This year marks the 40th anniversary of President Nixon’s signing the Supplemental Security Income program into law, as a support for low-income adults and children with severe disabilities. The advent of SSI marked a critical point in the expansion of services and supports for individuals with disabilities.

As recently as the 1960s, children with disabilities were stigmatized. It was expected that parents would put children with intellectual disabilities (formerly known as mental retardation), or physical or other mental impairments, into institutions. Over the past fifty years, a network of services and supports has developed to enable parents to care for their children with special needs at home. This network is neither perfect nor complete, but it has allowed millions of children to remain at home with their families and in their communities.

Over the past half-century, we have learned a great deal about childhood disability. The just-released issue of Brookings’ and Princeton’s journal *The Future of Children*, devoted solely to this important topic, contains a wealth of careful research, data, and proposed policy recommendations that add tremendously to what is known about children with disabilities. Many of the articles bear directly on our nation’s social policies regarding childhood disability, a key component of which is Supplemental Security Income (SSI) for children.

The goal of today’s event, to discuss the best ways to support children with disabilities and their families, is both timely and important. I look forward to discussing:

- How SSI serves as a key support for children with severe disabilities and their families;
- The impact of childhood disability on families, including negative effects on maternal health and family structure, reduced parental income, and the considerably higher likelihood of material hardships such as food insecurity, housing instability and homelessness, and utility shutoffs, even controlling for income and certain other factors;
- Recent trends in SSI for children, which closely mirror trends in childhood disability generally, as well as the likely factors underlying the increasing prevalence of childhood disability;
Outcomes for children with disabilities, in education, employment, health, and earning potential as adults, and the importance of investing in children during their younger years; and

Recommendations for strengthening SSI to better support children with severe disabilities, and offer them a better chance at a full, productive, and independent adulthood.

Who Receives Children’s SSI Benefits?

Will Bentley, age 9, lives in Covington, Kentucky with his parents and sister. Nearly from birth, his parents knew something was wrong. He was slow in learning to speak, and learned to sign so that he could communicate. He had frequent, violent seizures. An MRI eventually showed lesions on his brain, he struggles with anxiety and has memory problems. His mother Katie was forced to shut down her small business so that she could stay home with Will, whose care became a full-time job. Katie said, “I surrendered my career so that Will’s needs were met. SSI allows us to focus on what Will needs... At one time, Will was unable to do anything for himself. He could not even feed himself. Now he can read and zip his own jacket. For a parent with a child with a disability, the support that comes from SSI is a dream come true.”

The SSI program was signed into law in 1972, to aid any person unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment expected to result in death, or that has lasted or can be expected to last for a continuous period of at least 12 months.¹ Children with impairments of comparable severity were included from the beginning, in recognition that the needs of “poor children with disabilities are … greater than nondisabled children.”²

The current eligibility standard was tightened considerably as part of “welfare reform” in 1996, which in fact resulted in over 100,000 children being terminated from the SSI rolls. To qualify under the current eligibility standard, a child’s impairment or combination of impairments must either fall under one of the 14 types of disabilities included in SSA’s Listing of Impairments (e.g., Disorders of the Musculoskeletal System”), or result in “marked and severe functional limitations.”³ Just about 39 percent of children who apply are approved for SSI, a rate that has remained essentially constant since the implementation of the current eligibility standard.

Today about 1.3 million U.S. children and their families receive SSI. This is about 1.6 percent of U.S. children. Because SSI is a means-tested program, not all children meeting the medical eligibility requirements qualify for the benefit; they (and their families) must also meet very low income and resource limits. About 3.8 percent of low-income children (children living in households at or below 200 percent of the federal poverty level) received SSI in 2009. Even with the income support from SSI, over a third of children receiving SSI live in impoverished households (below the federal poverty

¹ Social Security Act, as amended by Public Law 92-603, enacted 1972.
³ 20 CFR § 416.906.
Estimates of the prevalence of childhood disability in the U.S. (discussed in great detail by Halfon and colleagues in their article in the current issue of The Future of Children, and also later in this statement) range widely. Data from the Federal government’s ChildTrends survey and the National Health Interview Survey of Disability (NHIS-D), two of the most relied-upon measures, indicate that roughly nine to 12 percent of children under age 18 in the U.S. have activity limitations due to chronic conditions, with about 8.1 percent having “serious” or “severe” disabilities. Compared with any of these estimates, the share of children receiving SSI (1.6 percent) is a small percentage of children with disabilities in the U.S.

There is some reason to believe that childhood SSI is “undersubscribed,” meaning that fewer children participate than are eligible. For instance, a recent study by the Dept. of Health and Human Services found that while about 21 percent of children living in foster care are eligible for SSI, only 5 to 6 percent receive the benefit. Furthermore, it is possible that families with working parents of children with disabilities are underrepresented in SSI, perhaps due to lack of awareness of the benefit and/or its financial eligibility criteria. In light of research finding higher rates of divorce and separation among two-parent families of children with disabilities, further research is warranted to explore whether outreach to these families in hospital and clinical settings might be helpful in reducing financial and emotional stressors that may lead to family dissolution.

SSI Provides Critical Income Support for Families Raising Kids With Disabilities

Many families face extreme hardship when disability strikes. The extra expenses they incur and the income lost when a parent reduces his or her hours, or leaves a job altogether to stay home to care for a child with a severe disability can be crushing. For many families with a disabled child, SSI means the difference between living above or below the poverty line, and between being able to provide for their disabled child, or having to go without basic necessities.

In recognition of the out-of-pocket expenses and lost parental income experienced by families raising children with disabilities, SSI provides a modest cash benefit—up to a maximum of $698 per month in 2012, but significantly less for many children, where there is other countable income in the household. The average children’s benefit was

My family would literally be homeless without SSI. I am the mother of Tyler and Noah, 5 year-old autistic twins. Both have severe symptoms – one is nonverbal and engages in typical autism behaviors like flapping his arms, spinning, and throwing tantrums; the other is verbal but has severe anxiety, intestinal problems, and sensory problems. I am separated from my husband and we have no other source of income besides food stamps because I cannot keep or find a job that allows me the flexibility needed to provide for my kids. I am on call all day every day to pick them up for daycare when they need care, get sick, or need to see a doctor.

--Rhonda Roberts, Eglin, TX

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just $592 in 2010. SSI also provides access to Medicaid coverage in most states.

The income support from SSI is critical for families who experience lost income due to caring for their child with disabilities. According to a new review of research by Stabile and Allin in the just-released Future of Children issue, between 10 and 30 percent of parents (usually mothers) with disabled children report stopping working entirely, and between 15 and 68 percent report cutting work hours to care for their children with disabilities. Mothers of high-risk infants were less than half as likely to return to work within the five years after their child’s birth. Mothers of children with especially time-intensive conditions are more than 40 percent less likely to work, and 38 percent reduce their hours. Unsurprisingly, they find that labor force disruptions are greatest for single parents (usually mothers).\(^5\)

Notably, recent research by Mark Duggan and Melissa Schettini Kearney finds that enrollment in children’s SSI had “little [negative] impact on parental labor supply.”\(^6\) In December 2010, despite near-record unemployment (9.4 percent), 41 percent of children receiving SSI lived with at least one employed parent. A decade earlier, when unemployment was at 4 percent, about 55 percent of children receiving SSI lived with an employed parent.\(^7\)

While striking, these findings come as no surprise. As anyone with experience caring for a child with disabilities can attest, special needs, flare-ups, and emergencies—such as an asthma attack, or a behavioral episode at school—can happen at any time. Especially for parents working in jobs that offer little flexibility or sick time, it is not uncommon to lose a job after one too many days taken off or afternoons of early departure for doctors’ appointments, or when the school calls to say the child must be taken home or to the hospital.

What’s more, Stabile and Allin note that raising a child with disabilities can take a considerable toll on parental health, commonly leading to stress and even psychological distress among parent-caregivers. Negative impacts on parental health may further contribute to depressed parental employment and earnings.

Stabile and Allin also document an array of expenses faced by families caring for children with disabilities, such as: transportation to and from doctors’ appointments and supportive services (especially in rural areas); specialized child care; adaptive equipment and reading aids; special diets and activities that help in overcoming or minimizing the effects of impairments; diapers for larger children and adolescents who are incontinent or not fully “potty-trained”; among others. Many of these expenses may not be covered by Medicaid or private insurance, forcing families to cover them out-of-pocket.

\(^5\) Id.


Research by Susan Parish and her colleagues documents the extent to which families caring for children with disabilities encounter material hardships due to economic insecurity. Families with a disabled child are twice as likely as other families with children to experience material hardships such as food insecurity (e.g., skipping meals because of lack of money, or running out of food), and housing and utility hardships (e.g., being unable to pay rent, or having utility service shut off)—even controlling for income, education, and other similar factors.8

Moreover, Parish finds that families raising more than one disabled child are even harder hit—over 70 percent of families with more than one disabled child receiving SSI report experiencing such material hardships—even with the income support from SSI.

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Parish and colleagues also find that 100 percent of those families experience “asset poverty,” meaning that they have less than three months of savings to sustain them in case of crisis or unexpected expenditures; this is unsurprising given SSI’s very low asset limits (families of children receiving SSI are not permitted to have more than $3,000 in countable resources in order to maintain eligibility for benefits).

Estimating direct as well as indirect costs to families raising children with disabilities, Stabile and Allin find that annual costs average $10,830 (noting that their estimate is likely conservative since it does not include other impacts on family health and well-being, including maternal mental health, costs to siblings, and other negative impacts that have been documented by researchers). The income support from SSI, which averages about $7,164 per year, thus partially offsets these costs, increasing family economic security considerably. Yet even with the income support from SSI, over a third of children receiving SSI benefits remain in poverty.9 Importantly, Stabile and Allin’s estimate is for families with disabilities generally; given that the children who receive SSI are by definition the most severely disabled, their families may incur greater than average costs.

**Recent Trends in Children’s SSI Enrollment: Reasonable, Understandable Growth**

About 1.3 million low-income children with severe disabilities received SSI in 2011. As noted above, the number of children on SSI is a small fraction of U.S. children with a disability. This is because SSI serves only those children with the most severe disabilities and limitations, and whose families meet the very low income and asset limits. The number of children receiving SSI has grown over time, with the past decade seeing growth from about 847,000 to 1.2 million (from 2000-2010). While this number may seem large, it means little by itself. Considered in the context of rising child poverty, population growth, and the increase in prevalence of childhood disability in recent years, it makes sense that more children would be receiving SSI. Moreover, as discussed in detail by Halfon and colleagues in their *Future of Children* article,10 there are a number of likely factors underlying the increase in U.S. children identified as having disabilities, including improved access to health care and advances in diagnosis and treatment; reduced stigma and greater acceptance of certain disabilities; rise in preterm births; environmental and demographic factors, among others.

a. **Growth in SSI Mirrors Increase in Child Poverty.**

Given that SSI is a means-tested program, growth in childhood SSI makes sense given the recent and striking increase in child poverty. In 2001, about 11.7 million children lived in poverty (16.3 percent of all children); by 2010, that figure had jumped to 16.4 million (over 22 percent of children).11 Comparing the number of children receiving SSI with the number of

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children in poverty, the share of poor children on SSI has remained nearly unchanged for over a decade (7.2 percent in 2001, vs. 7.8 percent in 2010).\textsuperscript{12} Similarly, the share of low-income children (at or below 200 percent of poverty) receiving SSI has remained essentially constant at between 3 and 4 percent. Thus, as our nation’s count of poor and low-income children has sadly climbed, more children with disabilities have become financially eligible for SSI.

Notably, childhood disability follows an “income gradient”: it is more prevalent at lower income levels. Halfon and colleagues note that poor children are 1.5 times more likely to have disabilities than non-poor children, a rate that has remained constant for the past half century. Disability prevalence rates among poor and low-income children are estimated at 11 to 12 percent, as compared with the 8 percent of children with household incomes above 200 percent of poverty.\textsuperscript{13}

b. Factors Contributing to Increased Prevalence of Childhood Disability and Growth in SSI Enrollment.

Growth in the number of children receiving SSI also may be due to rising prevalence of U.S. childhood disability. As noted by Halfon and colleagues, the number of U.S. children with activity limitations more than doubled in the period from 1981-2009, and increased fourfold in the last half century.\textsuperscript{14} Halfon and colleagues document a number of factors likely to account for the rising prevalence of childhood disability in the U.S. (and by corollary the growth in children’s SSI), including the following:

Access to healthcare for children has improved significantly, through Medicaid, the Children’s Health Insurance Program (CHIP), and Early Periodic Screening Diagnosis and Treatment (EPSDT). This advance has enabled earlier and better identification and diagnosis of childhood disabilities. Between 1998 and 2008, child enrollment in Medicaid increased from about 22 million to over 32 million.\textsuperscript{15} Likewise, enrollment in CHIP has increased from about 1.38 million in 1999 to nearly 5 million in 2009.\textsuperscript{16} Perhaps most dramatic was the rise in children receiving screening services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program, which is part of Medicaid—climbing from about 6 million to nearly 21 million children.\textsuperscript{17} Moreover, Halfon and colleagues note that advances in diagnosis and treatment, including better tools to diagnose chronic conditions—especially behavioral and emotional disorders—are likely have contributed, as well.

Changes in perceptions about disability, with growing acceptance and reduced stigma may also have contributed to the rise in prevalence of childhood disability and growth in SSI. This is likely especially the case for mental disabilities, such as Autism and ADHD. Halfon and colleagues highlight Attention Deficit and Hyperactivity Disorder (ADHD) as having declined in


\textsuperscript{14} Id.

\textsuperscript{15} HHS, HRSA, Maternal and Child Health Bureau, \textit{Child Health USA 2000}, and \textit{Child Health USA 2010}.

\textsuperscript{16}Kaiser Commission on Medicaid and the Uninsured (2009).

\textsuperscript{17} Id.
stigma considerably after the name of the condition was changed from “minimal brain dysfunction.”

Other factors cited throughout the current issue of *The Future of Children* as likely contributors to the increase in prevalence of childhood disability include various environmental factors (such as toxins and the stressors of poverty); demographic shifts (such as rising parental ages upon childbirth); and the rise in preterm births, which often lead to health conditions in childhood and later in life.

c. **Childhood Mental Impairments: Trends in SSI Mirror General Child Population.**

That mental disorders make up a large and possibly growing share of children’s disabilities appears repeatedly throughout the current issue of *The Future of Children*, and is highlighted as one of the central themes in the introductory chapter. As Halfon and colleagues note in their article on the “changing landscape” of childhood disability:

> Until the 1960s, the iconic image of disability was a child with polio, pictured in leg braces and supported on crutches. If there were a poster child for today, it might be a child with autism. While the girl with polio wore her disability for all to see, the boy with autism represents the new and less identifiable face of modern disability, a range of ubiquitous and not as easily recognizable mental health and neurodevelopmental disorders.

Today the leading causes of childhood disability are mental disorders, with the top three being speech and language delay, learning disability, and ADHD, followed by other emotional/mental/behavioral problems, and other development problems.\(^{18}\) According to the World Health Organization, mental disorders now account for 68 percent of disability among 10 to 24-year-olds.\(^{19}\)

Accordingly, it makes sense that children with mental disabilities comprise the majority of children receiving SSI.

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\(^{18}\) Halfon et al. 2012

Taking MR/ID together with other mental disorders, the overall share of SSI children with mental disabilities has remained between 65-70 percent for nearly two decades.\textsuperscript{20} What has changed in recent years is the diagnostic grouping within this overall category, both within the SSI program and among children generally. The share of children receiving SSI for intellectual disabilities (formerly mental retardation) has steadily declined (from 42.6 percent to 12.7 percent), while the share of children receiving SSI for other mental impairments has increased (from 23 percent to 53 percent).

Medical research suggests that this shift in diagnostic breakdown within the SSI program (and in other programs, such as special education) is reflective of general trends in childhood mental health diagnostic practice. Since the early 1990s, the diagnostic label of mental retardation, and later intellectual disability, has given way to more specific, precise diagnoses such as Autism, ADHD, and speech and language delay.\textsuperscript{21} More precise diagnosis is generally viewed as an advance in childhood mental health treatment, as it facilitates better-tailored treatment for children with disabilities.

Notably, over the past decade, SSI allowance rates for most individual mental impairment categories have either remained stable or declined. For instance, the allowance rate for children’s ADHD claims has steadily declined from 32.6 percent in 2002 to just 26.5 percent in 2010.\textsuperscript{22}

\textsuperscript{20} Social Security Administration, SSI Annual Statistical Reports, 1991-2010.
\textsuperscript{22} Social Security Administration, Office of Disability Policy, Title XVI Childhood Disability Data Analysis March 31, 2011.
d. Decline in AFDC/TANF Enrollment Since 1996 Far Exceeds Increase in SSI Enrollment

The 1996 shift from Aid for Families with Dependent Children (AFDC) to the Temporary Assistance for Needy Families (TANF) block grant has been theorized as contributing to the increase in child SSI enrollment. However, no evidence exists that a substantial shift of children from AFDC/TANF to SSI has actually occurred. The number of children receiving AFDC/TANF declined by 5.2 million between 1996 and 2009. During that same period, the number of children receiving SSI increased, but only by 245,000, an increase whose magnitude matches population growth and increased child poverty. Thus, even in the highly unlikely event that every additional child approved for SSI during that period was one who received or would have received AFDC/TANF, the increase in SSI enrollment would be just one-twentieth of the decline in AFDC/TANF.

Moreover, any such comparisons do not account for the substantial increase in child poverty over that period—at nearly 1 million children, the increase in child poverty was four times the increase in child SSI receipt.

What’s more, being poor is not enough to qualify for SSI. Applicants for SSI must meet the program’s stringent disability definition in order to qualify for benefits, and award rates have remained stable at about 39 percent for nearly the past 20 years. While some number of disabled children who received or would have received AFDC/TANF may now receive SSI, evidence of a widespread shift to SSI is not substantiated by the numbers.
Recommendations for Strengthening SSI to Better Support Children with Severe Impairments

Today’s conversation about how best to serve children with disabilities is both timely and critical. Many of the articles in the current issue of *The Future of Children* detail the poor outcomes common to children and youth with disabilities, including diminished employment outcomes and yearly as well as lifetime earning potential; greater risk of grade repetition, dropping out of high school, fewer grades completed, and lower likelihood of attending college; poor health in adulthood; and especially for those with mental impairments, greater risk of delinquency.

Discussions like today’s about how we can better support youth with disabilities to improve their chances at seeing better outcomes are vital to ensuring a better future for this population, and for our country. We can all agree that providing the support needed so that children and youth with severe disabilities can reach their potential and have the greatest chance of reaching self-sufficiency must be one of our nation’s foremost priorities—both for the benefit of the children themselves, and for the benefit of our nation. The articles by Stabile and Allin, Rauch and Lanphear,23 and Delaney and Smith24 make a strong argument for investing in children now, because those investments will pay off later in terms of reduced disability and healthcare spending, human capital, and our nation’s economic well-being overall.

What follows is a set of recommendations for strengthening the SSI program to better support children and youth with disabilities.

a. **Strengthen SSI Work Incentives to Better Support Transition-Age Youth.**

The SSI program as currently structured does provide considerable work incentives, especially for youth who are able (or want to try) to do some work. Under current program rules, the first $85 of earnings each month are not counted against an SSI grant. After that, only half of earnings are counted against the grant. This means an SSI recipient, child or adult, always receives more income if she works than from receiving the grant alone—the amount she receives from earnings plus the grant will be greater than the amount of just the grant. For recipients under age 22, the Student Earned Income Exclusion is even more generous, allowing SSI recipients under age 22 who are regularly attending school to exclude all earnings up to $1,640 per month, up to a yearly maximum of $6,600.25 (The purpose of the Exclusion is to help youth access internships and the other early work experiences that are so important to preparing for adult employment.) Additionally, in most states, Medicaid coverage is continued if the child ceases to receive the SSI cash benefit due to earned income, so long as certain criteria are met.

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An additional work incentive is found in the Section 301 program, which enables teenagers to continue receiving SSI benefits while they finish school and transition into special state-run vocational rehabilitation programs. This encourages them to complete school and enables them to begin working, build skills, and develop a connection to the workforce while transitioning off of SSI assistance.26

However, SSI’s work incentives should be further strengthened to more effectively support transition-age youth seeking to try work. As a preliminary matter, more effective outreach is needed to ensure that SSI youth are aware of the available work incentives. One study revealed that just 22 percent knew of the Student Earned Income Exclusion, and less than a third were aware of the option to keep their Medicaid coverage under the 1619(b) provision.27 Greater awareness of available work incentives could be achieved through better outreach by SSA, as well as individualized benefit counseling for SSI youth, to explain the projected impact of earnings on their SSI and Medicaid coverage.28

Additionally, I would echo Wittenburg and Loprest, among others, who recommend expanding the Student Earned Income Exclusion to exclude all income earned by qualifying youth, to further enable SSI youth to try working with no risk to their benefits. While this change would come at a small cost, it would result in long-term program savings if it succeeded in supporting youth to transition to work.29


Research suggests that whether and how well a family is able to provide for a child during the younger years may be the most important determinant of that child’s likely outcomes later in life.30 To that end, SSI provides critical financial support to families struggling to meet the needs of children with severe disabilities, and is thus a key ingredient in setting children up to have the best chance of success. At older ages, research shows that youth with disabilities benefit greatly from a comprehensive approach that addresses the unique challenges that they face in transitioning to adulthood, and to the world of work.31

As highlighted in the article by Aron and Loprest in the current issue of The Future of Children, services for children and youth with disabilities are often offered in isolation and even work at cross purposes. For instance, services for young children with

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28 See id at 184.

29 Id.


31 Id.
disabilities who have not yet entered formal schooling are not connected to special education services once in school. Likewise, services for high school-aged youth with disabilities are not well linked with support services for adults with disabilities, and youth are not tracked during that transition to assess whether they achieve independence.\(^{32}\)

Research suggests that transition-age youth have unique needs that defy a one-size fits all approach. Rather, youth at that stage require a tailored, comprehensive, and integrated approach that combines healthcare/medical services, educational supports, and employment supports. To this end, better interagency collaboration appears critically needed, across the Social Security Administration, the Department of Health and Human Services, the Departments of Education and Labor, and the Centers on Medicare and Medicaid Services.

Additionally, expanding vocational education/rehabilitation programs to children younger than age-18, ensuring that they have access to such programs (whether by prioritizing SSI youth, or providing waivers that enable direct funding for Vocational Rehabilitation agencies to work with schools), and promoting a seamless transition from special education to vocational programs is recommended.\(^{33}\)

Many of the above policy options are components of the Youth in Transition Demonstration (YTD) projects currently underway across the country. The PROMISE program, as well, seeks to explore how best to support transition-age SSI youth. Other recent and/or underway pilot programs include the Opening Doors to the Future Project, and the Transitional Employment Training Demonstration, exploring how to most effectively support improved outcomes for youth, through a more integrated, holistic approach to transition support.\(^{34}\)

The SSI Coalition for Children and Families has applauded SSA for its attention to the important transition from youth to adulthood. Pilot efforts should continue to be funded, and methods that show success should be implemented as nationwide policy.

c. **SSA Needs Adequate Funding to Perform Continuing Disability Reviews on Schedule.**

SSA is required by law to conduct periodic Continuing Disability Reviews (CDRs) to ensure that only those individuals who remain disabled continue to receive benefits. CDRs remain critical to SSI program integrity, and we strongly encourage Congress to provide SSA with adequate administrative funding such that it can comply with its legal obligation to perform on-time CDRs.

For SSI recipients under age 18, for whom eventual improvement is considered likely to occur, SSA is required by law to conduct a full medical CDR every three years; in cases where children are found disabled due to low birthweight, SSA must review children at age one.\(^{35}\) Failure to cooperate with the CDR process can result in termination of benefits. All CDRs performed in children’s cases are full medical reviews, evaluating


\(^{33}\) See id at 184-185.

\(^{34}\) See id.

\(^{35}\) Personal Responsibility and Work Opportunities Reconciliation Act of 1996, Public Law 104-193
whether there has been “medical improvement,” and if so, whether the child continues to meet the eligibility standard for disability.

Between 1996 and 2002, SSA remained “current” in completing on-time medical CDRs for children, thanks in large part to funding authorized as part of the “welfare reform” law of 1996. However, due to a decline in funding for CDRs since 2002, SSA has fallen short of completing its CDR obligations on time. According to SSA, as of July 2011, over 140,000 childhood CDRs had been performed for FY 2011, with just over half of reviewed children being found to remain eligible. While this figure does not represent the total number of CDRs that were called for based on existing law, it does reflect steady improvement since 2006.

CDRs are considered to be enormously cost-effective, yielding an estimated $10 or more in savings for every $1 spent in conducting the review. Quality Assurance review of medical CDR decisions in SSI cases shows them to be accurate more than 97 percent of the time. Actuarial projections suggest that funding SSA to carry out its mandate to conduct CDRs as required by law would yield significant savings. Additional program integrity funds were appropriated in 2011, representing a laudable step in the right direction. However, additional and ongoing funding is needed so that SSA may fulfill its statutory obligations in conducting on-time CDRs where required.

d. Further Research is Needed to Explore Value of Outreach to Families with Disabled Children.

As discussed above, raising children with disabilities can translate into considerable hardship for families. In addition to financial and material hardship, parents often experience adverse health consequences, stress and psychological distress, and documented by Stabile and Allin in their *Future of Children* article. Dennis Hogan explores in detail the family consequences of childhood disability in a new book devoted to the topic, finding that rates of divorce and separation are much higher for couples who give birth to children with children with disabilities than for other parents. Further research is warranted to explore whether outreach to these families in hospital and clinical settings might be helpful in reducing financial and emotional stressors that may lead to family dissolution.

e. Index SSI Asset Limits to Inflation.

As noted above, individuals with disabilities must meet stringent financial eligibility requirements in order to qualify for SSI. The SSI asset limits have not been increased since 1989, and today are just $2,000 for an individual and $3,000 for a couple or child living with a parent. Adjusted for inflation, these limits would be over $10,000 in 2012 dollars. The incredibly low asset limits force families to remain in abject poverty, and prevent them from having virtually any savings in case of emergencies or even needed

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37 Data obtained from SSA Office of Quality Assurance, June, 2011.
38 See id.
39 Dennis Hogan, Family Consequences of Children’s Disabilities (Russell Sage: April 2012).
home repairs. The SSI asset limits should be indexed to inflation, to vitiate the hardship caused by their being so woefully and artificially low.

f. **Implement Common Sense Changes to Income and Asset Rules.**

Two additional little-known aspects of SSI’s income and asset rules cause great needless hardship for families in foreclosure and facing unemployment.

Because of how the asset rules are written, disabled children whose families are forced to leave their homes due to foreclosure often end up losing SSI because their house gets counted as a “resource” once they are no longer living in it. No foreclosure exception is made to the general rule that “nonresident property” is counted as a resource. An exception should appropriately be made for properties in foreclosure.

Additionally, when a parent of an SSI child loses his or her job and collects unemployment compensation, the child often loses her SSI benefits due to “excess income.” This is because, as the income rules are currently written, unemployment benefits are treated as “unearned income,” and are not subject to the “earned income disregard” applied to income from work. Thus, every dollar of unemployment benefits counts essentially twice as much against the child’s SSI grant as the income from the parent’s job prior to unemployment. Individuals relying on unemployment benefits after losing a job already suffer a considerable drop in household income, as unemployment benefits replace just a fraction of recipients’ earnings. Loss of a child’s SSI benefits due to a quirk in the income counting rules just compounds the economic hit. Unemployment benefits should appropriately be counted as “earned income,” no different from the earnings they are intended to replace.

**Conclusion**

Children with disabilities—especially those who are also socio-economically disadvantaged and thus, in the words of Currie and Kahn, at “double jeopardy”—need more support, not less. As the House Ways and Means Committee explained in passing SSI in 1972, in words that remain just as true today:

> Disabled children living in low-income households are among the most disadvantaged of all Americans and are deserving of special assistance in order to help them become self-supporting members of our society.

As an essential support for low-income children with disabilities, SSI must be preserved and strengthened to help our nation’s most vulnerable children and youth achieve their fullest potential and become contributing members of society.