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Explaining Variation in Child SSI Receipt: The Role of Medical CDRs[†]

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While social safety net programs offer critical benefits for those who qualify, the administrative processes that govern the delivery of those benefits have important implications for beneficiaries. Monitoring eligibility helps ensure that only those who qualify continue to receive benefits, but it also can influence beneficiaries' well-being. For example, during the COVID-19 pandemic, Medicaid no longer conducted annual eligibility checks, helping many people to maintain coverage. The subsequent Medicaid unwinding after the pandemic officially ended in 2023 led to 25 million people losing their Medicaid benefits (Tolbert and Corallo 2024), with important implications for people's overall well-being (Bedoya and Sharfstein 2024). Even programs that have a consistent approach to recertify benefits eligibility, like the Supplemental Nutrition Assistance Program (SNAP), nonetheless can ultimately vary in implementation: Those who happen to be scheduled for certification interviews later in the month are less likely to maintain benefits, creating lapses in benefit receipt and ultimately lower long-term receipt of benefits (Homonoff and Somerville 2021).

In this paper, we study the role of medical continuing disability reviews (CDRs) in the trends of children receiving supplemental security income (SSI) payments.[1] These reviews assess whether a child's medical condition has improved and, if so, leads them to have their payments ceased if they also no longer meet the disability criteria required to qualify for SSI. From 2003 to 2021, the frequency with which the Social Security Administration (SSA) conducted these CDRs varied substantially because of shifts in available funding. For example, in 2008, about 0.4 percent of children receiving SSI underwent a medical CDR. In contrast, in 2016, 21.5 percent of children receiving SSI underwent a medical CDR, a difference of roughly 250,000 children. Relatively few children had payments ceased from 2003 to 2013, with only 0.08 percent of child SSI recipients having payments ceased from a CDR in 2008. In contrast, cessations were common from 2014 to 2017 as the SSA processed a large backlog of CDRs, with 4.9 percent of child SSI recipients having payments ceased from a CDR in 2016. In 2018, the agency was fully up to date on its medical CDRs for the first time since 2002.

Building on results from Hemmeter, Levere, and Wittenburg (2024), we first demonstrate that the frequency of these CDRs can explain a substantial share of the overall caseload dynamics during this period. In total, the number of child SSI recipients grew by 22.5 percent from 2006 to 2013, when processing of child SSI CDRs was relatively rare due to shifts in available funding and workloads. The child SSI CDR caseload then shrunk by 21.5 percent as more CDRs were processed from 2013 to 2021. The CDR processing patterns can explain about three-fifths of the program growth and subsequent decline.

We then explore in more depth the regional differences in CDR patterns and subsequent implications for caseload dynamics. Even as a federal program, SSI exhibits substantial regional variation, which has been explored in other contexts (e.g., Levere, Hemmeter, and Wittenburg 2024; Levere, Wittenburg, and Hemmeter 2022). The percent of caseload growth and decline that can be explained by CDRs varied substantially by geography, both when we considered SSA administrative regions

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[1]We explicitly refer to child CDRs that are not age-18 redeterminations or reviews of low-birth-weight children. For these other types of redetermination, the CDR procedure is more standardized and not subject to changes in funding availability.

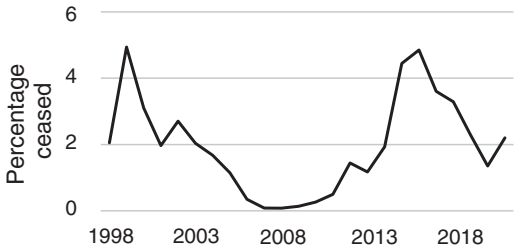

FIGURE 1. CESSATIONS FROM CDRS AS PERCENTAGE OF CHILD SSI RECIPIENTS

and individual states. Understanding regional variations—in the context of a federal program that has a uniform set of rules across the entire country—is critical to ensure equitable access to the program.

I. Context

SSI provides an important source of support for low-income families where a child has a disability. To qualify for SSI, a family must have sufficiently limited income and resources, and a child must have a medically determinable impairment(s) that results in marked and severe functional limitations and that is expected to last at least 12 months or to result in death. For those who qualify, SSI offers a maximum monthly cash payment of $967 in 2025. Nearly all children who qualify also automatically receive Medicaid coverage.

The law requires that the SSA conducts periodic medical CDRs to verify if child SSI recipients still meet the eligibility criteria. The frequency of these CDRs depends on the likelihood of medical improvement. Those whose conditions are expected to improve generally have a CDR scheduled for 6 to 18 months. Those for whom medical improvement is possible typically have a CDR scheduled for three years. Those whose conditions are not expected to improve have a CDR scheduled at 5 to 7 years. In practice, however, many of these CDRs have historically been postponed until the child reaches age 18, when all children must undergo a redetermination of eligibility under the adult rules. If the SSA finds that a child's medical condition has improved to the point that they no longer meet the SSA's definition of disability, and if they have no other qualifying disabilities, then the child's payments are ceased.

In practice, the frequency with which the SSA conducts these CDRs has varied depending on changes in funding and priorities. As a result, there was substantial variation in the frequency of CDR cessations as a percentage of SSI recipients over the past two decades (Figure 1). The notable drop in cessations from 2003 to 2013 exactly corresponds to a period of notable growth in the child SSI caseload. Similarly, the notable increase in cessations from 2014 until the present exactly corresponds to a period of declines in the child SSI caseload. Hemmeter, Levere, and Wittenburg (2024) estimate a predictive model using the difference in CDR cessation patterns over time to attribute the share of the caseload dynamics that can be explained by CDRs. They find that CDR cessations can typically explain three-fifths to two-thirds of the overall changes in the number of children receiving SSI.

Despite these fluctuations, an important result that emerges from Hemmeter, Levere, and Wittenburg (2024) is the persistently higher rates of cessations that occur for children living in socioeconomically deprived areas. Though such children make up a disproportionately large share of the SSI caseload (because of the means test associated with SSI), they make up an even larger share of the number of children ceased each year. These patterns highlight important inequities in whose benefits are ceased that can lead to potentially inequitable patterns in child SSI participation.

II. Data and Approach

Our data and methodology closely follow the main approach described in Hemmeter, Levere, and Wittenburg (2024), though we estimate patterns for states or regions rather than the overall nation. What follows is a brief summary of the data and methodology—for more detail, please see Hemmeter, Levere, and Wittenburg (2024).

We use data on all child SSI recipients available in the SSA administrative records. We identify characteristics of children through the Disability Analysis File, and we use the CDR Waterfall File to identify all children with SSI benefits ceased due to a medical CDR from 2003 to 2021. The main youth characteristics of interest include age, date of first SSI receipt, medical diary category (which reflects the likelihood of medical improvement), and primary diagnosis. We also use the child's address to identify the state—and, in turn, which of the SSA's ten administrative regions—in which they live.

To identify the role that CDRs play in overall caseload dynamics, we estimated a series of policy simulations to explore the hypothetical impacts of applying consistent CDR patterns across the study period. We start with a linear regression to estimate a probability that each child SSI recipient would have their benefits ceased, either under the 2008 CDR (or "low-CDR") regime or 2019 CDR (or "stable-CDR") regime, controlling for youth characteristics. Because we are exploring geographic variation, we also include state fixed effects. The underlying population for this prediction depends on which people would have been receiving benefits at the start of each year—our simulation thus occurs in a year-by-year fashion and accounts for the complex caseload dynamics wherein some people had their benefits ceased, though might not have under a particular CDR regime, or vice versa. The simulations also account for the possibility that those with benefits ceased ultimately return to SSI through another linear regression among those ceased.

The result of our simulation is a counterfactual caseload that estimates how the number of child SSI recipients would have evolved had the CDR regime stayed constant throughout the entire period. To attribute the share of the caseload stemming from CDR patterns, we calculate the difference in the net cessations (cessations minus returns) between the low-CDR regime and the stable-CDR regime. We then benchmark this difference relative to actual caseload changes during the period. For the regional approach, we vary this procedure by calculating the number of cessations and returns (summing probabilities) among those in a particular area (state or the SSA administrative region), rather than calculating these statistics among the entire country. Because reliable address data are only available starting in 2006, our analysis period also starts in 2006, rather than 2003 as it did in Hemmeter, Levere, and Wittenburg (2024). We do not directly control for other issues, such as the local economy, availability of legal support, or other factors that might affect SSI receipt.

III. Results

Variation in the frequency of CDRs has had a large influence in the pattern of child SSI recipient trends over time (Figure 2). The caseload grew by 22.5 percent from 2006 to 2013, a period of relatively rare CDRs. Instead, if the CDR processing frequency had consistently followed the patterns from the 2019 cohort (the stable-CDR regime), we estimate that the caseload would have only grown by 10.0 percent during this period, reaching 1.20 million instead of 1.32 million. The caseload would have been 1.35 million in 2013 if the CDR frequency had consistently followed the patterns from the 2008 cohort (the low-CDR regime). Thus, the net difference in the caseload between the stable- and low-CDR regimes indicates that CDRs can explain about 60 percent of program growth during this time. In other words, the SSA's policy of not conducting all the childhood CDRs that came due during this period resulted in substantially more children receiving benefits than might have otherwise been expected to continue receiving benefits. Conversely, when the SSA received full funding to conduct all childhood CDRs from 2013 to 2021, the increase in CDRs conducted explains 64 percent of the observed decline.[2] If the processing of child SSI CDRs

[2] The SSA attempted to reduce CDR processing in 2020 and 2021 due to COVID-related concerns. However, it still received full funding, and the number of CDRs remained higher than during the years the backlog grew.

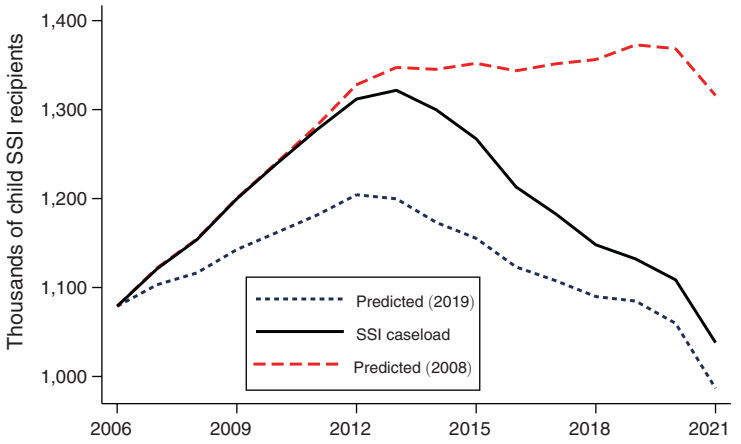

FIGURE 2. POLICY SIMULATIONS FOR SSI CASELOAD OVER TIME UNDER DIFFERENT CDR ASSUMPTIONS

had continued to be relatively rare, the caseload would have been roughly stable, whereas because CDR processing frequencies picked up, the number of child SSI recipients declined substantially.

As a federal program, the changes in CDR patterns might be expected to affect all areas proportionally, yet this is not the case (Table 1). The percent of caseload growth and decline that can be explained by CDRs varied substantially by geography. During the period of caseload growth, CDRs could explain a particularly large share of caseload increases in Atlanta and Chicago, explaining more than 100 percent of the growth. This means that the net difference in CDR cessations between the low- and stable-cessation regimes was larger than the actual growth in the caseload, suggesting that if not for the CDR patterns, the caseload may have declined. CDRs played less of a role in the Seattle, Dallas, and Denver regions.

Looking at the state level, we again find substantial heterogeneity in how much of the caseload patterns CDRs can explain (Figure 3). CDRs can explain more than half of the caseload increase in 25 out of 50 states and Washington, DC, during the period of caseload growth. The share explained is negatively correlated with the rate of caseload change during each period—for example, of the seven states where CDRs can explain the largest share of caseload growth, six had the number of child SSI recipients grow by less than 10 percent (the seventh grew by 10.5 percent). Yet, the low-caseload growth did not stem from processing relatively more CDRs. We calculated the ratio of actual cessations to the prediction based on the 2008 low-CDR regime cohort. These low-growth states had a similar ratio of cessations to the national average—thus, had CDRs actually been more frequent, caseloads may have declined in many of these states.

Patterns are relatively similar during the period of caseload decline, where CDRs can also explain more than half of the caseload decrease in 25 states. A similarly high negative correlation between the rate of caseload change and the share explained by CDRs emerges. States with the largest share explained also tended to see the smallest caseload declines. Yet, the low declines were not because of notably low actual CDRs (relative to the stable-CDR regime prediction).

IV. Discussion

Our analysis reveals that shifts in CDR frequency are a major driver of SSI caseload dynamics, significantly influencing both program growth and decline. However, these changes don't affect all groups evenly. Similar to Medicaid and SNAP, where administrative timing and state implementation lead to uneven access, the SSI program's regional disparities in how big a role CDR patterns play in caseload growth highlights critical equity concerns. Our research cannot say whether these CDRs

Table 1—Changes in Child SSI Caseloads and Share Explained by CDRs, by Region

Region	Caseload increase, 2006–2013 (percent)	Percent of increase explained by CDRs	Caseload decrease, 2013–2021 (percent)	Percent of decrease explained by CDRs
Atlanta	16.3	112.4	−19.4	91.9
Boston	27.1	33.4	−21.6	37.3
Chicago	12.1	106.2	−23.8	51.7
Dallas	50.2	39.4	−21.5	75.5
Denver	29.8	33.2	−20.2	42.4
Kansas City	17.6	52.2	−20.0	43.3
New York	19.1	45.1	−19.6	42.0
Philadelphia	18.4	65.7	−24.1	44.5
San Francisco	21.2	66.7	−23.1	54.2
Seattle	26.1	31.5	−18.3	41.7

Note: Region corresponds to the ten SSA administrative regions.

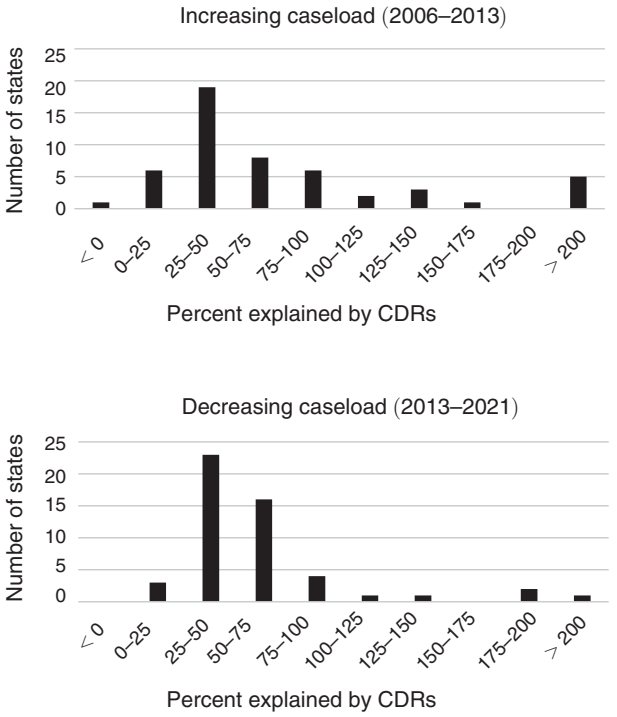

Figure 3. Changes in Child SSI Caseloads and Share Explained by CDRs, by State

accurately assess whether a child continues to meet the medical criteria, only that they are an inherent part of the program that can explain much of the changes in SSI caseloads.

There are also efficiency considerations in terms of program spending. A back-of-the-envelope estimate of the first order financial impact of the CDR patterns suggests that if CDRs had stayed stable from 2006 to 2013, roughly 137,004 more cases would have been ceased, reducing benefits by $1.35 billion in total during this period (2.0 percent of the $69.1 billion in total SSI payments to children). Conversely, from 2013 to 2021, if CDRs had not increased, the SSA would have paid a total of

$2.44 billion more (3.2 percent of total SSI payments) to SSI recipients who may not have otherwise received them.[3] The implications for family well-being and program costs, and any lasting effects of these administrative actions, are important considerations for all safety net programs.

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[3] To arrive at these estimates, we compared the actual net contribution from CDRs (cessations minus returns) from 2006 to 2013 to the predicted net contribution had patterns followed those of the 2019 stable-cessation regime. We then multiply by the average monthly SSI payment received in each year (scaled to 2023 dollars). For the period from 2013 to 2021, we compared the actual net contribution from CDRs to the predicted net contribution had patterns followed the 2008 low-cessation regime, and multiplied by the actual average monthly SSI payment.