

GAO

Testimony

Before the Subcommittees on Social Security  
and Human Resources  
Committee on Ways and Means  
House of Representatives

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SOCIAL SECURITY

Disability Benefits for Drug  
Addicts and Alcoholics Are  
Out of Control

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## SUMMARY

The number of addicts receiving disability benefits has grown substantially during the last 5 years. Currently, about 250,000 addicts receive disability benefits at an annual cost of about \$1.4 billion. Benefits to addicts are provided under the Social Security Administration's Disability Insurance (DI) and Supplemental Security Income (SSI) programs.

More than half of the 250,000 addicts on the rolls qualify for benefits based on medical problems other than their addictions (for example, cancer and heart disease). The remainder qualify on the basis of their addiction.

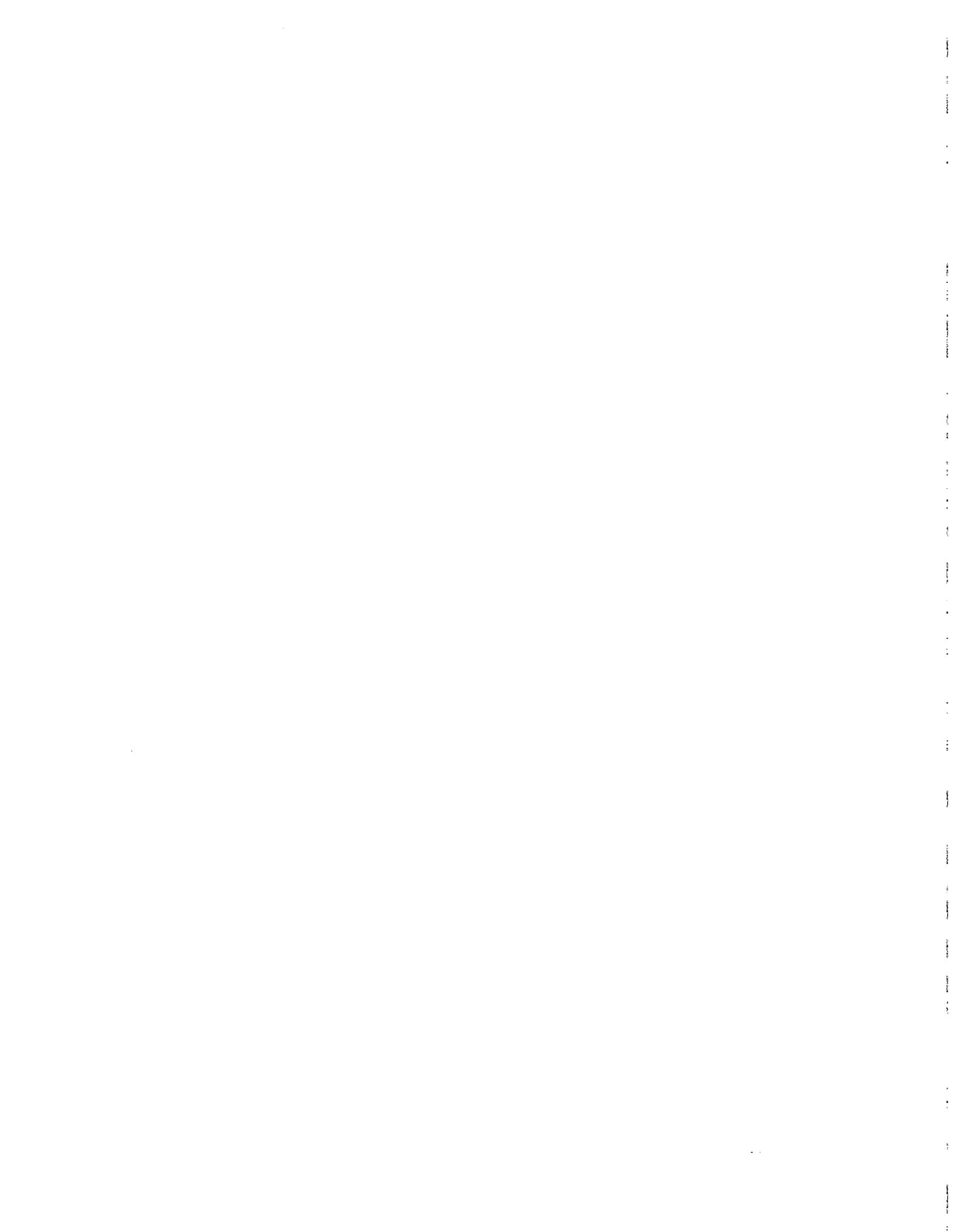
Under SSI, certain addicts are required to participate in treatment for their addiction and have a representative payee manage their benefits. There is no similar requirement in the DI program. Addicts included in the SSI drug addiction and alcoholism (DA&A) program are those who would not qualify for disability if their addiction ended. As of August 31, 1993, about 70,000 addicts were in this SSI program.

Most addicts receiving disability benefits are not required to be in treatment. SSA has only been responsible for assuring that addicts in the SSI DA&A program receive treatment. SSA knows little, however, about this population. Records show that only about 1 in 5 addicts in the DA&A program are in treatment. The status of many others is unknown.

Virtually all of the addicts in the SSI DA&A program have representative payees. However, for the rest of the addict population receiving benefits, less than half have payees. GAO believes that all addicts should have payees.

In those situations where payees are present, it is questionable how tightly these payees control the use of benefits. In the absence of tight controls, addicts are free to purchase drugs and alcohol to maintain their addictions. Finding qualified payees for addicts has been a long-standing problem for SSA. Payees serve on a voluntary basis. Further, most are relatives or friends. GAO believes that organizational payees would be in a better position to provide the tight controls needed over benefit payments to addicts.

GAO makes a number of recommendations to strengthen controls over benefit payments to addicts, including that (1) appropriate measures be taken to ensure that all DA&As are accounted for and monitored as required and (2) all addicts receiving DI and SSI benefits be required to have a representative payee. GAO also recommends that the Congress rethink the basic structure of the DA&A program and consider alternatives.



Messrs. Chairmen and Members of the Subcommittees:

Thank you for inviting me to discuss disability benefits paid to drug addicts and alcoholics by the Social Security Administration (SSA). My testimony is based on the work your Subcommittees requested.

We have found that at least 250,000 addicts receive disability benefits today at an annual cost to the Disability Insurance (DI) and Supplemental Security Income (SSI) programs of about \$1.4 billion. The number of addicts receiving disability benefits has grown substantially during the last 5 years, with over half of those on the rolls being added during that time. The vast majority of these addicts are receiving their benefits without any requirement that they be in treatment. Also, there is little assurance that the cash benefits provided to them are being spent wisely and are not being used to support their addictions.

My testimony today discusses the rapid growth in the addict population. It also addresses SSA's poor record of monitoring treatment for this population. Finally, I will talk about the need for more financial controls over payments to addicts.

#### BACKGROUND

Let me begin by providing some background information on how addicts qualify for DI and SSI benefits. Eligibility for disability benefits involving drug or alcohol addiction is determined like any other medical disorder. Benefits are awarded to persons who cannot work and whose physical or mental impairment will last for at least 12 months. Those awarded benefits are to be periodically reviewed to determine whether they are still disabled.

Substance addiction, by itself, can be a disabling medically determinable impairment. No additional physical or mental impairment is required. The impairment must be established by medical evidence consisting of symptoms, signs, and laboratory findings. (Appendix I provides a brief summary of how such disorders are evaluated.)

We should point out that more than half of the 250,000 addicts on the rolls qualify for benefits based on medical problems in addition to their addictions. For example, an addict may be eligible for benefits because of 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 diagnoses.

Under the SSI program, addicts who qualify for benefits on the basis of their addiction are required by law to have a third party, or representative payee, manage their benefits, and to participate in treatment for their addiction. Addicts included

in the SSI drug addiction and alcoholism (DA&A) program are those who would not qualify for disability if their addiction ended. There is no similar requirement in the DI program.

The objective of this special classification within the SSI program is to rehabilitate SSI recipients so that they will become productive members of society, and remove them from the SSI disability rolls. As of August 31, 1993, about 70,000 addicts<sup>1</sup> were in this SSI program. Most of them were alcoholics. Benefit payments to these individuals amount to about \$285 million annually.

For SSI recipients put into the DA&A program, an SSA office arranges for a representative payee to manage the person's benefits. 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 the DA&As, monitor treatment participation, and report to SSA on treatment status.

The types of treatment provided for DA&As can range from intensive in-patient care to outpatient care in informal support group settings. SSA is not permitted to pay for treatment nor can the addict be required to pay for it. Some services can be covered by state Medicaid programs, but there are large state variations in the type, amount, duration, and scope of services provided. The amount of state and federal Medicaid funding for treatment for SSI DA&As is not known because states do not keep records on the specific services provided to this population.

I will now turn to the growth in the number of addicts receiving benefits, and SSA's poor record of monitoring treatment and controlling benefit payments to this group.

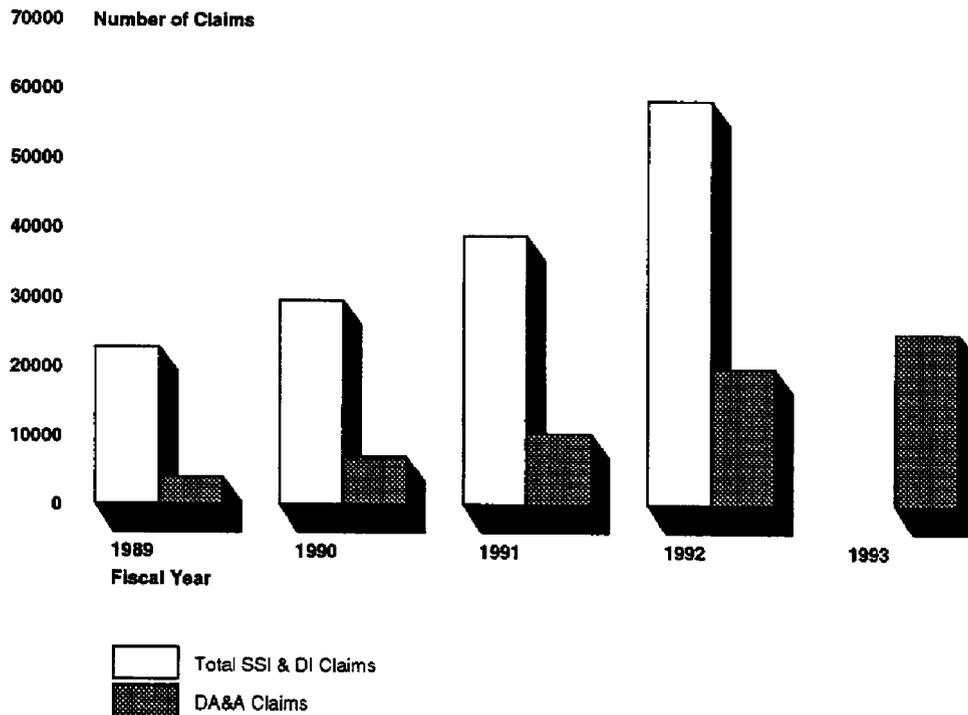
#### SUBSTANTIAL GROWTH IN PROGRAM ROLLS

The number of addicts receiving DI and SSI benefits has increased significantly in recent years, totalling about 250,000 persons today. Five years ago, there were fewer than 100,000 addicts on the rolls. Growth in the SSI DA&A population has also been substantial. From December 1989 through August 1993, the number increased from about 17,000 to 70,000, more than a 4-fold increase over the 4-year period. This growth is illustrated in the figure below.

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<sup>1</sup>By the end of December, 1993, the number of DA&As had risen to 78,000. Our analysis in this testimony is based on the DA&A caseload of 69,419 at the end of August.

Disability Claims Allowed Annually With an Addiction Diagnosis Compared with Increases in DA&A Cases (1989-1993)



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

There are many possible explanations for these increases, including increased SSI outreach and referrals from state welfare rolls, but the actual causes are not yet known.

THE TREATMENT STATUS OF THE VAST MAJORITY OF ADDICTS IS UNKNOWN

Except for some of the addicts in the SSI DA&A program, SSA does not know whether the vast majority of addicts are in treatment. The reason is that almost three-fourths of SSA's addict population is not required to attend treatment. With respect to those addicts who are in the DA&A program and for whom treatment is a requirement, only about 1 in 5 are in treatment.

SSA has done a poor job of monitoring compliance with the treatment requirement for the SSI DA&A addicts. While SSA has the capability to monitor treatment status through its

computerized records and through RMA reporting, both methods are seriously deficient. According to SSA records, only about 9 percent of the DA&As 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 HHS Inspector General in a 1991 report.

Most of the DA&As are in those states with RMAs. As mentioned earlier, through 1993, SSA had established RMAs in only 18 states. For those states without RMAs, SSA regional offices were to assume responsibility for the treatment monitoring function. According to SSA, however, no evidence exists that the regions complied with this requirement.

About 85 percent (60,000) of the DA&As receiving benefits are in these RMA states. Of these addicts, however, RMAs report that only half of them are actually being monitored and only half of these (about 15,000) are actually in treatment. Data are not available to explain why the treatment status of about 30,000 DA&As in the RMA states is not being monitored.

There may have been an underreporting of addiction diagnoses and DA&As in those states without RMAs because SSA and state disability determination offices apparently gave low priority to identification of these cases. California, for example, has an RMA and has about 26,000 DA&As, while states such as Texas and Florida, without RMAs, have only 365 and 543 DA&As, respectively. Only 38 DA&As are reported for the District of Columbia, where there has been no RMA.

The poor monitoring of the treatment requirement may have also contributed to the relatively poor outcomes under the DA&A program. For example, during 1993, the RMAs reported that, on average, only 75 addicts successfully completed treatment each month. During this same time period, the rolls of the DA&A program were increasing by about 2,000 addicts a month.

SSA is currently 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.

SSA, in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA), has also initiated two demonstration projects in the states of Washington and Michigan in an effort 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 REPRESENTATIVE PAYEE  
REQUIREMENT IS QUESTIONABLE

Many addicts do not have representative payees. We estimate, for example, that about 100,000 of the 250,000 beneficiaries with addiction disorders do not have payees. Studies in general have shown that, in those situations where payees are present, it is questionable how tightly they control the use of benefits. In the absence of tight controls, addicts are free to purchase drugs and alcohol to maintain their addictions. This situation leaves the government open to charges that it is an "enabler" because the benefits give addicts the means to support their addictions.

Virtually all addicts in the DA&A program have payees. Of approximately 185,000 addicts not in the DA&A program, however, less than half have representative payees.

There are little data showing how well representative payees do their job in controlling benefits for addicts. However, anecdotal data, including previous testimony before your Subcommittees, suggest that the representative payee requirement is not working well. A previous study of the addict population by SSA found payee controls, particularly when the addicts' friends were the payees, to be lax in many cases.

This study also showed that organizational payees such as RMAs and treatment facilities tended to provide the greatest amount of control. In this regard, we believe that organizational payees would be in a better position to implement the stringent controls needed over benefits paid to addicts. Further, we believe that organizations are better prepared to deal with those situations where addicts are abusive or threatening.

Finding qualified payees for addicts has been a long-standing problem for SSA. Payees are generally not paid and serve on a voluntary basis.<sup>2</sup> These circumstances coupled with the potential for incurring abuse or threats make the representative payee job a difficult sell for SSA.

CONCLUSIONS

SSA payments to addicts are out of control. The number of addicts is increasing at an alarming rate for reasons that are unknown. The requirements for treatment are not being complied with or properly monitored. And, there is little assurance that benefit payments are not being used for the purchase of drugs and

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<sup>2</sup>SSA is currently carrying out a demonstration program whereby qualified organizations can be paid up to \$25 per month for acting as a representative payee. The fee is paid by the beneficiary.

alcohol. SSA needs to take immediate action to deal with these problems and the Congress needs to reconsider the basic design of the DA&A program.

It is clear that more effective treatment referral and monitoring must occur with the current DA&A population. We are encouraged by SSA's recent and ongoing expansion of its RMA agreements which will provide national coverage for this population. However, simply establishing RMAs does not necessarily guarantee that all addicts will be monitored, much less be in treatment. SSA also needs to work closely with the RMAs and SAMHSA to better identify the treatment needs of these persons and to see that they receive the appropriate level of services.

SSA needs to strengthen and expand payee monitoring. We believe SSA should use organizations as representative payees to the maximum extent possible. Organizations would be better able to implement the more stringent controls needed over benefits paid to addicts. One way to expand the use of organizations is to use RMAs to provide payee services. Making the RMA the payee would have the effect of consolidating case management functions, including treatment for addiction and money management.

As is the case with addicts in the DA&A program, we believe the representative payee requirement should be applied to all DI and SSI addicts. The very nature of their medical problems suggests to us that SSA should require representative payees for all addicts receiving benefits. This is not the case now. There is no regulatory or programmatic requirement for the addicts not in the SSI DA&A program to have a representative payee. The public must have confidence that these funds are being used for the basic program purposes of food, clothing, and shelter.

Over the longer term, we believe that the Congress should rethink the basic structure of the DA&A program and consider such alternatives as extending the requirement for treatment beyond this group to all addicts receiving DI & SSI benefits. Another approach would be to require addicts to be in treatment before they receive benefits. This approach would in effect require applicants to put forth a good faith effort to try to rehabilitate themselves before they start to receive benefits.

RECOMMENDATIONS TO THE SECRETARY  
OF HEALTH AND HUMAN SERVICES

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

- take appropriate measures to ensure that all DA&As are accounted for and monitored as required,

- require all addicts receiving DI and SSI benefits to have a representative payee,
- use organizational payees for addicts to the maximum extent possible, and
- consider making the RMAs the representative payees.

The Secretary should seek whatever additional legislative authority may be needed to meet these ends.

MATTERS FOR CONSIDERATION BY THE CONGRESS

In view of the 20 years of experience with the program and the limited progress in addressing the problems of addicted beneficiaries, the Congress should reconsider the DA&A program's basic design including alternative approaches.

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Messrs. Chairmen, this concludes my prepared statement. I will be happy to answer any questions you or other members of the subcommittees may have.

QUALIFYING FOR DISABILITY BENEFITS  
WITH SUBSTANCE ADDICTION

- The Social Security Act provides for the payment of disability benefits to persons who cannot perform substantial gainful work and who have a medically determinable physical or mental impairment that has lasted or is expected to last for at least 12 months or to result in death.
- Substance addiction can be a disabling medically determinable impairment. No additional physical or mental impairment is required. Eligibility for disability benefits involving substance addiction is determined like any other medical disorder.
- The impairment must be established by medical evidence consisting of symptoms, signs, and laboratory findings. A finding of disability will depend on the severity and duration of the impairment and, where appropriate, the individual's remaining functional capacity. A functional assessment must consider the individual's ability to function over time, including periods of non-intoxification.
- Individuals may manifest a wide variety of mental, neurological, gastrointestinal, and other symptoms, signs, and findings. These include such things as anxiety, depression, confusion, hallucinations, dizziness, blackouts, seizures, blurred vision, nausea, and liver dysfunction. In many cases, although not required for a finding of disability, individuals with substance addiction disorders also have coexisting mental or physical impairments.
- Under the SSI program, there is a special classification for drug addicts and alcoholics (DA&A) when it is determined that the addiction is material to the finding of disability, or, said differently, when the individual would not qualify for disability if the addiction to drugs or alcohol were to end.
- Those persons classified as "DA&A" are required by law to receive their benefits through a third party, or representative payee, and as a condition of eligibility, to undergo treatment, if available, for their addiction.

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