THE SUPPLEMENTAL SECURITY INCOME PROGRAM

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I. Introduction

Supplemental Security Income (SSI) is a federally-administered, means tested program that provides cash – and typically Medicaid -- benefits to low income individuals who meet a categorical eligibility requirement of age or disability status. SSI essentially operates three programs for distinct populations: blind or disabled children, blind or disabled non-elderly adults, and individuals 65 and older (without regard for disability status). The program has a federally determined set of income, asset, and medical eligibility criteria and maximum benefit levels that do not vary across states. Nearly one-third of states supplement the federal benefit with state SSI benefits (paid for entirely by the individual states) though these payments account for just 6 percent of total SSI benefits paid.

In 2013 the federal government paid $54 billion in SSI cash benefits and in December 2013 there were 8.4 million SSI recipients. An additional $133 billion was paid for SSI recipients' Medicaid benefits in 2011.[1] More than half of SSI recipients in December 2013 received the maximum federal benefit of $710 per month (or more if supplemented by the state) with the rest having their benefits partially phased out due to relatively higher income. Approximately one-in-six current SSI recipients are under the age of 18, one-in-four are 65 or older, and the remaining 60 percent are between the ages of 18 and 64. The corresponding shares 25 years ago were 6, 44, and 50 percent, respectively, reflecting the substantial increase in SSI enrollment among children and non-elderly adults during this period. Total federal benefits paid for SSI disabled children and non-elderly adults nearly tripled over a 25-year period, rising from $14.6 billion in 1988 to $44.4 billion dollars in 2013 (SSA 2014f, all figures in real 2014$).

[1] This is the most recent year for which Medicaid spending data by eligibility category are available. CMS reports $223 billion for 14.1 million aged and disabled Medicaid recipients. Because this exceeds the number of SSI aged and disabled recipients, we scale this down by the ratio of SSI aged and disabled to CMS aged and disabled.

The SSI program has become an increasingly important part of the social safety net, especially for non-elderly adults and children. For the elderly, the SSI program typically supplements social security (OASDI) benefits for low-income individuals and households, providing a transfer of income intended to assist individuals with very low levels of income. The fraction of elderly individuals receiving SSI benefits has fallen steadily since the early 1980s, with this trend primarily driven by a corresponding increase in Social Security benefits.[2] In 2013, approximately 1-in-22 elderly individuals received SSI benefits versus 1-in-15 thirty years earlier.

For non-elderly adults, the SSI program provides cash income to disabled individuals with limited earnings history. The rationale for these income transfers is to provide an income floor to individuals with disabilities who are unable to engage in substantial gainful activity (SGA). Nearly one-in-four SSI disabled adults also qualify for benefits through the Social Security Disability Insurance (SSDI) program, which requires 10 or more years of earnings history, while the rest do not have sufficient work history to qualify for SSDI. Both programs are administered by the U.S. Social Security Administration (SSA) and have an identical set of medical eligibility criteria. The fraction of non-elderly adults receiving SSI benefits has increased substantially over time, from 1.5 percent in 1988 to 2.5 percent by 2013.[3] In the 2000 Means Tested Programs volume, Burkhauser and Daly make the important observations that (1) "disability" is neither a precise nor a static concept and (2) societal expectations about work for those with disabilities have changed over time as, for example, reflected in the 1990 Americans with Disabilities Act. These observations raise the issue of labor supply disincentives inherent in the SSI program, a point to which we return below.

SSI also provides benefits to low-income children with disabilities. The fraction of children

[2] The primary reason for this growth is that Social Security benefits are indexed to wages.

[3] This 1.0 percentage point increase is less than half the corresponding enrollment change for the SSDI program. This difference is likely driven by the growth in labor supply among women over time, which has made more of them eligible for SSDI benefits and their level of SSDI benefits higher as well (Duggan and Imberman, 2007). Because SSDI phases out SSI benefits one-for-one, an increase in SSDI benefits will tend to reduce SSI enrollment.

receiving SSI has increased by a factor of four since the late 1980s, from 0.4 percent in 1988 to 1.8 percent in 2013). This enrollment growth was primarily driven by two 1990 policy changes that expanded the program's medical eligibility criteria (Duggan and Kearney, 2007, GAO 1994). There is considerable overlap between the households with children served by this program and those served by the Temporary Assistance to Needy Families (TANF) program.[4]

But unlike TANF, SSI is a federal program and is not explicitly "temporary." The motivation for why families with a disabled child should get additional income, as compared to a family with a healthy child and the same level of income, is not explicit in the program. One could rationalize that such families might have additional child care needs to support parental employment or additional health care costs for the child. Or, one could argue that families with a disabled child have a need for occupational services, designed to help a child improve and excel in school. But in practice, the program taxes parental earnings and it does not explicitly tie benefits to child care or health care costs. Furthermore, if a child's condition improves, the family risks losing their SSI benefits. All of these observations raise questions about the incentives of the program and whether it is optimally designed to serve families with disabled children. We return to these points below.

When considering SSI alongside the panoply of means-tested cash transfer programs, we note four defining features of the program. These are features that stand in contrast to typical features of other means-tested income support programs in the U.S., including the Earned Income Tax Credit (EITC), TANF, the Supplemental Nutritional Assistance Program (SNAP), and Medicaid. First, as we have noted above, for the non-elderly the SSI program includes a categorical requirement of demonstrated disability, specifically, a disability that hinders labor

[4] In 2001, households with at least one child on SSI were more than three times as likely as households with children not on SSI to receive some income from the TANF program (Duggan and Kearney, 2007).

market or educational performance. Second, the program's benefit levels are relatively generous, especially compared to TANF cash benefit awards in low-benefit states, and are indexed to inflation. Third, SSI benefits are paid for with federal dollars, which can amount to large net transfers to states with a disproportionate share of low-income Americans. Fourth, the program is not intended to be temporary, so any distortions in behavior resulting from the program can potentially be long lasting.

These four features raise a particular set of theoretical issues. First, the categorical disability requirement is a form of "tagging", so named in the seminal work of Akerlof (1978), in which the government imposes certain eligibility requirements to target funds to groups with especially high needs. The existence of a tag allows the government to redistribute more than if all individuals were potentially eligible for the benefit. It also may provide an incentive for some individuals to overstate the severity of their medical conditions in order to qualify for the program. Second, there exists the standard trade-off between income protection and distortions to the labor supply and savings decisions of benefit recipients. Third, the federal nature of this program raises the possibility of spillover effects to state and local programs such as TANF. In the pages that follow, we review these issues in more depth and describe the relevant empirical evidence.

The outline of the paper is as follows. In section two we provide a brief summary of the history of the SSI program and discuss the most important features of the program today. Section three presents information about the caseload and caseload trends. Section four describes economic issues particular to the design and practical application of this program as well as a discussion of relevant empirical evidence. A final section concludes.

II. Origins and Structure of the SSI Program

The federal Supplemental Security Income program began paying out benefits in January, 1974 and replaced a combination of approximately 1350 different state and local programs that provided benefits to low-income aged, blind, and disabled individuals (Berkowitz and DeWitt 2013). Many of these programs had been partially funded by the federal government, and the size of benefits varied across states (Wiseman, 2010). In some cases, the uniform federal SSI benefit amount was lower than what had been paid by the previous programs. Because of this, a system of state supplements was introduced during the transition to SSI to ensure that no individual would receive lower benefits from the SSI program than they were already receiving from their state or local welfare program. Relatedly, because there was variation across geographic areas in the medical and income eligibility criteria, recipients already enrolled in state programs by early 1973 were grandfathered in to SSI, though anyone who enrolled in a state program after July 1973 would have their SSI eligibility determined according to the uniform medical eligibility standards in effect throughout the U.S.

Since its inception, the SSI program has been administered by SSA, perhaps partly because of the overlap in the populations served by the OASDI and SSI programs. Supporters of the program also argued that there would be less stigma from receiving SSI benefits if it were administered by SSA instead of local welfare offices. And because SSA already had a set of medical eligibility criteria defined for the SSDI program, it was well-positioned to apply these same criteria to SSI applicants. The two programs have used the same medical eligibility criteria for disabled adults during the last 40 years. By December of 1974, there were 4.0 million U.S. residents receiving SSI benefits and more than 60 percent of SSI recipients were aged 65 or older. Most of these elderly SSI recipients qualified solely due to low income and assets after reaching 65, though a substantial number also qualified initially due to a disability and remained on SSI

after reaching age 65. Legislation that took effect in the summer of 1974 required that SSI benefits be indexed to the consumer price index (CPI).

In contrast to SSDI, SSI has always paid benefits to disabled children.[5] In the first full year of the program, 71,000 children received SSI benefits; over the next 10 years this number tripled to 212,000. During the debate that took place in both houses of Congress in the early 1970s as SSI legislation was considered, there was little discussion of whether children should receive benefits from the SSI program and what the medical eligibility criteria for them should be. Evidence from the historical record suggests that a congressional staffer inserted a phrase about benefits for disabled children into the 1971 version of the House bill. This phrase remained in the final version that passed both houses of Congress and that was sent to President Nixon for his signature (Berkowitz and DeWitt 2013).

The shifting age distribution of SSI recipients over the last four decades is striking. As incomes among the elderly have risen during that time period, a smaller share has been eligible for the program. The fraction of U.S. residents aged 65 and up receiving SSI stood at 11 percent in 1974 and has trended steadily down to 4.7 percent by 2013. In contrast, the fraction of children and of non-elderly adults receiving SSI benefits has grown substantially during that same period. Perhaps the most important factor causing this growth has been an expansion in the program's medical eligibility criteria, a subject to which we now turn.

A. Disability Determination

We begin our review of the structure of the SSI program with a discussion of the program's disability determination process, considering first the process as it applies to adult applicants and subsequently to applicants under age 18. Income-eligible applicants over the age of

[5] SSDI does pay benefits to children but only as dependents of disabled workers. See Autor and Duggan (2006) for more background on the SSDI program.

65 do not need to demonstrate the existence of a work-limiting disability. If they satisfy the income and asset tests, they are eligible for SSI. This discussion about disability determination therefore only applies to those under the age of 65.[6] In addition, individuals can meet the categorical requirement for SSI through blindness if they have 20/200 vision or less with the use of a correcting lens in their better eye, or if they have tunnel vision of 20 degrees or less (SSA 2014a). These objective standards stand in contrast to the more subjective criteria employed to determine eligibility under the disabled criteria, as described below.

1. Disability determination for Adults

Non-elderly adults typically apply for SSI benefits through an SSA field office. Employees there determine whether the applicant meets non-medical requirements including sufficiently low income and assets. If monthly earnings exceed SSA's definition of SGA, the applicant is deemed categorically ineligible.[7] Applications that pass this initial screen are then forwarded on to a state agency, where the disability determination process is usually carried out by a two-person team. The first person is a state disability examiner, who assembles both medical and non-medical evidence and requests a consultative exam when the medical evidence is not sufficient to make a disability determination. The examiner also prepares (or assists in preparation for more complicated cases) an assessment of the applicant's residual functional capacity. The second person on the team is a medical consultant who reviews the available medical evidence provided by the applicant and acquired through one or more additional consultative exams. The examiner prepares the final determination, which is then signed by the

[6] About 45 percent of elderly SSI recipients first qualified for the program because of blindness or a disability. More specifically, in December 2013 there were 2.11 million SSI recipients aged 65 and up but there were only 1.16 million SSI recipients in the "Aged" category.

[7] The monthly substantial gainful activity amount increased from $500 to $700 in 1999 and has been indexed to inflation since. See http://www.socialsecurity.gov/oact/cola/sga.html for more information.

medical consultant.

A non-elderly adult applying for SSI benefits must demonstrate that he or she has a medically determined physical or mental disability that limits his or her ability to engage in SGA and further demonstrate that this disability will last at least 12 months or result in death. The federal guidelines are the same across states and are identical to those used by the SSDI program. In practice, there is variation in award rates, as the determination of disability status is made by individual examiners and often inevitably involves subjective judgments. Indeed, recent research (Maestas et al, 2013; French and Song, 2014) has shown that there is considerable variation across examiners in the disability determination even after controlling for the characteristics of applicants.

The SSA's disability determination process considers whether a medical impairment is severe and is expected to last for at least 12 months or to result in death. If the impairment passes this threshold and is on SSA's list of medical impairments, then the applicant passes the disability determination. If the impairment is not on this list, then SSA considers whether the applicant can perform labor market tasks that he/she previously performed. If this is possible, then the applicant is found to be categorically ineligible. If the applicant is unable to do past work, then SSA considers whether there are other occupations in the economy that he/she could perform. In this case, the examining team considers not only the applicant's medical condition but also his/her age, education, and work experience.[8]

Applicants who are initially rejected may appeal the decision. A first round appeal involves the application being considered by a second team of examiners. Applicants denied at this stage have the option to appeal to an administrative law judge (ALJ). When appearing before an

[8] See Wixon and Strand (2013) for a more detailed explanation of this process.

ALJ, the applicant is often joined by a lawyer or some other representative. The hearings are somewhat unusual in that only one side is represented – SSA does not have anyone there explaining the reason for the initial decisions. Here too there is an element of significant variation across judges. On this point, a paper by French and Song (2014) shows systematic variation in denial rates across SSA appeals judges. Applicants denied through that second appeals stage can try again by appealing to the Social Security Appeals Council and then to their district court.

In 2009, approximately 1.662 million individuals applied for SSI and met the initial income and asset screens. From this group, approximately 31.1 percent received an SSI award at this first stage. Of the 1.145 million rejected applicants, more than half (51.3 percent) appeal the decision. Only 10.2 percent receive an award at the next stage, suggesting that employees at the state Disability Determine Services rarely overturn the decisions made by their colleagues. However, that is not the case for ALJs. Of the 413 thousand rejected applicants appealing to an ALJ, the majority (57.9 percent) receive an award from the ALJ or at a subsequent stage. The large number of appeals substantially increases the SSI award rate among non-elderly adults from 31.1 percent (considering just the first stage) to 49.6 percent.[9] Put another way, more than 1-in-3 SSI awards to non-elderly adults are made on appeal. The average time from initial application to the first decision is four months while those appealing to the ALJ level or higher typically wait more than two years for the decision (OIG 2008).

2. Disability Determination for Children

The process of determining categorical disability eligibility for children has undergone substantial change since the program's inception. Like adult applicants, in order to be eligible for

[9] Left out of this calculation are the 14,189 applications still in process in the most recent data.

the program, a child has to be determined to have a disability lasting at least 12 months or resulting in death. Initially this was done by establishing that a child applicant had a medical impairment that appeared on the SSA list of qualifying medical conditions.

Two policy changes in the early 1990s introduced a greater emphasis on a child's functioning rather than a strict focus on medical conditions alone. First, the landmark legal case of *Sullivan versus Zebley* – full case name Louis Wade Sullivan, Secretary of Health and Human Services v. Brian Zebley, et al., 493 US 591 -- resulted in the addition of a functional assessment for children. In this case, the Supreme Court ruled on the side of the plaintiff's, finding that SSA's listing-only methodology for determining SSI child claims was inconsistent with the statutory standard of "comparable severity" for adult limitations set forth in the Social Security Act. The argument was that the current program rules did not provide SSI child claimants with an individualized functional assessment similar to the functional analysis considered in many adult claims. Second, prompted by the *Zebley* decision, in December of 1990, SSA issued new regulations in accordance with the Disability Benefits Reform Act (DBRA) of 1984 that revised and expanded SSA's medical listings for childhood mental impairments. The new medical listings for mental impairments provided more detailed and specific guidance on how to evaluate mental disorders in children as compared to the former regulations, which were put into place in 1977 (GAO, 1995.)

Over the early 1990s, use of the individual functional assessment (IFA), as well as the new DBRA criteria emphasizing functioning in determining mental disabilities, led to a large expansion in the number of children determined to be categorically eligible for SSI, many of whom had less severe disabilities than previous generations of SSI child recipients. In the three years prior to this change, the number of children receiving SSI benefits was growing by about 3 percent per year, from 241 thousand in 1986 to 264 thousand by 1989. In the seven years following these changes, the number of children on SSI increased from 265,000 in 1989 to

955,000 in 1996, an increase of 260 percent. In terms of the percent of children age 0 to 17 receiving SSI benefits, this increase reflects an increase from 0.4 percent to 1.4 (Duggan and Kearney, 2007).

In response to this caseload expansion, Congress revised the SSI eligibility rules for children as part of the 1996 welfare reform legislation. The revised provisions eliminated the IFA, but preserved the spirit of the functional limitation idea: to be determined categorically eligible, a child must demonstrate "a medically determined physical or mental impairment which results in marked and severe functional limitations, which can be expected to lead to death or which has been or can be expected to last for a continuous period of not less than 12 months" (SSA 2014c). This change resulted in nearly 100,000 children being terminated from the program in 1997, and the share of children receiving SSI remained at 1.2 percent from 1997 through 2000.

The new provisions further required children reaching age 18 to be re-evaluated to determine whether a child SSI recipient would continue to receive benefits as an adult. As a result, the current determination process for children is less restrictive than it was during the "listing-only" paradigm in effect before the *Zebley* decision, but more restrictive than it was during the early 1990s (Berkowitz and Dewitt 2013; Wittenburg 2011; and Wiseman 2010). Despite this, SSI enrollment has grown steadily since 2000, with 1.8 percent of children receiving SSI benefits in 2013. [10]

In practice, the change in child disability determination since the early 1990s has led to a situation where a child's disability status is frequently determined by a subjective determination about his performance in school, relative to peers his age. This has led to concerns

[10] During this same 2000 to 2013 period, the fraction of children in families with incomes below the poverty line also increased, from 16.2 percent to 19.9 percent. While this may have contributed to the increase in child SSI enrollment, recent research suggests that changes in poverty do not have a significant effect on SSI enrollment (Aizer, Gordon, and Kearney, 2014).

about how the program's eligibility criteria may increase the chance that a child is labeled with a learning disability, placed on medication in an effort to be deemed disabled, or receives (or not) inappropriate treatment therapies (Wen 2010; Wittenberg 2011). On the point of medication, a report by GAO found little evidence to suggest that medication use increased the chance that a child would be awarded SSI benefits (GAO, 2012). These are issues to which we return later in the chapter.

3. Continuing Disability Reviews

Continuing disability reviews (CDRs) have been required by law since the beginning of SSI. In practice, the frequency and stringency of CDRs have not been consistent over time, in many cases due to administrative backlogs and budget constraints (GAO 2006, 2014). The frequency with which SSA is expected to conduct CDRs on a disability beneficiary is set at the time the individual begins receiving benefits. The frequency is categorized into one of three groups, according to the likelihood that the individual's condition will improve: "improvement expected" (CDR every 6-18 months); "improvement possible" (CDR every 3 years); and "improvement not expected" (CDR every 5-7 years) (GAO 2006). For children, CDRs are required to be conducted every three years, except for benefits awarded for low birth weight, where CDRs should be conducted every 12 months (GAO 2012). Reviewers are required to conduct CDRs beginning with a neutral opinion about the beneficiary's disability status, rather than presuming the beneficiary still has a disability.

CDRs are conducted at two levels in order to maintain cost-effectiveness and efficiency: a mailer survey to all beneficiaries asking about their condition, and a full examination for select beneficiaries. SSA uses a statistical "profiling" method based on age, condition, and previous CDR results in order to predict how thoroughly to conduct the CDR. If a beneficiary is unlikely to improve, they are more likely to receive just the mailer. If the information about the

respondent's medical condition on the mailer suggests improvement, then SSA will conduct a full medical examination. If not, the mailer completes the CDR requirement. Certain cases skip the mailing process and are subject to a full medical examination from the beginning (GAO 2006). As of 2014, the mailer process was not used for children (GAO 2014). When SSA determines that an individual's benefits should be terminated, the beneficiary has a three-month grace period during which she can appeal the decision.

In addition to budgetary challenges that have prevented all CDRs from being completed on time, it is often difficult for state DDS offices to determine medical improvement, particularly in cases where the original disability determination was decided on appeal, indicating a less conclusive disability. Despite attempts to clarify the definition of a medical improvement in 1984, the standards of improvement for disability is often unclear (GAO 2006). This is particularly true when an individual's improvement is contingent on Medicaid benefits received as a result of participation in SSI. Despite these challenges, however, an SSA quality assessment of CDRs in 2005 found a 95% accuracy rate in CDR decisions.

When faced with budget constraints that limit the number of CDRs that SSA can conduct in a given time frame, SSA prioritizes CDRs in the following manner: (1) maintaining CDR currency; (2) age 18 redeterminations; and (3) cost-effectiveness. The priority on cost effectiveness often means that SSA prioritizes SSDI CDRs over SSI CDRs, since SSDI beneficiaries on average receive larger benefits than SSI beneficiaries. While potentially more cost effective in the short run, SSA has acknowledged that focusing on CDRs for children and younger beneficiaries may yield higher savings in the long run (GAO 14-492T 2014). As of August 2011, approximately 435,000 children on SSI were overdue for CDRs, more than one-third of the total child caseload (GAO 12-497 2012). In September 2011, SSA's inspector general estimated that "$1.4 billion in SSI benefits (had been paid) to approximately 513,000 recipients

under age 18 who should have not received them" (GAO 14-492T 2014).

Additionally, since 1996, child SSA cases have been required to be re-evaluated at the child's 18th birthday according to adult eligibility rules. Following the *Zebley* decision, child cases have been determined based on the child's ability to function at a comparable level to non-disabled children, while adult cases have always been determined based on an individual's ability to work, or participate in SGA (Hemmeter 2012). In many cases the transition from child to adult benefits leads to many terminations, and continuing beneficiaries are often re-assigned to a different diagnosis category. In 1997, just following the introduction of age 18 redetermination, 54 percent of 18–year olds lost their benefits. This number fell to 46 percent by 2006 (Hemmeter and Gilby 2009). Additionally, 30 percent of 18-year olds who kept their benefits were assigned to a new diagnosis group (Hemmeter 2012).

While children whose benefits are terminated may be able to work, recent research finds that their income earned from work does not fully replace the income from benefits they would have earned. Deshpande (2014b) finds that young adults whose benefits were terminated earned only one- third of what they would have received in benefits, and suggests that these former beneficiaries experience significant volatility in their earnings over time.

B. Means Testing and Benefit Levels

To qualify for the SSI program, individuals must have sufficiently low income and assets. In the case of children, a portion of parental and sibling income affects both SSI eligibility and the potential benefit if a person is eligible. For married adult applicants and beneficiaries, spousal income is considered in eligibility and award determination. Other family members' income and assets are counted toward an applicant's income and assets through a process called *deeming*. As deemed income and assets increase, a person's potential SSI benefits decline,

and we discuss the specifics of this below. This raises the standard incentive concern – that an SSI recipient and his/her family members may have a lower incentive to work and save due to program rules (Hubbard, Skinner, and Zeldes, 1995).

In 2015, the federal benefit rate (FBR) – which is the maximum monthly benefit level – was $733 for individuals and $1100 for couples. While the federal benefit rate is the same for recipients of all ages, the average actual monthly benefit amount varies substantially across age groups. In December 2014, the average benefit was $633 for child beneficiaries, $550 for non-elderly adult beneficiaries, and $426 for elderly beneficiaries. An SSI recipient's monthly benefit falls below the FBR if the recipient or a family member has earned or unearned income. The FBR is adjusted for a cost of living adjustment (COLA) using the consumer price index (CPI-W) each year. However, the value of the earned and unearned income exclusions for the SSI recipient – which define the threshold at which benefits begin to phase out - have not changed since the program began (Burkhauser and Daly, 2003) and the asset limits were last updated in 1989.

1. Adults age 18-64

The means-testing eligibility for SSI is based on income – both earned and unearned – as well as assets. In order to be eligible for SSI, a non-elderly adult must not have assets exceeding $2,000 if filing as an individual, or $3,000 if filing as a couple. The value of the individual's home and the value of one vehicle, as well as several small assets including grants and scholarships for educational purposes, personal effects (e.g. wedding rings), and life insurance policies, are excluded from the calculation of assets.

In terms of income, an eligible adult's benefit amount is equal to the difference between the maximum Federal Benefit Rate (FBR) and "countable income". In general, if an applicant is

determined to have countable income greater than or equal to the maximum benefit of $733 a month, then the applicant is not eligible for an SSI award. Similarly, if an SSI recipient's countable income rises above $733 in a month, his/her SSI benefit for that month falls to zero and his/her benefits may be terminated if this persists.

Countable income for a single adult SSI recipient is approximately equal to the sum of unearned income and one-half of earned income. There is a general (either earned or unearned) income exclusion of $20 per month and an earned income exclusion of $65 per month. Thus an adult SSI recipient with $300 per month in unearned income but no earned income would have countable income of $280. An adult SSI recipient with $300 per month in earned income but no unearned income would have countable income of $107.50. In other words, unearned income phases out the SSI benefit one-for-one while there is a (lower) 50 percent marginal tax rate on earned income. In principle, the adult SSI recipient's income would need to exceed $1500 per month to fully phase out the SSI benefit. Under the Section 1619 waivers enacted in 1987, beneficiaries may be eligible to receive cash payments until the SSI benefit is fully phased out, even after earnings exceed the SGA. In practice, this is relatively rare: Ben-Shalom and Stapleton 2015 finds that 10.4 percent of the 2001 SSI award cohort were allowed to earn above SGA for at least one month over a six year period from 2001 to 2007. Over the same time frame, 8.4 percent had earnings exceeding the phase-out threshold in at least one month, but maintained eligibility for Medicaid due to a Section 1619(b) waiver.[11]

The share of SSI recipients with earned income is quite small: in 2013, less than 5 percent of the non-elderly adult beneficiary population reported having earned income (SSA, 2014b). This makes clear that earned income is not generally the reason for benefit amounts falling

[11] See https://secure.ssa.gov/poms.nsf/lnx/0502302010 for more details on section 1619 waivers. In practice, these waivers have a similar purpose as the Trial Work Period for SSDI, allowing beneficiaries to test their work ability while maintaining eligibility for benefits and Medicaid temporarily.

below the FBR. Main sources of unearned income include transfer payments from Social Security, Unemployment Insurance or a household TANF award, as well as income brought into the household from other family members. Income from tax refunds and grants or scholarships are not counted towards qualifying unearned income; nor are non-cash benefits such as food assistance through the SNAP program.[12] In addition to the standard exclusions for earned and unearned income there is also a student income exclusion, which allows full time students to exclude a substantial amount of earned income from being counted towards SSI. In 2015, students aged 18-22 could exclude up to $1,780 per month from their own earned income.

When an adult SSI recipient is married, the spouse's income may "deemed" to the SSI recipient. Thus even if the SSI recipient has no income, if his/her spouse has substantial income, then this can substantially lower the SSI benefit. There is a 50 percent tax rate on the earnings of the spouse in the phase-out range and spousal earnings can be substantial before the SSI recipient's benefits begin to phase out. More specifically, if the applicant has no income, the spouse of an SSI recipient could earn $819 per month in 2015[13] before the SSI benefit begins to decline, and the spouse's earnings would have to exceed $2,285 per month before the SSI benefit would be fully phased out. Given a federal poverty level of $15,930 for a two-person family, this suggests that the family's income could reach almost 175 percent of the FPL before SSI benefits would be fully phased out.

If there are one or more ineligible children in the household, then earnings of the spouse can be even higher before SSI benefits are taxed. In 2015, the spouse of an SSI recipient can earn $1,186 per month, rather than $819 per month, before the phaseout of benefits begins if

[12] For more information, see http://www.ssa.gov/ssi/text-income-ussi.htm.

[13] The spouse receives the same $85 income exclusion ($65 earned and $20 either earned or unearned) that the SSI recipient would. Additionally, SSI benefits are calculated as the lower of the amount that the person on SSI would receive if the spouse's income was ignored and the amount that the couple would both receive if both were on SSI and it was included.

there is one child present in the household. Figures A1-A4 provide several examples of the thresholds at which SSI benefits start to phase out in several different income and family situations.

2. Children less than age 18

Child applicants are, by definition, under age 18, and not married or a head of household. If these conditions are not met, the applicant is evaluated as an adult. As with adults, the means testing involved in child eligibility determination is based on both assets and income. Child eligibility is based on the same asset limit as individual adult eligibility ($2,000), and includes both assets in the child's name and parental assets deemed to the child for the sake of eligibility determination. Applicants may subtract the amount of the adult income asset limit -- $2,000 for a single parent, $3,000 for a married couple -- from total parental assets, the remaining balance of parental assets is deemed to the child. This means that children in households where a single parent has more than $4,000 or a married couple has more than $5,000 in assets – net of excludable assets including a house, one vehicle, or educational grants, among others -- are ineligible for SSI.[14]

Countable income for child applicants is based in part on parental income deemed to the child. This specified deeming process is somewhat different from the deeming of spousal income discussed above for adult recipients. If a child applicant's parent(s) would be eligible for SSI based on their own income, then none of the parental income is deemed to the child. But if parental income exceeds the threshold for adult SSI eligibility, any income that is not used to "exhaust" the parent's hypothetical eligibility for SSI is deemed to the child as unearned

[14] Source: http://www.socialsecurity.gov/ssi/text-resources-ussi.htm, last accessed November 11, 2014

income.[15] The unearned and earned income exclusions are applied to parental income, as well as any deductions for other children in the household who are not receiving SSI or TANF benefits. If there is more than one SSI-eligible child in the household, the remaining income to be deemed is divided equally among all eligible children in the household.

The deemed income from parents is added to any additional earned or unearned income the child may have. Any public income maintenance payments made to other members of the household are not included in countable income.[16] Then, the standard earned and unearned exclusions are applied, and the remaining countable income amount is compared to the FBR. An eligible child's SSI benefit amount is determined as the amount by which the FBR exceeds countable income.[17]

As was true for adult SSI recipients, there is an effective 50 percent marginal tax rate on SSI benefits in the phase-out range. However, parental earnings can be substantial before a child's SSI benefits begin to phase out. Consider a family with one parent and one child on SSI. In 2015, he parent's earnings must exceed $1,591 per month before the child's SSI benefits begin to phase out. If there are two parents with one child on SSI, parental earnings must exceed $2,322 per month before the phase-out begins. This represents a very high level of earnings before benefit phase-out begins relative to SSI adults or other means-tested transfer programs such as TANF or food stamps.

According to data from SSA, more than two-thirds of children on SSI were living with only one parent in December 2013. An additional 12 percent reside with no parents, with most of these children likely living with other relatives or in foster care. Of the 1.163 million children on SSI

[15] The deeming rules changed in 1992 in such a way that led to a more generous treatment of parental income for deeming purposes. See Hannsgen and Sandell 1996, SSA bulletin.
[16] Source: cite: https://secure.ssa.gov/poms.nsf/lnx/0501320100, last accessed November 11, 2014.
[17] Source: https://secure.ssa.gov/poms.nsf/lnx/0500820510, last accessed November 11, 2014

residing with one or both parents, parental earnings was non-zero for 479 thousand (41 percent) and average parental earnings for this group was $1,789 per month. However, given the relatively generous income exclusions described above, these earnings resulted in deemed income for just 160,000 children. SSI benefits were actually reduced more frequently because of the child's own (usually unearned) income from absent parents, Social Security, or some other source.

C. Citizenship and Residency Requirements

Since passage of the Personal Responsibility and Work Opportunity Reconciliation Act in August 1996, resident aliens are only eligible for SSI if they were living in the U.S. prior to August 1996 and (1) receiving SSI prior to August 1996; (2) are blind and disabled, or (3) are on active duty or a veteran of the armed forces. If they arrived after August 22, 1996, refugees, asylees and certain other small categories of immigrants are eligible for benefits during their first seven years in the U.S. with refugee/asylee status.[18] Lawfully admitted permanent residents (LAPRs) with substantial work history (40 quarters of work) may be eligible to apply for SSI after five years. If the applicant is an LAPR and does not have sufficient work history, but their spouse does, this work history could count for determining eligibility.[19] Similarly, a LAPR child is eligible if her parents have sufficient work history.

As a result of these restrictions, noncitizen beneficiaries declined by nearly half, from 12.1 percent of the SSI population in 1995 to 6.7 percent in 2013. Throughout this period, noncitizen beneficiaries have been disproportionately elderly. Noncitizen beneficiaries accounted for nearly 31.8 percent of all aged beneficiaries in 1995, declining to 22.6 percent in 2013. The corresponding fractions for blind and disabled SSI recipients were 6.3 percent and 4.2

[18] Source: https://secure.ssa.gov/apps10/poms.nsf/lnx/0500502100, last accessed November 11, 2014.
[19] Source: https://secure.ssa.gov/apps10/poms.nsf/lnx/0500502135.

percent, respectively (SSA 2014b).

D. State Supplementation of SSI Benefits

In 2011 – the most recent year for which state supplement data is available for all states -- all but six states (Arizona, Arkansas, Mississippi, North Dakota, Tennessee, and West Virginia) supplemented the federal SSI benefit for at least some of their SSI recipients.[20] Of the remaining 45 states, most administer the optional SSI supplements themselves, though the federal government administers the supplement for almost one-third of the states. As shown in Table 1, states vary substantially with respect to the fraction of SSI recipients with a state supplement. For example, in Texas and New Mexico, just 0.3 percent and 0.1 percent of beneficiaries, respectively, received a state supplement in January 2011. In contrast, in a handful of states, including California, Massachusetts, New Jersey, and New York, among others, more than 95 percent of SSI recipients receive a state supplement. In some states – for example, Alaska -- there are actually more recipients of state supplements than federal benefits, because the federal benefit was fully phased out but the person still had sufficiently low income to receive the state supplement. In January 2011, there were 3.4 million individuals receiving state SSI supplements. Given that there were 7.66 million total SSI recipients, this suggests that about 4-in-9 of those on SSI have a state supplement.

[20] Four of these six states do supplement the benefit for the small number of SSI recipients enrolled since 1973. Several states – such as Michigan and Pennsylvania - are a mix in that the state administers the supplement for some recipients and the federal government for others

Table 1: Percentage of state SSI caseload receiving a state supplement

State	Share	State	Share
Alaska	138.6%	North Carolina	10.5%
Alabama	0.1%	North Dakota	0.0%
Arkansas	0.0%	Nebraska	20.5%
Arizona	0.0%	New Hampshire	54.8%
California	97.9%	New Jersey	96.0%
Colorado	42.0%	New Mexico	0.1%
Connecticut	17.3%	Nevada	24.3%
District of Columbia	5.5%	New York	95.7%
Delaware	4.0%	Ohio	0.5%
Florida	2.6%	Oklahoma	93.0%
Georgia	1.2%	Oregon	2.4%
Hawaii	10.8%	Pennsylvania	84.5%
Iowa	10.8%	Rhode Island	96.5%
Idaho	50.5%	South Carolina	3.4%
Illinois	9.7%	South Dakota	27.3%
Indiana	2.8%	Tennessee	0.0%
Kansas	15.8%	Texas	0.3%
Kentucky	2.1%	Utah	8.2%
Louisiana	2.5%	Virginia	3.4%
Massachusetts	98.2%	Vermont	96.8%
Maryland	3.1%	Washington	23.3%
Maine	101.7%	Wisconsin	101.3%
Michigan	88.8%	West Virginia	0.0%
Minnesota	47.7%	Wyoming	48.6%

Notes: Data from SSA 2011.

States also vary with respect to the generosity of the supplement. California's average supplement of $167 per month is about twice as high as New York's ($77 per month) and Massachusetts' ($79 per month) and more than three times the average in New Jersey ($46), Vermont ($54), or Rhode Island ($45).[21] The other six states with a federally administered SSI supplement provide it to less than one-in-four of their SSI recipients. In 2011, federally administered state supplements accounted for 6 percent of total federally administered SSI expenditures. Because 70 percent of SSI recipients with a supplement receive it from SSA,

[21] The average benefit amount is not readily available for the 33 states that administer the state supplement directly.

we estimate that total SSI supplements are 8 to 9 percent of total SSI expenditures.

E. Interactions with Other Government Programs

The vast majority of SSI recipients obtain health insurance through the Medicaid program. While most states automatically grant Medicaid coverage to all of their SSI recipients, enrollment is not 100 percent for two reasons. First, some eligible enrollees do not complete the necessary paperwork to enroll in the program. Second, twelve states have different and potentially more restrictive Medicaid eligibility requirements so that some SSI recipients are ineligible for Medicaid. Despite this, a recent study that used administrative data from SSA and the Centers for Medicare and Medicaid Services showed that more than 85 percent of SSI recipients are also enrolled for health insurance through Medicaid (Riley and Rupp, 2012).

Approximately one-in-three SSI recipients received Social Security (OASDI) benefits in 2013. As discussed above, Social Security benefits phase out SSI benefits one-for-one. Thus an SSI recipient with a $300 monthly Social Security benefit but no other income would receive an SSI benefit that is $280 lower (recall the $20 income exclusion) than the maximum SSI benefit. More than half (56 percent) of elderly SSI recipients receive Social Security benefits and the average monthly Social Security benefit among those who do receive it is $493 per month. Thirty percent of non-elderly adult SSI recipients also receive Social Security benefits, and virtually all of these benefits are paid through the SSDI program. The average monthly SSDI benefit among those SSI recipients with income from both programs was $534 monthly in December 2013. Only 7.5 percent of SSI- enrolled children also received Social Security benefits in that same month, with most obtaining this as a dependent of a retired, disabled, or deceased worker.

SSI and Medicaid also play an important role for many SSDI awardees who must wait for five months from the onset of their disability before their SSDI benefits "kick in" and 29 months

before their Medicare benefits take effect (Riley and Rupp, 2012). Some individuals awarded SSDI will receive retroactive SSI benefits for the first five months after the onset of disability and then SSDI benefits take effect in month 6 and lower (often to zero) the SSI benefit. As a result, the number of individuals exiting the SSI rolls each year is artificially high, because many are on just temporarily until SSDI payments begin.

Participation in the Supplemental Nutrition Assistance Program (SNAP) is especially high among SSI recipients. According to recent data from the Survey of Income and Program Participation, approximately 3-in-5 households with some SSI income also receive SNAP benefits. In contrast, only 8 percent of SSI households have any income from TANF and just 4 percent have any unemployment insurance benefits. As SSI benefits increase, a household's SNAP benefits will typically decline. Adult SSI recipients living alone are categorically eligible for SNAP benefits, though things become more complicated when there are additional household members.

Much previous research has examined the relationship between SSI and AFDC/TANF (Garrett and Glied, 2000). While some households have income from both programs, an individual cannot receive benefits from both. Thus if one of two children in a one-parent family is on SSI, the relevant family size for AFDC/TANF benefit computation would be just two. TANF is administered by states and benefit levels vary dramatically across states, with for example the maximum benefit in California more than five times greater than in Mississippi. Previous research has shown that SSI enrollment is much higher in states with low AFDC/TANF benefits, no doubt partly because these states tend to have a higher fraction of people in or near poverty. The growth in SSI enrollment during the 1990s cushioned the effects of the dramatic decline in AFDC/TANF enrollment during the same period. Data from the SIPP indicate that children are now twice as likely to reside in a household with some SSI income as in a household with some TANF income (6.9 percent versus 3.4 percent).

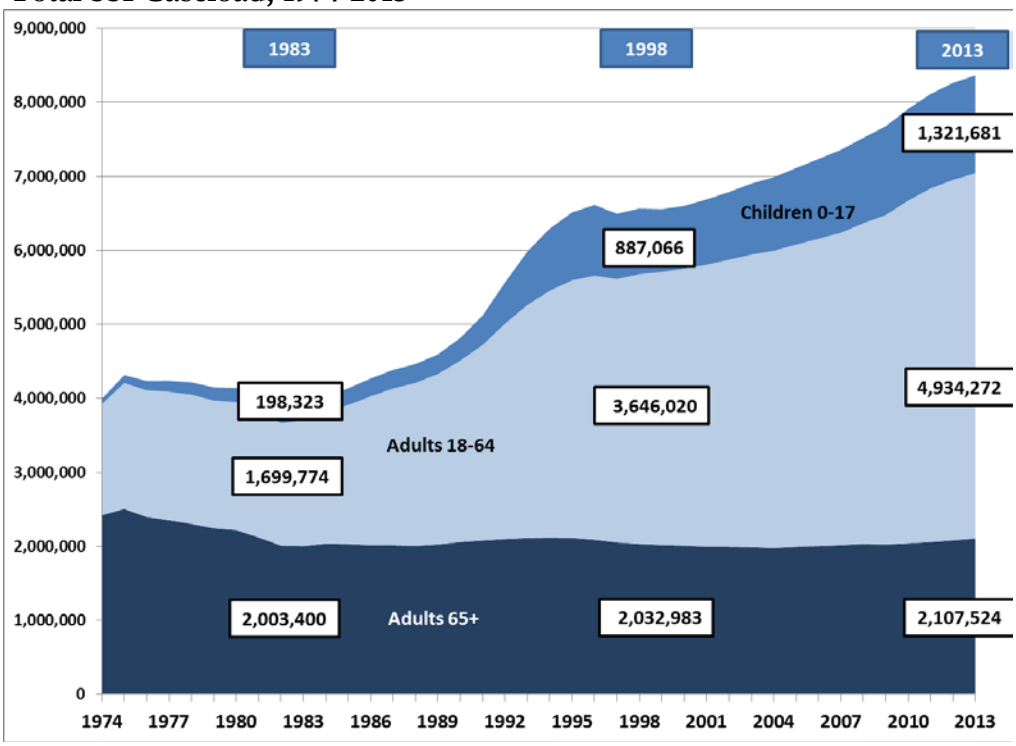
III. Program Caseloads

There have been substantial changes in SSI caseload growth and the composition of the SSI caseload since the program began in 1974. While SSI initially primarily paid benefits to the elderly, their share of the caseload has declined throughout the life of the program. Non-elderly adults' share of the SSI caseload started to increase rapidly in the mid-1980s following a liberalization of the program's medical eligibility criteria that we discuss in more detail below. The number of children on SSI also increased rapidly during the early 1990s as a result of similar expansions in the medical eligibility criteria, and while welfare reform temporarily reduced the rate of child participation in SSI, the growth in child participation has increased again over the past decade. In addition to changes in numbers of participants, there is significant variation in participation across states and disabilities in each of these three age groups.

A. Caseload trends

Figure 1 shows the trends in total caseload over time for each of the three age groups during the last forty years. The total caseload actually declined somewhat during the first ten years of the program, though it has more than doubled since 1983, increasing from 3.9 million in that year to nearly 8.4 million in 2013. However, the elderly caseload has remained fairly stable at about 2 million beneficiaries, declining from approximately 60 percent of the total caseload in 1974 to less than one quarter of the total caseload in 2013. Over the same time frame, non-elderly adults increased from less than 40 percent of the total caseload to nearly 60 percent of the caseload, and children on SSI increased from less than 2 percent of the total caseload to over 15 percent of the total caseload.

Figure 1: Total SSI Caseload, 1974-2013

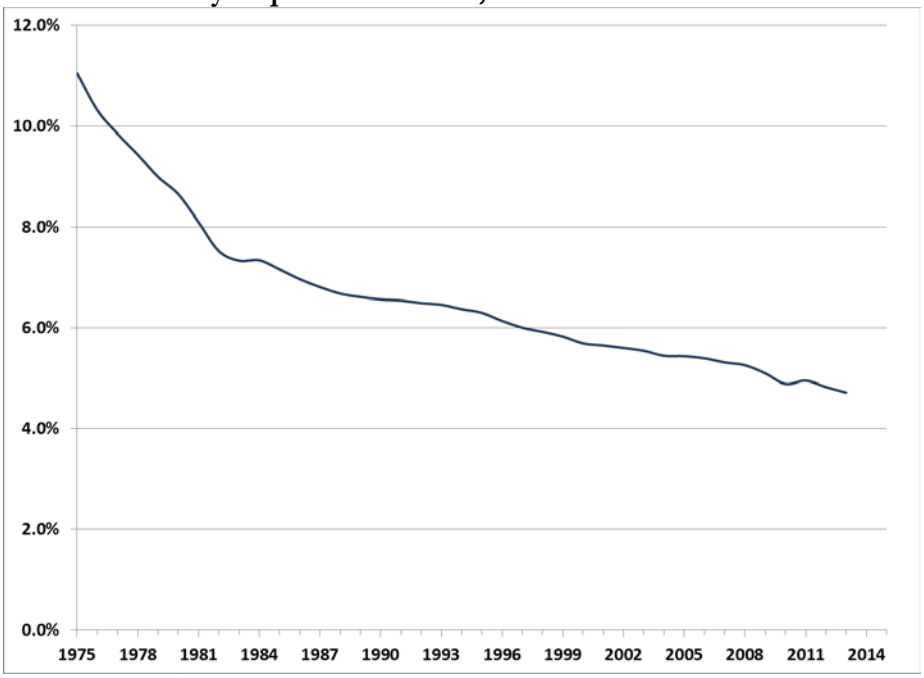


Notes: Data from SSA 2014b.

These changes in the percentage of the SSI caseload are mirrored by similar trends in SSI participants as a percentage of the total population in their age group. Figures 2a shows the steady decline in the elderly SSI population as a percentage of the total population aged 65 and up and Figure 2b shows the substantial increase in SSI enrollment among non-elderly adults and children. The increase for non- elderly adults started in the mid-late 1980s and for children in the early 1990s. Additionally, Figure 2b demonstrates that while participation has increased for non-elderly adults of all ages, younger adults ages 18-49 have experienced a larger relative increase in participation. Enrollment growth for all non-elderly groups slowed in the mid-1990s, though has picked up - and especially for children – since 2000. By 2013, SSI enrollment among children, adults 18-49, adults 50-67, and the elderly stood at 1.8 percent, 2.0 percent, 3.6 percent, and 4.7

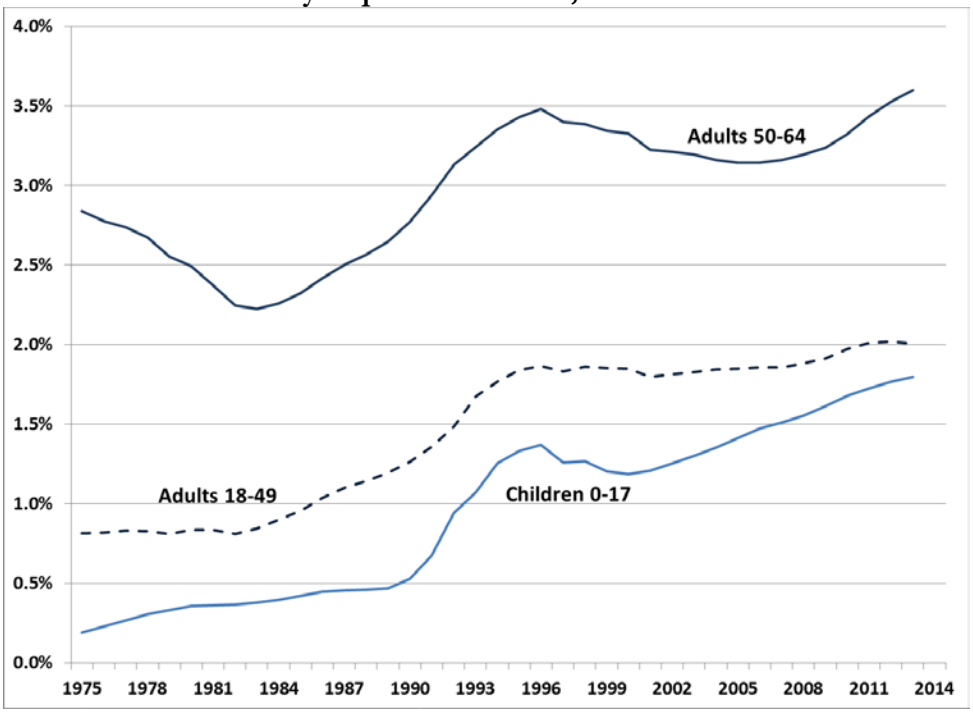
percent, respectively.[22] The fraction of individuals living in a household with one or more SSI recipients is of course substantially higher. For example, according to data from the Survey of Income and Program Participation, more than 6.5 percent of children are either on SSI or have a family member on the program.

Figure 2a: Percent of Elderly Population on SSI, 1975-2013



[22] Part of the increase in SSI enrollment among non-elderly adults during this period reflects the aging of the baby boom generation. However, there were substantial increases in enrollment even within age groups. For example, the share of adults aged 30 to 49 on SSI increased from 1.0 to 2.0 percent during the 1985 to 2013 period and the increases were similar for the 18 to 29 (0.8 to 2.0 percent) and 50 to 64 (2.3 to 3.6 percent) age groups.

Figure 2b: Percent of Non-elderly Population on SSI, 1975-2013



Notes: Data from SSA 2014b and U.S Census Bureau 2014.

Because the child caseload has increased so significantly, in particular since 2000, we devote special attention to examining trends in the child caseload. While increases in the caseload during the early-mid 1990s were driven by loosening medical eligibility criteria in the wake of the *Zebley* decision, the more recent caseload growth occurred after the eligibility criteria for children were tightened during welfare reform. Furthermore, there have been no significant changes in eligibility criteria for children since then. Figures 1 and 2b show that even during a period of constant SSI eligibility criteria for children, the child caseload increased 43 percent between 2002 and 2012, growing from 915 thousand to more than 1.3 million beneficiaries. Separating the caseload into physical disabilities, intellectual disabilities and other mental disabilities (e.g., autism, ADHD), reveals that the caseload growth has been driven predominantly by the mental disability caseload. The caseload for mental disability diagnoses increased from 340 thousand in 2002 to more than 700 thousand in 2012. Over the same period, the physical disability caseload increased by only 24 percent (from 337 thousand to 416 thousand). The

number of SSI-enrolled children with intellectual disability as the primary diagnosis declined by 47 percent, falling from 240 thousand in 2002 to 127 thousand in 2012. While the number of children receiving SSI for intellectual disabilities declined over the decade, this decline was not enough to offset the increases in the mental caseload (Aizer, Gordon, Kearney, 2013). This change likely partially reflects a change by SSA in the definition of intellectual disability relative to other conditions.

While growth in the caseload has been driven by non-elderly participants, SSI still supports a substantially larger share of elderly adults in the total population. For example, less than one percent of children under age 5 are on SSI, and approximately two percent of children 5 to 17 and adults between 18 and 49 are on SSI. However, the share of adults over 50 on SSI increases significantly, with approximately 3.6 percent of adults ages 50-64 participating on SSI, and more than 4 percent of adults over 65 on SSI. The share of enrollees who are males also varies substantially by age. Among children, boys are about two times more likely than girls to be enrolled in SSI. However, enrollment rates are approximately equal among adults in their thirties, forties, and fifties. And there are about twice as many elderly women as elderly men on SSI, though this partially reflects the longer life expectancy of women.

Table 2 examines award rates by age in 2013 and reveals a more nuanced picture. Among children, award rates are highest among those under the age of 5, with nearly 50 percent of applications for children under 5 being accepted, compared to 30 percent of applications for children 13-17. Award rates are relatively low among adults in their twenties and thirties approximately 20 percent of applications being accepted. However, award rates increase substantially for applicants in their forties and fifties, with the award rate in the 50-59 age range nearly twice that in the 22-29 age range. This sharp increase could partially reflect the role of education and vocational factors in the disability determination process, which makes it somewhat

easier to qualify when an applicant reaches age 50 (Chen and van der Klaauw, 2008).

Table 2: Percent of applications awarded benefits by age category, 2013

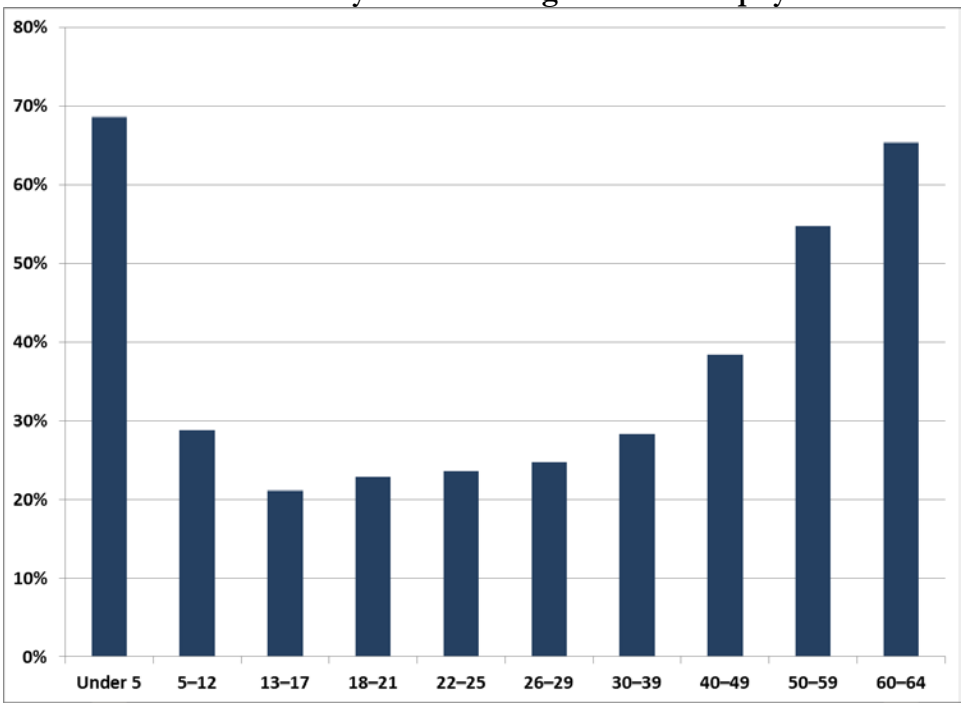
	Total Applications	Award rate
Under 5	157,736	49.8%
5-12	219,915	32.5%
13-17	80,965	30.8%
18-21	134,823	35.9%
22-25	109,576	23.7%
26-29	110,090	22.9%
30-39	314,498	23.8%
40-49	451,106	27.9%
50-59	598,354	43.3%
60-64	160,883	39.6%

Notes: Data from SSA 2014d.

B. Trends in qualifying diagnoses

The composition of disabilities shows substantial variation across age groups. Figure 3 shows that more than half of beneficiaries in the youngest and oldest age groups are eligible primarily on the basis of a physical disability – 70 percent of children under age 5 and 65 percent of adults age 60-64. In contrast, less than 30 percent of recipients in the age bins ranging from 5-12 to 30-39 had a physical disability as their primary diagnosis.

Figure 3: Percent of 2013 SSI disability caseload diagnosed with a physical disability



Notes: Data from SSA 2014d..

Mental and intellectual disabilities accounted for 57 percent of the total working age adult caseload in 2013.[23] As shown in Table 3, intellectual disabilities constitute the largest category of non-physical disabilities for adults in 2013, representing approximately 19 percent of the total non-elderly adult caseload. Mood disorders and schizophrenic disorders comprise the majority of the remaining mental disability caseload, accounting for 16 and 9 percent of the total caseload, respectively. The main categories of physical disabilities for adults include musculoskeletal conditions, which constitute 13 percent of the total caseload and over 20 percent of the total caseload for adults over 50. Nervous system/sensory disorders account for approximately 8 percent of the total caseload and have higher concentrations among younger adults, accounting for over 10 percent of the total caseload for adults ages 18-29.

[23] By comparison, new awards for mental and intellectual disabilities accounted for only 30 percent of adult awards (SSA 2014d), suggesting that the average duration of SSI enrollment is higher for beneficiaries with these conditions.

Table 3: Distribution of Disability Diagnoses by Age, 2013

Primary Diagnosis	% Age 0-17	% Age 18-64
Congenital anomalies	5.5%	0.8%
Endocrine, nutritional, and metabolic diseases	0.7%	2.6%
Infectious and parasitic diseases	0.1%	1.3%
Injuries	0.5%	2.6%
Mental disorders (subtotal)	*68.3%*	*57.4%*
Autistic disorders	10.2%	1.8%
Developmental disorders	21.2%	0.7%
Childhood and adolescent disorders not elsewhere classified	19.5%	1.0%
Intellectual disability	9.1%	18.9%
Mood disorders	3.2%	16.4%
Organic mental disorders	2.2%	3.9%
Schizophrenic and other psychotic disorders	0.3%	8.9%
Other mental disorders	2.6%	5.7%
Neoplasms	1.2%	1.3%
Diseases of the—		
Blood and blood- forming organs	1.1%	0.4%
Circulatory system	0.5%	4.3%
Digestive system	1.3%	1.0%
Genitourinary system	0.3%	1.0%
Musculoskeletal system and connective tissue	0.8%	13.2%
Nervous system and sense organs	7.8%	7.7%
Respiratory system	2.8%	2.1%
Skin and subctaneous tissue	0.2%	0.2%
Other	7.2%	0.3%
Unknown	1.9%	3.6%

Notes: Table 35, SSA 2014b.

For children, non-physical disabilities comprise approximately 68 percent of the 2013 caseload, with developmental, autistic, and other adolescent disorders accounting for 21, 10 and 19 percent of the total caseload, respectively. Another 9 percent of children have an intellectual disability as their primary condition. The largest categories of physical disabilities are congenital anomalies and nervous system/sensory disorders, representing approximately 5.5 and 8 percent, respectively, of the total caseload (SSA 2014b).

In addition to variation by age, diagnoses and caseload also vary substantially by gender and race. In 2013, men accounted for 47 percent of the working age adult caseload. Adult men and women were equally likely to receive SSI on the basis of a mental or intellectual

disability, with 59 and 56 percent of male and female recipients respectively receiving SSI for mental or intellectual disabilities. By contrast approximately two-thirds of the child caseload in 2013 was male, and 73 percent of boys received SSI for a mental or intellectual disability, relative to 58 percent of girls. Based on estimates from the Survey on Income and Program Participation (SIPP), 54 percent of child SSI beneficiaries were minorities in 2013, as compared to approximately 25 percent of non-beneficiaries. Slightly less than 40 percent of adult and elderly SSI beneficiaries were minorities in 2013, compared to approximately 20 and 13 percent of non-elderly adult and elderly non-beneficiaries, respectively.[24]

In terms of raw counts, boys are disproportionately likely to have a mental disorder as their primary condition. However, the rate of growth in the mental disability caseload was similar for girls and boys over the past decade. The caseload for boys increased by 110 percent, from 6.7 cases per 1000 in 2002 to 14.1 cases per 1000 in 2011. The caseload for girls increased by 116 percent, from 2.5 cases per 1000 in 2002 to 5.4 cases per 1000 in 2011. Perhaps as a result of the similar rates of growth across gender, the composition of the mental caseload for children has remained relatively constant across the age and gender distribution over the past decade. In both 2002 and 2011, approximately two-thirds of the child SSI mental disability caseload was comprised of boys ages 6-17. Girls 6-17 made up another quarter of the caseload, with the remainder of the mental caseload composed of the youngest girls and boys (Aizer, Gordon, and Kearney 2013).

Despite the growth in the child SSI caseload over the past decade, new SSI allowances for children with mental disabilities have remained relatively constant. While applications to child SSI increased between 2002 and 2011, there were approximately 104,000 initial allowances for mental disabilities among children in 2002 and approximately 106,000 in 2007 (Aizer,

[24] Author's calculations are from the 2008 Survey on Income and Program Participation, wave 15 (2013 data).

Gordon, Kearney 2013). While the number of allowances increased to nearly 132,000 in 2011, applications also increased by nearly 100,000 over the decade. As a result, the allowance rate for mental disabilities declined from 48 percent in 2002 to 41 percent in 2011 (GAO 2012). These trends suggest that caseload growth is likely driven by fewer children exiting the program, rather than more children entering SSI.

Another important determinant of the size and growth of the SSI caseload is the rate of exit from SSI. In 2013, the median duration of SSI participation among non-elderly adults was approximately 9 years (SSA 2014d). In 2013, the exit rate for non- elderly adults was approximately 10 percent. Among the 10 percent who left SSI, 60 percent left because of excess income or assets[25], 22 percent left due to death, and approximately 7 percent left due to no longer meeting the disability criteria. Among children, the exit rate was only 5 percent of the caseload. Approximately 37 percent of children exiting SSI left due to excess income, 6 percent left due to death, and approximately 27 percent left due to no longer meeting the eligibility criteria (SSA 2014d).

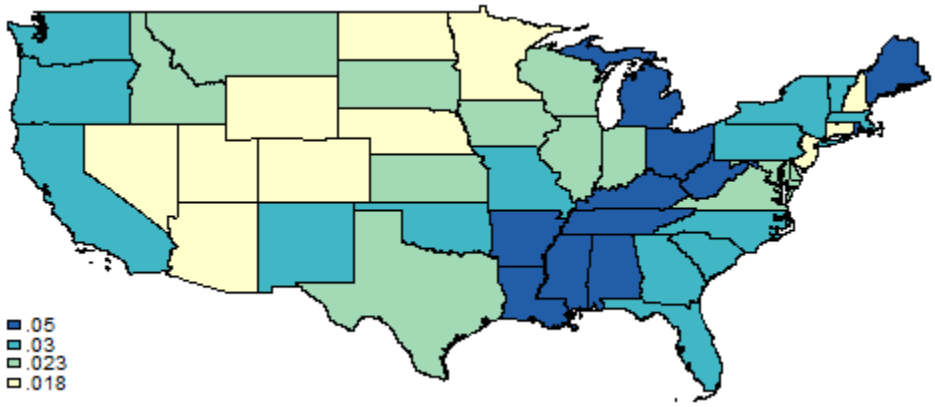
Additionally, while CDRs have been required by law since the beginning of the program, in practice the frequency and thoroughness of CDRs has not been consistent over time, in many cases due to administrative backlogs and budget constraints (GAO 2006, 2014). Between 2001 and 2011, the number of annual adult CDRs fell from 584,000 to 179,000, and the number of annual child CDRs fell from 150,000 to 45,000 (GAO 2014). As of January 2014, SSA estimated that it had a backload of approximately 1.3 million CDRs (GAO 2014). The low rate of program exit due to disability eligibility in both adult and child caseloads has been an issue of increasing concern for administrators and policymakers.

[25] This component of the exit rate may be artificially high because it may include some SSI recipients who switch to SSDI after the five-month waiting period.

C. Geographic Variation in SSI Enrollment

The fraction of people enrolled in SSI varies substantially both across and within states, ranging from a low of one percent in North Dakota to a high of greater than five percent in West Virginia. Some of this is accounted for by differences across states in income levels, which we do not attempt to adjust for in the figures that follow. Figure 4 groups states into quartiles of the non-elderly adult participation rate distribution. The map reveals that states with the highest rates of SSI enrollment tend to be in the South while many of those with low enrollment are in the West. Appendix Table A1 lists the fraction of non-elderly adults enrolled in SSI by state.

Figure 4: Non-elderly adult SSI population as percent of state adult population, 2013



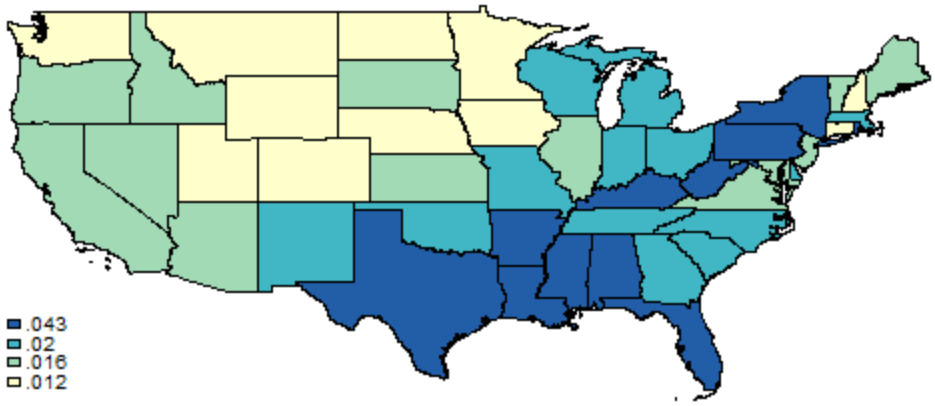
Notes: Data from SSA 2014e and U.S. Census Bureau 2014. Colors on the map represent quartiles of the participation distribution.

There is also substantial variation within states in SSI enrollment. For example, in the state of California, in which 2.6 percent of non-elderly adults receive SSI benefits. This state average masks considerable variation across counties: 1.0 percent of non-elderly adults in San Mateo County receive SSI benefits, as compared to 8.3 percent of their counterparts residing in Del Norte County (source data from SSA 2014e and ARHF 2013). Exploring within-state variation to determine how much is driven by population characteristics versus factors such as program awareness or disability

determination procedures would be a useful research endeavor.

Participation in the child SSI program also exhibits substantial geographic variation, as displayed in Figure 5. While most of the states with high adult participation also have high child participation, there are some differences. For example, while Texas is in top quartile of child SSI participation, it is below the median for non-elderly adult SSI participation.

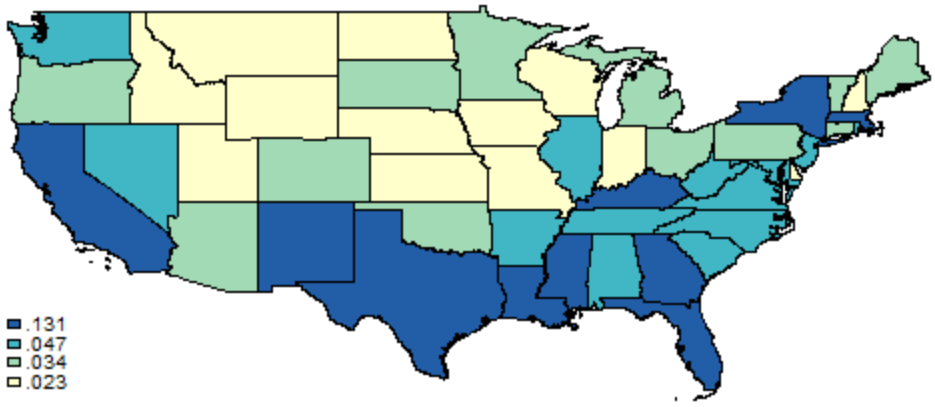
Figure 5: Child SSI population as percent of state child population, 2013



Notes: Data from SSA 2014e and U.S. Census Bureau 2014. Colors on the map represent quartiles of the participation distribution.

The elderly caseload – mapped in Figure 6 -- has a similar range and geographical pattern with the exception of two outliers: California and New York. In these two states, the elderly SSI caseload was approximately 13 and 9 percent of the total elderly population, respectively, which are the two highest state-specific enrollment rates. This likely reflects the more generous supplementation of SSI benefits in these states so that Social Security benefits are less likely to fully phase out the SSI benefits.

Figure 6: Elderly SSI population as percent of elderly adult population, 2013



Notes: Data from SSA 2014e and U.S. Census Bureau 2014. Colors on the map represent quartiles of the participation distribution.

In addition to variation in SSI enrollment rates across states, there is significant variation in caseload *growth* across states. While the majority of states with high caseload levels also experienced high growth, this is not true for all states. For example, consider the child SSI caseload. Texas had a relatively small child caseload in 2002 of approximately 9 cases per 1000 children, compared to a high of 32 cases per 1000 children in the District of Columbia and a low of 4 cases per 1000 children in Hawaii. However the child caseload in Texas increased by approximately 120 percent between 2002 and 2011, while it grew by approximately 50 percent in the District of Columbia and approximately 30 percent in Hawaii (Aizer, Gordon, Kearney 2013)

In an attempt to understand how the drivers of this growth relate to state characteristics, Strand (2002) examines variation in application and allowance rates across states for adult DI and SSI applications, and finds that approximately half of the variation in allowance rates can be explained by economic, demographic and health factors. Similarly, Rutledge and Wu (2013) find that poor health is a significant predictor of the state SSI caseload and application rate. By contrast, Aizer, Gordon, and Kearney (2013) examine state-level variation in the child SSI caseload and do not find a significant relationship between caseload growth and state-level variation in population diagnosis rates, health insurance coverage, poverty, or

unemployment rates. They find some evidence that participation in special education is positively related to child SSI caseload growth.

D. Enrollment in Other Government Programs and Intergenerational Connection in SSI Receipt

An examination of data from 2008 SIPP reveals that many SSI recipients also obtain benefits from other safety net programs. Table 4 shows that more than half of child, adult and elderly SSI beneficiaries receive food assistance from SNAP. Approximately 67 percent of children receiving SSI also receive SNAP, compared to just 22 percent of children not on SSI. Similarly, 58 and 56 percent of non- elderly adult and elderly beneficiaries receive SNAP, compared to 11 and 5 percent of non- beneficiaries, respectively. Nearly all beneficiaries in each age group receive health insurance through Medicare or Medicaid. The fact that not all beneficiaries receive benefits through Medicaid may partially reflect the fact some states have additional eligibility and enrollment requirements for SSI beneficiaries to receive health benefits. The high rates of participation in other means-tested programs are reflected in the income of households with SSI beneficiaries. Between 50-60 percent of all SSI households have incomes at or below 150% of the poverty line, compared to approximately 25 percent of non-beneficiary households.[26]

Furthermore, a significant fraction of the SSI caseload participates in other Social Security programs, either disability (SSDI) or retirement (OASI). Approximately thirty percent of adult SSI beneficiaries also receive SSDI, while two-thirds of elderly adults on SSI in the SIPP also report receiving OASI retirement benefits.[27]

Comparing households with a beneficiary in a given age category reveals substantial

[26] Author calculations from the 2008 Survey on Income and Program Participation

[27] According to the SSA Statistical Supplement, approximately 56 percent of aged SSI beneficiaries also receive OASI. The higher dual participation rate reported in the SIPP could reflect respondents confusing the two programs.

overlap in SSI participation across ages, in particular between non-elderly adults and children. For example, nearly 30 percent of households with a child on SSI also have a non-elderly adult on SSI. Similarly, 22 percent of households with an adult SSI beneficiary include a child on SSI, conditional on also having a child in the household.

Table 4: Individual SSI beneficiaries compared to others in the age cohort, 2013

	Child < 18		Adults 18-64		Adult 65+	
	No SSI	SSI	No SSI	SSI	No SSI	SSI
SSDI (ages 18-64)			0.03	0.29		
SS Retirement (ages 62+)			0.31	0.21	0.85	0.67
Medicaid	0.35	0.83	0.08	0.93	0.04	0.95
Medicare	0.00	0.00	0.03	0.29	0.97	0.99
SNAP	0.22	0.67	0.11	0.58	0.05	0.56
TANF	0.03	0.06	0.01	0.05	0.00	0.01
WIC	0.07	0.15	0.03	0.03	0.00	0
UI	0	0	0.02	0.01	0.00	0
Any non-cash benefit	0.52	0.99	0.31	0.97	0.15	0.98
Any cash benefit	0.08	1.00	0.05	1	0.03	1
Any housing benefit	0.06	0.31	0.03	0.25	0.03	0.36
Obs (unweighted)	16387	302	41932	1509	11782	562
% of total pop (weighted)	0.232	0.004	0.604	0.020	0.133	0.006
% of age category pop (weighted)	0.982	0.018	0.968	0.032	0.958	0.042

Notes: Data from wave 15 of the 2008 Survey of Income and Program Participation. Statistics calculated using SIPP reference month person weights (wpfinwgt). All respondents are in only one category above.

Section IV: Economic Issues

A. Conceptual Issues

The SSI program for non-elderly adults provides a transfer of income targeted to disabled individuals who are presumed to have limited capacity to obtain financial security through their own paid employment. The SSI program for children provides a transfer of income to families who have to contend with the burden of caring for a disabled child. As outlined in the introduction, there are four sets of theoretical issues that are of primary importance when it comes to the SSI program. First, there are conceptual questions related to the advantages and disadvantages of categorical eligibility requirements. Second, there are issues related to systematic disincentives to accumulate earnings and assets inherent to most means-tested transfer programs. Third, there are questions about long-term benefits and costs to program

participants, in terms of whether the program adequately and appropriately serves the needs of disabled individuals and their family members. And fourth, there are important issues about program spillovers, both across programs and across federal and state levels of government. In this section, we describe each of these sets of issues. We review empirical evidence on these issues later in the chapter.

1. Categorical eligibility

SSI eligibility is based in part on an applicant's successful demonstration of a disability that renders the individual unable to perform adequately in the labor market. But defining what it means to be unable to work or work at a sufficient level of earnings is not a precise concept. The ideal design of an income support program balances the social benefit of income redistribution against the social costs of labor supply disincentives. A key justification for a program with a categorical disability requirement is that by targeting such individuals, the program can transfer more resources to truly "needy" individuals, achieving greater targeting efficiency at a lower cost of productivity efficiency.

Akerlof (1978) and Nichols and Zeckhauser (1982) showed that by requiring a categorical "tag", an income redistribution program can more effectively screen out individuals who would "masquerade" as being in need of government assistance when they simply have a high disutility of work, but not an actual impediment to work. When a tag works as it should, the likelihood of Type II errors is reduced, meaning that fewer "undeserving" individuals will qualify, which leaves more resources available for those who are truly in need of income assistance. This comes at a trade-off with Type I errors, whereby some individuals who truly do need income assistance are erroneously labeled as not sufficiently disabled, or as Kleven and Kopczuk (2011) point out, are discouraged from applying.

In their seminal paper on the design of optimal disability insurance, Diamond and Sheshinski (1995) aptly noted that "any attempt to evaluate abilities to work will be subject to two types of error- admission of people ideally omitted and exclusion of people ideally admitted" (page 10). The authors describe how in the design of a disability benefit program, the challenge of balancing income redistribution and labor supply disincentives is even more complicated than in a typical income maintenance program because of the imperfect nature of defining disability. They note that blindness automatically qualifies an individual for a disability benefit in the U.S., even though many blind people choose to work instead. So the challenge is not simply that the severity of the medical condition is difficult to measure, but rather that the medical problem alone is not a sufficient guide to the disutility of work. They show that in a scheme where health status is costlessly but imperfectly observable, it is still optimal to provide a disability benefit program that screens on the basis of health such that the probability of being accepted onto the program increases with level of disability.

Parsons (1996) extends this framework to consider the optimal benefit structure of social insurance programs in the presence of two-way misclassification error whereby some members of the target group do not have the tag and some members of the non-target group do. This leads to a four-way payment system, in contrast to the three-way payment system of Diamond and Sheshinski (1995). Parsons concludes that a *dual*-Negative Income Tax system is optimal, with transfer payments that are more generous for non-workers with the tag as compared to those without, and with a premium paid to program-eligible individuals who work. Parsons further observes that the design of social insurance programs in the U.S. omits one of these prices, namely, work incentives for individuals assessed as program-eligible.

Kleven and Kopczuk (2011) develop a model that builds on the Diamond and Sheshinski (1995) model by considering what happens to the optimal benefit design when it is costly to

observe health status. Their model explicitly considers complexity in social programs as a byproduct of costly efforts to screen between deserving and undeserving applicants. The authors observe that while a more rigorous screening technology may have desirable effects on targeting efficiency, the associated complexity introduces transaction costs into the application process and may induce incomplete take up.

An additional, related problem not addressed in the Diamond and Sheshinski framework is that the link between a medical condition and labor supply will vary with economic conditions. For example, consider an individual with limited education and a verified condition of extreme back pain. Such an individual might not be able to perform physical labor, but could perform a desk job. However, the availability of desk work for an individual with limited education will depend crucially on local economic conditions. How should the design of SSI or SSDI requirements respond to these varying linkages between health status, economic conditions, and ability to work? This is an issue that warrants focused attention and to date, has not received a thorough treatment, either theoretically or empirically.

Another important consideration relevant to the categorical eligibility requirement is the possibility that disability status is mutable, and individuals might distort their behavior to select into the "disabled" category. To the extent that individuals distort their health or behavior so as to qualify as disabled – or to have their child labeled as disabled -- the loss in social welfare might exceed the benefits of the income transfer to such individuals. As the SSI caseload has become increasingly comprised of difficult-to-verify conditions, namely pain and mental disabilities, the possibility of less precise categorical labeling has increased. Furthermore, because the program is not meant to be temporary, any distortions in behavior resulting from the program can potentially be long lasting.

2. Work and savings disincentives

As is common to all income-support programs that establish benefits to be a decreasing function of earnings and assets, there is the trade-off between income protection and distortions to the labor supply and savings decisions of benefit recipients. As described above, SSI enrollment affects the incentive to work through an increase in the effective marginal tax rate in the phase-out region. This effect is not limited to the SSI recipient but can extend to other family members including spouses and parents. Of course, a program that is predicated on the concept of inability to work wouldn't have labor supply disincentives if that inability to work was a fixed or precise concept. For this reason, when one considers the effects of the SSI program on non-elderly adult beneficiaries, the issue is perhaps more appropriately considered an issue of imperfect categorical labeling than a typical labor supply disincentives issues.

When it comes to the child SSI program, we return to the paradigm of more typical labor supply disincentives. In that program, there is a question about whether other members in the household are discouraged from earning income, since additional income can cause a child in the family to lose SSI eligibility, and because SSI child benefits are a function of family income. This leads to the classic labor supply disincentives introduced by any means-tested income transfer program. The large income exclusions described above may substantially reduce the efficiency costs for families with children on SSI.

In addition, SSI has asset eligibility requirements for all three groups – children, non-elderly adults, and the elderly. The concept of asset limits raises the possibility that individuals are discouraged from saving or accumulating assets in order to apply for the program. Hurst and Ziliak (2006) provide a recent examination of this theoretical possibility in the context of welfare reform policies that relaxed asset restrictions in the Temporary Assistance to Needy Families (TANF) programs, finding no evidence of savings responses in response to relevant policy

changes. We review the evidence on savings and the SSI program below, which focus primarily on the incentives for adult SSI recipients. The reduced incentive to save may be especially harmful for children on SSI. Consider a family that wants to save for future educational or health care costs for a disabled child. Even a modest amount of savings by the parents can lead to the termination of the child's SSI benefits.

3. Benefits and Costs to Participating Individuals

The typical benefits of a short-term means-test income support program, such as unemployment insurance, is consumption smoothing. By providing income support through a period of temporary economic struggle, a transfer program allows an individual or family to maintain a floor and a smoother trajectory of consumption. But SSI is different than a typical program in that it is explicitly not intended to be temporary. The more relevant question for benefits of the program is what would an individual's income and consumption be in the absence of this explicit disability benefits program? In addition, are there health benefits that accrue to an individual who qualifies for SSI that would not be obtained if income were obtained through other means, either through work or other sources of unearned income? In this subsection, we raise a number of other conceptual issues related to the benefits and costs of program participation.

First, when considering the benefits of the SSI program to families with a child SSI recipient, one returns to the issue of justifying the payment of additional income to low-income families with a disabled child. One potential justification is that the presence of a disabled child in a family makes it more difficult for a parent to work outside the home. An empirical examination by Powers (2001) confirms this to be true. Using data from the School Enrollment Supplement to the October 1992 Current Population Survey, the author finds large negative effects

of having a disabled child on the probability that a wife or female head of household participates in the labor force, controlling for family and individual level characteristics. The size of the effect is substantial, comparable to having a child under the age of five in the house. Another possibility is that families with a disabled child incur more health care expenses. Related research by Buescher et al (2014), Stabile and Allin (2012), and Rupp and Ressler (2009) further suggests that parents of children with disabilities confront substantial financial costs and additional challenges in the labor market.

These observations raise two important questions. First, is the income received from the SSI program sufficient to make up for the income losses and higher expenses experienced by families with a disabled child? Second, do families use the additional income received from SSI to pay for goods or services that lead to improved parental work outcomes or improved health conditions for the disabled child? Both of these questions are open for research.

A second conceptual issue is whether the current structure of SSI is optimally designed to serve families with disabled children. Recall from Section II above that conditional on qualification, the level of SSI benefits is the same for disabilities with different severities. It is therefore plausible that the income support from the program more than offsets potential losses of income experienced by individuals (or families of children) with a fairly mild disability, but is not sufficient to support individuals (or families of children) with a severe disability. Furthermore, an individual or a child only maintains SSI eligibility if his condition does not show dramatic signs of improvement. This raises the possibility that individuals do not pursue paths to improvement or that parents withhold intervention treatments from their children in order to maintain eligibility.

A third issue that is especially relevant to a child's experience on SSI or experience trying to qualify is whether the labeling of the disability has positive or negative consequences. On the

one hand, the existence of the SSI program provides a financial incentive for families and administrators to evaluate a child for a disability and label that child with the qualifying diagnoses.[28] For children whose limitations might otherwise have gone unrecognized, this could have a beneficial effect of awareness and treatment. On the other hand, the label itself could lead to hindered educational opportunities or a reduced sense of urgency on the part of the parent or older child to overcome the limitation. These are conceptual considerations, with little rigorous empirical evidence.

A fourth and final issue is that SSI enrollment may lead to long-term dependency, both for children and non-elderly adults. Perhaps some qualifying individuals, with the proper individualized attention, would overcome a less severe disability. But one consequence of the SSI program is that parents and family advocates might be inclined to hold onto that label, in order to maintain eligibility for program benefits. This is an interesting question for future research to explore.

4. Program Spillovers

The federal nature of the SSI program serves a broad redistribution purpose, but it also imposes fiscal externalities between state and federal governments and programs. Benefit levels of the federal SSI program are relatively generous, especially compared to TANF cash benefit awards in low- benefit states. Thus, the award of SSI can amount to large transfers of federal dollars to individual states. Researchers have considered the extent to which individuals and states substitute SSI program benefits for state-funded transfer programs and how program features

[28] The notion that rates of child disability diagnoses would vary with financial incentives is not to be dismissed. Cullen (2003) presents evidence from school districts in Texas showing that a 10 percent increase in the supplemental revenue received by a district for having a disabled student leads to an approximately 2 percent increase in the fraction of students classified as disabled. As would be expected, she finds that this responsiveness is larger for disability categories that are milder and less precise, such as learning disability and speech impairment.

make this shifting more or less likely. We review this evidence below.

B. A Review of the Evidence

1. The Impact of Child SSI Participation on Short-Term Outcomes

There is some evidence that the receipt of child SSI income leads to a net increase in family income and a decrease in poverty rates. Duggan and Kearney (2007) consider how a child's enrollment in the SSI program affects short-term family outcomes including poverty, household earnings, and health insurance coverage. The authors make use of the longitudinal nature of the Survey of Program Participation (SIPP) to identify a change in household outcomes at precisely the time that the household begins receiving child SSI benefits, controlling for unobserved differences across households and observed outcomes in these same household in the months leading up to and immediately following a child's first enrollment in SSI. They find that child SSI participation increases total household income by an average of approximately $316 per month, or 20 percent. The estimates suggest that for every 100 dollars in SSI income transferred to a family, total income increases by more than 72 dollars. The enrollment of a child in the SSI program appears to lead to a small offset of other transfer income but very little, if any, impact on parental earnings.

Duggan and Kearney (2007) additionally find that for every 100 children who enroll in SSI, 22 children and 37 people are lifted out of poverty and an additional 28 people see their incomes increase to more than twice the poverty line. These results suggest that the increase in child SSI enrollment over recent decades has potentially played a large role in lowering child poverty rates below what they otherwise would have been. Providing further evidence of the anti-poverty effects of the SSI program, Schmidt, Shore-Sheppard, and Watson (2013) find that SSI program participation leads to a reduction in the likelihood that a family reports being food

insecure.

In a more recent investigation of the parental labor supply effects of child SSI participation, Deshpande (2014a) estimates the effect of removing children from the SSI program on parental earnings and household income. She does this using administrative data from the Social Security Administration and a regression discontinuity design and a difference-in-difference design that exploits SSA budget cuts for child medical reviews. Her estimates suggest that a loss of $1,000 in a child's SSI payment is fully offset by increases in parental earnings, driven entirely by intensive margin responses. The large earnings response is somewhat at odds with previous estimates from the welfare literature that suggest smaller parent labor supply elasticities with respect to child benefits, in particular the SSI results of Duggan and Kearney (2007) described above. Deshpande suggests that the discrepancy might reflect asymmetric responses to benefit gains – which is what Duggan and Kearney (2007) observe – and benefit losses – which is what Deshpande (2014a) observes.

An additional finding of the study by Deshpande (2014a) is that the removal of a child from the SSI program leads to lower rates of DI applications among parents and siblings. This finding is consistent with recent work by Dahl, Kostol, and Magstad (2014) demonstrating family spillovers in the likelihood of applying for Disability Insurance; those authors find that in the context of Norway, individuals are more likely to apply for DI if they have a parent on the program.

A remaining question for future research is how families use the additional income that they receive from the SSI program and to what effect. There is some evidence from other programs, but not specifically for SSI. For example, Meyer and Sullivan (2004) explore the effect of changes in welfare reform and tax policy on measures of consumption; Dahl and Lochner (2012) examine the impact of EITC receipt on educational outcomes for children; Evans

and Garthwaite (2013) examine the impact of EITC on maternal mental health. To the best of our knowledge, there has been virtually no work of this kind specific to SSI. Future research should consider how families make use of the additional income brought into the home by SSI and whether they are spent disproportionately on the recipient child. To fully understand the benefits of the SSI program, it would be useful to know whether the resources are used to fund additional consumption or parental leisure, to purchase market-provided childcare that allows parents to work outside the home, or whether the additional income leads to investments in education or health at either the child or family level.

Future research is also needed on the extent to which the incentives that the SSI program creates for families to obtain a disability diagnosis for their child leads to beneficial outcomes – say, by raising the parents' awareness of need and ability to pursue helpful interventions. We also need evidence about the extent of harmful reactions to this incentive. For example, the 2010 *Boston Globe* series written by Patricia Wen described with compelling and troubling anecdotes an unintended side effect of SSI the overmedication of children with psychotropic drugs in order to qualify for SSI benefits. However, the more systematic study by the GAO suggests that overmedication is not a widespread phenomenon among SSI recipients.

2. The Impact of Child SSI Participation on Long-Term Outcomes

To better appreciate the normative implications of SSI participation among children with disabilities, we need an understanding of the long-term outcomes for SSI recipients. One way to learn about this issue is to study the transition to adulthood for child SSI recipients. Do we see that relatively many child SSI recipients are able to productively transition into employment after age 18? Or do they remain dependent on government transfer programs, either SSI or another program? Does SSI participation enhance, impede, or have no impact on their long-term

opportunities and human capital development?

Loprest and Wittenberg (2005) provide a descriptive look at the transition experiences of child Supplemental Security Income (SSI) recipients just prior to and after age 18. They use year 2000 data from the National Survey of Children and Families (NSCF) to study the work preparation activities and family circumstances of a pre-transition cohort of youth age 14 to 17 and a post- transition cohort of individuals age 19 to 23, comparing income, work, personal and family circumstances of those on SSI benefits after age 18 to those who no longer receive these benefits. The data indicate that only a minority of pre-transition SSI recipients had ever participated in vocational training or vocational rehabilitation (VR) and many had never heard of SSI work incentive provisions. Their findings for the post-transition cohort show that those who no longer receive SSI at age 18 tend to be in better health and are more likely to be working than those who continue on benefits. They also find that among those who are removed from the SSI program at age 18, most continue to have incomes below poverty and about one-half dropped out of school and a third have been arrested. As the authors note, these findings are relevant to ongoing efforts to improve the transition process for child SSI recipients and to understand some of the circumstances of young people after the age 18 redetermination.

Additional descriptive evidence from Rupp et al. (2015) examines the long-term receipt of SSI and DI among child SSI recipients from a variety of award cohorts. They find that in general, child recipients from more recent cohorts receive benefits for a shorter period of time. They find that ten years after the SSI award, approximately 45 percent of the 2000 child SSI award cohort receives neither SSI nor DI, compared to only 25 percent of the 1980 cohort. They note a sharp break in the trends in transitions off disability benefits between cohorts who likely were not affected by the introduction of age 18 redeterminations and other eligibility restrictions in 1996 (i.e., cohorts from the 1980s and early 1990s) with cohorts who likely were affected (i.e., 1995

award cohorts and later). The authors also conduct a decomposition analysis that is consistent with their hypothesis that the change in trends is likely driven by policy changes rather than observed changes in characteristics of the child SSI caseload over time. Additionally, they find that relatively few SSI child recipients transition to DI as adults: ten years after the award, approximately 9 percent of the 1980 cohort received DI alone or concurrently with SSI, but this fraction falls to 3 percent for the 2000 cohort.[29]

Deshpande (2014b) builds on this descriptive work with a carefully designed empirical analysis. Her empirical approach exploits a policy change that increased the number and stringency of medical reviews for 18-year-olds, implemented as part of the 1996 PRWORA legislation. The law was written such that children with an 18th birthday after the law's enactment on August 22, 1996 experienced a discontinuous increase in the probability of being removed from the program, as compared to his counterpart with an earlier 18th birthday. This sets up the conditions for a regression discontinuity empirical approach to examining the relationship between program removal and subsequent outcomes. To conduct her analysis, Deshpande makes use of confidential SSA files. She links data from the Supplemental Security Record (SSR), which provides demographic information on SSI children, to the CDR Waterfall File, which gives information on all medical reviews for children and review. She links these child records to long-term outcomes using several additional SSA data sets, including the Master Earnings File (MEF) and the Master Beneficiary Record (MBR).

Deshpande (2014b) finds that SSI youth who are removed from the program earn on average $4,000 per year, an increase of $2,600 relative to the earnings of those who remain on the program, and not enough to make up for the $7,700 lost in annual SSI benefits. She finds that those

[29] While fewer cohorts can be compared over longer time frames, the fraction of recipients continues to increase over time. For example, 23 and 18 percent of the 1980 and 1995 cohorts received DI benefits twenty years after their initial child SSI award.

who were removed from the program spend on average nearly 16 years (the entire post-treatment period observed) with observed income below 50% of the poverty line, as compared to five years for those who are not removed from SSI at age 18. Importantly, these average effects mask heterogeneous responses. For some individuals, the removal from the program spurs increased work effort. The likelihood of maintaining earnings above $15,000 is 11 percent higher among those removed from the program, and this difference grows over time. An additional important finding is that income volatility is increased for those who do not maintain program eligibility.

The insight gained from Deshpande's work is important to understanding the economic hardship faced by SSI recipients who are terminated from the program at age 18. But, an important limitation to this work is that it does not answer the question of how those individuals would have fared if they had not spent earlier years on SSI. There exists the possibility that a child who is raised on SSI, or spends their teenage years receiving SSI, develops a different set of aspirations and invests less in human capital accumulation. Alternatively, the additional income from SSI could lead to more investment in the child and better educational outcomes. Either scenario would likely have an effect on long-term outcomes. What we learn from the Deshpande (2014b) evidence is that individuals who are removed at age 18 are not readily able to transition into stable employment. One potential policy implication from this is that more transition support programs and work training programs for individuals with (mild) disabilities would be beneficial. But the question of whether those individuals would have had improved long- term outcomes if they had not received child SSI income at all or for some length of time remains an open question.[30]

[30] Coe and Rutledge (2013) use data from the National Health Interview Survey linked to social security administration data to compare short and long-term outcomes of children who enrolled in the SSI program during three eras that they

A related question to the issue just raised is how SSI participation as a child impacts the likelihood of government transfer receipt as an adult. Does participation in this long-term form of assistance foster dependency on government transfers? Research is needed that both describes the associations between SSI program participation and later outcomes, but also empirically identifies the causal impact of child SSI receipt on later life program participation. Another way to pose this question is to consider whether a child with a similar condition who received TANF instead of SSI is less likely to "graduate" into government assistance at age 18? And importantly, how does any such difference translate into differences in labor force participation, future educational investment, and total earnings and economic well-being? Of course, this presents a significant challenge for researchers because the selective process by which individuals apply for, receive, and continue to receive SSI benefits suggests they are quite different from those not on the program.

3. SSI and Boys

An important demographic issue that arises in the context of the child SSI program is the disproportionate medical qualification of boys, minority boys in particular. Duggan and Kearney (2007) examine pooled SIPP data from 1992, 1993, 1996, and 2001 to explore the predictors of SSI participation, and how these compare to the demographic predictors of AFDC/TANF enrollment. They find that family structure, parental education, and race/ethnicity relate to program participation in similar ways between the two programs. In particular, children from single-parent families and less educated parents are more likely to

defined as pre-*Zebley* (1987-1990), *Zebley* (1991-1996), and post-*Zebley* (1997-1999). They observe that recipients are less likely to report care limitations as a child, to accumulate more work experience and less time on welfare as adults, and to be slightly less likely to have health insurance as adults. It is hard to draw strong conclusions from this analysis, however, since these differences presumably reflect (to some unknown degree) differences in sample composition. It is not surprising that children who entered SSI during the "lenient" years would be less disabled on average, and thus ultimately experience better outcomes.

enroll in both SSI and AFDC/TANF, as compared to children from two-parent families or higher educated parents. Black children are more likely to enroll than either Hispanic or white children, other characteristics held constant. A notable departure between the two programs is that conditional on other background characteristics, families with relatively more boys are significantly more likely to participate in the SSI program. This is consistent with the disproportionate presence of boys among the SSI caseloads, and the disproportionate likelihood that boys are diagnosed with mental disabilities and behavioral disorders.

What should we make of the disproportionate participation in SSI of boys and minority black boys in particular? Does this reflect under-, over-, or accurate placement? Is the system "optimally" diagnosing boys? The biological and medical literatures provide overwhelming evidence that boys are more likely to have mental and behavior disorders, something economists have recently come to research in terms of a "non-cognitive deficit". What metrics would we use to evaluate whether the extent of medical and disability determinations are accurate, or medically, rather than socially based? In other words, to what extent are boys with social or behavioral issues being diagnosed as medical problems, and what does this imply for the optimal design of the SSI program?

A separate question is whether the SSI program is particularly important for boys from single-parent, low-income homes, and whether enhanced program features would have even greater benefits for qualifying boys. Bertrand and Pan (2013) build on the literature about the importance of non-cognitive skills for educational and labor market success and the deficit that boys appear to experience along this dimension. The descriptive picture they present about the "trouble with boys" (from the title of their paper) is based mainly on data from the Early Childhood Longitudinal Study – Kindergarten cohort. They document that boys do especially poorly in broken families and that the early school environment has little impact on the non-

cognitive functioning of boys, in contrast to girls. They further demonstrate that boys appear to be particularly responsive (in a negative way) to the lack of parental resources experienced in a single parent home. An important question is to what extent does and could the SSI program mitigate these challenges facing boys from single-parent, low-income homes?

4. Program Interactions: Child SSI

Low-income individuals with a qualifying disability or with a child with a qualifying disability will often have a financial preference for the SSI program over TANF. As noted above, the SSI program is not time-limited and does not involve work requirements. In states with low levels of cash benefits for TANF, this financial incentive is relatively larger. Furthermore, states have a financial incentive to shift TANF recipients or applicants to the SSI program, since SSI benefits are paid for by the federal government. The gap between TANF and SSI benefits has tended to grow over time, since SSI benefit levels are automatically adjusted for cost-of-living changes, and TANF benefits are not, and have been declining in real terms.

Existing research has documented significant interactions between SSI and the Aid to Families with Dependent Children (AFDC) program in the years prior to welfare reform. Garrett and Glied (2000) find that in the early 1990s, states with the highest AFDC benefits saw the smallest increase in SSI participation among children. Kubik (1999) finds that families who were likely to receive higher levels of cash benefits from other programs were less likely to apply for SSI. Schmidt and Sevak (2004) demonstrates that single-women living in states that were early adopters of welfare reform policies were more likely to report SSI receipt. This set of findings across papers implies that individuals respond to differences in benefits across programs in a way consistent with utility maximizing behavior.

There is an additional, perhaps even more interesting, dimension to the shifting of

AFDC and TANF caseloads to the SSI program: this shift moves the financial burden of benefit payments from states to the federal government. Recall that SSI benefits are paid for entirely by the federal government, except in the case of state supplementation. In contrast, the cost of AFDC benefits were shared between states and the federal government, with this difference now amplified because states are essentially given block grants for their TANF programs. This means that states would benefit financially from shifting the AFDC caseload onto the federal SSI program. In a paper that confirms that states respond to that financial incentive, Kubik (2003) shows that states experiencing unexpected negative revenue shocks experienced larger increases in the size of their SSI caseload relative to their AFDC caseload. This finding can be interpreted as evidence of fiscal spillovers between different levels of government and has implications for the optimal design of programs in terms of state and federal cost sharing.

There are two other potentially important program interactions relevant to the child SSI caseload – interactions with Medicaid and health insurance more generally, and interactions with special education programs. Work by Anna Aizer (2009) shows that gaining access to health insurance through state-level expansions of the Children's Health Insurance Program has a sizable impact on the likelihood of a child reporting a mental disorder diagnosis and treatment. This raises questions about how access to health insurance affects the likelihood that a child will gain access to a qualifying SSI determination. Whereas Duggan and Kearney (2007) consider how SSI participation affects health insurance coverage rates, it would be useful to explore the reverse relationship of how health insurance access affects SSI participation. Aizer, Gordon, and Kearney (2013) find little relationship between state-level changes in health insurance coverage and SSI caseload growth, but additional exploration of this potential relationship is warranted, especially following implementation of the Affordable Care Act.

In addition to the link with health insurance, it is important to understand how the

SSI program and the educational system interact in terms of establishing disability, school needs, and SSI and special education eligibility. As reported in Table 3, a striking 68 percent of the child SSI caseload has a primary diagnosis of a mental disorder. Given this diagnostic composition of the SSI caseload, it stands to reason that SSI eligibility determinations overlap with special education determinations. Such conditions often show up in the educational system as learning disabilities or behavioral problems, often recognized by poor classroom performance. Survey data indicate that approximately 70 percent of child SSI recipients participate in special education at some point during their school years (Rupp et al, 2006).

As an empirical matter, it is difficult to disentangle the causal pathway from special education assignment to SSI participation, versus the causal relationship running from SSI enrollment to special education assignment. An unpublished 2007 working paper by Jessica Cohen presents evidence suggesting that increases in the SSI caseload brought about by the *Zebley* decision led to a significant increase in special education classification. Thinking about the relationship in the other direction, we note that special education determinations are made at a local level and depend greatly on the discretion of staff at the school level, guided by policy set at the state level. The prevalence of special education classification varies widely across states, including variation in whether students need a diagnosed disability to be classified as eligible for special education. Aizer, Gordon and Kearney (2013) provide evidence of an association between the prevalence of special education in a state-year and state-year SSI caseloads. Specifically, they find that special education is predictive of initial allowances, but not application rates. It could be that participation in special education contributes to caseload growth via increases the likelihood of application acceptance by, for example, lending greater credibility to the claim of disability. Cullen and Schmidt (2011) provide additional evidence of a link between these programs. Building on the observation in Cullen (2003) that localities in Texas with greater fiscal

incentives to label children as disabled experience relative increases in special education caseloads, Cullen and Schmidt (2011) find larger relative increases in SSI caseloads in such localities. Exploring these linkages in greater depth is an area worthy of additional research.

5. Evidence on the effect of SSI participation for working-age and elderly adults

Previous research suggests that the rise in SSI enrollment among non-elderly adults that began in the mid-1980s was driven by three main factors. First, there was a liberalization of the program's medical eligibility criteria in 1984 that made it easier for individuals with more subjective conditions such as back pain and mental disorders to qualify for the program (Rupp and Stapleton, 1995; Autor and Duggan, 2003). Second, given that SSI enrollment rates rise with age, the aging of the baby boom generation led to a mechanical increase in SSI enrollment (Duggan and Imberman, 2009). And finally, cutbacks in state general assistance programs increased the number of individuals applying for and ultimately receiving SSI benefits (Rupp and Stapleton, 1995).

Non-elderly adults who participate in SSI have very low labor force attachment, with just 4 percent having non-zero earnings in 2013. Because of this, the issue of work disincentives is perhaps not as pertinent as it is for other means-tested transfer programs. This likely explains why there are not as many studies of the effect of SSI program participation on outcomes for non-elderly adults. One exception is a study by Bound, Burkhauser, and Nichols (2003), who use panel data from the SIPP linked to SSA disability determination records to trace earnings and income for adult SSDI and SSI participants. They find that the earnings of applicants decline around the time of SSI application, but in terms of absolute changes these reductions are quite small, since labor income is very low for SSI applicants. The data indicate that the increase in benefit income received by SSI awardees in the months after initial application is largely offset by reductions in spousal income and other transfer income. Their findings suggest that SSI program participation

does not lead to a sizable increase in household income for SSI adult awardees, on average. However, presumably there is underlying heterogeneity, and for some SSI recipients who do not have access to spousal income or AFDC benefits from other family members, benefits from this program constitute a sizable increase in income.

In a series of studies, Neumark and Powers have investigated the behavioral responses of older adults to potential SSI eligibility under elderly categorical eligibility.[31] Recall that for elderly applicants, eligibility is based on income and assets and does not require a disability determination. Neumark and Powers (2000) examine the pre-retirement labor supply of men as they near age 65, using SIPP data. Their analysis uses a triple-difference strategy and finds that in states with more generous state supplementation of federal SSI benefits, there is a somewhat larger reduction in labor supply before age 65 among men who are likely to be eligible for SSI. They additionally find that this response is more pronounced among men who qualify for early social security benefits, which might be used to offset the reduction in labor earnings. In subsequent work, the authors confirm the finding of an anticipatory reduction in labor supply using CPS data and exploiting within-state changes in SSI supplementation levels (Powers and Neumark, 2005). Powers and Neumark (2006) confirm that these findings are not driven by cross-state migration related to SSI awards. This pair of authors has also found evidence of dissaving among likely eligible individuals as they approach age 65 (Powers and Neumark, 2003).

On the issue of program spillovers, Linder and Nichols (2012) present intriguing results suggesting that enrollment in temporary assistance programs might serve as a "gateway" to more permanent reliance on assistance. Looking at a sample of workers in the SIPP, the authors find that UI claimants tend not to apply for SSI, but do apply for DI at increased rates.

[31] Using data from the Health and Retirement Survey linked to SSA administrative records, Coe and Wu (2014) confirm that a higher expected SSI benefit is associated with a higher rate of take-up among adult and elderly individuals

Workers who are more likely to receive SNAP benefits are more likely to subsequently apply for SSI benefits. The authors are careful to note that while these results might imply a causal relationship between participation in temporary assistance programs and subsequent enrollment in a disability program, they also could reflect selection on health and income. Further research is needed into this issue. It is also important to note that the efficiency effects of such a causal pathway – should one exist – are unclear. If temporary programs serve in part to increase awareness of SSI among eligible individuals that are ideally admitted -- to use the language of Diamond and Sheshinki (1995) – then this could be welfare enhancing. If, on the other hand, they serve to bring individuals onto SSI who would otherwise return to work at fairly low levels of disutility of work, the social welfare implications are less clear.

In another study of program spillovers, Maestas, Mullen, and Strand (2014) examine what happened to SSDI and SSI applications in Massachusetts shortly following the 2006 state health insurance reform. The effect of the reform – a precursor to the 2010 federal Affordable Care Act -- was to expand health insurance access to individuals through the implementation of a state- wide insurance exchange and provision of subsidies. Theoretically, the effect of this expansion on SSDI and SSI applications could have gone either way. Recall that SSI recipients immediately qualify for Medicaid when they enter the SSI program. SSDI applicants qualify for Medicare only after a two-year waiting period. In the pre-health reform paradigm, individuals with a work-limiting condition might have been too hesitant to separate from an employer and apply for SSDI or SSI because if their application was unsuccessful, they would have given up their employer-provided health insurance, and risk being uninsured. The 2006 reform would mitigate this issue of "job lock" and potentially lead to increased applications for both SSDI and SSI. However, with the expansion of affordable health insurance, the value of SSDI or SSI falls due to a reduction in the relative value of the health insurance benefits that

come with program enrollment – either Medicare or Medicaid, respectively. Using administrative application data from SSA, the authors find that SSDI applications increased throughout the state post-reform, consistence with state incentives to shift health insurance costs to the federal program. For SSI, applications increased in counties with high baseline health insurance coverage rates – consistent with a job lock story – and decreased in counties with low baseline insurance coverage rates – consistent with a decline in the relative value of the SSI Medicaid award. These results speak to the interaction of health insurance coverage and SSDI and SSI, and to the fiscal externalities between programs paid for by state versus federal funds.

An early paper by Yelowitz (2000) similarly considered the interaction between health insurance provision and SSI caseloads, focusing on elderly individuals. That work considers the introduction of the Qualified Medicare Beneficiary (QMB) program during the 1987 to 1992 period; the program provides supplemental health insurance to Medicare seniors without requiring SSI enrollment. Consistent with the idea that part of the benefit of SSI enrollment is the Medicaid award, Yelowitz (2000) finds that the introduction of QMB led to a decline in SSI participation rates.

6. Evaluations of Demonstration Programs Designed to Increase Work among SSI Beneficiaries

Since the early 1980s, there have been a number of government-run large-scale demonstrations designed to evaluate the work incentives inherent in SSI and SSDI and to determine how to promote employment and self-sufficiency among current beneficiaries.[32] In 1985, the Social Security Administration introduced the Transitional Employment and Training Demonstration, the first large-scale intervention focused on SSI recipients. In 13 communities, working-age adult beneficiaries with intellectual disabilities were randomly assigned to treatment

[32] For a detailed description of the most relevant interventions, see Wittenburg et al 2013.

and control groups, where the treatment group received job placement, training, and prevention services. After six years, those who received intervention were 21 percent more likely to be employed than the control group, although on average earnings in the treatment group did not increase enough to offset SSI and SSDI benefits received. Other interventions in the 1990s, including Project NetWork and the State Partnership Initiative, provided a combination of case management, benefit counseling, benefit waivers, and employment assistance. These interventions all increased employment in the treatment group by a few percentage points, but not by enough to offset benefits (Wittenburg et al 2013).

Following these small demonstrations in the 1980s and 1990s, SSA launched the Ticket to Work (TTW) program in the early 2000s. Over three phases, this experimental program provided SSDI and SSI beneficiaries with vouchers that they could exchange for employment support and rehabilitation services. Though the intervention was found to result in an increased use of employment services, research has not found any subsequent increases in beneficiaries' employment or earnings. Two possible reasons for this lack of an impact could be the limited number of employment service providers, and the fact that the intervention was not targeted to specific sub-populations among SSDI and SSI beneficiaries. This is an area ripe for additional program experimentation and evaluation.

A recent randomized demonstration experiment sheds some light on the effectiveness of interventions designed to promote work and education among youth SSI beneficiaries, with the goal being to reduce the youth disability caseload. SSA launched the Youth Transition Demonstration (YTD) project in 2003. In six sites across the country, SSI and SSDI beneficiaries ages 14-25 were randomly assigned to treatment and control groups, where treatment groups received education and employment services, as well as a reduced benefit offset schedule in order to encourage more work activity. The intensity of service provision varied across the six sites in the

demonstration. The results of the demonstration, evaluated by Mathematica Policy Research, suggest that effects varied by intensity of service provision. In the most successful site, youth employment nearly doubled from 23 percent to 42 percent, while there was no increase in employment in sites with less intensive service provision (Wittenburg et al 2013). However, due to relatively small increases in earnings, the increased employment among participating youth did not reduce disability benefits. In addition to employment outcomes, researchers observed rates of criminal activity, finding some evidence that YTD reduced criminal activity among beneficiaries in locations with more comprehensive services, and locations with more intense services focused on employment (Fraker et al 2014).[33]

CONCLUSION

The SSI program provides cash assistance and health insurance to some of the nation's most vulnerable elderly, blind, and disabled residents. In December 2014 the program paid benefits to 8.5 million U.S. residents. Beyond the direct effects of the program on the recipient population, the program also has effects on the economic incentives and income security of beneficiaries' spouses, parents, and children. Additionally, the program affects incentives for potential future SSI applicants.

In this paper, we have briefly summarized the history of the SSI program since it was created 40 years ago, including important changes in the program's medical eligibility criteria. We have presented descriptive evidence on caseload composition and caseload trends, showing that the overall caseload has shifted toward younger recipients and non-physical disability diagnoses. Our discussion of conceptual issues and relevant evidence focused on four key issues. First, we

[33] In 2014, SSA, the Departments of Education, Labor and Health and Human Services began PROMISE, a new demonstration designed to promote education and employment among SSI youth and their families. See http://www.ssa.gov/disabilityresearch/promise.htm for more information.

described conceptual questions related to the advantages and disadvantages of categorical eligibility requirements and we showed that the SSI caseload has become increasingly comprised of difficult-to-verify conditions, namely pain and mental disabilities. Second, we described the issues related to systematic disincentives to accumulate earnings and assets inherent in the SSI program design, as in most means-tested transfer programs. Notably, there are far fewer examinations of studies of employment and earnings incentives of the SSI program as compared to the SSDI program because the SSI population tends to have close to no work experience. The more relevant set of questions for the SSI population are related to the full disability requirement for eligibility and whether there would be ways to increase the employability of those with less severe disabilities. Third, we described the questions and research about long-term benefits and costs to program participants, in terms of whether the program adequately and appropriately serves the needs of disabled individuals and their family members. And fourth, we presented information and evidence about program spillovers, both across programs and across federal and state levels of government. Throughout this chapter we have made numerous explicit references to areas where further study is warranted and open research questions remain.

In addition to the open research questions, there are a number of program design questions that warrant policy consideration. One critical issue is that of a full versus partial disability scheme. As described above, SSI eligibility is a dichotomous status and benefits are not dependent on disability severity. This stands in contrast to the disability systems of many other countries as well as the Veteran's Disability Compensation Program, where benefit awards are an increasing function of disability severity. A partial system could allow for functional limitations that didn't preclude the ability for productive market-based work, and thus would allow individuals to combine the receipt of benefits with earnings. A partial system would also avoid the undesirable program "cliff" where eligibility immediately goes to zero and all benefits are lost to the recipient if sufficient recovery is

observed.

Another policy design issue that should be considered is the justification for two separate federal disability programs: SSI and SSDI. In the case of adults, the disability determination uses a similar set of criteria, but eligibility for SSI is additionally based on income and eligibility for SSDI is additionally based on work history. They also have different waiting periods: zero months for SSI (and Medicaid) and five months for SSDI (24 months for Medicare). In addition, the financing schemes are separate, with federal SSI payments financed by general revenue and SSI payments financed by payroll taxes and the Social Security trust fund. Is this efficient from an operational standpoint, or would administrative costs and complications be substantially improved by the streamlining that would come from one federal disability program?

SSI is an important part of the U.S. safety net, but particular features of the program and the way it operates in practice raise questions and concerns about whether there is a more effective way to provide income support for individuals with work-limiting disabilities and families with disabled the children. We have attempted to systematically present these issues here for scholars and policy-makers to consider and explore.

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APPENDIX

Table A1: Percent of population on SSI, by state and age, 2013

State	Percent under 18 on SSI	Percent 18-64 on SSI	Percent 65+ on SSI
AL	2.58%	3.98%	4.29%
AK	0.69%	1.75%	5.66%
AZ	1.30%	1.77%	3.15%
AR	4.26%	3.77%	3.55%
CA	1.29%	2.64%	13.05%
CO	0.80%	1.42%	2.88%
CT	1.09%	1.74%	2.82%
DE	1.80%	1.84%	2.01%
DC	4.14%	4.17%	6.47%
FL	2.66%	2.28%	5.41%
GA	1.85%	2.53%	4.90%
HI	0.56%	1.73%	4.43%
ID	1.34%	2.18%	2.01%
IL	1.38%	2.14%	3.84%
IN	1.59%	2.18%	1.61%
IA	1.16%	1.89%	1.55%
KS	1.34%	1.86%	1.80%
KY	2.82%	4.74%	5.49%
LA	3.30%	3.94%	5.68%
ME	1.56%	3.31%	2.51%
MD	1.40%	1.96%	3.61%
MA	1.70%	2.76%	5.17%
MI	1.85%	3.10%	3.08%
MN	1.08%	1.79%	2.91%
MS	3.19%	4.28%	6.23%
MO	1.68%	2.66%	2.29%
MT	1.17%	2.11%	2.02%
NE	0.91%	1.69%	1.73%
NV	1.42%	1.57%	3.80%
NH	0.91%	1.75%	1.11%
NJ	1.28%	1.76%	4.72%
NM	1.85%	2.96%	6.23%
NY	2.07%	2.96%	9.19%
NC	1.93%	2.43%	3.51%
ND	0.69%	1.35%	1.60%
OH	1.89%	3.03%	2.59%
OK	1.96%	2.80%	2.84%

State	Percent under 18 on SSI	Percent 18-64 on SSI	Percent 65+ on SSI
OR	1.24%	2.29%	3.11%
PA	2.74%	3.00%	3.27%
RI	2.12%	3.16%	4.60%
SC	1.92%	2.60%	3.42%
SD	1.26%	1.86%	2.60%
TN	1.70%	3.16%	3.73%
TX	2.14%	2.20%	6.60%
UT	0.64%	1.25%	1.98%
VT	1.35%	2.83%	2.75%
VA	1.29%	1.85%	3.45%
WA	1.16%	2.28%	3.98%
WV	2.18%	5.03%	3.97%
WI	1.70%	2.17%	2.13%
WY	0.80%	1.40%	1.24%

Notes: SSI Participation counts from SSI Recipients by State and County, 2013. SSA Publication No. 13-11976. Population totals from the U.S. Census Bureau.

Figure A1: Adult SSI benefit with and without unearned income, 2015

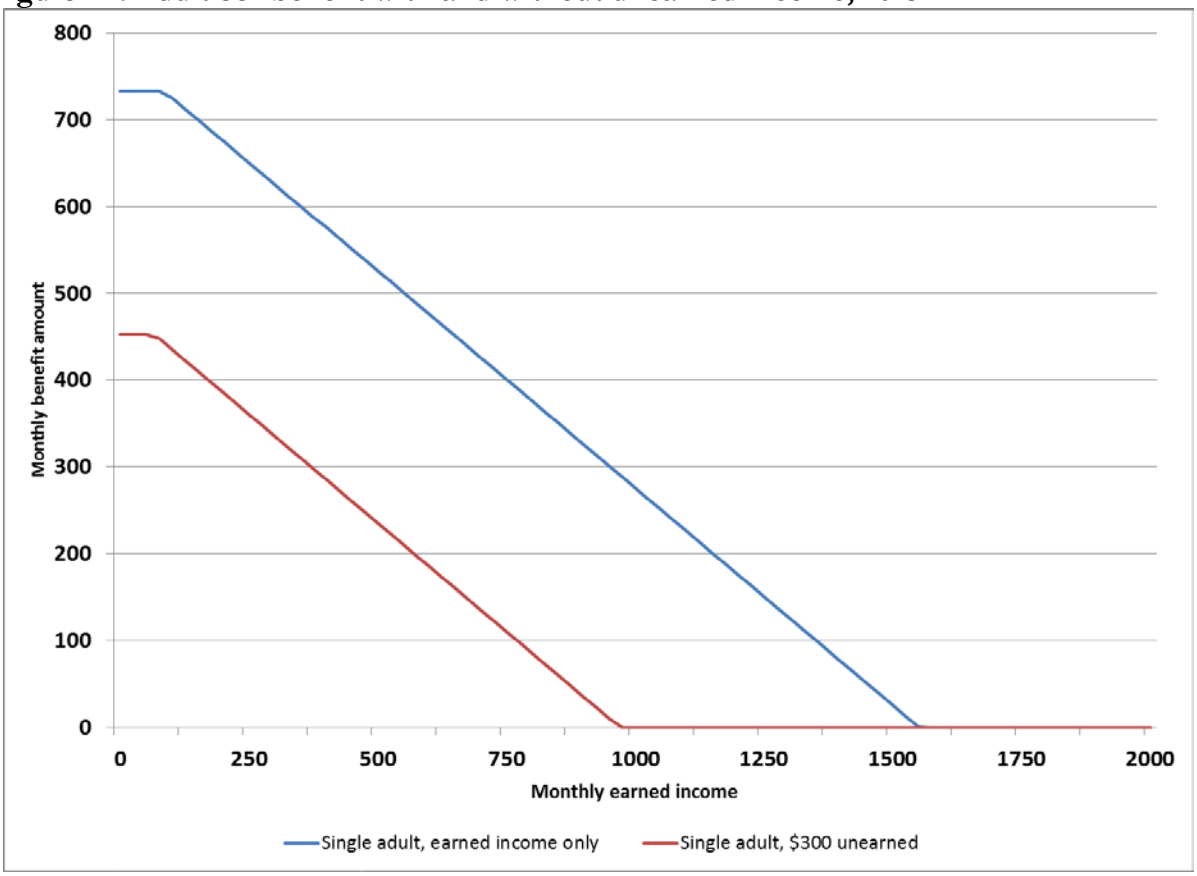


Figure A2: Adult SSI benefit based on applicant vs spouse income, 2015

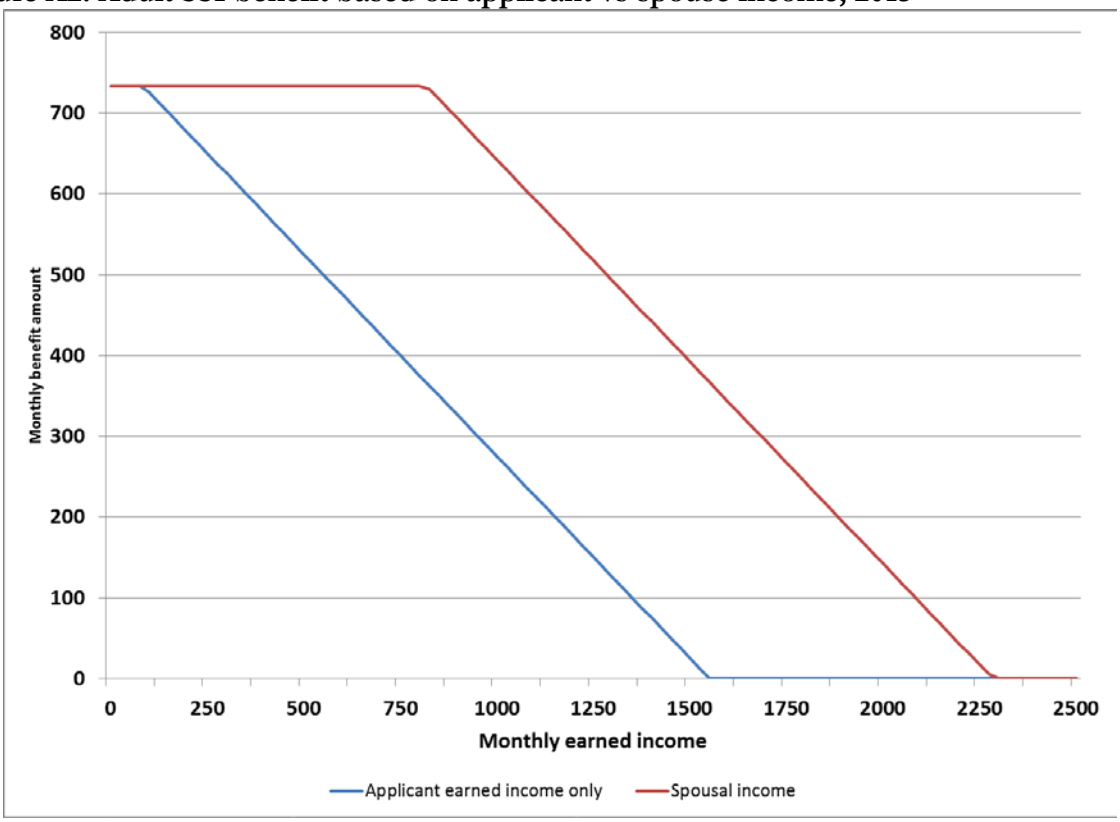


Figure A3: Child SSI based on parental earnings, with and without unearned income, 2015

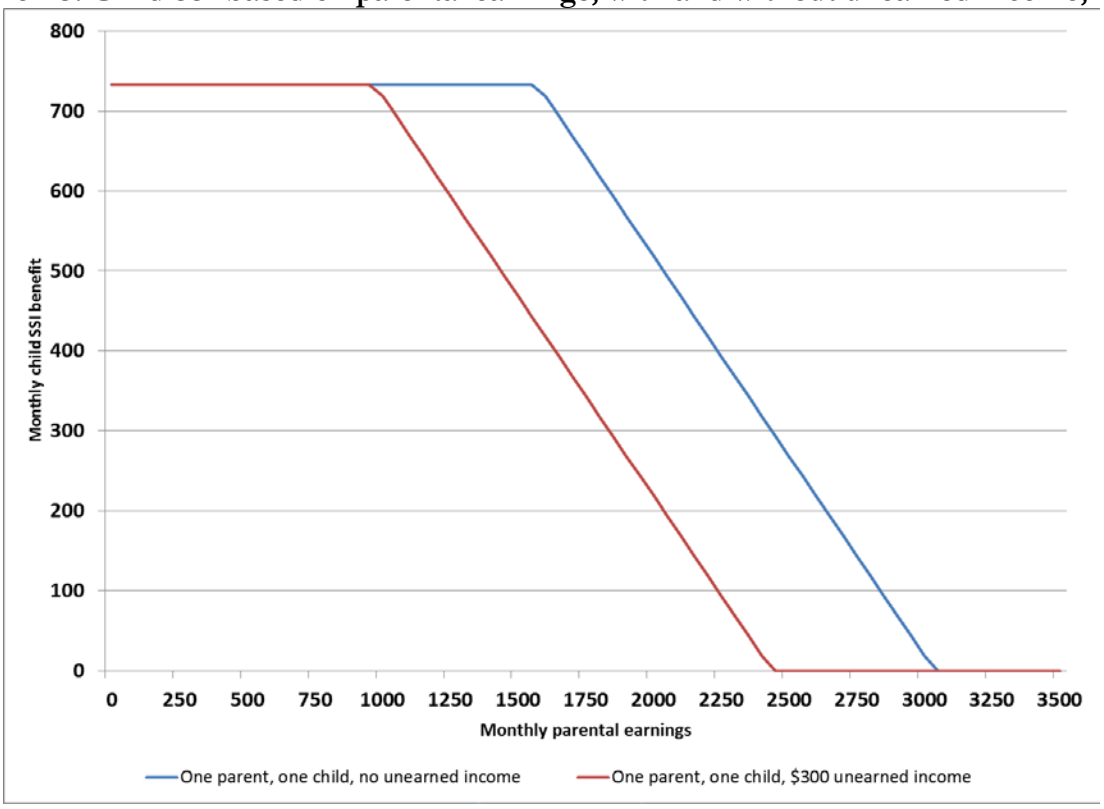
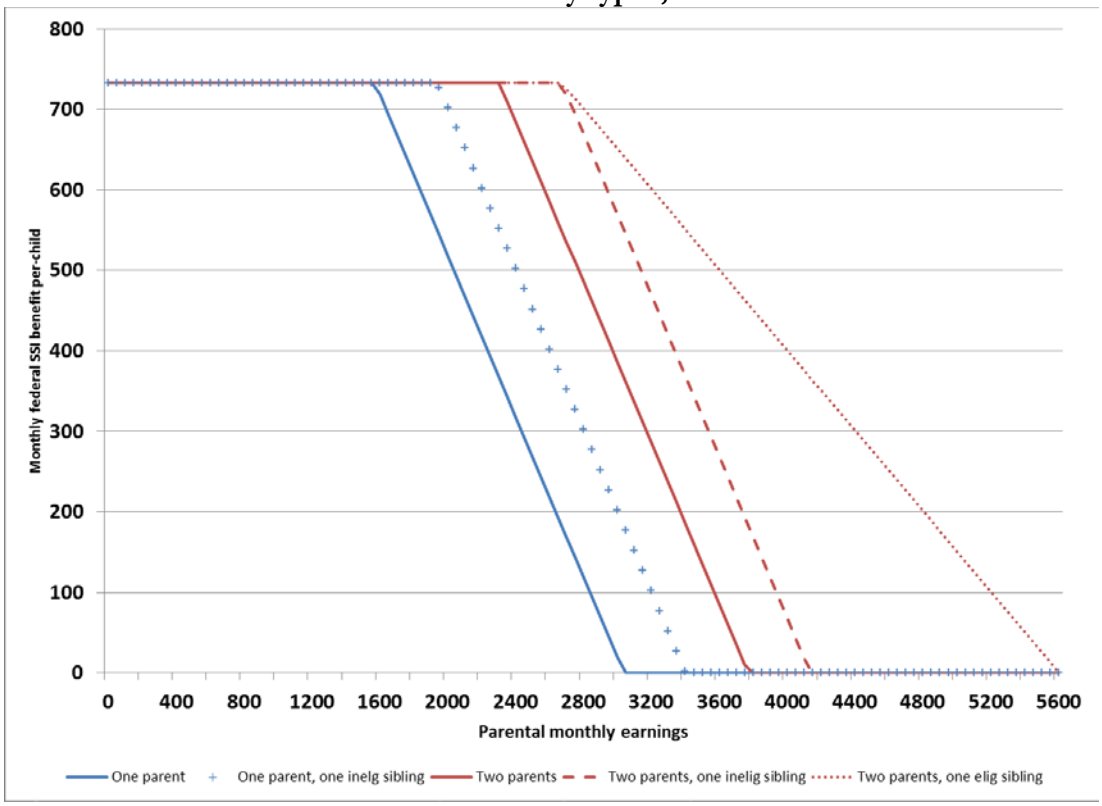


Figure A4: Child SSI benefit for different family types, 2015



Notes: Calculations in Figures A1-A4 based on formulas for benefit schedules outlined in SSA 2014c and correspondence with representatives from the Social Security Administration.