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SUPPLEMENTAL SECURITY INCOME

Recent Growth in the Rolls Raises Fundamental Program Concerns

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the growth of the Supplemental Security Income (SSI) rolls and changes in the characteristics of SSI recipients. Last year, the Social Security Administration (SSA) paid nearly $22 billion in federal benefit payments to about 6.3 million aged, blind, and disabled SSI recipients. Since 1986, benefit payments have increased by $13.5 billion, more than doubling. Benefits for the disabled accounted for almost 100 percent of this increase.

As figure 1 shows, before the mid-1980s, the number of all SSI recipients was relatively flat and decreasing for the aged. Since 1986, the number of disabled SSI recipients under age 65 has increased an average of over 8 percent annually, adding nearly 2 million younger recipients to the rolls, while the number of aged and blind recipients has remained level.

The trend toward younger beneficiaries receiving SSI, coupled with low exit rates from the program, means that costs will continue to burgeon in the near term. Without a slowing in the growth of this younger population, SSI will become even more costly in the long term.

Since 1991, three groups have accounted for nearly 90 percent of SSI's caseload growth. For each group--disabled children, legal immigrants, and adults with mental impairments--the rate of growth significantly outpaced the growth rate for all other SSI recipients. Of the 2 million mentally disabled adults, roughly 100,000, or 5 percent, are disabled principally by drug addiction or alcoholism.

My remarks today are based on GAO's recent work on disabled children, immigrants, and substance abusers. Figure 2 shows the dramatic growth in these groups as well as rough projections through the year 2000. More specifically, I will focus on trends in caseloads for each of these populations and explain what we know about the reasons for past and expected growth in these populations. Then I will close with some observations about fundamental program concerns that growth in these populations raises.

BACKGROUND

SSI provides the minimum income to needy aged, blind, and disabled persons. Congress established SSI in 1972 to replace federal grants to state-administered programs serving these populations. The grants varied substantially by state in benefit levels and eligibility requirements. The Congress intended SSI to supplement the Social Security insurance programs for those who had not earned a minimal Social Security benefit; Social Security benefits are also available to the blind and disabled as well as the aged. SSI benefits are paid from federal general revenues and are provided to people whose income and resources are below certain

Figure 1: Number of SSI Recipients

by Eligibility Group

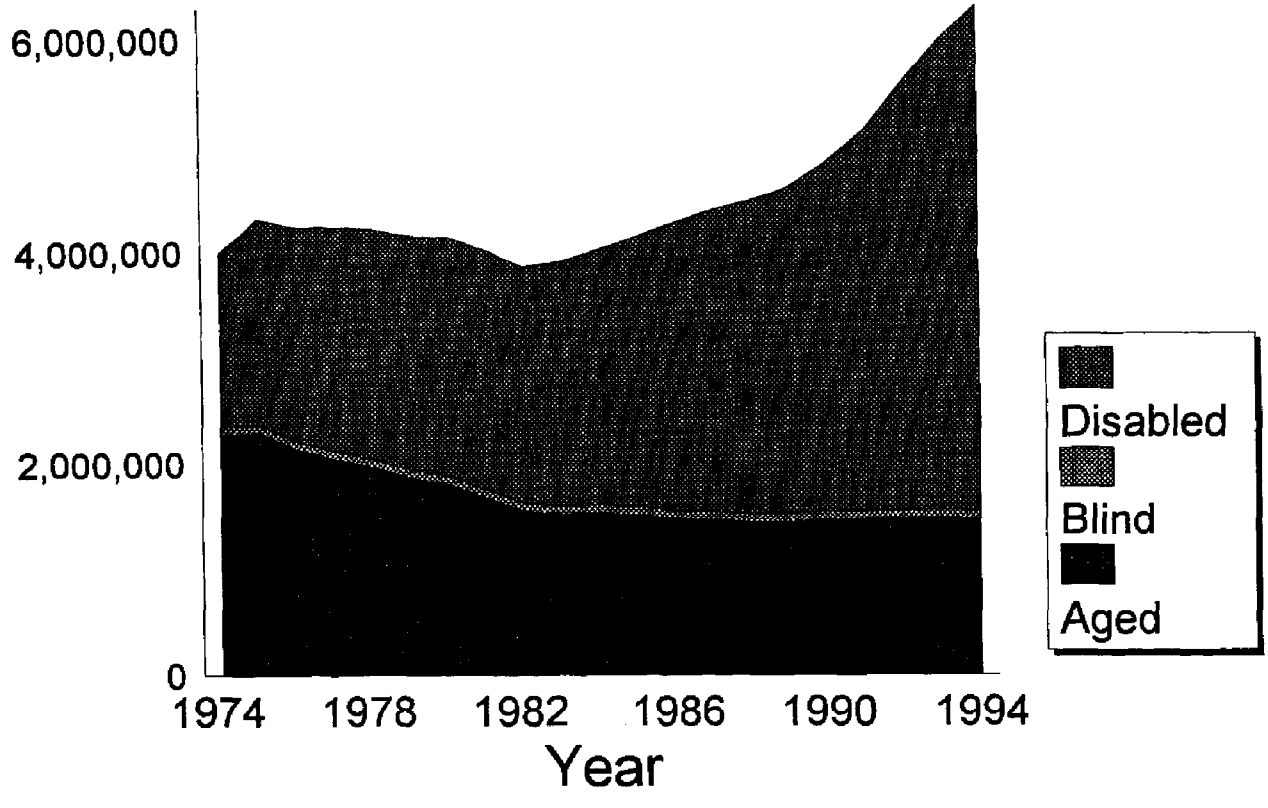
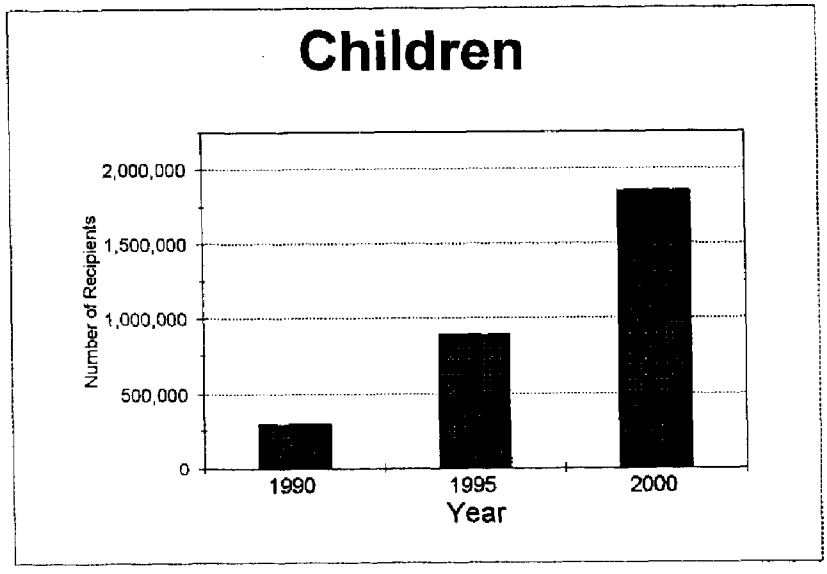
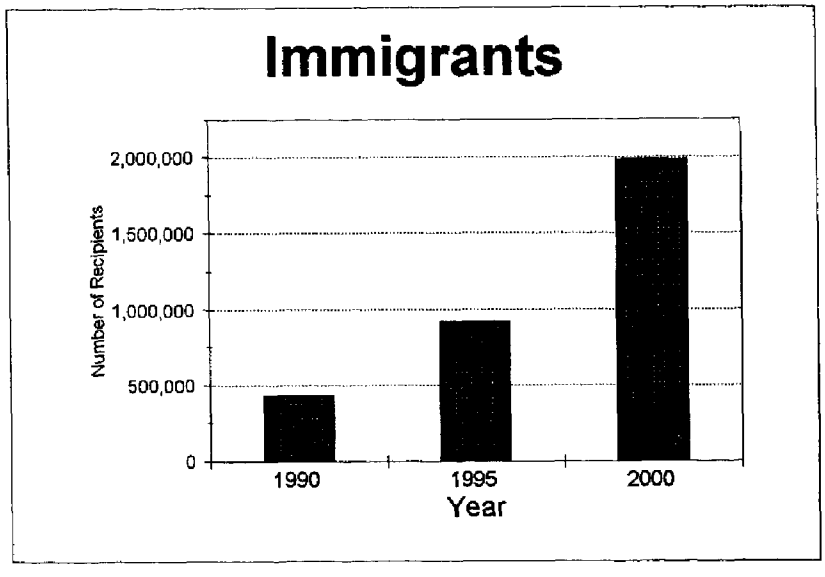
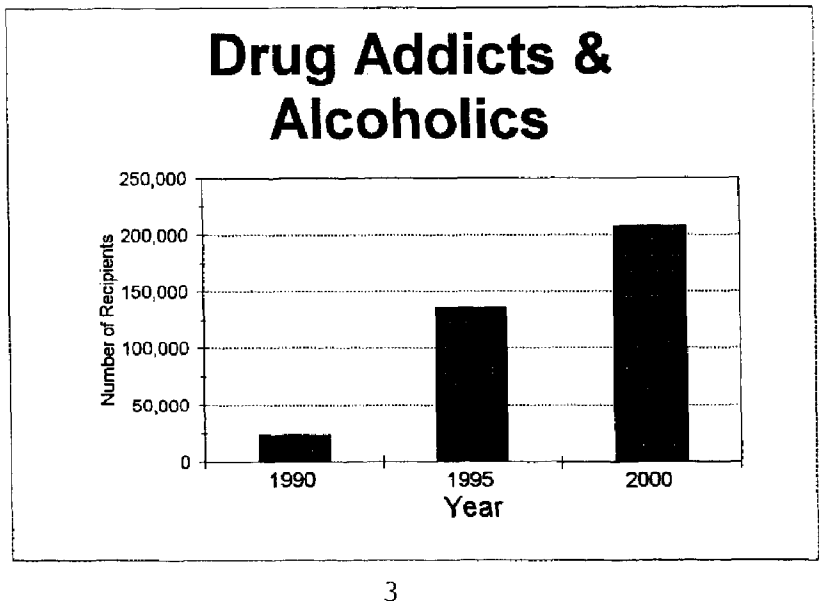


Figure 2: Projected Increase in SSI Caseload For Three Fast-Growing Populations







levels. They are different from Social Security benefits, which are paid from the Social Security trust funds to workers based on their payroll taxes.[1]

To be eligible for SSI, individuals must be 65 years old, blind, or disabled. To be considered disabled, individuals 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. 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 1994, the maximum federal SSI monthly benefit was $446 per month for an individual and $669 for a couple with both spouses eligible; these benefit rates are adjusted automatically 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. 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. This decrease reflects the fact that recent beneficiaries have very limited work history before going on SSI.

In addition to federal SSI benefits, states may choose to provide supplemental benefits. The District of Columbia and all but seven states provide these optional supplements. These state supplements vary, reflecting differences in regional living costs as well as in living arrangements. Most SSI recipients are also eligible for Medicaid and Food Stamps.

CHILDREN

Before 1989, the growth in child beneficiaries had been relatively low. Over the last 5 years, the number of children receiving SSI benefits has tripled, from almost 300,000 to almost 900,000 today.[2] Over the same time, children have become a larger portion of the SSI rolls--up from 6.5 percent to 14.2 percent. Benefit payments to children have increased as well--from $1.2 billion to $4.5 billion between 1989 and 1994.

The number of child beneficiaries is continuing to grow at a rapid rate. The number of children receiving SSI increased 15.8

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

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

percent from 1993 to 1994, and if this rate of growth continues, 1.86 million children will be receiving SSI benefits by the year 2000. (See fig. 3.)

Most of the growth is likely due to concerted outreach efforts by SSA and major changes in eligibility criteria for children. Increases in the number of poor families and rising numbers of disabled children also contribute. In addition, some believe that fraud and abuse--parents coaching their children to fake mental impairments--could account for some of the increase.

In 1989, the Congress required SSA to establish an ongoing outreach program targeted to poor blind and disabled children. The settlement pursuant to the February 1990 Supreme Court decision in Sullivan v. Zebley also required SSA to launch a national media outreach campaign, which was supplemented by a national children's SSI campaign conducted by child advocates. Since the outreach efforts began, the number of applications for children's benefits has grown more than fivefold.

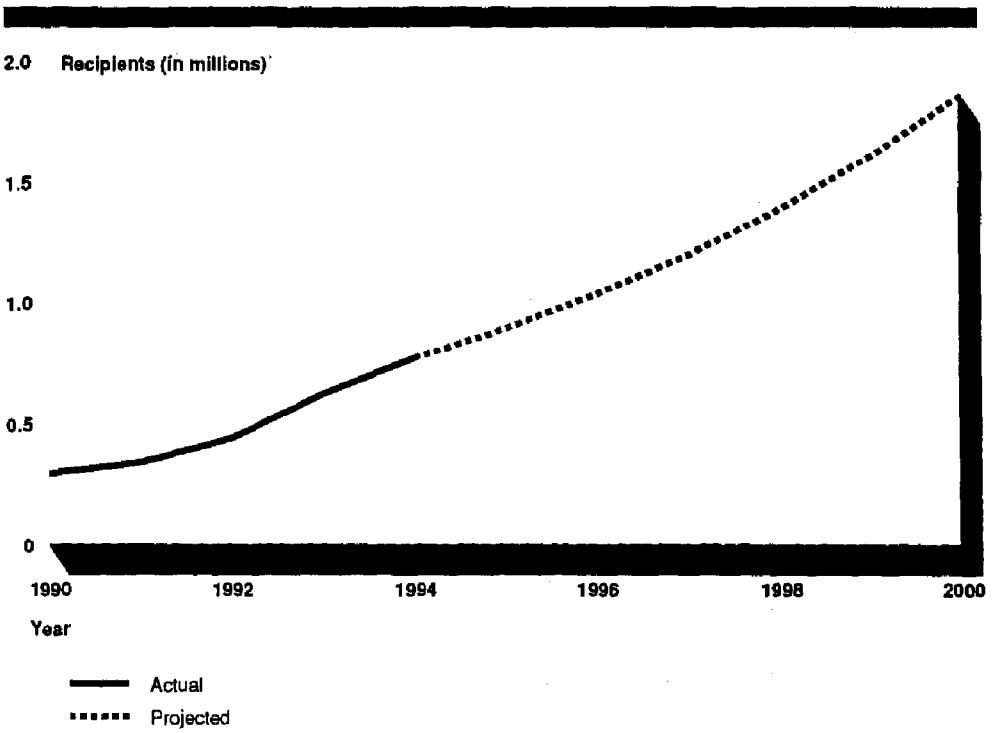
Eligibility changes have affected both growth and composition of the childhood SSI cases. In December 1990, SSA revised its medical standards for assessing mental impairments in children, adding separate listings for such impairments as attention deficit hyperactivity disorder, autism, and other pervasive developmental, personality, and mood disorders. Two months later, it also added the new individualized functional assessment process required by SSI statutory standards as interpreted by the Supreme Court, substantially expanding eligibility for children who did not meet SSA's strict medical criteria. As a result, the number of children qualifying on the basis of the revised medical standards for mental impairments tripled, from 1,900 a month before the change to 6,000 in 1994. In addition, the new functional assessment process has added about 219,000 children to the rolls through September 1994, accounting for one-third of all awards since it went into effect in 1991.

Children with mental impairments figure prominently in this growth. Increases in awards to children with mental impairments--based on the medical standards and the new assessment criteria--account for three-fourths of the overall increase in awards since the eligibility changes went into effect. In 1994, children with mental impairments received over 70 percent of all awards, including over 85 percent of awards based on the new functional assessment criteria.

IMMIGRANTS

Between 1982 and 1993, the number of legal immigrants receiving SSI increased an average of 16.5 percent a year. During this time period, the portion of immigrant recipients grew from about 3 percent of all SSI recipients to over 11 percent. In 1993,

Figure 3: Growth in SSI Children, Projected to the Year 2000



Source: Historical data from SSA.

an estimated 683,000 legal immigrants received SSI benefits at a cost of about $3.3 billion, based on our ongoing study of immigrants' benefits. Slightly more than 60 percent of these immigrants received aged benefits and the remainder received disabled benefits.

The numbers of legal immigrants in the SSI aged program and the SSI disabled program have increased dramatically. In 1982, 6 percent of all SSI aged recipients were immigrants; by 1993, 28 percent were immigrants. Immigrants constitute a much smaller percentage of SSI disabled recipients--about 6 percent in 1993, having increased from less than 2 percent in 1982. If the historical growth rate in the number of legal immigrants on SSI continues, this number could reach nearly 2 million by the year 2000.[3] (See fig. 4.)

Several factors may help explain the growth of immigrants on SSI, but no studies have yet established whether, and to what extent, these actually account for the growth. First, the number of immigrants admitted annually for legal residence in the United States has gradually increased in the last decade. For example, 880,000 were admitted in 1993, compared with 570,000 in 1985.[4] In addition, the legalization of nearly 3 million former illegal immigrants under the Immigration Reform and Control Act of 1986 may have expanded the population of immigrants eligible for SSI.

Second, the large increase in the percent of SSI aged recipients who are immigrants may be due in part to the admission of elderly immigrants for permanent residence who join family members already residing in the United States. Some legal immigrants are admitted into the country under the financial sponsorship of a United States resident. Sponsors sign an affidavit of support, in which they state they will provide financial assistance to the immigrant for 3 years. However, several courts have ruled that these affidavits of support are not legally binding.

Before 1994, the "deeming" provisions of the SSI program held that in determining eligibility for SSI, a portion of the sponsor's

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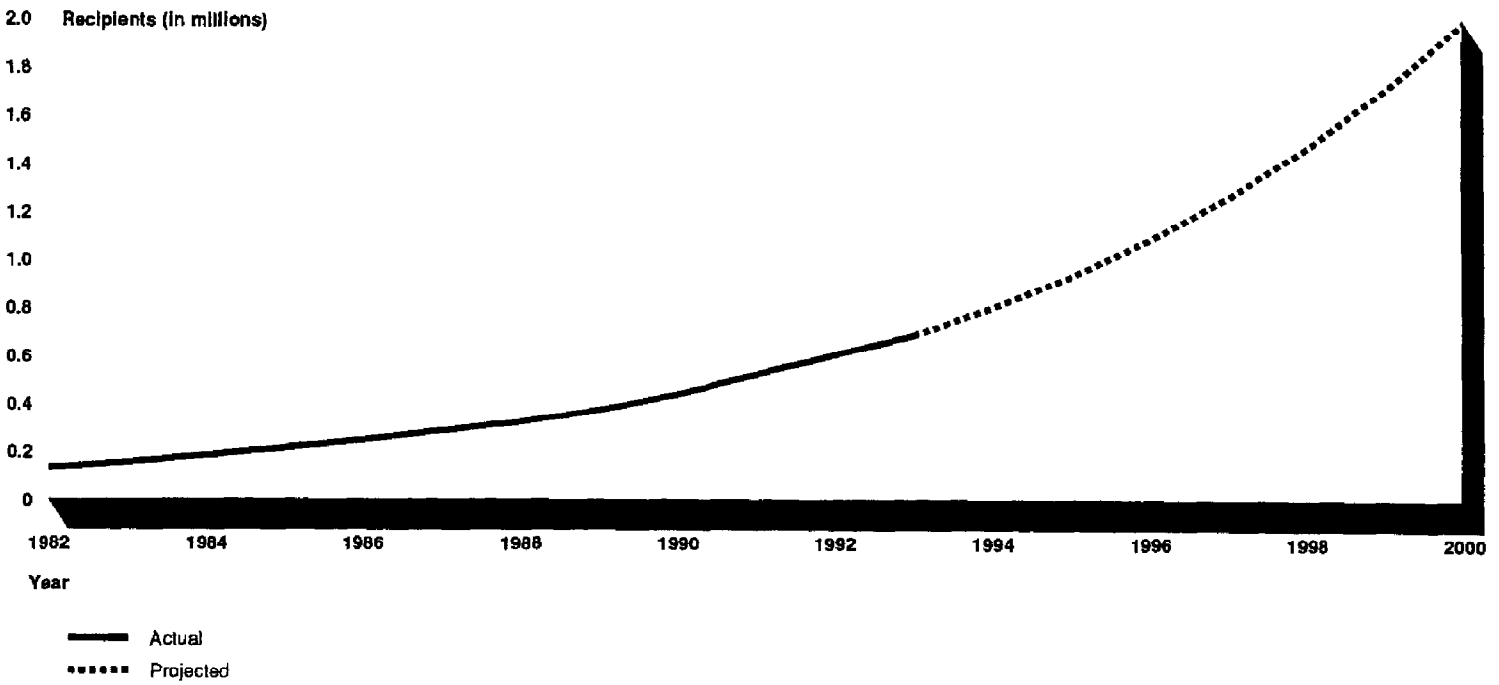
[3]This projection makes no adjustment for limitations of administrative data from SSI that may overstate the number of legal immigrants receiving benefits. SSI data may not have a recipient's current immigration status if an immigrant's status changed and the agency was not notified. For example, lawful permanent residents can become citizens after 5 years of residing in the United States and meeting other criteria. Immigration data that track legal immigrants over time suggest that at least 20 percent eventually become citizens.

[4]These figures do not include former illegal immigrants who were legalized under the Immigration Reform and Control Act of 1986.

Figure 4: Growth in SSI Immigrants, Projected to the Year 2000



Source: Historical data from SSA, Office of Supplemental Security Income.

income was deemed to be available to the immigrant for 3 years. Administrative data indicate that about 25 percent of lawful permanent residents receiving SSI applied for benefits within a year of the expiration of their 3-year sponsorship periods. Some of these may have been elderly immigrants who, not having resided in the United States long enough, did not qualify for Social Security retirement benefits. The deeming period for SSI was temporarily extended from 3 to 5 years starting in January 1994 through September 1996.

Third, the growth of immigrants in the disabled program may be due in part to fraud. Several news reports have provided accounts of legal immigrants being coached by middlemen on how to feign mental illness to qualify for SSI benefits. While state and federal investigations have identified some cases of fraud by immigrants in the SSI program, the extent of the problem is unclear.

DRUG ADDICTS AND ALCOHOLICS

Under a special SSI program commonly referred to as the DA&A (drug addicts and alcoholics) program, certain recipients (all called "addicts" here) can receive SSI benefits only if two conditions are met. Specifically, they must (1) undergo and comply with treatment, when available, and (2) have a third party or representative payee manage their monthly benefit payments. GAO work has documented past problems with the representative payee system.[5] The DA&A program is restricted to those addicts whose addiction is material to the determination of their disability; that is, if it were not for their addiction, they would not qualify for benefits.

About 101,000 DA&A recipients on the SSI rolls in 1994 received an estimated $382 million in annual federal SSI benefits. The SSI caseload grew nearly 700 percent for the DA&A program from only about 13,000 cases in 1988. We previously reported that 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 unknown.

This alarming growth and allegations of program abuse prompted the Congress to pass major reform legislation to strengthen controls of payments to addicts. These reforms were included in the Social Security Independence and Program Improvements Act of 1994 enacted on August 15, 1994.

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

For 1995 through the year 2000, the program is expected to continue to grow to over 200,000 DA&A cases, or about 53 percent, a much slower rate than that experienced in the 1988-1994 period (see fig. 5). This growth incorporates the programmatic changes made by the new legislation and represents the number of cases that will require treatment monitoring. SSA projects that for the SSI caseload the average rate for the 1995-1997 period will be about 27 percent; in 1998, a reduction in the growth rate of about 14 percent is projected; and the rate of growth for 1999 and 2000 is projected at only 10 and 6 percent, respectively.

According to SSA, much of the future growth is based on expanding referral and monitoring agencies to cover all states. These agencies--under contract with SSA--work with SSA field offices to monitor addict compliance with the treatment requirement. Past experience has demonstrated a relationship between the presence of one of these agencies and increased participation in the DA&A program. In 1993, SSA only had contracts covering 18 states but has increased that coverage currently to 45 states and the District of Columbia. The reduction in growth that is projected for 1998 is attributed to the new legislation that generally requires that, effective on March 1, 1995, SSI benefit payments to addicts in the DA&A program be terminated after 3 years.

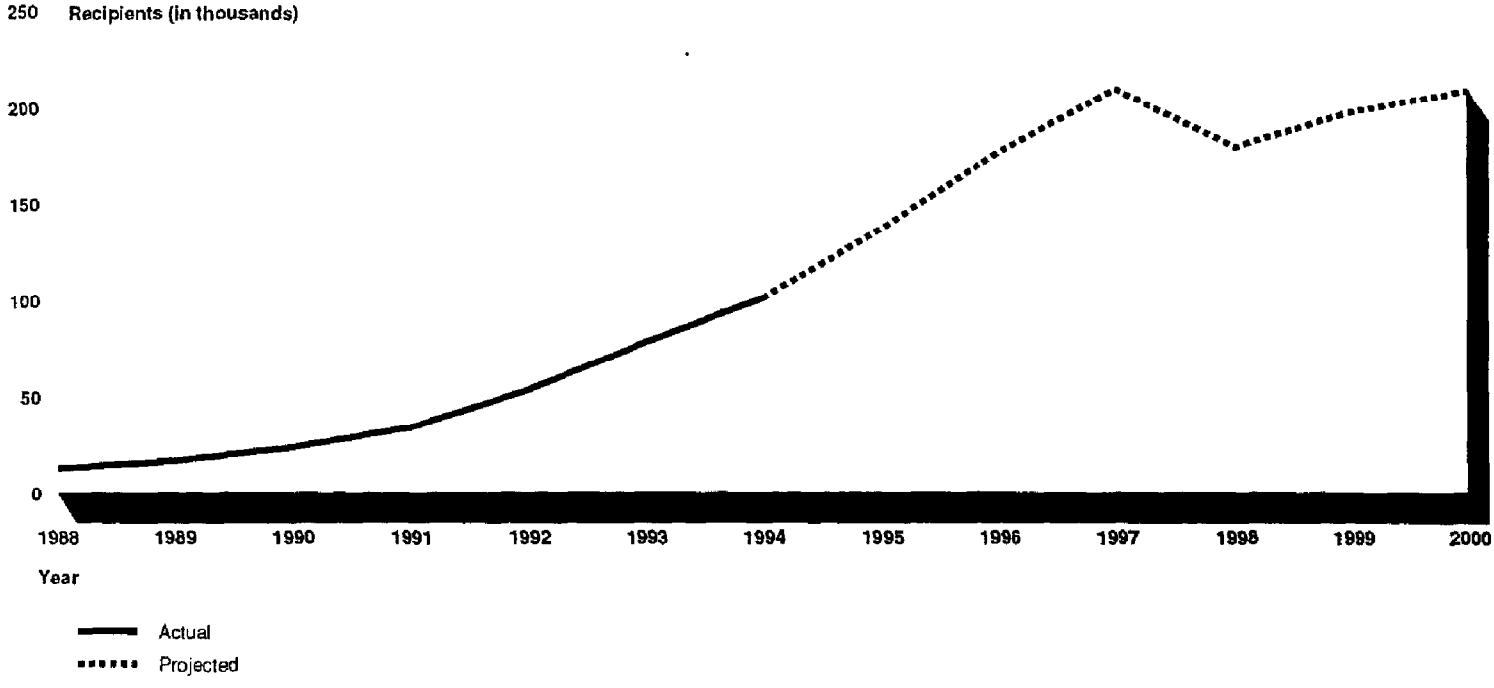
The legislation also mandates a number of other actions designed to strengthen controls over benefit payments to addicts. These actions include expanding the DA&A program requirements to cover Disability Insurance (DI) beneficiaries and mandating an SSA study of the feasibility, cost, and equity of requiring representative payees for all DI and SSI addicts, irrespective of whether their addiction is material to the determination of disability. The study is due no later than December 31, 1995.

FUNDAMENTAL PROGRAM CONCERNS

In looking at the overall growth in SSI beneficiaries in recent years, several fundamental program concerns have been raised. For example, there are questions about the appropriateness of recent expansions in eligibility. Concerns have also been expressed about whether SSI cash payments are an effective way to meet beneficiaries' needs. Still other concerns have surfaced that suggest that eligibility expansions and the cash payments that SSI provides leave the program vulnerable to fraud and abuse.

Regarding children, questions have been raised about the underlying rationale for providing benefits to disabled children through this program, which was designed primarily to replace income for adults whose disabilities precluded work. In addition, concerns have surfaced about the effectiveness of meeting the needs of disabled children and their families through cash payments rather than services directed to treatment of their specific

Figure 5: Growth in the SSI DA&A Population, Projected to the Year 2000



Source: SSA, Office of Disability

disabilities. Some also ask how the program could better meet the needs of disabled children to reduce their dependence on SSI as they become adults.

In the case of immigrants on SSI, immigration policy regarding sponsorship requirements and the length of time immigrants must reside in the United States before becoming eligible for benefits should be reviewed. The idea that one can sponsor a person for a short time, then pass that sponsorship obligation on to SSI raises concerns about the design of SSI rules. As a result, there have been proposals to change the eligibility criteria for recent immigrants as a means to stem the influx in immigrants on SSI.

For the DA&A program, some question whether stronger efforts should be made to rehabilitate drug addicts and alcoholics. In addition, some suggest that financing substance abuse treatment programs would be more effective than providing cash payments to addicts. Recent changes in the law continue cash payments through qualified representative payees, which should ensure better accountability, while better meeting the needs of addicted beneficiaries.

In conclusion, we believe addressing these fundamental program concerns should help improve the effectiveness of public expenditures and restore public confidence in the integrity of the program. The Congress has already taken action to address problems in the DA&A program and is considering alternatives for disabled children and immigrants. These issues deserve more deliberation, and we would be happy to work on them with you.

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

For more information on this testimony, please call Jane L.Ross, Director, at (202) 512-7215. Other major contributors include Assistant Directors Cynthia Bascetta, Chris Crissman, Cynthia Fagnoni, and Donald Snyder and evaluators David Fiske, Ellen Habenicht, Andrew Sherrill, Tom Smith, and Ken Stockbridge.

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