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GROWTH OF THE SUPPLEMENTAL SECURITY INCOME PROGRAM

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MARCH 27, 1995

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GROWTH OF THE SUPPLEMENTAL SECURITY INCOME PROGRAM

MONDAY, MARCH 27, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:30 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Chafee, Pressler, Moynihan, and Baucus.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning.

We are having a hearing on SSI this morning, a very important adjunct of our public welfare system, and one that has grown dramatically in the last few years for a variety of reasons, to all of which the witnesses today are able to direct their attention.

One of the things which has had tremendous play in the press is the attention deficit disorder of children. Needless to say, because of the publicity, we have had lots of letters. I am inclined to think that we have a Federal deficit disorder on occasion.

Hopefully, we will be able to address ourselves to that problem as well, if you can address yourselves to the SSI problem today.

Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Thank you, Mr. Chairman.

I have a statement I would like to place in the record.

But I would like to make a point regarding the attention deficit disorder. In 1969, President Nixon proposed the Family Assistance Plan, which was to be a guaranteed income for all needful persons, that would include aid to the blind and aid to the permanent and totally disabled, mainly adults, as well as Aid to Families with Dependent Children.

And, in the end, the only part of the President's proposal that was enacted was the provision for adults, the Supplemental Security Income. It has since expanded from the amount of court decisions, to include children with attention deficit and such like, and grown larger than we thought it would.

And we have a very distinguished panel of good Americans who will help to sort this subject out.

One of the things about the bill passed Friday in the House is that it would immediately eliminate SSI payments to a quarter of a billion of low-income children, defined as disabled.

So, let us hear about it.

Thank you.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. And we will start this morning with Dr. Herbert Kleber, who is the Executive Vice President and Medical Director of the Center on Addiction and Substance Abuse at Columbia University.

Doctor, it is good to have you with us.

STATEMENT OF HERBERT D. KLEBER, M.D., EXECUTIVE VICE PRESIDENT AND MEDICAL DIRECTOR, CENTER ON ADDICTION AND SUBSTANCE ABUSE, COLUMBIA UNIVERSITY, NEW YORK, NY

Dr. KLEBER. Thank you, Mr. Chairman, and Members of the Committee, for inviting me to address you on the issue of the SSI program for drug addicts and alcoholics.

I have been in the field of treatment and research for substance abuse for over 30 years, much of that time as professor of psychiatry at Yale, and head of the treatment program there.

In 1989, I had the privilege of being appointed by President Bush, and confirmed by the Senate, as the Deputy Director for Demand Reduction in the Office of National Drug Control Policy, under Bill Bennett.

In November of 1991, I left that office, and am currently professor of psychiatry at Columbia, and the executive vice president of a policy center, the Center on Addiction and Substance Abuse that Joe Califano and I set up approximately 3 years ago.

My testimony will stress that the Committee can best handle the rise in the SSI DA&A rolls by (1) requiring that individuals not be started on it until they have been in treatment, (2) permitting the SSI benefit to be required to be used for treatment, (3) insisting that the treatment be appropriate and the providers accountable for the outcome, (4) exploring changes in Medicaid that would make it possible for that program to pay for more appropriate treatment for addicts, and (5) increasing funds for research into medication development that might make outpatient treatment more effective, and overall treatment less costly, especially if we could have, as Senator Moynihan has been crusading about for years, a cocaine blocker.

Senator CHAFEE. What is that?

Dr. KLEBER. A cocaine blocker. A medication that would block the effects of cocaine.

Senator MOYNIHAN. I only hope we have such.

Senator CHAFEE. I am not opposed to it. I just never heard of it.

Senator MOYNIHAN. It is only for 19 years I have been yapping. [Laughter.]

Senator CHAFEE. Well, I am an attentive listener to Senator Moynihan's discussions. I am familiar with the ban on bullets and the redesign of the post office, but this is——

Dr. KLEBER. Between 1989 and now, the number of individuals in the SSI DA&A program increased from 17,000 to 100,000. While this is a large number, it represents less than 1 percent of addicts and alcoholics. So, while it seems like a large number, the number that is eligible could be extraordinarily higher.

Given the number of potentially eligible individuals, and the likelihood that many will qualify for other disabilities under SSI, the number of addicts and alcoholics on SSI may not diminish, even under the tighter 1994 law. And those who get on under other diagnoses will not be subject to either the 3-year limit or the mandatory treatment and representative payee requirement.

A recent study done by my organization, CASA, shows that approximately one-third of all disabled men on SSI—not just DA&A but in any disabled category in SSI—were regular users of illicit drugs.

The dynamics of addiction suggest that giving cash to active alcoholics and addicts, without requiring them to be in appropriate treatment, and then rewarding recovery by cutting off the funds, is not likely to lead to more than a 1 percent result in individuals getting off the rolls, as the GAO report pointed out.

Regarding program eligibility, I would therefore require prior treatment as a condition of eligibility for DA&A. If one has not had a significant exposure to treatment, whether voluntary or involuntary, and the data shows that involuntary treatment is just as successful as voluntary, it is hard to know how severe or intractable the disability is.

In this context, I do not consider repeated detoxification to be treatment. Detoxification is pretreatment.

To improve the program itself, I would make the following changes: One, I would make the benefit a method of paying for treatment. While not all addicts and alcoholics can be treated by our current methods, and many who are treated relapse, appropriate treatment in general can be both absolutely cost effective and relatively cost effective.

It is absolutely cost effective because studies show that a dollar invested in treatment yields between $3 and $7 elsewhere in the health and criminal justice system. It is relatively cost effective because the Rand study and others have shown that a dollar invested in treatment is 6 to 20 times more likely to reduce heavy cocaine use than the same dollar invested in supply reduction activities.

We currently have a major treatment shortage for drug addiction in this country. As some of the SSI money gets used for treatment, this will increase treatment availability and have a general beneficial ripple effect.

Not all treatment is created equal. Some are more comprehensive and more rigorous than others. For many of these individuals with severe problems, appropriate treatment would be the long-term residential program, such as Phoenix House, or intensive, structured outpatient programs.

Medication-assisted outpatient programs can markedly improve that outcome, and make treatment cheaper. Expanding treatment by $300 million—and remember, right now we are spending about $450 million a year for the SSI DA&A—would yield treatment for between 100,000 and 150,000 additional patients a year.

In residential programs, the full benefit amount would be paid to the program. In outpatient programs, some funds would go the program, and the rest for the enrollee's living costs. The division could be made by the individual making the assignment, as to what kind of treatment is most appropriate.

Two, it is important that treatment programs be accountable, as well as the enrollees. While many programs are well run, others are not. Programs need to be monitored for outcome. Those that are not able to achieve satisfactory results should lose the ability to accept SSI patients.

Three, change Medicaid reimbursement rules for this population. I believe that Medicaid should remain available to these individuals for at least 3 years after the SSI benefit ceases. However, Medicaid currently pays for more expensive and less effective hospital-based treatment for addicts, and usually does not pay for the ultimately cheaper and more effective approaches like the residential therapeutic community. Congress could direct HCFA to ease restrictions on Medicaid.

Four, invest funds in research. Although Congress has authorized $95 million for the medication development division at NIDA, it only appropriated $40 million. I would strongly urge the Committee to consider putting more adequate funding into this program to speed up development of an effective medication to block cocaine.

Research on substance abuse receives only 15 percent of the money spent for research into AIDS, cancer and heart disease, and yet is a leading cause of all of these problems.

In summary, while no one treatment modality can treat all addicts or alcoholics, an integrated system, with initial assessment and case management, can accomplish a significant amount.

Since our current treatment methods are not 100 percent effective, some funds may be needed for long-term inexpensive domiciliary care, with minimal treatment for those individuals who have tried and failed more intensive approaches.

The changes outlined above could further aid the endeavor started by the 1994 bill, and increase the likelihood that these individuals will become productive members of society.

Thank you sir.

The CHAIRMAN. Thank you.

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

The CHAIRMAN. And next we have Dr. Susan Martin, who is the executive director of the U.S. Commission on Immigration Reform. Doctor.

STATEMENT OF SUSAN MARTIN, PH.D., EXECUTIVE DIRECTOR, U.S. COMMISSION ON IMMIGRATION REFORM, WASHINGTON DC

Dr. MARTIN. Thank you. On behalf of Professor Barbara Jordan, our Chair, and members of the commission, I want to thank you for the opportunity to testify before you today.

I will speaking about a different aspect of SSI, and that is immigrant utilization, and eligibility for this program.

In the commission's first interim report to Congress, "U.S. Immigration Policy: Restoring Credibility", issued last September, the commission recommended a comprehensive strategy for enhancing the integrity of our legal immigration system, and improving our capacity to control illegal immigration.

In sum, the commission concluded that legal immigration is in the national interest of this country. But illegal immigration undermines not only our strong immigration tradition, but also our commitment to the rule of law.

We must, therefore, take steps to strengthen our legal immigration system, while curbing illegal immigration.

The commission believes that policy governing eligibility for public benefits, such as SSI, should be consistent with these objectives of our immigration policy.

The commission believes strongly that illegal aliens should not receive public benefits, other than in cases of emergency, where there is a public health or safety interest, or when the receipt is Constitutionally protected.

By contrast, the commission disagrees with those who would render legal immigrants ineligible for public programs, solely on the basis of their alienage.

The commission believes that such wholesale denial of eligibility runs counter to the objectives of our immigration policy and the long-term interests of this nation.

Legal immigrants are admitted because their entry is in the national interest. We may debate how many should come in, or in what categories, but the basic principle remains.

Most immigrants are family members of U.S. citizens and permanent residents, or foreign workers who U.S. businesses need in order to compete within a global economic labor market. U.S. law already bars those who are likely to become public charges.

The commission recognizes, however, that circumstances may arise after entry which create a pressing need for public health—unexpected illness, injuries sustained due to a serious accident, or a death in the family.

The commission is not prepared to lift the safety net out from individuals whom we hope will become integral parts of our social community. This is not to say that the commission condones immigrant utilization of public benefits.

We believe that the principal responsibility for assistance to immigrants rests with the immigrants themselves and their sponsors, not the U.S. taxpayer.

Our data indicate that the use of public benefits by the foreign-born is confined largely to elderly immigrants, primarily through SSI's program for the aged, blind and disabled, and to individuals admitted to country as refugees.

The commission is currently reviewing the refugee settlement program, and we hope to have specific recommendations to address this aspect of the problem.

So now I would like to concentrate on the second group, the SSI elderly recipients.

SSI program data reveal that approximately 25 percent of elderly SSI recipients are foreign-born. Overall, 10.6 percent of SSI recipients are foreign-born. The number of aliens receiving aged benefits increased from 92,000 in 1982 to 373,000 in 1992.

Under current rules, sponsor income is taken into account, or deemed, in determining eligibility for SSI, as is the case with AFDC and food stamps.

Senator CHAFEE. Could I just ask a question? Why do you use the term foreign-born and legal alien? What is the difference? In other words, there are plenty of people who were foreign-born, who have been citizens of this country for years and years. I do not see quite why your statistics would include foreign-born. That is not what we are dealing with here, as I understand it.

Dr. MARTIN. Right. In some cases, it is because the administrative data only has the information about the country of birth; it does not have the information about current citizenship or alienage.

Senator CHAFEE. I am not trying to contradict anything you are saying here, but it seems to me we should have a warning sign that foreign-born does not mean that you are a legal alien.

Dr. MARTIN. That is exactly right.

Senator CHAFEE. You could be a citizen for 50 years, and still be foreign-born.

Dr. MARTIN. Yes. That is exactly right. And it is a problem with our data and the inadequacies in some of our data collection.

Senator CHAFEE. Thank you.

Dr. MARTIN. However, the data that do pertain more specifically to legal immigrants, which would not include the foreign-born citizens, do show that there is a large increase in applications for SSI in the year immediately following the period of sponsor-deeming. And this is within the period of time in which naturalization can take place. So we are pretty sure that this does pertain to legal immigrants who have not yet naturalized.

These data can be interpreted in several different ways, however. And it is not clear from any of the information we have as to whether this is an abuse of the system, or this actually a following of the eligibility rules.

But, rather than deny eligibility altogether, on the basis of alienage, the commission recommends four other steps to take place to insure that abuse does not occur.

First, the commission believes that we must reinforce the view that responsibility for the support of immigrants rests firmly with those sponsoring their entry. Affidavits of support signed by the U.S. sponsors when an immigrant is admitted, should be a legally enforceable contract, and not just a moral obligation, as it is interpreted today.

With that type of legal responsibility, we will have a greater likelihood that sponsors will provide the support, and that there will not be a moving from Federal programs to State and local programs, which do not actually deem income.

Second, sustained use of public programs for reasons that arose prior to entry should be a grounds for deportation. Right now there is a very convoluted method for deportation. Even if somebody uses public programs for quite a long period of time during their first 5 years after entry, it is very difficult to take any action against that.

Third, alien eligibility for public benefits should be carefully spelled out in law. Right now we have many statuses and, in many of them, it is very unclear from program to program what the eligibility of permanent residents, those who are in temporary status, and those who are illegally in the country, are.

And, fourth, improvements are needed in the process used to verify the legal status of immigrants, so that we actually can tell in which status individuals are. The commission has recommended the development of a computer registry in order to verify the work authorization of aliens. And we believe a similar process could be used for public benefits as well.

We believe that effective enforcement of these provisions should help minimize the number of legal immigrants who need or depend on public assistance, while maintaining our commitment to the integration of legal immigrants into our society, thereby retaining a possibility for eligibility, but reducing any potential for abuse.

I would be glad to answer any questions you have on these proposals.

The CHAIRMAN. Thank you very much.

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

The CHAIRMAN. Next is Dr. Jerry Mashaw, who is the chair of the disability policy panel for the National Academy of Social Insurance.

Doctor.

STATEMENT OF JERRY L. MASHAW, PH.D., CHAIR, DISABILITY POLICY PANEL, NATIONAL ACADEMY OF SOCIAL INSURANCE, NEW HAVEN, CT

Dr. MASHAW. Thank you very much, Mr. Chairman.

I am pleased to be here this morning to testify on behalf of the panel that I chair at the National Academy of Social Insurance.

We were charged several years ago by the House Ways and Means Committee with a large study, which will be completed this fall, of the whole of disability policy in the United States.

A part of that has been an inquiry into the children's program, and that is what I have been asked to testify about today.

The panel has virtually completed its work on children's programs. And we have several basic findings, as well as number of recommendations, to make.

I think that I speak for virtually all the panel when I say that our basic concern is that this program not be misunderstood, both its realities and its purposes, and that the real problems of the program be addressed in the context of reforms that could be directed at distorted perceptions of program growth and abuse.

I think most of us know that there have been dramatic changes in the children's programs, in terms of the numbers over the last few years. Those are reasonably explicable in terms of changes brought about by court decisions, changes in the regulations, particularly with respect to the mental listings, outreach efforts that have been mandated by the courts and by the Congress, and also the recessionary period of 1990–1991.

I think, however, we should not necessarily mistake this wave for a trend. Those numbers topped out in 1993, and fewer new cases went on to the children's program in 1994 than went on in 1993. It remains to be seen whether there will be a continuous decline here, but it seems to me that it is certainly not the case that we should project those 1990 to 1993 increases into the indefinite future.

As a panel, I think we have come to understand this program as having some basic purposes to which most of us, I think, would subscribe.

The program serves a severely disabled population of children in very low-income families. As such, its purposes are to give these children a chance to develop in a home environment that is reasonably stable and can meet their needs.

And, for that purpose, cash income is crucial. It is necessary to avoid family dissolution and institutionalization. It is necessary to compensate for lost income that results from caregiving for severely disabled children, which is a very large portion of the economic problems of many of these families, and also to compensate for the extraordinary care expenses that result from having a severely disabled child.

Our committee has carefully considered substituting vouchers for cash income in this program. Because of our understanding of the program's purposes, and also because of administrative difficulties, we do not believe that this is an appropriate way to go.

Virtually all of our research reveals that in virtually every family having a disabled child, people are making adjustments with respect to their hours of work, with respect to their own aspirations for a career, which reduce their income. Vouchers do not deal with that problem.

And, second, the needs of disabled children are enormously varied. We are talking about special types of toys to help children gain motor skills. We are talking about alterations to houses in order to deal with their mobility restraints. We are talking about diapers, a whole range of goods and services that cut across virtually the whole of the economy. It seems unlikely that we would be able to come up with vouchers that could be accepted by all the providers who provide all of those different services.

We are very concerned, however, that this program have some changes made in it that deal with perceptions of abuse, that strengthen the validity of the assessment process, and that promote what is our most important goal, that is the integration of children into community life, and particularly into the world of work.

Most disabled children live into adulthood. If they are not to become dependent adults, the SSI program and other programs can help to facilitate that transition.

In particular, we have three sets of recommendations. First, in order to avoid perceptions of abuse in this program, we think that the maladaptive behavior listing should be altered and, indeed, eliminated, merged with other parts of the assessment process, and that caps should be put on the amount that can be received by any family for having children with disabilities—with perhaps some exceptions for foster care and adoptive parents.

Second, we think that the assessment process should be strengthened by changes in the regulations, which are quite technical, and I will not bore you with them at this moment. They are in my prepared testimony. But there should be a considerably greater use of standardized tests instead of subjective information.

And there should be a much greater use of global functional assessment, which is not so patterned on mental assessments or mental functional assessments, because this has the tendency both to over-include mental illness, and to under-include physical disabilities in the program.

And, finally, we think that this is a program that needs to do a great deal more to promote the development and avoidance of adult dependency. We think that can be done by a greater use of reviews in the CDR process and a greater emphasis on the Transition to Adulthood program, which is also a part of this program, but which has not been emphasized in the past.

Thank you very much.

The CHAIRMAN. Doctor, thank you.

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

The CHAIRMAN. Now, Dr. Jane Ross, who is the director for income security for the GAO.

Doctor.

STATEMENT OF JANE L. ROSS, PH.D., DIRECTOR FOR INCOME SECURITY, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. ROSS. Thank you, Mr. Chairman.

I am here today to talk to you about the recent growth in the Supplemental Security Income program.

Last year, over 6 million SSI recipients received $22 billion in Federal benefits, and $3 billion in State benefits.

SSI is one of the fastest growing entitlement programs, and program costs have grown 20 percent annually over the past 4 years.

You asked us to focus today on the factors contributing to caseload growth, the characteristics of SSI recipients, and ways to improve SSI.

Let me begin by talking a little bit about some of the factors contributing to growth, beginning with eligibility expansions. Table 1 in my testimony covers a variety of factors contributing to growth.

With regard to eligibility expansions, in 1984 the Congress expanded the definition of disability for both adults and children. The Act required new standards for mental impairment that incorporated the person's ability to compete in the job market. The Act also allowed SSA to consider non-medical evidence. It required SSA to consider the combined effects of multiple impairments, if no single impairment allowed a person to qualify for benefits.

Another aspect of eligibility expansion was that in 1990 a Supreme Court decision, Sullivan vs. Zebley, required SSA to add a less severe eligibility standard than had previously been applied for children.

A second source of growth in this period is program outreach. At the direction of the Congress, and on its own initiative, SSA has increased its outreach effort during the 1980's and the 1990's to better inform potential recipients of their SSI eligibility.

Beginning in 1983, there have been at least four Congressionally-mandated or court-ordered outreach initiatives.

In addition to more persons becoming eligible, fewer persons leave the beneficiary rolls. One reason is that SSA conducts very few continuing disability reviews on these SSI recipients to see if they still have the disability that first made them eligible.

As a result of Congressional directives, however, SSA now plans to conduct reviews on these adults and children turning 18.

A second reason that fewer recipients leave the rolls is that helping people with disabilities return to work has been a low priority for both the agency and the Congress. In fact, SSI and DI rehabilitation and work incentive provisions return virtually no one to work.

Another factor contributing to caseload growth is that many State and local governments have enrolled recipients of other welfare programs in SSI. Doing this saves State funds, while it also increases benefit levels for their citizens.

Finally, immigration has been a growth factor. Immigration steadily increased in the 1980's, accounting for over 30 percent of the U.S. population growth. And immigrants are almost twice as likely as citizens to receive these benefits.

Now, turning briefly from factors contributing to growth, to characteristics of current SSI recipients, overall growth in the SSI caseloads has been concentrated in the disabled part of the program, so that now nearly 80 percent of SSI payments are to the disabled.

Three groups have accounted for nearly 90 percent of this SSI growth since 1991—adults with mental impairments, children, and non-citizens. And SSI recipients now tend to be younger, they receive larger benefits than previously, and depend more on SSI as a primary source of income.

Let me conclude with some discussion of opportunities for improving the program. SSI is now primarily a disability program. The trends toward a younger population, more frequently mentally impaired, and more dependent on SSI as their sole source of income, provide compelling reasons to reexamine the program's priorities.

Improving program management and program integrity should be a high priority for SSA. For example, conducting more disability reviews would assure the public that benefits are not available to those who are no longer disabled.

Increased monitoring of drug addicts and alcoholics, and of translators who assist non-citizens, may also help to insure compliance with SSI requirements.

The current sponsorship agreements for immigrants should also be reexamined so that they are legally binding.

And we ought to look more at the relationship between impairments and work. Technology and medical treatment to help the disabled adapt are constantly improving, and society's perceptions of disability are changing. Therefore, in the longer term, we should put higher priority on returning recipients to work. This may require restructuring of the program, but it seems worth the effort.

Finding the appropriate set of actions to improve the SSI program may not be easy. These issues deserve more deliberations, and we would be glad to work with you on them.

Thank you.

The CHAIRMAN. Doctor, thank you.

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

The CHAIRMAN. Now we have Daniel Stein. Mr. Stein, I do not know how you got on this panel. You are the only person without a Ph.D. or an M.D. in this whole group. He is the executive director of the Federation for American Immigration Reform, an organization with which I am very familiar. Welcome.

STATEMENT OF DANIEL A. STEIN, EXECUTIVE DIRECTOR, FEDERATION FOR AMERICAN IMMIGRATION REFORM, WASHINGTON, DC

Mr. STEIN. Thank you, Mr. Chairman. It is an honor to be here, and I will try to be very brief, so I do not repeat any of the fine testimony that has been given to date.

FAIR is an organization working to reduce overall immigration. However, in our testimony today, we address the specific question of the increasing use of SSI by elderly immigrants, particularly those entering since 1980.

Mr. Chairman, it has been the policy of the United States, since almost the turn of the century, not to admit immigrants to this country unless there is evidence that they are going to be self-sustaining and supporting.

As early as 1885, and then through several legislative changes over the turn of the century, Congress sought to introduce measures to ensure that the taxpayer would be protected against immigrants coming in and immediately getting on benefits programs.

Between 1944 and the early 1970's, two key provisions of the immigration law were rendered effectively dead letters of the enforcement proceedings for aliens who had already entered the country. These are the so-called public charge bar, which would deny permanent resident status to an immigrant who was likely to, or after coming into the country was determined to be using public benefits.

And a second provision required that, if there was evidence that the person was going to become a public charge, a sponsor would be required to post either a bond—at some point in our history—or, later, an affidavit of support.

That affidavit of support was determined judicially to be a good faith pledge, and not enforceable as a contract between the U.S. Government and the sponsor in the mid-1970's.

At a time when we put in place an immigration program which puts enormous benefit, or enormous priority, on relative preference, or priority in the immigration selection criteria, the 1990 census now shows that many immigrants that came in earlier, since 1965, are petitioning to bring in elderly parents.

And, although some of the evidence is scanty as to the specific causes, it appears as though many of the immigrant children are having the parents transfer their assets to the children, rendering the parent eligible for SSI as soon as the deeming period expires.

This, in our view, plus the shifting demographics of the flow, as it relates to age, would explain the very rapid growth in the SSI rolls as it pertains to elderly aliens.

Senator CHAFEE. Is the deeming period 3 years?

Mr. STEIN. Senator Chafee, it is currently 5 years, temporarily. Congress extended it temporarily, I believe until the end of 1996, at which point it reverts back to 3 years.

Senator CHAFEE. And the interpretation of "deeming" means that you are, in effect, responsible for that person you have sponsored.

Mr. STEIN. Right. Yes.

Senator CHAFEE. Thank you.

Mr. STEIN. Mr. Chairman, we believe that public support of immigration is conditioned on the concept that it be considered a generally unmitigated benefit to the country. And, to the extent the evidence now shows that some immigrants are coming in with a premeditated intent to use certain programs like the SSI program, particularly when an elderly alien not having acquired any Social Security credit obtains an average benefit which exceeds that of the average native, the public support for immigration will weaken as a result of those trends.

First of all, with immigrants costing money, you might want to consider cutting immigration. That is our basic recommendation.

But, in the alternative, render the sponsorship pledge as chargeable. We are glad to see that the Jordan Commission has taken that position. Give the public charge test some meaning now in deportation proceedings.

There has been some talk in the House of doing that. When their main immigration reform bill comes through, we suggested that, if an alien uses means-tested public benefits for a 180-day period cumulatively over the first 5 years they are in the country, that would be prima facie evidence of deportability.

Alternatively, condition certain benefits on the acquisition of citizenship. One of the byproducts of this last election, and the rancorous debate over Proposition 187 in California, has been an extraordinary rise in the number of nationalization applications coming in.

Many immigrants who had determined themselves to not need to become citizens had become permanent resident aliens—millions and millions of them in California in particular—determining no need to actually go ahead with the nationalization process.

One of the political messages of 187, and some of the provisions in the Contract with America, send the signal that it is important to become a citizen, and that we should look at immigration as really the first step in the process of being a citizen.

And, to the extent we send that signal, and tell immigrants that it is important to become a citizen in order to obtain certain benefits and rights, such as voting, we will strengthen the civic fabric and once again make the immigration policy consistent with the national need and national interest.

I would commend to your attention testimony from Norman Matlock of the University of California at Davis, who has examined some of the census data from 1990, and found that 45 percent of all post-1980 immigrants who were living over the age of 65 in California are now on some form of welfare.

These are alarming trends, and inconsistent with the traditional concept of the immigrant contract with America, which is that you would come here, work hard and make your way up.

If we go back to the Ellis Island phase, 20,000 people were deported as likely to be public charges in some of those early years at the turn of the century. This is totally consistent with our history and tradition that we admit immigrants only if there is evidence that they are capable of making a living.

With that, Mr. Chairman, I would like to close now. Thank you very much for this opportunity to be heard.

The CHAIRMAN. Thank you very much.

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

The CHAIRMAN. And we will conclude with Dr. Carolyn Weaver, who is very familiar to us on this Committee. She is the resident scholar and Director of Social Security and Pension Studies at the American Enterprise Institute. She is one of our nominees for the advisory board on the independent Social Security Administration, and a former staffer of Bob Dole.

Welcome, Carolyn.

STATEMENT OF CAROLYN L. WEAVER, PH.D., RESIDENT SCHOLAR AND DIRECTOR OF SOCIAL SECURITY AND PENSION STUDIES, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC

Dr. WEAVER. Thank you, Mr. Chairman. I appreciate the opportunity to be here today to discuss what I think is the extremely important issue of SSI reform.

During the early deliberations over welfare reform, SSI basically stayed out of the limelight. And many people would, I think, prefer it to have remained so. But the sheer size and rapid growth of the program makes it clear that it should be a critical part of the welfare reform debate.

As Jane Ross indicated, SSI is the largest and fastest growing cash assistance program in the Federal budget.

It seems to me that reform is essential to prevent the growth of the last few years from becoming the norm in the next decade. There are holes in the system that need plugging. I see the problem of States shifting costs to the Federal Government through the SSI program, and also low-income families seeking ways to replace lost income or increase their incomes, as being potential additional demands on the system in the next decade.

In addition, there is the rapid growth of aliens on the SSI elderly program. In my view, were it to become generally known how far this has gone, it would begin to erode general public support for the program.

In the interests of time, I will focus on the provisions in the House bill, rather than on the broader issues, which are addressed in my written testimony. And I will touch on each of the topics considered to this point.

I would say up front that I certainly do not think that the House legislation is perfect, but I am not sure there is perfect legislation to be written in this area. SSI is extremely complex, and interacts with many other programs, and the growth of the program is determined by many things outside the control of the SSI program itself.

Beginning with SSI for children with disabilities this is the fastest growing element of the SSI rolls today. That rapid growth, together with concerns that kids are being coached to get on the rolls, has led to questions about whether the kids are truly seriously disabled, and also whether the payments are needed.

Importantly, kids are eligible for the same monthly payment, $458 a month, as an elderly adult, living in his or her own household. The public assistance received by other family members is not counted. There is no maximum applied to the amount of SSI a family can receive, and no marginal reduction in benefits for additional children on SSI.

AFDC families can substantially increase their income if their children can be reclassified as being disabled.

I would note that the Senate Finance Committee did not approve the original provision for SSI for children in 1972. They did not see the basic housing and food needs of disabled children as being demonstrably different from other poor children. It was health care needs that they saw as being an issue.

Notwithstanding the remarks of Dr. Mashaw, to the effect that we should not move toward a voucher for the added costs of raising a child with disabilities that are not met by other Federal programs, there are other ways this might be handled, for example, through the Medicaid program. There are a variety of options that would seem to fit the bill.

I would mention, of course, that the growth in the number of kids on the SSI rolls is part of a broader trend towards substantially more people with disabilities on the rolls than elderly people, and also the great increase in mental impairment allowances.

Second, on the issue of aliens or legal immigrants on the SSI program, this also is a serious problem, warranting prompt action, whether through the SSI program or through immigration policy generally.

There are two figures, figures 5 and 6, at the back of my testimony that illustrate what has been going on. The trends, I think, are relatively alarming.

The SSI elderly rolls have basically fallen continuously throughout history, from 2.3 million people in 1974 to about 1.4 million in the mid-1980's. For the first time in history, that trend is reversing, and the number of elderly people on the rolls is rising. Chart 5 illustrates that, in fact, the number of aged citizens on the rolls has continued to fall—by about 400,000 since 1982. The number of aged aliens, however, has increased by over 400,000, putting real growth into this part of the program.

Aliens receive substantially higher benefits, on average, than citizens do, putting additional pressures on costs.

As my testimony notes, this is as an area in which, I think, there is a hole that needs to be plugged. Aliens coming onto the SSI-elderly rolls tend to have arrived in the U.S. late in life. Eighty percent have come to the U.S. at age 60 or older. There is also a surge in applications at the end of the deeming period for immigrant sponsors, which is noteworthy.

I would also note that 45 percent of spending on the SSI elderly program is for aliens, and this figure is growing rapidly. I think that this trend threatens general public support for the program.

Third, addicts and alcoholics. You have heard about the rapid growth here. I would simply point out my concerns with trying to move from a cash-based entitlement to a treatment-based entitlement, as we have heard suggested this morning.

Clearly, more needs to be done to control program entry by addicts and alcoholics. This is a potentially enormous growth area in the program. But I just do not believe that the state of the art would allow us to know, let alone the Social Security Administration to know, which kinds of treatment are appropriate and cost-effective for which kinds of people. That kind of knowledge is simply lacking.

SSA has also demonstrated that it has a hard time administering services, as opposed to writing checks. Moving in the direction of monitoring treatment and evaluating treatment facilities would be very service-intensive, which is not one of SSA's strengths.

I will conclude by saying that there are much broader issues to deal with in both SSI and the Social Security Disability Insurance program. They have been around for a long time. They have to do with the difficulty of evaluating disability. They have to do with the question of when rehabilitation should take place, and the like.

As a theme for reform, I would suggest that we should be thinking about the front end of the disability process, that point at which somebody becomes disabled, before he or she ever moves into benefit status. Right now, we look at work incentives and rehabilitation at the tail end of that process.

We also have to begin factoring employers into the equation of getting people into the work force. They are largely ignored at this point. Many programs, whether it be the Americans with Disabilities Act, or the minimum wage law, or the DI tax, basically either ignore the employer or impose costs that make it that much more costly to employ the kind of people on SSI, people who are low skilled and severely impaired.

Thank you.

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

The CHAIRMAN. Mr. Stein, you mentioned permanent resident aliens here. And a great move towards naturalization. Can you expand on that a bit?

Mr. STEIN. The Immigration Service offices, district offices around the country, and particularly in Los Angeles, report a very dramatic surge or increase in the rate of new incoming applications for naturalization.

Many on-site interviews that I have read, and talking to people in the Service, suggest that for many years, we seem to have been sending the signal that it did not matter if you became a citizen or not. You could be a permanent resident alien. And, unless you cared to vote, just about everything else was available to you. Most of the Federal entitlement programs have, at one time or another, been expanded to include permanent resident eligibility. And, as a result of Supreme Court decisions, Graham vs. Richardson and Matthews vs. Diaz, State entitlement programs are also available to permanent resident aliens.

The CHAIRMAN. Now a question. If the permanent resident aliens are eligible for citizenship, from just a financial standpoint, how would we save any money by denying it to permanent residents if they then become citizens and are eligible anyway?

Mr. STEIN. There is no way to know exactly how much money one would save by restricting it to citizens only. Because we do not know how many in the process are currently eligible for citizenship.

But, as part of a basket of proposals, which would include tying it to citizenship and making the sponsorship pledge enforceable, and putting teeth in the public charge provision, you would at least deal with, or meet what appears to be growing evidence that people are coming in with the intention of getting on as soon as the deeming period expires.

And this would certainly make these sponsors think twice about signing these sponsorship pledges if they truly believe there is a possible civil action at some point to recover the costs, not just of SSI but, as we envision it, the sponsorship pledge would be enforceable as against any generally defined, means-tested public assistance, medical care and that kind of thing as well.

So what you are doing is trending down in the overall dependency rates that way.

The CHAIRMAN. Let me ask you this. Let us say there are 100 permanent residents in this country. We cut off their benefits. If 70 of them become citizens, at least you are not paying for 30. There is some marginal saving.

Dr. Ross, let me ask you. You are an expert at the GAO on this. What do you think about some of the limitations on payments in the House bill?

Dr. ROSS. Let me talk first about the children, and then the immigrants. With regard to children, I do not think we really know enough at this point about the variety of expenditures, or costs for various disabled children to know how to cash out that program and provide services. I think that is worrisome. Dr. Mashaw mentioned that, and I agree.

It is also troublesome to me that children who were entitled to benefits might be removed from the program because the eligibility standards changed. In 1984, continuing disability reviews suggested that you would have to improve before you would be able to be eliminated from the program. And I think that is a matter of some concern.

With regard to immigrants, I think there are other things that could be done besides eliminating the immigrants from the SSI program. We ought to be thinking about things like strengthening the sponsorship provisions, in particular, and the public charge suggestion that Mr. Stein made, with which I am not as familiar. But there are ways to tighten up the immigrant provisions without eliminating them from the program.

The CHAIRMAN. Dr. Martin, you did not touch on it, but my hunch is that you may have some knowledge of middleman coaches or translators who are almost coaching people on how to become eligible for the SSI benefits. Do you have any knowledge or background on this?

Dr. MARTIN. We have received a lot of anecdotal information about that. Also, I know that stories are developing. My sense is that it is coming from two factors; one is that there was a push in the mid-1980's to mainstream immigrants into the regular social service programs. And I think there was proactive effort on the part of SSI and State welfare offices to inform immigrants of their eligibility for these programs. So part of it, I think comes out of that.

The other part of it, I think, does come out of the fact that once the eligibility period after deeming comes up, there are a lot of questions about whether or not an individual can go on the rolls. And I think a cottage industry has developed, whose major aim is to provide that information.

The CHAIRMAN. Do you think there is much, I will call it, fraud in that, or is this simply an outreach program that is probably not fraudulent?

Dr. MARTIN. We have heard anecdotes of fraud. And there are some celebrated cases of fraud that have come out, and have been prosecuted. I think it is an element. My sense is that it is not the primary element. And part of that is because it seems that the deeming process is actually working.

The CHAIRMAN. The what process?

Dr. MARTIN. The deeming process actually works, that sponsors do take seriously that 3- to 5-year period, depending on the program, or else we would not see the surge in applications at the end of that period of time.

My sense is that the main thing happening is that the law now says that, after 3 years or 5 years, you are eligible. And these immigrants are income-eligible for it. They do not have the 40 quarters of Social Security. They do not have the alternative means of assets or income, and so they qualify. I think that is the major reason that they are on that.

That is why we would support a tightening of the sponsor provisions and the public charge provisions over a complete denial of eligibility, because that is a sledge hammer approach which takes off the rolls people where an exceptional situation has occurred, and there is real need for the assistance.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you. Mr. Chairman, this has been wonderful testimony.

On Friday, after a half century in the shadow of one orientation or another, the Social Security Administration becomes once again an independent agency. And Dr. Weaver is going to be one of those assigned to oversight of the Agency.

I would like to ask anyone who volunteers—I guess Dr. Weaver would be the first.

To what extent are we dealing with an aspect of the general management problem at the Social Security Administration? In 20 years, we have had 10 different commissioners, or acting commissioners. We have had great turnover. We have established a 6-year term and an advisory commission and so forth.

And this is the word—Martha Derck I think established it first—"The Social Security Administration was good at writing checks, which is what it began doing, but found great difficulty with disability." This involved the kind of assessments that Dr. Kleber is working on.

Is this going to be an institutional problem that cannot be addressed? You have a line which I find interesting, the "once disabled, always disabled" paradigm of social policy of the 1950's and 1960's, still deeply embedded in current Government policy, must be scrapped as a guiding principle.

What do you mean by once disabled, always disabled? Is this something taught as policy?

Dr. WEAVER. It is very much the underpinning of the Social Security disability programs, the notion that disabilities are complete and permanent. Certainly that is where the Social Security disability insurance program began. And, of course, SSI piggybacked on

DI. It has been a process over the last 15 years of superimposing work incentive features onto this structure.

Senator MOYNIHAN. We do have this overlay. When someone arrives in a welfare office disabled, is there a lawyer saying that you should go to the disability insurance line, or you go to the SSI line? Is disability insurance where you go if you have Social Security coverage?

Dr. WEAVER. Yes.

Senator MOYNIHAN. Basically, that is it?

Dr. WEAVER. Yes.

Senator MOYNIHAN. And the two programs cover the same problem?

Dr. WEAVER. Right. Many people have both disability insurance and SSI. And it is the same definition of disability.

Over the years, attempts have been made to superimpose so-called work incentive features onto the program. The problem is that they are tacked onto a program where you have already had to demonstrate that you cannot work in order to get onto it.

And then eligibility reviews are very infrequent. The incentives to get off the rolls apparently are not strong. Once on the rolls, virtually no one leaves voluntarily.

Senator MOYNIHAN. So you have the paradigmatic welfare program? Welfare began as a widow's pension in which there was no expectation that the adult would ever work. Now we find a different group of adults here, for whom work would be both appropriate and desirable.

Dr. Ross, would that be your perception, that the idea of once disabled, always disabled is sort of the pattern here?

Dr. ROSS. That was certainly the way the program started, when it began with people age 50 and over. Most people were impaired with some kind of a physical impairment.

Senator MOYNIHAN. That was SSI?

Dr. ROSS. Disability insurance.

Senator MOYNIHAN. Yes. The age 50, under President Eisenhower.

Dr. ROSS. Yes. But now, both of those programs, and especially SSI, have a much younger population. The average age is much younger. We are talking about mental impairments. And the whole notion about whether people stay for the rest of their lives really does need to be reexamined.

Maybe we need to think about people below a certain age differently. Maybe we should try a whole new way of doing rehabilitation with them before you talk about cash benefits.

Senator MOYNIHAN. Dr. Kleber would say, well, that is it, you are disabled, whether you are 6 years old or 26 years old, and that is it. That is a permanent condition.

Dr. KLEBER. That is correct as far as certain physical disabilities but addiction is not a permanent condition.

Senator MOYNIHAN. So, do we need legislation, or do we need a different administrative method? We need some energy.

Dr. WEAVER. I do not think there is any question that these are legislative issues, about who basically belongs on the program, and what the responsibilities of the Government are, and of those individuals. These are largely legislative issues.

Now, there also is no question that a lot of program growth can be attributed to management issues. For example, the failure to insure the integrity of the benefits rolls through periodic eligibility review.

Senator MOYNIHAN. Review? There is a 1.8 million backlog.

Dr. WEAVER. Yes, and I think that we frequently see that when those backlogs rise, allowance rates rise. There is some political pressure to get people on to the rolls.

And the failure to execute provisions like the representative payee program and other legislative requirements is an administrative problem. But, as far as work incentives and the like, those are important legislative issues.

Senator MOYNIHAN. Thank you doctor.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman

I would to address the panel as a whole. It seems to me that we have not seen any thing yet, as far as the elderly getting on these rolls.

I am not sure what relationship between citizenship and status as a legal alien has to do with it. It seems to me that, if the rules under our immigration laws are that an individual who comes in, becomes a citizen, and then can bring his or her parents and grandparents. I do not know. Is that the law? I do not know the immigration laws.

Dr. MARTIN. Not grandparents, parents.

Senator CHAFEE. Parents

Dr. MARTIN. Parents.

Senator CHAFEE. And, how about aunts and uncles?

Dr. MARTIN. No, only if they come in through some other route.

Senator CHAFEE. I see.

And then, at the end of the deeming period, which seems to be a little bit confusing here, whether it is 3 years or 5 years, if that individual by his or herself does not have adequate income, they can automatically go on the SSI rolls. That is a natural. Why not? Why would somebody not do it?

Senator MOYNIHAN. You need to be disabled.

Senator CHAFEE. No, no, no. Just aged.

Senator MOYNIHAN. Yes, just aged.

Senator CHAFEE. So these charts that Dr. Weaver has here, in figure 6, I am not sure they are accurate, or that they show the full impact because, again, it is not whether they are aged non-citizens. They could well have just recently come in and become citizens, and then they obviously qualify.

And so I would suppose, that everybody who brings in a parent—and we can only assume that that parent does not have the necessary quarters for Social Security—I gather the reason in your chart 5 here, "aged citizens receiving SSI," the reason it has declined so dramatically is because of Social Security and improvement in the benefits there.

So what we have here, I would believe, is more of an immigration law problem. Do we want to have a situation in the country where any recent citizen, or any citizen I presume, can bring in an aged parent and, at the end of 5 or 3 years, that parent is guaranteed to go on SSI? We have got a sure winner here, I would think.

Senator MOYNIHAN. They have got a sure winner.

Senator CHAFEE. They have got a sure winner. What a deal.

It seems to me that, as the word gets out, this thing is going to explode even further than it has. Is that right, Mr. Stein?

Mr. STEIN. Yes. I would like to add that one of the byproducts of this rush to naturalization that I spoke about is that you are going to see a rapid increase in the number of new citizens who are now petitioning for their elderly parents.

Senator CHAFEE. That is right.

Mr. STEIN. So these trends that are identified here in the elderly alien utilization patterns will grow very dramatically between now and the 2000 census. And we will see them maybe double or triple in the next 5 or 10 years.

Senator CHAFEE. Dr. Weaver?

Dr. WEAVER. It is also interesting to note that CBO has recently issued a report on immigration, in which they look at how immigrants land on the various public welfare programs. They find that 4 or 5 percent of the recipients of AFDC and food stamps are legal immigrants, which is about the proportion of legal immigrants in the overall population.

This compares with something about double that in the overall SSI population, and then close to 30 percent on the SSI elderly rolls. I think this makes it clear that there is a particular problem in SSI that you are identifying.

Dr. MARTIN. Senator, if I could also answer that. The commission is now looking at the admission criteria, and we will have recommendations in June as to who should be admitted in what numbers, and under what circumstances.

But now we believe that the most important thing that the Congress can do, if there are to be admissions of parents, is to insure that the sponsor agreement is a binding one, and to make sure that it is for a sufficient period of time that it will not end up having the type of impact that you suggested. If the children cannot provide the support, they have to understand that there is no free lunch for their parents in this country.

We think probably the hardest part of that——

Senator CHAFEE. I take it from what I hear that the time is temporarily a 5-year waiting period, the so-called deeming period. Is that right?

Dr. MARTIN. Right.

Senator CHAFEE. And you are suggesting it be longer than that?

Dr. MARTIN. That is one possibility, to increase the period of time, particularly when someone is coming in under a circumstance in which we know that they will not be able to work and become self-supporting because the age at which they come in would render that unlikely.

Senator CHAFEE. Well, I would think so. Could I just ask one quick question here?

The CHAIRMAN. Yes.

Senator CHAFEE. I would like to ask the experts here. I take it that, if there is a disability payment, it is a set sum, and not a gradation on the capacity of the child. Is that right?

Dr. MARTIN. That is right.

Senator CHAFEE. It is X dollars, whatever it is. Dr. Weaver, I think you said what it was.

Dr. WEAVER. The full unreduced payment for, say, an AFDC family, if one of those children became disabled, would be $458 a month.

Senator CHAFEE. And regardless of the severity. In other words, you could not have half of that if the child was fairly disabled.

Dr. KLEBER. No.

I will perhaps have other questions, Mr. Chairman. Is this the only round?

The CHAIRMAN. Yes.

Senator CHAFEE. Thank you.

Senator Pressler.

Senator PRESSLER. Thank you Mr. Chairman, for holding this hearing. And I want to thank the panel for their good information.

I want to ask someone—I think Dr. Weaver might be the correct person—on the drug and alcohol addicts situation, if an individual were to stop their job and, in a couple of months, declare himself to be an alcoholic, he could collect $458 a month, as I understand it. Is that a correct assessment of the situation? And he would not have to take any treatment or do anything about it?

Dr. WEAVER. You would have to be out of work longer than that.

Senator PRESSLER. All right. How long would I have to be out of work?

Dr. WEAVER. In both disability insurance and SSI, there is a 5-month waiting period.

Senator PRESSLER. There is a 5-month waiting period.

Dr. WEAVER. Yes. But once having met that requirement, there is no treatment required.

Senator PRESSLER. Would I have to have a physician deem me to be an alcoholic or a drug addict?

Dr. WEAVER. There would be medical evidence gathered, along with vocational information, to determine whether or not your addiction was severe.

One of the interesting suggestions made earlier was that, if indeed you are going to maintain cash support for these people, it might be very wise to have treatment be a predecessor to letting someone on the rolls, as a way of helping to get a fuller picture of the severity of that disability.

And the same may be true of people with mental impairments.

Senator PRESSLER. Now what does treatment for alcoholism or addiction consist of? How is that described or defined in today's rules?

Dr. KLEBER. I am probably the more appropriate person to answer that. There is no one treatment. We do have a range of treatments, including long-term residential therapeutic communities, places such as Phoenix House and Dayton Village, where people live for a year to 18 months.

You have intensive outpatient programs that can last 10 to 20 hours a week, and all the way down.

What you ultimately need is a continuum of services. For some addictions, you have appropriate medication, for others you do not. In general, you can fit the individual to the type of treatment. Some need more intensive, some need less intensive.

And I would have to disagree with Dr. Weaver's earlier testimony that we do not know enough about how to assign treatment. I have been assigning treatment to addicts and alcoholics for 30 years. I think we do know how. It is not perfect. It is also not perfect for heart disease.

Senator PRESSLER. What would you assign, for example?

Dr. KLEBER. Well, an individual who clearly does not have much in the way of vocational skills, who has led pretty much of a antisocial kind of life, probably should be in a residential environment with a very severe and structured kind of program. He does not need rehabilitation, there is no "re" to go back to. He needs habilitation.

In contrast, an individual who has vocational skills, who has some family support, may need some counseling, some self-help programs, in short, a very different kind of approach.

Senator PRESSLER. I know this has been in the popular press a great deal, as Dr. Weaver pointed out. How can we correct this? It seems as though this is one where you really do not have a clear definition of what chemical dependency or alcoholism is. It is one that could be abused indefinitely, it seems to me.

How do we get people off of this—what do they get, $458 a month—if they are an alcoholic or a drug addict? And how long can that go on?

Dr. KLEBER. Well, we do have clear definitions of what constitutes an addict or an alcoholic. The problem is that some of it is subjective, so that the examiner, to some extent, is guided by what the individuals tells him.

In a lot of psychiatric disorders, you do not have the objective criteria of missing eyesight or deformed limbs. It is a much more behavioral type of diagnosis that has to do with the individual's intake of these substances and the behavior that results from it.

But, yes, we do know how to diagnose this. We can diagnose it reliably. And, in terms of outcome, we can treat it, not 100 percent successfully. But then, we cannot treat cancer or heart disease 100 percent successfully.

Senator PRESSLER. Do we have some good numbers or some evidence that the programs are successful? Are there repeat cases? When you take someone in and give them treatment, when they are on these programs, do they get off of SSI or DI?

Dr. KLEBER. Well, SSI is probably the worst place to look for effectiveness because you have everything loaded against it being effective.

And the GAO report stated that, at the end of 4 years, only 1 percent of addicts and alcoholics got off of the rolls.

But if you look not at the SSI population, but at general studies of treatment outcome, you find at the end of, let us say, 3 to 5 years, a substantial number, probably a majority of the individuals who enter treatment, are no longer using illicit substances or abusing alcohol. But that is not in a system where you give the individual incentives not to get better.

Senator PRESSLER. Thank you, Mr. Chairman.

The CHAIRMAN. Although this is a hearing on SSI, the House has taken the children's services part of it and put it into the block grant, along with a plethora of other programs.

I would just be curious to pick this panel's brains as to what they think about the concept of the block grant. Forget for the moment the children's services part we put in, or add it if you want, it is a fair portion of SSI, but by and large the rest of it was not put in.

I will start this time with Dr. Weaver, and work the other direction.

Dr. WEAVER. As a general matter, I am fairly comfortable with block grants. I like the idea, as you hear about the desirable quality of block grants, of allowing for the diversity of efforts and for trial and error among the States. This is so important in programs where we are not sure precisely how to do things. We do not know exactly what the nature of the problem is, or how to fix it. Where there is a diversity of opinion, as I am fairly convinced there is in the treatment area, that is the benefit of block granting.

Of course, block grants require relinquishing certain responsibilities the Federal Government has taken on. That involves a major decision about which responsibilities the Congress is willing to pass back to the States.

In many cases, these programs became Federal through a very gradual process. SSI is a case in point. There were State-operated programs in the 1930's. It was a process of increasing Federal matching funds over time, until SSI was Federalized in 1972.

No one has suggested block granting SSI but, as a general matter, I am quite comfortable with the idea of block grants.

The CHAIRMAN. Mr. Stein?

Mr. STEIN. Mr. Chairman, on pages 15 and 16 of my testimony, I contemplate the potential Constitutional problems of a broad delegation from Congress to the States to make alienage determinations and classifications under SSI or any other Federal entitlement.

As I read Graham vs. Richardson from 1971, the Supreme Court said that, if a State is not going to be able to unilaterally decide which kind of aliens are going to get which Federal benefits, but that if Congress were to delegate that kind of block grant authority, Congress would have to very explicitly tell the States which aliens—and this gets pretty complicated—and which kinds of aliens can get which benefits.

And the second question, of course, is the State's ability to verify alienage status. Service providers at the State level do not have any easy, automated or efficient system to determine alienage or citizenship status, and to verify that alienage with the Federal Immigration and Naturalization Service.

So block grant administration would potentially implicate the whole range of administrative problems at the State level that we do not think were satisfactorily addressed in the House.

The CHAIRMAN. Dr. Ross?

Dr. ROSS. I would like to talk specifically about the SSI children's block grant, where the money is moving not only from the Federal Government to States, but it should be taken in the form of services. And that is the part that I think is especially problematic.

Many families with disabled children need cash. They need cash because they are replacing their lost wages, because they buy things such as vans, or need to redo their houses. And these are the kinds of expenditures that are much more easily made if the family has cash than if all these services are available.

So I think we will not be able to give disabled children and their families the kind of things they really need if you move to services and a block grant.

The CHAIRMAN. Do you want to comment on the general concept of the block grant?

Dr. ROSS. GAO, in general, has some cautions about block grants. While, in many cases, they allows more flexibility, we are very concerned about making sure that there is accountability, that we understand that the money went for the purposes for which it was sent to the States, and it is not being used some other way.

And we are also very concerned in many cases about allocation formulas that come in block grants. Some of the block grants that are currently in House bills have not looked too much at the allocation formula. So those are two areas where we have some reservations about block grants.

The CHAIRMAN. Dr. Mashaw.

Dr. MASHAW. Senator, I am generally well disposed toward decentralized administration of various kinds.

I think we should make some distinctions here between what is being decentralized, and who has control. If you are talking about income programs, it seems to me that block granting really is a choice between administration by families and administration by States. And there I would say we support administration by families. That is, that the distribution of income to families to satisfy the needs of their disabled children is a more sensible approach than decentralizing it to the States.

The CHAIRMAN. Let me ask you there though, do you mean the individual versus the State entitlement? You still have a fair bureaucracy in just getting the money to the individuals.

Dr. MASHAW. You do, but that bureaucracy is really almost invisible by comparison with the bureaucracy necessary to deliver the same value of services.

And it seems to me that, given the enormous heterogeneity of the children's population and the disabled population, that trying to set up State bureaucracies to deliver services that would meet those needs leads back in the direction of what we remember about AFDC back in the 1960's and 1970's, when we had small basic grants and large special needs grants, and a huge bureaucracy that was completely incapable of administering that program. And I worry about that.

I think, on the question of administration, one of the things that my panel is particularly interested in is not just moving toward getting States and localities involved, but getting the private sector involved.

I think that the bad experience that we have had with the disabled population, with respect to return to work, is not a question so much of the location of that activity at the Federal level or at the State level, but the lack of involvement of the private sector in that.

We are working on a number of proposals in which we hope to involve the private sector in return to work programs that would apply not just to the children's populations but to the adult populations as well.

The CHAIRMAN. Dr. Martin.

Dr. MARTIN. Any type of devolution of authority to the States, where immigration eligibility determinations are concerned, have to be very very carefully crafted.

One of the advantages to a binding affidavit of support is that it does provide a legal basis by which States can take sponsorship income into account, which many States feel that they cannot do at present.

With regard to the issue of the supplying to children, as well as to adults, there is another problem with the application, particularly if citizenship is a requirement for disability benefits for children. An immigrant child cannot naturalize on his or her own. Only a parent can naturalize, and then the child becomes naturalized; you have to be an adult to do so.

And it raises some questions as to whether we are in effect putting children into a Catch 22 because, as a child, they cannot naturalize because they do not have ability to take the oath. But, as immigrants, they would not be eligible for the assistance.

In the same way that the Supreme Court has held, in *Pyler* vs. *Doe* that you cannot take the actions of a parent and apply them in a way that would be harmful to a child, I think that whole set of issues would have to be raised.

This would be particularly true with an unfortunate hypothetical case where, let us say, there is a car accident and the parents are killed, the child is left disabled. If the child is an immigrant who cannot naturalize, he also cannot get assistance. That is obviously an extreme case, but it is the kind of hypothetical that makes one wonder about wholesale denial of eligibility, as to what it will do.

The CHAIRMAN. Dr. Kleber.

Dr. KLEBER. In theory, I have no problem with block grants. In practice, I have two major concerns. One, what is the formula that will drive the distribution? For example, if you did it with addicts and alcoholics on the basis of the current SSI distribution, you would reward those States who have been energetically trying to get people on SSI and DA&A to relieve some of their own burden.

For example, California has one-third of all the DA&A while New York State, which takes second place to none in the number of addicts, only has 4 percent. And I would have to say that we probably do have more addicts than California, but New York State has not been as vigorous in getting them on SSI.

So I would say that the formula is a critical variable. And we know with the SAMASA Treatment block grant, in terms of treatment, there are lots of problems with urban versus rural. Some States have waiting lists for treatment, some States have vacant slots. So, if the formula could be worked out, I would have no problem.

The second issues is State supplanting. One of the things we were very concerned about at ONDCP was that, as we increased the amount of Federal money available for treatment, States began to decrease their own funds. So if there is block granting of this money, especially if it is made a treatment benefit, then there should be very careful attention paid to State supplanting.

The CHAIRMAN. I hesitate to even get into the formula issue. Every Governor has a mathematical proof that their State is underfunded. And it does not matter what the formula is.

Senator Moynihan.

Senator MOYNIHAN. We have just heard testimony that New York State is not second. [Laughter.] What a learned statement.

I wonder if I could just explore for a moment the statement that Dr. Mashaw made. The distinction between administering services through the family, as against through Government. If we have a uniform national payment level, and we provide disability funds to families, and they work it out within their own resources and skills, as against a Government-provided level. You know you have the wherewithal in Government. Is that the point you are making?

Dr. MASHAW. Yes, that is the point. There are a number of ways that one might imagine developing service plans and so on for children, and authorizing individual services. All of those are extremely time consuming and bureaucratically expensive. And they involve significant micromanagement of family affairs which, it seems to me, one would not want to get into unless one found really serious levels of abuse.

Both in terms of existing State programs that intervene with respect to mistreatment of children, and also the representative payee program of the Social Security Act, there are ways of dealing with failure to use monies appropriately for the child. So I would be very hesitant toward a bureaucratization of that system.

Senator MOYNIHAN. I think, if we have learned anything, it is to try to avoid disappearing into regulation, and regulations where there are not that many uniformities. Is that not a basic administrative problem?

Dr. MASHAW. You have to give someone a lot of discretion. The question is whether you want to give discretion to families about their children, or whether you want to give it to bureaucrats, however well motivated.

Senator MOYNIHAN. We do not need to call them bureaucrats. We can call them——

Dr. MASHAW. Public officials.

Senator MOYNIHAN [continuing]. Public officials. But that sort of discretion always involves layer upon layer of review, just to protect the individuals involved. The arteries clog very quickly.

Dr. MASHAW. I recently attended a conference with respect to one of my granddaughters, who is a developmentally disabled child. To deal with 1 year's plan for this child, there were 13 of us around the table, 11 on the public payroll. This is a wonderful program for children with developmental disabilities, but it is enormously expensive to run.

Senator MOYNIHAN. We know that. And, to some extent, the whole problem the Social Security Administration has had with disability insurance is a paradigmatic experience. Is it not, Dr. Mashaw?

Dr. WEAVER. I wonder if I could add a couple of points here on the issue of SSI for kids.

Even if you agree with this argument, discretion should go to families, rather than service providers for example, if we move from cash to services to a block grant.

Senator MOYNIHAN. Tell me some of your politics. You have been through elections. You can say bureaucrats. [Laughter.]

Dr. WEAVER. In this whole discussion——

Senator MOYNIHAN. Faceless bureaucrats.

Dr. WEAVER. Faceless bureaucrats. Absolutely. [Laughter.]

The CHAIRMAN. I was just trying to achieve common ground, Carolyn.

Dr. WEAVER. The whole discussion here is presuming that the basic payment standard, $458 a month, is appropriate, but I would assert offhand that we have no evidence that it is. Take a typical AFDC mother with two kids. If she can get one of those kids on SSI, she picks up $458 a month. She loses $70 or $80 a month in AFDC. She can double family income by getting a child certified as disabled.

Senator MOYNIHAN. And possibly—let us be honest—stigmatized.

Dr. WEAVER. Absolutely. There is a real question, with kids coming on the rolls for behavioral disorders and other less severe mental impairments, about how good it is for the child to be put in a position of being classified as disabled so early in life, with something that may or may not have long-term consequences for his future well-being.

May I have one more moment?

The CHAIRMAN. Go ahead.

Dr. WEAVER. The other point I wanted to make pertains to this idea that SSI cash assistance for kids should somehow replace parents' lost wages. That is certainly interesting, but not an argument I have heard before about what the payment is for or how it would be set.

It has not been a concern for other poor families, or for other poor families who have seriously disabled kids, just not serious enough to get on SSI. We do not talk about trying to replace the lost wages of parents.

It has not been a concern, that I am aware of, for elderly people living in the homes of their children. We know that frequently an adult child has to cut back on or quit work in order to care for an elderly parent. We do not adjust the payment standard on that basis. It is related to the poverty level. SSI, along with food stamps, produces a payment level for an elderly individual that is near the poverty line.

That is the same payment a child living in the home of its own family is eligible for.

Senator MOYNIHAN. Thank you.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

I would like to perhaps contradict what Dr. Weaver says a little bit. We have seen these youngsters, some of them severely disabled, whose very low-income parents are looking after them, and who qualify for the SSI for children. And these children truly need the extra care. I do not think the comparison with AFDC is really quite fair.

Yes, they get more money, and yes the second child gets the same amount if you have two who are severely disabled, and that is a situation I am familiar with at home, where a mother does have two severely disabled children. And it takes everything she has got to look after these children. But, if those children were institutionalized, the costs would be far greater for the taxpayer than they are with her doing what she is doing.

I am not taking you to task. I am just pointing out that I do not think it is quite fair. There is a reason for this $458 a month for one of these disabled children because the mother truly cannot go to work, whereas an AFDC mother could have them in a day care center and all that.

Dr. WEAVER. I would just qualify to say that that depends entirely on the nature of the child's disability. We know that the range of disabilities is enormous, and that the severity within any particular disability can be very wide.

You might have a child with some severe medical condition, cerebral palsy or cystic fibrosis. You might have a profoundly retarded child with multiple physical disabilities. We can imagine the type of child who requires extraordinary care and would be in an institution, but for the availability of SSI and Medicaid. And I would mention that the House bill retains full cash for that type of child.

But there is another range of kids on the rolls. Remember, most are on the rolls for retardation or mental illness. They may or may not have any complicating physical impairments, and there may or may not be extraordinary medical costs associated with them. Of course, medical expenses are largely picked up by Medicaid, so it is a question of what are the extra costs for the family, in terms of basic living expenses that are not met by other Federal programs.

But, I agree with the point that some families no doubt have extra expenses that exceed $458 a month, certainly in concentrated time periods. The example has been given of someone who needs to make physical accommodations to their home for a physically impaired child.

Senator CHAFEE. But does this not get to the point we were discussing earlier. I would be glad for comment on this. Should there just be a flat sum once the child is determined to be disabled? Is that the qualification?

Whereas, as Dr. Weaver pointed out, there can be gradations of what is disabled. But is there fear that to turn it over to faceless bureaucrats is dangerous, is not the way to proceed, that you do not want to give somebody that discretion?

Could you just quickly comment on that? Dr. Martin, do you have any thoughts on that?

Dr. MARTIN. No. That is not my field.

Senator CHAFEE. You are an immigration specialist. Dr. Kleber?

Dr. KLEBER. Well, the VA has done it for years. They somehow manage to say that you are 10 percent disabled, psychiatrically, 20 percent disabled psychiatrically. I am not quite sure what arcane method they use to determine that, but at least they do make those determinations under law.

Senator CHAFEE. They have an appeal setup too. And that involves law, appeals judges within the system, and all that.

Dr. Mashaw?

Dr. MASHAW. I think we need to make one distinction here, Senator; that is between severity and duration. Virtually all the children who are on SSI disability are severely disabled. The duration of their disabilities may change. So it seems to me very important to have administration in place that continuously monitors and deals with transitions.

On the question of the amount, I think Dr. Weaver is absolutely right. I do not think anybody could say that $458 is the right amount to be given to every family.

On the other hand, it is very difficult to come up with another single amount, and it is extraordinarily difficult to come up with an individualized amount for each family, with respect to each child, as that child's condition changes over time.

So I agree that this is a lumpy benefit, but one which undercompensates a lot of families, as well as overcompensates families.

Senator CHAFEE. Dr. Ross?

Dr. ROSS. I agree with Dr. Mashaw.

Senator CHAFEE. It is just too complicated, and you would get into all kinds of problems because there may be changes over the period.

Dr. ROSS. Yes. The particular dollar amount now has no history behind it, but anything else that people have thought about is much more complicated.

Senator CHAFEE. Dr. Weaver, did you say in your testimony—I may have gotten it mixed up—that, "The Americans with Disabilities Act worked against the hiring of the disabled."?

Dr. WEAVER. I certainly do think that the reasonable accommodation requirement, which imposes unreimbursed costs on employers, works against the hiring of severely impaired, less skilled workers.

Senator CHAFEE. So, if McDonald's wants to hire an impaired individual, once they made that decision, they would have to have railings, and so forth?

Dr. WEAVER. Consider a person who has a hard time, in terms of productivity, meeting the demands of a minimum wage job. The firm must begin by paying minimum wage, and then incur any additional costs that might be required to allow that individual to work.

The ADA has different impacts on different groups of people with disabilities. I think others who have looked at this—economists certainly—would generally agree that the group least favored under this approach are just the kind of people on SSI, low skilled workers with poor educations, and who lack work experience.

Senator CHAFEE. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Martin, as best you know, what percentage of immigrants have sponsors?

Dr. MARTIN. Overall, the majority of those who are sponsored by family members—and that is about 450,000.

The CHAIRMAN. Out of how many?

Dr. MARTIN. Out of about 800,000.

Plus, you also have some variety of employment-based sponsored immigrants. And how to enforce responsibility on employers is distinct, but family members will, needless to say, be a challenging kind of issue.

We do think there should be some way in which an employer who brings in a foreign worker takes on responsibility for that worker. But we also do not want the worker to become indentured to that employer. That does not make sense.

The CHAIRMAN. Counting sponsors of all kinds, 60 percent 65 percent, 50 percent?

Dr. MARTIN. At least. I can get you more specific information.

The CHAIRMAN. Could you?

Dr. MARTIN. Yes.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, I think I would just like to go away and think about all we have heard here. I think here is a case for national standards. I think children are the same and different everywhere. We have in place a national provision, and I hope we continue that.

The House has proposed to abolish Aid to Families with Dependent Children, but not to abolish SSI, which interacts. I think they were right in the second case, and wrong in the first case.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Mr. Stein, I am not quite sure why you pay great attention to this individual becoming a citizen. For what? So the person becomes a citizen, is that going to make the person more or less likely to go on the SSI rolls? And in that period during the deeming, so the person does or does not become a citizen, what difference?

Mr. STEIN. Well, Mr. Chafee, we believe that this particular provision should be dealt with as part of a couple of other changes as well, such as extending the deeming period, during which the sponsors are required to support the alien during the entire period of alienage, until the new alien becomes a citizen.

Second, we think it is very important that——

Senator CHAFEE. If I understand it, you would suggest that if this person does not become a citizen, the deeming period would be 10 years. Whereas, if the person became a citizen during that period, then the deeming period ends.

Mr. STEIN. It does not necessarily have to end, but it could end at the point of naturalization.

Senator CHAFEE. Well, let us say it ends at 5 years. I do not get it. So the person is a citizen, and goes on the SSI rolls?

Mr. STEIN. Well, there is a lot of evidence that says that aliens are not becoming citizens in extraordinarily high numbers now, in places like California.

And, as a matter of general civics, it is not good to have large numbers of people coming in and never taking that step to swear allegiance and join the society. It is the Immigration and Naturalization Service. They are conjoined. And part of the incentive for aliens to become citizens would include eligibility for certain welfare programs.

The requirement that it be specifically tied to naturalization in the abstract, by itself, would not necessarily save much money but, if it is tied to extending the deeming period, denying eligibility and making the public charge benefit enforceable for all means-tested benefits while the alien is an alien, you will over time decrease the number of immigrants coming in who are likely to be a liability to the sponsor at any time during their alienage.

Senator CHAFEE. Well, I do not quite get it. When you take your pledge to become citizen, you do not say, "And I also swear I will not go on the SSI rolls."

In any event, one of the things I have gotten out of this testimony is that I would predict that the number of aged—whether they are citizens or non-citizens—on the SSI rolls is going to grow dramatically in the years ahead. That is what it shows here already, and I think that is going to continue.

But also I believe that these children, many of them very severely disabled, the parents are fully entitled in that case to every nickel that they get. In the instances I have seen, these parents are coping with extremely difficult cases. And the alternative would be to institutionalize the child, which would cost way more than $458 a month.

Thank you, Mr. Chairman.

The CHAIRMAN. Any others, Pat?

Senator MOYNIHAN. Well, yes. Just as a backup, you never know when you might need it, could Dr. Kleber give us more information about how you get the VA to declare yourself 10 percent psychiatrically disabled? [Laughter.]

Dr. KLEBER. I would not pretend to try to do that, Senator. I do not think I have that kind of wisdom. I would hope that we do not make the mistake we have made in the medical system. A decade ago, for every 6 physicians, we had approximately one manager or administrative type. Now, in the medical system, for every 2½ physicians, we have roughly one administrative type.

So I would hope that in the attempt to make savings in one part of the system, we do not simply increase the number of "faceless public servants." [Laughter.]

We need to keep in mind that this is a difficult task, and we do not try to do things that we do not do very well.

The CHAIRMAN. In your judgment, could that standard be applied to members of Congress?

Dr. KLEBER. No. They are public servants with a face. [Laughter.]

The CHAIRMAN. Thank you very very much, all of you. It has been most informative.

[Whereupon, at 11:15, the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF HERBERT D. KLEBER, M.D.

Mr. Chairman, members of the Committee, thank you for inviting me to address you on the issue of supplemental security income payment to drug addicts and alcoholics. I have been in the field of treatment, research and policy aspects of substance abuse for over thirty years. Much of that time was spent at Yale University as Professor of Psychiatry and the Founder and Director of the Substance Abuse Treatment Unit at Yale and The APT Foundation. The Unit when I left in 1989 had over a thousand patients in treatment for alcoholism and drug addiction at any one time, and, as well, was carrying out extensive research to try and develop new treatment methods for these patients.

In 1989, I had the privilege to be appointed by President George Bush, and confirmed by the Senate August 1st, as the Deputy Director for Demand Reduction for the Office of National Control Policy under its first director, William Bennett. I served until November 1st, 1991 and then left for New York City and currently hold two positions. I am Executive Vice President and Medical Director of the Center on Addiction and Substance Abuse (CASA) at Columbia University, a policy center founded by Joseph Califano, Jr., formerly Secretary of Health, Education and Welfare under President Carter, and myself, and, in addition, am Professor of Psychiatry at Columbia University and Director of a newly created Division on Substance Abuse at Columbia and the New York State Psychiatric Institute.

At CASA we are engaged in policy research on all aspects of substance abuse. Most recently, we were funded by the federal government to carry out an evaluation of the effectiveness of our national treatment system. The study will look at approximately two hundred programs and two thousand patients who will be followed over a period of one year. In addition, I am co-editor of the recently issued *Textbook on Substance Abuse Treatment* published by the American Psychiatric Association Press.

The toll substance abuse takes on our society is well into the hundreds of billions of dollars and affects every aspect of our daily life. It affects our health care system, crime, welfare, our economic competitiveness, and is the fastest growing segment of both the AIDS epidemic and the increase in tuberculosis. The problems brought about by substance abuse have been persuasively laid out in a book recently published by my colleague, Mr. Califano, entitled "Radical Surgery," which especially emphasizes that it will be hard to adequately reform our health care system until we do something about the treatment and prevention of substance abuse.

I will focus today on the questions Senator Packwood in his invitation asked me to address:

1. How should Congress address the dramatic increase in the Supplemental Security Income program rolls?
2. What changes should be made to the current eligibility requirements in the Supplemental Security Income (SSI) program?
3. Besides eligibility requirements, what improvements should be made to the Supplemental Security Income program?

My testimony will stress that the Committee can best handle the rise in the SSI Drug Addiction and Alcoholism (DA&A) rolls by (1) requiring that individuals not be started on DA&A unless they have been in treatment, (2) repealing the prohibition against requiring use of SSI funds for treatment, (3) insisting that the treatment be appropriate and the providers accountable for the outcome, (4) exploring changes in Medicaid that would make it possible for that program to pay for more appropriate treatment for addicts, such as therapeutic communities, and (5) increasing funds for research into Medication Development that might make outpatient treatment more effective and, therefore, treatment overall less costly.

1. How should Congress address the dramatic increase in the Supplemental Security Income program rolls?

In 1989, there were 17,000 individuals in the Drug Addiction and Alcoholism (DA&A) Program on the SSI rolls. One year ago this number had increased to 78,000 and it is now closer to 100,000, approximately 2 percent of the SSI disability rolls. The GAO has projected that it will at least double by the year 2000. At the time of the GAO Report when the number was in the 70,000 range, only about 11,000 were illicit drug users, 20,000 used both drugs and alcohol, and the rest were primary alcoholics. Since it is estimated that there are at least two and a half million drug addicts in need of treatment, at best approximately 1 percent of them are on the SSI DA&A Program. Further, there are 15–18 million alcoholics. With the pool of potential applicants being so large, the rapid increase in the past 5 years is some combination of more individuals and agencies learning how to get on the program; " . . . active outreach activities by SSA to promote awareness of the availability of SSI payments for those who have serious mental illness in addition to substance addictions," (Commissioner Chater, 3/22/95); and the lack of enforcement by the Social Security Administration of the representative payee and the treatment requirements. The tightening of the program by the 1994 law, with the 3-year upper limit and the mandatory representative payee and treatment requirements, should slow down this rise, but, given the number of potentially eligible individuals and the likelihood that many will qualify for other disabilities under SSI, the number may not diminish as much as many in Congress would hope. A study released in February, 1995, by the Center on Addiction and Substance Abuse (CASA) on the relationship of substance abuse to federal entitlement programs showed that, based on the NIDA National Household Survey, approximately one-third of all disabled men on SSI, regardless of their disability diagnosis, indicate regular use of illicit drugs. It is, thus, not simply the DA&A diagnostic group that is impacted by substance abuse. Lack of enforcement of the treatment requirement was illustrated in the GAO Report: they could verify treatment for just 20 percent of the DA&A population and found as well that many representative payees, especially friends and relatives of the eligible individuals, had trouble preventing the substance abusers from using the benefits to support their addiction.

There appear to be two main ways to decrease the rate of rise of the DA&A Program: the first is to change eligibility requirements, and that will be addressed below; the second is to enforce more stringently the treatment and representative payee requirements and to consider changing the nature of the treatment requirement. I will address the last point under Question 3. It is clear, however, from the GAO study that only 1 percent of the DA&A enrollees from 1990 had recovered or resumed work by 1994. The dynamics of addiction suggest that giving cash to active alcoholics and addicts without requiring them to be in appropriate treatment and then rewarding recovery by cutting off the funds is not likely to lead to more than a 1 percent result, especially for individuals with limited skills. One does not need to postulate "abuse" of the program to achieve such an outcome—it is the "use," the logical result of the system that has been in place. (It should be noted parenthetically that, according to Commissioner Chater, less than one-half of 1 percent historically of individuals overall on SSI ever leave the rolls to return to work.)

2. What changes should be made to the current eligibility requirements in the Supplemental Security Income (SSI) program?

Require prior treatment as a condition of eligibility for DA&A.

As noted above, if one looks at the current system, it flies in the face of much of what we know about the nature of the disorder of addiction. First, addicts have not been required to be in treatment for a minimum period of time before being found disabled. If one has not had a significant exposure to treatment, whether voluntary or involuntary, it is hard to know how severe or intractable the disability is. (In this context, I do not consider repeated detoxification to be treatment—detoxification is pre-treatment.) Once having received the disability award, there has been a failure to require treatment and a failure to monitor the representative payee and, finally, the addict is "punished" for recovering by losing his or her disability payment. Involuntary treatment has been shown in a number of studies over the past twenty years to be about as effective as voluntary treatment. If the Social Security Administration had over these years been requiring addicts on their rolls to be in treatment and the appropriate treatment was available, we would either see a slower rate of increase or fewer individuals on the roll.

In considering the eligibility requirements, it should also be noted that who is eligible and who is not is not always clear. For example, my colleague, Dr. Mitchell Rosenthal, Founder and President of Phoenix House, indicated in his Congressional testimony last year that in the New York Phoenix House Programs there are more than 900 adult residents of whom only 18 receive SSI disability benefits, and in California only 6 are on SSI out of 140 adult residents. Do current rules work against getting people to enter and remain in the most appropriate types of programs?

3. Besides eligibility requirements, what improvements should be made to the Supplemental Security Income program?

Make the DA&A benefit a method of paying for treatment.

Jim Burke, Chairman of the Partnership for a Drug Free America, noted in a recent talk that drug use is a preventable behavior and drug addiction is a treatable disorder. While it is certainly true that not all addicts and alcoholics can be treated by our current methods, and that many who are treated relapse a number of times before achieving eventful abstinence, it is also true that appropriate treatment in general can be effective with this group of patients. Treatment is both absolutely cost-effective and relatively cost-effective. It is "absolutely cost-effective" because studies show, for example the recent CALDATA Study from California, that a dollar invested in treatment saves between $3 and $7 elsewhere in the health and criminal justice systems. Thus, treatment pays for itself. It is "relatively cost-effective" because, as the recent study from the RAND Corporation pointed out, to reduce heavy cocaine use it would take anywhere from $6 to $20 invested in law enforcement or other supply reduction activities compared to $1 invested in treatment. I would like to suggest, therefore, that *the Committee consider eliminating the prohibition against the DA&A benefit being required to be used for treatment and, instead, make it a method of paying for treatment.* We currently have a major shortage of treatment in this country especially for the drug addict. Of the 2.5+ million addicts in need of treatment, the estimated national capacity is at best 1.4 million a year. Furthermore, only 12,000 beds are available nationally outside of prison for the kind of intensive residential treatment programs that may offer for this particular SSI disabled population the best chance for long term recovery.

All treatment is not created equal. Some treatment is more comprehensive and more rigorous than others. Further, treatment is not a "liberal" or a "blame society" response. It is a reasonable response to the addiction problem and data indicates, as noted, that involuntary treatment that is court ordered, for example, can work as well as voluntary treatment. *The mix of funds from the representative payee to be used for treatment, as opposed to living costs, would be determined by the recommendation regarding level of care from the required individual assessment.* For many of these enrollees with their severe problems, appropriate treatment will be long-term residential if available, or intensive structured outpatient programs that provide at least 10 to 20 hours a week of comprehensive treatment. Such treatment would include vocational and educational efforts as well as the more usual cognitive-behavioral, relapse prevention, self-help groups, and psychiatric assessment and treatment, as needed. It is primarily these kinds of programs that offer hope for this very difficult population. Emphasis needs to be on cessation of illicit drug use and alcohol abuse. If individuals cannot maintain that on an outpatient basis, even if intensive, then the individual needs to be in a residential program. Medication-assisted programs can aid in some patients doing better in outpatient approaches. These include Antabuse (disulfiram) or Revia (naltrexone) for alcoholics, and methadone, LAAM, or naltrexone for heroin addicts. We do not yet have an effective medication for cocaine, and one is badly needed. Currently, over $400 million is spent on SSI payments in the DA&A category. Expanding treatment by $300 million, for example, would provide 6–12 months of intensive residential treatment for 50,000 or more addicts and alcoholics a year. A mix of outpatient and residential treatment approaches would yield treatment for between 100,000 and 150,000 patients. Since treatment is required for the DA&A population under SSI, it appears appropriate that the money could go directly to the licensed treatment program as representative payee and be administered by them for the cost of the individual's treatment. In residential programs, the full amount would go to the program; in outpatient programs, some funds would go to the program and the rest for the enrollees' living costs (which can be relatively inexpensive in facilities such as Oxford Houses—self-run, self-help residences).

Hold treatment programs accountable.

It is important, of course, that treatment programs be accountable as well as SSI enrollees. Not all treatment programs are effective. Many are well run, but some are badly run. It is important, therefore, that programs be monitored as to their outcome, and those that are not able to achieve satisfactory results should lose the ability to accept SSI patients or, in fact, State funds. A level playing field as to the initial severity of the patient's multiple problems can be created by use of appropriate measurement instruments, such as the Addiction Severity Index. Modern technology makes it quite possible to evaluate how well a treatment program is doing and, if we are to use SSI funds partially to pay for treatment, then I urge that there be this accountability.

SSA should also be pressured by this Committee to more rapidly implement the Referral and Monitoring Demonstration programs for which they received $10 million last year to improve monitoring of this population. It is my understanding that, to date, this has not happened.

Change Medicaid reimbursement rules for this population.

We should also consider changing some Medicaid rules for this population. I believe that Medicaid should remain available to these individuals for at least 3 years after the SSI benefit ceases. However, Medicaid tends to pay for more expensive and less effective hospital-based treatment for addicts, and usually does not pay for cheaper, more effective approaches, like the residential therapeutic community approach. Congress could direct HCFA to ease restrictions on Medicaid reimbursement (related to the IMD—Institutions for Mental Diseases—regulations) that prohibit Medicaid reimbursement for residential treatment programs with more than 16 beds.

Why is there a persistent shortage of treatment for substance abuse?

Funding for treatment has been a bipartisan failure. The Republican president under whom I had the honor to serve did not ask for adequate funds for treatment, and the Democratic controlled Congress gave us substantially less than we requested. The reasons for this are not hard to come by: no one ever lost an election for being perceived as soft on treatment; the belief that treatment is largely ineffective; and, finally, many individuals, both ordinary citizens and policy makers, believe that addicts are not worthy of public tax dollars for their treatment since they brought the condition on themselves. Although it is certainly true that addicts played a major role in the development of their disorder, the same can be said for a number of other medical conditions for which we do not deny individuals coverage for treatment. The smoker who develops cancer of the lung or a heart attack, the diabetic whose lack of exercise and increased use of refined carbohydrates leads to an exacerbation of his diabetes, the hypertensive patient who fails to take his hypertensive medication, are all treated very differently by the medical and political system than the addict, and yet their contribution to their disorder may be equally as great. It is also true that, although there are clearly important volitional aspects in becoming an addict, once one has the disorder, there appears to be significant changes that occur in the brain, making relapse likely and increasing the difficulty of staying off.

Invest Funds in Research

Let me also urge you to consider that funds be put into research to improve treatment for substance abuse. Although treatment works, it does not work as well or as often as we would like. The Institute of Medicine recently released a report entitled "The Development of Medications for the Treatment of Opiate and Cocaine Addictions." A strong case is made in that report about the need for more effective medications to improve treatment, especially for cocaine. Although Congress has authorized $95 million for the Medication Development Division at the National Institute on Drug Abuse, that Division only has $40 million, and that was achieved by redistribution of NIDA funds. I would strongly urge the Committee to consider putting more adequate funding into this Medication Development Program so that outpatient treatment can become more effective. There is a need for a medication that would block cocaine's effects while the patient is in outpatient treatment. Such a medication would create a "window of opportunity" while the addict was learning the skills necessary to remain abstinent. There are also promising behavioral approaches for cocaine that new funds could investigate, and that could improve our treatment efficacy. CTAC, the research division of the Office of National Drug Control Policy is funding research on a potential cocaine vaccine and could usefully employ some of these funds on innovative research. It is shortsighted for a country to not adequately fund its research and development aspects. As Joe Califano pointed out in his book "Radical Surgery," *research in substance abuse receives only about 15 percent of the money spent for research into AIDS, cancer and heart disease, and yet is a leading cause of these problems.*

Conclusion

There is no one treatment for addiction. A variety of approaches are needed, ranging from the self-help fellowships of AA and NA, intensive structured outpatient programs, methadone maintenance and other medication-aided programs, short-term residential chemical dependency programs, and long-term residential therapeutic communities, such as Phoenix House, among other modalities. While no one treatment modality can treat all addicts or alcoholics, an integrated system with initial assessment and case managing can accomplish a significant amount. However, as an example of the treatment shortfall, we only have approximately 110,000 methadone slots for up to 1 million heroin addicts, less than 12,000 residential treatment beds in the United States for all heroin and cocaine addicts, and very few intensive structured outpatient programs for cocaine and alcohol addicts. We need to expand treatment, but especially need to expand the latter two modalities for the SSI patients. Many will need a long-term residential habilitation approach. Treatment often needs to remedy the social, educational and vocational deficits that prevent these individuals from leading reasonably productive, positive and drug-free lives after treatment. It may also be necessary to remember that since our current treatment methods are not 100 percent effective, some funds may be needed for long-term domiciliary care with minimal treatment for those individuals who have tried and failed our more intensive approaches.

I should like to close by noting that, although this group of patients frustrates all of us—you, your constituents, the families of the addicts, and the treatment community—they can be helped in many cases by the appropriate mixture of treatment and habilitation. While the current program is flawed, passage of the 1994 bill has improved some of the problems. Changes outlined above could further aid this endeavor and increase the likelihood that these individuals will become productive members of society.

PREPARED STATEMENT OF SUSAN MARTIN, PH.D.

On behalf of Professor Barbara Jordan, our Chair, and the Members of the U.S. Commission on Immigration Reform, I want to thank you for the opportunity to testify before you today.

First, let me explain the role of the Commission on Immigration Reform. It is a bipartisan body made up of eight Commissioners appointed by the Congress. Two Commissioners are appointed by the respective leadership of both parties in the House and the Senate, and the Chair is appointed by the President. We are a Congressional Commission. Our mandate from the Congress in the Immigration Act of 1990 charges the Commissioners to comprehensively analyze immigration policy, and to make specific recommendations for reform.

In the Commission's First Interim Report, *U.S. Immigration Policy: Restoring Credibility*, issued last September, the Commission recommended a comprehensive strategy for controlling illegal immigration. The Commission has been gratified that many of these recommendations have been incorporated in Senator Simpson's bill, S. 269, the Immigrant Control and Financial Responsibility Act of 1995. The Commission's recommendations have also received significant support from the Chairman of the House Subcommittee, Lamar Smith, and the Chair of the House Taskforce on Immigration, Elton Gallegly, as well as from the President in the State of the Union.

The Commission is pleased that this Committee has taken up the SSI issue with respect to immigrants. Immigrants have become an important percentage of SSI recipients, one which is large and growing.

It would appear that the disproportionate use of benefit programs by the foreign-born is confined largely to Supplemental Security Income program for the aged, blind and disabled. This is not too surprising when one considers eligibility criteria for the main source of income for the elderly, the Social Security program. Social Security requires beneficiaries or the spouses of beneficiaries to have worked for forty quarters, which is ten years. It is much more likely that native-born Americans as compared with immigrants will meet the work-quarter requirement. Most, though not all, Social Security recipients would be income ineligible for SSI. By contrast needy elderly who do not receive Social Security generally qualify for SSI.

This is even more apparent when examining the utilization rates for foreign-born by period of entry. Older persons who entered in recent time periods are more likely to receiving public assistance income than are those who entered while still in their working years. Those who were 55 years or older at the time of entry are the least likely to qualify for Social Security even if they work for a period of time after arrival. Only 4.2 percent of foreign-born persons who immigrated in the 1980's received

Social Security income in 1989, compared to 29 percent of the foreign-born persons who entered before 1980.

The foreign-born utilization of SSI is confirmed by administrative data. SSI program data reveal that approximately 25 percent of elderly SSI recipients are foreign-born. Overall, 10.6 percent of SSI recipients are foreign-born. This proportion has risen steeply since 1982, the first year that statistics were available,. when 3.3. percent of SSI recipients were foreign-born. The number of aliens receiving aged benefits increased from 92,00 in 1982 to 373,000 in 1992. The number of blind and disabled aliens increased from 92,000 in 1982 to 228,500 in 1992.

The apparent increase in the proportion of immigrants receiving SSI may be due, in part, to the recent arrival of an increasing number of older immigrants. Nearly twelve percent (416,000) of the foreign-born residents who were sixty years or older in 1990 entered during the 1980's. They had not earned sufficient Social Security benefits to be self-supporting. The number of immigrants sixty years or older in 1980 who entered during the 1970s, was only 262,000, just seven percent of the sixty years and older foreign-born population. More data needs to be gathered, of course, to determine the extent to which this explains the increase in alien participation in the SSI program.

The intersection of immigration policy and public benefits policy is a complex topic that episodically captures national attention, both among policymakers and the general public. In times of great labor force needs and abundant opportunity, there tends to be little attention to the domestic context of immigration. In times of slow or uncertain growth, restricted budgets, and reduced opportunity, sensitivity to domestic impact is heightened.

Now, with reform efforts underway on several major domestic policies, the effect of immigration—particularly illegal immigration—has been questioned. Immigration policy is viewed as yet another area ripe for reform. In this context, the Commission has examined closely the existing relationship between immigration and public benefit policies and their impact. The primary cause of concern to both the public and to the Commission is the lack of effective enforcement at our borders and the resulting presence of many aliens who have entered illegally. The Commission found that inconsistencies in immigration and benefits policy undermine the credibility of both.

The Commission believes that decisions on benefits eligibility should be consistent with and support the objectives of immigration policy. Legal immigrants enter the United States under U.S. law because their admission is considered to be in the national interest. The Immigration and Nationality Act delineates several categories of admission, most of them defined by the immigrant's connection to a U.S. resident or employers. Even in the category most characterized by humanitarian rather than strict national interest—refugee admissions—priority is given to individuals facing persecution because of their ties to the U.S. government, a U.S. resident, or a U.S. company. The Commission believes that benefits policy should reaffirm that the national considers legal immigration to be in the national interest. Both the immigrants themselves and the broader society have responsibilities toward ensuring that immigrants are, and continue to be, productive members of our social community who, if they need help, can benefit from the established safety nets.

The Commission recommends against any broad, categorical denial of public benefits to legal immigrants. No federal benefit program currently denies eligibility on the basis of alienage to legal immigrants. In some needs-based public assistance programs, such as SSI, AFDC, and Food Stamps, as a means of enforcing the public charge provision for exclusion and deportation, current law requires that program eligibility workers "deem" sponsor income as available to immigrants in determining financial responsibility.

In other social insurance programs, such as social security and Medicare, an immigrant becomes eligible on the same basis as citizens—through sufficient payroll contributions to the trust funds. There is a five-year residency requirement for enrollment for elderly immigrants who have not contributed sufficiently to the Medicare trust funds.

A considerable amount of public debate has focussed on the issues of eligibility of legal immigrants for public assistance programs. Indeed, during the past year a number of proposals for curtailing immigrant eligibility have been made. While some measures would affect all legal immigrants, others are more specifically aimed at individuals coming into the country for family reunification purposes. The proposals range from making all legal immigrants ineligible for all federal assistance programs until such time as they naturalize, to extending for some federal programs the time period during which a sponsor's income is counted or "deemed" available to determine need.

So what do we do about this? The Commission believes the following principles should guide policy on the benefits eligibility:

The safety net provided by needs-tested programs should be available to those whom we have affirmatively accepted as legal immigrants into our communities. The U.S. admits immigrants on the basis that they will not be a public charge. However, circumstances may arise after an immigrants entry that create a pressing need for public help—unexpected illness, injuries sustained due to a serious accident, loss of employment, a death in the family. Under such circumstances, legal immigrants should be eligible for public benefits if they meet other eligibility criteria. We are not prepared to remove the safety net from under individuals who, we hope, will become full members of our polity.

A policy to categorically deny legal immigrants access to such safety nets based solely on alienage would lead to gross inequities between very similar individuals and undermine our immigration goals to reunite families and quickly integrate immigrants into American society. For example, while two children in the same family may be equally poor, one may be a legal immigrant and, under proposals to deny benefits to legal immigrants, would be ineligible for assistance, while the other may be a citizen—by virtue of being born after the family arrives in the U.S.—and eligible for assistance.

The inequities for the legal immigrant child grow if eligibility is linked to citizenship, rather than a specified time, since the child may not naturalize, by law, until he or she is eighteen years of age. The only route to citizenship prior to that age is through the naturalization of his or her parent. If there were a categorical denial of eligibility to all legal immigrants and the parent is unable or unwilling to naturalize, the child would suffer the consequences of a parental action that he or she cannot remedy.

Sponsors should be held financially responsible for the immigrants that they bring to this country. In particular, the Commission recommends making affidavits of support signed by sponsors legally binding for a specific period of time and the development of mechanisms to enforce sponsors pledges of financial responsibility.

Affidavits of support are one means to ensure the Consular Officer that the alien will be supported in the United States and will not become a public charge. In accordance with Board of Immigration Appeals (BIA) rulings, the signatory sponsor's ability to provide the promised support must be given due consideration in determining whether to exclude a person as likely to become a public charge. Some courts, however, have held that such affidavits of support impose only a moral—and not a legal—obligation on the signatory sponsor.

Thus as affidavits are not legally enforceable, assurance that the alien will not become a public charge has relied primarily on the "deeming rules" applied by the statutory requirements that apply to sponsored immigrants in three federal means-tested entitlement programs—AFDC, SSI and Food Stamps. The deeming rules apply only to sponsored immigrants and are not used if a sponsored immigrant becomes blind or disabled after entry into the U.S., if an immigrant's sponsor has died, or if a sponsor's income and resources are depleted unexpectedly after the immigrant's entry. Also, refugees are statutorily exempt from deeming rules since their entry is based on humanitarian considerations rather than on family unity.

In 1993, the sponsor deeming period for SSI was temporarily extended to five years after admission. This change, authorized for a period of two fiscal years, resulted in saving that financed an extension of the Emergency Unemployment Compensation program. This use of immigrant eligibility revisions for budgetary advantage is a precedent that has opened the door to further revisions to immigrant eligibility in the current debate on welfare reform.

This extension of the deeming period for SSI resulted in part from the increased attention to the public charge issue and in part to data showing a rapid increase in SSI utilization by immigrants, many of whom are elderly and sponsored by their families. For example, in 1993, immigrants represented about 12 percent of the total SSI caseload and about 28 percent of the aged caseload, compared to 3 percent and 6 percent, respectively, in 1982. About 25 percent of all immigrants receiving SSI are legal immigrants who are not likely to have sponsors—primarily refugees, but also asylees, parolees, and others. The remaining 75 percent are legal permanent residents who are likely to have sponsors. One third of these began to receive SSI in the year immediately following the end of the sponsor deeming period.

These data can be interpreted in various ways. Some believe that these elderly immigrants, sponsored by their families, have always intend to apply for SSI benefits as soon as the deeming restrictions are removed. They argue that, at the time of entry, these elderly individuals have not intention of being self-supporting and that their sponsoring relatives have not intention of honoring their sponsorship role beyond the deeming period, creating precisely the situation the public charge provision is supposed to prevent.

On the other hand, no laws have been broken and the data do not imply that there is any specific fraudulent activity occurring. Sponsors and their elderly immigrant relatives are merely following the rules of program eligibility as they have evolved over the years.

The one conclusion that can be unequivocally drawn from the data is that the deeming policies have generally been effective in preventing sponsored immigrants from receiving federal welfare benefits during the deeming period. However, under federal welfare benefit programs the deeming rules apply even if immigrant sponsors are not actually providing financial support to the immigrant they have sponsored. As the affidavit of support have been judicially interpreted as a document that is not legally binding, there is currently no legal procedure to compel sponsors to actually provide such support. It is possible that a sponsor may refuse to provide financial support to the immigrant, but due to the sponsors income and-resources, the immigrant may also be ineligible for federal welfare benefits as a result of the deeming rules. The immigrant, may, however, be eligible for state and local assistance programs as these programs do not generally take into account sponsors; income in determining eligibility for benefits.

There are no data to indicate the prevalence of such sponsor abandonment of immigrants. Some experts argue that such cases are relatively rare, particularly in situations where the sponsor is a close relative of the immigrant, such as a son or daughter of an elderly immigrant. Some states and localities complain, however, that sponsored immigrants utilize their programs while awaiting the end of the deeming period for federal programs. Making the affidavit of support a legally binding document is necessary to close this loophole in the current sponsor deeming policies.

A legally-enforceable affidavit of support is a necessary complement to deeming policies. Deeming is used not only for immigrants, but for others as well, to ensure that the income and resources of legally liable individuals are taken into account when determining an applicants eligibility for benefits. For example, under the SSI program, there are both spouse to spouse and parent to child deeming policies, in addition to the sponsor to alien deeming policy. Making the affidavit legally binding would establish the legal, financial relationship between sponsors and immigrants. Deeming policies would continue to allow benefit programs to take this relationship into account when determining a sponsored immigrant's level of financial need as part of the eligibility determination process. In defining the sponsor's's responsibility, special consideration should be given to the issue of medical care.

It is likely that making the affidavit of support legally binding will serve primarily as an effective deterrent to sponsors. There is reason to assume that most citizens and legal permanent residents will voluntarily comply with such a legally binding affidavit. But to be fully credible, mechanisms must be developed to enforce such a new legal requirement.

Consideration should be given to the particular enforcement mechanisms developed to actually enforce the affidavit, so as to avoid unnecessarily complex and costly new regulations or bureaucracies. Federal, state, and local governments should be allowed to consider the sponsor/immigrant relationship on the same legal basis as current parent/child and spouse/spouse relationships and to hold sponsors to the same standards of financial responsibility with regard to the immigrant as are currently applied to spouses and parents of children. If an immigrant claims that a sponsor is not honoring his or her financial obligation, courts could render judgments of support on behalf of the immigrant and initiative procedures to ensure that support. Also the INS and the Department of State should review their policies to determine if immigration-related sanctions should be applied against sponsors who do not abide by their responsibilities.

Finally, making the affidavit of support legally binding should also provide states the authority to ensure that sponsors do not shift their financial responsibility to state and local public assistance programs. As some courts have determined that states cannot implement the same type of deeming programs for their public assistance programs as the federal government now does for its programs, this is an important protection. Abuse of the public charge provision should be grounds for deportation. A serious effort should be made to enhance and enforce the public charge provisions in immigration law to ensure that legal immigrants do not require public assistance and to provide clear procedures for deporting individuals who become public charges within five years after entry for reasons that existed prior to entry. In particular, the Commission recommends that deportation apply to sustained use of public benefits.

Specific provisions within U.S. immigration law are designed to ensure that those person seeking admission to this country will contribute to it, not merely to take advantage of its resources an the generosity of its people. For example U.S. immigration law currently bars the entry of those who are likely to be a public charge and contains provision for the deportation of individuals who become public charges within five years—unless they require aid for reasons that developed after entry. Effective enforcement of these provision helps minimize the number of legal immigration who to need or depend on public assistance.

These are the basic Commission recommendations that would apply to a discussion of SSI and immigrants.

PREPARED STATEMENT OF JERRY L. MASHAW

I appreciate the opportunity to appear before you today to report on the work of the Disability Policy Panel that I chair for the National Academy of Social Insurance. The Academy is a nonprofit, nonpartisan research organization. its members include some of the nation's leading scholars, policy analysts and administrators in the social insurance field.

Our project began with a request from the prior Chairmen of the Committee on Ways and Means and its Social Security Subcommittee that the National Academy of Social Insurance undertake a fundamental rethinking of the Social Security disability programs with particular emphasis on improving work outcomes for applicants, beneficiaries and denied applicants for disability benefits. To do that, the Academy assembled a panel of leading experts on disability policy. (A list of the Panel members is attached.) We are in the third and final year of our work and will report our findings and recommendations in the fall. We, however, are completing our work on the children's SSI program this spring.

In our work on the children's SSI program, we have commissioned field interviews with individuals with disabilities and their families, with service providers and those who administer programs at the State and local level. We also conducted focus groups with beneficiaries, including young adults and their families, and have read and consulted widely with experts in myriad aspects of disability policy, including experts on childhood mental disorders. Our findings and policy recommendations regarding the SSI program for children cover the following areas:

1. The fundamental rationale for providing cash benefits to low-income families who have children with significant disabilities.
2. Ways to strengthen eligibility criteria in response to public concern regarding the increased number of children who have qualified for such benefits since 1990 and ways to adjust family benefits when a family has more than one disabled child.
3. Ways to better link children with the disability-related services they need and to channel youths with disabilities into a work track as they approach adulthood.

Today I will focus on the first two areas: the rationale for the program and concerns about its recent growth. My testimony represents my own views, but is supported by the overwhelming majority of the members of the NASI Disability Panel.

I. THE RATIONALE OF THE SSI PROGRAM FOR CHILDREN WITH DISABILITIES

There is a clear rationale for cash support to families with a disabled child. The basic purpose of the se benefits is to support and preserve the capacity of families to care for their disabled children in their own homes by:

(1) Compensating for some of the income lost because of the everyday necessities of caring for a disabled child;

(2) Compensating for some of the additional, non-medical, but disability-related, costs of raising a disabled child;

(3) Meeting the child's and the family's basic needs for food, clothing, and shelter.

Without these supports, disabled children would be at a much greater risk of losing both a secure home environment and the best opportunity for integration into community life, including the world of work.

The fundamental role for the program is to promote the development of disabled children in the protective environment of their own families. The need for income support is based on several elements, the most important of which are the opportunity costs of care and the additional expenses of care. For many, if not most, families the first is the most significant.

The Panel's findings about the rationale and significance of the program are based on several observations about the nature of childhood disability, the nature of disabilities children on the SSI roles have, and the consequences of childhood disability for families.

A. Observations

First, despite a common lay view that many children with disabilities face early death, the reality is that the vast majority of children with cognitive, physical, or mental disabilities survive to young adulthood.[1] Furthermore, many such children and adolescents can be educated, can maintain important personal relationships and can become productively employed as adults. Thus, a central goal of disability policy must be to encourage the growth and development of these young people and their integration to the greatest extent possible in all aspects of American life as young adults. Substantial numbers of these young people should not require ongoing SSI benefits when they become young adults.[2]

Second, early intervention with appropriate family supports and services is effective. Increasing evidence shows that providing family support and services early to children diminishes long-term disability and dependence on public institutions.[3] Appropriate assistance to families and children can also prevent secondary disabilities—that is, prevention of additional disabilities secondary to the primary clinical problem. For example, the family whose child was born at 1000 grams (less than 3 pounds) and had some intercranial bleeding and pulmonary disease, will likely be eligible for both SSI and early intervention. Yet, with family support and appropriate services, this child will likely have limited disability and need substantially less support as she grows.

Third, family support and preservation should be a fundamental goal of public policy. For many families, caring for a child with disabilities requires exceptional expenditures of time and money, limiting out-of-home employment for family members. SSI support can prevent the breakup of families resulting from institutional placement of their child (or foster care) and enhances families' abilities to nurture their own children. Further, the burden of caring for a child with disabilities places significant strains on all family members and too often results in marital dissolution. SSI support, which is available to two-parent families, as well as to one-parent families, alleviates some of the financial stress associated with caring for a disabled child.

B. Children Receiving SSI Have Significant Disabilities

While there is great diversity within the SSI childhood population, they share two common realities: they live in low-income households and they have medically determined impairments that dramatically limit their ability to function.

Table 1. Children Receiving SSI, by Primary Diagnosis and Age, June 1994

Diagnostic group	Total	Under 3	3-5 years	6-12 years	13-17 years
Total number	781,980	59,170	114,480	359,560	248,770
Total with diagnosis	650,710	47,590	97,470	305,420	200,230
Total percent	100.0	100.0	100.0	100.0	100.0
Mental Retardation	43.5	8.1	27.5	46.7	54.7
Other mental and emotional disorders	22.2	7.4	15.7	24.2	25.9
Physical Disorders	25.5	52.3	42.0	22.7	15.6

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[1] Gortmaker, S. and Sappenfield, W., "Chronic Childhood Disorders: Prevalence and Impact," *Pediatric Clinics of North America*, 1984; 31:3–18. Newacheck, P.W. and Taylor, W.R., "Childhood Chronic Illness: Prevalence, Severity, and Impact," *American Journal of Public Health*, 1992; 82:364–371.

[2] Hack, M., et al., "School-age Outcomes in Children with Birth Weights Under 750 Grams," *New England Journal of Medicine*, 1994; 331:753–59. Hack, M., et al., "Health of Very Low Birth Weight Children During Their First Eight Years," *Journal of Pediatrics*, 1993; 122:887–92. Hack, M., et al., "The Effect of Very Low Birth Weight and Social Risk of Neurocognitive Abilities at School Age," *Journal of Development and Behavioral Pediatrics*, 1992; 13:412–20. Vohr, B.R., et al., "Neurodevelopmental and Medical Status of Low Birthweight Survivors of Bronchopulmonary Dysplasia at 10 to 12 Years of Age," *Developmental Medicine and Child Neurology*, 1991; 33:690–697. Gortmaker, S.L., et al., "An Unexpected Success Story: Transition to Adulthood of Youth with Chronic Physical Health Conditions," *Journal of Research in Adolescence*, 1993; 3:317–336. Pless, I.B., et al., "Long-term Sequelae of Chronic Physical Disorders in Childhood," *Pediatrics*, 1993; 91:1131–1136. Pless, I.B. and Wadsworth, M.E.J., "Long-term Effects of Chronic Illness on Young Adults," in Stein REK (ed), *Caring for Children With Chronic Illness*, pp 147-158, , New York: Springer Pub., 1989.

[3] Shonkoff, J.P., et al., "Development of Infants with Disabilities and Their Families: Implications for Theory and Service Delivery," *Mon Soc Res Child Develop*, 1992; 57:1–153. Shonkoff, J.P., and Hauser-Cram, P., "Early Intervention for Disabled Infants and Their Families: A Quantitative Analysis," *Pediatrics*, 1987; 80:650-658. Infant Health and Development Program, "Enhancing the Outcomes of Low Birth Weight, Premature Infants: A multi-site Randomized Trial," *Journal of the American Medical Association*, 1990; 263:3035–3042.

Table 1. Children Receiving SSI, by Primary Diagnosis and Age, June 1994—Continued

Diagnostic group	Total	Under 3	3-5 years	6-12 years	13-17 years
Nervous system and sense organs	12.7	16.1	19.8	12.6	8.7
Respiratory system	2.7	7.0	5.2	2.2	1.3
Infectious and parasitic diseases	0.4	1.3	0.8	0.3	0.1
Neoplasms	1.7	1.5	2.4	1.8	1.1
Endocrine, nutritional, and metabolic 1.1 1.6	1.6	0.8	1.1		
Circulatory system	0.7	2.9	1.3	0.4	0.4
Digestive system	0.3	1.2	0.8	0.2	0.2
Musculoskeletal system and connective tissue	1.2	1.2	1.6	1.1	1.2
Congenital anomalies	4.6	19.4	8.3	3.3	1.5
Other	8.8	32.2	14.8	6.4	3.8

Source: *Children Receiving SSI,* June 1994.

Among children receiving SSI, the most common primary diagnosis is mental retardation, accounting for 43 percent of all such children in June, 1994 (Table 1). The second most common diagnosis is mental disorders other than mental retardation, which accounted for 22 percent of all SSI children under the age of 18. These mental impairments include: organic mental disorders, schizophrenia, depression, manic and bi-polar disorders, autism, attention deficit hyperactivity disorder, learning and communication disorders and behavioral disorders. Impairments of the nervous system (such as cerebral palsy, epilepsy and other nervous system disorders) and sensory impairments (such as vision and hearing disorders) are the primary diagnosis for 13 percent of the SSI children. Respiratory disorders account for 3 percent. Diseases of the circulatory, digestive, or musculoskeletal systems, infectious diseases, neoplasms, and endocrine and metabolic disorders, combined are the primary diagnoses for 5 percent. Congenital anomalies and other disorders are the primary diagnostic codes for 13 percent of SSI children.

The difference in disabling conditions among age groups reflects the dynamic nature of childhood disability. Often it is difficult to have a precise diagnosis for newborns or very young children. Among infants and toddlers, under the age of 3, about half (52 percent) have congenital anomalies (Down's syndrome, congenital heart anomalies, or multiple dysfunctions) or other disorders (such as very low birth weight, growth impairments) as their primary diagnosis. Among children of elementary school age, nearly half (47 percent) had mental retardation as their primary diagnosis, while among teenagers, 55 percent had that as their primary diagnosis.

C. Most Children Receiving SSI Live with Their Families

The large majority of children who receive SSI live with one or both of their parents—although a minority reside in institutions or in foster care. In December 1994, 80 percent of SSI children lived with their parents, including 30 percent who lived with both parents. Those not living with parents include a small number (about 1 percent) who live in Medicaid institutions. The rest live with other relatives, in foster care, or on their own.[4]

D. Families' Experience with Childhood Disability

The Panel learned from interviews with families and service providers of the special demands that children's disabilities place on their families. The stresses include physical and emotional burdens, out-of-pocket costs and foregone earnings. Field research commissioned for the project reports:[5]

> While parents struggle to find sources of assistance, they must cope with the daily demands of physical care on their own. That care may include having to suction your baby girl's throat every 15 minutes to keep it clear for breathing; or carrying your son in his full-body neck to hip cast; or changing your eight-year-old son's diapers because he is not yet toilet trained. On top of these sorts of day-in and day-out demands come frequent trips to doctors, therapists, and hospitals.
>
> The burden of daily care falls on both parents, but among those interviewed in this study, the burden fell most heavily on mothers. The mothers often had

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[4] *Children Receiving SSI,* December 1994, Social Security Administration.

[5] Cedarbaum, *Policies for Children with Disabilities: Connecticut, Virginia, and Some National Trends,* Working Paper, National Academy of Social Insurance, January 1995, page 32.

left their jobs to become full-time caretakers for their disabled children. Leaving a job means not only disrupting one's career, but losing an income. One of the major strains of caring for a child with a disability is financial. In addition to lost opportunities for earned income, out-of-pocket expenses (for health care and related services, special clothing or equipment, or respite care) can be considerable.

All the pressures of raising a child with a disability put an enormous emotional strain on parents as individuals and on the bonds that hold marriages together. Some of the parents interviewed for this study report said they got divorced or separated from their spouses as a result of the tension of caring for a disabled child. More systematic studies indicate that this is not uncommon.[6]

The project also conducted focus groups with beneficiaries, including young adults receiving SSI and family members of such young adult beneficiaries. Screening for participation in the focus groups required that participants were able to speak for themselves and able to get to the focus group site. [7] Some of the young adult beneficiaries had profound health problems or disabilities that ruled out their ability to participate in a focus group and, in many cases, in competitive employment. The interviews with parents of young adult beneficiaries provide a family perspective on how they had dealt with the burden of daily care when their children were young, and how it continued as their children grew older.

- My daughter had brain cancer when she was 2. She just turned 20. She is three feet tall and weighs 50 pounds and needs 24-hour care . . . If I had $10 for every time we were told that she would not make it through the night, I would be rich . . . When a person needs 24-hour care, thank God there are two parents in the household. I would go crazy if I didn't work some. I work six months, then my wife works six months. (father, Portland, OR)
- My son, age 19, had a brain tumor and a stroke when he was 11. A good life for him is built around people he knows care. He can sense whether a person likes him or not. Or will be mean or not. He responds meanly if a person is mean to him. I could put him in a foster home. I won't do that. SSI is not enough. He is a sweet, loving teddy bear. He is nonverbal. 24-hour a day care is essential. Many people don't understand that. (mother, Portland, OR)
- My daughter was born with a visual impairment. She had a stroke when she was 3. She will be 19 . . . She understands simple commands, simple terms. She gets frustrated . . . she is nonverbal. We taught her appropriate-type touching. She responds to hugging. We direct her by shoulder rubs. (mother, Des Moines, IA)

E. Rationale

Our understanding of the rationale for the SSI program of cash support for low-income families of children with disabilities is based on our findings about the critical importance of family income support to family preservation, and the significant economic burdens that families face in caring for a disabled child.

Family Support and Preservation. An important part of the rationale for providing cash support to families of children with significant disabilities is based on fundamental principles of family support and preservation. These are based on findings that:

- If they are to thrive and have a chance to develop their capacities, children with disabilities or chronic illnesses need enduring family relationships with caring people in a nurturing home environment.
- Supporting families in their effort to care for their child with a disability in the home is more efficient, cost effective and humane than maintaining children with disabilities or other chronic illnesses in out-of-home settings. The cost of SSI benefits in support of families is far less than costs entailed in foster care, institutional or congregate care for children with disabilities.
- By and large, families are, in fact, the best caregivers for their children with disabilities.
- Financial support that is available to two-parent families can ease some of the strains that lead to a high risk of marital breakup among parents of children with disabilities.

Leveling the Playing Field—Easing the Financial Burden. As suggested in snapshots, from field research and focus groups, there are myriad special burdens placed on families. Cash support can ease those burdens, even if it cannot remove them. The added financial burden for families with disabled children include many

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[6] Cedarbaum, p. 33 and Mauldon, Jane, "Children's Risks of Experience Divorce and Remarriage: Do Disabled Children Destabilize Marriages?," *Population Studies 46* (1192), pp 349-62.

[7] Interviews with the young adults, themselves, are in the last section of the paper.

items that are not covered by traditional health care coverage. These include things such as child care for children that require ongoing specialized supervision because of severe mental illness or require other paramedical attention that parents learn to provide, but cannot always provide 24 hours a day; specially adapted shoes or clothing for children whose bodies don't match standard clothing; diapers and specially adapted clothing for older children who are not yet toilet trained; specially adapted toys and educational equipment for children who cannot manipulate typical equipment; and respite care for the child so that parents can attend to their own needs and those of other members of the family.

The Added Burden of Caring for a Disabled Child with Very Low Income. SSI children are in low-income families. Low-income families have even fewer resources to cope with the special needs of their children. The SSI benefits often must be used to meet basic household needs—such as food, clothing and shelter in order to provide a stable home environment for the child. For a child with physical or mental disabilities, growing up poor is likely to significantly reduce prospects for independence and self-support as a adult. The SSI benefit, in brief, has its rationale in meeting basic needs and economic stability for families of children with disabilities, as well as easing part of the added financial burden of meeting the disabled child's needs, family preservation and community integration.

Are Vouchers a Better Way? The Panel considered whether vouchers should be provided in lieu of cash assistance to aid children with disabilities. The rationale for such proposals seems to be to ensure that the assistance is, in fact, used for the child's benefit and for disability related expenses. Thus, one might issue the family a voucher that could be used only for the disability-related needs of the child. We rejected the voucher idea as poorly suited to meeting the real needs of families with disabled children and as administratively very cumbersome.

As noted above, the purpose of SSI benefits is not only to meet disability-related costs, but to meet basic needs of food, clothing and shelter for the child. The opportunity costs parents must face of foregoing paid employment in order to care for the child is a cost that cannot be met by vouchers. Further, the disability-related needs of the child are extremely varied, and the vendors of those goods and services are just as diverse. Should specially trained baby-sitters, clothing stores, vendors of diapers, transportation, toys, educational equipment, providers of respite care be required to accept vouchers in lieu of cash for the goods and services they sell? Should landlords accept vouchers as partial payment for rent, should contractors who adapt a child's home to accommodate disabilities be paid vouchers? To administer such vouchers would be administratively awkward and expensive. Moreover, it would add an extraordinary intrusion of bureaucratic micromanagement into decisions that can usually best be handled by families.

In those relatively rare instances where concern about parental abuse or neglect of their children is warranted, child protective services should intervene, regardless of the sources of the family's income.

II. CURRENT CONCERNS ABOUT PROGRAM STRUCTURE AND AWARD TRENDS

The problems of particular concern today seem to be related to the rapid growth in the program, to the use of functional assessment in adjudicating childhood disability, and reported instances of abuse of the program.

A. Program Growth

The rapid growth in the childhood disability rolls probably represents a temporary wave, not a long-term trend. The rapid growth in both claims and allowances is related to policy changes implemented in the early 1990's that include: Updates of the childhood mental impairments listings in December 1990 (that followed legislatively mandated updates in the adult listings of mental disorders); implementation of the Supreme Court decision in *Sullivan v. Zebley* in February 1991; and legislatively mandated outreach activities by the Social Security Administration as well as private efforts to enroll eligible children in the SSI program. As would be expected, the number of children entering the SSI childhood disability rolls grew rapidly after 1989 as a result of these changes. In addition, these changes coincided with a downturn in the economy in 1990-92.

Mental Disorders Listings Update. The update of the childhood mental disorders listings in December 1990 was based on the same conceptual framework used to update the adult mental listings in 1985. The change for adults was required by court decisions in the early 1980's and by legislation enacted in 1984 that required the new mental impairment criteria focus on evaluating the person's ability to perform substantial gainful activity in a competitive workplace environment. The new childhood listings emphasized functional criteria (like the adult mental listings published in 1985), and added new listings for certain specific conditions, such as attention deficit hyperactivity disorders, for children.

Zebley Decision. The U.S. Supreme Court decision in *Sullivan v. Zebley* in February 1990 expanded SSI eligibility criteria for children. When the SSI program was enacted in 1972, the law provided that children would be considered disabled for SSI purposes if they suffered from "any medically determinable physical or mental impairment of comparable severity" to that which would make an adult disabled.[8] Before the *Zebley* decision, childhood disability had been determined using only medical listings. A special set of medical listings had been developed for children, and children were found disabled if their condition met or equalled conditions found in either the medical listings for adults or the special childhood disability listings.

For adults whose impairments do not meet the medical listings, there is an additional step. The adult's "residual functional capacity" is evaluated and used to determine whether the claimant is able to do his past work, or any other work which exists in significant numbers in the national economy. There was no counterpart to the "residual functional capacity" assessment for children. In *Zebley*, the Supreme Court found that this did not meet the statutory requirement for determining "comparable severity." The regulations implementing the *Zebley* decision were issued in February 1991 and specified that children whose impairments did not meet or equal the medical listings would undergo an individualized functional assessment (IFA), as called for in the Supreme Court decision, to determine whether their impairments substantially limit their ability to function independently, appropriately, and effectively in an age-appropriate manner.

Outreach. Further, widespread publicity following the Court's decision, and concerted efforts by SSA and by private groups sought to enroll eligible children in the SSI program. Legislation enacted in 1989 stipulated that SSA should have an ongoing outreach initiative to enroll children in the SSI program. SSA as well as private foundations and interest groups launched SSI outreach activities.

The Economy. Finally, trends outside the SSI program also contributed to program growth. After 7 years of sustained economic growth, the recession of 1990–91 coincided with policy changes described above. As parents lost their jobs and wage income and depleted their savings, more children with disabilities met the income and resource requirements of the SSI program.

While the number of children entering the SSI roles grew rapidly as a consequence of the recent policy changes and the recession of the early 1990's, the growth in the number of children entering the SSI roles ended in 1993 and the number declined in 1994. Fewer children entered the SSI roles in 1994 than in 1993 (Table 2).

Table 2. Number of Children Receiving SSI, 1988–1994

Year	Total receiving SSI, December	New benefit awards in the year
1988	290,256	51,193
1989	296,298	54,497
1990	340,230	82,753
1991	438,853	125,821
1992	623,845	191,054
1993	770,501	225,611
1994	892,543	205,626

Sources: *Children Receiving SSI,* December 1994. Benefit awards from the Annual Statistical Supplement to the Social Security Bulletin, 1994.

B. Eligibility Based on Functional Assessment

Functional assessment of both children and adults is clearly a move in the direction of improving the determination of eligibility for SSI and SSDI. Looking at medical diagnoses that excluded functional measures would be both over- and under-inclusive. Indeed, for many childhood disorders, ability to function is a critical portion of purely medical diagnosis.

Nevertheless, functional assessment techniques are far from perfect. In particular, there is a potential problem with double counting; and functional assessments often use less than the best evidence. These problems can and should be remedied administratively.

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[8] Section 1614(a)(3)(A) of the Social Security Act.

Recommendations to Strengthen the Functional Assessments. We believe that changes are needed in the functional assessment in the mental disorders listings, in the individualized functional assessment that was included as a result of the *Zebley* decision, and in the interaction between the two. These changes would require SSA to revise its regulations for assessing childhood disability, but would not require an amendment to the Social Security Act. Congress could, however, require and set a timetable for the regulatory change as a way to clarify its intent and SSA's authority to strengthen, and in some ways tighten, the eligibility criteria.

The recommendation would modify both the individualized functional assessment (IFA) and the functional assessment in the childhood mental disorders listings along the following lines:

(1) Eliminate maladaptive behavior as a domain in the functional assessment, and modify the childhood mental disorders listings and the IFA.

(2) Increase use of standardized tests—such as the Vineland Scale—to assess functioning for children with mental disorders.

(3) Modify the IFA to be a more global assessment of overall functioning that is appropriate for children with physical disabilities or illnesses as well as mental disorders, and that is not so similar to that used solely for mental conditions.

Modify the Childhood Mental Disorders Listings. The proposal would eliminate maladaptive behavior as a functional domain in both the childhood mental listings and in the IFA. The proposal responds to concerns that parents coach their children to perform poorly to qualify for SSI. We do not believe that this problem is widespread, but that it can be eliminated without impairing SSA's ability to assess childhood disability effectively.

The functional assessment in paragraph B of SSA's mental disorders listings is made up of areas of functioning or "domains." The domains are illustrated in Chart 1 for both adults and children. For adults, a person is found to meet the level of severity of disability in the mental disorders listings if he or she has two of the following:

(1) Marked restrictions in activities of daily living;
(2) Marked restrictions in social functioning;
(3) Deficiencies in concentration, persistence and pace; or
(4) Repeated episodes of decompensation in work, or work-like settings.

The functional domains for children were patterned after those for adults, but differ in several respects. A child (age 3-18) is found to have a degree of disability that meets the listings if his or her impairment results in two of the following:

(1) Marked impairment in age-appropriate cognitive or communication functioning;
(2) Marked impairment in age-appropriate social functioning;
(3) Marked impairment in personal or behavioral functioning, evidenced by either:
  (a) Marked restriction in activities of daily living; or
  (b) Persistent maladaptive behavior destructive to self, others, animals, or property;
(4) Deficiencies of concentration, persistence, or pace.

This proposal would eliminate the domain in 3b and restrict the third domain to marked restriction in activities of daily living. Consequently, maladaptive behavior, in and of itself, would not be evidence of the disabling consequences of the child's impairment.

Experts in childhood mental disorders report that maladaptive behavior is not one of the key domains used to assess the functional consequences of childhood disability. Quantitative standardized tests are available to assess the disabling consequences of childhood mental disorders. The most common of these, the Vineland Scale, uses as the key functional domains communication, social, activities of daily living, and (for young children) motor functioning. These domains would remain modified in paragraph B functional assessment for children with mental disorders.

Increase Use of Standardized Tests. The proposal encourages use of standardized tests for both diagnosing and assessing the functional consequences of childhood mental disorders. As called for in current regulations, when standardized tests of functioning are used, two standard deviations from the mean is the measure of marked deficit, which means only the 2 percent with the most severe functional impairments would meet the level of disability specified in the regulations. Such standardized tests could be used by mental health experts SSA pays to perform consultative exams of child applicants who lack medical records.

Many of the standardized psychological tests for diagnostic and functional assessment can be administered by a trained lay interviewer who is not an M.D. or Ph.D.[9] As with many tests used in physical examinations, the test can often be administered by a trained technician, while relying on psychiatrists or psychologists to interpret the test results.

Chart 1. SSA's Functional Assessment of the Severity of Disabling Conditions—Current Policy

Adult Mental Disorders Listings	Childhood Mental Disorders Listings Children age 3–18	Childhood Individualized Functional Assessment (IFA)
The required level of severity is met with TWO of the following: 1. Marked restriction in activities of daily living. 2. Marked restriction in social functioning. 3. Deficiencies of concentration, persistence or pace. 4. Repeated episodes of decompensation in work, or work-like settings.	The required level of severity is met with TWO of the following: 1. Marked impairment in age-appropriate cognitive/communication function. 2. Marked impairment in age-appropriate social functioning. 3. Marked impairment in personal/behavior functioning as evidences by: a. Marked restriction in age-appropriate activities of daily living; or b. Persistent maladaptive behavior destructive to self, others, animals or property; 4. Deficiencies of concentration, persistence or pace.	"Guidelines" are ONE marked and ONE moderate limitation, or THREE moderate limitations among: 1. Cognitive function. 2. Communication function. 3. Motor function. 4. Social function. 5. Personal/behavioral function. 6. Concentration, persistence or pace.

Strengthen the Individualized Functional Assessment (IFA). The proposal would retain and strengthen the individualized functional assessment that was developed to comply with the Supreme Court's decision in *Sullivan v. Zebley*. Not having such a test and relying solely on the medical listings would discriminate against some children with very significant disabilities because not all disabilities are included in the medical listings. Furthermore, the medical listings, according to regulations, are set at a higher threshold of disability than is required by the statute, although listings for different body systems may vary in this regard.[10] To the extent that this is true, individuals whose impairments do not meet or equal the medical listings, but nonetheless have impairment(s) that meet the statutory definition, would be wrongly denied benefits if there were not a final step in the disability determination that assesses whether they in fact meet the statutory definition.

The basic structure of the current IFA, which is illustrated in Chart 1, is problematic because it so closely parallels the functional assessment in the childhood mental disorders listings, and sets a lower threshold for allowance based on essentially the same criteria. Consequentially, it appears to serve mainly as the basis for allowance for children with mental disorders. At the same time, the IFA may fail to identify

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[9] Among diagnostic tests mentioned by experts the Children's committee consulted, were extensive psychological profiles to identify ADHD, the Diagnostic Interview Schedule for Children (DISC), the Diagnostic Interview of Children and Adolescents (DICA), and the Kid's Schizophrenia and Depression Schedule (K-SADS). Standardized tests of functioning include the Vineland Scale, the Child and Adolescent Functional Assessment Scale (CAFAS) and the Global Assessment Scale for Children (C-GAS).

[10] Current SSA regulations (but not law) state that the listings level of impairment represents a higher level of disability than that specified in the law. Current regulations for adults state that: a) meeting or equalling the medical listings is supposed to represent an impairment that precludes any gainful activity; while b) the assessment of residual functional capacity (RFC) for adults is supposed to reflect inability to engage in any substantial gainful activity, after taking into account the person's age, education, and prior work experience (as called for in the law). For children, a similar distinction is made: the statutory level of "comparable severity" is an impairment that substantially limits functioning "independently, appropriately, and effectively in an age-appropriate manner," while an impairment that meets or equals the listings is supposed to preclude that level of functioning.

disabling consequences of combinations of physical impairments, or diseases some of which have very strict criteria in the medical listings. We believe that:

—Children, like adults, should not be denied disability benefits without having an assessment of the overall functional consequences of their impairments. The functional assessment should be broader and qualitatively different from the assessment used in the medical listings, and should be set at the level of disability called for in the law.

We believe that SSA should revise its regulations to provide a comprehensive global assessment that is appropriate for children with physical impairments or chronic or recurring illness as well as for those with mental disorders in combination with other impairments. Appropriate global criteria might include neurological, sensory, fine and gross motor functioning, stamina and endurance, immune deficiencies and vulnerability to disease and need for special equipment in order to function.

Caution Against Over-Reaction. We believe that new regulations should be developed expeditiously to strengthen the childhood eligibility criteria. At the same time, care should be taken to avoid radical shifts in adjudicative policy that have occurred in the past when steps were taken to strengthen eligibility criteria.

In its preliminary report, issued in March 1994, the Panel recounted lessons learned from the tumultuous history of the Social Security disability programs.[11] Steps taken to strengthen eligibility criteria in the late 1970s escalated to radical retrenchment policies in the early 1980s and resulted in denying or terminating benefits on a large scale. The widespread human suffering that followed precipitated judicial challenges and first reluctance, and ultimately refusal, of many states to implement the harsh policies. Congress followed with legislation to reverse the retrenchment policies. Legislation in 1984 restricted the conditions under which benefits of those on the rolls could be terminated and required SSA to ease the overly restrictive eligibility criteria for persons with mental impairments. Other legislation in 1989, while the *Zebley* case was being litigated before the Supreme Court, required that SSA engage in outreach activities to enroll eligible children in the SSI program.

Avoiding Perceptions of Abuse. In the childhood disability program today, any hard evidence of inappropriate benefit allowances is extraordinarily thin—and appears to be based on anecdotes or perceptions of dubious benefit claims, which upon investigation are most often found to have been denied. Further, SSA has put systems in place to investigate and take corrective actions to follow up on all allegations it receives about inappropriate benefit claims. The number of such cases reported to date is small.

While evidence of inappropriate allowances is very limited, data from administrative records show that children who receive SSI have very significant cognitive, physical or emotional disabilities. Mental retardation continues to be the most common primary diagnosis, with over half of all school-age children on the SSI rolls having that as their primary diagnosis.

We believe our recommendations to strengthen the eligibility criteria—by eliminating maladaptive behavior as a domain in the functional assessment, encouraging use of standardized tests in assessing mental disorders, and modifying the IFA to be a more global assessment that is not so similar to that used for mental disorders—will improve the process and will avoid any mistaken perception that inappropriate behavior, in and of itself, is a basis for allowing SSI benefits.

C. SSI Benefits for Families with More Than One Child with Disabilities

We believe that SSI payments to families with more than one disabled child should be calibrated to recognize economies of scale in shared living arrangements. There is currently no such adjustment in the SSI benefit for children. The absence of a family maximum permits unduly large benefits to be paid in those relatively rare cases of multi-beneficiary households.

We believe that family maximum limit should apply to such households. For example, the benefits would be: a full benefit for a family with one child; and an increment of 50 percent of the full benefit , each, for a second and third child; with an overall maximum on the total family benefit for those with more than three disabled children. These increments of 50 percent of the full benefit are about equivalent to the adjustments in the poverty threshold to take account of family size and the economies of scale from shared living arrangements. Such an adjustment is also consistent with other provisions of the SSI program, which pay 1.5 times the basic benefit to eligible married couples when both spouses meet the eligibility criteria as disabled, blind, or aged individuals.

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[11] *Rethinking Disability Policy,* Preliminary Status of the Disability Policy Panel, March 1994.

There may be a need for exceptions to the family maximum rule in certain circumstances. For example, families could be exempt from the rule for children who would otherwise require institutional care for their disabilities (so-called "Katie Beckett" children who need round the clock nursing care). Exemptions from such a limit are also appropriate for foster care families who care for more than one disabled child or families who work through social service agencies to adopt special needs children. Furthermore, the limit on cash benefits for families should not preclude Medicaid eligibility for aNy child in the family who meets the disability criteria of the SSI program.

The large majority of children receiving SSI are the only beneficiary in the family. Of the 800,000 children receiving SSI in March of 1994, fewer than 10 percent were in households that included more than one disabled child and they include children in foster care and adoptive families, as well as those living with their families. They rarely included situations with more than three disabled children in the household. Check the Scott numbers. We recommend:

—With appropriate exceptions for "Katie Beckett" children, foster care and adopted special-needs children, SSI benefits for families with more than one disabled child should be limited to 1.5 times the individual benefit for two children and 1.75 times the individual benefit for three or more children. No disabled child should lose Medicaid eligibility because of this limit on cash benefits.

D. Ongoing Assessment and Tracking

We believe that SSA should target continuing disability reviews (CDRs) on young children who have the best prospects of medical and functional improvement. For example, many very young children who qualify for benefits based on low birth weight should show substantial gains in development when reassessed at age one or two. Although a few conditions may be very disabling (such as multiple congenital anomalies or major central nervous system malformation), the large majority of very small children merit continuing disability reviews (CDRs). SSA's current initiative to conduct CDRs for children allowed because of low birth weight should be continued. CDRs might also target other types of childhood impairments that have good prospects for medical improvement as the child matures. We believe that:

- Children's progress should be tracked and periodically reviewed to ensure that those who recover do not remain on the SSI disability rolls and that those whose disabilities persist are linked to services appropriate to their changing needs as they grow older.

The purpose of ongoing reassessment of a child's condition is not solely to determine whether medical recovery has occurred. It should also reassess the basis for the child's continuing eligibility, as children's conditions and diagnosis may change as they grow older. Resources should be provided to SSA to review cases that are likely to improve.

Under current policy, when children are found no longer disabled under SSA's continuing disability review process, their SSI benefit ends. Their continued eligibility for Medicaid would then depend on rules that vary widely from state to state regarding Medicaid coverage for children who are not eligible for SSI.[12] We believe that Medicaid coverage should be continued for children who leave the SSI rolls if their diagnostic condition remains and Medicaid coverage is needed to control or ameliorate the disabling consequences of their conditions. That is:

—Children who leave the SSI rolls because the disabling consequences of their conditions are ameliorated or controlled by proper treatment should continue to have Medicaid coverage to continue their treatment.

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[12] Under Federal rules, effective April 1990, states are required to cover under Medicaid all children under age 6 whose income is below 133 percent of the federal poverty level. Since July 1, 1991, states are required to cover children under age 19 who were born after September 30, 1983, and whose family income is below 100 percent of the federal poverty level. Consequently, coverage of all children through age 18 with incomes below the poverty threshold will take effect in 2002. States are permitted, but not required, to cover pregnant women and infants under one year old with incomes below a State maximum that is above 133 percent of the poverty threshold, but not more than 185 percent. As of July 1993, 34 States had make use of this option to cover pregnant women and infants: 25 had set their income limits at the maximum of 185 percent.

THE NATIONAL ACADEMY OF SOCIAL INSURANCE DISABILITY PROJECT PANEL

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PREPARED STATEMENT OF SENATOR DANIEL PATRICK MOYNIHAN

I look forward today to an enlightened discourse on a subject of great sensitivity—disabled children. The Personal Responsibility Act of 1995, which passed the House on Friday, would immediately eliminate SSI payments to a quarter of a million low income disabled children.

The SSI disabled children's program has nearly tripled in the last 5 years. It now pays benefits on behalf of some 900,000 children. According to the Congressional Research Service, about two-thirds of the growth involves children with mental impairments. And more than half of the mental impairment awards have been for mental retardation.

I am aware of claims that parents are coaching children to behave in a manner that will qualify them for disability, and that children who have only mild behavior problems are being found to be disabled.

These are surely concerns that we should deal with.

But I do not believe that the action of the House, which is to overturn the 1990 Supreme Court decision in the case of *Sullivan v. Zebley* and eliminate the step in the disability process that provides for an assessment of a child's ability to function, is the appropriate response.

I am similarly concerned about the action taken by the House to eliminate AFDC, SSI, medicaid, and food stamp benefits for most legal immigrants.

In reporting the Unemployment Compensation Amendments of 1993, this Committee agreed that the income of the sponsor of an immigrant should be considered for a period of 5 years in determining whether the immigrant is eligible for SSI benefits. Most of us will agree that if a sponsor of a prospective immigrant signs a paper swearing to his ability and willingness to contribute to the immigrant's support, he should be required to do so. But I question the fairness of changing the rules for those legal aliens who are already in this country, as the House bill would do.

Today we will also be talking about the problem of substance abuse. We addressed this issue in legislation last year when the Congress voted to put strict limits on the conditions under which anyone who has been determined disabled on the basis of drug addiction or alcoholism can receive cash benefits. This issue comes back to us again as the result of action by the House to terminate SSI benefits for these individuals, without regard to whether they are seeking treatment.

I note that six Governors (Dean of Vermont, Carper of Delaware, Carnahan of Missouri, Thompson of Wisconsin, Engler of Michigan, and Carlson of Minnesota) have written a letter to Ways and Means Chairman Bill Archer on behalf of the National Governors' Association opposing all of these provisions in the House bill.

We have before us today a very expert panel, well equipped to provide the Committee with the kind of information we need to deal with these very complex issues. I look forward to hearing their views.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, I want to thank you for holding today's hearing on the Supplemental Security Income (SSI) program. As many of you might recall; the Special Committee on Aging—on which I serve as Ranking Minority Member—recently held a hearing which addressed many of the issues that concern us today. I am glad to see that these issues are receiving the broad-based attention they deserve. The past few years we have noted dramatic growth in the SSI program—significant increases in both enrollment and costs. Much of this growth has occurred in portions of the SSI program which provide disability benefits to substance abusers, legal immigrants, and children. We must control the growth rate of these SSI programs because it is simply not sustainable given today's fiscal reality.

Mr. Chairman, each week I receive letters from my home state of Arkansas—letters which refer to allegations of fraud and abuse within the SSI program. I am troubled by this negative public perception of the SSI program—a belief that SSI is vulnerable to misuse. This cynicism has undermined trust in a program which has historically worked to provide assistance for a disadvantaged population. It is therefore imperative that we eliminate any SSI program abuses and direct benefits to individuals truly in need.

As many of you know, my friend Senator Bill Cohen of Maine conducted an Aging Committee investigation which brought to light many of the problems surrounding disability benefits provided to drug addicts and alcoholics. I want to recognize Senator Cohen for his leadership in this area and am pleased that legislative changes made last year began to address abuses and problems in the program. There is still more work to be done, given the rapid growth of the SSI program and continuing public concern with fraud and abuse. As we make attempts to reform the system, we must take careful steps to link benefits to substance abuse treatment. For without treatment, substance abusers continue a downward spiral leading often to additional disabilities. They in turn further harm themselves while also increasing the strain on American taxpayers.

Looking at the population of SSI recipients, we recognize that the number of immigrants receiving benefits has increased—specifically from 6% of aged SSI recipients in 1982 to 28% in 1993. Our colleague Senator Alan Simpson of Wyoming has worked a great deal on immigration policy and has raised the issue of third parties coaching immigrants to feign disability in order to qualify for benefits. While we must control the high growth of the SSI program and work to eliminate fraud and abuse, it is important to proceed with both short term and long term concerns in mind. By merely cutting off means of support, we only succeed in encouraging immigrants to turn to state and local public assistance programs. This burden shifting, or passing off of federal responsibility to states, should be avoided because it accomplishes very little in terms of real reform.

Mr. Chairman, today we will also examine the growth of SSI benefits provided to children with severe disabilities. Many people assume this growth has resulted primarily from the implementation of the Social Security Administration's individualized functional assessment (IFA) process, which was mandated by the landmark *Zebley* ruling. While this ruling did spark program growth by enabling more children to qualify for SSI benefits, other factors must be taken into consideration. These factors include greater outreach activity mandated by both Congress and the courts, revised medical listings for the diagnosis of mental impairment, and increased child poverty.

I remain troubled by allegations of fraud and abuse in the SSI program for children with disabilities. Therefore, along with Congresswoman Blanche Lincoln of Arkansas, I co-requested a GAO report evaluating the methods used in the IFA eligibility determination process. I hope that in considering changes to the SSI program for children, we will use this report as well as other reports due to be issued this year. By taking the time to look at forthcoming reports, we, as lawmakers, will be armed with information helping us effect positive change in the SSI program.

Mr. Chairman, I look forward to hearing the forthcoming testimony today in hopes of gaining further insight into concerns regarding the SSI program. The challenge placed before us today is to reevaluate program intent and ensure that SSI programs serve those they were designed to help—the truly needy.

PREPARED STATEMENT OF JANE L. ROSS

Mr. Chairman and Members of the Committee:

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

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

To summarize the key points in the statement,

- —Major factors contributing to growth include eligibility expansions, outreach, limited emphasis on return to work, and immigration.
- —Before the mid-1980s, the number of SSI recipients was relatively stable and the number of aged recipients was decreasing. Since 1986, the number of disabled SSI recipients has increased an average of over 8 percent annually.[1] (See fig. 1.)
- —Disabled recipients now account for nearly 80 percent of federal SSI payments.
- —Three groups have accounted for nearly 90 percent of SSI's growth since 1991—adults with mental impairments, children, and noncitizens.
- —SSI recipients now tend to be younger, receive larger benefits, and depend more on SSI as a primary source of income.
- —Medical, technological, and social changes challenge the historic presumption that disabilities are total and permanent.
- —Ways to improve SSI include increasing reviews of the disability status of current recipients and placing more emphasis on rehabilitation, employment assistance, and work incentives.

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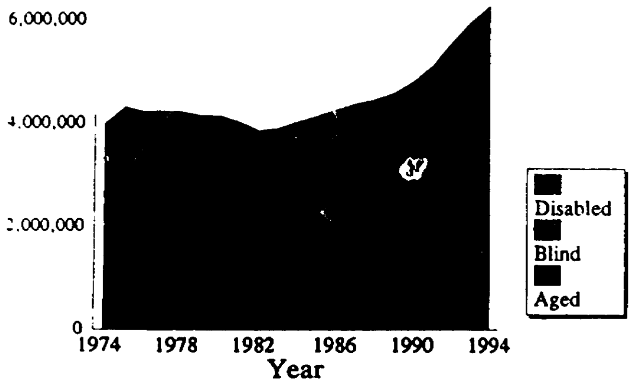
[1] Unless otherwise specified, we use the word "disabled" only for those recipients under age 65 and "aged" for those age 65 and over. When disabled recipients turn 65, SSI program data typically continue to count them among the disabled.

FIGURE 1: NUMBER OF SSI RECIPIENTS BY ELIGIBILITY GROUP



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

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

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

BACKGROUND

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

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

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

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

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

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

FACTORS CONTRIBUTING TO GROWTH

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

Table 1: Factors Contributing to Growth in SSI

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

ELIGIBILITY EXPANSION

Congressional oversight in the early 1980s found that serious questions had been raised by federal courts, professionals in the fields of psychiatry and vocational counseling, and us about the adequacy of SSA's standards to assess mental impairment for both DI and SSI. Addressing these concerns, the Congress passed the Disability Benefits Reform Act (DBRA) in 1984, effectively expanding the definition of disability for both adults and children. In particular, the act required new standards for mental impairments that incorporated the person's ability to compete in the job market. It also required SSA to consider the combined effects of multiple impairments if no single impairment were sufficiently disabling to allow someone to qualify for benefits and increased attention to the effect of pain on the ability to work. Further, the act allowed SSA to consider nonmedical evidence offered, for example,

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

by an applicant's family and friends. Finally, the act required increased emphasis on opinions of physicians treating the individuals and on evaluating their functional limitations.

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

PROGRAM OUTREACH

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

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

Beginning in 1989, SSA made SSI outreach an ongoing agency priority and conducted demonstration programs, increased coordination with other agencies serving the poor, and encouraged field office outreach initiatives. The Omnibus Budget Reconciliation Act of 1989 established a permanent outreach program for disabled and blind children. Also relating specifically to children, as part of the *Zebley* settlement, SSA was required to launch a national media campaign and conduct outreach to schools and welfare offices to enroll more children.

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

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

LIMITED NUMBERS OF CONTINUING DISABILITY REVIEWS (CDRS)

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

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

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

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

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

LIMITED RETURN TO WORK EFFORTS

Helping people with disabilities return to work has been a low priority of SSA and the Congress for both the SSI and DI programs, and, in fact, SSI and DI return virtually no one to work. This low priority is especially evident in vocational rehabilitation (VR), to which relatively few resources are allocated. For example, for every $100 SSA spends on cash benefits, it spends little more than $.10 on VR, and few recipients are referred for VR services. As we reported recently, VR beneficiaries receive, on average, only modest services and show limited long-term improvement.[5] In 1993, compared to $52 billion in combined SSI and DI benefit payments, $63 million was spent for rehabilitation. Of over 7 million SSI and DI disabled recipients, only 300,000 were referred for rehabilitation, and 6,000 were successfully rehabilitated.

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

FRAUD AND ABUSE

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

GROWTH IN IMMIGRATION

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

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

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

OTHER FACTORS CONTRIBUTE TO CASELOAD GROWTH

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

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

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

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

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

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

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

CHARACTERISTICS OF CURRENT SSI RECIPIENTS

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

Three subpopulations have accounted for nearly 90 percent of the growth since 1991—adults with mental impairments, children, and noncitizens.[7] These groups typically have not contributed much in Social Security taxes. Accordingly, they receive smaller concurrent Social Security benefits than other SSI recipients, or none at all, and therefore receive higher SSI benefits. Among the aged, recipients who did not qualify for any Social Security benefit increased from 12 to 35 percent of cases between 1986 and 1993. Among the disabled, they increased from 58 to 68 percent of cases over the same period.[8]

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

Table 2: Summary of SSI Caseload Growth Patterns

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

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

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

Table 2: Summary of SSI Caseload Growth Patterns—Continued

	Number of cases (1993)[1]	Percentage of all cases (1993)[1]	Average annual growth rate (1986–1993)
All other recipients	~2,900,000	48.4	<2.0%

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

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

Mental Impairments Predominate Among Disabled Adults

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

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

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

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

The alarming growth in DA&A cases and allegations of program abuse prompted the Congress to strengthen controls of payments to addicts in the Social Security Independence and Program Improvements Act of 1994. The act generally requires that SSI benefit payments to DA&A recipients end after 3 years. It also expands the DA&A program requirements to cover DI recipients and mandates an SSA study of the feasibility, cost, and equity of requiring representative payees for all DI and SSI addicts, even if they would be disabled without the addiction.

Mental Impairments Predominate Among SSI Children

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

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

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

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

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

Noncitizens Growing Fast Both Among Aged and Disabled Recipients

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

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

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

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

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

SSI's "deeming" provisions attempt to reinforce this immigration policy by factoring a portion of sponsors' resources into financial eligibility decisions and benefit calculations for the immigrants they sponsor;[12] in 1993, as many as 75 percent of SSI's non-citizen recipients would have been subject to these provisions when they applied. Before 1994, this deeming applied for 3 years from the date of immigration. Administrative data indicate that about 25 percent of immigrants receiving SSI applied for benefits within a year of the expiration of their 3-year sponsorship periods. The Congress temporarily extended the deeming period from 3 to 5 years starting in January 1994 through September 1996.

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

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

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

OPPORTUNITIES FOR IMPROVING THE PROGRAM

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

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

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

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

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

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

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

APPENDIX

RELATED GAO PRODUCTS

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

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

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

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

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

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

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

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

Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994).
Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).
Social Security: Increasing Number of Disability Claims and Deteriorating Service (GAO/HRD-94-11, Nov. 10, 1993).
Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27, 1993).
Social Security Disability: SSA Needs to Improve Continuing Disability Review Program (GAO/HRD-93-109, July 8, 1993).
Social Security: Rising Disability Rolls Raise Questions That Must Be Answered (GAO/T-HRD-93-15, Apr. 22, 1993).
Social Security Disability: Growing Funding and Administrative Problems (GAO/T-HRD-92-28, Apr. 27, 1992).
Social Security: District Managers' Views on Outreach for Supplemental Security Income Program (GAO/HRD-91-19FS, Oct. 30, 1990).
Social Security: SSA Could Save Millions by Targeting Reviews of State Disability Decisions (GAO/HRD-90-28, Mar. 5, 1990).

PREPARED STATEMENT OF DAN STEIN

Mr. Chairman, and Members of the Committee, my name is Dan Stein, and I am the executive director for the Federation for American Immigration Reform, or FAIR. FAIR is a national public interest membership organization working to end illegal immigration and implement a general moratorium on most legal immigration (such as that suggested in S. 160, introduced by Senator Richard Shelby). We support an immigration policy that serves the American people and our interests as a Nation. With 70,000 members in all 50 states, FAIR has become the leading organization in America working for tighter and better immigration laws.

Mr. Chairman, I would like to thank you for this opportunity to speak before this committee about an issue that is causing great concern among the American people—the growing number of immigrants on welfare, in particular Supplemental Security Income (SSI). Frequently, I will be calling attention to a new report published by your General Accounting Office, entitled *Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns;* GAO/T-HEHS-95-67 (January 27, 1995). This report details alarming growth in the use of SSI by elderly, indigent alien claimants. We also realize that this issue is sensitive and delicate. Everyone can understand the desire of immigrants to bring elderly parents, brothers, sisters, uncles and aunts. But there are financial implications to the relative preference system now operating that all taxpayers must consider, and this is the topic of today's hearing. Can we allow aliens to enter and reside with full access to direct cash, indirect and in-kind federal and state benefits in the long term?

GENERAL BACKGROUND

Nowhere is the phenomenon of unfunded mandates more pronounced than in the costs and burdens of immigration on the state and local taxpayer. As Michael D. Weiss, a professor of law at the University of Houston, recently observed:

> The federal government has retained exclusive jurisdiction over immigration, deportation, customs, and international relations. It is, however, insulated from the results of its failure because most of the social programs that illegal [and I would add legal—ds] immigrants place demand on, such as schools, welfare, the burden of failure shifted onto the governments and taxpayers of the states (and disproportionately shifted to the six "frontline" states of Texas, Florida, Illinois, New York, New Jersey, and California, which host over three-quarters of recent immigrants, both legal and illegal), the federal bureaucracy has little incentive to effectively control the border.

The public has questioned how long we can afford to provide public benefits to immigrants—guests of the nation, if you will—when we ourselves, the citizens who built this great nation, have to absorb the rapid decline in all forms of public investment, capital plant improvement and basic social services. It is a question of fundamental fairness.

SUMMARY RECOMMENDATIONS

We believe it is perfectly appropriate for Congress to condition the receipt of most public benefits for citizens, bona fide temporary refugees, or certain long-term alien residents. Further consideration should also be given to extending the deeming period far beyond what is provided today. Recent evidence from the GAO and various study groups of "premeditated benefits acquisition" by elderly immigrants demonstrates that a social safety net offered to aliens from substantially poorer nations can serve as a magnet for indigent aliens and a drag on the public treasury. This phenomenon is related to the fact that our immigrant selection process overemphasizes family relation over skills. We are in the midst of an extraordinary wave of migration, and over time, we can expect the skills and income earning potential of the immigrant flow to decline, and welfare use to go up.

Conditioning eligibility for public benefits on the acquisition of citizenship is good civics: It will encourage naturalization and help reduce the incentive to create an ever-growing class of "permanent" resident aliens in our midst. This is public policy, and strengthens the civic fabric. We also support a rewrite of the so-called "public charge bar" of the immigration law, a prominent feature in the law since the turn of the century. It is now a "dead letter" in domestic immigration law proceedings. We believe we need to make it more enforceable in deportation proceedings. Furthermore, FAIR recommends that Congress alter the sponsorship provisions to render them enforceable as a contract against the petitioning sponsors. The growing numbers of immigrants on SSI exemplifies the need for welfare reform for immigrants generally, and reconsidering the entire question of whether or not aliens who are likely to be—or remain—public charges should be admitted or remain as "resident aliens." At a minimum, sponsors should be financially able to care for elderly parents' basic income needs indefinitely, if not for more expensive medical and nursing home care, as a condition of permitting immigrants to bring elderly parents.

IMMIGRANTS' USE OF SSI [1]

The number of legal immigrants in the SSI program has grown dramatically in the past 10 years. This growth has directly correlated with the rising number of legal immigrants coming into the nation during the same decade. Today, newly-naturalized immigrants are bringing elderly parents to retire at taxpayers expense. Scholars, such as Norm Mattloff[1], have demonstrated that many immigrant families transfer assets out of the name of parents to render them eligible for SSI. Lacking any Social Security credits, the alien parents receive—on average—a higher monthly benefit than a similarly situated parent.

The recent GAO report, *Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns* details the growing trends of increased use of SSI by immigrants. In fact, the GAO found that between 1983 and 1993, the number of immigrants receiving SSI more than quadrupled (from 151,000 to 683,000). This growth in the rolls resulted in immigrants growing from 3.9 percent of the SSI roles to 11.5 percent. Today, immigrants are more likely than citizens to receive SSI or AFDC—6 percent of all immigrants compared with 3.4 percent of all citizens. SSI benefits for immigrants cost the American taxpayer $3.3 billion in 1993 alone. Given that immigration is a benefit, not a right, and that the general public does not expect to pay any significant money for immigration, such trends are a grave cause for concern.

The number of immigrants on SSI roles is primarily due to the overwhelming annual number of legal immigrants flow (due, as I mentioned above, to the nepotistic relative preference system). Immigration levels have reached an all-time high—almost a million people come to the U.S. for permanent residence each year. Either immediately, or after only a short wait, most new resident aliens are eligible for the full array of federal welfare and other benefits, including SSI[2]. Moreover, in just a few years these immigrants are eligible for naturalization and can then petition for their elderly parents and other extended relatives who then too would be eligible for benefits, and so on indefinitely without anyone being bound by our unenforceable sponsorship requirements and affidavits of support.

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[1] Mattloff, Norman, Department of Computer Science, University of California at Davis: See, testimony before the House Ways and Means Committee on Human Resources, March 1, 1994. "Welfare Use by Chinese Immigrants." Mattloff argues that some immigrant communities are using welfare as an entitlement, with immigrant children bringing elderly parents over with the expectation that the parents will apply for SSI. He find that, according tot he 1990 Census, 45 percent of all post-1980 immigrants over the age of 65 living in California are on welfare; he breaks down the following groups: 55 percent for Chinese; 39 percent for Filipino; 21 percent for Mexican; 66 percent for former Soviet Union; 74 percent for Vietnamese. Source: 1990 Census data (PUMS tape). California residents only. Mattloff testimony at 3.

[2] The current SSI "deeming period," i.e., the period during which the sponsors' income is attributed to the elderly parent, is five years. The normal deeming period is three years, but it was temporarily increased by Congress to five years. The deeming period will revert back to three years in the next 24 months unless Congress acts to extend it.

As mentioned before, the number of SSI immigrant recipients has quadrupled since 1993. The number of legal immigrants has almost doubled since that time—from 570,000 in 1985 to 880,000 in 1995 and this number does not include the 1986 amnestied population, many of which were eligible for welfare benefits.

The SSI roles are correlated positively with the overall increase in legal immigration, and the dramatic increase in the number of new immigrants' parents following to join. As SSI roles quadrupled, the number of immigrant parents entering the U.S. each year has almost doubled. In 1982, 34,220 parents immigrated to the U.S. Over the past 14 years this number has swollen to 62,428 annually[3]. The swelling SSI roles attest to the fact that many of them get on welfare immediately after their sponsors' deeming periods ends. According to the GAO, 26 percent of the immigrant SSI recipients are over 75 and 25 percent of all the immigrant recipients of SSI applied for benefits within one year of the expiration of their 3-year sponsorship deeming period. These elderly immigrant SSI recipients have most often not worked in the U. S. and not contributed taxes or Social Security but are now being supported by the American taxpayer for the rest of their lives.[4] This is an absolute injustice to the American people and simply not what the old "immigrant contract with America" was all about. It is not the American taxpayer who should be financially supporting the elderly immigrant but their children who petitioned for them to come here. A sponsor should be not only morally but legally bound to financially provide for their immigrant relative. However, this historical intent of the sponsorship and public charge requirements to keep immigrants off the public dole has been distorted and neutered through a lack of federal resolve and health care and related expenses, these trends highlight a troublesome trend that can not be sustained.

CONSISTENT WITH PAST POLICIES

Mr. Chairman, it has been the policy of the United States since before the turn of the century to deny admission to aliens who are "likely to become public charges." This policy reflects an overriding interest in the general public to insure that if we are to admit people here as immigrants, we want to insure that they are capable of earning a living and pulling their own weight. Taxpayers do not want to pay for immigration, legal or illegal. Public support for immigration is generally premised on the idea that our immigration program benefits the U.S. Unconditional support for immigration is eroding rapidly. In light of this trend, it is important to take a moment and revisit a couple of first principles.

Mr. Chairman, the Immigration and Naturalization Service, or INS, has been reporting deportation statistics since 1908. Back then, the INS was dropping public charge aliens in an aggressive manner. Between 1911 and 1930, the INS deported approximately 20,000 aliens as public charges.[5] During this period, any financial need of the immigrant was absorbed by the immediate family or private charity. It was never contemplated that the recent immigrants would be permitted to bring elderly relatives and place them on publicly-supported welfare programs. The "Immigrant Contract with America" is an old one: It holds that we provide an opportunity for a person to come here an begin anew; to leave behind attachments to the old country, and forge ahead in the spirit of American enterprise and drive. This contract held that you should join the polity by renouncing your old political allegiance, and joining a new one; that you should become a citizen and learn of the political philosophy and history underlying our founding political documents and institutions. It held that you could come, so long as you could contribute. And, it held that an immigrant is expected to naturalize within a reasonable period after being eligible to do so.

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[3] INS statistical Yearbook, 1987 and 1993.

[4] For years, the proponents of the economic benefits of immigration have told us that immigrants are a great economic "bargain" because they enter, work and pay taxes without having elderly parents collecting Social Security. See, e.g., Simon, Julian, The Economic Consequences of Immigration 108 (1989). "Immigrants typically arrive when they are young and healthy. Hence, new immigrant families use fewer welfare services than do average native families because immigrants do not receive expensive Social Security and other aid to the aged." Boston Irish News, Feb. 1990, at A1. Let's put that myth to rest: The recent trends that are the subject of this hearing today should put to rest the myth that immigrant labor is some kind of "free lunch" for the United States. Foreign labor may operate as an immediate labor subsidy for a particular employer, but the long-run impact of relative preferences following the admission of the foreign worker places unsustainably high costs upon the community-at-large. Noted immigration scholar and thinker Garrett Hardin calls this the PP-CC game (privatizing profits, common costs). See Hardin, Garrett, Living within Limits 223 (1993).

[5] INS Statistical Yearbook, 1992.

As I shall explain further below, today, immigrants, parolees, putative Asylees who have merely made application, those currently pending an adjudication and even, in some cases, illegal aliens, are eligible for many forms of welfare.

Immigrants enter our country already planning to bring elderly relatives and extended family, many of whom have no means of support or required anti-poverty relief. Married siblings, and, in time, needy uncles and aunts are permitted to join. As a result, the 1990 census shows that welfare use is increasing among immigrants, as skills, education and income levels all decline.

This is not the immigrant contract that the American people signed. It is not a fair deal for the taxpayer, and it is not one the people can and will continue to support.

The immigrant contract was turned on its head by three factors: (1) the effective elimination of the public charge bar as an independent basis for deportation, section 241(a)(5) or 8 U.S.C. 1251 (a)(5); (2) the rendering of sponsorship pledges as meaningless and unenforceable; and (3) the explosion of "great society" entitlements that altered entirely the financial implications of immigration for taxpayers and the incentives for the migrants themselves.

The State Department also has responsibility for enforcing the public charge bar, as well. Here the law still has some meaning, INA section 212(a)(3)(e). Whenever, in the opinion of a counselor officer at the time the alien applies for a visa, or in the opinion of the immigration officer—under the attorney general's delegation—at the time the alien applies for admission, the alien is likely to become a public charge after entry, that alien may be denied a visa and denied entry.

The Department of State continues to enforce this law with some zeal. In all cases where a visa must be obtained overseas, the consular officer can, and does deny visas based on the public charge provision. From 1990 to 1994, the State Department refused visas to 68,521 aliens on this bases. While some overcome the bar based on sponsorship pledges or newly-presented evidence of income, most do not. Millions more "nonimmigrant" or tourist visas are also denied overseas each year by the State Department.

Where the Breakdown Occurred

"Public Charge" becomes a dead letter

"Sponsorship pledges" are worthless

High Immigration Means Past Immigrants Bring Elderly Parents

Mr. Chairman, the public charge provision is no longer used to deport aliens. Unlike the turn of the last century, when tens of thousands of aliens were excluded at the border because of a likelihood of becoming a public charge, and tens of thousands of aliens were deported for having become a public charge after entry,[6] today, the INS has virtually stopped collecting statistics on public charge deportations. The handful actually deported form 1981 to 1989 demonstrates that in deportation hearings, public charge has become nearly a dead letter in INS proceedings.

In addition, nearly all classifications of aliens (other than illegal and certain temporary or "nonimmigrant categories") are eligible for a full range of federally—supported entitlements. Most of the alien classifications were created as a result of the administrative overburdening of the INS the fell into the huge catch-basin of INS administrative delay. This catch-basin is known as the alien "permanently residing under color of law," or PRUCOL.[7] PRUCOL aliens were established under a series of administrative decisions and judicial settlements entered into since 1978; most are the byproduct of either (1) the inability of the INS to remove aliens quickly, or (2) the inability of states to ascertain with accuracy who is an alien, and who is not, and if an alien, than what kind of "lawful alien" that person is (there are limitless varieties). This last problem is the fault of the federal Department of Justice; It lacks the capacity to offer state agencies reliable verification of citizenship or alien status or identity.

The inability of states to determine who is an alien and who is not, or to verify with federal government assistance, the alienage classification asserted by the claimant, is a major loophole thwarting efforts to remove ineligible aliens from federal/state entitlement schemes. Any effort to restore the public charge to enforceability or to bar legal and illegal aliens from various benefits must also address the abysmal documentary situation prevailing in the United States today.

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[6] See, Immigration Briefings, No. 91-11 (November 1991).

[7] See, Stein & Zanowic, *Permanently Residing Under Color of Law; The Opening Door to Entitlement Eligibility,* 1 Geo. Imm.L.J.231 (1986). Categories include deferred Enforced Departure, applicants for Suspension of Deportation, applicant for asylum, parolee, and many others. Work authorization is usually included pending the adjudication.

Why are public Charge and Sponsor's Pledges Unenforceable?

The public charge provision was effectively gutted over several years. In 1994, the Board of Immigration Appeals in *Matter of V—*, 21&N78 (March 25, 1944), established a three tier test for public charge determinations in deportation cases: (1) The state or other public entity must legally obligate the recipient of a public benefit (including a binding promise to repay); (2) the state or other entity must make a formal claim against the recipient; and (3) the recipient must fail or refuse to repay, and any sponsor or third party must refuse to repay.

Not surprisingly, such formal requirements soon rendered the public charge a dead letter. Very few public entities even have the legal authority to make a legally binding obligation for repayment in these circumstances.

The sponsors could be held liable until the 1970s, when several courts ruled that sponsors of immigrants have no legal obligation to repay. The courts transformed the sponsorship pledge into a moral obligation to provide assistance, a regrettably ineffective method of collecting on the pledge. But despite the court rulings gutting the meaning of the sponsorship pledged, the State Department and the INS have continued to require these unenforceable "affidavits of support" from putative sponsors as the basis for waiving routinely the public charge bar.

Between the unenforceability of the public charge bar, and the ineffectiveness of the sponsorship pledge, the INS has effectively stopped trying to deport aliens on that basis . Despite the law's appearance on the statute books, and the insistence of some immigration activists that this law constitutes some protection to the American taxpayer, the bottom line is that the entire process is out of control. Ultimately, it can only be solved through a revamping of our entire documentary identification scheme: a standardization of state birth records and electronically-verifiable immigration documents accessible by state agencies.

The emergence in the mid-1960's of the "Great Society" programs rendered the concept of "public charge" somewhat antiquated. The assumption by the Federal Government of a range of new authority to administer national health and welfare programs meant that all Americans would increase their chances of drawing on the public treasury at some point in their lives.

Supreme Court cases such as *Graham v. Richardson*, 403 U.S. 365 (1971) (striking down a state's ability to determine which aliens may receive benefits and which may not, based on the Fourteenth Amendment's Equal Protection Clause), and *Mathews v. Diaz*, 426 U.S. 67 (1976) (upholding Congress' plenary authority to deny benefits based on alienage classification), eliminated the states—and their administering agencies—as major players in determining alienage classification, eligibility and public charge liability.

A block grant scheme must consider the constitutional limitations on individual states' ability to differentiate between aliens and citizens in the provision of basic services. As an aside, the existence of the Supreme Court authority in Graham raises the question whether Congress could delegate to the states which benefits. Assuming states could actually make these determinations with any precision (something they could not now do without much more assistance from the INS in electronically verifying alienage classification and eligibility for benefits and on-line verification assistance of U.S. birth by the other states' vital statistics bureaus), there may also be a constitutional cloud over the idea. Such a scheme would certainly be subject to constitutional challenge, particularly if the block grant concept permits the states to administer benefits in a way inconsistent with the Federal immigration classification scheme. Any block grant delegation should specify with great precision which aliens are eligible for which programs and which are not.

The bottom line is that the forces identified in this testimony have led to a situation unsustainable for the American taxpayers: SSI is only the leading edge of a range of troubling trends: aliens may enter the country legally and illegally, and in a full range of cases obtain benefits on par with (and even to the advantage of) U.S. citizens.[8]

Recommendations: What should we do?

The situation calls for the following, at a minimum.

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[8] for example, under the AFDC guidelines, a family with two "ineligible alien" wage earners and two U.S. Citizen children receive preferential treatment under the eligibility guidelines over a similar household of all U.S. Citizens. This is because the ineligible aliens are removed from the per capita debt load calculus that determines the families monthly payment amount. Another example was the proposal by the Clinton Entitlement Reform Task Force last year that would require AFDC mothers to return to work after two years. The task force concluded that if the mother was present illegally, she could not be required to return to work. The reason? She is ineligible to work under Federal law.

I. Revising an alien's eligibility for welfare is critical to restoring the proper balance between immigrant rights and responsibilities. It is not enough for an immigrant to have paid taxes; by that standard, many immigrants could be deported on their negative tax liability alone.[9] Rather, we should recall that immigration is merely the first step on the road to citizenship, not a permanent "limbo" classification for aliens to remain in indefinitely. We call in the "Immigration and Naturalization Service," co-joined because immigration is the first step, and naturalization should be the last. Conditioning alien eligibility for welfare programs on the acquisition of citizenship is both good policy and good civics. It ties the community together, and furthers the community's interest in seeing immigrants join the national political community as full participating members. For elderly aliens who may have difficulty achieving citizenship, we have to ask ourselves whether we can really allow elderly persons without income earning potential, health insurance or assets to come en masse. The nation is already facing a growing health care crisis without importing extra obligations.[10] At a minimum, the deeming period should be extended far beyond the current five year period.

II. Barring welfare eligibility for aliens is also consistent with restoring the concept that immigrants may not come if they are going to cost taxpayers money. Immigrants should pay their own way. No federal or state taxpayer should have to pay a dime for immigration. "Affirmative immigration," by which I mean a national program that admits immigrants solely because those individuals want to come to live (as opposed to emergent, humanitarian and life-saving admissions) are optional for the American people. They will not support immigration programs that produce severe financial distress on local and state taxpayers. Welfare programs are an incentive to attract immigrants without education, skills or literacy to move to the United States. Making these programs available without enforceable sponsorship pledges or public charge bars simply invites an influx of those immigrants who have the most to gain by moving to a country with a generous social safety net.

III. **We should expand the definition of "public charge."** We should amend Sections 212(a)(4) and 241(a)(5) of the INA to insure that public charge deportation and exclusion are available for those aliens who are likely to use, or do use, Federal, state or municipal means-tested public assistance, including non-emergency medical care, food and housing assistance, or any other such program. The test for aliens who have entered, and are therefore subject to deportation, should be "means tested public assistance for at least 180 days within five years of the date of entry." Restoring value and meaning to the public charge definition will go a long way toward restoring public confidence in our immigration system.

IV. **Restore the enforceability of sponsorship pledges.** The American people are uniformly in support of restoring meaning and enforceability to the affidavits of support. We suggest that INA section 212(a)(4) be amended to require that a bond be posted by a responsible sponsor whenever it appears likely that an alien may become a public charge. Further, a guarantee of financial responsibility should be enforceable by the Attorney General of the State or Federal agency that has provided the assistance in any jurisdiction in which the sponsor or alien resides. If the sponsor fails to relieve the taxpayer of the debt obligations incurred on behalf of the sponsored alien, then the alien should be sent home.

Mr. Chairman, we know these are difficult and sensitive issues. Everyone would like to live in the same country with their own parents, and we would all love to be able to provide long-term retirement and medical care for everyone, everywhere. But the real world of limits operates here; we cannot be the home of last resort for all who would like to come. We believe that these changes are only the beginning of a long-term effort to restor public confidence in the ability of our immigration program to serve the public and national interest. On behalf of FAIR, I appreciate the

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[9] Nearly 70 percent of the aliens who received amnesty in 1986 lived in families so poor that they qualified for the Federal Earned Income Tax Credit. Source: INS Amnesty Data.

[10] Recall that the last great wave of immigration at the turn of the century did not include permitting very elderly persons to enter, unless they have a sponsor. In those days, the financial obligations for elderly immigrants or those who otherwise ran into difficulty fell on the family or private charities. Many older persons could not make a hazardous trip across the ocean, and many who did were barred as "public charges" at Ellis Island. This current wave is the first time in American history we have been admitting large numbers of elderly immigrants past their prime income earning years.

opportunity to appear before you today, and we look forward to working with you on this issue now and in the future.

PREPARED STATEMENT OF CAROLYN L. WEAVER, PH.D.

My name is Carolyn Weaver and I am a Resident Scholar and Director of Social Security and Pension Studies at the American Enterprise Institute. I am also a member of the Quadrennial Social Security Advisory Council and the new Social Security Advisory Board, and have served on the 1987 Disability Advisory Council, the 1989 Disability Advisory Committee and, in 1993, was a member of the National Academy of Social Insurance Study Panel on Disability.

Mr. Chairman, I appreciate the opportunity to testify on the important subject of SSI reform. During the early deliberations over welfare reform—and much talk of "ending welfare as we know it"—SSI remained comfortably out of the limelight, where it had been during much of its 23-year history. While some feel that this is where it still belongs, as a program serving some of the nation's most disadvantaged citizens, the rapid growth and now sheer size of SSI suggests otherwise. SSI the largest and fastest growing cash assistance program in the federal budget. This, together with allegations of possible abuse in the program, have catapulted SSI to center stage—and none too soon. The program is growing like gang-busters and, unbeknownst to many, serving a population very different than the population originally served. Reforms are needed to address both specific problem areas, such as those addressed in H.R. 1157, the welfare reform bill approved by the House Ways and Means Committee earlier this month, as well as more deep-seeded problems in the underlying premises of the program.

Having said this, I hasten to add that SSI has, indeed, been a vital lifeline for some of America's most vulnerable citizens—the elderly and the disabled poor. It provides a nationwide, minimum income guarantee ($5,496 annually for individuals and $8,244 for couples in 1995) that is cost-of-living adjusted each year and financed almost entirely by the federal government. The challenge is to find ways to eliminate inappropriate benefits and to improve the way benefits are delivered to the truly needy, encouraging work where possible and providing necessary support where it is not.

PROGRAM GROWTH

SSI is more costly and growing much more rapidly than AFDC (Aid to Families with Dependent Children), the focus of the welfare reform debate. As illustrated in Figure 1, in 1993, an estimated 6 million people received SSI, up nearly one-half since 1980 and one-quarter just since 1990. Federal spending stood at $21 billion, double its level (in real dollars) in 1980 and up nearly one-half since 1990. Federal spending on AFDC, by contrast, was $16 billion in 1993, up 23 percent in real terms since 1980. According to the President's budget, the SSI benefit rolls will grow so rapidly in the next few years that, by the end of the decade, the cost of the program (including federal and state spending) will exceed the cost of AFDC, Food Stamps, subsidized housing, the greatly expanded Earned Income Tax Credit, and all other major public assistance programs except Medicaid.

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

CHANGING MIX OF ELDERLY AND DISABLED RECIPIENTS

While many people view SSI as a program serving mainly as a safety net for the elderly poor, it actually serves mainly working-aged adults (and increasingly children) with disabilities. As Figure 1 makes clear, this has not always been the case. When SSI was created in the early 1970s—federalizing the old-age assistance, aid to the disabled, and aid to the blind programs around the country—most SSI recipients (about two-thirds) were, in fact, elderly. Typically, they were elderly people who were not eligible for social security or whose pensions left them in poverty. Over the years, as the elderly have gained eligibility for higher social security benefits and for private pensions, and their economic well-being has improved, the number of elderly people on the rolls has generally fallen. Whereas 2.3 million elderly people were on SSI in 1974, the program's first year in operation, the number fell to a low of 1.4 million in 1988 and has grown slowly to about 1.5 million today. Further significant declines would have been experienced since the 1980s were it not for the great increase in the number of elderly immigrants on SSI, as discussed further below.

Growth Areas—Disabled Recipients with Mental Disorders: Alongside this long-term decline in the number of elderly people on SSI, there has been an explosion in the number of disabled people on the rolls—doubling between 1974 and 1990, from 1.7 million to 3.4 million, and increasing by over one million in the past three years alone to about 5 million. Today, as shown in Figure 1, three out of four SSI recipients are people with disabilities.

Even holding total caseload constant, this change in the mix of SSI recipients has significant cost implications. The reason is that SSI-disability recipients typically receive much larger payments than elderly people on SSI ($373 monthly compared to $204 monthly in December 1993) owing to the fact that they are much less likely to have social security and other sources of income that reduce the size of their payments. As a result, whereas three-fourths of SSI recipients are disabled, 85 cents out of every dollar spent on SSI goes to SSI-disability recipients. As shown in Figure 2, this is up from 53 cents in 1974.

The population receiving SSI-disability is also changing and in ways that have onerous cost implications. In particular, recipients are getting younger and younger over time and are increasingly likely to be granted benefits based on a mental rather than a physical impairment. The typical person receiving SSI-disability today is in his or her thirties, has a high school education or less, and, in contrast to the familiar image of someone in a wheelchair with a physical disability or someone who is blind, has been granted benefits on the basis of a mental disorder—schizophrenia, chronic depression, or anxiety, for example. While some of these conditions are obviously severe and generally disabling in the labor market, others are not and, in any event, are notoriously difficult to evaluate with precision. As shown in Figure 3, fully one-third of adults on SSI-disability have a mental disorder—in addition to the one-fourth who have mental retardation. Young people with mental disorders are the fastest growing segment of the adult SSI population. The prospects that these people will ever return to work (or go to work) are very poor.

These trends raise a host of public policy issues, among them the efficacy of programs aimed at rehabilitation (or habilitation) and work, the suitability of treatment and medication requirements, and the ability to control program entry and ensure the integrity of the benefit rolls (particularly as states, under new financial pressures, seek ways to reduce general assistance caseloads and shift costs to the federal government). H.R. 1157 generally does not address these difficult issues.

Kids with Disabilities: As a result of a 1990 court order and new regulations that loosened eligibility for children, together with other regulatory changes in 1990, children with disabilities are the fastest growing segment of the SSI population today. Stretching SSI in ways never contemplated in 1972, 225,000 children with disabilities (mainly mental disorders, including the much-discussed attention deficit disorder, and mental retardation) were added to the rolls in 1993, triple the number in 1989. As shown in Figure 4, the number of children on the rolls now approaches one million, or close to one out of five people on the SSI-disability rolls.

According to the GAO, mental retardation and other mental disorders accounted for more than two-thirds of the growth in awards to children between 1988 and 1992. "Behavioral problems," which include personality disorders, attention deficit hyperactivity disorder, autism and other developmental disorders, accounted for one-fifth of mental impairment awards.

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

In this latter regard, kids are eligible for $458 monthly (in 1995), the same as an elderly person or disabled adult living in their own home, and this is payable regardless of their families' total income from public assistance. Set to ensure that, together with Food Stamps, the elderly and disabled poor have a near-poverty level of income, SSI payments are much higher than AFDC payments, resulting in large disparities in income support for poor families depending on the disability status of their children. In a typical state, a poor mother with two children, one on AFDC and one on SSI, receives twice as much public assistance as a poor mother with two children on AFDC. Were the latter mother able to have one of her children certified as disabled and qualified for SSI, she would, based on 1994 benefit amounts, forgo $72 monthly in AFDC in exchange for $446 monthly in SSI, raising her family's income from $366 to $740 monthly; were the other child to qualify for SSI as well, family income would rise to $1,104 monthly, fully triple that of the AFDC family. In contrast to AFDC, SSI pays each additional child the same benefit, with no reduction in marginal benefits, and there is no limitation on family benefits.

Evidently, the incentives are strong—for families, for those who care about them (whether physicians, teachers, friends or neighbors), and possibly even for the states in which they live (which must bear about 45 percent of the cost of AFDC but none of the cost of SSI unless they choose to supplement the federal payment)—to get children in low-income households classified as disabled.

Apart from the obvious financial concerns this raises, there are concerns about the long-term impact on the well-being of children of classifying them "disabled" so early in life with what may not, in fact, be an impairment that substantially limits the quality of their lives or their future prospects. Accurately assessing disability is always a problem, but especially when mental disorders are involved. The fear is that such a classification can be self-fulfilling, defeating the child's desire—and ultimately undermining his incentive—to succeed, leading potentially to a lifetime of dependency on government.

With welfare reform a top priority, it is only appropriate to question the premises of this program which was, after all, something of an afterthought when SSI was created in 1972. In the massive social security and Medicare bill moving through Congress in 1971, H.R. 1, which contained the original proposal for SSI, there was no mention of benefits for disabled children. Disability was defined in terms of complete inability to work and SSI payments were intended to replace lost income. The idea of payments for children (who did not work and had no earnings, but nevertheless had disabilities somehow construed to be of "comparable severity") apparently was conceived by a senior welfare official in the Nixon Administration who, although the record is not clear on this point, managed to get a 26-word amendment inserted into the legislation without objection or debate. The program so created was of little note for the better part of two decades, during which time cash assistance was made available to a group of no more than 200,000-300,000 children annually.

That changed in 1990 with the Supreme Court decision in *Sullivan v. Zebley*. In that decision, the Court ruled that the regulations governing childhood disabilities failed to grant benefits to children on the basis of impairments that were of "comparable severity" with those of adults and thus were inconsistent with the law. Under long-standing SSA policy, adults who were found not disabled based on the medical severity of their impairments have had vocational factors (i.e., their age, education, and work experience) and their "functional capacity" to perform work-related activities considered in evaluating the presence or absence of a disability; children were evaluated based solely on the medical severity of their impairments. The Court ordered SSA to relax the criterion used for assessing disability in children and to review the cases of hundreds of thousands of children denied benefits since 1981.

To implement this decision, SSA issued regulations creating a new test (referred to as an "individual functional assessment") to assess a child's ability or inability to behave in an "age-appropriate manner," a test that must be used when benefits would be denied on the basis of the severity of the physical or mental impairment alone. This, in the court's view, was one means of making disability benefits available to children on terms more comparable with adults. As made clear in the dissenting opinion by Justice White and Chief Justice Rehnquist, the meaning of "comparable severity" and the argument for applying individual functional assessments to children was not without controversy.[1]

The regulations implementing *Zebley* came on line at just about the same time as new regulations for assessing mental disorders, which, among other things, expanded the group of qualifying disorders to include attention deficit disorder, and

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[1] Justice White, joined by Chief Justice Rehnquist, wrote a dissenting opinion in which they made three key points: first, the critical terms "comparable" and "severity" are nowhere defined in the Social Security Act and their meaning is "anything but clear;" second, in defining disability in the statute, "comparable severity" is included the paragraph pertaining to medical severity not in the paragraph pertaining to non-medical (i.e., vocational) considerations; third, alleged deficiencies in the regulations do not argue for creating a new regulatory structure, rather, if there are medically determinable impairments that should be considered disabling because they are comparably severe, but are not considered, the individuals harmed should appeal to the Secretary and, if necessary, take their case to court. Concurring with the district court judge, the opinion stated "errors in applying the regulations in some cases do not demonstrate the invalidity of the regulations themselves."

elevated the importance (relative to medical evidence by physicians) of testimonials by friends, teachers, and family members in the evaluation of disabilities. The beneficiary rolls exploded. GAO estimates that 30% of the children coming on the SSI rolls since *Zebley* were awarded benefits based on the new "age-appropriate behavior" test, meaning that they would not have been found eligible under the criterion in place until that time; and that 70% were awarded benefits on the basis of the severity of their mental or physical impairments (overwhelmingly mental, as evaluated under the new mental impairment regulations).

The surge in the number of children on SSI-disability has brought this program into the open and, at least in the minds of some, raised the question of why we even have it, given that it appears to duplicate the purpose of AFDC, which is to help meet basic living expenses (such as food, clothing, and housing), albeit at a much higher benefit level, and Medicaid is available in either event. Proponents argue that the reason for the program and for the much larger benefits is that disabled children are much more expensive to raise than other children. This begs two questions—how much more expensive and how much of the expense is actually born by the families? Surely the cost of raising a disabled child varies enormously depending, among other things, on the type and severity of the disability. Consider a child with, say, cerebral palsy or a spinal cord injury as compared with one who is, say, blind or someone who has a behavioral disorder. (Most, recall, have mental retardation or a mental illness.) No doubt some of these children have enormous expenses—certainly larger than $458 monthly—and no doubt some have none at all. What's relevant then is the extent to which these expenses are unmet by other sources. Medicaid is critical in this regard. A relatively new program when SSI was enacted, Medicaid (enacted in 1965) has grown enormously in size and scope since the early 1970s. Under the law, states must provide a range of medical services to children in poor families, including in-patient and out-patient hospital care, physician services, and home health care; also, states have the option of providing certain other services and providing them to people (the "medically needy") who otherwise would not be eligible. In addition, as documented in a study just released by the National Academy on Social Insurance,[2] there are a number of other programs serving particular needs and particular groups, including the Children with Special Health Care Needs program, now part of the Maternal and Child Health Block Grant, the Education for All Handicapped Children Act, and the Part H Early Intervention program.

Within the context of the current system, a good case can be made for converting the SSI payment for children—an unrestricted cash transfer that is unrelated to their special needs and may or may not be used to meet them—into a voucher that can be used only to meet the added costs of raising a child with a disability that are not met by other programs, for example, medications and medical supplies not covered by Medicaid or the cost of physical modifications to a home required by a child with a mobility impairment. Alternatively, authorized services might be provided under the Medicaid program, with full federal financing. Other options are available. The idea would be to eliminate payments to families with no claim to them other than the presence of a disabled child, while meeting the legitimate needs of families with extraordinary expenses.

It is interesting to note in this regard that in 1972, the Senate Finance Committee rejected the proposal for SSI for disabled children. In its view, stated clearly in the Senate Report,

> "Disabled children's needs for food, clothing, and shelter are usually no greater than the needs of nondisabled children. . . . The needs of disabled children . . . are generally greater only in the area of health care expenses."[3]

The legislation approved earlier this month by the House Ways and Means Committee would significantly limit and refocus SSI spending for children. Under the bill, cash payments would continue only for children who meet the test of medical severity (not the new "individual functional assessment" relating to age-appropriate behavior) and are either in institutions or require the assistance of a parent or caretaker in the home to prevent institutionalization. For other children who meet the test of medical severity, authorized medical and non-medical services would be made available through a new block grant. (Funding would be based on the cash benefits that otherwise would have been paid to these children.) SSI would no longer cover children who fail to meet the test of medical severity.

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[2] "Policies for Children with Disabilities: Connecticut, Virginia and Some National Trends," by Jonathan G. Cedarbaum, working paper, National Academy of Social Insurance, Jan. 1995.

[3] The Supplemental Security Income Program: Report of the Staff to the Committee on Finance, U.S. Senate, April 1977, 95th Cong., 1st Sess.

While questions can (and will) be raised about the particular way the legislation addresses the problems of the SSI-children's program, reform is both critical and overdue. As currently designed, the program is costly and poorly targeted, creating perverse incentives and inequities in the treatment of poor families. In the context of the broader welfare reform movement, moreover, an unreformed SSI-children's program could well become an escape hatch—albeit an expensive and poorly targeted one—for families who lose eligibility under a reformed AFDC program.

Aliens: Another factor underlying the growth of SSI, addressed by H.R. 1157, is the rapid growth of aliens on the rolls.[4] According to the General Accounting Office, in 1993 the number of aliens on SSI was 683,000, or about 12% of the SSI caseload, up from 3% in 1982, at an annual cost of $3.3 billion. GAO predicts that if current trends continue, the number of aliens on SSI could reach 2 million within five years.

The growth is most pronounced in the SSI-elderly program. As clearly revealed in Figure 5, the halt in the decline of the SSI-elderly rolls noted earlier, which could easily be misconstrued as a weakening of the financial condition of the elderly poor, is actually due to the great expansion of aliens on SSI. As shown in Figure 6, aliens comprised 28.2% of the elderly on SSI in 1993, up from 5.9% as recently as 1982. The rapid growth in the number of aliens first moderated and then *fully offset* the historic decline in the number of elderly citizens on SSI. Indeed, were it not for the surge of aliens on SSI, the number of elderly people on the rolls would have fallen quite significantly—by about 400,000—since 1982.

Paradoxically, elderly and disabled citizens on SSI receive smaller—in some cases, much smaller—benefits than aliens. According to the Social Security Administration, in 1993, the average SSI payment for an elderly alien, for example, was $393 monthly, more than double the average payment for an elderly citizen, which was $176 monthly. The reason is that elderly immigrants generally have less countable income, especially social security, than elderly citizens. The changing mix of recipients thus puts upward pressure on costs that would go unnoticed by focussing on total recipients only.

The rising share of alien recipients is not unique to SSI; it has been observed in each of the major federal public assistance programs—Medicaid, SSI, AFDC, and Food Stamps—and, to some extent, reflects the huge influx of immigrants in the 1980s and early 1990s. What is unique to SSI is disproportionate growth. According to the Congressional Budget Office, in 1992, the proportion of legal immigrants on AFDC and Food Stamps, for example, was 4%-5%, roughly the same proportion as the proportion of legal immigrants in the overall population. The proportion of legal immigrants was double that in the SSI program as a whole, exceeding 10%, and, as noted above, hovered close to 30% (in 1993) in the SSI-elderly program.

That there is a hole in the SSI program (or in immigration policy) that needs plugging is further revealed by the fact that the average age at which immigrants on the SSI-elderly rolls enter the U.S. is high, suggesting that these people generally have not spent many years working and paying taxes only to fall into poverty in old age. CBO reports that among immigrants on the SSI-elderly rolls who arrived in the U.S. after 1974, roughly 80% were 60 or older when they arrived. In addition, among immigrants who, as a condition of admission for permanent residence, have sponsors who have signed affidavits of support, applications for SSI surge at the end of the period that SSA counts (or deems) their sponsors' income and resources in determining SSI eligibility. According to Social Security Administration data, fully 25% of lawfully admitted aliens on the rolls in 1993 applied for SSI in the 12-months after the deeming requirement expired.[5]

The legislation approved by the Ways and Means Committee would sharply curtail SSI (and other major federal welfare benefits) to people who are not U.S. citizens. Under the legislation, legal aliens would generally be ineligible for SSI; exceptions are refugees in the U.S. for fewer than 5 years, legal permanent residents age 75 or older who have been in the U.S. for at least 5 years, and veterans of the U.S. Armed Forces. In addition, the legislation would deem the income and resources of sponsors to aliens seeking SSI—and make the affidavits of support signed by sponsors legally binding—until such time as the alien becomes a U.S. citizen.

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

[5] In the report accompanying H.R. 1157, the House Ways and Means Committee states that "current eligibility rules for public assistance and unenforceable support agreements have proved wholly incapable of assuring that individual aliens not burden the public benefits system" (p. 40). This conclusion would appear to be fully [illegible]ified in the case of SSI.

Whether one views the explosion of aliens on SSI as a problem to be attacked through changes in immigration policy or through changes in SSI, there is clearly a hole that must be plugged. Already, according to CBO, noncitizens account for 45% of spending on the SSI-elderly program. Public support for this program will likely erode if it is seen for what it is fast becoming—a transfer program for immigrants who enter the U.S. late in life and make little economic contribution to it.

Addicts and Alcoholics: As highlighted by the popular press, even alcoholics and drug addicts are finding their way onto the social security disability rolls in growing numbers. According to the Social Security Administration, the number of people on the SSI-disability rolls with substance abuse as their primary disorder (in other words, without some other qualifying disability, such as cancer or heart disease), nearly quadrupled in the 3½ year period October 1990 to April 1994, rising from 23,000 to 86,000. The General Accounting Office reports that between the two disability programs administered by the Social Security Administration—SSI-disability and Disability Insurance—250,000 drug addicts and alcoholics are receiving monthly benefits at an annual cost of $1.4 billion, with over one-half of these addicts added to the rolls in the past five years. No doubt, many more people are on the rolls with addictions that contribute to their disabilities, such as people with severe organ damage or mental illness, or with addictions that are secondary to another disorder.

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

Unfortunately, the history of SSI would suggest that SSA is much better at mailing checks than at providing services (the representative payee program is a case in point), and this legislation is service-intensive. In terms of identifying, notifying, tracking, and monitoring recipients, evaluating the suitability of treatment facilities, and periodically testing for substance abuse, and in terms of the appeals that will inevitably result, this legislation is likely to be a bureaucratic nightmare for SSA. Worse, its likely effects on rehabilitation and benefit terminations are uncertain at best. For one thing, SSA is not authorized or funded to provide treatment and it can not require people to pay for it. The most SSA can do is make referrals. Benefits cannot be suspended, moreover, unless treatment is actually available. For another thing, the 36-month time limit applies only to those who would not be found disabled except for drug addiction or alcoholism, not to the (presumably much larger) group of people for whom substance abuse contributes to their disability. The incentives will be strong for people who are terminated from the rolls to simply re-file for benefits on the basis of other disorders, quite possibly disorders that existed at the time of the original application, such as mental illness.

More needs to be done to control this aspect of the program. Few would argue that cash benefits are in the best interests of addicts, and yet addicts will continue to be allowed onto the program. Ongoing cash support to addicts (and possibly to people with certain forms of mental illness) tends to promote dependency and perpetuate the very conditions that bring these people onto the rolls in the first place. Moreover, recognizing the number of people in the general population (especially the homeless population) thought to be serious substance abusers, many of whom presumably are or will become poor, the potential for substantial additional growth of this aspect of SSI is enormous.

The legislation approved by the House Ways and Means Committee would simply eliminate benefits based on drug addiction or alcoholism. For a 4-year period, $100 million would be made available to promote drug treatment and research; 95% of the funds would be channeled into a program to expand the availability of drug treatment, and the balance would be channeled into research on drug abuse and treatment. Perhaps in recognition of the limited evidence on successful treatment programs and SSA's limited capacity to monitor individuals and programs, no funds would be made available to provide particular types of treatment to particular individuals.

Ensuring the Integrity of the Benefit Rolls: If there is a common theme to the problems described above, it would appear to be a failure to ensure the integrity of the benefit rolls. Inadequate Congressional oversight, on the one hand, and inadequate diligence by program administrators, on the other hand, have combined to produce a program the growth of which is only loosely controlled and the transformation of which is poorly understood. Reform of this important program should not have to be driven by financial crisis or news reports of abuse.

Systematic review by SSA of the continuing eligibility of people on the rolls would be at least a step in the direction of ensuring the integrity of the benefit rolls. Periodic eligibility reviews are largely unheard of in SSI despite the fact that the disability component of SSI is the largest and fastest growing and that few impairments are completely disabling on a life-long basis. Last year, Congress mandated that SSA begin reviewing a minimum number of SSI-disability cases (at least 100,000 annually) and, over a 3-year period, review the eligibility of all SSI children turning 18 under adult disability standards. H.R. 1157 beefs up this requirement, mandating that reviews be conducted on all children (not just those turning 18) with non-permanent impairments every 3 years.

It is far from obvious how many reviews will actually be conducted, given huge backlogs of applications for new benefits and huge backlogs of reviews in the social security disability insurance program. Limited administrative funds is part of the problem. Weak incentives to terminate benefits is another part of the problem—weak among the states administering the disability determinations that must bear any extra general assistance costs resulting from the termination of SSI benefits, and weak among federal administrators who, with limited funds and obvious political pressures, would surely prefer to allocate resources to initial decisions rather than to decisions that may result in benefit terminations. Recognizing this, Congressional oversight becomes that much more important.

It is also far from obvious how effective the reviews will be in removing from the rolls people who don't belong there. In the DI program, for example, the medical improvement standard mandated in 1984 has sharply reduced the number of benefit terminations. While some of this drop has been the intended consequence of the legislation, there can be little doubt that some of it has been due to the practical difficulties of developing a legally defensible showing of improvement, particularly in cases involving mental impairments.

Having said this, conducting reviews, and doing so on a fairly broad-scale basis, can have two salutary effects. First, it can provide valuable information about problem areas in both the eligibility and review standards that would dictate legislative action. Second, it might help send a message to recipients that, despite appearances to the contrary, SSI is not an early retirement program.

- *Broader Issues:* While SSI does not present the problems in the forefront of the welfare reform debate—teen pregnancy, out-of-wedlock births, and the cycle of dependency—it nevertheless presents problems that demand public attention. Some of these problems can be dealt with on a piecemeal basis; others, particularly those involving the disability, will require a more comprehensive approach involving the underlying premises and design of SSI and the program it is modelled after, social security disability insurance, which, though serving a different population—working-aged people with significant work histories who generally are not poor—is plagued by many of the same problems. (DI and SSI use the same basic definition of disability and the same complex and costly administrative and appeals system to adjudicate claims, create similar disincentives to work, and face all the same financing problems.)

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

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

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

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

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

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

This suggest to me that the employer is a key part of the equation that is now ignored by policy makers. Consider the reasonable accommodation requirement in the Americans with Disabilities Act. This amounts to a mandated benefits program, the full cost of which is imposed on employers. Or consider the DI tax. Employers who make accommodations and go the extra mile to hire or retain people with disabilities—thus sparing the social security system of at least a portion of the potentially large cost of supporting these people for life—must pay the same DI tax as all other employers. Or consider increases in minimum wage laws and other mandated benefits programs. These policies increase the cost of hiring low-skilled workers, discouraging the employment of precisely the kind of people that dominate the SSI rolls, people with poor educations and job skills. An effective national policy that has work as its goal cannot ignore the employer side of the equation.

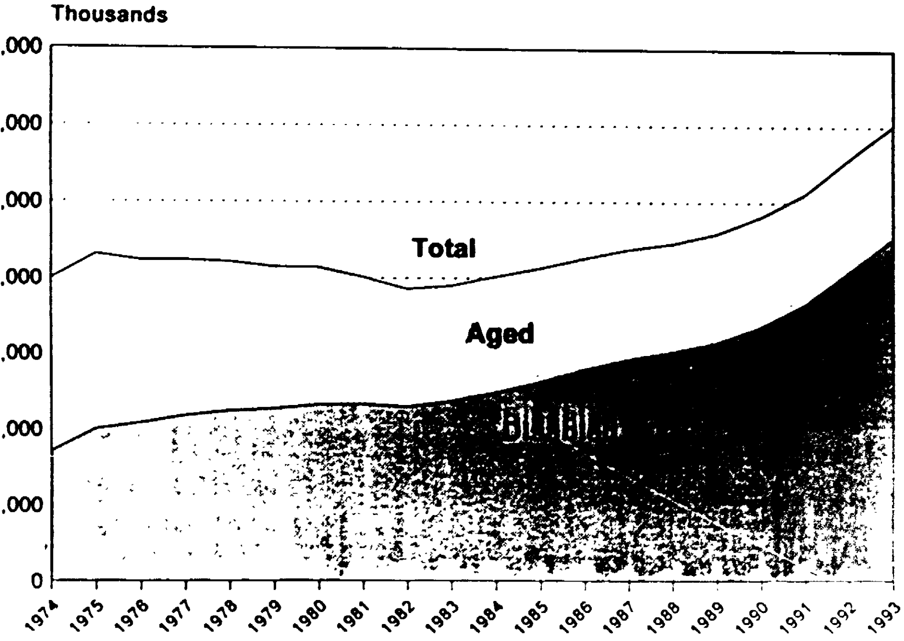
Finally, in the spirit of many of the reforms being discussed in social policy in recent years, there may be real benefit to reorienting SSI and DI toward transitional aid for people whose conditions are not permanently disabling. The presumption underlying federal policy should, in the main, be that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

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

Attachments.

Figure 1

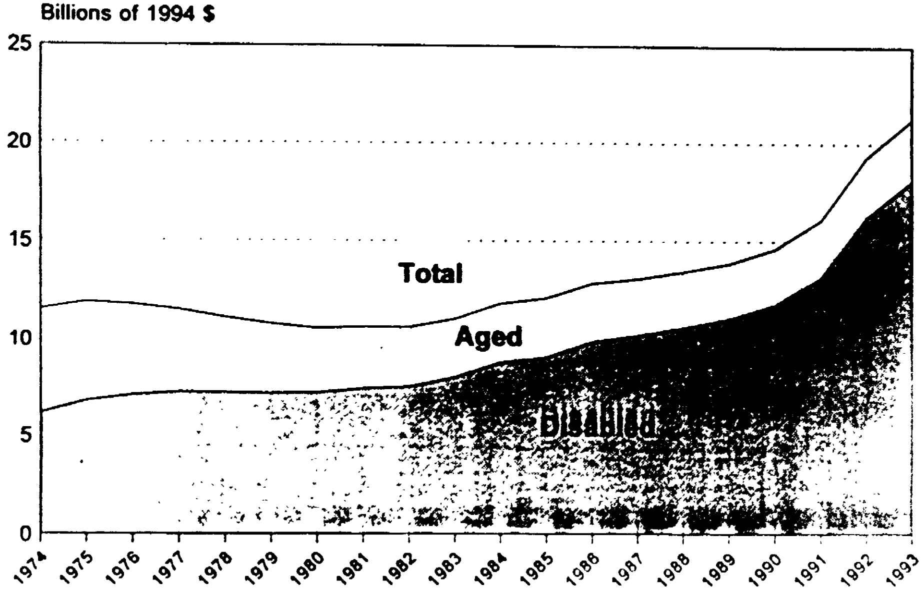
People Receiving SSI



Source 1994 Greenbook p 248 and Memo from M Staren SSA to C Weaver Feb 14 1994

Figure 2

Real Federal Spending on SSI: Recent Growth and Changing Composition



Source Social Security Bulletin Annual Statistical Supplement, 1985, p 241 and 1994, p 286

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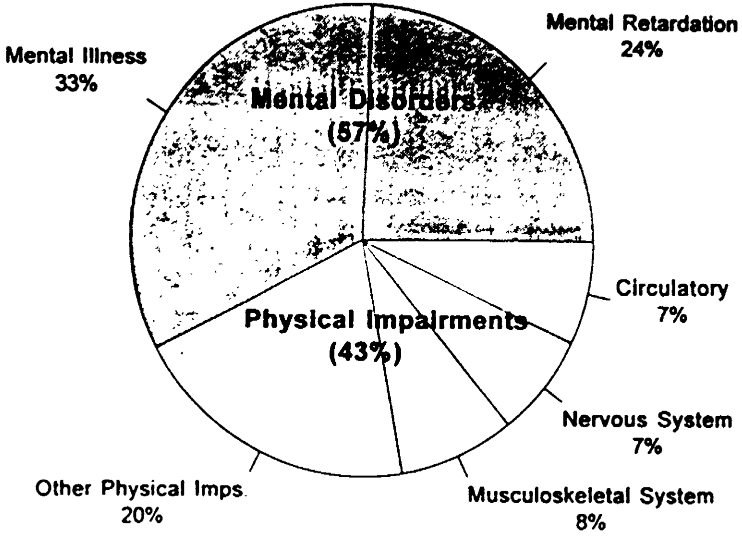
Figure 3

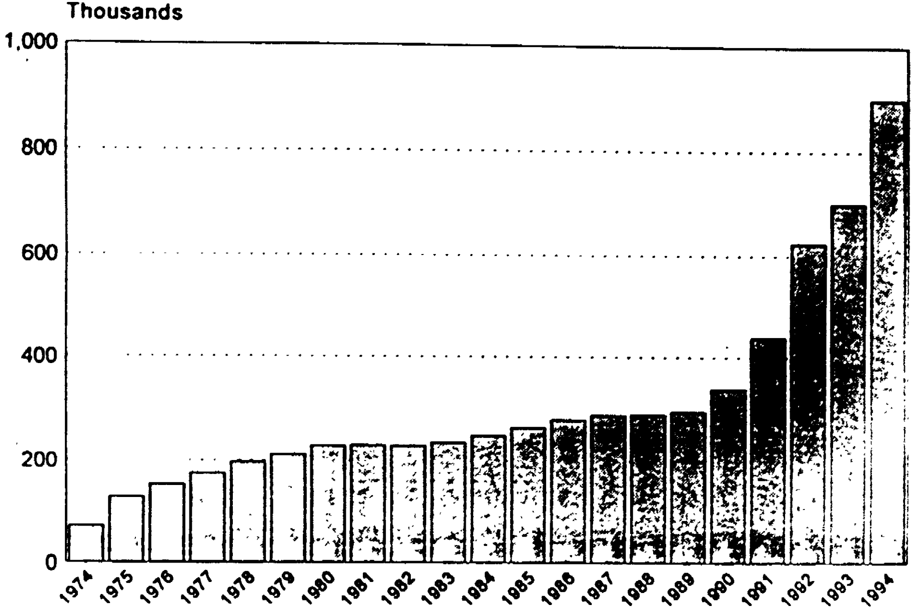
Adults on SSI-Disability Rolls
by Leading Cause of Disability, Dec. 1993



Source Social Security Bulletin Annual Statistical Supplement, 1994 p 300

Figure 4

Children Receiving SSI

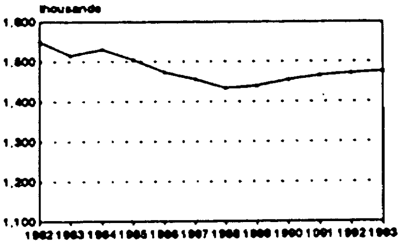


Note: Calendar years 1975-1992; fiscal years 1993-1994. Estimate for 1994.
Source: D. Koitz, G. Kollman, and J. Meisner. "Status of Disability Programs of the SSA, 1994," CRS Report for Cong. (June 6, 1994) p. 33, and Memo from M. Staren, SSA, to C. Weaver, Feb. 14, 1994.

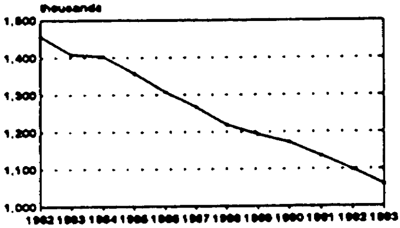
Figure 5

The Changing Composition of the SSI-Elderly Rolls

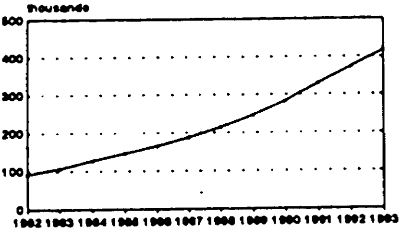
SSI-Elderly Rolls



Aged Citizens Receiving SSI



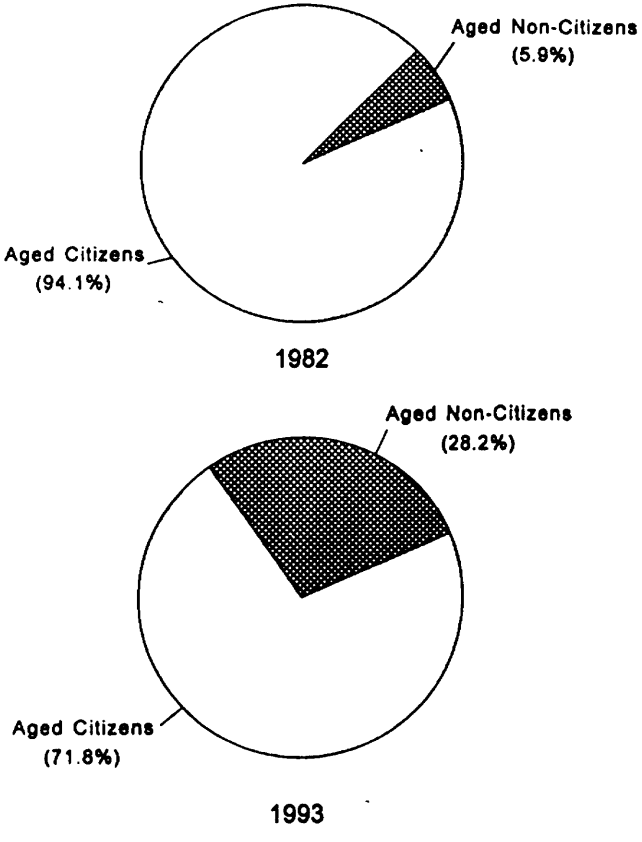
Aged Aliens Receiving SSI



Sources: 1994 Greenbook, p. 248, and Charles Scott and Elsa Ponce, "Aliens Who Receive SSI Payments," Office of Supplemental Security Income, March 1994, Table 2.

Figure 6

Non-Citizens on SSI-Elderly Rolls



	Citizen	Non-Citizen
Average SSI Payments to Elderly (Dec. 1993):	$176/mo.	$393/mo.
Ratio of Av Payments (Citizen to Non-Citizen):	45%	

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics is pleased to present a statement for the Committee record in support of the Supplemental Security Income (SSI) program. This is an issue of critical importance to children with disabilities and their families.

The SSI system is not without flaws. Unquestionably, a thoughtful and comprehensive review of the current SSI program is the most effective and responsible approach to addressing fiscal and policy issues. The Academy of Pediatrics would urge caution in adopting quick-fix simple solutions to complex SSI problems. Discussions center on cutting cash payments to families, providing vouchers for medical services received by SSI recipients or even block-granting the program. The frenzy of budget cutting in the short-term has very direct consequences for the mid- and long-term.

CRITICISMS OF SSI

Over the last year or so, the SSI program has been cited as a prime example of a federal program that is out of control. Congressional concerns relating to the SSI program focus on the extraordinary growth in the rolls of children receiving benefits, allegations that children are being encouraged to feign behaviors in order to qualify for assistance, and the concern that some parents are not using the cash benefit to help their children. As a result, the SSI program has become a target for Congressional fiscal paring.

The SSI program is not without flaws. Certainly, some of the criticisms waged against the program are appropriate. But Congress is walking dangerously close to reversing policies and abandoning programs that have provided children with disabilities opportunities that enable many of them to achieve levels of independence they would otherwise be denied. To abolish or so limit the existing program by cuts, terminating entitlement status, issuing vouchers or establishing block grants sentences thousands of children with disabilities to lives without freedoms and opportunities available to other children and will increase their long-term dependence on public support.

It is important to understand the chain of events that brought us to this point in the SSI debate. Children with disabilities were included in SSI as a result of legislation in the early 1970's. In 1977, the Social Security Administration published diagnostic criteria for determining eligibility for children, criteria that formed the basis of disability determination for over a decade(1).

Zebley Decision:

In February 1990, the US Supreme Court (in Sullivan v. Zebley) struck down the guidelines for determining childhood disability, ruling that they were too restrictive and discriminating against children. (2,3). The Court noted that adults applying for SSI had an additional opportunity for becoming eligible even if they did not "pass" the diagnostic criteria, through subsequent assessment of the person's functioning in terms of ability to work. No similar assessment of children's functioning occurred.

The Court, quoting the amicus brief of the American Academy of Pediatrics, required the Social Security Administration (SSA) to develop new and broader disability criteria, which have expanded the numbers of children receiving disability payments and also broadened access to two important public programs that collaborate with SSI: Medicaid and Title V. In February 1991, the SSA published a new childhood disability regulation (4) as a key step in implementing changes in the program for children. As part of the Zebley court decision and settlement, many families who had been denied benefits in the past received sizable retroactive lump sum payments (in some cases, many thousands of dollars) for their child with a disability.

To maintain financial eligibility for SSI benefits, most families had to spend these dollars in a brief period of time.

Changes in Social Security Administration Listings:

IN ADDITION TO PUBLISHING THE NEW ZEBLEY REGULATION IN 1991, THE SOCIAL SECURITY ADMINISTRATION HAS IN THE PAST FIVE YEARS REVISED SEVERAL CONDITION-SPECIFIC LISTINGS, MANY OF WHICH AFFECT DETERMINATION OF DISABILITY IN CHILDREN. A PARTICULARLY IMPORTANT CHANGE OCCURRED WITH THE PUBLICATION IN LATE 1990 OF A NEW MENTAL IMPAIRMENTS LISTING FOR CHILDREN, WHICH MARKEDLY EXPANDED THE DEFINITION OF DISABLING MENTAL HEALTH CONDITIONS FOR CHILDREN AD ADOLESCENTS. ALTHOUGH FOCUSING ON CONDITIONS OF HIGH SEVERITY (E.G., CHILDHOOD SCHIZOPHRENIA AND AUTISM), THE LISTING ALSO ADDRESSES LOWER SEVERITY, HIGHER PREVALENCE CONDITIONS SUCH AS ATTENTION DEFICIT-HYPERACTIVITY DISORDER (ADHD). ALTHOUGH ADA AND LEARNING DISABLED CHILDREN IS ONE OF THE FASTER GROWING CATEGORIES, IT STILL REPRESENTS A RELATIVELY SMALL NUMBER OF RECIPIENTS.

Impact of Zebley/SSA Changes on Enrollment:

The result of the Zebley decision and the Social Security Administration changes are dramatic. Where approximately 275,000 U.S. children received SSI benefits in 1989, almost 856,000 had enrolled by mid 1994(5). These numbers represent almost a tripling of children and adolescents with disabilities receiving SSI payments along with associated Medicaid benefits.

Nevertheless, this number is still smaller than the number of eligible children the American Academy of Pediatrics predicted in 1990. The program currently serves between 60 percent and 80 percent of the estimated 1.1 million to 1.4 million children eligible for the program (6).

DISPELLING MISCONCEPTIONS

Because of costs involved, the change in eligibility criteria has drawn attention to policies that seek to help children with chronic disease and disability become more independent and eventually more productive members of society. There is a misconception that the majority of children receiving SSI payments are often healthy children who have been coached by parents and guardians to behave disruptively in order to qualify for assistance.

Most children receiving SSI benefits have severe disabilities. About 40 percent have severe physical disabilities, conditions like leukemia, spina bifida, cystic fibrosis, or major heart abnormalities. Another 40 percent have significant developmental retardation, and the major eligibility criterion for retardation alone is an IQ of 60 or lower. The other 20 percent have other mental impairments, including childhood autism or schizophrenia, as well as ADHD and related conditions.

Another misconception is that parents use the money for purposes other than assisting eligible children. It would be naive not to acknowledge that there are some instances of that kind of misuse but, the instances of this fraudulent use of finds are minimal. Publicity surrounding these limited number of cases has skewed public perception of the SSI program. As a result, the onus now falls on the recipients to demonstrate how the SSI payment assists with the important needs of children with disabilities and their families.

Despite a commonly prevailing view that many children with disabilities are doomed to die in childhood or to lead non-productive lives dependent on public institutions, the reality is quite different. The large majority (90 percent or higher) of children with disabilities will survive to young adulthood, although with varying degrees of physical and psychological morbidity (7,8). Raising a child with a significant physical or developmental disability greatly increases family costs and decreases family income. Though public or private health insurance covers many medical care costs, these families face additional costs that are paid out-of-pocket. Furthermore, having a child with a disability significantly decreases the likelihood that both parents in two-parent families are employed. SSI benefits also help diminish dependence on other institutions and makes less likely that children with severe disabilities will be placed in long-term care institutions at much higher costs.

Examples of the use of SSI payments illustrate the importance of this program for struggling families: For the child in a wheelchair, the SSI payment can allow a family to pay for a van with a lift to transport the child to therapies and activities with the rest of the family. For a respirator dependent child, the SSI payment provides financial assistance for the exorbitant electric bills and a back-up generator if the electricity fails. And for the child with cerebral palsy who cannot speak, the

SSI payment can be used to purchase or adapt technology so the child can communicate not only basic needs but also thoughts and ideas with family and friends.

The Academy strongly urges Congress to preserve the intent of the SSI program. The Academy is currently working on several detailed recommendations which will be provided to the Finance Committee shortly. In the interim, the Academy offers the following suggestions for improving SSI:

1. *Most families need cash assistance in addition to medical services.* Providing cash assistance only to families who would otherwise institutionalize their children, as was proposed in the U.S. House of Representatives, would provide perverse incentives to families. Ample data demonstrate that raising a child with a significant physical or developmental disability greatly increases family costs and decreases family income. Although public or private health insurance covers many medical care costs, these families face many additional costs that are paid out-of-pocket.

2. *Mental impairment listings and determination can be improved.* Part B of the current mental. impairment listings examines the impact of a condition in several behavior and related domains. Within Part B and the subsequent Individual Functional Assessment (IFA), behavior disorders with lower severity and higher prevalence, such as ADHD and personality disorders, can be the basis for allowance based on the aggregate number of domain's in which a child is assessed to have an impairment.

The "marked" impairment level specified under Part B is subjective and opens Disability Determination Service (DDS) adjudicators to assessing disabilities differently, depending upon interpretation of a child's behaviors. ADHD and other behavioral disorders are medically determinable impairments. The severity of functional deficits they cause can be measured by existing psychological and behavioral tests, some specific to the condition, or by tailoring such tests. However, the SSA criteria emphasize relatively subjective evaluation of functional limitations in several related domains (e.g., cognition, communication, motor abilities, and social abilities) for assessing mental impairments in children. Therefore, AAP suggests:

- Through the use of more rigorous and reliable measures in assessment, access to benefits for children with ADHD and related mental impairments should be substantially limited by revision of the mental impairment listings and IFA for this group.

3. *Preservation of the IFA and the "Comparable Severity" test is essential but requires improvement.* The assessment of function is an every day activity of pediatricians. Children merit opportunity for access to SSI benefits through assessment of function comparable to Residual Functional Capacity (RFC) for adults. Yet, the current IFA implementation has substantial problems for children with certain mental impairments. Therefore AAP suggests:

- Using reliable and valid measurements of functioning;
- No longer assessing across multiple domains for ADHD; and
- Requiring longitudinal data including responses to treatment for children with ADHD.

4. *The AAP recommends methods of monitoring change in need over time.*

- Continuing disability reviews for appropriate populations:
  1. Very young infants
  2. Early adolescents with determination of likely prognostic tracks
  3. Late adolescents (18-19)
- Consider time limited benefits for certain populations, especially very young infants who are likely to improve in three years.
- Consider maintaining health benefits during periods of transition from SSI

5. *Linking children. at all ages, to services is a critical component of encouraging individuals off the SSI rolls. Build in incentives to community-based programs to connect services through such avenues as:*

- Establishing or building on a system of information and referral, linked with SSA offices, through a contract with private agencies, especially parent groups;
- Connecting with State coordinating groups and integrating Title V (MCH services for children with special health care needs, special education, Medicaid, depending on the major type of the child's disability);
- Coordinating care for individual families, based on the model of the IEP through IDEA legislation. This provides a plan that sets goals and allocates responsibility for achievement to specific participants or service providers.

The newly enacted Commission on the Evaluation of Disability in Children has been charged with critically reviewing SSI and providing recommendations by November 1995. It is the strong recommendation of the American Academy of Pediatrics that the Commission be the lead in exploring the very questions the Congress identified last year related to the SSI program. In months the Commission will report to Congress a detailed review of key aspects of the SSI program including:

- the appropriate use of the current SSI definition of disability for children under age 18 and the possible need for an alternative definition;
- the feasibility of providing benefits to children through noncash means, such as vouchers, debit cards, and electronic benefit transfer systems;
- the feasibility of meeting families' needs for help with higher costs of medical care for seriously physically or emotionally disabled children by expanding federal health programs;
- the desirability and possible methods of increasing the extend to which SSI benefits are used to help children gain independence and be able to work as adults; and
- the effects of SSI on disabled children and their families.

Congress should weigh their deliberations by referencing two important studies which address key criticisms of the SSI program.

In September 1994, the Government Accounting Office (GAO) released the report *Rapid Rise in Children on SSI (GAO/HEHS-94-225).* The report focused on the growth in awards for mental impairments and awards based on the new functional assessment process established by the Supreme Court decision on *Sullivan v. Zebley* (1990).

GAO reported, "Huge increases in the number of children awarded benefits because of mental impairments—including children with mental retardation and other mental disorders such as attention deficit hyperactivity disorder—account for more than two-thirds of the growth in awards." However, the report does not support previous theories that the rapid growth of children receiving SSI is related to the new functional assessment process. Rather, the report states, "70 percent of all awards went to children whose impairments were severe enough to qualify on the basis of SSA's medical standards alone, without the need for a functional assessment. Thus, most of the children who received new awards would have qualified for them even without the functional assessment process mandated by the Zebley decision."

In October 1994, the Office of the Inspector General (IG) released an audit *Concerns about the Participation of Children with Disabilities in the SSI Pro-am (A-03-94-02602). This report focused on several concerns: 1) the rise in the number of children receiving SSI benefits as a result of the Zebley decision, 2) children with learning disabilities were inappropriately being determined eligible for SSI benefits, 3)children are being determined eligible for SSI benefits without regard to actual financial needs created by their disability.*

The IG report stated, "Under the statue, the 'intent' of the program is to provide cash assistance to children with disabilities. Our review found that the program basically achieves that purpose." A letter from Inspector General June Gibbs Brown to SSA Commissioner Shirley Chater that accompanied the report referenced the confusion with the intent of the SSI disability program for children. In the letter, Brown wrote: "If Congress intended that the SSI program provide only cash assistance to children with mental impairments, then the program is successful . . . . However, 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."

This is an issue of critical importance to the children and their families. As Congress deliberates the future of the SSI program, the Academy urges that these suggestions be taken into consideration.

ENDNOTES

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3. Perrin JM, Stein REK. Reinterpreting disability: Changes in SSI for Children. *Pediatrics,* 1991; 88:1047-1051.
4. Department of Health and Human Services. Supplemental Security Income, Determining Disability for a Child under Age 18; Final Rule with Request for Comments. 20 CFR Part 416:5534-5565, 11 February 1991.
5. Social Security Administration, Office of Research and Statistics, Fast Facts and Figures about Social Security 1992, Table 2A4.
6. The estimate of all eligible children is based on National Health Interview Survey data of children meeting SSI's disability and income criteria.
7. Gortmaker S, Sappenfield W. Chronic childhood disorders: Prevalence and impact. *Pediatric Clinics of North America* 1984; 31:3-18.

8. Hobbs N, Perrin JM, Ireys HT. *Chronically Ill Children and Their Families. San Francisco: Jossey-Bass, 1985.*

STATEMENT OF THE CALIFORNIA STATE DEPARTMENT OF SOCIAL SERVICES

My name is Eloise Anderson and I am the Director of the California Department of Social Services (CDSS). The CDSS wishes to express its appreciation for the level of Congressional interest being shown for problems and issues in the administration of the Supplemental Security Income program and the State Supplemental Payment (SSI/SSP) program. Given the growing number of recipients of SSI/SSP disability benefits in California, your interest and concern are welcome and shared by the CDSS. Following are suggestions for legislation and other reforms that we feel would cause significant improvement to the program. We are advocating these changes in federal law and administrative practices to improve the integrity of the program.

ELIMINATION OR MODIFICATION OF CASH PAYMENTS OF SSI/SSP BENEFITS FOR DISABLED CHILDREN

Federal law requires SSI/SSP disability benefits for children to be paid in the form of cash grants, as are all other SSI/SSP benefits. There have been allegations presented to Congress and the Social Security Administration (SSA) that some parents use the recipient-child's SSI/SSP funds for purposes other than meeting the child's needs. California proposes the elimination of cash benefits for disabled children. In lieu of cash benefits, other alternatives such as the modification of Medicaid or the use of vouchers should be explored.

California urges that Congress fundamentally change cash grants to children while at the same time providing alternatives that ensure access to services for disabled children. These options should safeguard services and result in cost savings to state and federal governments.

IMPLEMENT TIME LIMITATIONS ON PAYMENT OF SSI/SSP DISABILITY BENEFITS

Current federal law provides medical improvement as the test for determining whether a disability recipient is still disabled. There is no time limit placed on the period that an individual may receive benefits. At the time of adjudication, a decision is made as to whether the individual's medical condition is expected to improve, may possibly improve, or is not expected to improve. Federal law requires that a continuing disability review (CDR) be done at least every three years for nonpermanent impairments. However, unless a timely CDR is performed, the recipient can continue to receive SSI/SSP benefits indefinitely despite having a impairment that may have improved sufficiently to allow a resumption of substantial work activity.

Currently, over one-third of all allowed disability claims are based on medical impairments that are expected to improve. In 1989, SSA placed a moratorium on CDRs and allocated its limited resources to servicing the escalating number of initial disability applicants. Since that time, only a very limited number of CDRs have been reviewed: Nationally in federal fiscal year 1994, 10,743 SSI/SSP CDRs were processed. Unless an individual reported medical improvement or returned to work activity with reported income, SSI/SSP payments would continue to be provided. Although California has recently resumed CDRs on a limited basis, there is a national backlog in excess of one million overdue SSI/SSP medical reviews. Hence, many individuals continue to receive SSI/SSP benefits long after their medical conditions have improved sufficiently enough to resume work activity. States, like California, that are experiencing difficult economic times cannot afford to bear these unnecessary costs, and neither should the federal government.

California recommends that time-limited benefits be imposed on individuals who have impairments that are expected to improve. Individuals with temporary rather than life-long impairments will know exactly how long their benefits will be available, and can plan accordingly. The duration of entitlement would depend on the nature of the impairment. The SSA already has the structure in place to make such determinations as it has developed a list of impairments where medical improvement is expected. These are known as "MIE" cases. This measure would significantly decrease the number of beneficiaries who continue to receive federal and state monies inappropriately.

California believes that time-limited benefits will allow better services to the SSI/SSP population. Given SSA's staffing and funding limitations, more resources would be available for processing initial SSI/SSP disability applications and the remaining CDRs.

IMPLEMENT MORE STRINGENT CRITERIA FOR EVALUATING SSI/SSP RECIPIENTS' CONTINUING DISABILITY IN 1984, FEDERAL LAW SUBSTITUTED "MEDICAL IMPROVEMENT" FOR "CURRENT SEVERITY" AS THE TEST FOR DETERMINING WHETHER A RECIPIENT IS STILL DISABLED AT THE TIME A CONTINUING DISABILITY REVIEW (CDR) IS DONE ON HIS/HER CASE. UNDER THE PREVIOUS RULES, BENEFITS COULD BE CEASED IF THE CDR ESTABLISHED THAT THE RECIPIENT WAS NOT CURRENTLY DISABLED USING THE SAME STANDARDS AS APPLIED TO INITIAL APPLICATIONS. UNDER THE 1984 IMPLEMENTING REGULATIONS, EVEN IF IT IS ESTABLISHED THAT THE INITIAL DISABILITY DECISION WAS QUESTIONABLE, WE CANNOT TERMINATE AN INDIVIDUAL'S SSI/SSP BENEFITS UNLESS THERE HAS BEEN MEDICAL IMPROVEMENT IN THE RECIPIENT'S CONDITION. THUS, A PERSON WHO MAY HAVE BEEN INAPPROPRIATELY GRANTED ELIGIBILITY ON THE BASIS OF A QUESTIONABLE OR MINOR IMPAIRMENT, OR ON THE SUBJECTIVE DECISION OF AN ADMINISTRATIVE LAW JUDGE, CAN CONTINUE TO RECEIVE BENEFITS IF THAT IMPAIRMENT STILL EXISTS AT THE TIME OF THE CDR.

The medical improvement review standard (MIRS) has resulted in an inequitable disability standard in which a recipient may continue to receive monthly payments for the same impairment that an initial SSI/SSP applicant would have been denied benefits.

Before the implementation of the MIRS, about 35% of CDRs resulted in termination of SSI/SSP benefits, while currently only 10% of those who initially qualify are ever removed from the disability rolls. Once receiving SSI/SSP benefits, there is little incentive for recipients to attempt to return to substantial work because few are ever terminated. This has placed an inordinate burden on both the state and federal funding programs. Hence, California strongly urges Congress to establish a modified "current severity" criteria for the evaluation of continuing disability. While the MIRS should remain the main criteria for evaluating CDRs, an additional step should be included in the review process. California recommends that SSI/SSP benefits be terminated if the adjudicative team determines that the initial decision was not supported by objective findings and the impairment is not currently severe.

IMPLEMENT MORE STRINGENT CRITERIA FOR DISABILITY BASED ON MENTAL IMPAIRMENT

In August 1985, the mental impairment criteria in the federal disability regulations were liberalized. The intent of the revised regulations was to more realistically reflect the effect of functional limitations caused by a mental impairment. Unfortunately, the implementation of the law has resulted in a subtle shift in reliance from objective to subjective evidence. Since that time, there has been a significant increase in the number of approved SSI/SSP claims involving a mental impairment In 1993, approximately 50% of all approved SSI/SSP claims had a mental impairment as the primary diagnosis. The more liberalized mental impairment criteria has allowed many individuals with mild anxiety or slight behavioral or maladjustment problems to become eligible for benefits. It has also resulted in increased reports that claimants can easily exaggerate their symptoms. As previously indicated, it is difficult to remove such individuals from the disability rolls unless clear medical improvement can be documented.

California recommends that consideration be given to initiating more stringent criteria for affective disorders, anxiety-related disorders, and personality disorders. Many individuals with such impairments do retain the ability to work, but are not motivated to seek employment when disability benefits can be so easily obtained. Given the large number of SSI/SSP applicants in California who allege mental impairments, we believe that a stricter standard will significantly reduce the number of questionable allowances.

ELIMINATION OF DRUG ADDICTION AND ALCOHOLISM AS QUALIFYING DISABILITIES FOR SSI/SSP BENEFITS

The number of individuals qualifying for SSI/SSP on the basis of drug addiction or alcoholism (DA/A) has been a growing concern in California. There are currently 31,000 SSI/SSP recipients in California whose primary disabling condition is DA/A. That number is growing by as much as eight thousand annually.

Even prior to the recent amendments to SSI/SSP DA/A law, the express intent of federal statute was to require recipients to undergo appropriate treatment in order to maintain their eligibility. In theory, their disability was also to be reviewed within a year or two of entitlement for evidence of medical recovery. But what CDSS found was that the Social Security Administration (SSA) would waive the requirement for treatment if local treatment facilities were unavailable or inappropriate. Such facilities could be deemed inappropriate or unavailable if the DA/A recipient was merely required to pay for transportation to the facility or make a nominal copayment for treatment. Furthermore, the SSA had imposed a several-year moratorium on continuing disability reviews so that even if the DA/A recipient underwent treatment, his disability was not reviewed for possible recovery. We have yet to see if the *new* law's attempt to force implementation of *old* law's basic intent will meet with any greater success. However, SSA's recently released regulations to implement new DA/A provisions are not significantly different from the previous DA/A regulations. In fact, the definition of when treatment is not available is not changed at all. California's position is that SSI/SSP payments provide a source of cash which, too often, is used to feed the addiction of the DA/A recipient. As such, the SSP/SSP payments provide an incentive for the drug addict or alcoholic NOT to recover from their addiction. California recommends the elimination of this cash incentive by excluding drug addiction or alcoholism from being considered in the disability determination for SSP/SSP eligibility. The House of Representative's Ways and Means Committee's bill, HR 1214, The Personal Responsibilities Act of 1995, takes this action. California requests that the Senate do the same.

RESTORE STATE CONTROL THROUGH THE ELIMINATION OF BOTH THE PASS ALONG AND ADMINISTRATIVE FEE REQUIREMENTS

I would also like to take this opportunity to point out an overriding concern with federal laws that inappropriately restrict the states' control over their own SSP programs. The primary offenders are the federal "pass-along" law (Section 1618 of the Social Security Act) and the administrative fees law (Section 1616 of the Social Security Act). The pass-along law was originally enacted in 1976, two years after forty-three states agreed to provide SSP benefits to all SSI recipients under assurances from the federal government that the states would be permitted to control their SSP costs. Contrary to those assurances, enactment of the pass-along law took SSP fiscal control away from the states by directly linking a site's federal Medicaid funding to its maintenance of certain minimum SSP levels. The 1976 law set states' minimum SSP levels at their December 1976 amounts. The law was enacted to prevent states from reducing their SSP rates when a federal increase was provided in the SSP payment standard. While the states objected to enactment of the original pass-along law, they vociferously protested the 1983 amendment that raised the SSP rate "floor" to the levels paid in March 1983. This amendment not only further reduced states' control over their own SSP expenditures but, in California's case, locked the state into SSP rates that reflected generous SSP increases *voluntarily* provided from 1976 to 1983.

Therefore, SSA interprets the pass-along law as also precluding states from consolidating their SSP payment categories and, thus, from simplifying SSP program administration by SSA. This issue carries a multi-million dollar annual price tag for California since, effective October 1993, federal law requires states with federally administered SSP programs to pay an administrative fee to SSA. I must emphasize that the legislative history of the laws enacting SSI show the clear intent of Congress to encourage states to supplement the federal SSI payment *by allowing for federal administration of the state supplement at no cost to the states.* Despite this commitment made to the states, the administrative fees law was enacted and currently the fee is $3.33 for every check issued; the fee will increase to $5.00 per check on October 1, 1995.

This year, California will pay more than $60 million in administrative fees. But of even greater concern is the fact that the fee schedule calls for payments to increase in the future based, in part, on the administrative complexity of a State's program. California would obviously like to simplify its program and reduce its administrative costs by consolidating its nearly twenty payment categories into fewer variations. Ironically, the state is prevented from doing so by SSA's interpretation that the pass-along law requires maintenance of a state's existing SSP variations. This unfairly penalizes states with complex SSP programs which, due to federal restrictions, are unable to streamline or simplify. While California objects to the entirety of the pass-along law, California believes SSA's interpretation goes well beyond the law's express intent.

The pass-along law denies states the flexibility needed to simplify and control SSP programs, or to adjust SSP grants to affordable levels in times of economic difficulty. The administrative fees law further reneges on the original commitments that the federal government made in its efforts to entice states to augment the SSI benefit. Surely these broken promises are contrary to efforts to increase responsibility, accountability and flexibility in the states.

The House of Representative's Committee on Ways and Means has addressed the pass-along issue in HR 1214, "The Personal Responsibilities Act of 1995," by repealing the federal mandate. California requests the Senate take the same action as well as repealing the SSP administrative fee law. We also request that the Senate enact a technical amendment to resolve a related minor issue regarding cash out of food stamps for SSI recipients in California. Section 2342 9a of PL 97-35, which has not been codified in the USC, permits California to provide cash benefits in lieu of food stamp coupons for SSI recipients *if* the State maintains SSP grants at the 1983 level. To enhance state flexibility, this mandate, too, must be repealed. California respectfully proposes repeal of the pass-along law and the repeal of the SSP administrative fees law.

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