



SSI

SSI: The Other Welfare Crisis

By Carolyn L. Weaver

Supplemental Security Income is the federal government's largest and fastest-growing cash welfare program and a ticket to other major benefit programs. To date, there has been no indication that the Clinton administration has any plan to confront the fiscal consequences of SSI growth in its own welfare reform plan. Congress would do well to put SSI on the table when it takes up the issue later this year.

President Clinton's plan for "ending welfare as we know it" is long on rhetoric and short on detail, but there is every indication that it will not tackle the federal government's largest cash welfare program, Supplemental Security Income (SSI). Serving elderly people and people with disabilities, SSI is more costly and growing much more rapidly than Aid to Families with Dependent Children (AFDC), the focus of the welfare reform debate. Since SSI is a ticket to food stamps and to government-funded health care, the fiscal consequences of its growth are felt throughout the U.S. welfare and health care system.

In 1993, an estimated 6 million people received SSI, up nearly one-half since 1980 and one-quarter just since 1990. Federal spending stood at \$23 billion, double its level (in real dollars) in 1980. Federal spending on AFDC, by contrast, was \$16 billion in 1993, up 23 percent in real terms since 1980. According to the Clinton budget, the SSI benefit rolls will grow so rapidly in the next few years that, by the end of the decade, the cost of the program (including federal and state spending) will exceed the cost of AFDC, food stamps, subsidized housing, the greatly expanded earned income tax credit, and all other major public assistance programs except Medicaid.

The rapid growth of SSI does not bode well for Medicaid, the nation's giant health care program for the poor. The reason is the relatively high cost of health care, particularly long-term care, for the aged and disabled poor. According to data compiled by the House Ways and Means Committee, among people receiving cash assistance in 1991, Medicaid spending averaged \$2,355 per capita—but was \$5,544 for people with disabilities, as compared with \$807 for AFDC kids. The bulk (approximately 70 percent) of Medicaid spending is for the aged and disabled, not AFDC mothers and children, as is often assumed.

How likely is it that SSI will be drawn into the welfare reform debate? Traditionally, SSI has enjoyed unusual support on Capitol Hill and a remarkable degree of insularity at budget time. In contrast to AFDC, SSI provides a nationwide, minimum-income guarantee (\$5,352 annually for individuals and \$8,028 for couples) that is cost-of-living adjusted each year and financed almost entirely by the federal government. Any serious discussion of SSI reform—or social security reform for that matter—almost inevitably brings forth proposals for *expanding* eligibility and *increasing* payment levels. The recommendations of a 1992 study panel on SSI had a

five-year price tag of \$100 billion!

SSI is widely viewed as a safety net for the elderly poor, but it has been transformed over the years into a program serving mainly working-aged adults (and increasingly children) with disabilities. When SSI was created in 1974—federalizing the old-age assistance, aid to the disabled, and aid to the blind programs around the country—most SSI recipients were elderly people who were not eligible for social security or whose pensions left them in poverty. As the economic well-being of the elderly has improved, the number of elderly people on the rolls has generally fallen. At the same time—and for reasons that are not entirely clear—the number of disabled recipients has soared, doubling between 1974 and 1990 and increasing by over 1 million in the past three years alone. Today, three out of four SSI recipients are people with disabilities.

What do we know about SSI-disability recipients? The typical recipient is in his or her thirties, has a high school education or less, and, in contrast to the familiar image of someone with a physical disability who is blind or in a wheelchair, was granted benefits based on a mental disorder—schizophrenia, chronic depression, or anxiety, for example. While some of these conditions are obviously severe and generally disabling in the labor market, others are not and, in any event, are notoriously difficult to evaluate with precision. Fully one-third of adults on SSI disability have a mental disorder (in addition to the one-fourth who have mental retardation); young people with mental disorders are the fastest-growing segment of the adult SSI population.

Thanks to a 1990 court order that loosened eligibility for children, children with disabilities are the fastest-growing segment of the SSI population. Stretching SSI in ways never contemplated in 1974, 225,000 children with disabilities (mainly mental disorders, including the much discussed attention deficit disorder and mental retardation) were added to the rolls in 1993, triple the number in 1989; the total number of children on the rolls now approaches 1 million.

As some on Capitol Hill and in the press have noted, even alcoholics and drug addicts are finding their way onto SSI rolls in growing numbers. According to the General Accounting Office, the

number of SSI alcoholics and drug addicts with disabling complications, such as chronic depression or organ damage (which does not include substance abusers with other qualifying disabilities, such as cancer or heart disease) tripled between 1990 and mid-1993, rising from 23,000 to 69,000.

Needless to say, these trends in the SSI-disability rolls are way out of line with trends in public health.

While SSI does not present the problems in the forefront of the welfare reform debate—teen pregnancy, out-of-wedlock births, and the cycle of dependency—it nevertheless presents problems that demand public attention. At the point of entry to the program, SSI creates strong disincentives to work, disincentives that are no less potent than in AFDC. Once on the benefit rolls, people receive cash assistance, but no rehabilitation, job training, or employment services—services that are no less critical to promoting work among people with disabilities than among mothers on AFDC. And in providing cash support with basically “no strings attached,” SSI tends to perpetuate the very conditions (alcoholism, drug addiction, or certain forms of mental illness, for example) that preclude work and promote dependency.

Further, SSI poses problems of eligibility determination that dwarf those in AFDC. Whether in assessing an adult’s ability to engage in “substantial gainful activity” or a child’s ability to engage in “age-appropriate activities of daily living,” the government’s decisions about who is disabled and the extent of the disability are costly, complex, inherently subjective, and frequently disputed. This raises many questions about the design of SSI, not the least of which is whether it should cover disabled children already eligible for AFDC and Medicaid. This, in turn, raises a question as to how much more the families of these children should receive for basic support than the families of other poor children receive.

In this latter regard, SSI payments are unrelated to the cash needs of children, let alone disabled children. Calculated to ensure that (together with food stamps) an elderly person or a disabled adult has a near-poverty level of income, SSI payments are much higher than AFDC payments,

resulting in large disparities in income support for poor families, depending on the disability status of their children. In a typical state, a poor mother with two children, one on AFDC and one on SSI, receives twice as much public assistance as a poor mother with two children on AFDC. Were the latter mother able to have one of her children certified as disabled and qualified for SSI, she would (based on 1993 benefit amounts) forgo \$57 monthly in AFDC in exchange for \$434 monthly in SSI, raising her family's income from \$367 to \$744 monthly. The states administering SSI and AFDC are hardly indifferent to this shift in support: they must bear about 45 percent of the cost of AFDC but none of the cost of SSI (states have the option to supplement the federal SSI payment, and only some choose to do so).

While few would debate whether poor children with disabilities are worthy of assistance, serious questions remain as to both the amount and the kind of assistance (cash or services, for example) that should be provided by the federal government. For these reasons and more, Congress would do well to put SSI on the table when it takes up welfare reform later this year. SSI is a critical if neglected aspect of America's welfare "crisis."

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