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Drink, drugs and disability: an introduction to the controversy

BY SHARON R. HUNT
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This paper reviews the history of the drug addiction and alcoholism (DA&A) program within Supplemental Security Income (SSI) and the controversies that dogged the years before its termination in 1996. The DA&A program began in 1972, and for reasons understood early on, it was susceptible to rapid growth and discrediting scandal. Through the mid-1980s, the program remained very small, mainly because of a conservative judicial climate that limited the grounds for claiming substance abuse as a disabling impairment. Once the legal barriers were breached, SSI became an attractive welfare alternative for impoverished substance abusers and for local governments seeking to shift welfare and medical assistance costs to the federal government. By the early 1990s, program growth was extraordinary, and oversight bodies deemed the program “out of control.” This was compounded by highly publicized misuse of funds by beneficiaries. Seen as an instance of state-induced harm, the program became an early target of the conservative welfare reformers who took control of Congress after the 1994 elections.

It is highly unlikely that when Congress passed the SSI program in 1972 . . . members realized they would be writing a guaranteed annual income and medical care [program] for addicts.

Rep. Rick Santorum, February 10, 1994

I think probably most of the American people would be outraged to find . . . that someone is even receiving disability when they inflict it on themselves.

Rep. E. Clay Shaw, Jr., February 10, 1994¹

Since 1950 the federal government of the United States has provided income support to people with work disabilities unrelated to military service. The eligibility of alcoholics and drug addicts for these benefits has always been controversial, but for over 25 years drug addiction and alcoholism were treated as potentially disabling impairments—albeit with official reluctance and confusion. In this paper we examine the history of the drug addiction and alcoholism (DA&A) “program”² operated by the Social Security Administration. This began with the authorization of Supplemental Security Income (SSI) in 1972, was extended to Social Security Disability Insurance in 1994, and was eliminated by Congress in March 1996.

In retrospect, it seems fair to say that the DA&A program was established on terms that invited controversy. For technical and fiscal reasons that were well understood early on, the program was extremely difficult to manage, and as a consequence it was susceptible to rapid growth and discrediting scandal. It was thus distinctly unloved by its bureaucratic parent. The Social Security Administration (SSA) largely ignored the program through the 1970s and 1980s and made no official effort to defend it once a newly conservative Congress laid siege in 1994. Still, even had the SSA been inclined to resist the lawmakers, it had little political leverage because the program lacked a unified constituency. Treating addiction as a work disability never sat well with many legislators and some members of the substance abuse treatment community; to use

a term that became popular in the 1980s, they believed the program “enabled” addiction.

We consider these issues in due course. However, to properly introduce what is of necessity a complicated story, we first lay some groundwork. Immediately below, we provide a brief summary of the two current Social Security disability programs, followed by a somewhat detailed treatment of the definition of work disability and the process by which it is determined. We then take up definitional aspects of drug addiction and alcoholism as qualifying impairments for disability. At this point, we sketch the DA&A program’s implementation from 1974 to the early 1990s. These are rather technical, even laborious sections, but they dissect the serious administrative problems that contributed to the DA&A program’s growth, introduce terms that recur throughout this paper and others that follow in this issue, and provide points of reference for these other papers, especially insofar as their findings reflect the influence of administrative processes.³

Finally, with this technical prologue complete, we analyze the SSI DA&A category’s extraordinary growth beginning in the late 1980s, the controversy it provoked, and the political response that resulted first in the program’s reform in 1994 and then in its elimination in 1996. In conclusion, we locate the controversy about the DA&A program in addiction’s ambiguous cultural status, the federal structure of American income maintenance, and the enduring tension between social welfare and social control in public welfare programs.

A last word by way of introduction: We rely for evidence on a variety of published and unpublished government documents, newspaper accounts, and interviews with dozens of people involved in one way or another with the DA&A program over the years. Hunt did most of the interviews in the course of her dissertation research (Hunt, 2000); Baumohl did others during research on SSI’s forebear, Aid to the Permanently and Totally Disabled (1950–74). Although public offi-

cials enjoy no human subjects protections, we promised anonymity to most of the civil servants and political appointees we interviewed. To fulfill our commitment to them and to others kind enough to speak with us candidly, we do not identify most of our informants, and our sources for many points are deliberately left a bit vague.

The Social Security disability programs

The SSA runs two programs for the disabled: Social Security Disability Insurance (DI) and SSI. As its name implies, DI is an “insurance-like” program: Workers make payroll deductions that over time qualify them for benefits based on average lifetime earnings should they ever become disabled.⁴ SSI, on the other hand, is a “welfare” program designed for individuals with little recent employment and few resources. Whereas substantial income or wealth is no bar to DI, SSI is “means tested.” Excluding (mainly) the value of a home and an automobile, SSI recipients may not have assets valued at more than \$2,000, or \$3,000 for a couple (SSA, 1999b).⁵ Some people collect both SSI and DI (they get “concurrent benefits”) because their DI benefits are very meager.

Because the American income maintenance system emphasizes rewards for work, social insurance typically offers more substantial benefits than welfare. In March 1999, as the SSI Study (summarized by the papers in this issue) left the field, the average monthly benefit for DI recipients was \$733, whereas the federal SSI benefit for individuals living in their own households was \$500 per month (SSA, 1999c). Some states (notably Alaska, California and Connecticut) supplement the federal minimum. In California, the supplementing state most relevant to this issue, even the enhanced value of SSI is considerably less than the average DI payment.⁶

Since the creation of Medicare and Medicaid in 1965, medical benefits have accompanied disability checks. DI recipi-

ents are eligible for Medicare after receiving benefits for 24 months (SSA, 1999d). Most SSI recipients are eligible for Medicaid, a means-tested counterpart to Medicare. (If their assets are sufficiently low, DI recipients qualify for Medicaid during the Medicare waiting period and beyond.) Eligibility for Medicaid is determined by the states, but 39 states and the District of Columbia (DC) use federal eligibility criteria, so their residents automatically qualify for Medicaid once approved for SSI (Office of Research, Evaluation and Statistics, 1999). Of the five states included in the SSI Study, only Illinois made Medicaid determinations not based entirely on federal criteria.

**The disability
determination
process**

For SSI and DI, statute defines disability as “the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.” The rules and procedures used to apply this definition are also the same for both programs. The sequential steps for determining medical eligibility are as follows: (1) If an individual is not currently performing substantial gainful activity (SGA, discussed below), a severe impairment or some combination of impairments must interfere with basic work-related activities and must be expected to last for at least 12 months. (2) If the level of impairment reaches a threshold defined in the official “Listing of Impairments,” benefits are granted. The “Listing of Impairments,” created by the SSA in 1968, is a catalog of conditions for each of the major body systems—described in terms of specific symptoms, signs, and laboratory findings—deemed severe enough to keep an individual from achieving SGA for a year or longer. (3) If the individual’s impairment does not meet the Listing or achieve comparable severity, it must interfere with work of the type done by the person during the last 15 years.⁷ (4) If past work cannot be performed, the person must be incapable of other work that exists in the *national* economy.

Age, education, past work experience and transferable skills are taken into account. If the individual cannot do other work, benefits are granted (adapted from Lahiri et al., 1995).

At initial application and the first level of administrative appeal, medical and other evidence is collected and disability determinations are made by an assigned state agency known as a Disability Determination Service (DDS). These activities are wholly federally funded. The DDS team consists of a physician (or psychologist) and a disability examiner. They rely on reports prepared by a claimant or the SSA field worker (which may include observations by family members and friends) and by a claimant's physician and other treating sources. If a claimant does not have a physician or if additional medical information is needed but cannot be obtained from the treating physician, the SSA pays for a consultative examination (SSA, n.d.).

There are four levels of appeal. Reconsideration, the first level, is a *de novo* review of the file (including any new evidence) by a DDS team that did not participate in the original decision. The second level is a *de novo* hearing before an administrative law judge (ALJ). The ALJ may bring in medical and vocational experts to help evaluate the evidence, and the claimant usually brings a representative (sometimes a lay advocate, but often an attorney). The claimant may present testimony (including new evidence), subpoena witnesses, and obtain answers to the ALJ's questions. The Appeals Council, the third level of appeal, may or may not grant a request to review an ALJ decision. The Appeals Council does not entertain new evidence. If the claimant has not been granted benefits after an Appeals Council decision, the last resort is to civil action in federal court (SSA, 1999a).

Some of the administrative and political problems of the DA&A program resulted from the process just described. The "medically determinable" nature of a potentially disabling impairment is particularly problematic. By relying on signs

and symptoms of impairment, supported by laboratory findings, a medical standard of disability serves as a “validation mechanism” by limiting the influence of evidence that can be manipulated by a claimant. As disability benefit programs are designed to ensure that those who can work do so, medical validation is a check against malingering, against unauthorized leave from the labor force (Stone, 1984; Liebman, 1976). However, drug addiction or alcoholism (or back pain, for that matter) often is not amenable to unambiguous medical evaluation. This is one of several factors that promote discrepant judgments about the severity of impairments and the presence of disability (Mashaw, 1983). As we will see, sometimes a condition’s ambiguity can be exploited systematically to defeat administrative mechanisms of caseload control.

The SSA’s disability programs must also determine what constitutes work, or, in the statutory language, the “substantial gainful activity” that a disabled individual cannot by definition perform. SGA is defined as the performance of *significant* physical or mental activities for remuneration or profit.⁸ For sighted persons, average gross earnings of over \$500 per month were taken to indicate SGA until July 1999, when the earnings level was raised to \$700. Job duties, hours worked, and any impairment-related work expenses are considered when determining SGA in a given case (Myers, 1993). As with other judgments in the disability determination process, agreement among raters about the performance of SGA is imperfect. Note, too, that pursuant to the substance of several court decisions incorporated in the Social Security Independence and Program Improvements Act of 1994 (P.L. 103-296), illegal activity may count toward SGA. Administrative law judges’ rulings with which we are familiar construe prostitution and drug dealing to require “significant physical and mental activity.” Drug addicts or alcoholics “earning” at the SGA level by such means are ineligible for disability benefits if these earnings can be plausibly established.

Finally, the length of the application process and subsequent appeals created a serious problem in the DA&A program. In 1993, as the program was growing very fast, the typical SSI or DI application process took about two years.⁹ DA&A claimants were especially prone to appeal; indeed, in fiscal year 1990, 40% of them received benefits only on appeal at the ALJ level, compared with 17% of the overall SSI disabled population (*Departments of Labor*, 1994a).¹⁰ One consequence of a successful appeal was that the SSA was obliged to make a “retroactive benefit payment,” what beneficiaries call “back pay.” In DI there is a waiting period that shortens the time for which retroactive benefits are owed; but in SSI the beneficiary is entitled to benefits from the date of application or, if later, the date on which he or she is determined to have become disabled. Until early 1995, “back pay” was awarded in a lump sum. This resulted in retroactive awards of many thousands of dollars all at once to the “representative payees” of people with certified drug and alcohol problems.¹¹ Some of this money was not used as the SSA and Congress would have liked, and its widely publicized misuse became an important feature of the controversy about the DA&A program. We consider this at greater length below.

Continuing-disability reviews

Between 1976 and 1984 the disability evaluation process described above for initial claims also was used to make determinations about the continuation of benefits. However, in the wake of an extraordinary controversy during the first Reagan administration, Congress restored an earlier “medical improvement standard.” This meant that benefits could not be terminated absent proof of medical improvement that enhanced a recipient’s ability to work. Even if work-relevant medical improvement had occurred, the SSA had to show that the individual was currently capable of SGA before a determination of “no longer disabled” could be made. This evaluation process is called a continuing-disability review (CDR), and as we discuss later, problems with the CDR process contributed significantly to the DA&A program’s difficulties.

Drug addiction and alcoholism as qualifying impairments for disability

Although alcoholism's legitimacy as a disabling impairment was subject to Congressional debate much earlier, neither alcoholism nor drug addiction was specifically mentioned in DI regulations until 1961. They appeared then under the personality disorder listing, and to yield disability they were required to be associated with psychosis or neurosis (New Regulations, 1961). When the detailed "Listing of Impairments" was introduced in 1968, addictions still were included as manifestations of personality disorders, "life-long, habitual, and inappropriate patterns of behavior" that could be "manifested by . . . addictive dependence on alcohol or drugs." To be disabling, however, the "addictive dependence" had to be accompanied by "evidence of irreversible organ damage" (Listing of Impairments, 1968). This became known as the "end-organ damage" criterion. It was a formidable eligibility barrier, and, especially in the years before widespread HIV infection, it favored the eligibility of alcoholics over drug addicts and ensured that eligible alcoholics usually were well into middle age and quite debilitated.

This was before the era of SSI, authorized by Congress in 1972 to consolidate and standardize, under federal funding and administration, existing programs for the impoverished elderly, blind, and disabled. SSI's forerunner in disability benefits was Aid to the Permanently and Totally Disabled, implemented in 1950 (later known as Aid to the Disabled, or ATD, the name we use here). In the mold of New Deal welfare programs framed as "grants in aid" to the states, ATD required states to share the costs of benefits and administration. Because they shared program costs, states were allowed leeway in their definition of eligible impairments, and disability determination was left to state welfare departments. State programs thus developed differently. California's program, officially called Aid to the Needy Disabled, was for

many years so strict that its administrators called it “Aid to the Nearly Dead.” New York, by contrast, adopted a liberal state plan and quickly had the largest ATD program in the country (Baumohl, 1990).

There was never a specific reference under federal law to the ATD eligibility of drug addicts or alcoholics. Most states relied on the DI standard or ruled out all personality disorders. New York took the initiative in November 1969 to make heroin addicts eligible, but our review of archived state ATD plans suggests that only Maryland moved in a similar direction before the advent of SSI.¹² By the end of the ATD era in 1974, some states did provide benefits on the basis of alcoholism. As a Senate Finance Committee staff report noted, even by 1970 every state had at least a few individuals classified as disabled due to alcoholism. Still, only 3% of the national ATD rolls at that time consisted of individuals with alcoholism as a primary or secondary diagnosis. As committee staff observed, while “some States have long determined alcoholics as disabled,” it was “probably on a case-by-case basis rather than as a matter of statewide formal policy” (Committee on Finance Staff, 1972).

In the legislative wrangling about the creation of SSI in 1971 and 1972, the Senate Finance Committee was greatly influenced by Senator Harold Hughes, an Iowa Democrat. Himself a recovering alcoholic, Hughes was chairman of the Senate’s Subcommittee on Alcohol and Narcotics and author of the 1970 Comprehensive Alcoholism Prevention and Treatment Act (the Hughes Act), which created the National Institute on Alcohol Abuse and Alcoholism. He recommended that drug addicts and alcoholics be denied eligibility for SSI.¹³ Like Hughes, the committee was concerned that the House bill to authorize SSI did not ensure addicted recipients’ compliance with treatment and worried that cash benefits would underwrite the purchase of drugs and alcohol (Committee on Finance Staff, 1972). The committee favored a new title of the Social Security Act that would compel participating states

to refer all alcoholics and drug addicts on SSI or Aid to Families with Dependent Children to certified treatment programs, monitor their progress, and make “protective payments” for food, shelter and clothing. Appropriate future applicants for federal welfare programs would be treated similarly (Committee on Finance, 1972).

Although the Department of Health, Education and Welfare (HEW), then the SSA’s parent agency, agreed with the committee in principle, it resisted the creation of a new and expansive program. In what Joseph Humphreys, then of the Congressional Research Service, recalled as the “fast and furious” House and Senate conference on the night of October 14, 1972, the Senate rescinded its proposal. It yielded to language in the House bill (H.R. 1 of May 26, 1971) that became the enabling legislation for SSI (P.L. 92-603). That bill, on the advice of New York’s Representative Carey, required drug addicts to comply with treatment. The House Committee on Ways and Means added the same requirement for alcoholics (Office of Legislative and Congressional Affairs [OLCA], 1993). It also included a provision for DA&A beneficiaries to have a “representative payee,” a third party, to receive their checks and manage their funds. These requirements were included in Sections 1611 and 1631 of Title XVI (SSI) of the amended Social Security Act.

SSA regulations concerning drug addiction and alcoholism

When implemented in January 1974, SSI was governed by temporary regulations similar to those for DI. However, there were significant and confusing differences. In SSI, addictions were no longer listed under personality disorder, but under the category “functional nonpsychotic disorder,” and evidence of irreversible organ damage was not required. In July 1975, DI adopted the SSI standard. However, an accompanying statement (Listing of Impairments, 1975), which noted that addiction to alcohol and drugs was not “in itself” a qualifying condition, proved confusing. While intended to remind adjudicators that as with any impairment, addiction had to be supported by evidence sufficient to substantiate disability, it

suggested to many disability-determination teams that the end-organ damage criterion remained in place. This would yield a whirlwind of litigation.

According to the Congressional Research Services' Humphreys, Congress meant to be strict about the definition of qualifying addiction and about conditions for continuing eligibility. However, because the committee reports provided only a limited record regarding the DA&A provisions (in part because the committee heard little from what was then a small and poorly organized treatment constituency), the SSA consulted a number of federal and state agency representatives about which SSI recipients should be labeled DA&A and therefore subject to treatment and payee conditions. Those consulted, believing these requirements would be very difficult to administer strictly, suggested that the law be interpreted in a "realistic manner." They advised the SSA not to apply the label to every beneficiary with an alcohol or drug problem. The SSA finally decided that individuals whose drug addiction or alcoholism was a "contributing factor to disability"—that was "material to the finding of disability"—would be subject to payee and treatment requirements (Kieffer, 1976). "Materiality" had nothing to do with SSA diagnostic codes. Rather, an individual had first to be found disabled, with medical evidence of drug or alcohol addiction present. It had then to be determined if the individual would be disabled *even if he or she ceased to use drugs and/or alcohol*. Drug addiction and alcoholism were considered "material" if the person *would not be disabled in their absence* (SSA, 1982). Consistent application of this hypothetical assessment would prove impossible.

Implementation of the DA&A provisions

In June 1970, approximately 34,000 ATD recipients had drug addiction or alcoholism as a primary or secondary diagnosis (Committee on Finance Staff, 1972).¹⁴ Only a primary diagno-

sis resulted in application of the DA&A label, and these individuals, transferred from ATD, comprised 97% of the 10,000 members of the SSI DA&A category at its inception (Solomon, 1995). Because of its uniquely liberal policy on heroin addiction, New York accounted for 98% of drug-addicted transferees in the DA&A category (Rush, 1980). The SSI law allowed all transferees to be exempt initially from federal disability criteria, but over the next decade many of New York's addicts died, went to prison, or were dropped from the rolls after CDRs conducted in 1976 and 1977. (These did not require a showing of medical improvement and may have applied the end-organ damage criterion in error.) Nationally, the SSI DA&A rolls declined steeply throughout the 1970s, reaching 4,000 at the end of the decade.

As Martha Derthick (1990) and Renato DiPentima (1984) have discussed at length, the SSA had very serious problems implementing and managing SSI during its early years. From its inception the SSA had conducted itself like a public insurance company; it had no experience with welfare programs, with their complicated and intrusive inquiries into the assets and living circumstances of sometimes resentful applicants. From the outset, dealing with the complexities of the DA&A category was particularly annoying to SSA managers and line staff alike, and the agency largely ignored the tiny and ever smaller population of DA&A recipients. However, some members of Congress were displeased to find that few new DA&A claimants were making the rolls. Between January 1, 1974, and May 1, 1976, only 205 new drug cases (3% of total drug cases) and 481 new alcohol cases (17% of total alcohol cases) joined the DA&A category. Representative Charles Vanik (D-OH), chairman of the Subcommittee on Oversight of the Committee on Ways and Means, offered possible explanations: (1) the SSA's definition of DA&A was too narrow; (2) alcoholics had other disabling conditions under which they were classified so as to "relieve" the SSA "of the

enormous administrative burdens of the treatment and payee provisions”; (3) the SSA had not developed referral services to get people into treatment so as to be eligible for DA&A benefits; and (4) there was no outreach system (Vanik, 1976a; 1976b:2).

The SSA’s response (Kieffer, 1976) was revealing. Its eligibility determinations and classification procedures were sound, the agency maintained.¹⁵ The treatment requirement was indeed difficult to implement. However, this was because Congress did not provide for a “new administrative structure to assume the operational responsibilities” (p. 42) and because funds were not appropriated to treat DA&A beneficiaries. By law, the SSA could not be responsible for treatment costs, but had to rely on Medicaid. However, Medicaid coverage for substance abuse treatment varied by state. Where coverage was not available, public facilities were the only realistic recourse for people poor enough to qualify for SSI—but many parts of the country lacked much public treatment capacity. Although publicly funded capacity would grow, poor people’s access to treatment would remain problematic.

To administer the treatment mandate, the SSA invented the referral and monitoring agency (RMA) to conduct initial assessments, identify appropriate and available treatment and refer clients to it, monitor clients’ progress and compliance, and report noncompliance to the SSA. The first handful of RMAs were chosen mainly from among state vocational rehabilitation agencies because they already performed disability determinations for the SSA and, per a 1965 amendment to the Social Security Act, were paid to rehabilitate DI beneficiaries (Weinberger, 1974). They did a poor and expensive job of the latter, as the General Accounting Office (GAO), the Office of Management and Budget, and HEW itself reported during the Carter administration. Thus, in August 1981, as part of the Omnibus Budget Reconciliation Act, Congress changed the rules to permit private rehabilitation agencies to compete

with state agencies, and altered the reimbursement formula so that no provider would be paid until a beneficiary had achieved nine continuous months of employment (Berkowitz, 1987). By 1984, with most state agencies opting not to get into the referral and monitoring business, the SSA had RMA contracts in only 10 states. However, these provided services to approximately 3,100 of the mere 4,000 DA&A beneficiaries at that time (SRA Technologies, 1986).

According to a staff member, in the early 1980s officials at SSA headquarters treated the DA&A program with “benign neglect.” Three or four different offices at headquarters had a hand in DA&A, but none of them did much about it. Few beneficiaries were sanctioned for noncompliance even when states attempted to implement the provisions: Recipients continued to receive checks while a noncompliance decision was in appeal, and this process could go on for a long time. As the result usually was a minor penalty, the effort to sanction seemed pointless.¹⁶

To the chagrin of SSA management, Congress mandated that the agency fund a demonstration project to determine whether case management influenced the improvement or recovery of DA&A recipients. In August 1983, when the study sites were selected, 3,506 people were on the SSI rolls for DA&A, the lowest figure since the program had begun.¹⁷ The study started with 608 subjects, and of those, only 91 were not monitored. Over the two-year study, only seven (1%) of the total returned to work or were determined to be no longer disabled, whereas over six times as many (46) died.¹⁸ Of those who lived, 58 became qualified under another impairment because that condition worsened, and 497 had no substantial change. Monitoring by case managers did not produce positive results: 1% of both the monitored and the unmonitored groups left the rolls because of employment or an end to disability. However, only 15% of those monitored died or changed impairment categories due to the deterioration of their health, compared with 31% of the unmonitored. Further,

while case management did not help subjects recover, it did keep them in treatment: 82% of those monitored remained in treatment throughout the study, compared with only 35% of the unmonitored. Of those not in treatment, 16% had negative outcomes versus only 9% of those in treatment (SRA Technologies, 1986). The lesson drawn by Thomas Price, the study's SSA project officer, was: "You could improve the quality of their lives, but you couldn't expect many to recover and go back to work."¹⁹

Despite the (unpublished) study, the DA&A program went unnoticed by Congress and the public for most of the 1980s because it remained very small. Even in 1989, DA&A beneficiaries represented only 0.7% of all SSI blind or disabled recipients between 18 and 64 years old. However, a surprised and unprepared SSA staff found the DA&A workload growing rapidly in the late 1980s—a time when the DA&A program was a bureaucratic backwater with one full-time employee. Congress and the Department of Health and Human Services' Office of the Inspector General (OIG) also took notice of the growth (OLCA, 1993). On the positive side, a 1991 OIG report noted that 99% of DA&A beneficiaries had representative payees (OIG, 1991). However, the report was on the whole quite damning. It observed that unclear SSA guidelines and DA&A regulations had created inconsistent program implementation across the states. The SSA did not know how many beneficiaries were in treatment; very few were monitored.

These were predictable results of rapid growth in a poorly supported program. The SSA regional staff was responsible for setting up cooperative agreements for RMAs, but if no agency was willing to be an RMA, the regional staff was supposed to assume the function. As this was unrealistic, to say the least, DA&A recipients in many states were not referred to treatment. Further, states with few such beneficiaries rarely wanted to bother with RMAs. As a regional staff member summed it up: "In the states, there was very little attempt to

put together any referral and monitoring agency unless there was some remuneration, and there was none forthcoming from SSA. SSA was never funded to do that even though Congress gave us the responsibility.”

In response to the OIG, the SSA formed a task force that included personnel from the Health Care Financing Administration and what was then the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). This group developed clearer definitions of appropriate treatment and successful rehabilitation, recommended improvements in access to treatment, and developed an RMA model protocol. As providing services was not part of its mission, the SSA approached ADAMHA about organizing and managing the referral and monitoring process. ADAMHA had similar reservations about whether the program fit its agenda, and these were compounded by the SSA’s unwillingness to transfer compensating resources. However, ADAMHA was willing to advise the SSA and collaborate on future projects. Thus, in September 1993, the new Substance Abuse and Mental Health Services Administration (a successor to ADAMHA, with an active interest in treatment) teamed up with the SSA to award the State of Washington and Washtenaw County in Michigan three-year contracts for demonstration projects to establish intensive case management models for DA&A beneficiaries. These projects included links to vocational rehabilitation services and were to identify mechanisms for providing representative-payee services through organizations. Illinois was funded for a similar project in East St. Louis in 1995.

In the early 1990s, 18 states had RMAs, allowing 45% of DA&A recipients to be monitored. Even so, the RMAs were a mixed lot: Some existed merely on paper, while others did intensive case management. In pursuit of consistency, the SSA issued a Request for Proposals in December 1992 to expand referral and monitoring capacity to all 50 states and the District of Columbia, using the model protocol as a guideline (DeWitt, 1995). By May 1994, RMA contracts were in place in 34 states

and the District. Eleven other states had agreements with the SSA to provide referral and monitoring services, making a total of 45 states and D.C. with RMA coverage. Maximus, a for-profit company specializing in management information systems, had a three-year contract to serve 29 states and D.C. (OLCA, 1994d; *Departments of Labor*, 1994b).

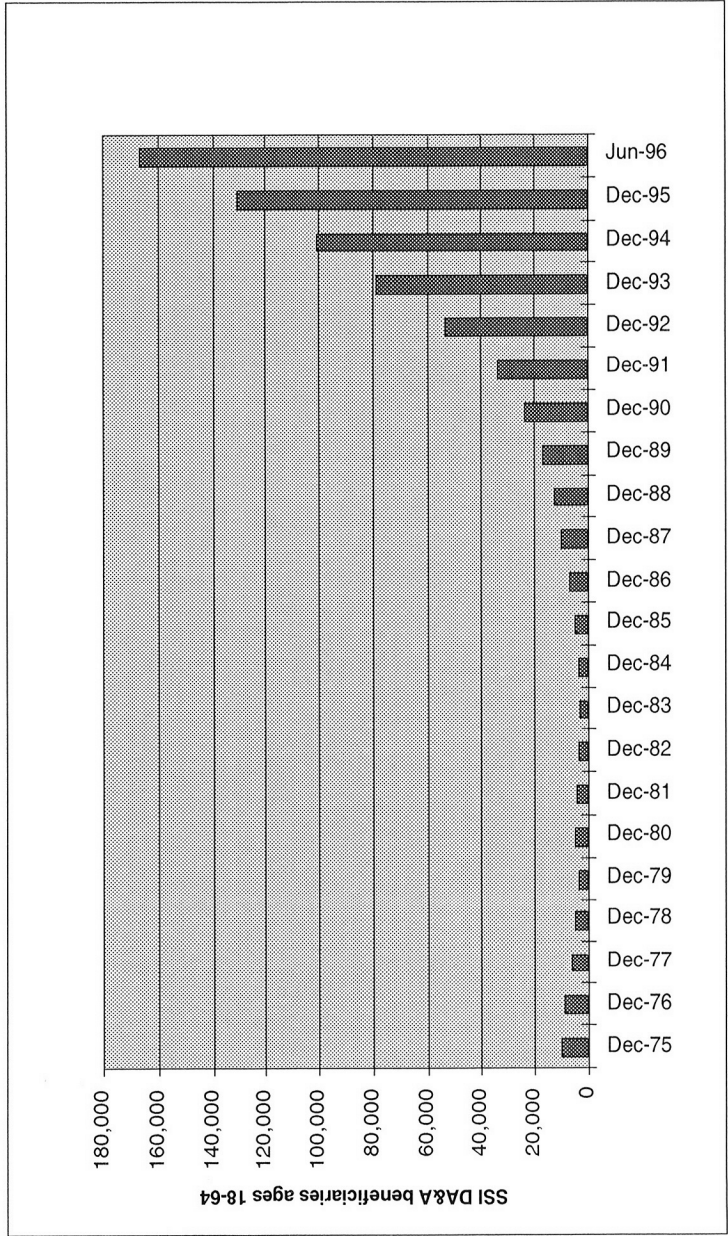
The SSA was at last fully implementing the 20-year-old DA&A provisions. At the same time, however, the GAO, Congressional committees, the OIG and others began to issue reports and make public statements about the SSA's inability to manage the DA&A program, now growing at a remarkable rate. It was widely noted, for example, that bartenders, liquor store clerks and fellow DA&A recipients served as payees. These stories were investigated by the SSA and determined to be true in only a few instances (OLCA, 1994c). By this point, however, Congress was ready to act.²⁰

Growth

Figure 1, compiled from SSA data, displays changes in the size of the SSI DA&A category (including concurrent beneficiaries) between the end of 1975, when such data were first aggregated, and June 1996, when there were almost 170,000 SSI DA&A recipients on the rolls. The period after 1989 produces an extraordinary slope, far steeper than that which would depict growth in the overall disability portion of the SSI program (Solomon, 1995; *Exploring Means of Achieving*, 1994b; Office of Disability, 1997; The Lewin Group, 1995).²¹ By February 1994, when two subcommittees of the House Ways and Means Committee held a joint hearing on the issue, Congress and the GAO were convinced that the DA&A program was "out of control" (*Exploring Means of Achieving*, 1994a).

Although DA&A growth occurred in all states, a handful contributed outside proportions, and some lagged far behind.

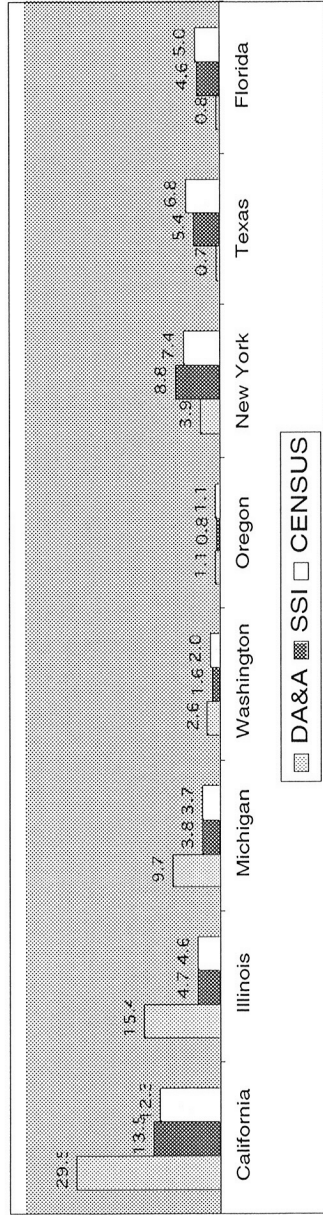
FIGURE 1
Growth in the SSI DA&A rolls from December 1975 through June 1996



Each state had an idiosyncratic DA&A growth curve that cannot be interpreted finely without close case study. By 1994, however, California, Illinois and Michigan, especially, had much higher percentages of DA&A beneficiaries than their respective shares of the SSI disabled population and the general population (see Figure 2). Figures for Texas, Florida and New York reveal just the opposite (SSA, 1995b; Population Distribution Branch, 1995; Office of Disability, 1995). Falling in the middle are Washington and Oregon, SSI Study sites along with California, Illinois and Michigan.

We can be certain that such disparities do not reflect true differences in the geographic distribution of people who met DA&A eligibility criteria. Still, it is not clear whether states made different judgments about SSI eligibility or understood or at least applied the materiality test in divergent ways, or whether the variable growth reflected differences in the volume and persistence of demand for benefits, perhaps due to the efforts of advocates. By some accounts, including that of Shirley Chater, SSA commissioner 1993–97, more recipients were labeled DA&A in states with active RMAs (*Departments of Labor*, 1994b). As a corollary, some insiders observed that in regions without RMAs, many individuals who should have been labeled were not (Office for Treatment Improvement [OTI], 1991). (If true, this explanation would account for the high relative numbers in California and Illinois, for early on the San Francisco and Chicago SSA regional offices stressed the “correct” coding of DA&A status, thus likely inflating their numbers relative to other, presumably less attentive, jurisdictions.) However, some SSA staff speculated that many qualified claimants were *denied benefits* in states without RMAs. This argument holds that disability-determination teams were less inclined to approve drug addicts and alcoholics in the absence of a way to ensure treatment compliance, and implies that different DA&A enrollments among the states did not result just from different labeling practices applied to those found eligible.

FIGURE 2
The percentage of all SSI DA&A beneficiaries living in eight illustrative states in December 1994 is compared with each state's percentage of the total SSI Disabled¹ and U.S. populations (ages 18-64)



¹ The SSI Disabled category includes some children and elderly people, whereas the DA&A population was between 18 and 64.

Differences among the states are impossible to explain conclusively with available data. Indeed, it is likely that notable differences among counties are obscured by the state-level aggregation of data. Even so, based on our interviews and reading of administrative materials, we think a number of processes combined at different times in different places to produce the national growth illustrated in Figure 1. First, the ambiguity of the regulations no doubt allowed divergent use of the DA&A category. Where liberal interpretation occurred, it may have resulted in more “real” DA&A cases *and* more inclusive labeling. Second, beginning in 1974, but most notably after 1983, a spate of federal court decisions thoroughly undermined the residual use of the irreversible-organ-damage criterion that formed the technical barrier to the eligibility of drug addicts and alcoholics. As we discuss below, court rulings and regulatory confusion were intimately related. Third, recession, declining tax revenues, and the spiraling costs of medical care in the late 1980s and early 1990s spurred some states and counties to cut back or eliminate their General Assistance (GA) programs and/or transfer as many GA cases as possible to SSI—eligibility for which also qualifies people for Medicaid in most states. The shifting of cases from GA to SSI also created additional revenue for some treatment and social service providers. Fourth, the first Reagan administration’s aggressive use of CDRs in the early 1980s produced a Congressional backlash that made it difficult to use this mechanism to shear the DA&A rolls as had been done in New York in 1976 and 1977. Finally, SSA outreach programs, particularly those directed to homeless persons, contributed to the expansion of the rolls. We now consider each of these factors.

Revisions of
the substance
addiction
regulations

Although the SSA carefully spells out procedures to be followed in determining disability, certain impairments elude the objectivity implied by a medical standard. Because evidence for the obsession and loss of control associated with addiction is based mainly on claimants’ self-reports, the most

important feature of a medical validating mechanism can be compromised. Moreover, the interpretation of complex evidence inevitably erodes the consistency of bureaucratic judgment, causing similar cases to be treated in different ways. The SSA understood this, of course, and after 1974 it revised the substance addiction disorder listing a few times, intending to clarify its administrative application rather than to change its meaning. But the practical effects were different: Each successive change seems to have made adjudicators and advocates for potential claimants ever more aware of the DA&A category while confusing the definitional issue further.

Perhaps most important to our story, in 1985, pursuant to the 1984 Social Security Disability Reform Act (P.L. 98-460), Substance Addiction Disorders became its own listing (12.09) under mental disorders (OTI, 1991). Listing 12.09 is a “reference listing,” meaning that the severity of the physical or behavioral changes resulting from “substance addiction” is measured against the severity listed for other impairments or disorders such as liver damage or depressive syndrome. This does not mean that claimants must *have* the impairment used as a reference. Rather, their impairment need only equal the reference listing’s severity requirements (Office of Disability, 1999).²² The use of a reference listing confused some adjudicators, who thought that in order to meet listing 12.09 the claimant had to first meet another, separate listing (OLCA, 1994a). This introduced an unintended new stringency and prompted numerous lawsuits, the most consequential of which was *Wilkerson v. Sullivan*.

Wilkerson v. Sullivan (1990) was a class action suit originating in Pennsylvania. It asserted that the secretary of HEW had willfully violated SSI regulations by failing to allow severe alcoholism alone to constitute a disabling impairment, thus disregarding decisions in two earlier cases (*McShea v. Schweiker* (1983) and *Purter v. Heckler* (1985)). The suit cited numerous other cases to show a high rate of error in the

determination of alcoholism claims, which the secretary attributed to the nature of bureaucracy. The federal district court sided with the claimants, ruling the Substance Addiction Disorders listing invalid because it required an additional impairment in the reference listing. This decision, which itself illustrated the confusion surrounding the use of a reference listing, was overturned by the 3rd Circuit, which suggested that the secretary improve his efficiency in adjudicating alcoholism claims by reminding the SSA and Disability Determination Service staff of the newest regulations and court interpretations. The resulting program directive from SSA headquarters in April 1991 attempted to further clarify the definition of disability to be applied to DA&A cases and stressed the importance of accurately identifying eligible individuals (*Departments of Labor*, 1994b). Because the directive was quite extensive, many field office staff and treatment providers assumed that it addressed a new regulation that liberalized DA&A eligibility. Although in fact nothing had changed but the interpretive climate (Gates, 1991), the DA&A rolls doubled over the next two years (*Departments of Labor*, 1994a).

Federal court decisions

As the SSA readily acknowledges, federal court decisions have significantly liberalized its policies over the years and led to more disability awards (GAO, 1994a). Federal courts did not look charitably upon alcoholics and addicts seeking disability benefits until the 1970s—until a time, that is, when the post-Prohibition alcoholism movement had achieved substantial cultural and political acceptance and the management of drug addiction had emerged somewhat from the punishing moralism that descended on drug policy in the 1920s (see White, 1998). As late as the 1960s, even as the U.S. Supreme Court likened heroin addiction to leprosy and mental illness (*Robinson v. California*, 1962), the 4th Circuit ruled in *Mays v. Ribicoff* (also 1962) that DI benefits could be denied to alcoholics because they could work once they stopped drinking. Most circuit court rulings during the 1960s supported

this view of “remediability,” thus undermining the claim that an addict’s impairment would persist. However, by the 1970s, although the Supreme Court was deadlocked on alcoholism’s status as a “disease” (*Powell v. Texas*, 1968), the venerable and oft-conflated clinical markers of “craving” and “loss of control” were becoming fundamental to addiction as the courts understood it (see Justice White’s opinion in *Powell*). The door was opening to successful litigation against denial of disability benefits.

The most important early decisions were *Badicheck v. Secretary of HEW* (1974) and *Griffis v. Weinberger* (1975). The former was a DI case from New York, the latter an SSI case from California. In both, the denial of benefits was vacated because the disability-determination process, including administrative appeals, had not considered “loss of control” when assessing the contribution of alcoholism to disability. *Griffis* concluded that chronic alcoholism could in and of itself be a disabling condition. As Orville Griffis was inclined to polypharmacy, the decision could be (and was) read to include drug addiction.

Given that the temporary SSI regulations of 1974 dropped the old DI addiction standard, it is not clear why HEW contested *Griffis*. It may be that the agency worried that too broad a standard would invite young claimants whose only impairment was alcoholism or drug addiction of relatively recent origin.²³ As it happened, in the wake of *Griffis* the SSA officially abjured its old rule in formal regulations issued in July 1975. However, as discussed above, that severe but transparent standard yielded to one that no one seemed to understand. The old standard thus persisted in use for years, and when it crumbled in the face of lawsuits, disability examiners and their hired clinical consultants differed in how they weighed the disabling potential of addiction.

Suits against the SSA mounted quickly. In the years after *Griffis*, two widely cited 9th Circuit (California region) rul-

ings, *Johnson v. Harris* (1980), a DI case, and *Cooper v. Bowen* (1987), an SSI case, reaffirmed that an addict incapable of SGA should be found disabled even in the absence of physiological damage. In an influential DI case, *Adams v. Weinberger* (1977), the 8th Circuit concluded not only that the irreversible-organ-damage criterion had been improperly applied, but that a claimant's testimony that he could control his drinking should not be taken at face value because of the powerful role of "denial" in alcoholism. Similarly, two cases mentioned above, *McShea v. Schweiker* (1983) and *Purter v. Heckler* (1985), both from the 3rd Circuit, concluded that alcoholism can cause disability independent of other conditions, and that the SSA must conduct a full and fair hearing about a claimant's history of alcoholism when there is evidence of denial.

Beginning in the mid-1970s, federal courts, led by the liberal and influential 9th Circuit, issued dozens of rulings that converged in their interpretations of eligible addiction, thus spreading a new dispensation for alcoholics and drug addicts. But while the courts created a necessary condition for the expansion of benefits, the justices did not scour America for potential claimants. In their pursuit of case-level justice, the courts created the possibility that SSI could be widely used by alcoholics and drug addicts—but other interested parties made it happen.

Shifting cases
from state to
federal welfare
rolls

When the courts breached the walls around the DA&A category, claimants in many areas shortly were at no loss for technical assistance by advocates and attorneys from non-profits or by private attorneys who specialized in disability claims. Many non-profits that provided small-scale, non-medical, residential substance abuse treatment—so-called recovery homes or therapeutic communities—also became advocates, in part because SSI provided a reliable income source by which residents could pay room and board. This indirect subsidy of treatment was a boon to state and county budgets, of course. Indeed, as the 1980s unfolded, state and local govern-

ments worked hard to transfer people from their welfare rolls to SSI. This push was spurred by recession-stimulated cuts in GA programs and the rapidly rising costs of medical care that jeopardized the solvency of public hospitals (Mashaw and Reno, 1996; Bound et al., 1998; Barnes et al., 1992). In some places GA applicants were asked to sign an agreement that they would apply for SSI and that their interim GA benefits would be repaid from any “back pay” (retroactive benefits). Beginning in 1989 the Illinois Department of Public Aid funded the Legal Assistance Foundation of Chicago’s SSI Advocacy Project (SAP) to counsel claimants on their applications, help them secure documentation (including psychological evaluations), and represent them in administrative hearings. During the first three years of the 1990s, SAP alone secured SSI or DI DA&A benefits for over 1,000 people (*Exploring Means of Achieving*, 1994c).²⁴

Liberalization of the CDR and mental impairment regulations

Before 1976, disability benefits could not be terminated without evidence of “medical improvement” and proof that a recipient no longer met disability criteria. Elimination of the medical-improvement standard in 1976 made termination easier, and in 1980 Congress dictated a timetable for the regular use of CDRs. In the early 1980s, taking full advantage of these uncontroversial policies, the Reagan administration set out to “purify” the disability rolls, as that administration called the process of disability review (Berkowitz, 1987: 124-5). By the autumn of 1984, the SSA had terminated 490,000 disability beneficiaries, many with mental impairments. The result was a political debacle: New York disability examiners refused to conduct CDRs; President Reagan was stunned to find cut off a Viet Nam War hero and father of three to whom he had personally awarded the Medal of Honor; even *The Wall Street Journal* sided against the administration. The courts ultimately reinstated the majority of those terminated. The SSA ceased all CDRs and denials of mental impairment claims until new regulations were published. The medical-improvement standard was reinstated in

1984, and new mental-impairment regulations were published in 1985 (Berkowitz, 1987; Derthick, 1990; Mashaw and Reno, 1996).

The 1984 Social Security Disability Reform Act (P.L. 98-460) required the SSA to issue the revised mental-impairment criteria that produced Listing 12.09, discussed above. At the same time, by giving increased weight to functional factors (whether an individual was capable of competing in the job market), the presence of pain, the combined effects of multiple impairments, medical reports from claimants' own physicians, and reports from family and friends, the new law liberalized the evaluation process by weakening the validating role of medical evidence and independent assessments (Mashaw and Reno, 1996; Stapleton and Livermore, 1996; GAO, 1994a; 1995). But while the SSA was liberalizing its requirements in this way, it was backlogged on CDRs because of the lengthy moratorium. The result was that the always high ratio of program entrants to departees became even higher.

SSI outreach efforts

Outreach to potential beneficiaries exacerbated the entry-to-exit ratio problem. With the explosion of homelessness during the 1980s, welfare workers in many cities took their services into shelters. Prodded by a congressional mandate that reflected state and local interest in shifting welfare costs, and anxious to live down the CDR disaster, the SSA began to systematically educate service providers about SSI in 1989 (Livermore et al., 1998; Hemingson, 1998). Congress appropriated \$27 million for outreach projects for fiscal years 1990 through 1994 (OLCA, 1994e). A 1994 survey of 1,300 SSA field office managers found that half "had made special arrangements" to take disability claims from various local institutions, including shelters and penal facilities (Muller and Wheeler, 1998:211). By all accounts, these efforts brought many new people onto the rolls, especially DA&A beneficiaries. But because administrative funds and disability-determination capacity were being cut at the same time,

the SSA could not handle the workload (DeWitt, 1995). Due to funding and legal constraints, CDRs were pushed aside in order to process new claims, which meant that few people were terminated at the same time that many more new awards were made (GAO, 1994a).

Ironically, the success of outreach would contribute to the perception by Congress that growth of the DA&A program was “out of control.” Equally important, however, it began to seem that the program’s beneficiaries themselves were out of control, a matter to which we now turn.

Controversy

In January 1992 William Whiting, a DA&A beneficiary, was found dead of a drug overdose in a Bakersfield, California, motel room. He had just purchased large amounts of drugs and alcohol with his retroactive SSI check (Otten, 1992). At about the same time, Linda Torrez, also a DA&A recipient from Bakersfield, was arrested for heroin possession, and while searching her apartment police found thousands of dollars in cash from her SSI “back pay” (Irvine and Goulden, 1992). It appeared in both instances that the representative payees also had drug and alcohol problems, making them poor choices to handle someone else’s money (Jackson, 1994). The Whiting and Torrez cases would be revisited many times over the next two and a half years by daily newspapers and weekly print and television magazines (see Hunt, 2000, for a thorough review). The DA&A program became mired in scandal, and its management problems made the SSA look irresponsible. On May 1, 1994, while legislation to “reform” the program was being marked up, Leslie Stahl introduced as follows a segment of CBS’s *60 Minutes*, called “Easy Money”: “If you’re a drug addict or an alcoholic and you are looking for an easy way to make some easy money, the Social Security Administration is more than willing to

help you out even when they probably know you are more than likely to use the money to buy more drugs or another bottle of booze.”

**The state as
“enabler”**

Controversy about the DA&A program was part of the broader contemporaneous debate about welfare reform, particularly the role of the state’s welfare apparatus in promoting “good citizenship”—most specifically, the obligation to work. Dissatisfaction with the major federal welfare program, Aid to Families with Dependent Children, had been mounting for years. Even the Democratic Party had developed its own work-promoting version of welfare reform based largely on the scholarship of Harvard economist David Ellwood and his associate, Mary Jo Bane (see Ellwood, 1988), both of whom went to work for the Clinton administration. The ascendancy of the Republican Party following the November 1994 elections radically changed the tone and politics of welfare reform, however, and yielded the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (P.L. 104-193). The PRWORA was based on premises laid out succinctly in *Contract with America* (Gillespie and Schellhas, 1994), the 1994 campaign manifesto drafted by Republican leaders in the House of Representatives. *Contract* opined that the liberal welfare regime dating from the 1960s “had the unintended consequence of making welfare more attractive than work” (p. 67). Moreover: “Government programs designed to give a helping hand to the neediest of Americans have instead bred illegitimacy, crime, illiteracy, and more poverty.” Welfare reform should “change this destructive social behavior by requiring welfare recipients to take personal responsibility for the decisions they make” (p. 65).²⁵

The DA&A scandal was a natural issue for welfare critics: Combining the themes of government wastefulness and state-inspired harm, it captured the attention of fiscal and cultural conservatives. Moreover, the myriad media reports made it clear that many professionals who worked with drug addicts

and alcoholics were contemptuous of the DA&A program. NBC's *Dateline*, in a story that aired February 8, 1994, featured a recovering alcoholic and shelter operator in Denver who opined that SSI checks to addicts were "killing them on the installment plan. The first day of every month they die a little." He added: "The Social Security Department [sic] is the largest supplier of drugs and alcohol to addicts in America." On the same program, a substance abuse/mental health clinician from Michigan stressed how difficult it was to motivate addicts to seek treatment, because the disability check was a deterrent (Goodman, 1994). The *60 Minutes* broadcast mentioned above gave a Stockton, California, methadone program administrator a similar forum in which to condemn the DA&A program as a misguided "enabler" of addiction. Only a handful of media stories took seriously the idea that disability payments to drug addicts and alcoholics might help them get back on their feet or at least keep them off the streets (Garaygordobil, 1993; Trachtenberg, 1994; Henry, 1994).

The SSA joined this chorus of praise for "personal responsibility." In May 1994 Commissioner Chater informed the Committee on Appropriations:

Over the years it has become clear to the medical profession that substance addiction is a disease that can legitimately be the basis for a finding of disability. The Congress and the Administration concur with this finding. However, I agree with you that the American public has a right to expect that those disabled by substance addictions will not simply continue on Supplemental Security Income disability payment rolls without taking responsibility for themselves. Unlike many other disabled individuals, those suffering from substance abuse can, to varying degrees, influence their recovery by their own actions. The public has the right, therefore, to expect that they will do all they can to cooperate in recovering from their addiction and become self-supporting. (*Departments of Labor*, 1994b)

Congress was happy to oblige the commissioner's interest in having DA&A recipients take responsibility for themselves.

Political response

During development of the 1972 DA&A provisions, the Senate Finance Committee wrestled with the concerns raised by the Whiting and Torrez cases and other, similar cases; the treatment and payee requirements of SSI were enacted to address them. But these provisions were never implemented systematically, and the events of the early 1990s persuaded many Congressmen of both parties that disability checks were not helpful in the management of addiction. By the mid-1990s they had come to the same conclusion offered by Senator Hughes in 1972. Representative (now Senator) Wayne Allard (R-CO) put it this way: “We all have compassion for people with a substance abuse problem, but giving cash benefits to addicts is not the way to deal with the problem. This approach does far more harm than good, often providing the very resources for addicts to continue their abuse and avoid treatment” (*SSI Reform*, 1995). Defending his 1996 proposal for a radically modified DA&A program, Senator Byron Dorgan (D-ND) asserted: “Substance abusers need treatment, not cash handouts from the Federal Government. . . . Instead, drug addicts and alcoholics [should] be provided with access to quality treatment for their diseases” (*The Social Security Act*, 1996).

Reform: the 1994 DA&A legislation

Congressional efforts to reform the DA&A program began with Representative William Thomas (R-CA); he introduced legislation in 1992 in response to the Whiting and Torrez cases, which occurred in his district. Thomas’s legislation, the substance of which anticipated the 1994 reforms, failed. Reintroduced in April 1993, it died in committee. In late 1993, Representative Robert Michel (R-IL) introduced much stricter DA&A legislation, and the Senate had a comparable bill, but neither got out of committee (OLCA, 1993). Two House Ways and Means subcommittees requested in 1992, and Senator William Cohen (R-ME) requested in 1993, that the GAO investigate SSA controls over disability payments made to drug addicts and alcoholics (OLCA, 1994b).

The movement to reform the DA&A program intensified early in the election year of 1994. Before the GAO report was released to the public, and just days before a House Committee on Ways and Means joint subcommittee hearing on February 10, Senator Cohen released some of the GAO findings in a widely publicized staff report (Cohen, 1994). At the hearing, a representative from the GAO, Jane Ross, testified that 250,000 “addicts” received disability payments at an annual cost of \$1.4 billion, with more than half getting disability based on other medical conditions (making them exempt from DA&A provisions).²⁶ Ms. Ross reiterated the OIG’s earlier concerns about the lack of attention to the treatment mandate. Specifically, she noted that the majority of DA&A beneficiaries were not in substance abuse treatment (only one in five, according to SSA records) and that the status of many was unknown. For those in treatment, she observed, the SSA had done a poor job of monitoring compliance. She surmised that representative payees, many of whom were family and friends, did not have tight control of the recipients’ funds, which allowed recipients to use their checks on drugs and alcohol (GAO, 1994b; *Exploring Means of Achieving*, 1994a). Commissioner Chater agreed that the agency was not fulfilling these responsibilities and conceded that doing so was not a high priority (*Exploring Means of Achieving*, 1994b).

The joint subcommittees of the Committee on Ways and Means and the staff of the Special Committee on Aging, under the direction of Senator Cohen, the ranking minority member, worked separately on new DA&A legislation. According to our sources, Committee on Aging staff were impressed by the “enabling” argument and by the apparent contradiction between the government’s long-running “war on drugs” on the one hand and its role as “the biggest writer of checks to drug addicts” on the other. However, Cohen did not believe it was his place “to challenge the medical science as to whether or not this was an impairment or a disability.”

He wasn't out to scuttle the program. The Ways and Means subcommittees, however, felt the political pressure of an election year and were encouraged by some Congressmen to terminate the program or to write legislation with the strictest possible language. Representative (now Senator) Rick Santorum (R-PA) was an important proponent of this position. Santorum favored drug testing for welfare recipients and a "one strike and you're out" approach to users of illegal drugs (Lambert, 1994).

According to Ways and Means staff, the details of the DA&A legislation were challenging to draft because of such strongly held, widely differing opinions. Senator Cohen successfully opposed the Santorum faction's push to dismantle the program, and eventually the House and the Senate Finance Committee reached agreement. Despite the goal of strict language, the bill was softened in the final mark-up.

On August 15, 1994, the Social Security Independence and Program Improvements Act (P.L. 103-296) was signed into law. In its original form, it was a popular bill intended only to make the SSA an independent agency—that is, to liberate it from the Department of Health and Human Services. Pushed by the House, the Senate Finance Committee attached the new DA&A provisions. These gave teeth to the regulations adopted over two decades earlier: The SSA had to establish RMA contracts in all 50 states, Puerto Rico, and DC, and effective with checks payable March 1, 1995, all individuals on SSI or DI with drug addiction or alcoholism "material to the finding" of disability were required to be in treatment, if available, and to make progress in treatment. Further, they were subject to progressive sanctions for noncompliance with treatment; were required to have a representative payee (organizational payees were officially preferred); would receive retroactive benefits in a series of payments spread over time; and could receive disability benefits for only 36 months in a lifetime for drug and alcohol addictions (Benefit Reforms for Individuals Disabled, 1995).²⁷

Congress believed the 1994 reforms would save money in the long run because the systematic treatment of DA&A beneficiaries would reduce long-term health care costs; noncompliant individuals would lose benefits, and the time limits would motivate people (SSA, 1995a). Indeed, time limits, an idea borrowed by federal welfare critics from state GA programs (Vartanian et al., 1999), would both reduce program costs and make them more predictable. The Congressional Budget Office (CBO) estimated that five-year (FY 1995–1999) savings of \$840 million would result from the DA&A provisions (Solomon, 1995).

Implementing the 1994 reforms

The SSA faced many obstacles to implementing the 1994 reforms. The agency had only six months in which to inform DA&A beneficiaries of the legislative changes; write an RMA Request for Proposals with a new scope of work; write policies and procedures; train the staff of 1,500 SSA field offices and the RMAs; develop a new computer system; and accomplish many smaller tasks besides. The planning and implementation process involved numerous departments within the SSA, as well as outside organizations such as the RMAs and their allied treatment programs. Indeed, the SSA was completely dependent on outside agencies to implement the treatment and payee mandates. Moreover, SSA DA&A policy and contracts staff knew little about addiction and the addicted. (As one recalled: “We probably should have spent a lot more time learning, whether we liked it or not. How do you deal with this population? What are the pitfalls? We had to learn that the hard way.”)

Given the complexity of the organizational environment, SSA leadership delegated management of the process to a core team representing various SSA components, and they assigned several staff to work solely on DA&A policies and RMA contracts. Even so, it took much longer than expected to get the RMAs in place. By January 1995, before official implementation of the new law, the SSA already had awarded RMA contracts or renewed continuing agreements that cov-

ered SSI beneficiaries in Washington, DC, and every state but Oregon (OIG, 1997; Office of Policy, 1995). However, to implement the 1994 legislation, the SSA had to reissue the Request for Proposals because the new law significantly expanded the stated scope of work by adding DI beneficiaries to the RMA caseload. The new contracts were not issued until September 1995. New York and Oregon were awarded contracts even later. The state-agency RMA in Oregon did not sign a contract until the end of February 1996, one month before Congress eliminated the DA&A category, and did not refer clients to services until July. New York also signed its contract early in 1996. In Michigan the state-agency RMA did not award a subcontract until March 1996 because an October 1995 award was contested. New York and Oregon were able to start up quickly, though, allowing many people to get services before the program's shutdown.²⁸

Once established, the RMAs placed 55,000 people in treatment nationally by September 1996. The new three-year contracts for \$416 million represented the largest program award ever made by the SSA. Ultimately, Maximus took on approximately 70% of the national workload, managing the referral and monitoring process in 42 states, DC, and Puerto Rico. Eight states, including four of the five in the SSI Study (Illinois, Michigan, Oregon, and Washington) had different contractors.

Although the requirement for new proposals delayed the start-up process, few RMAs could have handled the DI workload before September because they were still processing SSI recipients. For a number of reasons, and contrary to the more optimistic expectations of SSA staff and RMA managers, many RMAs needed six to nine months to get referral and monitoring structures in place. The biggest problem was that most RMAs relied on subcontractors to handle part of the workload. There were either too many cases for them to manage with their own personnel or clients were located in places where they did not provide services. Maximus, the single

largest RMA, is not a direct-care provider and had to rely solely on subcontractors. RMAs had particular problems finding subcontractors willing to handle the small rural caseloads because of the high costs and limited profits. Even in metropolitan areas, treatment agencies sometimes were reluctant to take on small caseloads because of the relatively great effort involved in establishing referral and monitoring procedures.

Other problems arose once the referral and monitoring structures were in place. First, the SSA did not provide RMAs with current beneficiary information in a timely way. The data tapes for the September 1995 contract contained many invalid addresses for beneficiaries and payees. Maximus staff reported that a significant number of records contained no address for the beneficiary; they had to send a letter to each payee asking him or her to put the recipient in touch. In the end, the Michigan RMA failed to locate over one-third of its assigned cases, a result of poor information on their whereabouts.

Second, the SSA had to depend on Medicaid and Medicare to pay for the “appropriate” and “available” treatment that recipients were to be offered under the DA&A provisions.²⁹ Although most DA&A beneficiaries qualified for Medicaid or Medicare, this did not guarantee coverage for substance abuse treatment, which is not a mandated Medicaid benefit. Some states cover a wide range of substance abuse services, but others do not. For uninsured and underinsured DA&A beneficiaries, the public treatment system was the fallback. States receive federal money in the form of “block grants” to fund public substance abuse programs, and they also use some of their own money this way. In most states these funds are channeled through the counties (and sometimes cities), which usually add their own small increments. However, there are substantial differences in the amount and kind of treatment services that states and their subdivisions provide and in how they target services. While states had the flexibility to provide services specifically to DA&A beneficiaries,

this may have meant taking funds from other established target populations (Social Security Administration, 1995a). As a top SSA administrator noted: “This was about rearranging the pie, not making it larger.” Congress thought it could solve this problem by approving the use of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) as treatment resources. Leaders of AA and NA bristled at the label of treatment, however, and the regulations guiding implementation of the 1994 law finessed the issue by permitting the “prescription” of self-help participation “by a treatment professional . . . as part of an individual’s treatment plan” (Benefit Reforms for Individuals Disabled, 1995:8148). Our interviews with claims representatives from several states indicated that some believed self-help participation alone qualified as treatment.

Most jurisdictions had basic treatment resources, but appropriate treatment was not available in many places. Maximus subcontractors, other RMAs, and SSA personnel reported that it was difficult to find treatment in rural areas, even in states that provided liberal Medicaid benefits. Methadone maintenance was limited in some areas, and most areas had little capacity to treat people with dual substance abuse and mental illness diagnoses.

Finally, as implementation of the 1994 law progressed, poor coordination between the RMAs and the SSA became apparent. The RMA contracts contained a very detailed scope of work that laid out what the RMAs should communicate to the SSA and how they should do it—but the elaborate subcontractual structure meant that information often was slow getting to the agency. A number of RMA subcontractors reported to the SSA that they found it difficult to get clinical assessments and compliance reports from often overworked treatment providers. As neither the RMA nor the SSA paid providers directly, they had little leverage. It was much easier to obtain the necessary information, the RMAs noted, if the subcontractor and the treatment agency were one and the same.³⁰

Use of the information received was another issue: The number of beneficiaries referred by the RMAs to SSA field offices (FOs) for noncompliance was far greater than the number whose benefits were suspended. Many fell into administrative limbo. An SSA regional staff member observed:

[B]ecause the policy was so complex and the procedures were so convoluted, and the workload was so small for the total overall mission of SSA, . . . these people got lost in the shuffle. . . . The [FOs] felt like they didn't have the time to put so much effort into these individual cases because they had so many other cases to deal with that weren't DA&A. . . . They just were never dealt with. You got a recommendation of noncompliance from the RMA and the CR [claims representative] would pick it up and say, "I don't know what to do with this," and put it down and the person's check would continue. The RMA closed it out but nothing effective would really happen. . . .

In addition, there was a backlog of cases referred to the SSA because treatment had been completed. After an individual had finished treatment, the FO was supposed to initiate a full medical CDR (Office of Training, 1995), but the SSA was so far behind on CDRs that such cases rarely left the rolls. The SSA initiated CDRs on 492 DA&A cases by October 1995; however, between March 1994 and September 1995, the RMAs had referred 2,182 cases to the SSA after successful completion of treatment. Only 32 cases were terminated for medical improvement after completing treatment (OIG, 1997).³¹ It is very likely that many DA&A recipients who benefited substantially from treatment remained on the rolls because they had no viable economic alternatives and because the CDR mechanism broke down.

Finally, even as the SSA worked furiously to implement the 1994 DA&A provisions, it clearly was only a matter of time before the program would be terminated. On February 15, 1995, four days after official implementation of the 1994 regulations, the Ways and Means Subcommittee on Human Resources voted to eliminate SSI (but not DI) DA&A bene-

fits during mark-up of the Personal Responsibility Act of 1995 (Solomon, 1995)—what became the PRWORA of 1996. The Balanced Budget Act of 1995 (H.R. 2491) also contained provisions to eliminate SSI DA&A benefits. Although both bills passed in the House and the Senate, they were vetoed by President Clinton for reasons wholly unrelated to the DA&A issue. A senior SSA administrator reflected on the effect: “By the time [the DA&A reform] was in its first year, it was on its way to being dead, and very few people invest enthusiastically . . . in something . . . on its way to the graveyard. So even though it wasn’t technically over until January [1997], it was over when people started saying it was over.” A claims representative noted: “So you had a situation where people were now supposed to comply. You’re getting a noncompliance letter. You call the people in. You say, ‘You need to comply, but your benefits are going to be shut off in January anyway.’ So I think their response most of the time was ‘What the hell. Why should I bother?’ ”

Toward the end, many RMAs and their subcontractors operated with skeleton staffs. Several had used temporary employees from the beginning because of the pending legislation to terminate the program. Many staff, both permanent and temporary, left once they heard that the program was doomed.

Efforts to save the DA&A program

Both political parties wanted to end the DA&A program. Maximus, standing to lose its very large RMA contract, hired the Wexler Group, a prominent Washington lobbying firm, to try to keep it alive. Beginning in the spring of 1995, Wexler worked side by side with the Legal Action Center,³² focusing mainly on moderate Republicans and Democrats in the Senate because the House was moving too fast on welfare reform for their arguments to make a difference. Concerned about conservatives “who were controlling the agenda,” Wexler “had to figure out a way to make the case to them.” Thus Wexler’s main pitch was that RMAs would eliminate fraud and abuse. Even so, a Republican staff member observed that this

approach was ineffective because it encouraged elimination of the program sooner rather than later: If savings came from severing people from the rolls for noncompliance, not as the result of rehabilitation, it wouldn't hurt to kick them all off right away. As put, he noted, Wexler's message was consistent with the Republicans' criticism: No one is helping these people, and RMAs are mere "federal nannies." Maximus eventually produced a report to explain the RMA program and show statistically why it saved money and could rehabilitate people. This was widely distributed on Capitol Hill, but Congress, searching for immediate savings, already had deemed the DA&A program disposable.

It is unlikely that any effort would have changed the course of events after November 1994, but the Wexler Group and Legal Action certainly tried. Because provisions to end the DA&A program were included in a number of bills, the advocates were constantly scrambling. Then, in September, *The New England Journal of Medicine* published the results of a study (Shaner et al., 1995) showing that for a sample of schizophrenic patients with a cocaine-dependence diagnosis, cocaine use, psychiatric symptoms, and hospital admissions increased each month shortly after disability checks arrived. In spite of its limitations, the study was taken to support the wisdom of eliminating the DA&A program. Legal Action was able to get only a few representatives of the badly divided treatment community to defend the program to their legislators.

Perhaps most damaging, 1996 was an election year, and no member of Congress wanted to be seen as a coddler of drug addicts or a bunch of "drunks," as a congressional staff member put it to a Legal Action representative. Neither Wexler nor Legal Action could find effective congressional sponsorship for an alternate proposal. While Senator Cohen had supported RMAs in testimony before the Senate Finance Committee in February 1995 and apparently was willing to offer an amendment, he could not get any Democrats to stand with him. The

advocates got Representative Charles Rangel (D-NY) to offer an amendment to the Personal Responsibility Act that would have kept Medicaid in place for those who lost SSI benefits—but it failed. One lobbyist believes the White House would have found some way to help if the SSA had vigorously defended the Maximus figures and its own stake in the DA&A program. However, the program was an administrative nightmare for the agency, and its leaders were happily rid of it.

Ultimately, provisions to eliminate the DA&A program were added to the Senior Citizens' Right to Work Act, H.R. 2684, which in turn was appended to H.R. 3136, the Contract with America Advancement Act of 1996 (Solomon-Fears, 1996). The Senior Citizens legislation increased allowable tax-exempt earnings for Social Security retirees; it was very popular, and the White House wanted it passed. Congress needed compensating savings of \$7 billion to offset this tax expenditure, and eliminating the DA&A program was an easy way to find \$5.7 billion. Coupling a favor to working seniors with the demise of the DA&A program created a classic opposition of worthy and unworthy groups of political claimants, making the bill unassailable.

There were two late efforts to maintain some benefits for DA&A recipients. Legal Action tried to have the DA&A provisions in the Contract with America Advancement Act struck, claiming that because SSI is a welfare program, savings from it could not be used as an offset under budget limitation rules. No senator was willing to declare the procedurally necessary point of order. On March 26, 1996, Senator Byron Dorgan (D-ND) introduced a bill to permit DA&A recipients to keep Medicaid and to provide access to treatment while requiring any alcoholic or drug addict on the disability rolls to have a payee (The Social Security Act, 1996). It died in committee.

Senator Dorgan's bill was merely the last attempt to save the DA&A program by turning it in the bluntly paternalistic direction favored by the Senate Finance Committee in 1972. Early in its lobbying effort, Legal Action, trying to "figure out what was preservable," proposed that DA&A recipients be given food stamps and housing vouchers in lieu of the bulk of their cash benefits. Any remaining cash would be managed by an RMA. The advocates argued that this approach would save as much as would the House bill to eliminate the program.³³ Legal Action's second, less desirable alternative was akin to the amendment offered by Representative Rangel: Former SSI DA&A recipients would retain Medicaid, but without the exclusion forbidding Medicaid reimbursement for services provided to 22- to 64-year-old recipients in residential mental-health or substance-abuse treatment facilities larger than 16 beds (Rubinstein, 1995). Finally, in January 1996, with the elimination of the program imminent, Legal Action proposed that the RMAs be maintained, treatment funding be increased by \$350 million for fiscal years 1997 and 1998, and Medicaid be extended without the institutional-treatment exclusion (Rubinstein, 1996). However, because this proposal failed to address the need to fund the tax expenditure in the Senior Citizens bill, it went nowhere.

**Demise: the
1996 DA&A
legislation**

On March 29, 1996, the 1994 DA&A provisions were overridden by H.R. 3136 (P.L. 104-121), which the President promptly signed. No new DA&A beneficiaries were approved as of that date, not even those with applications pending. As of January 1, 1997, DA&A recipients were no longer eligible for disability benefits. Each could apply for a "redetermination review" (including a new medical determination) and thus be considered on the basis of other impairment(s). Anyone who requalified and was considered to have a "DA&A condition" was assigned a representative payee if determined incapable of managing benefits. Those with DA&A conditions were referred to their state substance abuse agency

(which is not a treatment provider) but were not subsequently monitored. RMAs were phased out by January 1, 1997. H.R. 3136 appropriated \$50 million annually to the Substance Abuse Prevention and Treatment (SAPT) Block Grant for fiscal years 1997 and 1998 specifically for the treatment of former DA&A recipients (DiSimone, 1996). Committee on Aging staff secured these funds despite the Finance Committee's reluctance.

The Congressional Budget Office predicted that eliminating payments to SSI DA&A beneficiaries would result in federal savings of about \$1.4 billion from 1996 through 2002; \$1.9 billion would be realized by eliminating DI payments. In addition, terminating the RMA contracts would save \$144 million in 1997 and \$300 million a year between 1998 and 2002.³⁴ Trimming Medicare and Medicaid would create further savings: Medicaid savings were predicted to grow from \$73 million in 1997 to \$136 million in 2002, and Medicare savings from \$43 million to \$213 million in that same time. However, eliminating the DA&A category was expected to increase spending in other federal programs. Food stamp costs were estimated to increase by \$400 million from 1996 to 2002. The CBO also estimated that the qualification of some former recipients for what was then Aid to Families with Dependent Children would cost \$5 million annually. Also, \$100 million had to be set aside to treat former DA&A beneficiaries in the 1997 and 1998 fiscal years (CBO, 1996).

Many local officials and anti-poverty advocates worried that no safety net would remain for most former beneficiaries because many states had eliminated or scaled back their GA programs—poor sources of support to begin with (Greenberg and Baumohl, 1996). From these quarters came quick predictions of increased homelessness, crime, communicable disease, state and county medical expenditures, and drug and alcohol use (because there would no longer be a treatment mandate). Not until well after the law had been passed did the media explore widely the possibility that disability checks

had helped many people for whom this legislation might be devastating (Gogek and Gogek, 1996; Ellis, 1996; McGuire, 1996; Bender, 1996; Tobar, 1996; Wilder, 1996; Betancourt, 1996).

Because many individuals receiving unfavorable redeterminations would lose medical benefits, some states, notably California, temporarily extended Medicaid coverage. Continuing coverage, however, would be linked to employer-sponsored plans, eligibility for another form of public assistance, or enrollment in a state-sponsored health plan (as in Oregon). Those without coverage would have to rely on the public system. Congress thought it was addressing the problem of substance abuse treatment by allocating the \$100 million for it. However, the block-grant formula used to calculate how much each state would receive disproportionately benefited states with small DA&A populations.³⁵ Moreover, while states were obliged to ensure priority treatment to former DA&A beneficiaries, no report on their initiatives was due until the year 2000—when any consequences for having used the money otherwise would be unlikely. Indeed, narrative reports on the use of the fiscal 1997 funds (when submitted at all) show that states had mixed results in contacting former DA&A beneficiaries, let alone in developing specific services for them (DSCA, 2001).³⁶

Implementation of the 1996 provisions

The SSA Office of the General Counsel handled the DA&A cases cautiously because of the large number of individuals about to be terminated. The SSA did not want to become the target for disability advocates that it had been in the early 1980s. In fact, lawsuits did not materialize on nearly the scale anticipated.³⁷

The SSA had a little over two months to develop the notices that informed all DA&A recipients that their benefits would end in January 1997. These were mailed in June 1996 to both beneficiaries and representative payees (Office of Policy, 1996b). They informed beneficiaries of their right to request

an eligibility redetermination up to 60 days after receiving the notice. A recipient could employ one of several strategies to retain benefits: He (or she) could request a new medical determination on a condition other than DA&A, request SSI benefits based on age, or base an appeal on the assertion that the SSA's DA&A designation was a mistake (Office of Policy, 1996a). This last sort of appeal could be based only on administrative error and could not involve a review of the substance of an earlier decision.

The process for these redeterminations differed from that used to make an initial determination. Recall that at the initial level there is only a paper review by a disability examiner and a medical or mental health professional. If the claim is denied, the individual can request another paper review by a different team. For redetermination, SSI DA&A recipients could request a face-to-face meeting with a hearing examiner (as in a CDR) or another dossier review by a different disability-determination team. The option of a face-to-face hearing was installed to satisfy Goldberg-Kelly (GK) requirements, *Goldberg v. Kelly* being a 1970 U.S. Supreme Court decision ruling that welfare benefits cannot be terminated without due process. The individual is entitled to a face-to-face evidentiary hearing before any action can occur and is ordinarily entitled to benefits until the case is decided. (Because DI is not a welfare program, and thus is not subject to GK provisions, the avenue of appeal for DI recipients led directly to an administrative law judge.)

The SSA was to complete new medical determinations by January 1997 for all who filed appeals within 120 days of enactment of the 1996 law (that is, by July 29). Those on SSI who appealed within 10 days of receiving notice were protected under GK, giving them the assurance of full benefits through the initial level of appeal. The SSI portion of payments to concurrent beneficiaries was protected similarly (Office of Policy, 1996b).

Field offices had prescribed procedures, but, as always, some discretion. Claims representatives could grant “good cause” to extend the 10-day time limit to request GK benefit continuation or the 60-day time limit in which to file an appeal. However, they could not extend the 120-day statutory appeal deadline (meaning there would be no guarantee that the case would be processed by January 1st) (Office of Policy, 1996b). Many claims representatives used the good-cause provision quite liberally for individuals responding late to notices. A few told us that for individuals with credible excuses, they granted good cause even after January 1st.

The state disability-determination services had a huge workload to process before January. Because of the many-year backlog on CDRs, their resources already were overextended. Moreover, the vexing “materiality” decision was, if anything, more important in redetermination than in initial review because a positive finding meant a loss of benefits, not the application of special provisions. The redeterminations therefore needed to be made very carefully. Remarkably, the disability-determination teams got through most of the workload on time. Benefits were extended through January and February 1997 for approximately 1,400 individuals who filed an appeal on or before July 29 but did not receive a new medical determination by the end of 1996.

The CBO predicted that 75% of SSI DA&A beneficiaries would remain on the rolls under other impairments (Solomon-Fears, 1997). This admittedly rough estimate turned out to be very high, probably because a large number of people failed to pursue continued eligibility. By December 1997, 28% of the 166,666 SSI recipients (including concurrent beneficiaries) still had not requested a redetermination or filed a new application. Of those who took action, only 49% retained their benefits, or 35.3% of the total (Lewin and Westat, 1998).

Conclusion

Although it remained only a tiny piece of the Social Security apparatus, the DA&A program grew so fast in just the few years between 1989 and 1993 that it seemed beyond administrative control. Moreover, long-standing management and funding problems made the program susceptible to scandal, which finally broke just before the resurgent Republican Party took control of Congress after the 1994 elections. This timing was especially inopportune for the moderates who tried to save the program by reforming it. The new Republican majority in the House quickly set out to radically restructure and forthrightly remoralize the American welfare system. In the process, it overturned the DA&A reforms only recently enacted and just being implemented. The SSA leadership didn't quarrel, and Democrats saw no political point in taking up a cause with few adherents.

The treatment community was divided about the program's termination. Even before SSI, some treatment personnel had called ATD "Aid to Drinking," and New York's decision in 1969 to make drug addicts eligible was not uniformly well received. Many influential providers had long criticized the SSA for its failure to fully implement and supervise the treatment and payee provisions of the SSI law. In such quarters, the 1994 reforms seemed both sensible and long overdue, but the new congressional majority thought the reforms merely threw good money after bad. House leaders, especially, believed welfare programs harmed their beneficiaries. On the matter of addiction, they were distinguished from other critics of the DA&A program by their lack of faith in therapeutics. As a congressional staff person observed, "the members don't think treatment works, so why should we care if it's available?" (Feig, 1994:10).

Many observers saw the attack on the DA&A program as an assault on the "concept of addiction as a disease" (Feig,

1994:6). We don't share this view. No matter how ardently opposed to the DA&A program, its influential antagonists at least nodded to disease theory, but in a revealing way. Many congressmen troubled by the program emphasized that addiction is a "self-inflicted condition" (Wolf, 1995). This is a very old insurance-industry caveat concerning exclusions from disability coverage (Baumohl, 1990), and indeed the element of volition made DA&A recipients special targets from the beginning of the SSI program. While provisions of the Social Security Act direct disabled individuals to follow their physician's recommended course of treatment if it can restore the ability to work (SSA, 1980), we are not aware of any instance outside of the DA&A program in which this regulation has been enforced. DA&A beneficiaries certainly were the only group subject categorically to sanctions for avoiding treatment, and they were the first group ever subjected to an arbitrary time limit on benefits in what is by definition a long-term disability program. And yet, apart from this presumption of culpability, the status of DA&A recipients was not logically different from the status of those disabled by any condition amenable to improvement by adherence to a treatment regime or the modification of exacerbating behavior, whether diabetes, hypertension or depression.³⁸ Thus the history of the DA&A program reminds us that *addiction qua disease* remains profoundly moralized (or incompletely "medicalized," as social theory has it), a contemporary example of what Victorians called "vice disease": somatic tyranny resulting and persisting from repeated immorality or bad choices (Brandt, 1987; Musto, 1999). We have no contemporary term to capture so elegantly addiction's cultural ambiguity.

Had it remained small, confined mainly to aging alcoholics in bad health, the DA&A program might have survived. However, once the courts accepted the poorly defined criterion of "loss of control" and demanded that the SSA peer through a claimant's "denial," rapid growth and rampant confusion

were inevitable. As Jerry Mashaw (1983) and Deborah Stone (1984) have argued, medical-validation mechanisms always run into problems. However, the most serious problems arise when widespread desperation puts particular pressure on the boundaries these mechanisms have been established to protect. As the insurance industry learned during the Great Depression, when it was overwhelmed with claims, disability benefits look good from a bread line (Stone, 1984). Similarly, once welfare rights advocates laid low the end-organ-damage criterion, the DA&A program became attractive to poor alcoholics and drug addicts who, while younger and healthier than the beneficiaries of earlier years, had equally few options for material support. The DA&A program's demise does not solve this larger and far more significant problem. Nor does the end of the program address the incentives for local and state governments to shift cases to the federal rolls. Although rarely mentioned in congressional hearings, there is no doubt that the absence of a federal General Assistance category and universal medical coverage invites SSI and its linked Medicaid benefits to be used as such by local and state authorities willing to invest in claimant advocacy.

We think some further things are clear in retrospect. First, because the 1996 legislation was driven by political expedience rather than by sound planning, it was shortsighted in at least one respect: It is poor practice to spend a lot of money to put an ambitious reform in place only to disassemble it a year later without a completed evaluation. As an SSA administrator observed, the fully implemented DA&A program "never got a chance really to see what it would do, or what it could be made to do." Further, whatever the DA&A program's shortcomings, tens of thousands of poor and sometimes desperate people were told that for three years they would receive a check and treatment. When it was all taken away a year later, many were very angry, albeit cynically understanding. The way the DA&A program ended did not inspire admiration for the political process among former beneficiaries or RMA or SSA staff.

This much said, the SSA might have been the wrong agency to combine material and therapeutic support for alcoholics and addicts. Although the SSA managed the DA&A program much better in its last years, it is not a social service agency, nor does it have any organizational experience with coercing people for their own or the public's good. While the enhanced RMA program that began in 1993 was a large step in that direction, and while it put tens of thousands of people in treatment, the program's subcontractual structure was extremely complex, and in many parts of the country it seems not to have effectively linked material benefits with mandatory treatment and representative payee services. Fully realized, that would require an unflinching paternalism at once administratively coherent and clinically flexible—yet characterized by the procedural fairness for which the SSA is justly famous. It is not clear that the SSA (or any agency) could balance these somewhat incompatible goals. Indeed, such a project might raise anew the problems of overenthusiastic moral oversight and abuse of discretion that thoroughly plagued public welfare programs before benefit administration was separated from casework services in the early 1970s. SSI, a more straightforward income-transfer mechanism than other welfare programs, was invented to fix these problems, at least as they applied to the indigent blind, disabled and elderly—groups customarily assumed to need little in the way of coercive control. But alcoholism and drug addiction complicated the issue of disability in ways that were acknowledged only as afterthoughts. Whether Senator Hughes was correct in 1972 is a question for another day, or at least for a different paper, but he knew trouble when he saw it coming.

- Notes
1. U.S. House of Representatives, Committee on Ways and Means, *Exploring Means of Achieving Higher Rates of Treatment and Rehabilitation Among Alcoholics and Drug Addicts Receiving Federal Disability Benefits*, February 10, 1994 (Washington, DC: U.S. Government Printing Office, 1994), Serial 103-75. Santorum remark, 12; Shaw, 61.

2. Although it was colloquially so called, DA&A was not a program within the Social Security Administration, but an administrative designation with particular consequences for members of the category.
3. A very helpful critic observed: "From a rhetorical standpoint, [this material] gives the more tolerant reader a real feel for just how complex and labyrinthine the bureaucracy can be!"
4. To qualify for DI an individual must make payroll contributions for about one-quarter of the time after age 21 and up to the year of disability. The individual must also have recent work "covered" by such contributions equal to five of the last 10 years. Benefit level is based on average earnings in covered work. There are different rules for younger workers who have not been able to work 10 years (Mashaw and Reno, 1996).
5. There is a further "marriage penalty" associated with SSI: The sometimes very modest assets of a spouse may disqualify a claimant. People sometimes remain cohabitants or actually get divorced in the service of a partner's SSI and Medicaid eligibility.
6. In January 1997 (baseline for the SSI Study) an individual living alone with cooking facilities in California got \$156.40 in state supplementation of the \$484 SSI minimum. This supplement was high compared with those of other states because cash was provided rather than food stamps. Other states in the SSI Study provided the following supplements: Michigan \$14, Oregon \$1.70, and Washington \$28 in King County. The Illinois optional state supplement "is equal to the difference between monthly SSI benefit plus other income and the income-maintenance needs based on State standards" (Office of Research, Evaluation and Statistics, 1997, p. 32). The federal benefit amount in 1998 was \$494. Supplement amounts stayed the same in all states except Washington, where it fell by a dollar (Office of Research, Evaluation and Statistics, 1998).
7. A complicated medical evaluation of the individual's residual functional capacity (RFC) is performed at this point. In addition, a vocational specialist evaluates how RFC affects the individual's ability to perform specific jobs.
8. The qualifier "significant" mitigates the strictest hypothetical interpretations of profitable activity, constructions that might include (as one court put it in 1935) the case of a person without arms, legs, eyesight or hearing who might "make a little money by selling objects such as post cards, candy, or cigars" by having "his trunk conveyed to a busy street corner" (cited by Stone, 1984:74).
9. On average, initial application took 79 days; the reconsideration stage of appeal took 85; the ALJ hearing phase consumed 230; the Appeals Council review, 170. A very large number of applicants

went deep into the appeals process in 1993. Of 2.5 million SSI and DI claims, over 60% were rejected, and of this pool of over 1.5 million, 48% (about 730,000) moved to reconsideration. Of 346,000 cases denied at that stage, 54% (about 187,000) requested an ALJ hearing. Over two-thirds of these appellants were successful, but almost 90% of those who were unsuccessful took their cases to the Appeals Council (where only 15% were successful). Only a very small percentage (10%) of those denied by the Appeals Council sued in federal court (Mills & Arjo, 1996).

10. Wittenburg et al. (this issue) report that 32% of SSI-only DA&A beneficiaries on the rolls in March 1996 were approved for benefits at the ALJ level or beyond.
11. Retroactive benefits of less than \$4,000 were paid to the representative payee without evaluation. When an amount was more than \$4,000, the field office was required to evaluate the payee's ability to handle the accumulated funds unless the payee was a parent, spouse, or child with custody of the beneficiary; the legal guardian; a financial trustee; a social service agency; or a nonprofit institution or organization. Retroactive benefits could be held for a few months to allow for an evaluation, and if the payee was deemed incapable of handling the funds, installment payments were made in addition to the monthly benefit. Such evaluations probably were rare and superficial.
12. Some states did have a few drug addicts on their ATD rolls by 1970 (and California had 176 cases with a secondary diagnosis of drug dependence), but their addiction almost certainly was incidental to other impairing conditions that qualified them. Indeed, some may have been long addicted as a result of medical treatment for painful and intractable conditions and thus were legally maintained by physicians. Other than New York, only Maryland developed a detailed statement of eligible "narcotic addiction" prior to 1974. Even so, there is no evidence that Maryland ever qualified a significant number of addicts; there were no addicts on Maryland's rolls in 1970.
13. Hughes spoke before the Senate Finance Committee and was adamant that alcoholics and drug addicts not receive cash benefits (Joseph R. Humphreys, interview with Baumohl and Hunt, March 23, 1998). This potential for the mishandling of cash benefits was an ancient and not unfounded worry, first of private charities and then of public welfare agencies (Baumohl, 1989; Colcord, 1936).
14. There were 11,917 people with a primary diagnosis of alcoholism and 15,042 with alcoholism as a secondary diagnosis; 5,650 with a primary diagnosis of drug addiction and 1,193 with that as a secondary diagnosis (Committee on Finance Staff, 1972).

15. The SSA reported to the Senate Finance Committee prior to the passage of the SSI law that based on DI records of allowed cases for a primary diagnosis of drug addiction or alcoholism, few people would be coming into the DA&A program. There were approximately 9,750 allowed DI cases (0.5% of total allowances) of this sort from 1964 to 1969 (Committee on Finance Staff, 1972). In defense of the agency's practices, Kieffer referred to this history. Note, though, that this paltry number was a function of the end-organ-damage criterion that SSI had ostensibly abandoned by 1976.
16. Thomas E. Price, interview with Hunt, December 14, 1996.
17. Attrition over the years was due to death, discontinuance on the rolls, qualification based on age (which superseded disability), or a designation of permanent disability upon request or following a CDR. This designation removed the DA&A label.
18. The researchers thought their most significant finding was that 8% of the study population died over the 18-month period. This high mortality rate was equivalent to that for black males over 70 (SRA Technologies, 1986).
19. The study's utility was limited. Its results could not be generalized to rural and low-density areas, and the investigators believed its findings were distorted by the CDR moratorium of that period (see below). In the absence of CDRs, beneficiaries who improved medically probably were not given an official change in disability status. Even so, the characteristics of the DA&A population did not suggest much recovery potential: In the early and mid-1980s, it was a population in late middle age (47% age 50 or older) whose members were in poor health and had long histories of addiction and little education or work experience. A high percentage had been on the rolls for more than 10 years (alcoholics, 33.7%; drug addicts, 76.4%) (SRA Technologies, 1986).
20. The OIG issued three reports in 1994. They found that: (1) SSA DA&A records were incomplete and outdated, especially with regard to treatment status; (2) the majority of DA&A beneficiaries were not in treatment; (3) representative payees and beneficiaries were not well informed about DA&A requirements; (4) very few individuals left the rolls due to rehabilitation; (5) DA&A beneficiaries changed their payees more often than other disabled beneficiaries with payees. Specifically, they more often changed from one payee coded "other" (e.g., lawyers, friends, casual acquaintances) to another payee coded "other." This payee type is low on the SSA's "preference list," and the agency assumes they are at higher risk of misusing recipients' funds than other payee types (OIG, 1994a, 1994b, 1994c).

21. The SSI disabled rolls grew 360% from 1974 to 1994, and the DA&A category grew 1000% from 1975 to 1994. In 1994 the DA&A population represented 2.1% of SSI disability beneficiaries.
22. For example, Depressive Syndrome (a sub-part of Affective Disorders) is one of the reference listings. To receive benefits under the Depressive Syndrome listing, a claimant must meet requirements under both the A and the B criteria. Under the A criterion, an individual must have a medically documented persistence of the disorder, either continuous or intermittent. In terms of severity, the Depressive Syndrome is characterized by at least four of the following: "Anhedonia or pervasive loss of interest in almost all activities; appetite disturbance with change in weight; sleep disturbance; psychomotor agitation or retardation; decreased energy; feelings of guilt or worthlessness; difficulty concentrating or thinking; thoughts of suicide; hallucinations, delusions, or paranoid thinking." Under the B criterion, the individual must have at least two of the following: "Marked restriction of activities of daily living; marked difficulties in maintaining social functioning; deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors)."
23. This was a major stumbling block in the California State Department of Social Welfare's unsuccessful attempts between 1963 and 1965 to make alcoholism an eligible impairment in the state's ATD program (Baumohl, 1990). It was also a sore point for critics of New York's handling of heroin addiction after November 1969.
24. For a description of how the Advocates Division of a California county welfare department moved its GA clients toward SSI during the late 1980s, see Schmidt (1990:401-2, especially).
25. The PRWORA's countermeasures are a complicated combination of incentives and punishments directed at both welfare recipients and the states. Of note here is that the PRWORA permits the states a great deal of flexibility in using various funds to create training programs, support child care, and even fund alcohol and drug treatment. It also requires or permits the states to enforce a variety of "behavioral requirements" for continuing eligibility for full benefits in Temporary Assistance for Needy Families (TANF). Among these is the PRWORA's permission to the states to mandate treatment for alcohol and drug abusers and to require random drug testing under threat of forfeited benefits. (A failed provision of the original legislation would have forced the states to implement these provisions.) A further drug-related provision of the PRWORA is both more strin-

- gent and more commonly implemented: The act provides that unless a state passes contrary or mitigating legislation (27 states have done so), any person with a felony drug conviction for conduct after August 22, 1996 (the date of the PRWORA's signing into law) will be banned for life from TANF benefits (see Hirsch, 1999).
26. In its comments on the Ross report, the SSA emphasized that her number did not derive from an in-depth study and that it did not represent the actual number of beneficiaries with substance addictions (GAO, 1994b).
 27. The three-year limit began for DI beneficiaries only when appropriate treatment became available; but for SSI recipients it began on the date benefits started. Since benefits often (if not usually) were awarded retroactively and only after a lengthy period of appeal, this policy, had it survived, would have created a typical SSI-supported treatment period ranging from only a few months to perhaps two years.
 28. Oregon already had a system in place at the state level for other populations, and 50% of its caseload was in one geographic area. Michigan had significant start-up problems even after the state subcontract was awarded.
 29. As defined by the SSA, treatment in the least restrictive setting possible was "appropriate." "Available" meant that treatment was obtainable at no cost to the beneficiary. Availability also considered limitations affecting a beneficiary, such as ability to travel (Benefit Reforms for Individuals Disabled, 1995).
 30. While conceding that it might have been easier to obtain information, some SSA officials and treatment providers did not think RMA subcontractors should be referring "in-house." They believed the therapeutic and sanctioning components should be kept completely separate. Others believed that having everything under one roof provided continuity of care.
 31. The OIG (1997) had been critical of the SSA's lack of control over the RMAs for contracts active even before September 1995. A few of the OIG's specific concerns: The SSA did not provide a mechanism to ensure that all reported noncompliance cases were acted upon; the SSA did not require the contractor to report the cumulative number of DA&A cases in treatment, making it impossible to judge the contractor's effectiveness in placing people in treatment; the contract did not stipulate that there should be periodic reviews to assess the number of cases no longer on the disability rolls; and contractors were not required to develop a quality assurance program. The SSA RMA contracts staff did not agree with the findings, for the most part.

32. The Legal Action Center is a law and policy organization that advocates on behalf of people with criminal records and histories of addiction and AIDS.
33. Legal Action's figures came from the Maximus report defending RMAs. Maximus estimated that its program would save \$2.1 billion over five years. The saving would come from dropping ineligible DA&A recipients from the rolls (\$458 million); removing beneficiaries for noncompliance (\$611 million), fraud and abuse (\$197 million), completion of treatment (\$180 million), and as a result of the three-year time limit (\$598 million). Another \$54 million would be saved by suspending recipients for noncompliance (Rubinstein, 1995).
34. Real savings may actually have been greater. Based on a confidential report by members of the DA&A implementation team, *The Baltimore Sun* revealed in October 1994 that the actual cost of RMAs was nearly three times what Congress anticipated when it passed the legislation only months earlier. Whereas the SSA budget office told Congress that RMAs would cost about \$354 million over two years, the confidential report noted that the figure could be as high as \$1 billion by the end of 1996 and \$4 billion by the end of 1999. The report stated that first-year costs would run at least \$279 million, well above the estimate of \$148 million given Congress. The SSA was authorized to take a quarter of RMA funding from the retirement trust fund, but the *Sun* opined (and quoted members of Congress who agreed) that the legislation probably would have failed had true costs been known in advance (Haner and O'Donnell, 1994). The SSA responded that it could do the job with \$148 million (O'Donnell and Haner, 1994). Much later, a high-ranking SSA official conceded to us that this would not have been enough.
35. Each state received an additional 4% of its total Substance Abuse Prevention and Treatment Block Grant allocation (John J. Campbell, Center for Substance Abuse Treatment, personal communication, December 22, 1997).
36. Most states did no outreach but complied with the law by adding former and current SSI and DI recipients to the list of other "priority groups" (e.g., pregnant substance abusers) given preference for services. A handful of states, including Illinois, sent letters to individuals informing them that treatment was available. Other states planned to do so but were prevented by privacy laws. They relied on treatment providers, social service agencies, local SSA offices, and, in one case, the newspaper to get the word out about the availability of treatment. Some states used the block grant money to enhance or develop new programs for chronically treated or indigent clients because these populations are partially composed of current and former SSI/DI recipients. Many states spent a small percentage of the

money on HIV early-intervention services. In sum, it is impossible to know the extent to which the money served the intended population.

37. So far as we know, the only consequential class action was filed by a Baltimore legal services agency in late December 1996. It claimed that the SSA applied the law unfairly in separating the purely drug-addicted from the otherwise disabled by failing to consider medical evidence contained in a beneficiary's prior record. The SSA settled the suit in March 1997 by allowing 850 affected Marylanders new appeals on their redeterminations. The DDS was instructed to consult the prior record (Brennan, 1997). An SSA employee suggested that the low number of lawsuits resulted from Legal Aid's budget cuts and severe limitations on Legal Aid's permissible involvement in welfare cases and class actions. The treatment community's disunity on the DA&A program may also have restrained legal action.
38. In fact, it appears that alcohol- and drug-dependent patients comply with treatment just as frequently (or infrequently) as patients with type 2 diabetes mellitus, hypertension, and asthma. See McLellan et al., 2000.

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