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SUPPLEMENTAL SECURITY INCOME

Recipient Population Has Changed as Caseloads Have Burgeoned

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

Mr. Chairman and Members of the Committee:

Thank you for inviting us to speak about the rapid growth of the Supplemental Security Income (SSI) program. SSI provides means-tested income support payments to eligible aged, blind, or disabled persons. Last year, over 6 million SSI recipients received nearly $22 billion in federal benefits and over $3 billion in state benefits. SSI is one of the fastest growing entitlement programs; program costs have grown 20 percent annually in the last 4 years.

We have issued many reports on SSI and are continuing to study it closely. (A list of related GAO products is appended.) You asked us to focus today on factors contributing to caseload growth, how the characteristics of SSI recipients have changed, and ways to improve SSI.

To summarize the key points in the statement,

-- Major factors contributing to growth include eligibility expansions, outreach, limited emphasis on return to work, and immigration.

-- Before the mid-1980s, the number of SSI recipients was relatively stable and the number of aged recipients was decreasing. Since 1986, the number of disabled SSI recipients has increased an average of over 8 percent annually.[1] (See fig. 1.)

-- Disabled recipients now account for nearly 80 percent of federal SSI payments.

-- Three groups have accounted for nearly 90 percent of SSI's growth since 1991--adults with mental impairments, children, and noncitizens.

-- SSI recipients now tend to be younger, receive larger benefits, and depend more on SSI as a primary source of income.

-- Medical, technological, and social changes challenge the historic presumption that disabilities are total and permanent.

-- Ways to improve SSI include increasing reviews of the disability status of current recipients and placing more

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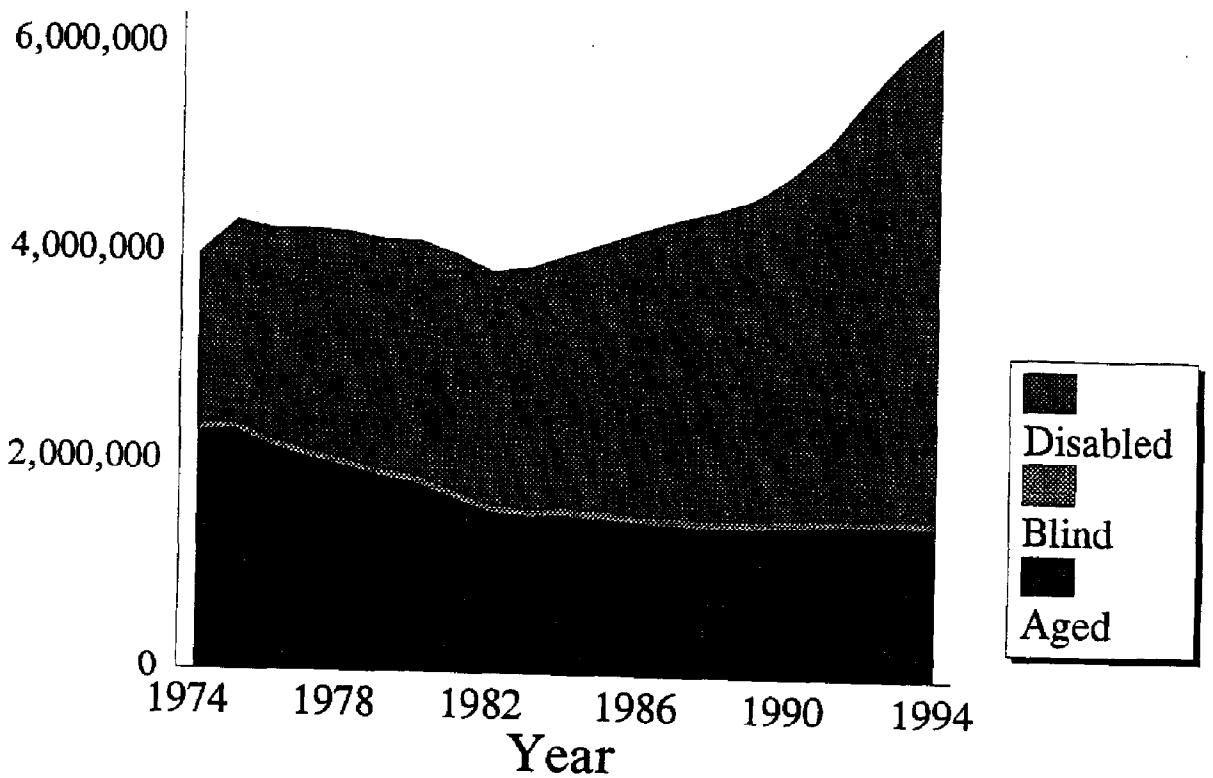
[1]Unless otherwise specified, we use the word "disabled" only for those recipients under age 65 and "aged" for those age 65 and over. When disabled recipients turn 65, SSI program data typically continue to count them among the disabled.

Figure 1: Number of SSI Recipients by Eligibility Group



Note: In this graph, "disabled" includes disabled recipients aged 65 and over, who numbered 630,000 in 1994. This count was not available prior to 1984.

Source: Annual Statistical Supplement to the Social Security Bulletin, 1976-1993, and SSA data.

emphasis on rehabilitation, employment assistance, and work incentives.

BACKGROUND

The Congress established SSI in 1972 to replace federal grants to similar state-administered programs, which varied substantially in benefit levels and eligibility requirements. The Congress intended SSI as a supplement to the Social Security Old Age, Survivors, and Disability Insurance (OASDI) program for those who had little or no Social Security coverage.

Federal SSI benefits are funded by general revenues and based on need, unlike Social Security benefits, which are funded by payroll taxes and, in effect, based on the contributions of individuals and their employers. The Social Security Administration (SSA) has overall responsibility for the SSI program.

To be eligible for SSI, individuals must be 65 years old, blind, or disabled. To be considered disabled, adults must be unable to engage in any substantial gainful activity because of a physical or mental impairment expected to result in death or last at least 12 months. For children, the impairment must be "of comparable severity" to one that qualifies an adult as disabled. Individuals cannot have income greater than the maximum benefit level or own resources worth more than $2,000 ($3,000 for a couple), subject to certain exclusions, such as a home. Individuals must also be U.S. citizens or legal immigrants.

In 1995, the maximum federal SSI monthly benefit is $458 per month for an individual and $687 for a couple with both spouses eligible; these benefit rates are adjusted annually for cost-of-living increases. This monthly benefit is reduced depending upon recipients' incomes, living arrangements, and other sources of support, including Social Security benefits. As a result of these adjustments, the average monthly benefit in 1994 was $325. Since SSI provides income support as a last resort, SSI recipients must file for any other benefits for which they may be eligible, such as Social Security or workers' compensation. In 1993, 40 percent of SSI recipients also received Social Security benefits, down from almost 60 percent in 1986.

In addition to federal SSI benefits, states may provide supplemental benefits. The District of Columbia and all but seven states provide these optional supplements. These supplements vary, reflecting differences in regional living costs as well as in living arrangements. In December 1994, nearly 3 million SSI recipients, or roughly half, received an average of about $110 per month in state supplemental benefits at a total cost to the states of about $3.5 billion. Most SSI recipients are also eligible for Medicaid and Food Stamps.

In addition to providing cash benefits, both SSI and the Social Security Disability Insurance (DI) program include return-to-work components. Both programs include work incentive provisions and screen and refer disabled and blind recipients to state vocational rehabilitation agencies. Refusing rehabilitation services is cause for benefits termination.

FACTORS CONTRIBUTING TO GROWTH

A variety of factors have contributed to the rapid growth in the SSI caseload, but the relative effects of these factors on growth are not fully understood. Program factors, such as expanded disability criteria and major outreach efforts, have brought more individuals onto the rolls at younger ages. At the same time, some disabled recipients may stay on SSI longer and at higher benefit levels than they need to because SSA has devoted little effort to (1) reviewing cases for medical improvements and (2) helping recipients return to work. Widely publicized reports of fraud and abuse suggest another potential source of growth, and such reports can also significantly erode public confidence in the program's integrity. In addition, various factors external to SSI, such as increased immigration, have contributed to growth as well. We summarize these factors in table 1 and discuss them below.[2]

[2]See also Social Security: Federal Disability Programs Face Major Issues (GAO/T-HEHS-95-97, Mar. 2, 1995).

Table 1: Factors Contributing to Growth in SSI

Program factors	
More persons brought into the program	Eligibility expansion: Legislative and regulatory changes have increased access to disability benefits. Program outreach: The Congress mandated that SSA seek eligible persons to apply for SSI through outreach campaigns.
Some recipients may stay on SSI longer than needed	Continuing disability reviews (CDRs): Until 1994, the law did not require SSA to perform CDRs for SSI cases, and SSA spent little effort on CDRs. Return to work efforts: Helping people with disabilities return to work is a low priority of the SSI program.
Fraud and abuse	Allegations have been made that certain SSI recipients, including children, immigrants, and drug addicts and alcoholics, may receive benefits though ineligible.
External factors	
Immigration	Growing numbers of immigrants have been admitted for legal U.S. residence.
Economic conditions	Recession may increase applications and affect eligibility and benefit levels.
Medical breakthroughs	Disabled individuals now have better chances to live longer through medical and technological advances.
Transfers from state programs	Some states help public assistance recipients move to SSI.
Health insurance	Individuals may be applying for SSI or staying on the rolls longer for affordable health insurance.

Eligibility Expansion

Congressional oversight in the early 1980s found that serious questions had been raised by federal courts, professionals in the fields of psychiatry and vocational counseling, and us about the adequacy of SSA's standards to assess mental impairment for both DI and SSI. Addressing these concerns, the Congress passed the

Disability Benefits Reform Act (DBRA) in 1984, effectively expanding the definition of disability for both adults and children. In particular, the act required new standards for mental impairments that incorporated the person's ability to compete in the job market. It also required SSA to consider the combined effects of multiple impairments if no single impairment were sufficiently disabling to allow someone to qualify for benefits and increased attention to the effect of pain on the ability to work. Further, the act allowed SSA to consider nonmedical evidence offered, for example, by an applicant's family and friends. Finally, the act required increased emphasis on opinions of physicians treating the individuals and on evaluating their functional limitations.

In addition to DBRA, a 1990 Supreme Court decision, Sullivan v. Zebley, ruled that SSA's disability determination process for children "does not account for all impairments 'of comparable severity' [to adults]..." and thus held children to a more restrictive standard. For those children who do not qualify by meeting SSA's strict listings of impairments, the Court required SSA to add an individualized functional assessment (IFA) of how their impairment limits their ability to act and behave in age-appropriate ways. Also in 1990, SSA issued regulations revising and expanding its standards for assessing mental impairments, specifically in children. These standards incorporated functional criteria, added impairments, such as attention deficit hyperactivity disorder, and increased the weight of nonmedical evidence from parents, teachers, social workers, and others. These changes reflected advances in medicine and science.

Program Outreach

At the direction of the Congress and on its own initiative, SSA has increased its outreach efforts to better inform potential recipients of their SSI eligibility. These efforts have attempted to reduce barriers for potential applicants, such as a lack of information about the program, perceived stigma from accepting benefits, and the complexity of the application process. Along the same lines, state and local agencies and nonprofit groups serving the poor have focused more attention on encouraging eligible persons to enroll, not just for cash payments but to establish eligibility for Medicaid and Food Stamps as well.

In 1983, the Congress passed legislation requiring SSA to identify all Social Security Old-Age beneficiaries whose benefits fell below the SSI benefit level and to notify them of the availability of SSI benefits. In addition to this one-time effort, the law required ongoing notices to Social Security beneficiaries who reach age 65 and certain disabled beneficiaries.

Beginning in 1989, SSA made SSI outreach an ongoing agency priority and conducted demonstration programs, increased

coordination with other agencies serving the poor, and encouraged field office outreach initiatives. The Omnibus Budget Reconciliation Act of 1989 established a permanent outreach program for disabled and blind children. Also relating specifically to children, as part of the Zebley settlement, SSA was required to launch a national media campaign and conduct outreach to schools and welfare offices to enroll more children.

In 1990, we reported on the views of SSA district managers on SSI outreach.[3] They acknowledged the need for outreach and believed they were doing enough. They were implementing a wide range of outreach activities, but it was not clear which were most effective. About 40 percent believed outreach was needed for non-English-speaking people.

In 1990, the Congress mandated that SSA expand the scope of its outreach efforts and provided $21 million for SSA to complete a series of outreach demonstration projects. As of 1994, SSA funded about 80 cooperative agreements targeting diverse populations such as African Americans, Native Americans, the homeless, the mentally ill, and persons who tested positive for the human immunodeficiency virus.

Limited Numbers of Continuing Disability Reviews (CDRs)

The purpose of CDRs is to verify that disabled recipients still have a disability that prevents them from working. In 1993 and 1994, we reported[4] that while SSA has had authority to perform such reviews for SSI recipients, it has done relatively few. In 1994, the Congress directed SSA to perform a minimum number of disability reviews for SSI recipients. Accordingly, SSA plans to conduct reviews on 100,000 SSI adults and on one-third of SSI children turning age 18 for each of the 3 fiscal years beginning in 1996.

In contrast, before 1994, the law already required SSA to conduct reviews at least once every 3 years for Social Security disability (DI) beneficiaries in cases where medical improvement is possible or expected, and regulations require that a review be scheduled every 7 years in cases where medical improvement is not expected. About 500,000 DI cases come due for a disability review

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[3]Social Security: District Managers' Views on Outreach for Supplemental Security Income Program (GAO/HRD-91-19FS, Oct. 30, 1990).

[4]Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994); Social Security Disability: SSA Needs to Improve Continuing Disability Review Program (GAO/HRD-93-109, July 8, 1993).

each year. However, while SSA has improved the disability review process, it has a current backlog of 1.8 million DI reviews. Based on available resources, it has planned for only 234,000 CDRs in fiscal year 1996. Since DI benefit rates are larger than SSI's, the cost-effectiveness of DI reviews may be higher. Still, since one in six DI recipients also receive concurrent SSI benefits, the backlog has also reduced to some degree the number of SSI terminations.

Limited Return to Work Efforts

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. This low priority is especially evident in vocational rehabilitation (VR), to which relatively few resources are allocated. For example, for every $100 SSA spends on cash benefits, it spends little more than $.10 on VR, and few recipients are referred for VR services. As we reported recently, VR beneficiaries receive, on average, only modest services and show limited long-term improvement.[5] In 1993, compared to $52 billion in combined SSI and DI benefit payments, $63 million was spent for rehabilitation. Of over 7 million SSI and DI disabled recipients, only 300,000 were referred for rehabilitation, and 6,000 were successfully rehabilitated.

Recipients may also perceive that the risk of losing benefits upon returning to work is too high. The SSI program has work incentive provisions to encourage recipients to try returning to work, without jeopardizing their cash and medical benefits should they fail, as well as ease the transition to work. However, many recipients are not familiar with these provisions or do not understand them. As a result, there may be significant unrealized potential for returning recipients to work or reducing their dependence on SSI.

Fraud and Abuse

A portion of SSI's growth may be attributable to increased incidence of fraud and abuse in the past decade. Limited empirical evidence makes it difficult to estimate the extent of the problem. Nevertheless, news reports have provided accounts of immigrants coached by middlemen to feign mental illness and children coached by parents to fake mental impairments by misbehaving or doing poorly in school to qualify for SSI benefits. Regardless of the actual extent of such abuses, reports like these can significantly erode public confidence in the program's integrity.

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

Growth in Immigration

Immigrant admissions steadily increased in the 1980s, from about 500,000 per year early in the decade to 900,000 in 1993. Altogether, immigrant admissions in the 1980s totaled more than 7.3 million. Over 30 percent of U.S. population growth in the 1980s can be attributed to immigration.

During the same period, noncitizens[6] have been one of the fastest growing groups of both aged and disabled SSI recipients. Since they typically have more limited histories of working in the United States than life-long residents, they qualify for smaller Social Security benefits. Thus, they are more likely to qualify for SSI.

Roughly half of those granted immigrant status in the 1980s were not subject to immigration policies that attempt to exclude people who are likely to become a public charge. Included are an unprecedented 1 million refugees and asylees who obtained full permanent resident status. Also, the Congress passed the Immigration Reform and Control Act in 1986, which resulted in legalizing over 2.5 million previously illegal aliens.

Other Factors Contribute to Caseload Growth

In addition to changes in the SSI program and population increases, a variety of other factors contribute to caseload growth.

Economic factors--such as the 1990-1991 recession--may account for some of the increase. In times of high unemployment, impaired persons may lose their jobs and turn to SSI for support. Even losing part of their income may allow them to meet SSI's financial eligibility requirements.

Also, the prevalence of some disabilities may have increased. For example, those who would not have been expected to survive certain health conditions 10 years ago, such as kidney disease, are now being kept alive by medical and therapeutic advances. Further, young adults who would not have been expected to survive spinal cord injuries now have a much better chance of survival and more opportunity to regain many functions. Finally, infants born with congenital defects or low birthweight have a better chance of survival today than in the past, although they may sustain disabilities.

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[6]Noncitizens other than immigrants (that is, those entering the United States to take up permanent residence) can also receive benefits. For example, not all refugees intend to stay in the United States permanently but are still eligible for SSI.

Many state and local governments have tried to enroll recipients of other welfare programs in SSI instead. Doing this saves state funds as well as increases benefit levels for their citizens. Based on discussions with 10 state welfare administrators, we estimate that at least half of all states fund programs that actively assist disabled public welfare recipients through the SSI application process. For example, five states reported using such programs to generate gross savings of about $90 million in a given year by helping enroll in SSI nearly 26,000 individuals receiving state benefits. Most of these gains came from one state, which reportedly saved over $60 million by helping nearly 15,400 public assistance recipients enroll in SSI instead of state general assistance in fiscal year 1994.

Finally, the recent increase in the number of people without affordable health insurance may have affected the size of SSI. The uninsured population under age 65 in the United States grew by 5 million between 1988 and 1992. Coupled with this growth, limitations in employer-based health care coverage for chronic conditions may have prompted some individuals to apply for SSI to obtain Medicaid.

CHARACTERISTICS OF CURRENT SSI RECIPIENTS

Overall growth in SSI caseloads has been concentrated almost exclusively in the disabled population, which grew an average of over 8 percent annually from 1986 through 1993, and now accounts for nearly 80 percent of federal SSI payments. During this period, aged caseloads have stayed level but would have decreased by 19 percent without the growth in noncitizen cases. The aged have decreased from 47 to 35 percent of all SSI recipients. Even among the disabled, the proportion of older recipients has decreased; those age 50 and older have decreased from 48 to 38 percent of disabled recipients. Blind cases have been a constant and small share of the total.

Three subpopulations have accounted for nearly 90 percent of the growth since 1991--adults with mental impairments, children, and noncitizens.[7] These groups typically have not contributed much in Social Security taxes. Accordingly, they receive smaller concurrent Social Security benefits than other SSI recipients, or none at all, and therefore receive higher SSI benefits. Among the aged, recipients who did not qualify for any Social Security benefit increased from 12 to 35 percent of cases between 1986 and

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

1993. Among the disabled, they increased from 58 to 68 percent of cases over the same period.[8]

Since many children and mentally disabled adults would not have qualified previously, much of the growth reflects a one-time addition of such recipients. Because of this, it is not clear that such dramatic growth would continue indefinitely; in fact, rates of caseload growth in the past 2 years have declined somewhat, though they are still high.

Table 2: Summary of SSI Caseload Growth Patterns

	Number of cases (1993)[a]	Percentage of all cases (1993)[a]	Average annual growth rate (1986-1993)
All SSI recipients	**5,984,330**	**100.0**	**4.9%**
Aged	2,091,651	35.0	0.7
Disabled	3,807,223	63.6	8.2
Children	770,501	12.9	16.4
Mentally disabled adults	1,252,300	20.9	11.0
Noncitizens	674,150	11.3	15.5
All other recipients	~2,900,000	48.4	<2.0

[a]Numbers may not equal the total because of overlaps in the populations listed. Blind recipients account for 1.4 percent of all cases, down from 2 percent in 1986.

Caseload growth varies dramatically by state. For example, growth in disabled caseloads ranged from less than 4 percent to more than 14 percent on average annually from 1986 through 1993. Moreover, states experienced concentrations of growth in different recipient subpopulations. For example, in California, Florida, Illinois, New York, New Jersey, and Texas, aged caseloads have grown substantially. Also, in California, Florida, New York, and Texas, a disproportionate growth in noncitizen caseloads has occurred, as might be expected because of the large immigrant populations there.

[8]In this instance, disabled recipients aged 65 and over are counted with the disabled and not the aged.

Mental Impairments Predominate Among Disabled Adults

Among disabled adults, mental impairments predominate. Mental retardation and other mental disabilities accounted for 51 percent of the growth in disabled adult cases from 1986 through 1993. Mental retardation was fairly consistent at 18 or 19 percent of disabled adults. However, growth in other mental impairment cases was more dramatic, increasing from 20 to 25 percent of cases over this period. So, all mental impairments accounted for 44 percent of disabled adult cases in 1993.

Mentally disabled adult recipients are younger on average than other disabled adults. As a result, they are likely to contribute to sustained growth in cases and benefit costs since they enroll in SSI at a younger age and can remain on the program the rest of their lives. Also, because these recipients are younger, whatever contributions they may have made to Social Security may be based on lower average wages than those disabled at later ages. As a result, any Social Security benefits they receive may be smaller than those of older recipients, and so their SSI benefits may be larger.

Included in the category of mental impairment other than retardation are those designated as drug addicts and alcoholics (DA&A), who numbered 100,000 in 1994. From 1988 through 1994, these cases grew an average of 41 percent annually, multiplying by a factor of 8. According to SSA, addicts required to participate in the DA&A program are those who would not qualify for disability if their addiction ended. Thus, the DA&A designation does not apply to all addicts on SSI. In May 1994, we reported on the DA&A program and found that 250,000 addicts receive either SSI or DI benefits; of these, more than half would qualify as disabled without their addiction.[9]

By law, these designated DA&A recipients must have a representative payee, or third party, manage their benefits and they must participate in treatment when it is available. Our work has documented past problems with the representative payee system. Further, while substance abuse treatment is required, SSA is not permitted to pay for treatment nor can the addict be required to pay for it. Exactly who pays for what types of treatment for SSI DA&A recipients is not known. Some services are covered by state Medicaid programs, but states vary greatly in the type, amount, duration, and scope of services provided.

The alarming growth in DA&A cases and allegations of program abuse prompted the Congress to strengthen controls of payments to addicts in the Social Security Independence and Program

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[9]Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS-94-128, May 13, 1994).

Improvements Act of 1994. The act generally requires that SSI benefit payments to DA&A recipients end after 3 years. It also expands the DA&A program requirements to cover DI recipients and mandates an SSA study of the feasibility, cost, and equity of requiring representative payees for all DI and SSI addicts, even if they would be disabled without the addiction.

Mental Impairments Predominate Among SSI Children

Before 1990, the growth in the number of disabled children receiving SSI was moderate, averaging 3 percent annually since 1984. Then, from 1990 through 1994, the number tripled to nearly 900,000. Their share of all disabled cases grew from about 10 percent before 1990 to 19 percent in 1994.

Mental impairments predominate among children, accounting for over half of all cases. Mental retardation, one of two broad categories of mental impairments, has consistently accounted for 37 percent of children receiving SSI, both before and after 1990. However, other mental impairments have increased from 5 to nearly 18 percent of children's cases, increasing from 17,000 cases in 1989 to 136,000 cases in 1993. In 1994, we reported that the portion of mental awards to children with behavior problems, such as attention deficit disorder, is just 22 percent but growing.[10]

As required by the Zebley ruling, SSA began to use individualized functional assessments (IFAs) to determine whether children are disabled. The new IFA process, which added 219,000 children to the benefit rolls through September 1994, permits the award of benefits to children with less severe impairments than those in SSA's medical listings of impairments.

We recently issued a report documenting the many subjective judgments built into each step of the IFA process.[11] We concluded that the likelihood of significantly reducing the level of judgment involved in evaluating age-appropriate functioning was remote and that more consistent decisions could be reached if children were evaluated on the basis of the functional criteria in SSA's medical listings. Based on our findings, we suggested that the Congress could consider eliminating the IFA, which would reduce the growth in awards and target disability benefits to children with more severe impairments.

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[10]Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations (GAO/HEHS-94-225, Sept. 9, 1994).

[11]Social Security: New Functional Assessments for Children Raise Eligibility Questions (GAO/HEHS-95-66, Mar. 10, 1995).

Noncitizens Growing Fast Both Among Aged and Disabled Recipients

From 1986 through 1993, the number of aged and disabled noncitizen recipients grew an average of 15 percent annually, reaching nearly 700,000 in 1993. In 1982, noncitizens were 3 percent of all SSI recipients; by 1993, they were nearly 12 percent. Of these, 62 percent qualified for SSI on the basis of being aged, and 38 percent qualified as disabled.

Had it not been for the growth in noncitizens, the aged SSI caseload would have decreased 19 percent from 1986 to 1993. Noncitizens grew from 12 percent of aged cases to 29 percent over this period.

While noncitizen disabled recipients are a smaller share of these cases, they are growing faster, averaging 19 percent annually from 1986 to 1993. They have increased by 180,000, from 3 percent of disabled cases to 6 percent.

Of noncitizens on SSI, 51 percent come from six countries--Mexico, the former Soviet Union, Cuba, Vietnam, the Philippines, and China, in order of caseloads. However, rates of growth vary significantly by country of origin, from an average of 11 percent annually for Cuba to 33 percent for the former Soviet Union, among these six countries.

Reflecting that immigration policy discourages admission of those who are likely to become a public charge, some legal immigrants are admitted into the country under the financial sponsorship of a U.S. resident. Sponsors sign an affidavit of support, in which they agree to provide financial assistance to the immigrant for 3 years. However, several courts have ruled that these affidavits of support are not legally binding. Refugees and asylees, moreover, do not need a sponsor to reside in the United States; in 1993, 18 percent of SSI's noncitizen recipients were refugees or asylees when they applied. In addition, the undocumented aliens legalized by the Immigration Reform and Control Act of 1986 were not admitted to the U.S. under these sponsorship provisions; in 1993, roughly 3 percent of SSI's noncitizen recipients were identified as part of this group when they applied.

SSI's "deeming" provisions attempt to reinforce this immigration policy by factoring a portion of sponsors' resources into financial eligibility decisions and benefit calculations for the immigrants they sponsor;[12] in 1993, as many as 75 percent of SSI's noncitizen recipients would have been subject to these provisions when they applied. Before 1994, this deeming applied

[12]These deeming provisions do not apply if an immigrant becomes blind or disabled after admission to the United States as a permanent resident.

for 3 years from the date of immigration. Administrative data indicate that about 25 percent of immigrants receiving SSI applied for benefits within a year of the expiration of their 3-year sponsorship periods. The Congress temporarily extended the deeming period from 3 to 5 years starting in January 1994 through September 1996.

OPPORTUNITIES FOR IMPROVING THE PROGRAM

As SSI caseloads have grown rapidly, they have become increasingly dominated by younger, mentally disabled recipients who may stay on the program longer. Disabled recipients now account for nearly 80 percent of federal SSI payments. Rapid growth in noncitizen cases further contributes to changes in the program's character. Both these younger and noncitizen recipients tend to depend more on SSI as their primary source of income. These trends provide compelling reasons to re-examine the program's priorities.

Improving program integrity should be a high priority for SSA. Conducting more CDRs would help assure the public that benefits are not available to those who are no longer disabled. Also, many have raised questions about the incentives for fraud and abuse created by cash payments, especially for children and drug addicts and alcoholics. Some have suggested that services, or a more flexible combination of cash and services, might reduce fraud and abuse as well as better meet the needs of disabled recipients. But more work needs to be done to assess the pros and cons of such alternatives. Increased monitoring of drug addicts and alcoholics and of translators assisting noncitizens may also help ensure compliance with SSI requirements.

Technology and medical treatment to help the disabled adapt are constantly improving, and society's perceptions of disability are changing. These trends, combined with the increased number of younger recipients, especially children, challenge the program's historic presumption that the disabilities it covers are total and permanent. In cases of physical disabilities among older workers, who previously predominated in the program, rehabilitation and returning to work were perhaps reasonably not emphasized. The program thus had little experience in supporting rehabilitative efforts that may hold more promise for younger recipients.

Therefore, helping disabled recipients return to work should have a higher priority and also is a focus of our ongoing work. This would entail more program emphasis on vocational rehabilitation, employment assistance, and work incentives. Finding effective approaches for recipients with mental impairments, particularly those with limited work histories, may require special attention. More emphasis on return to work should also signal to recipients that work, where feasible, is a program expectation. Such efforts should help decrease recipients'

dependence on SSI, help them achieve their productive capacity, and improve program integrity as well.

The growth in noncitizen cases raises issues about immigration policy in addition to issues about SSI policy. As currently written and enforced, the immigration provisions about sponsorship and the SSI provisions about deeming sponsors' income and resources do little to support the immigration policy of discouraging immigration of those who are likely to financially burden the state.

Finding the appropriate set of actions to improve the SSI program will not be easy and may take time. It may require legislative as well as administrative changes. We believe, however, that addressing these fundamental concerns can improve the effectiveness of public expenditures and help restore public confidence in the integrity of the program. These issues deserve more deliberation, and we will continue to work with you on them.

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This concludes my testimony. I would be happy to answer any questions.

For more information on this testimony, please call Jane Ross, Director, at (202) 512-7215. Other major contributors include Assistant Directors Cynthia Bascetta and Don Snyder and Senior Evaluator Ken Stockbridge.

RELATED GAO PRODUCTS

Social Security: New Functional Assessments for Children Raise Eligibility Questions (GAO/HEHS-95-66, Mar. 10, 1995).

Social Security: Federal Disability Programs Face Major Issues (GAO/T-HEHS-95-97, Mar. 2, 1995).

Welfare Reform: Implications of Proposals on Legal Immigrants' Benefits (GAO/HEHS-95-58, Feb. 2, 1995).

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

Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations (GAO/HEHS-94-225, Sept. 9, 1994).

Disability Benefits for Addicts (GAO/HEHS-94-178R, June 8, 1994).

Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS-94-128, May 13, 1994).

Social Security: Most of Gender Difference Explained (GAO/HEHS-94-94, May 27, 1994).

Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994).

Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).

Social Security: Increasing Number of Disability Claims and Deteriorating Service (GAO/HRD-94-11, Nov. 10, 1993).

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

Social Security Disability: SSA Needs to Improve Continuing Disability Review Program (GAO/HRD-93-109, July 8, 1993).

Social Security: Rising Disability Rolls Raise Questions That Must Be Answered (GAO/T-HRD-93-15, Apr. 22, 1993).

Social Security Disability: Growing Funding and Administrative Problems (GAO/T-HRD-92-28, Apr. 27, 1992).

Social Security: District Managers' Views on Outreach for Supplemental Security Income Program (GAO/HRD-91-19FS, Oct. 30, 1990).

Social Security: SSA Could Save Millions by Targeting Reviews of State Disability Decisions (GAO/HRD-90-28, Mar. 5, 1990).

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