

# Supplemental Security Income Benefits for Mental Disorders

James M. Perrin, MD,<sup>a,b</sup> Amy Houtrow, MD, PhD, MPH,<sup>c,d</sup> Kelly Kelleher, MD, MPH,<sup>e,f</sup> Kimberly Hoagwood, PhD,<sup>g</sup> Ruth E.K. Stein, MD,<sup>h,i</sup> Bonnie Zima, MD, MPH<sup>j,k</sup>

The Supplemental Security Income Program (SSI) provides financial support to low-income households with children and youth with severe disabilities. The program included children when it began in the early 1970s. The numbers of children receiving SSI benefits increased substantially in the early 1990s, in part through an expansion of the listings of mental health conditions with which children could become eligible. Over the past 20 years, larger numbers of children have received SSI benefits for mental disorders, and these increases have led to questions from the press and Congress regarding these numbers. Do they indicate more of an increase in mental disorders among SSI children than in the general population? The National Academy of Medicine (NAM; formerly the Institute of Medicine) convened a study panel to examine what is known about mental disorders among the child SSI population and how that compares with evidence about mental disorders in children in general. The NAM report provides detailed information about how SSI works, about the changing numbers of children receiving SSI for mental disorders, and some comparisons with other evidence about rising rates of mental disorders in the general population and especially among children living in poverty. The report indicates that increasing numbers of children with mental disorders in SSI mirror similar increases in the population in general. This article summarizes key evidence from the NAM report and suggests the implications for pediatricians.

The Supplemental Security Income (SSI) program provides cash assistance to people with moderate to severe disabilities. An important and underrecognized federal program for low-income families of children with physical, mental, and developmental disabilities, SSI provides substantial financial support for households raising children with disabilities, up to about \$6500 per year on a sliding scale based on income. Families of children with disability face higher costs with lower income. Public or private insurance does not cover many of the major costs associated with raising a child with a disability.<sup>1</sup> Furthermore, having a child with a disability decreases workforce participation

by parents.<sup>2</sup> The SSI program helps address these additional family costs and needs, and the income received from SSI can lower poverty rates among children and families. In 2010, including SSI benefits raised family income of 46% of child SSI recipients above the federal poverty line (FPL), and 78% of child recipients were the sole SSI recipient in their households.<sup>3</sup>

## BACKGROUND OF THE SSI PROGRAM FOR CHILDREN

Congress passed the SSI program in 1972 and included children after some debate, after the defeat of President Nixon's welfare reform proposal (ie, the Family Assistance Plan).<sup>4</sup> In

## abstract

<sup>a</sup>MassGeneral Hospital for Children, Boston, Massachusetts; <sup>b</sup>Department of Pediatrics, Harvard Medical School, Boston, Massachusetts; <sup>c</sup>Department of Physical Medicine and Rehabilitation, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania; <sup>d</sup>Children's Hospital of Pittsburgh of UPMC, Pittsburgh, Pennsylvania; <sup>e</sup>Nationwide Children's Hospital, Columbus, Ohio; <sup>f</sup>Department of Pediatrics, The Ohio State University, Columbus, Ohio; <sup>g</sup>Department of Child Psychiatry, New York University School of Medicine, New York, New York; <sup>h</sup>Children's Hospital at Montefiore, Bronx, New York; <sup>i</sup>Albert Einstein College of Medicine, Bronx, New York; and <sup>j</sup>Department of Psychiatry and Biobehavioral Sciences and <sup>k</sup>UCLA–Semel Institute for Neurosciences and Human Behavior; David Geffen School of Medicine at UCLA, Los Angeles, California

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Address correspondence to James M. Perrin, MD, MassGeneral Hospital for Children, 125 Nashua St, #860, Boston, MA 02114. E-mail: jperrin@mgh.harvard.edu

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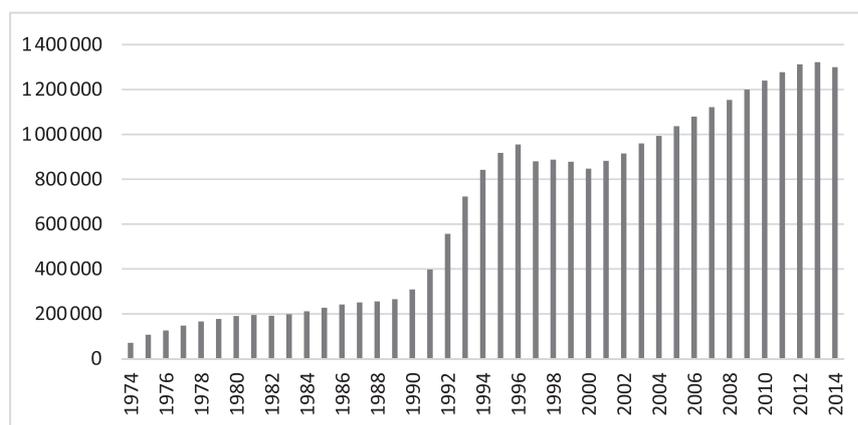
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addition to the child having to meet disability severity requirements, households must also meet financial eligibility requirements. Although households can have incomes up to approximately twice the FPL, 74% of children receiving SSI in 2010 live in households with incomes <150% of the FPL.<sup>3</sup>

Rates of increase in numbers of children receiving SSI benefits were fairly slow for the first 15 to 20 years, rising to ~350 000 by 1990.<sup>5</sup> A few major policy changes affected the children's SSI program at that time. First, the Social Security Administration (SSA) had determined children's disability in ways that differed from those used for adults. Specifically, SSA used a series of "medical listings" (ie, specific medical conditions with metrics of condition severity as an early step in determining disability). For adults who did not meet these listings or level of severity, the determination process then included an assessment of "residual functioning" (ie, a determination of whether the individual with his or her limitations was likely to find employment in the local marketplace). Children, however, received no similar assessment of functioning. A US Supreme Court decision in 1990 (*Sullivan v. Zebley*)<sup>6</sup> addressed this discrepancy and ruled that the SSA must provide a similar assessment of child functioning. Second, in an unrelated move, the SSA revised and updated its medical listings for child mental disorders, adding several new diagnostic categories, including attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD).<sup>7</sup> Finally, partly in response to another court order, the SSA conducted an extensive program from approximately 1989 to 1992 to reach out to eligible children and enroll them.

In response to these policy changes, the SSI program experienced



**FIGURE 1**

Increase in child SSI recipients, 1974 to 2014. Source: SSA Annual Reports: Children receiving SSI; compiled by authors.

substantial increases in numbers of child beneficiaries from 1989 to the mid-1990s, from ~300 000 recipients to >1 million. This increase led to substantial backlash in both the press and the US Congress that resulted in changes in the authorizing legislation in 1996,<sup>8</sup> revising the definition of childhood disability. Although allowing some forms of functional assessment, the new rules resulted in ~100 000 children losing their SSI benefits over the next year.<sup>9</sup> Since the 1996 changes, however, the children's SSI program has had persistent increases in numbers, with the current program including ~1.3 million recipients, ~1.8% of the US child population (Fig 1).

Because more than two-thirds of the increase in recipients since 1996 was among children with disabilities caused by mental disorders, new questions were raised again in the press and with the US Congress, specifically about whether too many children with mental disorders might be entering the SSI program.<sup>10,11</sup> In 2014, the SSA asked the National Academy of Medicine (NAM; formerly the Institute of Medicine) to convene a committee to review the patterns of increase in the SSI program for children with mental disabilities. The committee selected 10 mental disorders for analysis.

The NAM study and report examined the increase in child SSI recipients who qualified as a result of mental disorders and the possible reasons for that increase. It compared the growing numbers of children who qualified on the basis of mental disorders with epidemiologic data from national surveys covering the same time period. The present article summarizes the evidence from that study, describes trends in mental health problems among children, and offers implications for the pediatric community. For context, we then report increased numbers in 3 target conditions (ADHD, ASD, and intellectual disability [ID]) to demonstrate similarities with national trends for specific disorders.

## NAM STUDY AND METHODS

This article draws heavily on the work of the NAM Committee to Evaluate the Supplemental Security Income (SSI) Disability Programs for Children with Mental Disorders and staff whose report was published in September 2015.<sup>12</sup> In the present article, we mainly review data provided by the SSA (much of it in the public domain) indicating diagnoses over the decade 2004–2013 of the following: (1) total enrollees; (2) new applications each year; and (3) allowances and denials for each

year, for all children aged <18 years and for children with any of 10 selected mental disorders (ADHD, oppositional defiant disorder, conduct disorder, ASD, ID [previously categorized as mental retardation], borderline intellectual function, mood disorders, learning disabilities, organic mental disorders, and anxiety-related disorders). These 10 disorders are the highest frequency mental health diagnoses associated with SSI allowances. For an applicant child, a denial indicates that the child's condition did not meet SSI requirements; an allowance indicates that the child met the requirements.

Although speech and language disorders are also frequent among diagnoses listed for child SSI recipients, the SSA chose to have a separate NAM committee review that group of disorders. Data for SSA tables came from unpublished data supplied by the SSA (with the exception of Fig 1, which reflects annual reports from the SSA) and analyzed by the NAM committee. We also present published information from the National Health Interview Survey (NHIS) and the Centers for Disease Control and Prevention (CDC) to compare and contrast increasing numbers of children with specific mental disorders in the SSI program with those in survey data.

### CHILD SSI DISABILITY DETERMINATION AND DIAGNOSTIC PROCESS

It is important to recognize that the SSA uses strategies for determining diagnoses that differ from the methods of most national surveys of health and wellness. After parents apply on behalf of their child, usually providing a tentative diagnosis, SSA develops a case portfolio, based on medical and other records, both to confirm (or change) a diagnosis and to determine whether the condition is severe enough to meet SSA definitions of disability.<sup>13</sup> The child must have a medically

determinable impairment, either mental or physical, that results from "anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques."<sup>14</sup> If the child's condition "meets or equals the listing," they are awarded.<sup>15</sup> If not, there is an additional process of determining if their impairment functionally equals the listings. There are 6 areas of functioning that the SSA uses in this step: (1) acquiring and using information; (2) attending and completing tasks; (3) interacting and relating with others; (4) moving about and manipulating objects; (5) caring for yourself; and (6) health and physical well-being. Eligibility based on functional limitations requires that the child have marked limitations in 2 of the 6 domains or extreme limitations in 1 domain.<sup>16</sup> State Disability Determination Services conduct these evaluations, using national standards, with oversight by the SSA. Adjudicators developing these portfolios do not actually meet with or examine the applicant child. In cases in which enough information cannot be obtained, the SSA may commission an evaluation from a clinical expert to gather more data.

Figure 2 details this complex, labor-intensive process.<sup>12</sup> Especially in the case of children with multiple conditions, it may be easier to make the determination on the basis of 1 disorder than another. Therefore, in this process, the adjudicator may change the listed diagnosis if another exists, when it is easier to determine eligibility for benefits based on the second diagnosis. In this case, the SSA files list the second diagnosis. Thus, for example, an adolescent with the SSA-listed diagnosis of depression may also have substantial disability from other conditions that SSA does not report. For many conditions, especially ones with a wide range of severity such as ADHD, children

may have multiple comorbidities but that information will not necessarily appear in the SSA data files, which are coded based mainly on the qualifying condition.

For comparisons of increases in ADHD rates with the general child population, we used the NHIS, which identifies child and adolescent diagnoses entirely from parent reports that a physician or other health provider had given the child a diagnosis.<sup>17</sup> The NHIS provides no confirmatory evidence of diagnosis, although several studies have indicated similar rates of conditions when obtained by parent report or more in-depth diagnostic methods.<sup>18</sup> We also compared rates of ASD and ID with those reported by the CDC from the Metropolitan Atlanta Developmental Disabilities Surveillance Program.<sup>19</sup> This surveillance system includes several data sources beyond parent report to identify these conditions.

### FINDINGS

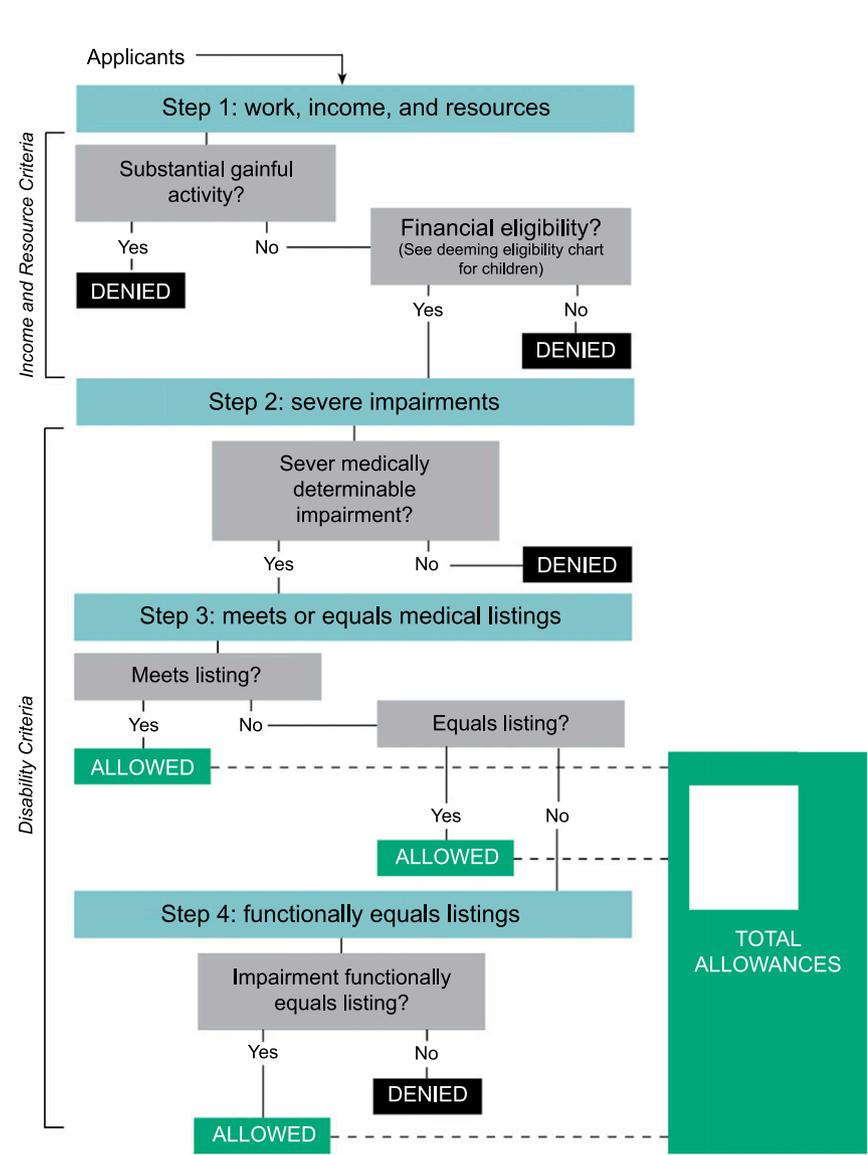
Table 1 provides information on the increase in total child SSI recipients and those who received benefits for the 10 major mental disorders over the years 2004 to 2013.<sup>20,21</sup> Child recipients grew from ~1 million in 2004 to 1.3 million in 2013, a 33% increase. Consequently, the percentage of US child beneficiaries grew from 1.35% of the population to 1.80%. During the same period, the total number of children receiving SSI benefits for mental disorders grew from ~540 000 to ~654 000, an increase of 21% (Table 2). Thus, rates of children who received SSI for disabilities due to mental disorders grew less than rates of total childhood SSI, with the percentage of children with mental disorders dropping from 54% to 46% of children qualifying for SSI benefits.

Rates of determination (ie, children applying for SSI who are either approved or denied SSI benefits) for

**TABLE 1** Increases in Numbers of Child SSI Recipients With Mental Health Conditions From 2004 to 2013

Year	Total No. of Child SSI Recipients	No. of Child SSI Recipients for 10 Major Mental Disorders	Percentage of Child SSI Recipients With the 10 Mental Disorders	US Child Population	Percentage of US Child Population Receiving SSI Benefits
2004	993 127	540 051	54.38	73 297 735	1.35
2005	1 036 498	562 402	54.26	73 523 669	1.41
2006	1 078 977	577 091	53.49	73 757 714	1.46
2007	1 121 017	583 947	52.09	74 019 405	1.51
2008	1 153 844	587 618	47.71	74 104 602	1.56
2009	1 199 788	600 115	46.81	74 134 167	1.62
2010	1 239 269	615 772	45.32	74 119 556	1.67
2011	1 277 122	631 602	45.28	73 902 222	1.73
2012	1 311 861	647 555	46.29	73 708 179	1.78
2013	1 321 681	654 370	46.41	73 585 872	1.80

Sources: SSA, 2014<sup>20</sup>; US Census Bureau, 2014<sup>21</sup>; unpublished data set provided by SSA. Reprinted with permission from *Mental Disorders and Disabilities Among Low-Income Children*. 2015, Excerpted from Table 3-1, by the National Academy of Sciences, Courtesy of the National Academies Press, Washington, DC.



**FIGURE 2** SSA steps in determining childhood disability. (Reprinted with permission from *Mental Disorders and Disabilities Among Low-Income Children*. 2015, Figure 2-1, by the National Academy of Sciences, Courtesy of the National Academies Press, Washington, DC.)

the top 10 major mental disorders remained generally stable over the study decade, with a slight increase in 2010–2012, dropping back in 2013. Over this time, new allowances for mental disorders (children who apply and actually receive benefits) also remained stable, at ~90 000 per year (Table 2).

Nevertheless, this pattern has resulted in a substantial increase in the total number of SSI beneficiaries among children with mental disorders, because many children remain on the SSI rolls for long periods of time. Termination of benefits happens much less frequently than new allowances, in part because SSI has limited resources for reviews of disability status and prioritizes reviews of groups most at risk for changing status: infants at age 1 year and adolescents at age 18 years.<sup>22</sup> Thus, the total number of recipients of SSI for mental disorders rose consistently over the decade (Table 2).

Allowance rates (the percentage of children who applied and were awarded) differ for the various mental disorders associated with disability. For example, nearly all applicant children with ASD or ID will have disabilities severe enough to qualify them for SSI, which is not the case for ADHD or borderline intellectual functioning. ADHD has

**TABLE 2** Numbers of Determinations, Allowances, Percent Allowed, and Recipients for 10 Major Mental Disorders, 2004 to 2013

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Determinations	211 191	210 316	198 857	197 612	203 522	215 813	240 506	256 867	249 152	225 667
Allowances	93 401	90 554	83 707	80 465	85 447	91 739	97 778	98 571	93 132	84 307
% Allowed	44.2	43.1	42.1	40.7	42.0	42.5	40.7	38.4	37.4	37.4
Recipients	540 051	562 402	577 091	583 947	587 618	600 115	615 772	631 602	647 555	654 370

Allowance means that SSA review of the child's condition led to a determination conveying SSI benefits. Analyses from unpublished data from SSA. Reprinted with permission from *Mental Disorders and Disabilities Among Low-Income Children*, 2015, excerpts from Tables E-1, E-3, and E-6, by the National Academy of Sciences, Courtesy of the National Academies Press, Washington, DC.

**TABLE 3** Rates of SSI ADHD Allowances and Recipients, 2004 to 2013

Year	No. of Child SSI Allowances for ADHD	No. of Child SSI Recipients for ADHD	% of Children at <200% FPL Who Receive SSI for ADHD <sup>a</sup>
2004	28 739	138 921	0.48
2005	28 023	155 847	0.55
2006	25 959	169 863	0.59
2007	24 630	180 665	0.62
2008	26 303	189 868	0.63
2009	27 668	199 866	0.63
2010	30 106	211 478	0.66
2011	29 871	220 708	0.68
2012	27 772	225 035	0.70
2013	24 181	226 363	0.72

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<sup>a</sup> Calculated from data from the US Census Bureau, 2015<sup>23</sup>; others, unpublished data provided by the SSA.

lower allowance rates than many other conditions, but the high numbers of children applying with a label of ADHD account for their notable presence on SSI.

#### Condition-specific Example: ADHD

Table 3 provides specific information on changes in ADHD allowances and recipients over the study decade.<sup>23</sup> Although allowances decreased in numbers (from ~29 000 in 2004 to 24 000 in 2013), numbers of recipients who received SSI benefits with a diagnosis of ADHD increased from ~139 000 to ~226 000, an increase of 63%. During this same period, rates of ADHD reported in the NHIS grew by 5% in the childhood population above the FPL but by 55% among children in households with incomes below the FPL (Table 4).<sup>24</sup>

#### Condition-specific Examples: ASD and ID

Figure 3 shows changes in rates of child reciprocity for ASD and ID over the study decade, with substantial increases in ASD mirrored by major decreases in ID. These findings are similar to the CDC Metropolitan Atlanta Developmental Disabilities Surveillance Program reports during the same period (Fig 4).<sup>19</sup>

### DISCUSSION

This study from the NAM examined increases in the SSI child population,

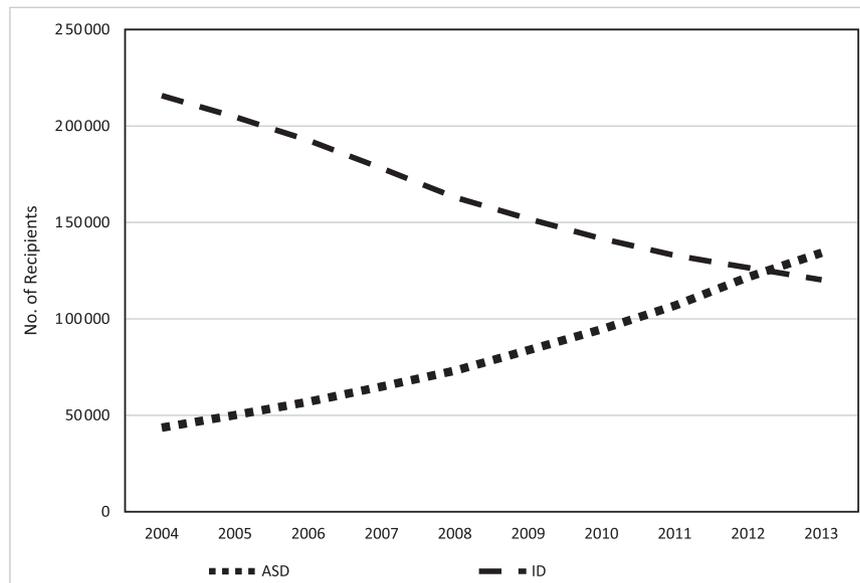
with a focus on children receiving benefits for mental disorders. Although numbers of children receiving SSI for mental disorders increased during the study period (2004–2013), they seem consistent with rates of increase of mental disorders in the general child population, especially those in low-income households. Poverty is a major risk factor for poor health status in childhood.<sup>25</sup> Children who live in poverty have higher rates of chronic health conditions and disabilities.<sup>26–28</sup> The relative peaks in determinations and allowances in 2009–2011 may reflect the higher rates of household poverty with the Great Recession. During this time, nonetheless, rates of new applicants and allowances did not substantially increase, indicating that the number of children receiving benefits continued to grow in large part because the rates of new recipients were not offset by equal rates of termination of benefits through review or aging out at 18 years of age.

When we examined specific, high-volume conditions (ADHD, ASD, and ID), we found that changes in SSI rates mirrored rate changes in other child surveys. Although numbers of child SSI recipients with ADHD increased, those rates reflected reports of rise in ADHD diagnoses among poor children in the United States. Similarly, changes in ASD

**TABLE 4** Estimated Percentage of Children With ADHD According to Poverty Status, NHIS

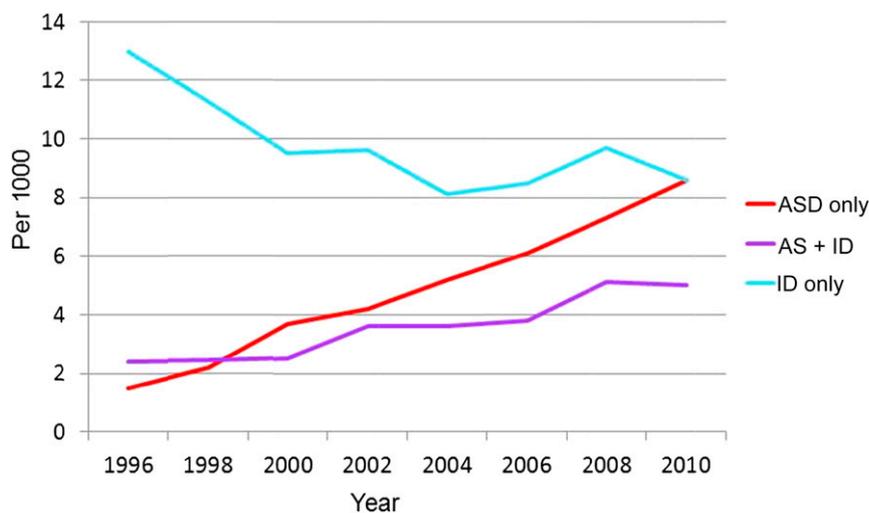
Variable	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Below FPL	7.5	7.9	9.4	9.0	10.1	10.5	10.5	10.4	12.3	11.6
At or above FPL	7.7	6.7	7.7	7.6	8.3	8.2	7.4	8.1	9.2	8.1

Source: Analysis by Child Trends of NHIS data, 1997 to 2013. ADHD. [www.childtrends.org/?indicators=ADHD](http://www.childtrends.org/?indicators=ADHD).<sup>24</sup> Appendix 1, 2014; Used with permission. Reprinted with permission from *Mental Disorders and Disabilities Among Low-Income Children*, 2015, excerpt from Table 12-3, by the National Academy of Sciences, Courtesy of the National Academies Press, Washington, DC.



**FIGURE 3**

Number of SSI recipients for ID and ASD. (Reprinted with permission from *Mental Disorders and Disabilities Among Low-Income Children*, 2015, Table 14-14, by the National Academy of Sciences, Courtesy of the National Academies Press, Washington, DC.)



**FIGURE 4**

CDC estimates of ASD and ID prevalence. Extracted from Braun et al.<sup>19</sup> Trends in the Prevalence of Autism Spectrum Disorder, Cerebral Palsy, Hearing Loss, Intellectual Disability, and Vision Impairment, Metropolitan Atlanta, 1991–2010 Metropolitan Atlanta Developmental Disabilities Surveillance Program. (Reprinted with permission from *Mental Disorders and Disabilities Among Low-Income Children*, 2015, Table 14-9, by the National Academy of Sciences, Courtesy of the National Academies Press, Washington, DC.)

and ID rates were similar to changes found in the CDC’s community studies of the prevalence of these conditions. ID has always been categorized by SSA as a mental disorder. Reported increases in ASD diagnoses in the general population may reflect, in part, children who

would have previously had a diagnosis of ID. The same changes may have affected the relative changes in ASD and ID diagnoses among SSI beneficiaries.

A major caveat for these comparisons, as noted earlier, is that SSA data may not provide accurate

indicators of a child's diagnosis. The SSA examines disability, whatever the cause, whereas the CDC and NHIS work to determine diagnosis, and the presence of a condition does not equate to disability.<sup>29</sup> Furthermore, national surveys have no universally used definition of disability. The SSA requirements for disability are much more strict than typical definitions, requiring the impairments to be severe enough to cause more than a moderate limitation in age-appropriate functioning in at least 2 functional domains, whereas surveys do not require a severity claim when identifying disability. The NAM report strongly recommends that the SSA develop more reliable and valid diagnostic and disability data to allow more accurate description of trends.<sup>12</sup>

Although questions have been raised about the substantial increases in children with mental disorders receiving SSI benefits, specifically questioning whether the increases experienced in SSI are higher than expected, this study documents that

the elevations are consistent with rates of increase in mental disorders in other childhood populations. Given the different methods used by the SSA compared with those used in national surveys, the consistency reinforces the findings from other studies that detection of mental disorders, including neurodevelopmental disabilities, is on the rise among all US children.<sup>27</sup> The rise of mental health diagnoses among receiving SSI benefits also mirrors both the rise in the presence of these conditions among children in general and children in poverty more specifically. Furthermore, these rates are also consistent with rising rates of disability due to mental disorders during the same period.

These data and review article provide important information for pediatricians. First, the increase of numbers of children with mental disorders receiving SSI benefits does not seem higher than expected or higher than in the general population. Second, although families of many children may apply (and in doing

so, ask their pediatricians to share clinical information with the SSA), the large majority of those who apply are denied benefits, especially for conditions with varied severity. Third, the program provides needed financial benefits to many low-income households raising children with severe disability.

#### ABBREVIATIONS

ADHD: attention-deficit/hyperactivity disorder  
ASD: autism spectrum disorder  
CDC: Centers for Disease Control and Prevention  
FPL: federal poverty level  
ID: intellectual disability  
NAM: National Academy of Medicine  
NHIS: National Health Interview Survey  
SSI: Supplemental Security Income  
SSA: Social Security Administration

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