

ASPE RESEARCH BRIEF

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HUMAN SERVICES POLICY - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The federal Supplemental Security Income (SSI) program, which includes children under age 18 with disabilities in low-income households, has grown in recent years. This research brief examines geographic variation in child SSI program growth and participation. The findings indicate substantial state variation in child SSI program growth (1998-2013), and state and county variation in recent (2013) caseloads, with clustering of higher levels of participation in Northeastern and Southern states. The program appears to have become a larger part of the safety net relative to the Temporary Assistance to Needy Families (TANF) program, as child SSI caseloads have increased while TANF program caseloads have declined in nearly every state, and 11 states now have more child SSI recipients than child TANF cash benefit recipients. The findings suggest that the factors influencing child SSI program participation, and the role of this federal program in the broader safety net, may vary significantly by region, state and county. Future briefs in this series will examine diverse policy and program environments in four states to better understand this variation.

THE CHILD SSI PROGRAM AND THE CHANGING SAFETY NET

The Supplemental Security Income (SSI) program, a federal income support program administered by the Social Security Administration (SSA), which includes children under age 18 with disabilities in low-income households, has grown in recent years. The growth in the child SSI caseload has varied substantially by state (as has the adult SSI caseload), though the factors driving this growth are not well understood (U.S. Government Accountability Office 2012; Aizer et al. 2013).

This brief, the second in a series under **ASPE's *The Child SSI Program and the Changing Safety Net* project**, examines state and county variation in child SSI caseloads for the most recent year in which data are available (2013), and state variation in child SSI caseload growth in the past 15 years (1998 to 2013). During this 15-year period, there were no major changes in child SSI eligibility requirements, yet child SSI caseloads grew by 45 percent nationally. The brief presents maps to observe trends and regional patterns in caseload growth, relative to the number of children and the number of children in low-income households. The maps provide insights into the regional patterns in child SSI participation and potential sources of caseload growth, and suggest clustering of program participation that varies substantially across and within states, and that often spans

ABOUT THIS RESEARCH BRIEF

This brief examines geographic variation in child SSI program growth and participation. It was prepared by David Wittenburg, John Tambornino, Elizabeth Brown, Gretchen Rowe, Mason DeCamillis, and Gilbert Crouse. The analysis was conducted by Mathematica Policy Research staff in collaboration with staff in HHS's Office of the Assistant Secretary for Planning and Evaluation.

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state lines. While this analysis cannot determine the specific factors driving the SSI caseload growth in recent years, it does indicate that regional, state and local factors appear to play an important role in the geographic variation in program growth.

The analysis presents ratios of child SSI caseloads to the number of children at the state and county levels (**SSI-child population ratio**), to observe the number of child SSI recipients per capita in each state. It also presents ratios of child SSI caseloads to the number of children in low-income households (i.e., below 200 percent of the federal poverty level) at the state and county levels (**SSI-child low-income population ratio**), to adjust for the number of children in low-income households who might meet the program's income eligibility requirements.¹ In addition, the brief presents such ratios for other major federal safety net programs that serve children, to consider the reach of the child SSI program in comparison to other programs.

The remainder of this brief is divided into four sections. The first provides an overview of the emergence of the child SSI program and its current eligibility requirements. The second section compares national trends in child SSI caseloads to three other major federal safety net programs that have changed substantially since 1998: (1) Temporary Assistance to Needy Families (TANF), (2) the Supplemental Nutrition Assistance Program (SNAP), and (3) the Medicaid/ Children's Health Insurance Program (Medicaid/CHIP). The third section presents maps to illustrate county, state and regional patterns in child SSI caseloads. The brief concludes with a discussion of findings.

The brief also includes appendices containing state-level comparisons of participation rates in the child SSI program with other major federal safety net programs. **Appendix A** includes tables with state statistics on these programs. **Appendix B** presents state data on child SSI caseload trends using graphics that sort the state ratios by size, providing another comparison to the maps in the brief.

Overview of the Child SSI Program

The SSI program provides income support to (1) adults with a disability with limited income and resources, (2) households of children with a disability with limited income and resources, and (3) individuals over age 65 with limited income and resources.² The SSI program was enacted in 1972 and began operations in 1974, and has become an increasingly significant source of income support to low-income households with children with a disability.³

Child SSI caseloads were relatively small until eligibility changes in the 1990s

As documented by Berkowitz and DeWitt (2013), the creation of the child SSI program was part of a larger shift in transferring supports for individuals with a disability from the states to the federal level in 1972. Nevertheless, states continued to play an important role in the development and administration of the SSI program, including through the operation of state

Disability Determination Services (DDS) to determine eligibility and, in several states, administration of state SSI supplemental benefits. Through 1989, caseload sizes remained relatively modest (265,000 child SSI recipients), especially in comparison to 2014 caseloads (1.3 million child SSI recipients). The size of the caseload through 1989 largely reflected the restrictive “listing-only” approach to eligibility, in which children could qualify only if their medical impairment met the medical Listing of Impairments definitions used for the adult disability program.

Two important modifications in 1990 resulted in a departure from the listing-only approach to eligibility and led to substantial expansion of the child SSI program (Davies et al. 2009). First, SSA modified the section of the Listing of Impairments that addressed eligibility for children with mental disorders, moving toward a more functionally based assessment of a child’s categorical eligibility. Second, in its 1990 *Sullivan v. Zebley* decision, the U.S. Supreme Court decided that SSA’s listing-only approach for determining disability in children did not reflect the “comparable severity” provision of the Social Security Act, in that the Listing of Impairments definitions were stricter for children than for adults. The Court ordered SSA to assess children individually, which resulted in SSA regulations to implement an “individualized functional assessment” to determine whether a child could function “independently, appropriately, and effectively in an age-appropriate manner.” Following these changes, the child SSI program more than tripled in size from 1989 through 1995 (Wittenburg 2011).

Eligibility for child SSI program has not changed since 1996

In 1996, the federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) substantially revised the post-*Zebley* child SSI eligibility definitions and required a redetermination of eligibility at age 18 under the adult rules.⁴ These changes made the eligibility requirements more restrictive, though still not as restrictive as the listing-only approach used before the *Zebley* decision.

To meet the child disability criteria for SSI, a child must have “a medically determinable physical or mental impairment which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months” (U.S. Code 42 2007). The income eligibility requirements are complex; the rules include “deeming” for both parental and child income, and households must generally have limited resources in order to qualify for benefits.⁵ According to Stegman and Hemmeter (2014), three-quarters of children who receive SSI have household incomes below 200 percent of the federal poverty level and approximately one-third live in households whose incomes are below the poverty level.

In 2014, the maximum SSI benefit was \$721 per month, and all but four states supplemented federal SSI benefits with an additional state benefit, averaging \$48 per month (for the states where data are available), for certain SSI recipients.⁶ The SSI benefit level is higher than other cash assistance programs, such as TANF. For example, Wiseman (2011) concluded that the

national average monthly TANF benefit for an entire household was approximately \$200 lower than the average SSI individual benefit. In most states, receipt of SSI qualifies individuals for Medicaid and, because of their relatively limited incomes, many individuals who receive SSI live in households eligible for other means-tested supports, such as SNAP.

State environments may influence child SSI participation

Although SSI is a federal program, a number of factors could result in state variations in the SSI-child population ratios presented below (Schmidt 2013). First, as noted above, state and local policy officials, program administrators, and advocacy groups often vary in outreach to households of eligible children. Second, state differences in economic, policy, and program environments can influence the opportunities of youth and their parents to obtain employment, education, and public assistance. Third, the demographic and income characteristics of the youth population vary by state. Although it is difficult to obtain data on state-level disability prevalence among children, there are substantial state variations in disability prevalence among adults (with higher rates concentrated in lower income states), so it is likely that there are also cross-state differences for children (Houtenville 2013). Fourth, although DDS agencies are required to adhere to federal policy in determining eligibility, states have considerable flexibility in managing their DDS review processes and disability examiner hiring and compensation, and in using private contractors to collect additional medical information on behalf of applicants (Social Security Advisory Board 2012). Finally, SSI optional state supplements could be a factor in state variation, but given the modest benefit level, and the fact that these benefits are not universal and the amount can vary by individual recipient, any effect is likely minimal.

There are large variations in state child SSI allowance (or applicant approval) rates, which likely reflect a combination of these four factors. For example, in 2013, 38 percent of initial applicants to the child SSI program nationally were approved ultimately, but allowance rates for child SSI applications ranged from 27 percent in Louisiana to 66 percent in Wyoming (see Appendix Exhibit A.1).

National Trends in Safety Net Programs Since 1998

To illustrate the child SSI program's growing role in the broader safety net from 1998 to 2013, we compare changes in child SSI caseloads to those of three other major safety net programs: (1) TANF, (2) SNAP, and (3) Medicaid/CHIP (**Exhibit 1**). We show child ratios for each program, which measure caseload sizes relative to the total number of children in each year, allowing us to observe program growth while controlling for population growth.⁷

From 1998 through 2013, there was substantial growth in the child SSI program. The SSI-child population ratio increased almost 45 percent from 1998 through 2013. In 2013, just over 1.3 million children, or about 1.8 percent of all children, received SSI.

Over this same period, SNAP and Medicaid/CHIP child population ratios have increased significantly, whereas TANF child population ratios (i.e., children receiving TANF cash benefits) have declined substantially. The SNAP child population ratios grew by 92 percent and Medicaid/CHIP ratios grew by 73 percent. The greater rate of growth in SNAP and Medicaid/CHIP relative to child SSI was influenced by a combination of economic, policy, and program factors, including an increase in the number of low-income households, changes in eligibility requirements, and outreach efforts to increase access to the programs (Laird and Trippe 2014; Rosenbach et al. 2007).

In contrast, the TANF child population ratios declined by nearly 52 percent since 1998.⁸ The declines followed the implementation of PRWORA (welfare reform), which introduced work requirements and time limits for recipients of TANF cash benefits (in contrast to the predecessor program, Aid to Families with Dependent Children [AFDC]) (Pavetti et al. 2009). Additionally, unlike the AFDC program, in which states received federal matching funds for program expenditures, the TANF program provides capped federal block grants to states, which changed incentives regarding state provision of benefits and services to low-income households and limited the available federal funding (Schott et al. 2012; Derr et al. 2009).

Exhibit 1. Major safety net program caseloads and trends, 1998–2013

	Caseload	Children (2013) Child population ratio	Change in child population ratio (1998 to 2010/2013)	Households Caseload (2013)
SSI (2013)	1,321,360	1.8%	44.8%	n.a.
TANF (2013)	3,065,630	4.2%	-51.9%	1,736,565
SNAP (2013)	20,849,000	28.3%	92.4%	10,224,000
Medicaid/CHIP (2010)	30,078,178	40.6%	73.0%	n.a.

Sources: Social Security Administration (1999 and 2014); U.S. Census Bureau (1998 and 2013); Department of Health and Human Services (1999); Administration for Children & Families (2014); U.S. Department of Agriculture, Food and Nutrition Service (2014a and b); Centers for Medicare and Medicaid Services (2014).

Note: Child population ratios are calculated as program participants divided by number of children in each year. N.A. denotes not available.

In summary, the child SSI program has grown substantially over the past 15 years, but it still serves a smaller number of children in comparison to other programs. The smaller size of the child SSI caseload relative to SNAP and Medicaid/CHIP (1.3 million vs. 21 million and 30 million recipients, respectively) is not surprising given that the SNAP and Medicaid/CHIP programs serve a much larger population of low-income households.⁹ However, the change in the SSI-child population ratio since 1998 indicates that the child SSI program is becoming a larger part

of the safety net relative to TANF. In addition, the individual caseload sizes understate SSI's role relative to TANF, given that average SSI benefit levels are much higher than average TANF benefits for children. For example, a recent Department of Health and Human Services report described how, at the national level, overall federal spending on child SSI benefits exceeds combined federal and state spending on child TANF cash benefits (Tambornino et al, 2015).¹⁰

State and County SSI Trends (1998–2013)

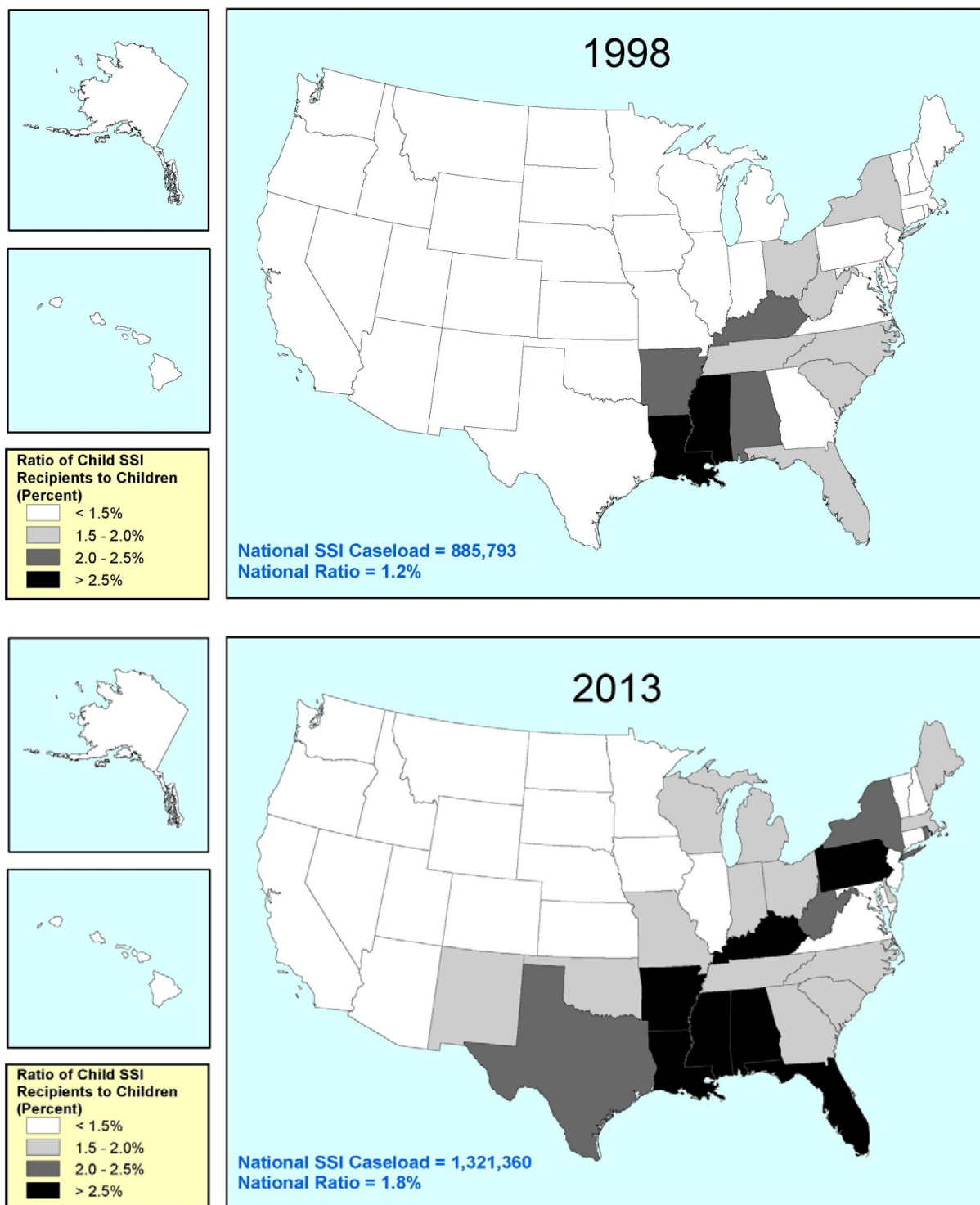
To illustrate how the child SSI caseload growth discussed above has varied across states, we present maps that show geographic distributions of SSI-child population ratios in 1998 and 2013 (**Exhibit 2**). The national ratio rose from 1.2 percent in 1998 to 1.8 percent in 2013, indicating that less than 2 percent of the nation's youth participated in SSI during each of these years. The relatively limited use of the program by the general population is not surprising given the disability and income/resource eligibility requirements for SSI. The white areas of the map show states that have SSI-child population ratios of less than 1.5 percent (approximately the national average from 1998 through 2013). We use progressively darker areas (grey, dark grey, and black) to show higher SSI-child population ratios in 0.5 percentage point increments, with the highest (black) ratios over 2.5 percent (Appendix Exhibit A.2 provides data on all state SSI-child population ratios in 1998 and 2013).¹¹

SSI caseloads vary by state

In 1998, while there were some initial state variations in caseload sizes, 37 states, including all of those in the western region, had SSI-child population ratios below 1.5 percent (**Exhibit 2**). SSI-child population ratios were generally higher in Southern states, particularly in Louisiana and Mississippi, which had ratios above 2.5 percent. The Midwestern and Western regions generally had the most states with the lowest SSI-child population ratios.

By 2013, the SSI-child population ratios in all states had increased, yet 25 states still had ratios below 1.5 percent. Similar to the pattern in 1998, all Western states except New Mexico had SSI-child population ratios below 1.5 percent in 2013. There was a pattern of larger SSI-child population ratios in Northeastern and Southern states, suggesting regional concentration in caseload growth, though some states in these regions (such as New Jersey) had SSI-child population ratios below 1.5 percent. The following seven states (all in the Northeastern and Southern regions) had SSI-child population ratios above 2.5 percent: Alabama, Florida, Pennsylvania, Kentucky, Mississippi, Louisiana, and Arkansas (ordered from the lowest to the highest). Although not shown on the map, there is also some evidence of increases in the states with the lower SSI-child population ratios (see Appendix Exhibit A.2). For example, in 1998, 24 states had SSI-child population ratios below 1 percent, whereas in 2013 only eight states had SSI-child population ratios below 1 percent.¹²

Exhibit 2. SSI-child population ratios by state (1998 and 2013)



Sources: Social Security Administration (2014); U.S. Census Bureau (2013).

Note: SSI-child population ratio is calculated as child SSI recipients divided by number of children.

Caseload growth concentrated in some states

A closer examination of state SSI-child population ratios and aggregate caseload sizes illustrates that a large portion of the growth was concentrated in a few states (see Appendix Exhibit A.2). The total child SSI program caseloads increased by 435,567 recipients from 1998 to 2013. During that period, two states—Pennsylvania and Texas—experienced substantial state-level growth (35,974 and 96,925 youth), which accounted for 30 percent of the national caseload growth. In addition, the SSI-child population ratios in these states more than doubled (from 1.4 to 2.8 percent in Pennsylvania and from 0.9 to 2.1 percent in Texas). Additionally, when the child SSI caseloads from two other large states—California and Florida—are added to those of Texas and Pennsylvania, half of the aggregate child SSI caseload increase from 1998 through 2013 is the result of increases in these four states (more than half of all children reside in these four states).¹³

Several states now have more child SSI recipients than child TANF cash benefit recipients. The TANF caseloads are still larger in terms of child recipients, as there were approximately four child SSI recipients for every 10 child TANF recipients in 2013.¹⁴ However, 11 states (Indiana, Illinois, Oklahoma, North Carolina, Florida, Georgia, Wyoming, Mississippi, Texas, Louisiana, and Arkansas) had more child SSI recipients than TANF recipients; in Louisiana and Arkansas there were more than twice as many child SSI recipients as child TANF cash benefit recipients (Appendix Exhibit A.2).¹⁵ By comparison, California, Maine, and Oregon had at least seven times as many child TANF recipients as child SSI recipients.

Patterns in SSI-child population ratios by county

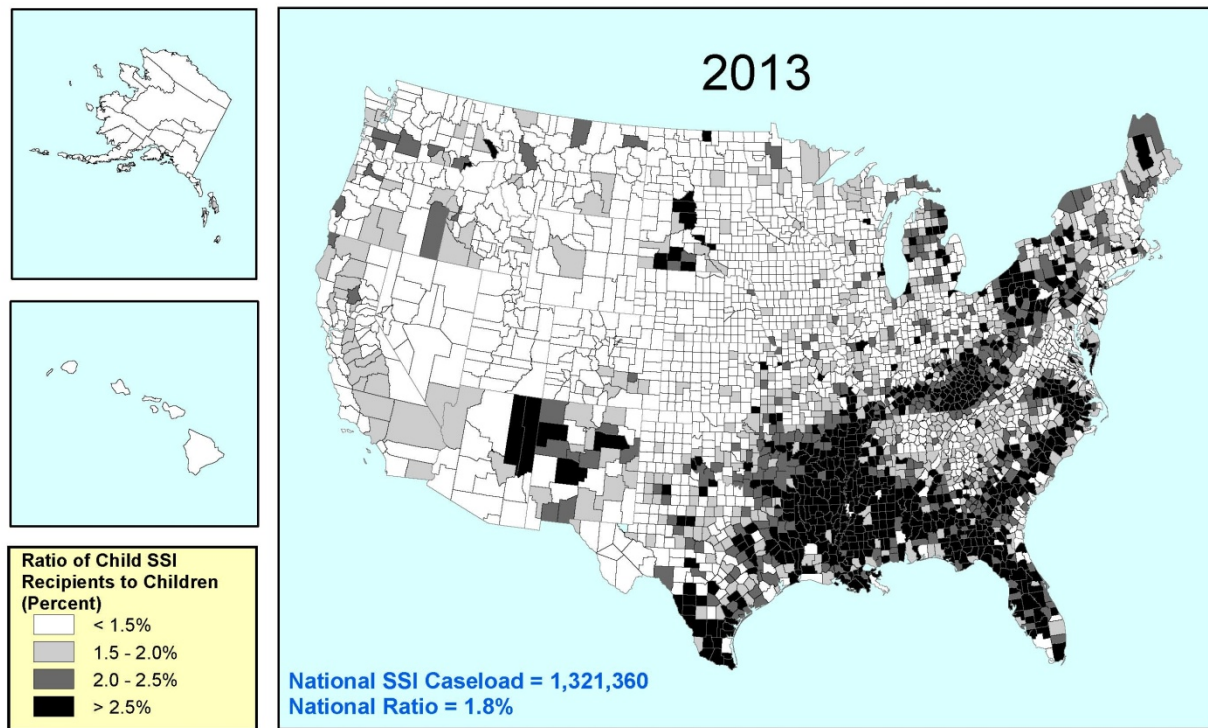
In **Exhibit 3**, we present a county-level map of the 2013 SSI-child population ratios, which provides a more localized view of variations in SSI-child population ratios. Some outliers are a result of small counties, so readers should use caution in generalizing from any single data point. Nonetheless, the county-level map provides further understanding of the geographic dispersion of SSI-child population ratios.

We find state variation in the county distribution of SSI-child population ratios, as some states (such as Florida and Louisiana) had heavy concentrations of certain SSI-child population ratios throughout almost every county, whereas other states had a mix of low and high SSI-child population ratio clusters. For example, in Texas, several counties clustered in the northern and western portions of the state had SSI-child population ratios below 1.5 percent, whereas several small counties in the southern portion of the state and in large urban areas (such as Houston) had rates above two percent.

One important pattern is that many of the counties with higher SSI-child ratios (shaded dark grey and black) are adjacent to one another, even across state lines. Specifically, many high SSI-child population ratio counties are heavily clustered, with relatively few high SSI-child clusters near lower SSI-child clusters (shaded white). The higher ratios are generally clustered in the

Appalachian Mountains and the southern portions of the Mississippi Valley, which previous research has identified as having historically higher concentrations of adults receiving disability benefits (McCoy et al. 1994; Houtenville 2014).

Exhibit 3. SSI-child population ratios by county, 2013



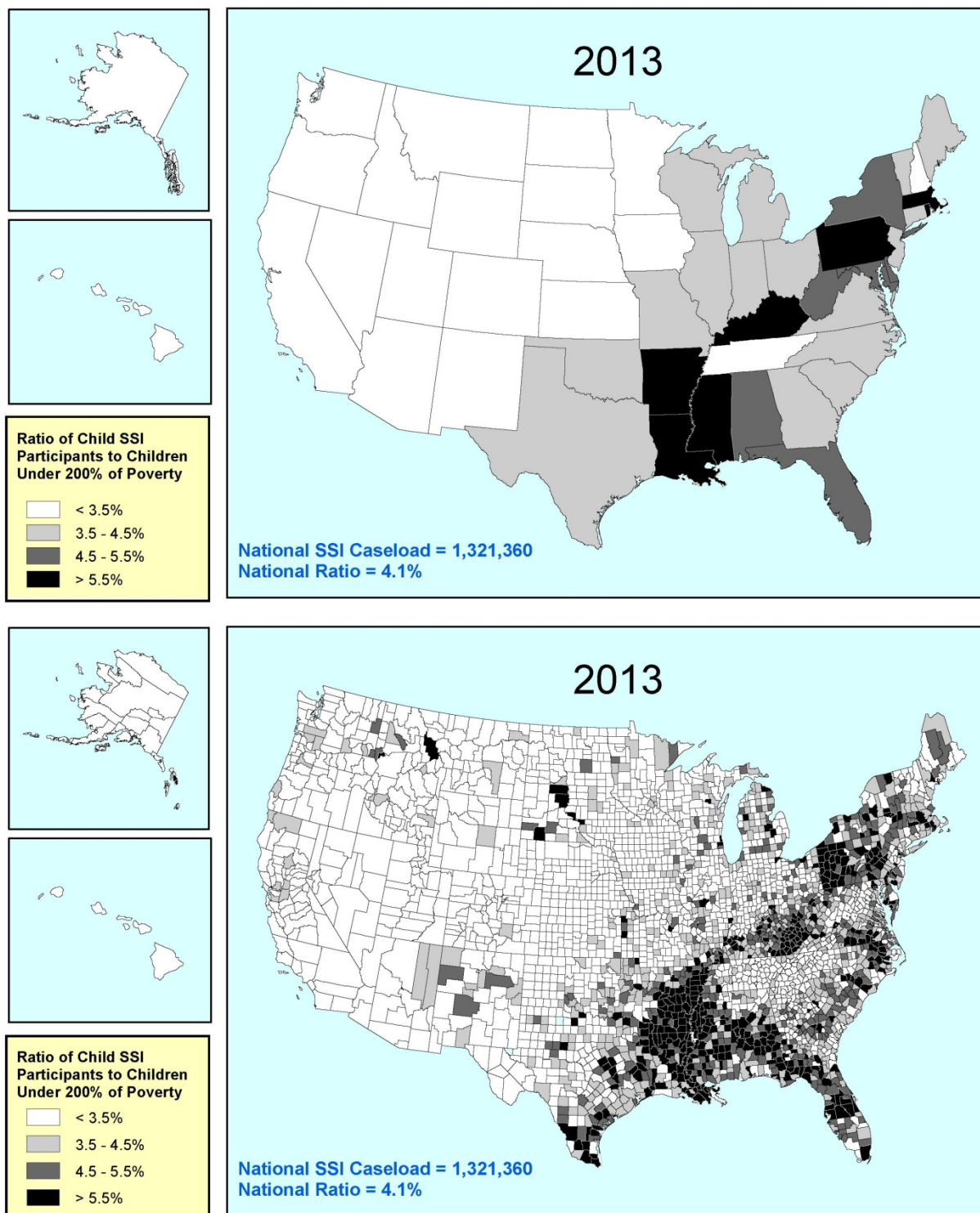
Sources: Social Security Administration (2014); U.S. Census Bureau (2013).

Note: SSI-child population ratio is calculated as child SSI recipients divided by number of children.

Regional patterns of SSI-child low-income population ratios and SSI-child population ratios are similar

One potential explanation for the patterns we observe is that some of the higher SSI-child population ratios noted above may be concentrated in lower-income states, particularly in the Appalachian Mountains and Mississippi Valley. To assess whether child SSI recipients are heavily clustered primarily in low-income areas, we present data for SSI-child low-income population ratios for 2013 in **Exhibit 4**. As stated above, we define low-income as below 200 percent of the federal poverty level, which approximates the income requirements for the program. Using the same coloring scheme as Exhibit 3 but adjusting the scaling for the percentage of children in low-income households, we present thresholds starting below 3.5 percent, which is just below the national SSI-child low-income population ratio of 4.1 percent in 2013. We then show progressively darker areas for higher SSI-child low-income population ratios from 3.5 to 4.5 (grey), 4.5 to 5.5 (dark grey), and above 5.5 (black).

Exhibit 4. SSI-child low-income population ratios by state and county, 2013



Sources: Social Security Administration (2014); U.S. Census Bureau (2013).

Note: SSI-child low-income population ratio is calculated as child SSI recipients divided by the number of children from low-income households (below 200 percent of the federal poverty level).

The patterns in Exhibit 4 for the SSI-child low-income population ratios generally mirror those in Exhibit 3 for the SSI-child population ratios. As in Exhibit 3, there is substantial state and county variation in ratios. All seven of the states with the highest SSI-child population ratios noted above (Alabama, Florida, Pennsylvania, Kentucky, Mississippi, Louisiana, and Arkansas) had low-income ratios above 5 percent (see Appendix Exhibit A.3 and dark grey/black areas of Exhibit 4). As in Exhibit 3, counties with moderate to high SSI-child low-income population ratios are often adjacent to one another.

Discussion

The above findings indicate substantial variation in child SSI caseloads in 2013, both within and across states, with evidence of clustering by counties that often extends beyond state lines, especially in Northeastern and Southern states.¹⁶ The caseload growth has varied substantially by state, and over half has been concentrated in four large states (Texas, Pennsylvania, Florida, and California). The child SSI program appears to have become a larger part of the safety net relative to the TANF cash benefits program, given that in nearly all states caseloads have increased while the TANF program caseloads have declined.

The large cross-state variation suggests that participation in the child SSI program resembles in some respects the cross-state variation found in federal-state programs such as TANF. In particular, the respective roles of TANF and SSI appear to be shifting in some states, as 11 states now have more child SSI recipients than child TANF cash benefit recipients (see Appendix Exhibit A.2). There does not appear to be a uniform state or local trend or single demographic, economic, or other factor to explain the variations (Aizer et al. [2013] reach a similar conclusion in their state-level analysis). The large state and county variations in SSI-child population ratios are likely to persist in the absence of major policy changes that affect eligibility or program interactions.

Future briefs in this series will examine the role of the child SSI program in the context of the broader safety net by comparing localities in four states with large variations in SSI-child population ratios and diverse policy and program environments (Philadelphia, Pennsylvania; Houston, Texas; Portland, Oregon; and Breathitt County, Kentucky).¹⁷ These briefs will report observations based on site visits to these localities in order to better understand factors that may influence geographic variation in the child SSI program and its changing role in the safety net.

Acknowledgements

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¹ We use percentages to describe ratios for ease of exposition and to facilitate comparisons between the two ratios. The SSI-child population ratio represents the percent of child SSI recipients in the population of children in each state. We present SSI-child low-income population ratios to assess whether our observations of the SSI-child population ratio are sensitive to changes in the size of the low-income population. Given that some of the child SSI recipients live in households above our low-income threshold (i.e., below 200 percent of the federal poverty level), the SSI-child low-income population ratios are not a percentage of children in the low-income population receiving SSI.

² The SSI benefit does not necessarily go directly to the household, but rather to a child recipient's "representative payee" who may or may not be a member of the household, to be spent by the child or his/her parent or guardian. For adult and elderly recipients, the benefit also may go directly to a representative payee.

³ SSI applicants or their guardian or legal representative must apply at a Social Security field office or Teleservice Center for an initial eligibility determination (limited to non-disability requirements such as income, resources, and citizenship). The field office refers qualified applications to state Disability Determination Services (DDS) offices, which are state offices funded by SSA to make disability determinations based on federal policy. In most states, applicants who are denied benefits can apply for reconsideration by the DDS (in some states, the appeal goes directly to an Administrative Law Judge), and if they are denied at this stage they can again appeal the decision (Social Security Advisory Board 2012).

⁴ Children under age 22 can continue to qualify for benefits under certain circumstances, such as through enrollment in school.

⁵ For more details on the income eligibility requirements for SSI, see <http://www.ssa.gov/ssi/text-income-ussi.htm> (accessed October 16, 2014).

⁶ Each state determines its optional state supplement amount, which SSI recipients will receive a benefit, and whether the benefit will be federally or state administered (see <http://www.socialsecurity.gov/ssi/text-benefits-ussi.htm>, accessed November 2, 2014). For average state supplements for child SSI benefits in 2014 (see Table 7 of http://www.socialsecurity.gov/policy/docs/statcomps/ssi_monthly/2014-09/table07.html, accessed November 2, 2014). Data currently available do not distinguish individual state benefit levels.

⁷ We include children in the denominator to control for the growth in the number of children from 1998 through 2013.

⁸ The TANF ratios throughout the brief refer to the number of children who receive cash benefits from TANF and/or a State Separate Program, but do not include children living in households who only receive TANF non-cash assistance (such as childcare). For Medicaid/CHIP, data are drawn from the Medicaid Statistical Information System (MSIS) State Summary Datamarts monthly reports, which began in January 1999; as a result, the Medicaid/CHIP data presented, unlike the other data presented in this brief, is from 1999 rather than 1998.

⁹ Unlike SSI, SNAP and Medicaid/CHIP do not require that recipients have a disability, and Medicaid/CHIP has significantly higher income eligibility requirements.

¹⁰ Although the total number of child SSI recipients (1.3 million in 2013) is smaller than for the other major safety net programs, the difference in number of recipients diminishes when the household unit is used as a rough comparison (Exhibit 1, column 4). In addition, federal spending on cash assistance for child SSI is higher than for TANF because, although SSI serves fewer children, average child SSI benefits are higher than TANF benefits, and the TANF program has capped federal funding, unlike the SSI program (Tambornino et al 2015; SSA 2014; Congressional Research Service 2014).

¹¹ Given the thresholds used, the maps do not capture increases from the lowest SSI-child population ratios (e.g., those below 1 percent) to higher thresholds below 1.5 percent. The endnote below describes movements in low ratio states over time.

¹² The 24 states that had SSI-child population ratios below 1 percent in 1998 included: Alaska, Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Iowa, Kansas, Maine, Maryland, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Oregon, Texas, Utah, Vermont, Washington, and Wyoming. The eight states that had SSI-child population ratios below 1 percent in 2013 included: Alaska, Colorado, Hawaii, Nebraska, New Hampshire, North Dakota, Utah, and Wyoming.

¹³ These four states contain roughly 30 percent of the U.S. population of children under age 18.

¹⁴ These estimates are calculated by comparing the SSI-child population ratios to the TANF-child population ratios in 2013 using data in Appendix Exhibit A.2.

¹⁵ These differences in the relative trends reflect both an increasing prevalence of child SSI recipients and a sharp decline in TANF caseloads. For example, although the list above includes some states that had increasing SSI-child population ratios from 1998 to 2013 (such as Florida and Texas), it also includes states with more moderate child SSI increases and very sharp TANF declines (such as Illinois).

¹⁶ The factors determining this clustering are not well known based on the existing literature. The geographic clustering may in part reflect clustering of recipients at the household level; for example, using matched Survey of Income and Program Participation and SSA administrative data, Stegman and Hemmeter (2014) found that over 20 percent of child SSI recipients lived in a family with another child SSI recipient in 2010, and that approximately 20 percent of child SSI recipients lived with an adult SSI recipient.

¹⁷ See Appendix A for a comparison of SSI program indicators with other safety net programs (TANF, SNAP, and Medicaid/CHIP) for all 50 states and the District of Columbia.

Appendix Exhibit A.1. 2013 SSI allowance rates, by state

	Child SSI applicants	Child SSI allowances	Allowance rate
United States	458,505	174,968	38.2%
Alabama	11,009	3,344	30.4%
Alaska	389	218	56.0%
Arizona	6,463	2,360	36.5%
Arkansas	10,648	4,132	38.8%
California	35,481	15,734	44.3%
Colorado	3,336	1,672	50.1%
Connecticut	4,067	1,315	32.3%
Delaware	1,526	458	30.0%
District of Columbia	1,483	543	36.6%
Florida	39,818	14,737	37.0%
Georgia	20,332	5,573	27.4%
Hawaii	574	235	40.9%
Idaho	1,743	940	53.9%
Illinois	16,366	5,550	33.9%
Indiana	10,421	3,428	32.9%
Iowa	3,061	1,334	43.6%
Kansas	3,266	1,517	46.4%
Kentucky	9,280	3,606	38.9%
Louisiana	14,656	3,913	26.7%
Maine	1,369	595	43.5%
Maryland	6,754	2,764	40.9%
Massachusetts	8,437	3,669	43.5%
Michigan	14,735	5,736	38.9%
Minnesota	4,696	2,176	46.3%
Mississippi	10,824	3,106	28.7%
Missouri	8,115	3,195	39.4%
Montana	752	409	54.4%
Nebraska	1,586	643	40.5%
Nevada	2,935	1,335	45.5%
New Hampshire	937	391	41.7%
New Jersey	9,810	3,618	36.9%
New Mexico	2,746	1,250	45.5%
New York	25,632	12,553	49.0%
North Carolina	16,434	5,357	32.6%
North Dakota	419	170	40.6%
Ohio	17,955	6,585	36.7%
Oklahoma	5,853	2,279	38.9%
Oregon	2,901	1,543	53.2%
Pennsylvania	25,935	9,745	37.6%
Rhode Island	1,630	598	36.7%
South Carolina	9,458	2,900	30.7%
South Dakota	819	381	46.5%
Tennessee	10,117	3,124	30.9%
Texas	46,680	18,858	40.4%
Utah	1,673	882	52.7%
Vermont	459	207	45.1%

Virginia	9,425	2,967	31.5%
Washington	5,382	2,757	51.2%
West Virginia	2,756	1,050	38.1%
Wisconsin	7,081	3,329	47.0%
Wyoming	281	187	66.5%

Source: Social Security Administration (2014).

Note: Allowance rate calculated by dividing allowances by applications.

Appendix Exhibit A.2. Comparison of SSI with other safety net programs serving children: Ratios of child recipients to total number of children

	Number of SSI children		SSI-child population ratio			TANF-child population ratio		SNAP-child population ratio		Medicaid/CHIP-child population ratio	
	1998	2013	1998	2013	Growth 1998-2013	1998	2013	1998	2013	1999	2010
United States	885,793	1,321,360	1.2%	1.8%	45.2%	8.7%	4.2%	14.7%	28.3%	23.5%	40.6%
Alabama	25,788	29,149	2.3%	2.6%	13.4%	4.1%	3.2%	19.1%	34.7%	26.7%	40.5%
Alaska	910	1,282	0.5%	0.7%	44.7%	10.5%	3.5%	10.9%	20.7%	17.0%	39.2%
Arizona	12,102	21,188	0.9%	1.3%	39.4%	3.9%	1.6%	13.5%	33.7%	20.2%	43.1%
Arkansas	15,665	30,336	2.3%	4.3%	86.5%	3.9%	1.6%	18.0%	31.6%	27.1%	57.2%
California	78,861	119,743	0.9%	1.3%	52.3%	16.4%	11.7%	17.8%	25.1%	28.1%	41.4%
Colorado	8,167	9,781	0.8%	0.8%	2.6%	4.2%	2.3%	8.6%	20.2%	12.4%	32.8%
Connecticut	5,239	8,890	0.6%	1.1%	76.6%	10.4%	2.6%	12.0%	19.5%	21.1%	32.3%
Delaware	2,517	3,719	1.3%	1.8%	37.6%	7.8%	4.2%	12.2%	34.4%	23.1%	39.8%
District of Columbia	2,867	4,228	2.5%	3.8%	50.4%	36.5%	12.0%	37.8%	47.5%	54.0%	75.9%
Florida	60,049	106,340	1.7%	2.6%	56.2%	6.0%	1.9%	13.7%	33.3%	22.0%	40.5%
Georgia	27,243	45,961	1.3%	1.9%	41.2%	7.2%	1.2%	17.3%	34.6%	26.9%	46.7%
Hawaii	1,051	1,696	0.4%	0.6%	57.1%	10.6%	0.8%	20.4%	23.8%	25.1%	39.1%
Idaho	3,228	5,761	0.9%	1.4%	51.7%	0.8%	4.2%	9.1%	25.0%	15.3%	33.2%
Illinois	41,629	43,270	1.3%	1.4%	10.9%	11.9%	1.3%	15.0%	29.4%	23.5%	48.3%
Indiana	17,479	25,435	1.1%	1.6%	41.6%	5.1%	1.5%	10.1%	27.2%	19.3%	40.6%
Iowa	5,785	8,393	0.8%	1.2%	46.8%	6.3%	4.3%	8.9%	25.0%	15.0%	32.9%
Kansas	6,415	9,731	0.9%	1.3%	48.9%	3.7%	2.0%	7.5%	19.6%	13.9%	26.2%
Kentucky	22,821	28,908	2.3%	2.9%	24.5%	9.1%	4.8%	17.8%	33.3%	41.2%	45.8%
Louisiana	31,950	36,801	2.6%	3.3%	27.8%	10.3%	1.3%	23.3%	38.0%	27.5%	63.8%
Maine	2,764	4,264	0.9%	1.6%	79.1%	9.0%	12.7%	14.1%	32.5%	24.3%	44.5%
Maryland	13,018	18,851	1.0%	1.4%	44.3%	6.7%	2.9%	12.7%	24.1%	19.3%	35.9%
Massachusetts	15,634	24,217	1.1%	1.7%	65.7%	8.1%	7.2%	11.1%	23.5%	25.4%	38.6%
Michigan	37,137	43,367	1.4%	1.9%	34.0%	9.7%	2.8%	15.6%	29.4%	23.1%	43.7%
Minnesota	9,487	13,905	0.7%	1.1%	47.3%	7.7%	3.1%	8.5%	18.8%	18.3%	28.7%
Mississippi	21,063	24,083	2.7%	3.3%	20.2%	6.1%	2.1%	22.5%	39.7%	28.7%	47.4%
Missouri	16,997	23,863	1.2%	1.7%	43.7%	8.4%	4.2%	14.6%	29.2%	27.1%	40.3%
Montana	2,017	2,613	0.9%	1.2%	34.5%	6.0%	2.4%	12.5%	23.2%	15.2%	34.8%

	Number of SSI children		SSI-child population ratio			TANF-child population ratio		SNAP-child population ratio		Medicaid/CHIP-child population ratio	
	1998	2013	1998	2013	Growth 1998-2013	1998	2013	1998	2013	1999	2010
Nebraska	3,666	4,209	0.8%	0.9%	12.3%	6.1%	2.8%	10.6%	18.1%	22.3%	34.9%
Nevada	3,613	9,361	0.8%	1.4%	83.1%	4.2%	3.0%	8.1%	24.5%	11.6%	25.4%
New Hampshire	1,706	2,613	0.6%	1.0%	71.4%	3.4%	3.8%	6.8%	17.7%	15.1%	31.3%
New Jersey	20,262	26,416	1.0%	1.3%	32.3%	7.5%	2.7%	10.7%	20.0%	17.4%	32.8%
New Mexico	5,662	9,587	1.1%	1.9%	71.8%	8.6%	5.5%	18.5%	39.6%	35.4%	61.8%
New York	71,024	89,587	1.5%	2.1%	37.9%	13.9%	6.7%	17.5%	28.7%	25.4%	39.9%
North Carolina	29,981	43,925	1.6%	1.9%	21.5%	7.1%	1.4%	13.9%	32.5%	24.7%	45.5%
North Dakota	1,071	1,045	0.7%	0.6%	-1.5%	3.9%	1.8%	10.3%	14.8%	13.6%	27.1%
Ohio	46,477	51,452	1.6%	1.9%	21.3%	8.8%	4.2%	11.6%	28.3%	19.9%	41.8%
Oklahoma	10,848	18,190	1.2%	1.9%	58.7%	5.0%	1.5%	15.7%	28.5%	22.1%	50.6%
Oregon	6,368	10,739	0.8%	1.3%	64.5%	4.1%	8.8%	12.1%	33.6%	19.3%	37.1%
Pennsylvania	40,354	76,328	1.4%	2.8%	105.1%	9.2%	4.7%	14.3%	25.3%	22.6%	35.2%
Rhode Island	2,889	4,759	1.2%	2.2%	86.6%	12.4%	4.7%	17.4%	28.5%	25.7%	42.6%
South Carolina	17,010	20,707	1.7%	1.9%	13.6%	4.9%	2.1%	17.5%	35.8%	31.8%	45.2%
South Dakota	2,242	2,551	1.1%	1.2%	12.8%	3.8%	2.7%	12.2%	23.1%	20.0%	39.3%
Tennessee	21,197	25,392	1.6%	1.7%	9.7%	7.6%	6.2%	19.1%	36.7%	39.7%	46.6%
Texas	50,094	147,019	0.9%	2.1%	140.2%	4.9%	1.1%	16.0%	31.6%	19.8%	38.5%
Utah	3,625	5,602	0.5%	0.6%	21.6%	3.1%	0.9%	7.5%	14.4%	11.5%	23.0%
Vermont	1,213	1,729	0.8%	1.4%	72.0%	8.4%	5.0%	12.8%	26.9%	33.1%	50.0%
Virginia	21,057	23,876	1.2%	1.3%	4.1%	4.3%	2.7%	12.1%	21.8%	17.1%	32.0%
Washington	11,416	18,297	0.8%	1.2%	51.3%	9.4%	4.7%	12.0%	26.6%	28.3%	43.2%
West Virginia	7,717	8,387	1.9%	2.2%	17.6%	8.3%	3.8%	26.7%	33.8%	33.4%	46.7%
Wisconsin	17,469	22,755	1.3%	1.7%	35.9%	2.4%	3.6%	8.1%	27.4%	15.4%	37.6%
Wyoming	949	1,059	0.7%	0.8%	6.9%	1.6%	0.5%	9.8%	13.1%	15.5%	34.3%

Sources: Social Security Administration (1999 and 2014); U.S. Census Bureau (1998 and 2013); U.S. Department of Health and Human Services (1999); Administration for Children & Families (2014); U.S. Department of Agriculture, Food and Nutrition Service (1999 and 2014); Centers for Medicare & Medicaid Services (2014).

Note: Child ratios in each program are calculated as program participants divided by number of children.

Appendix Exhibit A.3. Comparison of SSI with other safety net programs serving children: Ratios of child recipients to children in low-income households (below 200% of federal poverty level)

	Number of children on SSI	SSI-child low-income population ratio	TANF-child low- income population ratio	SNAP-child low- income population ratio	Medicaid/CHIP-child low- income population ratio
		2013	2013	2013	2010
United States	1,321,360	4.1%	9.5%	64.5%	93.5%
Alabama	29,149	5.2%	6.3%	68.9%	81.0%
Alaska	1,282	2.1%	10.7%	63.9%	127.0%
Arizona	21,188	2.6%	3.2%	66.4%	84.7%
Arkansas	30,336	7.9%	2.9%	58.0%	106.3%
California	119,743	2.8%	25.2%	54.0%	90.7%
Colorado	9,781	2.1%	6.1%	53.7%	85.9%
Connecticut	8,890	3.8%	8.7%	64.8%	116.3%
Delaware	3,719	4.7%	10.8%	87.5%	107.7%
District of Columbia	4,228	8.1%	25.7%	101.9%	150.7%
Florida	106,340	5.4%	4.0%	68.2%	85.5%
Georgia	45,961	3.7%	2.5%	69.6%	97.0%
Hawaii	1,696	1.7%	2.4%	73.0%	125.0%
Idaho	5,761	2.8%	8.7%	51.7%	69.6%
Illinois	43,270	3.5%	3.1%	72.1%	119.3%
Indiana	25,435	3.6%	3.3%	60.3%	88.9%
Iowa	8,393	3.1%	11.8%	67.8%	88.6%
Kansas	9,731	3.3%	5.0%	48.3%	63.6%
Kentucky	28,908	6.1%	10.3%	71.2%	95.4%
Louisiana	36,801	6.7%	2.7%	76.9%	131.4%
Maine	4,264	4.0%	30.8%	78.7%	110.5%
Maryland	18,851	4.6%	9.4%	78.5%	123.1%
Massachusetts	24,217	5.7%	23.8%	77.1%	133.3%
Michigan	43,367	4.3%	6.3%	66.2%	98.1%
Minnesota	13,905	3.3%	9.4%	57.3%	86.0%
Mississippi	24,083	5.8%	3.7%	69.9%	83.9%
Missouri	23,863	3.8%	9.4%	65.7%	91.9%

	Number of children on SSI	SSI-child low-income population ratio	TANF-child low- income population ratio	SNAP-child low- income population ratio	Medicaid/CHIP-child low- income population ratio
		2013	2013	2013	2010
Montana	2,613	2.7%	5.7%	54.2%	81.0%
Nebraska	4,209	2.2%	6.9%	44.4%	88.2%
Nevada	9,361	2.9%	6.2%	50.2%	55.5%
New Hampshire	2,613	3.4%	13.6%	63.2%	120.9%
New Jersey	26,416	4.0%	8.3%	61.9%	109.3%
New Mexico	9,587	3.5%	10.1%	73.1%	113.2%
New York	89,587	5.1%	16.0%	68.6%	99.6%
North Carolina	43,925	4.0%	3.0%	67.0%	95.9%
North Dakota	1,045	2.1%	5.8%	49.0%	76.8%
Ohio	51,452	4.5%	9.7%	65.2%	94.8%
Oklahoma	18,190	3.9%	3.1%	57.3%	102.3%
Oregon	10,739	2.8%	19.6%	74.8%	78.9%
Pennsylvania	76,328	7.2%	12.0%	64.4%	90.8%
Rhode Island	4,759	5.7%	12.0%	72.6%	107.9%
South Carolina	20,707	3.8%	4.1%	70.2%	90.8%
South Dakota	2,551	3.0%	6.6%	57.1%	95.1%
Tennessee	25,392	3.4%	12.4%	73.9%	94.5%
Texas	147,019	4.3%	2.3%	64.5%	76.6%
Utah	5,602	1.6%	2.3%	37.4%	57.8%
Vermont	1,729	3.8%	13.6%	73.3%	131.2%
Virginia	23,876	3.7%	7.8%	63.7%	98.0%
Washington	18,297	2.9%	11.9%	67.9%	111.7%
West Virginia	8,387	4.6%	8.0%	71.3%	98.3%
Wisconsin	22,755	4.5%	9.2%	70.2%	96.4%
Wyoming	1,059	2.4%	1.6%	40.9%	89.3%

Sources: Social Security Administration (1999 and 2014); U.S. Census Bureau (1998 and 2013); U.S. Department of Health and Human Services (1999); Administration for Children & Families (2014); U.S. Department of Agriculture, Food and Nutrition Service (1999 and 2014); Centers for Medicare & Medicaid Services (2014).

Note: Low-income ratios in each program are calculated as program participants divided by number of children in low-income households (below 200 percent of federal poverty level).

Appendix Exhibit A.4. Comparison of SSI with other safety net programs serving youth: Ratios of child recipients to children living in poverty (below 100% of federal poverty level)

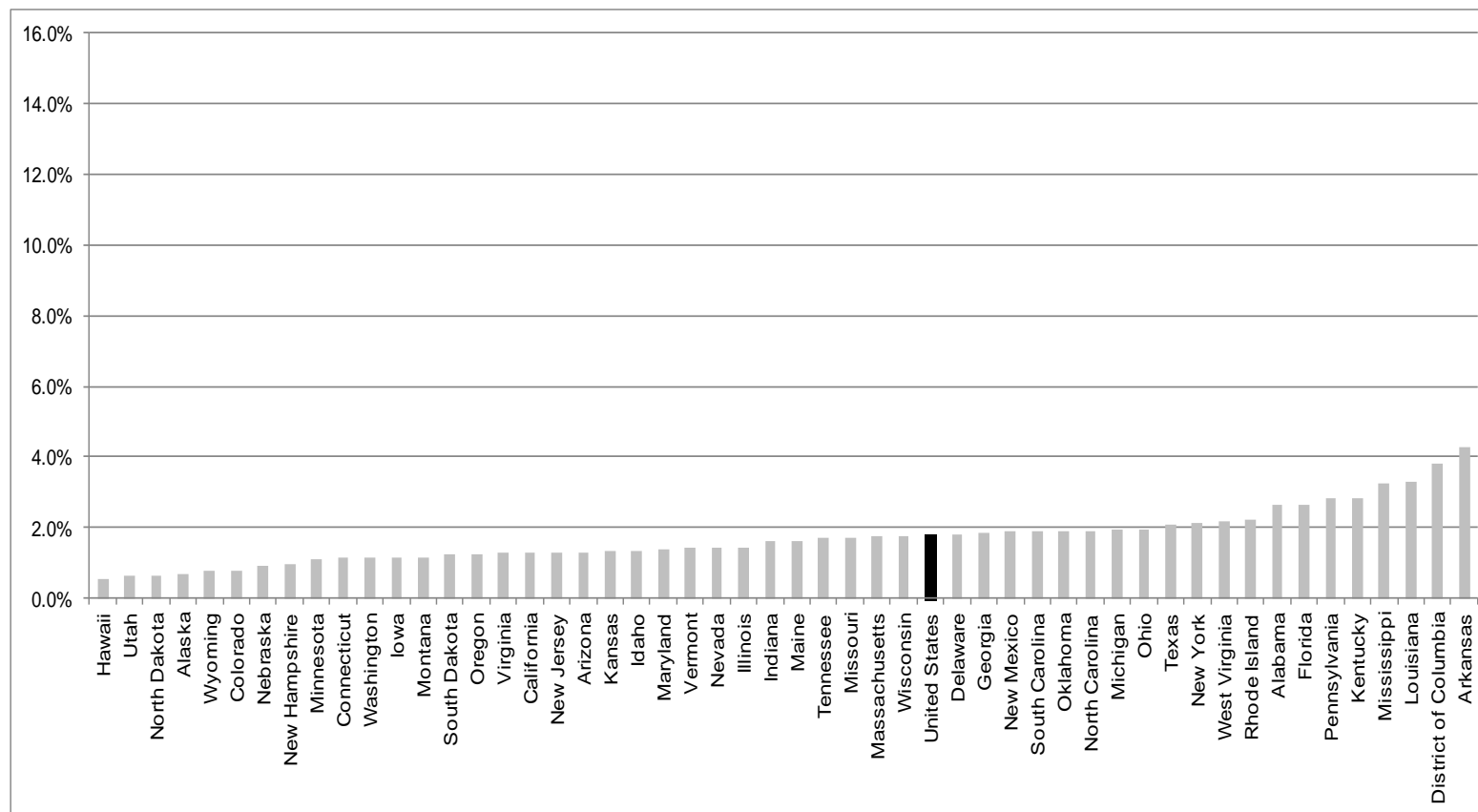
	Number of children on SSI	SSI-child poverty ratio 2013	TANF-child poverty ratio 2013	SNAP-child poverty ratio 2013	Medicaid/CHIP-child poverty ratio 2010
United States	1,321,360	8.2%	19.1%	129.6%	190.9%
Alabama	29,149	9.8%	11.9%	129.5%	147.4%
Alaska	1,282	5.8%	29.7%	177.3%	306.9%
Arizona	21,188	5.0%	6.3%	129.2%	178.9%
Arkansas	30,336	15.0%	5.6%	110.9%	210.9%
California	119,743	5.6%	50.8%	108.7%	190.8%
Colorado	9,781	4.7%	13.6%	120.8%	190.9%
Connecticut	8,890	7.9%	18.2%	135.4%	255.2%
Delaware	3,719	10.3%	23.9%	194.4%	221.2%
District of Columbia	4,228	14.1%	44.5%	176.7%	247.9%
Florida	106,340	11.0%	8.0%	138.4%	175.5%
Georgia	45,961	7.1%	4.7%	132.4%	190.4%
Hawaii	1,696	4.2%	6.0%	182.5%	289.6%
Idaho	5,761	7.1%	22.1%	132.1%	178.2%
Illinois	43,270	7.0%	6.2%	144.5%	251.2%
Indiana	25,435	7.4%	6.8%	124.9%	190.4%
Iowa	8,393	7.3%	27.3%	157.4%	207.9%
Kansas	9,731	7.4%	11.1%	107.6%	145.6%
Kentucky	28,908	11.5%	19.5%	134.7%	178.4%
Louisiana	36,801	12.1%	4.8%	139.1%	237.8%
Maine	4,264	9.5%	73.8%	188.9%	253.2%
Maryland	18,851	10.5%	21.5%	180.0%	280.4%
Massachusetts	24,217	10.9%	45.2%	146.6%	271.8%
Michigan	43,367	8.3%	12.0%	126.1%	189.1%
Minnesota	13,905	7.9%	22.3%	135.6%	191.7%
Mississippi	24,083	9.8%	6.3%	119.1%	147.7%
Missouri	23,863	7.8%	19.1%	134.2%	197.1%
Montana	2,613	5.6%	11.6%	110.6%	176.7%
Nebraska	4,209	5.2%	16.2%	103.7%	195.8%
Nevada	9,361	6.3%	13.5%	109.5%	116.7%

	Number of children on SSI	SSI-child poverty ratio	TANF-child poverty ratio	SNAP-child poverty ratio	Medicaid/CHIP-child poverty ratio
New Hampshire	2,613	9.7%	38.3%	177.8%	319.4%
New Jersey	26,416	7.9%	16.3%	121.6%	229.4%
New Mexico	9,587	6.1%	17.6%	128.0%	208.0%
New York	89,587	9.4%	29.9%	128.1%	191.3%
North Carolina	43,925	7.8%	5.8%	131.1%	185.6%
North Dakota	1,045	5.5%	15.0%	126.3%	169.6%
Ohio	51,452	8.7%	18.8%	126.9%	182.2%
Oklahoma	18,190	8.2%	6.5%	121.1%	207.7%
Oregon	10,739	5.9%	41.4%	158.2%	174.4%
Pennsylvania	76,328	14.8%	24.9%	133.3%	188.0%
Rhode Island	4,759	10.6%	22.3%	135.6%	226.1%
South Carolina	20,707	7.1%	7.7%	132.2%	175.5%
South Dakota	2,551	6.7%	14.6%	126.3%	222.0%
Tennessee	25,392	6.5%	23.6%	140.5%	184.7%
Texas	147,019	8.4%	4.6%	127.9%	151.2%
Utah	5,602	4.3%	6.1%	99.2%	147.8%
Vermont	1,729	9.1%	32.2%	173.7%	306.1%
Virginia	23,876	8.3%	17.3%	141.3%	224.0%
Washington	18,297	6.2%	25.2%	144.1%	240.4%
West Virginia	8,387	8.4%	14.5%	129.0%	188.5%
Wisconsin	22,755	9.6%	19.8%	151.1%	200.8%
Wyoming	1,059	5.9%	3.9%	100.0%	244.5%

Sources: Social Security Administration (1999 and 2014); U.S. Census Bureau (1998 and 2013); Department of Health and Human Services (1999); Administration for Children & Families (2014); U.S. Department of Agriculture, Food and Nutrition Service (1999 and 2014); Centers for Medicare & Medicaid Services (2014).

Note: Poverty ratios in each program are calculated as program participants divided by number of children living in poverty(below 100 percent of federal poverty level).

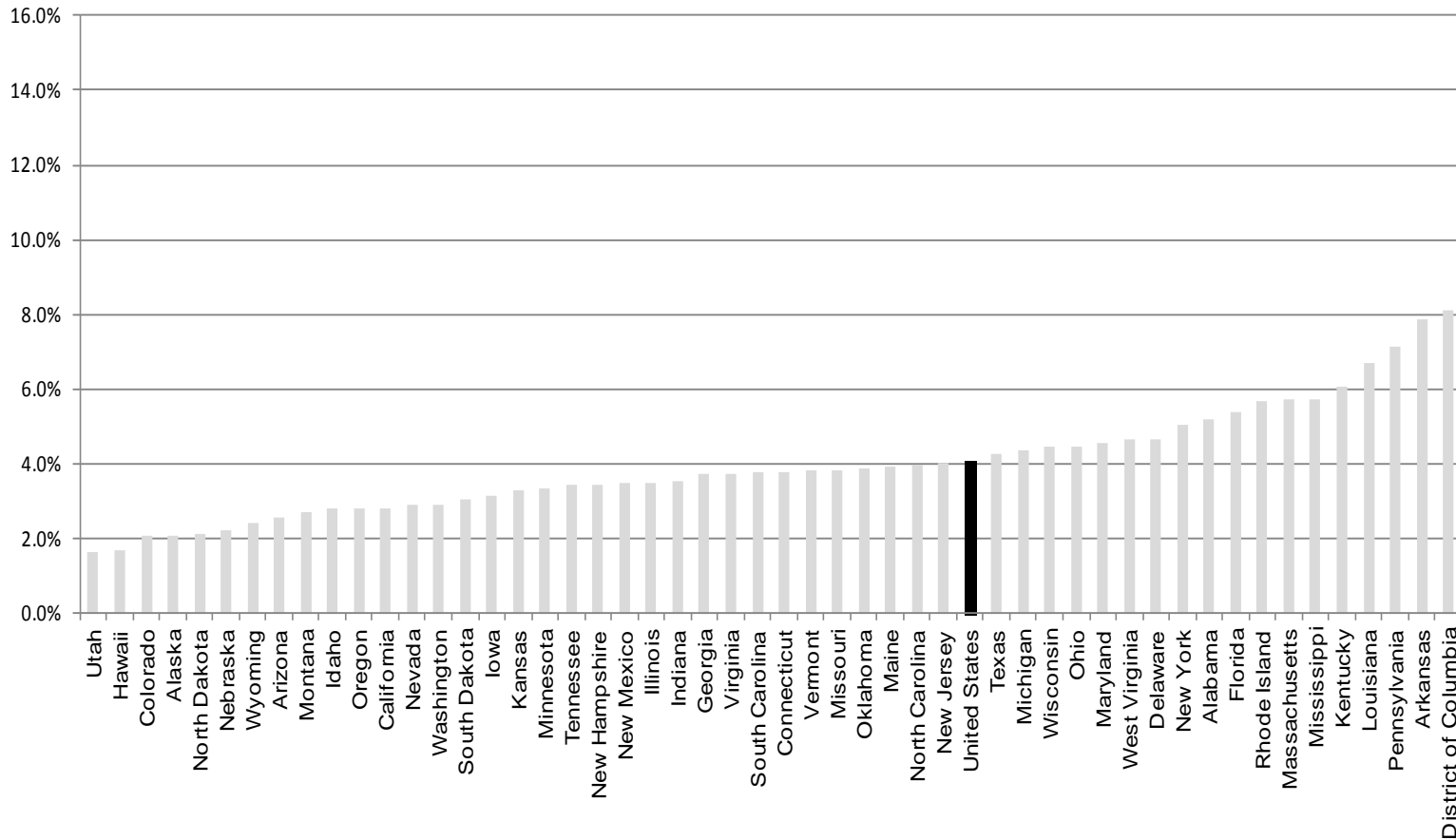
Appendix Exhibit B.1. SSI-child population ratios by state, 2013



Sources: Social Security Administration (2014); U.S. Census Bureau (2013).

Note: SSI-child population ratio is calculated as child SSI recipients divided by number of children.

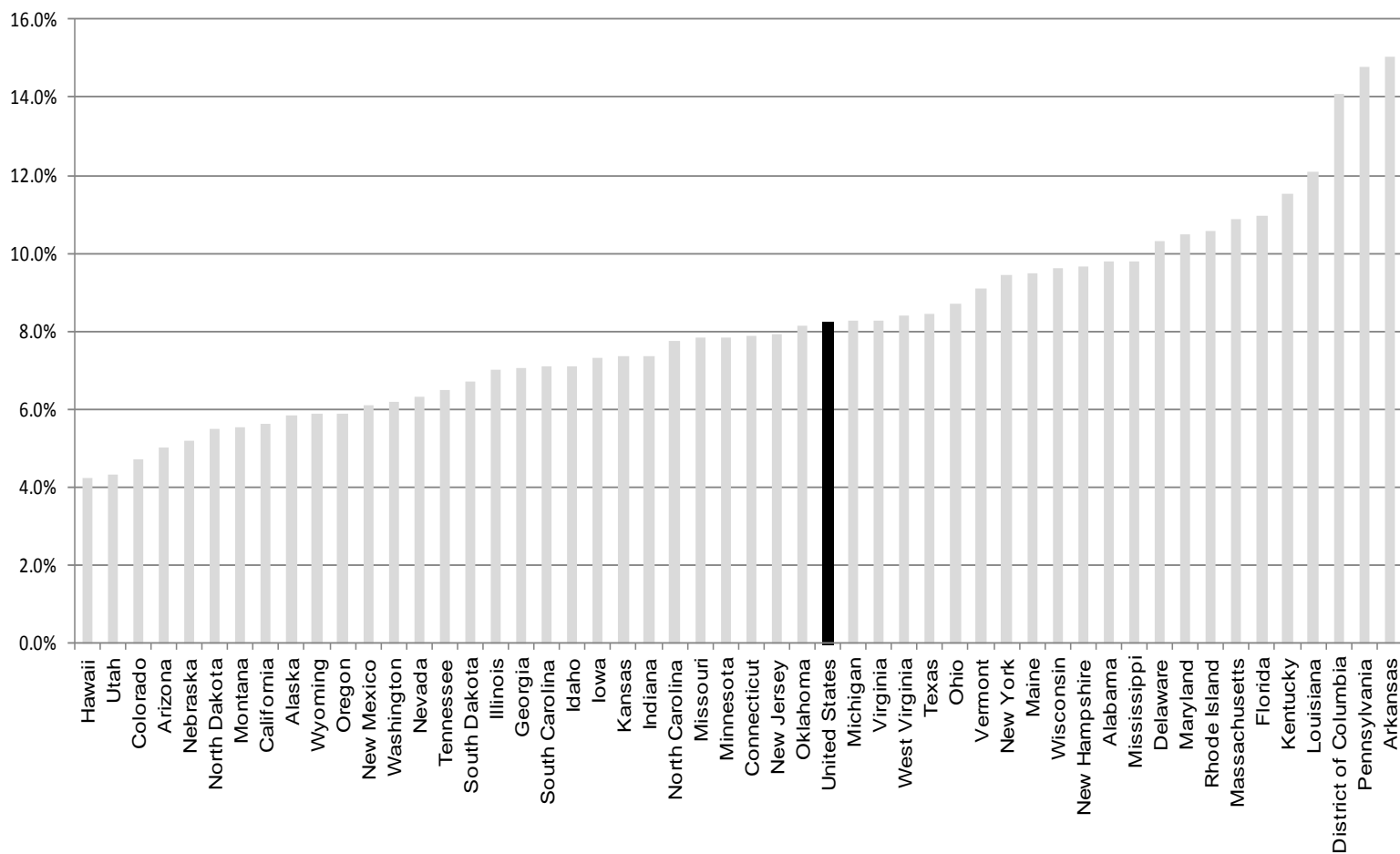
Appendix Exhibit B.2. SSI-child low-income (below 200% of federal poverty level) ratios by state, 2013



Sources: Social Security Administration (2014); U.S. Census Bureau (2013).

Notes: SSI-child low-income population ratio is calculated as number of child SSI recipients divided by number of children living in low-income households (below 200 percent of federal poverty level).

Appendix Exhibit B.3. SSI-child poverty (below 100% of federal poverty level) population ratios by state, 2013



Sources: Social Security Administration (2014), U.S. Census Bureau (2013).

Note: SSI-child poverty population ratio is calculated as number of child SSI recipients divided by number of children in poverty (below 100 percent of federal poverty level).

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