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Effects of Welfare Reform on the Supplemental Security Income (SSI) Program

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Findings

- PRWORA tightened SSI eligility standards for disabled children, excluded individuals diagnosed as disabled due to drug or alcohol addiction (DA&A), and made non-citizens ineligible.
- By 2001, the childhood SSI caseload was estimated to be 250,000 cases (22%) lower than it would have been in the absence of welfare reform.
- Use of SSI by legal noncitizens fell by 32% from 1994-1999, even though SSI eligibility was restored for most via a grandfather clause instituted in 1997.
- By April 1999, only 36% of former DA&A recipients had requalified for SSI under other medical conditions.
- Eight years after passage of PRWORA, we still know little about the well-being of former SSI recipients affected by changes in eligibility standards.

Background

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 is best known for eliminating the Aid to Families with Dependent Children (AFDC) program and replacing it with Temporary Assistance for Needy Families (TANF). However, PRWORA also made significant changes to the Supplemental Security Income (SSI) program, which provides means-tested income support to disabled individuals.

The SSI program experienced rapid growth in the early 1990s, with total caseloads increasing by 35% between 1990 and 1995 (**Figure 1,** right axis). Particularly large increases were experienced by three groups of SSI recipients (left axis). Between 1990 and 1995, childhood disability caseloads increased by 197%, noncitizen caseloads increased by 80%, and cases among individuals classified as disabled on the basis of a diagnosis of drug addiction or alcoholism (DA&A) increased by 470%. Due in part to concerns about these increases, PRWORA reforms of the SSI program focused on these groups of beneficiaries. The 1996 legislation replaced the existing eligibility standard for child disability cases with a more restrictive definition that applied only to child cases, and required redetermination of eligibility based on adult criteria when an SSI child turned 18. It made noncitizens ineligible for SSI, with the exception of refugees and other humanitarian immigrants, who were now subject to seven-year time limits.[1] (A year later, however, the 1997 Balanced Budget Act (BBA) grandfathered in eligibility for legal immigrants who had entered the United States before August 22, 1996, the date PRWORA was signed). Finally, PRWORA eliminated drug addiction and alcoholism as diagnoses that made one eligible for benefits. No new DA&A cases were allowed after the legislation went into effect, and all existing DA&A cases were to be terminated.

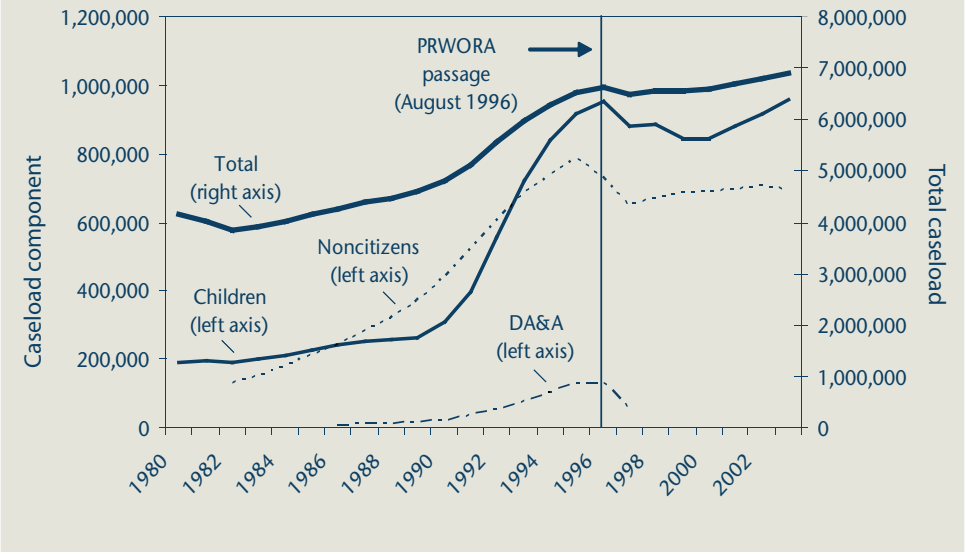
How did the PRWORA reforms affect SSI caseloads and beneficiaries?

Childhood Disability Cases

When PRWORA passed, over 950,000 children were receiving SSI, up from roughly 300,000 in 1990. The Social Security Administration (SSA) estimated that the eligibility of 288,000 children would have to be redetermined under the new law.

Administrative data show that as of August 1999, three years after PRWORA's passage,

Figure 1: Trends in SSI Caseload, 1980-2003



Sources for Figure 1: Total/Children: Social Security Administration Annual Statistical Supplement, 2003 for 1980-2002; SSI Monthly Statistics for 2003. Noncitizens: Social Security Administration Annual Statistical Supplement, 2003 for 1980-2002; Communication from Alfreda Brooks, SSA for 2003. DA&A: Barber (1994) for 1986-1988; Barber (1995) for 1989-95; Stapleton et al (1998) for 1996-97; Note: All figures are as of December of the given year. Caseload components excluded from figure are adults who qualify on the basis of criteria other than DA&A and citizens over the age of 65.

58% of the children with cases subject to redetermination remained eligible for benefits. Similar continuation rates were found for the first group of SSI children who faced the new age-18 redetermination process, with 55% remaining beneficiaries.[2]

However, these estimates do not take into account children who would have left the program in the absence of the legislation, or those who chose not to enter under the new rules. Simulation models of exit and entry to SSI suggest that the net impact of PRWORA was even larger than the initial decrease in caseloads. These models estimate that by 2001, the childhood SSI caseload was 250,000 cases (22%) lower than it would have been without passage of PRWORA.[3]

Less is known about PRWORA's effects on the well-being of former SSI recipients. Research on the pre-reform period suggests that SSI reduced poverty among families with disabled children, while reducing parental labor supply.[4,5] An analysis of the 1995-1999 period finds that child SSI reduced family poverty, but suggests an increase in maternal labor force participation.[6]

Analysis of data from the Survey of Income and Program Participation (SIPP) linked to SSA administrative records suggests that in the month after benefit loss, families that lost benefits due to PRWORA were 16 percentage points less likely to have a mother or father working, were 26 percentage points more likely to be using food stamps, and had family incomes that were lower by 53% of the poverty threshold than in the last month of benefit receipt.

Over a time horizon of 12 months, the effects on employment and food stamp usage were of similar magnitude, but the negative effect on family income did not persist.[7] This result is puzzling, since it is unclear what other sources of income these families may have received. Since the income measure used in the study accounts for family size, one possibility is that family living arrangements changed in response to the loss of SSI benefits. However, the authors caution against placing too much weight on the 12-month estimates due to their lack of statistical significance.[8]

There is also concern about the health insurance status of these children. The 1997 BBA grandfathered in Medicaid eligibility for children who lost SSI benefits due to PRWORA. However, qualitative evidence from 5 study sites suggests that one in four former SSI children had lost Medicaid at some point between the reforms and 1999.[9]

Noncitizen cases

Data from the Current Population Survey show a 32% decrease in the use of SSI by legal noncitizens from 1994-1999, while SSI usage of citizen families remained unchanged over the same period.[10]

This is surprising, since although the 1996 welfare reform provisions would have led to the loss of eligibility of 500,000 noncitizen recipients by August of 1997, the grandfathering in of noncitizens' eligibility

by the 1997 BBA meant that few legal immigrants had become ineligible at this point in time. There has been some evidence suggestive of "chilling effects," in which immigrants are discouraged from receiving benefits for which they remain eligible.[11] For example, refugees experienced declines in recipiency over this time period at least as steep as the declines for noncitizens, even though the special treatment of refugees meant that few had lost eligibility at this time.[12] Eligibility may play more of a role in the future, since the BBA created large differences in the treatment of legal noncitizens who entered the country before August 22, 1996 and those who entered after that date.

Finally, the seven-year time limit on refugee receipt of SSI was intended to give these individuals enough time to become citizens and therefore retain eligibility. However, many legal immigrants on the SSI rolls will not become citizens in the seven-year time frame, and will therefore lose benefits. SSA estimates that by the end of 2003, 2,400 refugees and humanitarian immigrants had lost SSI eligibility, and that between 2004 and 2010, an additional 48,000 will have reached their 7-year time limits, losing eligibility.[13]

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DA&A cases

As shown in **Figure 1**, by the end of 1997, the DA&A caseload as such had ceased to exist. By April 1999, only 35.5% of former DA&A recipients had requalified for SSI under other medical conditions, most often a psychiatric disorder.[14]

Evidence on how former beneficiaries are faring is limited. A multi-site longitudinal study of former DA&A recipients found that employment (defined as having any reported income from employment in the six months before the interview) increased from 20% to between 40 and 60% for those who did not requalify for benefits. However, the additional earnings were not large enough to offset the lost benefits for a majority of former recipients. Less than 25% of former recipients reported earnings of $500 per month or more (the approximate loss in SSI benefits).[15] In spite of this decrease in income, this study did not find widespread negative effects on those who no longer received benefits, as the majority did not report problems with lack of housing or increased hunger. However, the study sample used was quite dissimilar from the national DA&A population.[16]

How did PRWORA changes to other programs affect SSI caseloads?

Other changes associated with PRWORA, including the replacement of the Aid to Families with Dependent Children program with the Temporary Assistance to Needy Families program are also expected to have affected the SSI program. The populations served by SSI and AFDC/TANF are similar in many ways, and relatively high rates of physical disability and mental health problems among AFDC recipients have been documented.[17] There is also evidence that changes in economic circumstances or relative program incentives may result in changes in self-reported disability rates, leading to increases in SSI participation.[18]

> "Simulation models of exit and entry... estimate that by 2001, the childhood SSI caseload was 250,000 (22%) lower than it would have been without the passage of PRWORA."

Evidence from the pre-PRWORA era suggests that as the benefits of SSI receipt relative to other means-tested programs increase (or as the costs of SSI receipt relative to other programs decrease), SSI applications and caseloads rise.[19] The state level welfare reforms implemented through the waivers that preceded the 1996 legislation led to a 21.6 percent increase in the probability of SSI participation among single-parent families.[20] However, to date there has been no analysis of the indirect effects of PRWORA on SSI caseloads. One study of women leaving AFDC after welfare reform found that 23 percent of non-working welfare leavers were receiving SSI,[21] but other studies suggest that only between 4 and 12 percent of women on the welfare caseload at the time of welfare reform had received any income from SSI in the following six years.[22]

Conclusion

The 1996 PRWORA tightened SSI eligibility standards for disabled children, terminated the DA&A diagnosis as an eligible condition, and rendered noncitizens ineligible (although the 1997 BBA grandfathered in those who entered the U.S. before August of 1996). These changes led to a decrease in recipiency for three segments of the SSI caseloads that had been growing rapidly.

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However, eight years after passage of PRWORA, we still know little about the well-being of former SSI recipients affected by these changes. Knowledge is also limited about interactions between SSI and other means-tested programs like TANF, although evidence from before 1996 suggests that these interactions are likely to exist. Further research on these important questions is necessary. ■

Endnotes

Abigail Wattley provided excellent research assistance. I am grateful to Lynn Karoly for providing me with data. For a more detailed discussion of the effects of welfare reform on the SSI program, see Karoly, Lynn.A, Jacob Alex Klerman, and Jeannette A. Rogowski. 2001. "Effects of the 1996 Welfare Reform Changes on the SSI Program." In The New World of Welfare, ed. Rebecca M. Blank and Ron Haskins, 482-495. Washington, D.C.: Brookings.

[1] Other exceptions were those who had served in the military, and those who had spent 10 quarters in covered employment.
[2] Rogowski, Karoly, Klerman, Inkelas, Rowe, and Hirscher, 2002.
[3] Rogowski et al 2002.
[4] Kearney, Grundmann, and Gallichio, 1994; Kearney et al.; 1995; Lukemeyer, Meyers, and Smeeding, 2000.
[5] Garrett and Glied, 1997
[6] Duggan and Kearney, 2004.
[7] Karoly and Davies, 2004.
[8] Karoly and Davies 2004.
[9] Rogowski et al 2002.
[10] Fix and Passel, 2002.
[11] Fix and Passel, 1999.
[12] Fix and Passel 1999.
[13] Fremstead, 2004.
[14] Lewin Group, 1998.
[15] Swartz, Baumohl, and Lurigio, 2004.
[16] Wittenburg, Stapleton, Tucker, and Harwood, 2003.
[17] Loprest and Acs, 1995.
[18] Waidman, Bound, and Schoenbaum, 1995.
[19] Bound, Kossoudji, and Ricart-Moes. 1998; Garrett and Glied, 2000; Kubik, 1999; Kubik, 2003; Duggan and Kearney, 2004.
[20] Schmidt and Sevak, 2004.
[21] Loprest, 1999.
[22] Turner, Danziger, and Seefeldt, 2004; Acs, Loprest, and Roberts; 2001.

Full citations: www.npc.umich.edu/publications/policy_briefs/brief4/

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