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SHOULD ADDICTS GET WELFARE? ADDICTION & SSI/SSDI*

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INTRODUCTION

For a brief period in our nation's history, drug abusers and alcoholics could receive disability cash assistance and free medical coverage from the federal government by proving that their addiction was severe enough to disable them from holding any job. From 1972 until 1994, addicts could, with certain qualifications, receive benefits under Social Security Disability Insurance ("SSDI") or its sister program, Supplemental Security Income ("SSI"). These programs provided not only a nominal amount of monthly cash assistance, but also medical coverage through Medicaid, with which recipients could pay for drug treatment programs. The cases were eventually tagged "DA&A," which alternatively stood for "Drug Abusers and Alcoholics" (referring to the claimants themselves) or "Drug Addiction and Alcoholism" (representing the underlying impairment of the claim).

As one might expect, this aspect of the nation's welfare program was controversial. The recession of the early 1990s, among other factors, caused the welfare rolls to swell inordinately.[1] The increased welfare rolls generated more

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[1] For example, the SSI rolls alone increased from roughly 4.4 million in 1988 to roughly 6.3 million in 1994. *See* Christopher M. Wright, *SSI: The Black Hole of the Welfare State*, Cato Institute Policy Analysis No. 224 at 5 (Apr. 27, 1995), *available at* http://www.cato.org/pubs/pas/pa-224es.html (last visited June 10, 2002). *See also infra*

public resentment about providing any assistance to addicts, much less assistance based on their addiction.[2] In 1994, Congress passed legislation aimed at limiting the handouts to addicts: recipients were required to participate in treatment programs, and benefits were capped at three years.[3] Instead of shrinking the rolls of DA&A recipients, however, the numbers burgeoned even further. In 1996, Congress eliminated benefits altogether for those receiving SSI or SSDI on the basis of addiction.[4] Moreover, the 1996 changes require addicts who suffer from other impairments to demonstrate that substance abuse does not contribute materially to their alleged disabilities.[5] Substance abusers and addicts may receive benefits, but only on the basis of other qualifying impairments, plus a demonstration that their other disabilities would continue even if their substance abuse stopped.

Predictions about the likely outcomes of the changes varied considerably. Social workers and poverty advocates anticipated throngs of homeless, helpless addicts bounced from Medicare-funded treatment programs, driven to desperation by the deprivation of their only safety net.[6] Sponsors of the restrictive legislation probably believed that cutting off the supply of unearned income would force addicts to abandon their habits and re-enter the workforce. The Social Security Administration itself claimed that 75% of the 209,000

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notes 22-30 and corresponding text for a discussion of some of the statistical data and explanations offered by different commentators.

[2] *See* Wright *supra* note 1, at 23, 31 for several examples and anecdotes. Wright recounts a story from a California community newspaper about a drug raid in which "Bakersfield police found a paper sack with more than $5,000 in it . . . [the addict] produced documentation showing the money was hers via a lump sum payment from . . . Supplemental Security Income . . . . Her disability: she is a heroin addict." *Id.* at 23. This particular Cato Institute paper asserted that "[i]nvestigators have determined that as many as 90 percent of SSI substance abusers use their benefits to purchase alcohol and illegal drugs," recounting another anecdote of a San Francisco SSI recipient who allegedly used his lump sum check for retroactive benefits to purchase a large quantity of contraband for resale in smaller packages.

[3] Establishment of the Social Security Administration as an Independent Agency, Pub. L. No. 103-296 (1994).

[4] Social Security Earnings Limitation Amendments, Pub. L. No. 104-121 (1996).

[5] *See* Determining Disability and Blindness Medical Considerations, 20 C.F.R. § 404.1535 (2001).

[6] *See, e.g.*, The National Coalition for the Homeless, Safety Network Legislative Wrap-Up: The 104th's Legacy on Homelessness, Volume 15, Issue 4, Oct.-Nov. 1996, *available at* http://www.nationalhomeless.org/legwrap.html (last visited Aug. 20, 2002).

individuals affected by the new measures would easily requalify for benefits based on their other impairments.[7]

They were wrong. Nearly six years have elapsed since passage of the 1996 rules, and numerous studies have assessed the consequences with mixed results. The studies, however, clearly show that large numbers of addicts were dropped from treatment programs, some became homeless, most did not reenroll on Social Security and no one is known to have entered the workforce.[8]

This Article will begin to counter the dearth of treatment given to these issues in the legal academic literature. Whereas few scholars have proposed alternatives to the status quo, this Article presents several possible options to improve the current law regarding benefits for addicts. Part I reviews the historical developments of the current rules. Part II reviews the studies assessing the results of the 1996 legislative changes. In Part III, I explain and analyze the underlying arguments for and against providing SSI and SSDI benefits to alcoholics and drug addicts. This part begins with a working model for understanding the nature of addiction itself and describes the differences in perspective that underlie policy decisions. Specifically, this section discusses the moral hazard and rehabilitative approaches to welfare in light of social policy and law and economics theory. Part IV presents several possible alternatives for approaching the problem in the future, and the advantages of disadvantages of each one. Finally, the Conclusion recommends that addiction receive less punitive treatment in eligibility decisions for benefits, and identifies areas for further research.

I. HISTORICAL BACKGROUND

Congress amended the Social Security Act ("SSA") in 1956 to create a Disability Insurance program.[9] This program

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[7] Interim Report by the Lewin Group, Inc., Policy Evaluation of the Effect of Legislation Prohibiting the Payment of Disability Benefits to Individuals Whose Disability is Based on Drug Addiction and Alcoholism, ES-1 (April 28, 1998) [hereinafter Interim Report]; *see also infra* notes 54-60 and accompanying text.

[8] *See* Interim Report, *supra* note 7.

[9] For a good discussion of the history of the welfare programs related to disability, see Mark C. Weber, *Disability and the Law of Welfare: A Post-Integrationist Examination*, 2000 U. ILL. L. REV. 889, 923-32; Linda G. Mills & Anthony Arjo, *Disability Benefits, Substance Addiction, and the Undeserving Poor: A Critique of the Social Security Independence and Program Improvements Act of 1994*, 3 GEO. J. ON FIGHTING POVERTY 125, 127 (1996).

supplemented the survivors' benefits and retirement programs already in existence (SSDI).[10] The underlying basis for qualification was 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 of which has lasted or can be expected to last for a continuous period of not less than twelve months."[11] Congress restricted the Social Security system solely to applicants who paid in based on their earnings.[12]

In 1958, dependents were given coverage, and in 1960 the original age restriction (50-65) was removed.[13] In 1972, Congress created Supplemental Security Insurance for individuals in poverty who would not be covered by SSDI.[14] The 1972 amendments marked the beginning of specific provisions for drug addicts and alcoholics, although they did not identify addiction as an independent basis for awarding benefits.[15] In 1975, in response to growing consensus in the medical profession that alcoholism was a "disease" in its own right, the SSA amended its regulations to delete the requirement of physical organ damage before granting benefits.[16] In 1984, Congress passed the Benefits Reform Act, requiring the SSA to draft more "realistic" regulations addressing disabling mental impairments.[17] This led to the 1989 amendments, which

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[10] 42 U.S.C. § 423 (1956).

[11] 42 U.S.C. § 423(d)(3) (2002); Relationship to Provisions Requiring Deductions, 20 C.F.R. § 404.505(a) (2001).

[12] That is, the original program in 1956 included only SSDI, and not an SSI component for the poor.

[13] *See* Wright, *supra* note 1.

[14] Social Security Amendments of 1972, Pub. L. No. 92-603 (1972). This replaced the previous Title XVI of the Social Security Act, which had provided for grants to aid the blind, aged and disabled.

[15] Originally, the Social Security Administration did not treat alcoholism as a disease that could independently qualify an individual for benefits. Alcoholics were granted disability benefits only when their alcohol abuse manifested itself in physical symptoms of an independently recognized medical disorder of sufficient severity to constitute an "impairment" precluding employment, under the listing for that separate disorder. *See* Determining When a Consultative Examination Will be Obtained in Connection with Disability Determinations, 20 C.F.R. § 404.1519(c)(2)(iii) (1967); Wilkerson v. Sullivan, 904 F.2d 826, 835 (3d Cir. 1990) ("This policy, often referred to as one requiring end-organ damage, was arguably consistent with the formerly prevailing social and legal view that an alcoholic is simply an individual who lacks the will or moral fiber to curb his self-indulgence.").

[16] Rights and Benefits Based on Disability, 40 Fed. Reg. 30,262 (June 26, 1975).

[17] *See* 42 U.S.C.A. § 421 note (1991); *Wilkerson*, 904 F.2d at 835.

recognized alcoholism and addiction as independently qualifying impairments.[18]

SSI recipients whose addiction was "material" to the finding of disability were required to participate in treatment programs, where available, and to designate a representative payee to handle the funds paid by Social Security. Their cases were flagged with special DA&A codes for monitoring. No such restrictions were placed on individuals receiving SSDI, nor on SSI addict recipients who received benefits based on some other impairment.[19] Unlike SSDI, Congress based the SSI program partly on financial need, created strict income eligibility guidelines and offered no benefits for dependents.[20] Importantly, the mere presence of an addiction was *never* sufficient grounds to grant benefits. Rather, an alcoholic or addict had to provide convincing evidence that a combination of severe symptoms, whether related to the addiction or not, genuinely prevented the applicant from engaging in any gainful work activity.[21]

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[18] The definition of substance addiction disorders that the SSA adopted was "[b]ehavioral changes or physical changes associated with the regular use of substances that affect the central nervous system." Determining Disability and Blindness, 20 C.F.R. pt. 404, subpt. P, app. 1 (pt. A), § 12.09 (1989). It should be noted that the Social Security Administration never actually incorporated the definition of Substance Abuse Disorders commonly used by mental health professionals, as set forth in the *Diagnostic and Statistical Manual of Mental Disorders* (which at that time was in its revision of the third edition, commonly known as the *DSM-III-R*), despite being ordered to by at least one Circuit Court of Appeals. *See Wilkerson*, 904 F.2d at 832-33. The *DSM-III* (and subsequent revisions) provides a general definition of Substance Abuse Disorders that spans two full pages, before categorizing separate disorders for each intoxicant. The two basic requirements are an increasing "tolerance" to the substance and "withdrawal" symptoms following cessation, except withdrawal is unnoticable for Alcohol and Cannabis. *See* AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 164-65 (3d ed. 1980).

[19] Physician Comparability Allowances, Pub. L. No. 92-603 (1972). *See also* Interim Report, *supra* note 7, at I-2; *Inspector General Report on Implementation of Drug Addiction and Alcoholism Provisions of the P.L. 104-121 Before the House Comm. on the Budget, Task Force on Welfare*, 106th Cong. (2000) (statement of Ken Nibali, Associate Commissioner for Disability).

[20] For a detailed description of the process of obtaining benefits, and more of the administrative differences between SSDI and SSI, see Mills & Arjo, *supra* note 9, at 127-31.

[21] *See, e.g.*, Coleman v. Chater, 58 F.3d 577, 579-80 (10th Cir. 1995) ("Even if we were to accept plaintiff's contention that he is an alcoholic, '[t]he mere presence of alcoholism is not necessarily disabling.'") (quoting Thompson v. Sullivan, 957 F.2d 611, 614 (8th Cir. 1992)); Shelltrack v. Sullivan, 938 F.2d 894, 897 (8th Cir. 1991) (holding that to establish disability based on alcoholism, claimant must show loss of self-control to the extent he is unable to seek and use rehabilitation, and that disability is encompassed by Social Security Act); Arroyo v. Sec'y of Health & Human Servs., 932 F.2d 82, 87 (1st Cir. 1991) (finding that a claimant who seeks disability benefits on grounds of alcoholism must prove addiction to alcohol, loss of ability to control

Between 1988 and 1994, SSI's costs nearly doubled. By 1993, nearly six million people received benefits under the program, and payments totaled $20.7 billion.[22] The number of recipients with addictions also grew during this period from about 100,000 in 1989 to 250,000 in 1994, receiving a collective $1.4 billion in benefits.[23]

Several factors may have caused this growth. In 1982, the Social Security Administration issued an administrative ruling recognizing that alcoholism and drug addiction could in themselves be disabling diseases, even absent consequential physical or mental injuries such as liver disease.[24] The recession of the early 1990s also probably had an effect, as an increasing number of people with impairments found themselves unable to obtain gainful employment.

Professor Aaron Yelowitz suggested that as much as 20% of the growth in the SSI program in the early 1990s could be due to its attachment with Medicaid, which increased significantly in value and generosity immediately prior to this period.[25] SSI grew faster during this period than other federal welfare programs such as Aid For Families and Dependant Children ("AFDC"), apparently due to this connection.[26] Yelowitz cautioned against separating SSI and Medicaid. He estimated that the government would only save 4.2% by separating the programs.[27] Since SSI covers the poor, who generally have no health insurance, Medicaid coverage is a significant incentive for disabled individuals to enroll.

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drinking, and that alcoholism precludes claimant from engaging in substantial gainful activity); Clem v. Sullivan, 894 F.2d 328, 331 (9th Cir. 1990) (stating that mere evidence of alcohol abuse does not discharge claimant from initial burden of proving he is an alcoholic; "it is not the disease of alcoholism, but rather a claimant's uncontrolled drinking, that may constitute a disability.") Although these cases are cited here for the proposition that alcoholism alone did not qualify an applicant for benefits, they also recognized that with the foregoing qualifications, addicts could receive benefits as long as the remaining factors or requirements were in place.

[22] The entire AFDC program totaled $12.27 billion in 1993. *See* Wright, *supra* note 1, at 5 (citing U.S. HOUSE OF REP., COMM. ON WAYS AND MEANS, 1994 GREEN BOOK OVERVIEW OF ENTITLEMENT PROGRAMS (1994)).

[23] *See* U.S. Gen. Accounting Office, HEHS-94-128, Social Security: Major Changes Needed For Disability Benefits For Addicts 3 (1994), *available at* http://-www.access.gpo.gov/su_docs/aces/aces160/shtml (last visited Sept. 12, 2002).

[24] Evaluation of Drug Addiction and Alcoholism, S.S.R. 82-60 (1980).

[25] Aaron Yelowitz, *Why Did the SSI-Disabled Program Grow So Much? Disentangling the Effect of Medicaid*, 17 J. OF HEALTH ECON. 321, 321 (1998).

[26] *Id.* at 322. The SSI caseload grew at about 6.1% per year, while AFDC caseload grew at a more modest 4.1%.

[27] *Id.* at 346.

Some federal court decisions favorable to addicts probably also contributed to the growth of the program.[28] In fact, most DA&A cases were generally concentrated in a few states: California (24%), Illinois (12.2%), Michigan (7.8%), New York (5.2%), Ohio (4.8%) and Tennessee (4.4%).[29] The concentrations likely are due to a combination of overall population centers and federal circuit jurisdictions with rulings most favorable to DA&A plaintiffs.[30]

After the Republican takeover of Congress in 1992-1993, the pendulum began to swing back. Concerned about the growing numbers of addicts receiving benefits, Congress included special provisions addressing DA&A in the Social Security Independence and Program Improvements Act of 1994 to reduce the perceived moral hazard problem.[31] The provisions placed a three-year time limit on SSI/SSDI benefits to recipients whose cases were flagged as DA&A. The treatment, monitoring, and representative-payee requirements previously applicable to only SSI recipients now applied to SSDI recipients. Failure to comply with treatment resulted in suspension of benefits.[32]

Attempts to curb DA&A benefits failed. Instead, the number of beneficiaries grew substantially over the next two years.[33] Members of Congress believed payment of benefits to addicts "inappropriately divert[ed] scarce federal resources from severely disabled individuals" and "provid[ed] a perverse incentive, contrary to the long-term interest of addicts and alcoholics, by providing them with cash payments so long as they do not work."[34]

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[28] *See, e.g.*, Cooper v. Bowen, 815 F.2d 557 (9th Cir. 1987); Ferguson v. Schweiker, 641 F.2d 243, 248 (5th Cir. 1981) (stating that alcoholism alone or combined with other causes can constitute a disability); Johnson v. Harris, 625 F.2d 311, 313 (9th Cir. 1980) ("severe alcoholism alone may be disabling within the meaning of the Social Security laws"); Lewis v. Califano, 574 F.2d 452 (8th Cir. 1978) (stating that full and fair record of alcohol disability must be developed); Griffis v. Weinberger, 509 F.2d 837, 838 (9th Cir. 1975) ("The proposition that chronic acute alcoholism is itself a disease . . . is hardly debatable today.").

[29] *See* Interim Report, *supra* note 7, at II-25. These percentages are for SSI cases. The SSDI DA&A cases were more widely distributed across the country, but the same states had the highest concentrations.

[30] *See id.* at II-25-26. The First, Fifth, Sixth, Seventh and Ninth Circuits were noted to have had favorable rules for DA&A cases.

[31] Social Security Independence and Program Improvement Act of 1994, Pub. L. No. 103-296 (1994).

[32] *Id.*

[33] *See* Interim Report, *supra* note 7, at I-3.

[34] *Id.* (citing SENATE COMM. ON FINANCE, REPORT ON THE FAMILY SELF-

As a result, Congress again sought to remove the "perverse incentives" by enacting the Contract With America Advancement Act of 1996.[35] The Contract eliminated SSDI/SSI and Medicare/Medicaid coverage for those whose drug or alcohol addiction is a "contributing factor material to their disability."[36]

Essentially, the new standard for eligibility asks whether the claimant would still be disabled, due to other impairments, if he or she stopped consuming drugs or alcohol. The standard is set forth in the current SSDI regulations:

> How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability: (a) *General.* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability. (b) *Process we will follow when we have medical evidence of your drug addiction or alcoholism.* (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol. (2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling. (i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability. (ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.[37]

SUFFICIENCY ACT OF 1995, 104-96 (1995)).

[35] Contract With America Advancement Act of 1996, Pub. L. No. 104-121 (1996). The Contract provided for the phase-out of those already receiving benefits, pursuant to normal due process hearing requirements, and the implementation of strict rules for new applicants; these provisions are not terribly relevant to the discussion here.

[36] *Id.* at § 105. Addicts could, however, qualify based on other impairments. Recently in *Mitchel v. Commissioner*, 182 F.3d 272 (4th Cir. 1999), the Fourth Circuit rejected an attempt to challenge the legislation based on equal protection violations. The court found that there was a reasonable relationship between the legislation and a legitimate government interest in deterring drug and alcohol abuse. *See also* Nicole Fiocco, *The Unpopular Disabled: Drug Addicts and Alcoholics Lose Benefits*, 49 ADMIN. L. REV. 1007 (1997) (arguing that the 1996 elimination of benefits for addicts violates the Americans with Disabilities Act and the Rehabilitation Act).

[37] 20 C.F.R. § 404.1535 (2001).

In practice, this standard functions as a "but-for" test: if the applicant's disability would not exist *but for* continuing substance abuse, e.g., inability to concentrate or persist in tasks, then Social Security will deny the claim. This is particularly relevant for claimants suffering from a dual diagnosis of addiction and some other mental disorder, such as depression, schizophrenia or attention deficit disorders. However, claim adjudicators tend to disqualify any history of substance abuse. For instance, in *Sousa v. Callahan*,[38] the Ninth Circuit noted that the adjudicators below "failed to distinguish between substance abuse contributing to the disability and the disability remaining after the claimant stopped using drugs or alcohol. . . . Just because substance abuse contributes to a disability does not mean that when the substance abuse ends, the disability will, too."[39] Other courts have similarly held that the SSA cannot deny benefits merely because an addiction is present.[40]

However, the question of who bears the burden of proof for the "but-for" test remains unsettled. In *Brown v. Apfel*,[41] the Fifth Circuit held that the claimant bears the burden of proving that drug or alcohol abuse is not a contributing factor material to the disability. The Eighth,[42] Ninth[43] and Eleventh[44] Circuits followed suit on somewhat different facts.

On the other hand, a district court in Oregon held in *Clark v. Apfel*[45] that a policy set forth in an internal Emergency Teletype[46] bound the Social Security Administration to prove materiality in cases where the addiction and impairment are

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[38] 143 F.3d 1240 (9th Cir. 1998).

[39] *Id.* at 1245.

[40] *See, e.g.*, Sherman v. Apfel, 141 F.3d 1185, 1188 (10th Cir. 1998); Lee v. Callahan, 133 F.3d 927, 932 (9th Cir. 1998); Downs v. Apfel, 9 F. Supp. 2d 230, 235 (W.D.N.Y. 1998).

[41] 192 F.3d 492 (5th Cir. 1999) (finding that a claimant with chronic back pain and suicidal depression was not disabled because of insufficient proof that drugs/alcohol did not contribute materially).

[42] Middlestedt v. Apfel, 204 F.3d 847 (8th Cir. 2000) (holding that a claimant with heart condition and seizures failed to show that alcohol was not a material factor, thus, was not disabled).

[43] Ball v. Massanari, 254 F.3d 817 (9th Cir. 2001).

[44] Doughty v. Apfel, 245 F.3d 1274 (11th Cir. 2001) (holding that a claimant with anxiety disorders and dizziness bears burden of proof that alcohol was not a material factor).

[45] 98 F. Supp. 2d 1182 (D. Or. 2000).

[46] Emergency Teletypes are internal policy and procedure memorandum addressing urgent changes for local offices to implement, disseminating by faxing the local offices instead of publication in the Federal Register or internal policy manuals.

intertwined. The Emergency Teletype, EM-96-76 provided: "When it is not possible to separate mental restrictions and limitations imposed by the DAA and the various mental disorders shown by the evidence, a finding of 'not material' would be appropriate."[47] The court found that the agency did not follow its own internal procedures.[48] A West Virginia district court reached the same conclusion.[49]

The circuit court decisions have not addressed EM-96 in their rulings because the parties did not raise the issue. It is unclear whether their decisions override the policy set forth in the Emergency Teletype, or how circuit courts would treat the issue if raised. Another recent case from a district court in Illinois[50] mentioned the EM-96 problem, but the court did not say whether its holding depended on this or on other facts in the record.[51] To date, the state of the law regarding but-for causation is unclear.

But-for causation could function as a proxy, a way to punish drug use itself. However, it invites the adjudicator to speculate regarding whether *each symptom or impairment* might improve without substance abuse. When the claimant has the burden the analysis reverses to focus on whether the substance abuse is exacerbating the condition to the point where the substance abuse is deemed to cause the disability. Such analysis forces the adjudicator to speculate. The claimant cannot easily "prove" a claim without discontinuing substance

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[47] Emergency Teletype EM-96-76 from Dale Cox, Office of Disability, Social Security Administration, Answer 29 (Aug. 30, 1996), *available at* http://www.ssas.com-/daa-q&a.htm. EM-96-76 instructed local offices that the SSA had the burden of proof to show materiality in cases where the claimant's addiction and other alleged impairments are intertwined. Answer 29 reads:

> We know of no research data upon which to reliably predict the expected improvement in a coexisting mental impairment(s) should drug/alcohol use stop. The most useful evidence that might be obtained in such cases is that relating to a periods when the individual was not using drugs/alcohol. Of course, when evaluating this type of evidence consideration must be given to the length of the period of abstinence, how recently it occurred, and whether there may have been any increase in the limitations and restrictions imposed by the other mental impairments since the last period of abstinence. When it is not possible to separate the mental restrictions and limitations imposed by DAA and the various other mental disorders shown by the evidence, a finding of 'not disabled' would be appropriate.

Id.

[48] *Clark*, 98 F. Supp. 2d at 1185.

[49] Cutlip v. Apfel, CV No. 5:97CV154, (N.D. W.V. Aug. 10, 1998).

[50] Christidis v. Massanari, No. C50412, 2001 WL 1160846 (N.D. Ill. Oct. 1, 2001).

[51] *See id.* at *9.

abuse long enough to get medical documentation that the impairment is independent of the abuse. This subjective element leaves room for the adjudicator to overreact to any mention of DA&A in the medical records. Such references are generally explicit and visibly prominent,[52] and their prominence in the medical records creates a negative psychological effect.

Courts increasingly place the burden on the claimant to show that DA&A is *not* a material factor in the impairment. This allows the adjudicator to deny the claim as a default position until the claimant successfully challenges the denial. Adjudicators have just enough discretion to punish most drug users by denying their claims, even when more careful reflection and application of the regulations would weigh in the claimant's favor. Although past drug use is supposedly irrelevant to determining disability, the fact that present use *is* a factor could lead adjudicators to consider past use, as it creates a suspicion of present behavior patterns.

The rule also generates confusion regarding etiology in dual-diagnosis cases. Because many symptoms from the DA&A overlap those of other valid mental disorders, the question arises whether the claimant is self-medicating (through substance abuse) a pre-existing medical condition or whether the mental impairments are caused by the DA&A.

The pendulum does not appear to be swinging back in favor of the pre-1994 "rehabilitation goal," at least in the SSI/SSDI arena.[53] Instead, each circuit court considering the issue has ruled that the claimant has the burden of proof, increasing the bite of the 1996 reforms even further. In a sense, placing the burden on the claimants in a "but-for" case creates yet another incentive to discontinue substance abuse, to rehabilitate oneself. It appears, therefore, that the moral hazard paradigm, with its focus on incentives and the addict's ability to make rational choices in response, remains the reigning legal regime.

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[52] As a practitioner in this area, I have found in the files kept by the SSA for individual clients that one mention in the claimant's medical records about any history of substance is picked up and discussed on form after form completed by SSA medical consultants, consultative examiners and disability adjudicators.

[53] *See infra* notes 174-81.

II. THE RESULTS

In the years since the laws changed to reflect moral hazard concerns, numerous studies have analyzed the consequences for the 209,000 individuals whose benefits were terminated in 1997 and their communities. The empirical evidence indicates that results were not what Congress expected, nor have they been entirely optimal. The studies and results cast doubt on the accuracy of the incentives-based approach and moral hazard paradigm.

Perhaps the most important study was conducted by the Lewin Group on behalf of the Social Security Administration itself in 1997 and 1998.[54] The study was quite comprehensive and tabulated an overwhelming amount of demographic and sociological data about the affected parties. The study showed the adverse impact of the legislative changes to the welfare policy.

The Social Security Administration predicted that 70% of targeted beneficiaries would retain or re-establish their benefits on other bases. In fact, only half that number, 34%, did so.[55] In real numbers, this means 138,000 people permanently lost their benefits, while 71,000 were able to retain them or requalify.[56] About 28% never reapplied, either because they knew they would not qualify again under the new rules, or because of mental inability or misunderstanding.[57] Field offices were unable to contact many claimants to clarify the changes that were occurring because they did not have stable addresses.[58] A common report was that "those most in need of the benefit are also those least able to complete the reapplication (or initial application) process," because of low functional ability and "limited capacity to comply with the requirements of the relatively complex and time consuming reapplication process."[59]

The study notes in several places that the Social Security Administration misclassified as DA&A a certain

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[54] Interim Report, *supra* note 7.

[55] *Id.* at ES-1.

[56] Interim Report, *supra* note 7. Note that under the 1994 rules an estimated 35,000 would probably have lost their benefits for other reasons, such as noncompliance with treatment or reaching the end of their thirty-six month maximum.

[57] *Id.*

[58] *Id.* at III-11.

[59] *Id.*

percentage of the 209,000 people whose benefits ended abruptly in 1997.[60] The actual percentage is unclear. Some systemic practices inflated the numbers of DA&A recipients. In cases where substance abuse was present in tandem with other disabilities related to mental illness or back pain, which are notoriously difficult to document, claim adjudicators frequently granted the case on the basis of DA&A because it was easier to document and saved time.[61] Moreover, adjudicators and Administrative Law Judges knew that granting a case based on DA&A would force an applicant with *any* substance abuse problem to get mandatory treatment under the pre-1996 rules. Many thought they were helping the claimants by categorizing them this way.[62] This indicates that the DA&A numbers that incited Congress to pass the new measures were exaggerated, and many individuals wrongly terminated.

> In those states that had [Referral & Monitoring Agencies] before 1994, the designation [of DA&A] could result in referral to treatment. There were, however, few adverse consequences associated with the designation. . . . The designation of a program participant as a DA&A beneficiary appears, however, to have been an inexact process. . . . [P]ersons were designated as DA&A when substance abuse may not have been their presenting problem, or even a major factor in their disabling condition. As a consequence, when the termination process was implemented following the 1996 legislation, some recipients may have received termination notices who might otherwise have been unaffected.[63]

The biggest result of the new legislation was that far fewer people were in treatment programs. The study found "virtual unanimity" that former beneficiary participation in treatment programs "dropped dramatically."[64] Recipients usually lost Medicare and Medicaid benefits with the termination of SSDI/SSI, which eliminated their medical coverage for aspects of treatment.[65]

Additionally, the income level of former beneficiaries and their households decreased substantially. Although officials expected many individuals or their family members to move onto other state-run welfare programs, this did not appear to happen. The rolls on Temporary Assistance For

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[60] *Id.*

[61] Interim Report, *supra* note 7, at II-26, III-8.

[62] *Id.* at II-27, III-8.

[63] *Id.* at III-7.

[64] *Id.* at III-16.

[65] *Id.*

Needy Families ("TANF") and related programs did not increase significantly.[66]

The study also noted repeated reports that the "majority" of individuals whose benefits were terminated were "unable to remain in their prior housing arrangements, and some were thought to have become homeless."[67] Moreover, four different treatment agencies surveyed by the study reported deaths from suicide attributable, at least in part, to the termination of SSI/SSDI benefits.[68]

As stated above, one purpose of the 1996 legislation was to change the incentive structure for addicts and encourage them to re-enter the workforce. This did not occur. The Lewin Group study noted "very few reports of former beneficiaries returning to employment."[69] This was true "across all states and agencies."[70]

Interestingly, the study also examined the application of the "materiality" test discussed in the previous section.[71] Although the authors found the rule "relatively clear in principle. . . . Conversations with some hearings examiners left some doubt in [their] minds that the actual practice always conformed to the intent."[72]

Another study, presented by Kevin M. Campbell, Ph.D. of the Association of Health Services Research, found that in the year following the termination of SSI/SSDI benefits for addicts, participation in outpatient programs steadily declined.[73] Those in treatment programs whose benefits continued, however, actually had higher levels of treatment participation in the year after the legislation.

The Urban Health Study of the University of California-San Francisco examined data from six communities around the San Francisco Bay area, with a total of 1,224 subjects, all drug

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[66] Interim Report, *supra* note 7, at III-15-16. Two states reported an increase in the rolls for their General Assistance programs. *See id.* at ES-3.

[67] *Id.* at III-16.

[68] *Id.*

[69] *Id.* at ES-3.

[70] *Id.* at III-16.

[71] This is the but-for test found in 20 C.F.R. § 404.1535 (2002).

[72] Interim Report, *supra* note 7, at III-14.

[73] Kevin M. Campbell et al., *The Impact of Eliminating the SSI Drug Addiction and Alcoholism (DA&A) Category on Participation in Substance Abuse Treatment Among Former DA&A Beneficiaries*, Health Services Research: Implications for Policy, Delivery and Practice, June 1998 (abstracts available at http://www.academyhealth.org/abstracts/1998/campbell.htm (last visited Aug. 2, 2002)).

users.[74] Prior to the 1996 changes in the laws, subjects who received SSI benefits were much less likely to be homeless than those not receiving benefits (73 to 244, respectively).[75] Overall, the study concluded that intravenous drug addicts who received SSI benefits had more stable housing, used drugs less frequently and shared needles (a serious health risk) less often than intravenous drug users without SSI.[76] "In other words, it appears that SSI benefits contribute to general life stability and a reduction in drug-related harm."[77] Conversely, the study concluded that termination of benefits for addicts increased the severity of social ills such as homelessness, illegal activity and increased unsafe drug use.[78] This undermines the idea of a moral hazard in granting benefits, in that recipients actually used fewer drugs, and bolsters the rationale of a rehabilitation-based policy.

Another study examined the likelihood of former recipients to resort to crime, both before and after termination of benefits.[79] The researchers focused on former recipients in Chicago, selecting a random sample of 276. They found that about 70% of the subjects had been arrested at least once, with the most common crime being theft (22%), followed by battery (9%) and possession of controlled substances (8%). The study concluded that the relationship between criminal activity and SSI status was more complex than originally thought:

> Crime appears to be mediated more strongly by income level regardless of the source of that income (i.e., whether it comes from the government, family members, or employment). Thus, individuals who are employed, but at substandard wages, may be more likely to commit crimes to supplement their incomes than individuals who are supported by their families or the government at higher levels.[80]

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[74] *Id.*

[75] Jennifer Lorvick et al., *The Withdrawal of SSI Disability Benefits from Drug and Alcohol Addiction*, Harm Reduction Communication, Fall 1997, *available at* http://www.harmreduction.org/news/fall97/ssi.html (last visited July 30, 2002).

[76] *Id.* at 2.

[77] *Id.*

[78] *Id.*

[79] Arthur Lurigio et al., The Criminality of Former Supplemental Security Income Recipients for Drug and Alcohol Addiction Pre and Post-Benefit Termination, Presentation before the Academy for Health Services 16th Annual Meeting (July 31, 1999) (abstract available at http://www.academyhealth.org/abstracts/1999/lurigio.htm (last visited June 20, 2002)).

[80] *Id.*

The implications of this study are very serious. Crime is an externality of addiction. Again, however, it seems that the actual incentives are different from the intuitions about the moral hazards of welfare payments for addicts. A companion study conducted by two of the three researchers found that drug use in the Chicago area did not correlate to the receipt of SSI benefits at all.[81] Also noted was a significant number of individuals who "fell through the cracks" after the policy change, never reapplying for benefits despite having severe psychiatric disorders that would have qualified them for benefits independently of addiction.[82]

Simultaneously, another Chicago area study assessed the impact of the 1996 legislative changes on treatment participation. It noted that previous research indicated retention in treatment programs was "inversely related to drug use, criminality and homelessness."[83] This study analyzed the medical records of 632 subjects.[84] The findings revealed that patients were three times as likely to drop out of their treatment program after Congress terminated their SSI benefits (which included Medicaid) in 1997.[85] "The average length of stay (in group therapy visits) decreased 55% after the policy was implemented."[86] This study demonstrates that the reform measures did not foster incentives for addicts to rehabilitate at greater rates than when they received benefits.

In 1997 the National Health Care for the Homeless Council presented and published a study surveying 3,648 individuals, which focused on issues of housing and homelessness.[87] Over 50% of former SSI/SSDI recipients who

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[81] *See* James Swartz & Paul Goldenstein, The Prevalence of Lifetime and Current Severe Psychiatric Disorders, Drug Dependence, and Current Illegal Drug Use Among Former Supplemental Security Income (SSI) Recipients for Drug and Alcohol Addiction, Presentation at the Sixteenth Annual Meeting of the Academy for Health Services, Research and Health Policy (June 27, 1999) (abstract available at http://www.academyhealth.org/abstracts/1999/swartz2.htm (last visited July 31, 2002)).

[82] *Id.*

[83] Tom Brady et al., Impact of Welfare Reform Policies at one Substance Abuse Treatment Program in Chicago, Presentation at the Sixteenth Annual Meeting of the Academy for Health Services Research and Health Policy (June 28, 1999) (abstract available at http://www.academyhealth.org/1999/abstracts/brady3.htm (last visited July 31, 2002)).

[84] *Id.*

[85] *Id.*

[86] *Id.*

[87] NAT'L HEALTH CARE FOR THE HOMELESS COUNSEL, INC., THE EFFECTS OF SSI AND SSDI TERMINATION AS SEEN IN HCH PROJECTS (1999), *available at* http://www.nhchc.org/publications/ssi.htm (last visited July 31, 2002).

previously paid for their own housing were in emergency shelters one or two years after their benefits were terminated.[88] Another 26.4% were staying with friends or relatives, in a treatment bed or transitional housing.[89] Overall, 64.2% of those who lost their SSI/SSDI benefits "experienced a negative change in their housing status."[90] Regarding treatment program participation, the study found that 29.4% of the terminated SSI/SSDI recipients who had been in treatment programs dropped out of programs when their benefits discontinued.[91]

Taken together, these studies illuminate the unpleasant results of the legislative changes, such as increased homelessness, lack of access to substance abuse treatment and increased crime due to depleted income resources. A number of people "fell through the cracks," who would still merit SSI/SSDI benefits but who were unable to reapply and get enrolled once more. These are social costs that should not be ignored. It is, of course, difficult to quantify the costs of some of these problems compared with the gross savings of withholding benefits from the individuals. It is probably unrealistic, therefore, to attempt a strict, accurate calculation of net social gain or loss from granting or terminating benefits to addicts. None of the studies attempt such a wholesale endeavor. However, the empirical studies are valuable to the extent their results appear to belie the assumptions and predictions of either the moral hazard paradigm or the rehabilitation goal paradigm.

The empirical studies did not bear out the behaviors that the moral hazard approach predicted. The moral hazard approach drove the 1996 legislative changes. Thus the empirical data undermines the entire philosophical basis for our current policy. Receipt of public benefits did not encourage increased drug use, but lowered it. Terminated beneficiaries did not move into the workforce or become more self-sufficient when their benefits stopped. And addicts did not take measures to rehabilitate themselves once the "encouragement" of public benefits ceased. Rather, predictions based upon the rehabilitation-goal approach, which viewed addicts as unable to

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[88] *Id.*
[89] *Id.* at 17.
[90] *Id.*
[91] *Id.*

engage in much self-help toward productivity and self-sufficiency, seem more congruent with the results of numerous empirical studies.

Admittedly, those conducting many of the studies already advocate the rehabilitation-goal approach. For this reason, I analyzed the Lewin Group study, which the Social Security Administration oversaw, first and gave it the most discussion. If anything, the SSA had an incentive to justify its changed rules and portray its own optimistic predictions as being fulfilled. That the study concluded otherwise increases its credibility.

Why didn't the legislation achieve the desired results? A reasonable inference is that mistaken assumptions underlay the legislative action in the first place. Inaccurate assumptions or information generate inaccurate predictions. And inaccurate predictions lead to ineffective results.

III. MORAL HAZARD VS. REHABILITATION

The arguments *against* paying public benefits on the basis of DA&A are fairly straightforward: it seems counterintuitive to give a financial award to individuals for their self-destructive behavior, much less illegal activities such as the habitual consumption of contraband. Protecting individuals from the risks of such behavior is thought to create a moral hazard problem.[92]

On the other hand, the arguments in favor of granting public benefits to addicts focus on the goal of rehabilitation, and the inability of addicts to rehabilitate themselves without

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[92] The term "moral hazard" is generally used to refer to the perverse incentives that can be created by insurance, often explained with an anecdote about a farmer boasting to his neighbor that he had just purchased both flood insurance and fire insurance for the farm. "I understand the fire insurance," the neighbor replies, "but how do you start a flood?"

The etymology of the term has been traced back to the eighteenth century, when complex mathematical principles, the beginnings of modern probability theory, were employed by an elite group of professional gamblers to assess their chances of winning. "Hazard" was originally a term for dice games. *See* Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 239 (1996). A market for fire and marine insurance arose shortly thereafter, based on the same probability analysis and the idea of sharing or pooling risks. The original "moral hazards" were basically people the insurance companies sought to avoid, as their disreputable habits made them high risks (and thus, costly liabilities) for both more frequent mishaps and fraudulent claims. In the 1960s, the term was taken over by economists like Kenneth Arrow to refer to the counter-productive incentives inherent in all insurance programs, but this was framed in terms of economic "rational actors" (basically, normal people) as opposed to those lurking on the periphery of society's norms and morality. *Id.*

substantial help from others. Usually this approach rebuts the "moral hazard" argument by focusing on addiction as a disease, coupled with concerns about justice, mercy and redistribution of wealth.

These alternative perspectives have directly influenced the changes in legislation over the last few years, and continue to form the basis for policy proposals for the future. Before addressing the merits and implications of each approach, I consider the nature of addiction and assumptions about the degree of "choice" retained by those claiming alcoholism or addiction as a disabling impairment.

A. *Do Addicts Have a Choice?*

The arguments for and against offering public benefits to alcoholics or drug addicts depend heavily on assumptions about the amount of choice addicts exercise. Moral hazard arguments assume that the individuals in question can respond to incentives, sometimes indirect, and to some degree calculate and strategize about their own behavior.[93] Concerns about the perverse incentives of encouraging substance abuse, or the self-sufficiency incentives purported to attend the discontinuance of benefits, assume a certain degree of self-control, deliberation and "rational action" in the sense that economists use the word.[94] Similarly, advocates of a rehabilitation-oriented approach base their arguments on the idea that addicts are definitionally unable to help themselves, that their "disease" renders their consumption involuntary, and that outside intervention (from the state) is necessary to facilitate recovery.[95]

There is certainly no agreement on the nature of addiction, whether among medical professionals, academics or jurists.[96] Generally, those who suffer from addiction, and those

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[93] *See infra* notes 104-25 and accompanying text.

[94] See Jones v. Shalala, 21 F.3d 191, 194 (7th Cir. 1994), where Judge Posner explicitly opined that paying benefits to addicts gave rise to a lamentable moral hazard problem: "A likely outcome of awarding Jones benefits would, therefore, be to enable him to increase the scale of his addictions. That is an argument against awarding disability benefits for disabilities that are due to addiction, and the law is otherwise."

[95] *See infra* note 98.

[96] The Supreme Court has noted on several occasions that "alcoholism has too many definitions and disease has practically none." Powell v. Texas, 392 U.S. 514, 522 (1968) (rejecting "involuntariness" defense to public drunkenness conviction); Traynor v. Turnage, 485 U.S. 535, 550 (1988) (upholding the Veteran Administration's regulation treating alcoholism as "willful misconduct" in certain cases: "[E]ven among

treating them,[97] describe the phenomenon in terms of complete enslavement of the will, and readily use the label "disease" to describe this problem. Recent neurological studies provide some support for this.[98]

However, economists contradict the disease model by showing that consumption patterns, even among addicts, often respond to market forces such as price increases, criminalization and taxes on the products.[99] Addicts who are given money vouchers in exchange for "clean" urine tests each week respond well, and more so as the monetary amounts

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many who consider alcoholism a 'disease' to which its victims are genetically predisposed, the consumption of alcohol is not regarded as wholly involuntary"). Despite these expressions of skepticism on the part of the Court about the "disease" view of alcoholism (which would presumably apply to other addictions as well), the Court rejected the idea that the state of addiction could be criminalized in *Robinson v. California*, 370 U.S. 660 (1962).

[97] *See* AVRAM GOLDSTEIN, ADDICTION: FROM BIOLOGY TO DRUG POLICY (2001); AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 176 (4th ed. 1994) [hereinafter *DSM-IV*]. This section of the *DSM-IV* presents a rather sophisticated system for diagnosing and categorizing Substance Dependence Disorder generally. The Substance Abuse Disorders are all classified as 304._, with the suffix identifying which substance is the object of the addiction. The basic definition of an addiction, or Substance Dependence Disorder, is as follows:

> The essential feature of Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior. A diagnosis of Substance Dependence can be applied to every class of substances except caffeine. The symptoms of Dependence are similar across the various categories of substances, but for certain classes some symptoms are less salient, and in a few instances not all symptoms apply (e.g., withdrawal symptoms are not specified for Hallucinogen Dependence). Although not specifically listed as a criterion item, "craving" (a strong subjective drive to use the substance) is likely to be experienced by most (if not all) individuals with Substance Dependence. Dependence is defined as a cluster of three or more of the symptoms listed below occurring at any times in the same 12-month period.

Id.

[98] New brain-imaging technology demonstrates that many addictive substances alter the brain physiologically, sometimes permanently. *See, e.g.*, J.D. Jentsch & J.R. Taylor, *Impulsivity Resulting from the Frontostriatal Dysfunction in Drug Abuse: Implications for the Control of Behavior by Reward-Related Stimuli*, 146 PSYCHOPHARMACOLOGIA 373 (Oct. 1999); George F. Koob & Michael Le Moal, *Drug Addiction, Dysregulation of Reward, and Allostasis*, 24 NEUROPSYCHOPHARMACOLOGY 97 (2001); T.E. Robinson & K.C. Berridge, *Incentive-sensitization and Addiction*, 96 ADDICTION 103 (Jan. 2001).

[99] *See* Gary S. Becker & Casey B. Mulligan, *The Endogenous Determination of Time Preference*, Q. J. ECON. 112(3), 729 (1997), *reprinted in* BECKER, ACCOUNTING FOR TASTES 50-118 (1998) [hereinafter BECKER, ACOUNTING]; Gary Becker & K.M. Murphy, *A Theory of Rational Addiction*, 96 J. OF POLITICAL ECON. 675 (1988).

increase.[100] Classic behavioralists and some philosophers insist that addictive consumption cannot be "involuntary" in the same sense as blinking or grand mal seizures.[101] The fact that addicts take the necessary steps to purchase, administer and enjoy their favorite substance indicates a "voluntary" component to the problem that belies the appellation of "disease."[102] It is also somewhat self-serving for the medical community to pronounce something a "disease," as this may persuade insurers to reimburse treatment procedures.[103] And of course, addicts, like everyone else, have an incentive to describe their socially unacceptable behavior in terms that absolve them of moral culpability or responsibility.

The "disease" model does not collapse so easily, however, because considerable evidence exists that addicts act against many of their own preferences and self-interest to continue indulging their habit. Harvard Professor Gene Heyman pointed out that an addict faces a future of steadily increasing costs for continued consumption: escalating social and familial problems, increasingly deteriorated health, increased risk of

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[100] Suzette M. Evans et al., *Smoked Cocaine Self-Administration in Females and Voucher Incentives for Abstinence,* 10 J. SUBSTANCE ABUSE 143 (1998); Elizabeth Katz et al., *Reinforcement-Based Outpatient Treatment For Opiate and Cocaine Abusers,* 20 J. SUBSTANCE ABUSE TREATMENT 93 (2001); Michael Kidorf et al., *Increasing Employment of Opioid Dependence Outpatients: And Intensive Behavioral* Intervention, 50 DRUG & ALCOHOL DEPENDENCE 73 (1998) (making methadone access made contingent upon securing employment, as opposed to monetary rewards); Mark P. Reilly et al., *Impulsivity and Voucher Versus Money Preference in Polydrug-Depenendents Participants Enrolled in a Contingency-Management-Based Substance Abuse Treatment Program,* 19 J. SUBSTANCE ABUSE TREATMENT 253 (2000); Elias Robles et al., *The Brief Abstinence Test: Voucher-Based Reinforcement of Cocaine Abstinence,* 58 DRUG & ALCOHOL DEPENDENCE 205 (2000); Jennifer Rothflieisch et al., *Use of Monetary Reinforcers by Cocaine-Dependent Outpatients,* 17 J. SUBSTANCE ABUSE TREATMENT 229 (1999).

[101] *See, e.g.*, Herb Fingarette, *The Perils of Powell: In Search of A Factual Foundation for the "Disease Concept of Alcoholism,"* 83 HARV. L. REV. 793 (1970).

[102] Critics of the "disease" model, with its focus on the involuntary nature of addiction, often point to the fact that most substance abusers never develop serious dependency problems. Moreover, many who suffer from addiction simply rehabilitate themselves at some point through a process of tough choices and some changes to their surroundings. An oft-cited anecdote recounts how soldiers returning from Vietnam simply abandoned their heroin addictions upon their return to civilian life. *See generally* Fingarette, *supra* note 101.

[103] Noting that sometimes vested interests and professional agendas contribute to the stances taken on defining the problem, a federal district court in *Granville House Inc. v. Dept. of Health & Human Servs.*, 550 F. Supp. 628, 632 (D. Minn. 1982) stated, "[o]n one level, the debate appears to take the form of turf skirmishes. The American Medical Association ("AMA"), since 1957, has classified alcoholism as a physical disease. The American Psychiatric Association ("APA"), in the Third Edition of its *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*, lists alcoholism as a mental disorder."

trouble with the law and diminished ability to earn a living.[104] As costs increase, the benefits steadily decrease as the addict develops tolerance to the substance.[105] Thus, the addictive substance should have ever-diminishing utility to the addict. Nevertheless, the addict's appetite or preference for the substance continues to grow, apparently exponentially,[106] until a maximum point is reached, not of satiation, but of physical and temporal capacity to consume all available supplies. This seems "irrational" in the sense that most people use the term, and even "compulsive." Compared to other behaviors, addiction looks more like those that are coerced from an external source, and unlike the typical choices people make when they deliberate about what is best.

Heyman suggested a workable model for reconciling these apparent contradictions. Noting that most "rational actors" choose not between discrete alternatives or options, but rather between *combinations* of choices or alternatives, he built a sophisticated model in which a rational actor could tailspin into certain choices that become nearly 100% predictable, and resemble compulsion or lack of volition.[107] Choice involves, in the first place, an immediate decision about whether to consider only immediate options, or to place the current choice within a framework of clusters of choices.[108] Then the behavior

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[104] Gene M. Heyman, *Resolving The Contradictions Of Addiction*, 19 BEHAV. & BRAIN SCI. 561 (1996). Heyman, of Harvard University's Psychology Department, summarizes his key ideas as:

> (1) The behaviors that comprise addiction are voluntary even though their net consequences are aversive. (2) A voluntary aversive state can exist because the amount of behavior devoted to an activity is a function of its relative (rather than absolute) reinforcement rate (the matching law). (3) Local rather than overall value functions typically determine drug preference. . . . (4) But there are occasions in which the overall values functions determine preference, as when the drugs are not immediately available and options are under scrutiny.

Id. at 574.

[105] *Id.*

[106] One study found that morphine addicts, given unlimited supply, will increase their intake tenfold over the course of a month. *Id.* at 769-70. Addicts often consume doses that would have proved lethal to them in their initial period of consumption. *Id.* at 572.

[107] *Id.* at 567-71.

[108] Heyman subjects his students to a thought problem involving the selection of restaurants, Chinese or Italian, on a given evening. First, the students compare the utility of each option for that particular decision, and select the one yielding greater utility, based on given criteria. Then the problem is rephrased with preference considerations for how many nights in a row a person would like to eat at the same type of restaurant, which not only changes the equation, but usually changes the result. *See id.* at 567-69.

choice is made between the presently available options.[109] Using typical behavioral-economic equations and graphs, Heyman demonstrated how each time one chose only between discrete, immediate alternatives, rather than among a cluster of choices, the likelihood rose that subsequent decisions also focused on immediate options.[110]

Moreover, each consumption of an addictive substance lowers the future value of almost all alternative or competing goods and decreases the future value of the addictive good itself. Addictive goods also have certain unique traits that tamper with the preference scale. The goods generally provide an intense pleasure or utility that ensues much more rapidly (usually within seconds, or at most minutes) than almost all

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[109] To give another illustration, consider a simple, discrete choice between life and death. Compared by themselves, there hardly seems to be any choice at all. When these two extreme options are juxtaposed, the rational actor would inevitably choose life. A simple choice between an undesirable, self-defeating option, which definitionally forestalls all future enjoyment, and an option offering many possibilities for enjoyment into the indefinite future, is so clear as to almost not constitute a real choice. Put this way, it is tantamount to asking if the individual shall prefer what is preferable, or what is not preferred. Indeed, sometimes "rational actor" arguments verge on being tautological, as if saying that the rational actor will not prefer what she does not prefer.

> When the two, life and death, are isolated and juxtaposed in the framing of the question, one outcome or selection becomes virtually inevitable, and at least very predictable. The choice is greatly diminished. The degree of globalization in making comparisons is an initial, almost unconscious choice that can, in certain circumstances, control the outcome of the "choice" presented to the conscious mind. The point here is that the addict frames her "choice" in terms of simple, juxtaposed options, instead of as global sets of options. Of the simple options, one is preferable and the other is not, leaving the person "with no choice" but to indulge the craving.

See also Richard A. Posner, *The Ethical Significance of Free Choice: A Reply to Professor West*, 99 HARV. L. REV. 1431, 1445 (1986) ("An alcoholic surrenders an important part of his freedom and, it might seem, gets little in return. . . . If the 'choice' to become an alcoholic, or more realistically the assumption of the risk of alcoholism, is made on incomplete information or involves uncompensated costs to third parties . . . then it is not a 'free' choice in the Pareto-superior sense; and perhaps that is the case with addiction.").

[110] Heyman, *supra* note 104 at 567-73. This model uses occurrences rather close to one another temporally, within a one or two week period. Framing the choice in terms of immediate, discrete options is itself one of the preference-oriented "combinations" that can be chosen. These alternatives are called the individual's "Bookkeeping Scheme" in Heyman's article. While economists regularly acknowledge that people choose between combinations of goods, not discrete alternatives, their analysis of market behaviors typically works around discrete-choice models.

other sources of pleasure or utility in life.[111] Additionally, the intoxication process physically delays the enjoyment of other competing sources of good until the intoxication is over, and until any residual hangover subsides, which further discounts their value. Unlike most conventional enjoyments, such as eating a favorite food or watching an entertaining film, intoxicating substances lack the natural inhibiting function of satiation.[112] At some point, you have eaten so much that even one more bite of your favorite dish would have aversive consequences; one more time through your favorite movie would be tedious. Not so with intoxicants, whose consumption undermines the very mechanisms that facilitate moderate use. Further, physical discomfort from withdrawal symptoms strongly encourages repeated use.[113] Finally, a growing body of scientific research indicates that the substances alter the physiology of the brain, specifically the areas that mediate reward and conceptualize future values of goods.[114]

An addict, then, is on a track to exponentially increase utility in consumption of the addictive substance *compared to other alternatives*, as the value of competing interests continuously decrease with each (ab)use. This is not "irrational" in the sense that economists use the term, despite sliding toward self-destruction. If anything, the addict is being *hyper-rational*, choosing between discrete alternatives consistent with predictable preferences. The behavior becomes increasingly predictable, inevitable and less likely to be reigned in through thoughtful self-control.

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[111] These effects are highly reliable and unusually immediate. Conventional activities that alter one's mood in a desirable way are not as intense, immediate or reliable as those produced by drugs and alcohol. Religious ecstasy, sexual fulfillment or a "runner's high," for example, all require more effort, time and chance of failure. *Id.* at 572.

[112] *Id.*

[113] It should be noted that the *DSM-IV* does not consider "tolerance" or "withdrawal" features a *sine qua non* for Dependence Disorders; rather, they are "specifiers." *See DSM-IV*, *supra* note 97 at 176-78. Some substances produce far greater "tolerance" or "withdrawal" symptoms than others. The *DSM-IV* reports that Cannabis does not seem to produce any "withdrawal" symptoms. Recent studies, however, have disputed the *DSM-IV*'s position that Cannabis does not lead to withdrawal symptoms. One recent study found that two-thirds of Cannabis-dependant patients reported withdrawal. The same study found that progression from initial experimentation with Cannabis to regular use was quite rapid, matching the progression of tobacco dependence, and surpassing the progression of alcohol dependence. Thomas J. Crowley et al., *Cannabis Dependence, Withdrawal, and Reinforcing Effects Among Adolescents with Conduct Symptoms and Substance Use Disorders*, 50 DRUG & ALCOHOL DEPENDENCE 27 (1998).

[114] *See supra* note 98 and accompanying text.

Behavioral scientists recently applied a paradigm called "Momentum Theory" to the phenomenon of addiction, isolating the strength ("mass") of the preference from its rate of response ("velocity").[115] Heyman's explanation, though, more closely captures the acceleration of a falling object than simple momentum problems, since several factors combine to generate exponential growth in the direction and force of the preference.[116] The further an object falls, the harder it is to stop. Heyman's model explains quite well how addicts experience a "loss of control," observable to those around them (such as family or treatment providers), while at the same time appear to make a series of choices.

Heyman's model also highlights a difference in some earlier law and economic models for addiction.[117] Gary Becker described addicts as "rational actors" whose present decisions are weighted by future values of goods, such as the addictive substance, although he acknowledged that addicts generally discount the future excessively.[118] Others, such as Judge Richard Posner, portrayed addicts not only as hyperbolic discounters,[119] but also as present-oriented selves externalizing

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[115] *See, e.g.*, John Nevin & Randolf Grace, *Behavioral Momentum and the Law of Effect*, 23 BEHAV. & BRAIN SCI. 73 (2000).

[116] Acceleration of objects caused by gravitational force is calculated as 9.8 (meters)/seconds^2. Using this as a model for decisions and preference, one could analogize that the strength of the compulsion on the addict in a given situation is a factor of the addictiveness of the substance (representing mass), with the time of previous indulgence (either the length of the period of the addiction or the number of times the craving has been indulged) squared. The point is that the reinforcing action of the drug magnifies the likelihood of the next episode of consumption exponentially.

[117] Addiction poses one of the most common and serious challenges to the rational-actor model of the law and economics school. It appears to be the ultimate example of purely irrational behavior, of individuals continuing to act in a way they know to be self-destructive, counter-productive and against their other preferences. The impingement on the most basic assumptions of economic theory made addiction an important project for economic theorists, such as Gary Becker and (to a lesser extent) Richard Posner, to tackle and explain.

[118] *See* BECKER, ACCOUNTING, *supra* note 99, at 77-81.

[119] *See, e.g.*, RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 267 (5th Ed. 1998) ("The rational prospective addict knows that he is or will be hooked, so any permanent price reduction (as from legalization of drugs) will reduce not only the current cost of consumption but future costs."); ("An addict, in economic terms, is one whose demand for the addicting product is a positive function of his past consumption. (Addiction is thus a form of habituation.) The rational addict will perceive an increase in the cost of the product as in increase in his future rather than merely his present expenses, because consuming the product now will make him more likely to buy it in the future."). *Id.* at 529. *See also* A.L. Bretteville-Jensen, *Addiction and Discounting*, 18 J. HEALTH ECON. 393 (1999); George-Marios Angeletos et al., *The Hyperbolic Consumption Model: Calibration, Simulation, and Empirical Evaulation*, 15 J. ECON. PERSP. 47 (2001).

the costs of present consumption onto their future selves.[120] What economists call excessive discounting of the future appears to be mostly a failure to reach a certain level of abstraction in thought when making a decision.[121] This accords with Heyman's point that the initial decision to treat a choice as a simple selection rather than a complex, multifaceted commitment begins the spiraling effect of addiction, when the choice involves a substance that has certain intoxicating, non-satiating and tolerance-producing effects.

Heyman's model also helps explain the clinical reports that post-recovery relapses are not associated as much with exposure to token amounts of the substance as much as with life events that diminish the value of competing goals.[122] Contrary to popular urban legends, the "tiny sip" of alcohol generally does not prime the rehabilitated addict into a binge of renewed indulgence, nor do most relapses follow upon stints of "craving." Rather, the occurrence of situations prompting the recovering addict to engage in a certain type of choice—focusing on immediate options and opportunities instead of

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[120] *See* Richard Posner, *Rational Choice, Behavioral Economics, and the Law*, 50 STAN. L. REV. 1551, 1557 (1998); *see also* Richard Posner, *Are We One Self or Multiple Selves? Implications for Law and Public Policy*, 3 LEGAL THEORY 23 (1997). Posner adds that the ability to resist immediate gratification in order to enrich one's future is the difference between a childish approach and that of an adult. *See also* Bernard Williams, *Persons, Character, and Morality, reprinted in* MORAL LUCK 1 (1981). Becker explicitly disavows such a view, based on survey studies (and his analytical model) showing that addicts' present consumption is affected by future consequences, at least those related to permanent changes in the price of the addictive substance. BECKER, ACCOUNTING, *supra* note 99, at 11. Interestingly, behavioral scientists determined that the language faculties in the brain, rather than the faculties used to conceptualize time, govern self-control and resistance to temptation in general. *See, e.g.*, Adam Gifford, Remembrance of Things Future and Self-Control (2000) (unpublished manuscript, on file with California State University Department of Economics).

[121] Experiments with monkeys involved a game in which different size piles of food treats were displayed, and each monkey was allowed to pick one. The monkeys invariably picked the largest pile, but in the game, their first choice was always taken away and given to another monkey, leaving the first to select a second, smaller pile. Over time, the monkeys were trained to associate various sizes of treats with the written numerals one through nine. Then, and only then, could the animals "get" the game, and select a small pile first, knowing they would lose it to a companion, in order to have the biggest pile available for the second round. The symbolic or semiotic cognitive function (which enables language in humans) was shown to be the deciding force in playing the game right, not the monkeys' ability to conceive of time and duration. It should be noted that it took nine years to teach monkeys to play this game, and only a few minutes for human children to comprehend it. *See* Gifforrd, *supra* note 120.

[122] Heyman, *supra* note 104, at 571. Another relapse-inducing factor seems to be a revisiting of the environment or situation associated with the addictive consumption period.

more "global" goals and objectives—occasion a fall into the disavowed patterns of indulgence.[123]

In summary, Heyman's model of rational addiction seems to resolve the dispute about addiction being a "disease," by explaining both the compulsive nature of the problem and the apparent decision-making or volitional activity that occurs. He incorporated and reconciled the data from each competing body of literature on addiction. The model improves upon earlier views of "rational addiction" offered by Becker and others, and I rely on it throughout the rest of this article.

Heyman remarked that his model implicated the application of different incentives and treatment approaches than would normally be used to influence decisions.[124] The model recognizes that one has great difficulty stepping out of the choice-cycle of addiction, and increasingly so as the syndrome progresses. Disincentive measures, such as increased costs for the addictive substance, can be effective, but only if the cost increase applies exclusively to the targeted substance, and not to other goods or enjoyments in the person's life. Diminished values of goods or combinations competing with the addictive substance will foster addiction instead of abate it. Conversely, enhancing overall value functions for the individual makes the habit more resistible, bringing consumption under the control of overall values, rather than "local" or immediate functions.

This insight into the nature of addiction, and its relation to individual volition or free will, has significant implications for both the moral hazard analysis and rehabilitation policies. The conclusions in these matters ultimately indicate the proper direction for future policy and regulation.[125]

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[123] It should be noted that this phenomenon is not only troubling for the "disease" model proponents, who often maintain that "just one drink" is dangerous enough to make relapse inevitable, but also for behavioralists, as there is no correlation between fits of craving and relapse. This behavior is unique to humans—laboratory animals usually return to former consumption when "primed" with some alcohol or other substance. Humans, however, can remain resolute in their abstinence, even when exposed to a dose of the formerly enslaving substance.

[124] Heyman, *supra* note 104, at 570.

[125] Of course, there remain virulent objections to the very use of the term "rational" to describe or model addiction, especially by advocates for addicts' rights. *See, e.g.*, John F. Tomer, *Addictions Are Not Rational: A Socio-Economic Model of Addictive Behavior,* 33 J. SOCIO-ECON. 243 (2001); Rex Greene, *Towards A Policy of Mercy: Addiction in the 1990's,* 3 STAN. L. & POL'Y REV. 227, 229 (1991) (objecting to the rational-actor approach to addiction as the basis for policy decisions); Christine Jolls et al., *A Behavioral Approach to Law and Economics,* 50 STAN. L. REV. 1471, 1488 (1998).

B. *The Moral Hazard Problem*

Undoubtedly the biggest argument against giving benefits to addicts is that it provides special benefits, namely money and free health insurance, to people for engaging in undesirable, self-destructive or even illegal behavior in the form of substance abuse and addiction. At worst, providing welfare benefits might conceivably create an *incentive* to develop and nurse a bad habit that not only poses possible health risks, but significant externalities for innocent third parties, like children and spouses, fellow drivers on the road and law enforcement officers. At best, benefits provide a decreased incentive for recipients to rehabilitate or refrain from substance abuse, as the "costs" to the substance abuser are decreased. Under this view, the system artificially props them up. There are also policy concerns that the benefits indirectly pump funds into the illegal drug industry.[126]

This moral hazard problem was the underlying theme of the political bromides leading up to the 1994 and 1996 changes in the rules. The legislative history is replete with anecdotes of purported system abuses, including "junkies" who designate their suppliers as their "representative payees," and alcoholics who designate their local watering hole as the mailing address for their benefits checks.[127]

An important distinction, of course, is the difference between awarding benefits *to* addicts and awarding benefits *on the basis of* addiction. Current law makes this distinction—addicts can receive benefits, provided they have other legitimate, qualifying impairments, but no one can get benefits *because* of an addiction.[128] In practice, however, the distinction blurs in individual cases.

A significant assumption underlying the arguments against granting benefits on the basis of addiction is that the problem is the result of individual choices and decisions, however irresponsible and self-destructive.[129] This focus on the

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[126] For example, the Cato Institute's influential Policy Analysis Paper No. 224, "*SSI: The Black Hole of the Welfare State*" asserted: "SSI pumps money directly into the drug economy." Wright, *supra* note 1 ("The need for a government-administered disability insurance program has never been established and is particularly questionable given that a market for private disability insurance already exists."). *Id.*

[127] *See id.* for a convenient collection of the anecdotes shared by Congressmen, as well as some of the "scandals" highlighted by the media around the country.

[128] *See* 20 C.F.R. § 404.1535 (2001).

[129] The Cato Institute, for example, included this point in its Policy Analysis

will power and volition of the individual implicates questions of "responsibility." At this point, the linguistic instruments of the rhetoric are slippery. "Responsibility" can refer to the causation and agency of an action ("the junkies sleeping on the streets are responsible for the drop in tourism to our city"), or to the affixing of liability for undesirable happenings ("it is not their environment that is to blame for their problems, but the addicts themselves, who chose to try drugs in the first place") or to the *duty* to prevent undesirable situations ("these people should take responsibility for their own lives").[130] The linguistic problem is noteworthy because it blurs some of the policy discussions, especially the important distinction between how a problem arose and how it should be addressed. Strong assumptions about free will and human volition underlie the moral hazard arguments. Addiction results partly from the external incentives afforded to the addicts, and many assume an addict chooses her drug-induced euphoria over financial self-sufficiency.

Public assistance in general presents a collective goods problem. Social insurance (like SSDI and SSI) is a collective good to which everyone contributes, so that together we are all better off—but only if everyone else contributes as well.[131] The "good" that is attained is insurance against the devastating effects of becoming disabled or unable to work. Under the "rational self-maximizer" view, addicts seem to be the ultimate free riders. The rest of society works and contributes to the tax

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No. 224:

> Although alcoholism is more often the problem than drug addiction, substance abuse is now an independent basis for a finding of disability if it is deemed to preclude substantial employment. That change in the concept of disability was made in the regulations in 1975 but not fully implemented until later. At present, SSI operates on the philosophy that addiction is an illness and not a result of individual behavior and choices. However, the view that addiction is a disease remains disputed. Also, many health officials agree that even if addiction is a disease, a person retains significant elements of personal choice and personal responsibility. Because addiction is an independent basis for disability, able-bodied substance abusers can receive disability benefits without having to show liver damage or any other physical manifestation of their addiction.

Wright, *supra* note 1.

[130] MARTIN GILENS, WHY AMERICANS HATE WELFARE: RACE, MEDIA, AND THE POLITICS OF ANTIPOVERTY POLICY 174-203 (1999).

[131] *See id.* at 44 ("Surveys show that Medicare receives somewhat more support from the public, but Medicaid nonetheless garners strong public support even from middle-class respondents, few of whom would expect to benefit from the program themselves.").

base, which obviously involves the universal sacrifice of leisure time and escapist pleasures, while a few individuals are perceived to subsist in constant leisure and escapist pleasure as they leech a subsistence off the public good, making no contribution themselves.[132]

Additionally, welfare implicates reciprocity principles of gift-and-exchange. Oded Stark and Ita Falk argued that the reciprocity mechanism, which motivates relief efforts for the poor, is a utility function related in part to the gratitude of the recipients.[133] When welfare recipients appear ungrateful, or seem to be taking advantage of the public generosity, a tit-for-tat reaction ensues among the contributors.[134] Persistent substance abuse, which created the recipient's disability in the first place, seems to embody non-reciprocation or appreciation for the benefits conferred. The donor's response is to resent and retaliate, as a further function of the reciprocity.

Of course, a moral hazard is present in all disability insurance, private or public, for any type of impairment. The availability of unearned monthly income on the basis of any disability, such as blindness or partial paralysis, may create a perverse incentive for the recipient to ignore available treatment options and cures, and to engage more freely in risky activities that could result in a disabling accident or injury.[135]

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[132] While acknowledging that the public deeply resents welfare recipients perceived to be lazy and indolent, Gilens asserts that public resentment toward welfare recipients is more a function of public perceptions that the recipients are mostly racial minorities, who are stereotyped as lazy. *See id.* at 154-73.

[133] Oded Stark & Ita Falk, *On the Transfer Value of Gratitude, in* REFORMING THE WELFARE STATE 313-26 (Herbert Giersch ed., 1997).

[134] *Id.*

[135] A deeper moral hazard question lurks in the background of the debate regarding government benefits for the poor in all contexts, and whether such benefits provide a disincentive to become self-sufficient. *See* Lars Soderstrom, *Moral Hazard in the Welfare State, in* REFORMING THE WELFARE STATE 25-46 (Herbert Giersch ed., 1997); *see also* GILENS, *supra* note 130 at 185 (noting that survey respondents were actually *less* insistent on work requirements for welfare recipients than for "single parents with drug or alcohol problems"). Many criticize SSI/SSDI in general, apart from the segment relating to DA&A, for discouraging retirement savings and vocational rehabilitation. *See* David Neumark & Elizabeth Powers, *The Effect of Means-Tested Income Support for the Elderly on Pre-Retirement Saving: Evidence From the SSI Program in the U.S.*, 68 J. PUB. ECON. 181 (1998). This particular welfare program is not alone in this regard; AFDC has been said to create disincentives to work as well. *See* Elizabeth T. Powers, *Does Means-Testing Welfare Discourage Saving? Evidence from a Change in AFDC Policy in the United States*, 68 J. PUB. ECON. 33 (1998); this view has been challenged as a semantic game in D.A. Long, *From Support To Self-Sufficiency: How Successful Are Programs in Advancing the Financial Independence and Well-Being of Welfare Recipients?*, 24 EVALUATION & PLAN. 389 (2001).

Tom Baker summarized the usual rhetoric in this regard with his aphorism, "[b]ecause all insurance affects incentives to reduce loss, welfare will increase poverty, workers' compensation will increase worker accidents, and products liability will increase consumer accidents."[136] Yet disability insurance, both private and public, is widespread. The social costs (externalities) of having uninsured injured and disabled people in society, as well as general societal benefits, justify insurance.[137]

Economics lends one useful distinction to the discussion of moral hazards. Economists differentiate between *ex ante* moral hazard and *ex post* moral hazard.[138] *Ex ante* moral hazard refers to the incentive insurance provides to the insured to be less careful in preventing loss, at best, or to create losses to collect insurance at worst.[139] *Ex post* moral hazard refers to the incentive for the insured to exaggerate a loss after it happens, to prolong the loss or to fail to mitigate a loss through reasonable self-help measures.[140] *Ex post* moral hazard generally is more relevant to health and disability insurance, and therefore would be more relevant to SSI/SSDI.[141]

The distinction between *ex ante* and *ex post* is important in the present context because there are two phases of supposed choices connected to addictions. First, individuals

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[136] Baker, *supra* note 92, at 239. It should be noted that when insurance was first widely marketed in the nineteenth century, many criticized it as a form of gambling, an encouragement to crime and an interference with Divine Providence. *Id.* at 255-60.

[137] For a delineation of several society-wide benefits of the institution of insurance, countering the moral hazard arguments against insurance generally, see Deborah A. Stone, *Beyond Moral Hazard: Insurance As Moral Opportunity*, 6 CONN. INS. L.J. 11 (1999). Martin Gilens maintains that most Americans actually favor funding SSI/SSDI as necessary, much more so than welfare programs perceived to benefit able-bodied, working-age adults. *See* GILENS, *supra* note 130, at 12-13, 42-43, 212.

[138] *See* Baker, *supra* note 92, at 270, (citing George L. Priest, *A Theory of the Consumer Product Warranty*, 90 YALE L.J. 1297, 1314 (1981)).

[139] *See* George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1547 (1987) [hereinafter, Priest, *Insurance Crisis*] ("Ex ante moral hazard is the reduction in precautions taken by the insured to prevent loss, because of the existence of insurance.").

[140] *Id.* ("Ex post moral hazard is the increase in claims against the insurance policy beyond the services the claimant would purchase if not insured. In the context of medical insurance, for example, ex post moral hazard includes excessive (at full-price) visits to doctors, longer hospital stays, and more elaborate and expensive methods of treatment.").

[141] *Id. See also* Baker, *supra* note 92, at 270-71; Evan M. Melhado, *Economic Theory, Economists, and the Formulation of Health Policy*, 25 J. HEALTH POL., POL'Y & L. 233, 239 (2000).

choose to engage in some level of substance abuse that presents a risk of addiction; the level of risk varies with the nature of the substance and the frequency of use. Second, addicts continue to indulge their habits, which involves some level of choice, however irrational. Granting or withholding benefits for those who are already addicted can be predicated only on assumptions about the incentives for the latter choices. Withholding benefits would realistically deter against becoming addicted in the first place. The possibility of receiving paltry benefits after developing a debilitating addiction is unlikely to tempt anyone to pursue addiction. Thus, *ex ante* moral hazard should be irrelevant to policy decisions about SSI/SSDI benefits. *Ex post* moral hazard, however, is relevant to the SSI/SSDI issue, because of the concern with the incentives or disincentives to engage in self-help and self-recovery once a debilitating addiction is already present.

Ex ante and *ex post* are easily confused. There is an inescapable moral approbation on the first phase of choices, and a widespread aversion to "rewarding" such reckless or self-destructive behavior with cash benefits.[142] This moral issue is significant for rhetoric and politics, but should be kept separate from the "incentives" question for those who are now already addicted. Moreover, to the extent that the more relevant form of moral hazard is *ex post*, the appropriate devices should be employed to address it. These devices are more akin to co-insurance than deductibles. To the extent that the public benefits are meager enough to fall slightly below the basic cost of living, the recipients of disability benefits could be said to be co-paying a percentage of the loss every month. For instance, the standard SSI benefit in 2001 has about $530 per month. The co-payment does not take the form of writing a check to pay a portion of a bill, but is manifest when the recipient endures some of poverty's grinding.

Both moral hazard types contribute to an additional, insurance-type, economic problem, adverse selection.[143] Adverse selection refers to the unfortunate fact that the people most likely to incur losses often want insurance the most, while the safest individuals are likely to jump out of the insurance pool

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[142] *See* discussion *supra* note 92, and specifically Baker at 244-60.

[143] *See* Priest, *Insurance Crisis*, *supra* note 139, at 1548 ("Where insureds, ex post, can affect the level of claimed losses, the variance in expected risks increases. Those individuals who are less likely to gain from exaggerated visits to doctors or from more extensive hospitalization will drop out of the pool if full coverage is offered.").

completely.[144] This skews the risk-averaging and law of big numbers, which is the real advantage of insurance, making it less profitable or beneficial for everyone involved. In the welfare arena, adverse selection is an issue because those most likely to be long-term cases, due to their inability to engage in self-help, are more likely to seek welfare assistance in the first place. Thus, the addicts who are most able or motivated to kick their habit are more likely to do this themselves without going through the hassle of applying for SSI/SSDI and attending administrative hearings. Similarly, those who would take the least time in treatment to achieve recovery status are most likely to engage in self-help rather than seek government assistance.

Conversely, those with the most tenacious addictions are more likely to enroll on SSI/SSDI, which means that the ranks swell with long-term or lifetime dependents. Success in treatment and recovery is tied to the ease of social rehabilitation: "[recovering] physicians obviously don't have as far to go as street addicts."[145] This effect can create the appearance of incentives working to prolong addictions and encourage malingering. Incentives are at work, but these are adverse-selection incentives, distinct from the perverse, loss-increasing incentives of moral hazard. Applying the wrong incentive measures can generate a reverse adverse-selection problem, where those who need and merit the benefits the most are least likely to get them.

When insurers apply mechanisms such as deductibles, co-insurance and duty to mitigate loss (e.g., required treatment), the moral hazard is significantly diluted.[146] Since Social Security pays so little and requires so much compliance with doctor-recommended treatment,[147] these mechanisms are in place already.[148] The adverse selection problem actually counters the *ex post* moral hazard problem in this case, because

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[144] *Id.*

[145] Greene, *supra* note 125, at 229.

[146] Each type of hazard can be addressed and ameliorated through unique market mechanisms. Deductibles are a ubiquitous feature of insurance that addresses *ex ante* moral hazards, by forcing the insured to pay some fixed sum toward the total loss before filing a claim for the rest. *See* Priest, *Insurance Crisis*, *supra* note 139, at 1548. Co-insurance, in which claimants have to pay a percentage of each claim, is particularly useful in addressing *ex post* moral hazards. *Id.* Both deductibles and coinsurance mitigate the effect of each type of moral hazard to some extent.

[147] Treatment Required for Disability, 20 C.F.R. § 404.1536 (2002).

[148] Stone, *supra* note 137, at 28 ("Those who view insurance through the lens of moral hazard do not see this disciplinary or regulatory power.").

the individuals seeking SSI/SSDI benefits are those least likely to be able to help themselves. In other words, the nature of the disability is such that the applicants are to some extent the most helpless, and as previously discussed, helplessness is inversely proportional to the moral hazard effect. Finally, drawing public attention to a social problem, such as the debilitating effects of addiction, creates a type of reverse-moral-hazard effect and provides an indirect deterrent for others.

There are more substantive problems with applying the moral hazard model to welfare benefits for addicts. First, the underlying assumptions about the interplay of addiction, welfare and incentives are subject to criticisms on conceptual grounds. Second, the empirical evidence suggests that the predictions of the moral hazard model do not materialize as expected.

1. Conceptual Problems with the Moral Hazard Argument

If addicts consume involuntarily, or behave irrationally (in the sense used by economists), then the moral hazard incentive scheme would not apply. If the addict cannot scheme, or respond at all to market forces, then no moral hazard exists.

This article, however, adopts the rational-actor view of addiction, especially as laid out by Gene Heyman, although Becker's view yields the same results.[149] While the addict may exercise volition, she is locked into framing choices as simple, discrete options juxtaposed to one another, and ignoring attachments of those options to more global clusters of options and consequences. This makes it unlikely that external incentives will affect the addict as normal economic models predict. Certainly *ex ante* moral hazard schemes are unlikely, due to an addict's hyperbolic discounting of the future. *Ex post* moral hazard is more of a concern, as simple inaction would fall under this penumbra. Heyman's model demonstrates, however, that the incentives likely to affect the addict's decisions are only those that target the addictive substance *directly*, not indirectly.[150] Any external forces or stimuli that lower the overall value of competing options, especially future options,

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[149] *See supra* notes 118-20 and accompanying text.

[150] Heyman, *supra* note 104, at 600-03.

simply make addictive consumption more likely, and the internal pressure to consume more virulent.[151]

Instead, the "incentives" likely to reduce consumption or facilitate rehabilitation are: (1) directly increasing the cost of the addictive good, without diminishing the value of other life goods; and (2) enhancing overall values, which not only interferes with the discreet choice in a single episode of consumption, but lures the addict toward more abstract, forward-looking decision paradigms. Hence, clinics offering monetary vouchers to addicts for a weekly "clean urine" test prove very effective, not only in reducing consumption, but also in moving the individual back into the workforce. Increasing the addict's overall poverty is more likely to increase consumption than decrease it.[152]

2. Empirical/Inductive Research about Addiction, Welfare and Incentives

The first set of problems with the moral hazard approach is the conceptual difficulties with its underlying assumptions. The second set of problems is the empirical evidence testing the application of the approach. While both sides have a quiver full of anecdotes to share, and a few studies to cite, it seems that the best research indicates that the receipt of public benefits does not encourage or increase drug or alcohol dependency.

Proponents of the moral hazard argument usually bolster it with anecdotes of outrageous system abuses, and some clinical observations. For example, in 1995, the *New England Journal of Medicine* printed an article entitled, *Disability Income, Cocaine Use, and Repeated Hospitalization among Schizophrenic Cocaine Users: A Government-Sponsored Revolving Door?*[153] asserting that welfare programs were fostering drug abuse by subsidizing drug habits. The results of this study were merely that cocaine use, resultant psychiatric

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[151] *Id.*

[152] The essential argument is that addictive substances function as a type of "Giffen goods," an economic phenomenon in which the cost of certain inferior goods can actually increase consumption of the good due to the resultant decrease in overall income. *See* Neal Kumar Katyal, *Deterrance's Difficulty*, 95 MICH. L. REV. 2385, 2434-39 (1997) (arguing that drugs such as heroin function as Giffen goods).

[153] A. Shaner et al., *"Disability Income, Cocaine Use, and Repeated Hospitalization among Schizophrenic Cocaine Users: A Government-Sponsored Revolving Door?"* NEW ENG. J. MED. 333, no 9 at 777 (1995).

symptoms and drug-related hospitalizations all peaked during the first week of every month, which is when welfare beneficiaries typically receive their checks.[154] This does not, however, demonstrate a cause-and-effect relationship. The fact that addicts are more likely to binge, if at all, immediately upon the receipt of their only income for the month tells very little about the etiology of the addiction or its ongoing progress. Those who subsist entirely on government benefits issued once per month are likely to have general consumption patterns tied to this monthly spike in income. Retailers in poor neighborhoods are likely to find a surge in food and clothing purchases in the days following issuance of welfare checks.

A subsequent scientific study conducted by Robert Rosenheck and Linda Frisman in 1996 specifically disputed the *New England Journal of Medicine* article.[155] They conducted the study at nine sites involving 655 subjects.[156] The results showed a significant relationship between overall income level and substance abuse, whether alcohol or drugs: individuals with more income were more likely to purchase and abuse drugs and alcohol.[157] Rosenheck and Frisman concluded, however, that neither the source of income nor the amount of welfare benefits received had any correlation to drug use.[158]

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[154] *Id.* In many states, welfare recipients no longer receive "checks." Rather, direct deposit into a bank account is used to disburse cash assistance. The Social Security Administration strongly encourages beneficiaries to identify an account for electronic transfer of funds. States like Connecticut have switched to an Electronic Benefits Transfer ("EBT") card system, much like an ATM card, for Food Stamps, TANF and General Assistance payments.

[155] Robert Rosenheck & Linda Frisman, *Do Public Support Payments Encourage Substance Abuse?*, 15 HEALTH AFF. 192, 194 (1996). Rosenheck is a clinical professor of psychiatry at Yale Medical School and director of the Department of Veterans Affairs Northeast Program Evaluation Center; Frisman is associate director of the Northeast Program Evaluation Center and associate research assistant at Yale Medical School.

[156] *Id.* at 193.

[157] *Id.*

[158] However, the coefficients revealed no statistically significant relationships between public support payments and any of the substance abuse measures. In other words, in this study those who received high levels of public funding had no greater tendency to use or purchase drugs or alcohol than did public support recipients who received lower levels of funding. Also, although the findings suggest higher levels of substance abuse for the study group as a whole [i.e., veterans], on average, public support recipients reported significantly lower levels of substance abuse and spending than did those who did not receive any form of public support, even though the former group had higher total income.

Id.

Interestingly, a smaller longitudinal study on a subgroup of the subjects over an eight-month period showed that substance abuse habits did not change substantially despite fluctuating amounts of benefits received during the period, although admittedly the increase in benefits was in the form of housing subsidies.[159] In economic terms, however, the provision of in-kind support such as housing subsidies would simply free up more cash income for increased drug or alcohol spending, so the nature of the increased benefits should not matter. Following my previously discussed choice analysis, moving money from one area to another in this manner would require a global decision.

Rosenheck and Frisman noted several caveats, such as the possibility that the sample group could have skewed the results if public support recipients tend to be sicker and therefore less prone to abuse drugs and alcohol.[160] In reality, however, the opposite seems to be true, as those in the greatest distress tend to use substance abuse as a form of self-medication or escapism.

Rosenheck and Frisman observed that addicts were particularly vulnerable to homelessness and related health risks.[161] They urged policy makers to distinguish "the public health goal of protecting a vulnerable population from moralistic concerns that funds should not be spent on certain activities, especially when such funds have been shown to help remove homeless persons from the street."[162]

I present the Rosenheck and Frisman study for the simple point that the empirical evidence does not support the moral hazard predictions.[163] The moral hazard argument has a

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[159] *Id.*

[160] Rosenheck & Frisman, *supra* note 155, at 193. Anticipating a possible criticism that the subjects may not have been truthful about their substance abuse out of fear of losing their benefits, the authors point out that at the time of the study, no such consequences could have occurred, as the laws had not changed yet. There would have been no real incentive for the participants in the study to report untruthfully.

[161] *Id.*

[162] *Id.*

[163] Another study in 1999 found the same results as Rosenheck and Frisman, although the study was much smaller (218 subjects). *See* James A. Swartz & Paul Goldstein, The Prevalence of Lifetime and Current Server Psychiatric Disorders, Drug Dependence, and Current Illegal Drug Use Among Former SSI Recipients for Drug And Alcohol Addiction, Presentation before the Academy for Health Services Sixteenth Annual Meeting (July 31, 1999) (abstract available at http://www.ahsr.org/1999/abstracts/swartz2.htm) ("[N]or was there any relationship between disability status and illegal drug use for any of the drugs tested. . . . Contrary to some assessments of the SSI DA&A program, *drug use does not appear to be related to the receipt of benefits.*")

broad political appeal because it is so intuitive; most people respond to external incentives and are familiar with the social norms that prohibit a free ride. The argument is weakened substantially if the assumptions are simply incorrect, if rational decision making cannot be imputed to those living with serious addictions. Moreover, while moral hazard intuitions take great courage from anecdotes that confirm the fears, empirical studies show that the phenomenon does not really occur. Nevertheless, we cannot ignore the moral hazard problem, if for no other reason than it will continue to figure prominently in political debates and as part of the intuitive initial reaction on the part of voters. Although misguided, moral hazard concerns remain part of the political reality. And by "providing a 'scientific' basis for the abandonment of legal rules and social policies, the economics of moral hazard legitimate that abandonment as the result of a search for truth, not an exercise of power."[164]

C. *Rehabilitation Goals*

The arguments in favor of providing benefits on the basis of DA&A generally focus on the individuals themselves and the need for rehabilitation. Advocates of this approach view addiction from a medical perspective, as a disease, and tend to emphasize the uncontrollable behavior associated with the habit rather than free will and individual decision-making.

One argument in favor of assisting addicts, then, runs something like this: addicts are in the grip of an evil they cannot readily overcome. At best, withholding public assistance allows nature to take its course in slowly "thinning the herd"[165] and at worst hastens this cruel process. An addict either heroically overcomes addiction, taming the beast alone, or becomes increasingly dependent, unproductive, malnourished and marginalized from society. Eventually, he will become a vagrant, subject to the well-known perils of homelessness. He will finally succumb to exposure, starvation, insanity or street violence. In the alternative, his desperate situation will drive him to a life of crime for sustenance: theft, prostitution or for the entrepreneurial, the drug trade. Apart from the occasional

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(emphasis added).

[164] Baker, *supra* note 92, at 240.

[165] "[A] social Darwinist solution to rid society of unworthy people." Greene, *supra* note 125, at 233.

hero who rehabilitates successfully, the rest come to an inevitable demise with significant social externalities: devastated families, increased crime, neglected children, ubiquitous panhandling and unpaid emergency room bills. Alcohol alone was a factor in a third of the crimes by adult offenders in 1996.[166]

Public assistance provides a stabilizing influence, a safety net for those in a downward spiral. It enables them to obtain basic housing, a critical threshold between simple poverty and outright desperation and irrational living. With housing, hygiene improves dramatically and the individual can begin to accrue property, obtain employment and sleep unmolested on a regular schedule. Perhaps most significantly, benefits enable addicts to get professional treatment and recover from their underlying problem. SSI and SSDI both provide recipients with Medicare/Medicaid, which covers the cost of treatment programs, medications such as methadone and anti-depressants, and inpatient services. It would seem that everyone would agree upon a goal of helping addicts make better decisions so they can reintegrate as productive members of society. Cash assistance and medical coverage effectively target the skewed decision-making process of addicts to help them make better decisions, both for themselves and those around them.

Rosenheck and Frisman cite several studies to support the conclusion that "[a]ddictive disorders have been shown in virtually every community survey to be a major risk factor for homelessness, as well as for other health, social, and economic consequences."[167] Their article closes with a good summation of the rehabilitation-goal position:

> The substance abuse epidemic is having a devastating effect on our society, and all possible remedies should be investigated. This study suggests that policies that are developed on the basis of anecdotal evidence, even though they are responsive to the hardening tide of public opinion, may lead to inefficient and ineffective use of public resources, or to punitive withdrawal of funds that are desperately needed and have been shown to contribute to achieving their desired goals.[168]

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[166] *See* Dess Aldredge Grangetto, *Reducing Recidivism by Substance Abusers Who Commit Drug and Alcohol Related Crimes*, 10 J. CONTEMP. LEGAL ISSUES 383, 389 (1999).

[167] *See* Rosenheck & Frisman, *supra* note 155, at 199.

[168] *Id.* at 194.

Others share this view, especially those with expertise in the problem of homelessness. For example, the National Coalition for the Homeless published a series of Fact Sheets in 1999, one of which observes:

> Untreated addictive disorders do contribute to homelessness. For those with below-living wage incomes and just one step away from homelessness, the onset or exacerbation of an addictive disorder may provide just the catalyst to plunge them into residential instability. And for people who are addicted and homeless, the health condition may be prolonged by the very life circumstance in which he or she finds her/himself. Alcohol and drug use may help meet immediate needs by providing respite from otherwise stressful and sometimes violent conditions, and thus distract from activities oriented toward stability.[169]

The authors also cite studies by others demonstrating that "housing stability is essential for successful treatment and/or recovery."[170] When those suffering from addictions lack the resources to rent an apartment, to create some stability in their lives, treatment and recovery remain an elusive dream. Homelessness itself is not a bar to receiving SSI/SSDI benefits,[171] but deprivation of any source of income is an obstacle to retaining housing, and homelessness does substantially interfere with successful treatment of a substance abuse problem.

What is the government's responsibility to intervene in an addict's life? The question remains how to justify—much less mandate—government funding for addiction, which may devastate the individual's life and lead to homelessness. A partial answer is to address the externalities to addiction that policy discussions often overlook. Addicts do not only harm themselves. Many have families: parents, spouses, children, whose lives are seriously adversely affected by the presence of addiction in the home. Addiction can cause domestic abuse and neglect.[172] The state has other vehicles for addressing abuse

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[169] NAT'L COALITION FOR THE HOMELESS, ADDICTION DISORDERS AND HOMELESSNESS: NCH FACT SHEET #6 (Apr. 1999), *available at* http://www.national-homeless.org/addict.html (last visited Aug. 8, 2002).

[170] *Id.* (citing Deirdre Oakley & Deborah L. Dennis, *Responding to the Needs of Homeless People with Alcohol, Drug, and/or Mental Disorders*, *in* HOMELESSNESS IN AMERICA (1996)).

[171] This was ensured by the passage of the McKinney Act of 1987, Pub. L. No. 100-77 (1987).

[172] *See* JILL DAVIES, SAFETY PLANNING WITH BATTERED WOMEN: COMPLEX LIVES/DIFFICULT CHOICES 31 (1998) (citing G. Hotaling & D. Sugarman, *An Analysis of Risk Markers in Husband to Wife Violence: The Current State of Knowledge*, VIOLENCE

and neglect, but these measures have significant costs for the victims as well. The arrest and imprisonment of a family member often deprives the children, innocent bystanders to the root problem, of a badly needed source of income for the family.[173] The tearing apart of family units by state agencies, and placement by a byzantine foster care system, is certainly not an ideal solution to the problem. Such *post facto* measures fail to address the root problem of addiction. Moreover, the addiction problem itself is more efficient and effective than creating coping mechanisms for its destructive wake.

Another common externality is the cost to theoretical employers in the form of an addict's lost productivity. These costs are irrelevant here, as the SSI/SSDI programs apply *only* to those who are not engaged in any substantial gainful activity. This externality, however, should be part of the calculus for the overall social cost of disallowing benefits for DA&A. The ideal result of the termination of benefits is for the former recipients to re-enter the workforce. This is certainly preferable to the only clear alternative, relying on criminal activity for income. The addicts receiving assistance already demonstrated that the severity of their problem kept them from working. Forcing these individuals into the workforce is tantamount moving legions of demonstrably unproductive, irrational-choice actors into the American workforce, for employers to accommodate.

An instantaneous transformation of drug addicts or alcoholics into disciplined, productive, aspiring laborers is doubtful. Rather, the employers will have to either accommodate a great deal of wasteful activity (missed work, lack of productivity and interpersonal conflicts) or apply classic market forces and terminate the addict (or recovering addict). The addict will then move from job to job, for some protracted period, during which specialized skills and good work habits cannot be developed. For the employers, administrative personnel costs would probably increase. Even assuming that the harsh realities of the market would indeed force addicts to "wake up" and behave consistently in socially appropriate ways, a significant time factor is involved. During this transition, significant waste occurs and social costs are imposed on private employers and individual families.

AND VICTIMS 1, 101-24).

[173] *See* DAVIES, *supra* note 172, at 31.

Applying a social insurance program like SSI/SSDI to this situation diffuses this burden widely so the individual effects are less devastating.

A corollary to the rehabilitation argument essentially relies on a moral duty of the state to care for its most vulnerable citizens, such as the homeless and disabled. I do not discuss the moral argument at length here, because it tends to function simply as a statement of political party alignment. Further, the perceived *immorality* of substance abuse itself also weakens the argument. The morality of addiction is tricky. It is difficult to separate conceptually substance abuse from addiction, as addiction necessarily involves substance abuse, but the reverse is not necessarily true. In lieu of an argument about the government's moral duty to help the helpless, this discussion focuses on more pragmatic arguments for expenditures to stabilize and rehabilitate the addict.[174]

An important issue for rehabilitation arguments, and part of the justification for government intervention, is the underlying assumption that addicts are essentially helpless to rehabilitate themselves. This is a reasonable assumption under both the "disease" view of addiction, considering the behavior involuntary, and the "rational actor" view, discussed above.[175]

The degree to which an addict could engage in self-help or freely choose rehabilitation is at the crux of both the moral hazard problem and the rehabilitation goal. If addicts could cease and desist from their consumption of intoxicants given the right incentives, then the moral hazard argument and moral condemnation of the addict are more appropriate. If the addict is essentially helpless, then outside assistance is necessary to foster rehabilitation and would give addicts a chance for effective recovery.[176]

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[174] For a recent argument about the moral duty of government, see Hon. Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439 (1999).

[175] *See* discussion *supra* notes 96-103 and corresponding text. For a less precise treatment of the differing views on the voluntariness of addictive behavior, see Alan Schwartz, *Views of Addiction and the Duty to Warn*, 75 VA. L. REV. 509, 511-14 (1989), which focuses on liability for cigarette companies.

[176] There is a well-publicized study with rats involving cocaine dependence and treatment, indicating that increasing the standard of living or available pleasures and diversions of addicts decreases or eliminates substance abuse. *See* Greene, *supra* note 125, at 236 (citing Bruce Alexander et al., *Rat Pack Chronicle*, 22 BRIT. COLUM. MED. J. 54 (1980)) ("[I]solated rats offered unlimited access to cocaine in 'rat jails' quickly died from non-stop drug consumption. What has been little publicized, however, is the fact that these addicted rats—if returned to pleasant, socialized rat

A separate but related moral question remains about the volitional origin of the addiction, apart from the question of whether the addiction continues at the permission of the addict's will. Some policy makers and Social Security adjudicators may believe at some level that addicts, while unable to stop their current consumption, deserve to be punished for becoming addicts in the first place.

Early attempts to criminalize addiction seem based on moral approbation of becoming dependent rather than the morality of compulsively feeding the habit.[177] The Supreme Court, however, looked only at the morality of the habit and refused to criminalize addiction because "state of being" crimes are unconstitutional.[178] The use of addiction as a proxy for punishing the reckless exposure of oneself to the risk of disease presents a problem of moral luck.[179] Most people who engage in recreational substance abuse never become addicts,[180] so it is inappropriate to punish addicts for the consequence of their action rather than their intent in the original action itself. This invokes moral luck; the unintended outcome gives rise to culpability *sua sponte*.[181] It would be even more inappropriate to punish the unlucky ones for the activities of the whole group, as these individuals have already suffered the consequences of their actions.

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environments ('rat parks')—lose all interest in drugs.").

[177] One example of this thinking is set forth forcefully in Justice White's dissent in *Robinson v. California*, 370 U.S. 600, 685-89 (1962), which includes helpful references to earlier sources for this school of thought. Justice White's argument seems to be that addiction is inseparable from consumption, and that it is perfectly acceptable to punish consumption—even if the crime is proved circumstantially by the existence of addiction.

[178] *Robinson*, 370 U.S. at 660.

[179] "Moral luck" is a philosophical term describing the puzzle of moral culpability sometimes being tied to the unintended outcome of one's actions, in contrast to the usual approach that ties blameworthiness closely to intentions. *See* Williams, supra note 120, at 20; CLAUDIA CARD, THE UNNATURAL LOTTERY: CHARACTER AND MORAL LUCK, 32 (1996). Card herself seems focused on character and its relation to reputation, social relationships and opportunities and identity.

[180] *See* Greene, *supra* note 125, at 229 ("Nonetheless, most estimates conclude that 5-10% of casual illegal substance users will become end-stage addicts.").

[181] For another example of SSI recipients getting the short end of the stick from moral luck, see *Milner v. Apfel*, 148 F.3d 812, 815 (7th Cir. 1998) (providing a lengthy discussion of the "moral luck" problem by Judge Posner); for a discussion of moral luck in other recent court decisions see United States v. Martinez, 16 F.3d 202, 206 (7th Cir. 1994); *United States v. Smith*, 27 F.3d 649, 653 (D.C. Cir. 1994); *United States v. Davis*, 989 F.2d 244, 246 (7th Cir. 1993); *Int'l Ass'n of Heat & Frost Insulators Local 17 Pension Fund v. Am. Nat'l Bank & Trust Co.*, 13 F. Supp. 2d 753, 756 (N.D. Ill. 1998); and *United States v. Muntean*, 870 F. Supp. 261, 263 (N.D. Ind. 1994).

If there are people with addictions, helpless in their uncontrolled dependence, then rehabilitation, if successful, will likely require others to act. This imposes costs on the others; the only remaining question is how those costs should be allocated.

The rehabilitation goal has one other argument in its favor. If we continue to have a universal disability insurance program, as we do, then we especially want to encourage treatment and recovery from the disabilities that qualify people for the program. Returning people to the workforce makes more funds available for the remaining disabled individuals, but increases the number of workers who can contribute to the fund. This has the potential to lower the premiums per capita. Arguably, treatable or curable impairments should be prioritized because of the increased efficiency and the time value of the capital at stake, both in terms of increased premiums and lower debits to beneficiaries.

Even if one chooses to focus on character and environment as the cause of addiction, rather than innate biological traits of the addicts or seductive powers of the intoxicants, providing public assistance may be the best cure for addiction. It changes the dire situation that fostered the addiction. If the addict's desperate station in life contributes substantially to uncontrollable dependence, then cash assistance provides a more direct, efficient and effective solution than if the addiction is caused by more difficult things to change, such as innate traits of the addict or the substance.

In summary, the rehabilitation approach is the most consistent with empirical studies of the results of recent policies. A growing body of scientific, behavioral and social science literature provides new insights into the mental mechanisms of addiction, self-control and acquiescence to temptation. The emerging model tends to run counter to the traditional concerns of "moral hazard" as applied to SSI/SSDI payments, and indicates that provision of benefits may actually be the most prudent policy.

IV. POLICY ALTERNATIVES FOR THE FUTURE

Clearly, the moral hazard view currently reigns in the legal regime. Insofar as the assumptions of the regime are flawed, however, exploring possible policy alternatives is worthwhile. What follows is a discussion of some possibilities

for the future, including policies adverse to addicts, considering the advantages and disadvantages of each.

A. *Change Nothing*

This may seem obvious, but it is important to remind prospective policy zealots on both sides of an issue that the default position—and perhaps the most likely outcome where there is an even split of opinion—is to maintain the status quo. The advantage of the status quo is that it avoids the costs involved in fighting and winning a political battle to bring about changes.

Moreover, the current arrangement may represent a genuine political compromise that balances the values of different constituent groups in appropriate proportion. Put another way, things *could* be worse for addicts. Addiction could be penalized outright and absolutely by denying benefits regardless of other severe impairments that an addict may have. Obviously things could also be *better* for addicts, as they were in the pre-1994 period.[182]

To look at this political equilibrium from another standpoint, those advocating for more generous SSI/SSDI benefits must weigh the possible political backlash that might accompany a victory.[183] The social and moral stigma attached to substance abuse and addiction is unlikely to vanish anytime soon, so welfare benefits for addicts will continue to be controversial. This is not an entirely sufficient justification for maintaining the status quo, but it is a valid consideration to remember.

The costs of the current system are high, and are likely to increase over time.[184] The current arrangement shifts all the externalities or social costs of addiction—the costs not borne by the addict alone—to a concentrated few. The families and neighbors of addicts, and urban dwellers generally, mostly

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[182] Some could argue that the period from 1994-1996 was actually *better* for addicts than the pre-1994 period, in the sense that it mandated treatment referral and directed more addicts into programs.

[183] *See* Wright, *supra* note 1, which calls for a general abolition of the entire SSI system based in large part on the alleged abuses of the system by addicts (and, to a lesser extent, children).

[184] Costs include increased homelessness, decreased treatment participation, and inadvertent deprivation of those with multiple impairments besides addiction. It is not clear what makes addiction increase or fluctuate in the overall population across time.

innocent bystanders, bear the costs of addiction. SSI/SSDI benefits function as a type of insurance for these individuals, not just the addicts themselves, and spread the risks more evenly and diffusely across the population. The *costs* of an individual's addiction are the same whether borne by government, or the families and neighbors. An addict's daily sustenance must come from somewhere. The "somewhere" is probably family members or relatives who feel a familial obligation to provide housing and food to the individual. This burdens the providers financially and emotionally. This burden causes second-generation externalities such as lowered productivity (caretaking of an addicted family member takes time and energy), lowered consumption (because of depleted resources) and less private investment capital (also because of depleted personal resources). These externalities are accompanied by other intangible costs on the family.[185]

The addict's sustenance may also come from residential neighbors and those who work in or travel through the locale, in the form of theft or consumption of private charity. Additionally, neighbors bear involuntary externalities in the form of nuisance[186] and diminished property values occasioned by elevated crime rates.

An unsubsidized addict is also likely to partially externalize the cost of medical care. SSI/SSDI provides medical coverage through Medicaid or Medicare. Without this health insurance, individuals tend to use the local emergency room as their primary medical provider, leaving any bills unpaid.[187] The hospital and the larger medical community, both providers and users, bear these costs. (So do taxpayers, as the hospitals are often public.)

If it is true that the externalized costs of addiction (including the basic living expenses of the addict) are constant and certain, then an argument can be made for cost sharing

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[185] Half of adolescent drug users come from a home where there was an alcoholic or addicted parent, indicating an externality for the children in an addict's household. *See* Greene, *supra* note 125, at 229.

[186] "Nuisance" is being used here in the classic tort/property sense. State nuisance statutes providing statutory grounds for eviction can include drug activity per se, indicative of the virile externalities accompanying it. Public drunkenness criminal statutes also probably reflect the perceived externalities of substance abuse and addiction more than mere puritanical values, which would not result in a private/public distinction.

[187] Michael T. French et al., *Chronic Illicit Drug Use, Health Services Utilization and the Cost of Medical Care,* 50 SOC. SCI.& MED. 1703-13 (2000).

through government benefits. This cost sharing becomes risk sharing. Insurance spreads the costs of accidents and risk across the group of insured, and becomes a type of collective good. The externalities of addiction are not managed well under the current legal arrangement. Changing the current policies could obtain greater efficiency and overall social welfare.

B. *Make Things Harsher for Addicts*

It is, of course, possible to make things harder for those with addictions. While this may seem disingenuous in a paper arguing for better treatment, this alternative cannot be overlooked because it may be the most likely development in the short term. For instance, a growing number of courts place the burden on claimants to prove that their other recognized impairments would remain at the requisite level of severity without the presence of substance abuse.[188] Placing the burden of proof on claimants functions as a punitive measure against them for being addicts at all. It indirectly demands that the addict rehabilitate before getting benefits, because rehabilitation is the surest way to prove the continuance and severity of the other disabilities.

There are other ways to make the rules harsher for substance abusers and addicts. The 1996 federal welfare reforms, replacing the AFDC program with TANF block grants, allowed states to implement a lifetime ban from family-based cash assistance and food stamps for convicted drug felons.[189] Congress could apply a similar rule to SSI/SSDI applicants or apply a rule automatically denying benefits if any evidence existed that the claimant abused a substance at any time.

The social costs and externalities of such rules are basically the same as those attendant to the status quo, only on a higher level. The theoretical benefits provide extra incentives for people who refrain or rehabilitate themselves from addictive substances. However, such incentives take the form of extra costs on addicts or substance abusers, beyond those already in place. Potential SSI recipients are, by definition,

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[188] *See supra* notes 38-51.

[189] *See* Rukaiya Adams et al., *Double Jeopardy: An Assessment of the Felony Drug Provision of the Welfare Reform Act*, 1998 study published by the Justice Policy Institute in San Francisco, California, *available at* http://www.cjcj.org/jpi/doublejep-pr.html (last visited Aug. 29, 2002).

financially destitute, and prospective SSDI recipients are unable to work and face eventual bankruptcy, so claimants of these higher costs are essentially judgment-proof. Thus, any new costs imposed will be passed on to others instead of borne by the addicts themselves. There is probably a limit to the incentives one can place before individuals via regulatory mechanisms, short of depriving the individual of personal liberty and resorting to brute force or coercion. Once that limit is reached, additional costs will transfer automatically to innocent third parties who are related or close to the individual. Overall, additional negative incentives toward self-rehabilitation are inefficient well before reaching the point where the addict simply cannot suffer any more, or has no more to lose. The optimal point is difficult to determine precisely even from the "incentives work" point of view. The empirical studies evaluating welfare policy results merit extra consideration in this regard, because they illustrate the unfortunate and unexpected results of the punitive measures imposed so far.[190]

C. *Return to the World as it was Before 1994*

Many advocates for the homeless, SSI/SSDI recipients, and recovery and treatment programs seek a return to the pre-1994 policies. One option is to reinstate addiction as a qualifying impairment for disability benefits, at least when other physical or mental impairments are also present, contingent on the recipient entering a treatment program. The advantages implicate the general justifications for the rehabilitation-goal model. Providing addicts with cash assistance brings desperately-needed stability to their lives, encourages treatment, recovery and rehabilitation, provides some relief for the families and others around the addicts, and generally fulfills part of the duty to help the less fortunate. The costs, of course, are controversial. The perceived undesirable effects that led to the 1994 changes in the rules remain, and all the same arguments would circulate again.

Advocates of a return to pre-1994 policies need to assess the feasibility of "turning back the clock" in politics. Advocacy for doing *anything* the way it was done before the last set of changes is unlikely to be popular politically, as this will

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[190] *See supra* notes 54-91.

intuitively strike voters as regressive. From a purely pragmatic standpoint, advocates will be more effective originating something "new" to achieve the same purpose.[191]

D. *Return to the World as it was 1994-1996*

During the brief intervening period between the first wave of reforms in 1994 and the final legislation in 1996, addicts could receive SSI/SSDI benefits. Congress provided benefits for a maximum of three years, which was presumably enough time to successfully begin treatment, recovery and rehabilitation. During this short phase, treatment was not only required to maintain benefits, but a nationwide system, or network of specialized offices, was envisioned to refer the recipients to nearby treatment programs and monitor their compliance. This system was never fully implemented, so results were never available for thorough assessment.[192] Welfare recipients with addictions were required to designate a representative payee who received and managed the disbursed funds on the addict's behalf.[193] Finally, it should be noted that even applicants with other qualifying impairments or disabilities were required to participate in treatment programs for their substance dependence disorders.

Given the short life of this arrangement, it might be more politically feasible to "sell" it as a new, progressive initiative than the pre-1994 system. Most Americans, and even many politicians, simply do not remember it or never knew about it.

The advantages of this alternative are that it directly addresses the moral hazard concerns by conditioning benefits on certain desirable behavior. It clearly encourages treatment and rehabilitation, and provides an incentive to enter a treatment program during the three years while providing a temporary safety net to meet the needs of daily survival.

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[191] On the other hand, Martin Gilens asserts that Americans strongly favor health care provision for the poor, even if that means higher taxes. *See* GILENS, *supra* note 130 at 193.

[192] Neither sufficient treatment programs nor enough offices for referral and monitoring existed at the time.

[193] The Representative Payee system is still intact, albeit with some modifications, for claimants who are deemed unable to manage their own funds or who prefer a Representative Payee. *See* Representative Payment, 20 C.F.R. § 404.2001 (2002).

Requiring treatment also avoids unnecessarily penalizing those with other legitimate disabilities, and helps recovery.

One disadvantage of this alternative is that the referral and monitoring network is very costly to establish and maintain.[194] Since 1996, however, drug treatment courts have expanded for non-violent drug offenders in almost every state. These courts actively monitor the treatment compliance for participants.[195] There are now over 200 drug treatment courts around the country, addressing not only drug treatment needs, but also ancillary health and social services.[196] Perhaps this infrastructure could also accommodate referral and monitoring services for federal assistance recipients with a diminishing added marginal cost.[197]

Another possible disadvantage of this system is that it corresponded to a period of astronomical growth in DA&A applications and enrollment. It is unclear what factors are primarily responsible for this phenomenon. It may have been related to the economy in the early and mid-1990s, the widespread mislabeling of cases as DA&A in order to encourage as much participation in treatment programs as possible or outreach and advertising efforts by the Social Security Administration and private attorneys.[198] As discussed above, one study indicated that 20% of the growth may have been attributable entirely to the increased value in Medicaid during this period.[199] In any case, the spiraling numbers of recipients, and the attendant costs, contributed to the harsh political backlash in 1996, which left the DA&A individuals worse off than they were before. The subject merits further study to try to predict whether this process would repeat in today's political and social environment.

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[194] *See* Interim Report, *supra* note 7, at ES-III.

[195] *See* Grangetto, *supra* note 166, at 394.

[196] S.L. Wenzel et al., *Drug Courts: A Bridge Between Criminal Justice and Health Services*, 29 J. CRIM. JUST. 241, 243 (2001).

[197] *See* Gloria Danziger & Jeffrey A. Kuhn, *Drug Treatment Courts: Evolution, Evaluation, and Future Directions*, 3 J. HEALTH CARE L. & POL'Y 166 (1999) (calling for closer affiliation of Drug Treatment Courts with family courts to serve an expanded role in the community).

[198] *See* Interim Report, *supra* note 7.

[199] *See* Yelowitz, *supra* note 25. On the other hand, Martin Gilens indicates that there may have been political support for favoring this program over others during the Reagan era, as voters perceived it to be helping the "deserving poor," those who are truly disabled and unable to work. *See* GILENS, *supra* note 130, at 42.

E. *Add Addiction as a Factor that "May" or "Must" Be Considered Under the Grid*

Social Security regulations currently contain a special section called the Medical-Vocational Guidelines (the "Grid" for practitioners).[200] These guidelines provide applicants with an alternate path to qualify for disability benefits where their impairments do not meet the requirements of the listed qualifying impairments.[201] The Grid provides for adjudicators to consider factors such as age,[202] confinement to sedentary or light work,[203] inability to speak English,[204] educational deficiencies and lack of job experience.[205] Each of these factors can independently limit the number of jobs realistically available to an individual. Certain combinations of these factors yield a statutorily-required finding of "Disabled."[206] For many applicants, the Grid was a lifesaver.

Addictions also interfere with one's ability to find and maintain gainful employment. One policy option, therefore, is to include addiction as one of the factors the SSA will consider (or at least *may* consider), weighed together with other factors. This approach is untried. A district court in *Williams v. Sullivan*[207] proposed the model:

> As a rule, where a claimant suffers from nonexertional impairments that significantly compromise his or her ability to engage in the full range of employment activities that sheer physical capacities would otherwise allow, Secretary may not mechanically apply the Grid.

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[200] 20 C.F.R. pt. 404 subpt. P, app. 2 (2002). Note that in at least one sense, qualifying for benefits under the Grid is actually superior to "meeting a Listing," in that the statutorily-defined nature of the disability should make one immune to periodic medical cessation reviews. *See* RALPH WILBORN, WILBORN'S SOCIAL SECURITY DISABILITY ADVOCATE'S HANDBOOK VOL. 1: THE PROCESS UNIFICATION RULINGS, 9-1-33 (2000).

[201] 20 C.F.R. pt. 404 subpt. P, app. 1 (2002).

[202] *See, e.g.*, 20 C.F.R. pt. 404, subpt. P, app 2, at 201.00(g) & (h); Work Skills and their Transferability as Intended by the Expanded Vocational Factors, S.S.R. 82-41 (1982); Evaluation of Disability and Blindness in Initial Claims for Individuals Age 65 of Older, S.S.R. 99-3p (1999).

[203] *See* 20 C.F.R. pt. 404, subpt. P, app 2 at 201.00(a) & (b) (2002).

[204] *See id.* at 201.00(i).

[205] *See id.* at 201.00(c),(d) & (e).

[206] For example, a forty-five-year-old applicant restricted to sedentary work, who is illiterate in English and has no specialized skills from previous employment, is statutorily disabled. *See id.* at 201.17 (describing Medical-Vocational Guidelines). If an applicant with the same language and job skill deficiencies was age fifty, a light-work restriction would be sufficient to qualify automatically for benefits. *Id.* at 202.09.

[207] Williams v. Sullivan, 89-C5872, 1990 WL 70497 (N.D. Ill. May 7, 1990).

> Alcoholism and drug dependence are just such nonexertional impairments. While it is true that "[b]y itself, the mere finding that an individual suffers from alcoholism is insufficient to support a finding of disability" . . . alcohol or drug addiction that does not qualify as a disability under the listings may yet contribute to a finding of disability by preventing a claimant from holding a job otherwise within his or her physical capacities. Where such impairments constitute severe restrictions on a claimant's physical ability to work, . . . Secretary [should] call for the opinion of a vocational expert as to whether the claimant remains capable of performing any job in the economy.[208]

The advantage of this alternative is that it recognizes addiction as a debilitating impairment, without making benefits available solely on that basis. No factor in the Grid, except very high age, independently qualifies a person for benefits. Moreover, including addiction as a factor in the Grid removes the moral hazard that allegedly exists in giving benefits to addicts, as it depends on other factors that are completely, etiologically outside the claimant's control.

One possible disadvantage to this approach is a potential "watering-down" effect on the other factors, making it harder for non-addicts to qualify under the Grid than previously. In practice, including another factor could make those who would presently qualify under the Grid appear to be "missing" a component of true disability. This would be an undesirable effect. However, regulatory language could be phrased in such a way as to avoid this problem.

A similar approach was used for the impairment of obesity, which was removed from the Listings in 1999.[209] Yet, Social Security still treats obesity as a factor,[210] which could legitimately exacerbate other impairments, especially cardio-vascular and muskulo-skeletal problems.[211] While not part of the Grid, obesity interacts with the remaining listed impairments in much the same way as factors on the Grid. Also, regulations encourage treatment for obesity, and may penalize individuals who refuse to comply with recommended treatment from their own physician.[212]

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[208] *Id.* at *3 (citations omitted).

[209] On August 24, 1999, the Social Security Administration published a final rule in the Federal Register deleting Listing 9.09, *Obesity*, from the Listing of Impairments in 20 C.F.R. pt. 404 subpt. P, app. 1 (2002). The final rule was effective October 25, 1999. *See* 20 C.F.R. pt. 404.

[210] Evaluation of Obesity Purpose, S.S.R. 00-3p (2000).

[211] *Id.*

[212] *See* 20 C.F.R. §§ 404.1530, 416.930 (2002) containing provisions regarding

F. *Allow DA&A as a Listing With Progressive Benefits to Reward Recovery Efforts*

In a sense, this alternative would be a return to either the pre-1994 or pre-1996 scenario, with a significant modification: the cash benefits would increase incrementally over time as the individual continued with treatment and made progress. Addicts would receive medical coverage, making treatment possible from the outset, but the cash benefits would be lower than the normal $534 per month. Let us assume the benefits would start at $200 per month for the first six months or year. The promise of benefits increasing substantially after six or twelve months encourages the recipient to pursue treatment diligently. After two years of treatment, the cash assistance amount would increase again, and so on, until it reached the standard SSI amount that everyone else receives. Clinical studies show that escalating vouchers are very effective in encouraging complete abstinence for addicts in outpatient treatment programs, lending support to the effectiveness of this approach.[213]

The advantage of this approach is that it accommodates the moral hazard concerns of many policy makers without completely excluding those who suffer from addictions. It provides an addict with an incentive to seek out a treatment program and participate. The initial cash amount is too low for comfortable subsistence, so it does not give the recipient any disincentive to seek recovery or rehabilitation.

Such a system of structured or graduated benefits would function as an insurance deductible, a traditional device for preventing moral hazard and lowering costs of the insurer, which in this case is the SSA. The insurer and the recipient then share or divide the risks of moral hazard, adverse selection and the potential for malingering. Finally, this alternative has the political appeal of paying the addict less than is needed to survive, leaving no disposable income for indulging the habit itself. This helps resolve concerns that taxpayer money is being used to purchase drugs and alcohol.

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noncompliance with recommended treatment for all impairments.

[213] Kenneth Silverman et al., *Increasing Opiate Abstinence Through Voucher-Based Reinforcement Therapy*, 41 DRUG & ALCOHOL DEPENDENCE 157 (1996); Hendree E. Jones et al., *The Effectiveness of Incentives in Enhancing Treatment Attendance and Drug Abstinence in Methadone-Maintained Pregnant Women*, 61 DRUG & ALCOHOL DEPENDENCE 297 (2001).

The disadvantages of this approach are twofold. First, the nominal amount of cash assistance paid at the beginning may not be enough to realize any benefit to the recipient. Too little assistance will not stabilize the life of an addict, make basic housing accessible or effect other lifestyle changes necessary for effective treatment and recovery. Technically, the recipient is "underinsured," which means that some of the benefits of insurance are lost.

The second disadvantage of this approach is the administrative cost of having a special category of recipients whose benefit amounts are different from others, and change periodically. This approach requires more monitoring and record keeping by the SSA. However, complex monitoring and administration are possible because the current regime has individualized benefit levels for all SSDI recipients already (depending on how much the person paid into the system). Additionally, the current regime varies SSI levels for many individuals depending on their housing situation or other sources of income.

Allowing consideration of addiction as a legitimate disability, statutes could require an individual to show she has truly lost self-control or the ability to make responsible decisions. Indicia could include risking or passively accepting the disintegration of one's family, the loss of housing, loss of employment and other self-harming events. Such evidentiary requirements address policy concerns that some individuals may allege an addiction when their dependence is still mild enough that they could easily stop. It also helps further resolve moral hazard quandaries by implementing insurance "triggers" that no one with self-control and clarity of thought would willfully seek or cause.

G. *Make Eligibility Determinations Blind to DA&A*

A final alternative would be to make DA&A irrelevant to the determination of disability. This approach avoids penalizing those who suffer from other legitimate disabilities, while not directly subsidizing or "rewarding" the addiction itself. The deficiency of this approach is that it is very close to preserving the status quo, minus the burden placed on claimants with co-morbidity; this approach may not go far enough. As noted above, this appears to have been the SSA's approach from 1972 through 1983, and perhaps through 1994, if the Circuit Court decisions accurately reflect the general

practice.[214] This approach could be justified on the ground that there remains a heated debate about the nature of addiction and the role of volition. Intentionally ignoring the presence of addiction—neither awarding benefits on this basis nor penalizing claimants for having the problem—incorporates a degree of agnosticism on an issue still eluding societal consensus. If this solution were politically feasible, it may be the best option.

A NOTE ON THE COCAINE VACCINE

Scientists recently developed a successful vaccine for cocaine, and tests on human subjects are underway at Yale University.[215] The vaccine functions through antibodies and blocks the brain from receiving the desired effect of cocaine. As the cocaine vaccine becomes more widely available, and similar vaccines are developed for other addictive substances, the analysis of these cases could change substantially. Receipt of benefits for addicts could be made contingent on voluntary vaccination. At least for cocaine addiction, the addiction could theoretically be eliminated with a simple injection, which would make clear which debilitating symptoms remain without substance abuse.

One issue that remains unclear about the cocaine vaccine is whether immunized cocaine addicts simply switch to other drugs once cocaine fails to produce the desired effect. Studies on this point are not yet available.

The possibility of immunizing the population, or at least sectors of it (such as convicted drug offenders), raises several policy issues outside the scope of this paper. It could, over the course of several decades, make DA&A benefits unnecessary.

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[214] *See supra* notes 14-21 and accompanying text.

[215] Barbara S. Fox, *Development of a Therapeutic Vaccine for the Treatment of Cocaine Addiction,* 48 DRUG & ALCOHOL DEPENDENCE 153 (1997); Peter J. Cohen, *Immunization for Prevention and Treatment of Cocaine Abuse: Legal and Ethical Implications,* 48 DRUG & ALCOHOL DEPENDENCE 167 (1997); M. W. Johnson et al., *Active Cocaine Immunization Attenuates the Discriminative Properties of Cocaine,* 8 PSYCHOPHARMACOLOGY 163 (May 2000); Dawn MacKeen, *Immunized Against Addiction,* SALON, Apr. 26, 2000, *at* www.salon.com/health/feature/2000/04/26/vaccine/-index.html?CP=SAL&DN=110 (last visited July 30, 2002).

CONCLUSION

It is easy for most people to understand intuitively why drug addicts or alcoholics should not be given public assistance based on their addictions. It seems to invoke the type of moral hazard concerns and perverse incentives faced in many areas of life and prominent in ongoing policy discussions. No reasonable person wants to encourage substance abuse or addiction.

On the other hand, if indeed empirical studies accurately represent that welfare benefits do not encourage substance abuse, then these moral hazard concerns are unfounded. In addition, there are well-documented social costs and externalities for leaving addictions untreated, and depriving alcoholics and addicts of benefits has generated some unpleasant results. It would be better in the long run to try to stabilize the lives and housing situations of these individuals so that they can be reintegrated as productive members of society.

Several policy alternatives are available for the future. Given the wide array of policy considerations and concepts of addiction, the best approach is to allow alcoholism and drug addiction to be considered a serious limitation on employment, weighed with other factors in the Social Security "Grid," or viewed as one factor like obesity. This alternative is probably more politically feasible than returning to previous approaches that were discarded, where addictions independently qualified an applicant for benefits. It also allays many of the moral hazard concerns by requiring that the substance dependence occur in conjunction with other factors outside the applicant's control, such as age and illiteracy. The regulations would have to be carefully drafted so as not to dilute the weight of other legitimate factors already considered.

For pragmatic reasons, this article has sought to avoid sermonizing about issues of "justice," "fairness" or "mercy" on the helpless. These important values, however, cannot be ignored. Society may pay a price, eventually, for allowing some members to fall into desperate circumstances. This fear is not necessarily the best reason to act. Rather, a genuine concern for fellow human beings, properly considered, may suffice.