

DRC BRIEF

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What Have We Learned About SSI Receipt Among Children?

The Supplemental Security Income (SSI) program is an important, means-tested source of income for the families of children with disabilities. Although some research has shown that SSI improves outcomes for these families, policymakers have been concerned about the program's growth and the poor outcomes that many former child SSI recipients experience in adulthood. In this brief, we summarize research funded by SSA's Disability Resource Consortium (DRC) on the program's recent growth and the factors related to receipt of SSI by children. This research reveals dramatic variation in the rate of child SSI receipt at the state and county level, which is partly due to geographic differences in both the population and the economic circumstances that influence program eligibility. Changes in these two factors can explain a substantial share of the growth in caseloads since 2000. When children who receive SSI become adults, their employment rates and SSI receipt rates also vary from one state to another. The findings from these studies suggest that the SSI program is generally, if imperfectly, successful in delivering cash support to children with disabilities living in low-income households in a uniform manner. However, this cash support is not sufficient to lead to uniform outcomes throughout the country. Outcomes for such children with significant disabilities in low-income families depend on where they live, not just their disability or their family's financial circumstances. Lessons about how policies and programs have contributed to substantially better outcomes for SSI children in some areas can help policymakers and program administrators improve outcomes in areas where outcomes are poor.

THE SSI PROGRAM FOR CHILDREN

Supplemental Security Income (SSI) is an important income source for (1) qualifying children and adults with disabilities and (2) people age 65 and older. The eligibility criteria for children include having "a medically determinable physical or mental impairment

which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" (42 U.S.C. §1382c(C)(i)). Eligibility is also limited to children whose families have low incomes and scant assets. As long as they continue to meet these

The research reported herein was performed pursuant to a grant from the U.S. Social Security Administration (SSA) funded as part of the Disability Research Consortium. The opinions and conclusions expressed are solely those of the author(s) and do not represent the opinions or policy of SSA or any agency of the Federal Government. Neither the United States Government nor any agency thereof, nor any of their employees, makes any warranty, expressed or implied, or assumes any legal liability or responsibility for the accuracy, completeness, or usefulness of the contents of this report. Reference herein to any specific commercial product, process, or service by trade name, trademark, manufacturer, or otherwise does not necessarily constitute or imply endorsement, recommendation or favoring by the United States Government or any agency thereof.

Child SSI caseloads more than quadrupled between 1990 and 2018, from roughly a quarter million children in 1990 to over 1.2 million children in 2018. The child population grew just 15 percent over this same time period, from 64.2 million to 73.8 million.

requirements, children receive benefits until age 18, when their eligibility is reassessed using adult criteria.

The maximum SSI federal payment level is currently \$750 per month, although the actual amount paid to individual recipients is often lower depending on the sources and amounts of other household income. In addition, most states provide supplemental payments to SSI recipients. In 2018, the average federal payment to child recipients was \$656 (SSA 2018). Although these payment levels are relatively modest, and only a scant percentage of children receive SSI (1.7 percent in 2016), the payments lift nearly half of the 1.2 million child beneficiaries out of poverty in the sense that without the SSI income for the child their households income would be below the poverty line, holding other household income constant (Romig 2017). In addition, recent research highlights the benefit of SSI to the behavioral and health outcomes of children and families (Guldi et al. 2018).

Nevertheless, policymakers have been concerned about the growth in the child SSI program. Child SSI caseloads more than quadrupled between 1990 and 2018, from roughly a quarter million children in 1990 to over 1.2 million children in 2018. The child population grew just 15 percent over this same time period, from 64.2 million to 73.8 million. The federal costs of administering the program are substantial, and child SSI recipients have relatively poor outcomes as adults.

This brief summarizes findings from recent DRC-funded research on the child SSI program. These studies shed some light on the factors associated with caseload growth and poor adult outcomes. They also document that both SSI caseloads and the adult outcomes of beneficiaries vary dramatically at the state and local level.

GROWTH IN THE CHILD SSI PROGRAM

Before 1990, the child SSI program was small, serving only about 255,000 children in 1988. Caseloads tripled between 1991 and 1996, largely due to the Supreme Court decision *Sullivan v. Zebley*, which expanded eligibility by adding a

number of conditions including severe attention deficit hyperactivity disorder (ADHD) to the list of qualifying conditions for children. The welfare reforms ushered in by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) also included a number of provisions aimed at stemming the growth in the child SSI caseload as a consequence of the *Zebley* decision. Caseloads shrank for several years, but from 2000 to 2017 the child SSI program expanded over 40 percent, from 847,000 to 1.2 million recipients (SSA 2018).

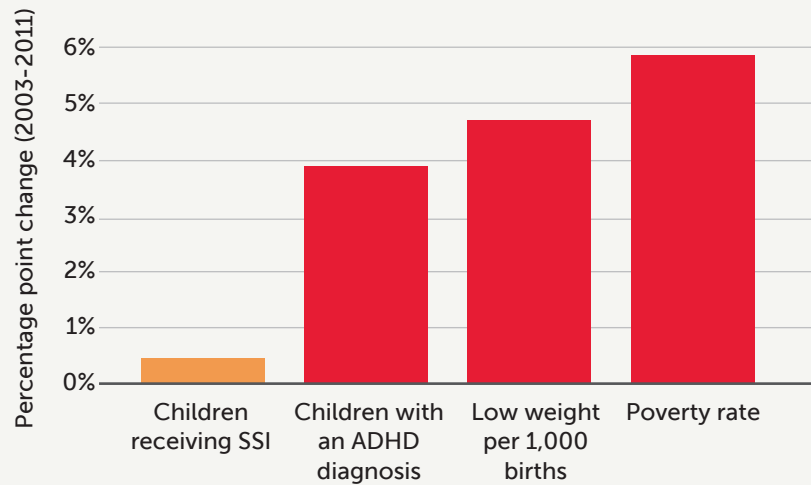
Although growth in the 1990s was likely due to changes in eligibility, research reveals other reasons for recent growth

A recent DRC-funded study notes there are no SSA policy changes that can explain caseload growth since 2000 (Schmidt and Sevak 2017). One possible explanation is that PRWORA unintentionally increased the attractiveness of SSI benefits relative to other cash benefits for low-income households with children; the latter had become time-limited under the Temporary Aid to Needy Families (TANF) program. Earlier studies reveal that both families and states have financial incentives to shift children and families from TANF to SSI, with the incentives for families particularly strong in some states with low TANF benefits, like Texas (Wiseman 2011). In one earlier study, Schmidt and Sevak (2004) find that female-headed households in states that approached welfare reform more aggressively were 22 percent more likely to receive SSI than comparable households in other states. Wittenburg et al. (2015) show that in 2013, 11 states had more child SSI recipients than TANF recipients, and that child SSI program expenditures exceeded the TANF program's federal and state cash benefits.

Using county level data, Schmidt and Sevak (2017) found that between 2003 and 2011, the percentage of children receiving SSI increased by an average of about half a percentage point across counties. This change took place at the same time as changes that likely led to an increase in the number of eligible children: the percentage of children with an ADHD diagnosis increased on average almost 4 percentage points (46 percent); the share of births that were low birth weight increased nearly 5 percentage points (7 percent); and the poverty rate increased by about 6 percentage points (33 percent) (Figure 1). Although

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Growth in child SSI and simultaneous changes in factors influencing eligibility



Source: Schmidt and Sevak (2017)

Figure 1

Counties with higher rates of low birth weights in infants, ADHD diagnoses, students receiving special education services, and poverty have significantly higher rates of child SSI receipt.

it is difficult to attribute causality, the authors estimate that changes in poverty rates, health conditions, and special education enrollment rates can account for 30 to 40 percent of the growth in child SSI participation between 2003 and 2008, before the Great Recession, and about 25 percent of the growth since the economic downturn.

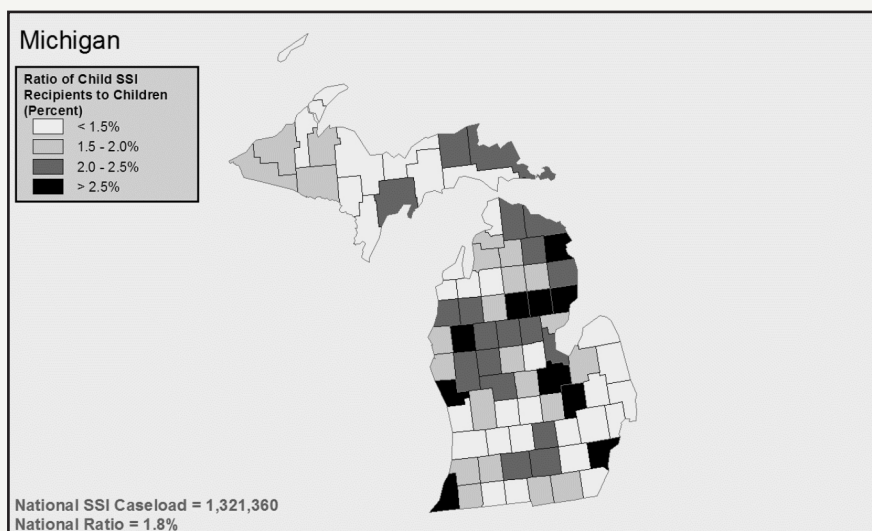
Receipt levels and growth in receipt vary dramatically across states and local areas

Nationally, the child SSI participation rate is about 1.7 percent, but this rate varies substantially across and within states. For example, Schmidt and Sevak (2017) find that in Pennsylvania, which had a relatively high child SSI participation rate of 2.8 percent in 2013, rates are low in the affluent suburbs of Philadelphia, but not in the affluent suburbs of Pittsburgh, and rates are generally higher in the western part of the state. Figure 2 illustrates similar geographic variation in Michigan, where participation is, not surprisingly, high in some high-poverty areas like Detroit and Flint in southeast Michigan, and is also high just outside of Gary, Indiana, in the southwest corner of the state. However, the rest of Michigan has substantial variation in participation without any obvious explanations. In another DRC-funded study, Gettens et al. (2018) illustrate the marked geographic variation in adult disability caseloads as well.

Schmidt and Sevak (2017) show that differences in relevant state- and county-level health and demographic and socioeconomic variables account for much of the geographic variation in child SSI participation. Counties with higher rates of low birth weights in infants, ADHD diagnoses, students receiving special education services, and poverty have significantly higher rates of SSI receipt. Counties with a higher share of Hispanics have lower rates, in line with previous findings that Hispanics are underrepresented in disability populations (Ben-Shalom and Stapleton 2014). Counties with a higher share of African Americans also have higher rates of child SSI participation. These differences in participation might reflect differences between certain demographic groups in disability prevalence, in other eligibility criteria like income, or in levels of knowledge about the program.

Schmidt and Sevak (2017) also show that the reasons underlying growth rates likely vary from one region or state to another. For example, changes in the prevalence of certain health conditions in the South is more strongly associated with child SSI growth than it is in other regions. Unemployment is positively associated with caseloads in the Midwest, but negatively associated with caseloads in the South. An implication is that national models of caseload growth likely produce estimates that dampen the significance of factors that are important in some states but not in others.

County-level variation in child SSI population ratios: Michigan, 2013



Source: Schmidt and Sevak (2017)

Figure 2

To continue receiving benefits after age 18, child SSI recipients must meet the adult criteria for disability, which are assessed through a process known as the age-18 redetermination.

ADULT OUTCOMES OF FORMER CHILD SSI RECIPIENTS

As they transition to adulthood, many child SSI recipients start working, whether or not they pursue postsecondary education, and many continue to receive SSI benefits. Employment and receipt of benefits are outcomes that are neither mutually exclusive nor exhaustive—a non-trivial share of former child SSI recipients receive neither benefits nor earnings. To continue receiving benefits after age 18, child SSI recipients must meet the adult criteria for disability, which are assessed through a process known as the age-18 redetermination. Like other adult SSI applicants, former child SSI recipients can appeal re-determination decisions.

Several DRC-funded studies focus on the adult outcomes of these young beneficiaries. To learn more about redetermination outcomes, Hemmeter et al. (2017) study all child SSI recipients following their age-18 re-determinations in the period from 1998 through 2006, examining data on their employment and benefit receipt through age 24. To examine the role of services the children receive as they approach adulthood, Hoffman et al. (2018) study a cohort of child SSI recipients ages 14 to 17 and examine their employment and SSA disability program participation outcomes 13 years later, at ages 27 to 30. Their findings are highlighted below.

Child SSI recipients are at high risk for poor outcomes as adults

Child SSI recipients have much lower rates of employment in their young adult lives than their counterparts without disabilities. Hoffman et al. (2018) find that only 42 percent of former child SSI recipients were employed at some point in their late 20s. This rate is substantially lower than the 77 percent employment-to-population ratio among people ages 25 to 34 in 2016 (Abraham and Kearney 2018). Other researchers show that those who are employed have much lower earnings than other young adults do (Lever 2017) and experience substantial income volatility (Desphande 2016a). It is possible that some former child SSI recipients may have invested less in career-oriented human capital or education than they would have if they were not expecting to keep receiving SSI in adulthood. Their consequently lower levels of education and skill further diminish their chances of being gainfully employed in adulthood, as if reinforcing a self-fulfilling prophecy. An encouraging finding by Hoffman et al. (2018) is that receipt of services from state vocational rehabilitation (VR) agencies is associated with significantly better employment outcomes in adulthood, and less reliance on disability benefits, but this evidence falls short of demonstrating a causal relationship.

SSI cessation and employment rates of former child SSI recipients also vary across states

Hemmeter et al. (2017) find that after all appeals, SSA ceases the benefits of roughly 34 percent of child SSI recipients following their age-18 re-determination. Across the states, cessation rates vary from 20 percent (District of Columbia) to 47 percent (Mississippi), with rates generally highest in southern states (Figure 3). In addition, the researchers find that adult employment rates are higher among those whose benefits are ceased than those who continue to receive benefits (50 percent versus 20 percent, measured at age 24)—presumably because their impairments are less severe, and they now face a more pressing need to earn money—but both rates are low relative to employment rates of young adults without disabilities. Although employment rates of ceased recipients across states were fairly similar, adult employment rates among continuing recipients varied across states, ranging from 14 percent (West Virginia) to 32 percent (Minnesota and North Dakota).

IMPLICATIONS FOR POLICY

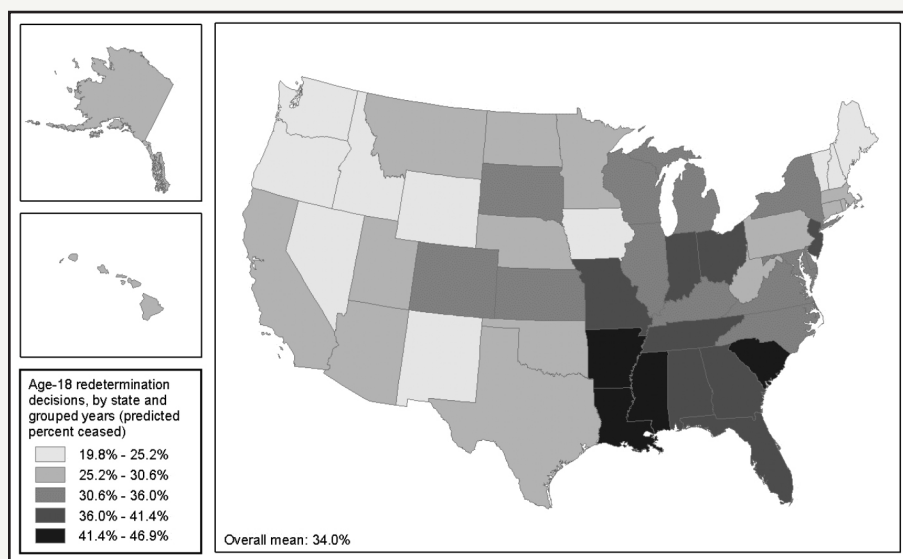
The Workforce Innovation and Opportunity Act (WIOA), passed in 2014, emphasizes the

commitment of the federal government to improve outcomes for youth with disabilities as they transition to adulthood. It requires state agencies to help prepare these youth for adult careers by providing pre-employment transition services to all students with disabilities beginning as early as age 14. More specifically, VR agencies must allocate substantial resources to build capacity, form partnerships with schools, and provide these services. The SSI program provides much-needed cash support to many of these vulnerable youth. A better understanding of the factors underlying growth in the child SSI program and the adult outcomes of child SSI recipients is essential for improving the transition of youth with disabilities to adulthood.

The finding that geographic variation in child SSI participation is substantially explained by health, demographic and socioeconomic predictors of SSI receipt suggests that the SSI program is generally, if imperfectly, successful in delivering cash support to children with disabilities living in low-income households in a *uniform manner*. It is clear from the substantial variation in adult employment and program participation outcomes for SSI children that providing such cash support is not sufficient to lead to *uniform outcomes* throughout the country. Outcomes for such children with significant disabilities in low-income families depend on where they live,

Figure 3 shows that SSI cessation rates following the age-18 redetermination vary widely across states, from 20 percent (District of Columbia) to 47 percent (Mississippi), with rates generally highest in southern states.

Rates of SSI cessation after the age 18 re-determination



Source: Hemmeter et al. (2017)

Figure 3

Lessons about how policies and programs have contributed to substantially better outcomes for SSI children in some areas can help policymakers and program administrators improve prospects in other areas where outcomes are poor.

not just their disability or their family's financial circumstances. Research is starting to produce evidence on why outcomes depend on where the child lives (Chetty et al. 2018). Lessons about how policies and programs have contributed to substantially better outcomes for SSI children in some areas can help policymakers and program administrators improve prospects in other areas where outcomes are poor.

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