitation systems have produced poor results.

Employers provide more job training to more individuals than all the vocational-technical schools and universities in our nation combined.

Tax incentives and on-the-job training dollars are useful tools (especially with middle-sized and large employers) in helping individuals obtain employment. Most employers are focused more on getting a good employee, dependable follow-up, and an honest relationship with the RTW provider. Some will choose not to utilize such incentives because of their fear of government intervention in their daily affairs.

Employers and disabled employees sometimes rely on the RTW provider as a mediator to help solve problems and decrease the chances of litigation. If, for example, a job simply doesn't work out for a person, a good provider will quickly facilitate transition into a new job somewhere else. The disabled employee avoids financial harm and the employer's chances of facing litigation are greatly decreased.

There is a significant movement on the part of employers in this country to move away from well-funded benefit packages for full-time employees toward the use of part-time employees who receive little or no benefit package. While this tendency disturbs me on a personal level, it has created opportunities for people with disabilities to enter the job market and gain experience. This phenomenon could be especially useful if a working mechanism is in place to allow beneficiaries to sustain their benefits. Some of the most successful PWIs have aligned themselves with temporary employment agencies to capitalize on this opportunity.

Organized labor has worked as a consistent supporter over the past 20 years of the PWI employment initiative and, in many cases, has actually taken the lead in building the bridge between people with disabilities and the employer community.

Many employers (especially large firms) have come to the realization that disability and its related unemployment are extremely expensive. Such employers are developing the internal capacity to do job station modification and other RTW interventions. These efforts, hopefully, will offset some of the growth in utilization of the SSDI system. Moreover, they provide a mechanism inside of industry to link a RTW program for those currently on the rolls.

WHAT WE HAVE LEARNED ABOUT PROVIDERS OF REHABILITATION AND RTW SERVICES:

The vast majority of professionals employed in these fields entered their profession out of a sincere commitment to help people with disabilities maximize their ability to be self-sufficient in our society. Most counselors possess a sincere interest in the welfare of the disabled individual; and if placed in a situation where the welfare of the client is pitted directly against the potential for their company to secure profit, they will err on the side of the client.

The provider community across the country has developed a highly refined set of skills to evaluate an individual's employability, to develop cost-effective RTW plans, and to use methods to re-engage people in competitive employment. Unfortunately, many state worker's compensation systems' efforts have focused vocational rehabilitation professionals on empirically determining on paper that disabled people are ready to return to employment. Outcomes have not focused on return to gainful employment. This phenomenon gets people off the state worker's compensation rolls but doesn't return people to work. It also results in the development of statistical surveys across our country that significantly understate the power of rehabilitation to actually return people to gainful employment.

Providers are ready, willing, and able to participate in an effective RTW effort for SSDI beneficiaries. Unfortunately, the current alternate provider initiative by SSA to "level the playing field" with private providers and state vocational rehabilitation agencies is more artificial than real. It will not retain a significant number of providers in the RTW effort. The proposed alternate provider method of paying for rehabilitation costs only after placement ignores the substantial losses associated with those who fail in the rehabilitation process and will require substantial amounts of working capital. It attempts to place all the risk on the provider and fails to "level the playing field" because the state vocational rehabilitation agencies are still fully funded for all their efforts (both successful and unsuccessful) through RSA. The reimbursement that state agencies currently receive upon successful client termination from benefits is a bonus payment or pure profit for the state agency. If Congress were to truly create a "level playing field" and pay all expenses out of General Fund revenues for attempting to rehabilitate social security recipients and then pay social security Trust Fund dollars for successful outcomes, thousands of private providers would participate. Such an effort would be prohibitively expensive, however, and would not represent a balanced approach of sharing risk between the government, the provider, and the person with disability.

Through the RDPs funded by SSA, we learned that returning beneficiaries to work is hard work, but doable. Successful projects would place 5 to 15 percent of those originally contacted at the Substantial Gainful Activity (SGA) level of employment as defined by SSA. Even with a 5 percent placement rate, private sector-based return to work is highly cost-effective and is more than a tenfold improvement over the current practice.

Beneficiaries participating in the Continuing Disability Review (CDR) process seem to display a significantly higher employment rate than the general caseload or those in the application process.

Providers across the country are willing to participate in milestone-based payment systems that focus on a combination of outcomes and savings to the Trust Fund. Literally thousands of RTW rehabilitation counseling firms, worker's compensation agencies, rehabilitation professionals, PWI operators, and rehabilitation facilities are in place and process the basic prerequisites to participate in a national RTW effort. Only a very small percentage, if any, can financially afford to participate in a system that does not pay any milestone payments but instead withholds all payment until Trust Fund savings are realized.

SSA is currently reviewing another strategy that would pay providers a percentage of the savings to the Trust Fund after a person leaves the rolls. Such rear-end loaded strategies like the alternate provider program place impossible operating capital requirements on providers. Only very large providers could even consider participation.

Many providers throughout the country (especially PWI operators and private worker's compensation firms) have very well-established relationships with literally thousands of employers throughout our country. They provide immediate, readily available access to small, middle-sized, and large employers throughout the entire economy.

WHAT WE HAVE LEARNED FROM WORKING WITH SSA

The vast majority of employees we have worked with in SSA (both locally and at the national level) are hard-working, intelligent, and dedicated. They possess a sincere and heartfelt commitment for people with disabilities and shoulder a serious sense of responsibility towards the Trust Funds they administer. By design and practice, SSA and its staff know very little about the specifics of return to work, how it works, how to contract for effective services, or how to work with consumers in a RTW plan. Their corporate culture has been designed around the mission of protecting those who, as defined by the listings and regulations, are incapable of work.

Knowledge gained from RTW Research and Demonstration Projects and Project Network experiences a very short memory cycle within the agency due to personnel moves and is not widely distributed or understood. The very nature of the experimental models drives up the cost of projects and substantially reduces the effectiveness of the projects. It seems clear, however, that the RDPs have shown that while SSDI recipients pose significant challenges, they can be returned to work in significant numbers by utilizing private organizations and networks within local communities.

Providers have known how to effectively place people into employment since the 1970's. The well-intentioned tendency of the agency to prove unequivocally through scientific study the hows, whats, whens, and wheres of a successful RTW effort will never, given the nature of return to work itself, be truly successful. Continuing to research this issue, while putting on hold a national implementation of a private sector-based program, will result in literally tens of billions of dollars being lost through missed opportunity. Literally hundreds of thousands of individuals who could be returned to substantial, gainful activities will be left to sit in idleness and dependency while we engage in a never-ending effort to empirically prove what people in the RTW and placement field have known for years.

IMPLICATIONS FOR THE DEVELOPMENT OF AN EFFECTIVE AND COST-BENEFICIAL RTW PROGRAM

Administration and Oversight:

The Return-To-Work Group recommends that:

1. An initial implementation of a national program begin immediately (see implementation plan).
2. A bipartisan commission of 9 individuals (3 consumers, 3 providers, 3 employers) be appointed to assist with rule making, oversee program implementation, review outcomes, recommend ongoing changes to improve incentives and remove program barriers, and report to Congress with SSA on the results of program implementation and recommendation for improvement.
3. The testing and refinement of various incentive strategies will be tested in different parts of the country during the first five years of implementation.
4. Program management will be contracted out to a private firm or firms that will have a presence in each region of the country. We believe having two firms each serving different parts of the country will provide a back-up in case one firm cannot perform to standards.
5. To ensure full geographic coverage, providers must assure that a network of services is available across a broad geographic area. Services available must include case coordination (case management), core services (assessment, counseling, training, plan development, placement, and support services), and specialized services (those designed to deal with unique barriers created by specific disabilities). Service access can be assured by several small organizations across a geographic service area coming together through contractual relationships to form their own network.
6. To simplify administration, billing, accountability, and the provision of a seamless service to consumers, SSA (through its program manger) will contract with the network provider(s) who will be responsible for all subcontractors and held accountable for all outcomes. This approach creates no new bureaucracy or layers, but simply utilizes existing providers and a private management firm.
7. Network providers will have to submit an annual audit to the contract manager to ensure billings are appropriate, allowable, and accurate. The provider will bear the cost for such audits.
8. Annual report cards for outcomes and customer satisfaction will be developed and made available to the public and all potential customers at program entry.
9. Periodic reviews of services and audits will be conducted by review teams contracted through the manger. Teams will consist of a consumer, an outside provider, and an SSA representative.

10. Milestone payments will be made for outcomes, in combination with a five-year follow-up commission based on Trust Funds savings used to reimburse providers.

11. All beneficiaries up for CDR be referred for mandatory RTW assessment. Those who participate in a RTW plan will receive an extension of benefits until completion and avoid disability review.

People with Disabilities:

To assist those who have a sincere interest in returning to work, we must provide a safe and understandable protection of medical benefits. The program must encourage and develop individual consumer choice and control throughout all aspects of the RTW effort. The effort must be grounded in organizations that have existing relationships with small, medium, and large employers in every community of our country. Meeting with hundreds of providers across the country has traught us that milestone payments are essential to attracting and retaining these well-established, small-and medium-sized providers. Counseling and case coordination must focus on the ability to instill positive work habits and attitudes in guiding people back to employment. Programs must help individuals market themselves in a way that is desirable and nonthreatening to the employment community. The system must provide incentives for providers to develop service plans and move individuals quickly and effectively toward return to work; and also provide long-term, ongoing support to assist individuals in retaining employment and developing a positive career ladder approach. Emphasis on simply finding individuals jobs will not result in a long-term, positive effect of keeping people off the rolls. Tying a significant percentage of the provider's fee to continued Trust Fund savings over five years, in combinatoiun with simple, clear, outcome-oriented milestone payments, will ensure a choice of providers for consumers, increase the access to more employers and jobs, enhance job retention, and, consequently, ensure greater long-term Trust Fund savings.

The model msut be designed to ensure that people with disabilities are responsible for following through on their RTW plan and are enablers of their own success. Each individual must participate and have active control in the development and sign off on a RTW plan that contains specific employment goals, both long-and short-term, specific objectives necessary to reach those goals, and an individualized economic analysis of the individual's plan to demonstrate the ability of the plan to move the person toward financial self-sufficiency. The provider and the consumer are considered partners whereby the provider and the consumer will financially invest in training and other necessary support to obtain employment. The network provider, case coordinators, or case manager will assist consumers in taking full advantage of funding currently available through vocational rehabilitation, JTPA, student loan programs, etc.

Employers:

The initiative must include providers of service who have a direct, ongoing relationship with employers of all sizes throughout our economy. Employer incentives to offset the cost of training and job modification will enhance the total number employed and the number of employers who participate. Incentives are not essential for all employers or all types of disability. While all employers may not utilize these benefits, they serve to attract a large segment of marginally interested employers who will not otherwise participate. The RTW effort must be viewed as a method to assist employers in being good corporate citizens and not be used as a method to threaten and intimidate employers into employing people with disabilities. A negative approach will guarantee utter failure.

Providers:

The initiative should utilize reimbursement methods that place heavy emphasis on rewarding outcomes and provide some incremental payment for completion of outcome-based milestones. Our research and analysis recommends three milestone payments for specific outcomes:

1. The development of a mutually agreeable RTW plan—$300
2. Obtain and retain employment for a reasonable period of time (60 days in our analysis)—$1,100
3. Reaching SGA/coming off the rolls—$1,300

A job retention follow-up fee of 25 percent of savings would also be paid. This reimbursement would be paid monthly and would be based on the percentage of the annual cost of maintaining the average beneficiary on the rolls for any given year. The fee would be adjusted annually.

To ensure long-term savings, we recommend a follow-up fee for five years for keeping individuals off the rolls. Such a system should encourage providers to find

initial jobs that provide stairsteps to more long-term, career-oriented employment and provide the incentive to encourage ongoing support of the individual to ensure the maintenance of employment. Approximately 80 percent of people who lose jobs in our economy do so because of poor work habits and "bad attitude." The payment system encourages providers to deal with these and ancillary issues that have a dramatic effect on long-term employability.

The primary measure of program quality should be a job that is chosen by the consumer that provides a level of support both financially and intellectually and that is otherwise acceptable to the customer. Experience by providers with other ouctome-based payment systems overseen by government agencies has taught us that agency staff have little or no understanding of the labor market or the full cost of RTW. They seem compelled to "Help" the consumer attain higher quality outcomes by adjusting process requirements and outcome levels necessary for payment. Attempts to externally define quality by imposing processes, approaches, or minimum income levels for jobs will retard the individual's ability to return to work, limit their access to jobs that provide a platform for labor market reentry, diminish individual choice, and, in effect, say that people with disabilities are incapable of making their own informed decisions. The system recommended here will provide true choice for consumers. If a provider can't develop a plan and deliver acceptable services, the consumer will choose another provider. With the customer goes the funding.

Quality assurance monitoring should be in place that ensures that funds are spent for allowable outcomes and that individuals are offered a full array of providers to develop their plans, have meaningful employment options, and exercise power and choice throughout the RTW effort. The initiative must encourage the development of local and regional provider networks that maximize access to the hidden job market and existing training and support services within local communities. Providers should have built-in quality improvement programs, submit to annual Certified Public Audits, have public report cards done on an annual basis, conduct standardized satisfaction surveys published in their report card, and be reviewed periodically by an external quality assurance team that includes consumer representation.

SUMMARY OF A NATIONAL IMPLEMENTATION MODEL

The following summary represents an overview of an implementation model for the development of a full-scale, national RTW effort staged over a seven-year period. The model attempts to establish a balance in dealing with the needs of all the stakeholders, balance risk across all partners, and is based on demonstrated outcomes from recent RDPs and Project Network. The model produces results that are highly cost-effective and incorporates the combined milestone and outcome payments previously cited. This payment method substantially limits the Trust Fund's financial exposure in developing this effort and essentially assures that SSA does not end up buying services instead of outcomes. It is also designed to ensure that even with very conservative or poor results, SSA would receive a positive cost benefit from their investment in the RTW effort. The payment milestones used have been vigorously negotiated. The milestones represented are below the cost of services historically experienced by providers. The state agency programs have been receiving over $10,000 on average to cover the cost of those coming off the rolls. The cumulative milestone reimbursement total for a person in our combined model is $2,600. Providers would have to keep people off the rolls for extended periods of time for profit to occur.

FULL NATIONAL IMPLEMENTATION MODEL

This full national implementation scenario is presented in four phases that progressively increase the degree of sophistication and the volume of services provided. It looks at the provision of services to applicants, CDRs, and general caseloads. The computer simulation program used to generate these outcome numbers utilized different assumptions computing enrollment and success rates for each of these discrete populations. Cost/benefit savings are calculated over the ten-year-average life of a case as currently reported by SSA. The model does not include the cost of extended medical coverage that has been recommended. PWIs nationally find that approximately 50 percent of the people they place enroll in employer health insurance plans which will save considerable federal funding. This savings should more than offset the cost of extended benefit plans that incorporate a staggered buy-in provision. The outcome assumptions used to calculate program costs and savings over time are based on actual results obtained by SSA Research and Demonstration Projects, Project Network, and national PWI data. These results were achieved

under current conditions. The work and employer incentives that have been recommended by various groups should significantly increase the participation, outcome rates, and projected savings. These increased savings would be partially offset by the cost of such incentives.

OVERVIEW: PHASE I—PREPARATION PHASE

Objective:

Complete basic regulatory development referral mechanism design and set up initial provider network to begin RTW services. Establish four implementation and refinement beta sites, one in each quadrant of the country. Should use RDP/Project Network or PWIs who have experience for this task. Notify public that the change is coming. Disability does not equal unemployability and/or retirement.

Timeline:

1 year
Total elapsed time—1 year

Key Activities:

- Set up consumer, employer, provider network and oversight committee.
- Develop fee-for-outcome guidelines.
- Solicit vendor from RDP Group, Project Network, PWI, state certified facility programs, and state certified injured worker programs.
- Develop self-placement model not requiring provider.
- Develop agreements with providers.
- Develop tracking system/M.I.S.
- Develop necessary regulations.
- Orient SSA staff.
- Develop national public relations campaign strategy and initiate.
- Determine incentives to be tested.
- Begin beta site programs.

Service Enrollment Levels

	Per Year	Phase Total	Cumulative Total All Phases
Applicants	N/A		
CDR	N/A		
General Caseload	N/A		
Youth	N/A		
Total Return-To-Work (SGA) Off Rolls	N/A		

Totals—Financial Summary

Net Cost Trust Fund Current Phase ($500,000 Public Relations, $300,000 SSA)	$800,000
Public Relations Costs	N/A
Trust Fund Savings Reinvested Annually in RTW	N/A
Savings to Federal Budget (Over 10 years—Cumulative Program)	N/A
Benefit/Cost Ratio (Federal Budget—Over 10 years)	N/A
Benefit/Cost Ratio (Excluding FICA & FUTA). (Total Savings/Incremental Cost)	N/A

OVERVIEW: PHASE II—OBJECTIVE

Initiate Program

Develop nationwide service delivery capacity with emphasis on getting people back to work who are medically stable and need support the least ("creaming") and dealing with malingerers. Provide opportunity for youth to seek employment and avoid disability syndrome. Begin changing public expectation away from disability equals unemployability toward everyone can participate in some level of gainful activity. Minimize need for incremental funding increase to initiate program.

Timeline:

2 years
Total elapsed time—3 years

Key Activities:

- Presidential Congressional announcement of new direction.
- Initiate public relations campaign within agency and with local communities.
- Notify prospective participants.
- Initiate referral system.
- Test referral system with Project Network providers, RDPs, and PWIs—first year.
- Expand referrals second year to facilitators, state certified providers, and individuals.
- Implement provider payment system.
- Implement monitoring system.
- Refine automated applicant referral and screening system.
- Coordinate national public relations campaign.

Service Provided To:

	Per Year	Phase Total	Cumulative Total All Phases
Applicants	0	0	0
CDR	45,000	90,000	90,000
General Caseload	4,688	9,375	9,375
Youth	0	0	0
	49,688	99,375	99,375
Total Return-To-Work (SGA) Off Rolls	.....	33,237	33,237

Totals—Financial Summary

Net Cost Trust Fund Current Phase	$153 million
Public Relations Costs	$2.4 million total
Trust Fund Savings Reinvested Annually in RTW	0
Savings to Federal Budget (Over 10 years-Cumulative Program Nominal $'s)	$2.9 billion
Benefit/Cost Ratio (Federal Budget—Over 10 years)	$13.96 saved for every $1 invested
Benefit/Cost Ratio (Excluding FICA & FUTA) (Total Savings/Incremental Cost)	$17.98 for every $1 invested

OVERVIEW: PHASE III OBJECTIVE

Expansion/Refinement

Expand number of providers, refine processes, serve more difficult to serve, extend services to select applicants, increase service capacity to fully operating, steady state level. Continue to reinforce with the public the expectation of employability of our disabled citizens. Operate RTW services exclusively out of savings to Trust Fund from prior year's efforts.

Timeline:

2 years
Elapsed time—5 years

Activities:

- Implementation.
- Focus on refinement of referral, follow-up, evaluation of components.
- Disseminate outcome and follow-up reports on all participating providers to clients and public from prior years.
- Full national implementation of applicant RTW referral system.
- Presidential/Congressional progress report to the nation.
- Bring on more specialized services and services to small community providers.
- Maintain public relations campaign.

Service Available To:

	Per Year	Phase Total	Cumulative Total All Phases
Applicants	6,250	12,500	12,500
CDR	45,000	90,000	180,000
General Caseload	9.375	18,750	28,125
Youth	0	0	0
	60,625	121,250	220,625
Total Return-To-Work (SGA) Off Rolls	.....	40,554	72,407

Totals—Financial Summary

Net Cost Trust Fund Current Phase	0
Public Relations Costs	$2 million total
Trust Fund Savings Reinvested Annually in RTW	$154.5 million
Savings to Federal Budget (Over 10 years—Cumulative Program)	$6.6 billion
Benefit/Cost Ratio (Federal Budget—Over 10 years)	$15.19 for every $1 invested
Benefit/Cost Ratio (Excluding FICA & FUTA) (Total Savings/Incremental Cost)	$19.78 for every $1 invested

OVERVIEW: PHASE IV OBJECTIVE

Full-scale Operation

Service level optimized to return maximum number of people to gainful activity, continue system refinement. Public attitude focuses on ability not disability. Benefits considered temporary assistance for most people with disabilities, not a form of retirement.

Timeline:

2 years
Elapsed time—7 years

Activities:

- Easier cases have been placed, providers seek out more difficult cases.
- Continue to refine referral system.
- Report on provider success for all prior periods.
- Poor providers drop out.
- More highly specialized providers develop niches.
- More difficult people being placed.
- Providers increase effectiveness.
- Rate of malinger applicants should drop.
- RTW services become more efficient and effective, standards of performance evolve.

Service Available To:

	Per Year	Phase Total	Cumulative Total All Phases
Applicants	10,000	20,000	32,500
CDR	50,000	100,000	280,000
General Caseload	37,500	75,000	103,125
Youth	0	0	0
	97,500	195,000	415,625
Total Return-To-Work (SGA) Off Rolls	.....	65,220	134,552

Totals—Financial Summary

Net Cost Trust Fund Current Phase	0
Public Relations Costs	$1.0 million
Trust Fund Savings Reinvested Annually in RTW	$400 million
Savings to Federal Budget (Over 10 years—Cumulative Program)	$12.3 billion
Benefit/Cost Ratio (Federal Budget—Over 10 years)	$14.36 for every $1 invested
Benefit/Cost Ratio (Excluding FICA & FUTA) (Total Savings/Incremental Cost)	$18.63 for every $1 invested

CONCLUSION

The key components to bring together an effective working partnership between people with disabilities, return-to-work providers, employers, and the federal government are known and available. Methodologies to return individuals to employment have been in practice for over 20 years and have demonstrated repeatedly that individuals with severe disabilities can be returned to gainful employment. Many individuals currently on the rolls are highly motivated to return to work; and many employers are ready, willing, and able to provide jobs, especially if reasonable incentives are provided to offset extra costs. The Social Security Administration has acknowledged the need for a return-to-work program and has expressed interest in pursuing a more aggressive approach. The key ingredient that is needed to bring together these essential stakeholders is a clear and decisive directive from Congress and the Executive Branch to proceed expeditiously with such a program. Private sector providers with substantial levels of experience are also ready, willing, and able to assist other partners in completing the design and implementation of an effective program.

We request that you give us and our other stakeholders the directive to move forward so that we may begin immediately to assist hundreds of thousands of individuals return to self-sufficiency and initiate an effort to stop the economic drain that is currently depleting the Trust Fund. We will assist you in whatever way possible to achieve these outcomes. Thank you for your attention to this issue and for requesting our input.

Chairman BUNNING. Thank you very much. Since we have all of you, and you have given us great testimony, I would like to let you know that if we don't get to ask all the questions, we are going to submit written questions to you for your response. I know I am not going to get to ask all the questions I have and I would like Barb and J.D. to do the same if they have questions.

[The following was subsequently received:]

Questions received from Hon. Jim Bunning, and Subsequent Responses from John Halliday

Question 1. Recognizing that you provide services to individuals with severe disabilities along with SSDI and SSI recipients, what is your average cost per client?

The average cost per SSI/SSDI recipient rehabilitated by the public vocational rehabilitation program in FFY 1996 was $4,986.00. The average cost for non-recipients was $3,261.00. This reflects the actual purchase of service costs for persons closed successfully rehabilitated.

An important issue in the discussion of costs for rehabilitation services is that SSA considers the public vocational rehabilitation program as the first dollar. Therefore, the Ticket to Independence proposal, as well as most other proposals, is based upon the continued use of the public vocational rehabilitation program for services. The result is that public vocational rehabilitation will be expected to pay for many of the necessary purchased services and provide vocational counseling. These costs will not be included in the cost estimates of return to work proposals of private groups. As a result, public resources will be used to provide the actual services, but the reimbursement will go only to the private program.

It is important that there is a clear understanding of the role of the public program in the specific proposals, so that the real cost to the public can be fully understood. A formal cost sharing agreement with the Social Security Administration and the Rehabilitation Services Administration needs to be developed to address the fact that public vocational rehabilitation dollars are being used, while the private providers are receiving reimbursement.

Question 2: You mention in your testimony that the timing of outreach to encourage recipients to return to work is poor. What are the optimum times to provide this outreach?

The experience of the public vocational rehabilitation program is that recipients are more likely to choose to engage in vocational rehabilitation either long before they apply for and start receiving benefits or after they have been receiving benefits for a period of time. Preliminary results from the RSA longitudinal study are that over 96% of the recipients that use vocational rehabilitation come from vocational rehabilitation outreach to the community, not from SSA referral. Approximately 25% to 30% of the people who use vocational rehabilitation are SSA recipients. The enclosed NIDRR study indicates that they have generally been receiving benefits for 40 to 55 months prior to engaging in vocational rehabilitation.

Referral at the time a person is determined eligible for disability benefits is not generally an appropriate point to initiate outreach. In fact, the Disability Determination Services (DDS) referral process often discourages, rather than encourages, recipients to apply for vocational rehabilitation. Currently, the DDS refers 10–15% of applicants to the public VR program at the time of disability determination, immediately following the completion of a complex process to prove their inability to work. As a result, only a small percentage of the people referred actually follow through and apply for VR services.

If Social Security is going to begin to place greater emphasis on employment of its disability program beneficiaries, a complete paradigm shift will be necessary. Beginning at the point of application for benefits and continuing through benefit cessation, beneficiaries should be reminded on a regular basis of the availability of vocational rehabilitation to help them return to work. Further, beneficiaries must have access to reliable, accurate and comprehensible information regarding work incentives and the impact of work on benefits. Without this, even those individuals for whom work incentives are potentially beneficial will not risk losing the security of cash and medical benefits.

Question 3: You mentioned in your testimony that State VR agencies are unable to service additional SSDI and SSI recipients because of funding issues. Under current law, State VR agencies are funded through the Rehabilitation Act and are 80% federally funded and 20% state funded. Also under current law, State VR agencies are reimbursed for reasonable expenses for recipients who return to work for 9 months. In these instances, State VR agencies are being paid twice. Please explain why you are under funded for the purposes of serving more SSDI and SSI recipients?

The resources available to the public vocational rehabilitation program are not sufficient to meet the demand for services from potentially eligible persons. The funding formula is a fixed amount that does not increase based upon demand for VR services. The eligibility criteria for vocational rehabilitation is much broader than for SSI/SSDI. The requirement for an order of selection in the Rehabilitation Act when states do not have enough funds to meet the demand for services is a clear acknowledgment of the limited resources.

The lack of sufficiency of funds for vocational rehabilitation services can most clearly be seen when one compares the VR allotment with expenditures for SSA disability programs. While hundreds of billions of dollars are spent on SSA cash and medical benefits which keep people dependent on government entitlements, only $3 billion is allotted to VR, which assists individuals to increase their independence.

The present reimbursement structure, as established by SSA to replace a prepaid approach, was designed to pay only for outcomes. The system was to create an incentive for states to aim for the SGA level of employment when serving SSI/SSDI recipients. The SSI/SSDI recipients who use the public vocational rehabilitation program have over a 50% employment rate after starting an employment plan. The majority, however, do not choose to work enough hours to achieve or maintain SGA, resulting in the public program not receiving reimbursement. This is due largely to financial disincentives in the SSA benefit structure. It should also be noted that, even in cases where the person achieves SGA, if the recipient has impairment related work expenses or subsidies, vocational rehabilitation often is not eligible for reimbursement.

Another factor that should be considered is that the public program is the only program that is required by law to reinvest the funds back into vocational rehabilitation services. The present alternative participant program and the various return to work proposals do not require that any funds be used for future services. It also must be remembered that the return to work proposals will no doubt continue to use the public program as first dollar and minimize the use of private resources.

Question 4: You say that 45,000 recipients enter the workforce each year because of efforts provided by the state VR program. Yet, in 1996, SSA reimbursed state VR agencies for little more than 6,000 recipients. Does this mean that the other 39,000 SSA recipients did not remain in the workforce for nine month or were there other reasons why state VR's were not reimbursed for these clients?

There are three issues involved in this question. The first is that the 6,000 cases reported by SSA reflects the number of cases that SSA was able to process for reimbursement, not the number of actual cases that the public program submitted which are expected to be eligible for reimbursement. Second, without direct access to SSA data, states cannot easily determine which of their consumers whose earnings are at SGA level are recipients of SSA benefits. Third, many SSA recipients who go to work as a result of the VR program choose to limit the number of hours worked, so as to retain SSA benefits.

In FFY97, SSA had over 20,000 cases in their system submitted by states, representing SSA recipients who had returned to work. At the present allowance rate of 66%, this would mean over 13,000 cases are likely to be at the SGA level. Even this significant increase is an understatement of the actual number of SSI/SSDI recipients that the public program has assisted to achieve SGA, as we are generally unable to access accurate information regarding whether or not individuals are SSDI/SSI recipients. In Connecticut, we were able to obtain access to a direct way of checking all of the employment closures for SSI/SSDI eligibility for a short period of time. The result was that we were able to identify 30% more cases of recipients who were working at the SGA level.

The public VR program is effective at assisting recipients to enter paid employment. It is the disincentives inherent within the SSA disability programs that keep individuals working below the SGA level. This is the primary reason CSAVR is recommending a restructuring of the disability program, with particular emphasis on disincentives around cash and medical benefits. The types of jobs and the wage levels of individuals who return to work through using the public VR program reflects the diversity of our economy. The key to the SGA issue is that although over 90,000 recipients entered paid employment in the last two years, most chose to keep their hours worked per week at a level that resulted in earnings below the SGA level. The NIDRR study showed that the SSDI/SSI recipients worked an average of about 25 hours per week while non-recipients worked over 30 hours per week. The choice of many recipients is to work to supplement benefits, rather than to replace benefits. The maintenance of cash and medical benefits is seen as critical by many of these individuals.

Question 5: In your testimony, you recommended simplifying SSA's work incentives, including employment-related work expenses, the SSI monthly payment reduction of $1 for $2 earnings over $85 per month, and the Plan to Achieve Self Support (PASS) program. You also suggested that these SSA programs be administered by State VR agencies. How would this work?

The work incentives could be more effective if the method of providing information was specialized and simplified at the community level. The present structure of going though the SSA district offices is ineffective and inefficient. The public vocational rehabilitation program has a national infrastructure that could be built upon so that a system of return to work information and technical support could be developed. The goal would be to use vocational rehabilitation professionals as specialists to provide education, approval of PASS and IRWE's and coordination of public/private initiatives. Public VR counselors possess the necessary education, training and experience to assist individuals in developing vocational goals which will lead to employment. The use of the public VR structure would minimize costs to SSA.

One approach would be for SSA to enter into an agreement with RSA to have the VR program establish a network of return to work information and education centers in the states. These would build upon the already existing outreach efforts by many state VR agencies to provide beneficiaries with information on vocational rehabilitation. It is through the state VR agencies' outreach that approximately 96% of beneficiaries have chosen to enter the vocational rehabilitation program. There is clearly a basic infrastructure in place and with some additional resources from SSA, this could be expanded to increase access for many more beneficiaries.

The CSAVR White Paper also recommends that SSDI use a gradual reduction in benefits, similar to SSI. The PASS program is essentially nonexistent at this time. It has a rejection rate for plans submitted in the 70% to 80% range, and is unpredictable in the time it takes to get a decision. The purpose and processes for the PASS program need to be clear. Using professional vocational rehabilitation counselors to administer the program would greatly increase its effectiveness.

Connecticut SSI and SSDI Beneficiary Work Incentives Survey Results

In 1997, the State Rehabilitation Advisory Council asked both public and private vocational rehabilitation providers in the Waterbury, Connecticut area to distribute a survey to their clients who were receiving benefits because of their disabilities. 106 individuals responded to this survey. It is important to remember that these individuals were exploring opportunities for work when they filled out these surveys. The following are some of the highlights from their responses:

- When these individuals were asked,
  "Have you tried to return to work?", they responded: YES 75%, NO 25%
  When asked:
  "Are you working now?", they responded: YES 36%, NO 64%
- Over half of the respondents received information about Work Incentives from questionably reliable sources. 75% of them said the information was helpful, ***BUT 68% did <u>not</u> go to work***.
- Although 65% said concern about Health Care Benefits did not keep them from returning to work, **71% stated that they *limited their earnings so that they could keep medical benefits.***
- When asked, "What Work Incentives did you find helpful?", NO respondent understood the term well enough to list even one actual Work Incentive.
- Respondents cited lack of information as a problem.

This information strongly indicates there is a lack of reliable information about Work Incentives and even when this information is presented, it is more complicated than the beneficiary can understand.

This information also seems to indicate that although beneficiaries want to work, their concern over health care benefits causes them to limit their earnings and therefore remain on benefits.

For more information about this survey and other findings concerning **Social Security Disability Insurance and Supplemental Security Income Work Incentives**, contact the State Rehabilitation Advisory Council at

Questions received from Hon. Jim Bunning, and Subsequent Responses from Rick Christman

You mentioned in your testimony that participation in a return-to-work program should be voluntary, at least until the program is in place for a period of time. Is there any point at which you think recipients who have work capacity should be required to accept rehabilitation services?

This is an interesting question. Inasmuch as I believe practically every person of working age with a disability of has some degree of work capacity, the answer should be "yes." However, I must also quality this answer and emphasis that it is important to understand that, for persons with significant disabilities, the full realization of vocational potential takes time and no small amount of expertise. As I described in my original testimony, the field of vocational rehabilitation has, as of yet, not been able to return significant numbers of beneficiaries to self-sufficient employment. Thus, to involuntarily compel large numbers of beneficiaries to attain assistance from a system which has not yet sufficiently focused itself on the attainment of self-sufficiency, could very likely result in a public policy disaster of colossal proportions. Rather, I believe it would be prudent to initiate return-to-work legislation on a voluntary basis. Over time, the innovations and service improvements which are certain to result from the implementation of a system of market-based competition, will strengthen the quality of vocational rehabilitation services nationwide. I would foresee that, with time, the enactment of return-to-work legislation greatly improving the efficacy and capacity of vocational rehabilitation services. Accordingly there could come some future point, which today I could not predict, wherein Congress could reasonably consider making assessments of vocational capacity for all recipients mandatory.

You also say that providers should not be ranked or graded. How can consumers make informed choices for services without some type of provider evaluation?

It is essential that consumers have access to clear and accurate information on the efficacy of providers in order to make informed choices. Basic information and outcomes-based performance indicators of such data as service locations, service area, numbers of persons served, types of services offered, types of disabilities served, success ratios, types of jobs obtained and wages obtained should be readily available to consumers in an accurate, standardized format. Collection and publication of such objective and obtainable data should be a function of a third party. It is this objective information which should be the prime driver of recipient choice.

Beyond some basic requirements to insure that providers are legitimate, I would leave the selection of service providers on the basis of the aforementioned data and avoid ranking or grading. I believe it will be far better for consumers to have a pool of providers which is inclusive, rather than exclusive. Ranking or grading, in my opinion, would be exceedingly complex and very difficult to perform in a reliable, unbiased manner. Ranking or grading would do little to improve the likelihood of positive outcomes and only serve to discourage the emergence of new providers, thus limiting consumer choice.

Questions received from Hon. Jim Bunning, and Subsequent Responses from Dr. Thorv Hessellund

1. You mentioned in your testimony that employers and clients often rely on the provider to mediate when problems occur. Under SSA's ticket proposal, a provision is made for protection and advocacy services solely for the SSA recipient. While consumers may well need a dispute resolution mechanism, what about providers? In the ticket proposal, do you see any potential situations arising where the provider may need a dispute resolution mechanism?

Answer: Yes. For example, there is a dispute over whether or not a bench mark was (is) achieved which would potentially result in payment to the provider and a step towards independence for the beneficiary. Suppose the provider is of the opinion that a beneficiary has the capacity to proceed with full participation in a return to work program or is able to return to work and the beneficiary disagrees with the opinion. In this case, the dispute is over whether or not payment is due. It is also about controlling costs in a fixed, benchmark payment environment.

On another level, it is also about the need for a forum for the parties to express their opinion regarding return to work issues (capacity to return to work; level of services provided; cooperation issues on the part of the beneficiary), and setting precedents.

There also may be situations where an impasse is reached regarding the feasibility of return to work services. Situations may exist where either side may contend that RTW is feasible and the other side disagrees.

Lastly, for the service provider, I would like to see an option to bring in a second opinion from an independent vocational evaluator to assist in a determination as to the feasibility of RTW.

2. You mentioned that your organization's providers are subject to peer review. Do you see peer review having any particular role in return-to-work legislation?

Answer: It is NARPPS' recommendation that all RTW service providers belong to a professional organization or be accredited through a national commission that has a peer review mechanism. The purpose is self-governance and preservation of public trust. There is a national certification process for rehabilitation service providers (Commission on Rehabilitation Counselor Certification). Additionally, most professional associations—NARPPS included—have a professional code of ethics by which members pledge to abide. There are varying degrees of state licensing requirements for providers of RTW services. The national association or an accrediting body provides an avenue for peer review when the code of ethics of an association has been violated. When questionable ethical behavior on the part of rehabilitation service providers is identified, it is in the best interest of the general public served by the profession and the maintenance of trust in the service providers, that the profession be allowed to review any alleged improprieties and make recommendations as to their accuracy as well as a remedy, if indicated.

3. You also suggest tying recipient and service provider incentives to benchmark outcomes. Could you provide some examples as to how this might work?

Answer: For example, benchmarks might include:

- Determining the feasibility of return to work. Service provider documents recipient participation in determination, reviews recommendations with recipient and has recipient sign off on report (agree or disagree) prior to submitting report and invoice for payment.
- IWRP signed by recipient and provider and submitted to the commission for review and approval. Payment to provider would occur when determination on IWRP is completed by the commission.
- IWRP successfully completed and signed off as such by recipient and service provider. Agreement (understanding) by recipient as to time limit and conditions of remaining benefits.

Questions received from Hon. Jim Bunning, and Subsequent Responses from Fred Tenney

A common theme in most of the return-to-work proposals is the need for consumer choice in obtaining rehabilitation services. You mention the success of case management in SSA's project network with which you've been a participant. Won't case management happen anyway, as providers work with the recipients to determine vocational goals, ongoing supports, etc? Do you believe a specific case management requirement needs to be addressed in the law?

Yes, I expect case management will be a natural course of events for "successful" vendors. My first blush reaction is to avoid mandating a case management model. There may well be valid reasons for including it in the legislation but none come to mind immediately. Hopefully, the consumers will insist on the level of service they need to become successful. It is certainly without question in my mind that the "successful" vendors will include that in their arsenal of services.

In your testimony you mention that employer incentives are most often discussed by people not in the job placement business. Are employer tax incentives critical to a return-to-work program in your view?

As I noted in my testimony do not feel employer tax incentives are "critical" to a return to work program. Certainly this would be a tool which would make the job placement task easier. However, if you review TJTC (targeted jobs tax credits) you will find that it was rare that small business took advantage of the program and

the large businesses that did take advantage frankly "beat the system" by surveying "en masse" the "new hires' after the fact for TJTC eligibility. There was little if any attention given to TJTC by human resource departments prior to hire. It's the party line to suggest that business and industry needs a financial incentive to "hire the handicapped," frankly that is not the case at all. Dependable manpower is at such a demand level that job placement is not the critical issue.

Should referral of recipients to providers be mandatory?

I have wrestled with this question for some time. If the question is in the literal sense them yes I do think mandatory referral is essential. To insure that all participants are given the opportunity to access the program mandatory referral is essential. If on the other hand, you're referring to mandatory "participation" I'm not so sure the time is right for that. Primarily because I believe the voluntary participation of those who volunteer will be overwhelming. If the program is as successful as I believe it will be then 5 to10 years down the road we might want to address those who are reluctant to pursue work. We have bitten off a big bite here with those folks that "want" to return to work.

Questions received from Hon. Jim Bunning, and Subsequent Responses from Stephen L. Start

Question 1: Some witnesses pointed out that milestone payments to providers would be costly and complicated to administer. What are your views?

In the last 27 years I have administered in excess of 500 government contracts to provide social services and employment services to a wide range of government entities. The milestone payment system recommended by the Return-To-Work Group would be one of the simplest contracts to administer when compared to the array of other options available.

We recommended three milestone payments: (1) at the completion of a signed plan, (2) after 30 days or 60 days of employment, and (3) after one year of employment or at the point of time the individual comes off the rolls. Each one of these payment points is easily verifiable and could be audited by certified public accounting firms available in each community across the country. In our proposal we recommended that every provider have such an audit on an annual basis. We anticipate the total cost of administration for the return-to-work program with this payment methodology would be approximately 4 to 5 percent, paid to a contracted manager. Administrative rates for government programs typically run from a low of 10 percent to as high as 30 and 40 percent. On a comparative basis, the milestone method we have recommended is very inexpensive.

Question 2: Have you compared the outcomes of your proposal to that of the Administration's ticket proposal. If so, what are the findings?

The Administration's proposal anticipates an increase of 3,000 to 6,000 per year in the number of individuals coming on the SSDI rolls as a result of implementation of their program. They also predict an additional 1,000 to 3,000 persons per year coming off the SSI rolls. These numbers are substantially below those anticipated by the proposal developed by the Return-To-Work Group. In developing our model and computer simulation to predict outcomes, the Return-To-Work Group utilized actual research outcomes obtained by Project Network programs conducted by Social Security and Research and Demonstration Projects conducted with private firms by Social Security. These research projects have been conducted over the past seven years and did not enjoy the benefit of Medicaid medical coverage extension or any of the incentives that are currently being contemplated by the committee. Assuming then that there is no increase in the success rates obtained over that in the research projects, our model indicates that over a seven-year implementation period, 134,552 people should permanently move off the rolls. Our projections included a seven-year phased in ramp-up of providers from across the country with full participation in year five of implementation. We also assumed that approximately 45,000 CDRs per year would be notified and encouraged to participate in the project. Based on our research results, the CDR population has a significantly higher likelihood of enrolling in services and returning to work than individuals who are simply applying for services or are on the general caseload. Several factors seem to contribute to the possible differences in projections we have developed as compared to those in the Administration's ticket proposal.

1. The Administration's proposal apparently has relied upon results obtained by the public VR agency in returning individuals to work. Our results are based upon actual research conducted with private firms who have produced significantly higher results than those obtained in the public sector.

2. The Administration's proposal does not implement a milestone program, and therefore, has a very conservative number of providers participating actively in the program. The milestone proposal presented by the Return-To-Work Group could easily attract several hundred networks to participate and several thousand individual providers to participate in those networks. After all rehabilitation costs and return-to-work costs are paid, our model predicts a 12.3 billion dollar federal savings to be realized as a result of the outcomes obtained during the seven-year implementation. The Administration's ticket proposal would, in all probability, only realize a savings in the one to two billion dollar range. In other words, there would be a 10 billion dollar opportunity cost loss as a result of implementing the ticket proposal as compared to the milestone proposal recommended by the Return-To-Work Group.

Computer modeling indicates that the addition of work and employer incentives could conservatively result in 264,658 people going off the rolls during the same seven-year implementation period, resulting in a savings of 23.9 billion federal dollars.

Question 3: You mentioned in your testimony that 75 percent of the net job activity in the United States comes from small- and medium-sized employers. How successful are providers in placing consumers with small- and medium-sized companies?

Very successful. The Projects With Industry program, which is a national placement effort of private providers funded under the Department of Education, is the best source of information regarding employers of people with disabilities. The experience of Projects With Industry on a national basis directly parallels the experience that S.L. Start & Associates, Inc., has had in the northwestern United States. Our experience indicates that over half of the individuals who are employed through our project and projects nationally are employed in small- and medium-sized businesses. The actual percentage may vary depending upon the economic composition of a specific local community and the affiliation of specific projects. There are projects, for example, that are closely allied with large manufacturers in the aerospace industry who place exclusively with large employers. There are other projects scattered across the country that focus virtually all of their activities on small- and medium-sized employers.

Question 4: Is it essential to have all various employee and employer incentives worked out before we initiate a national program?

No. It is absolutely critical, however, that some form of medical extension be implemented as part of any truly effective employment approach. In order of magnitude, the next most important barrier to deal with is the earning income cliff experienced, especially by those on the SSDI rolls.

There are a variety of approaches that have been suggested to deal with this issue, but perhaps the tax credit is the most viable way of fully offsetting negative incentive of returning to work. It is difficult to predict, however, the economic impact and full cost that this approach or others proposed may have on projected savings to the trust fund.

Providers who have participated in previous research projects have been able to return significantly higher numbers of individuals to employment than the current state-of-the-art program without the addition of these incentives. We believe that the addition of incentives will significantly improve the overall performance of the program, but that a program could be initiated which tests different approaches to determine which is most effective.

Question 5: You mentioned that employers and clients often rely upon the provider to mediate when problems occur. Under SSA's ticket proposal, a provision is made for protection and advocacy services solely for the SSA recipient. While consumers may well need a dispute resolution mechanism, what about providers? In the ticket proposal, do you see any potential situation arising where a provider may need a dispute resolution mechanism?

There are actually several ways in which disputes could arise where the provider would need a dispute resolution mechanism available to them. For example, if a provider spends a significant amount of private funds to provide education and training to an individual, and then the individual repeatedly turns down jobs that are well within their skill base and ability level. The provider would have expensed their funding in good faith, but the beneficiary would be preventing the provider (through the lack of their cooperation) from receiving the reimbursement they are due.

Another situation may be where a provider again expends dollars and professional service hours to return an individual to work. At the point in time when the individual is ready to obtain employment or shortly after they have obtained employment, the individual may choose to switch providers or switch the payment provision to a friend or relative. Without a dispute resolution method, neither the provider nor SSA would have a systematic way of dealing with this situation. The current rehabilitation act already requires a beneficiary to participate actively in their rehabilitation program to maintain benefits. If an individual has enjoyed the benefits of services provided by a private provider and then simply refuses to pursue employment, under current law, the individual could be denied future benefits. Some form of a mediation process must be present to determine where or not the individual is actively participating and whether or not a recommendation should be forwarded to SSA to deny further benefits to an individual who is not actively participating in rehab or seeking employment when they appropriately should do so.

The proposal presented by the Return-To-Work Group for consideration by Chairman Bunning contemplates that, at points in time, providers may, in fact, loan money to beneficiaries to participate in educational and rehabilitation efforts; or that the individual may directly contribute their personal finances to the realization of a rehabilitation return-to-work plan. Conflict could arise when a provider, in good faith, goes forward and makes their financial contribution to the individual's plan, but the beneficiary then reneges or withholds on their share of participation. I am sure there are other areas that could provide conflict between the provider and the beneficiary. These three seem to portray the primary areas of problem that might be anticipated from an outcome-based payment-type model where providers are expected to expense time and personal resources prior to receiving any form of compensation for their efforts. If some form of mediation is not available to providers, providers will become highly selective in the type of individuals they choose to serve, resulting in a significant reduction in the number of individuals who would be returned to work.

The use of a milestone payment system would decrease a provider's financial exposure and, therefore, reduce the probability of conflict between consumer and provider. If this program is to, in fact, be a partnership, then both partners must have rights, responsibilities, and access to a method to address grievances, should they arise.

DRAFT

ISSUES AND ANSWERS

The Return-To-Work Group's (RTWG) Recommendations to the House Ways & Means Sub-committee on Social Security Regarding the Expansion of Return to Work.

The RTWG is comprised of providers and consumers from across the country who came together in 1995 with one purpose in mind. To develop an efficient and effective return-to-work program for social security recipients that would allow the maximum number of individuals possible to achieve independence and self-sufficiency through employment.

The group had several key objectives. The design criteria that were used in compiling its research and making its subsequent recommendations. These included:

1. Maximize the amount of consumer control and choice.
2. Remove significant barriers and disincentives that were discouraging beneficiaries from seeking competitive, gainful employment.
3. Develop incentives that would offset any additional cost incurred by employers for initial hiring and training of people with disabilities.
4. Develop a reimbursement methodology for return-to-work providers that would only **reward LONG-TERM, substantial, gainful employment in a job that was CHOSEN, obtained, and RETAINED by the SSA beneficiary**.
5. Design a program that was administratively simple and cost-effective to operate.
6. Design a program that was financially viable and cost-effective to **ensure the long-term financial viability of the Trust Fund**.

In developing the design recommendations that were ultimately forwarded to the Sub-committee, the RTWG conducted dozens of telephone conference sessions to review issues. The RTWG also conducted several workshops and roundtables composed of providers, consumers, and representatives from the administration and other stakeholder groups.

Since the introduction of the Bunning legislation (H.R. 4230) in the 104th Congress, several issues have surfaced (especially in the consumer and advocacy community), specifically related to some of the language utilized in the Bunning Bill. The following is an attempt to discuss some of these key issues, give basic background on each issue, and outline the key features and benefits that we reviewed in developing our recommendations. The presentation of questions and answers is not necessarily in a rigid priority order.

ISSUE: Consumer Control

This issue was, in fact, a key design objective of the RTWG.

Background and Considerations:

For true control to exist, several minimum criteria must be present.

1. An individual must have available real and meaningful choices.

2. An individual must have relevant, factual knowledge and information about the features and benefits that underlie each of the choices available.

The RTWG recommendations placed emphasis on a reimbursement system for providers that had three key milestones, each of which are **controlled** by the consumer. The first payment point was the development of a long-range employment plan that was developed and signed off on by the consumer working in partnership with their chosen return-to-work provider. If a provider could not develop a plan that was acceptable and desirable to the consumer, the consumer would have the simple and available option of going across the street to the next provider and shopping until they found a provider that could develop a plan to meet their needs and desires. No provider would receive a penny of reimbursement until they could develop a plan authorized by and committed to by the individual.

The second major milestone payment is made after the individual is employed for 60 days. In other words, the provider would not be paid until the consumer/provider found a job that (1) is initially acceptable, and (2) which the consumer likes well enough to retain employment for at least two months. If the consumer doesn't like the job, he could quit during the initial probationaryperiod, and the provider would receive no compensation.

The third payment point is maintenance of employment at SGA level for approximately 12 consecutive months. Again, before the provider would receive this reimbursement milestone payment, the individual would have to stay in a job of his choosing, for now, in excess of 14 total cumulative months. If the individual decided they did not like the job and quit, the provider would simply not be paid until they found a job that was acceptable to the individual.

The fourth payment milestone actually is the key to ensuring that individuals seek employment that they can retain over the long term, and that service providers are motivated to continue to provide services for long-term employment and career development. The RTWG recommended that for a period of five years after the individual came off the rolls, the provider would continue to get a follow-up, long-term support fee on a monthly basis that was equal to 20 percent of the savings to the Trust Fund for having the individual off the rolls. It has become apparent that the substantial power for consumers behind this reimbursement methodology and how it differs drastically from the current system seems to escape many consumer and advocacy groups. At every step, the consumer is absolutely in control of their destiny and whether or not the providers are reimbursed for services. Because private companies and counselors they employ depend on the success of this model for their very existence, they must please the customer or go out of business.

To ensure that potential users of the return-to-work service had adequate information upon which to make a meaningful decision, several positions were built in the RTWG recommendations.

1. We recommended that, on an annual basis, all providers would receive a report card on the success of their services. This annual report card would be outcome-focused, showing, for example, the percentage of individuals who had successfully returned to work and retained employment for a specific provider compared to other providers within the geographic region. Additionally, it would analyze pay and benefit levels received by individuals placed through that provider.
2. Additionally, also on an annual basis, each provider would have to collect and report satisfaction surveys that would be reviewed and audited for accuracy on a periodic basis. These satisfaction surveys would be developed in concert with consumer groups and would focus on key satisfaction variables as defined by those groups. The results of each variable for a specific provider would again be published and compared to other providers within their service region.
3. The providers would also be required to maintain, in each participant's file, a signed affidavit that each service participant had received a personal copy of both the report card and the satisfaction survey and had reviewed this information. The presence of this affidavit would be audited on an annual basis by outside auditing firms. Providers who failed to document through affidavit that individuals had reviewed outcome and satisfaction information would become candidates for decertification.
4. Another key issue that is fundamental to the realization of true choice is availability of responsive, active providers in all geographic areas. This issue will be discussed later in this paper under the structure of the service system section.

ISSUE: The State Vocational Rehabilitation system will be put out of business by this legislation.

There is absolutely nothing in the recommendations from the RTWG or in the Bunning legislation that focuses on elimination of the current State-operated vocational rehabilitation system. In fact, in its recommendations to Congress and subsequent letters to the Sub-committee, the RTWG has made it clear that our recommendations are in no way intended to affect or change the current rehabilitation act and funding mechanism for State agencies.

Some have speculated that if this system is successful, it will result in the undoing of the State agency system. The RTWG does not believe this to be a likely scenario. The State VR systems, under the current structure, rules and regulations, have had difficulty in placing significant numbers of individuals off the social security rolls. They have, however, year-in and year-out for several decades, placed thousands of severely disabled people who are not on the rolls into competitive employment. The State agency system has a well-developed network of counselors, relationships with State legislatures, business relationships across the country, and a well-established political support base. We believe that a more likely scenario is that if the private sector is, in fact, successful, the State agencies will simply rise to the occasion and compete, tit-for-tat, in achieving outcomes that are acceptable to consumers and to the Congress. They will, most likely, request modification to the Rehabilitation Act that parallels the successful features of our

private sector program to enhance their success. For the doomsdayers who predict the end of State VR, nothing will promote the end of vocational rehabilitation faster, both private and State-operated, than continued poor performance.

The RTWG recommendations recognize that a strictly outcome-based reimbursement system such as the one proposed for this private sector model may have difficulty providing services to some individuals with severe disabilities. We, therefore, recommended that the legislation allow for the partnering of private sector funding with State agency funding to ensure that both sources would be available to assist difficult to serve individuals. The Bunning Bill was written to accommodate this recommendation. Not only would this strategy provide a dramatically enriched funding stream and number of opportunities for people with disabilities, it should encourage a spirit of partnership for both the State agency and private provider, where both the State agency and private provider could financially benefit from successful outcomes.

There is nothing in the RTWG recommendations or the Bunning legislation of 1996 to prevent or discourage individuals from continuing to utilize State agency services in the same manner that they are currently available. Individuals would simply have more choices from which to choose if the private sector program is adopted.

ISSUE: Creaming

People have raised the issue that since the proposed private sector program is primarily outcome-oriented, it will incent providers to cream or, in essence, pick the easy-to-serve individuals, leaving individuals with severe disabilities unemployed and unserved.

This was one of the first key issues addressed in discussions and debates by the RTWG during its initial forum held in Washington, D.C., with representatives of the Social Security Administration and our original co-chairs, Mr. Ed Roberts of the World Institute on Disability, and Mr. George Watters, a life-long advocate for people with disabilities. The pungent and clear response of Mr. Roberts to the creaming issue perhaps summarizes the RTWG recommendation. His response was, "**Good**, if we get those off the rolls who least need the support, perhaps we can save the disability trust fund for those who really need it." Every knowledgeable body that has reviewed the financial solvency of the Disabilities Trust Fund predicts that unless drastic measures are taken, it will be come insolvent within a short period of time. Any return-to-work strategy that does not have the ability to return a significant number of people to work within the next few years, in effect, jeopardizes the future of support for people with disabilities.

Because of the very low return-to-work rate for social security recipients under the current State-operated system, there is significant skepticism on the part of legislators and the public regarding the employability of individuals with severe disabilities. They openly ask the questions: Can these people really go to work? Do they want to? Are providers or professionals capable of providing any meaningful assistance? These questions must be answered with a resounding **yes**. Yes, people can work; yes, people do

want to; and, yes, providers can help them. It is critical,during the initial implementation of this program, that we demonstrate concrete success and savings to the Trust Fund. If we are unable, collectively, to make that demonstration, then the private sector initiative will undoubtedly be terminated by Congress, and in all likelihood, the State-supported programs will also be given up as a waste of time. The RTWG. therefore, has been opposed to any adverse selection criteria that would attempt to force providers to serve the "most in need or most severely disabled first." Implementing such an approach during the initial years of the private sector initiative could be fatal to this model. This is especially true, given the fact that providers only receive reimbursement if they are, in fact, successful. If, after reviewing results of the project for several years, it becomes evident that severely disabled individuals are not being served, then the Return-To-Work Commission recommended by the RTWG has the power and authority to modify the reimbursement methodology to deal with this issue.

An underlying, pivotal issue, however, around the point of creaming is the assumption that there are, in fact, a significant number of individuals on the rolls who could be thrown into the "cream" category. In spite of the reported low performance on returning beneficiaries to SGA, the State agency system in this country has proved itself to be highly effective in returning individuals with severe disabilities to employment. With all of its experience, network, background, and federal backing for initial plan implementation, it has only been able to place approximately one-half of one percent in recent years. **Where is the cream?** If it were easy, without doubt, the State system would be much more successful. The fact is that people on social security rolls have been determined, categorically, to have **severe**, long-term barriers to employment.

Those who are basically defrauding the system and do not have true disabilities are, unfortunately, the most difficult to return to work.

The issue of creaming has other ramifications beyond the severity of disability. Other issues include the specific types of disabilities that will or will not get service, the types of jobs that will be made available to individuals, and the geographic areas that are chosen across the country for service delivery. The RTWG attempted to deal with each of these issues specifically. The features of our proposal that deal with these items are covered in more detail under the section on structure of the program.

ISSUE: Structure of the Program

Several individuals have raised the issue that the recommendations of the RTWG as incorporated into the 1996 Bunning Bill are too bureaucratic and reflect the development of another bureaucracy that simply duplicates the State VR system.

The issue of administrative structure is one of the most difficult and intricate features that must be dealt with in developing an efficient and effective program that encourages consumer control and choice. The RTWG spent literally months grappling with and analyzing various possibilities and, in fact, held a special conference in Phoenix, Arizona,

to develop recommendations in this area. We felt it was critical to develop an administrative structure that was consistent or struck an optimum balance with the objectives defined in the opening paragraph of this paper. The key components of our recommendations will be discussed with relevant background and key features.

The RTWG recommended that the private sector, return-to-work program for the Social Security Administration be overseen by a bipartisan commission that was comprised of potential consumers, private sector employers, and return-to-work providers. There are several underlying considerations behind this recommendation.

One key consideration is the fact that the Social Security Administration and its corporate culture has little knowledge, background, or interest in the return-to-work field. The corporate mission of SSA, in effect, is to provide financial and medical support for severely disabled individuals who, by definition, are not employable. Within the administration, there are few individuals (with the exception of the Associate Commissioner of Disabilities and her key staff) who are knowledgeable, interested, or motivated around the issue of return to work.

The RTWG felt strongly that a successful program has to be a partnership between people with disabilities, private sector employers, and providers. Weakness in the program from the top down in any one of these critical segments will result in the program's failure. The old saying that "the chain is no stronger than its weakest link" is apropos. If the programming in its initial design and long-term operation does not satisfy the interests and needs of each group, it will fail. The RTWG also felt that it was not advisable to attempt, in the initial days, to design all the rules and regulations regarding all necessary safeguards, operating procedures, practices, policies, and incentives at this point in time. We believe a more effective strategy for initial, enabling legislation is to establish a basic, sound foundation for program operation with basic safeguards, allowing a balanced commission to review and amend program provisions based upon actual experience and outcomes. Some argue that the current rules and regulations faced by the State system are a primary deterent to success. We also felt that it was not advisable to try to build into legislation the types of provisions that would typically be contained in program rules and regulations; but that the operating details should be designed under the administrating agency (SSA) with direct input and oversight from a balanced commission.

The issues that are especially complex, such as removal of disincentives to people with disabilities to leave the rolls or the development of incentives for employers, require monitoring and modification over time. This is also true of the reimbursement system for providers. It may be necessary, for example, after the first two or three years of program operation to modify the reimbursement structure to more adequately incent providers to deal with people with very severe and complex disabling conditions. SSA simply does not have the manpower, resources, or knowledge base to deal with these complex issues. There was considerable fear, especially on the part of consumer groups, but also on the part of providers, that if the program was simply imbedded inside of the SSA

bureaucracy, it would become heavily bureaucratized, rule-burdened, ineffective, and inaccessible to change.

It was also felt that by establishing a bipartisan commission, which would report to Congress on an annual basis regarding the outcomes of the private section program, the barriers encountered and the satisfaction derived by participants, the return-to-work program would enjoy continuing interest and support from the Congress. It was envisioned that Congress would, in fact, develop some sense of ownership over the program and not simply stereotype it as another bureaucratic initiative. Politically, it was an attempt to keep the issue of employing people with disabilities high on the legislative agenda for several years to come.

SUB-ISSUE: Regional Administrators

The RTWG recommended that the day-to-day administration and management of the program be contracted out to a private administrator. It was further recommended that, on a national basis, at least two firms be chosen to serve the various regions throughout the country.

There are several key considerations behind these recommendations. It became clear to our group early in our investigation that the Congress and SSA alike felt that the day-to-day administration of this program should be contracted out. It was believed to be more efficient and effective to hire an outside firm to be monitored on a performance basis to oversee the program. A successful program should be available in all 50 states and provide services on an annual basis to between one and two million participants. The RTWG felt, after considerable debate, that it would be safer to entrust this very substantial administrative responsibility to at least two firms rather than simply letting one contract for a large national firm. While this is not a "to die for" proviso, it was simply intended as a safeguard to ensure that if an administrator was ineffective, an alternate would be readily available to take over their administrative responsibilities.

This approach is essentially the approach that has been developed or adapted by the SSA in its recent RFP for a firm to manage the Private Alternative Provider Program that they have attempted to initiate. Comments indicate that some groups interpreted the RTWG recommendations and the Bunning Bill to imply that there would be separate administrators in every region of the country. While that would not be precluded by our recommendations, it was not the intent or what was envisioned.

The State VR administrative structure is not considered to be an acceptable administrative alternative because it may, in fact, have a conflict of interest in administering and overseeing the program for the private sector, given the current perspective that such a program is a competitor that may put them out of business. Additionally, the administration and management of an outcome-based system that works with private sector providers is a very different administrative task than the administration of the State cost-reimbursement programs that operate under tight process control.

SUB-ISSUE: Network Coordinators

After significant deliberation, the RTWG recommended that the sub-committee use a network coordinator system at the local level as the primary vehicle for the delivery of services.

The network coordinator was envisioned as an organization or a group of organizations who joined together within a specified geographic area (such as a state) to provide the comprehensive array of services and specialties that would be required to assist a wide range of individuals with disabling conditions to attain employment within all the communities contained within that geographic area. To become a network coordinator, an agency or group of agencies would submit a request for qualifications, which would simply outline, describe, and affirm their ability to provide a comprehensive array of services as defined by regulation to all communities within the geographic area considered.

There were several key issues taken into consideration behind this recommendation. First, it is absolutely critical to understand the dramatic difference between a system that reimburses for successful, long-term outcomes as defined by the person with the disability, as contrasted with a fee-based or cost-reimbursement system that is currently operated by State VR. Participating providers would, in large part, be expected to invest significant amounts of capital to assist many of the individuals in returning to long-term, gainful employment. Providers would not receive a return on that investment until the individuals had been employed in all probability for a number of years. In other words, the provider would have to incur significant risk in supporting the individual. One of the features of the network was to allow for the formation of risk pools for the small, non-profit organizations, (especially those who specialize in serving individuals with specific types of disabilities) where they could share the risk and pool their resources and experience. It was felt that this provision would maximize the number of small, community-based, non-profits or small, private, for-profit providers that could participate in this program. This is a critical design feature to ensure maximum choice in every community and to also ensure maximum access to a diverse number of employers within a local economy. There was significant concern on the part of consumers and providers, alike, that if the use of networks was not encouraged, the large, national, for-profit and non-profit providers would take over the contract on a national basis and target large, easy-to-serve geographic markets and provide services to only those who were most easy to serve.

The RTWG recommendations included the provision that every network provider would ensure that within any community in the area covered by the network there was a minimum of two choices available for all core services. Core services included such basics as assessment, plan development, placement, follow-up, counseling, and training.

It was felt that the network strategy, which required service availability and choice in all communities, would also maximize the opportunity for specialized services and specialized providers to assist individuals with specific disabilities to obtain employment.

It was envisioned that because providers and the network itself would only receive reimbursement for outcomes, in effect, this system would create a "Community of **VESTED INTEREST IN SUCCESS."** Rather than private providers, non-profit agencies, and State VR competing for enrolled program participants, they would be encouraged, if not forced, to form partnerships that would result in the outcome of acceptable, long-term employment for people with disabilities.

The opportunity for small, non-profit organizations to form their own network ensures that they have the option available to participate in the program and to oversee their own activities. Small private firms could, likewise, form their own network or could become a direct provider of service on a sub-contract basis for larger, national corporations (for-profit or non-profit) that may be network coordinators within their local area. The network coordinators are not an administrative layer, but rather a mechanism for partnership in performance. They could, and would have to, provide direct services. This system has only one administrative layer between SSA and direct service provision. It is difficult to conceive how any national system designed to serve several million people could be administratively simpler.

There are several additional benefits to utilizing a network strategy to service rather than simple opening up service to all interest parties across the country.

Administrative costs would be kept to a minium because all admin and overhead costs will have to be paid by the network coordinators and service providers from their outcome-based performance payment. If resources are wasted on excessive admin, they cannot go into profit or service enhancements that ensure success. This strategy ensures that a maxium amount of resources will be dedicated to developing supports and services that ensure employment and carreer success. Networks that do not employ this strategy will probably go out of bussiness due to lack of income and poor performance reports. Also, satisfaction survey results will be published on an annual basis, which will inform prospective enrollees about the network's poor performance.

Networks that develop solid relationships with a wide range of highly effective core and specialty service providers who are results oreinted and well connected to the employer and community will be able to serve more difficult to serve individuals, thus increasing their market share, financial success, and service quality.

Small service providers who are highly effective will be able to work with one or more networks. In fact, good, small service providers who effectively specialize in serving individuals with specific disablities or who have well-developed connections with specific employer segments will be sought after by competing networks to provide service. Without a network type of strategy, small community-based providers would not

have the financial resources to particapate in an outcome-based payment system. The network provides an opportunity for small providers to share the financial burden with the network so they can afford to participate. The recommendation by the RTWG that **ALL** networks have at least two choices for core services in each community enhances choice for consumers and enhances opportunity for small providers and advocacy organizations that want to help people become independent.

Customers who have a specific organization they want to provide a direct service could require the network to allow them to utilize that provider. If the network refused, the individual could go to another network and solicit their support in using the preferred provider. If the provider was willing to provide services on an outcome basis, there is no reason the network would not accept them.

A key role of the network is to insure service coordination. Some individuals may choose to essentially provide their own services, or utilize their own acquaintances, providers or employers. Working with a network, all of this would be possible. The network's primary role would be to coordinate supports and handle the administrative billing and reporting to SSA. In essence, the customer would be able to tailor their plan and supports to their needs and circumstances.

Chairman BUNNING. Mr. Halliday, I would like to start with your testimony. Right now the State vocational rehabilitation agencies are the only source of rehabilitation services for SSA recipients. To what degree do you provide these services yourself, and to what degree do you contract out to other service providers?

Mr. HALLIDAY. Well, I would like to clarify one part of that question. We are not the only source. One of the largest myths in reading all the materials is that somehow there has developed this myth that the recipient can only come to the public agency.

The only thing the public agencies offer is the opportunity to educate the recipient as to what is available, not only through us, but through the SSA programs, and it is the consumer who chooses.

The consumer has all the choices they want. They can walk into the public or private program today. They can go to job service, they can go to DD, they can go to any one of these private providers, or the thousands of others.

So I do not know where that mythology came from, but I find it quite interesting, and would be interested to know what the source is.

Second, I would answer the question this way——

Chairman BUNNING. Well, they are the only agency that the Social Security Administration refers to.

Mr. HALLIDAY. That is correct. They are not the only people Social Security recipients are educated about.

Chairman BUNNING. No. But they have to go through you first.

Mr. HALLIDAY. No, they do not.

Chairman BUNNING. Well, then is there some breech in the law somehow.

Mr. HALLIDAY. No, no. It is the consumer's choice whether or not he or she responds to us. If the consumer calls us, and says, Gee, is there anybody else in the community, I say sure, who do you want to know about.

Chairman BUNNING. But, see, they have to go through you. They cannot go directly to the third party.

Mr. HALLIDAY. Absolutely they can. They can ignore our outreach to them, and tomorrow morning pick up the human service yellow pages, and walk right down the street. Nothing preventing the consumer from doing any of that at all.

Chairman BUNNING. Well, we will check with the Social Security Administration about that.

Mrs. KENNELLY. Could I just ask a question? Is it possible there is a difference on reimbursement?

Mr. HALLIDAY. Let me answer that——

Mrs. KENNELLY. You are the only one that can get reimbursed.

Chairman BUNNING. That is correct.

Mr. HALLIDAY. That is correct.

Chairman BUNNING. OK. Then they have to go through you.

Mr. HALLIDAY. Wait 1 minute, that is a critical issue, though, because what all the choice discussion is really about—and I am all in favor of choice; I think we are implementing that fine—is the issue of resources.

If we do not put resources, what everyone here previously has said, what milestones is about is putting more resources into the system.

But in the era of choice, the consumer is free to choose, and many do many other publicly funded programs for rehabilitation. And I think that is an interesting thing we should look at in terms of what other public resources are being used by recipients. Many are accessing many other public programs.

But as to the other question, 40 to 50 percent of the dollars in public vocational rehabilitation are spent outside the public agency. In Connecticut, it runs 40 to 50 percent. And where we spent that money is, over 50 percent of that money is spent with community rehabilitation program providers.

So that what the costs we are reimbursed for, very little of that cost has to do with services provided in the agency. It is reimbursement of the costs of the services we purchase.

If I do a van modification for a consumer, for $15,000, that is the cost. That $15,000 was not spent in my agency. It was spent with a private provider.

If I sent persons to a private provider as part of that, for job placement and situational assessment, and that resulting placement, that cost averages around $2,600 in Connecticut, is——

Chairman BUNNING. I am not going to let you talk all of my 5 minutes. I want to ask you another question.

Mr. HALLIDAY. Sure.

Chairman BUNNING. In your experience, are there certain areas of the country lacking facilities to provide services? If so, where are they, and how do you provide services to the other areas?

Mr. HALLIDAY. I can talk about the Northeast. I cannot talk about other areas of the country.

Chairman BUNNING. Talk about the Northeast, then.

Mr. HALLIDAY. In the Northeast, I have not seen that be raised an issue. What I have seen be raised as an issue is that waiting lists occur in public agencies and private agencies because the funds are not available. The connection is made with the consumer, but we do not have the money to purchase.

Chairman BUNNING. OK. Let me ask the other four panelists, in your areas of the country, are there other areas that have that problem?

Mr. START. I can talk to the Northwestern United States and I cannot think of a town, for example, in Washington or even northern Idaho, which is about as remote as you get, that does not have some kind of a provider, community-based, usually nonprofit, but also private there.

And some outreach, frankly, from a State agency, typically.

Mr. HESSELLUND. In terms of the private sector from NARPPS I agree. The private sector, there is rural rehabilitation, and then there is metropolitan rehabilitation. But we cover all the sections.

Chairman BUNNING. How about Kentucky?

Ms. GENNARO. I know that Mr. Christman has said that there are providers throughout the area. And as you said I am from the American Rehabilitation Association. We have members from all over the country.

Chairman BUNNING. Mr. Tenney.

Mr. TENNEY. Yes, in the Southwest, as well as the Pacific Basin where I have had some experience, there is a significant network of providers there that are available to provide these services, if they have the resources to provide the services. That is the whole key.

Chairman BUNNING. Barb, go ahead.

Mrs. KENNELLY. Thank you, Mr. Chairman.

Mr. Halliday, I believe you expressed concern that providing the tickets for the SSDI recipients to use in private vocational training could create a cost shift from private insurance to public vocational rehabilitation programs.

Could you expand further? And let me add another question onto that. If we prevented workers' compensation from requiring policyholders to use their Social Security tickets on the Workers' Compensation Vocational Rehabilitation Program, do you think that we might moderate the threat of a cost shift?

Mr. HALLIDAY. I need some clarification on the second question.

Mrs. KENNELLY. From the private to the public.

Mr. HALLIDAY. Yes. What is presently, as I understand it, existing, is if you buy private disability insurance, often the great majority will require you to apply for SSDI, if you reach a certain level, and once eligible the income you receive from SSDI is offset to what the private pays you.

So that is a savings to the private insurance company. Also, many of the private insurance companies do very aggressive rehabilitation. And as many of the private sector programs here indicate they provide that service.

That is accounted for and paid for in the premiums. We need to be careful that we do not set up a situation where what was already going to be provided at private cost as a result of what you and I pay as premiums for that insurance does not in any kind of ticket proposal end up with the public paying on top of that again.

Because what we would end up with, obviously, is a situation where we are doubling the resource without more people being served, as well as the money not going back into further service. It goes into a profit margin which, I am very in favor of profit margins, but I think the insurance system probably already has that well taken care of in their premium structure, I would hope.

As far as the workers' compensation, I think again we need to look carefully at what the relationship is between being on SSDI and workers' compensation, and be cautious again that if rehabilitation services are called for and covered for under the Workers' Compensation Program, that those are prioritized, and we are not again replacing those funds with Social Security funds.

I think those are a couple of areas of risk we run here.

Mrs. KENNELLY. Ms. Gennaro, for Mr. Christman. In the testimony that you read for Mr. Christman, he expressed concern about what would happen when a person needs services for more than one provider.

Now, when we had the Social Security Administrator here, he said that he believes providers of different type of services will enter into arrangements with one another. And maybe network and offer a range of services to the ticketholder.

Now, this whole concept of tickets is still controversial. Do you think they could build up this network, or they could work with each other with the proposal?

Ms. GENNARO. Well, I know in the testimony, his concern was simply how would the payment be worked out. And I believe that something certainly probably could be worked out, but in terms of the complexity, for instance, if a consumer starts with one provider, they provide a certain amount of services, and then they switch to another provider, how do you divvy up the payment. Things like that will be difficult.

Mrs. KENNELLY. When I was listening to the service talking, I think we have more work to do on that, in that whole area. And once again we are going to have to use the expertise of people like yourself.

Mr. Start, would you like to comment on that?

Mr. START. Yes. In the Return-to-Work Group's recommendations to deal with that issue, we recommended that it be required that a provider certify that they can provide a network of services across a predefined geographic area, like half of a State, to make sure the people in rural areas would get served, and to make sure that case management was in place to provide that seamlessness of services, and that the full array of services was there.

So that was a provision that we recommended to deal with that specific issue.

In terms of, by the way, the guidelines, like what would happen if somebody changed providers after they had had a job for 2 years, one of the reasons that we recommended the development of a commission was we considered this to be work in progress, and it will continue to be. And that we need to look at those issues in a combined way for a couple, 3, 5 years, to really refine all of the guidelines.

Mrs. KENNELLY. CBO says that they do not think the Social Security plan will bring that many people back to work, that the same ones that would have gone back go back. Do you have any reason why you think CBO is more or less negative on the Social Security plan?

Mr. START. I really do not. I mean, my major concern with the Ticket Proposal is just that I do not believe, nor any of the providers that I have talked with, that it will attract enough providers that will aggressively pursue people, and especially take some risk.

They are only going to place the for sure people, like the current program. People that are already going to be placed are the only ones you work with.

Mrs. KENNELLY. Thank you.

Chairman BUNNING. Mr. Hayworth.

Mr. HAYWORTH. Thank you, Mr. Chairman.

At the risk of sounding incredibly parochial, I am very pleased that on both panels today we have representatives from Arizona.

Chairman BUNNING. That was prearranged to take care of you. [Laughter.]

Mr. HAYWORTH. Selected especially for us. Well, Mr. Tenney, I am glad you are here. I am sorry my colleague from Georgia, Mr. Collins, is not. And I will spare you my efforts to impersonate his distinctive accent.

Let us talk some about incentives, and talk about your testimony where you say that demand exceeds the supply. I am curious about incentives, though, in small business. Do we see a discrepancy between corporate America and many small businesses when it comes to hiring in this regard?

Mr. TENNEY. Yes. There is a huge difference, as our experience has shown. The large corporations, at least in Arizona, the McDonalds and McDonnell-Douglas, and some of those other larger corporations, they get involved in the employer incentives pretty much after the fact.

They hire these employees, and then they will go out and hire a specialist to mine that field, that garden of incentives, to try to see what can we now reap, what kind of a benefit can we now reap as a result of hiring them, which is certainly not the intent of the incentives.

With the small businesses, which is where we place almost all of our people—most of our people go to work in the small businesses—they just do not really want to be bothered with what they call the government redtape, whether or not it is valid or invalid. That is not a judgment that we should subject them to.

They do not want to be involved with redtape. They just plain want people to go to work, and they sometimes find that it is not only good work, but it is a civic responsibility.

Mr. HAYWORTH. So, really, from your perspective, are you telling us that there is no real need to try and provide incentives to small business, based on your experience, or what should we provide?

Mr. TENNEY. Well, it is almost heresy for me to sit in this kind of meeting and say that, but what the heck I will be out of here probably soon anyway, so—yes, I would say, I think it certainly would help us. But I do not think that it is, from my own personal experience, I have not found that it is that important.

Mr. HAYWORTH. But the key is, if incentives are provided, that they should be as redtape free as possible.

Mr. TENNEY. As redtape free as possible, but incentives probably would be better used going to the employees as opposed to the employers. They seem to be the people that I think would most welcome it.

Mr. HAYWORTH. Fred, thank you for your candor and your testimony, and thank you, Mr. Chairman.

Chairman BUNNING. If the panel would sit back and relax, we have one vote, and we will go over and vote. The Subcommittee will recess until we return to finish our testimony. Thank you.

[Recess.]

Chairman BUNNING. The Subcommittee will come to order. If the panel would take their seats, we will try to complete this as expeditiously as possible, without being too quick.

First of all, I want to thank the panel for staying, and I would like to ask Dr. Hessellund some questions. You recommended providing SSA recipients with an informed choice of prequalified private and public rehabilitation professionals.

What criteria should be used, and how should rehabilitation professionals prequalify for a return to work program?

Mr. HESSELLUND. There are certain standards in the industry at this point, in terms of certification, certified rehabilitation coun-

selor, certified disability management specialist, and I will just give you my own experience, that I have just—one of my other jobs is director of vocational rehabilitation programs for a national case management firm that specializes in catastrophic injuries.

The standards we set were certified rehabilitation counselor with 5 years experience in the field. Now, those are the standards that we set for providing and having experience with catastrophic injuries.

So I would say that the standards are, there is a general standard you could set, but also that you would be prequalified with particular experience with a particular field, or a particular type of disability.

So I would say there are two standards. One, and this particular experience was with catastrophic injuries. So I would say it is both a level of education, of experience and certification, combined with experience with a particular type of population or disability.

And that is with the person, the rehabilitation counselor who is developing the vocational plan. There may be somebody else that is part of that network, as Mr. Start mentioned earlier, that would be providing the job placement services.

But that is where I would start and what I would recommend.

Chairman BUNNING. Would anybody on the panel like to make comment?

Mr. Start.

Mr. START. The Return-to-Work Group, in looking at this issue recommended that the individual that functions as a case manager within a network be a certified individual or an individual with the kind of prequalified experience that he just spoke to, but that we not require all of the individuals that work with folks have fancy certifications, because we would overburden it, and it would limit choice.

A lot of people would like to go with folks that may not be certified or have degrees to provide placement services followup and further case management.

Chairman BUNNING. Anyone else?

Ms. GENNARO. For community rehabilitation programs, there are certifications out there. Right now the name escapes me. But I also know that local offices of MRDD services and mental health services also provide certifications, and programs are also known to the State VR agency.

So there are systems in place already to assure quality.

Chairman BUNNING. Anyone else?

Mr. Tenney.

Mr. TENNEY. Yes. I would suggest that we really would not want to require certification on all level of provision of services. That is a good way to exclude a lot of people from the process, and to include those people who are already in possession.

So I think that in helping to develop the RTW proposal, we felt that if, indeed, we could do case management certification and then have the experience factor weigh heavily on the other disciplines, then we would do just fine.

Inasmuch as it is a prescriptive program, and inasmuch as it is a performance-based program, you still are not paying for anything you are not getting.

Chairman BUNNING. Mr. Start, I would like to ask you a couple of questions. You mentioned that in order for private providers to participate in a return to work program they would need substantial amounts of capital.

Several witnesses said yesterday that providers, even small providers, do not need up front capital to serve SSA recipients since an open market system would create innovative funding opportunities.

What are your views on this issue, and how do we insure that providers won't just produce milestones and not trust fund savings?

Mr. START. Well, that is quite a question. I do not know where the witnesses yesterday got their information that providers could come up with money to fund, for example, the Berkowitz model, the model that is based strictly off of savings.

I have helped start six businesses myself, and I can tell you for sure that you cannot take that proposal to the bank. There is no way. There is no experience base whatsoever. There is no industry history, knowledge.

You cannot even take it to a venture capitalist. I mean, they expect literally 1,000 percent return over a 5-year period, is what the venture capital guys want.

So I do not know where that comes from. What I do know is that in meeting with hundreds of providers across the country, presenting our proposal, in a variety of States, that many of them say they could participate with a small level of milestone payment like we have prescribed toward the front end.

In terms of making sure that you do not end up just buying milestones, it is critical that those milestones be priced, frankly, below cost, and the milestones that we have recommended are below cost.

People that try to just crank out milestones with that kind of a performance-based system will go out of business. And keep in mind that the primary thing here is an outcome-based model, where the outcomes are reported to the customers.

Customers simply are not going to go to providers that do not produce results. So somebody that tries to get by with just doing evaluations, set up an evaluation mill or something like that. They are going to go out of business in no time at all.

Chairman BUNNING. Did I understand your testimony, or was it someone else, that it generally costs about $11,000 to rehabilitate somebody and move them from the rolls, in the present situation? Your milestone suggestion would be less costly?

Mr. START. Yes.

Chairman BUNNING. Give me that cost.

Mr. START. OK. The numbers I used, the historical numbers that we had from Social Security research was that on average the State vocational rehabilitation system is reimbursed about $10,000 to $12,000 for the people coming off of SGA.

That is not necessarily cost at placement. That is 1 year later, and just for those that are successful. We used $2,700 total cost for ours.

We have also indexed those numbers, though, against other programs such as the Job Training Partnership Act. I managed about 30 or 40 of those. Mr. Tenney has managed them for 20 years.

And historical placement rates are, that is just getting somebody a job. That is not keeping a job for 1 year, like getting people off the rolls is, costs there run from a low now of about $3,000 to about $7,500, or so.

It depends on the kind of training, the twist that they want to put on it, how much education. But by any measure you used, Projects with Industry has 20 years' worth of data, in terms of keeping people off the roll that long.

So I do not see how anybody could practically make any money off of those kinds of milestones.

Chairman BUNNING. I want to tell you again that I will submit questions to you also, in writing, in case I did not get to them today.

The last question I want to ask the whole panel is that we have heard much testimony about medical coverage, and what a barrier that is to getting people to work, to return to work, if they are on some type of disability.

And it was suggested, 5-year Medicare coverage for those that are on disability right now. I would like to get all of your opinions. What is necessary, or what do you think is necessary, for that disincentive to be overcome, minimal.

In other words, if we write a bill, a new bill, what would be your suggestion to put in as a minimal coverage so that this would not be a barrier for people to go back to work, and they would be free to get a job, and not fearful of losing a job, fearful of losing their medical coverage.

So what reasonably can we expect, or what should we expect? For anybody on the panel.

Mr. HALLIDAY. I think there are two essential criteria. One is the availability, obviously, and the second is that you are paying for the kind of services that people who go to work need. They are prescription medication for the physical disability, and this is a particular problem in the Medicare system.

Look at what we cover under Medicaid, and figure out could we cover—because when we have people covered under Medicaid, we do not present this problem to a large extent. It's people covered under——

Chairman BUNNING. In other words, Medicaid, the system there is a better system than Medicare because of the——

Mr. HALLIDAY. Oh, yes. What it covered in terms of the nature—particularly outpatient and community service. That is where——

Chairman BUNNING. What type of—how many years? What are we looking at.

Mr. HALLIDAY. Well, the other I would look at is a combination of trying—and some States I know have tried this—of allowing people to go to work and continued Medicaid with a buy-in way that the private insurance covers what the private insurance will cover, and the Medicaid is only covering what the private insurance will not cover.

I mean, to give you the classic example, most private insurers today will set a limit on durable medical goods. If you use an electric wheel chair, it will cost $10,000 to $15,000.

If $1,500 is the limit on that, there is no way, no matter what coverage you have, that you are going to pay the difference of thousands and thousand of dollars.

Chairman BUNNING. Well, but would not people generally have durable equipment before they go to work?

Mr. HALLIDAY. Yes. But you are going to have to replace it.

Chairman BUNNING. Oh, eventually you will.

Mr. HALLIDAY. Yes.

Chairman BUNNING. And that availability ought to be there.

Mr. HALLIDAY. Right. That is what I am talking about.

Chairman BUNNING. Ms. Gennaro.

Ms. GENNARO. I would say that what you need to consider is when the person can actually afford to buy in. So in terms of setting a 1-year limit on that, I would be afraid that that would not be sufficient, because as you have heard from the earlier panel, especially, some people will work to their potential and still not be able to afford to buy into Medicaid or Medicare.

Chairman BUNNING. We could set a limit or a ceiling or a base for earnings, and then anything that gets above that would be partially responsible.

Ms. GENNARO. Yes. I think it makes sense to look to see when the person can afford to buy their own coverage or buy into Medicaid or Medicare.

And also as Mr. Halliday said, consider what Medicare does not cover, because many people have to try and figure out ways to get Medicaid coverage, because the Medicare coverage is simply not sufficient with, for instance, personal assistance care, and, as he mentioned, prescription drugs.

So you have to make sure that the needs that they have to be employed are met.

Chairman BUNNING. We do not want to have a disincentive, if we are going to write a new bill.

Ms. GENNARO. Yes.

Mr. HESSELLUND. When you are sitting on a panel like this, you want to give an answer, but I will say that that is more of a consumer issue. All I know is that working with the folks and trying to get them back to work that are on SSDI, this is one of the major blocks, one of the major barriers.

Chairman BUNNING. So we are going to have to come up with a solution whether we like it or not.

Mr. TENNEY. In Project Network, which is referenced often, we talked about 1,300 people. Interestingly enough, the very first question that they asked was not will I lose my check if I participate in this program. It is will I lose my medical insurance.

So it is essential from that standpoint, and what I would suggest is that you have sort of a three—you could have a three tier system. Either provide the insurance for them, or subsidize the insurance, or allow them to purchase the insurance, depending on maybe the level of income.

But at least have it be out there to be able to be purchased. Because if you put a time limit on it, what we have going on now out there is an increasing number of contract employers.

And one of the big reasons for going with a contract employer if you are in business is you do not have to provide insurance.

So often they do not provide any insurance to these people. And they contract with these disabled people to go to work for them, but they do not have to pay them any insurance. Makes for a wonderful system for them.

That is their main selling point that that they have, in contracting. So either provide the insurance, or subsidize the insurance through a similar approach to what you mentioned, either ramping up to it, but at least, at the very minimum, allow them to purchase reasonable medical insurance.

Chairman BUNNING. Mr. Start.

Mr. START. Yes. I concur with Mr. Tenney's comments on that. And those are in line with the Return-to-Work Group's.

A couple of other thoughts on it. If employer insurance is available, people should be encouraged, or not reimbursed, I guess, or allowed to extend their benefit coverage, if it is already there. So there might be some test to that effect.

What we found in our Projects with Industry is that 50 percent of the people that we place do get health insurance. Now, you need to make sure it was adequate health insurance. But in many cases, the employer insurance is more adequate in terms of drugs and some other things than the Medicaid coverage.

And another thing, I think, that is absolutely critical is education. There already is a provision in the law for extension. But the regulations are complicated, and people do not readily explain that. And I think the first panelist mentioned that earlier.

With a private sector, outcome-based model like we are talking about, if you do not understand the medical benefit extension coverage, and you cannot sell it to prospective customers, they are not going to come to you.

And so I think this outcome-driven system that we are talking about here for the providers is going to force providers to get educated about how those benefits work, how to make them available, how to build them into people's plans, or they are going to walk across the street.

But that education component has been a problem that needs to be solved as well.

Chairman BUNNING. Thank you. I want to thank the panel for their input today. We really appreciate your traveling here and giving us the data that we need to eventually write a bill.

With that, the Subcommittee is adjourned.

[Whereupon, at 4:02 p.m. the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT
of
The American Occupational Therapy Association, Inc.
for

Hearing
on
BARRIERS PREVENTING SSDI RECIPIENTS FROM RETURNING TO WORK

July 23 and 24, 1997

before the
Committee on Ways and Means
Subcommittee on Social Security

The American Occupational Therapy Association (AOTA) commends the Social Security Subcommittee of the Ways and Means Committee for holding hearings on the critical issues which prevent individuals with disabilities from returning to work.

AOTA supports the Subcommittee's efforts to encourage a review of current policies and practices. AOTA stands ready to assist the Subcommittee in its efforts to improve employment policies and enable all individuals to have the opportunity to work. AOTA presents the following comments and testimony to inform the Subcommittee about the potential role of occupational therapy in meeting the needs of injured workers and those with other disabling conditions to enable them to engage in the important human function of work.

AOTA acknowledges the many individual and policy barriers--health care, program funding limits, policy restraints--that prevent people from achieving economic independence through work there are accepted and proven services which can assist these individuals to assess their capabilities, to learn skills, and to achieve success in the work place.

Occupational therapy is one such service. Occupational therapy is reimbursed by both Medicare and Medicaid when medically necessary and is also reimbursed by private health insurance. It is also an important service in vocational programs such as those supported under the Rehabilitation Act and state workers' compensation programs. AOTA would encourage the Subcommittee to not only address the policy barriers but also review the funding and policies necessary to assure that individuals can have access to useful, proven services such as occupational therapy.

What is occupational therapy?

Occupational therapy is a health and rehabilitation service reimbursed under Medicare, Medicaid, health insurance policies, the Rehabilitation Act, workers' compensation, and other programs. It provides therapeutic interventions, such as work simulation and conditioning activities, for the assessment and treatment of individuals with disabilities. Occupational therapy can assist individuals whose ability to function in a competitive work environment has been impaired by physical or emotional illness, injury or condition. Treatment provided

by occupational therapy practitioners includes the assessment of functional limitations and capabilities to perform meaningful, productive work.

Occupational therapy therapists are health care professionals who are educated at the bachelor's or master's level; occupational therapy assistants have an associate degree in occupational therapy. Practitioners are licensed or otherwise regulated in every state and territory. Occupational therapy practitioners use their knowledge of the structure and function of the human body, the effects of illness and injury, and the components of activity to achieve recovery, to improve functioning and to increase their clients' involvement in productive and other activities.

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

- Performance areas are broad categories of human activity that are typically part of daily life. They are activities of daily living, work and other productive activities, and play or leisure activities.

- Performance components are fundamental human abilities that--to varying degrees and in differing combinations--are required for successful engagement in performance areas. These components are sensorimotor, cognitive, psychosocial, and psychological.

- Performance contests are situations or factors that influence an individual's engagement in desired and/or required performance areas.

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

Occupational therapy and work rehabilitation

These three elements of occupational therapy practice are key areas which must be addressed if successful return to work is to be achieved. For example:

> An individual who is injured on the job may have the potential to return to work and productive activities, which is a performance area. In order to achieve the outcome of returning to work and productive activities, the individual may need to address specific performance components, such as strength, endurance, soft tissue integrity, time management, and the physical features of performance contexts, like structures and objects in his or her environment. The occupational therapy practitioner, in collaboration with the individual and other members of the vocational team, uses planned interventions to achieve the desired outcome. These interventions may include activities such as strengthening exercises, body mechanics instruction, job site modifications or psychological motivation enhancement.

Occupational therapy's practice in work rehabilitation includes activities such as work conditioning and work hardening. Work conditioning and hardening programs are conducted by occupational therapy personnel to be individualized, work-oriented activity process that involves a client in simulated or actual work tasks. In work hardening, these tasks are structured and graded progressively to increase psychological, physical, and emotional tolerance and also to improve endurance, general productivity and work feasibility. The eventual goal of work hardening services is to improve the client's occupational performance skills to allow effective functioning in homebound, sheltered, modified or competitive work.

Evaluation and assessment are key components of work hardening. Consideration is given to actual capabilities, as well as to the needs for practicing preventive measures, avoiding abnormal physical or psychological stress patterns, being aware of and reducing environmental hazards, increasing safety in performing work-related tasks, and effecting a positive psychological adjustment to work.

Occupational therapy practitioners, to effectively intervene to achieve work capability or improvement, must be able to synthesize three major bodies of knowledge. These include:

- knowledge of neuromuscular characteristics of clients, including their limitations in strength, range of motion, and endurance
- the knowledge and skill to perform a complex task analysis of the job (e.g., analyzing whether the job to be performed by the client is repetitious, bilateral or unilateral, or requires constant or intermittent concentration); and
- knowledge of the psychosocial aspects of work including the need for productivity, recognition, self-confidence and achievement, and in psychopathological work disturbances.

Occupational therapists are uniquely qualified through their training and perspective to synthesize this knowledge for the design and implementation of work hardening programs and other efforts to promote the move from public income support to productive work.

A successful return to work can be dependent on issues that an occupational therapy practitioner is uniquely qualified to address such as:

Providing data concerning the individual's physical and psychological tolerances that are essential to appropriate fulfillment of the vocational planning process;

Providing analysis of tool or job site modifications, ergonomic modifications or use of assistive technology to remove barriers to success in employment;

Development of appropriate work behaviors that will improve retention and reduce recidivism;

Use of interventions to promote patient/client responsibility and self-management, critical factors in successful work.

Improving Success Through Functional Evaluation and Supports

Functional Assessment (Capacity) Evaluation is intended to match the individual's ability to work based on their physical and functional capacities. It is used to evaluate and assess the individual's interests, abilities, and needs as they relate to employment potential and limitations. Areas considered include job performance or work-related activities. As part of an overall effort to target an individual toward a job or employment situation which will result in a successful placement, the Functional Capacity Evaluation can provide critical information about training potential and needs, alternative career possibilities, need for reasonable accommodations, or possible ergonomic job modifications necessary to achieve a successful return to the competitive job market. The Evaluation can objectively measure and reflect the individual's physical abilities and any impairment which limits the individual's functional capacities and better design an approach to return-to-work as appropriate to the individuals current and future capacity.

Ensuring appropriate evaluation of individual potential and needs for support is critical to success in return-to-work. Any effort to reform the system must include attention to removing the barriers created by limited expectations, psychosocial difficulties resulting from the adjustment to changed work capacity or ability, and lack of ingenuity if modifying work to fit the individual. Occupational therapy practitioners play an important part in these evaluations and in the implementation of the results. Programs to encourage return-to-work must include a full approach from evaluation to implementation of appropriate supports to achieve success.

Occupational therapy is uniquely suited to participate in such evaluations and to assure that the appropriate supports are provided to meet the identified needs. These practitioners' perspective is unique. Their training and education includes the study of human growth, development and performance with special emphasis on the social, emotional, and physiological implications of illness, injury and disability. The use of this combination of perspectives and knowledge can be instrumental in moving individuals from SSDI or other programs of support to productive employment in the competitive market. Occupational

therapists can contribute to both the evaluation of an individual's capabilities and limitations as well as in the adaptation of work and home environments to support achievement of independence.

Conclusion

Occupational therapy can be an important component of a program to enable individuals to return to work, tailoring rehabilitation, work training, job modifications and placement for the individual.

Programs must be targeted, however, to address the variety and complexity of the physical, emotional, intellectual and psychosocial issues which an individual faces in coping with illness, injury or disability. Return-to-work efforts must recognize the complexity of issues and barriers, both in policy and in individual circumstances. Adequate funding with flexibility must be directed in this fashion if success is to be achieved not only for individuals but for the nation's policy goals.

The attached materials from AOTA provide background on the various roles and functions of occupational therapy in a complete return to work program.

Attachments:

Occupational Therapy Services in Industrial Rehabilitation Programs
Statement: Occupational Therapy in Work Practice

Occupational Therapy Services In Work Specific Industrial Rehabilitation Programs

Work specific industrial rehabilitation programs are comprehensive, outcome-oriented programs focused on functional restoration and return to work. Industrial rehabilitation programs use real or simulated activities as the principal means of treatment to minimize risk and promote optimal work capability of the individuals served.

Who will benefit from work specific industrial rehabilitation?

- Injured workers return more quickly and safely to employment with a clear knowledge of their capabilities for the job.
- Employers receive assurance that the employee is physically competent to perform essential functions of the job and ready to return to work. The employer will also realize a decrease in lost work days, lost productivity, and worker's compensation costs.
- Insurance carriers receive rapid case resolution and a decrease in the administrative costs of case management.
- Rehabilitation counselors gain a clear picture of the worker's physical capacities, which aids in focused program planning and expanded job options.

Who should be referred for work specific industrial rehabilitation?

- Individuals whose physical and behavioral tolerances do not allow return to a former position at full work performance.
- Individuals whose physical and behavioral limitations require modification and/or reasonable accommodation to return to the same job class or industry.
- Individuals who seek to re-enter the job market but require assistance in overcoming physical and behavioral barriers.
- Individuals who need to document their physical capabilities to perform specific job demands.

What are the goals of work specific industrial rehabilitation?

- To insure a smooth, rapid, and safe transition into the work force by addressing physical and behavioral which limit the worker's ability to function.
- To develop physical tolerance for work, including flexibility, strength, and endurance.
- To develop safe worker habits, such as correct sitting and standing postures, and safe lifting practices.
- To develop and reinforce appropriate work behaviors, such as punctuality and good relationships with coworkers and supervisors.
- To provide data concerning a worker's physical and psychological tolerances that are essential to the return to work.
- To provide a testing ground to determine if tool or job site modifications or assistive technology will remove barriers to work return.
- To develop and address the psychosocial issues such as coping with disability or loss of function

From The American Occupational Therapy Association, Inc.

PO Box 31220, Bethesda, MD 20824-1220 301-652-AOTA (2682) Fax: 301-652-7711

Facts About Occupational Therapy

Where is work specific industrial rehabilitation provided?

- At community leased O.P. clinics
- At freestanding rehabilitation centers/hospitals
- At hospital outpatient departments
- At companies/industry
- At occupational health facilities
- At health clubs.

Who pays for work specific industrial rehabilitation?

- Workers' compensation insurance plans
- Self-insured employers
- Individual insurance plans
- State and/or local agencies
- Individuals

What specialized education and experience do occupational therapy practitioners bring to work specific industrial rehabilitation?

- Occupational therapists hold bachelor's or master's degrees, and occupational therapy assistants have associate degrees. Occupational therapy education includes the study of human growth and development, with specific emphasis on the social, emotional, and physiological implications of illness and injury.
- Occupational therapy practitioners are also skilled in developing and guiding a job-specific program of graded activity for the worker, job task analysis, and job station and t[illegible] modification, and in identifying and remediating behaviors inappropriate to the work environment.
- Occupational therapy practitioners must complete supervised clinical internships in a variety of health care settings and are required to pass a national certification examination. Many states also require licensure for occupational therapy practitioners.

Revised 1994.

From The American Occupational Therapy Association, Inc.

PO Box 31220, Bethesda, MD 20824-1220 301-652-AOTA (2682) Fax: 301-652-7711

$5 Members/$8 Nonmembers

Health Professional Information Sheets

(Revised 1994)

These reproducible masters offer effective and inexpensive resources for informing health professional audiences about the services and benefits provided by occupational therapy.

Helpful Hints:

- Add a local contact name, address and telephone number to each sheet before duplicating. This could be a private practice, health care facility or state association.
- Use colored paper for duplicating. Stick to light shades for readability.
- Use all or part of the copy to produce your own fact sheets and brochures.*

Titles

Occupational Therapy in Acute Psychiatric Admissions
Occupational Therapy and Adaptive Equipment
Occupational Therapy and Adult Day Care
Occupational Therapy and the Americans with Disabilities Act
Occupational Therapy for Children in School Settings
Occupational Therapy and Community Mental Health
Occupational Therapy for Depressive Disorders
Occupational Therapy for Developmental Disabilities
Occupational Therapy in Early Intervention
Occupational Therapy for the Elderly
Occupational Therapy and Hospice Care
Occupational Therapy in Industrial Rehabilitation Programs
Occupational Therapy for Infants and Children
Occupational Therapy for Learning Disabilities
Occupational Therapy in Long-Term Care
Occupational Therapy and Long-Term Care in Mental Health
Occupational Therapy and Medicare Coverage
Occupational Therapy in Mental Health
Occupational Therapy in Neonatal Intensive Care
Occupational Therapy for the Psychogeriatric Patient
Occupational Therapy in Work Specific Industrial Rehabilitation

For a booklet of fact sheets for informing consumer audiences, contact AOTA Products.

* This permission does not apply to materials produced for sale.

The American Occupational Therapy Association, Inc.
PO Box 31220, Bethesda, MD 20824-1220
301-652-AOTA (2682) 301-652-7711 FAX

Statement: Occupational Therapy Services in Work Practice

The American Occupational Therapy Association, Inc. (AOTA), asserts that registered occupational therapists and certified occupational therapy assistants play an important role in promoting optimal levels of work performance for all individuals. The historical and philosophical basis of occupational therapy has long supported the use of work as an evaluation and treatment medium leading to productive employment or productive work. Work represents a major human performance area that encompasses life roles such as homemaker, employee, volunteer, student, or hobbyist. Home management, caregiving, educational and vocational activities, and retirement planning are all productive functions that can be described as work. To the occupational therapy practitioner, any activity that contributes to the goods and services of a society, whether paid or unpaid, is considered a work activity. Engaging in work is a productive activity and a medium and goal of occupational therapy.

The acquisition and sustenance of work skills and work behaviors is a developmental process that begins in childhood and continues through adolescence, adulthood, and old age. Thus, occupational therapists provide preventive, evaluative, remediative, restorative, and compensatory services that are designed to improve the functional work status of individuals in all age groups. Occupational therapy practitioners provide work-related services in many settings, including, but not limited to, acute care and rehabilitation facilities, industrial and office environments, work-evaluation and work-hardening programs, sheltered work programs, school-to-work transition programs, psychiatric treatment centers, programs for the elderly, educational systems, and home environments.

Work-related disabilities that affect job performance can arise from physical, cognitive, perceptual, psychological, social, or developmental dysfunction. The comprehensive educational background of the occupational therapy practitioner in the biological and behavioral sciences, including knowledge of psychosocial, neurological, cognitive, perceptual, and motor function (e.g., kinesiology and biomechanics); developmental theories; and the components of human performance enables them to make a unique contribution to the provision of services for the prevention or management of work-related disability. Through skilled observation and formal assessment of both the individual and the human performance requirements of the work environment, the occupational therapist can identify the individual's interests, abilities, and needs as they relate to job performance or work-related activities.

Occupational therapists conduct a comprehensive analysis of an individual's work-related strengths and limitations. From these data, the occupational therapist, often in collaboration with other members of the health care team, develops intervention strategies to enable the individual to explore work options, make occupational or vocational decisions, and obtain and maintain employment.

The Americans With Disabilities Act of 1990 (Public Law 101-336) provides civil rights protection to individuals with disabilities. AOTA supports these rights through advocacy for the individual and consultation in the areas of employment, public accommodation, transportation, government services, and telecommunications (AOTA, 1991). Therefore, in the belief that involvement in purposeful occupation promotes maximum performance in or adaptation to the work environment, occupational therapy practitioners facilitate the transition of workers and potential workers from their current environment to the workplace. To achieve the goals of occupational therapy in work disability prevention and management programs, the occupational therapist will

1. Obtain a comprehensive history of the individual's occupational performance related to activities of daily living, work, and play/leisure, and identify the individual's work-related behaviors, interests, abilities, needs, and goals.
2. Assess the sensorimotor, cognitive, and psychological skills and deficits of the worker and potential worker while considering his or her future goals.
3. Analyze resources, constraints, demands, and expectations in the home, school, work site, or community environment of the worker or potential worker to facilitate progress toward identified goals.

The occupational therapist, in collaboration with the occupational therapy assistant, will

1. Plan and implement an intervention program to assist the worker or potential worker to achieve maximum function in the area of work performance (e.g., acquire appropriate work skills, assume and maintain a work role).
2. Coordinate occupational therapy services with all of

the other services being provided to the worker or potential worker.
3. Document and communicate the intervention and progress of the worker or potential worker.
4. Participate in the placement of the worker or potential worker.
5. Provide recommendations about the job with respect to reasonable accommodation, essential functions, and adaptations.

With each intervention, the occupational therapy practitioner considers a person's age, interests, values, culture, skills and abilities, physiological and psychosocial status, motivation for change, available resources, and inherent role and task demands. Intervention strategies might include direct services and consultation in the following:

1. Education and instruction in injury prevention, safety, proper body mechanics, postural awareness, pain management strategies, exercise, joint protection, and symptom awareness.
2. Job-site evaluation, including a description of the essential functions of the job and needed modifications.
3. Education about and discussion of return-to-work issues and incentives to return to work and retain employment.
4. Activities to increase and improve general work behavior and skills.
5. Development of work-related activities that can be progressively graded to allow the worker to eventually perform simulated or actual work tasks that are the essential functions of his or her actual or anticipated job.
6. On-the-job training and evaluation.
7. Supported employment placement developed through the use of job-site analysis and a job coach.

The following case study examples illustrate ways in which occupational therapy practitioners assist persons with work-related performance deficits. These case studies are not intended to be an inclusive representation of all the ways in which occupational therapy practitioners provide service in the work arena.

Case Study 1

A carpenter with a work-related back injury enters a work hardening program 6 months after his injury. Due to continued restricted activity, this man is unable to safely perform the physical tasks required in his job. A physical capacity assessment, which includes testing range of motion, strength, sensation, and function in productive work tasks, is carried out. The occupational therapist observes and assesses this worker using a variety of standardized tests and actual and related simulation activities to identify the nature of his physical limitations and the appropriateness of his behavior in conjunction with his medical history. An analysis of the job is performed to identify the critical physical demands, essential functions, and psychological factors associated with the job and to investigate reasonable job accommodations. The occupational therapist then develops a work-hardening program in which the worker is assigned graded tasks that simulate or replicate his job in conjunction with conditioning activities to improve strength and endurance. The occupational therapy assistant monitors him while work demands are gradually increased until he is able to safely perform tasks that closely approximate the essential functions of his job during a typical workday. Education in proper body mechanics and lifting techniques is incorporated into the program. The occupational therapist develops a plan to address work behaviors and attitudes to deal with return-to-work issues. The worker subsequently returns to work.

Case Study 2

A local industry, which has noted an increased incidence of back injuries and cumulative trauma disorders among their employees involved in material handling, contacts a rehabilitation facility to develop an injury-prevention program. The occupational therapist is consulted to develop a program that addresses these issues. The process begins with a work-site evaluation that includes an analysis of essential functions of the job, observation of employees performing their job duties, interviews with work supervisors, and a review of injury reports and the company's Occupational Safety and Health Administration log to identify other variables contributing to the increased incidence. The occupational therapist develops an employee education and supervisor training program for presentation to the organization's management. This program recommends strategies including proper body mechanics, job-site warm-up exercises, postural awareness, reasonable accommodation, job modification or ergonomic redesign, supportive devices, return-to-work consultation for injured workers, and other injury-prevention techniques.

Case Study 3

A woman with a developmental disability has just begun working part time at a local grocery store. Her ability to systematically straighten and clean shelves is limited and inconsistent. The occupational therapist develops a self-monitoring and reinforcement program to increase the woman's work performance.

Case Study 4

A man who sustained a brain injury is participating in a treatment program for persons with traumatical brain injuries. Prior to the accident, the man was an auto mechanic. The rehabilitation team, including the occupa-

tional therapist, has determined that the man can potentially return to an employment position in a small engine-repair shop. Following an evaluation, the occupational therapist determines that the man has difficulty with his short-term memory as well as with learning new tasks and controlling his frustrations. The occupational therapist designs a program that includes simulated and actual mechanical repair, a notebook recording system to assist with his short-term memory problems, and a variety of work and leisure activities to increase his frustration tolerance.

Case Study 5

An adolescent with a learning disability is enrolled in a local school district's special education program. The occupational therapist and vocational educator work collaboratively to develop a work-study opportunity at a local restaurant. The student works at the restaurant as a dishwasher and as a prep cook. The occupational therapist sets up a job chart to cue the student to complete tasks in an efficient manner. The occupational therapy assistant also coaches the work-site supervisor in ways to train the student, using primarily demonstration followed by practice.

Case Study 6

A woman is a client of an inpatient psychiatric facility. She has been hospitalized several times and has been gainfully employed only once during the past 5 years. Although she has had difficulty getting along with co-workers and supervisors in the past, she expresses a strong desire to work and a willingness to return to school to improve her clerical skills. The occupational therapy practitioner develops a program to allow her to examine and improve her interpersonal skills as well as practice some clerical activities. The occupational therapy practitioner arranges for the client to be referred to the local vocational school for tutoring after discharge. Additionally, the occupational therapy practitioner facilitates a part-time work-study placement with a job coach for the client in a clerical setting. Ongoing counseling is negotiated with the local community mental health program.

Case Study 7

A male client who was in an inpatient and later in a partial hospitalization psychiatric program has been hospitalized multiple times for substance abuse and depression. He is a trained electrician but was fired from an electronics job 4 years ago. Since that time, he has worked as either a janitor or a night security guard and has held nine different jobs with scattered periods of unemployment. The occupational therapist takes an extensive work history and identifies an absence of leisure activities, a lack of a daily routine, extensive drinking, and an erosion of work habits. Now sober, the man states that he wants to work as an electrician. He participates in leisure counseling and interpersonal skills training while in the hospital. During this time, the occupational therapy practitioner engages him in a variety of tasks and activities designed to help him realistically identify his strengths and weaknesses as they pertain to work. Upon transfer to the partial hospitalization program, he is enrolled in a work-adjustment and on-the-job training program where he is able to work in a maintenance department doing a range of tasks, including some electrical work. He works closely with his occupational therapy practitioner to identify ways to manage stress and anxiety at work while experiencing the demands of a real job. He works in a similar job after discharge and begins taking an electronics course to update his knowledge in this area.

Summary

Occupational therapy practitioners focus on the individual's ability to participate in productive occupations throughout their life span. Through prevention, assessment, and intervention strategies, occupational therapy practitioners often collaborate with other members of the health care team and assist persons to optimize their ability to engage in purposeful occupation while facilitating a safe and successful entry into or return to work. ▲

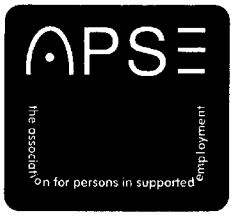
References

Americans With Disabilities Act of 1990 (Public Law 101–336), 42 U.S.C. §12101.

Kornblau, B. L. (1992). The Association—White Paper: Occupational therapy and the Americans With Disabilities Act (ADA). *American Journal of Occupational Therapy, 46*, 470–471.

Prepared by Karen Jacobs, MS, OTR/L, FAOTA, Carl Bettencourt, OTR/L, Paul Ellsworth, MPH, OTR, FAOTA, Susan Lang, MBA, OTR, Carolyn Levitan, OTR/L, Linda Ogden Niemeyer, OTR, Judy Place-Hayes, OTR, Desna Ratcliff, MS, OTR/L, Kathleen Reynolds-Lynch, MS, OTR, FAOTA, and Robin Chandler Sutherland, OTR, for the Commission on Practice (Jim Hinojosa, PhD, OTR, FAOTA, Chair).

Approved by the Representative Assembly March 1992.



August 4, 1997

The Honorable Jim Bunning
Chair, Social Security Subcommittee
B-316 Rayburn House Office Building
Washington, D.C. 20015

Dear Chairman Bunning:

As Chair of the Social Security Subcommitee, your have the rare opportunity to provide leadership in not only amending but also to recreating a social program the currently has a profound impact on the lives of millions of people with disabilities in this country. APSE commends you for your broad and welcoming reach into the community for answers and information on which to base your decisions on the reform of the Social Security disability program. On behalf of the 4000 members of APSE we wish to share recommendations which we have carefully structured to ensure equity and protections in the reform process for individuals with the most severe disabilities in this country. We respectfully request that the following comments be included in the record of the Subcommittee hearings on July 23 and 24 on Barriers Preventing Social Security Disability Recipients from Returning to Work.

APSE is a national organization committed to paid integrated employment for people with disabilities. We are a young organization, created in response to the growth nationwide of supported employment -- a collaborative model of job development and training which has opened labor market doors in most cases for the first time to individuals with intense personal and work support needs. Our members are key players in successful community employment -- supported employment service providers, people with disabilities, family members and employers. APSE membership is rapidly expanding across the country -- a clear statement of the success and popularity of the supported employment model.

In July of each year, APSE holds an annual conference on state of the art employment practices for individuals with significant support needs in the workplace. Social Security reform was a hot topic among our attendees this year. In fact, from the week of intense information sharing among more than 1200 supported employment advocates present at the conference, it is clear the issues before your Subcommitee regarding Social Security reform are crucial to the lives of individuals in supported employment. Certainly, supported employees are among those found on the rolls of SSI and/or SSDI. As an organization, APSE has a significant interest in the proceedings before

1627 Monument Avenue • Richmond Virginia 23220 • 804 278 9187 • fax 804 278 9377

your Subcommittee on Social Security reform.

Time constraints prevented us from more actively participating in these issues during July. APSE is a member of the Consortium for Citizens with Disabilities Vocational Work Group that presented testimony during the hearing. However, we were unable to reveiw and support the testimony prior to the date that it was presented. We are supportive of the document and would like to be added to the list of organizations supporting the statement. In addition, APSE has a number of comments, that either expand on or add to the CCD document. We welcome this opportunity to submit them for the Subcommittee hearing record.

- *Social Security reform legislation must encompass a level playing field and be free from discrimination based on level of disability.* Reform legislation must be broad and inclusive -- with work incentives that are available to *all* SSI/SSDI beneficiaries. For example, a "ticket" or "voucher" for services that is limited to individuals who meet specific standards such as "SGA for nine months" will exclude a large number of individuals who can and should become gainfully employed if provided appropriate supports. As has been pointed out in other testimony, most providers will not be able to afford the up front expense of these supports nor can they wait for the longer period of time that it will take for the support system to be put in place before receiving payment for their services. Too many people will be left with a meaningless ticket under such a proposal. As an alternative, we have outlined several recommendations, including a combination of the following: (1) meaningful and accountable benchmarks for voucher payments; (2) emphasis on collaboration from various funding streams leading to integrated employment (Medicaid, VR, school-to-work, education, state and local dollars, etc.); and (3) provider payments based on partial savings to the system when an individual's SSA benefits are reduced but not eliminated.

- *The concept of "feasibility for employment" or "employability" must not become a part of this reform legislation.* Opportunities for employment for people with severe disabilities is changing rapidly. Programs of evaluation, such as one presented during the hearings in July that would predetermine an individual's ability to work based on a multiple-step test, would lock us into a time that is in the past. The reality now is that people are working -- in spite of preconceived determinations that they cannot. If given a chance and sufficient support individuals still considered by many to be only candidates for sheltered employment or adult day activity centers are really successful in the labor market!!! Rather than bureaucratic evaluations that lock people into categories, APSE recommends that the reform legislation remain flexible on the issue of who can and cannot work, leaving these determinations to the individual and the provider of the services.

- *Access to medical care is essential.* It has been well documented and widely accepted that access to health care is a major consideration for individuals with disabilities as they seek employment options. Medical Buy-in is essential to the employment success of

individuals currently supported by SSI and SSDI. We are pleased to see this issue included in the discussions of Social Security Work Reform and strongly endorse effective sliding scale medical buy-in opportunities for individuals who are removed from the SSA roles due to increased income.

- *A gradual decline in SSA subsidies is an important incentive for people with challenging disabilities to risk employment.* APSE strongly endorses this principle. However, we have concerns and recommendations which differ slightly from those discussed by most other organizations. First, instead of waiting until the individual is completely off the Social Security rolls, we strongly recommend that the work incentives become available once the system begins to realize a savings. Under a gradual declining subsidy, this would be when the decline kicks in. However, for this approach to work, adjustments are needed to most current proposals to ensure equal access to the reform initiatives. The proposed mark of $500 for incentives will not work for many individuals whose SSDI eligibility is based on a childhood disability and who have no previous work history, or for others who become severely disabled as adults. They will need more time and resources than most providers can afford to carry alone in order to reach the $500 mark and, thus, savings to the system. The reality is that these individuals would not benefit from the reform initiatives -- nor will they be likely to leave the SSA rolls -- if they have to first earn $500. To address this concern, we suggest access to an earlier and slower decline. The formula must be carefully designed to ensure protection to the individual who would be giving up their right to the $500 earned benefit. We wish to work with you to further develop this proposal, seeking numbers that are in the best interest of the individual *and* SSA. We do believe the right formula will provide the opportunity for SSA to begin to save earlier and for the individual to realize the full benefit of the reform initiatives.

- *Provider incentives are equally important.* A provider who successfully facilitates employment for individuals receiving SSI/SSDI cash subsidies is helping to generate subsequent savings to the SSDI trust fund and SSI general fund expenditures. APSE supports the premise that allowing providers to share in the savings they generated will be an incentive for more successful placements. If provided in concert with the APSE decline recommendation above, we believe this to be an initiative that will attract more providers across the disability spectrum, allow individuals who are likely to be excluded from the earlier proposals equal access to work reform, and result in more savings to SSA.

- *Disability status should not change due to employment.* APSE supports the proposals for a permanent disability status for individuals who continue to have a disability as they return to work. Eligibility for this status should not tied to income. Individuals should be able to go to work secure in the knowledge that the SSA safety net is there should they need it.

- *Collaborative funding of up-front costs would increase provider incentives.* For the

reform initiative to work for individuals with more intensive employment support needs, providers must have access to outside financial assistance. Few providers can afford to take the risk of these supports on their own due to small budgets. If successful, the work of the provider will result in a savings to SSA. Since most individuals with intensive needs are already supported by the collaborative efforts of a number of local, state and federal agencies, APSE recommends the SSA work reform legislation encourage utilization of collaborative interagency efforts to fund the up-front costs. A strategy should be developed for equitable sharing in the incentive payments.

- *The PASS program holds much promise as an employment tool for individuals with more intensive employment support needs.* APSE recommends that the PASS program continue to be aggressively supported and strengthened as part of the array of support tools available to facilitate the path to self sufficiency.

- An *Employment Consultant Initiative would make it easier for individuals to utilize the reform initiatives effectively.* We have outlined proposals above that are designed to extend the work reform opportunities to individuals with more significant employment support needs. To facilitate the success of this program, APSE proposes a new authority to develop and support a system of employment facilitators across the country. This would be similar to the current system of Project Network facilitators. Our proposal is for a facilitator in each SSA region. The facilitator would be available to work with SSA beneficiaries seeking employment and referred through the SSA eligibility determination process. Assisting individuals in choice, self-determination and individual responsibility for self-sufficiency, the consultant would work in a collaborative model, facilitating cooperation among the various supports available (VR, MR/DD, housing, transportation, families, employers, others in the community, etc). The assistance would be available to any SSI/SSDI customer, with special emphasis on individuals who needs greater assistance in working through the system. With an awareness and concentration on choice and self-determination, the facilitator would assist both the individuals and the systems who support them to securely and responsibly proceed through the employment system.

  Funding: This model builds on the success of Project Network, taking the demonstration success to the next step of permanency in each region. Our proposal is initially for one individual in each region funded through SSA Administrative funds. The actual placement of that individual would be determined on a location by location basis, depending on the area (SSA regional office, Career Center, VR, MR/DD, etc) Our expectation is that this individual will become a very busy person and growth will be dictated by success. Expansion will be supported by some part of the trust fund/general fund savings. Thus, just as the providers recreate their work through their portion of the subsidy savings, this position within SSA would do likewise.

- *Following the SSA Alternate Participant model, APSE proposes that SSA administer this*

program through a management contract with an outside entity. The Social Security Administration has indicated that they do not currently have the capacity to manage a new program with the magnitude of the Social Security Work Reform proposals. We endorse the various recommendations that management be privatized. However, in supporting the outside management concept, we ask the Subcommittee to revisit the management provisions in the Return to Work legislation of the 104th Congress. We believe that the multiple layers required in the legislation would result in confusion and bureaucratic intimidation for consumers as well as providers. APSE strongly recommends that the management be less prescriptive in law, leaving flexibility to SSA and the managing agency to determine how best to implement the program.

- *Research and training are important tools to successful reform.* The reform proposals are charting new pathways for individuals with disabilities. Adequate resources should be dedicated to research and training to ensure a strong infrastructure for these new programs. that the new system remains dynamic and responsive to the changing needs of the customers. Solid research, demonstration and training programs should be in place to identify the changing needs of the SSA customers and ensuring a system dynamic enough to be respsonsive to those needs. For example, with the proper array of individualized supports and services, a disability - no matter how severe - should not be a permanent impediment to employment! Effective SSA research, demonstration and training programs can effectively deliver and demonstrate this message. APSE urges the Subcommittee to remember the importance of this research and training in building a new Social Security infrastructure.

For further information or clarification, please do not hesitate to contact me at 703-683-1166 (telephone and fax) or celanem@aol.com (e-mail).

Sincerely,

Celane M. McWhorter
Director of Public Policy

COURAGE C E N T E R

July 21, 1997

The Honorable Jim Bunning, Chairman
Subcommittee on Social Security of the Committee on Ways and Means
United States House of Representatives
B-316 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Bunning:

3915 Golden Valley Road
Golden Valley, MN 55422

(612) 588-0811
Fax (612) 520-0577
TTY (612) 520-0245

Thank you for the opportunity to provide a written statement to your committee on the issue of work incentives for persons with disabilities. We understand that you will be introducing a revised version of H.R. 4230, but are unclear what changes are being made. We commend you and your committee for tackling this very complicated problem, but fear that passing a bill similar to the old H.R. 4230 could be counter-productive if the concerns outlined in Attachment 1 are not addressed. We would hate to see a situation where Congress feels that it has addressed the issue of work incentives by passing this bill, and is then reluctant to take up other, more critical aspects of the problem.

While people with disabilities face many obstacles to employment, **the most critical issues are**:

1. the **need for continued access to Medicaid coverage** for long term supports (such as personal care assistance) that are not covered by Medicare or employer health insurance; and
2. the **need for a more gradual phase-out of cash benefits** as earnings increase.

These issues are described in the attached position statement of the Minnesota Consortium for Citizens with Disabilities (Attachment 2).

We understand that Medicaid (Title XIX) issues are more typically addressed by the Commerce Committee; however, the existing "1619B" program, which provides continued Medicaid access to persons previously receiving SSI, falls under Title XVI of the Social Security Act, rather than Title XIX. Presumably, a new "1619C" provision to allow comparable work incentives for persons on SSDI would also fall under Title XVI. It, thus, seems appropriate for your committee to take up a "1619C" provision, such as the proposal developed by Scott Lay from Oregon (Attachment 3).

A major concern with existing work incentives is that they are extremely complex and they treat people on SSI differently than people who receive SSDI or other benefits. The goal of any new work incentive legislation should be to **simplify the system and to ensure more consistency between SSI and SSDI. People with disabilities in similar circumstances should have the same opportunities to work, regardless of where they originally entered the Social Security system.**

We would be happy to provide any additional information you might need. Thank you.

Sincerely,

Anita Boucher
Courage Center
3915 Golden Valley Road
Golden Valley, MN 55422
(612) 520-0533

T. Jeff Bangsberg
Becklund Home Health Care, Inc.
8421 Wayzata Boulevard, Ste. 100
Golden Valley, MN 55426
(612) 544-0315

Attachments

Courage Center is a nonprofit organization that provides rehabilitation, enrichment, independent living, vocational and educational services to empower people with physical disabilities and sensory impairments to achieve their full potential.

Equal Opportunity Provider
A United Way Agency

Attachment 1

RECOMMENDATIONS FROM MINNESOTA DISABILITY ADVOCATES

ANALYSIS OF H.R. 4230

Emphasis on consumer choice diverts attention from more significant barriers

- We strongly support a broad choice of vocational services providers to meet unique needs of individuals with different disabilities, but lack of choice has not been a major obstacle in Minnesota.
- Experiences with individual vocational rehabilitation (VR) counselors vary, but, on the whole, they have been willing to refer to private providers of the consumer's choosing. Such referrals have been limited more by lack of funding for VR than by territorialism of VR counselors.
- The lack of long term care supports (i.e., access to Medicaid) is a much more significant barrier to employment than lack of choice.
- In pursuing a bill that significantly reduces the role of VR, we risk losing a major group of supporters for work incentive legislation--i.e., the VR counselors themselves. We do not want work incentive legislation to be bogged down by controversial, unrelated issues.
- **Reforms to promote greater efficiency and consumer focus in the VR system can and are being addressed in the Reauthorization of the Rehabilitation Act already passed by the House and currently being considered by the Senate.**

Incentives for consumers are weak:

- While H.R. 4230 provides strong incentives for private rehabilitation providers and for employers, it does little to provide consumers incentives to go to work.

Access to Medi*caid* is needed, in addition to Medi*care* access

Medicare is primarily an acute care insurance benefit. If disabled individuals have employer-based coverage, they would not necessarily need Medicare. However, if individuals are self-employed or their employers do not offer health insurance, Medicare would be beneficial.

Many employed persons with disabilities must still rely on Medi*caid* because the ongoing services they need are not covered by employer health insurance plans or even by Medicare. Such benefits include, but are not limited to: personal care assistance; specialized equipment and supplies; and comprehensive prescription drug coverage. The cost to purchase such services privately is beyond the reach of most people -- even those who are employed full-time. Thus, many people with disabilities must rely on Medicaid because it is the only way to have their long term health care needs met.

CONCLUSION:

While H.R. 4230 has value, it could be counter-productive if Congress people believe that, by passing H.R. 4230, they need not do anything further to overcome work disincentives. The real issues for persons with disabilities are health care coverage for long term care needs and a gradual phase-out of cash benefits as earnings increase.

Attachment 2

Adopted 6/9/97

MINNESOTA CONSORTIUM FOR CITIZENS WITH DISABILITIES
c/o Arc Minnesota, Attn: Bob Brick, 3225 Lyndale Ave., South, Minneapolis, MN 55408, (612) 827-5641

MEANINGFUL WORK INCENTIVES FOR PERSONS WITH DISABILITIES

THE PROBLEM:
Most people with disabilities are extremely capable and highly motivated to work. Advances in assistive technology and the civil rights protections of the ADA have opened up many new opportunities for employment. Nevertheless, many people with disabilities still cannot work because doing so causes them to lose coverage for ongoing health care and other disability-related needs. To qualify for needed benefits, people with disabilities have had to forego work and impoverish themselves. While several work incentive mechanisms do exist, different provisions apply to persons in different programs, giving some opportunities that others do not have. Specifically, the primary barriers to work are:

1. **LACK OF HEALTH COVERAGE TO ADDRESS LONG TERM NEEDS:**
Most work incentive proposals overlook the real issue for people with disabilities: health care coverage for long term needs. Typical health plans (including employer coverage and the federal Medicare program) cover only acute and primary health care services. They fail to address ongoing needs for services, such as: personal care assistance, specialized equipment and supplies, comprehensive prescription drug coverage, and other long term supports. The cost to purchase such services privately is beyond the reach of most people -- even those who are employed full-time. Thus, many people with disabilities need continued Medi*caid* coverage because it is the only way to have their long term health care needs met. While persons who previously received SSI can continue their Medicaid coverage under the 1619B program, no similar provision exists for persons receiving on SS*DI* or other publicly-funded benefits (such as veterans pensions). **People with disabilities should be allowed to contribute toward continued Medicaid coverage, based on ability to pay, instead of facing a "Sophie's Choice" between appropriate health care and employment.**

2. **ABRUPT LOSS OF CASH ASSISTANCE:**
When working, the cost of living for people with disabilities increases as they face new expenses for transportation, clothing and assistive devices. Some people with severe disabilities are unable to work full time and/or have little work experience. As a result, their starting salaries may not be high enough to support them without the cash supplement provided by programs such as SSDI and SSI. Instead of losing these benefits abruptly, **they need a gradual phase-out of their SSDI or SSI, commensurate with the gradual increase in their salary.**

MEANINGFUL WORK INCENTIVES BENEFIT EVERYONE:
Although expanding work incentives would allow some people to continue receiving limited assistance through public programs, taxpayers will ultimately benefit as many of these individuals' acute and primary health expenses are picked up by employer health insurance and they become taxpayers themselves. Working will allow individuals with disabilities to reduce or eliminate their dependence on other public programs such as Food Stamps and subsidized housing. Expanded work incentives are both ethically and fiscally prudent.

MN CCD is a broad-based coalition of organizations of persons with disabilities, providers, and advocates, dedicated to improving the lives of persons with disabilities. We address public policy issues that affect people with disabilities by collaborating with others, advocating, educating, influencing change, and creating awareness for understanding.

Attachment 3

A BILL

Proposal developed by Scott Lay, a disability advocate from Oregon

To amend title XVI of the Social Security Act to give persons with disabilities who lose disability insurance benefits due to employment the opportunity to receive benefits under section 1619.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled.

SECTION 1. ADDING ADDITIONAL POPULATION WHO MAY BECOME ELIGIBLE FOR BENEFITS FOR INDIVIDUALS WHO PERFORM SUBSTANTIAL GAINFUL ACTIVITY DESPITE SEVERE MEDICAL IMPAIRMENT.

(a) IN GENERAL. - Section 1619 of the Social Security Act is amended -

(1) by inserting:

"(c)(1) Any individual who loses Title II section 223 benefits due solely to SGA performance shall be eligible for benefits under (a) or (b) of this Section providing that the Secretary determines under regulations that such individual meets all other requirements of (a) or (b) except for prior 1611 or 1619 eligibility.

(2) (A) Determinations made under paragraph (1)(D) shall be based on information and data updated no less frequently than annually.

(B) In determining an individual's earnings for purposes of this subsection, there shall be excluded from such earnings an amount equal to the sum of any amounts which are or would be excluded under clauses (ii) and (iv) of section 1612(b)(4)(B) (or under clauses (ii) and (iii) of section 1612(b)(4)(A)) in determining his or her income.

(C) Determinations of eligibility for benefits under this title may be made prior to the termination of Title II benefits if such termination is expected (as with a successful TWP) in order to provide immediate transition."

(2) by redesignating subparagraph (c) as subparagraph (d).

(3) by redesignating subparagraph (d) as subparagraph (e).

(b) CONFORMING AMENDMENTS. -

CENTER FOR CAREER EVALUATIONS, INC.

WRITTEN TESTIMONY SUBMITTED REGARDING THE USE OF FUNCTIONAL CAPACITY EVALUATIONS IN THE RETURN TO WORK PROCESS
Submitted by Thomas P. Yankowski, M.S., C.V.E.

The Center for Career Evaluations (CCE) is a comprehensive vocational rehabilitation agency that assists people to return to work following an assessment of their functional abilities. CCE serves a wide range of clients, including industrially injured workers, disabled veterans, chronically unemployed individuals, and severely disabled individuals. As a private, employee-owned rehabilitation agency, CCE has provided evaluation services to more than 4,000 individuals in the past 12 years.

Regarding my own experience, I am Past President of the California Association of Rehabilitation Professionals and Western Regional Representative of the National Vocational Evaluation and Work Adjustment Association. I am also currently Chairperson of a Task Force that developed standards of practice for the use of Functional Capacity Evaluations to assist doctors in the determination of permanent disability ratings for industrially injured workers in California. The Task Force was comprised of representatives from the California Chapter of the American Physical Therapy Association, the Occupational Therapy Association of California, and the California Vocational Evaluation and Work Adjustment Association.

The cornerstone of CCE's Early Intervention Program is the Functional Capacity Evaluation. A Functional Capacity Evaluation is a systematic, objective assessment of an individual's current functional physical capacities on work-related tasks. It provides a baseline of physical functioning in critical work performance areas as defined by the Department of Labor, such as lifting, carrying, pushing, pulling, kneeling, stooping, bending, gripping, climbing and dexterity. At CCE, a Functional Capacity Evaluation consists of short-term, structured activities that measure critical work demands in a controlled setting over a 4-hour time period. It is conducted under the direct supervision of a qualified Work Capacity Specialist with a background in neuromuscular, cardiovascular, and bio-mechanical functioning, as well as vocational evaluation (VEWAA Standards, 1993).

In the past, CCE has provided Functional Capacity Evaluations to severely disabled individuals for the purposes of eligibility determination, disability ratings, treatment planning, job matching, and work restriction identification. In addition, CCE recently participated in a pilot project with the Social Security Administration to field test applicants to determine benefit eligibility. It should also be noted that the Social Security Administration recommended the use of Functional Capacity Evaluations for disability decision-making in its Re-Engineering Proposal (Plan for a New Disability Claim Process, 1994).

Five key issues emerge when determining an individual's work capacities in a Functional Capacity Evaluation. First, there is an important distinction to be established between the terms "medical impairment" and "vocational disability." The diagnosis of a medical impairment by a physician does not define the impact of the injury upon the individual's vocational alternatives. For example, a forklift driver with limited transferable skills who sustains a foot injury would have a more severe vocational disability than an accounts clerk with the same medical impairment. A Functional Capacity Evaluation is able to define the impact of the injury upon vocational options because the assessment is work-related. Even if physicians outline medical restrictions, they (1) rarely functionally define these limitations in terms of work and (2) rarely identify activities that the individual can perform in terms of work. A Functional Capacity Evaluation can do both.

Second, the general work restrictions outlined by a doctor and used for a disability rating procedure can often be misleading or incomplete. The classic example is the person who is restricted to sedentary work by the doctor due to the walking or standing required on a light level job. However, the person's lifting capacity might be in the light or medium categories of physical demands as defined by the Department of Labor, which would

1330 BROADWAY, SUITE 936, OAKLAND, CA 94612 Phone 510-465-4111 Fax 510-465-9163

greatly expand the number of vocational alternatives available. A Functional Capacity Evaluation would specifically provide information about a person's lifting capacity under a variety of conditions. A person with a shoulder injury may not be able to lift overhead, but is able to lift 50 pounds to table height. Another person with a knee injury may not be able to lift from the floor level, but is able to lift 20 pounds overhead from the table height.

Even if medical doctors have completed a Physical Capacity Evaluation form, their opinions are not based upon actual performance testing unless a Functional Capacity Evaluation was completed. A recent referral involved a roofer who had sustained severe burns to over 40 percent of his body when he fell down a flight of stairs onto a floor covered with hot tar. The treating physicians, who were burn specialists, listed his restrictions as "avoid exposure to chemical solvents and extremes in temperature." However, the doctors did not address his functional losses, particularly those related to his hands which had undergone multiple skin graft operations. The Functional Capacity Evaluation revealed the individual was more severely restricted. Additional functional limitations were identified in the critical job demands of heavy lifting, fine manipulation, ladder climbing, and forceful or repetitive gripping activities.

Third, a Functional Capacity Evaluation might be very helpful when the injured party expresses subjective complaints not substantiated by objective findings. The person's perception of the disability frequently differs from actual performance exhibited during the Functional Capacity Evaluation. It is critical for the Work Capacity Specialist to report only the physical signs and symptoms revealed in the Functional Capacity Evaluation, as "there is no truly reliable test for motivation" (Isernhagen, 1988). However, a Work Capacity Specialist is able to identify consistency of effort through the variety and reproduction of tests administered. The standardized testing procedures may also result in "performance-based" substantiation of the injured party's perception of their level of impairment. The purpose of the assessment, therefore, is to accurately document the individual's physical abilities as well as limitations.

Fourth, a Functional Capacity Evaluation provides an assessment of job modifications which can be critical to the development of viable vocational alternatives. On one case, a construction worker had a severe crush injury to his dominant right hand. He had limited transferable skills, a minimal educational background, and low vocational interests except construction work. During the Functional Capacity Evaluation, the injured party demonstrated an ability to write legibly for an hour using a writing aid and an ability to input data on a computer using a modified keyboard. As a result, the Work Capacity Specialist recommended a vocational training program for him to become a construction estimator with wages starting at $15 per hour. Using simple ergonomic aids and functional work simulations, the future earning capacity of the injured worker was significantly increased. With the advent of the Americans with Disabilities Act (ADA), it is imperative that functional testing procedures address the issue of reasonable accommodations. For severely disabled individuals in the Social Security program, the use of state-of-the-art technology will be critical in order to provide the necessary job modifications equipment.

Finally, a Functional Capacity Evaluation can be used as a source of documentation to refer an individual to Work Hardening or Work Conditioning programs. These programs are often recommended by professionals in the rehabilitation field for persons with chronic pain or emotional barriers to returning to work. They are highly structured, goal-oriented, individualized treatment programs designed to maximize a person's ability to return to work. Work simulation and conditioning activities are increased on a graduated basis to improve overall physical tolerances, stamina, productivity, and work behaviors (VEWAA Standards, 1993).

The Functional Capacity Evaluation provides a baseline of physical functioning which documents the rationale and recommended treatment plan for a Work Hardening/ Conditioning program. These programs may be particularly useful to recommend when the injured party claims to be totally disabled, has been unemployed for an extended period of time, or demonstrates an ability to improve work tolerances. On a recent case,

the treating doctor set a 10 pound lifting restriction for the injured party. However, it was the opinion of the Work Capacity Specialist that the individual could increase his lifting tolerances to 20 pounds in the light category of work following a four-week Work Hardening Program. Studies have shown a high return to work success rate following completion of a Work Hardening Program, particularly if the subject was referred early in the rehabilitation process (Beissner and Saunders, 1996).

In conclusion, the Functional Capacity Evaluation provides an accurate, functional assessment from which to make a decision regarding the feasibility of the individual's ability to perform the various levels of physical demands as defined by the Department of Labor. The Functional Capacity Evaluations performed at CCE have assisted many people to return to work, particularly if accompanied by a comprehensive Return to Work Strategy and Early Intervention Referral Program.

Even though three out of every ten Social Security Disability beneficiaries are estimated to be candidates for vocational rehabilitation, less than a half of one percent ever return to work (General Accounting Office Report). These rates are unacceptable. The lack of effort in the provision of rehabilitation services is a waste of human and monetary resources that will eventually result in the bankruptcy of the Trust Fund. People with disabilities deserve the opportunity to become fully independent members of society. Vocational rehabilitation can be the stepping stone for these individuals, but only if the door can first be opened. Functional Capacity Evaluations can provide such as a "gatekeeping role" for disability determinations in Return to Work programs within the Social Security Disability evaluation process. Standardized Functional Capacity Evaluations will ensure consistent and equitable decisions, resulting in an increased number of people who will be determined feasible for vocational rehabilitation, and ultimately be able to return to substantial gainful employment. Rather than being an obstacle for returning to work, Social Security Disability programs will act as a catalyst for people with disabilities to enter the workforce. The benefits of such a "gatekeeping" function far outweigh the costs.

Any anticipated legislation by Congress should, therefore, include the provision of Functional Capacity Evaluations in order to ensure the most cost-effective delivery of Return to Work services.

I thank you for the opportunity to present this testimony. If you have any questions or need clarification, I would be willing to provide oral testimony or respond to any correspondence.

Sincerely,

Thomas P. Yankowski, M.S., A.B.V.E.
President, Certified Vocational Evaluator

TY/jr

Bibliography

Beissner, K.L., Saunders, R.L., et al. (1996). "Factors Related to Successful Work Hardening Outcomes." Physical Therapy, Vol. 76, No. 11 (pp. 1188-1201).

California Vocational Education and Work Adjustment Association (1993). Standards for Provisions of Vocational Evaluation, Assessment and Work Adjustment Services and Types and Time Frames: Work Evaluation Services and Modules. California VEWAA Standards Committee.

Deutsch, Paul M. & Sawyer, Horace W. (1989). A Guide to Rehabilitation, New York, N.Y.: Matthew Bender & Co.

Isernhagen, Susan J. (1988). Work Injury/Management and Prevention. Gaithersburg, Maryland: Aspen Publishers.

May, Virgil R., III (1988). "Work Hardening and Work Capacity Evaluation: Definition and Process; Vocational Evaluation and Work Adjustment Bulletin, Vol. 21, No. 2 (pp. 61-64).

Scheer, Steven J. (Ed.) (1991). Medical Perspectives in Vocational Assessment of Impaired Workers. Gaithersburg, Maryland: Aspen Publications.

House Committee on Ways and Means
Subcommittee on Social Security
"Hearing on Barriers Preventing Social Security Disability Recipients from Returning to Work"
July 23-24, 1997

Statement for the Record
by
Dr. Robert Rudney
Chairman, EXCEL! Networking Group, Inc.

Mr. Chairman and Members of the Subcommittee,

As Chairman of the EXCEL! Networking Group, an all-volunteer self-help group of people with disabilities focusing in the employment area, I commend the Subcommittee for sponsoring hearings July 23rd and 24th on barriers preventing Social Security disability recipients from returning to work.

Operating in the Washington, D.C. area since May 1993, EXCEL! seeks to enhance the self-determination and advancement of people with disabilities through its Career Mobilization Project of educational, training, mentoring, and outreach programs. EXCEL! members work together to form an active volunteer network with the goals of developing competitive employment and professional opportunities, promoting education about disability, reinforcing positive public attitudes about people with disabilities, and contributing economically and socially to the community.

EXCEL!'s Career Mobilization Project is unique in that it empowers people with disabilities by making them responsible for project design and implementation. Through these empowerment programs, EXCEL! seeks to overcome dependency and passivity traits that are all too evident among people with disabilities operating within the vocational rehabilitation system.

I strongly endorse the Subcommittee's commitment to helping Social Security and Supplemental Security Income disability recipients to achieve gainful employment and increased independence. A number of EXCEL! members are SSDI or SSI recipients, and I know firsthand about the quandaries they face in seeking employment. While efforts to increase the level of SSDI/SSI client participation and choice are laudable, no real transformation of the system can take place without addressing the issue of sufficient medical coverage for those who leave the system.

I also share the Subcommittee's concerns regarding the effectiveness of the vocational rehabilitation system. EXCEL! members have grown frustrated and disillusioned in dealing with both public and private rehabilitation agencies. The incentives simply are not there to help clients find competitive employment. People with disabilities themselves have to make public and private agencies working in this field more responsive to their employment needs. One way is to provide these agencies with a little healthy competition. EXCEL! explicitly seeks to build bridges to employers and counseling organizations existing outside the insular disability/rehabilitation community -- out where 99 percent of the jobs are located. As a self-help organization, EXCEL! encourages the qualities of initiative, responsibility, enterprise, self-improvement, and teamwork -- precisely those qualities that employers are seeing among competitive job candidates.

As part of its Career Mobilization Project, EXCEL! holds monthly membership meetings featuring discussions by leading authorities on employment and career development issues, as well as interactive exercises to improve

members' work search skills and preparation. Over the past year, EXCEL! has sponsored presentations by human resources professionals from Electronic Data Systems, BDM International, the American Council on Education, and the Association of American Medical Colleges (among others).

In terms of training, EXCEL! recently received a grant from the Virginia Department of Rehabilitative Services to develop a pilot Design-Build program integrating career counseling and computer training for unemployed persons with disabilities. For each participant, this project seeks to create a blueprint for success in the job search (the "Design" component), bolstered by marketable and realistic computer skills acquired through the training process (the "Build" component). EXCEL! is working with Morris Associates (a leading Washington career counseling firm) and Patriot Computer Group to implement the program this fall.

EXCEL!'s unique mentoring program in partnership with the Washington Metro Chapter of the International Association of Career Management Professionals (IACMP) is entering its second year. The program provides one-on-one working relationships between volunteer IACMP mentors and EXCEL! mentees who are undertaking a job search. IACMP volunteers have also made EXCEL! workshop presentations on job search resources and career skill assessments. At the April 1997 IACMP Annual Conference in Washington, EXCEL! sponsored an expert panel session on "Innovative Approaches to Counseling of People with Disabilities."

EXCEL! also cooperates closely with Potomac KnowledgeWay, an alliance of business and non-profit organizations seeking to increase access and entrepreneurial opportunities on the Internet. An EXCEL! member is presently developing an Internet inventory of local disability services with "hot links" to relevant web sites. This fall, EXCEL! plans to work with members on tapping into the growing employment resources on the Internet.

I recognize that many of the employment problems faced by people with disabilities are motivational. To address these problems, EXCEL! and DateAble, a disability social group, are co-sponsoring an "Investment in Independence" workshop this September. This workshop, led by Lee Bussard of the Pacific Institute in Seattle, is designed to help people with disabilities maximize their potential in how they live, how they work, and how they play. Since 1985, Mr. Bussard (who was born with cerebral palsy) has been teaching people with disabilities how to craft a life vision and how to succeed in achieving that vision.

In sum, EXCEL! offers an operative model of a locally-based self-help group run by and for people with disabilities that focuses on employment and career development. EXCEL! seeks to provide its members with the practical tools and strategies to find competitive employment, but with the realization that they have to make the ultimate effort themselves. I urge the Subcommittee to consider self-help strategies exemplified by EXCEL!'s experience when it drafts legislation to encourage return to work by SSDI/SSI recipients.

BARRIERS PREVENTING SOCIAL SECURITY DISABILITY RECIPIENTS FROM RETURNING TO WORK

Statement from Susan J. Isernhagen, PT, President
Isernhagen and Associates
1015 E. Superior Street
Duluth MN 55802
(218) 728-6455
FAX: (218) 728-6454

Regarding hearing of July 23, 1997

Statement: On behalf of providers in the United States, Canada, Switzerland, Australia, Austria and The Netherlands.

I. **Introduction of Responder:**

I, Susan Isernhagen, have been a physical therapist providing return to work services for injured people for the last 15 years. In providing the services I have developed an objective functional capacity evaluation. This evaluation was researched, standardized and evaluated for positive outcome of returning chronically injured people to the workplace. It has been put in the form of a manual, wotj a training session and ongoing quality assistance. This functional evaluation is being used throughout the United States and in several other countries primarily for the purpose of reducing disability.

A frequently evaluated type of client is the person on Social Security Disability. Observations have been derived from years of personal experience with those that are considered disabled and are being evaluated regarding their ability to return to work. These observations also take into consideration 500 other providers' experience in dealing with disabled as well.

These comments should provide information regarding the barriers that prevent current Social Security Disability recipients from returning to work. There is no one person, method or concept that will break the barrier. Rather, the barriers must be broken using:

- Objective, comprehensive information on the client's ability to perform work functions.
- Constructive writing of reports that clearly indicate those abilities to the worker, employer, physician, SSDI and others.
- Linking of the functional limitations to physical impairments so that there is a demonstrated link between diagnosis and functional limitation.
- Comparison of functional abilities to specific work demands of a job or of a classification of jobs.

II. **The current SSDI system observed from a return to work specialist.**

First, those persons on Social Security Disability must be addressed as clearly having a disability. It is important for the practitioners and for all involved in the return to work process to acknowledge that there are physical dysfunctions present. This is the opposite point of view from practitioners who, consciously or unconsciously, identify those on disability as malingerers, fakers, symptom magnifiers, etc.

The objective of good functional testing and matching a disability recipient to work must begin with a bond of trust and respect between evaluator and the client. Therefore, in the evaluation process of identifying whether a person on Social

Security Disability can return to work, a clear review of the medical records along with respect for the injured worker is important.

Secondly, the Social Security Disability System is seen by recipients and medical providers as a system to provide temporary or permanent financial relief to the person who is unable to work. For professionals who wish to reduce work disability for the benefit of the client and society, this disability system should be viewed as temporary. This will allow the recipient and the system to find ways to continually identify when and if the person is ready to return to safe, productive work.

It can be observed in many recipients that they are fearful of losing "benefits" as they do not perceive how they will function in the world without these disability benefits. This is intertwined with their own doubt about their capability of working either productively, safely or without pain. Therefore, there may be resistance on the part of Social Security Disability recipients to lose their "income". One of the main methods for allowing SSDI recipients to return to work will be the assurance that income will continue and that their return to productive work will not lead to further financial problems down the road.

One additional barrier appears to be the perception that if they are removed from SSDI benefits, return to work and then again fail, that it will be much harder to receive benefits again. Therefore, the system can improve return to work professionals' success rate by removing the fear of loss of income and promoting that return to work is a positive step that can provide even greater financial benefits in the long run to the client.

III. **Problems with methods utilized in identifying work disability.**

a. The problem has been seen as medical, not functional.

Science continues to indicate that the measurement of impairment or the placement of a diagnosis cannot predict whether a person can function. If someone has limitation of motion in their shoulder, this does not mean that the person cannot use their arm. If a person has loss of strength in the leg, this does not mean that the person cannot walk. Rather, there is an interaction between a physical impairment, the motivation of the person, the technique used, and the requirements of the functional activity that in fact will determine whether the person will use their arm, walk, etc.

b. The correct method of evaluating function must be chosen.

Physicians are limited in their ability to produce functional information. While they are experts at diagnosis, and sometimes prognosis, physicians do not have the education or generally time and commitment to do functional testing.

The professional best able to do functional testing is skilled in kinesiology, pathology, anatomy and physiology. This is the physical therapist or the occupational therapist. This professional can work in conjunction with the physician (who provides diagnosis and contraindications to functional activity) in order to objectively evaluate the client's function.

c. Pain is often used as an indication of impairment or functional disability. In fact, people go to work everyday and are completely functional despite the fact they have pain. People work with headaches, backaches, chronic pain syndromes, rheumatoid arthritis, cancer, and many other types of physical problems that create discomfort. It is not the discomfort, per se, that produces the problem; it is rather the person's reaction to it. Therefore, skilled functional evaluators are

more likely to promote the ability level of a person. The reinforcement of ability and function to a client is extremely important for their own self-image and motivation.

Practitioners fail when they ask clients to "stop if it hurts". This gives the message that the person will somehow be injured or that the function that creates pain is going to create a future problem in the client. This could not be further from the truth. Many forms of pain are the results of arthritic changes, past injuries, scar tissue, inflammatory processes of a non-injurious nature, medications, etc. The ability to function safely through discomfort is important in society and especially important in those clients who have previously been determined as disabled. Professionals cannot infer that if a person has discomfort this means they are functionally impaired.

The true issue of pain is determining whether pain indicates pathology that, if stressed, would further injure the person. Therefore, the use of symptom reporting should not stop an activity, but rather alert the practitioner to identify whether the discomfort indicates pathology. An example would be if a person with a diagnosis of L4-5 disc herniation (non-surgical) were to state that an activity created further leg pain down their leg and tingling in their lower foot and toes, there would be then the need for the practitioner to identify whether these were symptoms that were coming from pressure on nerves. This, in fact, would be a reason to stop testing and to create a limitation to the activity that caused this nerve pressure. This does not mean the person cannot work, but rather that certain activities may be restricted as they create physical pathological pressures.

Conversely, the person with low back pain of a chronic nature may complain that their "whole back burns" or that the aching is deep and gets worse with every level of effort. If the content of the pain reports are primarily behavioral and do not conform to either pathological symptomatology or neuromusculoskeletal pathology, then these behavioral issues must be seen as the barrier. Behavioral issues with a practitioner that is skilled in objective functional evaluation is often dealt with by positive confrontation. The person should be assured that the discomfort they feel is real to them but not a discomfort that indicates "harm" will occur or that further functional activity will create an injury in the client.

One outcome study (part of this report) of chronically injured workers reinforces that chronically injured must understand when discomfort must be "worked through" and also when the worker must stop an activity. In this clinician's work with chronically disabled clients, it has been noted that when a person has their pain acknowledged, but also has their functional capacities emphasized, there is relief. Many people's pain complaints have been the result of the adversarial system where they have not been believed. When the practitioner doing functional testing is able to identify physical problems and how they relate to safe functional activity, the disabled client is relieved to know that function will not be harmful. They are given the power to know what positions, activities, etc. may allow them to be more functional and also understand which activities, positions, etc. they must avoid. This is a balance that all working human beings find in the workplace. It is merely that with chronically hurt persons this ability to balance activities has been removed. The power of a good functional capacity evaluation is that this balance and information to the client is restored.

d. A fourth problem is the subjective nature of many functional evaluations and physician reports. When a person's disability or ability is determined by asking the client what they can and can't do this makes the information subjective. The

medical professional or therapist is not using their skills in order to fully evaluate the client.

Many functional tests of chronically injured workers utilize approaches that are psychological and subjective. Perhaps this is due to the feeling that many of those on disability are "faking". This adds two barriers to return to work: lack of clarity in matching a person with their job and continued emphasis on pain which emphasizes disability rather than ability.

IV. **Functional testing matched with accurate job demands.**

The last barrier to be discussed in this paper regards the poor correlations that are often utilized in matching a person to their work. Vocational counselors who often play a part in this process are limited if the medical or functional information is unclear. Therefore, the medical and functional evaluators must clearly identify two components.

- The ability of the person to safely function identified in work activity terms and in length of the day the activity can be done.
- The physical requirements of a job or a job classification utilizing requirements for the person to perform maximally and throughout the workday.

Traditionally, the Dictionary of Occupational Titles has been utilized which is quite erroneous for specific jobs. It looks at "job classifications" but does not specifically address each individual injured worker's ability to do any individual job. It is too general.

For any one worker to obtain one particular job, there must be a specific match made of abilities and the job requirements. This is true in the competitive marketplace today, as it has always been. In the chronically injured worker, however, who is even more difficult to place, the general Dictionary of Occupational Titles has continued to be promoted. This is part of the failure. Many clients will state "Well it might say that on the job description but I can't do it because...". This is often true. The practitioner who does functional capacity evaluation must be much more able to make clear statements about specific work capabilities and how this correlates to specific jobs.

The lack of specificity in the DOT is analogous to choosing apparel. If the doctor identifies that the person has blisters on the sole of their foot and the therapist functionally identifies that walking on hot sand creates problems, both the doctor and therapist may indicate that a shoe is required. This is a general statement. If the injured party receives a shoe that does not fit, this will not improve the ability to walk. Rather, it will just create another barrier to the walking. The DOT is much like the shoe. It is a general answer but does not give specific information regarding a person's ability to do a specific job.

Vocational counselors continue to evaluate a person's doctor's report or therapist's functional capacity evaluation and then try and find job classifications. This is met with disbelief by the applicant and often job failure. This is not the fault of the vocational evaluator, this is the fault of the physician and therapist who have not taken physical safe job matching to the highest degree. Once the job matching is done, the vocational counselor can then work with better information.

Example of a job match grid.

Job Descriptions Explored: The job description for maintenance person in school district #202 is attached.

CRITICAL JOB DEMANDS	PHYSICAL WORK STRENGTHS	JOB MATCH
1. Use of long handled tools: occasionally	R hand grip: 40# occasionally L hand grip: 90# occasionally	Yes
2. Painting and cleaning surfaces with whole body reach: occasionally	Forward bend standing: continuously	Yes
3. General inspection of school areas	Walking: continuously	Yes
4. Floor to waist lift of boxes and pails: 1# 35# occasionally	Floor to waist lift: 40# occasionally	Yes
5. Front carry of boxes, tools, etc.: 1-40# occasionally	Front carry: 60# occasionally	Yes
6. One handed carry of pails (R or L): 1-40# rarely	R: 20# L: 55#	Yes
7. Stand: frequently	Standing tolerance: continuously	Yes
8. Walk: frequently	Walking tolerance: continuously	Yes
9. Squat: occasionally	Repetitive squat: continuously	Yes
10. Forward bend: occasionally standing	Forward bend in standing: continuously	Yes
11. Waist to over shoulder lift: 1-40# occasionally	Waist to overhead lift: 5# occasionally with modification	No Yes
12. Overhead painting and cleaning: occasionally	Elevated work: occasionally	Yes
13. Use of hand tools: frequently	R & L upper extremity coordination: frequently	Yes

V. **Conclusion:** The barriers here can be reduced if objective evaluation of the job has been done, objective evaluation of the worker has been done, and the critical elements of the worker are then compared with the ability to do work. In order to be the clearest, the therapist/physician combination should then indicate each job activity as a match or not match.

After the comprehensive functional evaluation and the care taken with the job match, it will be clear to the client that they do match the job. This helps remove their own fear that they may not be able to do work.

In the above example you can notice that there is one aspect of the job in which there is a "no" indicating this task does not have a job match. This can easily be turned to a "yes" by modifying that particular activity.

VI. **Outcomes:**

The clearest information on whether chronically injured workers such as those on Social Security Disability can return to work can be demonstrated in the outcome study performed by providers of objective functional testing who do job matching as well.

RETURN TO WORK OUTCOMES: IWS FCE
GOAL OF RETURN TO WORK

FCE CLIENTS WHO RECEIVED
NO OTHER SUBSEQUENT INTERVENTION

Methods: Retrospective audits of consecutive FCE clients were reviewed for outcome. Six months post FCE the clients were called to assess their return to work status.

- 416 clients were reviewed in this study.
- 317 clients were identified as having received no other form of treatment following the FCE, i.e. PT, Work Hardening or Work Conditioning.
- Of those, 280 clients were in the return to work process.
- Time off work from date of injury to FCE was calculated to be an average of 8.8 months, thus classifying these clients as "chronic cases".

The Isernhagen FCE utilizes a positive, objective method that facilitates return to work through objective testing, professional recommendation, and dialogue with the worker. The following study relays information about these 280 clients, and demonstrates the power of the FCE as a tool in the return to work process. Editorial comments are in italics following each group of statistics.

61% (170 of 280) of these chronic clients returned to work based on the results and recommendations of the FCE, with no other intervention:

Once a client has been off work beyond six months and is considered "chronic", statistics indicate very low return to work rates, and then only with extensive and expensive rehabilitation. However, these "chronic" patients returned to work based primarily on the functional capacity evaluation. Why?...This 5 hour, 2 part test is comprehensive and clearly describes functional abilities related to work. All parties can easily understand the specific findings. For return to work to be accomplished there must be agreement by at least 3 parties:

The doctor.....who must sign the release and is reluctant without objective information
The employer..... who may not accept the employee back at work
But most importantly the worker...who must make the decision that they feel capable of returning to work and believe the FCE information is correct

In view of such a strong work return based on a functional test only, one must first recognize the power of an effective test. Perhaps the skill of the therapist - to match functional capability with functional demands - actually has been overlooked.

SECTION I: CLIENTS WHO RETURNED TO WORK

The work level was indicated to be:

1. 36% Same Company, Previous job - same
2. 34% Same Company, Previous job - modified
3. 12% Same Company, New job
4. 18% New Company, New Job

70% returned to their previous jobs-same employer, (either at the same or a modified format) which is considered the best result by insurance companies. In total, 82% returned to work at the same place of employment. The combination of the FCE's clarity in defining modifications and the employer's willingness to modify the job based on objective information creates a positive outcome.

Of those clients who returned to work, work load was indicated to be:

1. 69% Full time
2. 26% Part time (4-8 hours/day)
3. 5% Part time (1-3½ hours/day)

More than two thirds of clients who returned to work were full time status. This is an excellent placement result, considering duration of time off work.

Of those clients who returned to work, the job satisfaction level was indicated to be:

1. 66% Satisfied with work level
2. 16% Wish to work harder
3. 18% Wish to not work as hard

Two thirds of these clients were satisfied with their work level at six months post FCE, and several wished to work at a higher level. When returned to work at appropriate functional levels,

clients can satisfactorily perform their tasks, which contributes to employee morale and work performance.

Client perceptions of attitudes at work were:
1. 53% People at work welcomed the client back
2. 19% People were neutral to the client
3. 17% People made it difficult for the client
4. 11% Self-employed, Not Applicable

Industry has made strides in overall attitudes regarding the return to work process. However, employers and peers at the job site can create an adversarial relationship. This is one aspect of work injury management that may need to be addressed.

Clients indicated discomfort level to be:
1. 15% Had no limiting discomfort
2. 58% Clients indicating "having pain but worked through it"
3. 27% Pain stopped the clients from working hard

Pain and function are not the same. A functional capacity approach, which focuses on pain rather than function, can limit return to work perception. IWS FCE, which focuses on safe function, however, allows for differentiation between pain and function, and focuses on the safe ***ability*** *of the person to functionally perform the job tasks required. These workers indicated they would continue to work as they could manage their discomfort level adequately.*

Clients indicated use of the FCE by others to be:
1. 75% Used by others to understand how the client could best work
2. 25% Was not aware that it was used by others

A high percentage of clients who returned to work knew the FCE helped place them back to work. This continues the interactive process started with the FCE, which encourage workers to take part in and understand their case management.

From the client's perspective, the Functional Capacity Evaluation
1. 21 % Verified the client was more capable than the client thought
2. 14 % Showed the client was less capable than the client thought
3. 65 % Showed what the client already knew

This indicates that when professionally evaluated, the worker's true perception and the evaluator's match most of the time. However, it is the objective results of the FCE, not the worker's perceptions, that allow release to work. Those who had a change in perception of their abilities appreciated the new information the FCE revealed.

Client understanding of the test and test results was indicated to be:
1. 93% Helped the client understand physical function
2. 7% Confused the client

Almost all clients became educated about their specific work abilities. Therefore, even though they "generally" understood their function, it was the FCE which allowed a more accurate work ability picture. This may have lead to their own decision to return to work.

The clients had this opinion about future exercise after taking the FCE:
1. 81% wanted to get stronger
2. 3% were discouraged about exercise
3. 13% Didn't matter
4. 3% No opinion

At the end of the FCE, clients know and understand their physical limitations, and this encourages them to find ways to improve their current level.

NORTH AMERICAN PARTICIPATION

Data collected from the following locations (16 clinics):

U.S.	AZ	Fearon Physical Therapy, Phoenix

	CO	Brookside Physical Therapy, Denver
	GA	PT Associates of Tifton, Tifton
	IL	St. Anthony Medical Center, Rockford
	IA	Duffy & Associates, Ankeny
	KY	Ortho Rehab, Louisville
	LA	Center for Functional Performance, Hammond
		PT Clinic of Lafayette, Lafayette
	MN	Douglas County Hospital, Alexandria
		HealthEast OPTimum Rehab Ctr., West St. Paul
		Isernhagen Clinic, Inc., Duluth
	NY	Columbia PT, Shodack
	ND	The PT Center, Bismarck
	OH	Blanchard Valley, Findlay
	WI	Wausau Medical Center, Wausau
Canada:	Nova Scotia	Cabot Physio, Sydney

OUTCOMES:
61% RETURN TO WORK
24% CASE CLOSURE
9% JOB NOT AVAILABLE
6% OTHER

VII. **Conclusion.**

Facilitating Social Security Disability recipients in returning to work.

1. It is extremely important to respect that they have a physical problem. They must not be considered malingerers or fakers at the outset.

2. It is extremely important to have a physician provide the diagnosis and objective contraindications to function. This would proceed objective functional testing.

3. Objective functional testing should be done by a therapist skilled in kinesiology, pathology, anatomy and physiology. The objective testing of actual work activities will take into consideration the safety of the client in performing the tests, the ability of the person to do both strength and endurance work activities, and provide a written report that clearly states work abilities and limitations.

4. After functional capacity evaluation of an objective nature, functional job analysis similarly objective, must be done. The DOT use must be minimized and more accurate job descriptions must replace the DOT.

5. After objective job matching is done, the worker who has participated in the entire process in an interactive way, should be brought in the final reporting. They were there during the functional test, they understand their problems, and they should by the end of testing understand the relationship between discomfort and safe ability. They should also understand which physical activities should be limited. With this internal understanding of their own abilities and limitations, they then should be able to identify with the job matching done through functional testing and functional job matching.

   The recipient must be a part of the process, not someone who has "received" the process. By being part of the process when the job matching is done, they will then see that objective measurements have been made which indicate their ability.

6. There should be a combination of specific functional testing of an objective nature given by a professional therapist. This must be combined with medical

testing done by a physician who has given contraindications and diagnosis. In Switzerland, the physician and therapist write their functional return to work statements in one report. The FCE utilized has been accepted by the Swiss Invalidity Board and the opportunity to have physician and therapist work together provides a strong teamwork base that assists the disability recipient.

7. Outcome studies such as the one presented in this testimony should be analyzed. They can be expanded. The important points to notice from this outcome are:
   - An average time off work of the recipients of the test was 9 months.
   - No other physical intervention or treatment was noted after the functional test.
   - The worker identified that the functional test was utilized in the return to work process.
   - The workers had identified that they continued to have discomfort (as most chronically injured workers do) but that they had learned to work through it.
   - They had been returned to work for up to 6 months and they continue to be at work. This would indicate that once the job match has been successful, that continued work is possible without reinjury.
   - The workers were highly appreciative of the greater understanding they had about their own body as a result of the functional testing.
   - 61% returned to work with primarily the functional testing as the final intervention.

8. Social Security Disability recipients are fearful of returning to work. The system often provides them with reason to believe that if they try work and fail, they may be disenfranchised. Therefore, those undergoing functional testing and medical evaluation must be assured that they will be treated fairly in the system.

   After this barrier has been broken, many of the psychological problems can be dealt with by better objective medical and functional testing. By not emphasizing pain complaints, by not emphasizing disability, and by being objective and caring, the therapist doing functional testing can bring about the best and safest performance of the worker. The client must always be part of the process and interactive with it.

   If there is inconsistency in performance or obvious uncooperation, this must be identified in a positive confrontational manner. This does not mean the recipient is bad, but perhaps they did not understand the "rules" of the test. If behavioral problems continue, these will be identified as behavioral problems, not physical problems.

   Once the inconsistency is identified and explained to the person, when given a chance to try the activity again the performance may be much better. This helps them break through old habit patterns and understand that they are being objectively evaluated and it is in their best interest to find out their own functional capacities.

9. The functional capacity evaluation must be written in clear, easy to read terms and the job matching for that client must be as specific as the functional capacity evaluation. Use of more specific job analyses rather than the DOT is a step toward specificity and success.

The disability problem appears very complex but as the outcome study indicated, perhaps the main issue missing from most disability management cases is objective functional testing with job matching. If this is done, many of the other psychosocial, medical, and communication problems are reduced. It is possible in today's world to do better objective functional testing and work with the worker on their own job abilities.

As with the Americans with Disabilities Act, if a job modification is the outcome of the job match, then good functional testing with job match also allows modifications to be identified. In the outcome study it should be noted that 50% of the clients went back to work at the same job, but with a slight modification. These modifications often cost nothing or were very low cost. Therefore, objective testing and job matching allows more likely use of job modification (reasonable accommodation).

The missing component of objective, quality functional testing can bring clarity to the Social Security Disability recipient. This emphasizes ability to perform safely in life and at work. Reports also will clearly indicate to the worker and to the employer that there is work ability. By having such clear documentation based on objective testing, it is very likely that return to work can proceed. Psychological problems will be reduced. This is to the benefit of the worker and society.

Thank you.

Addenda:
International PPG List
Full Vitae

Gle/sji\barriers

[Attachments are being retained in the Committee files.]

Written Testimony Prepared for the House Ways and Means Subcommittee on Social Security, July 23, 1997

Presented by Robert L. Sniderman, Ph.D., C.R.C., C.D.M.S., C.C.M.

This testimony is being submitted regarding the use of Functional Capacity Evaluations and their impact on successful return to work outcomes.

I submit this testimony as a practicing rehabilitation counselor in the private sector and vice president of operations for The Kalix Group, L.L.C., a company that provides vocational counseling and return to work services to disabled individuals in a wide range of settings. We provide services to individuals in conjunction with workers' compensation systems, long and short term disability programs, social security disability insurance evaluations, ADA compliance issues, and directly to employer in house return to work programs. In addition, as immediate past president of the California Association of Rehabilitation and Reemployment Professionals (CARRP) and as current California Representative to the National Association of Rehabilitation Professionals in the Private Sector (NARPPS) I submit this testimony.

Functional Capacity Evaluation is a valuable tool in the objective and accurate evaluation of disabled individuals. The evaluation objectifies an individual's current physical and cognitive functioning to enable a more accurate assessment of the capability for successful return to work.

Currently, medical examinations are typically used for this purpose. However, medical examinations will provide valuable information about an individuals impairment not the extent of their disability.

Functional capacity evaluations will not only provide information about an individuals functioning in real time, it can also identify issues of reconditioning due to a lengthy term of inactivity. Services can then be provided to accurately design and implement a program of reconditioning. The goal being to gain the capacity to return to work in a well defined and structured time frame. This will also facilitate a decrease in employer reluctance to hire disabled individuals as work readiness information can be imparted through the use of functional capacity evaluation.

I am not an expert at performing functional capacity evaluations (FCE) or related evaluation services. However, I have been providing rehabilitation counseling and return to work services to disabled individuals for over 20 years. I can attest to the benefits of utilizing FCE as a "gatekeeper", a basis for progressive return to work plans, therapy design and monitoring tool, and an evaluative tool that makes return to work services more efficient and cost effective.

Functional Capacity Evaluation first and foremost is a tool that my colleagues and I can utilize to help answer some very significant questions regarding an individual's ability to benefit or participate in a return to work program. Given the opportunity to design a return to work program for the Social Security Administration, FCE would be the gatekeeper for participating. There are key elements in rehabilitation and return to work that are well defined and can be evaluated during an evaluation. Being able to predict as accurately as possible and as quickly as possible an individuals ability to be successful in a return to work process is crucial. It is crucial from both cost effective and human factor perspectives. Return to work programs do not want to include individuals who will not be successful and also want to as much as possible exclude those who will have failure experiences. Failure experiences can be devastating to an individual who has struggled with issues of self-worth and capability. FCE can help identify for an individual and the professional working with that individual whether or not return to work services are appropriate to pursue at any given time.

How can Functional Capacity Evaluations be used as a basis for progressive return to work? The information that is generated by a FCE can be used by many professional in many ways. The most common purpose from the perspective of doctors, lawyers and the Social Security Administration is for

disability evaluation. The FCE allows what was an impairment evaluation to become a disability evaluation. For rehabilitation professionals, the FCE can also be used to design a progressive rehabilitation program that will help to move a disabled individual from being unable to participate in a return to work program to setting up some short term work hardening programs and work adjustment programs that will in a systematic and progressive fashion move the individual into a return to work program.

If a disabled individual is unable to participate in a return to work program and is participating in therapy, the FCE can be used to help physical and occupational therapists design and monitor therapy programs. The FCE can be used at intervals during therapy to monitor progress. If progress is not being made it provides the professional and disabled individual with the ability to make decisions about continuing with therapy or pursuing other avenues.

In conclusion, Functional Capacity Evaluation provides an accurate, objective assessment of an individual's ability to participate in a comprehensive return to work program. Using FCE in a "gatekeeping role" will help rehabilitation professionals working with disabled individuals to make responsible, accurate, and cost effective decisions regarding rehabilitation and return to work services.

I propose that the following be considered in drafting bill language:

Functional Capacity Evaluation services be available through a cost reimbursement format separate from a return to work voucher system.
We urge the inclusion of support and funding of functional capacity evaluations within the Social Security Reform effort.

STATEMENT OF

ELIZABETH A. CORP, CRC, CDMS, D-ABDA, FLMI
MANAGER
MET DISABILITY

This testimony concerns the use of Functional Capacity Evaluations and their importance in the return to work process. Bills H.R. 4230 - Bunning and H.R. 534 - Kennelly were also reviewed in preparation for this testimony.

Background

I have been asked to comment on **Functional Capacity Evaluations (FCEs)** and their relationship to return to work initiatives as a representative of a Group Short Term and Long Term Disability (STD/LTD) carrier, Met DisAbility, a division of Metropolitan Life Insurance Company (MetLife). Within Met DisAbility I am currently the Social Security program manager, a program that seeks to assist our clients in obtaining Social Security Disability Insurance benefits (SSDI) if they meet the SSA criteria for benefit payment. I also coordinate the Met DisAbility FCE vendor program and was the manager of the Met DisAbility Rehabilitation program through 11/96. Met DisAbility was awarded the 1996 National Association of Rehabilitation Professionals in the Private Sector (NARPPS) award for Best Insurance Company as a result of our excellent rehabilitation program.

Group STD/LTD Coverage

Group STD/LTD coverage is disability insurance that an employer purchases as an employee benefit. Coverage may be 100% employer paid or a combination of employer/employee paid. While coverage levels vary they generally do not pay more than 60-70% of pre-disability earnings for LTD plans. STD plans of coverage are similar to LTD, but it is not unusual for STD coverage to provide up to 100% of pre-disability earnings for a period of 6 months. STD coverage pays for brief periods of illness or injury that may prevent someone from working for several weeks or months. However, most people return to work prior to the conclusion of the six month STD period of benefits.

The intent of LTD coverage is to provide individuals with income replacement during a prolonged period of disability from accident or illness. Generally the insurance coverage is structured so that during the first two years of disability one need be disabled from his/her "own occupation" with any employer. After two years the disability language changes to provide benefits only to those who are disabled from "any occupation" for which they are reasonably qualified through education, training or experience. Once approved for these benefits, one can generally continue receiving benefits until age 65 as long as the disabling condition(s) remain consistent with the "any occupation" definition.

At Met DisAbility we take very seriously our trade mark "We Put Abilities to Work". From the time a claim is filed with us, our team of claim professionals encourage return to work by discussing it with the client, the client's physician(s), and the employer. We actively work with employers to accommodate those who need it and to return people to work even when they cannot work full time. Our contracts are structured to encourage partial return to work efforts as it has been our experience that often times people need a

period of modified or part time work as they regain their strength and stamina. We have in our employ medical and vocational rehabilitation specialists who coordinate medical management and return to work activities. As our clients are located all over the country and our disability offices are in five states, we do most of our work telephonically and retain the assistance of local medical and vocational rehabilitation providers when necessary.

Returning People to Work from a Period of Disability

In our experience we have found that the earlier one returns to work after a period of illness or injury, the better. People who become disabled and receive benefits from us are people who have a sustained period of employment prior to their illness or injury and thus generally have a job to which they can return during the STD portion of their claim. However, once people become eligible for LTD benefits, it is not unusual for employers to terminate their employment as well. In those cases, the client is not only struggling with the emotional and financial consequences of a disabling condition, but they are now

also facing the emotional and financial consequences of limited or no medical coverage, fewer dollars on which to live and the loss of employment. For these people the road back to work is often harder and more costly in both time and money.

Often the condition that has rendered them disabled is one that will have some residual functional limitations - be they in terms of strength and mobility deficiencies, poor sitting/standing tolerances, lack of stamina, fatigue, impaired mental agility or emotional difficulties. For these people a return to work will not only involve providing the **OPPORTUNITY** for employment, but also the **MEDICAL REHABILITATION SERVICES** needed to render them capable of sustaining a prolonged work effort. Such services do not come cheaply, but when compared to the amount of benefit dollars paid out over many years to remain off of work, the price is very reasonable. In addition, the purchasing of medical rehabilitation services also helps us determine if the individual is truly capable of a sustained work effort or if their condition is such that a return to work will not be practical.

At this juncture, I think it is important to note that the payment of rehabilitation services is generally an extra-contractual obligation. By that I mean that most of our contracts do not require the client to participate in rehabilitation services nor do they state that MetLife will be obligated to pay for those services. However, it has been our practice to provide rehabilitation services to clients who we determine will benefit from them in a return to work effort. After careful screening by our in-house rehabilitation staff, the clients are contacted and offered the services at no charge and we in turn pay for the medical and vocational services that are needed to render the client capable of returning to work. We do look to medical insurers to assist in this effort by talking directly with the medical carriers about the programming needed and then helping the client overcome the co-payment obstacles by having the co-payment billed to us. When there is no medical insurance or if the medical carrier cannot pay for medical rehabilitation services we then

will pay for those services on a time limited, results oriented basis. We do **NOT** pay for any medical or vocational services that are priced beyond the local reasonable and customary rate nor do we purchase services that are **NOT** geared toward a return to work effort. Rehabilitation efforts continue only as long as the client cooperates and participates fully in the programming and only as long as measurable goals are being achieved. We ask each of our rehabilitation clients to sign rehabilitation plans prior to the provision of services and those plans outline what we will provide, what the client's responsibilities are and what the projected outcomes will be. These plans are then amended as needed through out the rehabilitation program.

We view rehabilitation as a process that starts with the submission of a claim and does not end until the client is either able to return to work or is determined to be unable to work. We continually talk about work and its positive emotional and financial benefits and we do not stop talking about it until it is clear that the client will never return to work. In this regard we are very different from SSA. SSA essentially determines that someone is totally disabled and the idea of returning to work is barely mentioned once someone has been approved for benefits. As a result, the average SSDI/SSI client does not seriously consider a return to work because the attainment of benefits means that the client is **TOTALLY DISABLED**. SSA will need to make a fundamental conceptual change in its method of processing disability claims before this concept filters down to all aspects of the organization. SSA will need to **MANAGE** their SSDI/SSI claims with a return to work attitude from the initial application and will need to re-vamp its CDR process to ensure that people are not left on claim for a number of years with no mention of return to work. In addition, SSA will need to look to public/private partnerships to help finance the cost of medical and vocational rehabilitation. One way to do that would be change the current structure within Medicare that allows only a limited number of physical or occupational therapy sessions regardless of the amount of therapy needed to return the patient to a level of functionality needed to meet the demands of an eight hour work day.

Why Medical Rehabilitation Services, and FCEs in Particular, are Critical

STATEMENT OF
ELIZABETH A. CORP, CRC, CDMS, D-ABDA, FLMI
MANAGER, MET DISABILITY

In assessing the viability of a return to work effort, a number of factors are reviewed. Of importance are the client's physician's evaluation of the disabling condition and its impact on the client's ability to work. It is important here to clarify that physicians, by and large, are **NOT** knowledgeable of disability factors as they relate to work. Physicians are taught to diagnose and treat constellations of symptoms presented to them by the patient. They are **NOT** taught to be vocational or occupational experts and thus have limited knowledge of what the patient may do in their occupation and how the illness or injury that is being treated will impact the patient's ability to perform that occupation. They may know, for example, that their patient is a truck driver who delivers items to hardware stores, but they probably don't know if their patient is a long distance or local driver, if the truck is a semi trailer or a pick up, if the patient has to load or unload the truck, how much the pallets weigh, if the patient has to set up merchandise in the stores,

take orders for new deliveries, accept payments and do other bill processing, or how the patient's job relates to the occupation of truck driver for any employer. All of these aspects are **VERY** important to a vocational counselor who determines which job duties can be still be performed and which cannot. Generally all the physician knows is what the patient says and most of the time patients give very brief job descriptions. Patients rarely go into length about what their jobs entail unless they are asked detailed questions.

As a result it is not at all unusual for physicians to answer very vaguely and briefly when confronted by the question - "is this person who you are treating disabled from their own occupation or any occupation?" Most of the time this question, if it is asked at all, receives a curt response of "yes" to the own occupation, especially during the acute portion of the illness or injury, and a "don't know" or "yes" for the second portion without any supporting evidence to prove that such a question was fully evaluated by the physician. When pressed to produce test results or other objective measures to support this opinion most doctors revert to the fact that the patient recently underwent surgery and is now recovering or that the MRI showed that the patient has a "slipped disc".

Unfortunately, knowing that someone has an illness or injury and relating that to work requirements is not an easy task. It requires knowledge of anatomy and physiology as well as an in-depth knowledge of the requirements of occupations. One method to assist in making this determination is through a **Functional Capacity Evaluation (FCE). FCEs** are generally administered by physical or occupational therapists in therapy centers. These evaluations, and there are a number of types and kinds that have been proven valid and effective, are generally administered over several hours and sometimes days. Each evaluation looks at the client's ability to perform a variety of activities including strength evaluation, lifting, carrying, bending, walking, standing, and sitting tolerances, as well as recording the client's ability to follow directions, perform tasks repetitively and maneuver through various activities in a structured setting.

Once the client has completed the evaluation, the results are tabulated and assessed looking first at the consistency of the client's actions as compared to the medical information and then comparing the client's performance with that needed to perform various occupations for which the client is suited through education, training or experience. It is only then that a rehabilitation plan of action can be developed to help build on the client's strengths and to diminish or eliminate those factors that are limiting the ability to return to work. It is not unusual for these plans to recommend periods of **WORK HARDENING** or **MEDICAL REHABILITATION SERVICES** in a effort to bring the client back to a level of physical capacity that has been lost due to inactivity or the effects of prolonged illness or injury.

For those client's on SSDI/SSI the need for a **FCE** is critical to accurately evaluating what the client can and cannot do in relationship to work. For someone to met the SSA definition of disability they must be completely unable to work for a period of at least 12 months. That in an of itself means that those who receive SSDI/SSI benefits probably

have residual effects from the illness or injury that caused them to become disabled and those residuals need to be accurately assessed with an objective evaluation of their functional capabilities. Unless the client's functional abilities are evaluated and deficiencies strengthened or accommodated, vocational rehabilitation will not be effective in accurately matching abilities to job opportunities and the client will not be capable of sustained work activity.

Impairment and Disability in Relation to the Assessment of Functionality

According to the American Medical Association's book, "Disability Evaluation" there is a distinct difference between an impairment and a disability. An impairment is defined as "the inability to successfully complete a specific task based upon insufficient intellectual, creative, adaptive, social or physical skills."[1] Disability is defined as "a medical impairment that prevents remunerative employment."[2] The writers expand upon this distinction by explaining that impairment assessment is a medical evaluation while disability assessment is determined within an occupational setting, such as one's work place or through the use of functional capacity evaluations.[3]

As previously mentioned in this paper, the use of **FCEs** is an excellent way to determine a client's abilities and limitations or restrictions. My colleague, Dr. Leonard Matheson, wrote the chapter in "Disability Evaluation" that provides an excellent summary of what **FCEs** do and what they cannot do. I will not attempt to expand upon Dr. Matheson's excellent work, except to add that in our experience at Met DisAbility the information obtained from **FCEs** is invaluable to our disability management process. We have found that these evaluations provide objective, measurable information that clarifies the medical information we receive from the client's physician(s). Our experience has shown that **FCEs** are useful at several points during the disability claim process. During the "own occupation" portion of the claim, a **FCE** clarifies what is preventing the client from returning to his/her occupation and also helps us determine what medical and vocational services might be necessary to bring about a successful return to work. At the "any occupation" decision point, a **FCE** gives us information that allows a comparison of our client's abilities to those required of the occupations to which he/she may be capable based on education, training and experience. Even when someone has been approved for "any occupation" our management of the claim and return to work expectations do not end. We continue to manage the claim toward a return to work if at all possible and the use of **FCEs** helps us document which aspects of functionality can be increased through a concerted medical/rehabilitation effort and which aspects need to be considered permanently limited and/or needing accommodation.

It is our procedure to ask the client's attending (primary) physician to review all **FCE** results and to provide comment. Because we manage our claims using a triad of people - the client, the attending physician and the employer - in conjunction with our claim professionals, we look for any opportunity to remove the "dis" from "disAbility". We use **FCEs** to help clarify the functional factors that are preventing a successful return to work. In doing so, we recognize that many times the ability to return to work is clouded by emotional factors as well as physical. As a result we have also partnered with one of the premier mental health managed care providers, United Behavioral Health, a division of United HealthCare, in piloting a program to increase provider awareness of disability issues to bring about a speedier return to work for those with acute and chronic mental health conditions. This pilot and others are part of Met DisAbility's on-going program of pro-active identification of the factors that are impeding successful return to work efforts and preventing people from realizing their true potential.

Value of the FCE in the Determination Process and in the Provision of Services

---

[1] Demeter SL, Smith GM, Anderson GBJ: Approach to Disability Evaluation, *Disability Evaluation*,3, St. Louis, MO, 1996, Mosby
[2] Ibid, 3
[3] Ibid, 3

FCEs provide valuable objective information that can be used in making a determination of disability. As part of the determination process an **FCE** can provide accurate, measurable information that cannot be obtained from other sources. In particular, an **FCE** puts into precise terms the client's capabilities in regard to a variety of areas related to physical strength, endurance and stamina as well as cognitive abilities. Such information is often missing in routine medical reports and often is not quantified and objectified in physician narrative reporting. In addition, **FCEs** are conducted over several hours, four to six hours over one to two days is typical. An evaluation of this length is thus more reliable in predicting capabilities during an eight hour work day. **FCEs** should prove invaluable to the DDS and would be far superior to the current Residual Functional Capacity process due to their objectivity and uniform administration processes.

Medical Management as a Precursor to Vocational Rehabilitation

One of the realities of being out of work due to illness or injury is that an individual often becomes physically de-conditioned. The structure and routine of reporting to a work site on a daily basis is replaced with endless hours spent lying down or being inactive while the body heals. Unfortunately this level of inactivity often continues long after the acute phase of illness has passed. In addition, the stress of illness and the resulting physical inactivity often coincide with mental inactivity and that too contributes to being incapable of returning to a work place without a structured period of physical and mental preparation.

At Met DisAbility we discovered several years ago that we needed the skills and resources of short-term medical rehabilitation programming for a percentage of our clients in order to move them from a period of disability back to full time work. Our rehabilitation nurses coordinate the medical rehabilitation programming that may consist of targeted medical intervention or occupational and physical therapy services for clients

who need a structured method of re-building their physical and mental stamina. We work with local rehabilitation providers in conjunction with the client's physician to develop rehabilitation plans that are time limited and focused on a goal of return to work. In keeping with our claim philosophy, the client, the attending physician(s) and, when appropriate, the employer are parties to the planning process and we ask the client and attending physician(s) to work with the local rehabilitation provider to ensure that we are consist with the medical goals as well as the vocational goals.

Medical rehabilitation services generally last several weeks with services designed to alleviate or eliminate the functional limitations that are preventing a successful work return. In addition, if needed, we arrange for adaptive devices and seek employer accommodations to eliminate barriers. As with all of our rehabilitation programming efforts, we look for the most qualified service providers and we seek to share costs with medical insurers, state vocational rehabilitation, veterans programs, employers and other public-private partnerships. Our goal is to provide efficient, cost-effective service that will keep the rehabilitation program moving forward. We want services to be started timely and to eliminate any barriers to program success as quickly as possible. If that means that we must spend a bit more money for a service that will begin immediately as opposed to waiting a month or two for a spot to open up in a less costly program, we will spend the extra money because the reality is that the longer things are delayed the less likely our chances of achieving a successful outcome. Eliminating obstacles and barriers is the best way to ensure rehabilitation success and the Met DisAbility staff pride themselves on being pro-active managers of the rehabilitation process.

Impact of SSDI/SSI Return to Work Programs on Employers

The bills currently under consideration view return to work programming as being the method by which SSDI/SSI recipients will exit the disability roles. The problem with the methods being considered is that career counseling, job placement and other vocational activities are fine for people who have marketable skills and proficient reading and writing skills. However, this probably is not the case for SSI recipients who are receiving

benefits due to not only disability but also low income level. The poorest members of our society are generally those with the least formal education and often have cognitive or language difficulties as well. As a result these people are not as attractive to employers. Therefore it would not be uncommon for someone on SSI to not only need vocational programming, but also basic academic programming, skill training or skill enhancement and medical rehabilitation services prior to job placement. Without these additional services, the jobs one could qualify for would be minimum wage positions with little or no opportunity for advancement, jobs with few benefits and jobs providing the fewest opportunities to enable people to discontinue reliance on food stamps, welfare benefits, Medicare and Medicaid.

SSDI recipients would not be much better off. Even though these individuals have job histories, if they have been out of the employment market for two years or more it is very

likely that their skills have diminished and in some cases become obsolete. Any person entering the employment market today without basic computer abilities is facing a market that is limited and hostile. Computers have become a necessary part of today's corporate structure. The inability to use a computer and/or computer skills that are outdated will render someone marginally employable. As with SSI applicants, the longer an SSDI individual has been away from work, the more there will need to be time spent on skill enhancement or development prior to any sort of job placement activity. In addition, as has been previously noted, the provision of medical rehabilitation services are also recognized as being vital to successful work re-entry.

Functional Capacity Evaluations in the Continuing Disability Review Process

When beneficiaries are reviewed under the Continuing Disability Review (CDR) process, the Social Security Administration is seeking to determine if the beneficiary no longer meets the medical criteria for benefits. This process begins with a simple questionnaire that asks if the individual has worked. This is followed with questions regarding the individual's physical health, schooling and rehabilitation activities. How one answers these questions helps DDS determine if a more in-depth questionnaire is to be completed and if benefits are to be terminated due to substantial gainful employment and/or medical improvement.

It is in this portion of the CDR process that functional measurements would be of great value. As noted previously, **FCEs** can help isolate those factors that are truly limited from those that are limited only because the client chooses to limit them. In these cases of client self-limitation, the physician can become supportive of efforts that the client needs to undertake to bring about increased levels of functionality. For DDS the ability to accurately determine medical improvement is critical in making precise and consistent decisions. The use of **FCEs** at this stage in the process will be critical to the development of decisions that will withstand judicial challenges.

The FCE Process, the Disability Beneficiary and the RTW Process

In this paper I have emphasized how the **FCE** process assists the disability examiner - be it the DDS or, as in our case, the STD/LTD carrier. However, the **FCE** process also assists the disability beneficiary by providing accurate, objective measures of capabilities and limitations. It is not uncommon for a beneficiary to have incorrect or inaccurate information regarding the extent of impairment. This is not due to poor or incompetent medical care. Rather, it is often due to a lack of accurate information in regard to what is expected in terms of physical recovery and what to expect in regard to the mental and physical factors that negatively impact the recovery process.

By reviewing **FCE** results with both the disability beneficiary and the physician, a dialog may commence that will lead to more pro-active treatment and a better understanding of

the true limitations and capabilities of the individual. The **FCE** can also delineate between which limitations are physically based and which are psychologically based. This in turn could help direct the treatment modalities and the time frames in which to complete treatment for a more rapid return to work.

Financial Impact of FCE Utilization on the Social Security Trust Fund

The use of **FCEs** at approximately **$600** per **FCE** - cost might be reduced based upon volume - would appear, on the face of it, to be an expensive proposition for SSA. However, the cost of keeping people on the SSDI/SSI roles is much more expensive and also more damaging to our society. Our economy needs to keep employed those who are capable of working and our citizens need to recognize the value of contributing to our national economic strength. The return to work ideas outlined in the Kennelly and Bunning bills are wonderful in terms of assisting people who are job ready, however, as has been noted, many SSDI/SSI beneficiaries are not job ready and need a period of medical rehabilitation programming as well as vocational programming. **FCEs** can help determine which beneficiaries are job ready and which ones will need additional medical services. **FCEs** will also help DDS determine who should be capable of using the return to work programming options outlined in the bills and who are incapable of a return to work either now or in the future. This can thus help save money that might otherwise be spent on vocational efforts that will not come to fruition.

In addition to the use of **FCEs** to help determine who is appropriate for rehabilitation services, **FCEs** can also help beneficiaries understand the physical and mental requirements of successful return to work efforts. This in turn allows SSA the opportunity to more accurately predict who will be successful in their rehabilitation efforts, thus releasing trust fund dollars that might otherwise be paid out in benefits. Again, I must emphasize that the Administration must recognize that the cost of rehabilitation services needs to include medical as well as vocational rehabilitation components. Without this **"full service"** approach, results will be less than desired and may not be as long lasting as hoped. As a result, savings to the trust fund will not be significant if there is not a recognition of the long term effects of a poorly planned or incomplete rehabilitation program approach that only looks at vocational factors and not medical ones as well.

Public - Private Partnerships

The last item that I would like to mention is the need for strong public-private partnerships. The problems facing the SSA trust fund have a far reaching effect on all of society. At Met DisAbility we recognize that SSDI is not a panacea for every person with a disability. We continually look for rehabilitation opportunities and create those opportunities from the day a claim is filed until that option is no longer realistic for the client. We understand that for many people it is easier to think about what they cannot do rather than what they can do and we constantly work to help people recognize the

abilities they retain and how those abilities can be utilized in the work force. We also look to other providers of service be they public or private in an effort to share cost and avoid duplication of effort. It is only when all avenues are explored that we can truly say that we have maximized the potential of those needing assistance.

In regard to SSA, it is important that SSA foster relationships with not only the public and non-profit sectors, but also with private insurers and others who are working with SSDI/SSI beneficiaries. It is imperative that SSA not look to duplicate programming that already exists. SSA should also look for ways to share costs whenever possible. If the program goals are clearly stated and adaptable to what the beneficiary needs then the chances of partnering with public and private sector providers will increase. And as we know, when the chances of success increase the positive impact on the trust fund will also increase.

STATEMENT OF ANNIE V. SAYLOR
PRESIDENT

NATIONAL ALLIANCE FOR THE MENTALLY ILL

Chairman Bunning and members of the Subcommittee, I am Annie V. Saylor, President of the National Alliance for the Mentally (NAMI). I am also a native of eastern Kentucky, where most of my family still resides. Like so many members of the NAMI family, I have a sibling with a serious brain disorder. My sister has schizophrenia and lives with our family in Harlan County.

At the outset, I would like to thank you for holding this hearing on barriers to work faced by millions of Americans with severe disabilities who seek to achieve greater independence and dignity through employment. NAMI believes that we offer a unique perspective on the critical issues of work incentives, income supports, and employment for people with severe mental illnesses, which are brain disorders. NAMI is the nation's largest organization representing people with severe mental illnesses and their families. Through its 1,140 affiliates and chapters, NAMI represents 168,000 consumer and family members and works to promote greater public understanding of serious brain disorders such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and panic disorder. Our major activities include research, education, and advocacy aimed at reducing stigma and promoting independence for people with brain disorders.

NAMI has a strong interest in the issue of work incentives, income supports, and employment for people with disabilities. We share your vision of restoring fairness to the Social Security Administration's (SSA) disability programs by enabling those who are truly disabled to receive benefits quickly and stopping payments to persons who have fully recovered. Work is extremely important to people with severe mental illnesses and their families. Yet the supports necessary to achieve employment and independence are simply not in place for most people with these brain disorders who want to leave the SSI and SSDI rolls and join the workforce.

More importantly, the current SSI and SSDI programs themselves too often serve as barriers to work. While the Work Incentive Provisions of the Social Security Act do make it more possible for people receiving SSI or SSDI payments to go to work, most people with severe mental illness either do not know about, or do not understand, the provisions and therefore do not utilize these work incentives. This is true both for the so-called SSDI trial-work-period provisions and the SSI 1619(a) and 1619(b) programs. For too many people with mental illness there is a pervasive fear that employment will result in the immediate cut-off of cash benefits and the concurrent loss of critically important medical benefits. NAMI believes strongly that the episodic nature of mental illnesses justifies the need to maintain a basic safety net of assistance for people experiencing acute occurrence of severe symptoms.

Mr. Chairman, as you well know, after certain income disregards SSI beneficiaries lose 50 cents in benefits for every $1 in labor earnings, or a 50-percent implicit tax rate on earned income. SSDI beneficiaries lose access to cash assistance after reaching substantial gainful activity (SGA) beyond the current 45-month transition period. However, even in cases where people with mental illness decide to use existing Social Security work incentives, they still face the loss of medical coverage even if they are able to retain limited cash benefits after reaching SGA.

NAMI believes that it is the issue of access to medical coverage that is absolutely critical for people with serious brain disorders, especially coverage for prescription drugs. This issue generates a high level of concern among NAMI members. Without coverage for high-cost medication and other treatments for disorders such as schizophrenia and depression, many people find it hard to maintain a stable life in the community, let alone achieve complete independence through employment. Moreover, for many people with severe mental illnesses, the first step in the process toward competitive employment is supported employment or low-wage, service-sector jobs. Few of these opportunities offer employer-provided health insurance, especially for someone with a serious brain disorder.

Legislation that you introduced in the last Congress (H.R. 4230) is an important first step in addressing the concerns surrounding loss of health insurance coverage for people who want to move away from dependence on public programs through work. NAMI endorses the goal of making the SSI and SSDI programs more responsive to needs of people with serious brain disorders who want to leave the benefit rolls for employment. However, NAMI also has some important concerns with the bill as currently structured and would like to offer the following suggestions. We believe that these issues must be addressed to make the proposal more relevant to people with severe mental illness. We offer these concerns in the spirit of cooperation and willingness to work with you and all the members of the Social Security Subcommittee, on a bipartisan basis, to reform the current, outdated system.

1. **Assessment for Vocational Services**: People with severe mental illnesses should be presumed eligible for rehabilitation services, and assessment for needed services should occur separately from determination of eligibility for income-support benefits.
2. **Milestone Payment System**: NAMI supports including provisions that would allow providers to be paid for partial savings achieved through successfully serving clients with the most severe mental illnesses who can achieve part-time or cyclical work, but may never achieve full-time competitive employment.
3. **Medicare Health Care Extension**: NAMI supports efforts to extend Medicare eligibility, but wants to ensure that this initiative effectively reaches SSDI beneficiaries with severe mental illnesses.
4. **Employer Tax Credit**: NAMI supports efforts to create new incentives for employers to hire people with these brain disorders, but also wants to ensure that such a program is structured to that encourage hiring people with the most severe disabilities.
5. **Network Coordinators**: Any new alternative system designed to meet the employment needs of people with disabilities should be open to all persons with severe mental illnesses and the innovative programs serving their employment needs. It should also be open and accountable through outcome measures and meaningful consumer and family input.
6. **Return to Work Commission**: NAMI supports expanding membership on any commission to include involvement of consumers, families, and representatives of innovative programs that serve persons with the most severe disabilities.

Mr. Chairman, I would like to spell out in detail NAMI's concerns about the issues listed above.

Issue: Assessment of Capability for Vocational Adjustment
Your bill from the last Congress would continue the current system of Disability Determination Systems (DDS) for making determinations about whether an individual is disabled under the Social Security Act. Under the bill, this same DDS official who makes the disability determination will simultaneously be making a determination of whether employment at or above SGA is reasonably possible.

It is well established that the future ability of a person with severe mental illness to work cannot be predicted through a one-time assessment. This is due in large part to the episodic nature of severe mental illnesses, which prevents accurate assessment of employability at a single point in time. Therefore, for persons with severe mental illnesses, it is extremely unlikely that at the time there is a finding of disability the individual will reasonably appear to be able to achieve SGA. Any individuals determined to be disabled under a mental illness disability should NOT be evaluated at that time for their ability to work. Rather, the standard should be that they are ASSUMED to be able to work, and such a determination that they CAN'T should be made after application for employment services.

Also, SGA of $500 a month at the current minimum wage of $4.75 is achieved at just over 26 hours per week of work. The bill requires that this level must be maintained for nine months. This raises the first-time employment standard well above the reach of a vast majority of the recipients with a mental illness disability determination.

Issue: Milestone Payment System
Under the various proposals for a milestone reimbursement system, as much as two-thirds of the reimbursement for services occurs AFTER an individual leaves the rolls. This means leaving the rolls by achieving nine months at SGA income levels. NAMI is concerned that achievement of SGA as the principal employment milestone ignores the employment realities for the vast majority of people with severe mental illnesses who are on SSI and SSDI. As with the vocational rehabilitation (VR) system, this language relegates any employment outcome that is less than SGA to "failure" status. Yet, we know that there are many employment outcomes on the way to achieving complete independence from SSI or SSDI. Many of these employment stops do result in an individual receiving reduced SSI benefits. To relegate as a failure under the program an employment achievement that many consumers and families would consider a success will result in few serious attempts at work and no savings to the system.

People with severe mental illnesses have long been ill-served by a federal-sate vocational rehabilitation bureaucracy that creates incentives for counselors to "cream"; i.e., direct their energies into serving persons with less severe disabilities. NAMI is concerned that a milestone approach that rewards providers for getting people off the disability rolls will similarly create incentives for "creaming."

NAMI believes that a better approach would be to reward providers for any reduction in benefits that result from employment, rather than forcing these providers to pursue goals that simply may not be realistic for persons with the most severe brain disorders. This alternative approach could be accomplished by splitting the even smaller resulting savings from employment that is less than SGA between the provider and SSA.

Issue: Medicare Health Care Extension
Under your proposal, if an individual meets the disability determination standards under SSDI for three months in a row and is eligible for SSDI benefits and has monthly earnings of at least 160 times the federal minimum wage ($760/month), then he or she would remain eligible for Medicare for the next five years or until two months before he or she turns 65, whichever comes first.

As stated above, NAMI considers access to health coverage as possibly the largest barrier to employment for many people with severe mental illnesses. We applaud your effort to address this issue in a creative fashion. However, NAMI is also concerned that this proposed extension of Medicare coverage for SSDI recipients would not effectively reach many of the current beneficiaries with severe mental illness. Our specific concerns relate to setting the income level at $760 per month. This is full-time work (40 hours/week) at the federal minimum wage ($4.75/hour). Ending SSDI eligibility for Medicare at $500/month of SGA will create a $260/month gap. NAMI is concerned about the large number of people with severe and persistent mental illness as who would fall through this gap.

Finally, NAMI has had long-standing concerns about the scope of mental illness benefits available under Medicare. NAMI has longed believed that the scope of benefits available under the Medicare program is outdated and in need of reform to bring it in line with recent advances in psychiatric treatment protocols and standards in the private health care market. We look forward to working with you and your colleague Chairman Bill Thomas of the Health Subcommittee, to modernize and reform mental illness treatment services under the Medicare program.

Issue: Employer Tax Credit
This section of last year's bill creates a tax credit for employees who hire persons meeting the disability determinations under SSI or SSDI. The credit is equal to the wages paid to the individual during any eligible month of employment. NAMI strongly supports efforts to provide private-sector employers with an incentive to hire people with severe mental illnesses who want to leave the SSI and SSDI rolls. Using the tax code provides an efficient means of delivering this incentive to the private sector.

At the same time, NAMI is concerned about the definition of eligible months of employment in last year's bill; i.e., the first month in which the individual is employed on a substantially full-time basis at a monthly rate of pay equal to at least 160 times the federal minimum wage, or $760 per month. This is full-time work (40 hours per week) at the federal minimum wage ($4.75/hour). Given the employment patterns of people with severe mental illnesses, how many employers will benefit from this credit?

NAMI is very concerned that such a definition will result in employment determinations being made in favor of more employable, high-functioning people with disabilities and against persons with more severe disabilities. This lack of work history is especially the case with persons with severe mental illnesses who must overcome the constant barrier of stigma. In many cases these people, members of our NAMI family, have little or no work history. This is especially troubling for people with severe mental illnesses such as schizophrenia, where onset of the disease is typically in late adolescence, long before the individual has the opportunity to establish a record of employment.

It is interesting to note that while the majority of the people with severe mental illnesses served by Social Security's programs are on SSI, a substantial number of people are on SSDI. This is true even for persons who do not have the requisite number of quarters in the workforce in cases where they are the adult dependent of a retiree or an adult dependent of an SSDI beneficiary. Thus, SSDI work incentives are an important issue for NAMI families.

Issue: Network Coordinators
Under last year's bill, "network coordinators" would keep lists of eligible providers and review such providers based on job placement, job retention, timeliness, cost, etc. NAMI is very concerned about the impact this might have on the availability of services for people with severe mental illnesses. A system that scores providers solely on the basis of unrealistic assumptions about short-term employment prospects of clients with severe mental illness could jeopardize the success of innovative programs that focus primarily on this vulnerable population. A better approach would be to measure provider "success" against other providers on a population-specific basis; i.e., provider A's success in serving clients with severe mental illness compared to provider B's success with the same population.

NAMI is also concerned about including a requirement that each network coordinator prepare reports, on at least an annual basis, itemizing specific outcomes and consumer satisfaction with respect to specific services in a manner that conforms to a national modçl prescribed in regulation. NAMI applauds the requirement for outcomes to be measured, in part, by uniform customer satisfaction surveys. We strongly support the requirement for each beneficiary to be provided a copy of every report. However, we believe that any reports kept on outcomes and consumer satisfaction that are made available to the public should be presented in an understandable format that will allow easy comparison. Such a process should serve to empower consumers and families to distinguish the populations being served. For example, will consumers and families be able to determine a providers effectiveness in serving people with severe mental illnesses as opposed to, say, persons with spinal cord injuries?

Issue: Individual Employment Plans
Last year's proposal included a number of specific requirements for Individualized Employment Plans. Specifically, such plans would have required employment evaluations designed to assess: a) prior work history; b) educational background; c) mobility, cognitive, sensory, and mental impairments and limitations; and d) interests and

aptitudes and an inventory of the services determined by the network coordinator as most effective in obtaining employment or facilitating training for employment. The plan would also identify a) those services that are to be provided by generalists with respect to all populations and b) those services to be provided by specialists, including specialists in areas such as mobility, cognitive, sensory, and mental impairment.

NAMI supports requiring that services be provided consistent with an individual's needs. However, we are also concerned about whether the requirements above cover all of the employment-related needs of people with severe mental illnesses. For example, what about housing, access to medication, and other factors critical to employment success? NAMI urges that these factors at least be noted, even though they are outside the scope of the legislation needed to remedy these problems.

Another concern with the structure of any Individual Employment Plan relates to assessment of employment goals. Last year's bill would have required the Plan to set forth specific employment goals that relate to the availability of SGA within the economy of the region. This requirement excludes consideration of other types of employment, such as supported employment as a step toward achieving SGA. NAMI is concerned that the SGA standard may be too high for people with severe mental illness without recognizing that "employment" should be broadly defined as a success, even if it is not full-time employment and even if the goal of SGA is not immediately achieved.

Issue: Return to Work Commission
Last year's bill proposed establishment of a nine-member Return to Work Commission comprised of political appointees. This commission would be charged with developing a pilot program within six months. The commission would also be specifically required to make use of programs and providers participating in Project Network and Projects With Industries (PWIs). NAMI is concerned that such a short time frame for implementation of the pilot and specific requirements to utilize the Project Network and PWI models will give these participants a huge up-front advantage in the program. This will certainly provide them with a significant advantage in becoming Network Coordinators and Regional Administrators.

NAMI's experience in the current rehabilitation system has led us to the conclusion that systems such as Project Network and PWI do not have an outstanding record of serving people with severe mental illnesses and have not worked to integrate their services with state public mental health systems. NAMI urges that specific language be included that references providers with experience serving people with severe mental illnesses; e.g., psychosocial rehabilitation providers.

Conclusion
Mr. Chairman, on behalf of the NAMI board and membership, I would like to thank you for holding this important hearing. We look forward to working with you to reform Social Security's income support programs and the larger VR system to make them more responsive to the needs of people with severe mental illnesses, which are brain disorders, and ensure their long-term financial stability.

TESTIMONY BEFORE THE SUBCOMMITTEE ON SOCIAL SECURITY
OF THE COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 23, 1997
PREPARED BY JERALD L. HURT, PT
VICE PRESIDENT ,
NOVACARE, INC., OUTPATIENT DIVISION

Mr. Chairman and Members of the Subcommittee:

Thank you for permitting me the opportunity to submit this testimony related to the issue of facilitating the return of disabled persons to the workforce.

Background
I have been a licensed physical therapist for more than twenty years. As a routine daily task during that time, whether directly as a treating therapist or indirectly as a manager, I have grappled with the challenge of helping people to overcome physical impairments, regain the capacity to function and return to productive lives. Restoration of function is the fundamental objective of physical therapy and other physical rehabilitation professions. It is the achievement of the ability to utilize remaining functional capabilities that reduces the impact of chronic disabilities.

I presently serve as the Vice President of Clinical Services in the Outpatient Division of NovaCare, Inc. NovaCare is the nation's clinical leader in physical rehabilitation, operating 750 outpatient rehabilitation, orthotics and prosthetics, and occupational health centers nationwide; and managing rehabilitation programs in 1,900 long-term care facilities. NovaCare is the nation's largest employer of rehabilitation clinicians with 17,000 employees across 43 states, treating 35,000 patients per day.

Objective
The specific purpose of my testimony is to support the inclusion of the Functional Capacity Evaluation (FCE) as an essential part of the return-to-work process for individuals who meet the qualifications for payment under the SSDI and SSI Programs. Additionally, inclusion of a course of restorative physical rehabilitation as an option for appropriate individuals, as determined through an objective, valid and reliable testing process, is also essential if a return-to-work program is to be as effective and successful as possible.

The Dilemma
As I write this testimony, I am acutely aware that the merits of my arguments and those of my colleagues will not constitute the sole basis for your final decision, or ultimately, that of the Congress. You rightfully expect us to present cogent, persuasive information. Rather, your final decision will be a function of your assessment of the relative merits of that which we present, compared to that of other sincere and persuasive positions. Even in the absence of arguments opposing any given objectives, you have limited, finite resources to allocate. You cannot include everything that has merit.

In fact, the underlying issue of health care reform in general, and of a return-to-work program in particular, is that hard choices must be made among useful services, and those choices inevitably deny someone something they truly need. Instead of "medical necessity", health care reform is really a question of "relative medical necessity". This presents you a true dilemma, i.e., what justifiable and needed services will not be provided?

It is this inability to include everything that must be one of the most difficult fundamental tasks you perform as legislators. You must husband the resources of the nation and apply

them according to the will of the citizens. When it comes to health care, this task is particularly challenging because the apparent will of a given citizen often changes dramatically when he or she or their loved ones shift from the status of good health to that of ill health. The popular concept that there is an inalienable "right to health care" pits the finite resources of our nation against a literally infinite need. The term "infinite" is not an exaggeration. Only the achievement of "robust" immortality would reduce the need. Mere prolongation of life only adds years of individual need to the equation, and ultimately ends with death and its attendant need for increased resource utilization in any case.

It is not my intent with this observation to paint current efforts to reform health care and control its costs as either futile or inappropriate. Nor is it my intent to suppose I am capable of telling you your job. Rather, my goal is to respectfully persuade this committee that it is critically important for you and, indeed, all the citizens of this nation to acknowledge that if those finite resources are disproportionately expended helping people survive their spells of illness or injury and too little is left with which to help them achieve an acceptable quality of life during the balance of their years, then those resources have not been well allocated. Proper balance between resource allocation for "life saving" intervention and for "quality of life" intervention must be achieved.

In my experience, the preponderance of people have never really thought about this. Until, that is, they survive their own incident, thanks to the medical skills and technology available today, and need help rehabilitating their lives. If, at that point, the needs exceed the resources, the unfriendly, unkind aspects of our health care system become apparent. No doubt this reality formed the basis for the rule in primitive societies that obligated an individual who saved another's life to care and provide for that individual henceforth. I am certain no one in modern society would consider it honorable to intervene and prolong a person's life, only to knowingly abandon them to a life of suffering thereafter. Yet, that is exactly what we frequently accomplish. We expend heroic efforts and resources to save lives, then fail to provide adequate rehabilitation intervention to enable survivors to achieve and maintain what we would collectively acknowledge as a minimally acceptable quality of life. Examples of this "unintended consequence" abound in the ranks of the beneficiaries of SSDI and SSI support.

Discussion

I applaud the subcommittee for investigating the potential for returning chronically disabled citizens to the workforce. If a program such as the one being contemplated is successfully implemented, it will address the issue of balance in resource allocation in a meaningful way, offering these citizens, whatever the cause of their disability, a legitimate chance to escape dependency and regain a measure of control over their lives. As an added benefit, from the perspective of responsibly allocating finite resources, a successful program would also reduce costs, since the elimination of the cost of maintaining a citizen as a dependent of the state should more than offset the cost of providing the intervention necessary to do so.

One obvious danger in creating such a program is that it might not accomplish its goals. If too few recipients of support return to the workforce, the benefit of the program compared to other possible uses of resources would be questionable. Another danger is that inappropriate beneficiaries might be either granted or denied support as a result of erroneous criteria for determination.

It is to address these dangers that I urge the inclusion of the Functional Capacity Evaluation and optional restorative physical rehabilitation as essential components of the program, however it may ultimately come to be configured. Doing so will significantly reduce the potential occurrence of these undesirable outcomes.

An FCE, when properly done, provides quantified, objective baseline information regarding current functional performance. With this information, all interested parties can make informed decisions regarding the proper course of subsequent intervention for

each individual. Without this information, physically restorative or functionally rehabilitative intervention of any sort, no matter how skilled, may be inappropriate for the individual in question. This would inevitably result in unnecessary costs to the program and less than optimal results. With this information, however, individuals can be efficiently and cost effectively triaged into programs suited to their needs.

Comparable alternative methods for objectively measuring one's potential for returning to work do not exist. Assessment through observation by counselors or self-assessment by beneficiaries do not provide the objectively quantified measures of an FCE and do not, therefore, provide a comparable basis for targeted planning. They do not provide the full measure of available information that can enable both the disabled individual and the rehabilitation team members to agree on the steps necessary to achieve a level of function commensurate with a viable vocation.

This shared agreement between the rehabilitation team members and the disabled individual regarding his or her potential and the plan of intervention that will achieve that potential is critical to success. The population in question, by definition, has chronic disability. In many instances they have multiple disabling conditions. Their return-to-work will be achieved by enhancing and matching their remaining abilities with available vocations, not by eliminating all their disabilities.

The process whereby those abilities are identified and applied to specific functional/work activities must be one which gives the disabled individual a sufficient measure of hope that he or she is motivated to work toward the goal. This, again, is the product of a properly performed FCE. Specific tasks which can be correlated with components of specific vocational activities are done by the individual. Objective measurements are taken which compare that person's capacity to perform the tasks to those required to succeed on a job.

Analysis of the FCE results are utilized to pinpoint the impairments which are contributing to physical performance deficiencies, and a determination can be made as to whether the deficiencies may be overcome through various interventions. If physical impairments are targeted for a course of restorative physical rehabilitation, performance of an FCE thereafter will quantify the outcome of that rehabilitation and either validate the original determination of potential, or provide an objective basis for reassessment.

Speaking as a physical therapist, I cannot overstate how important it is for the client/patient to truly believe that the goals of therapeutic intervention are, in fact, achievable. Otherwise, it is unlikely that the client will participate fully in the rehabilitation activities, and success is seldom the outcome. This is the case for all levels of injury or dysfunction, no matter how minor. It is especially true for cases involving long term, chronically disabling conditions such as those which define the population under consideration here. The objective information provided by an FCE is the best tool available with which to convince a person of his or her own potential.

Speaking as a taxpayer, I endorse the concept of a staged program of intervention such as that presented in the testimony of my colleague, Dr. Matheson. If, at any point along the way toward return-to-work the individual no longer exhibits the physical and behavioral performance necessary to achieve a viable vocation, he or she must be excluded from further participation. The harsh reality is that many motivated individuals will have disabilities too great to overcome. The resources allocated to this program must be reserved for those who can demonstrate its success and justify its continuation for the benefit of future generations of disabled persons.

Those of us in the provider community must likewise subject ourselves to standards of performance that justify our participation in the program. Initial demonstration of capability may be achieved through meeting criteria established by one or more external organizations such as CARF (Committee for the Accreditation of Rehabilitation Facilities), JCAHO (Joint Commission on the Accreditation of Health care

Organizations), NCQA (National Commission on Quality Assurance) or others which might qualify for this role. Ongoing demonstration of capability through an accounting of results must also be included in the structure of the program. Just as an individual client/patient must continually justify participation by meeting established criteria, so too must providers justify their ability to participate. Only in this way will the resources allocated be protected from both abuse and misuse and, ultimately, produce the positive cost/benefit ratio anticipated.

Summary

- Implementation of a program to systematically enable chronically disabled individuals who meet current criteria for SSDI and SSI support to return to the workforce is an excellent investment of the nation's resources.
- Performance of a Functional Capacity Evaluation at one or more stages of the program is essential to provide the information necessary to determine the potential for any individual to succeed and to identify the rehabilitative interventions that are appropriate in each case.
- Many potentially successful individuals will be in need of restorative physical rehabilitation to ameliorate physical impairments that will otherwise limit their capacity to function at a level necessary to engage in and sustain a viable vocation.
- Both individuals and providers who participate in the program should be subjected to ongoing evaluation so long as they continue to be involved.

Thank you.