

Chapter One

Overview of the Supplemental Security Income Childhood Disability Program

Introduction

The Supplemental Security Income (SSI) childhood disability program was enacted by Congress in 1972 and implemented in 1974. It is administered by the Social Security Administration and is funded entirely from general revenues. SSI provides monthly cash benefits to the parents or guardians of low-income children with disabilities. In 1995, the maximum federal SSI payment is \$458 per month. All but seven states supplement the federal payment.¹ Over the past two decades, SSI has played a critical role in helping many thousands of families raise children with disabilities at home.

As of June 1995, just over 940,000 children received SSI benefits. The average monthly benefit was \$420.² Nearly three-fourths of the children had no other countable income, and approximately one-half lived in one-parent households. More than half lived in the states of New York, California, Texas, Florida, Illinois, Ohio, Louisiana, Pennsylvania, and Michigan. Boys outnumbered girls by a ratio of three to two. Approximately 37 percent of the children were white, 34 percent were Black, and nine percent were Hispanic.³ (See Tables 1-1 and 1-2.)

By statute, a child is considered disabled for purposes of SSI eligibility if he or she has a medically determinable physical or mental impairment that has lasted or is expected to last at least twelve months or result in death. The impairment must be comparable in severity to one that would prevent an adult from working.⁴ Under regulations established by SSA in response to the 1990 *Sullivan v. Zebley* Supreme Court decision, comparability is interpreted to mean that the impairment(s) substantially reduces the child's ability to function independently, appropriately, and effectively in an age appropriate manner.⁵

¹ These states are Arkansas, Georgia, Kansas, Mississippi, Tennessee, Texas, and West Virginia.

² This average is based on SSA data contained in the SSI ten-percent sample file for June 1995, which is drawn from 934,000 children (21 years old and under) who were due an SSI payment on July 1, 1995. Recipients ages 18-21 are included in the SSI childhood program if they are full-time students. This average includes federally-administered state supplemental payments.

³ The remaining 17.5 percent of children were not identified by race.

⁴ By regulation, SSA defines a medically determinable physical or mental impairment as one resulting from anatomical, physiological, or psychological abnormalities demonstrated by medically acceptable clinical and laboratory diagnostic techniques.

⁵ *Sullivan v. Zebley*, 110 S. Ct. 885, February 20, 1990.

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The SSI childhood disability program is operated through SSA's 1300 local offices. SSA relies on state disability determination services (DDSs) to determine an applicant's medical eligibility for the program.⁶

Table 1-1. Number of children receiving SSI, percentage distribution, and average amount of child's income, by type of income, June 1995⁷

Type of Child's Income	Number	Percent	Average monthly income or benefit amount
Total	934,180	100.0	---
With income ⁸	242,360	25.9	\$152
Earned income only	6,560	0.7	242
Unearned income only	231,870	24.8	146
Both earned and unearned income	3,930	0.4	374
With unearned income ⁹			
Total	235,800	25.2	\$146
Social Security	75,190	8.0	163
Veterans' benefits	2,350	0.3	62
Income based on need	22,520	2.4	101
Support from absent parents	75,540	8.1	152
Interest, dividends, etc.	10,020	1.1	3
Other	4,220	0.5	145
In-kind income	66,770	7.1	115
No earned or unearned income	691,820	74.1	---

⁶ The DDSs are funded entirely by SSA and are typically located in state departments of rehabilitation, education, or social services.

⁷ Social Security Administration, *Children Receiving SSI*, June 1995, ten-percent sample file. File includes children under age 18 and individuals ages 18-21 who are full-time students.

⁸ These amounts do not include income deemed to a child from parents in the household.

⁹ Children with more than one type of income are included in each category.

Table 1-2. Number of children receiving SSI, and percentage distribution by selected characteristics, June 1995¹⁰

Selected Characteristics	Number	Percent
Total	934,180	100.0
Age		
Under 1 year	13,920	1.5
1	23,740	2.5
2	27,500	2.9
3	35,970	3.9
4	42,640	4.6
5	47,310	5.1
6	51,020	5.5
7	52,650	5.6
8	55,560	5.9
9	59,450	6.4
10	61,480	6.6
11	60,590	6.5
12	61,700	6.6
13	62,950	6.7
14	59,920	6.4
15	58,590	6.3
16	55,470	5.9
17	49,140	5.3
18	22,070	2.4
19	13,030	1.4
20	11,200	1.2
21	8,280	0.9
Sex		
Female	341,530	36.6
Male	592,650	63.4
Race		
White	340,730	36.5
Black	318,450	34.1
Hispanic	83,420	8.9
Other	27,910	3.0
Unknown	163,670	17.5

¹⁰ Social Security Administration, *Children Receiving SSI*, June 1995, ten-percent sample file. The 18-21 year-olds included in the file are full-time students.

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Table 1-2 – continued.

Selected Characteristics	Number	Percent
Total	934,180	100.0
Living Arrangements		
Own Household ¹¹	146,610	15.7
Another's Household	30,030	3.2
Parent's Household	745,870	79.8
Medicaid Institution ¹²	11,670	1.2
Legal Status		
U.S. citizen	923,500	98.9
Alien - total	9,920	1.1
Lawful admission	6,730	0.7
Color of law ¹³	3,190	0.3
Unknown	760	0.1

Eligibility Determination

The process of determining a child's eligibility for SSI begins when his or her parents (or other caregiver) contact the nearest Social Security office to obtain an application for benefits and other forms to document the child's health and financial status. Upon receipt of the completed forms, the local Social Security office sends the file to the state DDS, where an adjudicative team consisting of a physician or psychologist and a disability examiner determines whether the child is disabled. The team first attempts to obtain medical evidence from the child's own medical sources. If the medical evidence is insufficient or unavailable, the DDS arranges a consultative examination (CE) by a physician to obtain medical evidence.¹⁴

¹¹ Children classified by SSA as "in their own household" may live with other relatives, in private hospitals, nursing homes, residential schools, foster care, or independently.

¹² A Medicaid institution is a medical facility where over half the cost of an individual's care is covered by Medicaid.

¹³ Color of law refers to the immigration status of children living in the U.S. with the knowledge and permission of the Immigration and Naturalization Service (INS) and for whom the INS is not contemplating deportation.

¹⁴ This team normally relies entirely on written documentation to make a determination and has no direct contact with the child.

By regulation, SSA has established two separate paths to SSI eligibility for children. One of these compares a child's condition to a list of impairments (and accompanying signs, symptoms, and laboratory findings) that the agency takes as prima facie evidence of disability.¹⁵ The listings consist of over 100 of the most commonly-occurring impairments. Examples include cerebral palsy, quadriplegia, blindness, leukemia, and loss of speech resulting from evident brain injury. When a child's impairment meets or equals a listing,¹⁶ the agency generally does not inquire about his or her functional capacity. The correlation between the listings and functional disability is assumed to be strong enough that eligibility is granted.

The major exception to this rule applies to childhood mental impairments, for which SSA has included functional criteria in the medical listings.¹⁷ To be granted benefits, children ages three and older must demonstrate both that they have a listed impairment and that it causes marked limitations in at least two of four functional domains.¹⁸ These domains are:

- * cognitive/communicative functioning;
- * social functioning;
- * personal/behavioral functioning, including
 - activities of daily living,
 - maladaptive behavior; and
- * concentration, persistence, and pace.

Under SSA's listings, children may also qualify for benefits by showing that they have an impairment or combination of impairments that "functionally equals" a listed impairment. To do so, a child must demonstrate that his or her impairment (which need not be one

¹⁵ These signs, symptoms, and laboratory tests indicate the required level of severity.

¹⁶ Medical equivalence applies to three categories of children: (1) those whose impairments are described in the listings but who do not exhibit one or more of the medical findings included in a specific listing; (2) those who exhibit all of the medical findings of a specified listing but not at the required level of severity; and (3) those who meet all of the functional criteria but only some of the diagnostic criteria.

¹⁷ Some physical listings also include functional criteria, such as cerebral palsy and musculoskeletal disease.

¹⁸ SSA regulations define "marked" as more than "moderate" but less than "extreme." When results from standardized tests are used as measures of functional limitation, a valid score that is two standard deviations below the norm for the test will be considered a marked limitation. However, SSA regulations state that, in assessing the validity of a test result, any discrepancies between formal test results and the child's customary behavior, functioning, and daily activities must be resolved.

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included in the listings) or combination of impairments causes the same restrictions required under the functional criteria in a listing.¹⁹

The second path to SSI eligibility applies to children who do not have impairments that meet or equal the listings. These children may demonstrate, through an Individualized Functional Assessment (IFA), a substantial reduction in their ability to function independently, appropriately, and effectively in an age appropriate manner. Created by SSA in response to the 1990 *Zebly* decision, the IFA is similar to the functional test in SSA's mental impairments listings but has a larger number of domains and less stringent eligibility criteria. SSA guidelines state that, in general, a child will be found disabled when his or her impairment causes moderate functional limitations in at least three of six functional domains²⁰ *or* causes one marked and one moderate limitation in at least two of six domains.²¹ For children ages three and older, the IFA domains are:

- * cognitive functioning;
- * communicative functioning;
- * motor functioning;
- * social functioning;
- * personal/behavioral functioning; and
- * concentration, persistence, and pace.

¹⁹ For example, a child who is unable to stand and walk because of an unlisted impairment could be eligible for SSI benefits based on functional equivalence to a listed impairment.

²⁰ SSA regulations define "moderate" as the range between "minimal" and "marked."

²¹ SSA guidelines do not provide adjudicators with a set formula for establishing eligibility based on the number of marked or moderate limitations a child demonstrates. Rather, they provide examples of combinations of moderate limitations and marked and moderate limitations that are frequently disabling.

A comparison between SSA's two functional assessments is provided in Table 1-3.

Table 1-3. SSA's Functional Assessments of Childhood Impairments	
Childhood Mental Impairments Listings	Individualized Functional Assessment
<p>The required level of severity is met when the child has marked limitations in two of the following:</p> <ol style="list-style-type: none"> 1. Cognitive/communicative functioning 2. Social functioning 3. Personal/behavioral functioning as evidenced by: <ol style="list-style-type: none"> a. activities of daily living, or b. persistent maladaptive behavior destructive to self, others, animals or property 4. Concentration, persistence, and pace 	<p>Guidelines state that benefits <i>may</i> be provided when the child has at least one marked and one moderate limitation or at least three moderate limitations among:</p> <ol style="list-style-type: none"> 1. Cognitive functioning 2. Communicative functioning 3. Motor functioning 4. Social functioning 5. Personal/behavioral functioning 6. Concentration, persistence, and pace

Disabling Impairments

In 1995, nearly 67 percent of all children on the SSI rolls were eligible for benefits based on mental impairments. Approximately two-thirds of these (42 percent of the total) had mental retardation. Other common mental impairments included mood disorders, conduct disorders, oppositional defiant disorder, personality disorders, learning disorders, and Attention Deficit Hyperactivity Disorder (ADHD).

At the end of 1994, the total number of children receiving SSI based on a diagnosis of ADHD was 63,500. This included approximately 26,000 children who met the criteria in SSA's listing for ADHD, 2,500 children who equalled the ADHD listing, and 35,000 children who qualified on the basis of ADHD through an IFA.²²

Children classified by SSA with physical disabilities as their primary diagnoses accounted for 33 percent of the SSI rolls in 1995. Among the most prevalent disabilities

²² Because there was neither an IFA nor a medical listing for ADHD prior to 1991, SSA is unable to determine whether it made any allowances based on this impairment in the earlier period.

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were leukemia, asthma, Down syndrome, spina bifida, congenital heart anomalies, deafness, blindness, nervous system disorders, epilepsy (which is not adequately controlled with medication), cerebral palsy, and, for infants, low birth weight (under 1200 grams, or two pounds). An overview of disabling impairments is provided in Table 1-4, and a complete listing is provided in Appendix 7-F.

Because combinations of impairments occur frequently in children, primary diagnoses may not indicate the extent of a child's disability. Beyond these classifications, however, SSA data provides little insight into the nature and extent of these children's impairments. Because SSA stops gathering medical evidence when it has accumulated enough to allow a claim, the agency does not consistently determine or record secondary diagnoses. Moreover, little systematic information exists at present on these children's utilization of medical services or other supports such as assistive technology, child care, or special education.²³

²³ Research is now being conducted to address these questions. For example, the Department of Health and Human Services is comparing computer tapes of Medicaid utilization by children receiving SSI and diagnostic criteria contained in SSA administrative records. See chapter seven for further discussion.

Table 1-4. Number of children receiving SSI, and percentage distribution by diagnostic group, June 1995²⁴

Diagnostic group	Total	
	Number	Percent
Total	934,180	---
Total with diagnosis	783,500	100.0
Mental disorders:		
Mental retardation	331,820	42.4
Psychotic and neurotic disorders	189,310	24.2
Physical disorders:		
Infectious and parasitic diseases	2,860	0.4
Neoplasms	12,570	1.6
Endocrine, nutritional, and metabolic	8,030	1.0
Diseases of the:		
Nervous system and sense organs	94,700	12.1
Circulatory system	5,580	0.7
Respiratory system	21,570	2.8
Digestive system	2,570	0.3
Musculoskeletal system and connective tissues	9,090	1.2
Congenital anomalies	35,250	4.5
Injury and poisoning	4,910	0.6
Other	65,240	8.3

Legislative History

In 1969, President Richard Nixon proposed legislation to reform the American welfare system, the Family Assistance Plan (FAP). This legislation would have replaced existing federal income maintenance programs with a guaranteed minimum income for all Americans. The original version of the bill maintained the existing federal-state program of assistance to individuals who are aged, blind, and disabled but established federal benefit standards and increased federal participation in the financing of benefits. After intense debate and numerous revisions, the House of Representatives passed two versions of FAP, first in 1970 and again in 1971.

²⁴ Social Security Administration, *Children Receiving SSI*, June 1995, ten-percent sample file.

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As approved by the House, the 1971 legislation (H.R. 1) federalized support for aged, blind, and disabled individuals and extended support to children. The principal author of this proposal was Thomas Joe, an analyst in the Office of the Secretary of Health, Education, and Welfare. He explained the inclusion of children in the program as part of a larger effort to create a uniform, national standard of support for individuals with disabilities. He stated:

The whole objective [of federalizing state programs of support for people with disabilities] was to establish uniformity, and we needed a common definition of who was eligible. Under the state programs, blind individuals were eligible at age 16, while other persons with disabilities weren't eligible until age 18. State rehabilitation programs had a third age standard -- their age criterion was 14. Younger children (in families whose resources and income did not exceed specified limits) would have been eligible under the family program. These age limits were completely arbitrary. Furthermore, I believed that, because of their special needs, children with disabilities deserved to be eligible in their own right, subject to income and resource limits.²⁵

The Committee on Ways and Means report which accompanied H.R. 1 cited the special needs of children with disabilities in justifying their inclusion in the program. It stated that:

... disabled children who live in low-income households are certainly among the most disadvantaged of all Americans and ... they are deserving of special assistance in order to help them become self-supporting members of our society. Making it possible for disabled children to get benefits under this program, if it is to their advantage, rather than under the program for families with children, would be appropriate because their needs are often greater than those of non-disabled children.

The Senate did not approve H.R. 1. After a long debate, it approved legislation which omitted the House Family Assistance Plan provisions but included the establishment of the SSI program for aged, blind, and adults with disabilities. Explaining the decision to extend the SSI program to adults only, the Senate Committee on Finance report stated:

²⁵ Telephone interview with Thomas Joe, August 6, 1995. Mr. Joe also stressed that the existence of disability-related needs beyond health care was evidenced at the time by "special needs allowances" offered in a number of states to children with disabilities.

The House justified its inclusion of disabled children under age 18 under aid to the disabled, if it is to their advantage, rather than under the program for families with children, on the grounds that their needs are often greater than those of non-disabled children. The needs of disabled children, however, are generally greater only in the area of health care expenses. In all but the two states that do not have Medicaid programs, children now eligible for cash assistance are covered under existing State medical assistance programs. Disabled children's needs for food, clothing, and shelter are usually no greater than the needs of non-disabled children.

A House-Senate conference committee reached agreement in October 1972. In the agreement, the Senate accepted the House provision to extend SSI eligibility to children. The conference report does not include an explanation for this decision.

Program Growth

SSA's early difficulties in implementing the adult SSI program have been well documented: short lead times, technological difficulties, and larger than expected groups of applicants.²⁶ These problems account in part for the agency's slow progress in implementing SSI for children. SSA did not formally issue its childhood disability listings until 1977. By 1979, 212,000 children had been granted eligibility. Growth in program rolls was modest between 1979 and 1989, increasing from 212,000 to 296,000 beneficiaries.

By contrast, the rolls nearly tripled between 1989 and 1994, increasing from 296,000 to 893,000 children. Program costs rose commensurately, from \$1.2 billion to approximately \$5 billion annually. While the SSI program as a whole also grew substantially during this period, childhood awards outpaced awards to adults. Children comprised six percent of the total SSI population in 1989, but 14 percent of the total SSI population in 1994. Table 1-5 traces SSI program growth over the past two decades.

The tripling of the SSI rolls results primarily from four factors: the *Zebley* decision, a 1990 revision of the listings of childhood mental impairments, enhanced SSI outreach activities, and an increase in the rate of childhood poverty.

The most widely noted source of growth is the 1990 *Zebley* decision, in which the Supreme Court found SSA's childhood disability regulations inconsistent with the Social Security Act. The Act entitles children to benefits whose disabilities are comparable to qualifying adult disabilities. SSA's procedures for evaluating childhood disability prior to 1990 did not, however, mirror its procedures for adult disability determination. For adults,

²⁶ See, for example, Martha Derthick's *Agency Under Stress*, Washington, D.C.: The Brookings Institution, 1990.

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SSA had established two separate paths to SSI eligibility: a listing of qualifying medical impairments and, for those whose impairments are not described there, an individualized assessment of residual functional capacity (RFC). SSA uses the RFC assessment to determine whether there is work that an individual can do, given his or her age, education, and past work experience.

Table 1-5. Number and percentage distribution of children who received a federal or state SSI payment, December 1974-June 1995

	Blind and Disabled Children ²⁷	
	Number	Percent of total SSI recipients
December 1974	70,900	1.8
1975	128,175	3.0
1976	153,128	3.6
1977	175,214	4.1
1978	197,499	4.7
1979	212,088	5.1
1980	228,564	5.5
1981	230,094	5.7
1982	229,151	5.9
1983	236,380	6.1
1984	248,633	6.2
1985	265,325	6.4
1986	280,137	6.6
1987	288,725	6.6
1988	290,256	6.5
1989	296,298	6.5
1990	340,230	7.1
1991	438,853	8.6
1992	623,845	11.2
1993	770,501	12.9
1994	892,543	14.2
June 1995	940,948	14.6

For children, SSA had established only the first of these two paths: a listing of qualifying impairments. The Supreme Court ruled that the listings alone failed to provide

²⁷ In June 1993, approximately 35,000 cases previously classified as children were reclassified as adults. Prior to that date, the counts may be slightly skewed because of the reclassification.

comparability with adult eligibility criteria. In response, SSA revised its childhood regulations to include the "functional equals" step and the Individualized Functional Assessment.

In addition to expanding eligibility criteria for children, the *Zebley* decision led to readjudication of a large number of previously denied claims. Following the decision, the district court required SSA to contact the families of 452,000 children who were denied benefits between January 1980 and February 1991. SSA offered to readjudicate their claims using the new functional criteria. Of this group, 339,000 children responded; and approximately 135,000 were ultimately found eligible and awarded benefits.²⁸ Many of these children were determined to have been eligible at the time of initial application. They therefore qualified not only for prospective benefits but for large retroactive lump-sum payments.

A second cause of program growth is SSA's 1990 revision of its listings of childhood mental impairments. SSA undertook this revision in response to the Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460), which required the agency to update its mental listings. Prior to this revision, SSA had listed only four general categories of qualifying mental impairments for children -- mental retardation, chronic brain syndrome, psychosis, and functional non-psychotic disorders. To reflect medical advancements in disability evaluation and treatment, SSA expanded this number to eleven. These are:

- organic mental disorders
- schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders
- mood disorders
- mental retardation
- anxiety disorders
- somatoform, eating, and tic disorders
- personality disorders
- psychoactive substance dependence disorders
- autistic disorder and other pervasive developmental disorders
- attention deficit hyperactivity disorder
- developmental and emotional disorders of newborn and younger infants (birth to age one)

This revision also placed increased importance on information from nonmedical sources, such as parents, teachers, and others knowledgeable about a child's day-to-day functioning.

²⁸ Social Security Administration, Office of Disability.

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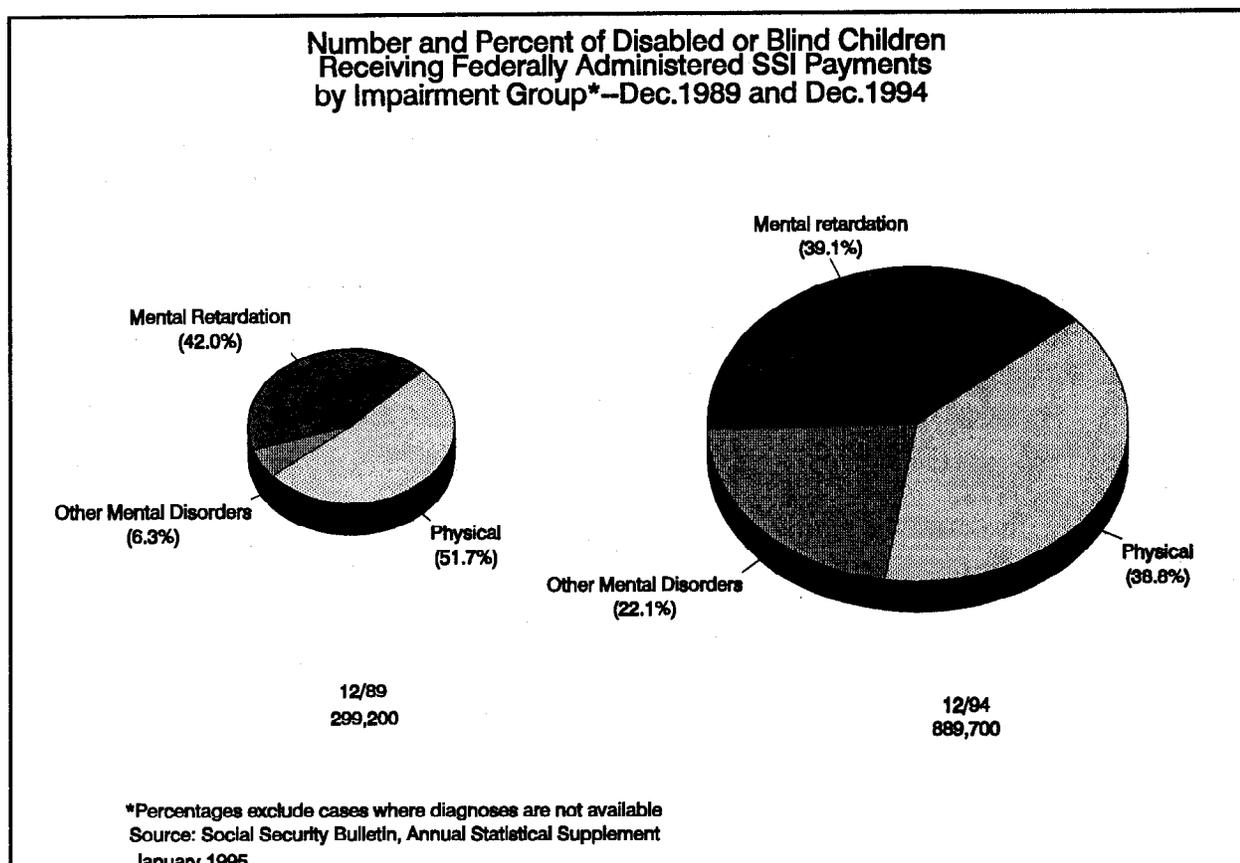
In September 1994, the General Accounting Office (GAO) issued a report comparing the impact that the new listings and the IFA had on program growth.²⁹ The GAO found that 59 percent of the growth in childhood benefit awards during 1991 and 1992 was attributable to the listings. The IFA, by contrast, accounted for only 41 percent of growth during this period. SSA's assessment of the relative importance of these changes assigns even greater weight to the mental impairment listings. The agency estimates that they account for 69 percent of SSI program growth since 1990, while the *Zebley* decision accounts for only 31 percent.³⁰

Together these changes not only led to a higher level of benefit allowances; they also altered the mix of impairments of children on the SSI rolls. In 1989, children with physical impairments comprised just over 51 percent of SSI recipients. Children with mental retardation and other mental impairments accounted for just over 48 percent. In 1994, children with physical impairments comprised nearly 39 percent of the rolls, and children with mental retardation and other mental impairments accounted for over 61 percent. Figure 1-6 illustrates these changes.

²⁹ General Accounting Office, *Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations*, September 1994.

³⁰ Social Security Administration, Office of Disability.

Figure 1-6.



A third factor contributing to the increase in SSI rolls is more difficult to quantify. This is SSI outreach activities. A 1989 statute required SSA to establish a permanent program of SSI outreach to low-income children.³¹ The *Zebley* decision also called for additional outreach efforts. In 1990, Congress appropriated \$3 million for SSA to target hard-to-reach populations. Since then, it has appropriated \$6 million each fiscal year for SSI outreach activities.³² As of August 1994, SSA had funded 136 outreach grants.

In targeting children, the agency sought organizations that could provide coordinated services, including Head Start affiliates, school districts, children's hospitals and clinics, Children with Special Health Care Needs Agencies, and state agencies administering programs

³¹ The Omnibus Budget Reconciliation Act of 1989, Public Law 101-239.

³² Congress appropriated no funding for outreach activities for fiscal year 1996, although SSA plans to fund outreach demonstration projects from unobligated funds of prior years.

Table 1-8.

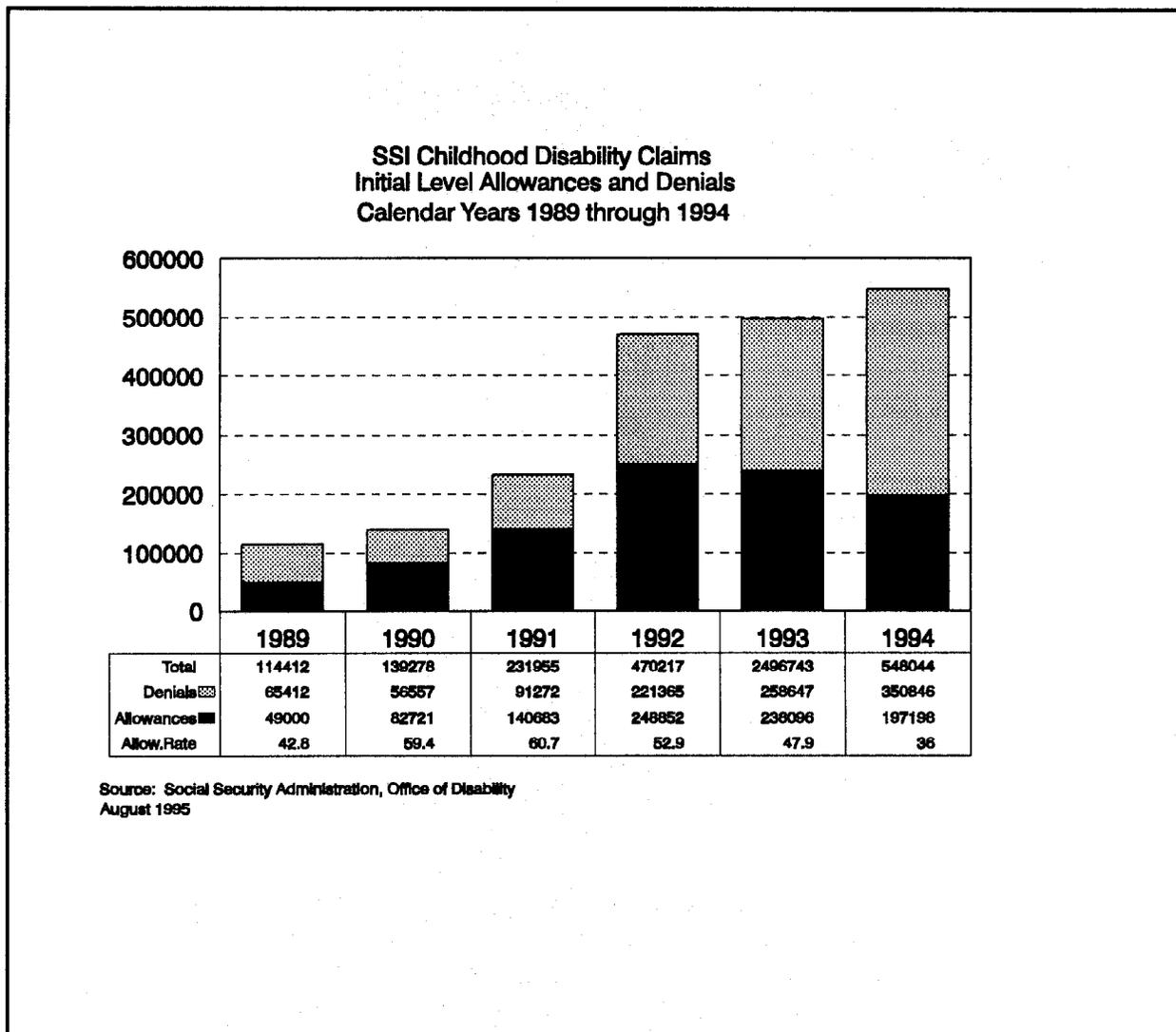
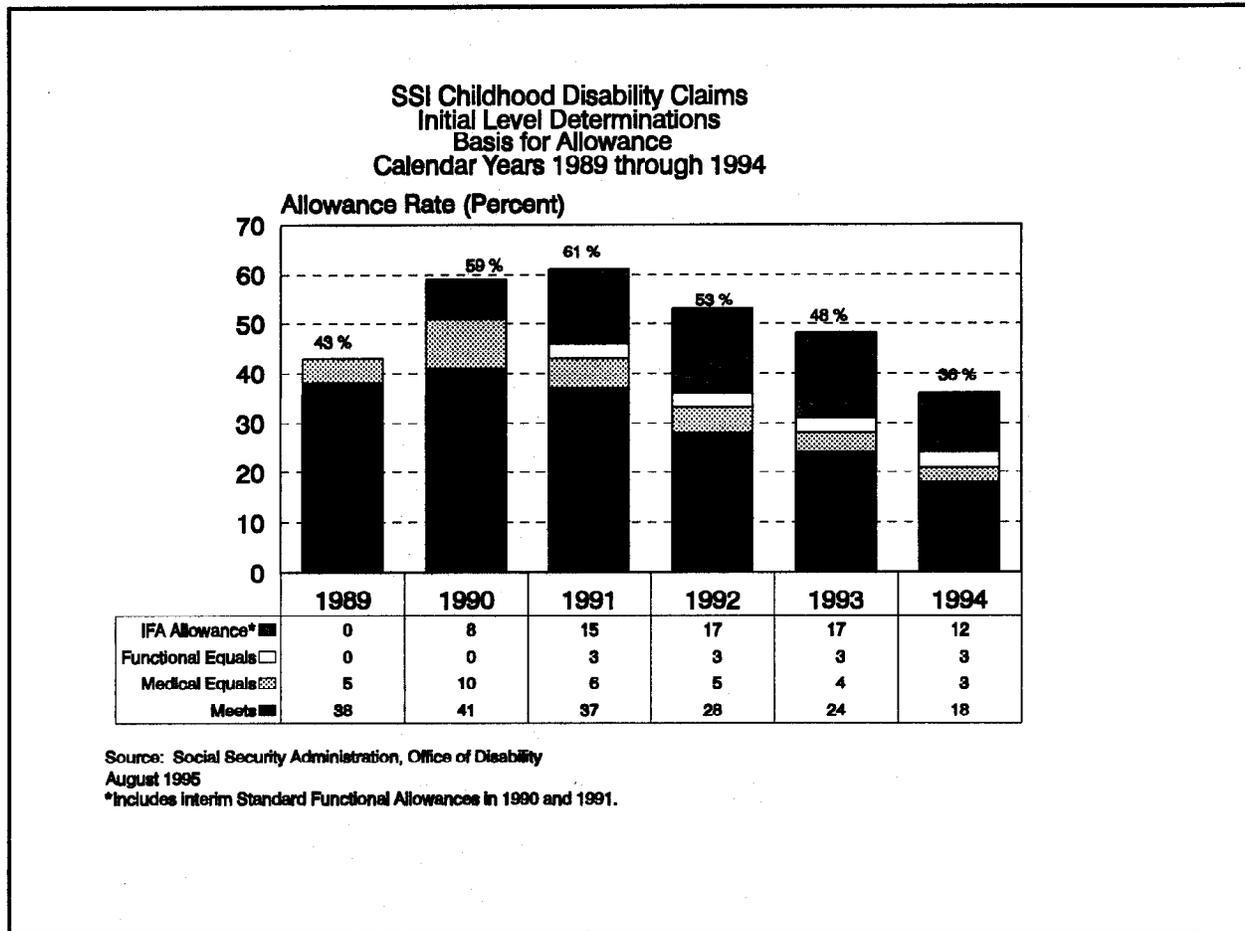


Table 1-9.



An additional alleged source of program growth is fraudulent SSI claims. Some observers contend that increasing numbers of parents are successfully coaching their children to feign disabilities in order to receive SSI benefits. Despite the decline in allowance rates to below the pre-Zebley rate, the news media has continued to report allegations of coaching.³⁷ Such coverage has fueled Congressional interest and heightened public concern that fraud may constitute a major source of program growth.

The most comprehensive investigation of these allegations to date was undertaken by SSA itself. The agency's efforts are three-fold. First, in May 1994, SSA examined a sample

³⁷ For example, T. Hargrove, "Misuse of Aid to Learning-Disabled Children Alleged." *The Atlanta Constitution*, December 30, 1994. J. B. O'Donnell, "Children are Coached to Get Aid, Social Security Admits." *The Baltimore Sun*, April 8, 1995. H. MacDonald, "Teaching Johnny to Fail." *The Washington Post*, June 18, 1995.

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of 617 claims based on impairments involving behavioral abnormalities and learning deficits. Of these 617 claims, 13 case files contained evidence to suggest possible coaching or malingering. Of these 13, only three were allowances. SSA judged that all these allowances were proper.³⁸

Second, in June 1994, SSA instructed the state DDSs to identify all childhood cases in which an adjudicator suspected coaching or sub-optimal performance. This suspicion could be based on as little evidence as a child's apparent failure to make his or her best effort on an IQ test. From June 1994 through August 1995, 690,644 childhood disability claims were processed by the DDSs. Of these, only 1,229 were identified for review, of which SSA determined that only 88 had been allowed benefits. Upon further review, the agency determined that all 88 allowances were proper.

Third, in September 1994, SSA established an 800-number to receive reports of fraud and abuse involving SSI childhood disability benefits. As of August 1995, 166 calls were received concerning 230 children. SSA determined that 108 of the 230 children had been allowed benefits. To date, it has reviewed 45 of these cases. Of these, 26 were upheld, four were terminated based on evidence in the case file, and the remaining 15 were terminated after additional evidence was gathered in a continuing disability review.

These findings are subject to two qualifications. First, SSA limited its analysis to its own written records. It did not interview parents, teachers, or other observers. Second, while the number of cases screened during this period was large, SSA did not screen the entire universe of children's claims. Given these limitations, SSA's finding cannot completely rule out that successful coaching and/or malingering is occurring in some instances or localities.³⁹ It does, however, suggest strongly that coaching is not a significant cause of growth in the SSI program.⁴⁰

³⁸ SSA, *Findings from the Study of Title XVI Childhood Disability Claims*, May 1994.

³⁹ The General Accounting Office has reviewed existing studies and found little evidence to suggest that coaching is prevalent. U.S. General Accounting Office, *Social Security: New Functional Assessment Process Results in Questionable Eligibility for Children*, February 1995.

⁴⁰ It should also be noted that, where coaching does occur, substantial civil and criminal penalties exist for SSI fraud.