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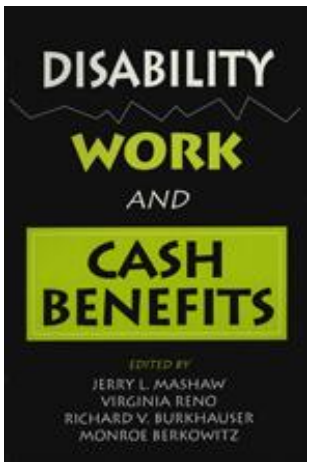

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Improving the Return to Work of Social Security Disability Beneficiaries

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This paper explores alternatives to the present system of rehabilitating or returning to work persons who are applicants for or beneficiaries of the disability programs of the Social Security Administration (SSA). The proposals are presented in two parts. Part I pertains to beneficiaries and is based on the benefit system as it currently exists. Part II proposes changes in how the SSA determines eligibility for benefits.

The following assumptions and beliefs underlie the recommendations:

1. The current Return to Work (RTW) system in social security is functioning poorly, as evidenced by the low number of persons who leave the rolls for reasons other than death or transfer to the retirement system.
2. The SSA's role in the RTW process should be minimized in favor of allowing market forces to operate.
3. Private sector providers should be encouraged to enter the market and to bear the associated risks, and they should be rewarded based on performance rather than on the costs of services provided.

The Existing Return-to-Work Program

Under the current arrangements, SSA is supposed to advise applicants about rehabilitation possibilities. Using SSA guidelines that may be adapted to state conditions, the state Disability Determination Service (DDS) refers beneficiaries to the state vocational rehabilitation

(VR) agency. The exact substance of this referral is not at all clear. The applicant may be informed of the existence of the VR program or may be given literature about it.[1] Apparently, in most SSA field offices, there is no concerted effort to inform applicants about what the program might do for them or about the relationship between these services and eligibility for the SSA benefits program.[2]

The individual interested in rehabilitation must submit a formal application to the state VR agency with evidence of his/her physical or mental condition. The VR counselor will interview the applicant, perhaps order further psychological or physical examinations, and decide whether the person should be accepted for services. If accepted, the client works out an individual written rehabilitation plan (IWRP) with the counselor that sets forth the intended services and the objective of the program.[3]

Under the usual VR rules, a client is considered rehabilitated if placed in a job or homemaker status for a period of two months. In order for the VR agency to be reimbursed by SSA for the costs of the services, it must meet a sterner test of rehabilitation. The beneficiary must be back at work earning more than the "substantial gainful activity" (SGA) level (currently $500 per month) for a period of at least nine months. If return to work for that period comes about, the VR agency is reimbursed for all reasonable expenses it incurred, subject to a maximum payment equivalent to the estimated savings to the SSA trust fund.

Using the traditional VR test, 40,155 beneficiaries were rehabilitated during fiscal year 1991, in the sense that they returned to work and remained at work for at least 60 days.[4] The average cost for their rehabilitation was about $3,600, more than $1,000 greater than the average cost for the nonbeneficiaries who were rehabilitated. The cost data are from the VR program and essentially represent purchased services. VR overhead and staff salaries, including the cost of the VR counselors, are not included in the averages.[5]

If the test is the one that SSA imposes before reimbursements are made, the number of rehabilitants decreases to a little more than 6,000 per year. In fiscal year 1993, nearly 300,000 persons were referred to VR, and 6,154 were rehabilitated in the sense of having earned SGA or more for nine months. The rehabilitation total is a relatively small number, some one-half of 1 percent of the persons on the rolls.

The appropriate comparison, however, is not with the number of persons on the rolls at a given time. It would be more meaningful to take a cohort of persons on the rolls and to follow this group through time to determine the number of individuals that return to work. Preliminary data from the New Beneficiary Survey show that most persons who leave the SSA rolls do so because they attain the age of 65 and transfer to the old age program or because they die. Some small number of persons return to work. We have no information about the number who return to work after receiving RTW services and the number that return without them. It seems safe to say that 3 percent, not all of whom have received any RTW services return to work, which is hardly a large number (Hennessey and Dykacz 1992 and 1993). The objective of a RTW program should be to improve that percentage.

Overall, nearly $64.5 million was paid to VR in reimbursements in fiscal year 1993. However, it appears that the program was cost beneficial from the point of view of the trust fund. The projected savings for fiscal year 1993 of $321.9 million was five times the amounts reimbursed.

Up until now, SSA's arrangements to reimburse providers have been with the joint federal-state VR program exclusively. In March 1994, SSA revised its regulations so as to allow the private sector to compete for the business. If the VR agency does not take on the case after a period of four months, the new policy will allow referral to alternative providers, including those from the private sector. This program is not yet in effect and awaits the issuance of detailed rules and regulations by SSA.

Allowing Market Forces to Operate

The limited effectiveness of the public VR system in taking persons off the rolls is not surprising. The VR programs have found other clientele, as Congress has asked them to concentrate on the disadvantaged, the mentally ill, persons with mental retardation, and persons with severe disabilities (Jenkins, Patterson and Szymanski 1992). Persons receiving benefits may be considered as difficult to rehabilitate since return to work means the loss of benefits. The issue of the disincentives

facing beneficiaries has to be faced squarely since it plays such an important role in return-to-work efforts.

We can consider a person who has recently been granted benefits. Obviously, that individual chose to apply for benefits and, with the award in hand, is now in an "equilibrium" position with no great incentive to change by starting an RTW program. Yet, the whole rationale for the RTW programs is that, somehow, the person will be better off by using RTW services, getting a job, and giving up the benefits. There may be a bit of a contradiction in this situation: having "chosen" to be on the benefit rolls, how could a person be better off by using RTW services and eventually leaving the rolls?

Before dealing with that issue, it is important to recognize that the interests of the benefits-paying agency and the interests of the individual beneficiary may be different. SSA is providing benefits, and it would be worthwhile for the agency to spend an amount on RTW services equal to what would be saved if the person left the rolls. The test for determining the amount is different, but would not the beneficiary be well advised to invest in RTW services so long as the cost is less than the net gain the person would enjoy by returning to work?

There are, however, two obvious sets of problems facing both the individual and the agency. One involves information. There simply is a great deal of uncertainty surrounding the efficacy of rehabilitation technology, the future labor market, and the success of RTW services in getting a person back to work at a wage that will be attractive to the individual and that will allow the agency to sever benefits. Obviously, since there are uncertainties, there are risks. Investments must be made today, but the return will not be forthcoming until some time in the future when and if the person returns to work. There is no guarantee of success, and the expenditures might be ineffective in putting the individual back to work.

The other problem has to do with the financing of RTW services. Even if the beneficiary is convinced that the timing is right and that a particular set of services that can be purchased from a provider is just the ticket to get back to work, the person may lack the necessary financing. The proposals in part II suggest some ways to deal with the capital markets problem. SSA would not have the same financial difficulties as the beneficiary since trust funds may be tapped to support these services. Although SSA has the advantage in the financing, the

agency probably faces more severe informational hurdles than does the individual. SSA has the problems of selecting beneficiaries for whom RTW services may be effective and of deciding the type of services, the provider, the timing of the services, and a host of other issues. The individual beneficiaries may be in a far better position than SSA to assess personal motivation and the type of services and providers with which they will be comfortable.

However, the individual beneficiary's evaluation of future prospects may be distorted. Beneficiaries may overestimate the value of leisure or they may underestimate the labor market value of their residual functioning capacities. A more realistic notion of the jobs for which they might be eligible, after a period of counseling, guidance, and perhaps even retraining, might emerge from a joint decision of the beneficiary and a provider of RTW services. The recommendations in this paper are based on the assumption that competition among providers in offering plans, together with the freedom that the beneficiary has in choosing a plan will result in an optimal solution to the information problem.

The alternative, of course, would be for SSA to pick out the candidates for RTW services or to offer these services to all. Offering and paying for rehabilitation services on an universal basis can be an expensive course of action, as demonstrated by the experience in workers' compensation. The large increase in the number of private sector rehabilitation providers came about after California amended its workers' compensation law to cover what might be termed mandatory rehabilitation. Although nothing in the law compelled employees to accept rehabilitation, employers and insurers were required to offer such services upon application of employees. Rehabilitation services were accompanied by a continuation of benefits, and the appropriateness of rehabilitation became an issue in the legal struggles over the rights to compensation benefits. Originally forecast to range from 3 to 5 percent of benefit costs, the program outlays reached as high as 15 percent (Monroe Berkowitz 1990; California Workers' Compensation Institute 1983). Variations of the mandatory rehabilitation provisions were enacted by several other states, including Colorado, Washington, Florida, and Maine. When the costs of the programs began to soar, each of these states abandoned the notion of compulsory rehabilitation.

The problems with compulsory rehabilitation were not difficult to identify. Rehabilitation services became a matter of right and were viewed as an attractive additional form of aid and a way to prolong periods of compensation benefits. Providers were paid for services rendered, be they evaluation services, counseling, training, or other types. Payment to the providers was not linked to results in the sense of return to work.

SSA's situation differs from that in workers' compensation, however. In the SSA programs, benefits are not a given for a finite period, and hence there would be less of a temptation for individuals to accept vocational rehabilitation just to prolong the period of benefits. On the other hand, the problems are similar, in that there are no obvious ways for the administrators to select persons for rehabilitation services. To make such services available to all brings with it expenses that may be out of proportion with the eventual benefits to the system.

Although states have abandoned mandatory rehabilitation or even mandatory evaluation for rehabilitation in workers' compensation, one legacy of that experience has been a thriving business of private sector rehabilitation providers. These individuals and firms are retained by employers and insurers to give services on demand. Since the employers are footing the bill, obviously these providers are called upon only when the employer or insurer makes a decision that the marginal dollar spent on services will yield a savings of that amount. It is doubtful that a public program such as SSA would be allowed to exercise these types of benefit-cost judgments in individual cases. Equity considerations would probably require uniform treatment of broad classes of beneficiaries. The following scheme proposed for beneficiaries of the system takes advantage of the growing number of private sector rehabilitation providers and minimizes the discretion exercised by SSA in the selection of clients to be offered services.

Part I: An Incentive-Based Reimbursement Scheme for SSA Disability Insurance Beneficiaries

The recommendations center around an incentive-based reimbursement scheme that assumes no change in the current test for benefits eligibility. It has two central features:

1. Payments to providers are conditioned on outcomes, with no necessary relationship to the costs of services.
2. All risks are borne by providers.

The scheme can be outlined briefly. SSA certifies a broad range of providers from the public and private sectors. VR becomes one of the players but would compete with providers from the private sector and possibly other providers from the public sector, including employment services. The watchword here is diversity, and hopefully providers would cover a wide scope of philosophies and methodologies.

1. SSA would screen new beneficiaries and eliminate those persons with no reasonable chance of returning to work--the terminally ill or those with only a few remaining years of eligibility on the disability insurance (DI) rolls, and also those persons who are expected to recover and to leave the rolls without any RTW services. All other beneficiaries would receive what can be termed a "ticket" or, to employ a term advocated by Steve Lavery from New Zealand, a "job card"[6] that can be used to receive services at any of the providers.
2. The ticket would have no predetermined value. Once deposited by the beneficiary at a provider, the ticket would become a contract between SSA and the provider to pay the latter a portion of the savings to the trust fund *during the period of time that the beneficiary is off the rolls and at work.*
3. The provider would not receive any compensation for services provided until the beneficiary completed the nine-month trial work period and was back at work for a period of time earning more than SGA. At that point, the provider would be paid a predetermined percentage of the amount that would have been paid

in benefits had the beneficiary remained on the rolls.

4. Providers would be paid each year that the beneficiary remained off the rolls for all or a portion of the year, according to the amount of savings to the trust fund.

Rationale for a New Scheme

The basic justification for a new scheme is that the current system is "broke and needs fixing." In a world where private sector providers are playing an increasing role in other benefit programs, it seems unwise either to exclude them or to have them play a secondary role in this market. There does not appear to be any reason for allowing the private sector in only after the public sector rejects or ignores the case.[7]

Beyond that, however, are the matters of monitoring and of provider incentives. Under the current system, providers bear the risk and are compensated only after the person leaves the rolls, and then solely for actual expenses incurred. Once the system begins to apply to private sector providers, SSA will have the unenviable task of auditing records and deciding issues of legitimacy of costs. Can fee schedules and utilization protocols be far behind? All this may not be too much of a problem in the VR program since the expenses of the agency are met from general appropriations, and, in a sense, the SSA reimbursements are found money for the VR agency.

Under the proposed scheme, there will be no auditing or monitoring problems since payment is according to results and not according to the cost of services provided. This should be a plus for the proposed system since, as is abundantly clear from the reengineering studies, SSA has difficulties in accomplishing its main tasks in the DI program without the challenge of monitoring a rehabilitation program (U.S. Department of Health and Human Services [HHS], SSA, September 1994a and November 1994b).

The prime virtue of the proposed system is that it seeks to replicate as many of the features of the private market as is possible. The tickets are held by the beneficiaries, who have the option of depositing them with a wide variety of providers. The providers are assumed to range along a spectrum, from job developers to those oriented more to the professional goals of rehabilitation counselors.

This scheme would appear to have many of the advantages of privatization that Weaver (1991, 1994) has stressed. Beneficiaries would have a choice among many competing providers, with different ideas about how to restore the person to a job. Providers would have few of the present constraints on the freedom of the VR program to devise return-to-work plans. The VR program understandably is obliged to follow the current priorities established by Congress and to follow prescribed procedures and processes. Adherence to the correct process may take precedence over outcomes.

Under the proposed scheme, the beneficiary is given a great deal of discretion. There is no obligation to deposit the ticket with any provider. The individual may choose to hold onto the ticket, preferring benefits to undergoing any regimen of rehabilitation. No mandatory compliance is contemplated. If, however, providers know that a particular person has a ticket, they will do all they can to persuade or cajole the person to deposit the ticket with them, and such competition for the custom of the beneficiary is all to the good.

The opposite situation may also prevail: no provider may agree to accept the ticket of a particular beneficiary. There may not be any provider who believes that the risk is worthwhile, that the person can be made job ready within the constraints of the reimbursement formula. Again, this would be an acceptable outcome. It would be a market judgment that the case cannot be handled at a profit to the provider.

Some Problem Areas

Who Should Be Issued Tickets?

One solution is simply to issue tickets to all beneficiaries. Persons who are terminally ill would not be in a position to deposit the tickets, and they probably would not be accepted once their condition was known. Older persons within a few years of age 65 might also have little motivation to deposit the tickets, and providers would be reluctant to accept them in light of the limited number of years remaining in which payments could be collected. The problem may solve itself, and there may be no good reason for SSA to try to sort out these groups. However, it would always be possible for SSA to write the rules so as to deny tickets to those over a particular age or with diagnoses where

death is expected within a short period of time. An alternative would be to issue tickets to persons in this group only on request.

A thornier problem is posed by those individuals who are expected to recover and leave the rolls without any services. Allowing these persons to have tickets will lead to accusations of "creaming" on the part of providers: the latter would only have to secure the tickets and retain them until the person went to work—and then claim the rewards. On the other hand, this is a difficult group to identify with any degree of certainty. Rather than expending the time and energy on identification, the strategy would be to issue tickets and to let the providers gain the benefits that might counterbalance some of the extraordinary costs involved in the more difficult cases. In all instances, the most that SSA would be paying would be a portion of the amounts spent had the person remained on the rolls.

In spite of the argument that no monetary losses accrue to SSA, perceptions are important in these matters. Therefore, SSA should try to identify a group that is likely to exit the rolls without services. Eliminating that contingent would allow the providers to prioritize services to those who have tickets and would keep them from "creaming" in the primal sense of giving assistance to persons who otherwise would have reached the same result.

What Happens if There Is a Change of Providers?

Two situations might be distinguished. One is where the beneficiary is dissatisfied with the provider, and the other is where the provider is unhappy with the beneficiary. The latter situation would seem to pose few problems. The provider can simply return the ticket to the beneficiary, or, if possible, sell it to another provider. There should be no objection to a market developing in these tickets.

The more difficult situation is where the beneficiary refuses to have anything more to do with the provider. In that case, the provider might still be able to sell the ticket to another provider. The ticket would be worth little to the former if the beneficiary has announced that no return to work is feasible until the original provider is off the case. An alternative to writing detailed rules and regulations and deciding subsequent disputes, would be to leave such matters to the negotiations between all of the parties, including more than one provider.

Inevitably some conflicts will arise, and it would seem to be reasonable to write legislation authorizing another mechanism to resolve such matters. One possibility would be final and binding arbitration with provisions for an expedited hearing.

What Is the Size of the Market?

An estimated 200,000 persons per year would realistically be in the market for RTW services. This number is based on the fact that 629,700 awards were made in 1993 (HHS, SSA 1994a, table 6.C1). If we eliminate all those over 50 years of age (316,669 persons) and those who are terminally ill (93,953 persons), we have 219,078 individuals remaining. Possibly 12 percent of the last number might be expected to recover and exit the rolls without assistance, which would leave 192,789 or roughly 200,000 persons to be issued tickets. Obviously, the number would be three times as great if everyone coming on the rolls were issued the tickets, but it is likely that there would be some reluctance on the part of SSA to issue tickets to those persons who were expected to leave the rolls without services. In addition, the older and sicker group would not be very attractive to providers.

How Will Providers Be Reimbursed?

The essence of the proposal is that providers are to be paid based on results as they become known. It is contemplated that the providers would expend the funds for services or find some other agency or body to finance them. The providers would not be reimbursed until such time as the person left the rolls, after which the provider would be paid a percentage of the benefit amount for the period the person was off the rolls. Such a calculation would be done yearly, and the provider compensated accordingly. Thus, the provider would have the incentive not only to return the person to work but to keep the person at work.[8]

A question can be raised as to whether the provider should be paid in the event the beneficiary medically recovers but does not return to work. In my view, payment should be conditioned not only on removal from the rolls, but on return to work. The provider can be seen as an advocate for the beneficiary, and it would seem problematic to have providers striving to prove to SSA that a medical recovery has occurred, without having the burden of placing and keeping the person

in a job that paid more than the SGA level. Thus, the proposed scheme would reimburse the provider only in the event of a return to work.

Table 1 illustrates how this reimbursement might work. The monthly benefit shown is the average amount awarded to a person of that age with a single dependent. The provider is assumed to be paid 30 percent of the annual savings. This is an arbitrary percentage that could vary and eventually would have to be set in negotiations between SSA and the providers.

Table 1. Incentive-Based Payments to Providers

Age	Annual benefit[a]	30 percent payable to provider annually	Potential number of years on DI rolls[b]	Present value of payments to providers[c]
25	$7,317	$2,195.10	39	$32,814.71
35	$9,853	$2,955.90	29	$40,173.63
45	$11,711	$3,513.30	19	$39,201.14
50	$11,936	$3,580.80	14	$33,282.92

SOURCE HHS, SSA (1993a) and author's calculations

a Annual benefit amount is based on the average benefit to a person of the age indicated, as shown in the *Annual Statistical Supplement to the Social Security Bulletin* (HHS, SSA 1993a, p 178), plus one-half of that amount for one dependent

b. The recipient may be on the DI rolls until age 65 One year is subtracted to account for the nine-month trial work period plus three months

c Present value of payments to providers was calculated assuming a 6 percent discount rate and annual compounding.

The reimbursement to the providers would be on a year-to-year basis. However, it is useful to calculate the present value of these payments so that providers can have some criterion for deciding how much should be spent in an individual case.[9] In making these present value calculations, the assumption is that the person remains on the rolls until age 65, unless death occurs previously. The calculations, in addition to taking mortality into account, make an adjustment for inflation and the fact that, under the most optimistic of assumptions, it would take at least a year before the person would leave the rolls. That amount of time is due to the nine-month trial work period plus the

three-month period before a person is taken off the rolls. The present value figure is a maximum amount that could be paid under the 30 percent sharing assumption. It is difficult to estimate the cost to the providers of the services necessary to remove the person from the rolls. Under the VR program, the average cost per case has been running about $10,000. A return of three to four times that amount is probably not excessive, considering that the payment is available only for successes. The provider would be paid nothing if the person never left the rolls.[10]

Part II: An Incentive-Based Proposal for SSA Disability Insurance Applicants and Beneficiaries

There are obvious advantages in providing RTW services before the benefits eligibility decision is made. One advantage is timing (Gardner 1988). The sooner the person is reached, the better the chances that services will be effective. The question is whether the whole spirit and ethos of the decision-making process in SSA might be changed so that rehabilitation or return to work takes precedence over benefits.

The SSA DI program bears the stamp of its origins. Unlike the situation in some countries, DI did not begin as an offshoot of the health program but as an addition to the retirement program. The concern was for persons whose income had stopped due to a disability. They were forced to "retire" due to a medical condition, and the feeling was that they should have somewhat the same benefits as people who retired due to old age.

The emphasis of SSA has been on the increasingly difficult task of determining who is and who is not eligible for benefits, in spite of the location of the determination process in the state agencies linked to the VR program, and in spite of the cooperative efforts through the years of the Beneficiary Rehabilitation Program (Monroe Berkowitz et al. 1982) and the current VR program. Rehabilitation has not come before benefits. It has been the other way around.

A policy such as the German one of placing "rehabilitation before pensions" (Aarts and de Jong, this volume) is not easy to bring about. New Zealand, for example, has changed the name of its basic accident

statute from the Accident Compensation Act to the Accident Rehabilitation and Compensation Insurance Act, but there is no real evidence that the new name has been accompanied by different priorities. Changing from an agency whose primary task is to determine which applicants should be paid cash disability benefits to one whose first interest is the return to work of applicants is not only difficult but probably requires modifications in support systems and other legislation.

One possible approach would be to charge the Disability Determination Services (DDS) with the responsibility of making a rehabilitation decision before making the basic one dealing with eligibility for benefits. The initial decision would be whether the applicant should or should not receive a "ticket," "job card," or simply a "voucher" for rehabilitation services. After that choice is made, the DDS would proceed to considering the matter of eligibility for benefits. Some applications would be allowed and others denied, without regard to whether the individuals were issued vouchers.

The test for the voucher could be essentially that now specified for acceptance into the general state-federal VR program. First, it must be established that the person has a physical or mental condition that constitutes a substantial handicap to employment for this individual; second, there must be a reasonable expectation that vocational rehabilitation services will benefit the individual's employability.

Just as the DDS may now call on testimony from medical experts in deciding whether to allow benefits, it may also call upon expert evaluators for advice regarding the benefits of vocational rehabilitation services for the individual's employment chances.[11] There are many different ways that the DDS might classify an individual's vocational rehabilitation potential. The simplest approach would probably be to place all applicants into three categories.

The first category would be those persons who are deemed not to have a physical or mental condition that would interfere with their employment. These people would be expected to return to the labor market without any VR services. Although the determination of vouchers and the determination of benefits would be done separately, presumably all of the persons in this category would end up in the group denied benefits.

The persons in the second category would be those who meet the eligibility requirements and who would be issued vouchers. SSA bene-

fits would later be allowed for some of these individuals and would be denied for others.

In the third category would be those persons with a sufficiently disabling physical or mental condition but who are so severely impaired that the judgment is made that they would not benefit from receiving VR services. The presumption is that most of these individuals would be allowed disability insurance payments, but some may not be able to meet the rigorous disability tests in the DI law.

In a second stage, the DDS would move to consider the applications on their merits. Persons in the first category presumably end up without vouchers and without benefits. It is anticipated that benefits would be allowed to persons in the third category who were denied vouchers based on the severity of their conditions and the poor outlook for employment. It is people in the middle category who pose the interesting issues. Some of these individuals might be denied outright, due to not meeting the existing SSA eligibility tests; however, they would still have their vouchers. This presents two problems. One is that, if we still wish to keep an incentive-based system for providers, we no longer have any obvious yardsticks with which to measure the compensation due providers who successfully find jobs for people in this group. The second problem is that there is no obvious source of financing for the RTW expenses. It is doubtful that there is any rationale for tapping trust funds on behalf of persons who have been denied benefits.

Financing Vouchers from a Loan Fund

One possible solution to the financing problem is to have Congress establish a loan fund from general revenues. The risks would be limited by the finite amount of the fund, which would be replenished by the repayment of the loans. Loans would be available at minimal rates of interest, and the obligation to repay would begin only when and if the person returned to gainful employment. Obviously, "failures" would result in a rapid depletion of the fund.

The fund could be used for two purposes. One would be to provide, where necessary, a modest living allowance for the person who might be without necessary support, having been denied SSA benefits. The other would be to reimburse the provider of RTW services. In order to adhere to the incentive- or performance-based philosophy, the provider

would not be paid unless and until the person returned to work and remained at work for a period of time. A minimum period of six months would be advisable.

Another issue has to do with the value of the voucher. Obviously, the higher the value, the more attractive it will be to providers, who are being asked to bear the risks of the RTW program. On the other hand, the value of the voucher will have to depend on the size of the fund. Since this proposal is not for an open-ended entitlement system, the fund will have a finite amount of money available to finance RTW programs. The generosity of the voucher might well fluctuate in accordance with fund balances.

There appears to be no ideal way to set the value of the voucher, but solutions might come from some experimentation over time. One approach would be to determine if the fund administrator, the DDS, or another appropriate body could make distinctions among applicants, based on the probability of their returning to work or on the forecast of the necessary services that would enable them to get back to work. Another experiment would focus less on the diagnosis of the individual and more on simulations, which would take into account fund balances and the attractiveness to providers of vouchers with values differing for persons in different disability categories.

Time-Limited Benefits

The other contingent of those persons issued vouchers would be individuals who qualified for benefits under the present definitions of disability. This group could be treated in the same way as proposed earlier for beneficiaries who would be issued tickets. However, in order to emphasize the philosophy of rehabilitation first and benefits second, the concept of time-limited benefits should be introduced. In a sense, any case that is recorded for a continuing disability review (CDR) is time limited. However, due to the press of other business, CDRs have not been conducted on a regular basis. A time-limited benefit would be different: recipients would be alerted to the fact that they are expected to return to the labor market and that their benefits are given to them for a finite period of time.

At the outset, a period of two years should be sufficiently long to determine whether RTW services were effective in getting the person

back to work. After the two-year period, benefits would automatically cease. If the person were not at work, a new application could be filed, with the understanding that, in addition to the usual tests of disability, SSA would take into account the record of cooperation of the applicant with the RTW services. In all other respects, the incentive-based scheme for beneficiaries that has been proposed would apply.

An Incentive-Based Proposal for Supplemental Security Income

It might be misleading to label this an RTW process since some of the Supplemental Security Income (SSI) clients may not have had any work experience. However, the problems are essentially the same, and an incentive-based proposal, as in part I would seem to be as applicable to SSI as to DI.

Certainly, there are also differences that need to be considered. First, in the case of DI, the test is the inability to work, whereas, in SSI, there is not only this criterion, but a test based on assets and income. Second, the conditions for entering the SSI rolls are not the same as the conditions for exiting from the rolls. Although there is talk about additional employment incentive provisions for DI, in the form of allowing the recipient to retain a portion of benefits while working, these rules are not yet in effect. Such incentives, plus a host of others, are in place for SSI recipients (HHS, SSA 1992, *Red Book on Work Incentives*). These provisions pose no real problems, although their existence does diminish the savings to government when a recipient goes to work. Of course, SSI is financed on a different basis than is DI. There is no trust fund for SSI, and payments are from general revenues.

In principle, the issues and procedures applicable to DI can be transferred to SSI. As in the case of DI, decisions would have to be made as to whether tickets would be issued to all SSI recipients at the time they are put on the benefit rolls, or whether tickets ought to be withheld from those too disabled, too old, and those expected to recover without the need for services.

It would be necessary to estimate the savings to the taxpayer if the person who has qualified for SSI is removed from the rolls. Such a calculation is currently made in order to evaluate the maximum amounts

that could be paid to VR in the case of rehabilitation of an SSI beneficiary. These estimates would be used, and a percentage of the savings would determine the value of the ticket.

Successful providers might have to be paid a different percentage of savings than would be true in the case of DI beneficiaries. Thirty percent may not be sufficient in the situation where the recipient is allowed to retain one dollar of benefits for every two dollars of earnings. The exact percentage should be set after a more thorough examination of the projected savings.

Conclusions

The current system designed to return disabled beneficiaries to work desperately needs to be changed. SSA is assumed to have its hands full trying to make the disability determination process work in an equitable and efficient manner and to have neither the expertise nor the financing to engage in the day-to-day management of the rehabilitation of its beneficiaries. At the same time, the return to work of persons on the rolls is assumed to be a responsibility of SSA.

Another important assumption is that no one formula, modality, or type of rehabilitation service is obviously superior to another when it comes to returning beneficiaries to work. Problems of what service to be used, when it should be used, and who should provide the service are best left to the market, where the individual preferences of beneficiaries can be matched with the different approaches of providers.

This paper advances several proposals for reform of the RTW system. In part I, the proposal pertains only to beneficiaries and requires no change in the present definitions of disability. The beneficiary would be provided with a ticket that could be used to obtain services from a wide variety of providers. Coming up with a set of services and the conditions for the administration of these services would be left to the interaction of the beneficiaries and the providers. In the absence of a market, the proposed system would have some of the advantages of a market.

Payments to providers would be based on results. If the beneficiary does not return to work, no payments would be due. The risk would be

borne entirely by the provider, whose incentive to get into this business would be based on the generosity of the amounts received if the beneficiary resumes employment. The experience of the DI program is that persons move off and on the rolls. The system of compensation proposed here, where providers are paid on a yearly basis only so long as the person is off the rolls, guarantees that the providers will have continued interest in monitoring the employment of persons returned to work.

SSA has nothing to lose from this system, in the sense that the agency can never pay providers more than a fraction of the savings accruing to the trust fund, and this would occur only after evidence is received that the savings have been realized. In this sense, the new system should not cost the agency any additional money. However, it is necessary to take into account any induced demand for benefits brought about by the increased payments to providers. The benefits package may now be more attractive to some persons who now would file for benefits. These costs are difficult to estimate but it is wise to assume that some additional costs would occur because of the induced demand.

For the system to work, providers have to be attracted to it and be willing to finance back-to-work programs on this contingency basis. Congress has to be convinced that providers should be paid amounts that have no necessary relationship to the cost of services provided.

Part II proposals are based on changes in the way that SSA administers the disability programs. Although the difficulties in bringing about fundamental change are not underestimated, the success of the part II proposals depends on SSA placing rehabilitation first and benefit awards second. Persons should be evaluated initially for suitability for RTW services, and those found suitable should be issued vouchers that are essentially claims on a loan fund. For those persons who are denied benefits, the value of the voucher would be determined by experiments. It is proposed that the funds be used for income support as well as for RTW services.

The incentive-based aspects of the RTW proposals for beneficiaries are maintained in part II, albeit in a modified form. For persons with vouchers who are allowed benefits, the proposed system should operate in much the same manner as in part I for beneficiaries, except that the benefits should be awarded on a two-year, time-limited basis.

The SSI program poses its own problems, stemming from the lack of an identifiable trust fund and the SSI incentive provisions that allow persons who are working to retain a portion of their earnings. The incentive-based scheme for beneficiaries (part I) should be applied to the SSI program, with appropriate modifications in the reimbursement formula for providers.

Change never comes easily to an established governmental program, nor should it. Each innovation ought to bear the burden of proving that it will bring benefits commensurate with its costs. Yet the RTW record cries out for reform. In keeping with the philosophy of the 1990s, this change ought to be one that does not create new open-ended entitlement programs or call upon the bureaucracy to accomplish tasks for which it is ill suited. In each of the schemes proposed in this paper, risk is transferred to the providers, payments are made only when results are evident, and a positive marginal benefit-cost ratio is guaranteed.

NOTES

1. The state Disability Determination Service (DDS) sends a list of beneficiaries and denied applicants who are considered to have rehabilitation potential to the state VR agencies These agencies may or may not contact the individual, who may or may not apply for services (Reno and staff 1994)

2 If asked by the applicant, personnel at the SSA district offices are instructed to tell claimants about the VR program and to give them a brochure with the address and phone number of the local VR agency. A brochure giving an overview of state VR services was last printed by SSA in 1981 and has been out of print for many years (Reno and staff 1994)

3. A more complete explanation of how the process works in the joint federal-state vocational rehabilitation program can be found in Mandeville and Brabham 1992 The VR program is based on legislation that began in the 1920s. A summary look at the chronology of this legislation can be found in Jenkins, Patterson, and Szymanski 1992, table 1 2 For a broader historical examination of the VR program, see Edward Berkowitz 1987.

4. Our discussion is narrowly focused on VR activity A study by Hennessey and Dykacz (1993) of a 1972 cohort of beneficiaries projected that 11 percent of the individuals would have either a medical or a work recovery, 36 percent would die, and 53 percent would have their benefits converted to retired-worker status at age 65 Of course, all beneficiaries will die eventually, the reference here is to the first event of interest after entitlement

5. These data are from unpublished tabulations from the Rehabilitation Services Administration, May 1994, and are cited in Reno and staff 1994

6. Lavery 1994. The advantage of the job card is that it can be encoded with information that might be used to differentiate potential rehabilitants, or, as Lavery would refer to such persons, "customers," in terms of the reimbursement formulas or other characteristics.

7 The preferential status granted the VR program is embodied in the law. However, section 222(d)(2) of the Social Security Act allows the Commissioner of Social Security to contract with other public or private agencies where a state is unwilling to participate or where it does not have

a suitable plan. By reason of these provisions, SSA will be contracting with private providers where the state VR chooses not to serve the person if and when detailed regulations are issued

8 Keeping persons at work or off the rolls is a problem. In their examination of a 1972 cohort of beneficiaries, Hennessey and Dykacz (1993, p. 59) show that about 43 percent of those beneficiaries who recovered ended their post-recovery period by becoming reentitled to disabled worker benefits.

9 Present value calculations are obviously sensitive to assumptions about trends in benefit amounts, termination rates, rates of discount, and a number of other factors For purposes of compensating VR where reimbursement cannot exceed savings to the trust fund, the SSA actuaries compute these present values. The following table presents the application of their formula to persons with the assumed benefits as shown. These sums are a good bit lower than the present-value sums in table 1. Unlike the VR arrangements, the reimbursements under the proposed scheme would be on a year-to-year basis Since it is contemplated that these reimbursements would always be merely a fraction of the yearly savings and would be paid only after these savings accrue, there would be no possibility of a payment to the providers greater than the savings to the trust fund.

SSA Computation of Present Value of Program Savings from Successful Rehabilitation

Age	Monthly benefit[a]	Computation of savings[b]
25	$407	$47,118 02
35	$547	$66,610 27
45	$651	$68,985378
50	$663	$61,887.88

a Monthly benefit amount is based on the average benefit to a person of the age without dependents as mandated in the *Annual Statistical Supplement to the Social Security Bulletin* (HHS, SSA 1993a, p 178)

b The formula for total savings to the SSA is as follows "A-Factor" +[(PIA-WC+SSI)* "B-Factor"], where the "A-Factor" represents savings resulting from administrative costs, and the "B-Factor" represents savings resulting from the expected eventual termination of benefit payments PIA = Title II Primary Insurance Amount, WC = Workers' Compensation payment, and SSI = Supplemental Security Income payments Tables of A and B factors are based on the alternative IIB set of disability, economic, and health utilization assumptions found in the 1988 SSA Trustees' Reports

10 In a meeting of private providers held on June 26, 1994, the basic outlines of the proposal were covered. Some providers expressed doubts that the program would be a viable one and were concerned about having to finance the services over what might be long periods of time before any returns would be received. Other providers thought the program offered opportunities and felt that it could be financed by recourse to bank loans or to the equities market. Before such a program is put into effect, it would be desirable to review concrete business plans from some of the providers who feel that the proposal would be attractive to them.

11 Evaluation for vocational rehabilitation feasibility is a difficult matter If the DDS offices use a cadre of evaluators to decide who is and who is not a suitable candidate, it would be desirable to separate this function from the provision of RTW services in order to avoid any conflict of interests.

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