
PROBLEMS IN THE SOCIAL SECURITY DISABILITY PROGRAMS: THE DISABLING OF AMERICA?

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THURSDAY, MARCH 2, 1995

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 10:30 a.m., in room SD-562, Senate Dirksen Building, Hon. William S. Cohen (chairman of the committee) presiding.

Present: Senators Cohen, Grassley, Santorum, Pryor, Feingold, and Moseley-Braun.

Staff Present: Mary Berry Gerwin, Staff Director/Chief Counsel; Sally Ehrenfried, Chief Clerk; Liz Liess, Counsel; Theresa M. Forster, Minority Staff Director; Kenneth R. Cohen, Investigator.

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

Senator COHEN. The hearing will come to order.

It's my understanding that Senator Pryor is on his way. I will begin with a somewhat lengthy opening statement and by the time I'm completed, I'm sure he will be here.

Ladies and gentlemen, good morning.

Today, we are holding a hearing to examine the tremendous growth in the Social Security disability programs and the major disincentives toward work and self-sufficiency that exists in the Federal disability programs.

We chose the Federal disability programs as the focus of the Special Committee on Aging's first hearing of the 104th Congress to signal the critical importance of the size and the cost of the disability programs to the solvency of the Social Security trust funds and, indeed, the goal of reforming our Federal welfare system.

Throughout the debates on the balanced budget amendment and entitlement reform, one message has come through rather loud and clear and that is: Don't touch Social Security.

At the same time we've been assuring senior citizens that we will leave Social Security untouched, a very real threat has been silently creeping up on the solvency of the Social Security trust funds—namely, the unfettered growth of the Social Security Disability Insurance Program.

The Social Security Disability Insurance Program for disabled workers of any age who have paid into the Social Security trust fund and the Supplemental Security Income Program, the SSI Pro-

gram, for the nonworking, disabled poor, are among the fastest-growing programs in the Federal Government.

Over the past decade, the number of recipients under the age of 65 on the Disability Insurance and SSI programs has risen from 4.2 million to over 7 million, representing an increase of almost 70 percent. The total cash benefits paid to these recipients has increased almost 60 percent in the same period.

The Social Security Administration sends out about \$1 billion in cash payments each week to people in the Disability Insurance and SSI programs. Despite the huge outlay of Federal dollars, we have paid very little attention to how these taxpayer dollars are being spent and how the nature of the disability programs has changed.

Over the past 2 years, my staff on the Aging Committee has worked with the General Accounting Office to identify weaknesses and perverse incentives in the disability programs. Last year, for example, we discovered how SSI and Disability Insurance benefits were being paid to drug addicts and alcoholics on the disability rolls and how they have directly fueled more drug and alcoholic addiction. Our investigation found that the word on the street was that SSI benefits were an easy source of cash for drugs and alcohol, and the message of the disability programs has been: "If you're an addict or an alcoholic, the money will keep flowing as long as you stay addicted. If you break the addiction, the money stops."

Rather than encouraging rehabilitation and treatment, the disability programs' cash payments to drug addicts and alcoholics have perpetuated and enabled drug addiction and dependency.

Last year, in response to our investigation, the Congress took swift action to place better protections on disability payments made to addicts and alcoholics. We mandated that all persons receiving disability benefits due to alcohol and drug abuse must receive treatment, imposed a 3-year cutoff of benefits for addicts and alcoholics, and toughened the rules in order to get cash out of the hands of the addicts.

While there continues to be a debate over whether last year's legislation went far enough, it was a major step, in my judgment, toward stemming the abuses in the disability program. Addicts using taxpayer dollars to shoot more drugs into their veins are perhaps the most vivid evidence of how compassion in the disability program has gone awry.

Unfortunately, drug addicts are not the only ones who have gotten the message that the disability programs are a good source of cash. The stories of abuse are rampant:

Translators and other middlemen coach immigrants on how to feign mental impairments and other disabilities in order to qualify for benefits, and scores of doctors submit false medical evidence to qualify claimants for SSI and DI benefits.

There have been widespread allegations that some parents are coaching their children to feign mental impairment and behavioral problems in order to qualify for SSI benefits. There is growing concern that the SSI Program for children inadequately targets assistance for children and can, in the long run, promote lifelong dependency rather than independence.

Even the States are finding that the Federal disability programs are a good deal. As the GAO is going to testify later this morning,

many States have developed aggressive programs to shift persons from their State welfare rolls onto the Federal disability rolls. For example, one State shaved about \$55 million from its budget by paying contractors to shift welfare recipients to the Federal rolls. These cost-shifting techniques are proving to be lucrative business deals for disability consultants who are paid for each person they shift off the State's books and onto the Federal rolls.

While more and more new beneficiaries are coming onto the rolls, fewer and fewer are ever leaving. Often, getting on disability means a lifetime of benefits, even for people who could return to work. Our investigation found, for example, that the Social Security Administration is grossly behind in conducting continuing disability reviews, so-called CDRs, to determine if persons are still eligible for benefits. The backlog of cases the Social Security Administration should have reviewed in the Disability Insurance Program alone is about 1.8 million cases, and is growing dramatically, about 500,000 cases each year.

In addition, the GAO will testify today that the Social Security Administration makes virtually no effort to help rehabilitate recipients so they can return to work. We do have a chart up here that all of you can see. According to the GAO, roughly one-tenth of 1 cent of every dollar spent for rehabilitation efforts as opposed to simply the payments themselves.

In addition, I might say, appallingly, only about 1 in every 1,000 persons on the disability rolls gets off the program through the Social Security Administration's rehabilitation efforts. The bottom line is the Federal Government is sending a very mixed message on disability. We are making the workplace more accessible to the disabled through the Americans with Disabilities Act, but the Social Security disability programs weave a web of dependency and undermine efforts toward independence.

In today's testimony, we will hear major criticisms of the SSI and Disability Insurance programs and how they can be restructured to better serve persons with disabilities.

I might point out that the Committee has a very strong record of protecting the disability process from unfair or cold-hearted assaults. As Senator Pryor and other members of this Committee might recall, I worked very closely with Senator Heinz, Senator Levin, and others to expose and prevent efforts in the early 1980's to purge people from the disability rolls unfairly.

We do not retreat from our support of the disability programs. However, if we allow the current abuses and administrative failures of the program to fester, there is a very real danger they will taint the entire disability program and, in turn, undermine confidence in the Social Security system itself.

The guiding principle in our review is to preserve the disability program for those who truly are in need of its assistance, yet not entrap those who could and want to be independent. Undertaking this review of the disability program is not risk-free. Any attempt to reform could be attacked as callous disregard for our most vulnerable citizens. Notwithstanding these attacks, it's our duty to push our programs to do more for the deserving and less for the cunning or the calculating.

The task before us brings to mind a book called "The Recovery of Confidence," written some years ago by John Gardner. In that book Gardner observed:

Our institutions have become caught in a savage crossfire between uncritical lovers and unloving critics, that at one end of the spectrum we have people who are so enamored with the status quo they would do everything they could to blunt and nullify and stultify any attempt to change. At the other end of the spectrum were those unloving critics—people who see absolutely no virtue or benefit in present programs and have nothing in the way of constructive proposals to announce, but simply want to tear down what currently exists.

The task before us is certainly a challenging one. As we struggle to look at the disability programs, we need to strike the balance between the need to reform and the need to retain. It is in this spirit that we hold this hearing today and we are looking forward to the testimony of the witnesses who have been asked and have volunteered to come before the Committee.

Before turning to Senator Pryor, who is I'm told still on the way—he is the ranking minority member of the Committee and I intend to thank him, and I will do so prior to his arrival, for his years of excellent service as the Chairman of this Committee. Under his distinguished leadership, the Aging Committee has been a very strong voice on a broad array of issues affecting older Americans. Senator Pryor has been a leader in the fight against high, out-of-pocket medical costs that are borne by millions of senior citizens, for establishing quality standards in nursing homes, and a host of other issues that have important and direct impact upon the daily lives of older Americans. So he has managed this Committee in a most distinguished and bipartisan fashion. I intend, notwithstanding the reversal of our roles, to maintain that same level of bipartisan, indeed nonpartisan, tradition of this Committee.

Finally, I would like to name, for the record—and to welcome those who are here—the members of the Special Committee on Aging for the 104th Congress. On the Republican side, we are pleased to have join the Committee Senator Pressler, Senator Grassley, Senator Simpson, Senator Jeffords, Senator Craig, Senator Burns, Senator Shelby, Senator Santorum, who is here, and Senator Thompson, who will be serving on the majority side of the Committee. On the Democratic side, we are pleased to have Senators Glenn, Bradley, Johnston, Breaux, Reid, Kohl, Senator Feingold, who is here, and Senator Carol Moseley-Braun. We are honored to have many long-standing members continue to serve on the Committee and we welcome three of our colleagues—Senators Moseley-Braun, Thompson, and Santorum—who are joining the panel for the first time. I am looking forward to working with all of them as we pursue a very active and productive year for the Committee.

Before turning to our first panel this morning, I would yield to Senator Feingold if you have any opening statement you care to make.

STATEMENT OF SENATOR RUSSELL D. FEINGOLD

Senator FEINGOLD. Thank you very much, Mr. Chairman.

I first want to congratulate you on your new role as the Chairman of this Committee. I followed your work in this long before I became a Member of the Senate. You, along with the previous

Chairman who is now the ranking member, have consistently demonstrated a bipartisan commitment to issues of importance to our Nation's seniors.

The selection of today's hearing is an excellent example of that commitment. I am pleased the Committee will spend time during the coming session focusing on the problems surrounding the Social Security disability programs. I see this issue as tied, in some ways, to the larger issue of long-term care for people of all ages with chronic disabilities.

In looking over a little of the testimony that was submitted for today's hearing, I was especially pleased to see a discussion of the sometimes perverse incentives of the current disability programs imposed on individuals who want to work. Work disincentives are clearly a direct result, not just of the particular program barriers that exist, but of an approach to providing assistance to those with disabilities that is essentially based on a welfare model.

I firmly believe that part of the solution of the problems of work incentives is to establish a flexible, State-administered, consumer-oriented, long-term care program which does not discriminate on the basis of age or income. While it may make good, financial sense to ask those with more means to pay more for their long-term care services through a sliding, fee-cost share system, it makes no sense to adopt a means test limit beyond which someone with a disability somehow suddenly becomes ineligible. It is precisely that kind of welfare model barrier that results in disincentives to work.

Significant long-term care reform would provide the flexibility needed for State administrators who are trying to cope with growing populations of eligible recipients under current unwieldy programs. Mr. Chairman, it could provide the kind of flexibility needed to address the critical concern that you have and that you have worked so hard to address, namely the problems relating to providing cash payments to individuals with alcohol or other drug abuse disabilities. It could also provide the flexibility needed by consumers of long-term care, each of whom face varying problems and differing economic and social circumstances.

To me, Mr. Chairman, it makes no sense to provide a cash payment to those with alcohol and drug-related disabilities, but it also makes no sense to impose a system designed for those with alcohol and drug-related disabilities on individuals with other problems.

I appreciate the emphasis on this topic and I look forward to working with you.

Thank you, Mr. Chairman.

Senator COHEN. Thank you very much, Senator Feingold.
Senator Grassley.

STATEMENT OF SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Thank you, Mr. Chairman.

I also want to congratulate you, this being the first meeting under your leadership. Thank you for your years of service on the Committee and showing for our party, as well as the entire Congress, a bipartisan approach to the issues you have been involved with and strong leadership in this area.

Well, we have this very important subject before us and I think, Mr. Chairman, we have to thank you for starting out the Commit-

tee's work on this subject because it does appear that the Congress has to take a very hard look at these two programs—the Supplemental Security Income and the Social Security Disability Program.

As I think you're going to hear from several of our witnesses, they are going to be confirming that enrollment in these programs has grown, kind of like topsy grows, over the last several years without a lot of plan or foresight and more importantly, as I see it, as a result of some court decisions more than by congressional intent. It is clear that they have grown because they are costing \$107 billion a year. That includes health insurance coverage. So we're obviously talking about a very substantial amount of money.

Not only has enrollment grown very rapidly, but it also seems clear that the main thrust of these programs results, for many beneficiaries, in something of a kind of perpetual disability even if there is a capability for work. By perpetual disability, I mean that the program seems to encourage enrollees to adopt a self-image as disabled and seems to make little effort to encourage enrollees to think very positively about employment.

There appears also to be a certain amount of fraud and abuse in these programs. Much of the evidence of this seems to be anecdotal, I'll have to admit, but we have heard a lot about abuse of the program, particularly by alcoholics and illegal drug users, and of course, a lot about abuse by those faking mental or behavioral problems.

I'm also encouraged that the weight in determining eligibility for children by nonmedical professionals seems to have increased in the wake of the Supreme Court's *Zebly* decision.

This all adds up to the fact that we need to be looking at it, so I say to you that we owe much to you and your committee staff for following up on the reports of abuse by illegal drug users and alcoholics. It seems to me that we need to follow up in addition to those, all such allegations. The program in question is too important to the truly deserving to allow possibly large sums of money to be misused. It goes without saying, as well, that the taxpayers' money must be spent right and the taxpayers have the right to expect that the moneys they are called on to make available for those who can't help themselves be used wisely.

Senator COHEN. Thank you, Senator Grassley.

Senator Santorum, before you begin, let me commend you for the work that you did on the House side in dealing with the issue of cash payments going to those who are addicted to drugs and alcohol. It was your leadership in the House that helped make that change last year a reality.

STATEMENT OF SENATOR RICK SANTORUM

Senator SANTORUM. Thank you, Senator.

It is your leadership on that issue here. Actually, we stole some stuff from you, so I appreciate the compliment but it goes to you in large measure. We did do a lot of work last year in the House and in the conference committee with respect to the Social Security Independent Agency Act. We were able to include some things to clean up the SSI Program. Frankly, it was a drop in the bucket, we said it at the time, and I am very pleased to see that the first

hearing we are having here looks at what I believe is the most fraud-ridden program in the Federal Government, the SSI Program. This is a program that needs a major overhaul.

If we're going to talk about welfare reform in this Congress, a lot of it is going to be booted back to the State, but we can't boot this one to the State; this is our baby, this is our messy backyard that we have to clean up. We have to do it not just for the benefit of the taxpayers, which seems to be noted when you hear about SSI's, but for the benefit of the people who are involved.

What we have done with the SSI Program for kids has not helped children in a lot of respects. We do help children with the SSI Program for the truly disabled and the bill which is being moved in the House, which I worked on with Congressman McCrery, and Congressman Kleczka from Wisconsin have worked on, is a very positive first step. It identifies the children who are truly in need, who are disabled, who have severe problems that are in need of the support of the American people in order to live a functional life. It relooks at not just the marginal but those who are enticed into the system by the dollars that are sitting there, that truly don't need the support of the Federal taxpayer, and in fact, I think it's actually counterproductive to get the support of the Federal taxpayer for the "problems" that these people have.

The *Zebley* decision was a travesty. It has hurt the disability community by showing and having the fraud that we've seen and the misuse of the program. I've gotten a lot of criticism in the past from the disability community because of my position on this. I've got to go out and fight for increased benefits, yes, increased benefits, for the truly disabled, but I am not going to allow people who are not disabled to undermine the validity of a program which should be targeted to people who need it.

We're going to work very hard, and I know Senator Cohen feels the same way, we're going to work very hard to make sure that the people who are in need of this program and who can stand up and justify the expenditure of funds before the American public get the money, get increased benefits that they richly deserve and need, and it's going to be at the expense of those who simply don't need it and who are not benefitting from being on the program.

So I look forward to working with the SSI for children program. It's something we must do. The drug addicts and alcoholics program I think is handled properly in the House bill, that we simply get rid of it. It is not serving the purpose intended.

We've got programs—I know the Chairman has commented on this—we've got an outreach program to go out and find more people so we can put them on this program. That's what the Administration wants to do, go out and find more people so we can sign them up to be disabled. It just blows my mind that this is the kind of mentality that this Government has, that we have to go out and find victims because they are not finding their way here quick enough.

We don't need to do that. We need to go out and make people more self-sufficient, not sign them up to warehouse them in welfare programs. We have an obligation on this committee, we have an obligation in this Congress, to do something about this program. It will be the mark of whether we are successful in changing govern-

ment if we don't do anything about this program. I hope and I know that the Chairman of this Committee and many members on it will work with me to make that happen.

Thank you, Mr. Chairman.

Senator COHEN. Thank you, Senator Santorum.

We now have with us the distinguished ranking member.

STATEMENT OF SENATOR DAVID PRYOR

Senator PRYOR. Senator Cohen, thank you.

I'm running late. I'm going to just urge you to get the panel going as quickly as possible.

Thank you for having this session and I will put a statement in the record and perhaps make a few comments in a moment.

Thank you.

[The prepared statement of Senator Pryor follows:]

STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, thank you for holding today's hearing on the disability portions of the Social Security (SSDI) and Supplemental Security Income (SSI) programs. In recent years, there has been rapid and expected growth in the enrollment in these two federal disability programs. This expansion of the rolls is due to many factors, including Congressionally-mandated outreach efforts as well as legislative and regulatory changes affecting eligibility determination. Along with this growth in the program have come increased concerns regarding fraud and abuse and possible disincentives for beneficiaries to receive rehabilitation and re-enter the workforce.

In testimony from witnesses today, I expect to hear a discussion of recent growth in both programs and the degree to which these programs are currently able to meet the needs of beneficiaries. In particular, we will have a review of the availability of vocational rehabilitation and assistive technologies for both SSDI and SSI recipients. We will also hear about the accessibility to treatment for those receiving benefits as the result of drug addiction and alcoholism. It is important that we strive to ensure that these programs be able to respond to the individual needs of those who are eligible for coverage while at the same time encouraging those who can work to re-enter the workforce or secure new positions of employment. We need to rethink program intent, reestablish priorities, and define the programs in ways that effectively target benefits, protecting stewardship of the public dollar. At the same time, we are charged with the protection of the truly needy—a population including the blind, the elderly, as well as children and adults with disabilities.

It is important to recognize that these are programs that affect and concern all age groups. We must respond to the public perception that the SSI program for children is vulnerable to fraud and abuse, but—as generations working together—we must proceed with care. We must not jeopardize quality of life for those deserving children currently receiving benefits. For thousands of families, SSI program benefits provide for the well-being of the child, meeting basic needs such as food, clothing, shelter and other necessities.

I remain committed to addressing troubling allegations of fraud and abuse in the SSI program for children with disabilities. I am concerned that these allegations are undermining a program which was intended to serve a needy and historically disadvantaged population. Alongside Rep. Blanche Lincoln (D-Ark.) and several other lawmakers, I co-requested a GAO report that evaluates the methods used by SSA in assessing children for SSI-disability benefits based on the new criteria SSA developed as mandated by the Supreme Court in 1990. I hope we will be able to use the findings in this report to further improve the eligibility determination process for children with disabilities.

Some of the overall changes to the SSI program which are currently being discussed will have far reaching effects on millions of beneficiaries. Before we make significant changes to the Social Security disability programs, it may be useful to incorporate into our reform efforts the recommendations of forthcoming national reports addressing these programs. First, the Commission on the Evaluation of Disability in Children based in the Department of Health and Human Services is slated to report to Congress by November 1995. The Commission will assess the concerns with the program, and study the potential for program changes. Second, the National Academy of Social Insurance has convened a Disability Panel which is con-

ducting a thorough review for Congress of the Social Security disability programs with particular emphasis on improving work outcomes for applicants, beneficiaries and denied applicants for disability benefits. The panel is also engaging in an in-depth review of the SSI program for children.

By taking the time to look at forthcoming reports, we, as lawmakers, will be able to effect change in the most informed and effective way possible. We will be armed with substantive information about the validity of alleged problems, the ramifications of proposed changes on beneficiaries, and the direction of program intent.

Mr. Chairman, I look forward to working with you and our colleagues to ensure the viability and effectiveness of these important programs. I welcome the witnesses, and I look forward to their testimony.

Senator COHEN. Does that set a precedent for Senator Carol Moseley-Braun? Would you care to follow?

STATEMENT OF SENATOR CAROL MOSELEY-BRAUN

Senator MOSELEY-BRAUN. It does, it does, absolutely.

Mr. Chairman, I would just like to say that I think we are all here interested in reform in this area but the attitude and the approach that we bring to that reform is equally important. I hope that we approach these issues with the sense of maintaining the safety net for those who are disabled. We need to get rid of fraud, waste, and abuse, and reform the program so it actually does what we believe it should do and what the American people have every right to expect it to do, but we must not start off in a punitive mode with regard to the reforms that all of us I think concur are necessary here.

I would yield the rest of my time so that we can proceed with the panel.

Senator COHEN. Thank you very much.

Ladies and gentlemen, our first panel, which has been sitting here very patiently—you are fortunate that all the members are not here this morning—consists of two individuals who will describe their personal experiences with the Social Security disability programs.

We will hear first from Mary Jane Owen, Executive Director, National Catholic Office for Persons With Disabilities here in Washington, DC and then we're going to hear from Bob Cote, Director, Step 13, a homeless shelter and rehabilitation center for substance abusers in Denver, Colorado.

Ms. Owen.

[The prepared statements of Senators Larry Craig, Conrad Burns, and Herb Kohl follow:]

STATEMENT OF SENATOR LARRY E. CRAIG

Mr. Chairman, thank you for holding this very timely hearing and for your continuing efforts to protect the rights of people with disabilities.

With both the House and the Senate discussing reform of our nation's welfare system, it is clear we must keep these Social Security programs in our sights. Their rapid growth, and the serious problems this committee has already uncovered, should raise warning flags for all policymakers. We cannot afford to ignore defects in these programs which may undermine our overall reform efforts.

As we work through these complex concerns, it is extremely valuable to have the insight and counsel of the distinguished witnesses on our panels today. I hope they can help us arrive at solutions that sacrifice neither compassion nor common sense.

These issues are complex in part of the SSA's definition of a disability. The program defines a disability as an inability to engage in substantial gainful activity by reason of a physical or mental impairment. This definition creates an all or nothing system for receiving benefits. Therefore, those who are able to work, but still require some financial assistance in order to cope with their disability, are discouraged from

working for fear of losing their benefits. This results in total dependency on the Government. We need a system that allows the disabled to be as independent as possible.

The cost of the SSI/SSI program has been driven higher due to abuse of the system. As a result of this hearing, I hope the committee will find solutions to curb abuse and fraud without excessive reviews or regulations. There are currently 26,954 Idahoans receiving benefits from this program. For the sake of those people who are in need, we must make sure that this program remains solvent and that there are adequate benefits available for those who need them. Halting fraud and abuse will help secure access to the program.

I look forward to your review of this matter. I have a specific goal in mind: to curtail fraud and abuse within the Social Security system and make benefits available for those who truly need them.

STATEMENT OF SENATOR CONRAD BURNS

Mr. Chairman, I want to thank you first of all for holding this hearing. I know this is an issue that is important to you personally and you have made a tremendous impact in bringing this to light, not only today, but in the last session.

We are doing everything we can to rein in the budget. We are attempting to make the government more accountable. And we are making every effort to ensure that those who need the government's help are actually the ones that are receiving it. This issue, focusing on benefits being paid to drug addicts and alcoholics, combines all three goals.

I was struck by Mary Jane Owen's testimony. It is clear that she is a woman of extreme integrity, but it is also clear that something is wrong with our system when she requests to be taken off the program and they continue to send her checks for years following. That just doesn't make sense. I applaud her for maintaining her independence and making it on her own. I only wish more folks would be so noble.

And the testimony given by Bob Cote was sobering. Hearing how he made his way off of skid row and is now helping others do the same is inspiring. However, to hear about the payments being made to bars and liquor stores in lieu of the actual beneficiary is outrageous. The Social Security Administration must have better oversight than that!

I think that it all boils down to a few key points. First, we need to emphasize responsibility. Ms. Owen said it perfectly—it's not about rights, it's about responsibility. And at the risk of sounding cliché—whatever happened to giving a hand up not a hand out? Yes, there are lots of people who need assistance and yes, it will be difficult to make sure the assistance they are given is being used to help not hurt them. But we must crack down.

It is disheartening to learn that in the entire history of the Social Security Disability Income program, and this comes from a former Commissioner, not one person has left the program as a result of being "cured." This is not a system that is helping. The chart displayed at this hearing indicates that for every dollar of cash benefits only one-tenth of one cent goes toward vocational rehabilitation. How can we expect people to get back on their feet when so little is spent encouraging that path?

Mr. Chairman, the programs that assist our country's disabled population are important. In no way should they be dismantled. But as the title of this hearing suggests, neither should they cause the disabling of America. I appreciate your willingness to bring this to light and I look forward to working with you to address issues like this.

You know, in this Committee, we often focus on issues that affect our nation's seniors, but this crosses the boundaries. SSI and SSDI impact not only the elderly and the disabled, but families, children, and single women like Ms. Owen trying to start a business, and men like Mr. Cote trying to foster independence. For these people, we need to make the programs work.

Thank you, Mr. Chairman.

STATEMENT OF SENATOR HERB KOHL

I would like to begin by commending the distinguished Chairman for his leadership on confronting the abuse of the Disability Insurance (DI) and Supplemental Security Income (SSI) programs by some drug addicts and alcoholics. Like the distinguished Chairman, I was infuriated to learn that some alcoholics and addicts are taking advantage of the Social Security system to feed their bad habits. The disclosure of these unfortunate abuses has cast a dark shadow over an extremely valuable program. Fortunately, last year we were able to pass legislation aimed at eliminat-

ing these abuses. Now the requirements placed on drug addicts and alcoholics are tighter, ensuring that those SSI recipients who truly deserve assistance receive help.

Although approval of last year's legislation was undoubtedly a step in the right direction, it was clear, even at the time of its passage, that a more thorough review of the DI and SSI programs was needed. I am proud to say that today's hearing is the next step we envisioned last year. Much to the distinguished Chairman's credit, he has not allowed last year's success distract him from the important matter at hand. Instead, through an in-depth investigation of the DI and SSI programs, we are in the position to conduct this hearing and improve on the beneficial work accomplished last year.

QUESTIONS, SENATOR HERB KOHL TO GAO DIRECTOR ROSS

Question 1. Director Ross, what has been the impact of the changes we made to the DI and SSI programs as they relate to drug addicts and alcoholics?

Response.—The Social Security Independence and Program Improvements Act of 1994, enacted on August 15, 1994, contained a number of measures to strengthen controls over payments to addicts (alcoholics and drug addicts) whose addiction is a contributing factor material to the determination of disability. Additional restrictions were placed on Supplemental Security Income (SSI) recipients and these and existing restrictions were extended to cover Disability Insurance (DI) beneficiaries. More specifically, the law contained the following key provisions requiring:

- (1) representative payee and treatment requirements for DI beneficiaries;
- (2) organizations as the preferred representative payee for addicts;
- (3) a time limit for benefits (generally 36 months);
- (4) specific penalties for the failure to comply with treatment requirements (benefit suspension or termination);
- (5) limits on the size of payments of past due benefits;
- (6) SSA to establish referral and monitoring agencies (RMAs) in all States; and
- (7) SSA to conduct demonstration projects on innovative approaches to the referral, monitoring, and treatment of addicts.

To implement many of the above provisions, in January 1995, SSA issued operating instructions to SSA components and state disability determinations services. Also, in February, implementing regulations were published in the Federal Register.

Through June 1995, 27,498 DI beneficiaries were required to comply with the representative payee, treatment, and other provisions of the law. With respect to RMAs, because of the many requirements of the new law, SSA determined that it would be necessary to terminate all existing RMA contracts (49 States and the District of Columbia) and effectuate new contracts. Consequently, in January 1995, SSA issued a request for proposal for RMA services in all States and Puerto Rico and the District of Columbia. On the basis of the response to the proposal, SSA expects to award contracts to cover all jurisdictions by September 15, 1995, except for Mississippi and Oregon. These two States did not submit a technically acceptable proposal and SSA now plans to issue another request for proposal in December 1995.

While SSA has developed operating instructions and regulations to carry out the law, specific data on the impact of the various other legislative provisions are generally not yet available. For example, measuring the impact of time limited benefits will not be available until fiscal year 1998 when the 3-year limit ends for addicts currently on the rolls. Also, data on the extent that addicts are suspended or terminated generally will not be available until sometime in fiscal year 1996 when RMAs have some operating experience under the new contracts. Concerning the mandated demonstration projects, SSA expects to make awards in fiscal year 1996.

Question 2. Through my work with the SSA, I have heard on numerous occasions that for every dollar spent on conducting disability reviews, between \$3 and \$4 would be saved. From your work, have you been able to estimate the savings resulting from increased reviews? Have you pinpointed any specific populations within the SSI and DI programs that, if regularly reviewed, would result in the greatest savings?

Response.—About \$1.7 billion could be saved by performing backlogged CDRs in the DI program. These potential savings are based on eliminating the backlog of DI disabled worker cases due for a CDR as of June 1995 or earlier, which was 1.5 million. If SSA were able to perform CDRs on this backlog, nearly all of the resulting savings would come from about half of the cases—about 790,000 beneficiaries for whom medical improvement (and therefore cessation of benefits) is expected or possible. The remaining backlogged cases are permanently disabled and generally not

expected to cease benefits; most are over 50 years of age and about half have been receiving benefits 11 years or more.

The \$1.7 billion savings—net of CDR costs—is based on SSA's estimate that CDRs would terminate 3 percent (after appeals) of the cases reviewed and that each termination would save an average of \$90,000 in lifetime DI and Medicare benefits that would have been paid over the beneficiaries' average length of stay on the rolls.

SSA has developed new computer profiling techniques to improve CDR efficiency. According to SSA, the profiles identify beneficiaries with the greatest likelihood of improving medically and becoming ineligible for benefits. Using this technique, SSA has identified cases with characteristics (such as age and type of impairment) similar to cases previously terminated because they were shown to have improved medically. As a result, SSA has determined that certain cases in the medical improvement expected or possible categories have the greatest likelihood of no longer qualifying for benefits. SSA continues to refine the profiles and use them to prioritize cases when assigning SSA's limited CDR resources so as to achieve the greatest benefit in terms of program savings for the funds spent on CDRs.

SSA has done few SSI CDRs in the past, but is in the process of testing its new profiling techniques on these cases also. The Social Security Independence and Program Improvement Act of 1994 now requires that SSA conduct at least 100,000 CDRs on SSI cases each year for the next 3 years, beginning with fiscal year 1996. SSA is also required to conduct CDRs on at least one-third of disabled recipients who turn 18 years old in each of the next 3 years. If conducting CDRs on SSI recipients is cost effective, additional program savings should be achievable.

Question 3. I have been involved with the GAO and the HHS Inspector General's office as they investigate the rise in the number of disabled children receiving SSI benefits. Although the IG's office has yet to conclude its investigation, proposals are being considered in the other chamber to eliminate entirely SSI cash payments to parents of children with disability. Understanding that this legislation is in the formative stages, what is your assessment of eliminating cash payments to disabled children? If you disagree with this approach, what alternatives are available to deal with the unsustainable growth of the SSI program?

Response.—We have not done work to support a position on whether the Congress should eliminate cash benefits to parents of disabled children. While cash benefits provide parents maximum flexibility to meet their children's needs, it does not provide assurance that the child receives services to treat his or her disability. Very little definitive research has been done on the costs of raising disabled versus non-disabled children, but we do know that the range of costs associated with having a disabled child is very great. Treatment and special need items for some disabled children can cost as much as \$1,000 a month or more, while for others, the costs of medication or services can be much less, depending on the nature and severity of the disability. Also, some of these costs may be met by other programs, such as Medicaid and special education, although there is no systematic evidence of the extent to which such programs may meet the needs of disabled children.

One option short of eliminating cash to disabled children, which would help to control program growth and enhance program integrity, is to make the eligibility criteria for children more stringent by eliminating the individualized functional assessment (IFA) as a basis for award. As we reported to you on March 10, 1995, in "Social Security: New Functional Assessments for Children Raise Eligibility Questions" (GAO/HEHS-95-66), the IFA process is fundamentally flawed. This new process, mandated by the Supreme Court in *Sullivan v. Zebley*, assesses the age-appropriateness of a child's behavior to determine his or her eligibility. It permits benefits to be awarded to children with less severe impairments than those previously awarded benefits. Since the IFA process went into effect in February 1991 through September 1994, more than 200,000 children have been added to the SSI rolls based on this less restrictive criteria, at an estimated annual benefit cost of \$1 billion.

We found serious problems with the IFA process. Specifically, each step of the process relies heavily on adjudicators' judgments, rather than objective criteria from SSA, to assess the age-appropriateness of children's behavior. As a result, the subjectivity of the process calls into question SSA's ability to ensure reasonable consistency in administering the SSI program, particularly for children with behavioral and learning disorders. Studies by both SSA and the IG documented these problems.

SSA's efforts have been aimed at process improvements rather than reexamining the conceptual basis for the IFA. Despite its efforts, too much adjudicator judgment remains. Although better evidence and more use of objective tests where possible would improve the process, the likelihood of significantly reducing judgment involved in deciding whether a child qualifies for benefits under the IFA is remote. We believe more consistent decisions could be made if adjudicators based functional assessments of children on the functional criteria in SSA's medical listings. This

change would reduce the growth in awards and target disability benefits toward children with more severe impairments.

**STATEMENT OF MARY JANE OWEN, EXECUTIVE DIRECTOR,
NATIONAL CATHOLIC OFFICE FOR PERSONS WITH DISABILITIES**

Ms. OWEN. Senator Cohen and members of the Committee, my name is Mary Jane Owen. I'm the Executive Director of the National Catholic Office for Persons With Disabilities and have held that position for almost 4 years.

Some have asked why, as a person in that position, I am coming before you to share my story. Those of you who were in the Senate when the Americans With Disabilities Act was first introduced for floor debate may remember that the first letter of support read was by the U.S. Catholic Conference and that letter said, "With passage of this bill, what was previously immoral, now becomes illegal as well." I also have the responsibility to represent and foster the pastoral statement that was unanimously passed by the National Catholic Conference of Bishops in 1978 which affirmed that not only must we work to welcome disabled people into the Catholic Church but into the "total fabric of society". It is in that regard that I appear before you to share my story.

First, let me say that as a blind person, I cannot read my written testimony and as a person with a number of spinal injuries, I have lost the sensitivity in my fingers to read braille, so I will summarize my written statement, which I hope you will review.

I think that in sharing my story I can help to illustrate the frustration of many people with disabilities, whether they are 16, 26, or 68—the frustration that they feel when they attempt to move from roles of dependency and stagnation into productive living, interactive living—as they deal with the Social Security System.

I came into this world with many gifts—I'm bright, I have a very serviceable body, I have a curiosity, I have an optimistic bent. Early in my life, while I was still in high school in the late 1940's, I was a CORE organizer, concerned about equity then. I have never lost my passion for dignity and respect for all people. I've been most fortunate. I started out as an artist, a designer, a dancer. I ended up doing welfare social work, became a psychiatric social worker and eventually a professor of research methodology.

It was during that time, as a professor, that I lost my sight in 1972 and first became associated in any way with the Social Security System as a recipient. I needed "a leg up", and that is a phrase that I quote from former Commissioner Gwendolyn King. I got it, but, as a result, in the years that followed, I was harassed because it was thought that I had received an overpayment. I will tell you in all candor that I know very few disabled people that have moved from Social Security benefit programs into paid employment that have not been harassed on the job and in their place of residence by Social Security with accusations of overpayments.

I would like also to share with you a definition of disability that I have been developing over the last 10 years, and it affirms that disabilities are the normal, anticipated, expected outcome of the risks, stresses and strains of the living process itself. When we think about it in that manner, disabilities become less an individ-

ual tragedy and become an expected event in any and every community.

I think that national policy should be based upon that expectation, that we become disabled over a lifetime. We acquire physiological glitches as a result of being alive, of living in very fragile earthen vessels. I think that no American should be forced to live in dependency and in stagnation as a result of national policy and programs. It is in that light that I appear before you.

When I acquired more disabilities, I was at that point working for the President's Committee on Employment of Persons with Disabilities. After I lost my sight and entered the job market again as a fully-rehabilitated professional, I was shocked to discover how difficult it was to find employment and was eventually hired by a community college in Oakland, California to head up a program called "University Year in ACTION." It was similar to VISTA. It was a program directed toward disabled people and elders.

One of the first problems I had in recruiting my students was "substantial, gainful activity," that odious phrase. Many of my students were afraid to enter this training program because of jeopardizing their benefits under the Social Security regulations. With the help of Senator Cranston and others, I was able to see that odious phrase removed from threatening my students, and we were able to bring in students who retained their eligibility as they acquired new skills in terms of community service.

As a result of establishing a national model, I was invited to testify before Congress and, as a result of that, was offered an IPA, Intergovernmental Personnel Agreement, to come to Washington and work in the national office of ACTION, Peace Corps. I was Special Assistant to an Assistant Director of that agency. In 1980, I moved to the President's Committee on Employment of Persons With Disabilities, where I had Congressional liaison responsibilities.

As I acquired more disabilities and ended up back in the National Rehabilitation Hospital here in Washington, D.C., I was "encouraged" to discontinue my work with the Federal Government and was once again dependent upon the Social Security System. When I was discharged from the National Rehabilitation Hospital on June 13, 1987, I was assured that I would be eligible for a program under Social Security called PASS, self support, moving toward return to self support and self sufficiency.

While I was in the hospital, I should say that I did not stop being productive. I wrote a journal article, that was published in an international publication, analyzing the rehabilitation and medical experiences that I had had. I also was allowed to address a national conference of women attorneys on the issue of "Baby Doe". So even while I was hospitalized (I emphasize this merely because once I left the hospital, I continued along those same lines), so there was not a big change in the way I viewed myself as a productive and contributing member of society.

I attempted to find out about the PASS Program and called SSA many, many times. I had professional friends call, and I had advocates call the Social Security Administration here in Washington, D.C. We could not find out what PASS was or how I should apply for it.

I developed a business plan which called for \$5,000 to establish my own consulting firm. I thought that being a consultant, writing and lecturing, would be a wonderful way to ease back into full-time employment. It was incredibly frustrating. I cannot tell you how frustrating it was to find myself, late in 1988, being called every 2 weeks by the Social Security Administration asking what I was doing. I wasn't making much money. I was making a reputation, and I was confirming my own sense of my dignity and worth, but I was told that if I was doing anything that was substantially gainfully active, I was not eligible.

During the months of this bothersome intrusion I attempted repeatedly to say there is some program within your system called PASS, and that program, I am told, will allow me to save certain moneys from SSI which I could then apply to establish my office business. I was told this is ridiculous. "If you are able to engage in substantial, gainful activity, you are not disabled and therefore, not eligible."

It was in the fall of 1989 that I finally said "Please, take me off your rolls. I do not want to receive another check, I do not want you interfering with my life. I refuse to be a victim. No one is a victim until they identify themselves as a victim, and I do not so identify. I refuse to define myself in the way you define me."

Amazingly enough, the checks didn't stop. The first one came, and I put it on a shelf—that was November 1989. The next check came, and I put that on the shelf above. Those checks have continued until very recently.

It has been an interesting life that I had during those months. At first, I decided that I would get maybe a few checks and I would write an amusing article—I do a lot of writing—about how this big, budgeted bureaucracy was unable to keep track of my eligibility and my request that I be terminated. It is interesting that with my request that I no longer be bothered with this system, I was not called anymore. So somehow, somewhere, there was a trigger that ended the biweekly telephone calls. I had told the gentleman, and I had included it in my letter requesting termination of the checks, that I would rather go out on the street and beg from strangers than deal with the system any longer.

Eventually, I was able, through the help of friends, through the help of other agencies, through the help of loans which I still continue to plug away at paying off, to succeed.

I do pray that in your deliberations, you can find a way where Social Security can begin to be what I think it should be—a leg up, a way of getting back into interaction. When I say that I think that everyone wants to live productively, I don't necessarily mean that everyone has to have a job; I mean that everyone needs to contribute whatever they can. I think there is no one on the face of this earth that doesn't have some giftedness to share with their community and their society. I would hope that you can help move the Social Security System, its regulations and its policies away from forcing people with disabilities into roles of dependency and stagnation and allow people with disabilities to fulfill their God-given potential, whatever that might be.

I would further suggest that those of us with disabilities can truly be catalysts in our society. My needs and my gifts, and your

needs and your gifts combined can build the strongest sense of community, and that's what we need in this Nation more than anything else right now.

Senator Cohen, I did bring with me those checks. I have here 42 checks uncashed, which total \$16,020. I have a playful cat that knocked some checks heaven knows where. They were not cashed, and so what I am sharing with you is over \$20,000 of uncashed checks that I have received. I only wanted \$5,000 to start my business. I didn't get it.

I thank you.

[The prepared statement of Ms. Owen follows:]

STATEMENT OF MARY JANE OWEN, EXECUTIVE DIRECTOR, NATIONAL CATHOLIC OFFICE FOR PERSONS WITH DISABILITIES

Senator Cohen and Members of the Committee, my name is Mary Jane Owen. I am the Executive Director of the National Catholic Office for Persons with Disabilities and have held this position since May of 1991.

PERSONAL BACKGROUND

The frustrations of people with disabilities as they attempt to move from roles of stagnation and dependency toward productive living following the development of assorted physiological glitches can best be illustrated in my testimony when one considers the many advantages I had when dealing with the Social Security system.

I was born with many gifts: A high degree of intelligence; a very serviceable body, an inquiring mind and an optimistic bent. While still in high school in the late 1940's I become a C.O.R.E. (Congress of Racial Equity) organizer and my commitment to human dignity has never faltered. I have been a designer, artist, dancer, welfare worker, psychiatric social worker, and eventually a professor of research and other subjects in a graduate school of social work. It was at that point I lost my sight and first encountered the Social Security system. I needed, in the words of former Commissioner Gwendolyn King, "a leg up." At that point I got it but later that help resulted in several years of harassment while I insisted I had not received an over payment. (I know few disabled persons who have moved from the SSA roles who have not faced this embarrassing harassment on their jobs and elsewhere.)

After years of job searching as a newly blind but fully rehabilitated professional, I was finally hired to head up a "University in ACTION" project in Oakland, CA, which included disabled and elder students. I had to secure modifications in the Social Security regulations relative to Substantial Gainful Activity to allow my students to join this training program. It became a national model resulting in my first testimony before Congress and an offer of an I.P.A. (Intergovernmental Personnel Agreement) which resulted in a position as a special assistant to an Assistant Director within ACTION/Peace Corps in 1979. In 1980 I accepted a position with the President's Committee on Employment of the Handicapped, which included Congressional liaison responsibilities. When I acquired additional disabilities I was "encouraged" to retire from my federal position.

A NEW DEFINITION OF DISABILITY

It also seems essential my definition developed over the past decade be shared:

Disabilities are the "normal," expected and anticipated outcome of the stresses, strains and assaults which result from the living process itself. Thus disabilities are not merely personal tragedies but expected events and must be anticipated within every community. Appropriate social policy must be developed to "normalize" such natural and ubiquitous events.

As a nation we need to anticipate these alterations in function and develop social policy and programs which take this reality into account and provide the essential resources which will provide assorted devices, services and techniques which allow people with disabilities to fulfill their potential. No American should be forced into a role of dependency or stagnation by national policy or programs.

MOST RECENT EXPERIENCE WITH SSA

Upon discharge from the National Rehabilitation Hospital on June 13, 1987, now a blind, partially hearing wheelchair user, my follow-up treatment plan involved Visiting Nurses' personal care and rehabilitation. I was told by the hospital staff I would be eligible for the Social Security's PASS program with the goal of becoming self supporting again. While an in-patient I had not ceased to be active and productive. I analyzed the medical/rehabilitation systems from a personal perspective for an international journal and addressed a workshop of women lawyers on the Baby Doe case.

Establishing a consulting office, writing and lecturing, seemed a career move allowing a realistic return to full time work. I prepared a business plan which required \$5,000.00 and began a frustrating and fruitless pursuit of information about PASS certification. I requested several people in professional/advocacy positions to aid in my attempt to get information. None of these inquiries resulted in information.

I was receiving SSDI and struggling at home with my home care assistant and a rehabilitationist to build my strength and increase my stamina. As I reconstruct that time in memory, it was late 1988 when I began to receive telephone calls approximately every two weeks from the local SSA offices asking if I was working. When I reported on my consulting and writing efforts which were adding very little to my financial resources, I was informed I was performing Substantial Gainful Activity and jeopardizing my eligibility. I repeatedly requested information about the PASS option, telling the SSA staff I'd been told this program would allow me to become self-supporting by collecting and saving certain money to apply to my business plan. The SSA employees who called said they'd never heard of such a thing and it sounded highly inappropriate. "You are supposed to be disabled and if you're working, you don't deserve benefits."

In the Fall of 1989 I verbally requested termination of SSA involvement in my life and followed that up with a written letter. I was surprised when checks continued to arrive and anticipated they'd stop soon. I did not cash them and though I might do an amusing column about this big budgeted bureaucracy's failure to keep their records straight.

The pile of checks above my desk continued to grow from 1989 to 1994. The earliest is dated 11/89. In a 12/21/94 letter to Mr. W. Burnell Hurt, an Asst. Regional Commissioner in Kansas City, I quoted my 1989 telephone conversation as including a statement along the following lines:

"I will never stop struggling to be self sufficient. I have no intention of playing the 'disability' role you think is appropriate for me. Please discontinue the SSA disability checks immediately. I would rather go out on the street and beg from strangers than deal any further with you!"

I continued in that recent letter: "As far as I was concerned, the SSA was not a system which was focused on helping people move from dependency toward independence and I wanted no more to do with it."

During former Commissioner King's administration, I had a subcontract to do two articles which were published in "Exceptional Parent" on making use of PASS. I disguised my personal example and included it as evidence of changes being made by the new commissioner, whom I saw as struggling to alter the system in positive ways. The administrator of PASS, with whom I had earlier shared lunch at Commissioner's King's conference table, would not approve my example in the published articles, asserting it was unrealistic. I modified the story to comply with her views and acknowledged that it was my personal experience to just a few friends and trusted colleagues.

To continue from my letter to Mr. Hurt: "Yes, amazing as it may seem, I was taken to have lunch with the SSA commissioner (Gwendolyn King) and to talk with her staff as a result of our having a mutual friend! I was still getting the checks and by this time was wondering exactly what to do. None of them had been cashed."

In concluding my report to Mr. Hurt, I asserted: "It was not easy for me to persist during the months following my discharge from the National Rehabilitation Hospital back in the 1980's. As a blind, partially hearing wheelchair user, I found many barriers in my path toward productive living and a meaningful job. During the time I was attempting to make it as a writer and consultant, I often felt frustrated that neither SSA nor the rehabilitation system were able to give me the assistance or support which would have moved me more easily and rapidly into a new career. But I have gained much in self recognition of my strengths and stubbornness. I know to the core of my being that no one can turn another into a victim. It is only when we accept that role ourselves that it has any meaning. I am not a victim nor was I one when the man from the local SSA office tried to make me into one by his in-

sistence that I couldn't be eligible for SSA funds if I was struggling to move toward greater self-determination and productivity. I am glad I resisted and told him to get out of my way and let me find assistance from sources which enhance my self-empowerment."

A recent form letter from SSA indicates to me there has been little shift away from a pejorative and negative approach toward those of us who strive to live as independently as possible. At a minimum, SSA should be reinforcing the basic dignity and value of each person, no matter their disabilities, encouraging moves toward productive living. We who have limitations and struggle to remain interactive can be positive catalysts, illustrating the "normality" of our shared vulnerability and confirming the necessity for interactive responsibility. My needs and strengths combined with yours can make for a powerful force in the world.

In conclusion, I hand you 42 checks which total \$16,020.00, far more than the \$5,000.00 I requested in my business plan. Some uncashed checks have unfortunately been misplaced totaling approximately \$4,000.00. I respectfully request you do with them whatever seems appropriate. I pray your deliberations relative to Social Security reform lead to expansion of opportunities rather than continued restriction of our God-given potential.

Thank you.

Senator COHEN. Ms. Owen, thank you very much.

I will see to it that all of these checks are passed around and shared with my colleagues so they can see the kind of integrity that you have demonstrated not only here today verbally and so articulately, but through your actions in refusing to cash over \$20,000 at a time when you were forced to go to friends and elsewhere to borrow the money to get started. I will share all of these with my colleagues.

Thank you very much and we will come back to you in a moment.

I might just say by way response to your suggestion that perhaps you would serve as an example for those who wish to pursue a life of productivity, I have a young man in my office in Bangor who was born without any arms. He drives his own van, he is a soccer player, he teaches archery, he's an expert marksman, and he is a role model for all who come into my office seeking assistance from the Federal Government. They look at this young man and see what he has accomplished during his lifetime and I must say it is a sobering reaction that they face.

Thank you very much and we will come back to you for questions in a moment.

Mr. Cote, I want to thank you, first of all, for all the help that you have given to this Committee. I might point out to Senator Santorum that it was largely through Mr. Cote's efforts that we learned of the serious abuse of the program of cash payments going to alcoholics.

Mr. Cote, why don't you proceed?

STATEMENT OF BOB COTE, DIRECTOR, STEP 13 HOMELESS SHELTER

Mr. COTE. My name is Bob Cote and I've been the Director of Step 13, which is a drug and alcoholic rehabilitation shelter in Denver, Colorado for the last 12 years.

I first became aware of supplemental Social Security income about 6 years ago when four gentlemen were passing out pamphlets on skid row where our facility is located in Denver, Colorado putting them in the hands of these street drunks. I went out there out of curiosity and got one. It said, "Are you an alcoholic or a drug

addict? Then you may qualify for supplemental Social Security income up to \$425 a month"—at that time, that's what they were getting. So I began a mission to stop this because I'm an alcoholic and if SSI had been around when I was drinking, I wouldn't be here today, Senator Cohen. I'd be dead because that's the only way that I know that an addict gets off SSI is when he dies. Unfortunately, I've watched 46 men die through supplemental Social Security income checks.

The Social Security Department is the largest supplier of drugs and alcohol to street addicts in America. A bar two doors from my facility—which I gave you the addresses and you found out—I was criticized, I was berated, they said it wasn't true, none of these checks were being sent to bars or liquor stores, but two doors from my facility where I'm trying to fix street people who are into dominant addiction, they were the recipient of \$160,000 in SSI checks. A liquor store three blocks from me was the recipient of over \$200,000 in SSI checks, they were sending them there as a mailing address and they were running up tabs. It's suicide on the installment plan is what SSI stands for.

When you figure that my budget is \$320,000 a year and I know that this bar right down the street is getting \$160,000 and a liquor store is getting \$200,000, and working against everything I'm trying to do, it was driving me crazy. I thank God that you finally listened. It took a long time and The Citizens Against Government Waste got involved in it and through that, this is being changed and as it should be because it's compassion without logic when you mail, especially retroactive checks up to \$20,000, to someone that is still in a dominant heroin addiction. What do you think he's going to do with it, go straighten out his life? He just upgrades it.

I know of two people that died when they received their first supplemental Social Security income check for being an addict because instead of buying cheap, skid row trash wine, they bought 100 proof bourbon. One of them, Clark Pittman, drank a whole fifth of bourbon, started on another and his heart stopped. I don't think taxpayers should be subsidizing addiction. It's misdirected funding, it should go to those that really need a hand up.

Mary Owen was talking about victims but I was a victim of my own vices and they are too and all this does is promulgate it to the point of just madness. Bob Woodson from the National Center on Neighborhood Enterprise is actually how this got started at an award ceremony here and it led to you and your Committee.

We have an organization known as GAP and about 100 of us met 2 weeks ago here in Washington, grassroots organizations and one of the things we focused on was SSI. These were people who run drug and alcohol addiction centers around the country—Houston, New York, Dallas. The Right to Privacy Act, people hide behind that and when \$1.4 billion is spent on supplemental Social Security income, it's not just \$1.4 billion, Senator Cohen. I'm being berated again saying that I don't know what I'm talking about and I'm going to look you dead in the eye and tell you, I do know what I'm talking about.

With this supplemental Social Security income for addicts, they also get a Medicaid card. They are using these Medicaid cards just as you or I would use a Visa to go to a Motel 6 and detoxification

centers. This is Federal funds also and it amounts to billions of dollars and that is being hidden through it's an invasion of their privacy.

Well, I know one man that stayed on a continuum at a detox center and I'll be happy to send you the papers and the tapes when this was taped 4 years ago because it outraged me, the Medicaid bills, and he was there 1,200 times. Even Forrest Gump could have figured out wait a minute here, mama, after about 100 times, something is not working here. They are using that for a residence, using that Medicaid card. So it would probably equal as much or half as what the checks would equal because they use them on a continuum.

The Grassroots Attorneys for Public Policy—these were all people who work in the drug and alcohol field—they hide behind the Privacy Act and let's just find out who these people are, who are we talking about and direct the funding to people who are really in need. I believe this was a great program when it started out. It was for if the head of the family became injured and unable to work, so on and so forth, and I think that is what America is about, giving people a hand up. I don't think it's about killing people on the installment plan.

I think we should have a war on the misuse of entitlements such as SSI because this is a total misuse and nothing good comes out of it. Many of the advocates say they cannot find treatment. They can't even find their shoes because they are so high on the money they get from the Federal Government. The first of every month is my worst date of the month because it's called Christmas Day, crazy money day. They get their checks and there are more ambulance runs, police calls, mayhem, because of these street pirates. People know they are getting their checks and they want their money to do their madness and it has created a big, big problem in this country and it needs to be corrected.

There should be what you suggested, a 36-month time limit. I think it should be 24 months because alcoholism and drugism is one fatal disease that you can cure fairly simply, just give it up. What's the incentive for someone to get off drugs or alcohol? If they get off it, they don't get the check anymore, see? I had one tell me, I'm a federally subsidized addict and there ain't nothing you can do about it. Well, I'm sitting here today and I hope there is something I can do about it.

I feel very, very strongly about this because I was drinking down on skid row and living under bridges, so on and so forth. Over the last 12 years, I've fixed many, many people. This program works totally against what I'm doing because I've had them file for it without my knowledge and as soon as they get it, they get a check for \$5,000 or whatever, and I believe I sent you some pictures. Right across from my facility in skid row, someone is renting a billboard to say "SSI disability denied? Call 59LEGAL. We'll get your check for you." So these property pimps were playing off this and this money was going every which way—the liquor stores, bars, lawyers, this and that except for what it was intended to do, to fix people. It's not, it's destroying them.

Again, I commend this Committee that this has finally come to light. Also, it's a personal affront to me. I'm going through the

same thing I did with SSI. They do get a Medicaid and Medicare card and they are using them in detoxification centers night after night after night, some as high as \$450 a night. Tom Bodette would put them up cheaper than that. So we need, please, to do something about this.

It is true and I hope that you do what you did with SSI and look into the options on the SSI as it is, that they are using as motels and shelters for \$400, \$200. Billy Palmer is just the tip of the iceberg. Unfortunately, he's dead but across the country, there are hundreds of thousands of people receiving these checks and using detox facilities and they say they're not getting Federal money to do anything. Well, they are getting reimbursed through Medicaid and Medicare and that needs to be stopped too.

Thank you.

[The prepared statement of Mr. Cote follows:]

HELPING "THE HOMELESS"

(By Bob Cote)

Bob Cote is the co-founder and director of Step 13, a homeless shelter and rehabilitation program for substance abusers in Denver, Colorado. It houses an average of 100 homeless, addicted men and up to 130 in the winter months. Its facilities include three floors of sleeping areas, eating facilities, a common area, a weight room, a chapel and a clinic where a doctor donates four hours of service each week. The building is well taken care of, complete with window boxes, and stands in striking contrast to the structures which surround it on Larimer Street, the heart of Denver's Skid Row. Since its inception in 1984, Step 13 has served more than 1,700 people. Its rate of recidivism is less than 74%, substantially lower than that of the majority of professionally staffed, government funded programs.

Cote is a member of the Grassroots Alternatives for Public Policy Task Force coordinated by the National Center for Neighborhood Enterprise.

I. HOMELESSNESS IS NOT A HOUSING PROBLEM

Despite the fact that "homeless" programs come under jurisdiction of the Department of Housing and Urban Development, homelessness is not just a lack of housing. For most homeless people, given them housing will not solve their problems. So when people say "Housing, Housing, Housing," at Step 13, we say "Responsibility, Responsibility, Responsibility."

If we really want to do more than just perpetuate homelessness, we must show people how to become responsible. Step 13 was designed to acknowledge and develop the responsibilities and capacities of its participants. After all, it does nothing for a person's confidence or self esteem to stand in a food line or a food stamp line. At Step 13, each client is required to work. Many start off at \$4.50 an hour doing jobs around our facilities, but after they have proven their consistency over some period of time, I have managed to make arrangements with 26 local companies who will hire them at progressively higher wages. Eight of Step 13's residents are currently making more than \$900 net pay a week at the airport. At the present time, I have more jobs available than I have clients who need them. We also have started a recycling business at the center, and this is helping us become even more self-sufficient.

Step 13 clients start out paying a nominal fee toward their room and board and sleeping in a bunk room. But as their job situation progresses, their financial obligation increases as does their living situation. They move to double occupancy rooms and then to private rooms that they can furnish and decorate as they like. (The monthly fees of \$120 together with the earnings of the recycling center make us about 60% self-sufficient. The rest of our budget comes from contributions.) When they are ready, one of our board members has an apartment building where she makes several apartments available to graduates of our program. Thus they gradually move from the street to a self-sufficient life on their own.

As individuals move up through this system, a dynamic of "constructive envy" is initiated which moves others to follow their path. Many Step 13 residents have known each other for a while. They have crossed paths in the jail, in the park, the detox facility, or the hospital. When they see one of their peers who has been work-

ing buy a nice car or move into a room with a phone and a 23-inch television, they respond. A counselor or a psychiatrist can sit and talk to an unwed mother or a street person for hours, and it goes in one ear and out the other. They know the game is on. But when they see one of their peers beginning to succeed, no one has to say anything. They see that he has a car, or a bank account, and they want to do the same thing.

We also take our clients from "me" to "we". They take responsibility for the shelter because we teach them that this is their home.

The founding philosophy of Step 13 is that any system or program that takes responsibility away from a capable person dehumanizes that person. Blind compassion does nothing to promote the self-esteem and self-respect of its beneficiaries. Taking responsibility for oneself, and knowing that others respect that, is the first step toward building self-esteem and self-respect.

II. THE HOMELESS SHOULD BE SEPARATED ACCORDING TO THEIR SPECIFIC PROBLEMS

Most of today's homeless shelters are the product of compassion that is not rooted in logic. They do not address the real needs of the 60% of the homeless population that is suffering from dominant addictions. In Colorado, a recent legislative package was recently presented that was entitled "PIES," People In Economic Stress. I like that acronym because I think the metaphor of a pie is useful in discussing the homeless. The homeless population is not a monolith. It is composed of people with a number of different needs and problems. More than half are addicted to drugs or alcohol. Another twenty percent suffer from a mental or emotional disability—the result of a wave of de-institutionalization that was prevalent in the 1960's. If the problems of these people are to be effectively dealt with, the "pie" must be sliced up and each section dealt with accordingly.

It does not take a genius to develop this strategy. It seems obvious that the most effective approach would be to identify the fundamental problem of a homeless individual and to treat that specific problem or direct that person to a place where that problem could be treated. It seems obvious that, if drug and alcohol addicts are tossed under the same roof as women and children who are in financial straits and people who are mentally or emotionally unstable, nothing good is going to happen. Yet that is essentially how our current approach to "The Homeless" works. There are people who simply need to find a job, but for alcohol and drug addicts, the problem lies in developing the dependability that will allow them to keep those jobs. Often, after receiving their first paycheck, they don't show up until the following week. Programs must be structured to fit the actual needs of the individuals they deal with.

To deal with their "homelessness," we must deal with the underlying problem. If we throw all these people under one roof, the way most homeless programs do, we only have a zoo. The conditions in many homeless shelters are so intimidating that many people would rather sleep on the street than go into the shelter.

Most shelters put a limit on the maximum stay of their clients, be it seven days, thirty days, sixty days, or even ninety days. But this limited stay cannot offer what is really needed to "fix" a street person who has been under the influence of a dominant addiction for five, ten, or twenty years. We have to be realistic about where many of the homeless are coming from and what their needs are.

Regardless of how compassionate the intention of homeless programs may be, if it gives only a handout and a bed, and fails to acknowledge and address their real problems, it essentially amounts to no more than killing them on an installment plan. The public is worried that homeless people may freeze to death in the winter, but they should know that many more deaths are caused by dehydration from alcohol and drug abuse even in the middle of July.

If the problem is faced head on, it doesn't take millions and millions of dollars to "fix" someone. In New York, a study produced in 1989 revealed that 65 percent of the homeless were addicted to drugs and alcohol. Yet in the past eight years, two billion dollars has been spent on simply sheltering—warehousing—the homeless.

It simply does not do much good to take a person with a dominant addiction, let him in at 7:00 p.m., give him a bed and a meal, and then put him back on the street with a donut and coffee at 7:00 a.m. Addicts and alcoholics will just go on feeding their addictions, and they will never get off the treadmill. They are destined to suicide on an installment plan.

Nearly 50% of the people who use homeless facilities in this country are suffering from a dominant drug or alcohol addiction. As they continue to drink, their self-esteem gets lower, their self-respect diminishes, and they drink more. When they drink enough and get sick enough they are hospitalized. And when they are released, they can get Supplemental Social Security income, because they are "dis-

abled" by their addictions. This gives them an income of \$517 a month—with no requirements to get treatment. Many of them take these payments directly to the bars and liquor stores. Our "compassion" literally kills them. I know of 41 individuals who received retroactive SSI checks and died from the binge they went on. Others just go on drinking it up month after month. They call the first of the month "Christmas Day" because that is when their checks come. And they take those checks directly to the bars. And when the money is gone, they are back in the shelters.

Taxpayers should not be subsidizing addictions. Supplemental Social Security income was set up to care for mothers whose spouses had died, or were injured in war, or who had debilitating diseases. The program began with good intentions, but as it was institutionalized through a growing bureaucracy, its practices grew very far from its original purpose.

We have to deal with each homeless person in terms of his or her specific problem. If the person's only need is for a job, then find him employment. If he or she has a mental or emotional problem, treat that. If he is addicted, that addiction must be addressed.

Our program deals with substance abuse, and has a better than 35% success rate. We also furnish job training, education, and try to meet any other needs a homeless person might have that keep him from returning to a useful and productive life.

THE NUMBERS GAME

There is a lot of money at stake in the "homeless business." Two billion dollars has been spent in an eight-year period. Since 1960, more than three trillion dollars has been spent on social services. If I had two trillion dollars, there wouldn't be a homeless person in the universe!

Many homeless shelters secure their funding by the numbers of persons they serve. Figures mean funding. But many of the homeless are counted over and over again, as they move from one soup kitchen to another over the course of the day.

But more than numbers of persons served, we should be asking how many successes has this or that program produced? A program that simply warehouses the homeless and provides no way out of this desperate situation only perpetuates suffering at a huge cost to society.

Step 13 does not apply for government funding of any kind. If I did, I would be required to have a Ph.D. or at least a Master's, hire certified social workers with Masters' degrees, two psychiatrists, several certified counselors, and staff to handle the paperwork. Our staff consists of former clients—they know and understand the clients in ways no 26-year-old with a Master's degree can do. These people can read you like a book. A professional may approach them who has a Masters in Sociology, but most of the homeless have a Doctorate in Streetology. When they confront each other, the game is on. It's predictable who will win.

Part of the reason that the people on the street trust Step 13 is that I had once been there myself. I know they think and they know that I can read them. To reach them, I walk the streets, I walk the alleys, and I go under the bridges. I don't wear a tie. When these people have confronted a tie in the past, it has always meant bad news: "We have a warrant for your arrest. You are sued for divorce. You are fired." I meet them where they are and deal with them on their own turf. You have to earn the respect of these people in order to work with them. That is the key.

The fact that my staff has degrees in Streetology instead of Sociology not only makes my program more successful, it is one of the reasons I can keep our costs down. As you can see by the chart, my budget is only \$320,000 a year to serve 100 clients at a time, and half this amount is paid by the clients themselves from their wages. I welcome a comparison with any state, city, or Federally funded program. Denver Cares, for instance, which is a 105-bed facility which does not offer all the services we do, has a budget of \$3.7 million annually. Its detox program is only three days, and the clients are back on the street.

The biggest secret in this country today is that there are solutions to the problems that face us, including homelessness. There are other privately-funded, community-based programs similar to my own in other cities around the country, that are actually helping homeless people get off the streets, get off drugs and alcohol, and turn their lives around. Freddie Garcia at Victory Fellowship in San Antonio, Texas, has treated and freed 13,000 men and women from substance abuse over the past 30 years through his church-supported program. Raul Gonzalez has a similar program in Hartford, Connecticut. Craig Soares in Atlanta has served around 8,000 people in the past three years at Victory House.

These programs are part of the Grassroots Alternatives for Public Policy (GAPP) Task Force organized by Robert Woodson, Sr., President of the National Center for Neighborhood Enterprise. And what we can all tell you is this:

This country could drastically cut the money it spends on helping the homeless if it would adapt public policy to encourage and strengthen the community organizations that are already achieving success.

And homeless programs should be forced to compete for funding on the basis of their records of actually alleviating the condition. I challenge you to compare any of the programs that are part of the GAPP task force with traditional homeless and substance abuse programs.

III. THE GRASSROOTS ALTERNATIVES TO PUBLIC POLICY APPROACH

This past weekend I participated in a task force meeting of grassroots groups which have demonstrated success in treating various problems of poverty. The task force was organized by Robert Woodson, president of the National Center for Neighborhood Enterprise (NCNE) at the request of House Speaker Newt Gingrich. We will make a full report to the Congress in about two weeks.

But here are some preliminary recommendations regarding programs for the homeless, developed from the experience of the past three decades of successful homeless and substance abuse programs from all over the country:

1. Disaggregate the homeless into categories according to their problems and treat their underlying problems.
2. Re-criminalize drug addiction.
3. Change licensing requirements to allow use of former substance abusers to be paraprofessionals.
4. Make performance and cost effectiveness the criteria for receiving funding.
5. Require any substance addicted applicant for SSI to participate in a positive program (substance abuse treatment, job training, education) and cease benefits if they fail to comply.
6. Revise laws of confidentiality to allow community treatment programs to access information needed to effectively serve all participants.
7. Mandate testing for participation in substance abuse treatment programs (at present, community-based programs are unable to test for HIV/AIDS, give breathalyzer or urine tests.)
8. Make Federal guidelines flexible enough to allow faith-based/spiritual community organizations to qualify for funding.

And the following recommendation is also suggested:

When an addicted person qualifies for SSI it does not stop with the \$517.00 a month check. It includes Medicaid, which addicted recipients use at Detoxification facilities. One such SSI recipient, Billy J. Palmer was at Denver Cares over one thousand times and Medicaid was used to pay for his ten hour stay at a cost to the taxpayer of \$200.00 per night. Therefore, there should be a limit set on the number of times a drug addict or alcoholic who qualifies for SSI can use their Medicaid card as someone else would use a Visa card to stay at Motel 6.

Senator COHEN. Mr. Cote, thank you very much for your very strongly-felt statement. As a matter of fact, when you combine the SSI program and the Disability Insurance program, along with health care benefits, the total comes out to about \$114 billion a year that is being spent. So it's not just a few billion; we're talking many billions. We are going to take very seriously your recommendation that we look further into how that money is being spent.

I might say for whatever consolation it might give you, whatever harassment or retribution is being heaped upon your head, I hope you will continue to hold the tide because if it were not for your efforts—I must point out you were not the only individual but you were perhaps the most critical individual pointing out the absolute absurdity of having payees be either liquor storeowners or bartenders, running up tabs in the hundreds of thousands of dollars for people who have designated these barowners and taverns as their representative payee. It was an absolute atrocity in terms of the system, but it took someone like you to come forward and ring

the bell and say something is wrong with the system. As a result of your coming forward and taking the criticism you've taken, we were able to pass legislation that may not go far enough, we may need to do more, but we who passed that legislation—Senator Santorum mentioned perhaps the reaction in his State was different, but I received a number of critical articles written about how inhumane this was, it was not an appropriate thing, especially for a Republican being accused of being hard-hearted and mean-spirited, saying wait a minute, we've got a pretty good record here. We were the ones who stopped the arbitrary termination of disability payments way back in the mid-1980's when they were just using computers, not having any personal interaction. They were drawing profiles and if you fit the profile, you were off without anyone ever coming into contact with that individual. We said, we can't do it, that's not the right way to develop a system. So we have a pretty good record of protecting those who truly are in need of assistance.

What we are not going to allow is the continuation of what you have called to your attention, along with others. As a result of your efforts, we did change the law and perhaps you can comment, if you can, as to whether you think other changes have to be made with respect to how that is being implemented?

Mr. COTE. Again, I would say, I'm being criticized as recently as yesterday, but I know that I'm right and I know that I'm never going to give up the fight. This isn't a matter of politically left or right; it's a matter of right and wrong, Senator. When taxpayers are subsidizing addicts and killing them, something needs to be done about it. I think no cash should ever be given to someone—as soon as they apply for supplemental Social Security income—and this is one of the things that came out of Mr. Woodson's GAP Task Force we had here—they should go into some sort of facility, whether outpatient, inpatient; they should be given urine screens; and if they are an alcoholic, go directly to the problem and never mind the issue.

The people dealing with them have a masters in sociology but every street dude I've ever ran into has a doctorate in streetology and the game is on. They can understand what's going to happen, so you make it very clear. You have 36 months, if you do not have a high school diploma, to get a GED or if you have a high school diploma, learn a trade or something and that is more than enough time to do something constructive and positive with this funding and turn people around.

I know in my heart, you can do that because I've turned around thousands of people—I haven't, they've done it themselves as I did, but I've watched people go from not having two dimes to rub together to owning their own home and driving a \$35,000 Nissan sports car. I'm kind of envious of him and I remember when he crawled in out of the gutter.

As a matter of fact, Mr. Woodson's Grassroots Attorneys for Public Police, we decided that there should be some way when the drug-addicted, supplemental Social Security income client uses that Medicaid or Medicare card in the detox, there should be a tracking system set up so that when they've been there 20 times or some-

thing, they are directed to another facility and say either shape up or ship out.

Senator COHEN. Let me just tell you how creative they are and how the legal beagles and such in prison take advantage of this.

I had one woman, as a result of the attention that you drew to this a couple of years ago, who called my office and said a relative of hers was getting out of the Maine State prison. He obviously had had access to drugs even while in prison but the first thing he was going to do was to apply for SSI when he got out because he was addicted to drugs and he was immediately going to be qualified for it. So the word spreads on the street and off the street in prisons as well.

You can see from that chart over there the growth in the disability rolls and program. You can just see the dramatic increase since 1986 to 1984 with a good deal of that coming from the SSI Program itself.

Mary Jane Owen, you have given dramatic testimony and it is evident that you are showing modesty when you say that you're an intelligent woman. That was perhaps the most articulate testimony I've heard in a long, long time, without notes, I might add.

The story you've told I think is really astonishing in terms of how you left the National Rehabilitation Hospital but you couldn't get \$5,000 to get yourself started. What do you think we ought to be doing in terms of changing the system as far as PASS is concerned? What is wrong with the system we've got now where you're being harassed to find out if you're doing any writing or consulting and is that significant, gainful activity?

I might point out the great irony involved, and Senator Santorum will confirm this. We had a court case that came down where a person was doing drugs. He was selling drugs and acquiring it for other people and they said, well, that's not significant, gainful activity, so you can be a drug dealer and still get your SSI benefits but you were put in the position of if you do a little writing, you're off.

Ms. OWEN. Right. You will find that in many ways my thoughts on that subject are quite common sense and concrete, but I would like to think that when we citizens put money into the Social Security System, that in a way it's a deposit against the future. I would hope there would be some way as we develop the physiological glitches that I maintain are a normal part of living, that we can draw down sufficient money for a one-time investment in the rehabilitation devices, the services, the technology that we need. I need a talking computer, I need a scanner, I need specific things to be interactive and participatory, and those are not a non-ending investment, a life-long cash investment. They are one-time, they are purchased, they are there.

To me, the idea of month after month after month until death sending out checks, just doesn't make sense. I know very few people—and I know that I know a different group than you do, Mr. Cote—but I don't know very many people with disabilities who don't want to be productive. The Louis Harris and Associates survey of 1986 indicated that most disabled people want to have a job, want to live productively. That has certainly been my experience. They don't have the tools and there is big brother, SSI, DI, mon-

itoring and forcing them really to live in dependent roles, and I consider this a disgrace.

I do want to go on to say again that I think that one of the things that is most at fault in this Nation today is our sense of disconnectedness, our sense of alienation from each other. We constantly talk about my "rights," "my rights," and not about "my responsibilities."

I think that as I move through the world today and need other people, I have to believe in the miracles of happenstance. When I wake up in the morning, I'm blind, I'm partially hearing, I'm in a wheelchair, I'm an old woman, I'm vulnerable and I have to go out into the world expecting miracles of happenstance, and I find them because I think people want to be interconnected. We're tired of being alienated and separated. I think we crave a sense of community. Those of us who are obviously vulnerable can't hide behind a mask as if we were autonomous. We can maybe be a lesson to the rest of the community.

Senator COHEN. You've been a lesson to all of us I think here today. One final question before I yield to Senator Santorum. Why did you finally stop receiving the checks? Were you able to finally prevail upon the Social Security Administration that you were no longer "disabled," that you were engaged in significant economic activity? Why did the checks stop?

Ms. OWEN. Senator, I love to lie about my age. It was an age issue. I became 65.

Senator COHEN. Are you sure you're not wearing a mask this morning? [Laughter.]

That was the reason that the checks stopped?

Ms. OWEN. Right.

Senator COHEN. But you could not prevail upon them to stop the checks from coming?

Ms. OWEN. I was curious about how long this would go on. I was trying to find out how to handle this in a nice way. At first, it was amusing and then it became bothersome. Then I began to talk to some of my friends and in fact, I was visited by a trainer within the Social Security Administration who I think is really a wonderful person and who suggested I should have a position as an adviser within the Social Security System.

He maintained that probably because of the additional expenditures of being disabled, everything costs me more. I cannot go into the grocery store and shop for myself; I have to pay premium prices for transportation. There are many additional expenses in living alone as a disabled person. His view was that therefore I might still be eligible for some of the money and he did not want to take the checks or discontinue them.

I told him that I didn't want the checks, that I didn't cash them, that I did not intend to cash them. That was about a year-and-a-half ago, so I did have that one contact where I was talking with a friendly, wonderful person that I think is a part of what I would hope is a new move within the Social Security Administration. But his view still was, you're probably eligible, I don't want to stop it. Let us look at your budget, let us do this, let us do that. And, as a blind person living alone, very actively involved in my career and trying to change the world, I'll be perfectly honest, I've got piles

and piles, boxes and boxes of ink print. You people just keep sending ink print out which is not accessible to those of us who are blind and I can't deal with all of it all the time.

Senator COHEN. Mr. Cote.

Mr. COTE. Senator Cohen, there's a couple of things. A month ago, Ralph Ariola, who is an SSI recipient that I knew, died in a detoxification center from alcohol poisoning; 4 years ago, there was a street man who came to the door and asked my desk guy if he could cash a check and it was an SSI check made out to Mr. Ralph Ariola. As Mary Jane Owen has stated here about their continuing to send these checks, obviously Mr. Ariola's check is still being mailed out. If you consider where these checks for these drug addicts and alcoholics are being mailed to, they are not pillars of the community, so that might be something. As I said, the only way I know you can get off SSI is if you died and many of them have. If their checks are still being issued, you could have quite a few stacks along with Mary Owen's.

Another point, I had a gentleman 5 years ago kill a man behind my building with a chunk of concrete. I'll use his name because I had a man from the Baltimore Sun talk to him. His name is Willard Redpaint. He came to my door 4 or 5 months ago and I thought he had escaped from prison but they had released him because he pleaded guilty to involuntary manslaughter or something and guess what he wanted me to do—cash his SSI check which he had been put on while he was in prison.

There are a lot of clinics around that take \$75 to be the payee, as Willard, and they dole out \$20 a day and Willard stated in that article, that's enough for six bottles of Night Train wine and he's on the track to no where. Again, that should be stopped too. No cash, no little enough to kill them on the installment plan.

Senator COHEN. Thank you, Mr. Cote.

Senator Santorum.

Senator SANTORUM. Thank you, Mr. Chairman.

Mary Jane, I just want to say that you've made a lot of good points and I think our points on creating victims and dependency in the system are incredibly valid. I think the point you recently made that impressed me the most was this whole idea of disconnectedness. That is something I talked about and have talked about for a long time that I don't hear much talk about and that what the government programs do to us as a society and to the individuals it is intending to help and the danger of these government programs of sort of removing us from our obligation to our fellow man and we pay our taxes, just leave me alone, not reaching out into the community and finding our role in helping each other out and sharing that sense of community.

I very much appreciate those comments and I think as we look at changing the social welfare network in this country, we have to not just eliminate government programs, change government programs but search for ways of how to increase because it's still out there. There are networks out there, there are people out there who do care as you've obviously found and have developed relationships with, but we have to continue in some way and maybe highlight and encourage that. If you have any comments on how we might be able to do that, I would be anxious to hear that.

Ms. OWEN. Yes, I do. If I could share just one other experience. I was a welfare worker for a while. Potentially, I was in trouble because I ran counter to the official standards of such a position. I had more clients on a track toward self fulfillment than any other person in the State of Arizona at that time. We could refer people to vocational rehabilitation and I had more people in that program than any other social worker in the State.

What I did was treat people, one by one. I didn't have much time, I had over 500 clients, but I would take people in my car to a grocery store so they could get out of owing the little neighborhood grocery store all of their welfare check, so they could go to Safeway, stock up and begin to get checks in their own home, those kinds of things in one case taking a client to ASU and showing her where the Arizona State University Admissions office was and introducing her to other services.

Several years later, I was stopped by the children of that particular client yelling for me to "Stop, Mrs. Owen, stop, Mrs. Owen." Their mother was on her way to California to take a job as a teacher—she had been a welfare client of mine. So I do think that we need personal interaction.

Another example to me—and I gained this story from a friend of mine, Hugh Gallagher, who is a historian, a disabled man—who was once at a meeting, and he had parked his car in the middle of a big lot early in the day, and now it's late at night, it's dark, and he's rolling in his chair and he's a weak man, rolling in his chair toward his car in the middle of a dark, dark parking lot here in Washington. As he's rolling, he sees three tough guys coming at him; they're going to intercept him before he gets to his car. We anticipate what that will mean, don't we?

Hugh had the wisdom and the wit, and he taught me a lot by that, of raising a hand and saying, "Thanks, guys, I know you want to help me, but I don't need your help; I've got it under control." When I've been in dangerous situations, I've taken that stance, too. I think that when we look to others for help, we share our vulnerability, and that touches on a very deep human level. I would suggest that we really need to foster that kind of sense of inner need, interdependent need. We've got to do it to save our Nation.

Senator SANTORUM. Thank you very much.

Mr. Cote, let me ask you, because you've made some comments that I'm not too sure exactly where you're coming from with respect to the program. As you know, we did pass the Social Security Independent Agency Act with a 36-month limitation on SSI. Obviously, we haven't run 36 months, so we don't know how effective or if you can tell me how effective that is, do you believe the time limitation is enough because at some point you talk about time limitation and at another point, you talk about elimination of all cash assistance. Which is the ideal and why?

Mr. COTE. Well, a little of both, but you should never give an addict that's into practicing addiction cash. He's not going to go straighten out his life with it.

Senator SANTORUM. So you believe we need to go further so that anyone who is addicted to drugs and alcohol should not be eligible for SSI checks? Is that what you're saying?

Mr. COTE. I think what we need is an SSI Corps for drug addicts. We have plenty of Federal land and let them go out there from the moment they file or if they are on it and make sure that they are doing something constructive. I'm talking about those that are capable. You know, any system that takes responsibility away from a capable person, dehumanizes that person. So most of these people that I know, the only problem they have is finding enough madness to keep them going.

Senator SANTORUM. Let me ask you, if elimination is not a possibility, which I would suspect would be tough around here, but if elimination isn't a possibility and we're looking at time limits, a couple of questions. First, is the 36-month time limit a reasonable time limit for someone if they are going to be receiving this check to work themselves out of this addiction?

It's really amazing a difference a year makes when we went through this thing in the House of Representatives last year in the subcommittee. A parade of witnesses appeared on how this was the most cruel thing we could ever do and how this was going to destroy the entire system, and don't you understand this is a disease and these people can't help themselves, that we need to just give them money, and it just went on and on and on. My feeling was we're not helping people, as you said, by just giving them money so they can kill themselves.

As the Social Security Commissioner testified before our Committee last year, in the entire history of the SSI Program for drug addicts and alcoholics, they do not have one documented case of anyone leaving that program as a result of a cure, not one documented case. I don't know how anyone explains that is helping somebody and you've made that point.

The question I have is, if perpetually giving them that doesn't help them, is there any point that we can say 12 months is what you should get, 24 months which is what we originally intended, then we stretched it to 36 to get a compromise. What is a good time frame?

Mr. COTE. I'll use our program, Step 13, as an example. We deal with very hard core street people that are into drug or alcohol addiction. We have no time limit and the reason that we do not is because 7 days, 30 days, 60 days, 90 days is not going to fix someone that is into a dominant addiction, but through our tracking system, and everyone there works and we have 26 companies, God bless them, that hire our clients, it's a little over a year, between a year and a year-and-a-half for those that make it, and 35 percent of them make it. I truly believe from the bottom of my heart that our success rate would be much higher if there was some way—because they have an easy exit, they just go out my door and down to the flop house that figures equal funding, so they let them in the door. A year or year-and-a-half and you have to consider, which I did, that I get some people who are totally illiterate, I get some people that just need a high school education or something, and then I've had airline pilots, veterinarians, architects and so it just takes a little hand up to get them back on track. So you have to go to the problem.

I was hoping that shelters could be sliced up like a pie but maybe you could slice this program up like a pie according to the

problem and go to the problem, but a year or year-and-a-half is plenty of time.

Senator SANTORUM. For someone who is chronic, illiterate, you name your worse case, and that's your worse case?

Mr. COTE. And I'm saying that I watched Bob Moore who was totally illiterate, been on the street for I think 15 years and he went to Emily Griffin's school in Denver and had to take remedial math and English, which he did. He got his GED and then went to Metro College and he left Step 13 after a year-and-a-half but he did get an Associates Degree in Drug and Alcohol Studies. He may be the exception but it should be a carrot on a stick approach. Everyone says it's victim, victim, victim, but it's responsibility, responsibility, responsibility. You have to make them take responsibility for themselves, those that are capable.

Senator SANTORUM. What do you think of the idea I've heard at prior hearings that the reason we can't require drug-free treatment as a condition for receiving benefits is that drug treatment isn't available? There just isn't enough availability of drug treatment, and therefore, it just simply isn't something that we can require.

Mr. COTE. Well, that's silly to me because all I have is a handful of antabuse and a Waring blender, some urine screen cups and a breathalyzer. The Disabled American Veterans gave us an old 35,000 square foot warehouse that was in the middle of skid row totally in disrepair and we rehabbed that. There's plenty of Federal property and I think under the Stewart-McKinney Act, you can get that property and say here's where you're going and here is what you're going to do, but look for the problem. I deal with street people and behind every street person there is a problem, mainly alcohol and drugs, but there are other problems too. Some of them have mental disabilities, so on and so forth, so homeless shelters should be sliced up like a pie. A single mother with two children shouldn't be thrown in with psychopaths, crack addicts, and practicing alcoholics and the same should go to SSI.

For those that are addicted, go to the problem. If they do not have an education or if they have some job skills or whatever, but again, they shield behind their right to privacy and confidentiality and they don't want you to know who these people are. I think it's about time that we did know who they are.

Senator SANTORUM. Thank you.

Senator COHEN. Thank you, Senator Santorum.

Mary Jane Owen and Bob Cote, thank you very much for coming forward. We will probably be calling upon you for further recommendations. Your testimony has been invaluable to this Committee.

We will now move on to the second panel which consists of: Jane L. Ross, Director, Income Security Issues, General Accounting Office. Your statement will be placed in the record in full and if you could try and summarize as best you can. We have two more panels to go and we want to give you plenty of time to outline what GAO has discovered with respect to these programs.

STATEMENT OF JANE L. ROSS, DIRECTOR, INCOME SECURITY ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY CYNTHIA BASCETTA, ASSISTANT DIRECTOR

Ms. ROSS. Thank you. I'll be glad to summarize.

I'd like to introduce Cynthia Bascetta, who has been the Assistant Director who has been involved in this work.

Senator Cohen and Senator Santorum, it's quite a challenge to come and follow such powerful witnesses. My testimony and my responsibilities are quite different but what I'd like to do today is share with you an overview of the DI and the SSI programs, the two major Federal disability programs.

I want to discuss four topics—the growth in the programs over the past 10 years, some of the reasons for the growth, the impact that fraud and abuse have had on the growth and on program integrity, and finally, the weaknesses in SSA's efforts to return DI and SSI recipients to work. I'd also like to suggest several ways in which we can improve the disability programs.

By way of background, DI is funded through payroll taxes that are paid into a trust fund by workers. In contrast to DI, SSI is not based on a work history. It's means tested and funded by general revenues.

Let me quickly move to program growth. We have a chart over here that demonstrates the points I want to make. In 1986, 4.4 million disabled persons received DI or SSI benefits. By 1994, that number had reached 7.2 million, an increase of 70 percent. As the number of DI and SSI recipients has grown, so has the amount that has been paid in benefits. As you said, Senator Cohen, that amount of cash benefits now is up to \$60 billion for the two programs combined. If you add Medicare and Medicaid health coverage for DI and SSI, then combined cash and medical benefits are about \$100 billion a year.

There are several reasons for program growth. Let me highlight just a few. One major reason has been changes in eligibility standards. These have occurred as a result of legislative changes, regulatory changes, and judicial action. The Social Security Disability Benefits Reform Act of 1984 changed the manner in which SSA evaluated mental impairments. The Congress acted in response to issues raised by the courts and by medical professionals, and assessments under the new mental impairment standards were required to focus on an applicant's ability to function in a competitive work environment rather than on a purely medical evaluation.

Another program expansion that has contributed to growth is the 1990 *Sullivan v. Zebley* Supreme Court decision which ruled that children with less severe mental and physical impairments than those in SSA's strict medical listings could qualify for SSI benefits. Also in 1990, SSA changed the regulations that covered childhood mental impairments adding, for example, coverage for attention deficit hyperactivity disorder.

The cumulative effect of these changes and several others is that the Federal disability caseloads are increasingly composed of people with mental impairments. You can see on the second chart over there that the type of impairments is shown with mental at the top and physical impairments at the bottom for both SSI and DI. You can see a sharp rise in the 1990's.

SSA outreach efforts, especially for SSI, have also contributed to program growth. In 1990, the Congress mandated that SSA expand the scope of its outreach efforts and provided \$21 million to SSA to complete a series of outreach demonstration projects. At the same time that a broader definition of disability and outreach efforts brought more people into the programs, beneficiaries were tending to stay longer on the rolls. In 1985, 8 percent of the disability insurance beneficiaries had been receiving benefits for 15 years or more. Now 12 percent are on for 15 years or more.

Possibly one of the reasons that people stay on the rolls longer is the reduction in the number of continuing disability reviews conducted by SSA. SSA conducts these continuing disability reviews to verify that people who are on the rolls are still entitled to benefits, that is, they are still disabled. The law requires that SSA conduct these CDRs at least once every 3 years if medical improvement is expected or possible. Seven months ago, as you well know, the Congress directed SSA to conduct more CDRs for SSI recipients as well.

In the early 1990's, the number of CDRs declined dramatically. Currently, the CDR backlog at the Social Security Administration is about 1.8 million cases, and about 500,000 cases are added each year. The amount of cases they work each year is not equal to that amount, so this backlog is increasing. CDRs not performed on schedule mean that significant payments could be made to individuals who are no longer eligible for benefits.

Let me turn now to the topic of fraud and abuse. It's very difficult to estimate how much such problems have contributed to growth, but it's clear that reports on fraud and abuse have weakened public confidence in the integrity of the SSI Program. Anecdotal evidence regarding children, immigrants, and substance abusers have generated much of the concern. Especially troublesome have been the allegations that parents coach their children to fake mental impairments by misbehaving or doing poorly in school so that they can qualify for a cash SSI benefit. Among immigrants, there is some evidence that interpreters have coached SSI applicants on how to appear mentally impaired, and we've already heard a great deal about program abuse among drug addicts and alcoholics.

As you know, Senator Santorum, up until last summer, there was very little assurance about who controlled the cash benefits, and there was virtually no oversight on whether people were in treatment. As a matter of fact, very few people were even obligated to attend treatment.

There are also some additional factors outside of the SSI program that have contributed to growth. For example, economic factors such as the recession in 1990 and 1991 may account for some of the increase. In times of high unemployment when impaired persons are working, if they lose their jobs, they then may apply for DI if they believe job prospects are slim.

Another factor has been the State efforts to enroll individuals receiving State welfare benefits onto SSI instead. States may be motivated to do this to save State funds, as well as to increase the benefit levels available to their citizens. SSI benefits are much higher than AFDC benefits in most States.

Based on discussions with State welfare administrators, we estimate that half of the States in the country fund programs to assist disabled public welfare recipients in applying for SSI. For example, five States reported using such programs to generate a gross saving of about \$90 million by helping enroll about 26,000 people who were on State benefits onto SSI instead. This kind of cost shifting is certainly not illegal but it is certainly a cause for some of the growth in the SSI Program.

The final topic I want to raise is how DI and SSI deal with returning people to work. Our studies suggest that these programs may actually inhibit people who want to work. Not more than 1 of every 1,000 DI and SSI beneficiaries leaves the rolls as a result of SSA's vocational rehabilitation.

Clearly, many people will never be able to work, but for those who want to try, one problem is the perceived high risk of doing so. In general, beneficiaries are not allowed to earn more than about \$500 a month without losing benefits. After a fairly short period, even with earnings this low, beneficiaries can lose their cash benefits and eventually, their medical coverage. Under these conditions, some beneficiaries may be making a very rational economic choice in not attempting to go back to work.

Another part of the problem may be that helping people to return to work hasn't been a high priority for the DI and SSI programs. This is especially evident when we look at vocational rehabilitation. As Senator Cohen's chart shows, for every dollar SSA spends on cash benefits, only about one-tenth of one penny is spent on VR.

Even for those people who have received VR from SSA, it has had limited effectiveness. That may be because beneficiaries come into the VR system at the end of a very complex, 18-month application process in which they spend all of their efforts focusing on proving that they are disabled, and therefore, cannot work. It seems like an odd time for SSA to then turn around and ask them if they want to try VR. Moreover, experts generally agree that rehabilitation offered closer to the time of disability onset has greater potential for being more effective.

New attitudes about the ability of many disabled persons to work, especially with new assistive technology, suggests that we may be underutilizing the productive capacity of disabled persons. If we were to think of disability as a continuum of individual ability rather than this choice between either being disabled or able-bodied, we might be able to begin to provide appropriate tools, training and support to assist those who can work while protecting those who can't.

Let me conclude by saying that each week SSA sends out about \$1 billion in cash payments to people on DI and SSI. These expenditures are particularly sobering in light of the findings that I've just discussed. Program growth over the past decade has been substantial, expenditures for cash and medical benefits now exceed \$100 billion annually, program integrity has been undermined by allegations of fraud and abuse, and the program has returned virtually no one to work.

Our work shows that there are several ways in which we can improve the disability programs. We can strengthen program management so that concerns about fraud and abuse are substantially re-

duced; SSA can review more cases through continuing disability reviews; and we can all begin to think about ways in which the Federal disability programs can help beneficiaries who want to work to achieve their productive potential. Finding the appropriate set of actions won't be easy and it may take some time, but we'd be glad to work with the Congress to improve and strengthen these programs.

This concludes my statement and I'd be glad to answer your questions.

[The prepared statement of Ms. Ross follows:]

GAO

United States General Accounting Office

TestimonyBefore the Special Committee on Aging
U.S. Senate

For Release on Delivery
Expected at 9:30 a.m.
Thursday, March 2, 1995**SOCIAL SECURITY****Federal Disability Programs
Face Major Issues**Statement of Jane L. Ross, Director,
Income Security Issues
Health, Education, and Human Services Division

GAO/T-HEHS-95-97

Mr. Chairman and Members of the Committee:

I am pleased to be here today to share with you findings from our ongoing work on Disability Insurance (DI) and Supplemental Security Income (SSI), the two major federal disability programs. DI and SSI, both administered by the Social Security Administration (SSA), have received much attention in recent years as program participation has grown dramatically. Accompanying this growth have been media reports that highlighted fraud and abuse in the SSI program, signaling to the public that the program has gone awry. Finally, critics contend that DI and SSI have trapped a generation of persons with disabilities in positions of dependency on these programs. Our reports and ongoing studies address these issues by reexamining the basic function and purpose of federal disability programs (see attached list of related GAO products).

DI and SSI programs present an all-or-nothing decision to those who apply. Applicants who meet the disability criteria receive cash benefits, and applicants found able-bodied receive no benefits. But this conflicts with prevailing views that disabled persons are an extraordinarily heterogeneous group. In addition, technological and medical advances have created more opportunities than ever for persons with disabilities to engage in meaningful and productive work. These new views coupled with advances suggest that the premise for DI and SSI may need to be modified. As a result, we may be underutilizing the productive capacity of many persons with disability.

In our testimony today, we show the tremendous growth in federal disability programs over the past 10 years and discuss reasons for that growth, including program factors and changes in society. We also comment on what is known about the impact of fraud and abuse on this growth and its effect on program integrity. In addition, we note legislative reforms included in the Social Security Independence Act last year that attempt to improve program integrity. Finally, we discuss the weaknesses in SSA's efforts to return DI and SSI beneficiaries to work. To develop this information, we analyzed administrative data for changes in the growth and composition of program caseloads; assessed program vulnerabilities to fraud and abuse; interviewed SSA and state officials, experts, and advocates; and conducted focus groups around the country with persons receiving federal disability benefits.

BACKGROUND

Before presenting our findings, let me provide some background on federal disability programs. The DI program was enacted in 1956 and provides monthly cash benefits and Medicare eligibility after a 24-month waiting period to severely disabled workers and their families. The program defines disability as an inability to engage in substantial gainful activity by reason of a physical or mental impairment. The impairment must be

medically determinable and expected to last not less than 12 months or result in death.

DI is administered by SSA and state disability determination services. The program is funded through Federal Insurance Contributions Act (FICA) taxes paid into a trust fund by employers and workers who must have worked long enough and recently enough to be entitled to benefits.¹ Cash benefits received by disabled workers average about \$660 a month and continue until a beneficiary returns to work, reaches retirement age (when disability benefits convert to retirement benefits), dies, or is found to have medically improved and regained the ability to work.

DI was originally established to extend Social Security old-age and survivors assistance to workers who became too disabled to work any longer. Although, in effect, the program served as an early retirement plan, original legislation also promoted the rehabilitation of disabled beneficiaries. At the time DI legislation was being considered, the House Committee on Ways and Means reported that it

"...recognizes the great advances in rehabilitation techniques made in recent years and appreciates the importance of rehabilitation efforts on behalf of disabled persons. It is a well-recognized truth that prompt referral of disabled persons for appropriate vocational rehabilitation services increases the effectiveness of such services and enhances the probability of success."

DI legislation required that persons applying for disability benefits be promptly referred to vocational rehabilitation agencies for services to maximize the number of such individuals who could return to productive activity.

SSI was enacted in 1972 as a means-tested income assistance program for persons who are aged, blind, or disabled. Unlike DI, benefits for SSI recipients are not based on work history. However, the two programs share the same procedure for deciding who is disabled and both programs terminate beneficiaries from the rolls in the event of medical improvement coupled with an ability to return to work. Moreover, the SSI law also required that applicants be referred for vocational rehabilitation.

SSI is funded through general revenues and like DI is administered by SSA and state disability determination services.

¹FICA payroll taxes are divided into the Disability Insurance Trust Fund, Old Age and Survivors Trust Fund, and the Medicare Trust Fund.

SSI disabled beneficiaries receive an average monthly cash benefit of about \$380 (beneficiaries in the 43 states that provide a monthly supplement received, on average, an additional \$110 in 1993) and immediate Medicaid eligibility.

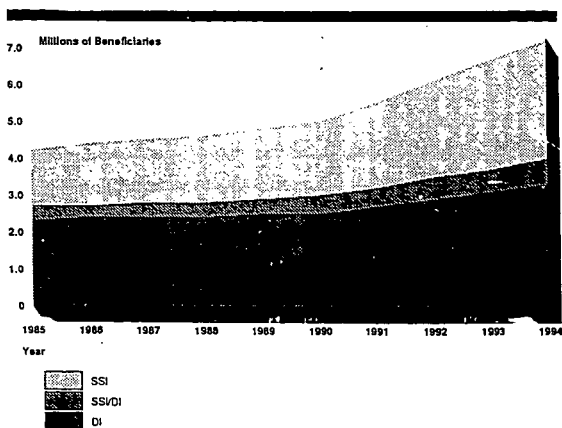
Let me now turn to our findings.

CASELOADS AND EXPENDITURES HAVE RISEN DRAMATICALLY

Participation in the disability programs has been increasing, and the pace of this growth has quickened recently (see table 1 and fig. 1). In 1985, 4.2 million blind and disabled persons under age 65 received DI or SSI benefits: 2.3 million received DI benefits, 1.6 million blind and disabled adults and children received SSI, and about 324,000 persons received both DI and SSI benefits; that is, their work history qualified them for Social Security coverage and their low income and assets qualified them for SSI. By 1994, the number of blind and disabled persons under age 65 receiving DI or SSI benefits reached 7.2 million--an increase of 70 percent from 1985. Specifically, DI increased 41 percent, SSI increased 105 percent, and the population receiving both DI and SSI increased 107 percent. Moreover, about 50 to 60 percent of the growth in size of these three subpopulations occurred over the last 3 years.

Table 1: Increases in Number of Beneficiaries and Cash Benefits (1985-94)

	1985	1994	10-year increase 1985-94 (percent)
Number of beneficiaries (in thousands)			
SSI children	265	893	236
SSI adults	1,295	2,311	78
SSI/DI	324	671	107
DI	2,332	3,292	41
Total	4,216	7,167	70
Cash benefits (in billions, adjusted for inflation)			
SSI	\$7	\$19	97
DI	\$19	\$38	45
Total	\$26	\$57	59

Figure 1: Growth in Federal Disability Programs (1985-94)

As the number of DI and SSI beneficiaries has grown, so has the amount paid in cash benefits.² In 1985, SSA paid \$19 billion in DI cash benefits and \$7 billion in SSI cash benefits. By 1994, cash benefits reached \$38 billion for DI and \$19 billion for SSI. Thus, the combined cash benefits in DI and SSI increased from \$26 to \$57 billion in 10 years (adjusted for inflation, the increase in the value of cash benefits was 59 percent). Moreover, the cost of DI and SSI benefits nearly doubles when factoring in the cost of health care coverage. For instance, in 1993, the cost of providing Medicare and Medicaid to beneficiaries was about \$55 billion, bringing the federal cost of cash benefits and health care coverage for the disabled to \$107 billion.

Impelled by estimates that the DI trust fund would be depleted in 1995, the Congress reallocated payroll tax receipts last year from the Social Security Old Age and Survivors Trust Fund into the DI Trust Fund. By the end of 2003, this measure will transfer about \$240 billion from the Old Age and Survivors Trust Fund into the DI Trust Fund.

PROGRAM FACTORS CONTRIBUTING TO GROWTH

What has caused the rapid growth in the number of DI and SSI beneficiaries in recent years? While the reasons for growth and their relative impact are not fully understood, evidence suggests that program factors have brought more persons into the programs and at the same time fewer persons have left. Allegations of fraud and abuse also raise concerns that some of the growth may include ineligible beneficiaries. We summarize these factors in table 2 and discuss them below.

²DI cash benefits include payments made to disabled workers and their dependents.

TABLE 2: Factors Contributing to Growth in SSI and DI

Program factors	
More persons brought into the program	<u>Eligibility expansion</u> : Legislative and regulatory changes have increased access to disability benefits. <u>Program outreach</u> : SSA sought eligible persons to apply for disability benefits through outreach campaigns.
Fewer persons leaving the program	<u>Continuing disability reviews (CDRs)</u> : SSA has been performing fewer CDRs than required by law.
Fraud and abuse	Allegations have been made that SSI recipients in certain subgroups, including children, immigrants, and drug addicts and alcoholics, have received benefits for which they were ineligible.
Additional factors	
Economic factors	Corporate restructuring and recession may increase program application.
Medical breakthroughs	Individuals who would not have survived certain medical conditions in the past now have better chances to live longer through advanced medical technology.
Immigration	Growing numbers of immigrants admitted for legal U.S. residence may have contributed to the rising portion of this group on SSI.
Shifting from state programs	Some states help public assistance recipients move to SSI.
Health insurance	Individuals may have applied for DI or SSI or stayed on the rolls to obtain affordable health insurance.

More Persons Brought Into the Programs

Several program changes introduced between the mid-1980s and the early 1990s have contributed to the increased number of persons receiving benefits. Among these changes are expanded eligibility standards and agency outreach efforts.

Eligibility Expansion. A major factor contributing to the increase in program growth over the past decade has been changes in eligibility standards, especially for mental impairments (which include mental retardation and mental illness). Standards

expanded largely due to the effects of legislative, regulatory, and judicial action.

In overseeing the program, the House Committee on Ways and Means reported that serious questions had been raised by federal courts, professionals in the fields of psychiatry and vocational counseling, and our agency about the adequacy of SSA's standards to assess mental impairment in both DI and SSI. Among other matters, the Committee expressed concern about the need to establish clear guidelines with respect to the disability determination process.

The Committee's concerns were addressed in the Social Security Disability Benefits Reform Act of 1984, which changed the manner in which SSA evaluated mental impairments. For example, new mental impairment standards were required to focus on evaluating the applicant's ability to function in a competitive work environment. Also, the act increased attention to the role of pain in restricting a person's ability to work and required SSA to consider the combined effects of multiple impairments when no one impairment is considered severe. Finally, the act placed a greater emphasis on medical evidence for disability claims from the applicant's treating physician and allowed SSA to consider nonmedical evidence offered, for example, by an applicant's family and friends.

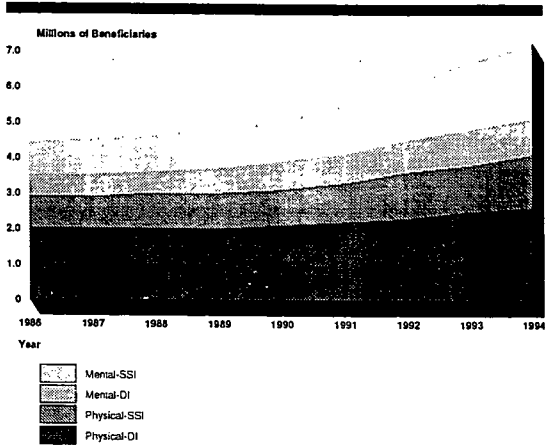
In 1985, SSA issued new regulations that revised the criteria for mental impairments. Among other changes, SSA issued distinct criteria for many qualifying mental impairments, developed a procedure to evaluate mental impairments that were not as severe as mental impairments listed in regulations, and established procedures to ensure that the medical portion of an applicant's case review be completed for cases initially denied if the evidence indicated the presence of a mental impairment.

In addition to the Social Security Disability Benefits Reform Act, SSI eligibility for children was also expanded by the 1990 Sullivan v. Zebley Supreme Court decision. Zebley held that SSA's interpretation of the law was too restrictive for children with less severe impairments than those who met SSA's strict medical listings of impairments. In 1990, SSA also expanded the number of childhood mental impairments in the listings from 4 to 11--adding such impairments as attention deficit hyperactivity disorder--and increased the weight of nonmedical evidence provided by parents, teachers, social workers, and others in determining childhood disability.

Together, these regulatory actions have changed federal disability programs--especially SSI--into increasingly including persons with mental impairments. The data show increases in the magnitude of mental impairment cases among all beneficiaries and newly awarded beneficiaries.

As seen in figure 2, the number of beneficiaries with mental impairments increased from 586,000 in 1986 to 1 million in 1994 (changing from 22 to 29 percent of the DI rolls). During this same period, the number of SSI beneficiaries with mental impairments increased from 940,000 to 2.1 million (changing from 50 to 59 percent of the SSI disability rolls).³

Figure 2: Number of DI and SSI Beneficiaries by Type of Impairments (1986-94)



Also, the percentage of newly awarded beneficiaries with mental impairments has increased. For instance, the percentage of all persons accepted into DI with mental impairments increased from 18 percent in 1985 to 26 percent in 1993. Data on comparable time periods in SSI are limited, but recent figures show that the percentage of all persons with disability accepted into SSI with mental impairments increased from 49 percent in 1991 to 55 percent in 1993.

³These figures include beneficiaries receiving both DI and SSI prorated by disability type and program.

Program Outreach. In addition to expanding eligibility standards, another contributing factor to increased program size has been SSA outreach efforts, especially for SSI. The purpose of outreach efforts has been to reduce the barriers that prevent or discourage potentially eligible individuals from applying for SSI benefits. Barriers identified in the past include lack of information about the program, perceived stigma from program participation, and the complexity of the application process.

SSA has conducted several outreach efforts since program inception. Recently, congressional and agency actions have been taken to ensure that all segments of the potential SSI population are made aware of their eligibility. For instance, a permanent outreach program for disabled and blind children was established by the Omnibus Budget Reconciliation Act of 1989; SSA made SSI outreach an ongoing agency priority in 1989; and 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 (HIV). As part of this effort, the Congress required that SSA spend at least 5 percent of these funds to evaluate its outreach efforts. In response, SSA awarded a contract for a cross-project comparison to develop and promote models for effective outreach. Moreover, as part of the Zebley settlement, SSA was required to initiate a publicity and outreach program to schools and welfare offices to sign up more children.

Fewer Persons Leaving the Programs

At the same time that eligibility was expanded and outreach efforts brought more persons into the programs, fewer persons were leaving.⁴ Two statistics highlight this growing tendency to stay on the rolls. In 1985, 13 percent of DI beneficiaries left the rolls; by 1993, this number had dropped to 10 percent. Beneficiaries are also leaving the rolls at a slower pace. In 1985, 8 percent of DI beneficiaries had been receiving benefits for 15 years or more; by the end of 1993, the ratio had increased to 12 percent.

⁴In 1992, the basis for DI terminations was as follows: conversion to retirement status (52 percent), death (45 percent), and failure to meet medical criteria or because of return to work (2 percent). The basis for SSI disability terminations among adults was as follows: excess income (55 percent), death (19 percent), no longer disabled (0.5 percent), and other reasons (25 percent).

What are the causes of persons staying on the rolls longer? Part of the reason reflects the greater prevalence of children entering SSI--especially children with mental impairments--who may be expected to stay on the rolls longer, and the trend toward younger adults entering the programs. However, another factor may be a reduction in the number of continuing disability reviews performed by SSA.

Continuing Disability Reviews. The purpose of a continuing disability review (CDR) is to verify that an individual on the rolls still has a disability that prevents that person from working. The law requires SSA to conduct a CDR at least once every 3 years on DI beneficiaries where medical improvement is possible or expected. For a case where medical improvement is not expected, SSA is required to schedule a CDR at least once every 7 years. Also, 7 months ago, the Congress directed SSA, in the Social Security Independence Act, to perform a minimum number of CDRs for SSI beneficiaries. While SSA had authority to perform SSI CDRs, as with the DI program, relatively few were done. Accordingly, as now required, SSA plans to conduct 100,000 CDRs on SSI adults and on one-third of SSI children turning age 18 for each of the 3 fiscal years beginning in 1996.

In the early 1990s--because of SSA resource constraints and increasing initial claims workloads--the number of DI CDRs declined dramatically. Currently, the backlog of DI CDRs is about 1.8 million cases with about 500,000 additional cases coming due each year. The number of DI CDRs planned for fiscal year 1996 is 234,000, which is less than one-half the number of CDRs coming due annually. To help reduce the backlog of DI CDRs, SSA now uses computer profiling and beneficiary questionnaires to more efficiently target limited CDR resources. While this new process will help, much more needs to be done.

Combined with the surge in applications and the growing tendency to remain on the programs longer, the decrease in CDRs performed has profound implications for expenditures. For example, the average DI beneficiary will receive about \$13,200 in cash and medical benefits this year. Extrapolating this figure, the average disabled beneficiary entering DI today will receive about \$225,000 in cash and medical benefits if he or she retains disability benefits until conversion to retirement benefits at age 65. CDRs not performed on schedule means that significant expenditures may be spent on individuals not eligible for benefits.

Fraud and Abuse

Some ask how much of the growth over the past decade may be attributable to fraud and abuse. Although limited empirical data make it difficult to estimate the extent of the problem, widespread media reports have weakened public confidence in the

integrity of the SSI program. Anecdotal evidence regarding children, immigrants, and substance abusers has generated much of the concern. Last year, the Congress and SSA undertook various actions to address fraud and abuse for these populations. Especially troublesome have been allegations that parents coach their children to fake mental impairments by misbehaving or doing poorly in school so that they can qualify for cash benefits. Teachers and other education professionals in particular have raised concerns about rewarding behavioral problems and poor academic performance with cash payments, which can amount to more than \$5,000 per child per year. Critics believe that these cash payments and Medicaid act as incentives for parents to coach their children. In addition, concerns have been raised that the program could foster lifelong dependence on government assistance if children come to view the label "disabled" as a lifetime entitlement to income and medical benefits.

Suspected fraud and abuse in the immigrant population is tied to claims for disability benefits that have been filed with the assistance of translators. Fraudulent acts by translators have included coaching SSI applicants on how to appear mentally impaired, using dishonest health care providers to examine applicants and submit false medical evidence to support alleged mental impairments, and providing false information on the medical and family histories of applicants. The Social Security Independence Act takes steps to prevent fraud by third-party translators by, among other things, increasing penalties for fraudulent acts by translators and health care providers. It also requires SSA to redetermine eligibility if fraud is involved.

Allegations of abuse among substance abusers have resulted in close scrutiny of the drug addicts and alcoholics program, which grew nearly 700 percent from 13,000 cases in 1988 to over 100,000 last year. Another 150,000 beneficiaries had other impairments that qualified them for benefits in addition to their addictions. The vast majority of addicts received benefits without any requirement that they be in treatment. In addition, there was little assurance that cash benefits were not being used to support their addictions. As a result, the Social Security Independence Act required individuals whose alcohol or drug addiction was a contributing factor to their disability to receive treatment and payment through qualified representative payees in order to continue to receive benefits. This should enhance program accountability, while better meeting the needs of addicted beneficiaries.

ADDITIONAL FACTORS CONTRIBUTING TO GROWTH

A number of additional factors outside the programs have potentially affected the size of DI and SSI over the past decade. For example, economic factors--such as corporate restructuring

and the 1990-91 recession--may account for some of the increase. In times of high unemployment, impaired persons may be at greatest risk of losing their jobs and turn to DI for support.

Another factor may be an increased prevalence of some disabilities among the nonelderly population. For example, persons 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 opportunities 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.

Also, the growing number of immigrants admitted annually for legal residence in the United States may have contributed to SSI growth. For example, 880,000 immigrants were admitted to the United States in 1993, compared with 570,000 in 1985. In addition, nearly 3 million former illegal immigrants attained legal residence status under the Immigration Reform and Control Act of 1986. Together, this increased population has likely contributed to the rising portion of disabled immigrants on SSI, which increased from less than 2 percent in 1982 to about 6 percent in 1993.

Another factor has been state efforts to enroll qualifying individuals receiving state welfare benefits in SSI. States may be motivated to do this to save state funds as well as to increase benefit levels available to their citizens. Based on discussions with 10 state welfare administrators, we estimate that at least one-half of all states fund programs that proactively assist disabled public welfare recipients through the SSI application process. For example, 5 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 persons without affordable health insurance may have affected the size of DI and SSI. The uninsured population under age 65 in the United States grew by 5 million persons 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 DI or SSI for health care protection.

WEAK RETURN-TO-WORK EFFORTS

Our work to date--based in part on the results of our focus group discussions with beneficiaries--suggests that the structure and administration of DI and SSI do not facilitate the movement of persons from disability rolls to payrolls and, indeed, act to inhibit many who want to return to work from doing so. Disability advocates have expressed concern about the high percent of disabled adults who are not employed--as high as 66 percent by some estimates. And the results of a recent national survey indicate that four of every five persons with disabilities who are not working want to work.

The limited resources spent by the programs in returning beneficiaries to work and our discussions with them indicate that SSA has a poor record in returning beneficiaries to work. In fact, not more than 1 of every 1,000 DI and SSI beneficiaries leave the rolls as a result of SSA's return-to-work assistance.

Why do so few beneficiaries return to work? Perhaps the major reason is the perceived high risk in doing so. Program provisions--called work incentives--are intended to allow beneficiaries to try to return to work without jeopardizing their benefits should their work attempt fail, as well as ease their transition to work. However, successful attempts at returning DI beneficiaries to work are generally defined as earnings of \$500 per month or more. This amount, when annualized, is below the federal poverty threshold. Even with earnings this low, DI beneficiaries would lose their cash benefits and eventually their medical coverage. Under these conditions, some beneficiaries may be making a rational financial choice in not attempting to go back to work.

Another part of the problem may be that helping people with disabilities to work is not a priority of DI or SSI. This is especially evident when we look at vocational rehabilitation (VR), which appears to be a low priority and to have limited effectiveness. For example, for every \$100 SSA spends on cash benefits, it spends a little more than a dime on VR. Moreover, about 1 of every 200 DI and SSI beneficiaries are referred for VR services.

While we do not know what the appropriate level should be or what other employment assistance might be required, we believe that we need to determine how much this underrepresents the potential for returning beneficiaries to work. As we reported recently, VR beneficiaries receive, on average, only modest services and show limited long-term improvement.⁵ Another reason

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

for VR's limited effectiveness is the fact that it is offered to beneficiaries at the end of a complex 6 to 18 month application process, during which time applicants are focusing on proving their inability to work. However, experts generally agree that rehabilitation offered closer to the time of the onset of a disability has the most chance of success.

CONCLUSIONS

Each week, SSA sends out about \$1 billion in cash payments to persons on DI and SSI. These expenditures are particularly sobering in the context of our findings that

- program growth over the past decade has been tremendous;
- including medical benefits, expenditures now exceed \$100 billion annually;
- program integrity has been undermined by allegations of fraud and abuse; and
- the programs virtually return no one to work.

Our work shows that federal disability programs need improvement. We are working on identifying alternative ways in which federal disability programs can enhance the productive capacity of beneficiaries who want to work. To this end, we are ready to help the Congress in its deliberations on program improvement.

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This concludes my prepared statement. I will be happy to answer any questions you may have.

For more information on this testimony, please call Cynthia Bascetta, Assistant Director, at (202) 512-7207. Other major contributors include Brett Fallavollita, Senior Evaluator; David Fiske, Senior Evaluator; Susan Higgins, Senior Evaluator; Barbara Bordelon, Senior Evaluator; Ellen Habenicht, Evaluator; and Tom Smith, Senior Evaluator.

APPENDIX

RELATED GAO PRODUCTS

APPENDIX

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

Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS-94-128, May 13, 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: 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: Racial Difference in Disability Decisions Warrants Further Investigation (GAO/HRD-92-56, Apr. 21, 1992).

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

Social Security Disability: Action Needed to Improve Use of Medical Experts at Hearings (GAO/HRD-91-68, May 20, 1991).

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

Impact of Vocational Rehabilitation Services on the Social Security Disability Insurance Program (GAO/T-HRD-88-16, May 26, 1988).

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Senator SANTORUM. Thank you, Ms. Ross.

A couple of questions we got last year when we had people come up and testify as to the GAO as you just did, talking about cases of fraud. We were wholesaley assailed as saying, oh, this is just an isolated case here and there; you can't make policy on this. Do you have any more concrete evidence of fraud? We've heard about crazy checks and we've heard about the coaching of kids; we've heard about the abuse in the drug and alcohol program. We've heard about all these things. We've heard about the immigrants and the phoney translator. In fact, we had a case testify before us about the California situation which MediCal uncovered. Is there anything that is a littler harder as far as data that we can look at to make this assessment?

Ms. ROSS. Let me go through each of the three groups you talked about.

With drug addicts and alcoholics, in the work we did which we reported to your subcommittee last year, we basically examined program structure to see if SSA was actually abiding by the rules. Were they actually making sure that the 70,000 SSI recipients who were supposed to be in treatment were in treatment, were they monitoring them? We found that they weren't.

Senator SANTORUM. What percent were in treatment? Do you have that number?

Ms. ROSS. What I recall was that SSA only knew that 1 in 5 was in treatment. That's not to say all the other 4 out of 5 weren't in treatment. They simply weren't monitoring at the time. They since have extended their monitoring agencies to all States and of course the amendments last summer will tighten that a great deal. The bottom line is we looked at program structure, but we don't have specific instances where we did field work and found people who were committing fraud.

On the topic of children, we were asked to see if we could find evidence of coaching. We weren't able to do that work because in order to actually demonstrate coaching, you'd have to have a parent tell you that they'd coached a child, or have other people tell you that they knew coaching had gone on. I suppose there could be some instances where a child could say he or she had been told by a parent to misbehave or do poorly in school, but we were again not able to find specific instances because it became clear that was not a useful activity for us. Again, we looked at program structure and have studied in detail the individualized functional assessment for children, which is worrisome.

Senator SANTORUM. Before you jump off, you said you've done a lot of looking into the IFAs. What is your conclusion as to what risks are inherent in the way IFAs are now done?

Ms. ROSS. Well, we have two worries. One is that these assessments are too subjective; that they have several different elements that are very subjective and that therefore, you can't have any sort of comparability across the country. Our second real concern is in the element of how severe the disability is and how that is evaluated. When the level of severity is as low as it is for an IFA, it will be a very subjective decision. We're very concerned that you cannot fix that part. So we don't think that the IFA process, in its current form, ought to continue.

Senator SANTORUM. So your recommendation is to eliminate IFAs and go to another system of assessment, maybe something like what Medicaid uses for that kind of disability evaluation?

Ms. ROSS. Actually, we presented a matter for Congressional consideration rather than recommendation. If you wanted to tighten the rolls and make sure that you were targeting more severely disabled children, you could eliminate the IFA. You could also revise the functional criteria in the medical listings for children and see if you could expand it somewhat to take care of certain cases or circumstances that were severe enough to warrant an award, but not at the less severe level in the current IFA.

Senator SANTORUM. It is accurate that someone who is hyperactive, age and appropriate behavior I think was one of the terms, that person receives the same amount of cash assistance as someone who has multiple disabilities, Downs Syndrome, severely handicapped, a wheelchair-bound person, they get the same amount of money?

Ms. ROSS. That's true because the amount of money is determined by the family's financial circumstances, not by the extent of the child's disability.

Senator SANTORUM. I'm sorry, you were going to talk about immigrants.

Ms. ROSS. Immigrants is an area, again, where we have done some amount of field work and have actually had some of our interviewers sit in on cases where it turned out there was fraud. This was just happenstance. We have not, again, tried to add up the numbers. Most of those cases aren't being taken forward either. SSA, I understand, is now trying to change its procedures to keep records of cases where they think there might be translators who are fraudulent but until recently, it was difficult to have those cases pursued legally through the U.S. Attorneys Office, so there weren't very many lists being kept and there wasn't very much work being done.

Senator SANTORUM. I'm just confused. I remember having this discussion last year with the Social Security Administration when we had the presentation of the case before the subcommittee and then I think it was the Oversight Subcommittee if I remember, maybe it was a combined hearing. This case was 2 or 3 years ago, the case in California and we asked the Social Security Administrator whether they were aware of this case. They said they were, that it had been on the books for a couple of years, and we asked if anyone who had gotten their eligibility through this process, if they had gone back and determined who they were and had done any kind of CDR. The answer was no, they were not going to do that; that it wasn't "cost effective" to do these CDRs.

In fact, when we implemented the just recently passed legislation, I think 100,000 kids and a third of adults or something like that is what we decided to do, the biggest comment I got from the Social Security Administration was, we'll do it but it's not cost effective for us to do this.

Do you agree with that, that doing CDRs is not cost effective and if it isn't cost effective, is there any other reason we would do CDRs even though it may not save us money?

Ms. ROSS. Well, if CDRs are done so that you're targeting people where you think there might be a medical improvement, they are very cost-effective. I've seen a range of estimates, but it's either 4 to 1 or 6 to 1 for DI beneficiaries, and SSA now has a much more refined process that they are using, so that it's much less costly. So the benefits should be even greater.

That is not to say that if you try and do a CDR on just some set of people that it will be that cost beneficial, but if you try and target toward people where you think you might have medical improvement, or have had medical improvement, that should be the case.

Senator SANTORUM. Can you give me a reason the Social Security Administration is so unwilling to do CDRs and allocate the resources necessary to keep up with the backlog or at least stop adding to the backlog of CDRs? Does it have anything to do with the way we appropriate funds for administrative costs as opposed to the entitlement nature of the awards that don't count against the Social Security Administration's budget?

Ms. ROSS. It does. I think there are two things that have been going on. One is that there has been, as our chart shows, a huge flow of initial applications into SSA and they are fairly swamped or they have been over the past several years trying to take care of those.

Senator SANTORUM. Because of the expanded eligibility?

Ms. ROSS. For all the variety of reasons.

The same kinds of people who would do continuing disability reviews are the people who are involved in trying to process these initial applications, so they have a current resource problem and it's exacerbated because of the budget rules of 1990 that you already talked about. That is, their administrative funds are part of the discretionary budget and the savings would all occur in the entitlement part. So they don't feel that they have the extra resources they would need either in terms of people or budget to go beyond a certain level.

We haven't examined how they have made their decisions about how to deploy their people precisely but I understand this budget issue.

Senator SANTORUM. Maybe what we need to do is look at whether a percentage of the savings from doing CDRs could be allocated to the administrative budget so we don't have the situation where we are, in effect, discouraging SSA from spending the administrative overhead money in a cost effective way of reducing the pay-go or entitlement aspect of their budget.

Senator COHEN. Thank you, Senator Santorum.

Let me apologize to you, Ms. Ross, I had to attend a Government Affairs Committee meeting. They were one vote short—that sounds familiar—of passing a line item veto measure to the floor, so I had to depart and make up for that one vote.

Could I just draw your attention to the issue of cost shifting? I mentioned this in my opening statement. There seems to be a growth industry among the States to determine ways in which they can take people either off AFDC, the foster parent programs, perhaps even Medicaid or other types of programs and put them onto the disability insurance or SSI rolls.

Can you walk us through how that is done and is taking place? Do you have information on that?

Ms. ROSS. I do. Many States—39—enter into agreements with SSA under which SSA repays the State for general assistance paid to SSI recipients between the date of application and the first SSI check. They also use State employees or contract with organizations that help people apply for SSI. For instance, they assist people in completing forms for SSI or for Medicaid, they help them with medical records, and they make appointments for them.

Senator COHEN. Does the State hire advocacy groups who then get compensated by a percentage of whatever the State might have received by way of Federal reimbursement, they get a percentage of that if they are able to successfully shift recipients from the State rolls onto the Federal rolls?

Ms. ROSS. They do hire advocacy groups and I understand that sometimes payment is on a contingency fee basis depending on how many SSI recipients the group can enroll.

Senator COHEN. Are you seeing a growth in those other States turning to that?

Ms. ROSS. Over the last few years, there's definitely been a good deal more cost-shifting, both from the general assistance programs and from AFDC.

Senator COHEN. Could you comment a little bit more about the *Zebley* case in terms of the individualized functional assessment process? I take it you would agree that is an overly broad definition for the standard that has been established?

Ms. ROSS. Our view is that the individualized functional assessment now is so subjective that it's very difficult to have consistent decisions being made.

Senator COHEN. Does this also have another hidden effect, for example, that these children who might have attention deficit problems where they can't focus for any specific period of time—I have that kind of deficit from time to time as I sit on the Senate floor but nonetheless—do we risk labeling children as being disabled at a young age by this kind of interpretation in terms of what constitutes a disability so that they are then on a long road to being impaired as far as getting into the job market? The stamp is now set, you are disabled because of an emotional or mental disorder or disability? Are we seeing a program started which is only going to escalate down the road in terms of complicating the problems of getting people into the work force and off the disability rolls?

Ms. ROSS. There's been a lot of concern that, especially when you're talking about children with mental impairments, that they will be labeled and that it will be difficult for them to move beyond that label. Especially when cash is attached to that label, it's a very difficult circumstance for these very-low-income families, so you can imagine the tensions they face.

Senator COHEN. Is there any follow-up process on the part of the Social Security Administration in terms of how they monitor how the cash payments are being used?

Ms. ROSS. There really aren't any requirements in the program for how the cash is used. The cash is to be used for the benefit of the child.

Senator COHEN. No counseling?

Ms. ROSS. It's a decision for the parents. In different families, parents would spend the money in different ways,

Senator COHEN. But there is no counseling requirement? We're talking about treatment requirements for alcoholics and drug addicts, but you say now we've got a child who has a mental impairment, attention deficit, whatever it might be, but no counseling required. So it seems to me once you qualify, then you're always mentally impaired as such or emotionally impaired and qualify for disability payments or SSI payments?

Ms. ROSS. There aren't any requirements for particular kinds of treatment or any other special educational treatments.

Senator COHEN. Senator Santorum has raised the issue of cost effectiveness. Is there an argument that they will make saying if we start to monitor this, it is going to cost us more money; it will not be cost effective under any imaginable standard? Are we going to face that kind of argument if we say giving cash payments for those who have been labeled to be mentally impaired and yet no requirement for counseling, if we have a requirement for counseling, we have to monitor, we have to hire people, therefore, you haven't saved any money.

That is an argument that I think will now hold up because if we're talking about putting people into the stream of this disabled system from the very beginning of their young lives, it's, for the most part, a lifetime position. Most of the people, as these charts show, once they get on, they don't get off unless they die, as Mr. Cote mentioned but they stay on. There's very little in the way of documentation of anyone getting off the disability rolls.

Ms. ROSS. I can't speak for Social Security, so I don't know whether they would tell you this isn't cost-effective. I know GAO has thought a little about what SSA does and what it does best. What it does best is determine someone's eligibility for a cash benefit and then pay that benefit.

As we add these other more service-related requirements, they may not have exactly the right set of people to do that. We may want to think more broadly than SSA as we now know it in trying to think about returning people to work. How do you get children ready for work? What is the right mix of skills and responsibilities, and is SSA the right place to put all of these things?

We don't have a recommendation but we have a real concern about whether SSA is the right place to do all of these things.

Senator COHEN. GAO has a report evaluating the vocational rehabilitation program that found that 87 percent of the vocational rehabilitation clients receive diagnostic and evaluation services, 73 percent receive counseling and guidance, but 12 percent or less receive assistance in categories like job training, placement or vocational training. Have we got a misallocation of emphasis here?

Ms. ROSS. Well, it certainly sounds like it, doesn't it? Most people who have been involved with the VR system are concerned that it is relatively ineffective. As we've done our work at SSA and its relationship with the VR, I certainly would underscore that. For the DI beneficiaries who go to vocational rehabilitation, it's relatively ineffective.

Senator COHEN. Do you know whether the VR program has a policy about getting equipment? Mary Jane Owen indicated earlier

she has finally achieved a talking computer or you need a talking computer. Any indication what the policy is on getting equipment to people who can overcome a disability or handicap with the new technology?

The young man that I mentioned in my office, an astounding story about this man born with no arms who can do everything that you and I can do. He can feed himself with his feet, he drives his van with his feet, he picks out coins out of his shoe and passes them to the tolltaker with his feet. He's an expert archer, marksman, soccer player and I equipped him, in my office, with a talking computer. Now he handles all the casework.

Is there anything going on in vocational rehabilitation programs for getting that kind of equipment? He's off disability, he's working now and he is a real role model for people, as I indicated before, coming into my office complaining about problems. They take a look at him and say, I'm okay.

Ms. ROSS. I can see why that would stop a lot of people. My understanding is that there is a great deal of flexibility in the current VR system to do this sort of thing. We haven't looked at ourselves to see the extent to which these single-time purchases are being made or how frequently.

Senator COHEN. Is that something you think we should be focusing on?

Ms. ROSS. I think so because I think there are a lot of people who have single-time requests that could help them a great deal.

Senator COHEN. One final question. What about decoupling some of these programs? We noticed we have SSI and DI programs but also the health care provisions of it. Is there a way to segregate this out. Should they all be lumped together and if you qualify for one, you qualify for all? Have you looked at that?

Ms. ROSS. We haven't looked at it but we are going to look at it as part of our ongoing work incentive studies. It is very worrisome because for people with the health insurance risks that most disabled people have, leaving Medicare or Medicaid coverage behind is a high-risk proposition.

Senator COHEN. Those are all the questions I have right now.

Senator SANTORUM. Mr. Chairman, if I could just follow up on a couple of things.

I mentioned the 1990 Budget Act and you mentioned it. I just can't help but notice the terminations per thousand dropped dramatically from 1990 to 1991 which may support the contention that having one in a pay-go provision and one in a discretionary, appropriated account may, in fact, be fostering a lot of the problems we're seeing here with CDRs not being done. I'd just refer you to that chart.

The other thing I wanted to cover was the whole outreach and monitoring that is being done. I think you mentioned in your testimony last year that we had several monitoring and outreach offices set up and that they were expanding these, they were going to create more offices. I assume that's been done. Have you seen that has having a direct effect on the expansion of this program, these outreach offices?

Ms. ROSS. Let me be clear that I know what you're talking about. When I'm talking about the monitoring offices, I'm talking about

those institutions in each State that are supposed to make sure they're tracking the drug addicts and alcoholics. Are you asking with those in place, are more people being—

Senator SANTORUM. My understanding was there were outreach offices, that there's a program in place to do outreach, to find more people, to get them signed up, et cetera. I understand that part of it was also to do some monitoring but I'm more concerned about the outreach program.

Ms. ROSS. Okay; there are several outreach efforts that have been going on at SSA, especially as related to the SSI Program. We think and they think that those outreach programs have been responsible for some of the growth in the SSI Program.

Senator SANTORUM. They consider that a success in that more people can get on this program through this outreach program and that's a success?

Ms. ROSS. I think their perspective is that they want to be sure that people who are entitled are able to get their benefits.

Senator SANTORUM. Is this program continuing to expand? Can you give me a sort of status report as to where they are in these efforts of outreach? Are we continuing to create more outreach offices or programs?

If I recall, last year we had testimony about an outreach office—maybe it was 2 years ago—that was just opening up in Washington, D.C. and there were some dozen or two dozen people in the District of Columbia who were on the SSI Program for drug addicts and alcoholics. They were encouraged with this new outreach effort in Washington that they were going to put a few zeros at the end of that. Has that occurred, do you know? Have you tracked any of this stuff?

Ms. ROSS. We haven't tracked that in the past couple of years. We don't know what happened to the D&A population in States that just opened referral and monitoring agencies and we haven't looked at the whole outreach effort to see if we thought we could say exactly how much of the growth was due to that. That would be very difficult.

Senator SANTORUM. If I recall, the last time we discussed this, where the outreach efforts were focused is where the greatest growth in these programs had occurred; that there were certain States and I believe Illinois, California, Michigan, I think were three of the States that come to mind, that had done an extensive amount of outreach and as a result, they had a disproportionate share of drug addict and alcoholic people on their rolls. Has that continued to occur in those States? Has it happened in other States who have instituted outreach programs? What's going on out there? Is there plan in fact just dragging a lot of people into the system either through taking them, as Senator Cohen has suggested, from State rolls and putting them on the Federal rolls, or by just finding new people and putting them on the rolls?

Ms. ROSS. Since SSA did a lot of expansion of their monitoring for the D&A population and put those institutions in every State, we have not looked, but we would be happy to try and get some information and get back to you on that.

Senator SANTORUM. I would appreciate that because what I suspect is that these programs are great facilitators, as Mr. Cote was

saying, of going out and recruiting people to sign up to these programs who may be eligible and I'm not too sure doing them a particularly good service.

Thank you, Mr. Chairman.

Senator COHEN. Ms. Ross, before you leave, let me indicate in terms of trying to put some perspective on this, this Committee, in the past, has played a very active role in trying to ensure that those people who are truly in need of assistance because of their disability, in fact, are not cut off from those rolls arbitrarily. I mentioned back in the early 1980's, there was a program put in place to remove people from the disability rolls simply by constructing a profile. If that person had a back injury, for example, that disabled him or her, and so much time had transpired, the computer said that person fit the profile for someone who should be discontinued.

That was not, in my judgment and that of the other members of this Committee, an appropriate way to deal with those who are on the disability rolls. So we want to make sure that we protect that, have face-to-face contact, make sure that the Social Security Administration was doing the right thing, and to take those people off who truly needed to be taken off and keep those who deserve to be on, to stay on.

It may be—I don't know if this is the case—that the Social Security Administration is a bit gun shy after running into criticism and controversy in the early 1980's and they have been reluctant to take any measures to really discipline the system in the 1990's, but it's our job to try to achieve a balance here.

This is not going to be some overzealous purging of everyone on the disability rolls from SSI or DI. Our goal is to really make the system work. That's what the country is really crying out for. They look at the system and think it's being abused, that people are taking advantage of it.

People get on the rolls by saying they're stressed out. Most of us are stressed out during the course of a day or week, but there seems to be such an expansive interpretation that many people who are paying into the system or who are forced to pay into the system through the various withholding payments, saying this isn't working, there's something wrong here. I see people who are fully capable of working simply drawing on the system and that's part of the anger that's taking place today.

So what we want to do is to improve the system to make it really work as it is designed to work. Hopefully, we will continue this hearing and others to structure such a reform of the system.

Thank you very much for attending this morning.

We will now move to our third panel. Next we are going to hear from a panel of experts on the disability program, substance abuse treatment and rehabilitation. Our panel consists of: Dr. Carolyn Weaver of the American Enterprise Institute; Dr. Sally Satel, M.D., Visiting Professor, Department of Psychiatry, University of Pennsylvania; Dr. Gerben DeJong, Director, National Rehabilitation Hospital Research Center; and Edward Eckenhoff, President and CEO, National Rehabilitation Hospital.

Ms. Weaver, if you would proceed.

**STATEMENT OF CAROLYN WEAVER, AMERICAN ENTERPRISE
INSTITUTE**

Ms. WEAVER. Good morning. Thank you for inviting me to testify.

I'd like to mention at the outset that I work at the American Enterprise Institute and am a member of two public advisory councils—the Quadrennial Social Security Advisory Council and the new Social Security Advisory Board. I am here to speak with you as a scholar at AEI rather than representing either of these groups.

I'd like to begin by commending you for holding this hearing on the problems of the Social Security Disability Insurance and SSI programs. I think it's terrific. The problems in these programs are serious, and are long term in nature. They've become much more serious, in the last 5 years when there has been an explosion of the benefit rolls.

Fortunately, in a sense, the DI program is trust fund financed, because the effect of this rapid growth is so obvious. What was once a program solvent for 75 years is a program that would have been insolvent this year but for the tax increase put in the law last year, which increased the DI tax rate by over 50 percent.

The rapid growth of the two programs, DI and SSI, is a symptom of deep-seated problems that tend to undermine the well-being of both the workers that support these programs as well as the people the programs were designed to serve.

I'll bring to your attention very quickly the set of charts at the back of my written testimony. Most of them are quite familiar to you. Apart from the rapid growth of the SSI benefit rolls, shown in Figure 1, I'd note the transformation that is taking place in the program from one serving elderly people to one serving mainly overwhelmingly people with disabilities.

The second figure shows that the largest group of disabling conditions comprises mental disorders, which are notoriously difficult to evaluate with precision. The fastest growing segment of the disability rolls, next to kids on SSI, is young adults with mental disorders. These people have very poor prospects of ever going to or returning to work.

Figure 3 is the familiar figure regarding kids on SSI-disability. There were 200,000 to 300,000 recipients annually for much of the history of the program. This number bumped up above 500,000 with the *Zebley* decision in 1990 and has continued rising to reach nearly 1 million kids on SSI. This is about one out of five people on SSI-disability.

Figure 4 deals with the rapidly growing share of aliens on the SSI-elderly rolls and the final two charts deal with the sharp deterioration in the financial position of DI.

What I'd like to do in my remaining time is discuss the common problems that all of these trends seem to imply and some of the directions that reform might take.

I would note first that despite dramatic improvements in science, in medicine and technology, and in the workplace as it accommodates people with disabilities, there have never been more people on the Federal disability rolls—about 10 million people between the two Social Security programs at a cost of about \$60 billion, or more than \$100 million including Medicare and Medicaid. Most people are prime-age men and women who will never return to work.

As discussed further in my written testimony, our system is based on an out-of-date early retirement model. People spend a great deal of time out of the work force proving that they can't work before they can begin receiving checks. Once on the rolls, the prospects are extremely remote that they will ever be reviewed for continuing eligibility and the probability is low that they would be found ineligible if reviewed. In addition, while recipients are frequently referred for vocational rehabilitation, few get services, and fewer still are rehabilitated.

Over the last 15 years or so, there have been a number of efforts to create work incentives in the system. These provisions generally have been quite ineffective. They are superimposed on the back end of the disability process, creating an ever-more complex program, and dealing with the problem when it's undoubtedly too late. The trick, it seems to me, is to catch people before they ever leave work or the path from education—and training—to work. Research has shown that labor market outcomes are far better if people can be accommodated at the workplace after having, say, a heart attack, than if they leave the work force and try to get back.

Beyond that, employer involvement, which has been largely ignored in disability programs to date, is critical. Whether the ADA and the mandated accommodation costs on employers, the DI tax, minimum wage increases, or other mandated benefit programs, employer costs and incentives are typically ignored as they affect the employment of the disabled.

Each of these policies tends to raise the cost of hiring low-skilled, severely disabled workers such as those that are on SSI. They tend to price these very people out of the labor market.

I agree that we should consider options that would make lump sums of money available to people to make purchases that could facilitate work, through say a loan of a couple of year's of expected future cash benefits. The loan would be repayable out of benefits if the purchase failed to result in work. Alternatively, there might be a services-only option for people who wish to try an alternative to Social Security.

We should also consider time-limited benefits for nonpermanent impairments to reorient the way people think about disability programs. People could be allowed on the rolls for 2 or 3 years, knowing that at the end of that period they must either be off the rolls or prepared to reapply for benefits. We should reconsider the VR system, which has proven ineffective for SSA clients. I have written quite extensively on moving toward a voucher system for VR and I believe that holds real promise.

Finally, in the longer term, it will be important to rethink the role of the Federal Government in insuring people with disabilities. If the purpose is insurance, then we have insurance markets that can handle the routine risks faced by the typical worker. The Federal Government could then target resources on people who would not otherwise be insured through private markets.

[The prepared statement of Ms. Weaver follows:]

**THE SOCIAL SECURITY DISABILITY PROGRAMS: INCREASING
WORK DISABILITIES IN AMERICA?**

Testimony before the Senate Special Committee on Aging
Hearing on Problems in the Social Security Disability
Programs: The Disabling of America?
March 2, 1995

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Mr. Chairman. My name is Carolyn Weaver and I am a Resident Scholar and Director of Social Security and Pension Studies at the American Enterprise Institute. I am also a member of the Quadrennial Social Security Advisory Council and the new Social Security Advisory Board. I have served on two public advisory councils dealing with federal disability policy. It is in my capacity as an economist and a public policy researcher that I speak to you today.

I'd like to begin by commending you on holding this hearing and focussing attention on some of the critical problems plaguing the social security disability programs, both Supplemental Security Income and Disability Insurance. These problems, many of which are reflected in the persistent and now rapid rise in the cost of these programs, adversely affect the well-being of not only the workers and taxpayers who must support them but also the people they were intended to serve. Your efforts in the area of payments to substance abusers is a case in point: unbeknownst to most observers, the Social Security Administration has paid monthly cash benefits to people "disabled" by reason of drug or alcohol addictions--with basically no-strings-attached--costing taxpayers over a billion a year and tending to perpetuate the very conditions that brought these people onto the benefit rolls in the first place. Rehabilitation, recovery, and return to work are the last things on the minds of administrators worried about getting checks out on time. The legislation you helped craft instituted significant changes in the the way addicts will be served by the programs, and, it would appear, may well trigger even more significant changes in the months ahead.

More importantly, your efforts, together with those of concerned members of the House of Representatives, have put SSI squarely on the table for consideration in the welfare reform debate, which is precisely where it ought to be as the largest, and fastest growing, cash welfare program in the federal budget. Until last year--and throughout the many discussions of "ending welfare as we know it"--SSI remained on the shelf, where it had been throughout most of its 23-year history, immune to the scrutiny received by other welfare programs. Without serious scrutiny, the program had quietly entered a period of very rapid growth and had begun to serve a population very different than the one it served when it was created. It is now in need of serious reform.

Although the focus of my testimony is SSI, the problems plaguing the social security disability insurance program are much the same. Both programs discourage work and promote dependency; both are premised on out-of-date concepts of disability (such as "once disabled always disabled" and "disabled means unable to work"); and thus both, in my view, are fundamentally at odds with a central goal of the Americans with Disabilities Act, which is to promote work and independence among the nation's disabled, and with a central premise underlying that Act, which is that, in the main, people with disabilities can work and want to work. The DI program is also growing rapidly--so rapidly, in fact, that this \$38 billion (FY94) trust-fund financed program would be insolvent now but for the hefty tax increase enacted quietly last fall. This program too is in need of reform.

Having said this, I hasten to add that SSI has been a vital lifeline for some of America's most vulnerable citizens--the elderly and the disabled poor. It provides a nationwide, minimum income guarantee (\$5,496 annually for individuals and \$8,244 for couples in 1995) that is cost-of-living adjusted each year and financed almost entirely by the federal government. The challenge is to find ways to eliminate inappropriate benefits and to

improve the way benefits are delivered to the truly needy, encouraging work where possible and providing necessary support where it is not.

Program Growth:

SSI is more costly and growing much more rapidly than AFDC (Aid to Families with Dependent Children), the focus of the welfare reform debate. As illustrated in Figure 1, in 1994, the most recent year for which data are available, an estimated 6.3 million people received SSI, up nearly one-half since 1980 and one-quarter just since 1990. Federal spending stood at \$24 billion in FY 1994, more than double its level (in real dollars) in 1980. Federal spending on AFDC, by contrast, was \$17 billion in 1994, up one-third in real terms since 1980. According to the President's budget, the SSI benefit rolls will grow so rapidly in the next few years that, by the end of the decade, the cost of the program (including federal and state spending) will exceed the cost of AFDC, Food Stamps, subsidized housing, the greatly expanded Earned Income Tax Credit, and all other major public assistance programs except Medicaid.

Since SSI is a ticket to Medicaid (and can be a ticket to Food Stamps as well), the rapid growth of SSI does not bode well for the nation's giant health-care program for the poor either. The reason is the relatively high cost of health care for the aged and disabled, particularly long-term care. According to data compiled by the House Ways and Means Committee, in 1992, Medicaid spending averaged \$2,936 per capita--but was \$7,700 for the elderly and \$7,612 for people with disabilities as compared to \$1,752 for AFDC adults and \$959 for AFDC kids. The bulk (approximately 70 percent) of Medicaid spending is for the aged and disabled, not AFDC mothers and children as often assumed.

Changing Mix of Elderly and Disabled Recipients

While many people view SSI as a program serving mainly as a safety net for the elderly poor, it actually serves mainly working-aged adults (and increasingly children) with disabilities. As Figure 1 makes clear, this has not always been the case. When SSI was created in the early 1970s--federalizing the old-age assistance, aid to the disabled, and aid to the blind programs around the country--most SSI recipients (about two-thirds) were, in fact, elderly. Typically, they were elderly people who were not eligible for social security or whose pensions left them in poverty. Over the years, as the elderly have gained eligibility for higher social security benefits and for private pensions, and their economic well-being has improved, the number of elderly people on the rolls has generally fallen. Whereas 2.3 million elderly people were on SSI in 1974, the program's first year in operation, the number fell to a low of 1.4 million in 1988 and has grown slowly since then to about 1.5 million today. (The primary reason for the recent growth in the elderly rolls, discussed further below, is the influx of large numbers of immigrants on SSI.)

Growth Areas--Disabled Recipients with Mental Conditions: Alongside the long-term decline in the number of elderly people on SSI, there has been an explosion in the number of disabled people on the rolls--doubling between 1974 and 1990, from 1.7 million to 3.4 million, and increasing by over one million in the past three years alone to 4.8 million. Today, as shown in Figure 1, three out of four SSI recipients are people with disabilities.

The typical person receiving SSI-disability is in his or her thirties, has a high school education or less, and, in contrast to the familiar image of someone in a wheelchair with a physical disability or someone who is blind, has been granted benefits on the basis of a mental disorder--schizophrenia, chronic depression, or anxiety, for example. While some of these conditions are obviously severe and generally disabling in the labor market, others are not and, in any event, are notoriously difficult to evaluate with precision. As shown in Figure 2, fully one-third of adults on SSI-disability have a mental disorder--in addition to the one-fourth who have mental retardation. Young people with mental disorders are the fastest growing segment of the adult SSI population. The prospects that these people will ever return to work (or go to work) are very poor.

Kids with Disabilities: Thanks to a 1990 court order and new regulations that loosened eligibility for children, together with other regulatory changes in 1990, children with disabilities are the fastest growing segment of the SSI population today. Stretching SSI in ways never contemplated in 1974, 225,000 children with disabilities (mainly mental

disorders, including the much-discussed attention deficit disorder, and mental retardation) were added to the rolls in 1993, triple the number in 1989. As shown in Figure 3, the number of children on the rolls now approaches one million, or close to one out of five people on the SSI-disability rolls.

According to the General Accounting Office, the "huge increases in the number of children awarded benefits because of mental retardation and other mental disorders" accounted for more than two-thirds of the growth of awards between 1988 and 1992. In the more recent period, 1991-1993, "behavioral problems," which include personality disorders, attention deficit hyperactivity disorder, autism and other developmental disorders, accounted for one-fifth of all mental impairment awards to children.

Rethinking SSI for Kids: Between the rapid growth of the benefit rolls and news reports of kids being coached on how to behave "inappropriately" so as to qualify for benefits, the payment of SSI to children has become the focus of some controversy. There are two main concerns: first, are the kids seriously disabled within the meaning of the law, and second, are the payments needed? Poor families with kids on SSI receive much more support than other poor families.

In this latter regard, kids are eligible for \$458 monthly (in 1995), the same as an elderly person or disabled adult living in their own home, regardless of their families' total income from public assistance. Set to ensure that, together with Food Stamps, the elderly and disabled poor have a near-poverty level of income, SSI payments are much higher than AFDC payments, resulting in large disparities in income support for poor families depending on the disability status of their children. In a typical state, a poor mother with two children, one on AFDC and one on SSI, receives *twice* as much public assistance as a poor mother with two children on AFDC. Were the latter mother able to have one of her children certified as disabled and qualified for SSI, she would, based on 1994 benefit amounts, forgo \$72 monthly in AFDC in exchange for \$446 monthly in SSI, raising her family's income from \$366 to \$740 monthly; were the other child to qualify for SSI as well, family income would rise to \$1,104 monthly, fully triple that of the AFDC family. (In contrast to AFDC, SSI awards each additional child the same full benefit, with no reduction in marginal benefits, and there is no limitation on family benefits.) The states administering these programs are hardly indifferent to this shift in support since they must bear about 45 percent of the cost of AFDC but none of the cost of SSI (states have the option to supplement the federal SSI payment and only some choose to).

With welfare reform a top priority, it is only appropriate to question the premises of this program--all the more because it was an afterthought in the original SSI legislation. In the massive social security and Medicare bill moving through Congress in 1972, which contained the original proposal for SSI, there was not even a mention of children's benefits. Disability was defined in terms of complete inability to work and SSI payments were intended to replace lost income. The idea of payments for children (who did not work and had no earnings, but nevertheless had disabilities somehow construed to be of "comparable severity") apparently was conceived by a senior welfare official in the Nixon Administration who, although the record is not clear on this point, managed to get a 26-word amendment inserted into the bill, without objection or debate, as it moved through Congress. The program so created was of little note for the better part of two decades, during which time cash assistance was made available to a group of no more than 200,000-300,000 children annually.

All of this changed in 1990. In that year, in *Sullivan v. Zebley*, the Supreme Court ordered SSA to relax the criterion used for assessing disability in children and to review the cases of hundreds of thousands of children denied benefits since 1981. To implement this decision, SSA issued regulations creating a new test of eligibility based on a child's ability or inability to behave in an "age-appropriate manner," a test that must be used when benefits would be denied on the basis of the severity of the physical or mental impairment alone. This was intended to make disability benefits available to children on terms more comparable with adults, who, if found not disabled based on the severity of their impairments alone, have vocational factors (i.e., their age, education, and work experience) considered in combination with their "functional capacity" to perform work-related activities. These new regulations came on line at just about the same time as new regulations for assessing mental disorders, which, among other things, expanded the group of qualifying disorders to include

attention deficit disorder, and elevated the importance (relative to medical evidence by physicians) of testimonials by friends, teachers, and family members in the evaluation of disabilities.

The GAO reports that 30% of the children coming on the SSI rolls since the Zebley decision was implemented were awarded benefits based on the new "age-appropriate behavior" test, meaning that they would not have been found eligible under the criterion in place until that time; 70% were awarded benefits on the basis of the severity of their mental or physical impairments (overwhelmingly mental, as evaluated under the new mental impairment regulations).

The surge in the number of children on SSI-disability has brought this program into the open and, at least in the minds of some, raised the question of why we even have it, given that it appears to duplicate the purpose of AFDC, which is to help meet the basic living expenses (such as food, clothing, and housing) of children in poor families and which also ensures Medicaid eligibility. Proponents argue that the reason for the program and for the much larger benefits is that disabled children are much more expensive to raise than other children. This begs two questions--how much more expensive and how much of the expense is actually born by the families? Surely the cost of raising a disabled child varies enormously depending, among other things, on the type and severity of the disability (consider a child with, say, cerebral palsy or a spinal cord injury or who is deaf and blind, as compared to one who is deaf or mentally retarded, but not profoundly so and with no other complications). No doubt some children have enormous expenses--certainly larger than \$458 monthly--and no doubt some have none at all. What's relevant is not the size of these expenses but the extent to which they are unmet by other sources. Medicaid is critical in this regard. In addition, as documented in a study just released by the National Academy on Social Insurance, there are a number of other programs serving particular needs and particular groups, including the Children with Special Health Care Needs program, now part of the Maternal and Child Health Block Grant, the Education for All Handicapped Children Act, and the Part H Early Intervention program.

Within the context of the current system, a good case can be made for converting the SSI payment for children--an unrestricted cash transfer that is unrelated to their special needs and may or may not be used to meet them--into a voucher that can be used only to meet the added costs of raising a child with a disability that are not met by other programs. (Expenses such as these might include physical modifications to the home of a child with a sight or mobility impairment.) Alternatively, expenses that are necessary but not otherwise covered might be provided under the Medicaid program at Federal expense. The idea would be to eliminate payments to families with no claim to them other than the presence of a disabled child while meeting the legitimate needs of families with extraordinary expenses. Neither change would preclude more major reforms of SSI, such as providing block grants to the states in lieu of some or all of the current program.

The legislation approved last month by the House Subcommittee on Human Resources (H.R. 1157) limits and refocuses SSI spending for children in the following way: it continues cash payments to the most severely disabled children; authorizes payments for services, both medical and nonmedical, for other disabled children; and eliminates, as the basis of a finding of disability, the "age-appropriate behavior" test. Under the bill, cash payments would be payable in full only to children found disabled under the test of medical severity (not the new age-appropriate behavior test) and who require the assistance of a parent or caretaker in the home to prevent institutionalization. (Children already on the rolls would have to meet the medical severity test to continue receiving cash payments, but would not have to meet the assistance requirement.) Other children coming onto the rolls, who also would have to meet the medical severity test, would be eligible for medical and nonmedical services only, and these services would be financed by a new block grant to the states.

Addressing SSI for children is critically important in the context of welfare reform. An unreformed SSI program could well become an escape hatch--albeit an expensive and poorly targeted one--for families who lose eligibility under a reformed AFDC program.

Aliens: Another factor underlying the growth of SSI is the rapid growth of aliens on

the rolls.¹ According to the GAO, in 1993 the number of aliens on SSI was 683,000, or about 12% of the SSI caseload, up from 3% in 1982, at an annual cost of \$3.3 billion. GAO predicts that if current trends continue, the number of aliens on SSI could reach 2 million within five years.

The growth is most pronounced in the SSI-elderly program. As clearly revealed in Figure 4, the halt in the decline of the SSI-elderly rolls noted earlier, which could easily be misconstrued as reflecting a weakening of the financial condition of the elderly poor, is actually due to the great expansion of aliens on SSI. (This resulted, at least in part, from the huge influx of immigrants during the 1980s and early 1990s.) As shown in the figure, aliens comprised 28.2% of the elderly on SSI in 1993, up from 5.9% as recently as 1982. The rapid growth in the number of aliens first moderated and then fully offset the historic decline in the number of elderly citizens on SSI. Indeed, were it not for the surge of aliens on SSI, the number of elderly people on the rolls would have fallen quite significantly--by about 400,000--since 1982.

Paradoxically, elderly and disabled citizens on SSI receive smaller--in some cases, much smaller--benefits than aliens. According to the Social Security Administration, in 1993, the average SSI payment for an elderly alien was \$393 monthly compared with \$176 monthly for an elderly citizen; among the disabled, the figures were \$429 and \$340, respectively. The reason for this seeming anomaly is that immigrants generally have less countable income, especially social security, than citizens have, which reduces SSI payments. The changing mix of recipients thus puts upward pressure on costs that would go unnoticed by focussing on total recipients only.

The legislation approved by the House Subcommittee on Human Resources sharply curtails SSI (and other federal welfare programs) to people who are not U.S. citizens. Under the legislation, only refugees in the U.S. for fewer than 5 years and legal permanent residents 75 or older who have been in the U.S. for at least 5 years would continue to qualify for benefits.

Addicts and Alcoholics: As your committee noted last year--and as highlighted by the popular press--even alcoholics and drug addicts have found their way onto the social security disability rolls in growing numbers. According to the Social Security Administration, the number of people on the SSI-disability rolls with substance abuse as their primary disorder (in other words, without some other qualifying disability, such as cancer or heart disease), nearly quadrupled in the 3-1/2 year period October 1990 to April 1994, rising from 23,000 to 86,000. The GAO reports that between the two disability programs administered by the Social Security Administration--SSI-disability and Disability Insurance--250,000 drug addicts and alcoholics are receiving monthly benefits at an annual cost of \$1.4 billion, with over one-half of these addicts added to the rolls in the past five years. No doubt, many more people are on the rolls with addictions that contribute to their disabilities, such as people with severe organ damage or mental illness, or with addictions that are secondary to some other disorder.

The legislation passed last fall took a step toward limiting payments to substance abusers. Under the law, SSI payments for people disabled by reason of drug abuse or alcoholism will be suspended during periods of failure to comply with a treatment program. In addition, benefits will be terminated after 36 months (excluding any periods during which payments are suspended for failure to comply with treatment). SSA is responsible for referring recipients to appropriate treatment programs and monitoring their compliance.

Unfortunately, this provision will be a bureaucratic nightmare for SSA--in terms of identifying, notifying, tracking, and monitoring recipients, evaluating the suitability of treatment facilities, and periodically testing for substance abuse, and in terms of the appeals that will inevitably result; worse, its effects on rehabilitation and benefit terminations, as well as on actual budget savings, are likely to be limited at best. For one thing, SSA is not authorized or funded to provide treatment and it can not require people to pay for it. The most SSA can do is make referrals and it has no special expertise regarding which facilities

¹ Aliens are immigrants legally admitted to the U.S. and refugees and other special groups (the largest being the illegal immigrants who were given legal status by the 1986 immigration reform legislation) permanently residing in the U.S. under "color of law." Illegal aliens are not eligible for SSI.

or kinds of treatment will be most effective for particular individuals. Benefits cannot be suspended, moreover, unless treatment is actually available. For another thing, Medicaid will be continued during periods of suspension and after termination from the benefit rolls. Finally, the 36-month time limit applies only to those who would not be found disabled except for drug addiction or alcoholism, not to the (presumably much larger) group of people for whom substance abuse contributes to their disability. People will continue to be granted benefits based on substance abuse disorders.

The legislation approved by the House Subcommittee on Human Resources simply eliminates benefits for people whose primary diagnosis is drug addiction or alcoholism. For a 4-year period, \$100 million would be devoted to expanding the availability of drug treatment and to research on drug abuse and treatment.

A Word About DI: As suggested earlier, the social security disability insurance program is plagued by many of the same problems as SSI. Though serving a different population--working-aged people with significant work histories who generally are not poor--the program applies the same basic definition of disability, uses the same complex and costly administrative and appeals system to adjudicate claims, creates similar disincentives to work, and faces all the same financing problems. From a fiscal standpoint, however, DI is trust-fund financed, rather than general-revenue financed, meaning that unanticipated growth translates directly into a deteriorating reserve cushion with which to meet future benefits and ultimately, if uncorrected, into program insolvency. Unlike SSI, that is, rapid growth is action-forcing.

Figures 5 and 6 are illustrative in this regard. As shown in Figure 5, DI spending, like SSI spending, has grown very rapidly in recent years--up 32% in real dollars between 1990 and 1994. (SSI spending over the period increased by an astounding 72% in real terms.) That this growth in DI was not anticipated by the Social Security Board of Trustees, or by Congress in 1983 when it last took up the issue of social security financing, is clearly revealed in Figure 6. The 1983 Trustees projected, based on their intermediate (II-B) projections, that with the package of changes adopted then--which included revenue and spending measures affecting DI--reserve funds would grow to 430% of annual outgo, or to about 4 years' worth of benefits, by the year 2010; the DI fund was projected to remain solvent until 2060. Under the Trustees' pessimistic (III) assumptions, reserves would still peak at a respectable 220% in 2005, although DI was slated for insolvency in 2021. In fact, as revealed by the 1994 Trustees' Report, DI was headed for insolvency in 1995. Were it not for the tax increases enacted last year, which increased the DI tax quite substantially (and reduced the retirement tax by an equal amount), DI would be insolvent now.² To keep DI solvent for a few more years, that is, the legislation will shift an estimated \$240 billion from the OASI (old-age and survivors insurance) trust fund to the DI fund over the next 10 years.³

Since the long-range cost of all three social security insurance programs--OASI, DI, and HI (Hospital Insurance, or part A of Medicare)--has increased significantly in recent years, the ability to reallocate taxes among the programs to stave off insolvency is inherently limited. Tax reallocations are short-term solutions to serious long-term financing problems.

Broader Issues: While the social security disability programs do not present the problems in the forefront of the welfare reform debate--teen pregnancy, out-of-wedlock births, and the cycle of dependency--they nevertheless present problems that demand public attention. Some of these problems can be dealt with on a piecemeal basis; others will require a more comprehensive approach involving the underlying premises and design of the programs.

For example, there are serious questions as to whether the social security disability

² The DI payroll tax (employee and employer rate combined) was increased from 1.20% to 1.88%, or by a whopping 57%, in the period 1994-1996, to 1.7% in the period 1997-1999, and to 1.80% in 2000 and thereafter. The OASI share of the tax was reduced proportionately, leaving the overall social security tax unchanged.

³ The solvency of "social security" is unaffected because the operations of the two trust funds are normally merged in discussions of financing.

programs--premised on the complete inability to work--are congruous with modern views of the potential and the abilities of people with disabilities. Despite dramatic improvements in science and medicine, in technology and information, and in the educational opportunities of young people with disabilities, which have improved the quality of life of people with disabilities as well as the job opportunities open to them, the number of people on the disability rolls has never been higher. In 1993, some 9.7 million people, including family members under the DI program, received checks from the Social Security Administration based on a disability totalling \$56 billion (including Medicare and Medicaid, spending exceeded \$100 billion). Most disability recipients are prime-age men and women; most will never leave the benefit rolls.

For too long, the programs have operated as "early retirement" programs. People must go through a lengthy process to establish that they can not work, at least as evaluated by the Social Security Administration. This inevitably involves not working, possibly for an extended period of time, even if the individual retains some work ability. Once on the rolls, the individual faces only the most remote prospect of being reviewed for continuing eligibility and, even if reviewed, a very low probability of being found ineligible under the "medical improvement" criterion added to the law in 1984. Workers awarded benefits are frequently referred for vocational rehabilitation, but few receive services and fewer still (6,000 or about 1% of workers added to the DI rolls in 1993) are ultimately deemed to have been "successfully rehabilitated." In 1993, less than one-half of one percent of disabled workers voluntarily left the rolls for any reason--whether rehabilitation, return to work, medical recovery, or a finding of ineligibility. These problems stem from flaws in the basic design, administration, and funding of the social security programs as well as the vocational rehabilitation program.

The "once disabled always disabled" paradigm of social policy in the 1950s and 1960s, still deeply embedded in current government policy, must be scrapped as a guiding principle in the 1990s. Recovery, rehabilitation, and work are widely shared goals among working-aged Americans, including otherwise healthy people who are injured on the job or become seriously ill and individuals who are born with or later develop disabilities who seek lives of dignity and self-respect. These goals are undermined by the government only at great fiscal and social cost. "Disability" is not a black or white, yes or no, all or none concept, invariant with respect to individual choice or government policy. Disabilities exist on a continuum, as do the underlying medical impairments, and how disabling an impairment is in the labor market is affected by the incentives and constraints faced by particular individuals.

Over the years, efforts have been made to superimpose work incentives on the current system, but they have been largely unsuccessful. While the reasons, no doubt, are many and varied, two stand out: first, work incentives and other policies designed to promote work have typically been superimposed on the back end of the disability process--once the individual has left the labor force or made the transition from school to unemployment and has begun drawing cash benefits; second, they have built a more and more complex system atop the central (contradictory) policy--the definition of disability--which requires that individuals be unable to work.

The trick, it seems to me, is to focus efforts on the front end, keeping people at work or on the path to work so that they never enter the system in the first place, a system described by some disabled people themselves as a "trap." Research has demonstrated, for example, that employees who become disabled (for example, have a heart attack or an accident) have much better labor market outcomes in terms of employment and earnings when their employers work with them from the onset of the disability, maintaining the continuity of the employee-employer relationship throughout hospitalization and rehabilitation. The place of employment is critical.

The same message is echoed by rehabilitation counselors. Early intervention--ideally before the individual has ever lost his job--is critical to success.

This suggests that the employer is a key part of the equation that is now ignored by policy makers. Consider the reasonable accommodation requirement in the Americans with Disabilities Act. This amounts to a mandated benefits program, the full cost of which is imposed on employers. Or consider the DI tax. Employers who make accommodations and go the extra mile to hire or retain people with disabilities--thus sparing the social security system of at least a portion of the potentially large cost of supporting these people for life--

must pay the same DI tax as all other employers. Or consider increases in minimum wage laws and other mandated benefits programs. These policies increase the cost of hiring low-skilled workers, discouraging the employment of precisely the kind of people that dominate the SSI rolls, people with poor educations and job skills. An effective national policy that has work as its goal cannot ignore the employer side of the equation.

Also, the spirit of many of the reforms being discussed in social policy in recent years, there may be real benefit to reorienting SSI and DI toward transitional aid for people whose conditions are not permanently disabling. The presumption underlying federal policy should, in the main, be that people who are disabled can gain the skills necessary to work; people who become disabled will recover and go back to work. A practical change in current policy that might help bring about such a reorientation would be to place a time limit on benefits. For example, benefits might be granted for a period of three years. Individuals could reapply for benefits, and, if found unable to work, be granted another three-year stipend, but the presumption would be that work would follow.

Other options worth considering:

-- a services-only option (or partial services option) for people eligible for DI. It is clear that for some individuals it would take little more than a specially equipped computer (a talking computer, for example), a mechanized wheelchair or other assistive device, or some additional course work to allow them to work, possibly in the home. Expenses such as these might be made possible if they could be financed with the equivalent of, say, one or two years' worth of benefits up front.⁴ Individuals choosing this option would permanently forego cash (or accept a lower level of cash benefits in the event work failed) in order to receive necessary services.

-- loans against one's own future benefits. Similar in spirit to a services-only option, DI applicants or recipients could receive, in a lump sum, one or two years' worth of benefits to finance needed equipment or services, such as education and training, aimed at facilitating work. Loans would be repaid out of future benefits in the event work failed.

-- rehabilitation vouchers. The public vocational rehabilitation program has proven ineffective at returning DI and SSI recipients to work. There is a clear need for more choice for consumers and more competition in supply from private providers. Vouchers would be a step in that direction.

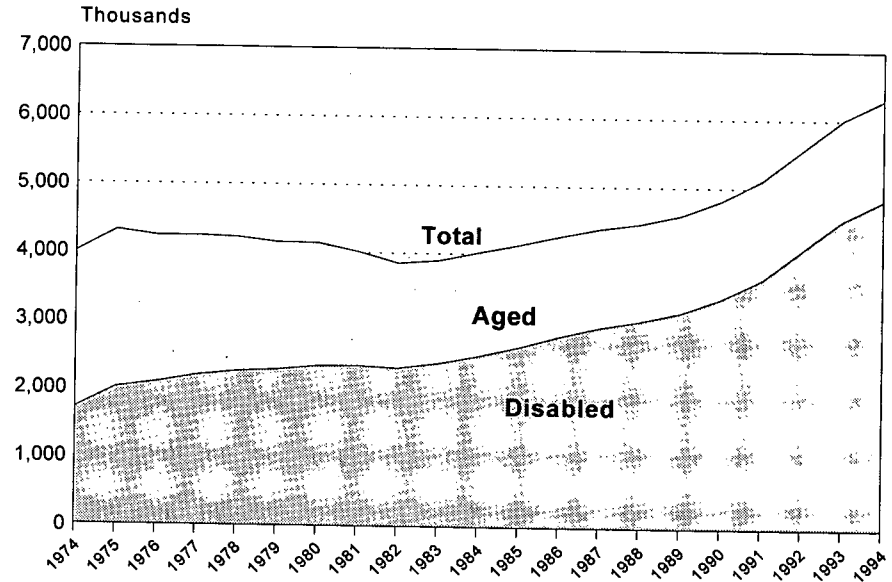
In the longer term, we need to rethink the role of the federal government in providing disability insurance. If the role of the DI program is, indeed, insurance, then private companies are well-equipped to handle the routine risks faced by typical workers, to verify eligibility, and to monitor the accuracy of the benefit rolls. They can serve only part of the work force, however. Federal resources should be targeted on those with special needs that cannot be met by private markets.

Resolving the problems inherent in the social security disability programs will not be easy task, of course, and inevitably will have to be accomplished over time. The task is surely worth the effort, however, and this will become increasingly clear in the years ahead as the Americans with Disabilities Act--which offered so much hope to so many--falls short of its goals, as it surely will with so many people finding their way onto the social security disability rolls--to date, a one-way ticket out of the labor force.

April 3, 1995
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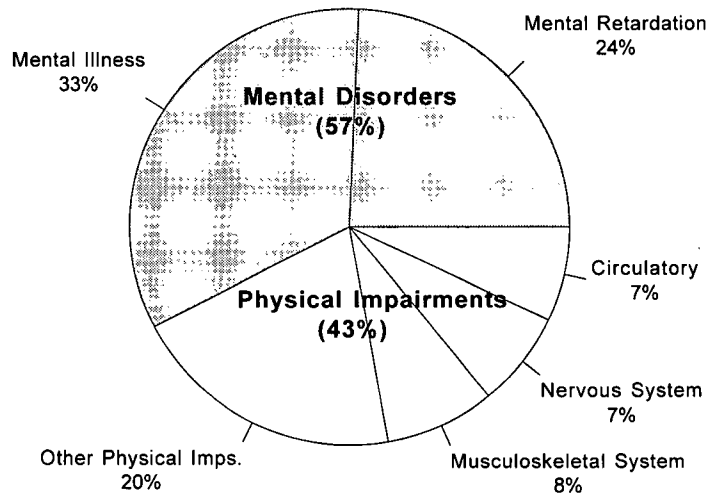
⁴ A worker with average earnings who becomes disabled in 1995 is eligible for about \$10,000 annually, cost-of-living-adjusted annually. This excludes amounts payable to dependent spouses and children.

Figure 1
People Receiving SSI



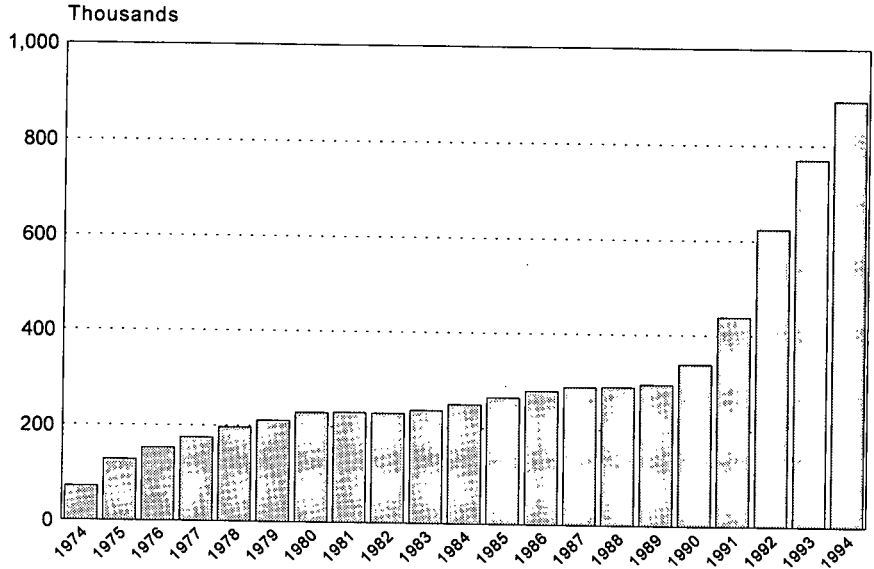
Source: 1994 Greenbook, p. 248, Memo from M. Staren, SSA, to C. Weaver, Feb. 14, 1994, and Art Kahn, SSA, April 4, 1995.

Figure 2
Adults on SSI-Disability Rolls
by Leading Cause of Disability, Dec. 1993



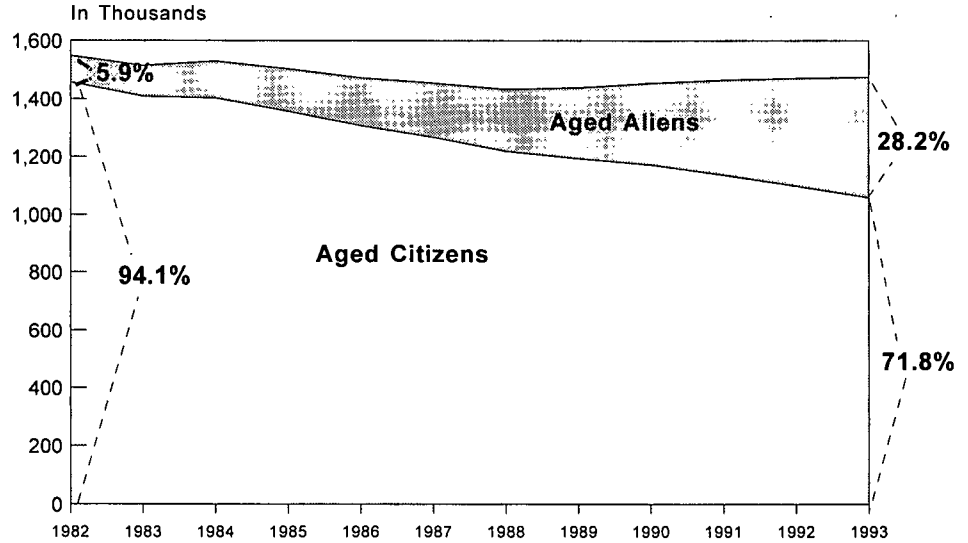
Source: Social Security Bulletin, Annual Statistical Supplement, 1994, p. 300.

Figure 3
Children Receiving SSI



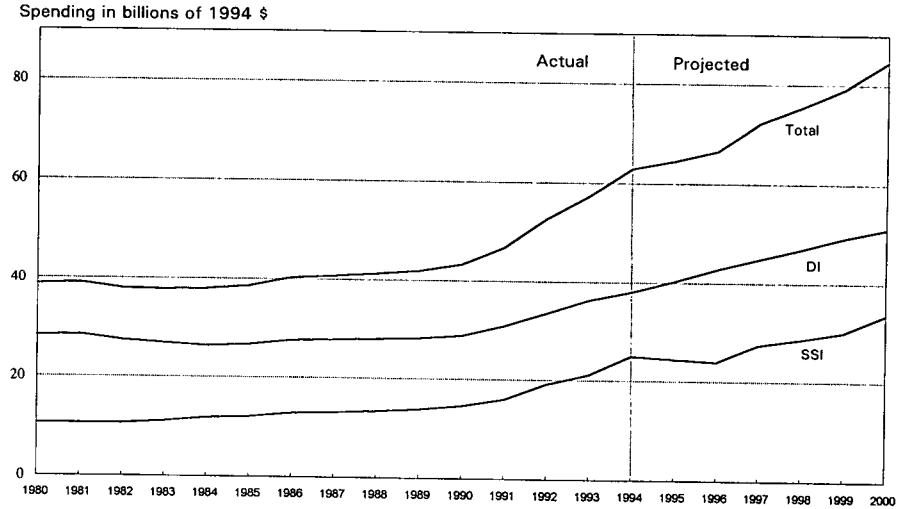
Source: D. Koitz, G. Kollman, and J. Meisner, "Status of Disability Programs of the SSA, 1994," CRS Report for Cong. (June 6, 1994), p. 33, Memo from M. Staren, SSA, to C. Weaver, Feb. 14, 1994, and Eli Donkar, SSA, March 30, 1995.

Figure 4
Aged Persons Receiving SSI and
Declining Share of Citizen Recipients



Source: Charles Scott and Elsa Ponce, "Aliens Who Receive SSI Payments,"
Office of Supplemental Security Income, March 1994

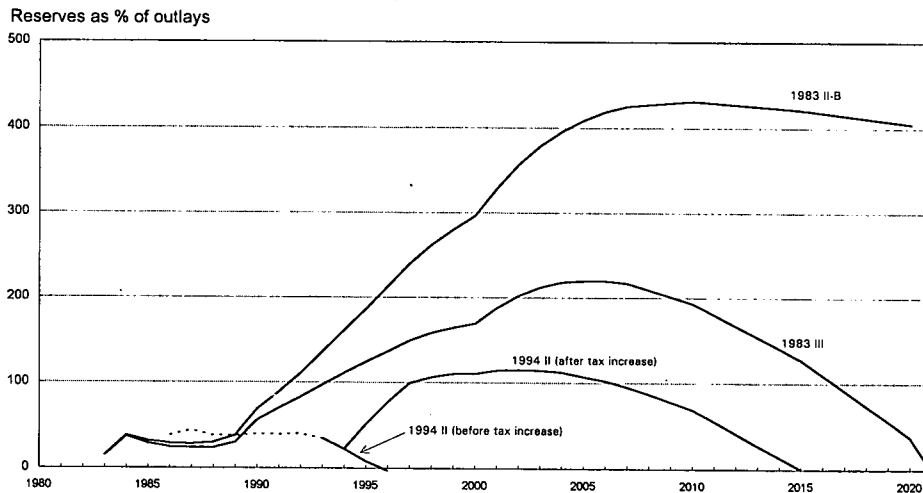
Figure 5
The Rising Cost of the Social Security Disability Programs (DI and SSI):
1980-1994 and as Projected in President's Budget



Source: 1994 OASDI Trustees' Report, FY96 Historical Tables of US Budget, and Memo from the Office of the Actuary, SSA, March 17, 1995; calendar year data 1980-1993, fiscal year data 1994-2000.

Note: Figures do not include Medicare and Medicaid spending on disabled. Also, SSI includes spending for the aged, which accounts for a declining and now small (15%) share of spending. SSI spending flattens artificially in period 1994-1996 due to number of payment periods in each year (13, 12, and 11, respectively).

Figure 6
Disability Insurance Reserves as Percent of Annual Outlays:
As Projected in 1983 and 1994



Source: 1983 and 1994 OASDI Trustees' Reports and data provided by SSA (1994).

Note: Alternative II and II-B projections are based on "intermediate" assumptions; alternative III are based on "pessimistic" or "high cost" assumptions. Dashed line indicates actual reserve ratio.

Senator COHEN. Thank you very much, Ms. Weaver.
Dr. Satel.

**STATEMENT OF SALLY L. SATEL, M.D., DEPARTMENT OF
PSYCHIATRY, YALE UNIVERSITY SCHOOL OF MEDICINE**

Dr. SATEL. Thank you for inviting me to address you today on the matter of supplemental security income to addicts and alcoholics.

I'm an Assistant Professor of Psychiatry at the Yale School of Medicine. I'm on leave this year visiting at the University of Pennsylvania. For the past 8 years, I've worked in public clinics and medical centers treating scores of individuals who have received SSI payments through the drug abuse and alcoholism programs (DA&A). I draw from that experience now in offering the committee two points of view as you reconsider this entitlement.

The first is that the very idea of a cash disability program for addicts and alcoholics is inherently flawed. Second, I'd like to show that clinical realities of addiction actually do suggest ways in which one can restructure DA&A or rethink it totally in order to promote rehabilitation while minimizing the kinds of perverse incentives that accompany a cash benefit.

The problems with DA&A were very vividly described by Mr. Cote. I believe they reflect a troubled programmatic philosophy, and I'll discuss that in a moment.

First, I'd like to say that the horror stories that everyone has been hearing are not simply anecdotes; there is quantitative evidence to show that they are systematic. Several research studies document the diversion of benefits by patients currently in treatment, so you can imagine what many people who aren't in treatment do with their monthly check.

The most persuasive evidence of the dysfunction of the system I feel comes from a report that was released in November by the Inspector General of HHS. It was compelling because it assessed a very large sample of individuals, 20,000 people who were on DA&A. It followed them forward for 4 years from 1990 to 1994 and found that less than 1 percent of this cohort of 20,000 had resumed work or been designated recovered by 1994. One percent is a pitiful number, considering the fact that addiction is not a permanent disability.

However, when you examine the faulty assumptions underlying DA&A, that 1 percent actually is not so surprising because functionally, the way DA&A has viewed addiction is as a chronic, disabling impairment, a largely irreversible defect that precludes work. And if you do conceptualize it that way, the solution does indeed appear to be income maintenance. Yet that formulation ignores the fact that people who are addicted are typically able-bodied, typically able-minded, and potentially employable when they stop using drugs. So helping them make the transition from being disabled to being functional is clearly key, but that's not done with income maintenance; that's done with treatment.

As we have seen, cash can feed the addicts' habits, but even perhaps more damaging, I think, is the message that an unlimited cash benefit communicates. It says that addiction is irreversible and impossible to overcome.

The 3-year limit that was imposed, if nothing else, goes far to dispelling that notion, but even with the cutoff, there are some weak links in the program. For example, if no treatment is available, then in a way, we're back to square one. We have been actively using individuals who are being supported by the taxpayer, having all their needs met and now actually their stipend is even bigger because of the prorated benefit. People get their base benefit of \$450 plus that amount again in the prorated back pay.

I realize, of course, this is not the intent of the program, but it's a realistic probability since treatment is at a premium and as you know, there are at least 100,000 people on waiting lists for public programs in the country on any given day.

What can we do then? This is an ideal opportunity to build upon the important provisions introduced last year by Senator Cohen. Those two key provisions were to take money out of the hands of irresponsible recipients and payees, and to emphasize treatment as the centerpiece of the disability program.

The next step might be to rethink DA&A entirely, but that can only be done as long as adequate funding for treatment is provided. The House Ways and Means Committee I believe is considering a model where DA&A is dismantled and some money is shifted to the States so they can expand their residential treatment programs. I am in favor of this on the clinical basis that addicts need treatment and they don't need money. I do, however, worry that shifting of funds might not occur and that's key. Funding treatment is very important.

The prospect of taking cash benefits away from addicts raises some questions. Some people allege that crime will increase and that homelessness among the recipients will increase. These concerns are legitimate, but I think they are unlikely. In fact, I'm sure they are unlikely to materialize provided residential addiction treatment is made available. This kind of treatment is really the modality of choice for hard core addicts and alcoholics, the people for whom this entitlement was intended.

Skills for resisting relapse, resocialization, job training and beginning employment often take place and should take place during residential stays which are often about an average of a year—they can range from 12 months to 24 months. Following this, it often makes sense for a person to live in "recovery housing"—drug-free housing for a year to 2 years.

When you think of the benefit that people get as I said, sometimes now \$900 a month with a \$450 base and the doubling of it through probation, that amount can easily pay for drug-free housing in a year. Residential treatment costs might run from about \$15,000 to \$18,000. Depending on the supplemental payments people get, those can also be paid for but would not be covered entirely based on the average benefit amount.

Another question that comes up is, is curtailing cash benefits discriminatory? That strikes me as a very hollow objection to which I respond; why maintain an outwardly equitable arrangement for addicted persons when we have abundant evidence that it doesn't meet their needs. Moreover, there is Federal precedent in managing addicted persons differently from other classes of disabled people.

Consider the Americans with Disabilities Act. That does not include workplace accommodations for active alcoholics. Nor does the Veterans Administration consider alcoholism or drug addiction conditions eligible for service-connected benefits. I think these are very important things to keep in mind. The VA, however, does provide treatment for these individuals and again, I think that is key.

So where does that leave us? I think there are several principles we have to keep in mind. The first is that we should give alcoholics and addicts what they need. Again, that's treatment and not cash. As we've seen, the money can be abused. It also makes the program very attractive to people and it also makes people too dependent on it.

Second, since there is a shortage of treatment, why shouldn't the benefit pay for treatment? Right now, SSA can't require that one's benefit go to pay for treatment. It seems to me that's what the benefit should be for, residential treatment that will preclude the development of homelessness and give these people the best treatment modality. Therefore, I think DA&A, if it's to be preserved, would best be a direct treatment benefit rather than a cash benefit.

Finally, in closing, I'd like to make one more comment, a word about reclassifying some of the people who found their way into this disability inappropriately. Those are people with severe and persistent mental disorders, schizophrenic and bipolar individuals who may also be using drugs. They are called the dually-diagnosed. Those people should not be in DA&A; they have to be reclassified. A time limit makes no sense for them and the removal of Medicaid would be disastrous.

What does make sense, and Senator Cohen recommended this a year ago and I think it was prescient, is that these individuals receive pay and must comply with a treatment requirement. If we're worried that addicts can't manage their benefits, how in the world is a psychotic addict going to manage his benefit responsibly?

Also, in my statement, I've written about some successful programs that work with dually-diagnosed and I can give you names and documentation of very successful ones in Washington State and New Hampshire that have done excellent work, have treatment models that combine payeeship and treatment.

So in conclusion, I'd like to say, returning to the situation with addicts, first, we have to recognize that addiction cannot be managed with cash benefits like other disabilities; that this is not discriminatory but rather a clinically-informed response to the needs of these individuals; and lastly, I'd like to suggest that the benefit itself becomes a treatment benefit and not a cash benefit.

Thank you very much.

[The prepared statement of Dr. Satel follows:]

STATEMENT OF SALLY L. SATEL, M.D., YALE UNIVERSITY SCHOOL OF MEDICINE,
DEPARTMENT OF PSYCHIATRY

Thank you for inviting me to address you today on the matter of Supplemental Security Income (SSI) to Addicts and Alcoholics.

I appear on this panel as a psychiatrist. I am currently on leave from the Psychiatry Department at the Yale University School of Medicine and am now a visiting assistant professor at the University of Pennsylvania School of Medicine. Last year, as a Robert Wood Johnson Health Policy Fellow, I worked in the then-minority Labor and Human Resources Committee and the office of Senator Nancy Kassebaum.

In the past 8 years, I have worked in public clinics and in VA medical centers, treating scores of individuals who were enrolled in SSI's DA&A (Drug Abuse and Alcoholism) disability program.

The gross inefficiencies and misguided compassion of the DA&A program are now infamous. Last year, the then-minority ranking member of this Committee, Senator Cohen, released a powerful investigative report that turned a harsh spotlight on the issue and, ultimately, led to major revisions in DA&A. Recently, the Human Resources Subcommittee of the House Ways and Means Committee voted to deny SSI eligibility to drug addicts and alcoholics while directing funds to provide additional treatment for substance abuse.

As members of the Committee reconsider disability entitlements, I wish to offer two points.

The very idea of a cash disability program for addicts and alcoholics, while perhaps appearing responsive to their needs, is inherently flawed.

Clinical realities suggest practical ways to restructure the current system to promote rehabilitation while minimizing the perverse incentives that inevitably accompany cash benefits for disability.

DA&A: PROBLEMS REFLECT TROUBLED PHILOSOPHY

Unintended consequences

Let me begin with the DA&A program. This entitlement, established in 1972, provides income maintenance to those unable to work as a function of addiction to drugs or alcohol. Horror stories about the program abound. I will not recount them but will confirm that, indeed, they portray common clinical experience: patients I have known routinely used their funds to purchase alcohol and drugs and, others, upon receiving checks, dropped out of treatment completely or abandoned ongoing job searches.

Not just anecdotes

Defenders of the DA&A program condemn the anecdotal nature of these reports. But systematic assessments support them. For example, a study presented at the 1994 American Psychiatric Association meeting showed that cocaine-abusing SSI recipients had much higher levels of absenteeism and positive urines for cocaine during the first few days of the month—coinciding with the arrival of their benefit check. Another study, from a methadone clinic at the University of California, San Francisco, found that patients who received retroactive 'lump-sum' payments from SSI dropped out of the clinic and resumed heroin use shortly after that payment arrived.

The most persuasive evidence comes from the office of the Inspector General at HHS. The IG's report, released November 1994, is especially compelling because it assessed a large sample—20,000 DA&A recipients. It documents that DA&A was largely unsuccessful in moving people off the addiction 'disability' rolls: less than 1% of the cohort of 20,000 recipients enrolled in 1990 had resumed work or were designated recovered by 1994.

A 1% 'recovery' rate is pitiful: addiction-induced disability is rarely a chronic condition. Yet, the behavioral and psychological dynamics of severe addiction are perfectly consistent with these data considering the current structure of DA&A. First, any program that gives cash to addicts invites misuse. Severely addicted persons have virtually no 'choice' but to divert whatever limited financial resources they might have to the suppression of intense drug cravings and physiologic withdrawal.

Further, the perverse incentive of a cash benefit effectively rewards addiction while it punishes functional adaptation and recovery. This incentive may be even greater now that recipients will be receiving prorated retroactive benefits. Under this arrangement, many beneficiaries will receive an average of \$900/mo (around \$450 benefit + equal amount in prorated retroactive 'lump sum'). In many states, a monthly supplement of \$100–\$200 accompanies the DA&A benefit payment. Those with large retroactive payments (exceeding at least \$16,200) will receive this 'double' benefit for the life of the entitlement which is now 3 years. Not only are these funds tax free but they are, of course, complemented by medicaid and food stamps. By comparison, a minimum wage job pays about 30% less with no guarantee of health insurance.

Faulty assumptions

Functionally, DA&A has viewed addiction as a chronic disabling impairment (that is, a largely irreversible defect that precludes work), the solution, indeed, appears to be income maintenance. But this formulation ignores the reality that a person who is addicted is typically able bodied, able 'minded' and potentially employable

when not using substances. Thus, helping addicted individuals make the transition from 'disabled' to employable is key; this is achieved through treatment, not income maintenance.

Not only can cash benefits feed habits but, perhaps even more damaging, an unlimited benefit communicates to them that addiction is irreversible and impossible to overcome. The newly imposed 3-year limit, if it does nothing else, dispels that notion.

But even with a 3-year limit, some systemic weaknesses persist. For example, if there is no treatment available for the actively using recipient, he or she will still receive support. Indeed, the taxpayer will be subsidizing the basic needs of the addict while they wait for a treatment slot to open up and while they, most likely, continue to use drugs or alcohol. And now, with the prorated retroactive lump sum, such recipients will be very generously supported.

While treatment availability is beyond the control of the recipient, to be sure, granting income maintenance to an individual not participating in treatment is regressive. It certainly runs counter to the model of self-sufficiency envisioned by those who revised the regulations last year. Yet, given the poor availability of treatment slots (especially residential rehabilitation slots—the modality most needed by hard core addicts), such a scenario will be common.

It is also important to recognize that while DA&A applicants can indeed be poor and addicted, many others may be poor because they're addicted. Consequently, the most sensible way to interrupt this cycle is through detoxification and treatment, not DA&A welfare payments.

Treatment scholarship

If one reframes the goals of DA&A as a "treatment scholarship"—and de-emphasizes the welfare dimension of the program—that is aimed at supporting addicts while they participate in treatment, start on the path to 'recovery', search for a paying job and become employed, the program then makes more sense. But it still has weaknesses.

For example, disability determination for DA&A is not straightforward. In fact, it can be very difficult for examining clinicians—who typically evaluate an applicant in a single session—to assess the severity of his or her addiction and the extent to which it interferes with the ability to do some kind of work. Relying on the applicant's self-report for much of the history further confounds the accuracy of the clinical picture. And then, when an individual is deemed eligible and enrolled in DA&A, he or she may confront a shortage of treatment opportunities. And, finally, if treatment is obtained, the likelihood of poor compliance with treatment will trigger new and cumbersome procedures for withholding benefits and reinstating them when treatment compliance resumes.

Projected growth

The newly enacted laws attempt to plug gaps but, in doing so, risk increasing the regulatory apparatus of DA&A. All the while, the enrollment is growing. It is now about 100,000 (up from 78,000 a little over one year ago) and promises to at least double by 2000 according to the GAO.

That may be a very conservative projection when one considers, for example, that there are thousands of additional addicts and alcoholics who are eligible for DA&A, only they haven't been formally assisted in applying for the benefits. Potential enrollees include 25–50% of the nation's homeless population who abuse substances, as well as thousands among the nation's 2.7 million hard core addicts. All are eligible insofar as they are poor, unemployed and addicted. To the extent that there is a subpopulation of recipient who simply seeks to 'game' the system, some of the new regulations may indeed discourage them. For example, (1) an institutional payee system, (2) prorated lump sum retroactive payments, (3) a treatment requirement that is enforced and (4) a 3-year limit will most likely deter those looking to DA&A for an easy monthly check. While the size of this subpopulation is unclear, if treatment is unavailable the obstacles to abuse will be less effective since, as mentioned earlier, the recipient, can enjoy monthly checks without any 'strings attached'.

In sum, despite the new regulations, DA&A remains a worrisome entitlement program: it is easy to qualify for, difficult and expensive to monitor, unable to guarantee rehabilitation and can entrap the very individuals it means to release from the grip of their addiction. Meanwhile, the program is growing in cost, enrollment and regulatory burden.

NEW DIRECTIONS

Fortunately, the debate over the fate of DA&A is situated in the midst of a genuine reevaluation of federal entitlement programs, their meaning and structure. It is

an ideal opportunity to build upon the important provisions introduced last year by Senator Cohen. Those provisions sought to protect individuals from abusing benefit payments while emphasizing the central role of treatment in DA&A and enforcing compliance with it.

The next step, therefore, might be even more bold: to rethink DA&A entirely as long as adequate funding for treatment is provided. Shifting its funding directly toward the states so that they can expand their public residential treatment programs, is one possibility which I would support on the clinical basis that addicts don't need money, they need treatment. However, it is essential that the funds planned for 'reallocation' to treatment be substantive (at least the cost of annual benefit payments, which will be about \$400 million in 1995) and that these monies do indeed reach their target.

Will crime, homelessness increase without cash benefits?

Critics of this approach charge that the discontinuation of monthly benefit checks will increase crimes committed by ex-recipients who now must steal in order to obtain the funds needed to buy their drugs. They also assert that homelessness will occur in those who pay rent with their monthly benefit. (These are the same concerns, you will recall, that were expressed last year when the Congress considered imposing the 3-year limit on DA&A benefits).

Such concerns are legitimate but unlikely to materialize provided residential addictions treatment is made available. Such treatment is often essential for hard core addicts and alcoholics provides a drug-free living environment for 3-12 months. Skills for resisting relapse, resocialization, job training and beginning employment take place during a residential stay. A year in a residential program costs between \$15,000-\$18,000. Drug-free housing, a useful follow-up to residential treatment, is between \$9,500-11,000 per year.

Is curtailing cash benefits discriminatory?

Still others protest that cash payments under DA&A (or denying SSI eligibility altogether) "discriminates" against addicted persons. Last year, the decried the imposition of a 3-year limit, prorated backpay, an institutional payee and enforced treatment; all for the same reason. This strikes me as a hollow objection. Why maintain an outwardly 'equitable' arrangement for addicted persons when there is abundant evidence that it doesn't meet their needs?

Moreover, there is federal precedent managing addicted persons differently from other classes of 'disabled' people. The Americans with Disabilities Act, for example, does not include employment protections and workplace accommodations for active alcoholics and addicts. Also, the Veterans Administration explicitly denies service-connected benefits for veterans on the basis of addiction. It does, however, provide treatment for these individuals. In this context, an argument could easily be made for keeping DA&A enrollees on Medicaid to the extent that it pays for rehabilitation treatment (but NOT simply for free-standing detoxification services which are very expensive and, unless part of a treatment program, can easily be exploited in revolving-door fashion).

Specific recommendation for DA&A

Several principles emerge:

First: it must be recognized that addiction cannot be managed like other 'disabilities and that this is not discriminatory but rather a clinically informed response to their special needs.

Second: a cash benefit is hazardous: (1) it can be abused, (2) it makes DA&A too attractive, (3) it makes DA&A recipients too dependent.

Third: Since there is a treatment deficit, the benefit itself should be used for treatment. SSA has explicitly discouraged this but it would seem to me that treatment is perhaps the best use of a cash benefit.

Taking this one step further, Congress should consider changing DA&A (if they decide to preserve it as an entitlement) from a cash benefit to a direct treatment benefit. Funds tied to an individual would then be transferred to the recipient's state drug and alcohol system to purchase residential treatment for him. A 3-year time limit continues to make sense. Quality control/accountability regarding the quality of the residential treatment facility will be important.

Reclassify the mentally ill addicted

Any discussion about the fate of DA&A must consider the fact that a sizeable percentage, estimated to be between 40 and 60% of those in the DA&A program, should never have been placed in DA&A to begin with. Some of them have permanent alcohol-induced organicity (dementia) or other physical impairments that, independent of addiction, would qualify them for disability. Another, perhaps larger, subgroup

are those with addiction superimposed upon a primary, pre-existing severe mental illness, such as schizophrenia or bipolar illness.

Whatever the fate of DA&A, these individuals must be reclassified under the category reflecting their primary disabling condition so that income maintenance benefits and Medicaid continue.

Reclassification alone, however, is insufficient. It is still essential that cash benefits go to institutional payees. Also, a treatment requirement must be imposed if the condition has potential for response to care, or if deterioration can be slowed through treatment.

Right now, unfortunately, severely mentally ill (SMI) persons under SSI are simply mailed a check. There is no reciprocal arrangement whereby individuals receive federal support as a condition of participating in psychiatric treatment and of compliance with medication. And while the SMI are sometimes incompetent to manage their funds, psychotic individuals who also use drugs or alcohol (the 'dually diagnosed') are surely incapable of making rational decisions concerning a benefit check.

A model plan for the dually diagnosed

There are creative ways to design a disability program for SMI persons who also abuse drugs or alcohol using built-in incentives. These would help motivate compliance and, ultimately, improve the mental health and social adaption of recipients. I would like to briefly describe a model for devising a more intelligent disability program based on a payee program currently operating in a large outpatient clinic where several hundred dually diagnosed patients on SSI receive care.

In this clinic, every patient has a payee account. Management of this account ranges from basic (the entire SSI check is received by the treatment agency and immediately transferred into a patient's bank account) to a tightly managed type of account from which rent money is electronically transferred to the landlord and local utility companies. Rather than make the remaining cash available to the patients, the treatment program organizes shopping outings for food, clothes and incidentals to ensure that their money is spent on needed items and not drugs or alcohol or given to unscrupulous neighborhood operatives who seek out vulnerable patients at check time and talk them into making 'loans'.

Patients can earn more monetary freedom by demonstrating good treatment participation, some level of independent function, negative urine screens and responsibility in managing small amounts of cash, which are used as test evaluations. Some patients are even able to advance and become their own payees after demonstrating solid responsibility, stability and treatment compliance over many months. Decreases in inpatient utilization, incarceration and homelessness have been reported by treatment systems that employ a payee arrangement with contingency-payment.

Currently, a research project is underway with SMI cocaine addicts. It is based on a completed study of non-SMI cocaine addicts which found considerable reduction in cocaine abuse and increased compliance when patients were given vouchers for participating in treatment and for negative urines. In situations where addicts and alcoholics (with or without SMI) are on state welfare, this is a promising model whereby they can 'earn back' their benefit check on a contingency basis.

In sum, the payment of cash benefit based on addition-induced disability has led to many problems and to costly regulatory remedies. The original intention of DA&A was to rehabilitate addicted individuals. Not only is income maintenance irrelevant to that goal, it can actually harm recipients. I suggest an inventory of the DA&A program in order to remove individuals with physical and severe mental illnesses that independently disable and to reclassify these persons under their primary mental or physical disability. Optimally, these persons would be assigned payees and participation in mandated treatment.

Individuals whose sole 'disability' is addiction should receive what hard core addicts need: residential treatment and rehabilitation, not welfare.

Senator COHEN. Thank you very much, Dr. Satel.
Dr. DeJong.

STATEMENT OF GERBEN DeJONG, PH.D., DIRECTOR, NATIONAL REHABILITATION HOSPITAL RESEARCH CENTER

Mr. DEJONG. Thank you.

Good morning. My name is Gerben DeJong and I serve as the Director of the National Rehabilitation Hospital Research Center lo-

cated here in Washington, D.C. I also serve as a Professor in the Department of Family Medicine at Georgetown University.

I want to thank the Committee for inviting me to testify today. I want to make clear that I do not speak for any particular organization or constituency, although I know there are many who share my views. I'm here mainly because I've been a long-time student of how the Nation's health and income policies affect the lives of Americans with disabilities. As a result, I have come to develop certain views about the need for major reform of the Nation's income programs.

Currently, I also serve on the Disability Panel convened by the National Academy of Social Insurance which has been organized to rethink our Nation's approach to disability income assistance. The panel includes many of the Nation's leading experts on disability income policy. It is conducting an in-depth and comprehensive review of the Disability Insurance Program and its relationship to the Supplemental Income Program. The panel will issue its final report this coming November.

I want to make clear that I am not speaking for the Disability Panel; I want to say, however, that the panel finds the issues to be vexing and often frustrating. At times, it appears that every creative solution also has a significant downside. I mention this because I want to caution the Committee against any hasty solutions that at the surface may appear promising, but in execution, may often present new difficulties.

The core of the problem, in my view, is that the DI and SSI programs are governed by policy assumptions that are grossly out-of-date. Our two main disability income programs had their beginnings in the 1950's during the Eisenhower Administration. These programs are based on the assumption that an individual was either disabled or not disabled and individuals who were found disabled were so hopeless that future prospects for work were impossible. To become eligible for benefits under either program, the law required that a person have a medical condition that either would render him or her totally unable to work or would result in death. The disability had to be considered total and permanent. Thus, the precursor to the SSI Program was known as the Aid to the Totally and Permanently Disabled.

Despite changes made in the DI and SSI programs since their inception, the basic assumptions underlying these programs remain largely unchanged. Eligibility for program benefits continues to be based on a determination that a person is unable to work because of a medical condition. This creates an inherent and self-fulfilling work disincentive that cannot be addressed adequately through incremental measures. After demonstrating so earnestly that they are disabled enough to qualify for DI or SSI, many disabled persons become convinced that they are too disabled ever to work. This is also the point that was underscored by Dr. Weaver a moment ago.

In order to encourage work, Congress has, since 1980, liberalized "the back end" of the DI and SSI programs by enabling program participants to retain a portion of their benefits when accepting gainful work. Despite these changes, remarkably few people have taken advantage of these work incentive provisions and leave the

DI and SSI programs as noted by other witnesses here this morning.

Many reasons have been offered for the failure of various work incentive provisions to encourage people to accept gainful work. Yes, they are complicated, difficult to understand, and create uncertainty. These work incentives must be simplified and confusing differences in work incentives between the DI and SSI programs must be eliminated.

Still, I believe that none of these changes can fully overcome the extent to which people internalize their own disability when proving to disability examiners that they are too disabled ever to work again.

Let's be candid here. We demand a very high threshold of disablement in order to qualify for benefits. In so doing, we also set into motion a set of behaviors that have enduring consequences when people internalize the assumption that they are too disabled to work. In short, by making it difficult to get on the system, we sometimes make it difficult to get off the system.

I'm not recommending that we liberalize the definition of disability for income eligibility purposes. We do, however, need to recognize that the world of disability has changed dramatically over the last 40 years. Today, many people with severe impairments can work and do work. Improvements in medical rehabilitation, new assistive technologies, work site modifications, and the changing expectations of people with disabilities have enhanced opportunities for independent living and gainful work. Those who were at one time thought to be too disabled to benefit from rehabilitation services are now routinely "rehabilitated." They have demonstrated that severe impairments do not automatically mean banishment to the backwater of American economic and social life.

My co-panelist this morning and colleague, Mr. Eckenhoff, President and CEO of the National Rehabilitation Hospital, will in his testimony illustrate with examples of how modern rehabilitation and new technologies enhance opportunities for employment and independent living in ways not envisioned 40 years ago.

He will also mention new threats to rehabilitative services that result from the short-sightedness of managed health care companies that are rapidly becoming the dominant player in the health care finance today in both the private and public sectors.

In light of these changes, what can we do that will help facilitate return to work and help eliminate or reduce the self-fulfilling character of the current definition of disability used in SSA's disability determination process? I want to convey several ideas and recommendations.

One, recognize that disability is a function of both the individual's impairment and the level of environmental accommodation. Two, remove from current policy any assumption that work disability is necessarily permanent, although the medical condition or impairment may be. Three, modify the statutory definition of disability to include the availability of worksite accommodations and environmental adaptations as a consideration in determining eligibility for income benefits. Four, consider providing claimants who meet the current definition of disability but not an expanded environmental definition a one-time voucher that can be used by the claim-

ant or the employer to purchase environmental or worksite accommodations in order to obtain employment in lieu of income benefits.

Five, update periodically SSA's list of qualifying impairments to include consideration of new technologies and environmental accommodations that may avert work disability. Six, modify tax policy by offering greater deductibility of or tax credits for impairment- and work-related expenses. Consider using the earned income tax credit mechanism as a way of fostering greater labor force participation, especially for those in low wage jobs.

Seven, simplify and harmonize the work incentive provisions within the DI and SSI programs. Eight, consider providing return-to-work vouchers for DI and SSI income beneficiaries that can be used by beneficiaries or prospective employers in purchasing environmental and worksite accommodations. I might add here that Dr. Weaver, my copanelist this morning, has been a major advocate of that concept and that idea.

Nine, include the availability of environmental accommodation as a consideration when reviewing a person's continued eligibility for disability income benefits. Finally, for newly disabled workers, attempt to ensure that the worker and his or her last employer do not lose their attachment to one another. Research has shown that once disengaged from the last place of employment, the worker's prospects for return to work are considerably diminished. This means that the private sector must do more to accommodate newly disabled workers if public assistance is to be averted.

If we include the availability of environmental accommodation in the definition of disability, it will undoubtedly reduce the number of who qualify for income benefits. Thus, the notion of environmental accommodation would represent a significant breakthrough in disability income policy and would also represent significant cost savings. In exchange for these cost savings, the Congress should consider the different ways in which environmental accommodation could be financed through the limited voucherization of income benefits and the use of tax breaks for both people with disabilities and their employers.

The current DI and SSI definitions of disability also run counter to a key assumption in the Americans With Disabilities Act which asserts vigorously, albeit implicitly, that having a disability, i.e., an impairment, does not render a person unable to work. The ADA does so by placing the expectation that reasonable accommodation will be made. It conveys the presumption that people with disabilities can and want to work. In short, the policy assumptions of the DI and SSI programs are out of sync with the assumptions of the ADA which more closely reflect current capacities of people with disabilities to participate in the economic and social life of the community.

It's time to update the eligibility criteria of the DI and SSI programs to reflect these new realities.

Thank you.

[The prepared statement of Mr. DeJong follows:]

STATEMENT OF GERBEN DEJONG, PHD, DIRECTOR, NATIONAL REHABILITATION
HOSPITAL RESEARCH CENTER

Good morning. My name is Gerben DeJong. I serve as the Director of the National Rehabilitation Hospital (NRH) Research Center located here in Washington, DC and

serve as a professor in the Department of Family Medicine at Georgetown University School of Medicine.

I want to thank the Committee for inviting me to testify today. I want to make clear that I do not speak for any particular organization or constituency, although I know that there are many who share my views. I am here mainly because I have been a long-time student of how the nation's health and income policies affect the lives of Americans with disabilities. As a result, I have come to develop certain views about the need for major reform of the nation's disability income programs.

Currently, I also serve on the Disability Panel convened by National Academy of Social Insurance to rethink our nation's approach to disability income assistance. The Panel includes many of the nation's leading experts on-disability income policy. It is conducting an in-depth and comprehensive review of the Disability Insurance (DI) program and its relationship to the Supplemental Security income (SSI) program. The panel will issue its final report this coming November.

I want to make clear that I am not speaking for the Disability Panel. I want to say, however, that the Panel finds the issues to be vexing and often frustrating. At times, it appears that every creative solution also has a significant downside, I mention this because I want to caution the Committee against any hasty solutions, that at the surface appear promising, but in execution present new difficulties. If Congress find the AFDC program difficult to reform, wait till it tries to reform the DI and SSI programs, which are far more complicated owing, in part, to the complexity of the multifaceted eligibility criteria that seek to establish the presence or absence of a qualifying disability.

I recognize that Congress may have its own timetable, but I would urge that the Congress await the findings and recommendations of the Disability Panel before it concludes its deliberations. I believe you will find the Panel's report to be forward looking and will address many of the issues that have to come to public attention in recent months.

OUT-OF-DATE POLICY ASSUMPTIONS

The core problem is that the DI and SSI programs are governed by policy assumptions that are grossly out of date. Our two main disability income programs had their beginnings in the mid 1950s during the Eisenhower Administration. These programs were based on the assumption that an individual was either disabled or not disabled, and individuals who were found disabled were so hopeless that future prospects for work were impossible. To become eligible for benefits under either program, the law required that a person have a medical condition that either would render him or her totally unable to work, or would result in death. The disability had to be considered total and permanent. Thus, the precursor to the SSI program was known as Aid to the Totally and Permanently Disabled (ATPD).

Despite changes made in the DI and SSI programs since their inception, the basic assumptions underlying these programs remain largely unchanged. Eligibility for program benefits continues to be used on a determination that a person is unable to work because of a medical condition. This creates an inherent and self-fulfilling work disincentive that cannot be addressed adequately through incremental measures. After demonstrating so earnestly that they are disabled enough to qualify for DI or SSI, many disabled persons become convinced that they are too disabled ever to work.

FAILURE OF DI AND SSI WORK INCENTIVES

In order to encourage work, Congress has, since 1980, liberalized the "back end" of the DI and SSI programs by enabling program participants to retain a portion of their benefits when accepting gainful work. For example, DI beneficiaries can (a) retain their eligibility for reinstatement of cash benefits should a return-to-work effort prove unsuccessful and (b) retain their Medicare benefits while working. SSI participants can (a) retain a portion of their cash benefits (§ 1619(a)) and (b) retain their Medicaid benefits (§ 1619(b)) (under specified conditions) when accepting gainful work. Despite these changes, remarkably few people take advantage of these work incentive provisions and leave the DI and SSI programs.

Many reasons have been offered for the failure of various work incentive provisions to encourage people to accept gainful work. Yes, they are complicated, difficult to understand, and create uncertainty. These work incentives must be simplified and the confusing differences in work incentives between the DI and SSI programs must be eliminated. Still, I believe that none of these changes can fully overcome the extent to which people internalize their own disability when proving to disability examiners that they are too disabled to work.

Let's be candid here. We demand a very high threshold of disablement in order to qualify for benefits. In so doing, we also set into motion a set of behaviors that have enduring consequences when people internalize the assumption that they are too disabled to work. In short, by making it difficult to get on to the system, we also make it difficult to get off the system.

WORLD OF DISABILITY CHANGED

I am not recommending that we liberalize the definition of disability for income eligibility purposes. We do, however, need to recognize that the world of disability has changed dramatically over the last 40 years. Today, many people with severe impairments can work and do work. Improvements in medical rehabilitation, new assistive technologies, worksite modifications, and the changing expectations of people with disabilities have enhanced opportunities for independent living and employment. Those who were at one time thought to be too disabled to benefit from rehabilitation services are now routinely "rehabilitated." They have demonstrated that severe impairments do not mean automatic banishment to the backwater of American economic and social life.

My co-panelist and colleague, Mr. Edward Eckenhoff, President and CEO of the National Rehabilitation Hospital, will, in his testimony, illustrate with examples of how modern rehabilitation and new technologies enhance opportunities for employment and independent living in ways not envisioned 40 years ago. He will also mention new threats to rehabilitative services that result from the short-sightedness of managed health care companies that are rapidly becoming the dominant player in health care finance today in both the private and public sectors.

SOME RECOMMENDATIONS

In light of these changes, what can we do that will help facilitate return to work and help eliminate or reduce the self-fulfilling character of the current definition of disability used in SSA's disability determination process? I want to convey several key ideas and recommendations:

1. Recognize that the disability is a function of both the individual's impairment and the level of environmental accommodation.
2. Remove from current policy any assumption that work disability is necessarily permanent although a medical condition or an impairment may be.
3. Modify the statutory definition of disability to include the availability of worksite accommodations and environmental adaptations as a consideration in determining eligibility for *income* benefits.
4. Consider providing claimants, who meet the current definition of disability, but not an expanded environmental definition, a one-time voucher that can be used by the claimant or the employer to purchase environmental or worksite accommodations in order to obtain employment in lieu of income benefits.
5. Update periodically SSA's list of qualifying impairments to include consideration of new technologies and environmental accommodations that may avert work disability.
6. Modify tax policy by offering greater deductibility of, or tax credits for, impairment-work-related expenses. Consider using the Earned Income Tax Credit (EITC) mechanism as a way of fostering greater labor force participation especially for those in low-wage jobs.
7. Simplify and harmonize the work incentive provisions within the DI and SSI programs.¹
8. Consider providing return-to-work vouchers for DI and SSI income beneficiaries that can be used by beneficiaries or prospective employers in purchasing environmental and worksite accommodations.
9. Include the availability of environmental accommodation as a consideration when reviewing a person's continued eligibility disability income benefits.
10. For newly disabled workers, attempt to ensure that the worker and his/her last employer do not lose their attachment to one another. (Research has shown that once disengaged from the last place of employment, the worker's prospects for return to work are considerably diminished.) This means that the private sector must

¹An important step in simplifying work incentive provisions is to assure access to health care. We need to find ways to divorce health benefits from income or work status. Health care represents the single largest expenditure and the greatest source of uncertainty and anxiety for people with work disabilities. For example, according to our research at the NRH Research Center, people with work disabilities, incur on average, approximately six times the amount of hospital costs than those that are not work disabled.

do more to accommodate newly disabled workers if public assistance is to be averted.

POTENTIAL COST-SAVINGS

If we include the availability of environmental accommodation in the definition of disability, it will undoubtedly reduce the number who qualify for income benefits. Thus, the notion of environmental accommodation would represent a significant break-through in disability income policy and would also represent a significant cost-savings. In exchange for these cost savings, the Congress should consider the different ways in which environmental accommodation could be financed through the limited voucherization of income benefits and the use of tax breaks for both people with disabilities and their employers.

The current DI and SSI definitions of disability also runs counter to a key assumption in the Americans with Disabilities Act (ADA) which asserts vigorously, albeit implicitly, that having a disability, i.e., an impairment, does not render a person unable to work. The ADA does so by placing an expectation that "reasonable accommodation," will be made. It conveys the presumption that people with disabilities can and want to work.

In short, the policy assumptions of the DI and SSI programs are out of sync with the assumptions of the ADA which more closely reflect current capacities of people with disabilities to participate in the economic and social life of the community. It's time to update the eligibility criteria of the DI and SSI programs to reflect these new realities.

Senator COHEN. Thank you very much, Mr. DeJong.
Mr. Eckenhoff.

STATEMENT OF EDWARD A. ECKENHOFF, PRESIDENT, NATIONAL REHABILITATION HOSPITAL

Mr. ECKENHOFF. Thank you, Mr. Chairman.

On my way over this morning, I had my window down in the car and one of the people on the sidewalk said, hi, Pat. I want you to know I'm not Pat Buchanan. My wife and my mother tell me I'm far better looking. [Laughter.]

I am the President of the National Rehabilitation Hospital. It's a large hospital, one of the largest specialty institutions in our country for the physically disabled. We accepted nearly 2,000 inpatients last year; we provided nearly 75,000 outpatient visits.

I say all of this because of one point and that is that we understand disability; we see a great deal of it; and I would like to talk to you today about one point that has not been talked about. I know the morning is growing long but I would wish for those of you who have not read my testimony because I'm sure I'm going to forget to say some of what I did write.

The one thing I would like to talk about today is equipment. The Senator asked one or two questions about equipment and I should tell you that I walk the way I do because I was thrown from an automobile 32 years ago—I was not at fault. My mother was always concerned about that and I feel like I always have to defend that I wasn't at fault. I was a passenger. I did break my back and throughout these last 32 years, I have required certain pieces of assistive technology. That has afforded me to get to and from work, it's afforded me to walk around work; it's afforded me to fly nearly 100,000 miles a year. Without that, I must tell you I probably would have been in some nursing home in some bed.

Let me just briefly mention that there is a great deal of assistive technology on the market today. I was privileged to have sat on one of the Star Wars panels for quite some time that had but one re-

sponsibility and that was to transfer technology to those of us who require it or need it on the face of our Earth.

One of the things that makes me disabled is not my spinal cord injury; it is gravity. If I'm to have a pair of braces, I can stand up, not unlike braces that one might wear on their teeth—a little bit heavier, I might add—and if I don't require braces, then I require a wheelchair, there are 4,000 different types of wheelchairs today that can be prescribed for a person requiring such a mobility device.

I would offer to you that many of the disabled in this country today no longer have access to that equipment. I think it starts with Social Security in many respects, Medicare, Medicaid, and many of the private insurance companies today are taking note and unfortunately, following the lead. We have horror stories at our hospital where patients are not provided the necessary equipment that could make them independent, could make them productive, could assist them in reintroducing themselves to the worksite. That is of major concern.

Here it is ironic that we have some companies who will pay for a hospital stay in a system such as ours, but refuse to buy any of the discharge equipment necessary to bring about the level of independence we've already taught them they can very easily secure. That is of major, major concern.

We have brought just two pieces of equipment today that we would just briefly like to show you and then I will conclude. Tom Dang behind me I believe is in a wheelchair that is electric but now has a capability of standing. We have brought this to a number of people who require such positions when working. The latest one is a chef. We have placed barbers in such chairs and all too frequently now, the managed care company and the private sector doesn't understand that this is the ticket to someone's productivity for possibly 30 to 40 years. The average age of the spinal cord-injured person is 25 years old. We are living long lives. Thank God. We are living until we're 60 and 70 and there is no reason why we can't invest in some system such as this that will bring us back to a state of productivity.

Patty Pyatek, a speech language pathologist from our hospital, has a device that we're finding terribly important to many disabled people. Patty, do you want to demonstrate that?

Let me just conclude by saying, and again, I'm sorry that I'm missing much of what I wrote, but let me conclude by saying that I think many of us now are beginning to fall between the cracks. We are looking at models, we're looking at the Medicare system, we're looking at Social Security, we're looking at the Medicaid system and all too frequently, we no longer have the devices that can bring us to a state of independence.

Not too long ago, a patient came to my office and said, you know, I wanted to walk like you. I was severed in the lumbar section of the spine, which as a rule means they probably can ambulate, an L-1, L-2 paraplegic. The managed care company said why don't you get the wheelchair. He said, I'm not interested in the wheelchair, I want the braces. He could walk and yet for \$3,500, the company said we're not going to buy it; we will buy the \$1,000 wheelchair, and this person now possibly is going to remain in a

wheelchair for the rest of his life so as to save but \$2,000 for a profit-oriented, managed-care company.

Not too long ago, we had a patient in our hospital, a Federal employee, multiple sclerosis, degeneration of functional abilities, going by the wayside, needed a wheelchair. It took 4 months for the case manager to ascertain whether or not that wheelchair was needed. In the meantime, the person couldn't stay in the hospital, couldn't get around the house and was admitted to a nursing home.

I fear that the more we become profit-oriented in the private sector with HMOs and managed-care companies, the more problems the disabled of our country are going to have.

Thank you, sir.

[The prepared statement of Mr. Eckenhoff follows:]

STATEMENT OF EDWARD A. ECKENHOFF, PRESIDENT AND CHIEF EXECUTIVE OFFICER,
NATIONAL REHABILITATION HOSPITAL

Good morning. My name is Edward Eckenhoff. I am President and CEO of the National Rehabilitation Hospital, a private, not-for-profit medical rehabilitation facility located in Washington, D.C. I appreciate the opportunity to appear before you today to discuss assistive technologies and worksite accommodations that have opened up a world of employment opportunities for people with disabilities. These opportunities need to be taken into account when we consider the future of the Social Security Disability Insurance program. I would also like to share my thoughts on the impact of managed care on medical rehabilitation, and how managed care is likely to frustrate the attempts of people with disabilities to live independently and productively.

When the Americans with Disabilities Act (ADA) was signed into law in 1990 by President Bush, America took a giant step toward recognizing the values and needs of persons with disabilities. The basic principle behind ADA is that disability is a natural part of the human experience. It should, in no way, diminish the fundamental rights of individuals to live independently, work productively, contribute to society, and simply enjoy life.

ADA, in the past five years, has served as a wake-up call to the American public and to policy decision-makers. The fruits of the law can be seen in work places, in medical facilities, in schools, and on the faces of millions of Americans who now, more than ever, can hold their heads high, even if they are seated in a wheelchair or reading your lips.

Along with the ADA, there has been another important development that has dramatically changed the lives of many disabled people. That has been the recent advancement of "assistive technology" which lends physical support to persons with disabilities and helps them to bridge the gap between their physical abilities and their goals. These assistive devices come big and small, but each carries precious significance to a person with a disability.

Wheelchair technology, for example, has undergone a tremendous revolution in the past quarter-century, with wheelchairs becoming more lightweight, stronger, and easier to use. Standing wheelchairs are putting users into an upright position. Artificial limbs, or prostheses, and braces such as the one I wear have seen great advances recently with the introduction of lighter-weight materials. Computer chips are now being used in limb prostheses to allow a much more natural gait for the person with an amputation.

Transportation also has improved greatly for persons with disabilities. Important developments have been made in the adaptation of automobiles and vans through the use of special devices for steering, braking, and acceleration. These advances have greatly improved the ability of persons with disabilities to get from place to place independently. For many of these individuals, technology that allows them to drive again is not a luxury, but a necessity.

And what about the little things that make life so much easier? Simple products that reduce one's dependence on another: stocking aids that allow people who cannot bend over to dress themselves, velcro cuffs that fasten onto shavers, special toothbrushes and hairbrushes that allow grasping for those whose hands and fingers cannot, and "reachers" to extend the reach of someone in a wheelchair.

I'll give you some real-life examples of how assistive technology can restore independence and work productivity. One man we have had the pleasure of helping is a vocational counselor who works to create jobs for disabled and disadvantaged cli-

ents. "Mr. K." has longstanding reduced visual acuity in each eye, secondary to ocular albinism and nystagmus. One of the greatest barriers he faces is reading and completing the paperwork and numerous forms that go along with his job. Through the use of a flatbed scanner and a software program, he now is able to scan books, journals, pictures, and even handwritten letters and reports, and display them on the computer monitor at a magnification from one to 32 times their size. He can also print material for his own use at magnification levels up to 8x. Obviously, these accommodations make a drastic difference in his ability to handle all aspects of a challenging and rewarding job.

Another remarkable example is "Mr. C.," a commissioner of a government agency who has cerebral palsy. Despite his inability to speak, he is able to carry on conversations with the use of one of these PRC Liberators, which we will demonstrate for you. This communication device gives him a synthetic voice that allows him to speak in person and on the telephone, to address conferences as the keynote speaker, and to access his computer faster than any touch-typist can. His achievements are impressive, and largely due to his ability to use a communication device so deftly that tone, inflection, and pauses are all incorporated to create a dynamic presentation.

My third example is a motivated chef who worked at a popular Washington restaurant until the day he was kidnapped and shot, which left him with a permanent spinal cord injury. In a manual wheelchair, "Mr. N." could no longer work in a commercial kitchen. However, when given the opportunity to rise in a standing wheelchair, he had access to all of the pans, spices, and vegetables in the overhead storage or the walk-in freezer. The use of a standing wheelchair gives Mr. N. a number of therapeutic and social benefits, but none are greater than being able to return to his artistry as a chef.

These examples of the successful use of assistive technology are very encouraging, but the sad fact is that two-thirds of those with a work disability do not work. According to a 1993 U.S. Census Bureau survey, nearly 10 percent of the working-age population, or 15.6 million people, report a work disability, and 10.2 million of them are not working. In older people, aged 55-64, nearly 22 percent say they are unable to work because of a disability. The estimated cost to society of this disability-related unemployment is \$150 billion.

Do these people want to remain unemployed? Absolutely not! A 1994 survey taken by the National Organization on Disability and Louis Harris indicates that 79 percent of non-working people with disabilities would like to have a job, up from 66 percent in a 1986 poll. Given the choice, most people do not want to be poor. Yet 40 percent of adults with disabilities today live in households with earnings of \$15,000 or less, compared to 18 percent of able-bodied adults. Only 10 percent of people with disabilities have household incomes of \$50,000 or more, compared to 22 percent of those without disabilities. This gap in income levels has not diminished since 1986.

As my colleague Gerben DeJong has pointed out, a major reason why people with disabilities remain out of the work force is their fear of losing government benefits or insurance payments. The 1994 Harris survey shows that that fear is shared by nearly a third of respondents, while only 18 percent of those surveyed in 1986 cited that as a reason for unemployment.

Clearly, the disability insurance program has not responded to the social and technological changes that have occurred since its original design. When disability insurance began in the 1950s, our economy was based on manufacturing, and it was reasonable to expect that workers with a physical impairment would have difficulty maintaining a job that required physical labor. But with the proliferation of electronic telecommunications and assistive technologies, disability no longer needs to be an impediment to gainful employment. Yet only one out of every 200 disability insurance beneficiaries leaves the program by returning to work. Only about six percent of SSI adult recipients are currently working. They are trapped inside an outdated system that provides work disincentives and flies in the face of both technological advances and the strides made by the Americans With Disabilities Act.

The other issue I would like to discuss today is one that greatly concerns me. It is the failure of our disability insurance system to cover the assistive technology and long-term rehabilitative care that allows people with disabilities to return to the workplace and lead productive lives. Today, most disability insurance beneficiaries are covered by Medicare, and SSI participants are covered under Medicaid—both of which are moving rapidly toward managed care, such as HMOs. These HMOs—including some of the biggest—often do not pay for durable medical equipment such as wheelchairs, prosthetic devices, or worksite accommodations, even when they can restore an individual's ability to work. If there is coverage, it is limited and may include only half the cost of a standard manual wheelchair. Coverage of rehabilita-

tive care is usually limited to 60 to 90 days. There is generally no coverage of vocational therapy services, which contradicts the primary goal of rehabilitation—to return patients to their optimal level of functioning, including returning to work.

You may have heard media reports of Dion Johnson, a local high school football star who broke his neck last year making a tackle. Following Dion's rehabilitation at the National Rehabilitation Hospital, doctors determined that he needed a motorized wheelchair that would allow him to rejoin his public school and pursue normal teenage activities. His family's insurance company would only pay \$8,000 of the \$17,000 price tag of the wheelchair, or would pay for just the frame, not the upper part with the electronic equipment. Rather than compromise Dion's mobility, his parents were forced to pay the \$9,000 difference. Dion is one of the lucky ones, however. Not all insurance companies provide that much coverage—and not all families can afford to pay the expenses the insurers fail to cover.

Stroke patients are another group that is being victimized by the health care system. Strokes are the leading cause of disability in the United States today, affecting half a million people each year. Today, we have the knowledge and skills to rehabilitate stroke patients to a high level of independence, but only a fraction of these individuals receive therapy that could improve their ability to move on communicate normally. That is because our system of managed care has determined that it is more "economical" to place stroke patients in nursing homes.

May I give you some other real-life examples? Without my bracing, I could not stand, nor walk. Yet for 32 years, I've had access to such appliances, and have been independent. Had I not had access to my braces, the only other form of mobility for me would have been a wheelchair. There are managed care companies today that will purchase neither for a spinal cord-injured person such as myself. Without resources, we are literally confined to our bed, unless we want to revert to crawling around our home!

May I remind you that the average age of the newly spinal cord-injured person in our country is 25 years old; 75 percent are males. Most have the ability and desire to work. Yet without assistive equipment, the work site becomes inaccessible and work becomes an impossibility—unless, of course, the disabled person has a cadre of friends who agree to carry the individual to work, as Caesar was once carried.

Or how about the example of an HMO that decided to save money and purchase a wheelchair instead of braces for a patient who could well have walked. The braces cost more, and the company opted for the cheaper approach. To be lowered into a wheelchair—possibility for the rest of someone's life—so as to save one or two thousand dollars is so terribly short-sighted. Yet this is what is happening.

Or how about the example of a lady, a federal employee, I might add, who was diagnosed with multiple sclerosis and suffered a significant decline in functional status. She was seen on September 1, 1993, and required a wheelchair to continue her independence. It took the case manager months to review the need for one piece of equipment. In the meantime, the person was admitted to a nursing home, as she could no longer get around without the new wheelchair.

My last example is beginning to happen frequently. A person may receive an approval for either in-patient rehabilitation care, out-patient care, or the purchase of needed assistive equipment, only to be denied by someone else at a different level in the same managed-care company. Often, the equipment or therapies already have been received, and, because of a retroactive denial by someone else, organizations such as ours are forced to write the entire experience off as bad-debt or free care. What is worse is having to return to the patient's bedside and tell him or her that what was ordered is no longer approved by the insurance company and therefore will not be received. The patient might well call the managed-care company's case manager, who then simply states that the doctor or hospital was the culprit. They made the decision to reverse themselves! Absurd? Yes—yet these and other horror stories are becoming commonplace. A growing number of prepaid managed-care companies pay lip service to quality, but appear to be only interested in costs.

Statistics tell us that seven out of every ten Americans will acquire a disability, either temporary or permanent, in his lifetime. We all drive cars, participate in sports and recreational activities, and run the risk of becoming a victim of violent crime. We are all getting older. The fact is, we no longer can assume that it will never happen to us. I would venture to say that every able-bodied person in this room knows someone with a permanent disability. It really could happen to you or a loved one. And if and when it does, trust me, you are going to want to know that you can get all of the medical, rehabilitative, and financial support that it takes to return to a full, productive life.

We need to make sure that our disability programs take into account the productive capacity of their beneficiaries and concentrate their resources on returning peo-

ple with disabilities to work. Insurers—and now policymakers—need to understand that persons who have disabling conditions require a complex and continuing set of services that extend beyond their immediate illness or injury. Our health care system needs to have provisions for long-term management of chronic illness and disability and for the sponsoring of tools necessary to facilitate a better quality of life for the 43 million Americans with disabilities. We can no longer afford to let insurers overlook long-term benefits to individuals and society so that they can maximize their own short-term profits.

Thank you for this opportunity to share my concerns with you today.

Senator COHEN. Thank you very much, Mr. Eckenhoff.

In other words, you're saying as we move to managed care, your fear is that we will be cutting back on employment of assistive devices that you just mentioned here this morning?

Mr. ECKENHOFF. Absolutely, and my fear is that the Medicare Program is now terribly ripe for HMO delivery as is the Medicaid program. We already have a number of Medicaid recipients around the country that are under managed-care and I just see this ballooning.

Senator COHEN. What would be the cost of the device that was just demonstrated?

Mr. ECKENHOFF. Unfortunately, cost for some of the equipment is high. The cost of that chair is between \$13,000 and \$15,000, although the price has come down. It was a prototype at one point costing about \$20,000, so we are getting the prices down. On the liberator, it's about \$7,000, but frequently these are one-time costs.

Senator COHEN. Well, I think it has to be balanced against if we look at the people who are going on it earlier and earlier ages and staying on their lifetime, I think it averages out to about \$250,000 is probably the average paid out during the course of those who are on disability payments, so when you measure even the \$13,000, the \$20,000 or the \$7,000, these devices are very cost effective looking at the long term as opposed to the short term.

A couple of quick questions. I know we're running late and I will try and be brief. Your full statements will be included in the record.

Ms. Weaver, there has been testimony about whenever there is high unemployment, we see a corresponding jump in the disability rolls. Do we ever see when the employment improves, a reduction in those disability rolls?

Ms. WEAVER. Good question. I wish I had some data in front of me. I do know that the unemployment rate frequently is used as an excuse for why award rates are going up. In the last 5 or 10 years, award rates have been rising because allowance rates have been rising. More people are being granted benefits through thick and thin times. There has been an administrative loosening of the system.

Administrative law judges are reversing substantially over half the cases that they hear. Again this is through thick and thin. The surge in the benefit rolls preceded the rising unemployment rate during the most recent recession by at least 2 or 3 years.

Senator COHEN. Obviously, if someone loses their job, they can no longer produce an income, there's got to be a great deal of stress within that family structure. Stress is now being cited as one of the factors that allows people to qualify for benefits.

The question I would have is if the stress is removed or if the job employment picture improves, one, should that be in fact a qualification factor, stress alone, its severity being to such a degree that a person can't function? I must tell you I've seen people who are on disability rolls by virtue of stress who are fully capable of working and do not return to work, and have virtually a lifetime guarantee.

Dr. Satel, Senator Santorum was raising the issue of treatment. You recommend treatment as opposed to cash benefits or using the money for treatment. Is there, in fact, a shortage of treatment facilities in the country for those who are addicted to alcohol and drugs?

Dr. SATEL. Yes. There are only about 12,000 residential beds. So there is a great deficit in that particular kind of care. Most care is outpatient, clinic-based. That is insufficient for these kinds of individuals.

Senator COHEN. Do you think the changes in the law passed last year at least appear promising in terms of dealing with this issue?

Dr. SATEL. I think they will go far to weed out whatever segment of the applicant pool was sort of gaming or really not that committed to recovery. By that, I'm referring to the four provisions—pro-rating the benefit so people don't get one huge lump sum up front; having a responsible payee, preferably an institutional payee—I understand individuals now can have access but individual payees although I think the institutional payee is a better idea; also the treatment requirement I think will dissuade some people from applying if, again, they are not sincere about improving. Finally, the time limit may discourage applicants. So those will help, I believe.

Senator COHEN. Dr. DeJong, the fear of losing medical benefits, is that one of the factors that discourages people from moving off the disability rolls? Is that something we really have to look at?

Mr. DEJONG. Yes, and I think it's a very important consideration because sometimes the value of the Medicare or Medicaid benefit to a person with a disability is greater than the value of the income benefit because a person with the disability uses more health care services and has more to lose when they lose their health benefits.

We have, over the last decade and a half, tried to ameliorate that situation to a certain extent by enabling a person to retain a certain measure of their Medicare and Medicaid benefits when they do return to work. The problem is there are usually time limits associated with that, number one. Number two, I think many people with disabilities just don't trust the Government to hold up to its part of the bargain when they return to work. I think it's not just the health benefit itself but also, as we noted earlier, some people have ongoing needs for other kinds of assistance that are customarily paid for through our health insurance system or health benefit system and people just don't want to lose eligibility for these things.

Senator COHEN. We have a situation where, according to the GAO, the Social Security Administration doesn't place a high priority in terms of getting people off the rolls back into the work force. Vocational rehab doesn't seem to have either a high priority or a very large success rate.

Have you made any other study of other nations in terms of how they cope with this situation and what kind of programs they have?

Mr. DEJONG. Yes, I have. In 1984, I was a Fulbright scholar in the Netherlands working with the Social Security Council and their research staff and looked at the disability programs there. There is an example of a country we would not want to emulate because of the tremendous growth in the disability programs there.

For the people who are most severely-impaired, that is people with severe physical impairments, there are some remarkable programs. These assisted technologies are financed independent of the health care system and independent of the social services or income system. In fact, there is a kind of separate, independent authority for the financing of this kind of a service. I think we may wish to look at that.

I think the other difficulty with the program in the Netherlands is that in our country we must be considered fairly, completely or as we say, totally disabled sometimes. In the Netherlands, they have a system where with only "15 percent disability" you can get on the system, but soon 15 percent becomes 30 percent, becomes 60 percent becomes 80 percent which 10 qualifies you for 100 percent of benefits. I don't think we want to model that.

Very often I think people are critical of our system because it's an either-or proposition, you're either on or you're off and rather than having kind of a partial disability income system, and I would really caution anyone moving toward a partial disability income system because I think it's fraught with problems and difficult to administer.

Senator COHEN. Senator Santorum.

Senator SANTORUM. Thank you, Mr. Chairman.

Ms. Weaver, you mentioned with the DI Program, your recommendation would be that we do some things for employers to keep people in the workforce, get them before they leave the workforce as a way of keeping people off the disability rolls. You didn't provide any ideas for SSI, this was more for DI. What about SSI? What's the trick there?

Ms. WEAVER. Yes, I was referring mainly to DI because of the population it serves, working age people, middle age and older, with substantial work records. In SSI, many recipients are younger people who may never have entered the work force.

Avoiding policies that arise the cost of hiring low-skilled, severely impaired people is critical, but it may well be that subsidies for first-time employment would be appropriate, something that helps these people get into the labor market that first time. The job skills that can be gained in the first job, any first job, can be extremely valuable. If the Government can help that transition to the first time job, I think that could make a lot of sense.

Senator SANTORUM. You also talked about time-limited benefits. As you know, we're time-limiting benefits now for DA&A and the question I have is, are you suggesting we should time limit benefits for others?

Ms. WEAVER. No, in the same way. What I have in mind is that when people come in and file for benefits, they understand that benefits are not granted for life just because SSA historically has chosen not to reevaluate eligibility. Everyone would come in with

an understanding that benefits last for, say, 3 years, and that they are expected to be working on recovery, rehabilitation, whatever, and be back to work at the end of that. A person could refile at the end of that period and be reevaluated for another time-limited benefit.

Under this approach, people would be reevaluated under the standards at the time, rather than under the cumbersome medical improvement standard. This standard, put in the law to protect people who had been on the rolls many years, expecting that benefits would continue, is preventing people from being removed from the rolls who are not qualified, because of the impractical problems of developing a legally defensible case that improvement has taken place. It's very hard to look back at a record, particularly for the many people with mental impairments, and look at another record today and say, is it better or worse? It's a different set of words characterizing behavior. With a 3-year term, expectations would be very different and a new decision would be perfectly reasonable. So this would be very different than the kind of thing you have in mind, where you're off the rolls in 3 years. This would be a requirement that you reapply at the end of the period if you wish to be considered for further benefits.

Senator SANTORUM. Automatic review.

Ms. WEAVER. Would you mind if I make one point that in speeding through my testimony, I didn't have the opportunity to make. I know the issue of SSI for kids is not the focus of this hearing but it's certainly a big issue on the House side and will be as the legislation moves over here.

I can't underscore enough how important I think it is to address the children's issue within the context of welfare reform. The benefits are so high in relation to AFDC, there are no marginal reductions for extra kids, no family cap on benefits. A typical AFDC family with two kids can go from making \$72 a month to \$458 a month for one of the children by getting him qualified for SSI. It creates enormous disparities in the well-being of poor families and creates other problems as well. If you fail to deal with this now, I believe that SSI will become the escape hatch for families that fall off the reformed AFDC Program.

Senator SANTORUM. I agree with you.

Dr. Satel, let me sort of reiterate or maybe ask in a different way the Chairman's question with respect to treatment and the availability of treatment. We provided a provision in the DA&A reforms that if treatment isn't available, that we stop counting the months as to your eligibility. That was because there is this dearth of treatment availability.

If we do what you suggest which is to turn it into a treatment voucher program instead of a cash assistance program, do we not in a sense solve the treatment availability problem? If the money is there, it's not like there's a big block and there's this wall that stops people from setting up treatment centers. The reason treatment centers aren't there is because the money isn't there to pay for these treatment centers to be there.

If we set up a system which creates the pool of money for those treatment centers to be able to survive, then we've solved the problem?

Dr. SATEL. I would agree. A treatment benefit superimposes the need for that treatment upon the need for the basics of living, in other words, housing, food, shelter, those kinds of things, yes. One thing though I would be cautious about is a literal voucher system. I wouldn't give anybody a little voucher in their hands. We've got enough unscrupulous, fly-by-night kinds of treatment programs springing up. You'd want to filter it, I would think, through the State and they could have their accountability and reporting system choose the kinds of programs that they feel are most responsible.

Senator SANTORUM. You were here when Mr. Cote testified about Medicaid using these as hotels. What is the danger there? Is there a danger there?

Dr. SATEL. Again, this kind of arrangement would obviate the need for seeking out a detox bed just so you could have a place to sleep but two other thoughts. One is I'd be suspicious about Medicaid paying for any free-standing detox. I worked in a hospital where it was literally a revolving door, always leading back in because free-standing detox that is not attached to a treatment program is a way to spend the night. For heroin addicts, about 10 days in detox is a way to cheapen your habit. As you know, you spend a few days detoxing, you go out and you could use less heroin and get the same effect. It's really a dysfunctional arrangement. So just as a separate issue, I think free-standing detox is not something we should be in the habit of sustaining anyway.

As an aside, these still are destitute individuals, poor people. I still think they should have Medicaid available to them for medical problems. They are also a medically-ill population. They usually do well with some medical treatment, but when you take these people in off the street, you find often some serious infections and those kinds of problems.

Senator SANTORUM. Should there be a limitation on treatment or should treatment be available?

Dr. SATEL. I'd like to think that if we have the kind of treatment programs available that someone like Mr. Cote runs, that they will be self-limiting. They will do good work and gradually reintroduce people to the work force and to the community. Remember, some of them have never worked, being addicted since you were aged 15 is a long resocialization process. That's really what the treatment should be, should be resocialization and vocational.

There is also a kind of mechanism called supported employment. This has been used more for the severely mentally ill where instead of Medicaid paying for these individuals to be in a day hospital all day, Medicaid pays for a job coach and they have a sheltered kind of employment. I know that can work very well for some people and so often, work is therapy.

Senator SANTORUM. Thank you.

One final question for Mr. Eckenhoff and that is, you talked about equipment. One of the things we had worked on, and I had worked with some of the House guys on the kids program and how we're going to reform that, if we do in fact drop people off the rolls, which I believe we will, taking some of that money, obviously not all of it but some of that money and the idea now is to use it for

a block grant to the States to help the more severely disabled to go back into the mainstream of life, that kind of stuff which is fine.

I had originally offered the idea of why can't we set this as sort of an account or some sort of system available. Representative Kleczka and I had talked about this Medicaid-plus program which would be for exactly the kinds of things we talked about, sort of an assisted living—an account that can be drawn upon for the individual. The problem we confronted was the administrative overhead costs of doing this kind of program would be very, very severe.

You mentioned I think the way the Netherlands sets up their own separate program. Do you have any ideas or thoughts? Is it better to just give it to the States and have them sort of work with the individual to see what money could be available to help with assisted technology or do you think it's better to try to create some sort of entitlement to these programs individually?

Mr. ECKENHOFF. I'm not so sure entitlement works. To me, entitlement has gotten to a point where it's sort of a bad word. I think there are a number of different routes one could go I think even by looking at systems such as ours. I think that might well work.

We're expected to provide a great deal of free care today. We're expected to provide a lot of bad debt today. We're in the business, our hospital is about a \$100 million a year system, so to heck with how much you might make or might not make, we have the capacity to writeoff a lot of expenses and we're beginning to do that.

My suspicion might be, and I'd have to think about it and study it, but were we to have a grant such as that, were other rehabilitation systems to have grants such as that, we are a center where many of the physically disabled will come first and foremost. We are even being expected to be primary care physician, primary care organization now to the disabled population, so that might work.

We have a grant, for example, from I think it's the Department of Education which is a Tech Act grant, here for only the residents of the District of Columbia but is something similar to what you've asked and we are beginning to dole out equipment that otherwise probably would never have been received by these recipients.

I would love to study that with you and to come up with some good solutions.

Senator SANTORUM. Please do.

Thank you.

Senator COHEN. Let me thank all of you for coming forward to testify this morning with just one final comment. While we may shift to greater treatment emphasis, we have to be ever diligent in terms of looking at that treatment because we may have another rise in health care fraud through the establishment of phoney clinics as well. So that's something we have to look at.

Thank all of you. Your full statements will be included in the record and we will follow up with you with individual questions from this point on.

Our last witness today is Ann DeWitt, Director of the Maine Disability Determination Services. Ms. DeWitt has made a number of very insightful observations over the years on how we might improve our disability process. I know you have gone through travel

contortions in order to be here and I appreciate your rearranging your schedule to be with us this morning. Please proceed.

STATEMENT OF ANN DeWITT, DIRECTOR, MAINE DISABILITY DETERMINATION SERVICES

Ms. DEWITT. Senator Cohen, my name is Ann DeWitt. I am the Director of the Maine Disability Determination Services Agency. I have worked with Social Security disability claims for 25 years. I wish to thank you and your committee associates for allowing me to speak on the Social Security Disability Program.

This past year has brought specific problems into public view with press and television accounts of unsupervised disability payments to addicts, disability payments to children with behavior problems, and disability payments to immigrants who come to this country with sponsors.

The current national controversy has caused local problems for us. When our agency allows childhood claims with attention deficit disorder as directed by current Social Security rules, we are brought into conflict with special education teachers who believe undermine their efforts to help children be capable, productive citizens. Some of these teachers believe parents who contribute to the child's problems are rewarded with checks.

These media accounts that we've all described today, while alarming, do not address a serious, underlying malfunction of the disability system viewed as a whole. The fact is that State decisionmakers, such as examiners and physicians in the Maine State Agency use medical, objective standards when deciding individual disability claims at the initial and reconsideration levels. In the States, doctors decide what effect a medically-determined impairment has on a claimant's remaining functional abilities. These State decisions are subjected to rigorous Federal quality review. Most States make the correct decision, 96 percent of the time according to Federal reports. Cases found to be in error are sent back to us for correction.

When a claim is appealed to a Federal administrative law judge, subjective, legalistic standards are used to determine individual disability claims. Judges or staff attorneys, not doctors, make the critical judgment regarding what effect a medically-determined impairment has on a claimant's remaining ability to function. Administrative law judge decisions are not subjected to quality review.

The result of the more liberal review on appeal is that about 1,300 beneficiaries who would not receive benefits under State standards are added to the Maine disability rolls each year. This number may seem unimportant when compared to the 47,000 beneficiaries currently receiving monthly checks in Maine.

The trend, however is upward, as you have heard many times today. Maine experienced a 55-percent increase in SSI disability claims between 1991 and 1994. With more claimants applying and more subjective standards in use, the trend will be for more people to be on the disability rolls nationwide.

Another result of the increased volume of applications is that States are unable to undertake continuing disability reviews and to stop benefits to people who have improved. Thousands of claims

are awaiting review because States are too busy doing initial claims.

Administrative law judges overturn about 70 percent of claims denied at the State reconsideration level. These reversal rates are seen by most onlookers as evidence of problems with State decisionmaking. The truth is that States have always acted as unwilling screens. Our disability programs lack a goal, both a program for those who earned coverage under Social Security and the program for those of low income and resources suffer from the same systemic problem. As claims go to higher levels of appeal, more liberal standards are applied. Each level should have the same standards.

If Congress wants more citizens on the disability rolls, then States should be given the ability to have State workers decide what effect a medically-determined impairment has on functional ability and State decisions should have less quality review. If, on the other hand, Congress wants fewer citizens on the disability rolls, then administrative law judges should be required to use physicians to make medical judgments about functional abilities and administrative law judge decisions should have quality review.

The national redesign of the disability program that is now underway does not adequately address the aforementioned problem. A troubling aspect of the current Federal design project from a State perspective is that the membership of the Redesign Task Teams include few State decisionmakers. The people whose jobs are most heavily affected by the redesign are proportionately the least involved.

My greatest concern is for the future. If the systemic Social Security disability program problems are not addressed, there may well be no money left for even the most severely disabled citizens in the 21st Century.

Again, I thank you for allowing me to testify.

[The prepared statement of Ms. DeWitt follows:]

STATEMENT OF ANN DEWITT, DIRECTOR, MAINE DISABILITY DETERMINATION SERVICES

My name is Ann DeWitt. I am the Director of the Maine Disability Determination Services agency. I have worked with Social Security Disability claims for 25 years. I wish to thank this committee for the opportunity to speak about the current problems in the Social Security Disability Program.

This past year has brought specific program problems into public view with press and television accounts of unsupervised disability payments to addicts, disability payments to children with behavior problems and disability payments to immigrants who came to this country with sponsors. When our agency allows childhood claims with attention deficit disorder as directed by current Social Security rules we are brought into conflict with special education teachers who believe we undermine their efforts to help the children be capable, productive citizens. Some of these teachers believe parents who contribute to the child's problems are rewarded with checks.

These media accounts while alarming do not address a serious underlying malfunction of the disability system viewed as a whole. The fact is that state decisionmakers (such as examiners and physicians in the Maine State agency) use *medical, objective* standards when deciding individual disability claims at the initial and reconsideration levels. In the states, doctors decide what effect a medically determined impairment has on a claimant's remaining functional abilities. These state decisions are subjected to rigorous federal quality review. Most states make the correct decision 96% of the time according to federal reports. Cases found to be in error are sent back to states for correction.

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Administrative Law Judge decisions are not subjected to quality review. The result of the more liberal review on appeal is that about 1,300 beneficiaries who would not receive benefits under state standards are added to the Maine disability rolls each year. This number may seem unimportant when compared to the 47,000 beneficiaries currently receiving monthly checks. The trend, however, is upward. Maine experienced a 55% increase in SSI disability claims between 1991-1994. With more claimants applying and more subjective standards in use, the trend will be for more people to be on the disability rolls nationwide. Another result of the increased volume of applications is that states are unable to undertake continuing disability reviews and to stop benefits to people who have improved. Thousands of claims are awaiting review because states are too busy with initial claims. Administrative Law Judges overturn about 70% of claims denied at the state reconsideration level. These reversal rates are seen by most onlookers as evidence of problems with state decision-making. The truth is that states have always acted as unwilling screens.

Our disability programs lack a goal. Both the program for those who earned coverage under Social Security and the program for those of low income and resources suffer from the same systemic problem. As claims go to higher levels of appeal more liberal standards are applied. Each level should have the same standards. If congress wants more citizens on the disability rolls then states should be given the ability to have state workers decide what effect a medically determined impairment has on functional ability and state decisions should have much less quality review. If on the other hand congress wants fewer citizens on the disability rolls, then Administrative Law Judges should be required to use physicians to make medical judgments about functional abilities and Administrative Law Judge decisions should have quality review.

The national redesign of the disability program that is now underway does not adequately address the forementioned problems. A troubling aspect of the current federal redesign project from a state perspective is that the memberships of the redesign task teams include few state decision-makers. The people whose jobs are most heavily affected by redesign are proportionally the least involved.

My greatest concern is for the future. If the systemic Social Security disability program problems are not addressed there may well be no money left for even the most disabled citizens in the 21st century.

Again, thank you for allowing me to appear and speak on this very important public issue.

Senator COHEN. Thank you very much, Ms. DeWitt.

You've heard a number of allegations made about the children's disability program and since the *Zebley* decision, I want to know have you seen any evidence in your position of parents who are coaching their children or abusing them in order to qualify for disability under the SSI Program?

Ms. DEWITT. I've seen a problem in the community that seeks these benefits in that it becomes common knowledge that this is a good way to earn a little extra money. I know that may sound harsh, but my sister works with the Head Start Program and in that community, they say, why don't you get your child on disability, we've got to pay the rent, we've got to pay this, we've got that, and the worst example is one that I know personally of somebody who is alcoholic and who does not give the money they get for the child to benefit the child. I just know that personally. That's just anecdotal.

Senator COHEN. But you think there is at least some evidence beyond the anecdotal stage where people, low income or otherwise, who might see a benefit in having their child coached to either act out to show this attention deprivation disorder or do you see examples of abuse?

Ms. DEWITT. I only hear from the special education. They believe that is true. They have told me—this is secondhand, that's why I'm

being a bit evasive, but I'm told every week of how much trouble we're causing them because they believe, many of the special education teachers, that there is coaching going on.

Senator COHEN. The teachers believe there is coaching going on?

Ms. DEWITT. Yes, they do, and they think the trouble is that we give money to the families and undermine their efforts to help make the child be productive and that the family doesn't even use the benefit for glasses or, in an emotional case, for counseling.

Senator COHEN. Do they talk about any evidence of physical abuse? We've heard some pretty dramatic horror stories about abuse?

Ms. DEWITT. More neglect, a great deal of neglect. People simply need parenting courses. The money could very well go for parenting courses in my view. I personally know of many instances where neglect is rampant.

Senator COHEN. So basically the payments are going to?

Ms. DEWITT. To the parents who are neglecting the children.

Senator COHEN. And the children are going to these classes and the teachers are trying to cope with a problem which is being contradicted or undermined by the parents at home?

Ms. DEWITT. That's right.

Senator COHEN. My understanding is there is very little oversight taking place by anybody on this?

Ms. DEWITT. None.

Senator COHEN. None.

Ms. DEWITT. My point I would make is that it hurts the child for whom the benefits were originally granted.

Senator COHEN. You also were critical about the national redesign of the disability programs. What are the flaws you think were not dealt with by this redesign program?

Ms. DEWITT. It's an ongoing program, as you know. The problem is they didn't decide what they wanted to do and they did not include the States in any significant way. Every report you read says they did, but they did not. The only true State representative was somebody who hasn't done cases for years. None of the people who actually do cases were involved. I tried to get one of my supervisors to be on the most important panel which deals with the medical involvement. He's a line worker and a supervisor, and finally, the system ended up taking a doctor who is going to have a different outlook, and there are no line workers on that committee.

Senator COHEN. What kind of authority do you have in terms of reviewing these cases? Does the Social Security Administration give you any authority to speak of to conduct these kinds of reviews?

Ms. DEWITT. No. We do what we're told. For instance, we all are aware that the continuing disability reviews are way overdue, but they don't come to us. We can't do cases that don't come to us.

Senator COHEN. As I pointed out, there is a backlog in those cases of about 1,800,000 right now. They are increasing every year at a rate of 500,000. The Social Security Administration I think has set a goal of doing 250,000 reviews but no effort is made to deal with the backlog at all and no reviews at all at the SSI level.

Ms. DEWITT. I'm very concerned about the continuing disability reviews. Some of my colleagues in New England, my peers, have

told me that their caseloads are dropping; they are afraid they are going to have to let people go who have taken 2 years in training. These people could productively be used to do the continuing disability reviews that are way over time.

Senator COHEN. Does your office get any encouragement at all from SSA to report examples of fraud?

Ms. DEWITT. None.

Senator COHEN. That's something you think we should turn our attention to?

Ms. DEWITT. Yes.

Senator COHEN. Those are all the questions I have. I want to thank you very much, especially for your making an extraordinary effort to be here, through the snow and ice. I don't know how many inches they finally accumulated up in Maine, but at least a foot or more not to mention the ice, so we really do appreciate your coming down here for this event.

Ms. DEWITT. Thank you for having me.

Senator COHEN. The Committee will now stand adjourned.

[Whereupon, at 12:40 p.m., the Committee was adjourned, to reconvene at the call of the Chair.]

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