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## State-to-State Variation in SSI Enrollment for Children with Mental Disabilities: An Administrative and Ethical Challenge

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### Abstract

**Objective**—The objective of the study was to examine variation by state in the rates of Supplemental Security Income (SSI) determinations, allowances, and receipt of benefits among children for ten selected mental disabilities in 2013. This report describes ten-year (2004–2013) trends in SSI determination rates among children living in households below 200 percent of the federal poverty level.

**Methods**—A systematic review of SSI administrative and U.S. Census Bureau data by a multidisciplinary consensus committee convened by the National Academies of Science, Engineering and Medicine (2015).

**Results**—Less than 1% (N=654,370) of U.S. children in 2013 were recipients of SSI for mental disabilities. Controlling for differences in the numbers of low-income children by state, the rate of determinations for children with mental disabilities ranged from 1,441 per 100,000 low-income children to 251 per 100,000, an almost 6-fold difference; allowance rates varied from 16% to 78%, a 5-fold difference; receipt of benefits ranged from .7% to 5.3%, a 7-fold difference. Although the national average rate of annual SSI determinations declined by 2% between 2004 through 2013, wide state variations remained, ranging from a 48% increase to declines of 33%.

**Conclusion**—There are unexplained and large discrepancies across states in the review and receipt of SSI benefits for low-income children with mental disabilities. Inequities that cannot be explained by the severity of a child's disability or by a family's financial need violate the ethos of equitable access to federally entitled services. Improving access for eligible children and creating greater consistency across states in implementation of this program is an attainable goal.

The Supplemental Security Income (SSI) program is one of the few federal programs to provide monthly cash assistance to low-income families of children with mental disabilities that result in severe impairment. SSI eligibility often improves access to mental health services as it assures referral to state Title V programs and, in most states, qualifies children for Medicaid. Increasing numbers of children receiving SSI benefits for ADHD in recent years, in contrast to estimates that the prevalence of child psychiatric disorders has been relatively constant (1), led to media attention and a GAO Report (2). In response, the Social Security Administration commissioned the National Academies of Science, Engineering and Medicine (NASEM) to examine recent growth in low-income children with mental disabilities served by the SSI program (3). The full report, available at <http://iom.nationalacademies.org/Reports/2015/Mental-Disorders-and-Disabilities-Among-Low-Income-Children.aspx>, describes features of the national context that may contribute to the rise in SSI benefits for these children (4); summaries of the main results of this report are available (5–9). Federal entitlement programs, such as SSI, provide personal financial benefits to potential beneficiaries who have a legal right (enforceable in court, if necessary) whenever they meet eligibility conditions that are specified by the standing law that authorizes the program. There are few entitlement programs for children with mental disabilities. These children are known to be significantly underserved (10). Eligibility for benefits has the potential to equalize access to services. State-to-state variations in administration of entitlement programs raise fundamental ethical as well as practical questions about why eligibility should differ based on state residence. Therefore the objectives of this brief report are: to describe variation by state in the rates of SSI determinations, allowances, and receipt of benefits for ten selected childhood mental disabilities as of 2013, and to describe ten-year trend data (2004–2013) in SSI determination rates among low-income children (those living in households below 200 percent of the federal poverty level (FPL)). [Note: SSI uses the term “mental disabilities.” These include psychiatric or mental disorders as well as developmental and intellectual disabilities. We use the term mental disabilities in this paper to be consistent with SSI terminology.]

## Methods

The committee focused on ten mental disabilities: attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, autism spectrum disorders, intellectual disability, borderline intellectual function, mood disorders, learning disabilities, organic mental disorders, and anxiety related disorders. These were selected because they are the highest frequency diagnoses associated with SSI allowances and are included in the SSI list of “mental disabilities.”

Data on SSI determinations, allowances and recipients for these 10 disabilities from 2004–2013 were provided by the Office of Disability Policy Management Information and the Office of Research, Evaluation, and Statistics. Determinations refer to the total number of applications reviewed to determine whether an applicant meets financial eligibility and criteria for severe impairment. Allowances refer to the percentage of determinations found to be severely disabled. Recipients refers to all children who are cumulatively eligible during a given year, i.e., are newly deemed or continue to receive cash assistance, irrespective of when they became eligible.

The absolute number of determinations and recipients will vary between states because of differences in state population sizes and the numbers of low-income children in each state. Accordingly, we generated state-specific rates taking into consideration both the total population size and estimates of the number of low-income families, using data from the U.S. Census Bureau data 2015 Current Population Survey. For each state, we estimated the number of children under 18 years of age and living in households below 200 percent of the FPL (from 2004 to 2013) as a proxy for the number of children who were income eligible for SSI. This served as the denominator to calculate state-specific determination, receipt and eligibility rates in 2013.

## Results

The NASEM report (2015), *Mental Disorders and Disabilities Among Low-Income Children*, found that approximately 1.3 million children received SSI disability benefits in 2013, representing 1.8% of all U.S. children. Of these beneficiaries, about 50% (.89%) had disabilities due to mental disabilities.

### Determinations

State-specific rates of determinations for the 10 mental disabilities varied by a factor of 5.7, ranging from a high of 1,441 per 100,000 income-eligible children in Pennsylvania, to a low of 251 per 100,000 in Nevada (see online supplement)

The rate of determinations also varied, with Western states lower than Eastern states. A cluster of states with low determination rates was found in Southeastern states, whereas high determination rates clustered in Northwestern and Western states (see online supplement).

### Allowances

In Georgia, 16% of applications for SSI benefits for the 10 mental disorders were approved, in contrast to 78% in Alaska, a 5-fold difference. Nationally, this rate averaged 37%, but it was greater than 50% in 13 states, and less than 25% in 7 states (see online supplement).

### Recipients

The percentage of low-income children who are recipients within a state is an indicator of the coverage of the SSI program for children with severe mental disabilities in that state. In 2013, 7% of low-income children were recipients in Hawaii while 5.3% of low-income children were recipients in Pennsylvania; this is a 7.6 fold difference (see online supplement). Figure 1 shows a map of the variations in percentages of poor children who are recipients for the selected mental disabilities across states.

### Changes in determination rates

Between 2004 and 2013, the average annual rate of determinations all for low-income children in the U.S. decreased 2%. Here again, there were significant state variations. In this time period, the rate of determinations in Rhode Island increased by 48%, from 584 per 100,000 low-income children (2004), to 864 per 100,000 in 2013. In Utah and Texas, it increased by 32%, and in Connecticut, by 31%. In other states, such as Minnesota, North

Dakota, Kansas and Nevada, the determination rate decreased by at least 33% (See online supplement).

## Discussion

The Committee was not asked to nor did it examine the reasons for the large discrepancies across states. Nevertheless, the administrative data provided by the SSA show wide variation by state in determination, allowance and receipt rates of SSI benefits for child mental disabilities. Ten-year trends in determination rates also varied substantially across states. The likely consequence of these inconsistencies is that the likelihood of receiving SSI benefits for children with severe mental disabilities depends on the state of residence: the same child is likely to become a recipient of SSI benefits if they reside in one state, but will be denied benefits if they live in another state. This is an inequity in both the spirit and implementation of this federal entitlement program.

Variations are found in other service programs for children with health and mental health needs. For example, an analysis of data from the 2007 National Survey of Child Health found a three-fold difference in rates of child mental health issues between the highest and lowest states (11). Similarly, variations in rates of special education services for emotional disturbance, as defined by IDEA education legislation, a federal entitlement program for special education services, differ 33-fold across states (12–13). This is despite a federally mandated definition of emotional disturbance.

It is important to note that the issue of inequity is different from the issue of low or high rates. It is unknown what the “correct” rate of determinations, allowances or receipt for SSI benefits might be. While estimates of the prevalence of each of the 10 mental disabilities are discussed in the report, the issue of equity in implementation is different from the issue of whether a rate is low or high.

Nevertheless, these variations violate the spirit of federally-mandated programs for children with special needs. Factors that likely contribute to this variation may include differences in the determination process, state policies, and external factors outside the administration of the SSI program. The process of determining eligibility for services in the SSI program is unique and is not based upon standardized measures of diagnoses and impairment that are often used in epidemiologic studies or national surveys of child health. When a parent applies for and is given a tentative diagnosis, SSA develops a case portfolio, based on medical and other records, to confirm or change the diagnosis and to determine if it meets the SSA-defined definition of disability. These evaluations are carried out at the state level by state Disability Determination Services (DDS). While states use national standards with oversight by the SSA, they do not physically examine the child, although they may request examinations and testing. Further, an assessment of severity is necessary to determine the extent of the disability, irrespective of the specific diagnosis. Those who apply for SSI often have multiple disabilities, and it is often easier to make the determination on the basis of one than another. This process itself may contribute to inconsistencies in implementation of program requirements.

In 2015, the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), examined state variations in SSI pediatric caseloads (14), and concluded that regional, state, and local factors likely influenced program growth. Factors that might affect the variation included advocacy groups and their power to influence policies; differences in state economies that affect the opportunities of parents and youth to obtain public assistance; demographic variations; and state Disability and Determination Services (DDS) review processes, which provide latitude in compensation, hiring of examiners, and use of private contractors.

It is also possible that state-specific policies affecting implementation of public benefit programs may influence state rates. For example, SSI benefits may be substituted for Temporary Assistance for Needy Families (TANF) benefits in some states, the latter of which uses state dollars. Prior analyses of adult allowance rate variation suggest that about half of the variation might be explained by factors external to the program, such as numbers of applications and insurance coverage (15).

## Conclusion

Given that income supports are likely to improve long-term mental health outcomes for children (16), interventions to ensure greater consistency in the implementation of the SSI program may have a large effect on the future health of children with mental disabilities living in poverty. There is an ethical argument for ensuring that the spirit of federal entitlement programs is reflected in more equitable access to these programs. Eligibility and receipt of benefits should not depend on state residency, but rather on consistent implementation of program benefits.

## Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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**Figure 1.**

Percentages of children in low-income households who are recipients of SSI benefits for selected mental disorders, by state, for 2013. Sources: U.S. Census Bureau, 2015; unpublished data set provided by the SSA.

The source of this figure is The National Academies of Sciences, Engineering, and Medicine (2015) report, *Mental disorders and disabilities among low-income children*. Washington, DC: The National Academies Press.