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The Supplemental Security Income Program

Mary C. Daly and Richard V. Burkhauser

2.1 Introduction

Supplemental Security Income (SSI) is a nationwide federal assistance program for aged, blind, and disabled individuals with low incomes. The SSI program was enacted in 1972 and began paying benefits in 1974, replacing a patchwork of state-run entitlement programs created under the Social Security Act of 1935 and its amendments in 1950. The establishment of SSI was the culmination of a four-year debate over a more overarching welfare reform proposal—the Family Assistance Plan (FAP)—intended to extend the federal social safety net to all low-income Americans. Although Congress eventually rejected the universality of FAP, it passed SSI, a categorical welfare program based on the same negative income tax principles as FAP but targeted on a subset of low-income individuals not expected to work—the aged, blind, and disabled.

SSI began as a relatively small program providing benefits to a largely elderly population. Since that time SSI has grown to become the largest federal means-tested cash assistance program in the United States, with a caseload dominated by children and working-age adults with disabilities. In 2001, an average of 6.7 million people—the vast majority under age

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sixty-five—received federal and state SSI benefits totaling over \$32 billion. Rapid program growth, the changing composition of SSI beneficiaries, and increasing pressure to devolve federal responsibility for social programs to state governments, as well as to integrate traditional “non-workers” into the labor market, have all raised questions about the role that SSI plays in the broader U.S. social welfare system.

In 1972, those not expected to work included individuals aged sixty-five and older, the blind, and people with disabilities. These categories have always been somewhat arbitrary and difficult to establish and assess, particularly with regard to disability. But dramatic changes in social expectations over who should work and who should be entitled to income transfers have renewed the debate over whom SSI should serve. On the one hand, individuals are living and working longer, and the Americans with Disabilities Act (ADA) has granted people with disabilities a legal right to equal access to employment, suggesting that the aged, blind, and disabled may be better able to work than in the past. On the other hand, the normal retirement age for Social Security benefits is increasing, welfare reforms have placed limits on the number of years single mothers with children may receive benefits in lieu of working, and poverty rates among children remain high. These circumstances suggest that income maintenance programs like SSI will play an increasingly important role in the U.S. social safety net. All these factors will have an impact on the politically determined boundaries of the only remaining federal cash-based means-tested entitlement program without time limits available to both adults and children.

In this chapter we provide the basic information necessary for SSI policymakers to make informed choices about its future. In section 2.2 we review the program’s history and describe the structure and evolution of SSI program rules. In section 2.3 we provide expenditure, caseload, and program recipient statistics. In section 2.4 we summarize the primary economic issues related to the SSI program. In section 2.5 we review the empirical evidence regarding these issues. We summarize our findings in section 2.6.

2.2 History and Structure of the SSI Program

The SSI program is a nationwide federal assistance program administered by the Social Security Administration (SSA), which pays cash benefits to low-income individuals who are sixty-five years of age or older or who are blind or disabled. The SSI program was enacted in 1972 and began paying benefits in 1974 replacing the state Old-Age Assistance, Aid to the Permanently and Totally Disabled, and Aid to the Blind Programs created by the Social Security Act of 1935 and its amendments in 1950. In this section we review the history of the SSI program, describe current program structure, eligibility criteria, and benefit levels, and discuss how the program’s goals and rules have evolved over time.

2.2.1 Original Rationale and Program Goals

The establishment of a federal income maintenance program for the aged, blind, and disabled, SSI was the culmination of a four-year debate that began with a more overarching welfare reform proposal, FAP, proposed by President Nixon on 8 August 1969.¹ FAP was the first serious attempt to institute a federal negative income tax program equivalent to those proposed by Stigler (1946), Friedman (1962, 1968), and Tobin (1969). FAP departed from existing welfare policy in three important ways: (a) It was universal rather than categorical, with low income and assets as the only eligibility criteria; (b) it was run through the federal tax system rather than being administered by state and local governments; and (c) it had a low benefit reduction rate, in keeping with the notion that low tax rates provide desirable work incentives.²

Congress eventually rejected the idea of an income maintenance program for all Americans with low income but on 17 October 1972 created the SSI program, a categorical welfare program targeted on the subset of the poor who were aged, blind, or disabled. The SSI program passed after FAP failed largely because Congress believed that providing income assistance to needy individuals not expected to work was likely to have a much smaller negative impact on employment than a universal negative income tax program. In 1972, those not expected to work included individuals age sixty-five and older, the blind, and people with disabilities, subgroups of the population that already were targets of state-based assistance programs.

In keeping with some of the themes of FAP, the new SSI program federalized benefit administration, set minimum benefit standards, imposed uniform eligibility criteria, and set low benefit reduction rates on labor earnings. Legislative records suggest that SSI was intended to reduce variability in the types of individuals allowed onto the rolls and in the amount of assistance they received, to make economic resources the only determinant of eligibility for those meeting the categorical requirements, and to provide incentives for beneficiaries to work to supplement their income and move toward rehabilitation (U.S. House of Representatives, Committee on Ways and Means 1971).^{3,4} Thus, under SSI, Congress federalized benefit administration, set minimum benefit standards, imposed uniform

1. See Burke and Burke (1974) and Smeeding (1994) for a more detailed historical discussion of how SSI became the nation's first negative income tax program.

2. The key features of most negative income tax (NIT) proposals are universality, federal benefit administration, and low benefit reduction rates. For a fuller discussion of the origins of NIT policy see Burkhauser and Finnegan (1989, 1993).

3. Most legislative models of the NIT, including FAP and SSI, impose both an income and an asset test. Throughout this chapter we refer to income and assets as economic resources.

4. Under the former state-run programs the amount of assistance could vary from recipient to recipient according to an individual's assessed needs, age, and living situation.

eligibility criteria, and set relatively low benefit reduction rates on labor earnings. In addition to adopting some of the administrative mechanisms of FAP, the SSI program began to blur the traditional ability-to-work standard for determining who should be entitled to public welfare payments. By extending SSI benefits to the needy families of children with disabilities, Congress expanded the social safety net to include families headed by adults who were “employable.”^{5,6}

2.2.2 SSI Eligibility Criteria

As noted earlier, SSI is an income support program for low-income individuals who are aged, blind, or disabled. Thus, SSI eligibility is a function of three program-based categorical criteria—age, disability, or blindness—as well as more general requirements associated with income and asset limits, and citizenship and residency rules. The SSA is responsible for screening applicants and making awards for SSI. Table 2.1 summarizes the SSI eligibility requirements described in detail in the remainder of this section.

Means Tests

To be eligible for SSI, individuals must fall below federally mandated income and asset limits. In 2002, the countable income limit was set at \$780 per month (\$9,360 per year) for individuals and \$1,170 per month (\$14,040 per year) for couples. The countable income limit is determined by the federal benefit rate (FBR) and increases annually with the average U.S. wage index. In general, the countable income limits fall just short of the U.S. Census Bureau official poverty thresholds.⁷ SSI applicants also must meet countable asset limits. In 2002, asset limits were set at \$2,000 for individuals and \$3,000 for couples. Unlike the countable income limits, the asset limits are not indexed for inflation. Thus, over time, countable asset limits for SSI eligibility have become stricter. Countable asset limits were last changed in 1989, rising from \$1,500 for individuals and from \$2,250 for couples.

As noted earlier, not all income received by individuals or couples is countable. Exclusions include a \$20 monthly income disregard for all forms of income with the exception of means-tested income and an additional \$65 monthly disregard for any labor income.⁸ After these disregards,

5. Poor children with disabilities had previously been included in state AFDC programs.

6. A final category of people allowed onto the SSI rolls, despite their potential to find alternative private support, were noncitizens. By law, legal immigrants had to show income sponsorship before immigrating to the United States. Largely due to the definition of income in the SSI means test, the 1972 legislation allowed sponsored immigrants who were poor to apply for SSI. This primarily affected the SSI aged program.

7. For example, in 2001, the Census Bureau poverty threshold for all single-person households (under and over age sixty-five) was \$754 per month (\$9,044 per year). The countable income cutoff for SSI was \$740 per month (\$8,880 per year) in 2001.

8. In certain cases, impairment-related expenses may be deducted from this total. Also, income is disregarded when it is used for Plans for Achieving Self Support (PASS).

Table 2.1 SSI Eligibility Requirements in 2002

Requirement	Definition	Exceptions/Exclusions
Limited income ^a	<p>Countable income must be</p> <ul style="list-style-type: none"> • below \$780 a month for single adult or child • below \$1,170 a month for couple <p>(In states that pay SSI supplements, countable income can be higher)</p>	<p>Not all income counts. Some exclusions are</p> <ul style="list-style-type: none"> • \$20 per month of most income • \$65 per month of wages and one-half of wages over \$65 • food stamps • home energy/housing assistance
Limited resources ^a (property and other assets a person owns)	<ul style="list-style-type: none"> • \$2,000 for single adult or child • \$3,000 for couple (limit applies even if only one member is eligible) 	<p>Not all resources count. Some exclusions are</p> <ul style="list-style-type: none"> • the home a person lives in • a car, depending on use or value • burial plots for individual and immediate family • burial funds up to \$1,500 • life insurance with face value of \$1,500 or less
Citizenship/residence ^b	<ul style="list-style-type: none"> • resides in one of the fifty states, Washington, D.C., or the Northern Mariana Islands; and • U.S. citizen or national; or • certain American Indians; or • lawful permanent resident with forty work credits; or • certain noncitizens with a military service connection; or • certain refugee or asylum-type noncitizens during the first seven years; or • certain noncitizens in the United States or receiving SSI on 22 August 1996 	<p>Exception to residence: certain children of U.S. armed forces personnel stationed abroad</p>

(continued)

for every \$1 in labor earnings a worker loses \$0.50 in SSI benefits. Therefore, after all income disregards, an SSI recipient faces a 50 percent implicit tax on labor earnings.⁹ Neither the income nor the asset exclusions are indexed for inflation.

In-kind assistance from government programs like food stamps and public housing are not counted as income against the individual's overall SSI benefit. All other benefits from government programs are taxed at 100

9. As we will discuss below, for those SSI beneficiaries receiving other means-tested program benefits, the effective marginal tax on work can be much higher.

Table 2.1 (continued)

Requirement	Definition	Exceptions/Exclusions
Categorical: sixty-five or older, blind or disabled; blind; disabled	<p>Meet only one of these:</p> <ul style="list-style-type: none"> • age sixty-five or older • corrected vision of 20/200 or less in better eye • field of vision less than 20 degrees • physical or mental impairment that keeps a person from performing any “substantial” work and is expected to last twelve months or result in death • for a child’s impairment, “marked and severe functional limitations” expected to last twelve months or result in death 	<p>Person whose visual impairment is not severe enough to be considered blind may qualify under the nonblind disability rules:</p> <ul style="list-style-type: none"> • A job that pays \$780 per month (\$1,300 if blind) is generally considered substantial work. • Special work incentives allow some income and resources to be excluded and permit payment of special cash benefits or continuation of Medicaid coverage even when a blind or disabled person is working.

Source: SSA (2002b).

^aIf only one member of a couple is eligible, the income and resources of both are considered in determining eligibility. If a child under age eighteen is living with parents, the parents’ income and resources are considered.

^bIf a noncitizen has a sponsor who signed a legally unenforceable affidavit of support (Immigration and Naturalization Services [INS] form I-134), the sponsor’s income and resources are considered in determining eligibility and payment amount for three years following the date of lawful admission. (This rule does not apply to noncitizens who become blind or disabled after legal admission for permanent residence or to noncitizens who are not lawful permanent residents.) If the sponsor signed the new legally enforceable affidavit of support (INS form I-864), the sponsor’s income and resources are considered until the noncitizen acquires forty work credits or becomes a citizen. (This rule applies to noncitizens who become blind or disabled after admission for permanent residence and to noncitizens who are not lawful permanent residents.)

percent. Countable resources include resources other than the home a person lives in, a car (depending on use or value), and limited amounts of life insurance and burial funds.¹⁰ In cases where an eligible individual resides in a household with ineligible individuals, a portion of the other persons’ income is considered when determining the amount of the SSI payment. This process, known as “deeming,” applies to married couples with one eligible member, parents of child applicants, and U.S. sponsors of noncitizen applicants. The deeming rules are straightforward: If an individual or couple is living in another person’s household and is receiving both food and shelter from the person in the household, the federal benefit rate is reduced by one-third.

Although the federal benefit rate—and, thus, the monthly income test—

10. In 2002, the dollar value on disregards on assets was \$4,500 for a car or medical treatment, \$1,500 on life insurance, and \$2,000 on personal property and household furnishings.

rises with inflation each year, the monthly income disregards, the asset limits, and the value of allowable assets (e.g., car, household effects) are not indexed, and thus have fallen substantially in real terms since SSI began. The real decline in the income disregards and asset limits over time has effectively eroded the value of SSI benefits and narrowed the population of potential recipients relative to 1974 levels. Consider first the 1972 set disregards of \$20 on all income and \$65 on labor income. Valued in 2002 dollars, these disregards would be \$84 and \$275 per month, respectively. Adjusting the asset limits for inflation discloses the same pattern. Valued in 2002 dollars, the asset limits set in 1972 would be \$6,345 for individuals and \$9,517 for couples,¹¹ compared to the \$2,000 and \$3,000 limits currently in place. Thus, compared to when it was enacted in 1972, SSI now covers a narrower and less economically advantaged portion of the income distribution.

Citizenship and Residency Criteria

In addition to meeting the economic resource criteria, individuals also must meet residency and citizenship requirements. To be eligible for SSI an individual must be a resident of the United States and a U.S. citizen, a U.S. national, or a “qualified alien” in an SSI-eligible noncitizen category.¹² The current SSI-eligible noncitizen categories generally can be characterized as covering individuals who were lawfully in the United States as of 22 August 1996, individuals who are refugees or in refugee-like situations, and individuals who have contributed to the country either by service in the military or through extended periods of work. These relatively restrictive allowances for noncitizens were implemented under 1996 welfare reform (PRWORA) and were a direct response to concerns that newly arrived noncitizens with immigration sponsors were increasingly applying for, and receiving, SSI benefits. The SSI provisions in the 1996 welfare reform act generally excluded these individuals from receiving SSI by mandating that the income of the noncitizen’s immigration sponsor be considered in the means test.

Categorical Eligibility Criteria

Individuals meeting income, asset, and citizenship tests may qualify for SSI benefits based on three categorical criteria: age, blindness, or disability. Applicants need only meet one of the three criteria, although some applicants fit multiple categories. The categorical program requirements for the aged and the blind are straightforward. Individuals are categorically el-

11. Had the asset limits of \$2,000 (individuals) and \$3,000 (couples) set in 1989 kept up with inflation, they would be \$2,856 and \$4,284, respectively, in 2002.

12. The term *qualified alien* is defined in section 431 of Public Law (P.L.) 104-193, as amended by P.L. 104-208 and P.L. 105-33. See Parrot, Kennedy, and Scott (1998) for a complete listing of the qualifying criteria.

igible for SSI based on age if they are age sixty-five or older. Individuals may receive SSI benefits for the blind 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. These objective standards make for relatively easy and uniform screening of aged and blind SSI applicants at offices of the SSA across the United States.¹³

In contrast, the disability screening process is more complex. First, there is no simple definition of disability.¹⁴ The most frequently applied model of disability comes from Nagi (1965, 1969a, b, 1991). In the Nagi model, disability is a dynamic process in which an individual's pathology interacts with the socioeconomic environment.¹⁵ The dynamic nature of the disability process is represented by the movement through three stages: pathology, impairment, and disability. The first stage, pathology, is the presence of a physical or mental condition that interrupts the physical or mental process of the human body. An example is deafness. This leads to the second stage, impairment, which Nagi defines as "a physiological, anatomical, or mental loss or abnormality that limits a person's capacity to function." For example, deafness limits the ability to interpret sound. The final stage, disability, is an inability to perform or a limitation in performing roles and tasks that are socially expected. For example, a person with deafness is unable to use the telephone. Under the Nagi model, those with a pathology that causes a physical or mental impairment that subsequently limits one or more life activities—such as work—but who nevertheless work would not be considered to have a work disability.¹⁶ (This is the case whether work was possible through changes in the work environment, ac-

13. Although the measurement of these "objective standards" is relatively straightforward, the justification for using them as standards for inability to work is less so. A literature exists that argues that categorical age is not a useful measure of ability to work. A parallel literature exists that suggests that functional ability rather than medical condition is a superior criterion for determining ability to work (Library of Congress 1998; Wunderlich, Rice, and Amado 2002).

14. Mashaw and Reno (1996) argue that the appropriateness of any definition of disability depends on the purpose for which it is used. They document over twenty definitions of disability used for purposes of entitlement to public or private income transfers, government services, or statistical analysis. In the ADA of 1990, disability is defined as a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment. La Plante (1991) provides a useful discussion of alternative definitions that can be used to estimate this population. Burkhauser, Houtenville, and Wittenburg (forthcoming) provide detailed analyses of different definitions of disability in national representative U.S. surveys.

15. The World Health Organization (WHO) has a model of disability very similar to that of Nagi. The key to both of these definitions is the recognition that individuals move from the presence of a health condition to a point where it begins to impinge on activities that are socially expected of them and that this movement is related to the environment in which individuals live. See Jette and Badley (2002) for an excellent comparison of the Nagi and WHO models.

16. This measure closely resembles what Verbrugge (1990) calls social disability, or the intersection of an individual's physical impairment (e.g., deafness) and the environmental challenges of the activities required by a social role, such as work.

cess to rehabilitation, or individual adaptability.)¹⁷ The first component is the presence of a pathology—a physical or mental malfunction, or the interruption of a normal process, or both. This leads to a second component, an impairment, which Nagi defines as a physiological, anatomical, or mental loss or abnormality that limits a person's capacity and level of function. The final component of disability is defined as an inability to perform, or a limitation in performing, socially expected roles and tasks. For men and, increasingly, for women of working age, market work is a socially expected role. Hence, those who are unable to perform or are limited in their ability to work are considered disabled.

The disability determination process for SSI incorporates some of the reasoning put forth in Nagi's disability definition. Applicants for disability benefits move through a multistep process in which their pathology, impairment, and level of functioning are judged. Applicants thought to be unable to engage in any substantial work become eligible for benefits. Below we describe the process of disability determination for both adults and children applying for SSI disability benefits.

Like the aged and blind, persons seeking disability benefits also apply at an office of the SSA. Once the federal officials and the applicant have gathered sufficient information to complete the application, it is submitted to a state agency for determination of disability. State disability examiners, working with vocational and medical consultants, act as the primary gatekeepers of both SSI and Social Security Disability Insurance (SSDI).¹⁸ Disability decisions are made by state agencies acting under contract to the federal government. Therefore, although disability eligibility criteria are uniform across the country, the interpretation of these criteria, and hence the disability determination process itself, can and does systematically vary from state to state and over time. Table 2.2 shows differences in mean allowance rates (initial acceptances to initial applications), by state between 1974 and 1993. As the table indicates, mean allowance rates vary considerably across states, ranging from lows of 28 in Louisiana and New Mexico to highs of 48 in Delaware, New Jersey, and Rhode Island.

Disability Screening for Adults

SSA defines adult disability as the inability to engage in substantial gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last at least twelve months.

17. For example, a person with deafness who is accommodated at the workplace with a Telephone Typewriter machine that permits him or her to use the telephone.

18. SSDI is a social insurance program that provides payments to individuals who have paid Social Security taxes for the appropriate number of quarters and who are judged to be disabled under the SSA guidelines. Unlike SSI, it is not means-tested. However, it does have restrictions on labor earnings consistent with its criteria for disability eligibility. See Bound and Burkhauser (1999) for a fuller discussion of this program from an economic perspective.

Table 2.2 Mean Disability Allowance Rates by State, 1974–93

Current State of Residence	Mean	Standard Deviation
Alabama	32	4.8
Arizona	41	6.0
Arkansas	32	5.6
California	37	7.5
Colorado	40	5.8
Connecticut	45	8.9
Delaware	48	4.7
District of Columbia	39	8.0
Florida	37	6.4
Georgia	33	7.2
Illinois	37	5.8
Indiana	40	7.3
Iowa	44	8.7
Kansas	41	5.2
Kentucky	33	3.8
Louisiana	28	8.4
Maine	44	6.1
Maryland	37	5.1
Massachusetts	44	7.8
Michigan	37	6.8
Minnesota	45	7.5
Mississippi	31	5.9
Missouri	38	6.8
Montana	37	6.5
Nebraska	43	6.1
Nevada	39	6.9
New Hampshire	42	5.5
New Jersey	48	9.4
New Mexico	28	5.3
New York	41	9.2
North Carolina	40	6.1
North Dakota	42	5.9
Ohio	42	7.8
Oklahoma	33	6.7
Oregon	37	6.7
Pennsylvania	39	7.4
Rhode Island	48	4.7
South Carolina	37	4.7
South Dakota	46	4.5
Tennessee	35	6.4
Texas	34	6.2
Utah	45	5.9
Vermont	46	5.3
Virginia	36	3.4
Washington	40	8.4
West Virginia	30	8.3
Wisconsin	46	6.5
Wyoming	39	5.1
Total	39	8.2

Source: Burkhauser et al. (1999).

Notes: The mean allowance rate for a state is defined as the mean of the state's yearly initial acceptance to initial application ratio for the years 1974–93. Allowance rates are based on SSDI applications and acceptances.

Applicants must be unable to do any work that exists in the national economy for which they are qualified by virtue of age, education, and work experience. The United States does not award federal disability benefits for partial disability.¹⁹

As a practical matter, SSA asks the state disability determination offices to follow a five-step procedure in their initial disability determination.²⁰ First, the examiners check to see if applicants are currently working and making more than the “substantial gainful activity” (SGA) amount—\$780 a month in 2002. If so, their application is denied. As can be seen in figure 2.1, almost no cases are rejected in this manner, since presumably the SSA field offices have already checked to see if applicants are working before they send applications to the disability determination office.²¹ Second, the state disability examiners determine if the applicant has a severe impairment that is expected to last twelve months or result in death. If not, the application is denied. About 20.1 (13 + 7) percent of all applicants were denied at this step in 2000. Third, the state disability examiners look to see if the impairment meets the medical listings. If the impairment is listed, applicants pass the categorical screening for disability. If the impairment is judged to be equivalent to one of the medical listings, then applicants also meet the categorical requirement for benefits. Most recipients who pass the disability screening do so at this stage because their impairment either meets or equals one on the medical listing (22 percent of all applicants were approved at this step in 2000).

Fourth, if a decision cannot be reached on medical factors alone, applicants are evaluated in terms of residual functional capacity. If they are found to be able to meet the demands of “past relevant work” their claim is denied (20 percent of all applicants were denied at this step in 2000). If individuals are deemed unable to do past relevant work, examiners determine if the impairment prevents the applicant from doing any other work. Here vocational factors are considered. If, for example, applicants’ maximum sustained work capacity is limited to sedentary work and they are at least age fifty to fifty-four, with less than a high school education and no skilled work experience, then they would be considered disabled and pass the categorical screening. In contrast, if applicants’ previous employment experience includes skilled work, then they would not receive benefits. At

19. However, as will be shown later, in some instances the SSI program allows individuals with disabilities to exceed the earnings limit and continue to receive SSI benefits, making it a type of partial disability insurance. Most other western industrialized countries provide partial disability benefits to their working-age populations. For a discussion of disability program rules in other western industrialized nations see Aarts, Burkhauser, and deJong (1996).

20. Our discussion of the adult disability determination process draws heavily on Bound and Burkhauser (1999).

21. The percentages in figure 2.1 are based on outcomes from initial SSDI applications, the data available from published sources. However, there is no reason to believe that the patterns for SSI would be significantly different.

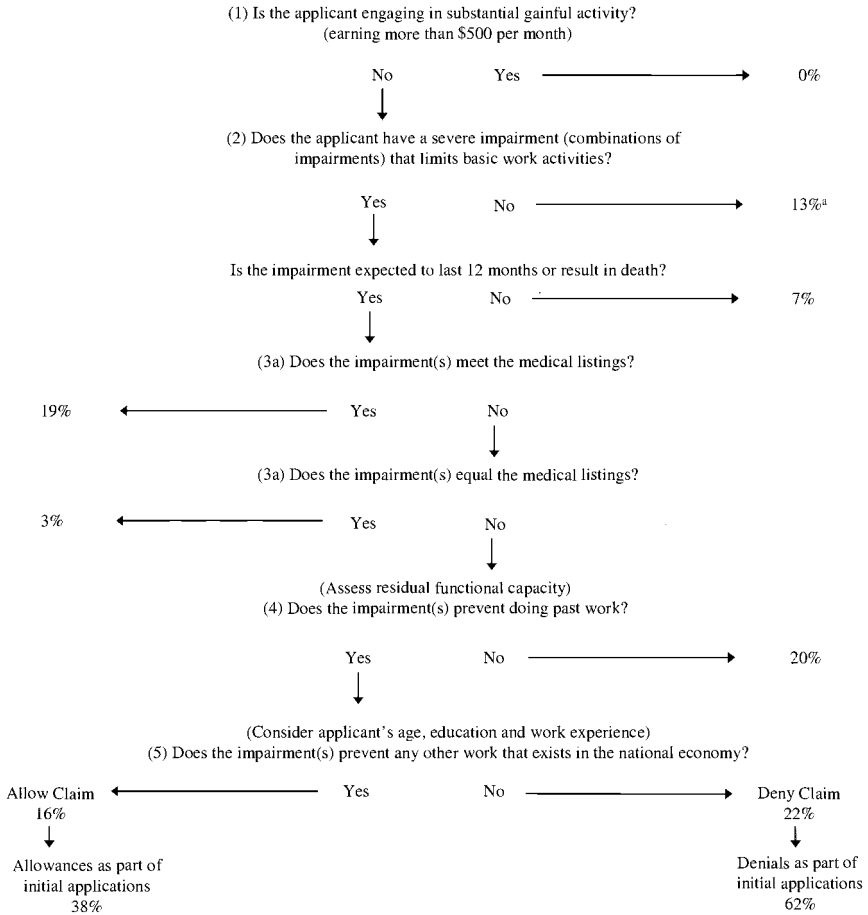


Fig. 2.1 SSA initial disability determinations, sequential decision-making process, and outcomes of decisions on initial SSDI applications, 2000

Source: Authors' calculations using SSA Office of Disability data, SSA-831 Disability Decision file.

^aThis response includes 5 percent of claims that were denied because the applicant failed to cooperate in obtaining evidence needed for the claim. The other 8 percent were denied for "impairment not severe."

this stage, 16 percent of all applicants were determined eligible for benefits and 22 percent were denied benefits in 2000.

Applicants who are denied benefits can ask for a reconsideration. Their file will then be reviewed by a second team of examiners. If they are rejected after reconsideration, individuals may appeal the case to an administrative law judge. It is at this stage that applicants will for the first time come face to face with a gatekeeper. Individuals denied benefits at this stage may appeal the decision to the Social Security Appeals Council and then to the

district courts. In 2001, about 33 percent of those initially denied benefits appealed the decision. About 10 percent of those who appealed the decision eventually were awarded benefits (SSA *SSI Annual Statistical Report*, 2002b).²² For the claimants who are allowed benefits at the initial level or who do not appeal, the application and decision process usually takes a few months. For those who appeal to the administrative law judge, the process can take a year or more.

Disability Screening for Children

Screening children for disability eligibility has proven to be even more complex and contentious than adult disability screening. When the SSI program was originally considered, Congress recognized the potential difficulties of applying the standard SSA disability definition to children. Thus, under the original legislation, Congress wrote that a child should be considered disabled if “he suffers from any medically determinable physical or mental impairment of comparable severity” to a disabling impairment in an adult (SSA 1997). In practice, children originally qualified for SSI if they had “a medically determinable physical or mental impairment which results in marked and severe functional limitations, and which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.” Between 1974 and 1989 the child disability determination process did not include a functional assessment or take into account the equivalent of adult vocational factors. See figure 2.2 for a comparison of the child and adult initial disability determination process.

This changed in 1990, when the Supreme Court decided the case of *Sullivan v. Zebley*. The court ruled that in order to meet the standard of equal treatment, a functional limitation component parallel to that of adults must be included in the initial disability determination process for children. In response, SSA added two new bases for finding children eligible for benefits: (a) functional equivalence, which was set at the medical listing level of the disability determination process, and (b) an individual functional assessment (IFA), which was designed to be parallel with the functional and vocational assessment provided for adults. By allowing applicants who did not meet the medical listing to be found disabled if their impairments were severe enough to limit their ability to engage in age-appropriate activities, such as attending school, the IFA lowered the level of severity required for children to be eligible for SSI benefits (U.S. GAO 1994, 1995).²³

22. There is some evidence that the proportion of claimants who appeal and the proportion of decisions that get reversed rise and fall with the percentage of initial denials (Lando, Cutler, and Gamber 1982).

23. Following the Zebley decision a large number of previously denied cases were reassessed and awarded disability benefits. This can be seen in the caseload statistics presented later in this chapter.

Adults	Children: Pre-Zebley	Children: Post-Zebley	Children: Post 1996 Welfare Reform
1. Are you working? Y = Deny N = Deny	1. Are you working? Y = Deny	1. Are you working? Y = Deny N = Deny	1. Are you working? Y = Deny N = Deny
2. Do you have a severe impairment? N = Deny	2. Do you have a severe impairment? ^b N = Deny	2. Do you have a severe impairment? ^b N = Deny	2. Do you have a severe impairment? ^b N = Deny
Compare impairment to medical listings	Compare impairment to medical listings	Compare impairment to medical listings	Compare impairment to medical listings
Mental	Mental	Mental	Mental ^f
Other	Other	Other	Other
3a. Meet both diagnostic (A) and functional (B) criteria? Y = Allow	3a. Meet both diagnostic (A) and functional (B) criteria? Y = Allow	3a. Meet both diagnostic (A) and functional (B) criteria? Y = Allow	3a. Meet both diagnostic (A) and functional (B) criteria? Y = Allow
3b. Medically equal medical listings? Y = Allow	3b. Medically equal medical listings? Y = Allow	3b. Medically equal medical listings? Y = Allow	3b. Medically equal medical listings? Y = Allow
3c. Meet criteria in medical listings? Y = Allow; N = Deny	3c. Meet criteria in medical listings? Y = Allow; N = Deny	3c. Medically equal medical listings? Y = Allow	3c. Functionally equal medical listings? Y = Allow
Assess residual functional capacity (RFC)			
4. Can you do past work? Y = Deny		Do individualized functional assessment	
Consider age, education and work experience		4. Given IFA, is impairment(a) of comparable severity to that which would disable an adult? Y = Allow; N = Deny	
5. Can you do any other work? N = Allow; Y = Deny			

Fig. 2.2 Sequential initial disability determination process for children

Source: Created by authors using disability determination guidelines in SSA *Annual Statistical Supplement* (various years).

^aBefore 1990, SSA policy in SS Ruling 83-19 explicitly prohibited using an overall functional assessment to find that a claimant's impairment equaled the medical listings. A claimant with multiple impairments could meet or equal the listings only if at least one impairment, alone, met or medically equaled a specific listing.

^bA medically determinable physical or mental impairment of comparable severity to one meeting adult definition.

^cThe childhood mental disorders listings were modified in 1990 to include functional criteria similar to those put in the adult listings in 1985.

^dA medically determinable physical or mental impairment that results in marked and severe functional limitation.

In 1996, as part of welfare reform, Congress modified the definition of disability for children. Legislators replaced the comparable severity (to adults) criterion with a definition of disability that is unique to children. Under the new definition, a child's impairment—or combination of impairments—is considered disabling only if “it (they) results in marked and severe functional limitations, is expected to result in death or has lasted or can be expected to last at least 12 months” (SSA 1996). The new focus on assessing the severity of impairments among children was reflected in changes in the evaluation process. The legislation removed the IFA, replacing it with a criterion based on functional equivalence or evaluations of the extent to which impairments create medical listing-level severity. The revised rules defined medical listing-level severity for functional limitations as (a) marked limitations in two broad areas of functioning, such as social functioning or personal functioning, or (b) extreme limitations in one area of functioning, such as inability to walk (SSA 1997). In practice these changes meant that although functional limitations continued to include behavior-related limitations, they no longer covered the same breadth of functioning included in the IFA. For example, Congress specifically removed maladaptive behavior disorder from the functional listing criteria. Thus, the post-1996 standard represents a broader measure of disability than originally applied to children, but a narrower standard than the one used between 1990 and 1996 (see figure 2.2).

2.2.3 SSI Benefits

Federal Benefit Levels

Each eligible SSI beneficiary in his or her own household with no other countable income received a federal cash payment of \$545 per month in 2002 (\$817 for jointly eligible couples). The federal SSI benefit is increased each January by the cost-of-living index used to adjust all Social Security Old-Age, Survivors, and Disability Insurance (OASDI) benefits. Although the original objective of the SSI program was to guarantee an income at the poverty level, from the beginning the federal minimum SSI benefit was set below the official Bureau of the Census poverty line. Excluding state supplementation, SSI payments represent about 75 percent of the poverty threshold for an eligible individual, and about 90 percent of the threshold for an eligible couple; these percentages have remained relatively constant over time.²⁴

SSI recipients are required by law to apply for every government pro-

24. This difference arises in part because the SSI program and the U.S. poverty thresholds assume different economies of scale. The SSI program assumes that a single person needs 67 percent of the couple benefit to be equally well off; the U.S. poverty threshold assumes that a single person needs 80 percent of the couple benefit to maintain an equivalent standard of living.

gram for which they may be eligible. In most states, recipients receive state supplemental payments and become eligible for Medicaid and food stamps without making a separate application.^{25,26} Since 1986 SSI benefits and eligibility for Medicaid have been continued for those who earn above the SGA; this is known as 1619(b) status.²⁷ In general, the special eligibility test for Medicaid applies if the individual has earnings over the level that offsets his or her SSI benefits but is still lower than a threshold amount established in the state in which he or she resides.²⁸ Adult SSI recipients with disabilities also are eligible for federally funded, state-administered vocational rehabilitation.²⁹

State Supplementation

In designing the SSI program Congress recognized that states may want to boost benefit levels beyond the federal program. In addition, Congress wanted to ensure that those states paying above the federal level in 1972 would continue to provide the same level of assistance as they had prior to the federalization of SSI. As a result of these two goals, there are two types of state supplementation for SSI: mandatory and optional.³⁰ Under mandatory supplementation, states whose Old-Age Assistance and Aid to the Permanently and Totally Disabled benefits were greater than the federal minimum had to make up the difference in mandatory state supplements.³¹ Although nearly every state was subject to mandatory supplementation in 1972, increases in federal benefit levels over the years have left only a few SSI beneficiaries receiving mandatory payments today.

In 2000, forty-five states and the District of Columbia provided optional supplemental benefits (columns [1–3], table 2.3). States offering supplements can follow the same rules as the federal SSI program and have the program administered by SSA, or they can administer their own program

25. We discuss states' latitude in determining Medicaid eligibility for SSI recipients later in this section.

26. In most cases, individuals who are eligible for SSI are categorically eligible for food stamps. The exceptions to this general rule are SSI beneficiaries living in households where other members do not receive and are not applying for SSI. These individuals must apply for food stamps at the local food stamp office and meet the household income test to obtain food stamp eligibility.

27. In 1995, only about 46,000 (1.3 percent) of the 3.5 million SSI disability recipients were in 1619(b) status (Mashaw and Reno 1996).

28. In making this determination, the SSA takes the average expenditures on Medicaid and SSI (including state SSI) and compares this amount to an individual's earnings.

29. The Ticket to Work/Work Incentives Improvement Act of 1999 expanded the eligible pool of vocational rehabilitation providers available to disabled SSI recipients by allowing beneficiaries to receive vocational rehabilitation services from not-for-profit and for-profit vendors. The first tickets from this program were issued in 2002.

30. For a detailed description of state supplementation see Ponce (1996).

31. Mandatory state supplements applied to individuals receiving benefits in December 1973.

Table 2.3 SSI State Supplementation and Coordination with Other Programs

United States and District of Columbia	Administration of Optional State Program ^a			Method of Mandatory Passalong		Medical Eligibility Determination		Interim Assistance Reimbursement Agreement with SSA
	State	Federal (SSA)	Federal and State	Payment Levels	Total Expenditures	Federal Criteria	State Criteria	
Alabama ^b	*			*		*		*
Alaska	*			*		*		*
Arizona	*			*		*		*
Arkansas ^c				*		*		*
California	*	*		*	*	*		*
Colorado	*			*	*	*		*
Connecticut ^b	*			*		*	*	*
Delaware	*	*		*		*		*
DC		*		*	*	*		*
Florida ^b	*			*		*		*
Georgia ^c				*		*		*
Hawaii		*		*		*	*	*
Idaho	*			*		*		*
Illinois	*			*		*	*	*
Indiana	*			*		*		*
Iowa			*	*	*	*		*
Kansas ^c				*		*		*
Kentucky ^b	*			*		*		*
Louisiana ^d	*			*		*		*
Maine	*			*	*	*		*
Maryland ^d	*			*		*		*
Massachusetts		*		*		*		*
Michigan			*	*		*		* ^c
Minnesota ^b	*			*		*	*	*
Mississippi ^c				*		*		*
Missouri	*			*		*	*	*
Montana		*		*		*		*
Nebraska	*			*	*	*		*
Nevada ^b		*		*		*		*
New Hampshire	*			*		*	*	* ^c
New Jersey		*		*		*		*

(continued)

Table 2.3 (continued)

United States and District of Columbia	Administration of Optional State Program ^a			Method of Mandatory Passalong			Medical Eligibility Determination			Interim Assistance Reimbursement Agreement with SSA
	State	Federal (SSA)	Federal and State	Payment Levels	Total Expenditures	Federal Criteria	State Criteria	SSA		
New Mexico	*			*		*		*	*	* ^c
New York			*	*		*		*	*	*
North Carolina	*			*		*		*	*	*
North Dakota ^b	*			*		*	*	*	*	*
Ohio ^d	*			*		*	*	*	*	*
Oklahoma	*			*	*	*	*	*	*	*
Oregon	*			*	*	*	*	*	*	*
Pennsylvania	*	*		*		*		*	*	*
Rhode Island ^b	*	*		*		*		*	*	* ^c
South Carolina ^b	*			*		*		*	*	*
South Dakota ^d	*			*		*		*	*	*
Tennessee ^c	*			*		*		*	*	*
Texas ^f	*			*		*		*	*	*
Utah ^b		*		*		*		*	*	*
Vermont ^b			*	*		*		*	*	*
Virginia	*			*	*	*	*	*	*	*
Washington			*	*		*		*	*	*
West Virginia ^f	*			*		*		*	*	*
Wisconsin	*			*		*		*	*	*
Wyoming	*			*		*		*	*	*
Total states	29	11	5	40	10	40	11	33		38

Source: SSI Annual Statistical Report (SSA 2002b).

^aSee body of text for description of the various forms of state supplementation.

^bState no longer has any recipients receiving mandatory minimum state supplementation.

^cMandatory minimum state supplementation program is federally administered. No optional program.

^dMandatory minimum state supplementation program is federally administered.

^eState provides assistance only in initial application cases. No assistance provided during periods that SSI benefits are suspended or terminated.

^fState does not have a mandatory minimum state supplementation program.

and use state-specific eligibility criteria. Despite the apparent cost advantage to federal administration, states have increasingly opted for state administration of supplemental payments. About three-quarters of states providing optional supplementation administer their own programs or jointly administer them with the federal government. Only eleven states rely solely on federal administration.

Although a majority of states have optional supplementation programs, a number of factors minimize the importance of these programs. First, only twenty-three states provide supplements to the vast majority of SSI recipients living independently in their own households.³² In the remaining states with optional programs, supplements are paid only to the minority of SSI recipients living in institutions.³³ Second, because state supplements are not annually adjusted for inflation, the real value of the median state supplemental payment to individuals living independently declined by about 60 percent between 1975 and 1997.³⁴

That being said, public concern over states' reducing their SSI supplemental payments when federal benefit levels rise led Congress to mandate that states pass along SSI benefit increases resulting from annual cost-of-living adjustments. States may meet this passalong requirement by maintaining payment levels year to year (the payment levels method) or they may spend the same amount of money in the aggregate that they spent the year before the federal benefit rose (the total expenditure method). In 2002, forty states used the payment levels method and ten states used the expenditures method (columns [4–5], table 2.3).

Coordination with Other Programs

In addition to SSI federal and state cash payments, SSI beneficiaries frequently gain automatic eligibility to Medicaid and Food Stamp programs. Generally, SSI recipients are categorically eligible for Medicaid. A state may either use SSI eligibility criteria for determining Medicaid eligibility, or it may use its own criteria as long as the criteria are no more restrictive than the state's January 1972 medical assistance standards.³⁵ Forty states use SSI criteria and eleven states use eligibility criteria more restrictive than those of the SSI program (see columns [6–7], table 2.3). States may also enter into agreements with SSA to make Medicaid eligibility determinations for them, based on the federal SSI criteria; thirty-three states have such contracts with SSA (column [8], table 2.3).

32. Over 90 percent of SSI recipients live in their own households (U.S. House of Representatives, Committee on Ways and Means 1998).

33. One explanation for the ongoing supplementation of SSI recipients living in institutions is that supplementary SSI payments provide states with a mechanism of supporting such facilities.

34. Over time some states have even reduced the nominal value of supplemental payments.

35. This final option is known as the 209(b) option.

With the exception of California, SSI recipients in all states may be eligible for food stamps.³⁶ The SSA offices notify applicants and recipients of SSI of their potential eligibility for food stamps. Eligibility for the Food Stamp Program is determined by the food stamp office.

Finally, thirty-eight states (column [9], table 2.3) have agreements with SSA to be reimbursed for basic needs assistance provided during the period during which an eligible individual's SSI application for benefits was pending, or an individual's SSI benefits were suspended and subsequently reinstated.

2.2.4 Administration and Financing

As a federal income maintenance program, SSI is funded from general revenues and is administered by the SSA. Although, as discussed earlier, many states supplement federal benefit levels, over time the share of supplemental benefits paid by states has declined. In 1975, state SSI expenditures accounted for approximately 27 percent of total SSI payments. In 2001, state supplemental payments amounted to about 11 percent of annual SSI expenditures (SSA 2002a).³⁷

2.2.5 Summary

Although the goals of the SSI disability program have not changed since its inception in 1974, its structure has been subject to numerous legislative, administrative, and court actions. These actions have primarily focused on making the disability criteria more target effective and on enhancing incentives aimed at returning recipients to the workforce. For the child disability component of the program, changes have focused on providing an appropriate vocational criterion for children that does not unduly discourage rehabilitation and school success. Notably, there have been few changes to the means test criteria and no adjustment for inflation in these criteria, meaning that over time, the amount of income that will disqualify one for SSI has fallen in real terms, or, simply put, the means test has become more restrictive. Finally, other legislative efforts have centered on limiting the eligibility of noncitizens. The legislative history of SSI shows that the primary mechanisms used by policymakers to alter the coverage and the generosity of SSI have been changes in the categorical eligibility criteria, rather than changes in the size of SSI benefits.

36. California cashes out food stamps, and SSI recipients in California receive a cash payment in their state supplementary payment in lieu of food stamps.

37. The numbers reported reflect the average for all states. Looking across states, in January 1999, the federal share of the maximum SSI benefit ranged from 58 percent in Alaska and 74 percent in California to 100 percent in the eight jurisdictions without a supplemental program (CRS 1999).

2.3 Program Statistics

2.3.1 Trends in Expenditures, Caseloads, and Benefits

The SSI program has grown substantially in both recipients and expenditures since it first paid benefits in 1974. However, its growth has varied over time (figure 2.3). Between 1974 and 1982, caseloads fell by 4.5 percent and real federal expenditures declined by about 15 percent. This decline caused concern among policymakers that too few potentially eligible recipients were enrolling (Menefee, Edwards, and Schieber 1981). After this slow start, the number of SSI beneficiaries increased steadily until 1996, growing from roughly 3.9 million in 1982 to 6.6 million in 1996, a 70 percent increase. Federal payments for the program rose even faster during this period, with the greatest growth between 1989 and 1992. Valued in 2001 dollars, total annual payments increased from \$17.6 billion in 1982 to \$32.5 billion in 1996, an increase of about 85 percent. Between 1996 and 2001 (the last year of data available) caseloads and expenditures have risen by less than 2 percent. Despite rapid growth in the SSI program over time, as a percentage of total federal outlays SSI expenditures have remained relatively stable at 1.9 percent since the program began in 1974.

2.3.2 Trends in Characteristics of Recipients

Originally considered a program for the elderly, SSI is now dominated by adults and children with disabilities. Figure 2.4 shows the age composition of SSI beneficiaries between 1974 and 2001. In 1974, the majority of the SSI caseload was over the age of sixty-five. The number of aged beneficiaries peaked at 2.5 million in 1975, gradually dropped to around 2 million in 1982, and remains at about that level. In contrast, the number of blind and disabled adults (aged eighteen to sixty-four) on SSI has more than doubled since 1974, with the most rapid growth occurring after 1982.³⁸ In December 2001, 3.8 million adults aged eighteen to sixty-four received SSI benefits, about 2.1 million more than in 1982. The number of blind and disabled recipients who are under age eighteen has also grown substantially in recent years.³⁹ Between 1974 and 1989 the child caseload increased to about 185,000. However, following the Zebley decision in 1990, the number of blind and disabled children rose rapidly, reaching 955,000 by 1996.⁴⁰ Since then, child SSI rolls have declined slightly, falling to 881,000 in 2001.

38. This growth is almost entirely due to increases in the number of disabled beneficiaries. The number of working-age SSI recipients eligible due to blindness has remained relatively constant over time (SSA *Annual Statistical Supplement*, various years).

39. Again, the growth is almost entirely explained by increases in the number of disabled children.

40. As noted earlier, this increase was due both to the reassessment of previously denied cases and to the increase in applications due to the more lenient eligibility rules.

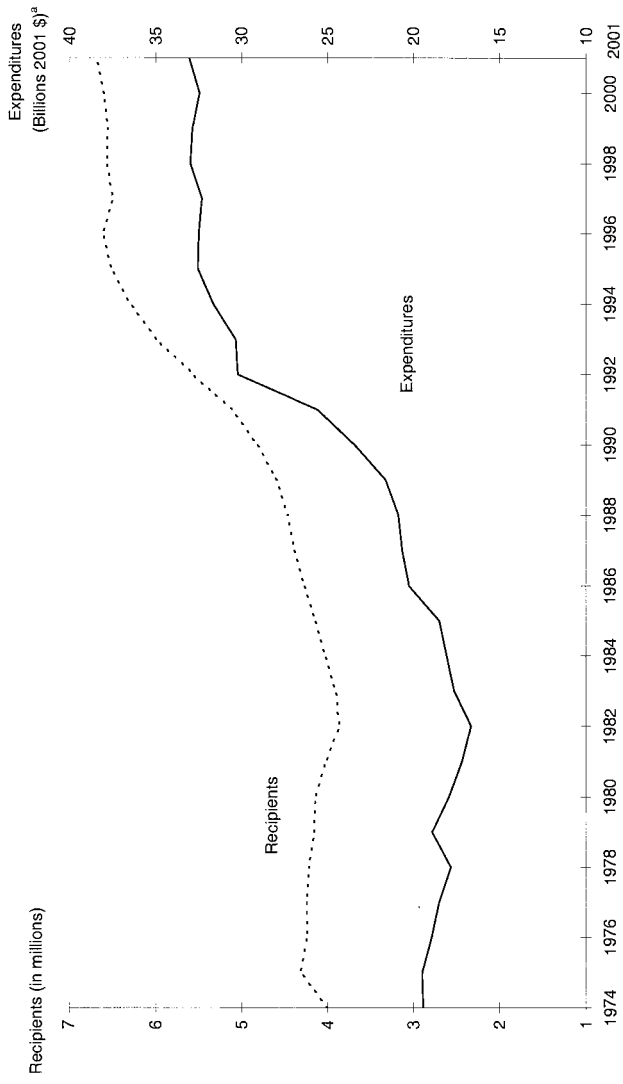


Fig. 2.3 SSI program growth, 1974–2001

Source: SSA (2000, 2002b).

^aAnnual expenditures estimated from monthly amount from December of each year.

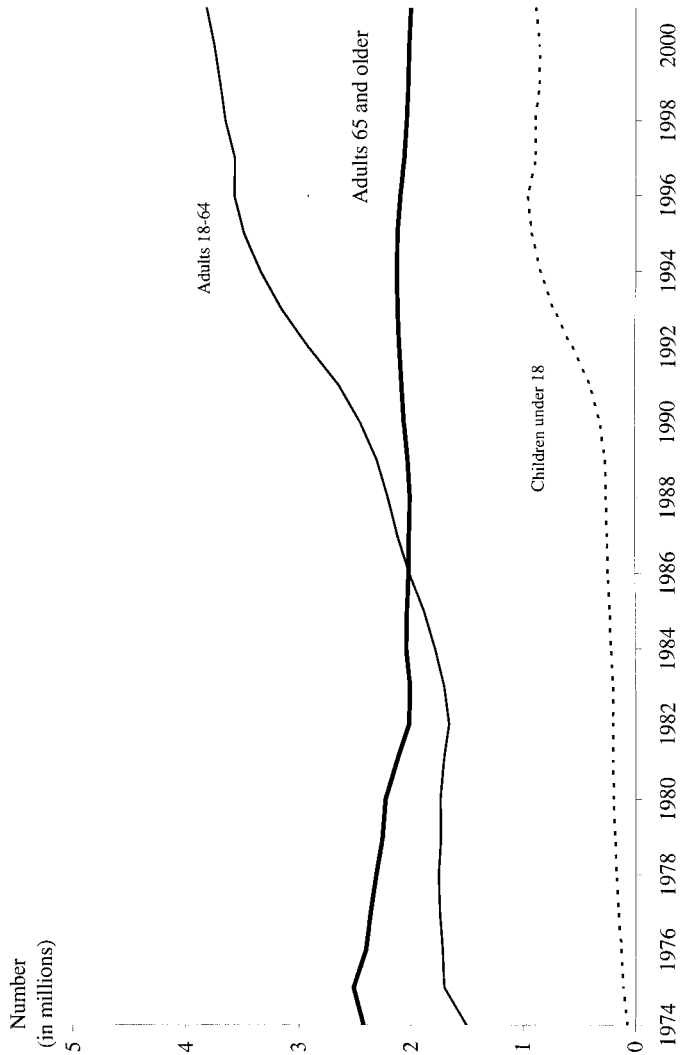


Fig. 2.4 SSI caseloads by age group, 1974-2001

Source: SSA (various years).

Table 2.4 Trends in Key Characteristics of SSI Beneficiaries, 1975–2001

	1975	1984	1987	1990	1992	1994	1996	2001
<i>All SSI Recipients</i>								
<i>Age</i>								
Less than 18	2.5	5.3	5.7	6.4	10.0	13.4	14.4	13.2
18 to 64	39.4	44.2	48.3	50.9	52.3	53.0	54.0	57.0
65 and above	58.1	50.6	46.0	42.7	37.7	33.7	31.6	29.8
<i>Gender</i>								
Male	35.5	34.8	36.1	37.2	39.0	41.1	41.5	41.7
Female	64.2	65.1	63.9	62.8	61.0	58.9	58.5	58.2
<i>Citizenship</i>								
Noncitizens	n.a.	4.5	6.4	9.0	10.8	11.7	11.0	10.4
<i>Disabled SSI Recipients (under age 65)</i>								
<i>Qualifying Diagnosis</i>								
Physical	n.a.	n.a.	49.0	47.0	44.7	42.2	41.3	39.0
Mental Retardation	n.a.	n.a.	26.9	26.6	27.1	27.6	27.5	25.0
Psychiatric Disorder	n.a.	n.a.	24.1	26.4	28.2	30.2	31.2	36.0

Source: SSI Annual Statistical Report (SSA 2002b).

Note: n.a. indicates information is not available.

As a result of rapid growth in adult and child disabled beneficiaries, the SSI population looks dramatically different today from the way it did when the program was created. In 1974, blind and disabled adults and children comprised only 40 percent of the SSI population. In 2001, over 70 percent of SSI beneficiaries were disabled individuals under the age of sixty-five.

Table 2.4 shows that other key demographic characteristics have also changed since the program's inception.⁴¹ The first section of the table shows the age, gender, and citizenship composition of all SSI recipients. Since 1975, the proportion of males has increased. In 1976, more than two-thirds of SSI recipients were female. In 2001, about 60 percent of SSI recipients were female. Another notable change in the composition of the SSI population has been the rapid increase in the number of noncitizens receiving benefits. In 1982, the first year for which records on citizenship were kept, a little over 3 percent of all SSI recipients were noncitizens. In 1994, two years before citizenship became a requirement for new applicants, about 12 percent of all SSI beneficiaries were noncitizens. This percentage fell slightly once the citizenship restrictions were imposed, but noncitizen beneficiaries remain a sizable component of the SSI population—10.4 percent in 2001.

41. Notably, race is not included in the table. Information on the racial composition of SSI beneficiaries in the 1998 *Green Book* showed an increase in the number of Latinos enrolled in the program over time. These data also showed that African Americans are disproportionately represented among child and adult disabled beneficiaries. Unfortunately, there are no comparable data on race after 1995.

The second section of table 2.4 shows trends in the three main qualifying diagnostic categories—physical impairments, mental retardation, and psychiatric disorders other than mental retardation—for SSI recipients with disabilities (adults and children). In the early years of the program, less than one-quarter of SSI beneficiaries qualified on the basis of psychiatric disorders other than mental retardation. Following expansions in the eligibility criteria for mental impairments in both adults and children, the number of adults and children qualifying for SSI on the basis of a mental impairment began to grow. As a result, in 2001, 36 percent of all SSI recipients qualified on the basis of mental impairments other than mental retardation.

2.3.3 SSI Participation

An important policy concern with respect to all public assistance programs is the degree of participation among eligible individuals—that is, of the people who meet the categorical, economic resource, and citizenship tests, what proportion is receiving SSI benefits. It is relatively straightforward to make such calculations for those aged sixty-five and older, and a literature exists on this question. Unfortunately, the difficulties of establishing and assessing disability for adults and children not only make it difficult for policymakers and administrators to accurately determine SSI eligibility for those who apply, but also make it difficult for researchers to calculate program participation rates that require some estimate of the eligible disabled population that does not apply for benefits. Existing nationally representative data sources lack sufficient information on either economic characteristics or health characteristics to generate precise estimates of the population eligible for the disability components of SSI. As a result, there is almost no research on SSI participation rates among the eligible population with disabilities.⁴²

In table 2.5 we provide a preliminary approximation of take-up rates for SSI that we believe is useful in establishing broad trends. We use the official U.S. Bureau of the Census poverty calculations and show the share of SSI recipients in age-based poverty populations. This method was used in the 1998 *Green Book* for the population aged sixty-five and older. On the one hand, because our estimates do not account for citizenship, assets, and especially disability status, they will understate program participation among those in the poverty population who are eligible. On the other hand, since those eligible for SSI may have household incomes above the official poverty line, our approximations may overstate program participation

42. It is possible to estimate the population with some level of disability using national data sources (see Bound and Burkhauser 1999 for examples). It is much more difficult to isolate the subpopulation within this broader category that would meet the medical listing or vocational criteria for SSI eligibility.

Table 2.5 SSI Participation Rates among Poor, 1974–98, by Age Group

	Take-Up Rates			Disability Prevalence
	65+	18–64	< 18	18–64
1974	78.5	14.8	0.7	—
1975	75.6	14.8	1.0	—
1976	72.3	15.0	1.2	—
1977	74.1	15.3	1.4	—
1978	71.3	15.4	1.7	—
1979	61.0	14.4	1.7	—
1980	57.4	12.5	1.6	20.3
1981	55.1	11.0	1.6	19.2
1982	53.6	9.7	1.4	17.4
1983	55.3	9.6	1.4	17.5
1984	61.2	10.5	1.6	19.3
1985	58.8	11.3	1.7	19.0
1986	58.0	12.6	1.9	19.2
1987	56.6	13.4	2.0	18.8
1988	57.6	13.9	2.0	18.7
1989	60.3	14.8	2.1	19.6
1990	56.3	14.9	2.3	19.7
1991	55.0	15.0	2.8	18.9
1992	53.5	15.5	3.6	19.3
1993	56.3	15.9	4.6	20.4
1994	57.9	17.5	5.5	21.4
1995	63.7	18.9	6.3	19.9
1996	61.0	19.1	6.6	20.7
1997	60.8	19.7	6.2	21.3
1998	60.0	20.7	6.6	21.3

Source: Authors' calculations using data from the Current Population Survey.

Notes: Dashes indicate data not available. Take-up rates are calculated as the number of SSI recipients divided by the number in poverty in each age group. Data for take-up rates are from the SSA and the Census Bureau. Disability prevalence is calculated as the percentage of the poverty population eighteen to sixty-four years of age answering "yes" to the Current Population Survey question: "(Do you/Does anyone in this household) have a health problem or disability which prevents (you/them) from working or which limits the kind or amount of work (you/they) can do?" This question was not asked of children.

among all eligible households. Nonetheless, the trends in table 2.5 are revealing of how SSI is being used by low-income persons.

As the first column of table 2.5 shows, the participation rate among the poor elderly declined from 78.5 percent in 1974 to 53.6 percent in 1982. Since then, participation rates have fluctuated from year to year but have remained well below the highs recorded in the early years of the program. In general, no more than two-thirds of elderly individuals living in poverty receive SSI benefits. More complete measures of participation suggest that take-up rates among the elderly are lower than the gross measures indicate.

Table 2.6 Prevalence of Multiple Program Participation by SSI Recipients, 1999, by Gender and Age Group (%)

Simultaneous Program Participant ^{a,b}	Male			Female			All
	0-17	18-64	65+	0-17	18-64	65+	
SSI recipients							
OASDI	7.3	31.8	55.9	7.2	29.1	60.4	37.6
Medicaid	79.6	89.9	91.9	78.4	90.8	92.3	89.4
Medicare	c	32.2	77.7	c	27.8	88.0	41.4
General assistance	c	0.5	0.8	c	2.3	0.4	1.0
WIC	c	c	c	c	4.4	c	1.4
School meals	78.6	0.8	c	75.9	0.5	c	10.8
TANF	c	1.9	0.5	1.2	11.8	1.0	4.5
Unemployment insurance	c	c	c	c	c	c	c
SSI households							
Energy assistance	11.7	10.9	9.4	7.3	13.6	10.3	11.4
Housing assistance	9.8	6.6	6.6	11.9	12.4	8.6	9.4
Food stamps	37.0	39.3	31.2	36.2	50.9	42.5	42.6

Source: SSA, *SSI Annual Statistical Report* (2002b).

^aBased on data from the Survey of Income and Program Participation.

^bBased on SSA administrative records.

^cLess than 0.5 percent of SSI recipients in the gender/age group participate in the program.

Researchers consistently find the participation rate among persons eligible for SSI aged benefits at between 45 and 60 percent (Menefee, Edwards, and Schieber 1981; Warlick 1982; Coe 1985; Shields et al. 1990; McGarry 1996).

The remaining columns in table 2.5 show SSI participation rates for poor adults aged eighteen to sixty-four and poor children. Consistent with the caseload growth highlighted in figure 2.4, participation rates among poor working-age adults and children have risen over time. Participation rates among poor adults rose from 14.8 percent in 1974 to 20.7 percent in 1998, with the most rapid increases occurring during the 1990s. Reciprocity rates for poor children also increased rapidly during the 1990s, rising from 2.1 percent in 1989 to 6.6 percent in 1998. As column (4) shows, the prevalence of disability has not risen since 1980, which suggests that the increase in SSI take-up rates among the poor is not a function of increased disability.

2.3.4 Multiple Program Participation among SSI Beneficiaries

A large fraction of SSI beneficiaries participate in other government programs. Table 2.6 shows simultaneous program participation for SSI recipients and their households by gender and age in 1999.⁴³ In 1999, 36.1

43. Unless otherwise noted, the percentages reported in table 2.6 are based on estimates from the Survey of Income and Program Participation and taken from the *SSI Annual Statistical Report* (SSA 2002b).

percent of all SSI recipients also received OASDI, either for retirement or disability. Receipt of OASDI was most common among men and women aged sixty-five and older. Medicaid receipt was nearly universal, with 89.4 percent of all SSI recipients on the program. A substantial fraction of SSI recipients also received Medicare benefits—41.4 percent in 1999. Looking at other means-tested programs, 42.6 percent of households with an SSI recipient also received food stamps, and about one in ten received energy or housing assistance.

Separate data from the 1998 *Green Book* produced by the U.S. House of Representatives (not shown) indicate that over time the percentage of SSI recipients receiving OASDI and Medicare has been declining. At the same time the percentage of SSI recipients receiving food stamps, assistance from the special Supplemental Nutrition Program for Women, Infants, and Children (WIC), free or subsidized meals, and public housing has been rising. The fact that a growing share of SSI recipients receive benefits from multiple means-tested programs suggests that the work incentives faced by the typical beneficiary are increasingly complex. SSI beneficiaries face multiple implicit taxes in the form of reduced benefits from SSI and any other transfer programs, plus the regular assortment of federal, state, and local taxes, as well as the loss of medical insurance for those not meeting the 1619(b) provisions. As others have shown, the cumulative marginal tax rates for individuals receiving multiple programs can be quite high (Giannarelli and Steuerle 1995; Keane and Moffitt 1998).

Although the empirical literature on the effects of changes in these various marginal tax rates will be discussed later in this chapter, it is useful to lay out the tax circumstances SSI recipients potentially face. Figure 2.5 (from Burkhauser and Wittenburg 1996) shows how a single male's 1994 net income changes with each additional dollar of his labor if he is eligible to receive the federal SSI benefit of \$458 and the average cash value of Medicaid insurance for SSI disability of \$540 per month. With no labor earnings, this person would receive \$998 per month in SSI benefits and Medicaid insurance.

As the figure shows, the interaction of the Earned Income Tax Credit (EITC) and federal taxes as well as food stamps, which one-half of all SSI beneficiaries receive, significantly alters the marginal tax rates faced by recipients with various amounts of labor earnings. The EITC phase-in subsidy to work offsets Social Security (FICA) taxes, but because the Food Stamp Program subtracts 24 cents in food stamps for every dollar of labor earnings, the net tax on the first dollar of labor earnings is 23.85 percent. This tax rate continues to the SSI disregard level of \$85 per month. At this point the 50-cent loss in SSI benefits per dollar of labor earnings interacts with the food stamp program taxes on work, resulting in a net tax of 58.85 percent. When the EITC plateau begins, the net tax on labor earnings rises to 66.5 percent, and when the EITC phaseout tax begins, the net tax on la-

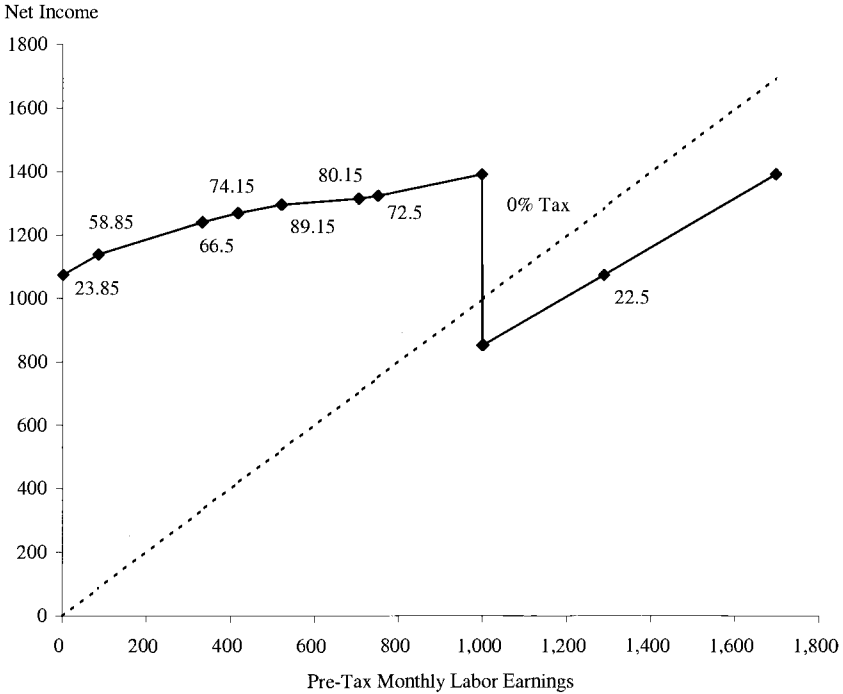


Fig. 2.5 Marginal tax rates on labor earnings and net income for a single person receiving Medicaid, SSI, and food stamps in 1994

Source: Burkhauser and Wittenburg (1996).

bor earnings rises to 74.15 percent. When the federal income tax standard deduction level is passed and federal income tax starts, the marginal tax rate rises to 89.15 percent. Marginal tax rates only begin to fall after food stamps and EITC break-even points are reached. The final increase in tax rates occurs just before SSI benefits phase out, when all Medicaid benefits are lost because earned income now equals the Medicaid special eligibility plateau. The reduction of such cumulatively high marginal tax rates via a single universal income support program was one of the arguments made in support of President Nixon’s original FAP program.

2.4 Review of Economic Issues

Although economic analysis of social programs frequently takes the goals of the program as given, with SSI the motivation for the program is itself an important determinant of how we view the behavioral reactions to it. In this section we first discuss the economic rationale behind a federal income floor for the subset of the poor who are aged, blind, or disabled.

Next, we review the theory related to individual responses to the existence and structure of SSI including take-up, work, savings, and disability-reporting behavior. Finally, we consider the equity goals of SSI and discuss attempts to evaluate program effectiveness.

2.4.1 Public Income Provision for the Aged, Blind, and Disabled

As noted earlier, SSI was born out of a failed effort to provide a guaranteed income floor under all Americans—FAP. Hence, although the motivation for providing an income floor to the subset of the adult poor who are aged, blind, or disabled is primarily distributional, it also rests on a political compromise that offered this entitlement only to categories of individuals not expected to work. Although this compromise allowed SSI to become law in 1972, social expectations regarding work have changed over time for the three groups targeted by SSI—the aged, blind, and disabled. Individuals are living and working longer; the normal retirement age for Social Security benefits has been raised; and the ADA has granted people with disabilities a legal right to equal access to employment.

Although work expectations have risen for the aged, it is people with disabilities who have experienced the largest shift in public attitudes. In 1990, people with disabilities successfully argued that unequal access to jobs—rather than an impairment—is the primary barrier to employment opportunities. As a result, people with disabilities gained legal rights to accommodation under Title I of the ADA. Some disability advocates even have argued that there is no such thing as a disabled worker; rather, there is only a society that does not provide the appropriate accommodations for such individuals.⁴⁴ In a world of full accommodation, the disability-transfer population should be zero. Such attitudinal changes raise basic questions about how society should treat people with disabilities. Most fundamental of these questions is whether people with disabilities should categorically be expected to work or not.

These types of cultural changes potentially shift the boundaries of the population that is not expected to work and hence is eligible for a categorical guaranteed income floor based on age or disability. As the opportunities for employment and the demand for the productivity of people with disabilities and those over age sixty-five increase, the clear categorical lines drawn between them and other groups with similar difficulties finding work, such as low-skilled or less-educated younger persons, or single mothers facing welfare limits, are increasingly blurred.

The original political compromise that made the families of disabled children eligible for SSI was slightly different and represented a departure from the not-expected-to-work criterion applied to the aged and to adults

44. See Johnson (1997) for alternative views of the rights and responsibilities of people with disabilities.

with disabilities. Some argued that SSI benefits for disabled children replaced the earnings of parents forced to reduce their work effort in order to care for their newly disabled child. Others argued that SSI-children benefits indirectly offset extra disability-related household expenses. In both cases, SSI-children benefits were intended to offset lost income and partially return the family to its previous level of economic well-being. (See NASI 1995 for a fuller discussion of these issues.)

2.4.2 SSI and Behavioral Change

If the aged and disabled adults are neither able nor expected to work, then many of the disincentives discussed in regard to other means-tested transfer programs are irrelevant. In such a world, cumulative marginal tax rates could approach 100 percent with no change in work behavior, and SSI could provide relatively high income guarantees and still maintain relatively low break-even points (the income level at which a person is no longer eligible for benefits). Moreover, to the degree that age and work disability are clearly defined and immutable categories, differences in the guarantees, time limits, or funding mechanisms for SSI and other programs would have little effect on SSI allowances and caseloads. In such a world SSI program participation is purely a function of the prevalence of health limitations in the low-income population. We will suggest that none of these premises hold with respect to the disability component of SSI. Thus, SSI policymakers must take behavioral changes on the part of potential SSI recipients and state and local governments into account when establishing program eligibility criteria and considering future program rules.

Propensity to Apply for SSI

Disability is neither a static nor a precise concept. Responses to the onset of health conditions depend not only on the severity of the impairment, but also on the social environment that people with health impairments face—including the availability of employment; the availability of accommodation, rehabilitation, and retraining; the presence of legal supports or protections; and the accessibility and generosity of SSI and other government transfer programs. The propensity for individuals to apply for SSI benefits depends on the probability they place on their health impairment and vocational circumstances being sufficient to meet the SSI disability eligibility standards as well as on their employment potential and the generosity of SSI relative to other forms of public assistance. The latter comparison is particularly relevant in light of 1996 welfare reform (PRWORA) that restricts the access to, and generosity of, alternative public assistance programs. If low-income adults have health conditions or have children with health conditions, the generosity of SSI relative to other alternatives may induce individuals to apply for benefits.

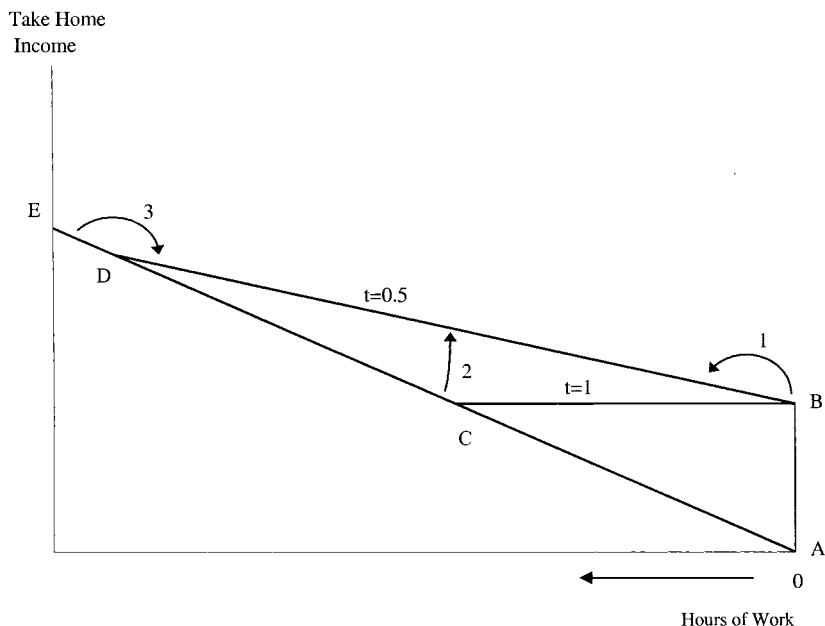


Fig. 2.6 Budget constraints with different marginal tax rates (BC: marginal tax rate = 100 percent; BD: marginal tax rate = 50 percent)

Source: Hoynes and Moffitt (1996).

Program Participation and Work Incentives

The economics of program participation and labor supply for individuals potentially eligible for SSI mirrors the analyses of these issues in programs such as Aid to Families with Dependent Children (AFDC) and Temporary Assistance for Needy Families (TANF). Thus, to understand the work disincentives embodied in the SSI program, we turn to the framework used for other categorical welfare programs. Moffitt (1986) provides a discussion of the basic economic issues. In these models individuals make choices that depend on the income gained from the program and the costs of participating, including the time and money costs associated with applying for and maintaining eligibility for benefits.

To see how this works in the case of SSI, consider the conventional labor-leisure model diagramed in figure 2.6.⁴⁵ Figure 2.6 compares the budget constraint of an SSI program with a 50 percent marginal tax rate ($t = 0.5$) to one with a marginal tax rate of 100 percent ($t = 1.0$). Segment

45. This discussion draws from the expositions in Moffitt (1986), Hoynes and Moffitt (1996), and Moffitt's review of the AFDC/TANF program (chap. 5) in this volume. This discussion is made primarily in the context of adults with disabilities.

ACDE of the figure represents the budget constraint of those not categorically eligible for SSI. The line has a slope equal to the hourly wage rate, w . Segment ABCDE applies to the same individuals if they are categorically eligible and if they face a marginal tax rate of 100 percent. Benefits are taxed one dollar for each dollar earned and phased out at the break-even level (point C). That is, even though they are categorically eligible for benefits, their labor earnings offset all SSI benefits at hour levels greater than point C. Segment ABDE applies to the same people, but now they face a marginal tax rate of 50 percent. Benefits are taxed at a rate of 50 cents per dollar earned, and the break-even hours point is D. Under this model, categorical eligibility for SSI benefits unambiguously reduces work effort relative to not being categorically eligible. There is an income effect associated with the guarantee (AB) and a substitution effect associated with the marginal tax rate (BC or BD). The income and substitution effects work in the same direction, and hours of work among participants fall. Only those whose optimal hours worked prior to program eligibility were beyond the break-even hours point may not be affected, and even then it will depend on the shape of their indifference curve (i.e., some would be willing to accept less income by substantially reducing work and living on program benefits).

The next question to ask is what happens if the marginal tax rate is reduced. Here the answer is unclear; the net effect of a reduction in t , from 100 percent (BC) to 50 percent (BD), is ambiguous. The arrows in figure 2.6 show the various responses that could occur following a reduction in the marginal tax rate (represented by a shift from segment BC to BD). For individuals initially receiving SSI benefits and not working (i.e., initially at point B), a reduction in the tax rate may encourage participants to work more, which is represented by arrow 1. At the same time, a reduction in t expands the range of individuals eligible for benefits and brings some portion of those categorically eligible but not previously receiving SSI onto the rolls. As these individuals move onto SSI their work effort is reduced, as shown by arrow 2. Arrow 3 shows that some categorically eligible individuals who continue to earn too much under the lower tax rate may be motivated to reduce their hours of work enough to become eligible for benefits, thereby combining work and SSI benefits. Finally, it is also possible that a reduction in t will increase payments by enough to induce previously eligible persons on earnings grounds but not on categorical grounds (segment AC) to risk entry onto the rolls.

Taking each of these possibilities into account, the net effect of a lower marginal tax rate on work effort is ambiguous. The only thing that is clear is that lower marginal tax rates increase caseloads. A lower tax rate makes more categorically eligible individuals eligible for the program on income grounds and, given positive take-up rates, unambiguously boosts the number of individuals on the rolls. Moreover, by lowering the costs associated

with staying on the rolls, lower marginal tax rates reduce exit rates from the program, thereby increasing caseloads. Finally, lower marginal tax rates may induce those on the margin of categorical eligibility on health grounds to apply for benefits, since the gains to program acceptance have increased.

Unlike SSI benefits for the elderly, where categorical age eligibility is easily demonstrated and benefit receipt is automatic if one meets the means test, categorical eligibility for SSI benefits is more difficult to demonstrate. Thus, eligibility for benefits is not certain, and models of SSI application must take this risk of nonacceptance into consideration. In general, those considering applying for SSI will value disability benefits with a probability of less than one. Holding the underlying health condition constant, the probability of acceptance onto the rolls will depend on the disability screening process. Conditional on the same impairment, tighter eligibility criteria are likely to increase the probability of denial and reduce the expected value of applying. In contrast, looser criteria increase the probability of acceptance and increase the expected value of applying.⁴⁶ In either case, individuals facing uncertainty surrounding acceptance, informational hurdles, or stigma associated with benefit receipt may be induced to participate by the increase in benefits associated with the lower marginal tax rate.

If those categorically eligible for benefits on health grounds are completely unable to perform any substantial gainful activity under any circumstances, then there is no need to lower the marginal tax rate on SSI, since those on the program are neither expected nor able to work. However, to the extent that work is both possible and expected for people with disabilities who meet the other eligibility criteria, policy discussions with respect to trade-offs between tax rates, guarantees, and break-even points become much closer to those taking place for other income maintenance programs.

The same model also incorporates stigma and other fixed program costs. As in other income maintenance programs, the presence of stigma and other program costs associated with applying for benefits explains why some categorically eligible individuals are observed on segment ACD. As fixed program costs and stigma decline, participation among this group will rise. What the model in figure 2.6 does not show are potential program interaction effects. As discussed in figure 2.5, the actual budget constraint facing those categorically eligible for SSI benefits is more complex, with more nonlinearities due to the cumulation of taxes from multiple programs. In a like manner, multiple program eligibility will cause complications for those interested in the behavioral effects of other transfer programs. Burkhauser and Smeeding (1981) and Powers and Neumark (2001) show that the incentives to accept actuarially reduced Social Security ben-

46. Weathers (1999) develops a multiperiod model of the SSDI application process in which the optimal time of application following the onset of a disability is a function of the opportunity cost of lost wages versus the gain in SSDI, adjusted for the probability of acceptance. A similar model could be used to predict the timing of SSI disability applications.

efits (OASI) at younger retirement ages are increased for those who would be eligible for both SSI and OASI at age sixty-five, since OASI benefits after a small disregard are taxed on a dollar-for-dollar basis by SSI.

Finally, one can also use the model in figure 2.6 to think about the labor-supply behavior of parents of children with disabilities. If a child is judged eligible for SSI benefits, then an able-bodied parent faces the same marginal tax rates, guarantees, and break-even points shown in figure 2.6. Stigma, information costs, and reduced program benefits (adjusted for the probability of acceptance) also apply. One additional issue that affects parents of children with disabilities is how benefit receipt will influence the future well-being of their child.

Saving Behavior

The presence of asset testing in the eligibility criteria for SSI may reduce saving among those meeting other eligibility criteria. This point is made generally about means-tested programs. Hubbard, Skinner, and Zeldes (1995) argue that when eligibility is tied to assets, individuals meeting the income test have incentives to reduce their savings in order to qualify for benefits. Among those applying for SSI benefits, the most likely group to be affected by the asset test is the elderly, who may have accumulated savings over their lifetime.

2.4.3 Balancing Efficiency and Equity Concerns

Our discussion above has focused on the behavioral effects of the SSI program. This focus on the efficiency costs of SSI-induced behavioral change ignores the social benefits of SSI and may lead some to conclude that a socially optimal SSI program would have no behavioral impact on benefit applications, work, or saving. This conclusion is inappropriate for two reasons. First, even if actual disability status were perfectly observable, society would probably still want to target some level of benefits on disadvantaged low-income workers and their families even if it resulted in some efficiency losses. Hence, the more important question is not whether there are program-related behavioral changes but whether they are small relative to the social gains from redistributing income to less advantaged persons. Analyses of the welfare implications of the SSI program should focus on this second and more important question.

Second, in a world where the socially appropriate eligibility standard for SSI is difficult to assess, some individuals will be denied benefits who are less capable of work than is socially acceptable. In such a world, a more lenient eligibility criterion will involve a trade-off between the reduction of type II errors on the one hand and the additional costs of type I errors on the other. The issue is this: In the presence of uncertainty, do the social benefits outweigh the efficiency costs arising from increasing the probability of guaranteeing an income floor to those below some minimum level of work capacity at the cost of also providing these funds to some who are

more capable of work? In both cases, it is appropriate to assign some value to SSI as a mechanism for providing social protection against the economic consequences of aging and disability for disadvantaged workers. To do otherwise would be to hold too narrow a view from a social policy perspective. See Bound et al. 2002 for a fuller discussion of these issues.

2.5 Review of the Evidence

In the previous section we reviewed the potential consequences on application, work, and saving behavior of SSI program rules and showed that if the aged or disabled adults are capable of work, the SSI program rules could influence their behavior. We also discussed how SSI program rules could affect the work behavior of the parents of children with disabilities. In this section we review the empirical literature on the effects of the existence and structure of SSI on behavior. Despite the size and importance of the SSI program, the empirical literature on its behavioral effects is relatively small. Moreover, almost without exception, empirical studies focus on only one of the three groups SSI targets. For this reason, the empirical evidence on the behavioral effects of SSI for each target population group will be discussed in turn.

2.5.1 SSI and Adults with Disabilities

*Work Effort of Adults with Disabilities*⁴⁷

Most of the research on the work effort of those with disabilities focuses on a broader population than those receiving either SSI or SSDI. The most common analyses rely on nationally representative survey data that include questions about whether a health limitation prevents individuals from working or limits their ability to work full time or to do certain jobs.⁴⁸ Although such research is not as targeted as one might like, it does provide a backdrop for understanding the types of trends faced by the SSI program.

Based on these data, figure 2.7 shows that over the past two decades employment rates for those with disabilities as well as SSDI and SSI caseloads have varied greatly, fluctuating with the economy, changes in benefit eligibility criteria, and the implementation of other public policies intended to support people with disabilities. The figure shows employment rates of working-age men and women with self-reported disabilities and the number of individuals receiving disability benefits for the period 1980–99. The employment data come from Burkhauser et al. (2002) and reflect the em-

47. This discussion draws from Burkhauser and Daly (2002).

48. Although numerous scholars have questioned the validity of such data, Burkhauser et al. (2002) show that questions of this type can be used to track trends in outcomes, such as employment, for the population with disabilities.

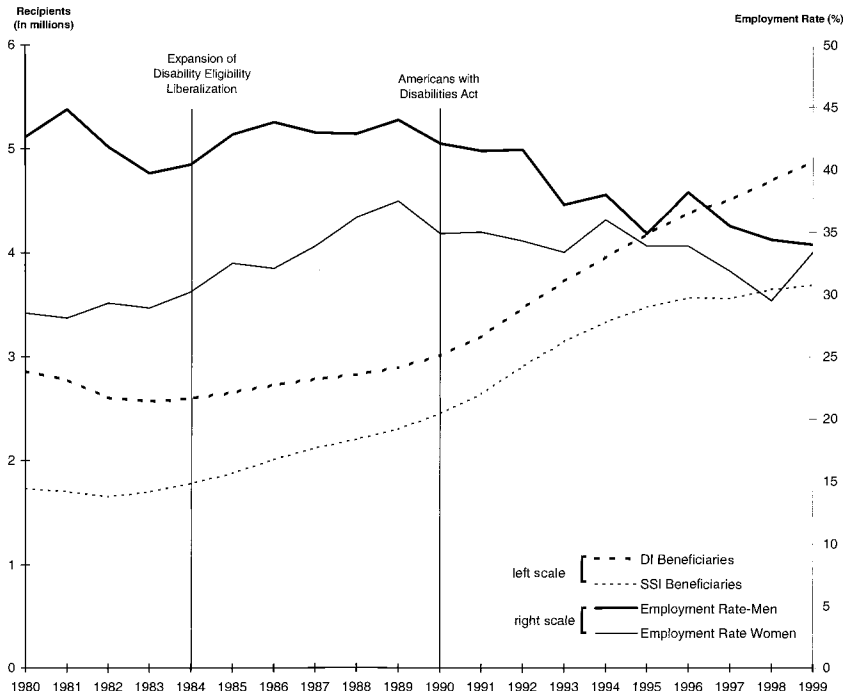


Fig. 2.7 Disability benefit rolls and employment rates among working-age men and women with disabilities

ployment rates of Current Population Survey (CPS) respondents who say they are limited in the amount or type of work they can perform. Data on SSDI and SSI beneficiaries come from the SSA (2002a). Also indicated in the figure are a few key events: the liberalization of disability screening in 1984 and the passage of the ADA in 1990.

The trends in figure 2.7 highlight the major concerns of disability policymakers over the past two decades. First, the number of disability beneficiaries has increased continuously since the eligibility expansion and liberalization in 1984, with especially strong growth during the 1990s (application and acceptance rates in the 1990s rivaled those experienced during the expansion period of the late 1970s). Second, whereas employment rates for those with self-reported work limitations rose through the economic expansion of the late 1980s, they have fallen almost continuously since, even during the strong expansion of the 1990s.

So far, three major hypotheses have been proposed to explain this decline. Kaye (forthcoming) argues that declining employment rates among those with disabilities in the 1990s were caused by dramatic increases in the severity of impairments. Hence, for Kaye, the recent trends are health-based and not a reflection of changes in public policy. Other researchers

have taken a more social environment-oriented view. For example, DeLeire (2000) and Acemoglu and Angrist (2001) attribute the downturn in employment among those with disabilities during the 1990s to the passage of the ADA. Bound and Waidmann (2002) argue that changes in disability benefits eligibility and generosity made it easier and more profitable for workers to leave the labor force and take benefits. Autor and Duggan (2001) suggest that a combination of disability benefits that replaced a greater share of labor earnings and declining job opportunities for low-skilled workers induced an increasing share of workers to choose benefits over employment. Which one of the many changing social variables deserves the most credit is a matter for future research, but in all likelihood the true cause is a combination of factors, rather than a single policy action or identifiable event.

While researchers debate the reasons for the declining employment and rising benefit rates of men and women with disabilities during the 1990s, policymakers are debating whether these outcomes are signs of success or failure of U.S. disability policy. For some advocates of those with disabilities, the increasing disability benefit rolls reflect an appropriate increase in support for a group of workers with limited labor market opportunities. For others, the increased rolls reflect the shortcomings of a transfer-focused policy that failed to provide the necessary supports (e.g., universal health insurance, rehabilitation, and job services) to allow individuals to select work over benefits. For others still, the outcomes observed during the 1990s are simply evidence of the law of unintended consequences in policy making, whereby policies to promote economic well-being (in the case of benefits) and work (in the case of the ADA) actually increased the disability benefit rolls and reduced employment.

Whichever explanation accounts for the decline in employment among those with disabilities, research by Bound, Burkhauser, and Nichols (forthcoming) shows that one must be careful in making general statements about the population targeted by SSI based on aggregate data on the population with disabilities or data on the SSDI targeted population. Table 2.7, taken from Bound, Burkhauser, and Nichols, uses longitudinal data from the Survey of Income and Program Participation (SIPP) linked to Social Security administrative files to compare the monthly labor earnings and employment of those who apply for SSI or SSDI three years before application, one to three months before application, and three years after application. As table 2.7 shows, unlike SSDI applicants, the vast majority of SSI applicants are not employed three years before they apply for benefits. Only 25 (28) percent of those awarded (denied) SSI were working three years before their application, and their average monthly labor earnings were only \$144 (\$260). Moreover, both their employment and their average monthly labor earnings were a small fraction of the employment and labor earnings of SSDI applicants three years prior to application.

Table 2.7 Average Monthly Labor Earnings and Employment Rates and How They Changed before and after Application for SSDI and SSI (in January 1990 dollars)

Population	Before Application ^a			Application ^b			After Application ^c		
	Monthly Labor Earnings ^d	Employment Rate ^e	Monthly Labor Earnings ^d	Employment Rate ^e	% of Before Earnings ^f	Monthly Labor Earnings ^d	Employment Rate ^e	% of Before Earnings ^f	
Supplemental Security Income									
Awarded SSI	144	25	17	6	12	63	12	44	44
Denied SSI	260	28	89	15	34	105	19	40	40
Social Security Disability Insurance									
Awarded SSDI	1,575	87	248	16	16	87	11	6	6
Denied SSDI	1,248	81	154	17	12	434	31	35	35

Source: Bound, Burkhauser, and Nichols (forthcoming); 1990–93 SIPP data merged to SSA disability determination records.

^aThirty-six to thirty-eight months prior to application.

^bOne to three months after application.

^cThirty-seven to thirty-nine months after application.

^dAverage includes zeros.

^ePositive labor earnings in at least one month over the period.

^fAverage monthly labor earnings during application period divided by average monthly labor earnings before application.

^gAverage monthly labor earnings after application divided by average monthly labor earnings before application.

The data in table 2.7 suggest that the factors causing the low employment and labor earnings of SSI applicants at the time of application and after they move onto the SSI rolls were in effect well before the time of their application. This is not surprising, since Bound, Burkhauser, and Nichols also show that the typical SSI applicant is less likely than the typical SSDI applicant to be white, a high school graduate, married, wealthy, or living in a high-income household prior to application.

Factors Affecting SSI Participation

Although application for SSI disability benefits is a function of health, it is also influenced by program rules and benefits. These include eligibility criteria and the generosity of benefits relative to work, the comparative generosity and availability of other means-tested welfare and social insurance programs, macroeconomic conditions (national, state, and local), and applicants' education and job skills. During the 1990s, considerable attention was devoted to understanding the link between these nonhealth factors and SSI caseload growth. The following discussion reviews the evidence on determinants of SSI caseload growth, looking first at the relationship between caseload dynamics and screening stringency (benefit supply) and then at factors affecting the demand for SSI benefits, including ease of benefit access, benefit generosity relative to work and other programs, and economic conditions.

The SSA began modifying its disability determination process in the mid-1970s. Concerned that state offices were not consistently and uniformly applying the residual functional capacity (RFC) and vocational standards in adult disability determinations, in 1979 SSA published regulations specifying who was to be classified as disabled, essentially tightening the eligibility criteria. The SSA also tightened its policy towards benefit terminations in continuing disability reviews (CDRs) by state Disability Determination Services (DDS), permitting benefit termination without proof of medical improvement. This policy resulted in a threefold increase in the number of cessation decisions on continuing reviews by state agencies (Lewin-VHI 1999). Consistent with the tighter standards, the yearly allowance rate (initial acceptances divided by initial applications) of adult SSI disability applications began to fall in 1976 (table 2.8).

The Social Security Disability Amendments of 1980 continued the trend of tightening the disability determination and review process. Importantly, the 1980 law changed both the frequency and nature of medical eligibility reviews done on disability beneficiaries.⁴⁹ Before 1980, the only beneficiar-

49. The 1980 law tightened SSA control over the state disability determination services. In particular, the SSA had previously reserved the right to review initial determinations before they were transmitted to the applicant, but during the 1970s it reviewed only 5 percent. The 1980 amendments required that SSA review two-thirds of successful applications. To enforce administrative control over administrative law judges, the secretary of Health and Human

Table 2.8 SSI Allowance Rates and Annual Changes in Beneficiaries, Adults 18–64, 1974–2001

	Allowance Rate (%)	Number of Beneficiaries (thousands)	Yearly % Change in Beneficiaries
1974	47.8	1,503	
1975	52.6	1,699	13.0
1976	47.1	1,714	0.9
1977	42.2	1,737	1.3
1978	36.4	1,747	0.6
1979	31.5	1,727	-1.1
1980	29.5	1,731	0.2
1981	29.5	1,703	-1.6
1982	26.6	1,655	-2.8
1983	32.2	1,700	2.7
1984	38.2	1,780	4.7
1985	32.0	1,879	5.6
1986	36.8	2,010	6.7
1987	36.2	2,119	5.4
1988	37.1	2,203	4.0
1989	39.5	2,302	4.5
1990	40.5	2,450	6.4
1991	39.4	2,642	7.8
1992	44.5	2,910	10.1
1993	41.1	3,148	8.2
1994	39.4	3,335	5.9
1995	42.5	3,482	4.4
1996	41.6	3,569	2.5
1997	40.8	3,562	-0.2
1998	42.9	3,646	2.4
1999	43.0	3,690	1.2
2000	39.4	3,744	1.5
2001	38.0	3,811	1.8

Source: Authors' calculations from SSA data, *SSI Annual Statistical Report 2001* (2002b).

Note: Allowance rates equal initial awards divided by initial applications.

ies targeted for medical eligibility review were those who had conditions that were likely to improve over time. The new law stipulated that all beneficiaries should periodically receive continuing disability reviews and that all but those deemed to have permanent disabilities should be reviewed

Services was empowered to appeal administrative law judge rulings that were favorable to the applicant.

Prior to 1980, the law provided that disability determinations be performed by state agencies under an agreement negotiated by the states and the secretary of Health and Human Services. The 1980 amendments required that disability determinations be made by state agencies according to regulations of the secretary. It also required the secretary to issue regulations specifying performance standards to be followed in the disability determinations, and if the secretary found that a state agency was failing to make disability determinations consistent with regulations, then the secretary was required to terminate the state's authority and assume federal responsibility for the determinations.

every three years. The 1980 law made permanent the practice of using the same standards in CDRs that were applied when initially evaluating claimants. In addition to tightening the disability adjudication and review process, the 1980 law established two key work incentives: (a) the 1619(b) provision, and (b) the deduction of impairment-related work expenses (IR-WEs) from earnings when determining the SGA. As noted earlier, the 1619(b) provision authorized a three-year demonstration project, allowing for the payment of special SSI benefits (and the retention of Medicaid coverage) for SSI recipients who exceeded the SGA level. Section 1619 became permanent in 1986.

As could be expected, the 1980 law had a discernible impact on administrative practice. As demonstrated in table 2.8, the yearly allowance rate for adult SSI disability recipients fell from a high of 52.6 percent in 1975 to 26.6 percent in 1982. The number of recipients fell from 1.75 million in 1978 to 1.66 million in 1982. This decrease occurred despite the economic recession of 1980–82. This removal of individuals from the rolls generated a major political response. Most of the people removed from the rolls appealed the decision, requesting a hearing before an administrative law judge and causing a huge backlog of cases. As a result, some state governors instructed their DDS service not to terminate anyone from the disability rolls unless that person's conditions had improved.⁵⁰

In 1984, in response to concerns that federal disability policy had become too restrictive, the SSA agreed to a moratorium on CDRs pending the enactment and implementation of revised guidelines. The 1984 law had profound effects on the standards used to evaluate a person's potential eligibility for SSI. When reviewing existing beneficiaries, the burden of proof was shifted back to the SSA to show that a beneficiary's health had improved sufficiently to allow him or her to return to work. A moratorium was imposed on re-evaluations of the most troublesome cases—those that involved mental impairments or pain—until more appropriate guidelines could be developed. Finally, benefits were continued pending the outcome of an appeal.

The 1984 law substantially increased the weight given to source evidence (i.e., evidence provided by the claimant's own physician) by requiring that it be considered first, prior to the results of an SSA consultative examination. The SSA was also required to consider the combined effect of all impairments, whether or not any one impairment was severe enough to qualify a person for benefits. Perhaps most important, the SSA substantially revised its treatment of mental illness, reducing the weight given to diagnostic or medical factors, and emphasizing the ability of an individual to function in work or worklike settings.

50. For a fuller discussion of disability policy in this period, see Berkowitz and Burkhauser (1996).

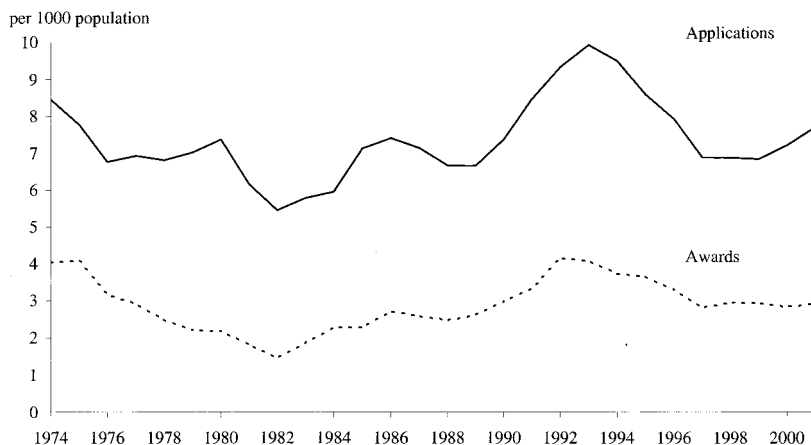


Fig. 2.8 Applications and awards among population 18–64 (per 1,000 in population)

Source: SSA (various years).

Table 2.8 shows that the dip in the SSI adult disability population that occurred between 1978 and 1982 was reversed thereafter and rose about 4 or 5 percent a year during the economic growth years of the later 1980s. When the next economic downturn came in the early 1990s, conditions were ripe for a surge in applications and in the number of people on the SSI disability rolls. The increases in the disability transfer population in the early 1990s exceeded anything seen in SSI since the start of the program. The annual acceptance rate for SSI adult disability benefits was almost 45 percent in 1992, the highest since 1976. Economic recovery and Congressional action with respect to SSI disability eligibility in 1996 have slowed the growth in the working-age adult SSI population, and acceptance rates in 2000 and 2001 were back to the levels of the late 1980s. However, the economic downturn could result in an increase in the rolls.⁵¹

The legislative history underlying the disability screening process highlights how access to benefits has changed over time. Figure 2.8 shows that the desire for SSI disability benefits has also fluctuated. Fluctuations in applications have been as large as changes in the SSI disability rolls. To some extent these fluctuations have mirrored changes in eligibility standards, contracting when eligibility standards were tightened in the late 1970s and

51. As part of more general welfare reforms in 1996, Congress removed drug and alcohol addiction as allowable conditions for SSI eligibility. In 1995, there were about 135,000 SSI recipients whose disability was based solely on drug addiction or alcoholism. The Congressional Budget Office estimated that about 65 percent of these individuals would be eligible for SSI based on other sufficiently disabling conditions. For a full discussion of these reforms and their impact see U.S. House of Representatives, Committee on Ways and Means (1998).

early 1980s, rising after the relaxation of eligibility standards in 1984, and falling again following the tightening of standards in the mid-1990s. However, other factors, including local economic conditions, outreach efforts by both SSA and state governments to search for eligible candidates, and the generosity of SSI relative to other programs, are all likely to have contributed to the variability in applications over time.

A number of scholars have estimated the link between local economic conditions and SSI application rates. The fact that SSI is a national program restricts the extent to which regional variation in benefits can be used to identify the effect of the program on applications. However, Black, Daniel, and Sanders (2002) used regional variation in economic conditions to identify the effect of financial incentives on the decision to apply for SSI (and SSDI) disability benefits. In particular, they examined the impacts of the coal boom during the 1970s and the coal bust during the 1980s on the number of SSI beneficiaries. Using panel data on 186 counties in Kentucky, Ohio, Pennsylvania, and West Virginia, they estimated an elasticity of program payments with respect to local area earnings of between -0.5 and -0.7 for SSI recipients. Although these results lend some support to the notion that labor market conditions in an area affect the decision of individuals to apply for disability benefits, the point estimates are hard to interpret. Black, Daniel, and Sanders interpret the estimated coefficient on the local earnings variable as reflecting the effect of changes in the financial attractiveness of disability benefits. However, given the nature of the specification used, it is possible that the earnings variable is picking up the effect of general economic conditions rather than the relative financial attractiveness of SSI.⁵² Furthermore, their estimates reflect the short-run effect of changes in the local economies in Kentucky, Ohio, Pennsylvania, and West Virginia on the number of disability beneficiaries. Given the fact that the typical SSI spell is lengthy in duration, long-run effects likely will be substantially larger than short-run effects.

A considerable amount of government-sponsored research has attempted to explain the dramatic growth in the SSI population in the early 1990s. A useful summary of this work can be found in Rupp and Stapleton (1995). Much of this analysis has used the considerable variation in state-level applications and awards to test the models. Using cross-state data from 1988–92, Stapleton et al. (1998) find convincing evidence that the recession of the early 1990s contributed to the rapid rise in the number of applications for SSI benefits. They estimate that a 1 percentage point rise in the unemployment rate was associated with a 2 percent rise in applications for SSI. The effects on final awards were somewhat lower. Finally, they found that the changes in the unemployment rate had a smaller effect on

52. As will be discussed shortly, the evidence that recessions lead to increases in the number of applications for SSI is strong.

benefit awards than on applications, suggesting that recessions induce those with less severe disabilities to apply for SSDI and SSI benefits.

Stapleton et al. (1998) also provide strong, if indirect, evidence that changes in screening stringency in the 1990s played a central role in explaining program growth. Indeed, the very fact that award rates were rising at the same time that application rates were rising would seem to suggest an important role for changes in screening stringency. They find that changes in the unemployment rate, together with other factors they include in their models, could explain almost all of the growth in applications for impairments related to conditions of internal organs, but could account for much less of the growth in applications for impairments related to musculoskeletal or mental health conditions. These patterns suggest that regulatory changes such as the increased weight given to pain and other symptoms, the increased reliance on source evidence, and the broadening of the standards used for those with mental impairments have contributed importantly to the recent surge in applications for SSI.

Whereas the 1990s recession seems to be part of the explanation for the rapid rise in applications for SSI benefits that occurred during the first part of the 1990s, no such rise occurred during the severe recession of the early 1980s. A reasonable interpretation of these patterns is that the tightening of eligibility standards that occurred during the early 1980s counteracted the effects of the 1980s recession. During the mid-1980s, when eligibility standards were relaxed again, the booming economy slowed any immediate response. However, when the 1990s recession hit, applications grew rapidly.

Researchers studying the increases in SSI caseloads have found evidence that an important factor explaining the growth in SSI over the 1990s has been efforts by states to shift individuals off state-funded programs such as general assistance and onto SSI. States that cut general assistance benefits experienced above-average growth in the application for SSI benefits (Lewin-VHI 1995). Using monthly administrative data from Michigan, Bound, Kossoudji, and Ricart-Moes (1998) find that the increase in the application for SSI benefits exactly coincided with the end of general assistance in Michigan. However, they also find that general assistance benefits are typically less generous than are SSI benefits. This finding is surprising within the context of a simple labor supply model that ignores the relative costs of application for these two types of benefits. The fact that many potentially eligible people did not apply for the more generous SSI benefits suggests that applying for disability benefits may be difficult and onerous. There is also considerable anecdotal evidence that states and third parties often act as intermediaries to facilitate the SSI application process (Livermore, Stapleton, and Zeuschner 1998; Bound, Kossoudji, and Ricart-Moes 1998).

Brown, Hoyt, and Scott (1999) approach a similar question using county-

level data on SSI and AFDC participation rates. They find that prior to 1996 welfare reform, variation in AFDC programs across states explains little of the variation in SSI participation. They also find that program and eligibility variables explain more of the county-to-county variation in SSI participation than in AFDC participation, suggesting that SSI is a more tightly targeted program than AFDC. Still, they conclude that given the significant changes in welfare programs embodied in the transition from AFDC to TANF, SSI participation rates likely will be affected.

Increases in the value of Medicaid benefits for individuals on SSI also may have contributed to the recent growth in applications for both programs. Yelowitz (1998) uses cross-state variation in Medicaid benefits to estimate the effect of changes in their value on participation in SSI. In particular, in response to court orders, many states increased Medicaid benefits in 1991. Using these changes, Yelowitz estimates that increases in the value of Medicaid that occurred over the late 1980s and early 1990s can explain about 20 percent of the increase in the working-age population receiving SSI benefits.

However suggestive Yelowitz's results are, they do not seem to be very robust. Stapleton and his colleagues (Lewin-VHI 1995) used Yelowitz's methodology to look at the effect of changes in the value of Medicaid on the application for SSI benefits and found no measurable effects. Given the expectation that increases in the value of Medicaid would initially have a proportionately bigger effect on the number of applications (a flow) than on the beneficiaries (a stock), this nonresult is surprising. Although it is hard to imagine that eligibility for Medicaid benefits does not make SSI more attractive, finding statistical evidence of this effect has proven to be quite challenging.

Effects of Work Incentives and Disincentives

Because the United States has few program alternatives that offer long-term benefits to working-age persons who are not working, the relatively generous benefits and imperfect screening mechanisms in SSI could pose significant work disincentives for persons with disabilities who are considering applying for benefits. Additionally, the high marginal tax rates for those on the program could discourage exit from it and entry into the labor force.

A large empirical literature has tried to estimate the magnitude of moral hazard effects. Some of that literature has examined the net effect of SSI (and SSDI) on labor force participation rates, such as how much higher participation rates would be were it not for these programs. However, this literature has primarily focused on estimating the disincentive effects of SSDI program parameters, benefit generosity, or screening stringency. For a complete review of this literature see Bound and Burkhauser (1999). Al-

though it is tempting to look to the SSDI literature to gain some insights into how the SSI program affects the behavior of low-income adults with disabilities, doing so is problematic. First, whereas both programs use the same criteria of inability to perform substantial gainful activity with respect to establishing categorical eligibility, the benefit structures of the two programs are quite different.⁵³ Second and perhaps more important, as noted earlier, typical SSDI applicants have much different socioeconomic characteristics and work histories than typical SSI applicants.

As seen in table 2.7, most of the individuals who apply for SSI were not working three years prior to application. More importantly, the causes for their low employment rates at that time likely were more closely associated with the problems faced by low-skilled or poorly educated workers generally than with specific effects of poor health or of the work disincentives of SSI or SSDI. Furthermore, only 19 percent of those who were denied SSI benefits were employed three years after their application (table 2.7). In contrast, 35 percent of denied SSDI applicants were employed three years after application. These patterns suggest that changes in program work incentives and disincentives for those on the SSI rolls are less likely to induce them to leave the rolls and return to employment than would be the case for SSDI beneficiaries. This seems especially likely given that far fewer SSI beneficiaries than SSDI beneficiaries worked three years prior to application when they presumably did not have a work limitation severe enough to qualify for benefits.

Although it is not clear that SSDI research will shed much light on the work behavior of SSI recipients, there is a large literature on the work incentives and disincentives in other welfare programs. This empirical research consistently finds that recipients are unresponsive to changes in marginal tax rates (for reviews of this literature see Moffitt 1986 and Hoynes and Moffitt 1996). This literature provides little evidence that individuals participating in means-tested programs respond to financial incentives by working more. Research on the extent to which individuals with disabilities have the same income and substitution elasticities of participants in other programs would be an important step in determining whether the results discussed are applicable to the SSI population.

Finally, the small amount of research that does exist on the work efforts of SSI recipients suggests that, despite special allowances for SSI recipi-

53. For example, SSDI is an insurance-based (non-means-tested) program with its benefits based on past individual earnings history, whereas SSI is a flat-rate means-tested welfare program. SSDI provides recipients Medicare benefits after they are on the program two years and restricts its recipients to labor earnings up to \$750 per month for a limited period, after which they face a significant program “notch” and lose all SSDI benefits. The SSI program provides its recipients with immediate access to Medicaid and, once on the program, allows them more generous work options compared to SSDI.

ents who receive earnings (e.g., 1619[a] and [b] status), only a small percentage of disabled adult SSI recipients work.⁵⁴ In 1976 only 3.4 percent of all disabled adult beneficiaries worked. Since that time, the percentage of disabled adult SSI recipients with earnings has nearly doubled, but, at 6.3 percent in 2001, it remains quite low.⁵⁵ A somewhat more optimistic picture comes from work by Muller, Scott, and Bye (1996), who look at the work history of SSI recipients. They find that among a sample of SSI beneficiaries coming onto the rolls between 1976 and 1988, approximately one-quarter worked at some point during the time they received benefits.

In response to the low number of SSI recipients who work, the SSA has conducted two large-scale return-to-work demonstration projects to study the effectiveness of providing rehabilitation and employment services to SSI beneficiaries. The first, the Transitional Employment Training Demonstration (TETD) project, which operated between 1985 and 1987, focused on SSI beneficiaries whose primary condition was mental retardation. The second, Project NetWork, operated between 1992 and 1995 and included SSDI and SSI beneficiaries with a wide range of diagnoses. The two demonstration projects were run in a similar fashion. Eligible beneficiaries in selected cities were invited to participate in the two projects. Volunteers were then randomly assigned to treatment and control groups. The treatment groups were provided with rehabilitation and employment services, whereas the control group was not. Using both survey and administrative data, the effectiveness of the rehabilitation and employment services could then be studied by comparing outcomes of the experimental and control groups.

Analysis of the impact of the TETD project suggests that the employment and rehabilitation services provided to SSI beneficiaries significantly increased earnings for participants over the six years they were observed (earnings of the treatment group were close to 70 percent higher than the control group, roughly \$4,000 in 1996 dollars), but the program only had a small impact on average SSI payments (\$870 per participant). This small reduction in SSI payments was not nearly sufficient to cover the average costs of transitional employment services for program participants (Thornton and Decker 1989).⁵⁶ However, when the employment and earnings gains for program participants are weighed against the costs of providing the employment services, the program may very well have produced

54. Section 1619 (P.L. 96-265) became law in 1986. These provisions dramatically altered the earnings opportunities for SSI disabled adults. Section 1619(a) allows recipients to maintain their SSI (and Medicaid) benefits even when their earnings exceed SGA. Section 1619(b) extends Medicaid coverage to workers whose earnings make them ineligible for SSI cash payments.

55. Data on recipients who work come from SSA (2002b).

56. The net effect of the transitional employment services is harder to evaluate and depends crucially on the extent to which the services provided by the project substitute for other services paid for by the government (Thornton and Decker 1989).

a net social benefit. Similar results were obtained from Project NetWork. Analyses of the program (Kornfeld and Rupp 2000) show that during the first two years of operation Project NetWork produced modest net benefits to persons with disabilities, as earnings gains among participants more than offset reductions in SSI and SSDI benefits. However, the small gain in earnings was not nearly sufficient to offset the costs of administering Project NetWork. Moreover, data for a third-year follow-up on about 70 percent of the sample show that earnings gains declined to about zero, suggesting that the increase in earnings may have been temporary.

Importantly, in both cases the fraction of program eligibles who volunteered for either TETD or Project Network was small—roughly 5 percent in each experiment. This suggests that, however beneficial it might be to those who participate, the provision of transitional employment services to those on SSI who volunteer for services is unlikely to have much of an impact on the overall SSI population. This is hardly surprising. As shown earlier in this chapter, only a small fraction of SSI applicants were working in the years prior to application. In addition, beneficiaries go through a long process to establish that they have medical conditions that prevent them from performing substantial gainful activity. At least at the time they apply for SSI benefits, applicants would appear to have put substantial energy into becoming eligible for program benefits—benefits that must more than compensate applicants both for any loss of income associated with moving onto SSI and for the costs associated with applying for benefits.⁵⁷ For the great majority of those awarded benefits, their health is unlikely to improve over time and their labor market opportunities are probably deteriorating. Moreover, those who return to work may be subject to high marginal tax rates.⁵⁸ Under such adverse conditions it is not surprising that voluntary returns to work are rare.

2.5.2 SSI and Families of Children with Disabilities

As noted earlier, the primary justification for awarding cash benefits to poor families containing a disabled child is that the families of disabled children face additional economic burdens associated with their child's poor health (see NASI 1996). These economic burdens may include lost earnings from a parent who provides care for the disabled child and medical and nonmedical expenses related to the child's specific disability. How-

57. As will be discussed later in this chapter, the cost of applying for SSI disability benefits for the average applicant may be lower today than in previous periods. To the extent that welfare reform has changed the SSI applicant pool, individuals may not be making a choice between work and benefits but rather between other welfare and SSI.

58. The evidence we have on the extent of work activity by those who have been awarded SSI benefits comes mostly from the analysis of Social Security Earnings data. Anecdotal evidence suggests that some fraction of those on SSI are actually working, but are working "off the books." Research targeted on such off-the-books work by SSI beneficiaries along the lines of that done by Edin and Lein (1997) on welfare recipients would be valuable.

ever, SSI child benefits are not based on an earnings replacement or expenditure offset formula but, rather, are means-tested against current income. It is difficult to know a priori whether beneficiary families experience dramatic drops in labor earnings or increases in net-of-disability expenditures in family income. In fact, it is equally possible that recipient families have low incomes prior to the onset of the child's disability, and that the additional burdens placed on families with a disabled child are not the root cause of their current financial situation.

As with the adult SSI program, the child SSI program faces the problems related to moral hazard—incentives for parents to have their children become and remain eligible for SSI. The degree to which this potential moral hazard causes behavioral changes with respect to gaining and maintaining eligibility depends, to some degree, on the pre-disability economic circumstances of the covered families. If the typical family is a middle-income family that experiences a dramatic decline in its economic well-being at the onset of the child's disability, but in all other ways has the market and social characteristics necessary to attain middle-income status, then cash programs that only partially offset these losses are unlikely to lead to major disincentives for labor market participation or the child's recovery. However, if the typical family that comes onto the SSI rolls is already economically vulnerable (e.g., family members have few market skills, it is a one-parent family, etc.) prior to the onset of the child's disability, eligibility for SSI is likely to have much greater economic importance. Poor families that have a child with a disability may be able to completely replace or even increase their family income if their child's disability results in the receipt of SSI benefits. Thus, pre-disability differences in economic well-being alter the replacement rate of SSI among families of children with disabilities and make the moral hazard of behavioral change much greater among pre-disability low-income families than among middle- or high-income families.

Factors Affecting SSI Participation

As is true for the adult disability determination process, the disability determination process for children has undergone substantial revision. As noted earlier, the most important change came in 1990 when the Supreme Court required SSA to significantly broaden the eligibility criteria for childhood disability. The same year as the Zebley decision, SSA also released regulations revising the procedures used to evaluate mental impairments among children. The new rules expanded SSA's medical listings for childhood mental impairments by adding such illnesses as attention deficit hyperactivity disorder (ADHD) and by incorporating functional criteria in the listings. Similar to the changes made in the adult process, SSA modified the types of evidence used to judge the damage of mental illness; less emphasis was placed on the testimony of medical professionals and more weight was given to the information parents, teachers, and counselors pro-

vided about the child's condition. As with the IFA, the new mental impairment regulations focused on how disabilities affected a child's performance in school.

Following these changes, the child SSI caseloads grew rapidly. Data from the SSA show that between 1989 and 1996 the number of children under eighteen receiving SSI more than tripled, from 265,000 to 955,000. Applications increased from 132,000 in 1989 to 541,000 per year in 1994, and awards more than quadrupled. The yearly allowance rate on applications rose from 39 percent in 1989 to a peak of 58.1 percent in 1992. In 1992, the number of children on SSI grew by 40 percent (U.S. GAO 1998).

In response to rapid caseload growth and a burgeoning concern that the disability determination process was allowing too many children without serious medical problems onto the disability rolls, Congress narrowed the criteria for childhood disability in 1996. In addition, Congress mandated that SSA redetermine the eligibility of children on the rolls who might not meet the new eligibility criteria because they received benefits on the basis of the former, more lenient, standards.⁵⁹ In 1997, the number of SSI recipients under age eighteen fell 7.9 percent and by 2001 was still 7.7 percent below the 1996 high (see figure 2.4).

Economic factors also influence the decision of families to participate in SSI. Evidence suggests that a large fraction of the children coming onto the rolls in the 1990s previously participated in the AFDC program. Daly and Burkhauser (1998), using data from the National Longitudinal Survey of Youth (NLSY), calculate that two-thirds of children found eligible for SSI in the early 1990s were in families already receiving some type of welfare assistance. Other things being equal, families eligible for multiple programs are likely to select those programs that provide the highest net benefit to them. Although additional costs are associated with SSI (e.g., more stringent application rules, greater stigma related to receiving benefits, etc.), as the benefit difference between SSI and other programs increases, more families will be willing to incur these costs to improve their economic situation.

Kubik (1999) tests the empirical significance of this prediction. He finds that AFDC recipient families who successfully qualify a child for SSI benefits can increase family income substantially. Table 2.9 (taken from Kubik 1999) shows how a family's income can change when a child moves from AFDC to SSI. The analysis is for two states, Maryland and Connecticut, and demonstrates two points: (a) Families can significantly improve their economic well-being if someone in the family qualifies for SSI, and (b) the generosity of SSI relative to AFDC has grown over time, implying that the

59. The SSA originally identified 288,000 children as potentially affected by changes in the eligibility criteria. In 1998, SSA scaled back its estimates; new estimates suggest that fewer than 100,000 children will become ineligible for SSI (U.S. GAO 1998).

Table 2.9 AFDC and SSI Benefit Levels for Maryland and Connecticut, 1990 and 1994 (in dollars)

State	AFDC Benefit for Family of Three (1)	AFDC Benefit for Family of Two (2)	Difference ([1] – [2]) (3)	Federal SSI Benefit (4)	Net SSI Benefit ([4] – [3]) (5)
Maryland					
1990	4,872	3,804	1,068	4,632	3,564
1994	4,392	3,432	960	5,352	4,392
Connecticut					
1990	6,660	5,424	1,236	4,632	3,396
1994	8,160	6,588	1,572	5,352	3,780

Source: Kubik (1999).

Notes: All benefit levels are state maximums, assuming the family earns no countable income. Both Maryland and Connecticut did not provide SSI state supplements to children during this time period.

incentive to transfer to the SSI program has grown. Table 2.8 shows that a family of three living in Maryland in 1990 could have increased monthly family income by over \$3,500 if one child transferred to the SSI rolls. By 1994, this advantage had grown to almost \$4,400. Since other in-kind benefits such as Medicaid and food stamps remained constant, the family experienced a net gain in income if the child moved from AFDC to the SSI rolls.

A small number of empirical papers have examined the responses of AFDC participants to changes in the SSI program, including the post-Zebley broadening of the childhood disability criteria, and increases in the relative generosity of SSI benefits during the 1990s (see RAND 1998 for a thorough review of this literature). Garrett and Glied (2000) examine the impact of the Zebley decision on SSI and AFDC caseloads using the Zebley ruling as a “natural experiment,” representing an exogenous increase in the supply of SSI benefits (i.e., eligibility criteria are relaxed and more families are allowed onto the SSI program). They exploit the state-level variation in the difference between SSI and AFDC payments to test whether families are responsive to increases in net benefits. Their findings suggest that families are responsive to differences in program generosity. They found that in low-AFDC states, where the difference between AFDC and SSI payments would be largest, about 53 percent of the new post-Zebley child SSI cases switched from the AFDC program; nationally, only about 43 percent of new SSI child cases came from the AFDC program.

Along the same lines, Kubik (1999) examines the incentives for families to identify children as disabled when SSI benefits are more generous than AFDC benefits. Using data from the National Health Interview Survey (NHIS) and changes in the difference in SSI and AFDC benefits, Kubik finds that reported disabilities—particularly mental impairments—were

higher in low-AFDC-benefit states than in high-AFDC-benefit states.⁶⁰ Using data from the CPS on household SSI receipt, he also finds that relatively generous SSI benefits (relative to AFDC payments) affect SSI participation. Kubik estimates that a 10 percent increase in SSI benefit generosity increases the probability of SSI participation among families with low education by 0.39 percentage points—a 5 percent increase in SSI participation. Overall, Kubik finds a significant and positive relationship between the marginal value of SSI benefits and the prevalence of disability, and receipt of SSI, among children.

Effects of SSI on Work Effort of Families

SSI support for families potentially affects the labor market effort of parents. However, there is not a large empirical literature on this relationship. Indeed, of the literature on childhood SSI, only the Garrett and Glied (2000) and Kubik (1999) papers consider this issue. Garrett and Glied estimate that the Zebley decision had a significant impact on the employment of unmarried women without a high school education. Kubik finds similar results; examining behavior after Zebley, Kubik finds that increases in SSI benefits lowered the probability that low-education household heads work. He estimates that a 10 percent increase in SSI benefits decreases labor force participation of low-education household heads by about 2 percent. The empirical evidence on the effects of SSI benefit levels on parental work effort after Zebley suggest that, in addition to responding to the particular health needs of a child, mothers also respond to the income effect present in the guarantee as well as to the high marginal tax rates placed on their labor earnings.

2.5.3 SSI and the Behavior of the Aged

Factors Affecting Participation

Researchers have offered a number of hypotheses to explain the low enrollment in SSI among the elderly, including lack of knowledge about the program and eligibility criteria, prohibitively expensive application costs (e.g., time cost or cost of learning), and unobserved costs of receiving benefits (e.g., welfare stigma). Early work on this topic focused primarily on the roles of welfare stigma and program knowledge on the decision to apply. Coe (1985) reported that of the SSI nonparticipants classified as eligible (48 percent of all eligible individuals), a significant fraction were not aware of the program or did not think they were eligible. Coe also found that benefit levels were positively and significantly related to participation,

60. To account for state-specific factors that may affect the prevalence of disability, Kubik examines this relationship before and after Zebley. Thus, he measures the change in the prevalence of reported disability and compares it to the change in the difference between SSI and AFDC benefits by state.

with each \$10 in additional benefits resulting in a 2.4 percentage point increase in the probability of participation. This is consistent with the notion that relatively high benefit levels would outweigh any noninformational barriers to participation, such as access costs. However, Coe notes, noninformational barriers accounted for only 25 percent of the negative effect of low benefits on participation. The primary reason lower benefit levels decreased participation was that eligible individuals facing low benefit levels were more likely to believe that they were not eligible to participate. Warlick (1982) also concluded that program information and the difficulty of the application process were the primary reasons for low participation rates among the eligible elderly.

Recent work by McGarry (1996) draws a slightly different conclusion. McGarry extends previous research by using detailed asset and income information from the 1984 Survey of Income and Program Participation to more accurately classify eligibility by accounting for differences in benefit levels introduced by state supplementation, and by explicitly controlling for measurement error in the estimation process. McGarry concludes that the participation decision is primarily determined by the financial situation of eligible individuals. She finds that although all persons eligible for SSI are poor, the probability of participation declines as the number of alternative resources increases. Similar to Coe, she finds that the elasticity of the expected benefit is about 0.5 and that, after controlling for size of the SSI payment, those with greater resources are less likely to participate.⁶¹

McGarry departs from previous research in finding little evidence that welfare stigma or informational program costs affect participation. However, as she notes, her results must be interpreted with caution. The estimated model is a reduced-form version, which includes variables likely to affect participation through more than one path. If a variable operates in opposite directions on different factors, its importance may be obscured. Thus, although she argues that the negative coefficient on years of schooling implies that lack of information does not deter participants, this result can just as easily be interpreted as evidence of stigma associated with receiving benefits (i.e., more educated individuals feel more stigma associated with receiving benefits).

In general, the low SSI participation rates among the elderly remain something of a mystery. Although there is reason to believe that some individuals are uninformed about the program or their eligibility for benefits, there is not much evidence that a large fraction of the elderly poor in need of assistance are constrained by transactions costs. What does appear to be the case is that eligible individuals who are close to the margin on the

61. Coe's measure of other resources includes only the home ownership variable. McGarry uses a more extensive set of resource measures, including home and other asset ownership, labor earnings over the year, and the ratio of income to needs.

means test are less likely to participate in the program. As Coe (1985) argued, this may be due to individuals' misunderstanding the income disregards and other program rules that determine eligibility. Thus, unless individuals are sufficiently below the means test guidelines, they believe that they will be ineligible and thus do not apply. This interpretation is consistent with McGarry's simulation of responses given a change in benefit levels. McGarry examined how raising the federal income guarantee to the U.S. poverty line affected the participation of those previously and newly eligible for benefits. She finds that raising the benefit level increases the participation rates of those previously eligible by 16.5 percentage points, from 0.534 to 0.699. In contrast, she finds that less than 30 percent of those newly eligible under the increased income limit participate in the program.⁶²

Saving Behavior

Although it is well recognized that means-tested programs create incentives for potentially eligible individuals to alter their behavior to ensure qualification, few studies have rigorously reviewed the incentives facing elderly individuals close to the age and resource tests for SSI. Yet it is likely that SSI program features create disincentives for working and saving as individuals approach the age of eligibility. Neumark and Powers (1998) focus on the relation between saving behavior and SSI receipt among the elderly. They argue that SSI's influence on the saving patterns of elderly individuals should vary with the expected level of their benefits and the likelihood of receiving them. In practice, individuals with low lifetime earnings living in high-benefit states should reduce saving more than high lifetime earners living in low-benefit states. Neumark and Powers use state-level variation in the generosity of supplemental SSI payments to identify the effects of SSI on the saving behavior of the elderly. They find that SSI reduces the saving of men and women nearing the age of retirement who are likely participants in the program.

SSI and Labor Force Participation at Older Ages

There only are a handful of papers that discuss SSI and the labor force behavior of older workers. Duggan (1984) finds that SSI has a negative impact on the labor force participation of men and women over fifty-four years of age, with especially strong effects for men. Powers and Neumark (2001) investigate the role that SSI plays in exercising the early retirement option in the Social Security program. Although Powers and Neumark

62. McGarry (2000) simulates the effects of changes in eligibility criteria on participation and costs. She finds that extending the income guarantee for all elderly individuals to the poverty line has the largest impact. Modifications to SSI that increase income disregards or eliminate the asset test or base income eligibility are less costly but also have less of an impact on poverty.

find only weak empirical evidence that eligibility for SSI benefits positively influences early retirement decisions, these effects may increase in coming years. The normal retirement age for receiving Social Security benefits is now in the process of increasing from sixty-five to sixty-seven over the next fifteen years, increasing the value to those eligible of the SSI bridge, especially for those in very poor health.

2.6 Summary and Conclusions

The enactment of the SSI program in 1972 was the culmination of a four-year debate over a much more overarching welfare reform—a federally funded minimum income guarantee for all Americans. Unlike Nixon's FAP proposal, SSI was targeted on the subgroup of low-income individuals "not expected to work." Since then, SSI has grown dramatically, with the composition of SSI beneficiaries shifting toward adults and children with disabilities.

How one views the increases in the SSI disability population is largely influenced by one's view of the social purpose of SSI. For those who see SSI as an incomplete substitute for a universal guaranteed income program like the NIT, expansions in the SSI program are seen as appropriate because they bring the United States more into line with most Western European countries that provide such a universal minimum social safety net for all their citizens. However, for those who are worried about the long-term effects of a lifetime on government transfers, the rise in the prevalence of disability transfer recipients—particularly among poor children and younger adults—is of more concern.

Whatever perspective one takes, however, as the population on SSI changes and the group of those not expected to work narrows, the structure of SSI comes into question. As we have shown, the SSI population has dramatically shifted over time. It is now dominated by children and young adults with disabilities. To date, despite some attempts to offset the negative work incentives in SSI (section 1619), exits from SSI to employment, even among this younger population, have been rare. As shown earlier in this chapter, for individuals and families receiving SSI and other transfer program benefits the marginal tax rates can go from 50 to near 100 percent at relatively low earnings levels. Although such high tax rates and relatively generous guarantees make sense for populations not expected to work, in a population where work is possible, they seriously discourage work. Hence, for those with a capacity to work, SSI, together with eligibility for other programs, can become the "poverty trap" that the original supporters of Nixon's single universal FAP program were trying to avoid.

Such concerns are particularly relevant in light of other government policies to protect those with disabilities. Support for civil rights-based legislation like the ADA is based on the idea that people with disabilities

should have equal access to employment. Supporters of this type of legislation view unequal access to jobs to be a greater impediment to employment than a health impairment. Furthermore, they ask that social policy focus on altering workplace institutions to more fully accommodate people with disabilities. Hence, in a world of full accommodation, they argue that the disability transfer population should be zero. Fundamentally, the current policy debate over expanding SSI transfer rolls hinges on the role people with disabilities should play in society. Should people with disabilities be expected to work or not? If yes, then policies targeting people with disabilities—particularly the young—would be better focused on education, rehabilitation, job training, and accommodation than on increasing or expanding transfers. Likewise, for children with disabilities, investing more time, energy, and resources in enhancing their education and development, rather than focusing solely on supplementing the income of their households, might be more desirable.

In general, our examination in this chapter suggests that in the absence of a universal guaranteed income program for all Americans, the operational flexibility of the categorical eligibility criteria for SSI has made the program sensitive to both downturns in the business cycle and increases in the pool of vulnerable people. Moreover, when the dividing lines separating the working-age adult and child populations eligible for SSI from those eligible for other income-based benefits are imprecise, as with disability, policy changes in other welfare programs are likely to affect SSI caseloads.

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