United States General Accounting Office

GAO

Testimony

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

For Release on Delivery
Expected at
9:00 a.m. EDT,
Wednesday,
June 5, 1996

SOCIAL SECURITY

Disability Programs Lag in Promoting Return to Work

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GAO/T-HEHS-96-147

Social Security: Disability Programs Lag in Promoting Return to Work

Mr. Chairman and Members of the Committee:

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

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

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

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

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

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

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

Background

DI and SSI—the two largest federal programs providing cash and medical assistance to people with disabilities—grew rapidly between 1985 and 1994, with the enrollment of working-age people increasing 59 percent, from 4 million to 6.3 million, and the inflation-adjusted cost of cash benefits growing by 66 percent. Administered by SSA, DI and SSI paid over $50 billion in cash benefits to people with disabilities in 1994. To be considered disabled by either program, an adult must be unable to engage in any substantial gainful activity because of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last at least 1 year. Moreover, the impairment must be of such severity that a person not only is unable to do his or her previous work, but, considering his or her age, education, and work experience, is unable to do any other kind of substantial work that exists in the national economy.

Both programs use the same definition of disability but differ in important ways. DI, established in 1956, is an insurance program funded by payroll taxes paid by workers and their employers into a Social Security trust fund. The program is for workers who, having worked long enough and recently enough to become insured under DI, have lost their source of income because of disability. Medicare coverage is provided to DI beneficiaries after they have received cash benefits for 24 months. Almost 4 million working-age people (aged 18 to 64) received about $34 billion in DI cash benefits in 1994.[3]

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

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

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

Caseloads Have Changed Since the Mid-1980s

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

Statute Provides for Returning Beneficiaries to Work

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

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

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

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

Technological Advances and Social Change Foster Return to Work

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

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

Current Program Structure Impedes Return to Work

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

Table 1: Summary of Program Design and Implementation Weaknesses

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

Work Capacity of DI and SSI Beneficiaries May Be Understated

The Social Security Act requires that the assessment of an applicant's work incapacity be based on the presence of medically determinable physical and mental impairments. SSA maintains a Listing of Impairments for medical conditions that are, according to SSA, ordinarily severe enough in themselves to prevent an individual from engaging in any gainful activity. About 70 percent of new awardees are eligible for disability because their impairments meet or equal the listings. But findings of studies we reviewed generally agree that medical conditions are a poor predictor of work incapacity.[6] As a result, the work capacity of DI and SSI beneficiaries may be understated.

While disability decisions may be more clear-cut in the case of people whose impairments inherently and permanently prevent them from working, disability determinations may be much more difficult for those who may have a reasonable chance of work if they receive appropriate assistance and support. Nonmedical factors may play a crucial role in determining the extent to which people in this latter group can work.

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

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

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

[6]For example, S.O. Okpaku and others, "Disability Determinations for Adults With Mental Disorders: Social Security Administration vs. Independent Judgments," American Journal of Public Health, Vol. 84, No. 11 (Nov. 1994), pp. 1791-95; and H.P. Brehm and T.V. Rush, "Disability Analysis of Longitudinal Health Data: Policy Implications for Social Security Disability Insurance," Journal of Aging Studies, Vol. 2, No. 4 (1988), pp. 379-99.

employment. Neither do they allay the fear of losing medical coverage and other federal and state assistance that beneficiaries who return to work may face. Studies have identified the risk of losing medical coverage as a major barrier to beneficiaries' returning to work. Beneficiaries who work and continue to earn countable income above certain amounts will eventually lose medical coverage even though they have not necessarily improved medically or obtained affordable coverage elsewhere.

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

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

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

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

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

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

The practices underlying these strategies are summarized in table 2.

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

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

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

Early Intervention Critical to Return to Work

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

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

Identifying and Providing Return-to-Work Services Effectively

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

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

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

Work Incentives Facilitate Return to Work

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

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

Return-to-Work Outcomes Could Be Improved Through Restructuring

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

[7]For example, J.C. Hennessey and L.S. Muller, "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work," Social Security Bulletin, Vol. 58, No. 1 (spring 1995), pp. 15-28; R.J. Butler, W.G. Johnson, and M.L. Baldwin, "Managing Work Disability: Why First Return to Work Is Not a Measure of Success," Industrial and Labor Relations Review, Vol. 48, No. 3 (Apr. 1995), pp. 452-67; and R.V. Burkhauser and M.C. Daly, "Employment and Economic Well-Being Following the Onset of a Disability: The Role for Public Policy," paper presented at the National Academy of Social Insurance and the National Institute for Disability and Rehabilitation Research Workshop on Disability, Work, and Cash Benefits (Santa Monica, Calif.: Dec. 1994).

Studies have shown that a meaningful portion of DI and SSI beneficiaries possess such characteristics. The DI and SSI disability rolls have been increasingly composed of a significant number of younger individuals. Among working-age SSI and DI beneficiaries, one out of three is under the age of 40.[8] In addition, in 1993, 35 percent of 84,000 DI beneficiaries expressed an interest in receiving rehabilitation or other services that could help them return to work, an indication of motivation. Moreover, a substantial portion—almost one in two—of a cohort of DI beneficiaries had a high school degree or some years of education beyond high school.[9] The literature also suggests that lack of work experience is a significant barrier to employability.[10] A promising sign is that about one-half of DI and one-third of SSI working-age beneficiaries had some attachment to the labor force during the 5 years immediately preceding the year of benefit award.[11]

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

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

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

[9]J.C. Hennessey and L.S. Muller, "Work Efforts of Disabled-Worker Beneficiaries: Preliminary Findings From the New Beneficiary Followup Survey," Social Security Bulletin, Vol. 57, No. 3 (fall 1994), pp. 42-51.

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

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

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

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

Conclusions

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

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

Contributors

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Related GAO Products

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

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

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

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

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

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

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

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

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

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