United States General Accounting Office

GAO

Report to Congressional Requesters

May 1994

SOCIAL SECURITY

Major Changes Needed for Disability Benefits for Addicts

GAO/HEHS-94-128

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-253838

May 13, 1994

The Honorable Andy Jacobs, Jr., Chairman
The Honorable Jim Bunning, Ranking Minority Member
Subcommittee on Social Security
Committee on Ways and Means
House of Representatives

The Honorable Harold Ford, Chairman
The Honorable E. Rick Santorum, Ranking Minority Member
Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives

Recent media reports as well as February 1994 hearings held by your committees[1] have raised several issues concerning disability benefit payments to addicts, including (1) the alarming increase in the number of addicts receiving benefits, (2) the need for tighter controls on benefit payments, and (3) the desirability of restructuring the program to improve the payoff from treatment. As you requested, we have assessed the effectiveness of Social Security Administration (SSA) controls over disability payments made to drug addicts and alcoholics (addicts).

Addicts may receive disability payments under SSA's Disability Insurance (DI) and Supplemental Security Income (SSI) programs. Both programs have the same disability criteria. State agencies called disability determination services (DDSs) determine whether applicants meet the criteria.

You expressed particular interest in payments to certain addicts under SSI. By law, these individuals must participate in treatment—when appropriate treatment is available—for their addiction and have a representative payee or third party manage their benefits as a condition of receiving disability benefits. These requirements provide the framework for SSA's drug addiction and alcoholism (DA&A) program. According to SSA, addicts required to participate in the program are those who qualify for disability because of their addiction. You also sought our recommendations for improving SSA's controls over payments to addicts in general.

[1]Joint hearings were held on February 10, 1994. GAO testimony was titled Disability Benefits for Drug Addicts and Alcoholics are Out of Control (GAO/T-HEHS-94-101).

In doing our work, we analyzed SSA's computerized SSI and DI records an interviewed SSA headquarters and regional officials. We also visited drug and alcohol treatment facilities and organizations under contract with SS to monitor the treatment of addicts receiving benefits. Appendix I inclu additional details on our objectives, scope, and methodology.

Results in Brief

The number of addicts receiving disability benefits has grown substanti in the last 5 years—from fewer than 100,000 to about 250,000 currently.[2] The cost of providing disability benefits to the current addict populatior about $1.4 billion per year.

The vast majority of addicts receiving disability benefits are either not i treatment or their treatment status is unknown. Although the 78,000 addicts in the SSI DA&A program are required to attend treatment, becaus of poor monitoring by SSA, only about 1 in 5 are in treatment. The remaining addicts are not required to attend treatment, and SSA does no know their treatment status.

About 100,000 addicts have not been assigned a third-party or representative payee to manage their benefits. Consequently, SSA has no assurance that these individuals are not using their benefit checks to bu drugs or alcohol. But, in many cases when payees have been assigned, how tightly they control benefit payments is questionable. Most of these payees are relatives or friends. Because addicts can abuse, threaten, an otherwise pressure their payees, we believe that organizations would make better payees for addicts than friends or relatives. Organizational payees, such as those under contract with SSA to monitor addicts' treatment, would be better positioned to provide the tight controls need over benefit payments.

We believe that SSA needs to act to ensure that all DA&A recipients are in treatment and that all addicts have a third-party or representative payee Also the Congress needs to consider expanding the treatment requirem to all addicts and restructuring the program to improve the payoff from treatment.

Background

Eligibility for disability benefits involving drug or alcohol addiction is determined like any other medical disorder. Benefits are awarded to th

[2]In commenting on a draft of this report, SSA said that our estimate "most likely does not reflect t true number" of addicts. We agree and, as discussed in this report, believe it is likely greater than 250,000.

who cannot work and whose physical or mental impairment is expected to last for at least 12 months or result in death. The impairment must be established by medical evidence consisting of symptoms, signs, and laboratory findings. Those awarded benefits are to be periodically reviewed to determine whether they are still disabled.

About 250,000 addicts receive disability benefits under the DI and SSI programs at an annual cost of about $1.4 billion. More than half of these addicts qualify for benefits on the basis of medical problems in addition to their addictions. For example, an addict may be eligible for benefits because of acquired immunodeficiency syndrome (AIDS) or disabling medical problems associated with heart disease or cancer. But all these people have addictions severe enough that the condition is included as a part of their diagnosis. Other addicts qualify solely on the basis of addiction, which by itself can be a disabling medically determinable impairment.

Under the SSI program, addicts who qualify for benefits on the basis of their addiction are required by law to get treatment for their addiction and have a third-party or representative payee manage their benefits. These addicts are included in the SSI DA&A program and are those who would not qualify for disability if their addiction ended. The DI program has no similar requirements.[3]

The objective of the SSI DA&A program is to rehabilitate addicts to be productive members of society and remove them from the SSI disability rolls. As of December 1993, the program had about 78,000 addicts.[4]

The average age of the SSI DA&A recipients is 42, the majority are male, blacks outnumber whites, and more suffer from alcoholism than from drug abuse. Benefit payments to these individuals amount to about $285 million annually.

SSA arranges for representative payees to manage the benefits of SSI recipients put into the DA&A program. SSA also is responsible for treatment referral and monitoring. In some states—18 by the end of 1993—SSA sends the case to a referral and monitoring agency or RMA. RMAs are state government or private organizations that arrange treatment for DA&A

[3]Under the DI program, DI beneficiaries are not required to attend treatment. However, when claimants have been determined to be incapable of managing benefits or legally incompetent, SSA assigns representative payees for them.

[4]The analyses in this report are based on the SSI DA&A caseload of 69,419 at the end of August 1993.

recipients, monitor treatment participation, and report to SSA on treatme status, including noncompliance.

The types of treatment for SSI DA&A recipients can range from intensive inpatient care to outpatient care in informal support group settings. Dat are not available on the types of treatment provided specifically for SSI DA&A recipients. In general, however, the vast majority of treatment for addiction in this country is provided on an outpatient or ambulatory bas rather than through an inpatient or residential program.

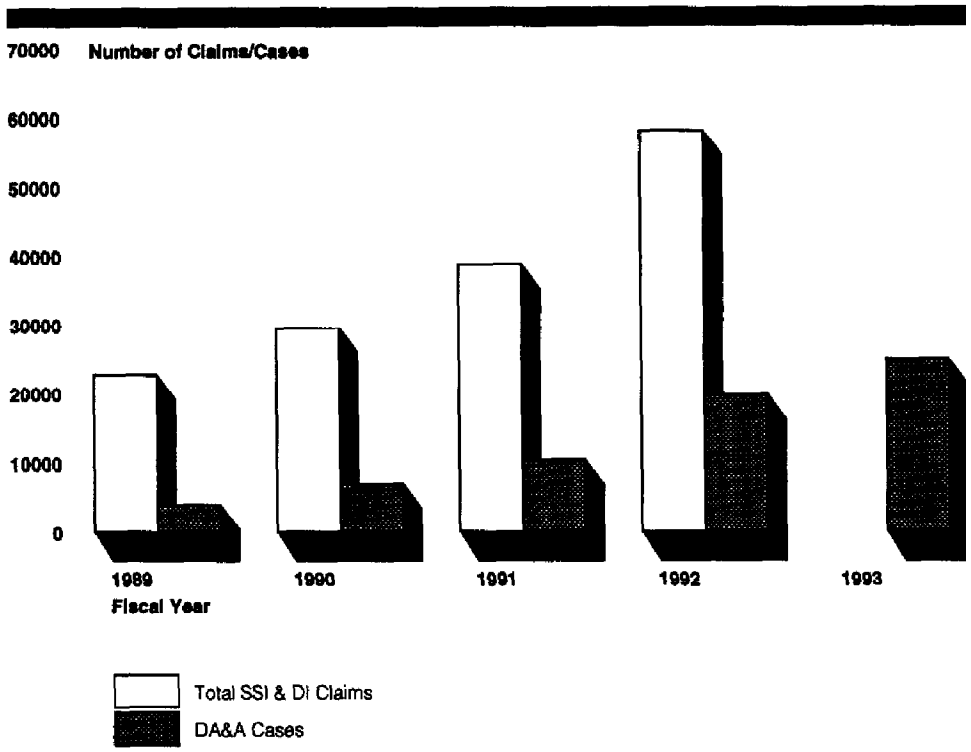
Exactly who pays for what types of treatment for SSI DA&A recipients is n known. SSA is not permitted to pay for treatment nor can the addict be required to pay for it. Some services are covered by state Medicaid programs, but states vary greatly in the type, amount, duration, and scop of services provided. How much money state Medicaid programs spend treatment is generally not known because states do not keep specific records on payments made on behalf of addicts or other subpopulations In general, most treatment for addiction in this country is paid for by fur from federal block grants and state and local governments.

Substantial Growth in Program Rolls

The number of addicts receiving SSI and DI disability benefits has increas significantly in recent years, totaling over 250,000 people today. See appendix II for information on the number of addicts receiving benefits the 50 states and the District of Columbia.

Five years ago, fewer than 100,000 addicts were on the rolls. The DA&A population has also grown substantially. From December 1989 through August 1993, the number increased from about 17,000 to about 70,000—more than a fourfold increase in the 4-year period. The annual growth in allowances with addiction diagnoses and DA&A cases is illustrated in figure 1.

Figure 1: Disability Claims Allowed Annually With an Addiction Diagnosis Compared With Increases in DA&A Cases (1989-93)



Note: Number of claims allowed with addiction diagnoses is not available for 1993.

Many possible explanations exist for these increases, including increased SSI outreach and cutbacks in state general assistance programs that have resulted in more SSI applications. However, the extent to which these and other factors contribute to the increase is not known.

While the number of individuals with addiction diagnoses has increased significantly in recent years, the number of such individuals receiving benefits remains relatively small in comparison with all individuals receiving disability benefits. People diagnosed with addiction account for about 4.8 percent of the adult SSI population while DA&A recipients represent about 2.6 percent. Similarly, DI beneficiaries who are diagnosed with addiction represent about 2.8 percent of the adult DI population.

The Treatment Status of the Vast Majority of Addicts Is Unknown

Except for some of the addicts in the DA&A program, SSA does not know whether the vast majority of addicts are in treatment. About two-thirds of SSA's addict population is not required to attend treatment as a condition for receiving benefits. With respect to addicts in the DA&A program for whom treatment is a requirement, relatively few are in treatment.

SSA has poorly monitored compliance with the treatment requirement for addicts in the DA&A program. While SSA can monitor treatment status through its computerized records and through RMA reporting, both methods are deficient. According to SSA records, only about 9 percent of the DA&A recipients are in treatment. The remainder are not in treatment (7 percent) or their treatment status is unknown (84 percent). This same situation was reported by the Department of Health and Human Services' (HHS) Inspector General in a 1991 report.

Although about 85 percent of the DA&A population (60,000) is in those states with RMAs, as mentioned earlier, SSA had established RMAs in only 1 states through 1993. For those states without RMAs, SSA regional offices were to assume responsibility for treatment monitoring. According to SSA however, no evidence exists that the regions monitored treatment.

Of the addicts living in states with RMAs, however, RMAs report that only half of them (30,000) are being monitored, and only half of these (about 15,000) are in treatment. Data are not available to explain why the treatment status of the remaining 30,000 DA&A recipients in the RMA states is not being monitored. Two possible reasons are that (1) SSA lacks the necessary funding for the RMAs to monitor all DA&A recipients and (2) appropriate treatment may not be available.[5]

Adequate Monitoring by RMAs Is Needed in All States

The absence of RMA monitoring in most states may have contributed to th underreporting of addiction diagnoses and DA&A recipients. Also, inadequate monitoring may have contributed to the relatively poor outcomes under the DA&A program. SSA is taking steps to correct these shortcomings.

Underreporting of addiction diagnoses and DA&A recipients in the states without RMAs may occur because SSA and the state DDSs apparently have given a low priority to identifying these cases. California, for example, ha an RMA and had about 26,000 DA&A recipients, while populous states

[5]Where appropriate treatment is not available, RMAs do not actively monitor these cases. In fiscal ye 1993, the 18 RMAs reported about 400 cases where treatment was not available.

without RMAs, such as Texas and Florida, had only 365 and 543 DA&A recipients, respectively. Only 38 DA&A recipients were reported for the District of Columbia, which has no RMA.

In the states with RMA monitoring, little evidence exists of positive outcomes. For example, during 1993, the RMAs reported that, on average, only 75 addicts successfully completed treatment each month. During this same period, the rolls of the DA&A program were increasing by about 2,000 addicts a month.

Moreover, the successes reported by the RMAs are not necessarily examples of rehabilitation and removal from the SSI rolls. Rather, they reflect completion of a specific treatment plan. SSA does not know how many addicts in the SSI DA&A program have been removed from the disability rolls due to rehabilitation. Also, the SSI DA&A program refers few addicts for vocational rehabilitation.

SSA is establishing RMA monitoring in all 50 states and the District of Columbia. We believe this move, while belated, is nonetheless a good one. An SSA study showed that—in comparison with a control group that did not receive RMA monitoring—the RMAs accomplished their basic mission of keeping addicts in treatment. However, as evidenced by the inadequate monitoring in RMAs, simply establishing RMAs does not necessarily guarantee that all addicts will be monitored, much less get treatment.

SSA, in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA), has initiated two demonstration projects in the states of Washington and Michigan to improve the DA&A program. Both projects are attempting to enhance case management and to develop improved referral and monitoring procedures that could be applied in other states.

Effectiveness of the Current Representative Payee Requirement Is Questionable

While virtually all addicts in the DA&A program have representative payees, many other addicts do not have payees. We estimate, for example, that about 100,000 of the 250,000 addicts receiving SSI and DI disability benefits do not have payees.

Finding qualified payees for addicts has been a long-standing problem for SSA. Payees are generally unpaid volunteers.[6] These circumstances,

[6]SSA is currently carrying out a demonstration program in which qualified organizations can be paid up to $25 per month for acting as a representative payee. The beneficiary pays the fee.

coupled with the potential for incurring abuse or threats from addicts, make finding representative payees difficult for SSA. When addicts have payees, the vast majority of them are relatives or friends.

Studies in general have shown that, in those cases in which payees are present, how tightly they control benefit payments is questionable. In the absence of tight controls, addicts are free to purchase drugs and alcohol t maintain their addictions. This situation leaves the government open to charges of "enabling" because the benefit payments give addicts the mea to support their addictions.

Little data exist on how well representative payees control benefit payments for addicts. However, anecdotal data, including previous testimony before the Social Security and Human Resources Subcommittees, suggest that the representative payee requirement is not working well. A previous SSA study of the addict population found payee controls to be lax in many cases, particularly when addicts' friends were the payees.

This study also showed that organizational payees such as RMAs and treatment facilities tended to provide the most control. We believe that organizational payees would be better positioned to implement the stringent controls needed over benefit payments to addicts. The reason f this is that organizations can more effectively deal with situations in whi addicts are abusive or threatening.

We believe SSA should use organizations as representative payees to the maximum extent possible. One way to expand the use of organizations is to use RMAs to provide payee services. Making RMAs the payees would consolidate case management functions, including treatment monitoring and money management.

As with addicts in the DA&A program, we also believe the representative payee requirement should be applied to all SSI and DI addicts. The nature such beneficiaries' medical problems suggests that SSA should require representative payees for all addicts receiving benefits. This is not the ca now. In fact, no regulatory or programmatic requirement exists for addic not in the DA&A program to have representative payees. The public must have confidence that these benefit payments are being used for the basic program purposes of food, clothing, and shelter.

Reexamination of the DA&A Program Needed

The DA&A program has not changed since the SSI program began more than 20 years ago. While the fundamental structure of the program is sound—that is, requiring addicts to have a representative payee and attend treatment—a rethinking of the program is long overdue.

First of all, benefit payments to addicts should be examined in a broader context. The DA&A program as currently structured applies only to about one-third of the addicts currently receiving DI and SSI disability benefits. As noted earlier, we believe that all addicts should be required to have representative payees. We also believe that the Congress should consider expanding the DA&A treatment requirement to all addicts who receive DI and SSI disability benefits.

Several other reform proposals were disclosed in a February 10, 1994, joint hearing before the Subcommittees on Social Security and Human Resources, Committee on Ways and Means. These proposals include the following:

- requiring addicts to complete 3 months of treatment before they are eligible to receive benefits;
- providing addicts vouchers instead of cash for buying essentials such as food, clothing, and shelter; and,
- establishing a "bridge" for addicts who are "cured" of their addiction, possibly a continuation of benefits in decreasing amounts.

Conclusions

SSA payments to addicts are out of control. The number of addicts is increasing at an alarming rate for reasons that are not well understood. The requirements for treatment are not being complied with or properly monitored. And there is little assurance that benefit payments are being used for the basic necessities rather than for the purchase of drugs and alcohol. SSA needs to take immediate action to deal with these problems, and the Congress needs to tighten controls for both the SSI and DI programs as they relate to drug addicts and alcoholics.

In the short term, SSA needs to place RMAs in all states and strengthen RMA monitoring to assure that all DA&A recipients in pay status are accounted for and monitored as required. Also, SSA needs to expand and strengthen representative payee monitoring.

It is clear that more effective treatment referral and monitoring must occur with the current DA&A population. SSA needs to work closely with the

RMAs and SAMHSA to better identify the treatment needs of these addicts and to see that they receive appropriate services.

Over the longer term, the Congress needs to consider expanding the treatment requirement of the DA&A program to include all addicts receivin DI and SSI disability benefits. Also, the Congress should rethink the program design to improve the payoff from treating addicts.

Recommendations to the Secretary of HHS

The Secretary should direct the Commissioner of SSA to strengthen controls over disability benefits paid to addicts in the following ways:

- establish RMAs in all states,
- take appropriate measures to ensure that all DA&A recipients are in treatment and accounted for and monitored as required,
- require all addicts receiving SSI and DI benefits to have representative payees, and
- use organizational payees for addicts to the maximum extent possible an consider making the RMAs representative payees.

Matters for Consideration by the Congress

The Congress should consider expanding the treatment requirement to al addicts and restructuring the program to improve the payoff from treatment.

Agency Comments

By letter dated April 15, 1994, SSA agreed that it had not done well in administering the SSI DA&A program but stated that it is initiating changes to meet this responsibility.

Concerning our recommendations to improve monitoring, SSA stated that all states and the District of Columbia would have RMAs by the end of this year. With respect to our recommendation that all DA&A recipients be in treatment, accounted for, and monitored, SSA said that monitoring does n guarantee that all individuals will get treatment because appropriate treatment—free to the recipient—must also be available. We continue to believe that the status of all DA&A recipients should be monitored and tha this is fundamental to ensuring that these individuals attend treatment. Further, while SSA has no data on the status of the 30,000 individuals not being monitored in RMA states, lack of appropriate treatment is not likely major reason for this. In fiscal year 1993, for example, the RMAs reported that appropriate treatment could not be found for only 400 DA&A recipien

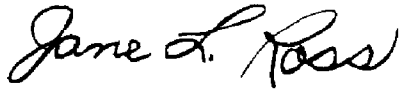
SSA also said that the report implies that it has a greater role than ensuring that the SSI DA&A recipients are in treatment and is failing in this duty. We disagree. The report clearly states that currently SSA is only required to assure that DA&As are in treatment and asks the Congress to consider extending the treatment requirement to all addicts on the DI and SSI rolls.

With respect to our recommendations to strengthen and expand the representative payee program for addicts, SSA said that immediately expanding the SSI DA&A criteria to DI beneficiaries would be costly and it is difficult to find payees. We know that these changes cannot be made overnight and will take time to fully implement. But we believe that this further supports that SSA act now to develop a plan to ensure that these addicts are eventually assigned payees. Concerning our recommendation requiring payees for all other addicts receiving DI and SSI benefits, SSA indicated that it did not want to require that all addicts have payees and that these decisions should be decided on a case-by-case basis. We disagree. Because an individual is an addict seems to us sufficient justification to warrant assigning a representative payee. Further, this is the same basic rationale for the legislative requirement for assigning payees under the SSI DA&A program. SSA agreed that organizational payees are generally preferable for DA&A recipients. Moreover, it agreed with our recommendation that RMAs be considered as organizational payees.

SSA also made a number of technical comments, which we incorporated as appropriate. SSA's comments in their entirety appear in appendix III.

We are providing copies of this report to the Director of the Office of Management and Budget; the Secretary, HHS; the SSA Commissioner; and to other congressional committees with an interest in this matter. We will also make copies available to others upon request.

Please contact me on (202) 512-7215 if you have any questions about this report. Other major contributors to this report are listed in appendix IV.



Jane L. Ross
Associate Director
Income Security Issues

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Abbreviations

AIDS	acquired immunodeficiency syndrome
DA&A	drug addiction and alcoholism program
DDS	disability determination service
DI	Disability Insurance
HHS	Department of Health and Human Services
RMA	referral and monitoring agency
SAMHSA	Substance Abuse and Mental Health Services Administration
SSA	Social Security Administration
SSI	Supplemental Security Income

Objectives, Scope, and Methodology

Our primary objectives were to assess the (1) effectiveness of eligibility restrictions that the Social Security Act places on drug addicts and alcoholics who receive disability benefits under the SSI DA&A program and (2) adequacy of controls over payments to addicts in general.

In conjunction with our primary objectives, we were asked to provide information on addicts in both the SSI and DI programs, including, but not limited to their numbers and medical diagnoses, the presence and types c representative payees, and their treatment status. In addition, we were asked to answer several questions on the types and financing of treatmer provided to addicts in the SSI DA&A program.

We analyzed selected data from SSA's computerized master files for SSI recipients and DI beneficiaries who were addicts in current payment status. We also extracted data from SSA's computerized 831 files, which provide data on claims on a calendar-year basis.

Data on SSI addicts were extracted from the computer records on August 1993, and data on the DI addicts were extracted on September 9, 1993. Th 831 files were analyzed for the years 1988 through 1992. Calendar year 1993 data were not available at the time of our review. Because the mast computer files show only primary medical diagnoses, we used the 831 da primarily to estimate the number of addicts with substance abuse as a secondary medical diagnosis.

We interviewed disability program officials at SSA Headquarters and in SSA's Chicago, Dallas, San Francisco, and Seattle regional offices. We visited treatment centers in Oakland, California, and in the Seattle, Washington, area. We also visited referral and monitoring agencies in California, Washington, Pennsylvania, and Maryland. In addition, we obtained data from the RMA in Chicago, Illinois, and various SSA field offices in the Chicago, San Francisco, and Seattle regions.

Our work was performed between July 1993 and February 1994 in accordance with generally accepted government auditing standards.

Number of Addicts by State

State	Grand Totals	Substance Abuse Diagnoses				
			SSI Non-DA&A		DI Non-DA&A	
		SSI DA&As[a]	Primary[b]	Secondary[c]	Primary[b]	Secondary[c]
Alabama	**3,953**	397	284	1,847	344	1,081
Alaska	**345**	134	26	85	40	60
Arizona[d]	**2,593**	672	207	455	429	830
Arkansas	**2,074**	154	97	1,027	168	628
California[d]	**34,935**	23,561	3,564	211	3,613	3,986
Colorado	**3,306**	291	206	1,250	226	1,333
Connecticut	**3,715**	190	193	918	283	2,131
Delaware	**517**	26	16	109	26	340
District of Columbia	**920**	37	50	583	17	233
Florida	**13,728**	465	430	7,088	544	5,201
Georgia	**8,332**	484	480	3,387	463	3,518
Hawaii[d]	**957**	209	30	158	95	465
Idaho	**536**	98	47	195	54	142
Illinois[d]	**27,723**	11,643	3,302	2,102	3,705	6,972
Indiana	**5,130**	957	666	845	901	1,761
Iowa	**1,539**	195	54	411	118	761
Kansas	**1,721**	100	84	628	188	721
Kentucky	**6,374**	912	601	3,029	481	1,351
Louisiana	**2,259**	189	264	1,228	199	379
Maine	**1,615**	284	125	225	235	746
Maryland[d]	**2,472**	604	225	408	300	935
Massachusetts	**9,287**	1,679	1,270	2,066	1,124	3,148
Michigan[d]	**14,524**	6,315	662	2,018	1,853	3,676
Minnesota[d]	**5,171**	1,992	308	552	761	1,558
Mississippi[d]	**1,547**	177	192	363	188	627
Missouri	**3,586**	524	115	927	331	1,689
Montana[d]	**985**	222	46	389	82	246
Nebraska[d]	**1,091**	107	22	379	73	510
Nevada[d]	**1,174**	273	73	137	221	470
New Hampshire	**719**	26	37	182	64	410
New Jersey[d]	**4,759**	366	442	1,770	418	1,763
New Mexico	**1,270**	177	121	609	136	227
New York[d]	**15,536**	2,887	2,456	5,006	1,668	3,519
North Carolina	**6,215**	388	275	2,493	413	2,646
North Dakota	**870**	81	9	436	55	289
Ohio[d]	**9,086**	1,91	968	2,749	1,064	2,386

(continued)

Appendix II
Number of Addicts by State

State	Grand Totals	Substance Abuse Diagnoses				
			SSI Non-DA&A		DI Non-DA&A	
		SSI DA&As[a]	Primary[b]	Secondary[c]	Primary[b]	Secondar
Oklahoma	**2,369**	167	117	1,372	126	5
Oregon	**2,799**	618	159	573	324	1,1
Pennsylvania[d]	**7,657**	1,849	713	2,141	742	2,2
Rhode Island	**1,290**	96	67	499	83	5
South Carolina	**2,271**	167	137	1,176	201	5
South Dakota	**1,220**	127	24	751	53	2
Tennessee[d]	**4,962**	1,593	591	816	798	1,1
Texas	**6,833**	319	274	3,425	402	2,4
Utah	**1,250**	87	74	527	89	4
Vermont	**606**	90	57	127	74	2
Virginia	**3,054**	516	177	769	382	1,2
Washington[d]	**5,003**	1,941	312	523	662	1,5
West Virginia	**2,108**	572	218	386	304	6
Wisconsin[d]	**6,755**	2,524	390	1,137	928	1,7
Wyoming	**458**	19	11	252	17	1
Total	**249,199**	**69,419**	**21,268**	**60,739**	**26,065**	**71,7**

[a]SSI DA&A recipients in current payment status as of August 2, 1993.

[b]Number of addicts in current payment status as of August 2, 1993, (SSI) and September 23, 1993 (DI).

[c]Estimated number of addicts based on claims allowed during the years 1989 to 1992 and the relationship between those with primary diagnoses of substance abuse versus those with secondary diagnoses of substance abuse.

[d]States (18) with RMAs as of December 31, 1993.

Comments From the Social Security Administration

THE COMMISSIONER OF SOCIAL SECURITY
BALTIMORE, MARYLAND 21235

April 15, 1994

Joseph F. Delfico
Director
Income Security Issues
U.S. General Accounting Office
1 Massachusetts Avenue
Room 400 National Guard Building
Washington, D.C. 20548

Dear Mr. Delfico:

Enclosed is our response to the General Accounting Office draft report, Social Security: Major Changes Needed for Disability Benefits Paid to Drug Addicts and Alcoholics. If we can be of further assistance, please let us know.

Sincerely,

Shirley S. Chater
Commissioner
of Social Security

Enclosure

COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT, "SOCIAL SECURITY: MAJOR CHANGES NEEDED FOR DISABILITY BENEFITS PAID TO DRUG ADDICTS AND ALCOHOLICS" (GAO/HEHS-94-128)

Thank you for the opportunity to comment on the General Accounting Office (GAO) draft report regarding proposed changes to the drug addicts and alcoholics (DA&A) provisions. We agree that SSA has not done well thus far in administering the SSI DA&A requirements, and we are initiating changes designed to fulfill our responsibilities. However, we have a number of concerns about the recommendations that are contemplated, as well as the way the information in the report is presented. Our concerns about each of the recommendations to the Secretary follow.

GAO Recommendation to the Secretary of Health and Human Services (HHS)

The Secretary of HHS should direct the Commissioner of SSA to strengthen controls over disability benefits paid to addicts in the following ways:

1. Establish referral and monitoring agencies (RMA) in all states.

2. Take appropriate measures to ensure that all DA&A are in treatment and accounted for and monitored as required.

3. Require all addicts receiving supplemental security income (SSI) and disability insurance (DI) benefits to have a representative payee; and

4. Use organizational payees for addicts to the maximum extent possible and consider making the RMAs the representative payee.

SSA Comments

Establish RMA's in all states

In the Commissioner's statement for the record of the February 10, 1994 joint hearing held before the House of Representatives Committee on Ways and Means, Subcommittee on Social Security and Human Resources, she stated, "SSA has taken major steps to improve referral and monitoring services. SSA has developed a contract process structured to require each RMA contractor to perform numerous specified tasks that will assure both better service to SSI recipients and greater management oversight on SSA's part of the referral and monitoring process." RMA contracts are now in place in 33 States (and should be in all 50 States by the end of this year). SSA is implementing substantial initiatives to improve the DA&A RMA process.

Take appropriate action to ensure that all DA&As are in treatment and accounted for and monitored as required

Under the Act, SSA is authorized to require only that SSI DA&As are in treatment and then only "so long as such treatment is available." The monitoring that SSA is currently required to do is limited to monitoring those who are receiving treatment because treatment is available. The draft report appears to imply that SSA has a greater duty and is failing to carry out this duty.

The statement that DA&A recipients are not in treatment because of poor monitoring is misleading. While improved monitoring is the first step towards increasing treatment enrollment, monitoring alone will not result in treatment of all DA&As. Appropriate treatment must also be available at no charge to the recipient. If treatment is not appropriate or available, monitoring will not change recipient status. We suggest omitting "Because of poor monitoring by SSA...." We recommend the draft report should be revised to state with greater clarity the limits of SSA's current authority.

Require all addicts receiving SSI and DI benefits to have a representative payee

Because of resource limitations and the difficulty of finding payees for DA&A beneficiaries, we are concerned about immediately extending the representative payee requirement to all DI beneficiaries whose substance abuse is material to the finding of disability. Based on our past experience, we believe it would be costly and difficult to find and maintain representative payees for substantial numbers of additional DA&A beneficiaries. This increased cost would result not only because of the usual workload associated with selecting and monitoring representative payment, but also because of the more frequent changes of payees with regard to addicts.

Individuals entitled to title II benefits, or wholly disabled due to some other impairment, are not required by law to have a representative payee as are the title XVI beneficiaries due to their addiction. Instead, for these beneficiaries, we make independent decisions about their ability to handle funds. SSA should also retain the option of individual payee if no organizational payee is available.

Use organizational representative payees for addicts to the maximum extent possible and consider making the RMAs the representative payee.

We agree that organizational payees are generally preferable for beneficiaries who are DA&As. Organizational payees may be in a better position to avoid intimidation and manipulation by the beneficiary in an attempt to obtain cash, which can be used to support their addiction.

Further, we agree that consideration should be given to selecting the RMA as representative payee for DA&A beneficiaries. This would link financial management to case management and treatment.

However, we do not believe that nonorganizational representative payees should be precluded since there are likely to be situations in which no local organization or agency is available to act as payee. Despite extensive payee outreach in recent years and the temporary provision that permits qualified social service agencies to collect a fee for representative payee services, there has been little increase in the number of available agency payees. In addition, expiration of the fee for service provision on July 1, 1994 will further reduce the incentive for agency participation.

Other Comments and Observations

On page 2, first paragraph, second sentence--please insert "when appropriate and available" before "for their addiction."

On page 5, first full paragraph." We suggest the following changes. First sentence--insert "active" after "basis of their," and insert "if available and appropriate" before "for their addiction." Second sentence--substitute "substance abuse" for "addiction." Third sentence--substitute "legal provisions" for "requirements."

Page 5, second paragraph--We suggest that the first sentence should read, "The objective of the SSI-DA&A program is to *encourage* rehabilitation of addicts...."

Page 5, footnote 2, second sentence--replace "However, at its discretion, SSA can and does assign representative payees..." with "However, when claimants have been determined to be incapable of managing benefits or legally incompetent, SSA assigns representative payees for them."

Page 10, last paragraph, second sentence--it would be helpful. to describe what it meant by a poor outcome." Also, speculation that inadequate monitoring may contribute to poor outcomes under the DA&A program seems to contradict the information on page 11 about claimants who have been monitored.

Page 12, first paragraph, last sentence--there is also no guarantee that treatment will result in rehabilitation.

Page 12, third paragraph, first sentence--we suggest changing "many other addicts do not have payees" to "other addicts are not required to have payees."

Page 13, first paragraph, before "These circumstances"--we suggest including a statement that claimants have the right to request a new payee and to appeal SSA's selection of payee.

Estimated Number of Addicts

Finally, the report estimates 250,000 addicts are receiving disability benefits. We understand that this number was derived not from any indepth study, but from assumptions based on the number of beneficiaries with a diagnostic code indicating substance addiction. Since SSA has not historically done a thorough job of coding these cases for title XVI (and has had no reason to systematically code them for title II), this estimate most likely does not reflect the true number of beneficiaries with substance addictions.

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