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Growth and Changes in Recipient Population Call for Reexamining Program

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The Honorable Bob Packwood
Chairman, Committee on Finance
United States Senate

The Honorable Bill Archer
Chairman, Committee on Ways and Means
House of Representatives

The Supplemental Security Income (SSI) program is the largest cash assistance program for the poor and one of the fastest growing entitlement programs; program costs have grown 20 percent annually in the last 4 years. SSI provides means-tested income support payments to eligible aged, blind, or disabled persons. Last year, over 6 million SSI recipients received nearly $22 billion in federal benefits and over $3 billion in state benefits.

In the past year, the Congress has focused much attention on SSI's growth. Last year it enacted provisions limiting drug addicts' benefits, and this year it is considering further restrictions for these recipients as well as for children and noncitizens. Since January, we have reported several times on SSI and related issues.[1] We initiated this report to provide an overview of the SSI program and its recent history. Specifically, the report examines factors contributing to caseload growth and changes in the characteristics of SSI recipients.

We developed the information for this report by reviewing the literature as well as interviewing officials and analyzing data from the Social Security Administration (SSA), which has overall responsibility for administering the SSI program. To examine state caseloads and different recipient populations, we analyzed 10-percent sample data files for each December from 1986 to 1993, the only years these files were available. These files are random samples of all cases in a given month on the Supplemental Security Record (SSR), which is the master administrative database on SSI recipients.

Results in Brief

Since the mid-1980s, a variety of changes in the SSI program have made benefits available to a broader population. Both congressional actions and court decisions have allowed a wider range of impairments to qualify as disabilities, notably for mentally impaired adults and for children. Also, the

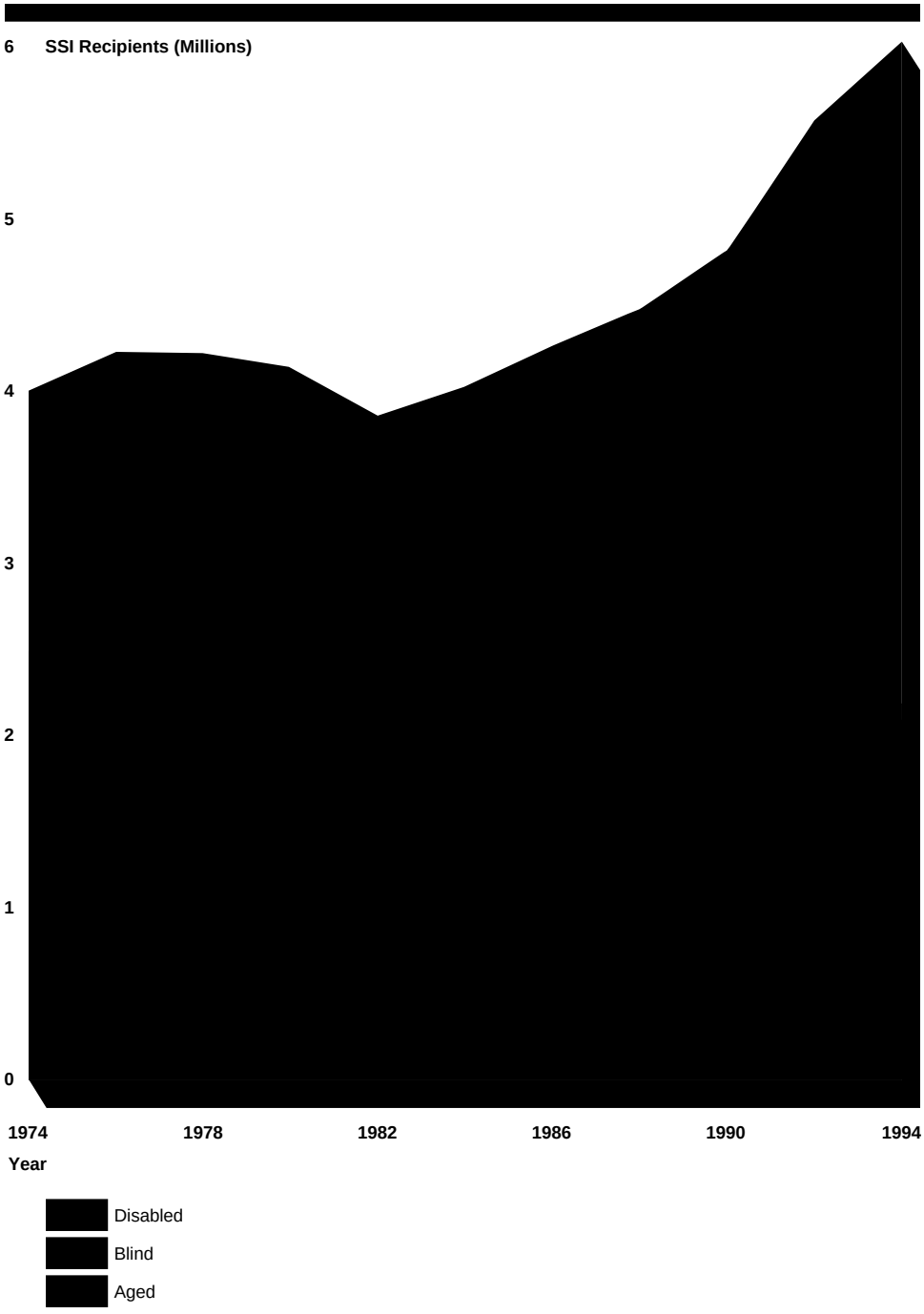
[1]See list of related GAO products inside the back cover.

Congress has mandated increased outreach and publicity efforts to help overcome barriers to getting SSI. Meanwhile, some disabled recipients may stay on SSI longer and receive larger benefits than they would otherwise because the program has devoted little effort to checking that recipients continue to be disabled and helping them return to work.

Since these program changes began, the SSI recipient population has changed dramatically; disabled recipients now account for nearly 80 percent of federal SSI payments.[2] Before the mid-1980s, the number of SSI recipients was relatively stable, and the number of aged recipients was decreasing. Since then, the number of disabled SSI recipients has increased an average of over 8 percent annually; the number of aged recipients has remained almost level. (See fig. 1.)

[2]Unless otherwise specified, we use the word "disabled" only for those recipients under age 65 and "aged" for all recipients aged 65 and over. When disabled recipients turn 65, SSI program data typically continue to count them among the disabled. Disabled recipients aged 65 and over accounted for 10 percent of all SSI recipients in 1993, and their number increased an average of 2.4 percent annually from 1986 through 1993.

Figure 1: Number of SSI Recipients by Eligibility Group



Source: Annual Statistical Supplement to the Social Security Bulletin, 1976-1993, and SSA data.

Three groups have accounted for nearly 90 percent of SSI's growth since 1991—adults with mental impairments, children, and noncitizens. SSI recipients now tend to be younger, stay on SSI longer, receive larger benefits, and depend more on SSI as a primary source of income.

These changes in the SSI program and its recipients call for reexamining how best to serve this needy population while reassuring the public of the program's integrity. Moreover, medical, technological, and social changes are challenging the historic presumption that the disabilities that SSI covers are total and long term. Therefore, the program should emphasize helping SSI recipients achieve their productive capacity and thereby help decrease their dependence on SSI. As the administration and the Congress explore how to help these recipients return to work, SSA can take steps now to strengthen program integrity. For example, increasing the number of reviews of recipients' disability status beyond the minimal number currently required would help ensure that those who are no longer disabled do not receive benefits.

Background

The Congress established SSI in 1972 to replace federal grants to similar state-administered programs, which varied substantially in benefit levels and eligibility requirements. The Congress intended SSI as a supplement to the Social Security Old Age, Survivors, and Disability Insurance (OASDI) program for those who had little or no Social Security coverage.

Federal SSI benefits are funded by general revenues and based on need, unlike Social Security benefits, which are funded by payroll taxes and, in effect, based on the contributions of individuals and their employers.

To be eligible for SSI, individuals must be either at least 65 years old, blind, or disabled. Individuals cannot have income greater than the maximum benefit level or own resources worth more than $2,000 ($3,000 for a couple), subject to certain exclusions, such as a home. This financial eligibility test also factors in the income and resources of spouses living in the same household or parents, in the case of children. Individuals must

also be U.S. citizens or immigrants lawfully admitted for permanent residence or aliens "permanently residing under color of law" (PRUCOL).[3]

To be considered disabled, adults must be unable to engage in any substantial gainful activity[4] because of a physical or mental impairment expected to result in death or last at least 12 months. For children, the impairment must be "of comparable severity" to one that qualifies an adult as disabled. SSI and the Social Security Disability Insurance (DI) program use the same standards and procedures for determining disability. An applicant whose disability claim has been rejected can appeal at four levels. Exhausting all appeals can take more than 2 years. Applicants whose appeals succeed are awarded SSI payments retroactive to the date of their application.

In 1995, the maximum federal SSI monthly benefit is $458 per month for an individual and $687 for a couple if both spouses are eligible; these benefit rates are adjusted annually for cost-of-living increases. This monthly benefit level is intended as a guaranteed minimum income and therefore is reduced depending upon recipients' incomes, living arrangements, and other sources of support, including Social Security benefits and the income of spouses living in the same household or parents, in the case of children. Still, because SSI is an individual entitlement, no cap exists on the benefits a household may receive. Because of the various benefit adjustments, the average federal monthly benefit in 1993 was $324 for the disabled and $195 for the aged.

Since SSI provides income support as a last resort, SSI recipients must file for any other benefits for which they may be eligible, such as Social Security or workers' compensation. In 1993, 40 percent of SSI recipients also received Social Security benefits, down from 49 percent in 1986. Under DI, someone must be disabled continuously for 5 months before benefits begin, which is not true under SSI. Therefore, many receive SSI benefits only until they become eligible for DI, if their DI benefit is then large enough to make them ineligible for SSI. About 75 percent of disabled

[3]PRUCOL is not an immigration status, such as immigrant or refugee. Rather, it is an eligibility status defined in the enabling legislation for major federal assistance programs, including SSI. PRUCOL is more frequently a transitional status for aliens who are becoming permanent residents than for those whose deportation has been delayed, though it can be either. Initially, PRUCOL was interpreted to include primarily refugees and asylees. Court decisions have broadened it to include other categories of aliens. Nearly 75 percent of SSI recipients in this PRUCOL category are refugees or asylees.

[4]"Substantial gainful activity" is defined as earning more than $500 per month.

adult SSI recipients who also qualify for DI benefits stop getting SSI within 1 year, compared with about 29 percent of other disabled adults.[5]

In addition to federal SSI benefits, states may provide supplemental benefits.[6] The District of Columbia and all but seven states provide these supplements.[7] These supplements vary, reflecting differences in regional living costs as well as in living arrangements. In December 1994, nearly 3 million SSI recipients, or roughly half, received an average of about $110 per month in state supplemental benefits at a total cost to the states of about $3.5 billion.

Most SSI recipients are automatically eligible for Medicaid and Food Stamps. In 1993, Medicaid benefits averaged about $2,600 for aged SSI recipients who received Medicaid benefits and about $5,000 for blind and disabled SSI recipients, excluding nursing home and institutional care.[8] In September 1994, a one-person household eligible for both Food Stamps and SSI, with no other income, could receive up to $83 per month, or nearly $1,000 per year, in Food Stamp benefits, depending on the state.[9] (Income, including SSI benefits, reduces Food Stamp benefits.) Thus, the cost of Medicaid and Food Stamps for SSI recipients may exceed the cost of SSI benefits, which averages more than $4,000 per year, though many SSI recipients might qualify for these programs even if they were not on SSI.

Some families receiving Aid to Families With Dependent Children (AFDC) have one or more family members who receive SSI, though no recipient may receive both SSI and AFDC benefits. In determining a family's AFDC benefit, the program does not consider an SSI recipient part of the family. In 1992, the average AFDC monthly payment per family was $374. By having one child qualified as disabled under SSI, an AFDC family can increase its income by as much as $458 per month, which would more than double the average AFDC benefit.

[5]Kalman Rupp and Charles G. Scott, "Length of Stay on the Supplemental Security Income Disability Program," Social Security Bulletin, Vol. 58, No. 1 (1995), pp. 29-47.

[6]Also, states must supplement benefits for those covered by the state assistance programs that SSI replaced in 1974 if the previous benefit was higher than the federal benefit level.

[7]These seven states are Arkansas, Georgia, Kansas, Mississippi, Tennessee, Texas, and West Virginia. North Dakota leaves the supplements up to the counties but pays 50 percent of the benefit costs. Also, the Northern Mariana Islands do not provide supplemental benefits. The Northern Mariana Islands are the only U.S. territory whose residents are eligible for SSI.

[8]In this instance, disabled recipients aged 65 and over are counted with the disabled, not the aged.

[9]In Hawaii, because of higher food costs, the maximum Food Stamp benefit for SSI recipients was $187 per month. California provides increased cash aid instead of Food Stamps.

In addition to providing cash benefits, both SSI and the DI program include return-to-work components. Both programs include work incentive provisions and screen and refer disabled and blind recipients to state vocational rehabilitation agencies. Refusing rehabilitation services is cause for benefits termination. SSI's work incentives include

- disregarding the first $65 to $85 of earned income and half of the remaining earned income in determining benefit levels;
- disregarding income used for impairment-related work expenses for the disabled and any work expenses for the blind;
- disregarding income or resources set aside to achieve a work goal, such as education or starting a business;
- continuing benefits even if earnings exceed the "substantial gainful activity" amount, though earnings still reduce benefits as described above;
- continuing eligibility for Medicaid even though earnings may reduce SSI cash benefits to nothing; and
- allowing recipients to be reinstated if their work attempts fail or their ability to work is erratic.

Factors Contributing to SSI's Growth

A variety of factors has contributed to the rapid growth in the SSI caseload, although the relative effects of these factors on growth are not fully understood. Program factors, such as expanded disability criteria and major outreach efforts, have brought more individuals onto the rolls at younger ages. Widely publicized reports of fraud and abuse suggest another potential source of new recipients, and such reports can also significantly erode public confidence in the program's integrity.

Meanwhile, some disabled recipients may stay on SSI longer and receive more in benefits than they would otherwise because SSA has devoted little effort to (1) checking that recipients continue to be disabled and (2) helping recipients return to work.

In addition, various other factors have contributed to growth; some of these are external to SSI, such as increased immigration and economic conditions. We summarize these factors in table 1 and discuss them below.[10]

[10]See also Social Security: Federal Disability Programs Face Major Issues (GAO/T-HEHS-95-97, Mar. 2, 1995).

Table 1: Factors Contributing to SSI's Growth

Program factors	
More persons brought into the program	Eligibility expansion: Legislative and regulatory changes have increased access to disability benefits. Program outreach: The Congress mandated that SSA seek eligible persons to apply for SSI through outreach campaigns. Fraud and abuse: Allegations have been made that certain SSI recipients, such as some children and immigrants, have received benefits though ineligible.
Some recipients on SSI longer	Continuing disability reviews (CDR): Until 1994, the law did not require SSA to perform CDRs for SSI cases, and SSA spent little effort on CDRs. Return to work efforts: Helping people with disabilities return to work is a low priority of the SSI program.
Additional factors	
Immigration	Growing numbers of noncitizens have been admitted to the United States, and noncitizens are more likely to receive SSI than citizens.
Economic conditions	Recession may increase applications and affect eligibility and benefit levels.
Medical breakthroughs	Disabled individuals now have better chances to live longer through medical and technological advances.
Transfers from state programs	Some states help public assistance recipients enroll in SSI.
Health insurance	Individuals may be applying for SSI or staying on the rolls longer to have Medicaid coverage.

Eligibility Expansion

A congressional oversight committee in the early 1980s found that federal courts, psychiatric and vocational counseling professionals, and we had raised serious questions about the adequacy of SSA's standards for assessing mental impairment for both DI and SSI. Addressing these concerns, the Congress passed the Disability Benefits Reform Act (DBRA) in 1984, effectively expanding the definition of disability for both adults and children. In particular, the act required new standards for mental

impairments that incorporated a person's ability to compete in the job market. It also required SSA to consider the combined effects of multiple impairments if no single impairment were sufficiently disabling to allow someone to qualify for benefits and required increased attention to pain's effect on the ability to work. Further, the act allowed SSA to consider nonmedical evidence offered, for example, by an applicant's family and friends. Finally, the act required increased emphasis on opinions of physicians treating the individuals and on evaluating their functional limitations.

In addition to DBRA, a 1990 Supreme Court decision, Sullivan v. Zebley, 493 U.S. 521, ruled that SSA's disability determination process for children "does not account for all impairments 'of comparable severity' [to adults]..." and thus violated the law because it held children to a more restrictive standard. For those children who do not qualify by meeting SSA's strict listings of impairments, the Court required SSA to add an individualized functional assessment (IFA) of how their impairment limits their ability to act and behave in age-appropriate ways. Also in 1990, SSA issued regulations revising and expanding its standards for assessing mental impairments, specifically in children. These standards incorporated functional criteria, added impairments that qualified as disabilities, such as attention deficit hyperactivity disorder, and added more weight to nonmedical evidence from parents, teachers, social workers, and others.

Program Outreach

At the direction of the Congress and on its own initiative, SSA has increased its outreach efforts to better inform potential recipients of their SSI eligibility. These efforts have attempted to reduce barriers for potential applicants, such as a lack of information about the program, perceived stigma from accepting benefits, and the complexity of the application process. Along the same lines, state and local agencies and nonprofit groups serving the poor have focused more attention on encouraging eligible persons to enroll, not just for cash payments but to establish eligibility for Medicaid and Food Stamps as well.

In 1983, the Congress passed legislation requiring SSA to identify all Social Security Old Age recipients whose benefits fell below the SSI benefit level and to notify them of the availability of SSI benefits. In addition to this one-time effort, the law required ongoing notices to Social Security recipients who reach age 65 and to certain disabled recipients.

Beginning in 1989, SSA made SSI outreach an ongoing agency priority; it conducted demonstration programs, increased coordination with other agencies serving the poor, and encouraged field office outreach initiatives. The Omnibus Budget Reconciliation Act of 1989 established a permanent outreach program for disabled and blind children. Also, as part of a settlement related to the Zebley decision, SSA launched a national media campaign and conducted outreach in schools and welfare offices to enroll more children.

In 1990, we reported on SSA district managers' views on SSI outreach.[11] They acknowledged the need for outreach and believed they were doing enough. They were implementing a wide range of outreach activities, but it was not clear which were most effective. About 40 percent believed outreach was needed for non-English-speaking people.

Also, in 1990, the Congress mandated that SSA expand the scope of its outreach efforts and provided funds for SSA to complete a series of outreach demonstration projects. Since then, SSA has provided $33 million for 136 cooperative agreements targeting diverse populations such as African Americans, Native Americans, the homeless, the mentally ill, and persons who have tested positive for the human immunodeficiency virus.

Fraud and Abuse

A portion of SSI's growth may be attributable to increased incidence of fraud and abuse in the past decade. A lack of empirical evidence makes it difficult to estimate the extent of the problem. Nevertheless, news reports have provided accounts of foreign-born SSI applicants coached by middlemen or translators to feign mental illness and children coached by parents to fake mental impairments by misbehaving or doing poorly in school to qualify for SSI benefits. Regardless of the actual extent of such abuse, reports like these can significantly erode public confidence in the program's integrity.

Limited Numbers of CDRs

The purpose of CDRs is to verify that disabled recipients still have an impairment that prevents them from working. In 1993 and 1994, we reported[12] that while SSA has had authority to perform such reviews for SSI

[11]Social Security: District Managers' Views on Outreach for Supplemental Security Income Program (GAO/HRD-91-19FS, Oct. 30, 1990).

[12]Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994); Social Security Disability: SSA Needs to Improve Continuing Disability Review Program (GAO/HRD-93-109, July 8, 1993).

recipients, it has done relatively few. In 1994, the Congress directed SSA to perform a minimum number of disability reviews for SSI recipients. Accordingly, SSA plans to conduct reviews on 100,000 SSI adults and on one-third of SSI children turning age 18 for each of the 3 fiscal years beginning in 1996.

In contrast, before 1994, the law already required SSA to conduct reviews at least once every 3 years for Social Security DI recipients in cases in which medical improvement is possible or expected, and regulations required that a review be scheduled every 7 years in cases in which medical improvement is not expected. About 500,000 DI cases come due for a review each year. However, while SSA has improved the review process, it has a current backlog of 1.8 million DI reviews. Given available resources, it has planned for only 234,000 CDRs in fiscal year 1996. Since DI benefit rates are larger than SSI's, the cost-effectiveness of DI reviews may be higher. Still, since 1 in 6 DI recipients also receives concurrent SSI benefits, the backlog has also reduced to some degree the number of SSI terminations.

Limited Return to Work Efforts

Helping people with disabilities return to work has been a low priority of SSA and the Congress for both the SSI and DI programs, and, in fact, SSI and DI return virtually no one to work. This low priority is especially evident in vocational rehabilitation (VR), to which relatively few resources are allocated. For example, for every $100 SSA spends on cash benefits, it spends little more than $.10 on VR, and few recipients are referred for VR services. As we reported in 1993, VR beneficiaries receive, on average, only modest services and show limited long-term improvement.[13] In 1993, compared with $52 billion in combined SSI and DI benefit payments, $63 million was spent for VR. Of over 7 million SSI and DI disabled recipients, only 300,000 were referred for VR, and 6,000 were successfully rehabilitated.

Recipients may also perceive that the risk of losing benefits upon returning to work is too high. The SSI program has work incentive provisions to encourage recipients to try returning to work, without jeopardizing their cash and medical benefits should they fail, as well as ease the transition to work. However, many recipients are not familiar with these provisions or do not understand them. As a result, a significant

[13]Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27, 1993).

unrealized potential may exist for returning recipients to work or reducing their dependence on SSI.

Growth in Immigration

The number of immigrants steadily increased in the 1980s, from about 500,000 per year early in the decade to 900,000 in 1993. Altogether, immigrants in the 1980s totaled more than 7.3 million. Over 30 percent of U.S. population growth in the 1980s can be attributed to immigration.

For this report, we use "immigrants" to refer to those with "lawful permanent resident" status. Foreign-born people seeking to immigrate to the United States can obtain this status with an immigrant visa issued overseas by the U.S. State Department. However, those already residing in the United States can also obtain this status. For example, refugees and asylees are not considered immigrants upon arrival here but are eligible for lawful permanent resident status after 1 year of continuous residence in the United States. Also, under the Immigration Reform and Control Act of 1986, certain undocumented aliens can change to permanent status. Because noncitizens other than immigrants may receive SSI benefits and because some immigrants eventually become citizens and then receive benefits, we use "noncitizens" to refer to all foreign-born residents who have not yet become citizens.

Since the 1980s, noncitizens have been one of the fastest growing groups of both aged and disabled SSI recipients. Also, noncitizens are more likely to receive SSI than citizens; roughly 3 percent of noncitizens receive SSI compared with 1.8 percent of citizens. Among other reasons that may explain this, noncitizens typically have more limited histories of working in the United States than life-long residents and therefore qualify for smaller Social Security benefits; in turn, they are more likely to qualify for SSI. Still, the likelihood of receiving SSI probably varies for different types of noncitizens. Refugees and asylees may be more likely than citizens to receive benefits while immigrants admitted through normal procedures may be no more likely or even less likely than citizens to be on SSI; data limitations make it difficult to say.[14]

[14]Data limitations that prevent drawing firmer conclusions include the following: (1) the general population data we examined estimated the noncitizens' status on the basis of country of origin rather than their actual status and (2) SSI data about noncitizens reflect their status at the time of application and not upon entering the United States. See Michael Fix and Jeffrey S. Passel, Immigration and Immigrants: Setting the Record Straight, The Urban Institute (Washington, D.C.: 1994), pp. 19-22, 34, and 63-67.

Roughly half of those granted immigrant status in the 1980s were not subject to immigration policies that attempt to exclude people who are likely to become public charges. Included are about 1 million refugees and asylees who obtained full permanent resident status. Also, the Congress passed the Immigration Reform and Control Act in 1986, which legalized over 2.5 million previously illegal aliens.

Other Factors Contribute to Caseload Growth

In addition to changes in the SSI program and the general population increases, a variety of other factors has contributed to caseload growth.

Economic factors—such as the 1990-91 recession—may account for some of the increase. In times of high unemployment, aged or disabled persons may lose their jobs and turn to SSI for support. Losing even part of their income may allow them to meet SSI's financial eligibility requirements.

Also, the prevalence of some disabilities may have increased. For example, those who 10 years ago would not have been expected to survive certain health conditions, such as kidney disease, are now being kept alive by medical and therapeutic advances. Further, young adults who would not have been expected to survive spinal cord injuries now have a much better chance of survival and more opportunity to regain many functions. Finally, infants born with congenital defects or low birth weight have a better chance of survival today than in the past, although they may sustain disabilities.

Many state and local governments have enrolled recipients of other welfare programs in SSI. When such recipients are eligible for SSI, state and local governments can reduce their own spending as well as increase benefit levels for their beneficiaries. From discussions with 10 state welfare administrators, we estimate that at least half of all states fund programs that actively assist disabled welfare recipients through the SSI application process. For example, five states reported using such programs to generate gross savings of about $90 million in a given year by helping enroll in SSI nearly 26,000 individuals receiving state benefits. Most of these gains came from one state, which reportedly saved over $60 million by helping nearly 15,400 public assistance recipients enroll in SSI instead of state general assistance in fiscal year 1994.

Finally, the recent increase in the number of people without affordable health insurance may have affected the size of SSI. The uninsured population under age 65 in the United States grew by 5 million between

1988 and 1992. Coupled with this growth, limitations in employer-based health care coverage for chronic conditions may have prompted some individuals to apply for SSI to obtain Medicaid.

Characteristics of Current SSI Recipients

Overall SSI caseload growth has been concentrated almost exclusively in the disabled population, which grew an average of over 8 percent annually from 1986 through 1993 and now accounts for nearly 80 percent of federal SSI payments. During this period, the aged SSI population stayed almost level but would have decreased by 10 percent without the growth in noncitizen cases.[15] The aged SSI population has decreased from 47 to 35 percent of all SSI recipients. Even among the disabled SSI population, the proportion of older recipients has decreased; those aged 50 and older have decreased from 36 to 28 percent of disabled recipients. Blind recipients have been a constant and small share of the total. (See app. I for more detail on age demographics.)

Three subpopulations have accounted for nearly 90 percent of the growth since 1991—adults with mental impairments, children, and noncitizens.[16] These groups typically have not contributed much in Social Security taxes. Accordingly, they receive smaller concurrent Social Security benefits than other SSI recipients, or none at all, and therefore receive higher SSI benefits. (See table 2.) Among the aged, recipients who did not qualify for any Social Security benefit increased from 12 to 36 percent of cases between 1986 and 1993. Among the disabled, such recipients increased from 69 to 73 percent of cases over the same period. (See app. I for more detail on concurrent benefit and SSI benefit levels.)

[15]This and many of the other statistics cited in this report are estimates based on our analysis of a 10-percent random sample of SSI recipients. Therefore, these estimates are subject to sampling error. However, because of the extremely large sample sizes (roughly 500,000 cases per year), the sampling errors for national estimates are very small, generally less than plus or minus 1 percentage point at a 95-percent confidence level.

[16]See also Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns (GAO/T-HEHS-95-67, Jan. 27, 1995).

Table 2: Summary of SSI Caseload Growth Patterns

	Number of cases (1993)[a]	Percentage of all cases (1993)[a]	Percentage average annual growth rate (1986-93)	Average monthly benefit (1993)
By selected subpopulations				
Mentally disabled adults	1,751,000	29.3%	11.0%	$325
Blind or disabled children	770,501	12.9	16.4	397
Aged or disabled noncitizens	674,150	11.3	15.5	316
All other recipients	2,900,000	48.0	<2.0	
By eligibility group				
Aged	2,091,651	35.0	0.7	195
Disabled	3,807,223	63.6	8.2	324
All SSI recipients	**5,984,330**	**100.0**	**4.9**	**$278**

[a]Subgroups may not add up to the total because of overlaps in the populations listed. Blind recipients accounted for 1.4 percent of all cases in 1993, down from 2 percent in 1986.

Because many children and mentally disabled adults would not have qualified previously, much of the growth reflects a one-time addition of such recipients. Because of this, it is not clear that such dramatic growth will continue indefinitely; in fact, rates of caseload growth in the past 2 years have declined somewhat, though they are still high.

Caseload growth varies dramatically by state. For example, growth in the disabled SSI population ranged from 4 to 17 percent on average annually from 1986 through 1993. Moreover, states experienced concentrations of growth in different recipient subpopulations. (See app. I for state-level detail.) For noncitizen cases, seven states accounted for 84 percent of the growth—California, New York, Florida, Texas, Illinois, New Jersey, and Massachusetts, in descending order; these states receive the largest shares of immigrants. Across all states, the rates of growth in noncitizen cases varied considerably, from 7 to more than 25 percent annually on average.

Mental Impairments Predominate Among Disabled Adults

Among disabled adults on SSI, mental impairments predominate, accounting for 56 percent of such cases in 1993. Moreover, they accounted for 64 percent of the growth from 1986 through 1993 in cases for which diagnoses were available. Mental retardation cases grew an average of 9 percent annually but constituted a fairly level 25 percent of the disabled adult caseload. However, growth in other mental impairment cases was

more dramatic, averaging 13 percent annually and increasing from 26 to 33 percent of cases over this period.

Mentally disabled adult recipients are younger on average than other disabled adults; 82 percent are under age 50 compared with 57 percent for other impairments. As a result, these recipients are likely to contribute to sustained growth in the caseload and benefit costs since they enroll in SSI at a younger age and typically stay on longer. Also, because these recipients are younger, whatever contributions they may have made to Social Security may be based on lower average wages than those disabled at later ages. As a result, any Social Security benefits they receive may be smaller than those of older recipients, and so their SSI benefits may be larger. (See app. I for more detail on the age and benefit levels of the mentally disabled.)

Included in the category of "mental impairment other than retardation" are those recipients designated as drug addicts and alcoholics (DA&A), who numbered over 100,000 in February 1995. From 1988 through 1994, these cases grew an average of 41 percent annually, multiplying eightfold. Addicts required to participate in the DA&A program are those who would not qualify for disability if their addiction ended. Thus, the DA&A designation does not apply to all addicts on SSI. In May 1994, we reported on the DA&A program and found that 150,000 addicts receive SSI benefits; of these, more than half would qualify as disabled without their addiction.[17]

By law, these designated DA&A recipients must have a representative payee, or third party, manage their benefits, and they must participate in treatment when it is available. In our May 1994 report, we noted that finding qualified payees for addicts has been a long-standing problem for SSA. Payees are generally unpaid volunteers; the vast majority are relatives or friends. An SSA study found payee controls to be lax in many cases, particularly when addicts' friends were the payees. The study also showed that organizational payees tended to provide the most control because they can more effectively deal with abusive or threatening addicts.

Further, while substance abuse treatment is required, SSA is not permitted to pay for treatment nor can the addict be required to pay for it. Exactly who pays for what types of treatment for SSI DA&A recipients is not known. Some services are covered by state Medicaid programs, but states vary greatly in the type, amount, duration, and scope of services provided. In

[17]Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS-94-128, May 13, 1994).

our May 1994 report, we noted that only about 9 percent of DA&A recipients were in treatment; the remainder were either not in treatment (7 percent) or their treatment status was not known (84 percent). SSA was then taking steps to correct shortcomings in its monitoring efforts.

The alarming growth in DA&A cases and allegations of program abuse prompted the Congress to strengthen controls of payments to addicts in the Social Security Independence and Program Improvements Act of 1994 (SSIPIA). The act generally requires that SSI benefit payments to DA&A recipients end after 3 years. It also expands the DA&A program requirements to cover DI recipients; gives preference to organizations as representative payees; and mandates an SSA study of the feasibility, cost, and equity of requiring representative payees for all DI and SSI addicts, even if they would be disabled without the addiction.

Number of Children on SSI, Especially With Mental Impairments, Is Growing Fast

Before 1990, the growth in the number of disabled children receiving SSI was moderate, averaging 3 percent annually since 1984. Then, from the beginning of 1990 through 1994, the growth averaged 25 percent annually, and the number tripled to nearly 900,000. Their share of the disabled SSI population grew from about 12 percent before 1990 to 22 percent in 1994. Also, SSA researchers project that, from age of first eligibility to age 65, children on SSI will receive benefits for more than 25 years on average compared with about 15 years for those aged 18 to 34 and less than 10 years for those aged 35 and above.[18] So children recipients especially contribute to sustaining higher caseloads.

Mental impairments predominate among children, accounting for over half of all cases. Mental retardation, one of two broad categories of mental impairments, has consistently accounted for 37 percent of children receiving SSI, both before and after 1990. However, other mental impairments have increased from 5 to nearly 18 percent of children's cases, increasing from 17,000 cases in 1989 to 136,000 cases in 1993. In 1994, we reported that the portion of mental disability awards to children with behavior problems, such as attention deficit disorder, is just 22 percent but growing.[19]

As required by the Zebley ruling, SSA began to use IFAs to make disability determinations for children whose impairments do not meet SSA's strict

[18]Rupp and Scott, pp. 29-47.

[19]Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations (GAO/HEHS-94-225, Sept. 9, 1994).

listings of impairments. The new IFA process, which added 219,000 children to the benefit rolls through September 1994, permits the award of benefits to children with less severe impairments than those in SSA's medical listings of impairments. In our recent report on the IFA, we noted that about 84 percent of children qualifying based on IFAs have mental impairments.[20] Also, about one-half of the awards for behavioral disorders, including attention deficit disorder, are based on the IFA criteria.

The news media have widely reported allegations that parents coach their children to fake mental impairments by misbehaving or doing poorly in school so they can qualify for SSI benefits. Our recent report in part attempted to assess the IFA's vulnerability to such coaching. However, we found that substantiating and measuring the extent of such coaching are extremely difficult. Studies we reviewed found little evidence of widespread coaching but could not rule it out.

Nevertheless, our report documented the many subjective judgments built into each step of the IFA process, which make it difficult to administer consistently and leave it susceptible to manipulation. We concluded that the likelihood of significantly reducing the judgment involved in evaluating age-appropriate functioning was remote and that more consistent decisions could be reached if children were evaluated on the basis of the functional criteria in SSA's medical listings. Given our findings, we suggested that the Congress could consider eliminating the IFA, which would reduce the growth in awards and target disability benefits to children with more severe impairments.

Some households have more than one child on SSI. SSI benefits are adjusted only for the income of parents, not of other children, so benefits for each additional child may be as high as for the first child. According to a recent SSA study,[21] 8.5 percent of SSI recipients live in households receiving two or more checks, excluding group living situations and couples with no other SSI recipients in the household. Nearly three-quarters of these recipients live in households with only two recipients. About 0.6 percent of SSI recipients live in households with more than three recipients. About 24 percent of those in multirecipient households are children under age 18 while another 35 percent are adults living with their parents.

[20]Social Security: New Functional Assessments for Children Raise Eligibility Questions (GAO/HEHS-95-66, Mar. 10, 1995).

[21]Alfreda Brooks, Lenna Kennedy, and Charles Scott, SSI Recipients in Multirecipient Households, Social Security Administration, unpublished, March 1994.

Number of Noncitizens Growing Fast Among Both Aged and Disabled Recipients

From 1986 through 1993, the number of aged or disabled noncitizen recipients grew an average of 15 percent annually, reaching nearly 700,000 in 1993. In 1982, noncitizens constituted 3 percent of all SSI recipients, and, in 1986, they constituted 6 percent; by 1993, they constituted nearly 12 percent. Of these, 69 percent were at least 65 years old, and 31 percent were disabled.

Had it not been for the growth in noncitizens, the aged SSI population would have decreased 10 percent from 1986 through 1993. The noncitizen caseload grew from 9 percent of aged cases to 23 percent in this period.

Although disabled recipients constitute a smaller share of noncitizen cases, their number is growing faster, averaging 19 percent annually compared with 14 percent for aged cases from 1986 through 1993. They have increased from 3 percent of disabled cases to 5.5 percent.

Recent media reports and congressional hearings have focused attention on allegations that translators and other intermediaries help non-English-speaking noncitizens fraudulently qualify for SSI disability benefits. In some parts of the United States, the noncitizen populations speak so many different languages and dialects that SSA is unlikely to have staff proficient in each of them. While the full extent of such activities is unknown, translators are known to have coached claimants to fake mental impairments, such as delayed stress syndrome or depression. They have controlled disability determination interviews by answering all questions asked of the claimants. They have prepared applications for numerous claimants using identical wording to describe the same mental impairment. They have also established relationships with unscrupulous doctors who have submitted false medical evidence.

More generally, noncitizens on SSI have come to this country under a variety of circumstances, as discussed earlier. For example, some have come through normal immigration channels, and others have come as refugees or asylees. Different provisions in both immigration law and SSI policy apply to these groups. Patterns of caseload growth also vary among groups of noncitizens. However, SSI data only permit analysis of recipients' immigration status when they applied. Some refugees may have converted to normal immigrant status by the time they apply, and some immigrants may have become citizens.

Some legal immigrants are admitted to the country under the financial sponsorship of a U.S. resident. The Immigration and Nationality Act of

1952, as amended, provides for excluding aliens who are likely to become public charges. Aliens can show they will be self-sufficient, among several other ways, by getting a financial sponsor. Sponsors sign an affidavit of support, in which they agree to provide financial assistance to the immigrant for 3 years. However, several courts have ruled that these affidavits of support are not legally binding. Refugees and asylees, moreover, do not need a sponsor to reside in the United States; in 1993, 18 percent of SSI's noncitizen recipients were refugees or asylees when they applied. In addition, the undocumented aliens legalized by the Immigration Reform and Control Act of 1986 were not admitted to the United States under these sponsorship provisions; in 1993, roughly 3 percent of SSI's noncitizen recipients were identified as part of this group when they applied.

SSI's "deeming" provisions attempt to reinforce this immigration policy by factoring a portion of sponsors' resources into financial eligibility decisions and benefit calculations for the immigrants they sponsor.[22] In 1993, as many as 75 percent of SSI's noncitizen recipients could have been subject to these provisions when they applied, but many of these may not have come to the United States under financial sponsorship. Before 1994, this deeming applied for 3 years from the immigration date. About 25 percent of immigrants receiving SSI applied for benefits within a year of their 3-year sponsorship period's expiring. The Congress temporarily extended the deeming period from 3 to 5 years starting in January 1994 and continuing through September 1996.

Refugee and asylee cases are growing somewhat faster than immigrant cases, averaging 18 percent annually from 1986 through 1993 compared with 15 percent. Still, they constitute just 18 percent of all noncitizens on SSI compared with 74 percent for immigrants. Refugees and asylees constitute a larger share of SSI's disabled noncitizen population than SSI's aged population, 23 percent compared with 16 percent.

About 46 percent of noncitizen recipients applied for SSI within 4 years of entering the United States. Only 5 percent of SSI immigrants applied within a year of entry compared with 52 percent of the remaining SSI noncitizens, as might be expected from the sponsorship provisions for immigrants. About 44 percent of disabled SSI noncitizens have been in the United States

[22]These deeming provisions do not apply if an immigrant becomes blind or disabled after admission to the United States as a permanent resident.

less than 5 years as of 1993, compared with 57 percent of aged noncitizens.[23]

Of noncitizens on SSI, 51 percent come from six countries—Mexico, the former Soviet Union, Cuba, Vietnam, the Philippines, and China, in descending order of caseloads. However, rates of growth vary substantially by country of origin, from an average of 11 percent annually for Cuba to 33 percent for the former Soviet Union, among these six countries. Except for Cuba, these are the countries with the largest shares of immigrants to the United States overall.

Concluding Observations

As SSI caseloads have grown rapidly, they have become increasingly dominated by younger, mentally disabled recipients, who stay in the program longer. Disabled recipients now account for nearly 80 percent of federal SSI payments. Rapid growth in noncitizen cases further contributes to changes in the program's character. Both these younger and noncitizen recipients tend to depend more on SSI as their primary source of income.

Over the long term, these trends provide compelling reasons to reexamine the program's assumptions and priorities, which will require thoughtful attention. They raise issues not only of which populations the program should serve but also whether the program should provide cash benefits only or work with recipients more actively to help them increase their self-sufficiency.

More specifically, technology and medical treatment to help the disabled adapt are constantly improving, and society's perceptions of disability are changing. These trends, combined with the increased number of younger recipients, especially children, challenge the program's historic presumption that the disabilities it covers are total and long term. In cases of physical disabilities among older workers, who previously predominated in the SSI program, rehabilitation and returning to work were perhaps reasonably not emphasized. The program has thus had little experience in supporting rehabilitative efforts, which may hold more promise for younger recipients.

Therefore, finding effective ways to help disabled recipients achieve their productive capacity and work as much as possible should have a higher priority. This applies at least as much to children as adults; disability has a

[23]In these percentages, disabled recipients aged 65 and over (who constituted 8 percent of all noncitizens) are counted with the disabled, not the aged.

very different meaning for them. Children who cannot function at an age-appropriate level may be able to develop so that they can work by the time they reach adulthood. Also, finding effective approaches for recipients with mental impairments, particularly those with limited work histories, may require special attention. More emphasis on returning to work should signal to recipients that work, where feasible, is a program expectation. Such efforts should help decrease their dependence on SSI, help them achieve their productive capacity, and improve program integrity as well.

The growth in noncitizen cases raises issues about immigration policy in addition to issues about SSI policy. The immigration law's provisions on sponsorship and the SSI provisions about deeming sponsors' income and resources may not adequately exclude immigrants from the United States who are likely to become public charges.

Over the short term, however, SSA can do a variety of things to bolster program integrity. For example, we have previously recommended conducting more CDRs, which would help reassure the public that benefits are not available to those who are no longer disabled; although the Congress last year required a minimal number of these, more could be done. Also, as we have previously recommended, increased monitoring of drug addicts and alcoholics would help ensure that they are getting treatment; also, finding organizations instead of family and friends to serve as their representative payees would help ensure that their cash benefits are spent for food, clothing, and shelter, not drugs and alcohol. In the case of applicants who do not speak English, increased monitoring of translators and finding ways to use agency-selected translators would help minimize the opportunities for fraud and abuse.

The Congress could also consider a variety of program changes. For example, we have already noted that the Congress could consider eliminating the IFA used in making some disability determinations for children. This would improve the consistency of the process and make it less susceptible to manipulation. It would also reduce the growth in awards and target disability benefits to children with more severe impairments.

Agency Comments

We shared a draft of this report with SSA program officials for a technical review. They found our report and our analysis of SSA data to be generally

accurate. They had some technical comments, which we have incorporated where appropriate.

SSA officials objected that we cited fraud, waste, and abuse as causes of program growth even though determining the extent of such problems is difficult. However, we state only that these are possible causes of growth and clearly acknowledge the lack of information about their extent.

SSA officials also noted that, with regard to the drug addict and alcoholic population, SSA is well on the way to implementing the stringent requirements of SSIPIA, which address both monitoring treatment and using institutional payees. They also noted that SSA has taken strong measures to combat interpreter fraud. Assessing such activities is beyond the scope of this report.

Please contact me on (202) 512-7215 if you have any questions about this report. Other GAO contacts and staff acknowledgments are listed in appendix II.

Jane L. Ross
Director, Income Security Issues

Contents

Abbreviations

AFDC	Aid to Families With Dependent Children
CDR	continuing disability review
DA&A	drug addicts and alcoholics
DBRA	Disability Benefits Reform Act of 1984
DI	Social Security Disability Insurance
IFA	individualized functional assessment
OASDI	Social Security Old Age, Survivors, and Disability Insurance
PRUCOL	permanently residing under color of law
SSA	Social Security Administration
SSI	Supplemental Security Income
SSIPIA	Social Security Independence and Program Improvements Act of 1994
SSR	Supplemental Security Record
VR	vocational rehabilitation

Additional Information on SSI Caseload Growth

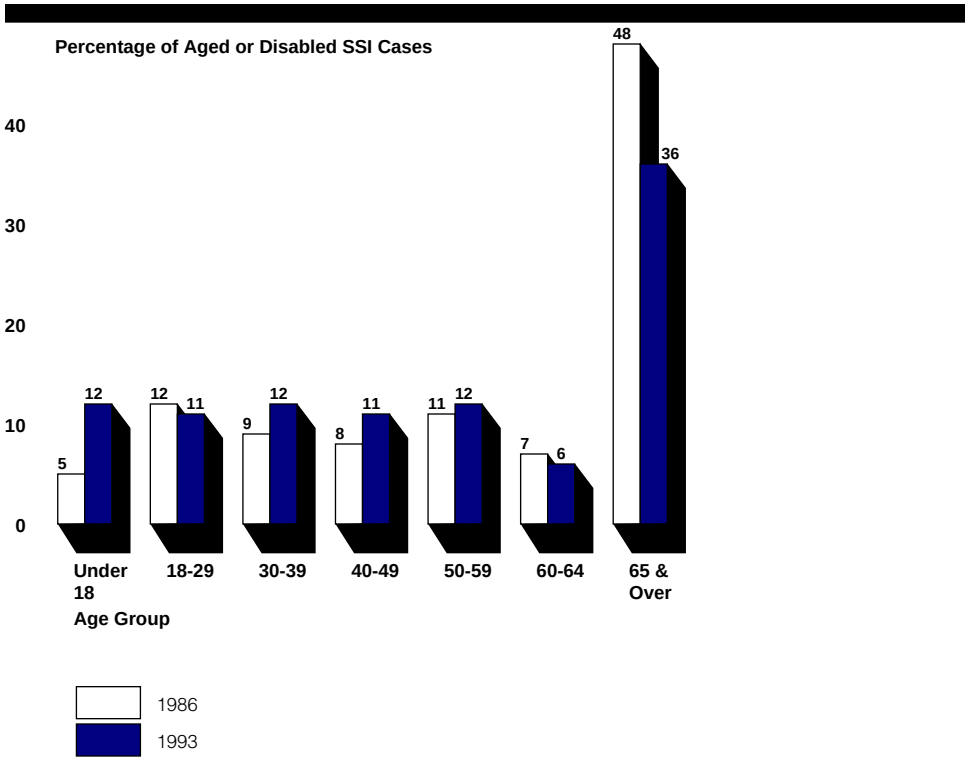
Since 1986, more SSI recipients are younger and receive smaller concurrent Social Security benefits and larger SSI benefits. Three groups of recipients have accounted for the vast majority SSI's caseload growth—adults with mental impairments, children, and noncitizens. The first two groups tend to be younger than other recipients. All three groups are less likely to qualify for concurrent Social Security benefits at all, and those recipients who do qualify tend to get smaller Social Security benefits. In turn, all three groups tend to get larger SSI benefits. At the state level, patterns of caseload growth among these three groups vary considerably.

Recipient Population Is Getting Younger

Younger SSI recipients are increasing as a share of all recipients. (See fig. I.1.) From 1986 through 1993, every age group under 60 except one has increased as a share of SSI recipients, although those aged 60 and over have decreased substantially.[24] The 50 to 59 age group increased its share slightly but only because of the dramatic decline in the 65 and over age group's share; as a share of disabled cases alone, the 50 to 59 age group decreased from 21 to 18 percent (not shown in graph). The most dramatic increase was in the under-18 age group, from 5 to 12 percent of all cases.

[24]All of the analysis in this appendix excludes blind recipients, who accounted for 1.4 percent of all cases in 1993, down from 2 percent in 1986.

Figure I.1: Younger Recipients Are Growing Share of SSI Cases
(1986-1993)



Comparing these results with U.S. population trends puts them in perspective and reveals a notable increase in recipiency rates. The small drop in the 18 to 29 age group as a share of cases corresponds with a larger drop as a share of the U.S. population, which reflects the aging of the baby boom generation. (See fig. I.2.) Dividing the SSI population by the U.S. population for each age group gives us a recipiency rate. Recipiency rates increased for every age group under age 65; again, the most dramatic increase proportionally was in the under-18 age group. (See fig. I.3.) Overall, SSI's recipiency rate increased from 1.7 to 2.3 percent from 1986 through 1993.

Figure I.2: Change in Age Distribution in U.S. Population (1986-1993)

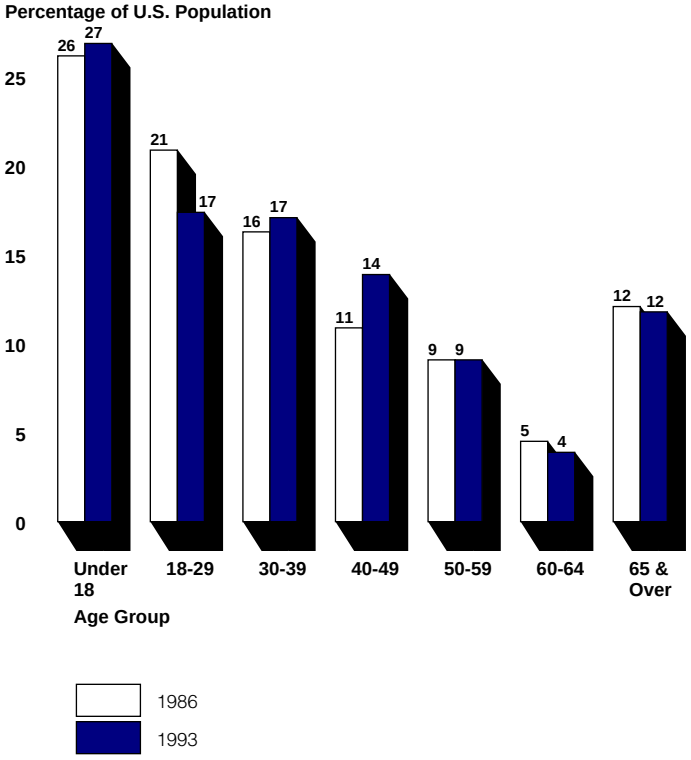
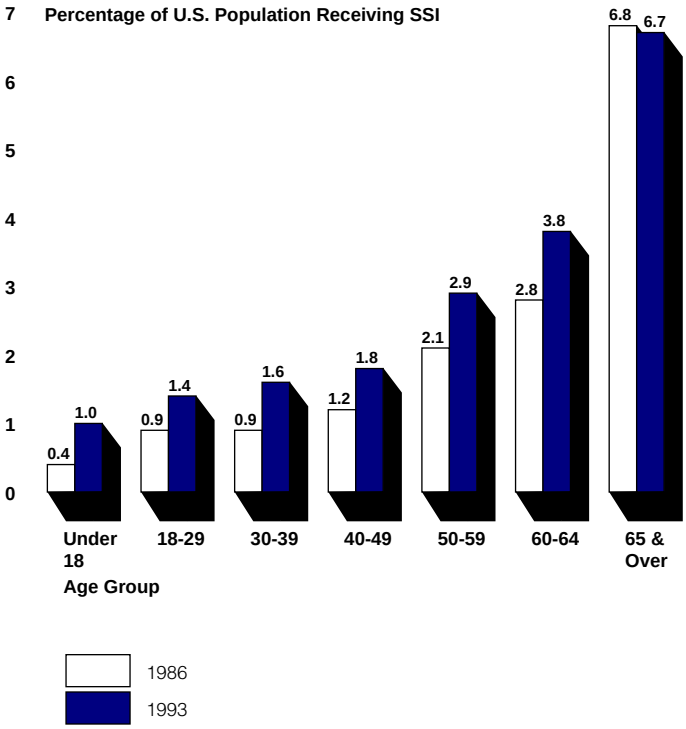
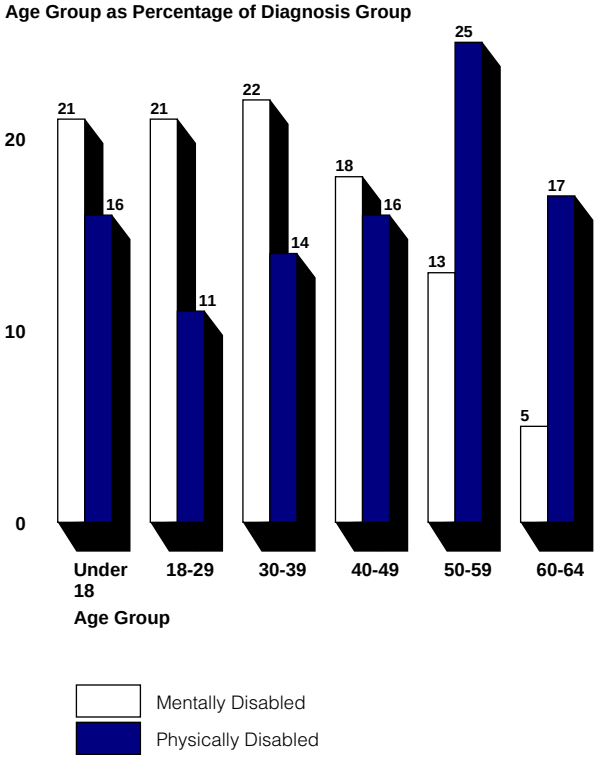


Figure I.3: Change in SSI Recipiency Rates by Age Group (1986-1993)



Mentally disabled recipients tend to be younger than those with physical disabilities. Nearly 65 percent of all mentally disabled recipients are under age 40 compared with about 41 percent of the physically disabled. (See fig. I.4.) Conversely, nearly 70 percent of disabled recipients under age 40 have mental disabilities compared with less than 50 percent of those aged 40 and over.

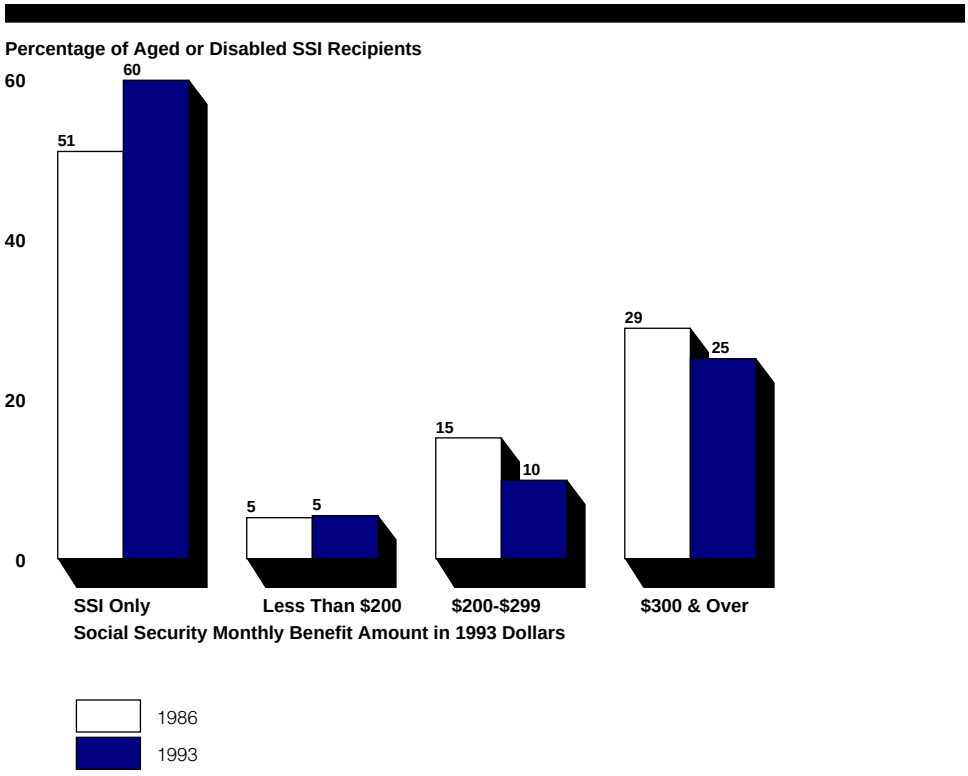
Figure I.4: Mentally Disabled Recipients Tend to Be Younger Than Other Disabled Recipients (1993)



Recipients Are Getting Fewer and Smaller Social Security Benefits

Since 1986, the share of SSI recipients who do not qualify for any concurrent Social Security benefit has increased from 51 to 60 percent. (See fig. I.5.) Meanwhile, the share of all recipients who receive concurrent benefits decreased in the highest categories of Social Security benefit amounts.

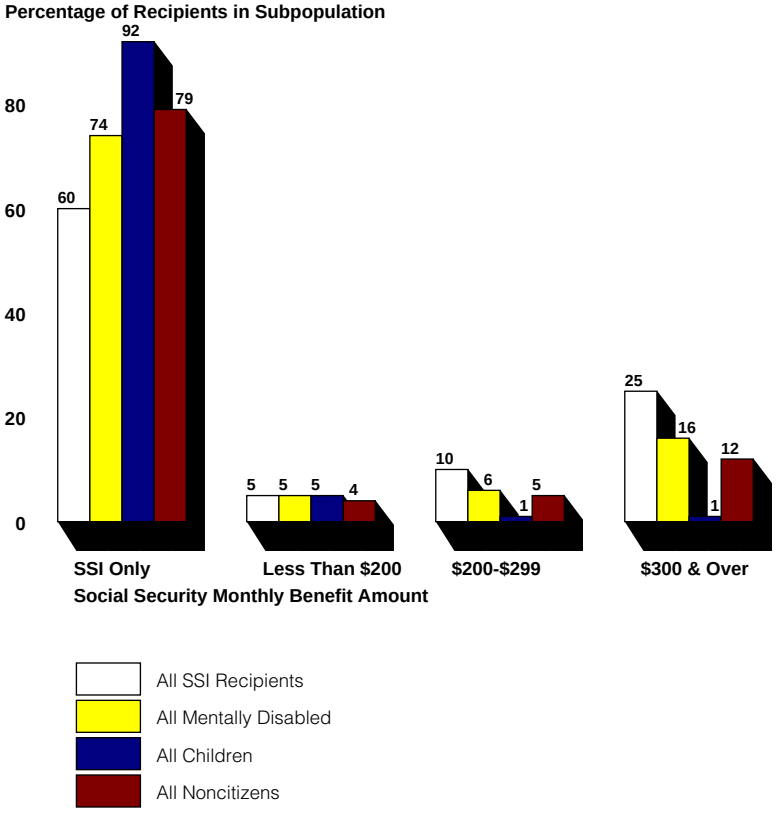
Figure I.5: SSI Recipients Receiving Social Security Benefits, by Amount of Social Security Benefit (1986 Versus 1993)



Each of the three fast-growing groups that we highlight—adults with mental impairments, children, and noncitizens—have proportionally fewer recipients who also qualify for Social Security benefits than the SSI population as a whole. (See fig. I.6.) Of those group members who do qualify for Social Security, a smaller share get larger benefits compared with other SSI recipients.[25]

[25]About 8 percent of children on SSI received Social Security benefits in 1993. Children can receive Social Security benefits as dependents or survivors of workers that qualify for Social Security.

Figure I.6: SSI Recipients Receiving Social Security Benefits—Three Fast-Growing Subpopulations, by Benefit Amount (1993)

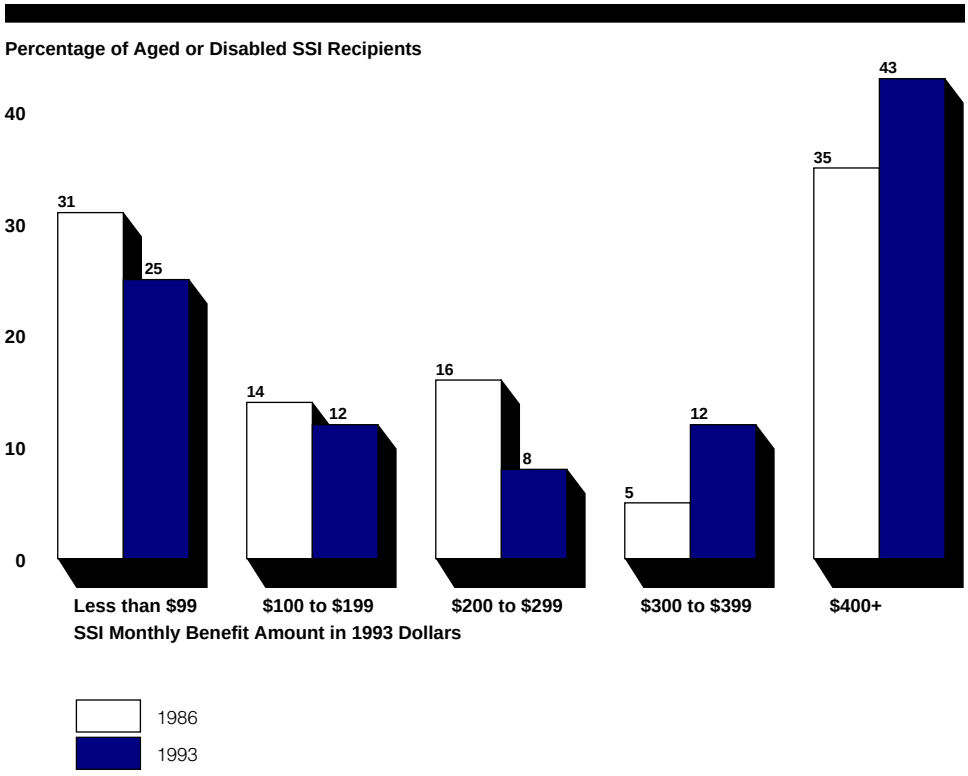


Note: These numbers exclude blind recipients.

Recipients Are Getting Larger SSI Benefits

More SSI recipients got larger SSI benefits in 1993 than in 1986, even after adjusting for inflation. (See fig. I.7.) The share of SSI recipients in each benefit amount category under $300 per month declined while the share in the highest benefit categories increased. In fact, the average SSI benefit increased 16 percent in constant, that is, inflation-adjusted dollars. The declining share of SSI recipients who also qualify for Social Security contributes to this trend, but some of the trend could result from decreases in other sources of income and financial support. The increasing share of SSI recipients who are disabled also contributes to this trend because the disabled have higher average benefits.

Figure I.7: More SSI Recipients Are Getting Larger Benefits (1986 Versus 1993)



State Experiences Vary Widely

Figures I.8 and I.9 summarize by state patterns of SSI caseload growth overall and for the three fast-growing populations we highlight.[26] Rates of SSI caseload growth varied considerably by state and for different subpopulations within states. For 1986 through 1993, average annual growth rates for all SSI recipients ranged from 3 to 12 percent.[27]

[26]Unless otherwise specified, we use the word "disabled" only for those recipients under age 65 and "aged" for those aged 65 and over. When disabled recipients turn 65, SSI program data typically continue to count them among the disabled.

[27]All of the state-level statistics cited in this appendix, except for recipiency rates, are estimates based on our analysis of a 10-percent random sample of SSI recipients nationwide. Sampling errors do not exceed plus or minus 4.1 percentage points at a 95-percent confidence level. Given these sampling errors, readers should be cautious when making their own comparisons between these state-level estimates because the difference between estimates may not be statistically significant.

Figure I.8: State Data on SSI Caseload Growth, by Eligibility Group

	All SSI recipients			Aged		Disabled	
State	Average annual growth rate (1986-1993)	State caseload as percent of U.S. total (1993)	Recipiency rate (1993)	Average annual growth rate (1986-1993)	Group as percent of state total (1993)	Average annual growth rate (1986-1993)	Group as percent of state total (1993)
Alabama	3%	2.6%	3.6%	-3%	39%	8%	61%
Alaska	8	0.1	1.0	2	26	10	74
Arizona	9	1.1	1.5	3	30	12	70
Arkansas	3	1.5	3.7	-4	37	10	63
California	5	16.3	3.1	3	46	7	54
Colorado	8	0.9	1.4	2	28	10	72
Connecticut	5	0.7	1.2	4	29	6	71
Delaware	4	0.2	1.3	2	29	6	71
District of Columbia	3	0.3	3.2	0	34	4	66
Florida	7	5.0	2.1	3	44	11	56
Georgia	3	3.1	2.7	-2	39	7	61
Hawaii	6	0.3	1.4	6	50	6	50
Idaho	7	0.2	1.3	1	23	10	77
Illinois	8	4.1	2.0	2	23	10	77
Indiana	7	1.4	1.4	0	19	10	81
Iowa	5	0.7	1.4	-2	26	8	74
Kansas	6	0.5	1.3	-1	23	9	77
Kentucky	6	2.5	3.7	-1	30	10	70
Louisiana	4	2.9	3.8	-2	33	9	67
Maine	3	0.5	2.2	-1	34	6	66
Maryland	5	1.2	1.4	2	34	7	66
Massachusetts	4	2.4	2.4	-1	35	8	65
Michigan	6	3.2	1.9	-0	22	9	78
Minnesota	7	0.9	1.2	1	28	10	72
Mississippi	3	2.3	5.0	-3	40	9	60
Missouri	4	1.8	2.0	-3	28	8	72
Montana	7	0.2	1.4	2	24	10	76
Nebraska	5	0.3	1.2	-0	27	7	73
Nevada	9	0.3	1.1	3	30	14	70
New Hampshire	6	0.2	0.8	2	22	8	78
New Jersey	6	2.3	1.7	3	36	7	64
New Mexico	6	0.7	2.4	2	37	9	63
New York	6	9.1	2.9	4	38	7	62
North Carolina	3	2.9	2.5	-1	40	7	60
North Dakota	3	0.1	1.3	-2	33	7	67
Ohio	7	3.6	1.8	0	19	10	81
Oklahoma	3	1.2	2.1	-3	37	8	63
Oregon	7	0.7	1.4	2	26	9	74
Pennsylvania	5	3.9	1.9	1	29	7	71
Rhode Island	4	0.3	2.1	-0	34	7	66
South Carolina	3	1.7	2.8	-2	39	6	61
South Dakota	6	0.2	1.7	-1	29	10	71
Tennessee	4	2.8	3.2	-2	35	8	65
Texas	5	6.2	2.0	2	44	9	56
Utah	11	0.3	0.9	3	18	13	82
Vermont	4	0.2	2.1	-3	28	7	72
Virginia	5	2.0	1.8	0	36	8	64
Washington	7	1.4	1.5	2	25	9	75
West Virginia	5	1.0	3.2	-0	26	7	74
Wisconsin	5	1.7	2.0	-2	26	8	74
Wyoming	12	0.1	1.0	2	22	17	78
United States total	**5%**	**100.0%**	**2.3%**	**1%**	**36%**	**8%**	**64%**

Source: Data on recipiency rates from Committee on Ways and Means, U.S. House of Representatives, Overview of Entitlement Programs: 1994 Greenbook. Other data from GAO analysis of SSA's 10-percent sample of the Supplemental Security Record file.

Figure I.9: State Data on SSI Caseload Growth, by Selected Subpopulations

	All mentally disabled		Children		Noncitizens	
State	Average annual growth rate (1991-1993)	Group as percent of state total (1993)	Average annual growth rate (1986-1993)	Group as percent of state total (1993)	Average annual growth rate (1986-1993)	Group as percent of state total (1993)
Alabama	20%	37%	18%	15%	8%	0%
Alaska	11	41	11	9	a	10
Arizona	20	37	17	13	19	10
Arkansas	20	33	22	18	a	0
California	9	31	14	6	17	30
Colorado	13	39	16	12	20	8
Connecticut	9	42	12	9	15	10
Delaware	14	41	12	17	a	3
District of Columbia	9	35	13	9	14	5
Florida	19	31	22	14	12	22
Georgia	14	36	16	12	20	2
Hawaii	9	31	9	5	10	25
Idaho	21	46	16	21	a	2
Illinois	22	50	21	15	15	9
Indiana	18	49	19	19	12	1
Iowa	13	47	16	15	13	3
Kansas	22	49	20	18	15	4
Kentucky	18	42	17	11	a	0
Louisiana	24	39	19	20	8	2
Maine	12	38	9	7	7	2
Maryland	13	37	17	11	17	11
Massachusetts	16	38	14	7	15	14
Michigan	21	51	23	15	13	4
Minnesota	17	48	20	12	17	10
Mississippi	18	34	18	16	a	0
Missouri	16	44	20	16	15	1
Montana	13	38	12	12	a	1
Nebraska	13	42	15	17	a	2
Nevada	23	37	20	11	17	13
New Hampshire	12	48	11	14	a	3
New Jersey	15	37	15	12	14	17
New Mexico	16	30	17	13	27	6
New York	15	35	17	11	14	19
North Carolina	13	34	19	12	22	1
North Dakota	11	40	12	10	a	1
Ohio	20	53	20	17	16	2
Oklahoma	15	35	20	14	15	2
Oregon	17	43	17	12	17	8
Pennsylvania	14	43	16	13	15	4
Rhode Island	17	40	11	10	13	14
South Carolina	14	35	16	13	13	1
South Dakota	10	37	17	17	a	1
Tennessee	18	41	17	11	16	1
Texas	17	27	15	12	16	13
Utah	20	52	20	19	17	6
Vermont	14	44	11	9	a	1
Virginia	16	37	20	13	16	6
Washington	15	43	17	10	18	14
West Virginia	17	43	13	10	a	0
Wisconsin	15	49	20	16	18	4
Wyoming	19	46	a	16	a	1
United States total	**16%**	**38%**	**18%**	**12%**	**15%**	**12%**

[a]We omitted these estimates because the number of cases in these categories in these states was very small, especially in 1986.

The states with the most SSI recipients, in order of caseloads, are California, with 16.3 percent of all cases; New York, with 9.1 percent; Texas, with 6.2 percent; and Florida, with 5.0 percent. To put each state's share in perspective, recipiency rates also vary widely by state, from 0.8 percent in New Hampshire to 5 percent in Mississippi for 1993; the U.S. rate was 2.3 percent. These percentages are calculated as the average number of monthly SSI recipients over the state's July population. For the four largest states, the recipiency rates were as follows: California, 3.1 percent; New York, 2.9 percent; Texas, 2.0 percent; and Florida, 2.1 percent.

Of the four largest states, none had both growth rates and shares of cases consistently higher or lower than the national average for all three highlighted populations. California had a faster growth rate and a larger share of cases than average only for noncitizens. New York and Texas generally mirrored the national experience, but New York had a substantially larger share of noncitizens, and Texas had a substantially smaller share of mentally disabled recipients than the national average. Florida had a slower rate of growth for noncitizens but a larger share of them.

For the mentally disabled, average annual growth rates varied from 9 percent in three states, including California, to 24 percent in Louisiana. This group as a share of state cases ranged from 30 percent in New Mexico to 53 percent in Ohio.

For children, average annual growth rates varied from 9 percent in Hawaii and Maine to 23 percent in Michigan. This group as a share of state cases ranged from 5 percent in Hawaii to 21 percent in Idaho.

For noncitizens, average annual growth rates varied from 7 percent in Maine to 27 percent in New Mexico. This group as a share of state cases ranged from virtually 0 percent in five states to 30 percent in California.

GAO Contacts and Acknowledgments

Contacts

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In addition to those named above, the following individuals made major contributions to this report: Cynthia A. Bascetta, Assistant Director, and Vanessa R. Taylor, Senior Evaluator (computer science).

Related GAO Products

Supplemental Security Income: Recent Population Has Changed as Caseloads Have Burgeoned (GAO/T-HEHS-95-120, Mar. 27, 1995).

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