

**RISING COSTS OF SOCIAL SECURITY'S
DISABILITY PROGRAMS**

HEARING
BEFORE THE
SUBCOMMITTEE ON
SOCIAL SECURITY AND FAMILY POLICY
OF THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

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MARCH 22, 1995
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RIISING COSTS OF SOCIAL SECURITY'S DISABILITY PROGRAMS

WEDNESDAY, MARCH 22, 1995

U.S. SENATE,
SUBCOMMITTEE ON SOCIAL SECURITY
AND FAMILY POLICY,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:04 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Alan K. Simpson (chairman of the subcommittee) presiding.

Also present: Senators Nickles and Conrad.

OPENING STATEMENT OF HON. ALAN K. SIMPSON, A U.S. SENATOR FROM WYOMING, CHAIRMAN OF THE SUBCOMMITTEE

Senator SIMPSON. Well, thank you. The hearing will come to order. Sorry for the tardiness there on my part. Not unknown, but unexplained. No, that is not right.

Anyway, we have a hearing this morning in the Subcommittee on Social Security and Family Policy for the purpose of considering issues and options relating to the soaring costs of the Social Security Administration's two disability programs, Social Security Disability Insurance, and Supplemental Security Income.

I think I shall reserve the balance of my opening remarks so that we might proceed with the schedule of my colleagues, Senator Cohen and Senator Santorum.

Knowing how this place works more intimately than many others, and I appreciate all of you, if you will bear with me, we will have the remarks of Senator Cohen and Senator Santorum, and they may leave if they wish, or, of course, stay here for the entire morning. I know that they might wish to do that, and it will be great if you do.

Then I will get right on to the three fine witnesses. And Jim Slattery. We should take care of you, too, Jim.

Mr. SLATTERY. You do not need to take care of me, Mr. Chairman.

Senator SIMPSON. All right. Bill Cohen, my old friend, and a man who came to the Senate when I did.

[The prepared statement of Senator Simpson appears in the appendix.]

**STATEMENT OF HON. WILLIAM S. COHEN, A U.S. SENATOR
FROM MAINE**

Senator COHEN. Thank you very much, Mr. Chairman. First of all, let me say that I am pleased to be here, and that the committee is looking at the SSI program and the Disability Insurance program as part of the entitlement reform process.

First of all, there is some irony, I think, that many of us in the Senate and the House are declaring Social Security to be off-limits for any sort of reductions or changes, but at the same time we have ignored what is really eating away at the foundation of the Social Security system, and that is the Disability Insurance program.

Both the SSI and the Disability Insurance program are among the fastest growing in the Federal Government. Just over the past decade we have seen the rolls grow for those under the age of 65 who are on DI or SSI from 4.2 million to seven million, representing an increase of almost 70 percent.

The Social Security Administration sends out roughly \$1 billion a week, and I think what is most striking is not only the figure, but the fact that there is very little in the way of oversight in terms of how these dollars are being spent.

When we talk about abuses that are fairly patent, we look to the drug addiction and the alcoholics who are receiving Disability Insurance payments.

Last year and the year before, the Aging Committee found that the word on the street was that the SSI benefits were an easy source of cash, and the message of the disability programs has been, if you are an addict or an alcoholic, the money is going to keep flowing as long as you are addicted, if you get off the addiction the money stops.

So, rather than having a policy that encouraged rehabilitation and treatment, we were actually helping to perpetuate that addiction and dependency.

I will give you an example. Just a couple of weeks ago Senator Santorum and I were attending the Aging Committee hearing. Mr. Bob Cote, who is the director of a homeless shelter in Denver, testified that he personally knew of 46 addicts who had died from drug overdoses from the drugs that they bought with SSI checks.

He went on to testify that a liquor store just down the street from his shelter was a representative payee for over \$200,000 in SSI payments, and a bar just two doors down from the shelter was a representative payee for \$160,000 in SSI checks. I think the taxpayers were justifiably outraged to learn of this particular abuse.

Now, last year we made a change in the law. We mandated that all people receiving disability benefits due to alcohol or drug abuse must receive treatment. We imposed a 3-year cut-off for the benefits for addicts and alcoholics, and we toughened up the representative payee rules in order to get the cash out of the hands of the addicts. I think that there is still room for adjustment of the changes that were made, but at least it was the first major step that we have taken.

I would like to point out that the abuse is not confined to drug addicts or alcoholics. There are many who are feeding off this particular system. For example, we have testimony of translators and other middle men who coach immigrants to feign mental impair-

ments and other disabilities in order to qualify for benefits. There are fraudulent doctors who submit false medical evidence to qualify claimants for SSI and Disability Insurance benefits.

There are parents. Mr. Slattery and others may testify about the allegations—at this point they are mere allegations—that some parents are actually coaching their children to feign mental impairments and to encourage behavioral problems in order to qualify for SSI status.

There are even States who have tapped into this particular system, Mr. Chairman. Let me point out that a number of States have developed very aggressive programs which use hired consultants to find ways to get people off their welfare rolls onto the disability rolls.

There is one State that has shaved about \$55 million from the State budget by paying contractors to shift welfare recipients onto the Federal rolls, which translates to nearly 15,400 recipients who enrolled in SSI instead of State assistance during the last fiscal year.

These cost shifting techniques, again, are brought about by the hiring of disability consultants, and they are paid on a per capita basis for every person they move off the State books onto the Federal books.

There is a major problem with the disability programs in that they do little to really monitor what goes on once you qualify. In fact, those who get on the disability rolls rarely come off.

If you look at the statistical average, about one out of every thousand who get on the disability rolls are ever moved off those disability rolls, and that is primarily because the focus has not been on rehabilitation, but rather on simply having an outreach program to reach those people who might qualify.

It seems to me to be inconsistent, on the one hand, to have an Americans With Disability Act that we passed and supported, to encourage those who suffer from disabilities to get into the work force, and yet have another Federal program that encourages people to stay out of the workplace.

So it seems to me what our goal ought to be, to protect the truly needy, that we, in fact, ought to make changes that encourage more continuing disability reviews. This is something that will be very cost-effective.

It costs roughly \$1,000 to conduct a disability review. That will pay off handsomely in view of the fact that once you are on disability the average lifetime payment that goes out to that person receiving disability is about \$225,000.

So, I think what we have to do is place less emphasis on the outreach program, more on work incentive programs and vocational rehabilitation. There are other recommendations that I have in my prepared statement, but just let me, in the closing moments here, relate a story of a woman who testified before our committee a couple of weeks ago, Mrs. Mary Jane Owen. She is blind. She is hearing impaired. She has lost the sensitivity in her fingertips so she cannot read by braille. She is in a wheelchair and she was on SSI. She had developed a business plan to establish her own consulting firm.

When she went to the Social Security Administration to seek assistance so that she might accumulate \$5,000 under the so-called Pass Program so that she might start her own consulting business in order to acquire a lap-top computer—one that she could talk to, since she could not type—she was refused this assistance. In fact, she was made to feel that she should remain on the disability rolls.

Back in 1989, she decided she did not want disability payments any longer, and so advised the Social Security Administration in 1989, but the checks kept coming. She refused to cash those checks, and I think in rather significant and symbolic testimony before the committee, she presented me with a total of \$16,000 in checks that have continued to come to her, even though she wanted no assistance from the Social Security Administration. She said for me to do with these checks what I saw fit. Well, I did not go to the local bank, or forge her signature.

But I thought it would be important and symbolic, and not to overdramatize the moment, since we have the Commissioner here today, to present these checks that were sent to Mary Jane Owen many years after she insisted—I do not want the checks, I do not need the checks anymore—but the checks kept coming.

So, she wanted me to dispose of them appropriately, and I am doing so by handing you \$16,000 worth of checks that you can put back in Social Security.

Thank you very much, Mr. Chairman. If you have any questions, I will be happy to answer them. I will not be able to stay for the entire hearing. I will listen to a couple of more witnesses, and move on.

[The prepared statement of Senator Cohen appears in the appendix.]

Senator SIMPSON. Dr. Chater, you will have the opportunity to receive the checks in a more formal manner when you have your remarks. That was very dramatic, indeed. I enjoy serving on the Select Committee on Aging with you as our Chairman, Senator Cohen. You have presented us a dramatic situation and we appreciate it. Feel free to leave at any time you may wish.

Now our good colleague from Pennsylvania, and new member of the Senate, and a fine, contributing member that we are enjoying very much, Senator Santorum.

STATEMENT OF HON. RICK SANTORUM, A U.S. SENATOR FROM PENNSYLVANIA

Senator SANTORUM. Thank you, Mr. Chairman. I appreciate the opportunity to testify before your committee on a subject area that I worked on very diligently as a member of the House Ways and Means Subcommittee on Human Resources last year in putting forward proposals that are now actually in the bill on the House floor, working with Congressman McCrery and Jerry Kleczka, a Democrat from Wisconsin.

It has been a bipartisan effort, and I hope that that continues over here in the Senate, to deal with what I believe is one of the most serious problem areas in Federal welfare policy.

You are going to hear a lot of testimony about the increases in SSI and the dramatic increases in the number of enrollees and the amount of money spent. We have provided for the committee some

graphs from the Green Book that show the amount of money, and just since 1989, almost doubling in SSI, and the number of recipients just skyrocketing.

What I want to focus on is not the program in general, but a couple of specific programs. I think Senator Cohen did an excellent job in going over the DA&A program, and talking about the problems with the program shifting from the State to the Federal level.

In fact, we have had State legislators call us just outraged at what their State is doing, saying, I cannot believe we are out there recruiting people to get out of our programs and, in many ways, getting people to do and say things that they would not otherwise say and do just to get money back to the State coffers and from the Federal coffers.

So, I think Senator Cohen has hit the nail on the head there. I would like to leave a place marker here for us to come back because we are doing a fair amount of research with some of our State legislators in Pennsylvania to look at just that issue.

I think Senator Cohen is also right on the Continuing Disability Review problem. If I can make a comment on that. He is right, they are cost-effective, but they are not cost-effective for the Social Security Administration. The reason is because the way we budget the Social Security Administration.

If you do a CDR, if you are the Social Security Administrator, that comes out of your appropriated account. That comes out of money that you get appropriated. But if you save money through the CDR, that comes out of the pay-go account, so you use appropriated funds to save money on the entitlement side.

So the Social Security Administration has no incentive to go out and save that money because it just costs them administrative funds and they do not get to realize any of the savings.

I think if we are going to seriously address this issue to, in fact, encourage them to do that, is to possibly give them a percentage of the savings toward their administrative budget so they have some incentive to go out and do these.

I know it is costly. We have had discussions, and Senator Cohen was involved, as he mentioned, last year in enforcing the Social Security Administration to do more Continuing Disability Reviews, which they are doing. But I think it is just the tip of the iceberg, and it is a very serious problem and I hope we and this committee can work to try to resolve that.

The two programs I wanted to focus on today within SSI are the SSI for Children's program, and the SSI Program for Legal Non-Citizens.

With respect to the SSI for kids program, if I told this committee that we were going to propose a bill that would double the number of children on SSI when it is fully phased in in 1997, from 1989 to 1997, we would double the number of children on SSI and provide up to \$4,000 per child more in benefits, I would suspect the Chairman and the other members of this committee would say, no way, we cannot afford to do that, this is ridiculous. I mean, you are going to blow the bank.

The fact of the matter is, that is exactly what the House Republican bill does, it doubles the number of children on SSI and increases their benefits up to \$4,000 per child. It is being roundly

criticized for one simple reason, and that is that already the number of children on SSI from 1989 has tripled.

One of the principle reasons for that is the *Zebley* decision in 1991, which created the standard of Individual Functional Assessments for children, which has resulted, I think, in one of the most damaging things that we have ever seen to the Disability cause in this country, because we have seen marginal people, people who frankly do not meet the standard of what most of us would see as being disabled, be put on this program, and the number is skyrocketing.

We had testimony in the House that I reviewed that had a principal come in and talk about how 50 percent of the children in his school applied for SSI. 50 percent of the children. What are we doing? We are creating a system of children who believe that disability is the way to seek some sort of independence. It is not. It is not. Senator Cohen is absolutely right. We passed the Americans with Disability Act so we can empower people, not bring them into the system.

So, I think that this standard has to be changed, and the House bill does that. It eliminates the Individual Functional Assessment, overturns the *Zebley* decision.

Senator NICKLES. What decision?

Senator SANTORUM. The *Zebley* decision. It was a Supreme Court case in 1991. We think that is the most important thing to do to reduce the rolls. In fact, the House bill would drop all those people off the rolls and use some of the savings as a block grant to the States to, in fact, better serve the people who qualified for disability under the traditional standard of disability that I think is a very acceptable one to everyone. We think that is targeting the benefits to those who need it most, and it is a very humane way of dealing with the situation.

I have examples, and we have provided them just to the committee. This is from someone who is working in the SSI system, someone who provided these examples to us on the condition of anonymity, and, in fact, scrubbed them so no names are used. We provide them to the committee just to show you a situation that is really deteriorating out there that has money—

Remember, when you have a child who is in a dysfunctional home because of abuse and as a result gets qualified under these Individual Functional Assessments as being disabled, as all these cases will show you, the check that that child receives does not go to the child, it goes to the abusive parent, in many cases.

There is case, after case, after case here where you are just rewarding behavior of parents that is simply deplorable. I hope that this committee will look upon this as not an attack on the disabled, but truly trying to empower the people who have disabilities at the expense of folks who simply should not be on the system in the first place.

Finally, with respect to legal non-citizens, the provision in the House bill, both the Republican and what is called the mainstream Democrat bill, eliminates cash assistance for non-citizens.

I would suggest that this is an appropriate measure for a couple of reasons. Number one, I think principally, as Senator Simpson knows, who is very close to the immigration policy in this country,

we have not seen a dramatic increase in the number of legal immigrants in this country.

But, if you look at the number of legal immigrants who are receiving SSI in the last chart in your folder, it went from, in 1982, about 100,000 to today, almost 800,000. There is a problem here. What we believe is we have to look very carefully at how we are allocating benefits to legal immigrants. The suggestion in the House is to eliminate it.

I think the committee should look at this very carefully and look at some of the evidence that Senator Cohen talked about with some of the fraud that is involved in this, and hopefully make a decision that our program should, as the House bill does, encourage citizenship, which the House bill does, and encourage sponsors of immigrants, because this provision in the House bill only deals with sponsored immigrants, to take more responsibility for the people that they are responsible for bringing into this country.

I appreciate the indulgence of the Chair in my testimony going a little long, and I thank you for the opportunity to testify.

Senator SIMPSON. Thank you very much, Senator Santorum. That is very important for us to hear your views.

[The prepared statement of Senator Santorum appears in the appendix.]

Senator SIMPSON. I just have a question for each of my colleagues, and then Senator Nickles may have a quick question, then you certainly feel free to participate or not, as you wish.

But the Social Security Act itself required that Disability recipients be referred always to State vocational rehabilitation agencies. The GAO has found that, for every \$100 spent by the Social Security Administration, one dime was spent on rehab and only one of 200 recipients was actually referred to rehab. I suppose that explains why, in some ways, in 1993 only half a percent of Disability recipients voluntarily left the rolls.

What is your thought about rehabilitation and the requirements, duties, and obligations of rehabilitation, Senator Cohen?

Senator COHEN. Mr. Chairman, that has been the problem, I think, in the past. Let me go back to the drug addict and alcoholic problem. We had roughly 250,000 people who qualify for the Disability Insurance program and SSI by virtue of their addiction.

Out of the 250,000, roughly 78,000, those on SSI, were required to get treatment. Out of the 78,000 required to get treatment, only about 8,000 were actually seeking or receiving treatment.

So, you had a \$1.2 billion program which most of us, the American taxpayers, had no idea what was happening to the money. In fact, it turned out most of it was going into the arms and stomachs of those who were addicted. That came about primarily because the emphasis has not been on seeking treatment. The same would apply to rehabilitation. There has not been enough emphasis on forcing those who are disabled to seek rehabilitation.

As I mentioned in my opening statement, it seems somewhat ironic, on the one hand, that we have the ADA Act, which is really designed to encourage those who are disabled to get into the work force, and yet, as the program has been administered under Social Security for Disability Programs, it really has not had an outreach

program other than to bring people into the system, but not to get them off the system.

So, I think what we have to do is, number one, put less emphasis on outreach, more on the CDRs, the Continuing Disability Reviews, and during that process of the CDRs, to then instruct and try to encourage those to move on to rehabilitation.

Second, we have had a problem in terms of a one-size- fits-all type of mentality. Namely, each individual who is assumed to be disabled, we assume that we have just one program. You are either disabled totally or you are rehabilitated. We have to have a much more flexible system. We have to have more flexibility in terms of analyzing what it takes to get people back into the work force.

For example, you may have someone who is severely handicapped or has a severe disability, and yet through the use of technology—we had testimony before the Aging Committee that there are remarkable breakthroughs in technologies that will allow people who, heretofore, had been considered totally disabled. But with the aid of this new technology, people can be completely functional in the right type of work environment.

So what we have to do is develop flexibility in terms of what kind of rehabilitation will put these individuals to work and allow them to get out of the trap of being permanently disabled.

You may need technology on the one hand, or you may need counseling. So, what we have to have is, number one, more reviews, number two, less outreach and more encouragement for vocational rehabilitation and training.

Senator SANTORUM. If I can just add to that. First off, I agree exactly with what Senator Cohen has said, and I would just make one further comment. This is more of a general comment. That is, in our welfare system it is easier to maintain than to transition. It is much easier to cut a check to somebody than to sit down and have that person sit down and work out how we are going to get that person off this system. It takes time, it takes energy, and these people just simply do not spend the time and energy.

A lot of the reason is, they just have too much work, a matter of case load. It is very easy to distribute the check. It is very hard to actually put time and invest in someone the necessary time and energy to move that person off and back into the productive mainstream of life. Until we change that, I think we are doomed to have a maintenance welfare system and a maintenance disability system, which does not serve anybody.

Senator COHEN. Could I add just one note to what Senator Santorum was saying?

Senator SIMPSON. Yes.

Senator COHEN. I think the Commissioner is going to testify to this. But I believe there is a backlog on Continuing Disability Reviews of nearly a half a million. Even with an aggressive program—I think the Commissioner is looking at conducting some 250,000 reviews in the course of each year—it still will not be anywhere near enough to deal with the backlog.

So, Senator Santorum is correct, we have got a half a million people out there that are likely never to be reviewed. They will stay on the rolls until the age of 65 and receive an average of \$225,000 during the course of that time.

We are putting out \$1 billion a week for those on disability. That does not include health benefits, it does not include food stamps. So, you can see that the price tag is much higher than the \$57 billion or so, it gets up to about \$110-\$111 billion a year if you include the health benefits along with food stamps.

Senator SIMPSON. Let me just ask one final question of Senator Santorum. Obviously, I know you have followed this issue of immigration and benefits and we are going to be processing a major piece of legislation which will deal with all of these things.

I think an interesting statistic I recall from this is that six percent of the people in the program are aliens, but they are consuming 12 percent of the funds. That is an interesting statistic.

The House bill cuts off persons after 5 years, refugees. We have a lot of problems in this land defining the difference between refugees and permanent resident aliens, and asylees, and illegal immigrants, and so on. But that is a very key thing. You can often read an article now in a major newspaper and they start out with the word immigrant and end with the word refugee as if they were the same.

They are totally, totally different. Refugees are persons fleeing persecution based on race, religion, national origin, or membership in some political or social organization. That means they are fearing for their safety.

So, when they hit the next country they are found asylum, but they do not stop there. They go through three or four other countries and misuse the system to get here. Third country resettlement was never what we were to be about.

But the others, with regard to immigrants and the support system and the public charge, that went onto our books in 1882. So when I hear people, oh, you guys are doing it again, I say, no, that happened to be in the statute since the year 1882, not 1982. But about 70 percent of those on SSI/Disabled are legal immigrants and not refugees. According to GAO, six percent of America is non-citizens, 28 percent of SSI are non-citizens, six percent of SSI disabled are non-citizens.

We have some serious issues to which, when we address them, we will be accused of, again, what we are always accused of, and I have been accused of forever here, dealing with things that are filled with emotion, fear, guilt, and racism. Yet, we have serious things.

But my question for you is very simple. You are now, I believe, the youngest member of the United States Senate, supplanting a member to my left who, when he came here, was the youngest member of the United States Senate, Senator Nickles. Now he is one of the old, grey-haired battalion here.

But I want to ask you a question. It is your generation that is going to be most affected by what we do. Everything we are doing with the Entitlements Commission, everything we are trying to do, does not affect anybody over 50. All the howling we get is from people over 50 and the groups that prey on them, if you will allow me to use that phrase.

So, what are we going to do with the Social Security system, in your mind, so that people of your generation will at least believe that there is something there?

Senator SANTORUM. That was an issue that, as you well know, came up in my campaign and one that I spoke out about, which I was told that you never do in a campaign, and paid some political price for it. But I think it was important that we were able to get through that.

I was just speaking to a group of students at Temple Law School the other day, overwhelming numbers, and they were saying, look, Social Security is not going to be there for us, do not kid us, it is not going to be there. I mean, do not stand up and say you can take Social Security off the table and preserve it for us. We are paying into this thing and it is a pipe dream.

I can tell you that a lot of young people are looking for alternatives. They are looking for something where they can put money into the system and have some assurance that it is coming back out.

Now, I do not know what the best system is. Some are talking about the Chilean system that they have put into place as a possible option, which basically preserves folks in the system who are near retirement, and then provides alternatives to those who are younger. I do not know whether that is a viable option, but I do think we do have an obligation.

I mean, I know you are famous for pulling out, I think it is, your father's Social Security records and how much he put in the system and how quickly he got it back. Well, I will not be able to do that because, unless I live to be 100 or something, get anywhere near back the money that we are putting in.

That is a generational inequity. We have got to address that. But, at the same time—and you are right, people over 50 should not be affected because they are well along their way, and, frankly, have planned for that—we do owe an obligation for future generations to do something about this issue and I hope that this committee will face the music at some point and realize that there are a whole generation of Americans out there, of which I am one, that feel we have a right to get something for the money we have paid in, too.

Senator SIMPSON. I would ask Senator Nickles if you have any questions of our two colleagues, and tell Senator Conrad we are glad to have you here. We are just winding up hearing from our two colleagues, and asking a question or two. Then if they wish to go to other duties, then we will go into the panel.

Did you have any questions of our two colleagues?

Senator NICKLES. Mr. Chairman, just a couple of comments. One, to thank you for having this hearing, and, two, maybe to encourage you to have additional hearings, including hearings on Social Security. I think the comment that Senator Santorum just made on Social Security, talking about your father and others, I think we could maybe clarify some misgivings and some misstatements that people have about Social Security, trust funds, and so on, and maybe by having a hearing specifically for that purpose.

You mentioned that Senator Santorum is the youngest member of the Senate, and I used to have that title. I also contributed to the Social Security for years when the maximum Social Security payment, you maxed out on the system, was \$200-400, and now it is \$5,000 plus, matched by your employer.

So, times have changed in a relatively short period of time and there is a significant problem that we have not faced. I know the Senator from Wyoming is willing to talk about that.

One of the problems that we have confronting us right now, both Senator Cohen and Senator Santorum have been real leaders in at least bringing this to our attention. I remember Senator Cohen confronting many of us last year, talking about the number of alcoholics and drug addicts that were on the system. That was news to me, shocking news.

And you were talking figures, Senator Cohen, if I remember, in the billions of dollars. That was shocking to me. And to find out that these individuals were receiving cash payments that were used to subsidize their drug habits and alcohol habits, that was shocking to me. So, I compliment you for your leadership.

I did note in your statement that you said we have helped close that gap, but still I think you said we have, what a 3-year limitation on it? I guess I would fall on the side that says maybe we have not done enough. I am one that looks at total amounts of money that we spend. I am kind of fixated by growth rates.

I see that under SSI in 1994, it grew by 20 percent, and the Disability Program in 1994 grew by 13 percent, yet inflation was what, around 3 percent. So you have one program growing almost seven times the rate of inflation, one growing about four times the rate of inflation. That is not sustainable, that is not affordable, that is not supportable, and it has to be changed. Senator Santorum has done some great work. He has talked to me about this program.

I appreciate the homework he has put in it as a House member, and so many of the recommendations that our two colleagues are making I am going to be very receptive to. I think we have to slow down the rate of growth of these programs.

Some people are going to call those cuts, but I do not think we can sustain 20 percent rates of growth in this program. And if we are going to have some reductions in the rate of growth, I would think one area to look at would be to quit making cash payments to drug addicts and to alcoholics. That does not mean we are not compassionate, but it means we have to reduce the rate of growth and maybe that would be one area to do it.

Senator Cohen mentioned one thing that kind of shocked me, and I will ask, Bill, if this is correct. Did you mention in your statement that on the Disability Income Program that it is only like one out of 1,000 that actually is deleted from the rolls; is that correct?

Senator COHEN. That is correct.

Senator NICKLES. That is not acceptable. Maybe it is because we are not doing these Continuing Review programs. I do not know what it is, but that is not acceptable. We have to do a better job.

Also, I think I remember Senator Santorum mentioned the explosion of some of these programs, and you were not just talking about drug addicts. You were talking about an explosion of the program dealing with children, and maybe that is not easy, but part of that was due to legislation.

Senator SANTORUM. It was due, in principal part, to a court case called the *Zebly* decision, which broadened the definition of disability.

Senator NICKLES. Broadened the disability definition to include what?

Senator SANTORUM. They now do what is called Individual Functional Assessment. It is to the point where, if you have age inappropriate behavior, you could actually qualify.

A lot of children are qualifying because of acting up or having problems in the classroom, being a discipline problem, being someone who has maybe had problems at home with abusive parents and then having that spill over into the classroom.

Mom applies for SSI and you have before you case, after case, after case of that scenario from what we found out in Pennsylvania, where you have a situation where kids get this, they have high IQs, when mom or the parents are okay, in several of these cases, the kids are okay. But when mom is abusive, the kids dump it out in the classroom. So what happens? Mom applies for SSI. Who gets the check? Mom.

Is that going to help this child? I do not think so. I do not think that is necessarily what the SSI program was intended to do. It was supposed to be an income supplement to help parents deal with disability, deal with a problem which is going to cause them more expense because of the disability, and not paying parents who cause the disability. That is what we have seen in some of these instances.

Senator NICKLES. The payment would be in the neighborhood of what, \$4,000 per year, per child?

Senator SANTORUM. It is more than that. It was \$458 a month.

Senator NICKLES. Is there a situation where individuals would see that maybe a neighbor or maybe someone that they are familiar with qualified for it, therefore, if they could get their child to act up maybe they would go through the application and qualify and have this be somewhat of a contagious application?

Senator SANTORUM. There is a tremendous amount of anecdotal evidence to that case, and a lot of the disability advocates say, prove it. Where have you seen cases and can prove it? Well, the best case in point is the sheet I gave you. I cannot prove it because I have got someone who is bound by privacy laws that they cannot discuss these cases. They cannot come before a committee and say, here are all the problems, here is what we have seen, because they have got severe limitations on what they can discuss.

I know Congressman Slattery will talk about some of the evidence that they have turned up from educators who have given testimony about the problems that they have confronted in the school systems, and really the detrimental effect this program is having on children who simply should not be in this program. This, in a sense, carrot, should not be out there for parents who simply are not raising their children in a way that we would like to see it done.

Senator NICKLES. Mr. Chairman, again, I thank you for having this hearing, and I thank our colleagues as well for their leadership on a sensitive issue, and one that is not probably popular to carry. I compliment them for their courage.

Senator SIMPSON. Thank you very much, Senator Nickles.

Senator Conrad, did you have any questions you would like to ask? Yes, Senator Cohen.

Senator COHEN. Before you comment, could I just make one point in response to what Senator Nickles said about those who are alcoholics or addicts. I think we have to approach this, by hopefully, seeking solutions in an intelligent fashion, not simply a punitive one.

For example, some would suggest that we simply cut off any payments under either Disability Insurance or SSI to anyone who is suffering from addiction. That may seem like the emotionally right thing to do at the moment, but I am not sure, in the long-term, it is going to be the most productive one.

If, in fact, you do not encourage treatment for those who are addicted, then their addiction continues until they then suffer, in all likelihood, a mental impairment. That mental impairment may qualify them for disability benefits, under which they are not required at that point to seek any treatment and they would be given cash payments.

So, what we ought to be doing is seeking treatment and insisting upon treatment. What we ought to be doing in terms of the other programs for disability is seeking vocational training and rehabilitation and not simply the payment.

So, I think we have to approach it in an intelligent fashion and not simply one in which we are overwrought with passion and emotion about the abuses that have been going on. Now we have to structure it in a way that really will produce the right result for us as a society. I thank you.

Senator SIMPSON. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman.

I share the concern that people have with the growth of these programs. I mean, it is clearly not sustainable. At a time we have deficits that stretch from here to the end of time, we have got to address a whole series of things that really require painful choices. But let me just try to put this in context in terms of questions that I might ask.

I would ask my two colleagues, nobody is talking about doing away with these programs, is that correct? I mean, we are not talking about eliminating SSI or Disability.

Senator COHEN. No. Some, in fact, are talking about precisely that for addiction and alcoholism.

Senator CONRAD. Well, I would ask you, what is your position. Do you think SSI ought to be eliminated, or part of it ought to be eliminated?

Senator COHEN. I think I just stated it just a moment ago. We have made some changes. The entire goal of the SSI program and Disability Insurance for those who are addicted to either drugs or alcohol should be to get treatment to help cure the addiction, if that is at all possible.

It seems to me that if we simply say, no treatment, no rehabilitation, then we have got problem citizens on our hands which are going to be passed on to someone, either to the States under general welfare, or to some other Federal program. So the goal ought to be—

Senator CONRAD. So if there is a problem, fix it.

Senator COHEN. And do it in the right way. The right way is not to hand monthly payments to alcoholics or addicts. The right way

is not to give retroactive cash payments up to \$18,000-25,000 to addicts and say, here is your check for back payments, who then go out and either crash their automobiles or die of drug overdoses.

The correct solution is not to name a bar or a tavern as the representative payee and say, here is the \$160,000 so you can run a tab for these 40 alcoholics. That is an insane proposition as far as our system is concerned.

So, we have made changes, at least the first step. More may have to be done, but I do not think the answer is to terminate the programs. We have got to deal with the people; how do we deal with them in a responsible fashion and get the result that society needs.

Senator CONRAD. Senator Santorum.

Senator SANTORUM. Yes. I have a little different answer. Just let me go back to what we worked on in the House in addressing the three areas where I think we need to make major changes.

Number one, in picking up with the drug addicts and alcoholics program, what is being suggested in the House is, I think, a sensible response to the problem. What we kept hearing from the drug addiction community who wanted to see this program continued is, the reason these people do not get treatment is because of the unavailability of treatment. There just is not enough treatment centers out there so, as a result, we simply cannot do that.

So, what the House bill does is it cuts off cash benefits completely, but takes \$400 million of the savings, which is roughly about a quarter of the savings, and takes that money and invests it in drug treatment and makes all these folks who would otherwise not be eligible and have money available for drug treatment.

It is, in fact, treating the problem, not providing cash. We think providing cash is the wrong answer. It is a wrong incentive. You drink enough to the point you cannot work and cannot be functional, we will pay you money.

Now, that does not make a lot of sense to a whole lot of Americans. But what we do say is, if you have that problem and it is an illness, an addiction, fine, we will provide dollars for treatment for you and allow you to then go out and hopefully be recovering and to go on with your life.

Senator CONRAD. So you would favor cutting off cash payments completely?

Senator SANTORUM. I would, for drug addicts and alcoholics, yes. I am flexible with the number, but providing a substantial amount of that money to be directed at treating the problem, not rewarding, in a sense, the problem.

The other two areas that I would look at—and Senator Simpson and I talked about it briefly—which is the area of sponsored immigrants. Now, I know members of the committee are aware that when an immigrant comes into this country under a sponsorship agreement, a sponsor signs a document that says that they will provide for that individual and that their income is available to that immigrant who comes into this country. I think, under the extension of unemployment benefits a couple of years ago, we extended that provision that the sponsor would be required to provide for the immigrant for 5 years.

As everyone knows, the amount of time that a sponsored immigrant has in order to qualify for citizenship is five years. So, what

we are basically saying in this bill is, let us just require these folks, if they want to apply for welfare benefits or SSI, to be citizens.

So, we have really just taken it the next step and said that citizenship is going to be required in order to receive those benefits. If you are a sponsored immigrant—an asylee or a refugee—the program does not change. But for sponsored immigrants we are going to say the family—and it is almost in all cases families—who bring the immigrant over here is going to take more responsibility and we are going to encourage citizenship by requiring that.

Finally, what we have done with children is look at the Individual Functional Assessment area, the kids who have come on as a result of the *Zebley* decision, remove them from the system, give them, obviously, the opportunity to reapply under a different standard, a Medicaid kind of disability standard, and then take the savings, which we believe would be substantial, and apply a portion of that money back to the States for block grants to be provided for additional services, non-Medicaid services, like equipment and other things that people with disabilities do need, and provide that extra money to, in fact, provide more services for people with disabilities.

Senator CONRAD. How many children would be taken off under the formula that you have described?

Senator SANTORUM. I think it is around 25 percent. That is a rough number. That is from memory.

Senator CONRAD. 25 percent would be 220,000, something like that.

Senator SANTORUM. I think the number of children—let me see my—

Senator CONRAD. 892,000 children is the number I have for 1994.

Senator SANTORUM. It is about 225,000.

Senator CONRAD. Those would be those that have mental impairment under the court determination?

Senator SANTORUM. Who have age inappropriate behavior and behavioral problems.

Senator CONRAD. I must say, when you look at the growth, obviously, this is an area in which there has been enormous growth. You have to question “age inappropriate behavior.” What does that mean?

Senator COHEN. I think we used to get racked on the knuckles when we behaved in that fashion.

Senator SANTORUM. I got worse than that. [Laughter.]

Senator CONRAD. But what happens to those kids who really are legitimately mentally impaired?

Senator SANTORUM. Those people would be adjudged under a standard that existed for quite some time and if they have psychosis or if they have a severe mental problem, then they would be able to qualify.

Senator CONRAD. So the goal here is to deal with children. We are talking about taking some 200,000 off the rolls. What we are trying to get at are those that really do not have some kind of debilitating disability.

Senator SANTORUM. If you think about, what is the purpose of the program, is to provide cash assistance for people who have ex-

traordinary needs that parents cannot provide for that requires them to be on Medicaid or requires them to get cash assistance.

A lot of these problems, while they may be problems that parents have to deal with with children, and we sympathize with that, are they to the level that we should provide government payments and, even more importantly, is this carrot that is there for those really causing more problems with children than it is solving for children?

Senator CONRAD. Well, it seems to me we have, as in all these cases, a balancing act, to some degree, Mr. Chairman. I mean, obviously I do not think anybody wants to take children that really are legitimately deserving and not provide assistance and support for them.

On the other hand, we are on a course here that cannot be sustained. That is very, very clear. There has to be abuse, when you look at these numbers, that has to be addressed.

Senator SIMPSON. I thank you. Trying to give equal time to my colleagues, we are going to set the clock next time 5 minutes each. But I would say, we all should take a look at these Pennsylvania case file examples. These are rather striking, where the names have been removed. There are really quite, quite startling and they are apparently from the agency, from the bureaucracy.

Senator SANTORUM. That is correct.

Senator SIMPSON. I would just say one other thing. You say you paid a political price for speaking frankly about Social Security, and yet you won.

In Nebraska, Senator Kerrey, who headed up the Entitlements Commission, while he was in a reelection year, won. I think the moral of the story is, people are starting to figure it all out. And if young people between 18-50 cannot figure it all out, they are not going to get any sympathy from me.

That is the way I come at it, because I cannot believe how they can remain—not you, thank heaven you are a spokesman for them—unorganized, because the other groups out there have the horses. Thank you very much. I appreciate your testimony. It is very helpful to us.

Let me just, if I may, take just a minute or two. I delayed an opening statement, and I am going to give each of the witnesses seven minutes instead of five, which is a very generous act on my part. We want to hear your testimony, obviously. But I just wanted to say, in those opening remarks, I will assure that the balance of them be placed in the record.

But in October of 1994, I want people to understand this, Congress voted to reallocate a portion of future payroll tax revenues from the OASI Retirement Trust Fund to the SSDI Trust Fund. Not too many howled about that as we moved stuff around in there. You will hear our constituents say, you guys robbed the trust fund, and you did this, and you did that. I did not hear any accompanying howl about that.

We did that because the SSDI Trust Fund was teetering perilously on bankruptcy, broke. As a result of that legislation, there will be about \$240 billion less, less, in the Retirement Trust Fund in the year 2003. I do not hear much talk about that.

If nothing changes and we continue to talk a good game and cast no tough votes, I expect that in the year 2001 Congress will be ex-

pected to reallocate funds from the Retirement Trust Fund to bail out the insolvent Medicare Trust Fund.

I do not think we can afford to continue these errors of the past and repeatedly divert funds from the Retirement Trust Fund because, according to the 1994 annual report of the Board of Trustees of the Federal Old Age and Survivors' Insurance and Disability Insurance Trust Funds, i.e., Social Security, in the year 2013, Social Security benefit payments are expected to be greater than revenues from the payroll tax. According to that same report, by the year 2029 Social Security will be broke, gone, zip. The trustees know it, we in Congress know it, the powerful interest groups know it, and the public has not figured it all out yet, which is very sad.

In last year's report the trustees reported the doomsday date to be 2036. In just 1 year, the doomsday date then has moved 7 years, 2036 to 2029. Remember, please, in 1983 we were told the doomsday date would be the year 2063. Remember what is happening here. We were told in 1983, when our good member of this panel helped save the Social Security system, Pat Moynihan, that the doomsday date was 2063.

It is already 2029 and the Advisory Committee will come in and undoubtedly move it up another few years when they come in with their report. So that is where we are. It would be unconscionable to accelerate this date any further than we have done already in allowing this program to spin, and continue to spin, out of control.

These exploding costs are not unique to SSDI. The costs of the other disability program, SSI, which is funded directly from general funds, are soaring at an even more rapid rate, and the GAO estimated that since 1985, a 60 percent increase in the compliant costs of both programs. That is a word that we have used several times here today, unsustainable.

These payments to the disabled of \$57 billion, each week \$1 billion in cash payments to persons on SSDI and SSI. This is now the fourth largest category of entitlement spending.

So, we are here today to try to get a handle, or at least an understanding, of why this is exploding. It is a sensitive topic, a hot button item, determining whether a recipient is disabled. I remember when President Reagan suggested that this be looked into they nearly ripped him asunder. Yet, he was right.

I know that under this administration with this President, others have talked about the need to get this program under control, those people who see it and understand it. I admire that within this administration.

So, we are here to hear of these problems and we are the ones where they come for assistance, and they give us the story and say, you have to help. Then we help, and boy, do we. The number of constituents increased to unprecedented levels last year as increasingly desperate claimants sought help with their languishing cases. We are going to hear about the backlog and how the system will respond to those with genuine disabilities. It cannot continue to casually award benefits without much more careful scrutiny, and after the benefits are awarded the integrity is gone unless there would be follow-up, review, and monitoring to determine when a person is rehabilitated. So, we have a lot to do and much to learn.

Now, please, in the order of the witnesses, Dr. Chater, please. Dr. Chater, of course, being the Commissioner of the Social Security Administration; and David Koitz, a Specialist in Retirement and Social Policy, Congressional Research Service of the Library of Congress; and the Honorable Jim Slattery, former colleague of ours in the House, and a very able legislator I worked with personally and enjoyed thoroughly, the Chairman of the Childhood Disability Commission of Washington, DC.

Dr. CHATER, PLEASE.

STATEMENT OF HON. SHIRLEY S. CHATER, COMMISSIONER OF SOCIAL SECURITY, WASHINGTON, DC, ACCOMPANIED BY DR. SUSAN DANIELS, ASSOCIATE COMMISSIONER FOR DISABILITY

Dr. CHATER. Thank you, Mr. Chairman. May I introduce to you Dr. Susan Daniels, to my left, who is our Associate Commissioner for Disability.

It is a pleasure to be here today. I thought it might be most helpful to you if I simply reviewed the significant disability growth that has occurred, talk a little bit about the reasons for that growth, and then share with you some of the measures that we want to pursue to maintain costs and to address this growth. I will, of course, submit to you my full written testimony for the record.

First, let me talk about disability program growth. I want to make it clear now that the administration shares your concern about increases in disability program participation.

You have heard that since 1989 the number of disability beneficiaries for both programs grew 47 percent, from 5.4 million to 7.9 million. In the SSDI program, the growth was 37 percent, but in the SSI disability program the growth was 53 percent. Consequently, the annual benefits grew 72 percent, from \$33.8 billion in 1989 to \$58 billion in 1994.

Now, we have been working hard to determine some of the causes for the increase. We conducted a number of studies and have concluded that the causes of the increase have to do with economic and demographic trends, as well as some program-specific factors that have been leading contributors to the increasing applications, as well as to the decreasing terminations—the number of people who go off the rolls.

So, first, if I might, I would like to talk about the causes of the increase in applications, and I direct your attention to the chart to my right. The unemployment rate is the single largest factor affecting application rates for the SSDI program. This occurs, for example, when severely impaired workers who were working despite their disabilities lose their job and then apply for benefits.

We saw this factor come into play during the recession of the early 1990s, as you can see from the chart. Similarly then, this recession put more people into poverty, increasing the universe of potential eligibles for the Supplemental Security Income program.

Two demographic factors are significant. First, the baby boom generation is aging and more of its members are reaching that time in their lives when they are increasingly vulnerable to disability.

Second, an increasing proportion of women have worked long enough now to be insured for Social Security disability, and they

are coming on the rolls. We believe that these trends will continue to be a source of program growth in the future.

Now, I also mentioned some program-specific factors that have also stimulated an increase in applications. For example, legislation and court decisions have resulted in changes that have attracted more applications.

The classic example is the 1990 Supreme Court decision in the case of *Sullivan v. Zebley*, which expanded the number of children eligible for SSI benefits. I would also cite as an example the 1984 Congressional mandate which caused us to revise the criteria for evaluating disability, particularly involving mental impairments.

Now, if I might, let me turn to decreasing terminations, that is, the decreasing number of people who come off the rolls. At the same time that applications have been increasing, terminations have, indeed, been decreasing.

Some of the reasons are as follows. One, more applications and awards to younger people with mental impairments. Now, why should that make a difference? Well, these people are physically healthier than older recipients and, therefore, they live longer and they stay on the rolls longer.

Second, the increasing number of baby boomers on disability rolls has lowered the average age of disability beneficiaries.

A third reason, is the increase in disability awards to women, who have a greater life expectancy than men and so, of course, they would stay on the rolls longer.

Now, SSA has taken some initiatives to take care of some of the problem. As I said, we are concerned about this growth in disability benefits and we want to, and are, taking some specific actions to address the factors which are under our control.

These are addressed at some length in my written testimony, but I would like to just mention to you two of them now. The first, is CDRs, the continuing disability reviews. On the chart you can see that in 1995 and 1996 we are going to do many more CDRs.

First, we are determined that the only people who receive benefits should be those who meet the legal requirements for receiving them. Toward that end, our proposal to do continuing disability reviews is very much intact.

The Administration's fiscal year 1996 budget includes a request for sufficient funding so that we can increase the number of CDRs, as you see on the chart, to 431,000, which represents a threefold increase over 1994.

A second strategy that I would like to point out to you has to do with our employment strategy. We know that less than one-half of 1 percent of the individuals who receive Social Security disability insurance ever leave the rolls to go back to work, and we want to address this problem. So we are developing a plan that will address current disincentives and will restructure the way we help our beneficiaries return to work.

In conclusion, Mr. Chairman, I want you to know that this Administration shares your concern about the growth and we have, accordingly, launched some initiatives, including the two that I just mentioned to you. I want you to know, too, that I look forward to working with you and your committee on these issues. Of course, I am always pleased to answer your questions.

Senator SIMPSON. Thank you very much, Dr. Chater. We do appreciate that indication of cooperation. You have always been very cooperative with me and I have enjoyed visits with you.

[The prepared statement of Dr. Chater appears in the appendix.]

Senator SIMPSON. David Koitz, please.

STATEMENT OF DAVID KOITZ, SPECIALIST IN RETIREMENT AND SOCIAL POLICY, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS, WASHINGTON, DC

Mr. KOITZ. Mr. Chairman, I am really not supposed to take a position on this issue from CRS, but I have to say I was pleased that you are holding such a broad-based hearing on both programs and their growth.

Some of the earlier hearings on disability tended to be more focused, either on one or other of the programs, or they focused on children, substance abusers, CDRs, ALJs. This is one of the few comprehensive hearings on this subject, and I personally think it is long overdue.

There has been a lot of discussion about rapid growth. I guess I have been among people writing about it. But, given the volume, I thought maybe in my CRS hat I could throw up a small caution flag. At least, that is the way I will start out.

There are 10 million people getting benefits in both of these programs, but they only represent four percent of the entire population. We still have 130 million people who get up and go to work every day, so it is not like there is this huge segment of the population alleging disability to draw an income from public funds.

But I cannot end it there, because the growth of these programs has been fairly dramatic. To ignore it would be, using a phrase I have heard you use a lot, sticking your head in the sand.

I was thinking, is there a way to sort of capsulize this? Is there a way to pinpoint the problem? Are there just a couple of issues here that I could bring to the attention of the committee to really focus on?

I had a hard time coming to any such conclusion, because it is not simple.

This program has evolved incrementally over almost 40 years now. Some of the problems really go back. For instance, the basic administrative structure of the program is an issue.

There are the hot button items now too, the substance abusers, for instance. I thought maybe I could look to them to explain it. Well, maybe total enrollment growth has only been 100,000 or 150,000 in the last 5 years due to substance abusers, while total growth has been almost 3 million in both of these programs. So, substance abusers would only explain maybe three or four percent of the total growth.

Obviously the children represent large numbers, immigrants also are contributing, the CDR problem is a part of it. There are, in fact, many, many factors contributing. The point is that it is really difficult to lay blame on particular items.

If you look at the substance abusers, the children, and the immigrants with respect to disability—we have had total growth in SSI of 1.8 million people in the last 5 years—about half is due to them, but there has been a lot of other growth.

This is kind of a long-winded excuse for a lengthy statement, which I would submit for the record. I can try to condense a few points for you now or wait till you have some questions.

Senator SIMPSON. Why do you not go ahead and use the existing time and let me hear your quick review.

Mr. KOITZ. All right.

Since 1984, which was the last time Congress altered these programs in any major way, the overall population in the United States grew by 11 percent. In contrast, enrollment in these programs rose by 60 percent. Since 1989, their expenditures have doubled. There has been a lot of speculation about what is behind the growth, but nothing conclusive.

The recession has been over for 4 years and the total employment in the United States has risen by eight million people, yet the number of disability applications remains at an all-time high. Thus, it would be misleading to conclude that the principal cause is a poor employment picture.

Outreach by the SSA and the advocacy community, efforts by State and local governments to shift people from their programs to Federal ones, the 1990 *Zebley* court decision liberalizing SSI rules for disabled children, and generally growing awareness of the programs, together, may have more to do with what has been going on in the state of the economy.

Moreover, while applications have recently leveled off, there is an unprecedented number of cases being appealed. In the 1994-1996 period, SSA says it will process 1.7 million of them. Although some will be summarily dismissed, with SSA's Office of Hearings and Appeals reversing denials at an 80 percent rate, there will be more than a million people added to the rolls simply because of appeals decided in this 3-year period.

Looking farther out, the Baby Boom generation is on the edge of its disability-pr1 years. The oldest boomers are now 49. As they enter their fifth decade, the incidence of disability among them will rise. The Social Security trustees projected last year that the number of DI recipients would grow from 5.8 million today to 8.8 million over the next decade. Under the actuaries' most recent projections, after taking the reallocation into account, the DI Trust Fund would become insolvent in 2015. At that point, the checks could no longer be paid on time. At that point, total DI enrollment would exceed 10 million people, and reallocating again from the retirement program would be unlikely, given the nearness of its own financial insolvency.

Finally, the simple fact that there are big dollars involved makes these programs an issue. Together, DI and SSI disability payments represent the fourth largest category of Federal entitlement spending, and this does not even take into account the subsidiary benefits that many recipients receive through Medicare, Medicaid, food stamps, State SSI supplements, and Social Services. Thus, to the extent that aggregate entitlement growth is considered unsustainable in the long-run, the magnitude and growth of these two programs cannot be ignored.

Over the last 20 years, enrollment has been volatile. It has not gone up and down like Unemployment Insurance, but there has

been no smooth trend reflecting a society that is gradually growing older.

People often look for economic reasons, such as rising or falling unemployment, or general health trends in society, to explain the volatility. They assume that because the basic definition of disability in the law has been the same since the mid-1960's, the rules of the program have not changed.

They also assume that administrative practice is a constant. However, much, if not most, of the programs' volatility probably results from legislation, court decisions, and administrative changes.

In the early 1970's, SSA had responsibility for the Black Lung Program and they had to implement SSI. Between 1970 and 1977, DI doubled. As things subsided, as the claims subsided, the Administration on its own started to tighten up and enrollment actually started to fall. I think it began in 1978.

Senator SIMPSON. I had not known they had rigged it with a bell. Very well done. Did you have a quick summary here?

Mr. KOITZ. No, I think I will save it for questions and answers.

Senator SIMPSON. All right.

[The prepared statement of Mr. Koitz appears in the appendix.]

Senator SIMPSON. Jim Slattery, it is good to see you again. I always enjoyed working with you here. We had a lot of common interests and I enjoyed that very much. Nice to see you again, Jim.

STATEMENT OF JAMES SLATTERY, CHAIRMAN, NATIONAL COMMISSION ON CHILDHOOD DISABILITY, WASHINGTON, DC

Mr. SLATTERY. Thank you, Mr. Chairman. It is also good to see you. I also have fond memories of the time we worked together on veterans' issues, budget issues, and others. So, it is great to see you and other members of the committee today.

I am appearing today as the Chairman of the National Commission on Childhood Disability. The Congress established the commission last year as part of the legislation that gave the Social Security Administration independent status. In that legislation the Congress asked the commission to conduct a comprehensive review of the Supplemental Security Income program for children.

Let me just observe at this point that all of the money involved with the SSI program for children is general fund money, it is not trust fund money.

In this legislation you asked us to tell you whether the SSI definition of childhood disability is appropriate, whether an alternative definition would be preferable, and whether the needs of children with disabilities can be met through cash benefits, vouchers, expanded health coverage, or some combination of these. So, that is the work that the commission is attempting to do.

The commission was appointed in January by Health and Human Services Secretary Donna Shalala. It is composed of 14 experts that have broad experience in the areas of law, medicine, ethics, psychology, and disability policy. So, it is a broad commission with a lot of expert capability.

Recognizing that the Congressional timetable on this issue has accelerated, the commission has been conducting bi-weekly meetings. We have been meeting on Saturdays also in an attempt to move up the deadline for the report that we would like to submit

to the Congress, from the November 30, 1995, date set in the legislation to a time in July and August. So, we hope to complete our work at that time.

You asked that I focus today, Mr. Chairman, on the recent sharp growth in the SSI Childhood Disability Program, so that is exactly what I will do. That seems an appropriate place to start, since this growth was the main impetus for the creation of the commission.

During the decade between 1979 and 1989, the SSI Childhood Program grew at modest rates, increasing from 212,000 in 1979 to 296,000 in 1989. By contrast, the rolls nearly tripled between 1989 and 1994, rising from 296,000 to 893,000 children, with an annual budget of nearly \$5 billion.

Now, the most widely noted cause of these increases is the *Sullivan v. Zebley* court decision, which you have already heard about this morning. But let me emphasize at the outset that the *Zebley* decision has received a great deal of public attention, but it is not the primary cause of SSI program growth for children.

There are also two other very significant factors driving the rise in SSI childhood payments. These are SSA's 1990 revision of its medical listings of childhood mental impairments, and the SSA outreach activities that have been mandated by Congress and the courts.

Let me begin with *Zebley*. The *Zebley* decision was issued by the Supreme Court in February of 1990. In it the court found that SSA's childhood disability regulations were at odds with the definition of disability in the Social Security Act.

That definition requires that benefits be paid to any child whose disability is comparable in severity to one that would prevent an adult from working, an interesting definition.

In deciding which adults are eligible for benefits, SSA applies two separate tests, a listing of qualifying medical impairments, and for those whose impairments are not described there, an individual assessment of what is called Residual Functional Capacity. They refer to it as RFC.

SSA uses the RFC assessment to determine whether there is work that the individual can do, given his or her age, education, and past experience. For children, by contrast, SSA had established only the listing of qualifying impairments. The court ruled that this listing alone failed to provide the comparability with adult eligibility criteria that is required by the statute.

To establish comparability, SSI revised its childhood regulations to include an Individualized Functional Assessment, now referred to as the infamous IFA, modeled on its adult assessment.

Now, following the *Zebley* decision in February of 1990, the District Court required SSA to re-adjudicate the claims—and catch this—of children who had previously been denied SSI benefits.

So, SSA had to contact, by court order, the families of 452,000 children who had been denied between January of 1980 and February of 1991, and offer to re-adjudicate all of these claims using the new functional criteria. Of this group, 339,000 responded, and approximately 135,000 children were ultimately found eligible and awarded benefits.

Because many of these children were determined to have been eligible at the time of their original application, they qualified not

only for prospective benefits, but for larger, retroactive lump sum benefits.

A second event which occurred in 1990 has also fueled SSI program growth. This was SSA's revision of its childhood mental impairment listings.

Prior to this revision, SSA had listed only four general categories of qualifying mental impairments for children: mental retardation, Chronic Brain Syndrome, psychosis, and functional non-psychotic disorders.

Under its 1990 revision, SSA expanded this number to 11, explicitly recognizing several impairments whose disability impact has been identified by medical professionals only recently. These include Attention Deficit Hyperactivity Disorder, anxiety and mood disorders, and behavioral disorders.

Last fall, the General Accounting Office completed a study comparing the impact of these new listings with that of the IFA. The GAO found that 59 percent of the growth in childhood benefit awards during 1991 and 1992 was attributable to the listings and 41 percent to the IFA.

The third factor that has caused SSI rolls to increase is more difficult to quantify: it is SSI outreach activities. A 1989 statute required SSA to establish a permanent program of SSI outreach to low-income children, and a year later the *Zebley* agreement called for additional outreach efforts. So, these are the three factors that are really driving the growth in the SSI program as it affects children.

The last point that I would make, and then I would be happy to answer your questions, Mr. Chairman, members of the committee, is the fact that between 1974 and 1992 the number of children in this country who are poor has also dramatically increased. It has increased from roughly 15 percent to 22 percent.

Some studies indicate maybe as many as 25 percent of our children now are low income. So, as that universe increases, clearly, the number of disabled children within that group is also going to increase. So that basic reality is also a factor affecting this.

So, Mr. Chairman, with that, I would conclude my testimony. I would tell you that we are going to press ahead to complete this work as quickly as we can. You have given us until November, but I am going to try and be done by the 1st of August, if you will give me that much time. It is a very complex issue, as you can see, and one that deserves a lot of attention.

Senator SIMPSON. We intend to give it that.

[The prepared statement of Mr. Slattery appears in the appendix.]

Senator SIMPSON. We will have rounds of 5 minutes and see how far we go here. But one of the things we talked to Dr. Chater about when she appeared before the full committee of Senator Packwood and Senator Moynihan, I want to just ask this again. It seems to me this is very important, and I am not going to belabor it because there will be other opportunities.

But we established the Social Security Administration as a "independent" agency. The language of the statute says "There is hereby established as an independent agency in the Executive Branch of the government a Social Security Administration," and then the

duties, of course, and so on. "The Commissioner will be appointed for a term of six years." And that is that.

The question is, I do not think anything we suggest or you suggest will work unless you truly think you are independent. If you believe that the President can still jerk you around, or the Congress can still jerk you around, you are not going to be able to function.

I want to ask you what you mean, what you think the statute means. We need to rely on you to give us information of what to do, and it is all going to be politically hot, every bit of it. You will never furnish anything that will not be red hot, because we have a real tough issue.

You need to tell us what to do, how you feel about CPI, affluence testing, COLAs, phasing up the retirement date, these things. I know that you do not wish to do that, but I wonder why, if you feel you are totally independent. If you do not feel you are independent, then we all must have missed something when we set it up.

Dr. CHATER. Mr. Chairman, I value very much our forthcoming independent status on March 31st, which is not very far away. I look forward to the characteristics that will come to us because of independence.

One is that it will certainly make us, as an agency, more accountable to the American people. It will certainly give us the visibility in which to share information with the American public about what Social Security is and what it has been, and where it needs to go.

I view my leadership role as one in which I will work with the Administration, will work with Congress, and will take under consideration all of these reports and results that are coming now from a variety of sources, our own Board of Trustees, which has a legally mandated obligation to look at the solvency every year, the board on which I sit.

I am looking forward to the Childhood Commission's recommendations. I look forward to bringing to your attention the Advisory Council's report which is due this summer. The Council, indeed, has been asked to look at some of the solvency issues.

I view my leadership role as one of sharing with you and others all of this information in a way that I can make recommendations to the Administration and to you, to members of Congress, focusing on a bipartisan approach, and I would underline and emphasize the bipartisan approach.

I firmly believe the only way we are going to deal with long-term problems in Social Security is to find a way to work together, because I know that we all want to solve this problem.

So, independence, I think, will make it possible for us to reach out to Congress, to the Administration, to the American public, and bring to you some possibilities, some recommendations, for discussion and, in the end, a solution.

Senator SIMPSON. Well, we must have your recommendations, even if they are hard and very emotional. We must have that from you, or else there was really no purpose to set it up independently, in my mind, at least I did not think it was a good idea, anyway, removing it from Health and Human Services, because of the ad-

ministration of it, but that is beside the point. But, since it is, we must have that.

Mr. Koitz, in your testimony you stated that SSDI benefits may be too high in the long term when compared to future retirement benefits. Could you explain that a bit more for me?

Mr. KOITZ. As you are well aware, the normal retirement age is supposed to rise gradually from 65 to 67 over a 22-year period. When it is fully effective you will still be able to get benefits at 62, you are just going to have to take a 30 percent reduction rather than a 20 percent reduction.

Today, if you file for DI at 62, when you file for retirement, the reward for winning a DI benefit is a 25 percent increase. When this thing becomes fully effective in the year 2022, that increase will jump to 43 percent.

And if you were to look at the impact under some of the proposals dealing with Social Security solvency, such as raising the retirement age to 70, assuming we keep age 62 as the entry point, that incentive could go to 70 percent.

So, today where you have most people coming in and filing only for retirement benefits, in the future you could have a huge incentive to file for both.

Senator SIMPSON. Indeed, a very big incentive.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman.

This is really a challenge when we look at what is occurring, because it is not, as Mr. Koitz says, a simple matter. But it is certainly one that has to be dealt with because you look at the explosion of these costs and you look at what we are going to have to do over the next 7 years, or 9 years, whatever trend line we adopt to bring balance to the budget. Something simply must be done. It becomes a very serious challenge.

Commissioner Chater, I would be interested, in line with those thoughts with respect to our need to balance the budget over the next 7-9 years, what are your projections for future growth in these programs? Do you anticipate that these trend lines that we have seen are going to continue, or is there going to be some leveling off?

Dr. CHATER. Based on preliminary data of some studies that we have been doing, we see the disability applications leveling off in the next years. The growth in the SSI disability program, as has been explained by Mr. Slattery, seems to have come from the children. We are seeing a slight decrease, actually, in the number of applications in the SSI program.

We have contracted with a company to do an independent and objective study trying to quantify some of the reasons—the economic, the demographic variables, and so on—so that we can have a better notion of exactly what the contributing factors are, and to see if our assumptions are correct, that there is a leveling off.

Senator CONRAD. So you see a leveling off in disability and you see some actual decline in SSI.

Dr. CHATER. Yes, in the near future.

Senator CONRAD. Well, that is the best news I have heard today. That will take some of the pressure off of the system.

Mr. SLATTERY. Senator?

Senator CONRAD. Yes.

Mr. SLATTERY. If I might interject here one point. I think your staff has copies of these tables that show where we are headed with the allowances and applications for SSI disability for children, and it clearly shows that there is a leveling off in the number of applicants being approved. Excuse me for interrupting.

Senator CONRAD. No, I am glad that you did.

I would like to ask Commissioner Chater, what is SSA doing to address the Continuing Disability Review, backlog?

Dr. CHATER. I would start to answer that question by saying that, in the past, I am told, the agency made a decision to take initial claims versus doing as many CDRs as the agency should have done. The reason for that had a lot to do with the *Zebley* decision. As has been explained to you, we had an enormous case load of applications to review.

In 1994, we did more CDR's than we had done in the past, in 1995, we are in the process of doing more. And, as I said, in my 1996 budget we have requested \$216 million to do more than 400,000 CDRs, and we will continue to increase the number we do annually over the next several years because we feel very strongly that we should ensure the integrity of the program. We should be very, very sure that only people who deserve to be on the rolls are, indeed, on the rolls.

Senator CONRAD. What does it take to do a CDR?

Dr. CHATER. We do a number of things. First of all, we have put into place a procedure whereby we send out mailers to our clients and have them respond in terms of whether they have been able to go back to work, whether they have seen a doctor, that sort of thing. We review the responses in conjunction with a profile developed from information in our records to determine the likelihood of medical improvement. For cases in which medical improvement is likely, we interview, exchange information, require additional medical evidence, to determine whether they are capable of working and should come off the rolls or that they are still eligible for benefits.

Senator CONRAD. Do you have an estimate, how many man hours does it take to do a Continuing Disability Review?

Dr. CHATER. Let me see.

Dr. DANIELS. For cases which are done solely through the mailer process, the cost is about \$50 per case. For cases in which a full medical review is required, the cost is about \$1,000 per case through all appeals levels..

Senator CONRAD. And how long does it take?

Dr. DANIELS. Well, it would depend on the case. For an individual who had a thorough medical record and had contacts with physicians and had an ongoing, good medical record, it could take two, three, four weeks.

But, if the adjudicator had to develop the medical record, that is, send the individual out for exams and then wait for the material to come back, it could take several months. So, it depends upon the quality of the case and how the case needs to be developed, and each one is different.

Senator CONRAD. And how many people are doing these disability reviews?

Dr. DANIELS. They are done by the Disability Determination Services, the DDSs in each of the States. The same agencies that do the initial medical determinations are assigned a certain number of CDRs to do each year. And, as the Commissioner said, next year we plan to assign many more for them to do.

Senator CONRAD. Do we have some measure of productivity? I mean, are you able to look at what different offices are able to produce in terms of CDRs?

Dr. DANIELS. Oh, absolutely. We have workload reports on every State agency.

Senator CONRAD. I have many more questions, Mr. Chairman.

Senator SIMPSON. I know you do. So do I. But we will just exhaust ourselves here till noon.

Let me ask you, Jim Slattery. In your opinion, are these disability standards for children too lax, where are you with that? What are your thoughts?

Mr. SLATTERY. I must tell you, Mr. Chairman, we have just been holding hearings for about 2 months and we have had three meetings so far, and then these Saturday meetings. I have not finalized my own thinking on this matter. I can tell you though, just based on the preliminary information that we have received, it appears that there has been a period of liberalized review and qualification process, as evidenced by the fact that the allowance rate increased significantly from about the mid-30's pre-*Zebley*, to about 50 some percent thereafter.

Well, I can give you the exact numbers. Pre-*Zebley*, the rate of allowance was 38 percent, it increased to about 55 percent post-*Zebley*. But, during 1994—and this is the good news, I suppose—the rate declined to 36 percent. So we have seen a spike up in the allowance rate, and then a drop-off in the allowance rate. It appears to be leveling off at this point. So, I think that is a result of several things.

SSA has sent out some directives to the State, to Disability Determination Services, instructing them to really tighten their adjudication claim process, and I think there is some effect that we are seeing there.

Senator SIMPSON. Mr. Koitz, I might ask you that same question about these disability standards. What do you think about those, are they too lax, too inappropriate, what?

Mr. KOITZ. Three years ago when we were first asked by committee staff to look at this program again, that was my gut instinct, that there was generally a loose adjudicatory climate. I did not take long after jumping in to not be convinced anymore. That was the situation in the mid-1970's. Clearly, the adjudicatory climate was contributing to growth then, but there are so many other things going on now.

When you look at the allowance rates generally over a period of the past four or 5 years, they have not moved that much. There was a spike when SSA tried to deal with a surge in the workload in 1992, but then it dissipated. I have not seen any of these numbers with respect to children that Mr. Slottery refer to.

Senator SIMPSON. Well, you have been crunching those numbers and looking at it, and I consider you an expert in this. So, lumping it all together, why do you think this happened?

Mr. KOITZ. That is the answer I wanted to start with.

Senator SIMPSON. Now you are going to get in trouble. It is all right, we will protect you. You have heard that before, have you not? So speak freely, nothing will go out. [Laughter.]

Mr. KOITZ. I guess I would say I really do not like looking at the economy as the principal cause. I think that all those things I cited in terms of what might stimulate people—outreach programs, the *Zebley* decision—I think they are all contributing.

I also think, and I will get into the CDRs for a second, that there is another aspect to the CDRs that involves more than the number of people who get terminated. SSA is supposed to be doing 500,000 CDRs a year based on the 1980 amendments; in recent years, it has been far fewer.

But I think the impact of that is also on the enrollment side. People are influenced not just by the approval rate that exists on a new claim, they are also influenced by what happens to them when they get into the program.

If the message going out there is, once on you will never be removed, I think that is also a stimulus in terms of enrollment. That might add to the public awareness impact I spoke of earlier. The hot button items, I think—like I said before, the substance abuse, the children, the alcoholics—are easy targets, but there are far more things going on than just them.

Senator SIMPSON. It is my experience dealing with immigration that whenever we would talk about things like cut-off dates for amnesty, or whatever we were doing, that the communication systems in the world that go out through the network of people who watch carefully for the benefits in this country of any kind, would make Ma Bell look like two tin cans with a piece of string; they really get the word out.

My hunch is, the word is out, and the word is really out if you can be 62 years old and retire and get disability. When you retire you get 75 percent of your benefit, or 80, but if you are determined to be disabled, you get 100 percent of your Social Security benefit at the age of 62.

From what I can gather from my research, nobody goes back and checks on very many of them, and this is how we got into part of this, anyway. Once you get on, there is nobody around, they have not got the budget, and I know we will hear, well, if we just had more money we could do this.

But it is worth the risk. The worst thing that can happen to you is you stay at 75 or 80 percent of the benefit. The best thing that happens to you is you get 100 percent of the benefit, and it is only 3 years, and nobody shows up in the 3-year period, maybe one out of 10. It is worth running that risk. I think that is out there. Would you agree with that?

Mr. KOITZ. I do not know how big it is, but, yes, it is out there.

Senator CONRAD. I would ask each of you, if you were in our position and you have got to deal with the balancing of the needs of people who really are disabled, people who really are legitimately in need, and at the same time address the budget crisis that we confront, what would you do?

I mean, you are four of the most knowledgeable people in the country on this. You deal with this every day, we deal with it inter-

mittently, at best. What would you do? Mr. Koitz, how about if we start with you. What would you do and what would you not do?

Mr. KOITZ. I have got to be real careful here. I am from CRS. We have a bunch of these items in pending legislation.

Senator SIMPSON. I will talk to Jim Billington about it all. You go ahead.

Mr. KOITZ. You have a bunch of items in the Welfare Reform Bill that I really cannot talk about. It would be difficult for me politically.

One area, let me just mention, has to do with the CDRs. SSA really is constrained, like other Federal agencies, by the cap on discretionary spending. If we want to beef up spending on disability, and on CDRs in particular, then the money has got to come from somewhere.

If you increase their appropriation, under the rules of the game it has got to come from somebody else's. I think, as the Commissioner may have pointed out earlier, or someone else, you do not get credit for the benefit savings.

Now, the actuary will tell you that for every dollar you spend on CDRs, you are going to get \$4-6 back over the lifetime of the people affected. But if you cannot use that money to offset the cost of performing these CDRs, it is like a tight box.

And, when you look at what has gone on since 1990 when the claims started surging, they are putting their effort into claims, not CDRs. It is largely because there is not enough money left over. I do not know of a Commissioner in the history of this program, when faced with a claims surge, who has not put administrative dollars there first. That is, in fact, what has gone on, I think, with the last three Commissioners. This is just a difficult choice and you have to do it. So, it is the budget box, again, that makes things a little difficult.

At the same time, if you open the door for SSA's relief from the discretionary cap, you have to ask who is going to come in next? That is the big budget dilemma that you face. So, it is complicated.

Senator CONRAD. I tell you who would be in next, would be the IRS, and legitimately so.

Mr. SLATTERY. Yes.

Senator CONRAD. Dr. Chater?

Dr. CHATER. Well, I, of course, would ordinarily point out at this time that in the 1980's we had 80,000 employees to do all of the work that we have to do. Today, we have 64,000 employees to do all the work we have to do, plus all of the increases that we have heard about.

So, it seems to me that one of the things that we as an agency can do, and are doing, to control costs is to maintain the integrity of the program, to try to look for ways that we can more effectively and efficiently do our work.

Toward that end, we have a proposal in place to completely re-engineer the way we look at our disability clients, the way we take the applications, and the procedure that we go through to make a determination of eligibility. We have in place our own internal quality assurance program. Therefore, I can sit here today and tell you that we exceed a 90 percent accuracy rate in the kinds of things that we do.

We are also looking for different ways to restructure our agency so that we can serve the customers best, but at the same time maintain the integrity of the program.

Senator CONRAD. Well, let me ask you this. I guess part of the frustration I have is, when you look at this, how do you diagnose the problem? Do you diagnose it as, well, this is really population growth, is it really outreach, is it really the court decision, that is the reason for this growth?

Or do you say to yourself, this court decision has really gone too far and we have a lot of people who are being swept up in this who are being made eligible that really should not be eligible? How do you diagnose the problem?

Dr. CHATER. When we look at the whole program and we decide that we might need to change a bit of the legislation, we bring to your attention a suggestion for change in legislation. We have been working internally on some of the things that we might do to make some of the program aspects tighter, different, and we will be asking for legislative changes.

Mr. SLATTERY. Senator, if I could.

Senator CONRAD. Yes.

Mr. SLATTERY. If you could give me until the 1st of September—I am going to beg for another 30 days; I said earlier it would be August—and give me some time out here, we will come back with some solid recommendations to help you make these decisions. I am confident that we can do that.

Let me just say though, I think one of the most important things that Congress could do in the area of SSI and children is to really have a thorough debate as to what you want the program to be. There is great ambiguity in the law, I contend, and the legislative history of the program as it affects children is rather sparse, to say the least.

So I think it would be very good for this committee and the Congress to debate the question of, for example, is this program supposed to provide money to low-income families with disabled children, and to all of them?

Is it intended to be a more narrow program in that it would provide funds to low-income families with a disabled child to cover additional costs that result from having a disabled child in the family? Is it intended to provide some assistance to a family to cover a loss of income that might be earned if a spouse who is staying at home to care for a disabled child was able to work outside the home?

These are the kinds of things that I think the Congress really needs to look at, debate, and decide as a matter of public policy. Congress should decide what the program is supposed to do, and then we need to look at how to best administer that.

I would just point out that right now we are into a situation where the courts have gotten involved, clearly, with *Zebley*. That accounts for 41 percent, as I indicated in my testimony, of the growth in this program for disabled children.

Then you have the change in the medical listings, and accounts for a big part of it, too. Then you have court cases and legislation telling SSA, go out and really find these children that are disabled and bring them into the program. So those three factors, as best

as we can determine at this point, are what is really driving the increase in the SSI program for disabled children.

Again, I want to emphasize that it appears this trend is leveling off. If you refer to this one chart that you should have, it shows that the actual number of allowances has declined.

It peaked out in 1992 at 248,000, it dropped just a little bit in 1993 to 238,000, and then in 1994 it is down to 197,000. So it is showing that this thing has peaked out and is on a decline. It is very difficult to determine where we are going to be in a couple of years on this, though.

Senator SIMPSON. Kent, you would be interested, as I was, that when this program, SSI, was enacted in 1972 it was particularly directed to the elderly, blind, and disabled. The word "children" was not even in there. Now, think about that for a minute, how far we have gone from the program.

So, it goes to your question. Somebody better define what it is we are supposed to be doing, because it was for the elderly, the blind, and the disabled, SSI. Unlike SSDI, benefits were not based on work history.

Mr. SLATTERY. If I could just make an observation, and I hope I do not offend anybody in doing this. As a person who spent 12 years on that side of the table, sometimes we do not really fully comprehend what the changes in the laws do. We don't understand what the court changes and court orders do to the people in the government that we all sort of flippantly refer to as bureaucrats.

Sometimes they are put in horribly impossible situations. The courts tell them to do this, and Congress is telling them to do something else, and then we all get after them because the cost of the program is growing too fast.

So, that is why I think it is so important for us at this time to really have a good, thorough debate about what you want the program to be. Let us clarify it, let us make a decision on that, and then let us figure out exactly how we can best administer it.

Senator SIMPSON. Let me ask you a question then, because we have talked about cash and the misuse of cash is dramatic, and obviously will be if a mother or father is using drugs and trying to get the child into a situation where they can get cash.

So what about a voucher system for these people? If we are going to do this review, which I think is very critical, then why not vouchers which are more targeted and given to assure that they get to the right spot instead of the user, the abuser, or the child abuser or the person who has got the kids so screwed up that they want to get that done so they can get money. Now, I know that that is bizarre, but you see, I have to listen to the horror stories on the other side all day.

Mr. SLATTERY. I understand. I understand, Senator.

Senator SIMPSON. So I get to throw in mine, which usually irritates people to the depth of their being. But, nevertheless, that could be.

Mr. SLATTERY. Yes. Well, clearly, a review and a study of the viability of a voucher approach is within the purview of this commission, and we are looking at that.

Let me just share with you also. One of the interesting things I found about this is that the amount of money that a child and that

child's family receives, after the initial determination of disability, is driven by the income level of the household, the family.

So, for example, if you are determined to be disabled with a serious case of Attention Deficit Disorder, you may become eligible for a \$458 monthly payment if the family income triggers that.

There is not a relationship between the severity of the disability and the payment granted, unlike, for example, with the veterans' system where you have a tiered system that starts out with 10, 20, 30, 40 percent disability, and your compensation is based on that severity of disability.

In this program for children, once you trigger disability, then the payment is related to the income of the family, not to the severity of the disability.

That is something that we are looking at because it is different than, for example, the veterans' system that I was familiar with as the Chairman of the Compensation and Pension Subcommittee of the House Veteran's Affairs Committee for a few years. It is something that we are looking at. I would caution the committee that, if you move in that direction, obviously you complicate the process significantly.

Senator SIMPSON. Very worthwhile paying attention to what you are going to report and to what the Advisory Committee is going to report on Social Security, and they are going to come in in June or July; is that not correct, Dr. Chater?

Dr. CHATER. That is correct.

Senator SIMPSON. So I hope they will have screwed up their courage to the sticking point and will give us something other than pap. At least the trustees have done that when they are telling us the thing will go broke, and that is under the intermediate projections.

I had an incident shared with me from a Los Angeles county commissioner who I worked with on immigration, and obviously California is the most affected State. A California physician was recently involved with an SSI application filed by a person from Armenia who had never yet entered the United States. Now, this happened. I can present it to anyone that would wish. That, to me, is a very serious problem.

First of all, how could an application from outside the United States from a person who has not yet entered even be considered? It would seem to me you could just take a snap and toss it back out through the window. It does not take any wizardry to reject that.

How could someone apply for that without stepping on U.S. soil? Then we are hearing that these applications are being prepared by "volunteer centers." How can we be sure that those are not fraudulent applications?

Or the payoff system. You get me on the system, I will give you a cut of the stuff. I guess, to me, how much outreach is enough? I think that the word about SSI has apparently traveled across the entire world, and it is this: come on over and try to get onto the gravy train if you can. That is part of this. It is not the big part. We do not know what part, but it is part of it.

Do we really need any outreach efforts at all in light of the staggering backlog of unreviewed cases of individuals already on SSI? Who is it we are trying to reach?

Dr. CHATER. Well, the outreach program really has less to do with the alien population than the disabled children, so I would make that point. Second, I would say that to get SSI you must be a resident. You have to be legally in this country.

Senator SIMPSON. I know that.

Dr. CHATER. You cannot do that.

Senator SIMPSON. What has happened?

Dr. CHATER. We will check that.

Senator SIMPSON. I think that would be good.

Dr. CHATER. We want to check everything that is alleged to be wrong. About the question that you raised about centers serving as volunteers to help people with applications, yes, it is true that some of the community organizations do that.

In fact, I visited some in California where a particular community organization would help people apply for Social Security, particularly if they could not speak the language very well.

But we have tightened up considerably on review of applications, even those done in a volunteer way, and we have brought in many of our own interpreters so that we no longer have to depend as much upon the interpreters who come from those community organizations. And SSA employees have been reminded they can stop an interview any time they doubt the quality of the interpretation.

We also have in place a policy that if we suspect a medical doctor of writing too many claims that are identical or appear to us to be false, we alert the State DDS's to no longer use those particular physicians and to give existing evidence from them little or no weight.

Senator SIMPSON. I thank you. I have one more 5-minute round that I want to ask, just to advise you all, and then we can conclude. Perhaps Senator Conrad would wish to have another, too, but it is his turn now. I am not accounting against his 5 minutes. Yes.

Senator CONRAD. The House plan that we have heard testimony about this morning would propose cutting some 200,000 children off the rolls. I would be very interested in what your impression is of that proposal and what the effect would be on children.

Would it hit children that are legitimately deserving? Is there so much abuse in the program that we have got to take this kind of meat axe approach? I would be very interested, Mr. Slattery, in your impression of that proposal.

Mr. SLATTERY. Well, again, this is based on our preliminary discussions. But let me share with you that a total elimination of the IFA is going to create some problems that existed pre-*Zebley*.

Specifically what you will get into is a situation where there will be children that have multiple impairments. If you look at each impairment and try to match it up with some kind of listing, they may not be disabled. However, once you look at the totality of all of their impairments, then they are clearly disabled. That was the essence of the *Zebley* case.

I would just also point out, for example, with the total elimination of the IFA you could get into a question such as if a child has diabetes, for example, how are we going to deal with him?

Now, with some medication that child may be able to function normally but with severe diabetes it may not be the case. With the total elimination of an IFA, you get into the question of, are these children going to be kicked off the rolls?

There are also examples of children who have, perhaps, multiple sclerosis, or spina bifida, and there are questions as to how they would fit into this listing process that would be in place if the IFA was totally eliminated.

So, there is a role for the Individual Functional Assessment in determining childhood disability. I do not know, as I sit here today, exactly what that role is, but the total elimination of it, I do not think, makes sense. I think if it was totally eliminated, you will see a number of children who are truly disabled being eliminated from the rolls. I have cautioned people to be very careful about that, and I have also said that when you are looking at a universe, again, of some 890,000 children that are disabled and you talk about taking 200,000 off the rolls, that is a major change in the program.

It is very important for all of us to understand the profile of those 200,000 children in making a determination—and this is where it gets back to the legislative process—that those 200,000 children are not disabled, and therefore, are not eligible for the program.

Senator CONRAD. If we had case studies on those 200,000 children, what would they look like? I get the feeling from some of the testimony of Senator Santorum that there are kids with Attention Deficit Disorder. And this is something we would have dealt with by being a little more disciplined when I was growing up, now we put them on SSI. I mean, is that really what we are talking about? What would we see if we saw the faces of these 200,000 children?

Mr. SLATTERY. Well, that is a very good question and it is one that I have asked our Commission to help me answer more specifically so that everybody can understand it. When we make our final report on this we will be able to provide you with that kind of information.

But, again, just a minute ago I mentioned questions about, for example, a child that has diabetes, a child that has multiple sclerosis, a child that has spina bifida. There are questions as to how they would fit into the definition of disability that would remain after the elimination of the IFA.

Senator CONRAD. Mr. Koitz, I would be interested in your response to the question.

Mr. KOITZ. Let me just make an overall point about awards to kids. Most of the kids coming into this program, whether through the IFA process or through the medical listings themselves, are mentally retarded.

Senator CONRAD. Are mentally retarded.

Mr. KOITZ. Right. The last figure I saw—

Senator CONRAD. That is the biggest population. I was noticing that.

Mr. KOITZ. Among the mentally impaired, that is the biggest group.

Senator CONRAD. They are mentally retarded, they are not Attention Deficit Disorder, they are actually mentally retarded.

Mr. KOITZ. Right. Now, the listings have been changed, maybe, about four or 5 years ago and there has been some functional assessment actually put into the listing that people perceive as being the next step in the process, but it actually is in the listing itself. This is one of the areas.

Senator CONRAD. But would we be knocking 200,000 mentally retarded children off?

Dr. CHATER. May I respond to that, please?

Senator CONRAD. Go ahead.

Dr. CHATER. Perhaps I can give you the figures that I have here. Of the 890,000 children on SSI, 39 percent are mentally retarded. That comes to about 350,000 children. In addition, 22 percent are labeled as having "Other Mental Disorders." That is the 200,000 children we have been talking about. Perhaps another example will suffice. Perhaps a child has applied for disability based on some sort of a musculoskeletal condition.

But our determination service knew that, because of the mental disorder that the child also had under an Individualized Functional Assessment—in other words, they saw that disorder first so they recorded or coded in our records the fact that this child had an "Other Mental Disorder."

If we were to take the 200,000 children off the rolls quickly and without a lot of thought, we would have to probably re-review those cases, to identify and re-code the person with the musculoskeletal condition.

In other words, some of the children in this mental category are physically disabled as well. That is the caution that I think we need to keep in mind.

Mr. SLATTERY. If I could, about 13 percent of the total universe that we are looking at are children who have behavioral disorders. Now, as I understand the way our statistics are compiled, that number includes ADHD children, although technically ADHD is not a behavioral problem.

But, again, if you are looking for a percentage of the total of 890,000 children that are on the program, approximately 13 percent are in this group of behavioral disorders.

Senator SIMPSON. This is very perplexing, and no one at this table or in the Congress is interested in being mean-spirited, ugly, or evil. You have worked with Democrats and Republicans in the House, so I have, so has Senator Conrad. We are not looking how to get rid of people and throw veterans out in the street, and children, and break bedpans in the hospitals. That is not what we are here doing. But I want to enter into the record a very fascinating article in The Baltimore Sun of January 22nd, Sunday, 1995, thoroughly researched, and the Commissioners' News Digest has furnished us with this copy. This is called "America's Most-Wanted Welfare Plan."

[The article appears in the appendix with Senator Simpson's prepared statement.]

Senator SIMPSON. The case is a discussion of a woman in Lake Providence, Louisiana, for whom the doctor wrote on her application, "Patient is determined to become a ward of the government." This is not welfare queen stuff. I have been through all that stuff.

This is a very fascinating discussion of a person who picked up nine Federal checks a month, tax-free, adding to \$46,700 a year.

Guess why. Because of this definition under government rules that translated into a failure of her children, who were 13 to 22—they lagged behind in school and scored poorly on psychological tests—to demonstrate “age appropriate behavior,” qualifying each of them for \$458. The payments in the community, according to this reporter and to the people who witnessed this happened, were called “Crazy Checks.”

Now, if every time we hear the horror story of, button your shirt, your heart fell out, I get to pull one of these out of the box. That is the only way we are going to get this done. It will not be done on the basis of emotion, fear, anguish, and guilt. But the most extraordinary thing is, and my staff compiled this, when they finished they said that they felt that all of them could qualify for benefits. Here is the qualification for “mental disability” under the Social Security Administration rules and regulations. I have spent a lifetime in mental health work, my father before me, my wife, very active.

Here is how you qualify under the Social Security Administration for emotional disorders. A) if you have four of the following: loss of interest in activities, trouble sleeping, agitation, decrease or increase in appetite resulting in weight change, decreased energy, feelings of guilt or low self-esteem, difficulty concentrating.

Two of them are very valid and very potent, and they are two of the nine. One, is suicidal thoughts, and hallucinations, delusions, or paranoia. Those are real. The other seven afflict all of us in some way every day of our lives.

Then if you have three of the following you may be manic. Here is that list.

Senator CONRAD. Could you read the ones that apply to you every day? [Laughter.]

Senator SIMPSON. Yes, I could. Agitation. [Laughter.]

Senator SIMPSON. Just like a steer. Then decreased energy from the schedule they give us. Feelings of guilt. A little bit of that flips back and forth in this place. Difficulty concentrating. Trouble sleeping. I do not have that, at least according to my wife.

Senator CONRAD. Dr. Chater, do you have an application with you? [Laughter.]

Senator SIMPSON. No, wait. As Kent knows, and he works in this stuff, it is funny, but it ain't funny. Now, here is the list. You may be manic if you have three of these: (1) hyperactivity; (2) racing thoughts; (3) uncontrollable talkativeness. I mean, everybody would flunk that test. Inflated self-esteem. I mean, that is a trait of great glory here.

Decreased need for sleep, easy distractibility, failure to recognize unpleasant consequences of actions, and then a real one: hallucinations, delusions, or paranoia. Now, if you have a combination of the above you may be manic depressive, according to your own work.

Then if you have any of the following you may qualify: a history of unexplainable symptoms beginning before age 30 that resulted in unnecessary medication, doctors visits, and changes in living habits.

Then in personality disorders, it says if you have any one of the following ingrained behaviors you may qualify, and here they are: seclusiveness, unreasonable suspicion or hostility; odd thinking, speech or behavior; mood swings; chronic dependency, passivity, or aggression; unstable relationships and impulsive, damaging behavior.

And any of the above, combined with at least two of the following, will make you eligible. That is: restriction of daily activities; inability to function socially; inability to concentrate or complete work tasks; deteriorating work quality.

I am telling you, if that is the scenario, then it does not matter what we revisit here if suddenly you have taken this from 4-11, as you discuss, and that this is the scenario, from your source, as to how people qualify for \$458 a month.

Dr. CHATER. Senator, I would like to ask Dr. Daniels to respond to your comment, please.

Dr. DANIELS. I think what you were reading from was the list of symptoms that a doctor would use to make a diagnosis. First of all, I would like to say how those are developed. Those are developed with physicians specializing in mental illness and in mental impairments.

These particular traits that you were talking about are traits that occur in depth, in persistence, and in ways that not only show themselves in a person's life in a casual way, but in a way that is really very debilitating to them.

So we could read off any of those lists things like sleeplessness and irritability, and we know that each of us has various symptoms of these things in our daily lives, but a physician making this kind of determination would be looking for those characteristics that are persistent for a person and that debilitate them.

These are the kinds of things that a doctor would be looking at in terms of making a diagnosis of a medical-based mental illness. Now, I say that because this diagnosis is not made by a lay person. The Social Security Administration requires that a physician look at the symptoms and give us information about the symptoms, and then not just the symptoms, but, as you just read, how those symptoms interfere with the person's daily functioning. So, there is the A list and the B list.

Even if the person had all of those symptoms and the doctor said the person was mentally ill, and those were the symptoms of their mental illness, if they did not debilitate the person if it did not, in fact, cause them to have difficulty in activities of daily living, have difficulties in concentration or finishing tasks, then they still would not be qualified. The person must meet both criteria.

I think if you just take one piece, it does not make sense. You have to read the whole list and recognize that a physician is, in fact, making this determination.

Senator SIMPSON. Well, it is not funny and I think all of us realize, if you wanted to game a system based on that you could game the system, especially if you had a translator, who was your own, brought into the office.

You must begin to do something with that, because a translator who is bringing the person in, I have found, is telling a horror story that no one would reject. That is what we are looking at here.

I intend to look at that, and I think it is important that we do. But what happened with this particular case here where the stack is now about two feet high of this person who now is into the system for \$47,000 a year, including her common law husband, who is too obese to work. He weighed 300 some.

It is a pathetic and unbelievable thing, but he was unable to work because of his weight and nothing apparently was done with regard to that. 386 pounds is what the common law husband weighed, and he was awarded the same amount by the judge. One of the daughters is doing fairly well, and it is a tragic, tragic situation. But nothing here requires that the money go to the disability.

Mr. SLATTERY. Well, Senator, if I might just comment, I am personally familiar with the case that you have referred to. I have read The Baltimore Sun article that you referred to. We have also heard directly from a man by the name of Willie Lee Bell that is prominently mentioned in that article. He has testified before our commission.

One of the things that we are looking at at this point is some kind of a cap on the total amount of money that a family might receive under this disability program, so that if you have five children, or 10 children, or whatever, there would be an aggregate limit on the amount of money a family might receive. Currently, there is not such a cap. So, that is one thing that we are looking at.

And I want to assure the members of the committee also, that the members of the commission are very concerned about the disincentives in the existing law, and we are looking at this from the standpoint of trying to make sure that the incentives are consistent with the goal of moving people toward a life of independence. We are very concerned about the stories that you have referred to. Members of the commission have looked at that and we are trying to sort through it. We will do the best we can.

Senator SIMPSON. Kent, did you have any further questions?

Senator CONRAD. Dr. Chater, have you found multiple members of a family to be a big part of the case load, or to what degree is this a problem?

Dr. CHATER. It is not a big part of the caseload. May I submit for the record our statistics that show you exactly how many families received benefits with five members, four members, three, two, and single? That would be helpful to you. I do not have the numbers in my head, but I would like to submit it for the record.

[The information referred to follows:]

NUMBERS OF INDIVIDUALS WHO RECEIVE SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS WHO ARE LIVING WITH OTHER SSI RECIPIENTS

[By unit size and percent of total recipient caseload, March 1994 Data]

Size of multi-recipient unit	Number of recipients ¹	Percent of all recipients
2	367,120	6.2
3	103,320	1.7
4	27,360	.4
5	5,500
6	1,800
7	1,400

NUMBERS OF INDIVIDUALS WHO RECEIVE SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS WHO ARE LIVING WITH OTHER SSI RECIPIENTS—Continued

[By unit size and percent of total recipient caseload, March 1994 Data]

Size of multi-recipient unit	Number of recipients ¹	Percent of all recipients
8	320
12	720
All units	516,540	8.5

¹ Based on 5 percent sample: Does not include eligible couples.

Senator CONRAD. But your assertion is that that is not a big part of it.

Dr. CHATER. The number of multiple recipients in a family is relatively low.

Senator CONRAD. All right.

Senator SIMPSON. I want to thank you very much. Thank you, Senator Conrad, for taking an interest here. I enjoy working with him on it. Senator Breaux is the Ranking Member of the subcommittee. I look forward to working with him on this issue. He could not be present today.

Thank you. You have given us a great deal of provocative material and we are going to try to do some sensible things with it. I can assure you, it will be done in good faith.

Thank you very much.

[Whereupon, at 12:19 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SHIRLEY S. CHATER

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) disability programs. As you requested, I will address the reasons for growth in both disability programs and some measures we are actively pursuing to address the growth and the resulting costs.

Before I begin my discussion, Mr. Chairman, let me point out that there are some indications that the growth of the program has slowed. In 1993 and 1994 SSDI applications and awards have remained about the same, and applications and awards for the SSI disability program have actually decreased. However, it is impossible to draw a conclusion for the long term based on this limited experience. Nevertheless, I would like to make it clear that the Administration is concerned about the increase in the disability programs over the past several years. As I will be discussing in further detail later in my testimony, preliminary findings show that program growth is driven by both an increase in applications and a decrease in terminations. The fluctuation in the number of applications and terminations are, in turn, driven by economic, demographic, and program-specific factors which I will describe. There are actions we have taken and can take to address program-specific factors relating to growth; however, as you know, certain changes are beyond the Social Security Administration's (SSA's) control, such as personal health status, environmental conditions, and general economic and demographic factors.

It's important to realize that the current growth in disability costs is not a new experience for the disability program. In the Social Security Amendments of 1977, Congress increased the funding of the DI program to accommodate this growth in program costs. However, by the time the Social Security Amendments of 1983 were enacted into law, disability incidence rates had declined significantly, and the future cost of the DI program was projected to be much lower than previously estimated. The funding for the DI program was accordingly reduced in the 1983 amendments. Subsequent developments, including legislative changes and court decisions, have led to higher rates of program growth approaching the growth experienced in the 1970s. Had the funding provided for the DI program in the 1977 amendments been retained, the DI Trust Fund today would actually have an actuarial surplus over the next 75 years.

To facilitate our discussion today, as you requested, I will begin by providing you with a look at what we believe are the reasons for the recent overall growth in the SSDI and SSI programs, particularly focusing on the last 5 years. I would then like to briefly address the two categories of benefits in the SSI disability program which have been the focus of much attention in recent years—children and drug addicts and alcoholics. Following that, I will describe our initiatives to address program-specific factors contributing to growth in the disability programs. Finally, I will discuss our action plan for the future.

REASONS FOR SSDI AND SSI DISABILITY PROGRAM GROWTH

The number of people receiving disability benefits from these two programs rose from 5.4 million in 1989 to 7.9 million in 1994, an increase of 46.6 percent. As a result, benefit payments grew from \$33.8 billion 1989 to \$58 billion in 1994, an increase of 72 percent.

To determine the causes for the recent growth in disability, SSA, in conjunction with the Department of Health and Human Services (HHS), conducted an analysis in 1992 of the SSDI program and prepared a report for the Board of Trustees of

the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. We surmised that certain factors—such as unemployment and demographics—contributed to the recent growth in the SSDI program. However, although there has been general agreement among experts that these factors account for much of the recent growth in the disability program, we were unable to quantify the impact.

After receiving our 1992 report, the Board of Trustees recommended that we initiate a research effort to establish whether the growth represents a temporary phenomenon or a longer-term trend.

In response to this recommendation, and in cooperation with our colleagues in HHS, we contracted with Lewin-VHI, in 1993, to produce an independent assessment which would quantify the reasons for disability program growth. While we do not yet have a final report on this study, preliminary findings confirm many of our earlier assumptions.

Both our past and current analyses and that of Lewin-VHI indicate that disability program growth can be attributed to the reasons I mentioned earlier, the economy, demographics, and program changes. Let me explain how these three elements have influenced the increase in disability applications.

ECONOMIC FACTORS

Economic conditions appear to be a large factor in affecting application rates for the SSDI program. The most direct way this can occur is when severely impaired workers, who previously worked despite their disabilities, lose their jobs and apply for benefits. Similarly, the most recent recession put more people in poverty, thus increasing the universe of potential eligibles for SSI benefits. As the economy has improved, the SSDI program is experiencing a slowing in applications.

DEMOGRAPHIC FACTORS

In addition, two demographic factors have largely contributed to increased applications:

- the aging of the baby boomers has made them more vulnerable to disability; and
- an increasing proportion of women have worked long enough to be insured for SSDI benefits.

We believe these demographic trends will continue to be a source of program growth in the future.

PROGRAM-SPECIFIC FACTORS

In addition to the influence of economics and demographics, there are a number of program-specific factors which have caused increases in the disability program. For example:

- Legislation, regulations, and court decisions have resulted in changes to both the SSDI and SSI disability programs. One example is the Supreme Court's decision in *Sullivan v. Zebley* which mandated a change in the way SSA evaluates disability in children. The Court held that instead of evaluating children with disabilities using solely a medical listing criteria, SSA must provide children with a functional assessment based on their ability to perform age-appropriate activities. The new criteria increased the number of children eligible for SSI benefits. While the *Zebley* case involved children applying for SSI benefits, we believe that the wide publicity given the case may have prompted some workers to apply for SSDI benefits as well.
- As a result of a 1984 congressional mandate, we revised the criteria for evaluating disability, particularly involving mental impairments. These revisions contributed to recent increases in the proportion of applications that result in benefit awards.
- SSA's "outreach" efforts have also influenced the disability growth in recent years. Outreach efforts—intended to inform potential eligibles about the SSI program—have also influenced the number of SSDI applications, because many of the SSI applicants are eligible for SSDI benefits. Also, the growth has been influenced by increased public awareness of the disability programs due, for example, to congressional actions or class action court cases which sometimes mandate that SSA conduct public information initiatives. Advocacy groups also conduct their own outreach efforts.
- Finally, State cuts in general assistance and State and local efforts to have persons with impairments apply for Federal programs have contributed to the increase in SSI disability claims.

We expect to have a final report on Lewin-VHI's study this summer. This report will further refine and extend their preliminary findings and attempt to determine if these effects are likely to recur in future recessions.

DISABILITY TERMINATIONS

Having discussed the underlying reasons for the increase in the number of people applying for disability benefits, I would now like to turn to the other end of the spectrum—disability terminations, or the number of people leaving the disability rolls.

Disability benefits are terminated when a beneficiary medically recovers, returns to work, or dies. In addition, disability benefits are terminated when beneficiaries reach age 65 because they are transferred to the retirement rolls. The percentage of beneficiaries whose disability benefits are terminated has steadily declined. There are several reasons this has occurred. For example:

- The baby boom cohort has contributed to a general lowering of the average age of disability beneficiaries;
- There have been more awards to people with mental impairments who tend to be younger and physically healthier, and therefore remain on the disability rolls longer;
- The 1984 Disability Benefit Reform Act required a medical improvement standard for continuing disability reviews;
- Medical and technological advances have increased life expectancy; and
- There has been an increase in the number of female beneficiaries, who tend to have a greater life expectancy than males.

Clearly, these factors are, to a great extent, beyond our control. However, SSA conducts two important activities—continuing disability reviews (CDRs) and “employment strategies”—which can affect the number of disability terminations. CDRs help ensure that only those who are truly disabled continue to get disability benefits, whereas our employment strategies are intended to help beneficiaries who remain disabled enter the workforce, despite their disability. I will discuss these activities in greater detail in just a moment.

GROWTH IN SPECIFIC SSI PROGRAM AREAS

Now that I have described some of the reasons for growth in both the SSDI and SSI programs, let me turn to a discussion of the area where growth has been most controversial—the SSI program. While it is true that both programs have been growing rapidly, in the last 5 years, the SSDI program has grown by about 37 percent compared to approximately 53 percent for the SSI disability program. In the SSI program, there are two groups of SSI recipients which together represent about 20 percent of the SSI disabled population—children (18.5%) and drug addicts and alcoholics (2%). Much discussion has surrounded these categories of recipients in recent years. Therefore, I would like to briefly discuss the growth in the number of these recipients.

GROWTH IN THE NUMBER OF SSI CHILDREN

I will focus first on the growth in the number of disabled children receiving SSI benefits. Growth in this category of beneficiary is the single most important factor in the growth of the SSI disability program. During the past 5 years, the number of disabled children receiving SSI has tripled—growing from about 296,000 in 1989 to just over 890,000 at the close of 1994. Children now represent about 18.5 percent of the total SSI disabled population compared to 9 percent 5 years ago. Moreover, during that same period, program costs associated with children grew from about 1 billion dollars annually to five billion dollars annually.

We believe that this increase can be attributed to three major causes: the *Zebley* decision (which I mentioned earlier); updates to the medical criteria for evaluating mental disorders in children; and outreach efforts mandated by the Congress.

The increase in the number of children receiving SSI, particularly based on mental impairments, along with the evaluation of behavioral criteria, has led to allegations about abuse in the SSI program. SSA, the Congress and the media have received inquiries from school teachers, psychologists, and State legislators alleging that some children with relatively mild impairments, such as learning disabilities and other behavioral problems, are being found disabled; and that parents may be coaching their children to misbehave or under perform in an effort to receive benefits.

Mr. Chairman, although these complaints are anecdotal in nature, I want to assure you that we have investigated every allegation and will continue to do so. I am determined to maintain the fiscal integrity of the SSI program.

For instance, in an effort to determine whether these alleged abuses exist, we undertook a study of childhood disability claims to see if new regulations were being applied correctly and whether there was any evidence of malingering or coaching. Our study focused on impairments involving behavioral abnormalities and learning disorders.

We found that the rules governing the evaluation of disability in children were generally being applied correctly by those making disability determinations. Of course, if any problems are found, we will certainly take corrective action. In addition, studies by the Office of Inspector General for the Department of Health and Human Services and the General Accounting Office have not found evidence of widespread abuses in the program. Nevertheless, we are continuing to look for ways to ensure that only those children who meet the current statutory and regulatory definition of disability receive benefits. Let me mention here that the Commission on the Evaluation of Disability in Children, which was mandated by the Social Security Independence and Program Improvements Act of 1994 is examining the statutory definition of disability for children. The Commission, in consultation with the National Academy of Sciences will study the effects of the current SSI definition of disability as it applies to children under age 18 and their receipt of services, including the appropriateness of an alternative definition. It will also examine the feasibility of other major changes in SSI benefits for children, including the desirability of providing benefits through non-cash means, such as vouchers. In addition, the Commission will look at other issues, including ways to increase the extent to which benefits are used to help a child achieve independence and an ability to work. We understand that the Commission has expedited its review and we are very optimistic that the forthcoming recommendations from the Commission will assist us in determining appropriate reform in the eligibility criteria and payment options for childhood disability benefits.

While we feel confident that we are administering current law and regulations properly, we do agree with the concerns about the growth of the program. The criteria for determining whether a child's impairments are significant enough to warrant Federal assistance for that child and his or her family is an appropriate subject for serious discussion. While change may be warranted, we are not convinced that the measures currently under consideration in the House provide the answers.

- Changing a large part of the program from direct cash benefits to State block grants reduces the flexibility of families to determine the best way to spend money to assist their children with disabilities. At the same time, it would require the creation of State bureaucracies to administer programs for service that would be more complex than the Federal cash benefit program currently in place.
- "Fixing" the definitional issue by simply removing a step in the process rather than better defining by law and regulation the population of children to whom assistance should be provided may lead to the inadvertent exclusion of children with serious disabilities.

The Administration sees the need for careful reform in this area. We believe prudence dictates waiting until the reviews identified above are completed.

GROWTH IN THE NUMBER OF DRUG ADDICTS AND ALCOHOLICS

Mr. Chairman, let me now briefly address one other area of growth in the SSI disability rolls: the increase in the number of individuals who receive benefits based on drug addiction and alcoholism. Although DA&A recipients currently represent only 2 percent of the SSI disabled population, this area of growth has been the subject of much attention and controversy, as well as recent legislation. And, in fact, over the past 5 years, the number of individuals receiving SSI based on DA&A has significantly increased—from about 17,000 in 1989 to just over 100,000 in December 1994. The growth in the DA&A rolls has primarily resulted from two factors:

- Emphasis on the need for the State Disability Determination Services (DDS), which make the disability determination for SSA, to code accurately cases involving DA&A impairments; and
- Active outreach activities to promote awareness of the availability of SSI payments for those who have serious mental illness in addition to substance addictions.

The growth in the number of SSI recipients receiving disability benefits based on DA&A has also led to increased public concerns and questions about the fundamental nature of the SSI program and whether it is appropriate to provide cash benefits to such recipients. Questions have also been raised about the responsibility these individuals have to seek recovery. Unlike many other disabled individuals, those

suffering from substance addictions can, to varying degrees, influence their recovery by their own actions.

In response to such concerns, the Social Security Independence and Program Improvements Act of 1994 included new restrictions on the payment of benefits to SSDI and SSI beneficiaries whose disability is based on DA&A. The new provisions generally limit the payment of SSDI and SSI benefits to 36 months, establish mandatory, progressive sanctions for noncompliance with treatment, and require installment payments of retroactive benefits to representative payees.

We are implementing the new provisions and are hopeful that these new measures will provide strong motivation for individuals disabled by substance addiction to improve their condition and become self-supporting.

INITIATIVES TO ADDRESS PROGRAM-SPECIFIC FACTORS

Mr. Chairman, you also asked me to discuss options to address the increasing program growth. As I stated previously, preliminary findings of the Lewin-VHI study clearly indicate that high unemployment is one of the most important factors influencing growth in the SSDI program. Again, the state of the economy is beyond SSA's control; however, if low levels of unemployment are maintained, it may have a corresponding effect of decreasing the number of SSDI and SSI applications filed.

Although economic and demographic influences are beyond SSA's control, let me describe to you efforts we have been making to address factors within our control.

SSI CHILDREN

Let me turn first to initiatives to ensure that only children who are eligible under current law and regulations receive SSI disability benefits. Since the implementation of the childhood disability regulations in 1991, we have conducted a special review of SSI disability childhood medical determinations to ensure that they are correct. In addition, we have:

- Provided training to all adjudicators on those issues which are most easily misinterpreted and on the adjudicator's role in detecting coaching and malingering;
- Reviewed all childhood disability claims in which coaching or malingering is either alleged or suspected;
- Established several 800-numbers across the country for teachers and other school personnel to make confidential anonymous reports about perceived coaching or malingering; and

We are assessing the childhood disability regulations to determine whether the new standards are being applied correctly or whether they require some adjustment. On this point we are working with the Commission on the Evaluation of Disability in Children.

DRUG ADDICTS AND ALCOHOLICS

We have also made excellent progress in implementing the provisions of the 1994 legislation placing restrictions on the payment of benefits to drug addicts and alcoholics. For instance, we developed and published regulations necessary to implement the new law despite a 6-month timeframe and the complex nature of the issues addressed in the regulations. We also issued notices to DA&A beneficiaries explaining the new provisions and advising that they are subject to them. Additionally, we now have referral and monitoring contracts or agreements in place for treatment purposes for the District of Columbia and all States except one. (We expect to have a contract in that State by the end of the year.)

QUALITY ASSURANCE

Mr. Chairman, in addition to the efforts we are directing to specific populations of beneficiaries, we have a number of safeguards in place to ensure the integrity of the disability programs overall. For example, we review a statistically reliable sample of decisions to assess the accuracy of all aspects of disability claim processing.

Moreover, we established sunset provisions on our regulations involving disability criteria to ensure that they reflect up-to-date medical knowledge and that our rules are being applied accurately. We will be aggressively reviewing these rules as they sunset.

CONTINUING DISABILITY REVIEWS

Let me now focus on the two activities I mentioned earlier which can affect the number of terminations: continuing disability reviews, or CDRs, and employment strategies. Once beneficiaries are on the rolls, Mr. Chairman, CDRs ensure that

only those beneficiaries who continue to be disabled remain on the rolls. The upsurge in initial disability applications required that difficult decisions be made about the prudent use of limited administrative resources. Accordingly, in recent years, decisions were made to give highest priority to processing initial claims in order to ensure that eligible applicants with disabilities receive their benefits as quickly as possible, because these benefits are often the only means of support for the disabled and their families.

Nevertheless, to help preserve the integrity of the disability programs, we recognized that we need to strike a better balance between addressing the growing workloads in initial disability claims and conducting CDRs. However, the increasing pressure of other major workloads would not allow continued use of the traditional lengthy, labor-intensive CDR process. Thus, in 1993 SSA implemented a more efficient CDR process through the use of a mailer and statistical profiles.

This new process is twice as cost effective as our previous process and has increased the number of people we identify as medically improved. We are further refining this process to develop mailers that are specifically related to the beneficiary's impairments, and to evaluate the use of additional information to determine the likelihood of medical improvement, such as Medicare utilization data.

Although we continue to be faced with resource constraints, I want to assure you that I am determined to increase the number of CDRs we conduct. In fact, the Administration's FY 1996 budget includes a request for funds to increase the number of CDRs we conduct in FY 1996 to 431,000—a threefold increase over FY 1994.

EMPLOYMENT STRATEGIES

Mr. Chairman, let me now focus on employment strategies, which is our other initiative related to terminations. Employment strategies are designed to help individuals with disabilities enter the workforce. This is a crucial effort since, historically, less than one-half of 1 percent of the individuals who receive SSDI benefits ever leave the rolls to return to work. I would add, Mr. Chairman, that the trends I mentioned earlier—that beneficiaries are younger on average, live longer, and are less likely to leave the rolls—underscore the importance of initiatives designed to encourage persons with disabilities to receive rehabilitation services and enter the workforce.

Most individuals with disabilities have a strong desire to work, and we want to make sure they have the opportunity to do so. That is why we are intensifying our effort to assist beneficiaries and applicants in making the transition from dependence to independence.

I have established a proactive strategy team to develop approaches to increase the employment of current and potential disability beneficiaries, thereby promoting economic self-sufficiency and reducing their dependence on disability benefits. This team is headed by our Associate Commissioner for Disability, Dr. Susan Daniels. Dr. Daniels' team has been obtaining information from Federal agency partners, members of the disability community and outside experts to obtain broad input on the problems and barriers individuals with disabilities face.

In the near future, we will make decisions about how best to implement employment strategies. I am optimistic that we can help many of our beneficiaries achieve a more rewarding life, while at the same time reducing disability program costs.

ACTION PLAN FOR THE FUTURE

Given the recent growth in the SSDI and SSI disability programs, Mr. Chairman, it seems clear that we may need to take steps to control future program growth particularly since as, I have indicated, demographics will continue to be a source of growth in the future.

I have already outlined a number of actions we are taking to ensure that only those who are disabled actually receive benefits. We are also working to help those who remain disabled enter the workforce.

For example, within the next few months, we will have the results of important reports that will help us better understand the reasons for the growth in the program and the best ways to deal with that growth. For instance, I have already mentioned the work being done by the Commission on the Evaluation of Disability in Children. Also, at the request of the House Committee on Ways and Means, the National Academy of Social Insurance has convened a Disability Policy Panel which is currently examining the interrelationship of income support policy and employment of people with disabilities. More specifically, the panel has been asked to review the definition of disability and its effect on employment and receipt of benefits.

I believe we need to have the information all of these groups will provide in order to make informed decisions about the future of the disability programs. For, when

we talk about changes in the SSDI and SSI programs, we must consider the importance of those programs to millions of Americans, and to American society as a whole—nearly 8 million beneficiaries receive SSDI and SSI benefits each year.

Therefore, it is critical that we maintain appropriate support for children with disabilities and move cautiously in recommending changes to the SSDI and SSI programs, so we do not hurt the programs and the millions of Americans who depend upon them.

CONCLUSION

In closing, Mr. Chairman, let me stress that, while there are indications that the situation may be improving somewhat, the Administration remains concerned about the growth in the disability programs. That is one reason we have undertaken major initiatives to improve the CDR process, and to help disabled individuals become productive members of the workforce. We are, of course, also working hard to implement new rules for drug addicts and alcoholics, as required by legislation enacted last year.

One of the most fundamental requirements in controlling program growth is to have an understanding of the factors underlying that growth. To that end, the Lewin-VHI research project begun in 1993—which will be completed a few months from now—will help us better identify and quantify those factors. Moreover, it should help us determine whether this recent growth represents a temporary phenomenon, or a longer-term trend.

We look forward to working with you, Mr. Chairman, to determine what changes need to be made in the SSDI and SSI disability programs.

PREPARED STATEMENT OF SENATOR WILLIAM S. COHEN

Good Morning. I want to thank the Chairman for holding this morning's hearing to address the escalating costs of the Supplemental Security Income program.

I am pleased that the SSI program is on the table as part of entitlement reform, but I am concerned that many of the reforms that have been discussed this year do not address the root problems and backward incentives of our federal disability programs.

GROWTH OF THE DISABILITY ROLLS

At the same time we have been assuring senior citizens that we will not touch Social Security, 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.

SSI and SSDI are among the fastest growing programs of the Federal government. Over the past decade the number of recipients under age 65 on the DI and SSI programs has risen from 4.2 million to over 7 million, representing an increase of almost 70 per cent. The total cash benefits paid to these recipients increased almost 60 per cent in the same period.

The Social Security Administration sends out about one billion in cash payments each week to persons on the DI and SSI programs. Despite this huge outlay of federal dollars, we have paid little attention over how these taxpayer dollars are being spent and how the nature of disability programs has changed.

I would like to share with the committee a few examples of how the federal disability programs are sorely in need of reform.

DRUG ADDICTS AND ALCOHOLICS ON DISABILITY

Perhaps the most blatant example of how our federal disability programs have gone haywire came to light in an investigation of SSI and SSDI benefits being paid to drug addicts and alcoholics conducted by my staff on the Special Committee on Aging with the General Accounting Office.

We found that the "word on the street" is that SSI benefits are an easy source of cash for drugs and alcohol. The message of the disability programs has been: "If you are an addict or an alcoholic, the money will keep flowing as long as you stay addicted. If you get off the addiction, the money stops." Rather than encouraging rehabilitation and treatment, the disability programs' cash payments have perpetuated and enabled drug addiction and dependency.

For example, just a few weeks ago at a hearing I chaired in the Senate Special Committee on Aging we heard from Bob Cote, the director of a homeless shelter in Denver. Mr. Cote told the committee in riveting testimony that he personally knew 46 drug addicts who had died from drug overdoses from the drugs they bought with

SSI checks. Mr. Cote went on to testify that a liquor store down the street from his shelter was the representative payee for over \$200,000 in SSI checks, and a bar just two doors down from his shelter was the representative payee for \$160,000 in SSI checks.

Taxpayers were outraged to learn that situations like these have been going on for years with almost no oversight by the Social Security Administration on how these tax dollars and trust fund monies have been used.

Last year, in response to our investigation, the Congress took steps to place better protections on the disability payments made to addicts and alcoholics. We mandated that all persons receiving disability benefits due to alcohol or drug abuse must receive treatment, imposed a three year cut off for benefits for addicts and alcoholics, and toughened the representative payee rules in order to get cash out of the hands of addicts.

While there will continue to be debate over whether last year's legislation went far enough, it was a major step toward stemming abuses in the disability program.

OTHER ABUSES IN THE DISABILITY PROGRAMS

Drug addicts and alcoholics 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 fraudulent doctors submit false medical evidence to qualify claimants for SSI or 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 life-long dependency rather than independence.
- Even states are finding that the federal disability programs are a good deal. 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 state budget by paying contractors to shift welfare recipients to the federal rolls. This translates to nearly 15,400 recipients who enrolled in SSI instead of state assistance in fiscal year 1994. These cost-shifting techniques are proving to be lucrative business deals for disability consultants who are paid for each person they move off the state books and onto the federal program.

THE DISABILITY PROGRAMS DO LITTLE TO MONITOR THE ROLLS

At the same time the rolls are surging, fewer persons are leaving the disability rolls. Often, getting on disability means a lifetime of benefits, even for persons who could return to work. Our investigation found, for example, that the Social Security Administration is grossly behind in conducting continuing disability reviews to determine if persons are still eligible for benefits.

In addition, the SSA makes virtually no effort to help rehabilitate recipients so they could return to work. Appallingly, only about 1 in every 1,000 persons on the disability rolls gets off the program through the SSA's rehabilitation efforts. The federal disability programs have failed to keep pace with a more accessible workplace being created through the Americans With Disabilities Act and advances in medical technology.

In short, at a time when disabled Americans have the opportunity to become more independent, the federal disability programs are fostering dependency.

POSSIBLE SOLUTIONS

The guiding principles in our review of the disability program should be to preserve benefits for those who truly need assistance yet not entrap those who could and want to be independent.

There is more work to be done to tighten the restrictions enacted last year on drug addicts and alcoholics on SSI and SSDI, but flatly abandoning all assistance to SSI and SSDI recipients whose primary impairment is substance abuse may be harsh and counterproductive. Stripping these recipients of Medicaid eligibility would ensure that they do not receive treatment for their substance abuse, thus guaranteeing that they will not be rehabilitated and return to work.

Additionally, the practical effect of such a total prohibition would be to have a large number of these recipients reapplying for benefits on the basis of another impairment, such as mental impairments. Since the new representative payee safe-

guards passed last year do not apply to mental impairments, substance abusers would once again be eligible to receive unsupervised cash benefits to feed their addictions.

- To address other flaws in the SSI/SSDI programs, I strongly recommend that the Social Security Administration be required to conduct more continuing disability reviews to remove ineligible persons from the rolls. The estimated cost of one CDR is \$1,000. Today, if the average DI beneficiary receives benefits until age 65, roughly \$225,000 will be spent on benefits and health care costs. Failure to conduct targeted CDR's on recipients with impairments most likely to show improvement is simply penny wise and pound foolish.
- The priorities in SSA must be examined to place less emphasis on outreach. While we should make benefits available to those who are eligible, the outreach efforts by SSA have proved lucrative for states, disability consultants, and others who manipulate the system, but very costly for the federal government. It is time that we step back from our outreach efforts and shift SSA's emphasis toward educating recipients about work incentive programs and promoting vocational rehabilitation, as well as conducting continuing disability reviews.

Further, while a daunting task, we should work toward more flexibility in the structure of the disability program. SSI is a "one-size fits all" program but it provides benefits to a diverse group of individuals. Young and old, some are able to work with the help of new technology, while others would benefit from counseling—yet the disability programs treat each of these cases the same. We must rethink our disability programs so that we help those who can be independent get off the disability program and provide long term assistance to those who continue to need assistance.

In closing, Mr. Chairman, I would like to share with the committee the story of a very impressive woman, Mary Jane Owen, who testified before the Aging Committee earlier this month.

Ms. Owen, who is blind, hearing impaired, and uses a wheelchair, was on SSI and developed a business plan to establish her own consulting firm. When she sought assistance from the Social Security Administration to apply for the SSA's PASS program that would allow her to keep her benefits while she saved the \$5,000 she needed to buy a laptop computer, doors were shut in her face at every turn. She was so put off by the lack of attention and being treated like a victim—she asked Social Security to stop sending her benefits. But the checks never stopped coming. At the Aging Committee hearing, Ms. Owen handed me a pile of uncashed checks totalling just over \$16,000. Mary Jane Owen asked me to take these checks and do with them what I felt was appropriate. I want you to know that all she ever wanted from Social Security was \$5,000 to buy a voice-activated computer. She did not get it—and she did not get help from the disability program to become self sufficient. Ms. Owen's checks are a powerful symbol of how our current disability programs have failed to help Americans with disabilities become independent. We can and must do more to better meet the needs of millions of Americans with disabilities.

PREPARED STATEMENT OF SENATOR BOB DOLE

I commend Chairman Simpson for calling this hearing to examine the soaring costs of the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs.

No doubt about it, scrutiny of SSI is overdue. In recent years the Finance Committee has looked at SSDI growth after predictions by the Social Security Trustees of insolvency in the Disability Insurance (DI) Trust Fund. That problem has been solved—at least in the near term—by last year's Social Security Independence and Program Improvements Act which reallocated more FICA tax to the DI Trust Fund.

However, a check by my staff found that the last time the Finance Committee held a hearing on any aspect of the SSI program was 9 years ago, in July of 1986. At that time, the Subcommittee on Social Security and Income Maintenance Programs considered a bill I had introduced to make SSI work incentives permanent law.

Many are concerned about SSI, and for good reason. In the five years between 1989 and 1994, the rolls grew 42 percent, from 4.1 to 5.8 million recipients. Expenditures jumped from \$15 to \$24 billion. CBO recently projected the rolls will grow by another 2.2 million persons by 2000, and expenditures increase to almost \$43 billion.

Some might say these numbers reflect success in helping poor people who are disabled or elderly. Others believe that they are signs of a program out of control. Or even if the program is working properly, we can't afford it.

It seem to me that if we are to tackle SSI growth in a responsible way, we need to begin by looking at three issues.

First, is SSI being abused? We have a fundamental obligation to the American people to make sure that either such reports are unfounded, or that we are ready to fix them.

I expect other members have heard, as I have, stories that some children on SSI are not disabled, or money is spent in ways that do not benefit the child. Even if these allegations are untrue—as some contend—we must make sure children's SSI is working as intended. No doubt about it, for some families with a severely disabled child, SSI can be a lifesaver. It allows them to care for their child at home—who might otherwise be institutionalized at much greater cost to the government—or obtain services they could not otherwise afford. I think we can all agree if a small payment can help a disabled child stay with his family, or grow into a productive adult, it is better for the child and better for society.

Another sore point is cash benefits for drug addicts and alcoholics. Last year, at the prompting of Senator Cohen, Congress sharply limited SSI benefits for substance abusers and tightened treatment requirements.

But I still have doubts about the wisdom and fairness of cash benefits for substance abusers. Substance abuse is a terrible scourge to individuals and families, but I would like to see convincing evidence that SSI helps people get off drugs. At most SSI should be a hand up, not a hand out. And it should not under any circumstances help people continue their drug habits.

Second, is the Social Security Administration managing the SSI program properly, and consistent with congressional intent? For example, we need to know if disability determinations are being correctly made and that persons no longer disabled are being terminated. But let me also add that this means people who need benefits get them as well.

Third, have our cash programs—and our other disability programs for that matter—kept up with our national disability policy? How prepared are we for the future? Five years ago we passed the Americans with Disabilities Act, which set national disability goals of equal opportunity, full participation, independent living, and economic self-sufficiency.

Disability benefits do little to promote independence or economic self-sufficiency. There is no career ladder for Social Security recipients. We need to help more people get off the disability check and on to a paycheck.

If we are in trouble today, consider the future. Little attention has been paid to the rapidly growing number of people with disabilities. Medical science increasingly keeps people alive from once fatal conditions, albeit often with severe and lifelong disability. And given that disability increases with age, the aging of the American population predicts a sharp growth in disability over the next several decades.

Taken together, this information should allow us to move forward. Let's not forget though that SSI has provided a basic income to some of the poorest and most disadvantaged members of our society. As other members of the subcommittee will recall, fifteen years ago we mandated a program to remove persons from the disability rolls who were no longer disabled. Well intended, but hundreds of thousands were dropped, only to be reinstated by courts. Governors were up in arms. It seems to me we are smart enough not to repeat that history.

PREPARED STATEMENT OF DAVID KOITZ

Mr. Chairman and Members of the Subcommittee: At the request of Finance Committee staff the Congressional Research Service did two recent studies of the status of the disability programs of the Social Security Administration (SSA), one in 1992 and another in 1994. I was asked to speak to you today about some of the things we found and about some of the issues now affecting these programs, particularly those related to their rapid growth.

There are now nearly 10 million people receiving Social Security and Supplemental Security Income (SSI) disability benefits. Together, these two programs represent the largest disability benefit programs in the nation with estimated expenditures of \$66 billion in FY 1995. Administered by SSA with assistance from State-run agencies, nearly 2.7 million disability claims will be filed in 1995 with 1/3 or more of them being approved at the initial stage. The process is massive and very cumbersome not only because two levels of Government are involved, but because claimants who are initially denied can make 3 appeals to SSA and then go to Federal court.

Recipients of SSA's disability programs...

1980...	6.9 million
1984...	6.2 million
1989...	7.1 million
1995...	10 million (estimate)

While their numbers are large, it should be kept in mind that SSA's disability recipients represent less than 4% of the overall population. In contrast, nearly 130 million people still get up and go to work every day. Simply put, the vast majority of our society is not alleging to be disabled to acquire an income from public funds. Moreover, the recent growth that has given rise to many concerns about these programs may be subsiding. Recent workload statistics show applications have leveled out. My point here is not to minimize the size of these programs or the issues surrounding them, but only to lend some perspective.

The growth in new applications has subsided, but the size of these programs still poses major long-range issues

Since 1984...

U.S. population rose by 11%
SSA's disability enrollees rose by 60%

The issues with these programs are significant. Since 1984, which was the last time Congress altered them in any major way, the overall population of the United States has grown by 11%; in contrast, enrollment in these programs rose by 60%. Since 1989, enrollment has risen by 40% and expenditures have doubled. There has been a lot of speculation about what drove up applications between 1989 and now, but nothing conclusive. The recession has been over for 4 years, unemployment has fallen from 7.7% to 5.4%, and total employment in the U.S. has risen by 8 million people. Yet the number of Disability Insurance (DI) and SSI applications remains at an all-time high. Thus, it would be misleading to conclude that the dominant factor behind the recent growth in the programs was a poor employment picture. Outreach by SSA, efforts by State and local governments to enroll people in Federal programs, promotion of these programs by the advocacy community, the 1990 Zebley court decision liberalizing SSI rules for disabled children, and generally growing "awareness" of the programs within the population may together be more important than the state of the economy in explaining what has been going on.

Moreover, while applications may have leveled off, there are an unprecedented number of cases where appeals are being sought and that number is still growing. In the 1988 to 1990 period, 740,000 appeals were processed. For the 1994-96 period, SSA now estimates the number will be 1.7 million. Never before has the agency processed 600,000 appeals a year with end-of-year backlogs of nearly the same magnitude. Although some appeals will be summarily dismissed, with SSA's Office of Hearings and Appeals reversing denials at an 80% rate, there will be more than a million people added to the rolls simply because of appeals decided in the 1994-96 period.

*Trustees' estimates of future
DI enrollment (in millions)*

1995.....	5.8
2005.....	8.8
2015.....	10.2

Looking farther out, the baby-boom generation is on the edge of its disability prone years. The oldest boomers are now 49. As they enter their 5th decade, the incidence of disability among them will rise. The social security trustees projected last year that the number of DI recipients would grow over the next decade from 5.8 million to 8.8 million. Under the social security actuaries' most recent projections—taking into account last year's reallocation of retirement taxes to DI—the DI trust fund would become insolvent in 2015. At that point, the checks could no longer be paid on time. At that point total DI enrollment would exceed 10 million people. And reallocating again from the retirement program would be unlikely given the nearness of its own financial insolvency. Under last year's combined projections for the 2 programs, insolvency would occur in 2029. This year's report is likely to show it occurring sooner. And if the pattern of past forecasts follows, the insolvency point could move foreword again in subsequent reports.

Projected points of insolvency...

Disability Insurance (DI)...	2015
Old Age and Survivors Insurance (OASI)...	2030
Combined...	2029

Finally, the simple fact that there are big dollars involved makes these programs an issue. Together, DI and SSI disability payments represent the 4th largest category of Federal entitlement spending, and this does not even take into account the subsidiary benefits many of these recipients receive through medicare, medicaid, food stamps, state SSI supplements, and social services. Only the social security retirement and survivor program, medicare, and medicaid are larger. Thus, to the extent that aggregate entitlement growth is considered unsustainable in the long run, the magnitude and growth of these two programs cannot be ignored.

Changes in policy and administrative practice probably explain more of the volatile enrollment of these programs than economic and health trends in society

Over the last 20 years, enrollment has been volatile. It hasn't gone up and down like unemployment insurance, but there has been no smooth trend reflecting a society that is gradually growing older.

The implementation of the Black Lung benefits program in the early 1970s—which SSA had initial responsibility for—and the SSI program in 1974 put a lot of strain on SSA. Large numbers of new claims and the work involved in taking over adult public assistance rolls from the States was enormous and for a time overwhelmed the agency. Cases had to be processed quickly, rules were relaxed, and reviews of existing recipients were marginal. Notably, the DI rolls nearly doubled from 1970 to 1977. As the workloads subsided later in the decade, SSA took small steps to tighten up, and enrollment began to fall. The decline picked up speed in the early 1980s when the Reagan Administration launched a major effort to remove ineligible from the rolls. Nearly 1.3 million recipients were re-examined from March 1981 to December 1983, and 475,000 were given benefit-cessation notices. Al-

***Percent of initial awards based
on mental disorders...***

DI:

in early 1980s...	11%
in 1993...	26%

SSI-disability:

in mid 1970s...	30-35%
in 1993...	55%

lowance rates on new claims dropped as well. Overall DI enrollment declined until 1983 and SSI enrollment stayed relatively flat for a 4-year period.

Strong criticism was levied at SSA and the Administration over the large number of recipients who were affected by the reviews. Many whose benefits were ceased by State agencies were reinstated by SSA's Administrative Law Judges and the Federal courts. Congress became concerned that too many of the benefit terminations were insupportable, and many Governors told their agencies to stop the reviews. Eventually, the Administration put a moratorium on itself. However, the issue subsided only with the passage of legislation in 1984, the major provisions of which instructed SSA to revise its criteria for evaluating mental impairments and limited the circumstances in which someone could be removed from the rolls if the agency were unable to show the person's condition improved. These issues and others had originated with major class action suits.

In 1984, few people were aware of how significant the changes would be. There was little understanding that mental impairments would become the single most prevalent basis for new awards. In the early 1980s, they accounted for maybe 10-11% of initial DI awards; by 1993 they accounted for 26%. For SSI, they rose from 30-35% in the mid 1970s to 55% in 1993. The provision limiting cases that could be ended without showing medical improvement, coupled with the loss of administrative resources from a large down-sizing of SSA, had a major impact on the number of cessations. Basically, with some exceptions, if the agency cannot show today that a recipient's medical condition has improved, it cannot remove the person even if it were to determine that the person is not entitled under the rules. Limited data from the 1970s suggest that maybe 40% of the recipients reviewed then received benefit-cessation notices. The rate since passage of the 1984 amendments has not exceeded 15% and was only 9.9% in 1993. Moreover, many such cases have been reversed upon appeal, so that the ultimate rate could be as low as 5 or 6%. Where through much of the 1970s these reviews (coupled with cases where recipients returned to work) resulted in people being removed from the rolls at a rate of 20 per thousand recipients, in 1993 it was estimated to be 2 per thousand.

There were other changes in the 1984 amendments that also contributed to a loosening trend including giving more weight to statements from a claimant's personal physician, to allegations of pain, and to the combined impact of multiple impairments where none alone would qualify the claimant. Although other factors may have contributed, the DI rolls starting growing again in 1984 rising by 13% by 1989. The SSI rolls grew by 32%.

The Court system had a major impact again in the 1990 Zebly case by liberalizing the rules for impaired children seeking entry to SSI. The Supreme Court said that children had to be evaluated on a basis "comparable to adults"—language that was in the original SSI statute—the result of which has been SSA's attempt to assess whether children claiming disability can function on an "age appropriate" basis. Major changes were made with regard to evaluating mental impairments as well. Subsequently, the number of children on the SSI rolls grew from 296,000 in 1989 to 900,000 today. This alone accounts for 1/5th of the overall enrollment increase in SSA's disability programs since 1989.

People tend to look for economic reasons, such as changing unemployment, or at general health trends in society, to explain enrollment changes in these programs. They start by assuming that because the definition of disability in the law has been the same since the mid-1960s, the rules of the program haven't changed. They also

assume that administrative practice is a constant. However, much, if not most, of the program's volatility probably results from legislation, court decisions, and administrative changes. Simply put, the program is highly sensitive to what many would view as subtle rule and process changes.

The failure to conduct reviews of existing recipients affects the public's perception of the program, not just the number of ineligible people who remain on the rolls

<i>Annual number of DI recipients required to be reviewed by law...</i>			
			500,000
<i>Actual & projected...</i>			
1991...	45,446		
1992...	46,214		
1993...	49,202		
1994...	81,691	(plus SSI... 4,363)	
1995...	184,000	(plus SSI... 10,000)	
1996...	234,000	(plus SSI... 116,000)	

For more than 5 years now, the agency has stretched its resources to process claims. And this has taken its toll on the monitoring of people on the rolls. Under legislation enacted in 1980, SSA should be reviewing the medical condition of 500,000 DI recipients a year. For the last 5 years, the number has been fewer than 100,000; in 3 of them, it has been under 50,000. In SSI, even though the number of disabled enrollees exceeds that of DI, there have been even fewer. In reaction, Congress mandated last year that at least 100,000 SSI recipients be reviewed annually for the next 3 years and that all children be reviewed when they reach age 18. However, the issue really gets down to limited administrative dollars. Like other federal agencies, SSA is bound by Government-wide budget "caps" on discretionary spending. The agency can be required by law to do more, but it has to be given the resources to do so. The difficulty here is that if you give SSA a larger appropriation, it has to come from someone else's. SSA's latest appropriations request shows that for DI and SSI combined, it will do 194,000 medical reviews in FY 1995 and 350,000 in FY 1996. While higher than in recent years, they will affect only 2 to 4% of the programs' total recipients each year.

People quickly recognize that there are costs involved in keeping ineligible people on the rolls—the actuaries project that for every dollar spent on reviews, there are 4 to 6 benefit dollars to be saved. But the failure to remove ineligible people from the rolls also may be encouraging enrollment. The message being sent is that "once on, you may never be removed." With children, the prospect may be benefits for an entire lifetime. Moreover, with the claims process being lengthy and difficult, and with delays being compounded by the high volume of claims, once enrolled, a person has ample reason to pause before contemplating an attempt to work.

Simply put, the public's perception of the overall climate of the program—whether it is "loose" or "tight"—is likely to be influenced not just by the rates at which people are allowed or denied benefits, but by what is expected of them when they get in.

SSA's Planned "Administrative Reforms" Could Be Costly

The Committee may want to pay careful attention to the new administrative reforms that SSA recently launched. Conceptually, they could be the most far reaching steps ever taken to improve the process. The agency's goal of greatly reducing the time it takes to get a final decision addresses an unrelenting source of public frustration and tension between the agency and Congress. But the changes also could be far reaching in terms of how many people get into the program. The reform hinges on expansion of the initial stage of decision making, in part by bringing the claimant and disability examiner face-to-face. The current process relies mostly on an examiner's review of a "paper" file. Past experiments with face-to-face contact suggests that it will result in more awards, and the concern is that this happens in part because the examiner becomes more sympathetic. Moreover, eliminating the

first stage of appeal as SSA proposes—the so-called reconsideration stage—may cause more people to seek hearings and appeals where their chance of reversal now averages 80%.

It's not that face-to-face contact is inherently bad—hopefully it would render many legitimate benefit awards sooner—but why should there continue to be 2 more levels of de novo or open-record appeal that includes another face-to-face hearing? Even if relatively fewer denials are appealed under SSA's plan, if a substantial number of cases will continue to be reversed because different standards of disability exist at the appellate levels—which many analysts believe—the process is unfair. It should not be looser for someone who appeals than it is for someone who simply accepts the initial decision. If it is due to submission of new evidence or directly or worsening conditions, what's the point of making it an appeal to a judge? It is not an appeal of an earlier denial; it is a new case and at least in theory should be remanded back for another first-stage review.

The status quo has been defended for years based on the premise that the front-end process is so weak, you need to keep the record open for appeals to assure that claimants have a fair shot. Simply put, you need to allow the introduction of new evidence at all stages of decision making, even though the last three are supposed to be for appeals. But if the first stage is to be greatly improved, why shouldn't the appeal levels be made truly appellate by requiring that the decisions made there be based on the same set of facts used by the initial decision maker? In addition, under SSA's plan, face-to-face contact would be offered to the claimant prior to issuing a first-stage denial. Is there then really any need for another level of semi-formal, "due process," open-record hearings conducted by administrative law judges? Wouldn't a less formal, closed record, review by someone other than a judge suffice?

The agency says that its reforms will be cost neutral, but it has little basis to estimate the overall impact of the changes it is planning. Although lacking many important details, conceptually, they are huge. While a good case can be made for what SSA is planning at the initial stage, it becomes a piecemeal and possibly very costly change if fundamental reform of the later stages is not considered at the same time.

DI Benefits May Be Too High in the Long Term When Compared to Future Retirement Benefits

*Advantage to receiving DI benefits
instead of retirement benefits
at age 62...*

Today... they would be 25% higher

In 2022 (when full retirement
age is 67)... they would be 43% higher

If full retirement age were raised
to 70... they would be 70% higher

Looking long term, there is an issue with DI benefit levels. As a result of the 1983 Social Security Amendments, the age at which a retiree gets full benefits will rise from 65 to 67 gradually over a 22-year period. It begins in the year 2000. People will still be able to get benefits at 62, but they will take a larger "early-retirement" reduction. Retirees today who elect benefits at 62 can also file for DI, and if they are successful, their benefits will be 25% larger—simply put, they don't suffer an "early retirement" reduction. When 67 becomes the full-benefit age in 2022, the advantage to getting DI at 62 will be 43%. Many people have at least some form of impairment when they reach their 60s, and if they don't have a job or are marginally employed when they file for DI, making an assessment of whether it is their impairment that precludes them from working can be highly judgmental. With the prospect of receiving 43% higher benefits, it may be reasonable to assume that many "early retirees" will file simultaneously for DI and retirement benefits. If the age for full benefits were raised to 70—to help, for instance, resolve social security's long-range insolvency problem—the incentive for an age-62 retiree to file for DI

would jump to 70%. Thus, in addition to the inequity of the situation, what is now a simple claims process for most retirees could turn into a lengthy and complex one in the future. I would note that one measure addressing this issue was proposed in a social security solvency bill introduced last year by former Representative Jake Pickle (H.R. 4275).

With More Younger People Getting Into the Program, "Time Limits" on Benefits May Be Desirable

Another issue arises from the increasingly younger ages at which people are getting DI benefits. In 1956, when the program was enacted, you had to be at least 50 to qualify. It was designed to serve older workers in physically-demanding jobs whose impairments made work difficult or impossible. In effect, DI made early retirement possible. To a large extent, the program's regulations continue to reflect this emphasis. However, considerably different people are being served by the program today—most notably, they are younger. In 1958, the average age of men awarded benefits was 59 and 2 months; in 1993, it was 47 and 8 months. Almost 50% of the men awarded benefit in 1993 were under age 50; 28% were under age 40. Moreover, today mental disorders account for nearly twice as many initial awards as heart disease; in 1981, the opposite was true.

The point is that while many people still enter this program after a lifetime of arduous work and with little likelihood of leaving, the rising proportion of awards going to younger people suggests that maybe the concepts of the program ought to be re-examined. One revolves around the duration of benefits. The issue is whether they should be time limited—say to 3 years—especially for people under age 50 or 45 whose impairments are not clearly permanent. Giving benefits for a defined length of time doesn't mean that a person can never again receive them. It simply says that the Government is not assuming you will need them for the rest of your life. It says that it is not an "early retirement" award. It says that you have to be evaluated again and that you have to get another award if benefits are to continue. And it doesn't necessarily mean that the 5-month waiting period for DI has to be met again either. In essence, it may be more symbolic than substantive, but it could send a different message about the role of the program.

Medical Presumptions of Disability May Need to be Narrowed

A related issue revolves around the so-called medical listings. These are regulatory criteria that describe medical conditions (and the severity thereof) that allow people to get benefits presumptively assuming they are not working or are earning less than \$500 a month. In 1993, about 2/3s of all initial awards were made on this basis. In these types of awards, the question is not asked of whether the person has enough functional capacity to do some work. It is asked only if they are unable to qualify presumptively. Studies and survey data, however, suggest that there are many people who are working today who could meet the presumptive criteria if they stopped working and applied. The point is that there may be too much reliance on presumptions of disability to qualify people for benefits. The agency itself has raised the question of whether the presumptions should be narrowed.

I raise these two issues as long-range ones because both would require labor-intensive changes. They would be time consuming and require more staff. At a time when SSA can't meet existing process requirements in the law, when the Government is downsizing the bureaucracy, and when ever-tightening constraints on discretionary spending are likely, it is hard to see how these types of reforms could be implemented soon.

Expectations That "Rehabilitation" Can Reduce the Number of People on the Rolls May Be Too High

One last issue I would raise deals with the impact of "rehabilitation" on enrollment. Experience through the 1970s suggests that only modest changes in the size of the programs could be expected from rehabilitation. And it was for this reason that the Reagan Administration greatly reduced rehabilitation expenditures in 1981. SSA's spending on rehabilitation has risen since the early 1980s, but it is still much below the levels experienced in the 1970s. However, because the number of younger people coming into the programs has been rising, and the rolls overall are notably younger than 15 or 20 years ago, there may be more reason today to put more resources into rehabilitation.

I would offer one note of caution though. With SSA taking 2.7 million claims a year, its ability to track cases on a large scale is very limited. It has always seen its primary role as processing payments—it makes decisions and authorizes checks. It is not in the case management, social work, rehabilitation, or job placement business. So while more effort toward rehabilitating SSA's disability enrollees may be desirable, it is not clear that the agency could or would ever give it great attention.

The Increase in Children, Drug Addicts and Alcoholics, and Aliens on SSI

I also was asked to comment on the sharp rise in SSI enrollment of impaired children, substance abusers, and immigrants. As I mentioned earlier, 1/5 of the overall growth in SSA's disability rolls since 1989 is attributable to children joining the SSI program. They account for 1/3 of SSI's disability-related growth. Most of this increase—perhaps 2/3s of it—involves children having mental impairments, with mental retardation being the largest single cause. Awards for other mental impairments—e.g. attention deficit, mood, personality, and infant disorders have been rising very rapidly as well, but more than half of the mental impairment awards have been for mental retardation. Although there has been a lot of publicof disabled adults. GAO recently testified that at the beginning of this year there were 101,000 SSI recipients receiving benefits due to alcoholism or drug addiction, up from 17,000 in 1989. Alien recipients rose from 370,000 to 798,000—or by 428,000. About 200,000 of this rise was due to disability claims. Together, these two groups of recipients account for less than 300,000 of a 1.2 million overall rise in disabled adults on SSI.

Nonetheless, when you view these three categories of recipients together—children, immigrants, and substance abusers—they account for half of the overall 1.8 million rise in SSI disability enrollment over the last 5 years.

*Increase in overall SSI enrollment
since 1989.....* 1.8 million

Increase in:

child recipients...	600,000
immigrant recipients...	200,000
substance abusers...	100,000

As you are aware, the House welfare bill would remove many of these recipients from the rolls as well as preclude many new entrants. CBO recently projected that in 1997 there would be 750,000 fewer people on SSI due to disability as a result of these measures. Some of the affected children would be eligible for services under a new State grant program. There also would be 250,000 fewer immigrants on the aged rolls. I would be glad to address any other questions you may have about these measures. However, in keeping with CRS's role of neutrality on pending legislation, I would have to decline to take a position on them.

Mr. Chairman, this concludes my testimony.

PREPARED STATEMENT OF SENATOR RICK SANTORUM

Mr. Chairman, I'd first like to thank you for the opportunity to appear before the subcommittee today. As you may know from my previous life in the House of Representatives, I spent a good deal of time and research on welfare reform policies, and more specifically in the area of the Supplemental Security Income (SSI) programs. During the 103rd Congress, I served as the ranking Republican on the Human Resources Subcommittee on Ways & Means. In that capacity, we took a hard look at the very topic you are covering today—the growth in SSI and recommendations for controlling those programs. And working in cooperation with our Oversight and Social Security Subcommittees, we feel we have laid the foundation for real reform in the SSI programs as a whole.

While details of my House activity on welfare reform in general can be left for another time, I'd like to get right to today's discussion of the beneficiary and cost growth in SSI, as well as my own recommendations on those programs. In no order of priority, we may want to first look at the SSI Children's program.

SSI FOR CHILDREN

Since the *Zebley* decision in 1990, we have seen an obvious and enormous growth in the amount of beneficiaries and amount of federal dollars spent in this program—the number of children on SSI reached 683,000 in 1993 while the amount of spending was \$24 billion. And while this is clearly the major catalyst in the growth and costs of the program as a whole, an alarming and controversial ancillary effect has

been the amount of fraud and abuse that is perceived and has been reported within the children's program itself—more specifically with regard to the definition of “disability” that the *Zebley* decision solidified.

Under the beneficiary criteria for disability that now exists for children, or individualized functional assessments (IFAs), we continue to see instances of fraud and abuse in the program that has not only drained resources, but has created a present day perception of the program that is far from positive. And while some dispute the validity and very existence of the fraud and abuse, their lack of recognition of these happenings serves only as a means for hindering federal assistance to those at the fundamental core of the disability program itself—those with severe mental and physical disabilities.

In legislation last year (HR 4419), I proposed replacing the cash program with one of a “voucher” system for treatment. This was done as a means to eliminate some of the financial attractiveness and cash incentive of the program and to move toward targeted assistance to the individual “need” of the beneficiary and more direct treatment of the specific disability itself. As you are aware, Mr. Chairman, the Social Security Independent Agency Act contained language from Ways & Means commissioning a study of the “voucher” idea. That study is ongoing and those results are due sometime later this year, or early next year. We may hear about that progress from some of our other witnesses.

Other suggestions and another approach to the problem is contained in the Personal Responsibility Act now before the House of Representatives. Last year, I had the opportunity to help draft the Personal Responsibility Act, and have followed the recent House activity on that proposal as closely as anyone. Specific to SSI, I have had discussions with Congressman Jim McCreery, the sponsor of Title VI of the bill. The proposal contained in that bill suggests the following:

- eligibility under the IFA criteria would be eliminated;
- at least once every 3 years, SSA will conduct continuing disability reviews (CDRs);
- target resources and increased benefits to the severely disabled;
- children made ineligible by IFA elimination may reapply for SSI coverage, under other disability criteria.

While some have perceived these changes as severe, I think the proposal deserves a hard and thorough look, especially in view of the factors discussed previously which are driving the growth and costs of the programs. As I continue my work in this area, I will pursue a similar approach to that presented by Jim McCreery in the House bill.

LEGAL NONCITIZENS

Recently, Commissioner Chater testified before the Senate Judiciary Committee that growth in legal noncitizens receiving SSI has reached 738,000 in 1994. In looking at trends over the past several years, Commissioner Chater also testified that the rolls in this program have increased 12% over the last five years. In 1993, when we first looked at the growth in these programs, we saw an even more severe increase in beneficiaries in the years preceding Commissioner Chater's figures—from 110,000 in 1982 to over 650,000 in 1989.

While the factors behind the rise are varied, several very clear recognitions can be made. First, the “sponsor” arrangement for immigration and financial support criteria are non-binding and unenforceable. In turn, the number of noncitizens applying for SSI following the deeming period is alarming. Last year, the Honorable Barbara Jordan in her study on immigration policy testified before my Ways & Means Subcommittee on this very subject matter. Second, abuse has been exposed in several immigrant communities where beneficiaries are illegally qualifying for the program. We also received extended testimony on this last year in Ways & Means.

In 1993, through the Ways & Means Committee, we were able to increase the deeming period from three years to five. Around that same time, I proposed the following options in the House Republican welfare reform bill:

- encourage naturalization following the five year deeming period by allowing an additional year for citizenship (the one-year is based on national averages);
- strengthen the sponsorship arrangement by insisting on the financial commitment of the sponsor;
- eliminate federal assistance for legal noncitizens.

These proposals have proven very controversial over the last two years, and will continue to be in the context of the provisions currently contained in the Personal Responsibility Act in the House. It is a policy that, as a first generation Italian-

American, I have spent considerable resources on in terms of its policy direction, and will continue to work on in the Senate. I welcome your interest in this process.

DRUG ADDICTS & ALCOHOLICS

Mr. Chairman, I will not cover today the area of the SSI Drug Addict and Alcoholic program in view of the testimony of Senator Cohen. I greatly appreciate Senator Cohen's contribution and efforts on this program, and more recently the hearing he held in the Aging Committee. I will continue to work with Senator Cohen on this and other programs. At this time, I would only draw your attention to the Personal Responsibility Act provisions which would abolish the DA & A program and federal SSI and Medicaid assistance to drug addicts and alcoholics altogether. Additionally, that proposal would redirect \$400 million from the savings to fund additional drug treatment and research.

FRAUD & ABUSE

Additionally, Mr. Chairman, I will call your attention to the changes contained in the SSA Independent Agency Act relative to interpreter fraud. In cooperation with Congressman Jake Pickle, I offered a section on fraud to that Act which are now law. In particular, those provisions covered the following:

- set strict guidelines for use of third-party translators;
- elevated SSI fraud from a misdemeanor to a felony;
- set more frequent reporting requirements between agencies & to Congress;
- established criteria for casefile review and redeterminations.

We hope to see significant results from these changes in combating the many abuses and problems brought before our congressional committees. I am as anxious as anyone to see the practical effect of this law, and have had favorable responses already from those individuals we have developed a relationship with over the past two years and that work in these immigrant communities.

Last Mr. Chairman, I would like to leave open the opportunity to share with you some work that is ongoing at this time. I have been examining the interplay between the public assistance programs in my state to the federal programs of SSI and Medicaid. A few weeks ago, Senator Cohen shared with the Aging Committee the occurrence of "program shifting" in his state. I would like to come back to you in the future with regard to some investigative work and research regarding that phenomenon in Pennsylvania. You may be alarmed by the degree to which this has added to the program growth and costs as well.

Thank you Mr. Chairman for having me here today. I look forward to working with you and the committee on this and other policies.

PREPARED STATEMENT OF SENATOR ALAN K. SIMPSON

We meet this morning for a hearing of the Subcommittee on Social Security and Family Policy for the purpose of considering issues and options relating to the soaring costs of the Social Security Administration's two disability programs—Social Security Disability Insurance and Supplemental Security Income.

On October of 1994, Congress voted to reallocate a portion of future payroll tax revenues from the OASI Retirement Trust Fund to the SSDI Disability Trust Fund. We did this because the SSDI Trust Fund was teetering perilously on the brink of insolvency. As a result of this legislation, there will be about \$240 billion less in the retirement trust fund in 2015.

If nothing changes, I expect that in the year 2001 Congress will be expected to reallocate funds from the Retirement Trust Fund to bail out the insolvent Medicare Trust Fund.

We cannot afford to continue our errors of the past and repeatedly divert funds from the Retirement Trust Fund.

Let me explain why not.

According to the 1994 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, in the year 2013, social security benefit payments are expected to be greater than revenues from the payroll tax. According to that same report, by the year 2029 social security will be broke.

In last year's report, the trustees reported the doomsday date to be 2036. In just one year, this doomsday date moved up 7 years from 2036 to 2029.

This is where we are. It would be unconscionable to accelerate this doomsday date any further than we have done already by allowing our government programs to spin out of control.

But what I understand is that exploding disability costs are not unique to the SSDI program. The costs of the other disability program, SSI, which is funded directly from general funds, are soaring at an even more rapid rate than SSDI costs. Recently, the General Accounting Office estimated that since 1985 there has been almost a 60% increase in the combined cost of both programs. This is unsustainable. In 1994, payments to disabled individuals totalled about \$57 billion. In other words, each week in 1994, the Social Security Administration sent out over \$1 billion in cash payments to persons on SSI and SSDI. These two programs are now the 4th largest category of entitlement spending.

We are here today to try to get to the bottom of why the costs of the disability programs are exploding.

However, I appreciate that this is a sensitive topic. Congress has long been interested in disability insurance issues because determining whether a recipient is disabled for purposes of the Social Security Administrations's disability programs is among the most difficult and sensitive tasks of the Federal Government.

Congressional offices quickly and rightfully hear of problems in the disability system because requests for assistance mount when delays in receiving benefits occur. In our offices, the number of constituent inquiries rose to unprecedented levels last year as increasingly desperate claimants sought help with their languishing cases.

Mistakes can have tragic consequences, exposing some people who have worked their entire lives until becoming disabled to dire consequences.

While the system must respond to the needs of individuals with disabilities, it cannot afford to casually award benefits without careful scrutiny. Moreover, once benefits are awarded, the integrity of the system demands that beneficiaries are closely monitored to determine if and when an individual is rehabilitated.

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JANUARY 23, 1985

Commissioner's News Digest

Shirley S. Chater, Commissioner of Social Security

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SUNDAY, JANUARY 22, 1985

BALTIMORE, MARYLAND

SPECIAL REPORT

America's most wanted welfare plan

Rosie Watson finally found the key to Social Security's generous disability plan. Now, a hostile Congress wants to slam the door to save taxpayers billions.

By John B. O'Donnell
and Jim Hester
Sun Staff Writers

LAKE PROVIDENCE, La. — Early in her 18-year crusade to get federal disability checks for her entire family, Rosie Watson was examined by a skeptical doctor who wrote: "Patient is determined to become 'a ward of the government.'"

Determined she was. Rosie Watson lost that particular skirmish but won the war, exploring each legal avenue until she got monthly checks from Social Security for herself, her common-law husband and all seven of her children.

Today, if you visit this bleak Mississippi River backwater on "check day," you're likely to see Ms. Watson at the post office picking up nine federal checks totaling \$3,893 — tax-free income that adds up to \$46,716 by year's end. Few working families in the county earn more.

The story of Ms. Watson's success — her single-minded pursuit of benefits and the government's on-again, off-again resistance — shows how a once-modest federal program got out of control.

Originally aimed at providing life's necessities for poor adults too old, ill or disabled to work, Supplemental Security Income (SSI) now sends checks to



Photo by a writer

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Money changes hands on "check day" in Lake Providence.

many other groups, including children with hard-to-diagnose mental ailments.

Congress, led by its new Republican majority, will begin hearings Friday aimed at cutting down to size this check-writing behemoth run by the Social Security Administration just outside Baltimore.

What's at stake for Rosie Watson is a livelihood.

She gets \$343.50 a month in disability payments because she was found by a Social Security law judge to be too depressed out to work. Her common-law husband, L. C. Lyons, was awarded the same amount when a judge ruled that his 386 pounds made him too obese to work.

Their children, ages 13 to 22, lagged behind in school and scored poorly on psychological tests. Under government rules, this translated into a failure to demonstrate "age-appropriate behavior" and qualified them to get \$458 each — payments so widespread in Lake Providence and other communities around the nation that they are popularly known as "crazy checks."

A visitor to Rosie Watson's small bungalow would be hard-pressed to find any sign of high living.

The screen door hangs open. Soaps blare from the television. The living room overflows with worn furniture. The kitchen is caked with dirt. Roaches crawl the walls.

"I got nothing to hide," says Ms. Watson. Indeed, she and Mr. Lyons authorized Social Security to release her family's records to *The Sun* — thousands of pages, a stack about a foot high — which tell the story of her quest.

"It's done a lot for our family," she says. "The problem is, we're

not able to work, and it's the best income."

There is little question about that.

Created by Congress two decades ago, the SSI program has become the nation's most generous welfare plan.

Its 6.3 million recipients include not only the aged, blind and injured, but also others more controversial: alcoholics and drug addicts who support their habits with the cash; immigrants; and 900,000 children, 61 percent of whom get checks for mental problems.

The cost of SSI more than doubled in the past five years. It is expected to increase another 55 percent by 1999.

Already it costs the federal government more than the original "welfare" program, Aid to Families with Dependent Children (AFDC).

To Sen. Robert C. Byrd, a West Virginia Democrat, it is a "well-intentioned entitlement program run amok."

Rosie Watson first tried to get aboard when she was 23.

She was an eighth-grade dropout with an infant and a toddler, collecting \$90 a month in AFDC, when she heard about SSI shortly after it was launched in 1974. Realizing that the new disability plan paid better than traditional welfare, she filed her first application.

She was turned down, but she would persist over the years with 17 more applications for her family. With the rules permitting unlimited applications and unlimited SSI checks to a household, there is no indication that she did anything but exercise her right to seek benefits from a government program.

The long quest

First in the family to go on the SSI rolls was her second child, Sam. It was 1978 and he was 4 when Ms. Watson filed his application. He had just been declared "mild mentally retarded" by evaluators at Northeast Louisiana University. Ms. Watson had told them that he was violent, a threat to other children.

Relying on that report, Social Security decided in June that Sam should get benefits. But, a month later, a snag developed: Concerned

that checks were being handed out too casually, the agency had begun to second-guess new awards. A pediatrician reviewing Sam's file said that his "problem" was normal childhood behavior. Social Security workers tossed Sam off the rolls.

Ms. Watson applied three more times unsuccessfully for Sam, then in 1981 gave up — temporarily.

For 27 months, she made no claims. During

that period Social Security underwent profound change, the result of the worst crisis in its history.

The agency had admitted in 1980 that 20 percent of disability recipients shouldn't be getting checks, prompting Congress and the Reagan administration to order a purge of the undeserving.

Social Security kicked hundreds of thousands of people off the rolls, generating a public outcry that forced Mr. Reagan to end the purge in 1984. Congress, the courts and Social Security reacted by opening up the rules, producing a sharp rise in the number of people entering the program — including a tripling of the children's rolls between 1989 and 1994.

Determination to guard the public purse against cheaters gave way to concern about cheating the deserving poor.

Sam Watson was one of the first to benefit from this new attitude.

In February 1984, at the peak of the backlash, Ms. Watson filed his fifth application, again claiming that he was retarded and had behavior problems. "I have to keep knives or weapons away from him — he has injured his brother," she said.

Sam was soon getting his checks.

Now 21, Sam still gets a check. Critics say there is little incentive for him to overcome his disability. His parents would lose



After 11 years and five rejections, Social Security approved disability for Rosie Watson.

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ANDRE LAMBERTSON/SUN STAFF PHOTO

A teddy bear and boom box provide company for Oleaner, 13, the youngest of Rosale Watson's seven children. Her mother gives her only daughter a \$20-a-month allowance out of her \$458 BSI allotment.

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the money if he does. And Social Security rarely checks to see if children are still disabled. The agency has not reviewed Sam's condition since awarding him benefits.

It is a pattern that conservatives see in many government entitlement programs — benefits that encourage recipients to lead unproductive lives.

Not only did Sam become the first Watson to win benefits, he was the first to get a retroactive "bonus."

Because SSI payments are backdated to the date of application, no matter how long it takes Social Security to award benefits, each successful applicant gets a retroactive payment. In 1984, Sam's was nearly \$900, covering the three months between application and approval.

Eight years later, Sam produced a much larger "bonus" for Ms. Watson. Social Security sent her nearly \$10,000 after concluding that Sam really should have been put on the rolls in 1980. In 1993, Sam's brother Cary got a similar \$10,000 payment. In all, the family has received \$37,000 in tax-free

retroactive payments.

Sam and Cary's checks grew out of a 1990 Supreme Court ruling known as the Zebly decision. Social Security was told to evaluate children as thoroughly as it does adults and ordered to reopen a half-million cases dating from 1980.

The result: The doors to disability payments were thrown open for children. So far, 134,000 of them, including Sam and Cary, have shared in retroactive payments of \$1.4 billion.

By November 1991, six of Ms. Watson's seven children were on the rolls.

Cary became the last, finally making it in February 1993.

Ms. Watson filed his first application in 1989 when he was 18. A psychologist found him "borderline ... easily irritated ... aggressive and explosive" and noted that he had killed a man in self-defense.

Caseworkers turned him down.

Ms. Watson applied again and got the same answer. This time she appealed to a judge.

Meanwhile, Cary went to prison for nearly two years for kicking his pregnant girlfriend, injuring her and the child, and his case was

put on hold. Once freed, he went to a psychologist who told Social Security that he had an IQ of 53, "strong anti-social features in his personality and is volatile and explosive."

And, added Dr. Bobby L. Stephenson, of Monroe, La., "He said he does not want to work."

A month later, in February 1993, the judge awarded Cary monthly checks, and gave him the retroactive payment, excluding his jail time.

Essed access

Sart to finish, Ms. Watson's quest for her children took 15 years. It spanned a period when Social Security and Congress eased access to benefits for a number of reasons; importantly for the Watson family they included expansion of the list of mental ailments that qualify. Today, mental problems are the primary diagnosis for almost two-thirds of the children among the 4.5 million disabled BSI recipients. Ms. Watson's offspring are among the two-thirds.

Only one of them, Oleaner, 13, baby of the family, still attends Southside Elementary School, across the street from the Watson house.

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The principal at Southside is Wilbe Lee Bell, a man who despises the SSI program.

Broad-shouldered and soft-spoken, Mr. Bell knows poverty, too. He grew up with 10 brothers and sisters in a four-room sharecropper's house on Epps Plantation in West Carroll Parish, where his father worked 12 hours a day. His failed kidneys would automatically qualify him for disability payments from Social Security if he chose not to work.

He has watched the tidal wave of SSI applications up close. For each pupil who applies, he gets a questionnaire from Social Security, so he knows first-hand of the scramble for "crazy checks."

Mr. Bell says, "I is lowering the academic standards of this school."

Echoing complaints from other states, he and his staff say children are encouraged by their parents — some say coached — to perform poorly and misbehave to get disability checks.

"The children 'don't want to fail,' he says. "They are doing what mamma wants."

Social Security claims that coaching is not widespread, and federal investigators, thwarted by privacy laws, have been unable to document its dimensions.

As for Ms. Watson, she says that no such thing happened.

There is a single hint of it in the records, an allegation that George, now 14, wasn't trying "to the best of his ability" on a 1981 IQ test.

"I ain't never told any of 'em to act crazy and get some money," says Ms. Watson.

"Social Security will send you to their own doctor. They're not fooled because those doctors read your mind. They know what you can do and not do.

"I have people come up to me and say, 'Why are you getting all those 'crazy checks?'

"I say, 'You don't have to be crazy. It's a mental benefit. You can have some kind of sickness.'"

Uncertain statistics

Although "crazy checks" are an ingrained part of the culture and economy of this poor town, there is a question of how many young people really get the money.

Social Security checked a list of 515 pupils who attended Southside Elementary last year

and said that 56 of them were getting SSI benefits, out of 118 who had applied.

Mr. Bell, the principal, scoffs at those figures. He says that half the pupils have applied, including 120 in the past school year alone. And, he believes many are collecting checks.

At 44, Roste Watson wears the years heavily. She was reared in this flat expanse of farm country, where jobs are few and the population is leaving.

She is polite and matter-of-fact as she talks with her visitor from her living room sofa in a house that lacks a telephone but has two police scanners — "That's so I know what's going on."

"What's going on" includes violence and crime that make Lake Providence, with a population of 8,000, a microcosm of what is going on in many towns across America.

"I was born and raised here and this town has really gone down," Ms. Watson says.

When she was growing up, "it was nice," she said. "Now, it's terrible. All the stuff going on now — drugs and stuff, purse snatchings, stealing checks from the mall — wasn't going on then. That's why I have a post office box."

As soon as she extracts the nine checks from that box, she cashes them. She gives the full amount to Sam, 21, and Cary, 22, the father of two children who has moved out of the house since being awarded benefits. The remaining funds are

used for the other children and household expenses.

Most of the money goes for the children, to "see that they have what's needed," Ms. Watson says. "With what's left, I pay bills and buy food."

One "need" is \$120 allowances for George, 14, David, 17, Willie, 18, and Danny, 19.

"Being the age they is and being out there with their little girlfriends, they need the money," she said.

Ms. Watson pulls a wad of bills and monthly payment books from her purse. Loans cost her more than \$1,300. She says they include payments for various household purchases, furniture, washing machine and storm repairs.

There are bills for cable television, utilities and insurance policies. She spends \$400 a month on food, which is supplemented by a backyard garden.

There is no requirement that the SSI money be spent

to overcome a child's disability. Indeed, there is no requirement that a parent demonstrate that the disability requires added expenses.

Ms. Watson frankly says that she has none. One thing that probably makes that easier is the fact that each member of the Watson family on SSI automatically gets Medicaid for health care, a benefit that is potentially worth as much as the SSI payments.

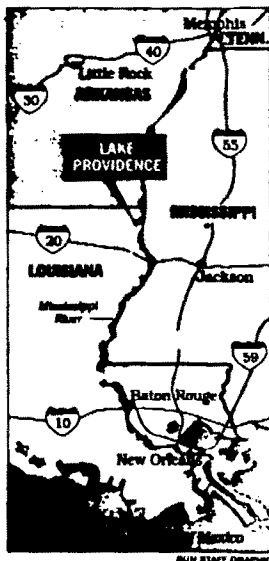
The only expense she mentions for Oleaner is a \$20-a-month allowance.

A shy, friendly child, Oleaner sits next to her mother on the sofa. She plays with a teddy bear, proudly shows off her boom box and occasionally sucks her thumb.

She goes to the kitchen and returns with a tin plate of canned meat and crackers. Settling onto another sofa in front of the television, she prays silently before eating lunch.

She is Ms. Watson's only

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SUN STAFF COURTESY

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daughter. Her mother, aware of the high teen pregnancy rate here, is protective, trying not to let her out of her sight.

While their presence on the SSI rolls is evidence that Ms. Watson has looked out for the well-being of her children, she also has had to work hard for herself.

Her pursuit of benefits took 11 years, longest in the family. She applied five times before finally convincing Social Security that she is disabled.

Her persistence is reflected in the shifting array of physical complaints she claimed. In 1974, it was high blood pressure, heart trouble and bad nerves that prevented her from working.

In 1975: anemia, dizziness, nerves and bad kidneys. In 1976: low blood pressure and heart problems.

In 1984 she blamed stomach problems, epilepsy and sinus trouble and the following year it was epilepsy again, along with fibroid tumors and "female problems."

A physician who examined her in 1974 wrote: "This patient's employability will be directly related to her motivation." Two years later, another doctor told Social Security that she wanted to be "a ward of the government."

After her third rejection in 1976, Ms. Watson put her own case aside for eight years while she pursued checks for the children. In 1984 and 1985 she applied for herself and failed. Both times, caseworkers said that she could work.

However, a psychiatrist, Dr. Jacob W. Storey, summed up her bleak situation in 1985: "This is a 34-year-old black female who has seven children under 12 years of age, an alcoholic husband and no money, who complains of insomnia, crying spells, depression."

The doctor reported that she has experienced hallucinations, has passed out when upset and has suffered some type of seizure disorder since she was 11.

After her fifth rejection, Ms. Watson decided for the first time to appeal her case to a Social Security judge rather than start anew. He sent her to another doctor who reported that she was "limited intellectually and most likely retarded ... has what appears to be a long-standing seizure disorder ... is either suffering from a chronic schizophrenia with depressed mood or from major depression."

"In any event," the doctor said, "these conditions combine to make it impossible for this lady to cope with the stresses of any type of

competitive employment."

Two days before Christmas 1985, Ms. Watson received news she had waited a long time to hear.

A judge's ruling

The judge said she couldn't cope with the stress of work, blaming her problems on "her home life and the alcoholic husband, along with

the lack of finances." But he said she should be able to work in the future and ordered Social Security to check on her in a year — a task it took four years to get around to.

Two years later, Mr. Lyons got good news.

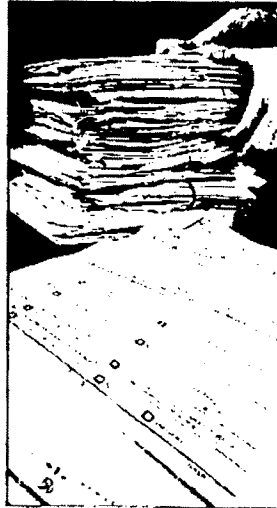
Despite testimony that suggested he could work, a judge awarded the former logger and carpenter benefits because he weighed 386 pounds.

A separate, unstated issue was whether work was available for Mr. Lyons — or anybody else — in East Carroll Parish, where cotton was once king. Machines have replaced field hands — and new jobs have not replaced the back-breaking labor in the cotton fields.

With 57 percent of its residents living below the federal poverty level, only a third of them holding jobs and another third less than 16 years old, East Carroll Parish is ripe for SSI. Ten percent of its residents are on SSI, compared with 2.4 percent across the United States generally. Their checks bring \$4 million a year to this community.

The high rate is common in Louisiana, which has the seventh largest number of children on SSI rolls in the United States — 36,000 at the end of 1993 — despite its relatively small population. Maryland, for example, was 25th, with 9,000 children getting benefits.

As she sits in her living room, Ms. Watson appears in sharp con-



JEFFREY F. BILL/SUN STAFF PHOTO
Stacks of records tell the story of the Watsons' 16-year effort to get federal disability checks.

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ANDRE LAMBERTSON/SUN STAFF PHOTO

Willie Lee Bell, principal at Southside Elementary, decries SSI and says the scramble for "crazy checks" is lowering the academic standards of his school. He is shown relaxing in his back yard.

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trust with the woman who emerges from her records. At times in conversation she is combative, able to recall intricate details of the family's two-decade quest for SSI, occasionally critical of people who have "copped an attitude" toward her.

She recalls a dispute last year with a junior high school principal that began when her son George's books were stolen from his locker. The principal insisted that she replace them, but she refused, saying that it was the school's responsibility because George had left them where he was told to. Neither she nor the principal gave in, she says, and George finished the year without books.

"He got F's and will be in the seventh grade again," said Ms. Watson, seemingly proud of the stand she took.

The thick Social Security file portrays a different woman, seemingly incapable of any activity, physical or mental.

In the past 10 years she has told caseworkers and doctors that she "doesn't know what country we live in," that her "ability to recall is almost void," that she can't handle money or count, that she needs help cooking because she forgets what she's doing and that "when ever I get up to do anything, I pass out and must have someone with me at all times."

The history of SSI suggests that the Watson family will remain on SSI permanently, with the children eventually moving to the adult rolls, as have nearly 300,000 adults who got their first SSI checks as children.

It is a pattern that troubles defenders and critics of the program alike.

Critics say that giving no-strings-attached cash to the parents discourages them and the children from trying to overcome the disability.

June Gibbs Brown, chief investigator in the Department of Health and Human Services, wrote last October:

"If Congress intended that the SSI program provide only cash assistance to children with mental impairments, then the program is successful."

But, she added, "If Congress intended that

the SSI program should help children overcome their disabilities and grow into adults capable of engaging in substantial gainful activity, changes

are needed."

Shirley S. Chater, the Social Security commissioner, acknowledges that she is concerned when children are labeled as being disabled.

That "could be a self-fulfilling prophecy," she said.

"We know that if a child comes on the disability rolls, they tend to stay on for a very, very long period of time."

Adds Mike Baumann, who makes disability decisions in Shreveport, La., where the Watson cases were decided: "The kids are being told that their worth is in sucking off the government teat, that their worth is in not achieving."

Ms. Watson views the issue in more practical terms. Where critics see high incomes for people who do nothing for the money, Ms. Watson sees only a stack of bills and a big family to feed.

"I think it's a good program,"

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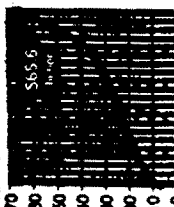
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BY THE NUMBERS: SOCIAL SECURITY'S DISABILITY PROGRAMS

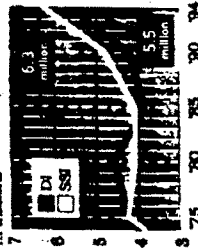
Disability Insurance (DI) is for workers who have contributed to the Social Security retirement trust fund through payroll taxes. They are entitled to draw early if they are disabled by illness, injury or accident. DI pays \$40 billion a year to 5.5 million people.

Supplemental Security Income (SSI) is for the disabled aged and poor who have contributed little or nothing to the trust fund. Costs are covered by the taxpayers. SSI pays 6.3 million people \$25 billion a year. Some qualify for benefits from both programs.

SSI, DI cost
In billions of dollars

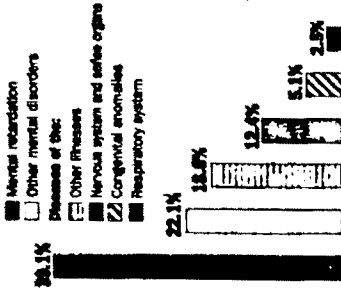


SSI, DI rolls
In millions

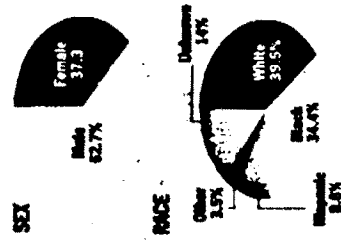


SOURCE: 1994 U.S. Budget and Social Security Administration

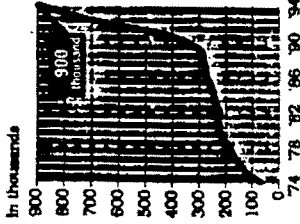
Percentage of children receiving SSI by diagnostic group, Dec. '94.



Percentage of children receiving SSI by sex and race



Disabled children on SSI.



In 1974, about 16,000 cases were unclassified. In 1994, 10,000 cases were unclassified. SOURCE: Social Security Administration

SHARRELL MCCORMICK; JEFFREY COLLINS/USA TODAY GRAPHIC

Monday:
Some 250,000 addicts and alcoholics receive \$1.4 billion in Social Security disability.



They routinely squander the money on drugs and alcohol, overdose and die. But Congress has refused to provide treatment.

Tuesday: More than 700,000 immigrants collect \$4 billion in disability because Congress and Social Security opened SSI to the mentally ill, aliens and scam artists. Now, the problem is so big it will be difficult to fix.

Wednesday: What began as a high-stakes game of political poker in 1969 turned into America's most generous welfare plan. Expanded by Congress, it now threatens the Social Security retirement fund and increases the federal deficit.

THE SUN.

II / PERSPECTIVE

SUNDAY, JANUARY 22, 1995

MARY JUNCK, Publisher and CEO

J.R.L. STERNE, Editorial Page Editor

JOHN S. CARROLL, Editor

Welfare Run Amok

Every taxpayer who wants government to use money wisely and in a manner helpful to the nation and its citizens will be appalled by the story in *The Sun* today about a Louisiana family that receives \$46,716 a year, non-taxable, from the \$25 billion Supplemental Security Income program, one of the chief federal welfare efforts.

But the bigger outrage is not the money that a resourceful mother has succeeded in extracting for herself, her common-law husband and all seven of her children — based on claims of mental or medical disability — but the fact that the government, especially Congress, is the real villain in this story. Most distressing of all is the failure of the House and Senate to ensure that this federal largess is used to help alleviate the disabilities that this program is supposed to address.

Veteran Sen. Robert C. Byrd of West Virginia calls SSI "a well-intentioned entitlement program run amok." He has lamented "the damage that is being done to our children in teaching them that their future lies not in hard work but in ripping off the government for benefits." If the former Senate Democratic leader feels that way, imagine the cries of outrage from conservative Republicans now in control of Congress.

In a series of articles this week, *The Sun* will describe not only how families on SSI amass incomes greater than their working neighbors. It will

report on government lapses that permit abuses involving aliens and drug/alcohol addicts. Congress undoubtedly will seek remedies. But the gaping flaws in the haphazardly built SSI program reflect the difficulties and ambiguities that arise when society tries to help unfortunate citizens in the face of predictable attempts at exploitation. That so many elements are involved — lawmakers, administrators, judges, advocates, critics, beneficiaries — only complicates the matter.

Clearly, the SSI program should be reformed so that payments to individual families reflect the number of family members receiving benefits. The better-known Aid to Families with Dependent Children program (AFDC) has such provisions. Clearly, there should be more uniform means-testing and greater oversight required by Congress on how benefits are being used. And yet policing the welfare system costs money. The government has to be prepared to throw enough resources into this effort so taxpayers come out ahead in the end.

Many disadvantaged Americans truly need the help provided by SSI and related programs. Many truly use it in the way intended. But unless this program is dramatically re-tailored, the clamor for welfare reform could lead to Draconian actions in which the innocent — especially children — are punished for the actions of unscrupulous adults and a bungling government.

PREPARED STATEMENT OF JIM SLATTERY

Good morning, Chairman Simpson and Members of the Subcommittee. I am Jim Slattery, Chairman of the National Commission on Childhood Disability. Congress established the Commission last year as part of the legislation that gave the Social Security Administration independent status.¹ In that statute, you asked the Commission to conduct a comprehensive review of the Supplemental Security Income program for children with disabilities. You asked us to tell you whether the SSI definition of childhood disability is an appropriate one; whether an alternative definition would be preferable; and whether the needs of children with disabilities can best be met through cash benefits, vouchers, expanded health coverage, or some combination of these. You also asked the Commission to analyze the effects of the SSI program on children and their families, and to explore whether SSI can be restructured to improve the chances that children who receive benefits will achieve their full work potential as adults.

The Commission was appointed in January by Health and Human Services Secretary Donna Shalala. It consists of 14 members, whose names and backgrounds are described in the appendix to my statement. The members include nationally recognized experts in the fields of law, medicine, ethics, psychology, and disability policy. I have found that this group brings a great depth of knowledge to the tasks in our mandate. They are objective people who have a high regard for the facts, and they are aggressively tackling the complex issues in the SSI program.

Recognizing that the Congressional timetable on this issue has accelerated, the Commission has been conducting biweekly meetings, including regular Saturday sessions. While the statutory deadline for our report is November 30, 1995, we are making an effort to complete our deliberations within a shorter period, while still doing justice to the complexity and critical importance of our task. It is our goal to provide you with recommendations this summer, by late July or August.

You asked that I focus my comments on the recent, sharp growth in the SSI childhood disability program. That seems an appropriate place to start since this growth was the main impetus for the creation of the Commission. During the decade between 1979 and 1989, the SSI childhood program grew at modest rates, increasing from 212,000 to 296,000 beneficiaries. By contrast, the rolls nearly tripled between 1989 and 1994, rising from 296,000 to 893,000 children. As a result, program costs soared, rising to approximately \$5 billion annually.²

The most widely noted cause of these increases is the *Sullivan v. Zebley* Supreme Court decision. Let me emphasize at the outset, however, that while *Zebley* has received a great deal of public attention, it is not the primary cause of SSI program growth. There are also two other, very significant factors driving the rise in SSI childhood payments: These are SSA's 1990 revision of its medical listings of childhood mental impairments, and the SSI outreach activities that have been mandated by Congress and the courts. Let me begin with *Zebley*.

The *Zebley* decision was issued by the Supreme Court in February 1990.³ In it, the Court found that SSA's childhood disability regulations were at odds with the definition of disability in the Social Security Act. That definition requires that benefits be paid to any child whose disability is comparable in severity to one that would prevent an adult from working. In deciding which adults are eligible for benefits, SSA applies two separate tests: a listing of qualifying medical impairments and, for those whose impairments are not described there, an individualized assessment of residual functional capacity (RFC). SSA uses the RFC assessment to determine whether there is work that the individual can do, given his or her age, education, and past experience.

For children, by contrast, SSA had established only the listing of qualifying impairments. The Court ruled that this listing alone failed to provide the comparability with adult eligibility criteria that is required by the statute. To establish comparability, SSA revised its childhood regulations to include an Individualized Functional Assessment, or IFA, modeled on its adult assessment.

Following the *Zebley* decision, the district court required SSA to readjudicate the claims of children who had previously been denied SSI benefits. SSA contacted the families of 452,000 children who had been denied between January 1980 and February 1991 and offered to readjudicate their claims using the new functional criteria. Of this group, 339,000 children responded; and approximately 135,000 were

¹The Social Security Independence and Program Improvements Act of 1994, Public Law 103-296.

²Social Security Administration, "Children Receiving SSI" (December 1994), p. 6.

³*Sullivan v. Zebley*, 493 U.S. 521, 110 Supreme Court 885, February 20, 1990.

ultimately found eligible and awarded benefits.⁴ Because many of these children were determined to have been eligible at the time of their original application, they qualified not only for prospective benefits but for large retroactive lump-sum payments.

A second event which occurred in 1990 has also fueled SSI program growth: This was SSA's revision of its childhood mental impairments listings. Prior to this revision, SSA had listed only four general categories of qualifying mental impairments for children—mental retardation, chronic brain syndrome, psychosis, and functional non-psychotic disorders. Under its 1990 revision, SSA expanded this number to eleven, explicitly recognizing several impairments whose disabling impact has been identified by medical professionals only recently. These include Attention Deficit Hyperactivity Disorder, anxiety and mood disorders, and behavioral disorders.

Last fall, the General Accounting Office completed a study comparing the impact of these new listings with that of the IFA.⁵ The GAO found that 59 percent of the growth in childhood benefit awards during 1991 and 1992 was attributable to the listings. The IFA, by contrast, accounted for only 41 percent of growth during this period.

The third factor that has caused SSI rolls to increase is more difficult to quantify: This is SSI outreach activities. A 1989 statute required SSA to establish a permanent program of SSI outreach to low-income children.⁶ A year later, the *Zebley* agreement called for additional outreach efforts: Responding to the requirements of Congress and the *Zebley* court settlement, SSA publicized the existence of the SSI program widely and contracted with many private, non-profit groups to help identify eligible children. The agency also published and distributed pamphlets, conducted demonstration projects at children's hospitals, contracted with local school districts and special education programs, and worked with nationally recognized groups of parent volunteers.

It is worth noting that SSA's outreach success may be related to a larger economic phenomenon in this country—namely, the increase in poverty among American children. Between 1974 and 1992, the rate of poverty among children increased by nearly half, rising from 15 percent to 22 percent.⁷ The resulting decline in the economic well-being of children is a troubling reality for all of us. It has also made the SSI payment level more attractive to families, and may have led some states, under the fiscal stress of rising AFDC application rates, to encourage and help families to respond to SSA's outreach efforts.

These three changes in federal policy—the regulations resulting from the *Zebley* decision, the revision of the childhood mental impairments listings, and SSI outreach—do not tell the whole story, of course. The more important question underlying all these changes is whether the children who have recently been added to the SSI rolls are truly disabled or whether there has been a loosening of eligibility standards.

It does appear to the Commission that the SSI program experienced a period of more liberal eligibility, but we also see evidence that corrective mechanisms are now at work reversing that trend. Perhaps the most compelling indicator is the SSI benefit allowance rate. During 1992 and 1993, SSI childhood allowances rose from the pre-*Zebley* rate of 38 percent to a full 55 percent. The 1994 rate has declined to 32 percent—actually lower than in the pre-*Zebley* period.⁸

Another point worth noting is that SSA has now completed the Court-required review of *Zebley* class action members. As a result, it is no longer awarding the very large retroactive lump-sum payments that were the subject of controversy and media attention last year.

Finally, SSA's own efforts to tighten its adjudications appear to be having an impact. Responding to problems identified in its own studies and those of the HHS Inspector General, SSA has issued a series of directives to the State Disability Determination Services, instructing them to tighten their adjudication of claims in specific ways.⁹ The agency has also conducted training sessions across the country on the use of the IFA. State DDS officials have told the Commission that these instruc-

⁴ Social Security Administration, Office of Disability.

⁵ U.S. General Accounting Office, *Rapid Rise in Children on SSI Disability Rolls Follows New Regulations* (GAO/HEHS-94-225) September 1994.

⁶ The Omnibus Reconciliation Act of 1989, Public Law 101-239.

⁷ Committee on Ways and Means, U.S. House of Representatives, *Overview of Entitlement programs* (July 15, 1994), p. 1148.

⁸ Social Security Administration, Office of Disability.

⁹ Social Security Administration, Office of Disability, *Training Guide—Title XVI Childhood Disability Claims* (SSA Publication 64-051), June 1994. This publication includes 13 instructions that SSA previously sent to the state DDSs.

tions are having an impact in addressing the more liberal adjudicative climate that developed in some regions in the wake of the *Zebley* decision.

In short, the Commission does not believe that the SSI program for children is now in a state of crisis, nor is it about to plummet out of control. This is not to say that no action needs to be taken. We see several critical policy issues that must be addressed.

The first is a fundamental ambiguity in the purpose of this program. As you know, the legislative history of SSI for children is sparse; and individual opinions about the purpose of this program differ sharply. Is SSI supposed to cover the cost of food, clothing and shelter fallow-income children with disabilities? Or is it supposed to cover the extra costs that low-income families incur in caring for such a child? Should SSI be treated as compensation for a parent who stays home to care for a disabled child? Or should the funds be used as an investment in the child's future independence? The Commission is struggling with these fundamental questions, because their answers will necessarily shape our response to the specific issues you have asked us to address.

Second, we need to understand the incentives that are created by paying cash benefits to low-income families with disabled children. The Commission is deeply concerned by reports that, in an effort to obtain benefits, some families are coaching their children to appear disabled or pressuring them to perform poorly in school. So far, neither the Commission nor SSA has turned up any hard evidence that such coaching is widespread—nor is there evidence that it is a successful strategy for obtaining SSI benefits.¹⁰ Yet we cannot ignore the reality that SSI is a significant source of income for low-income families and, as a consequence, may provide an economic incentive for families to attempt to qualify children for benefits.

Another, more serious incentive arising from the payment of cash benefits applies to families with truly disabled children. Here the moral hazard is that the family may become dependent on SSI and, in order to continue to receive payments, decline to seek treatment aggressively or fail to encourage a child to do his or her best to overcome a disability. The members of the Commission share the belief that SSI should be a program that encourages—not hinders—a family's efforts to help a child reach his or her full potential. We are seriously exploring changes that would eliminate such disincentives.

Finally, the Commission is delving deeply into the question of whether the SSI program changes that I described previously may have subtly liberalized eligibility standards for some specific conditions, allowing some children with minor or temporary disabilities to qualify for benefits. Let me stress that, if this problem exists, it cannot be solved with simple changes such as turning the clock back to the pre-*Zebley* standards. The SSI childhood disability regulations are detailed and complex—and necessarily so, we believe, because childhood disability is a complex reality. This Commission has the expertise to analyze the childhood listings and functional assessment in a comprehensive manner—and to develop policy recommendations that assure equal, fair treatment for all children, regardless of the nature of their disability. We ask only that you give us the time we need to complete this important work.

In closing, I want to emphasize that, in tackling these issues, the Commission shares an important belief. We all believe that we have a responsibility to justify to the working people of this country any income transfer that we recommend. We are keenly aware that, for every dollar we propose spending on this program, we are taking a dollar from the paycheck of a working American. That reality brings with it an obligation to justify our recommendations—not to treat the SSI income transfer, or any other income transfer, as a given right.

In closing, Mr. Chairman, we are hard at work, grappling with the policy issues you have given us. We understand the need to move quickly and are determined to have answers for you in coming months.

Childhood Disability Commission Members

Polly Arango National Director of Family Voices, a national coalition that speaks for children with special health needs. The mother of a child with multiple disabilities, Ms. Arango is active in national health reform for children with disabilities.

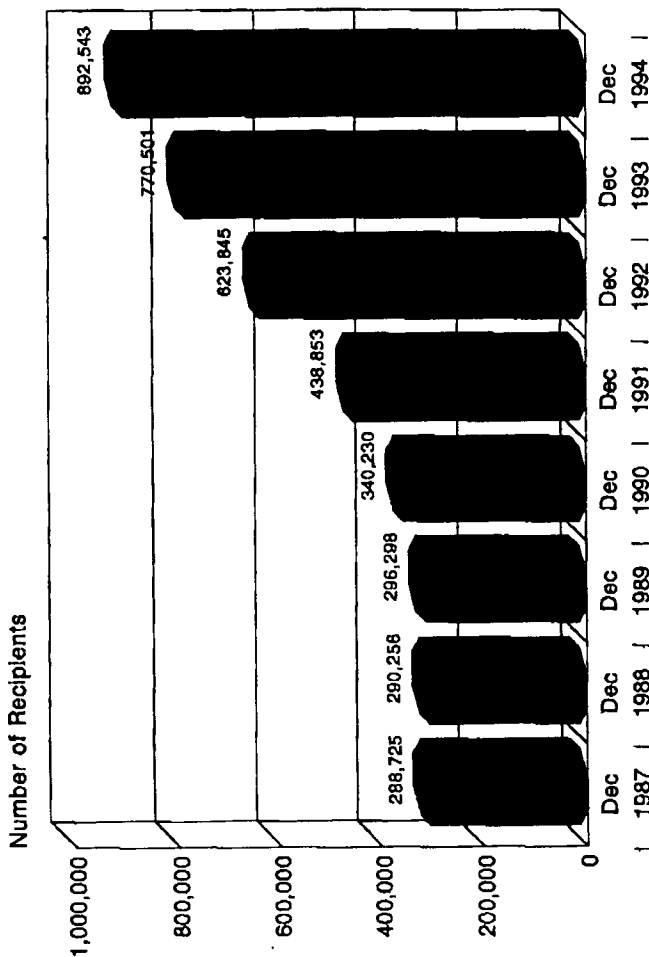
¹⁰ Social Security Administration, *Findings for the Study of Title XVI Childhood Disability Claims*, May 1994. In this study, SSA analyzed 617 claims based on behavioral disorders and learning disabilities. It found evidence of coaching or malingering in only 13 of the 617 cases, of which only 3 were benefit allowances. SSA determined that all 3 of these allowances were appropriate.

- Adrienne Asch, Ph.D.** Professor in Biology, Ethics and the Politics of Human Reproduction at Wellesley College, Wellesley, Massachusetts. A noted ethicist and social psychologist, Dr. Asch has researched legal and ethical problems in health care delivery and participated in the Project on Implications of Population Screening for Cystic Fibrosis. Dr. Asch has written extensively on disability, bioethics and health care, stigmatization of the disabled, home care, rehabilitation, imperiled newborns, and reproductive technology.
- Dolores Berkovsky, M.S.N., L.M.S.W.** Director of Children's Services for Catholic Charities of Fort Worth, Texas. Ms. Berkovsky is responsible for a large continuum of grassroots child and family services, including programs that promote family preservation, adoption of children with disabilities, and out-patient assessment and treatment services. Ms. Berkovsky is also involved with families and children at the state level, where she is instrumental in child and family advocacy committees such as the Children's Community Research Group.
- Wade F. Horn, Ph.D.** Director of the National Fatherhood Initiative, a group that promotes father restoration in American families. A clinical child psychologist, Dr. Horn is a nationally recognized expert on Attention Deficit Hyperactivity Disorder and served as the National Executive Director for the organization, Children and Adults with Attention Deficit Disorders, in 1993. Dr. Horn also served as the Commissioner for Children, Youth and Families in the Administration for Children and Families during the Bush Administration.
- Jennifer Howse, Ph.D.** President of the March of Dimes Birth Defects Foundation. Previously, Dr. Howse served as Associate Commissioner for the Office of Mental Retardation and Developmental Disabilities for the state of New York. She has also served as the Executive Director of the Greater New York March of Dimes, and the Pennsylvania State Commission for Mental Retardation.
- Sharman Davis Jamison** Speech therapist, member of the National Advisory Committee of the Howard University Research and Training Center, and the President's Committee on Employment of Persons With Disabilities. The parent of an adult daughter who is autistic and deaf, Ms. Jamison develops and implements parent training throughout the country, and provides advice to parent training and information centers regarding disability issues.
- Dan Johnson** Director of the Office for Persons With Physical Disabilities in Madison, Wisconsin. Mr. Johnson is responsible for the development and coordination of programs for persons with physical disabilities in Wisconsin. He provides planning and definitions of program policy, goals, and objectives to ensure the delivery and coordination of services essential for independent living and self-sufficiency.
- Paul Marchand** Director of the Association for Retarded Citizens (ARC). Mr. Marchand is a leading spokesperson for children with disabilities, especially those with mental disorders.
- James M. Perrin, M.D.** Associate Professor of Pediatrics at Massachusetts General Hospital in Boston, Massachusetts. Dr. Perrin has written extensively on the organization of services for children with chronic physical disorders, and co-authored *Home and Community Care for Chronically Ill Children and Chronically Ill Children and Their Families*.
- M. Carmen S. Ramirez** President and Founder of Schools Are For Everyone. Ms. Ramirez has extensive community volunteer experience in issues affecting children with disabilities, including minority and non-English speaking families. She was appointed by Governor Ann Richards to serve on the Texas Continuing Advisory Commission for Special Education. Ms. Ramirez also serves on the Governing Commission of the Texas Parent and Training Information Center for Latino Parents of Children With Disabilities.
- Carol Rank** Director of the Kansas Disability Determination and Referral Service. Ms. Rank works closely with Kansas' State Services for Children With Special Health Care needs and other agencies to further understanding of the requirements for the children's SSI program.
- Jim Slattery** Former United States Representative from Kansas and partner in the Wiley, Rein and Fielding law firm of Washington, D.C. Mr. Slattery was elected to the House of Representatives in 1982 and served six terms. He served 12 years on the Energy and Commerce Committee, where he was active on environmental, health care, railroad and telecommunications issues. Mr. Slattery also served for 6 years on the House Budget Committee and the House Veterans' Affairs Committee. His primary interests included deficit reduction, health care access in rural areas, and Medicaid coverage for children from low-income families.
- Rud Turnbull** Co-director of the Beach Center on Families and Disabilities at the University of Kansas. Mr. Turnbull is a nationally known expert and author

in disability policy issues. He has served in national leadership positions in several organizations, including the Association for Retarded Citizens, the American Association on Mental Retardation, the Association for Persons With Severe Disabilities, and the American Bar Association Commission on Mental and Physical Disability Law.

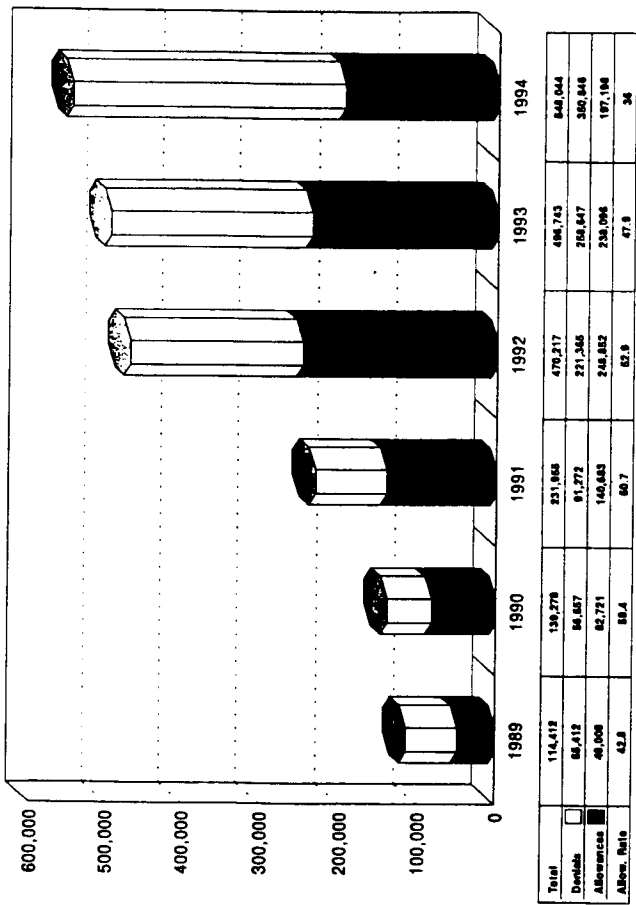
Barbara Wolfe, Ph.D. Director of the Institute for Research on Poverty at the University of Wisconsin, where she is also a member of the faculty of the Department of Economics, the Department of Preventive Medicine, and the LaFollette Institute of Public Affairs. Since the 1970s, Dr. Wolfe has written a number of publications regarding health care issues including a 1994 article, "Reform of Health Care for the Nonelderly Poor." Dr. Wolfe also co-authored a recent book, *Succeeding Generations: On the Effects of Investments in Children*.

Title XVI Childhood Disability Recipients Growth from December 1987 Through December 1994



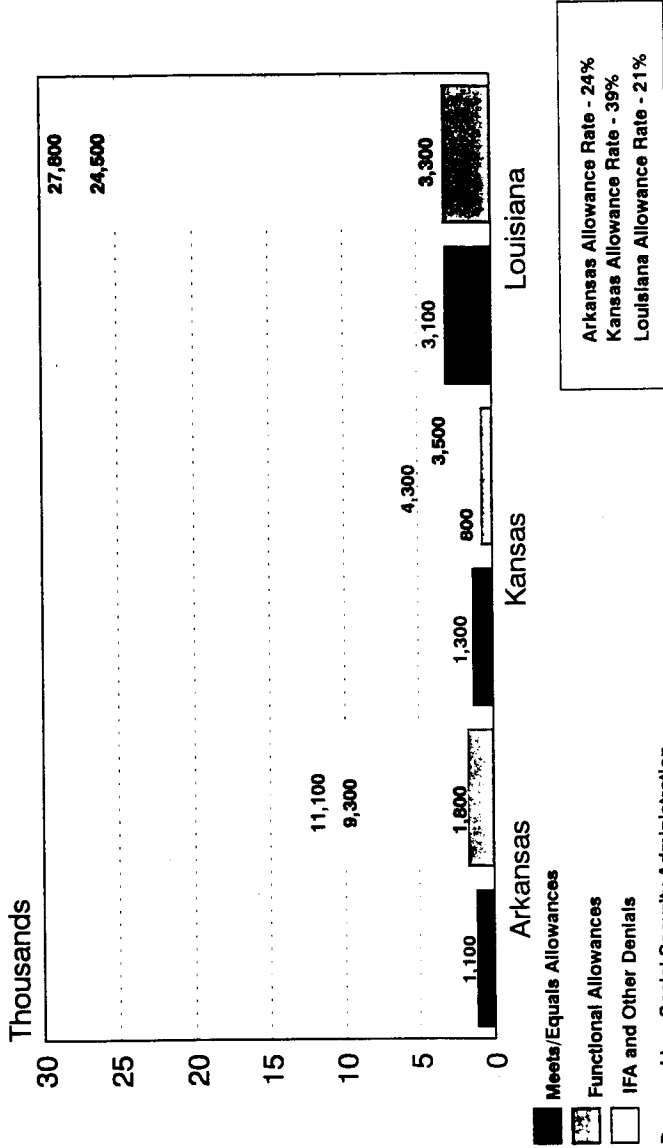
Prepared by: Social Security Administration

SSI Childhood Disability Claims Initial Level Allowances and Denials Calendar Years 1989 through 1994



Prepared by: Social Security Administration, Office of Disability
Date Prepared: February 1995

Title XVI Disabled Children Initial Level Determinations Calendar Year 1994 A Comparison of Arkansas, Kansas, & Louisiana



Prepared by: Social Security Administration

COMMUNICATIONS

STATEMENT OF THE AMERICAN REHABILITATION ASSOCIATION

(SUBMITTED BY SY SCHLOSSMAN, INTERIM PRESIDENT)

Mr. Chairman: Thank you for this opportunity to present testimony for the record on the growth of enrollment in the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. The American Rehabilitation Association (American Rehab) is the largest national Association representing providers of medical, vocational and residential rehabilitation services to American with Disabilities. American Rehab's 900 members serve over 3 million individuals each year with rehabilitation services. We employ nearly 200,000 professionals and para-professionals dedicated to assisting individuals with disabilities to maximize their independence and productivity.

The Committee is currently considering a number of broad issues as it examines welfare and related subjects. One of these is the growth of the SSI and SSDI programs, and the corollary problem that very few people receiving benefits due to disability return to work. Our statement focuses on how to remove work disincentive from the system and how to promote employment for individuals with severe disabilities without financial penalties and the loss of medical coverage.

According to the GAO Report, "Federal Disability Programs Face Major Issues" (GAO/T-HEHS-95-97, March, 1995), one of the primary reasons for the growth in enrollment of the SSDI and SSI programs is the small numbers of beneficiaries and recipients who leave the disability roles to accept employment. The reasons why individuals with disabilities do not leave the disability roles for employment are complex and varied, however lack of timely access to appropriate medical and vocational rehabilitation services is one of the leading barriers to employment for this population.

The major assumption behind the current definition of disability is that employment and disability are mutually exclusive. Many, although not all, individuals with disabilities are fully capable of working, if given an opportunity, appropriate supports, and the financial rewards which come with work.

The current eligibility determination system forces an individual with a disability to prove that no residual work capacity remains in order to be eligible for SSDI benefits. The explicit message to successful SSDI benefit applicants is that they should give up all hope of ever being gainfully employed. This creates a nearly impenetrable psychological barrier that few individuals can rationalize away in order to become mentally prepared for the rigors of undertaking a search for employment.

The SSDI eligibility determination system should be changed from a medical classification system that assumes a lack of any residual work capacity and retires an individual from the work force to a functional evaluation system which identifies work potential and then encourages the maximization of that work potential. The new system would recognize the difference between individuals who have disabilities which truly do eliminate any work potential, such as a terminal illness, from individuals with disabilities who can work given appropriate supports.

The concept of appropriate supports means the elimination of all financial and psychological disincentives to work. The current disability determination system first forces an individual to struggle to become eligible for benefits by establishing no capacity to work at all, then immediately refers the individual to vocational rehabilitation services, and finally tells the individual that if their vocational rehabilitation efforts are successful, they will be penalized by the virtual total revocation of all their benefits—no matter what level of income they may be earning, so long as it is above \$6,000 per year if the person has a disability other than blindness, or \$11,280 for an individual who is blind or visually impaired. This unfairly treats an

individual earning \$12,000 per year the same as an individual earning \$100,000 per year.

The current system does this by creating the fiction that, because the individual is working, the individual is no longer disabled. Of course, the disability does not magically disappear upon reentry into the work force; it continues indefinitely, along with the difficulties it engenders: the extraordinary, and ongoing, cost of equipment, supplies, and support services; and a tendency to change over time, requiring comparable changes in lifestyle, work situation, and support services.

This fiction thus becomes a work disincentive in its own right. Former SSDI beneficiaries who have reentered the work force once again must prove they have no residual work capacity in order to reestablish eligibility for benefits should the individual have a change in condition. This is true even if the individual merely needs to locate a different type of job in order to accommodate a change in their disability.

The new system would eliminate this fiction by acknowledging that some disabilities are life-long in nature, and continue the individuals' eligibility for SSDI in-kind benefits, such as Medicare, beyond the onset of work.

In order for the new program to be truly successful, all other disincentives to work must be eliminated, including the lack of access to medical insurance, paternalistic treatment of beneficiaries, and an abandonment of the "penny wise but pound foolish" philosophy that has underlaid the development of our Social Security disability policy in the past. In order for the US to remain competitive in the future, and to enable individuals with disabilities who are SSDI beneficiaries to achieve productive independence in their own futures, we must begin viewing monies spent in the disability program as investments in human capital. Only through this fundamental change in the disability program will we ever be able to assist SSDI beneficiaries to return to work.

It is not that we cannot afford to spend the money to make these investments. The SSA Trust Fund paid out \$50 billion in FY 1990 in SSDI, SSI, and Medicare to beneficiaries. This money was all spent as part of a retirement program, which provides benefits below the poverty level. There is every indication that this amount will continue to grow in the future. In contrast, during the same period, SSA spent only \$60.2 million to provide vocational rehabilitation services to beneficiaries. This represents an investment in the future of only one-tenth of one percent (.1%) of all the resources spent on beneficiaries.

The fact is that we cannot afford not to invest in a new kind of future—one of productive independence for individuals with disabilities, and of increased productivity for the entire nation.

We believe this new future can begin if the principles outlined below and policy recommendations are put in place.

- **Return to Work As the Goal:** While expecting every person with a disability to work is unrealistic, not assisting those who could work is inequitable and very poor policy. Because disability is a continuum, a disabled/nondisabled binary system is not effective. Return to work is accomplished through a commitment that begins at the onset of disability; therefore the return to work goal must underlie all parts of the system.
- **Early Intervention Is Critical to Success:** Immediate assistance in establishing a return to work objective and mind set, tied to needed medical and vocational rehabilitation services and supports, and continuing contact, facilitates a successful return to work.
- **People vs. Case Management:** Assisting individuals, rather than managing cases, should result in higher success rates in navigating a treacherously complex system of rehabilitation, employment opportunities, work incentives, and needed supports during the return to work effort.
- **Prevention:** SSA should authorize interventions and rehabilitation services designed to maintain workers on the job who have no private insurance coverage, thereby preventing some individuals from being determined eligible for SSDI.
- **Incentives:** Financial incentives to work for persons with disabilities, employers, insurers, and service providers alike will provide adequate support for those for whom return to work is a realistic goal.

American Rehab believes these principles are represented in the following specific recommendations for a revised national disability policy.

American Rehab recommends four strategies to solve the problem of growth in the SSDI and SSI roles: (1) enable newly eligible SSDI beneficiaries to have immediate access to medical and vocational rehabilitation; (2) revise the current Return to Work Program by allowing consumers to select their Vocational Rehabilitation providers from among private and public agencies; (3) provide direct income subsidies to disabled workers bridging off of public assistance through income tax credits and

deductions; and, (4) allow disabled workers without private health insurance to participate in Medicare or Medicaid through purchase of this public health coverage.

(1) Enable newly allowed SSDI beneficiaries immediate access to medical and vocational rehabilitation services.

Currently, there is a 24 month waiting period between the determination of eligibility for SSDI benefits and the beginning of Medicare eligibility. This waiting period often elapses without the beneficiary receiving any medical rehabilitation services. These services might mitigate the severity of the disability by preventing or postponing the onset of more severe disability, prevent or postpone the onset of a secondary disability or promote the more rapid return to work. SSDI beneficiaries should be eligible to receive medical rehabilitation services available under Medicare immediately upon determination of eligibility. This may or may not be coupled with full medical coverage. That is, beneficiaries would benefit from full Medicare coverage, however if this is not feasible, then, at a minimum, beneficiaries should be covered for medical rehabilitation.

Similarly, referral and access to vocational rehabilitation services should be made available to beneficiaries immediately upon determination of eligibility. The current system of rehabilitating beneficiaries through State Vocational Rehabilitation Agencies is ineffective and unwieldy. Under this system, not more than one of every 1,000 SSDI and SSI beneficiaries returns to work (Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed, GAO/PEMD-93-19, August, 1993). American Rehab recommends that it be replaced by a new system using private vocational rehabilitation providers. A system in which a fiscal intermediary in each State facilitates referrals and reimbursements to private providers should be developed in cooperation with private vocational rehabilitation providers.

(2) Revise the current Return to Work Program by allowing consumers to select their Vocational Rehabilitation providers from among private agencies.

There are many models of vocational rehabilitation service delivery used by Workers' Compensation programs in the various states and by rehabilitation providers in other countries which are worthy of trial by SSA. However, there is another source of proven techniques for vocational rehabilitation and placement of SSDI beneficiaries which has been virtually ignored by SSA: its own Research Demonstration Program.

SSA has spent over \$30 million in demonstration programs involving over 100 primarily private rehabilitation providers during the last few years to investigate ways to increase placement of SSDI beneficiaries into jobs. Mandated by Congress in Section 505 of the Social Security Amendments of 1980, Congress directed SSA to conduct a series of demonstration projects designed to increase the number of beneficiaries who return to work and to produce savings to the Federal government. SSA has collected large amounts of invaluable information concerning the problem of placements, but SSA has done nothing to implement any of the proven techniques that could be used to increase the placements of SSDI beneficiaries into jobs.

We propose two initiatives: (A) allow direct contracting by agenda SSA to any public or private provider of rehabilitation services selected by the consumer, and, (B) the establishment of a risk/reward system for reimbursing rehabilitation service providers.

A. Direct contracting with consumer selected rehabilitation providers.

People with disabilities who are SSDI beneficiaries and consumers of vocational rehabilitation and placement services have no choice in the providers of their services. Consumers are assigned to a service provider by SSA, which by law must be a state vocational rehabilitation agency, usually by type of disability rather than type of services required. Consumers who determine that they are not receiving appropriate or quality services generally have no recourse other than to purchase services themselves from private vendors. Given the cost of private services and the state of most consumers finances, this is an option few can afford.

Active participation in rehabilitation increases the chances of a successful outcome, in this instance a successful return to work that ends reliance on cash assistance. Enabling consumers to choose their rehabilitation providers gives the individual a feeling of ownership in the process. This choice of service providers treats the beneficiary as an adult, capable of making significant life choices, thereby enhancing the individuals self-esteem and confidence. Choice eliminates the conflicting signals currently sent by the referral system, which tells beneficiaries they are capable enough to work, but they are not capable to select where to go for vocational services.

In order to enable consumers to select their own providers, SSA must be able to refer to and contract with providers of rehabilitation services in addition to State

Vocational Rehabilitation Agencies, agencies which the General Accounting Office has found do not work well and are not effective. By restricting referral and contracting only with state vocational rehabilitation agencies, SSA forces these agencies to be all things to all people. Given the diversity of individuals with disabilities and their individual needs, and the other extensive responsibilities these agencies have, this is truly a mission impossible. It would be much more productive to utilize the vast capacity of the private rehabilitation service providers available throughout the nation to assist SSDI beneficiaries to return to work.

B. Establishment of a Risk/Reward system.

There is tremendous potential for reduction of dependency and cost savings for the SSDI trust fund that is not being realized because so few SSDI beneficiaries receive effective rehabilitation services.

The present authority for delivery of rehabilitation services under the Social Security Act is inadequate for two reasons. First, all services are provided through referrals from state Disability Determination Service to the vocational rehabilitation agencies. Second, the state VR agency is reimbursed for services only when the SSDI beneficiary receiving such services is placed in a job, earns more than the SGA rate and does so for more than the trial work period. The State VR must use money from other sources and programs up front for the SSDI beneficiary with the hope of being reimbursed by SSA. Hence, there is little incentive for state agencies to expend VR funds to help SSDI beneficiaries. At best the cost can be recovered in successful cases. There is no payment for service when they do not result in SGA. Thus, the net effect is a loss for the state agency. The policy of reimbursing state agencies only for successful cases has been the law since 1981. The policy of making all referrals through state VR agencies dates from the origin of the Beneficiary Rehabilitation Program (BRP) in the 1960s.

We believe that the volume of rehabilitation services and return to work of SSDI beneficiaries can be expanded with net savings in cost to the trust fund through a combination of direct referral of beneficiaries to rehabilitation providers and payment for services based on savings to the government, rather than the cost of services. American Rehab has advanced this concept to SSA for years.

Consider this. If a beneficiary is returned to work and goes off cash assistance there is a savings to the trust fund. The value of the rehabilitation services should be determined by such savings. Apart from humanitarian considerations, if the cost of rehabilitation is less than the cost of maintaining benefits, then it makes sense to spend money for rehabilitation services. Various studies have addressed this cost-benefit relationship. We suggest that is not necessary to theorize about it and, indeed, that the relationship can be made explicit with benefits for all concerned.

This can be done by providing for direct referral of beneficiaries to rehabilitation providers and for payment to such providers based on savings to the trust fund, as such savings accrue. Providers would bear the risk for the effectiveness of services, but be compensated not on cost, but on savings to the trust fund. This can be achieved by providing for payments to be made for service when a beneficiary goes off the rolls and continues so long as the beneficiary is employed and does not return to the SSDI rolls. Payment should be based on a percentage of the cash assistance that would otherwise be paid to the individual. A reimbursement system that rewards outcomes both during the rehabilitation process, at job attainment, and throughout the employee's tenure in the workforce and off the disability roles would benefit all parties.

Obviously, the higher the percentage and the longer the duration of payment the greater the incentive for providers to accept the risk of providing services under such a contingency arrangement. Providers would have to make very explicit judgments about the potential for rehabilitation and the costs of services. Furthermore, there would be an incentive to provide continuing assistance to beneficiaries since payment to the provider would continue only so long as the beneficiary stayed off the SSDI rolls. This approach is a win-win-win situation—for the beneficiary, the rehabilitation provider, and certainly the SSDI Trust Fund.

(3) Provide direct income subsidies to disabled workers through income tax credits and deductions.

Individuals with disabilities incur substantial expenses in the conduct of their everyday lives as they try to learn, work, recreate, and live in the community. The cost of personal assistance to enable individuals with severe disabilities to work can be a barrier to employment, as individuals with disabilities often do not earn enough in wages to afford to pay for personal assistance in addition to a rent or mortgage, utilities, food, and related life expenses. Other examples of extraordinary expenses include the cost of accessibility modifications such as a wheelchair lift for

a van or hand controls for a car; a wheelchair ramp or alternative signaling device for an accessible home; or medications and medical supplies. There are major expenses for assistive technology, including wheelchairs, hearing aids, guide dogs, computers, augmentative communications devices and the training and maintenance costs of the equipment. Not the least of these extraordinary expenses is for health specialists above and beyond the typical health expenses incurred by the average person. All of these expenses conspire to trap individuals with disabilities in a cycle of poverty and total government dependency from which most cannot escape without tax assistance to level the economic playing field.

In order to promote the goal of employment and increased self sufficiency for individuals with disabilities, there must be financial incentives for beneficiaries and recipients to take the risk of leaving the disability roles for payrolls. This could be accomplished by extending the current Earned Income Tax Credits for low-income workers with disabilities, and by creating a Personal Assistance Services Tax Credit for working individuals with disabilities who have significant needs for personal and technological assistance in order to work.

The Earned Income Tax Credit should be extended so that it helps bridge the gap between the Substantial Gainful Activity level and a minimum income level for low-income workers with disabilities. The present Substantial Gainful Activity level for non-blind beneficiaries is \$500 per month, or \$6,000 per year—less than the Federal poverty level. It is impossible for an individual with a severe disability to live on this level of income, especially given their extraordinary expenses of living with a disability.

In addition, we recommend changes to address the cost of long-term services for working persons with the most significant disabilities. To do this, we propose a tax credit of one-half of all personal assistance services up to \$15,000 for any individual with a disability who is working. Expenses for personal assistance services beyond \$15,000 per year would be deductible as a medical expense.

The proposed tax credits and changes in medical care deductions for Personal Assistance will help to offset the extraordinary expenses of living with a disability and assist people with disabilities to enter the workforce by giving them a measure of economic equity with those wage earners and tax payers who do not need to pay these extraordinary costs.

Personal assistance is defined as one or more persons or devices assisting a person with a disability with tasks which that individual would typically do if they did not have a disability. This includes assistance with such tasks as dressing, bathing, getting in and out of bed or one's wheelchair, toileting (including bowel, bladder and catheter assistance), eating (including feeding), cooking, cleaning house, and on-the-job support. It also includes assistance with cognitive tasks like handling money and planning one's day or fostering communication access through interpreting and reading services.

We believe that the inclusion of these amendments would greatly enhance the ability of individuals with disabilities to become and remain contributing members of American society. Encouraging people with disabilities to become tax-payers rather than tax-takers would reduce the out-flows of the SSDI Trust Fund and increase the revenues to both the General Fund and the SSDI Trust Fund.

(4) Allow disabled workers without private health insurance to participate in Medicare or Medicaid by purchasing this public health coverage.

Linking eligibility for in-kind services such as health insurance to the lack of employment is unnecessary and counterproductive. The lack of health coverage serves to create a substantial barrier to employment for individuals who have difficulty finding affordable health insurance. Numerous studies have documented the fear of beneficiaries and recipients in leaving SSDI or SSI because they cannot afford or cannot find health insurance. Allowing disabled workers to "buy-into" health coverage by paying the required premiums and deductibles will ultimately save money by removing the risk of loss of their health insurance and giving them and incentive to reduce their reliance on cash assistance and enable them to become tax payers instead of tax users. In lieu of reforms of the health insurance market that eliminates preexisting conditions, guarantees portability, and reduces the cost of coverage for individuals with disabilities, opening Medicaid or Medicare for disabled workers would eliminate a major barrier to employment.

I must emphasize one point before I close. Unemployment among working age persons with disabilities is due to a combination of factors, including lack of health coverage, lack of long term supports for severely disabled persons, a continuing misconception that people with disabilities can't work, the failure of our educational system to adequately prepare young persons with disabilities for a lifetime of work, and the difficulties in transitioning from dependence on disability related cash as-

sistance and in-kind support programs to financial independence and self-reliance. Americans with disabilities are citizens who expect to participate fully in society with all the opportunities, privileges and responsibilities of every other citizen.

Thank you for this opportunity to submit this statement for the record. If you have further questions, please contact Tony Young of the American Rehabilitation Association at 202-789-5700 or 1350 I Street, Northwest, Suite 670, Washington, DC 20005.

