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Left Behind: SSI in the Era of Welfare Reform

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Left Behind: SSI in the Era of Welfare Reform

Abstract

SSI was established in 1972 and born out of a compromise between those wanting to provide a guaranteed income floor under all Americans and those wishing to limit it to individuals not expected to work, at that time, the aged, blind, and disabled. SSI is now the largest federal means-tested program in the United States, serving a population dominated by low-income adults and children with disabilities. With other forms of federal support devolving to state programs (e.g., welfare), policymakers pressing to redefine social expectations about who should and should not work, and the Americans with Disabilities Act guaranteeing people with disabilities the right to employment, the goals and design of SSI have come under scrutiny. In this article we review the role that SSI has played to this point and consider the directions SSI might take in a work-dominated welfare environment where people with disabilities increasingly wish to be included in the labor market.

Left Behind: SSI in the Era of Welfare Reform

In 1974, when Supplemental Security Income (SSI) began as a program to aid the aged, the blind, and individuals with disabilities who are also poor, it was relatively small, providing benefits to a mostly elderly population. SSI is now the largest federal, means-tested, cash assistance program in the United States. In 2001 an average of 6.7 million people received benefits, and federal and state expenditures for the program totaled over $32 billion. The majority of SSI recipients are under 65, and the caseload is dominated by children and working-age adults with disabilities; only about 30 percent of recipients are elderly (see Figure 1).

The rapid growth of SSI and the changing composition of its beneficiaries are sufficient reason to explore its role in the broader structure of U.S. social welfare programs. An examination is the more urgent because of the current efforts to integrate a variety of people who have not worked, or were not previously expected to work, into the workforce. Since SSI was established, social expectations regarding who should work and who should be entitled to income support have changed dramatically. Most people are living and working longer than in 1974; in addition, the Americans with Disabilities Act (ADA) of 1990 granted people with disabilities a legal right to equal access to employment, suggesting that the aged, blind, and disabled may be more likely to work than in the past.

The accelerating devolution of fiscal and administrative responsibility for social programs to state and local governments has changed some of the dynamics driving the SSI program. SSI will clearly be affected by the changed legislative environment for social welfare programs. There are now strict time limits on cash assistance and new requirements that

recipients of public assistance, with few exceptions, work or prepare for work. What are the likely interactions between SSI and Temporary Assistance for Needy Families (TANF), the main cash welfare program? Now that TANF is no longer an entitlement, and control of TANF policies is largely in state hands, will the role of SSI in the social safety net change?

Of special importance is the question of whom the program should serve. The boundaries separating the working-age and child populations eligible for SSI from those eligible for other income-based benefits are imprecise and fluid, as we shall later show, and their demarcation is a political almost as much as it is a medical decision. The persistence of high poverty rates among children, even during the long and robust economic expansion of the 1990s, suggests that some form of income maintenance program must remain a crucial part of the social safety net. But should SSI play that role?

In this article we review the role that SSI has played to this point, examining in particular the evidence regarding its behavioral and labor market effects on the population of working-age adults. We briefly consider the directions SSI might take in a work-dominated welfare environment with a multiplicity of state and federal programs.

The Rationale for SSI

In 1972, Congress rejected the Nixon administration's Family Assistance Plan (FAP), the first serious attempt to institute a federal program that would provide support for all low-income families. But it passed legislation creating SSI, largely because providing income assistance to people not then expected to work seemed unlikely to have much effect on employment. Through SSI, Congress federalized the administration of benefits, set minimum benefit standards, imposed uniform eligibility criteria, and set relatively low benefit reduction rates on earnings from work. But at the very beginning of the program, Congress began to blur the traditional

ability-to-work standard for determining who should be entitled to public welfare payments. By extending benefits to the needy families of disabled children, SSI expanded the social safety net to include families headed by adults who were "employable."

The goals of SSI have not changed, but the program itself has undergone extensive legislative and administrative revisions over the years. These have sought primarily to make the criteria for disability more precise (the term generally used is "target effective") and to encourage recipients to return to the workforce. The Social Security Disability Amendments of 1980, for example, allowed recipients to deduct some work expenses from earnings, thus in effect raising the level of allowable earnings. And in the 1996 welfare reform legislation, Congress restricted the eligibility of noncitizens for SSI, out of a belief that the program had become a magnet for newly arrived noncitizens with immigration sponsors.

Qualifying for the Program

The categorical criteria

The first two criteria for SSI eligibility—age and blindness—are straightforward and easily determined. Disability screening is more complex, and has been extremely controversial. First, there is no simple definition of disability. The most common measure in the economics literature distinguishes three components: the presence of (1) a pathology—a physical or mental malfunction—that leads to (2) an impairment—a physiological, anatomical, or mental loss or abnormality—that results in (3) an inability to perform, or limitation in performing, socially expected roles and tasks.[1] For men, and increasingly for women, market work is a socially

1. For further discussion see S. Nagi, *Disability and Rehabilitation: Legal, Clinical, and Self-Concepts of Measurement* (Columbus: Ohio State University Press, 1969), and "Disability Concepts Revisited: Implications to Prevention," in *Disability in America: Toward a National Agenda for Prevention*, ed. A. Pope and A. Tarlov (Washington, D.C.: National Academy Press, 1991). A useful discussion of disability measurement also can be found in Jette A., and E. Badley, Conceptual Issues in

expected role, and those unable to work or limited in their work ability are considered to be disabled.

SSI applicants move through a multi-step process in which their pathology, impairment, and level of functioning are judged. Although the disability criteria are federal and therefore uniform nationwide, state disability agencies, working with vocational and medical consultants, act as the primary gatekeepers and make the determination of disability. If a decision cannot be reached on medical grounds alone, applicants are evaluated in terms of their "residual functional capacity" (can they work, either in the kind of job they have held in the past, or in another kind of job?). The interpretation of the criteria clearly varies systematically from state to state and over time. For instance, the 20 year average, from 1974 to 1993, of within state initial acceptance rates, (i.e. the percentage of those who apply for SSI benefits who are accepted at the first level of evaluation each year in a given state), ranged from lows of 28 percent in Louisiana and New Mexico to highs of 48 percent in Delaware, New Jersey, and Rhode Island.

Screening children has proved more complex and contentious than screening adults. The originally stringent criteria for eligibility were broadened in 1990 as a result of the U.S. Supreme Court decision, Sullivan v. Zebley. This decision held that to meet the standard of equal treatment, the initial determination of disability must include a functional limitation component parallel to that of adults—for example, certain schooling difficulties should be considered ground for eligibility. With the addition of these new and broader grounds, the SSI child caseload, about 185,000 in 1989, began to grow rapidly, reaching 955,000 by 1996. In that year

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the Measurement of Disability." in The Dynamics of Disability: Measuring and Monitoring Disability for Social Security Programs. (Washington, D.C.: National Academy Press, 2002.)

Congress, as part of the welfare reform legislation, again raised the bar for eligibility by redefining the criteria and since then program growth as been slower.

The economic criteria

To be eligible for SSI an individual must have "countable income" less than the federal benefit rate, $9,360 per year in 2002, and "countable assets" below $2,000 (for couples, the amounts are 150 percent of the individual rate). Not all income is countable: $65 a month in earnings are disregarded. Thereafter, for every dollar earned, a recipient loses $0.50 in SSI benefits. In-kind assistance like food stamps and public housing subsidies and $20 in income from other sources are disregarded, but all other government benefits are taxed at 100 percent. If someone eligible for SSI lives with others who are not—a spouse, or working-age parents—a portion of the income of those others is also considered in determining the amount of the SSI payment.

Although the federal benefit rate and thus the monthly income test rise with inflation every year, the income disregards, the asset limits, and the value of assets that are allowed (a car, or household goods) have never changed, and have fallen substantially in real terms since 1974, eroding the value of the SSI benefits and narrowing the population of potential recipients. In 2002 dollars, for example, the $65 earnings disregard would be $275; the $2,000 asset limit for an individual would be $6,345. The population now eligible for SSI is thus smaller and more economically disadvantaged than it was in 1974.

SSI Benefits

In general, SSI beneficiaries with no countable income receive the maximum monthly benefit ($545 for an individual, $817 for a couple in 2002. Although the original objective of SSI was to guarantee an income at the poverty level, the federal minimum benefit in fact never

represented more than about 75 percent of the poverty threshold for an eligible individual (90 percent for a couple).

SSI recipients are required by law to apply for every government program for which they may be eligible. In most states, they are automatically eligible for food stamps and Medicaid. A majority of states pay an SSI supplement, but several factors minimize the importance of these. For example, only 23 states provide supplements to the vast majority of SSI recipients living independently in their own households. Because state supplements are not annually adjusted for inflation, the real value of the median payment to individuals declined by about 60 percent between 1975 and 1997.

As a federal income maintenance program, SSI is funded from general revenues and the federal government pays the bulk of the benefits.[2] States thus have an incentive to move individuals to SSI from state programs, including TANF, which is federally financed as a fixed block grant that does not rise as caseloads increase. This fiscal incentive may well explain the active role state welfare agencies play in SSI outreach programs.

Profile of SSI Recipients

Demographic composition of the SSI rolls

As the basis of eligibility and the age composition of SSI recipients have changed, a number of other key demographic characteristics also have changed (Figure 2). First, the proportion of males and non-whites has increased. So too has the number of noncitizens, which shrank when restrictions were imposed in 1996, but still constitutes about 11 percent of the SSI

2. In 1975, state supplements accounted for about 27 percent of all SSI payments. By 1998, the state proportion had declined to 13 percent of the total.

population. Second, the number of recipients qualifying on the basis of physical disability has shrunk, and over 35 percent of the caseload now is qualified on the ground of psychiatric disorders (the percentage qualifying by virtue of mental retardation has remained essentially stable).

What proportion of people who meet the categorical, economic, and citizenship tests for SSI are actually participating? We can provide only a rough approximation, using census data. We estimate that the participation rate of the poor elderly declined from around 79 percent in 1974 to about 54 percent in 1982; it has fluctuated since then, but no more than two-thirds of poor, elderly people now receive SSI benefits. Participation rates among poor people of working age, in contrast, have risen, especially during the 1990s; in 1998, 20 percent of this group were SSI recipients, up from 15 percent in 1974. Recipiency rates for poor children also increased rapidly over the 1990s but remain in comparison low—around 6.6 percent in 1998.[3] Increases in disability rates did not cause the changes; these rates have not risen since 1980.

Multiple program participation among SSI beneficiaries

As SSI policies mandate, a large fraction of SSI beneficiaries participate in other government programs (Table 1). In 1999, nearly all SSI recipients received Medicaid—89.4 percent. A substantial fraction also received Medicare—41.4 percent in 1999; forty percent were also receiving Old Age, Survivors, and Disability Insurance, on the ground either of retirement

3. In 2001 the U.S. population with incomes below the poverty threshold included 17.8 million people of working age and 3.4 million people over 65, a poverty rate of 10.1 per cent; there were11.7 million poor children under 18, a poverty rate of 16.3 percent. U.S. Census Bureau, *Poverty in the United States, 2001,* Report P60-219, September 2002**,** Table 1.

or disability.[4] In the same year, 40 percent of SSI beneficiaries lived in households receiving food stamps, over 5 percent were receiving the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and another 25 percent were receiving free or reduced-price meals. One in ten received energy or housing assistance. Over time, the proportion receiving social security and Medicare has declined, while the proportion receiving other public benefits has risen. 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. We discuss how this potentially affects the behavior of SSI beneficiaries later in this article.

Factors Affecting SSI Participation

Supply of and demand for benefits

While application for SSI disability benefits is a function of health, it also is influenced by the eligibility criteria of income support programs, both social insurance and means-tested, the generosity of their benefits relative to work, macroeconomic conditions, and the applicant's education and job skills. In this brief discussion we look first at the evidence regarding caseload dynamics and the supply of benefits, and then at the demand for benefits.

The supply of benefits has fluctuated over time, largely as the stringency of the screening regulations has fluctuated. From the mid-1970s through the Social Security Disability Amendments of 1980, the disability determination and review process was steadily screwed

4. The Social Security Administration (SSA) administers Old Age, Survivors, and Disability Insurance (OASDI). Old Age and Survivor's Insurance (OASI) is the benefit generally known as "social security." Social Security Disability Insurance (SSDI or DI) provides payments to individuals who have worked for the required period and are judged to be disabled under the SSA guidelines. It is not means-tested, but does have restrictions on labor earnings. The Social Security Administration also administers the SSI program.

tighter. The number of SSI recipients fell, and the level of complaints about the harshness of the system rose. In 1984, the Social Security Administration (SSA) issued revised guidelines that loosened the requirements. Thereafter, the number of working-age adults with disabilities rose by about 4–5 percent a year during the economic growth years of the 1980s. When the next downturn came in the early 1990s, conditions were ripe for a surge in applications. The increases in the disability transfer population in the early 1990s exceeded anything seen since the program began. Acceptance rates rose to almost 45 percent in 1992, well above those in the 1980s. Economic recovery and Congressional action with respect to SSI disability have tempered the growth in the working-age adult SSI population, but acceptance rates remain well above those in the 1980s, suggesting that rolls could easily increase in response to weaker economic conditions.

Fluctuations in applications have been as large as changes in the disability rolls. To some extent they have mirrored changes in eligibility standards, but other factors—local economic conditions, outreach efforts by the SSA and state governments, and the relative generosity of SSI—have also contributed. Regulatory changes, such as the increased weight given to pain and other symptoms, the increased reliance on evidence from the patient's own doctor (rather than SSA examiners), and broader standards for those with mental impairments all contributed to the surge in applications. Among economic factors, long-run effects appear to be more important than transient local fluctuations. The national recession of the early 1990s contributed to the rapid growth of SSI; it has been estimated that a 1 percentage point rise in the unemployment

rate was associated with a 2 percent increase in applications.[5] Eligibility standards and economic circumstances clearly interact: for example, in the earlier recession of the 1980s, at a time of tightened eligibility standards for SSI, there was no such surge. Changes in the unemployment rate had a smaller effect on the number awarded benefits than on applications, suggesting that recessions induce those with less severe disabilities and greater likelihood of being rejected to apply for SSI benefits.

The SSI program also grew over the 1990s because of state welfare policies. Many states cut General Assistance—once a common form of state cash welfare for single men or others who did not qualify for AFDC—and those that did experienced above-average growth in applications for SSI benefits. Indeed, a number of state governments made conscious efforts to shift individuals onto SSI. States and other third parties such as private social welfare organizations have often acted as intermediaries in the complicated SSI application process to make these transfers easier.

Program Incentives and Caseload Dynamics

Like all public assistance policies, programs for the disabled must contend with potential "moral hazard" problems and with work disincentives induced by program rules.[6] 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

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5. D. Stapleton, K. Coleman, K. Dietrich, and G. Livermore, "Econometric Analyses of DI and SSI Application and Award Growth," in *Growth in Disability Benefits: Explanations and Policy Implications*, ed. K. Rupp and D. Stapleton (Kalamazoo, MI: W. E. Upjohn Institute, 1998).

6. Moral hazard is formally defined as the risk that the presence of a contract (in this case a social contract to provide benefits) will affect the behavior of one or more of the contract parties. The classic example is in the insurance industry, where coverage against a loss might increase the risk-taking behavior of the insured.

SSI could pose significant work disincentives for persons with disabilities who are considering applying for benefits. Additionally, the high marginal tax rates associated with multiple program participation could discourage exit from it and entry into the labor force. These same factors potentially affect the labor market decisions of adults with disabled children on SSI.

If those with disabilities were not expected to work, the bundle of program disincentives we have discussed above would be irrelevant. Marginal tax rates could approach 100 percent with no change in work behavior. Moreover, to the degree that age and work disability are clearly defined and immutable categories, differences in guarantees, time limits, or funding mechanisms for SSI and other programs would have little effect; the size of the SSI program would primarily reflect the prevalence of health limitations among low-income families. But neither the definition of disability nor the condition itself are immutable. And if work is both possible and expected for people with disabilities who meet other eligibility criteria, then policy discussions of SSI must consider such issues as, for example, the trade-offs among tax rates, guarantees, and break-even points.

In the United States, the typical working-age person with a disability acquired that disability at some point during his or her work life.[7] Social policy may, therefore, influence not only whether such workers remain in the labor force or end up in a transfer program, but also the speed at which the transition takes place. Thus the behavioral responses to worsening health depend not only on the severity of the condition but also on the social environment for people

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7. In 1992, 70 percent of men and women who reported a health-related impairment said it started during their work life. R. Burkhauser and M. Daly, "Employment and Economic Well-Being Following the Onset of a Disability: The Role for Public Policy." In J. Mashaw, V. Reno, R.V.Burkhauser, and M. Berkowitz (eds.) Disability, Work, and Cas Benefits (Kalamazoo, MI: W. E. Upjohn Institute, 1996).

with health impairments—the availability of jobs, of accommodation, rehabilitation, and training, the legal supports and protections, and the accessibility and generosity of SSI and other government transfer programs. Because the 1996 welfare reforms removed entitlement to many public assistance programs, SSI policy decisions must also, increasingly, take into account the actions of state and local governments.

In the end, the more important question is not whether the SSI program induces behavioral changes, but whether these changes are small relative to the social gains from redistributing income to less advantaged persons. In general, there is a social consensus that it is important to protect people against the economic consequences of age and disability. But because a socially appropriate eligibility standard for SSI is difficult to assess, a more stringent set of definitions will deny benefits to some who are less capable of work than is socially acceptable. More lenient criteria, however, involve a trade-off: given the presence of uncertainty, do the social benefits outweigh the efficiency costs of giving benefits to some who do not "deserve" them—who are more capable of work?

Adults with disabilities

Despite a large literature on the magnitude of the moral hazard effects of SSDI, AFDC, and food stamps, little research exists on the moral hazard problem in SSI.[8] While it is tempting to look to the research on other programs to gain insight into how the SSI program affects the behavior of low-income adults with disabilities, doing so is problematic. Comparisons to SSDI are constrained by the fact that the typical SSDI applicant has very different characteristics from

8. A review of this literature is J. Bound and R. Burkhauser, "Economic Analysis of Transfer Programs Targeted on People with Disabilities," in *Handbook of Labor Economics* 3(c), ed. O. Ashenfelter and D. Card (Amsterdam: Elsevier, 1999).

the typical SSI applicant, who is mostly younger and poorer, more likely to come from an ethnic or racial minority, to have functional limitations arising from mental conditions, less education, and fewer work skills and experience. Comparisons to other means-tested programs eliminate some of these problems, but are troubled by their broader scope of coverage and easier entry and exit (i.e., no disability screening).

The small amount of research that does exist on the behavior of SSI applicants or recipients shows that the average SSI recipient faces substantial disincentives to leave the rolls. Recent research shows that only a small fraction of SSI applicants work in the years leading up to their application. This limited work history combined with the long process of establishing that they have a medical condition that prevents them from working makes it difficult for beneficiaries to locate employment that compensates them for the loss of income associated with moving off of SSI and into the labor market. Finally, those who consider returning to work may be subject to very high marginal tax rates, in the form of reduced benefits from SSI and other transfer programs, plus the regular assortment of federal, state, and local taxes, as well as the potential loss of medical insurance (Medicaid).[9] Combined these implicit and explicit taxes can produce very high marginal tax rates for SSI recipients. For example, in 1994 a single male SSI recipient faced net tax rates ranging from 23 percent ($0 earnings) to 89 percent ($522 earnings).

In the hopes of offsetting some of these disincentives, adult recipients of SSI are eligible for a variety of federally funded and state-administered vocational rehabilitation programs; the pool of eligible providers was expanded in 1999 by the legislation called, significantly, the

9. Medicaid can be lost for those not meeting the 1619(b) program requirements. Those eligible for 1619(b) get to keep their Medicaid coverage for some period beyond when they exceed the means-test.

Ticket to Work/Work Incentives Improvement Act. But efforts to encourage SSI recipients to return to work have proved discouraging. The SSA conducted two large-scale return-to-work demonstration projects to study the effectiveness of providing rehabilitation and employment services to SSI beneficiaries; these were the Transitional Employment Training Demonstration, TETD (1985–87), and Project Network (1992–95). Both programs called for volunteers. The first focused on mentally retarded beneficiaries, the second on beneficiaries with a wider range of diagnoses. Both projects were evaluated using random-assignment methodologies. For both, the conclusions were similar: TETD produced significant earnings gains for participants over six years, but the small impact on SSI payments was not nearly sufficient to cover the average cost of providing services to participants. In Project Network, earnings gains in the first two years were enough to offset reductions in SSI and SSDI benefits, but did not offset the costs of administration and training, and a third year follow-up showed that earnings gains had declined to zero. In both programs, the fraction of those eligible who volunteered was very small, around 5 percent. This suggests that transitional employment services are unlikely to have a large effect on the SSI population as a whole.

Families of children with disabilities

The primary justification for awarding cash benefits to poor families containing a disabled child is that they face economic burdens associated with their child's poor health. These burdens may include lost earnings as well as medical expenses, but SSI child benefits are not based on an earnings replacement or expenditure offset formula; they are simply means-tested against current income. With current data, it is difficult to know whether families of children with disabilities became low-income due to earnings declines and/or increases in expenses associated with the onset of the child's disability or whether the families which qualify

for SSI benefits had low incomes before the onset of the child's disability. In the latter case, the extra burdens of the disability would not the root cause of their poverty.

The moral hazard faced by families whose child receives SSI benefits—the incentive to have their child become and remain eligible for SSI—depends to some degree on their economic circumstances before the child became disabled. If the typical family is a middle-income family whose economic well-being declines drastically when their child becomes disabled, a cash benefit that only partially offsets these losses is unlikely to be a real disincentive to work or to the child's recovery. But for families that are already economically vulnerable, SSI benefits for a disabled child may replace or even increase family income.

It has been estimated that perhaps as many of two-thirds of the children coming onto the SSI rolls in the early 1990s, after the Zebley decision, were in families already receiving some type of welfare assistance.[10] Other things equal, families eligible for multiple programs are likely to select those that provide them with the highest net benefit. SSI is associated with higher costs (more stringent application rules, greater stigma, etc.), but as the benefits associated with other programs shrink in comparison, more families may be willing to incur these costs to improve their economic circumstances. According to Kubik (1999) in 1990, a family of three, living in Maryland with one disabled child, could have increased monthly family income by over $3,500 if one child transferred to the SSI rolls.

Clearly behavioral change is much more likely in families confronted with such financial incentives. And there is evidence that families are more likely to report disabilities in

10. Kubik J. "Incentives for the Identification and Treatment of Children with Disabilities: The Supplemental Security Income Program." Journal of Public Economics 73 (1999): 187-215.

children—particularly mental impairments—in states with low welfare benefits than in states with high welfare benefits. At the same time, work is affected. The Zebley decision appears to have had a significant dampening effect on the employment of unmarried women without a high school education, and increases in SSI benefits lower the probability that poorly educated household heads will work.[11] In general, the evidence suggests that working-age adults and families of children with disabilities are moving from other welfare programs to SSI.

SSI: An Old Program in a New Era

As noted earlier, SSI was born out of a compromise between those wanting to provide a guaranteed income floor under all Americans and those wishing to limit it to individuals not expected to work, at that time, the aged, blind, and disabled. Times have changed since this original compromise. Individuals are living and working longer, the normal retirement age for Social Security benefits has been raised, the Americans with Disabilities Act has granted people with disabilities a legal right to access to employment, and congress has agreed that nearly all Americans (even young, single, mothers with children) are expected to work. For policymakers, this creates a conundrum: Should people with disabilities be expected to work or not?

This conundrum has been brought to the forefront by recent trends in employment and benefit receipt among those with disabilities (Figure 3). Figure 3 shows employment rates of working-age men and women with self-reported disabilities and the number of individuals receiving benefits for 1980-2001. As the figure shows, while employment rates for those with self-reported disabilities rose through the economic expansion of the late 1980s, they have fallen

11 J. Kubik, "Incentives for the Identification and Treatment of Children with Disabilities: The Supplemental Security Income Program," *Journal of Public Economics* 73 (1999): 187–215; A. Garrett and S. Glied, "Does State AFDC Generosity Affect Child SSI Participation?" *Journal of Policy Analysis and Management* 19, no. 2 (2000): 275–95.

almost continuously since, even during the strong expansion of the 1990s. At the same time that employment has been falling, the number of individuals on disability benefits (SSI and SSDI) has been rising.

While researchers debate the reasons for the declining employment and rising benefit rates of men and women with disabilities during the 1990s, policy makers 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 individuals with limited labor market opportunities. For others, the increased rolls reflect 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, where 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.

Whatever perspective one takes on the increase in the SSI disability population, as the population of SSI changes and the group of those not expected to work narrows, the structure of SSI comes into question. First, despite some attempts to offset the negative work incentives in SSI, exits to employment, even among this relatively younger population, are rare. The high tax rates and relatively generous benefits of SSI, which made sense for populations not expected to work, are a serious disincentive in a population where work is possible. For those with a capacity to work, SSI and the eligibility for other programs that it conveys can become a classic "poverty trap." Since the Zebley decision, moreover, nearly a million children have entered the SSI rolls. Given the broad commitment to integrating people with disabilities into the workforce

embodied in the ADA and welfare-to-work programs of the 1990s, major initiatives to integrate these children into the workforce rather than onto adult disability rolls are likely to be considered. Policies targeting young people with disabilities would surely be better focused on education, rehabilitation, job training, and accommodation than on increasing or expanding transfers. Especially for the children, investing more time, energy, and resources in education and development than in income supplementation for their families might be desirable.

Second, in the absence of a universal, guaranteed-income program for all Americans of the kind envisioned in the Nixon administration's FAP, the operational flexibility of the eligibility criteria for SSI has made the program sensitive to economic downturns and to increases in the pool of vulnerable people. The recent legislative changes in the social safety net and the increasing percentage of the population aged 50 and over—a point at which the incidence of disability rises sharply— in combination with the end of the record growth period of the 1990s business cycle and the slide of the economy into recession makes further increase in the rolls likely.

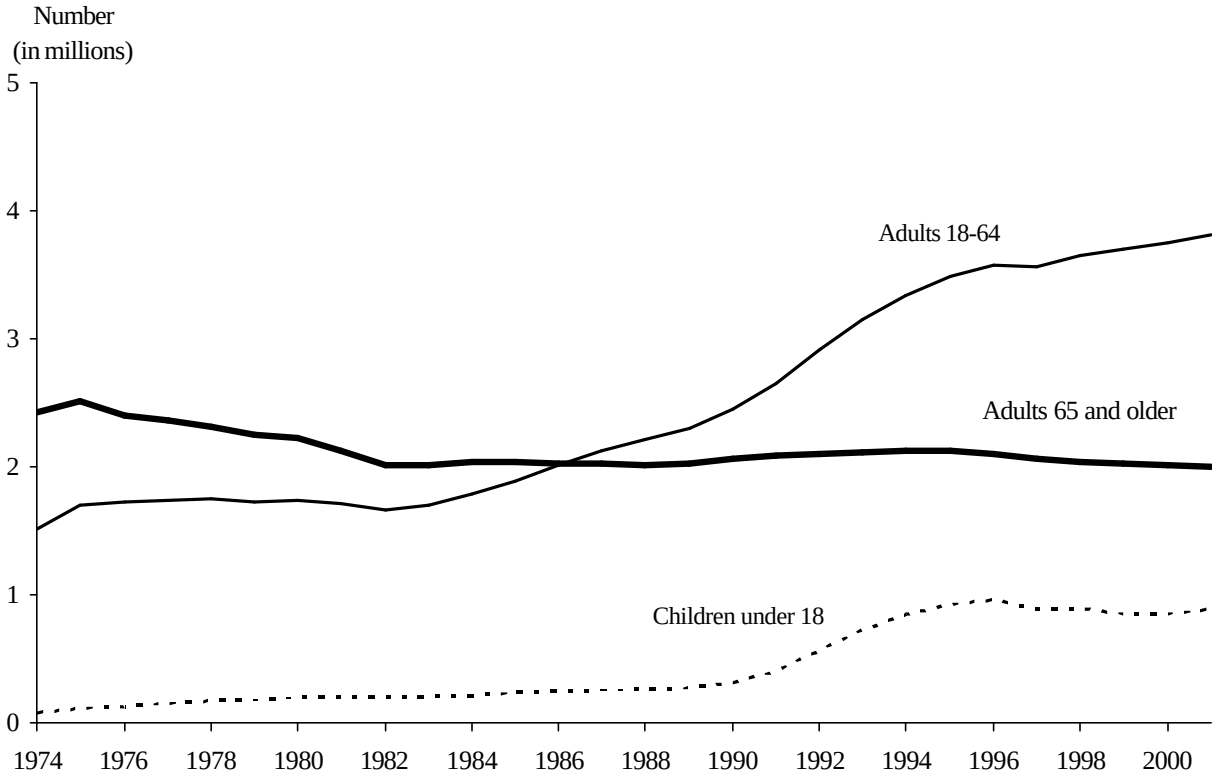
Table 1. Prevalence of Multiple Program Participation by SSI Recipients, 1999 By Gender and Age Group

	Male			Female			All
	0-17	18-64	65+	0-17	18-64	65+	
	(in percent)						
Simultaneous Program Participation[a]							
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

[a]Based on data from the Survey of Income and Program Participation.
[b]Based on SSA administrative records.
[c]Less than 0.5 percent of SSI recipients in the gender/age group participate in the program.

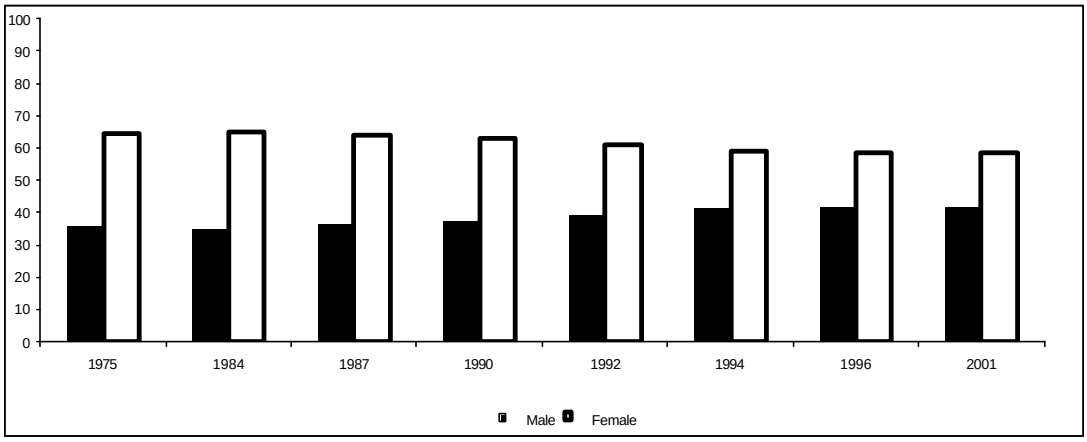
Source: 2001 SSI Annual Report.

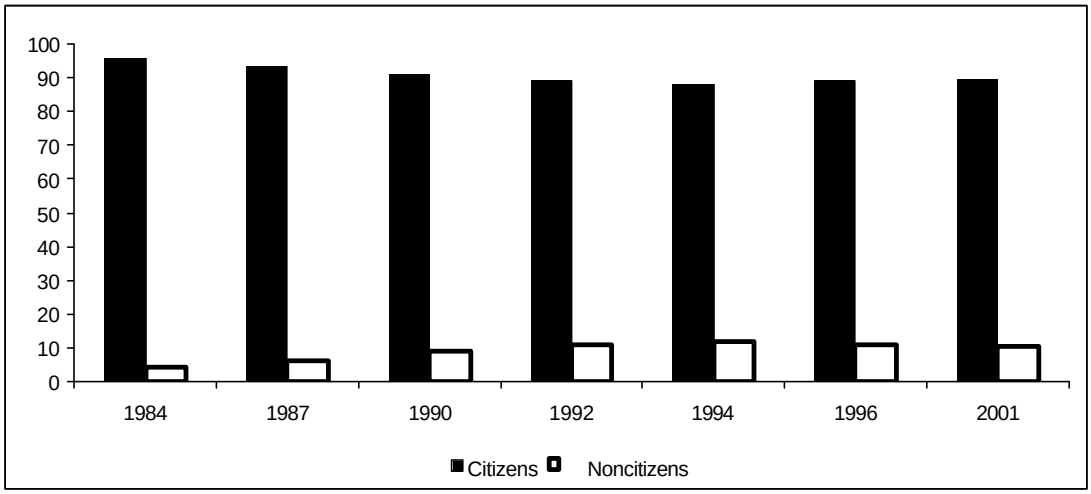
Figure 1. SSI Caseloads by Age Group, 1974-2001

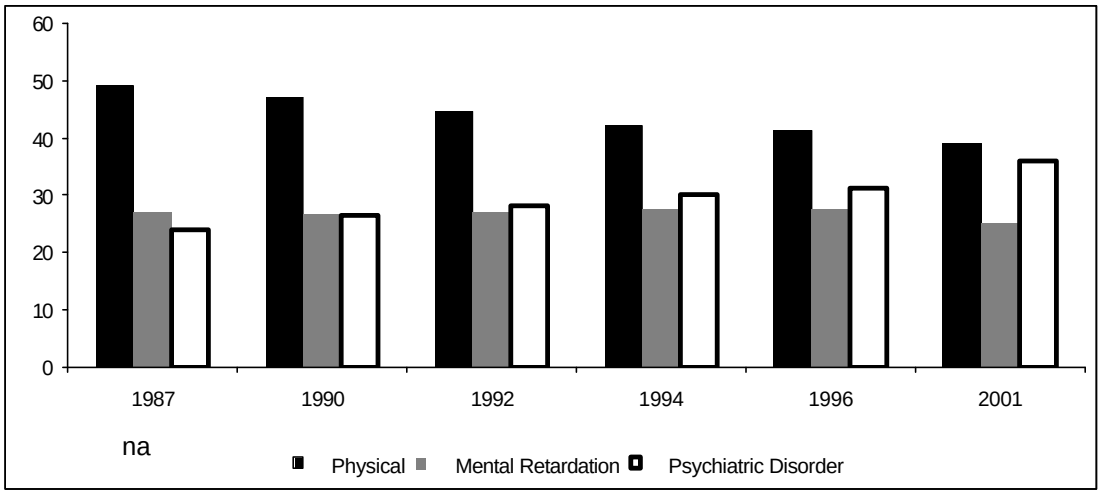


Source: Annual Statistical Supplement, SSA various years.

Figure 2. Trends in Key Characteristics of SSI Recipients







Disability Benefit Rolls and Employment Rates among Working-Age Men and Women with Disabilities