Potential Savings From Redetermining Disability Among Children Receiving Supplemental Security Income Benefits

Published in final edited form as:
Acad Pediatr. 2012 November ; 12(6): 489–494. doi:10.1016/j.acap.2012.07.001.

Potential Savings from Redetermining Disability among Children Receiving Supplemental Security Income Benefits

Christian D. Pulcini, MEd, MPH, **Milton Kotelchuck, PhD, MPH**, **Karen Kuhlthau, PhD**, **Alixandra A. Nozzolillo, MS**, and **James M. Perrin, M.D.**
Tufts University School of Medicine (C.P.) and the MassGeneral Hospital for Children, Department of Pediatrics, Harvard Medical School, and MGH Center for Child and Adolescent Health Research and Policy (M.K., K.K., A.N., J.P.), Boston, MA

Christian D. Pulcini: cpulcini@partners.org; Milton Kotelchuck: mkotelchuck@partners.org; Karen Kuhlthau: kkuhlthau@partners.org; Alixandra A. Nozzolillo: aanozzolillo@partners.org; James M. Perrin: jperrin@partners.org

Abstract

Objective—To compare costs of redetermining disability to direct savings in SSI payments associated with different strategies for implementing Continuing Disability Reviews (CDRs) among children potentially enrolled in SSI from 2012–2021.

Methods—We reviewed publicly available reports from the Social Security Administration (SSA) and Government Accountability Office (GAO) to estimate costs and savings. We considered CDRs for children ages 1–17 years, excluding mandated Low-Birth Weight and Age 18 Redeterminations that SSA has routinely carried out.

Results—If SSA in 2012 performs the same number of CDRs for children as in 2010 (16,677, 1% of eligibles) at a cessation rate of 15%, the agency would experience net savings of approximately $145 million in benefit payments. If CDR numbers increased to the highest level ever (183,211, 22% of eligibles, in 1999) at the same cessation rate, the agency would save approximately $1.6 billion in benefit payments.

Discussion—Increasing the numbers of CDRs for children represents a considerable opportunity for savings. Recognizing the dynamic nature of disability, the agency could reassess persistence of disability systematically. Doing so could free up resources from children who are no longer eligible and help the agency better direct its benefits to recipients with ongoing disability and whose families need support to meet the extra costs associated with raising a child with a major disability.

Keywords

SSI; children; disability; costs; savings

Address correspondence to: James M. Perrin, MD, Division of General Pediatrics, 100 Cambridge Street, Room 1542, Boston, MA 02114, Phone: (617) 726-8716; fax (617)726-1886, jperrin@partners.org.

The authors report no conflicts of interest.

INTRODUCTION

The Supplemental Security Income (SSI) program, established under Title XVI of the Social Security Act, provides benefits to financially needy individuals who are aged, blind, or disabled.[1] Congressional action in the early 1970s included children with disabilities (0–17 years of age) in SSI to provide benefits to address the extra expenses of low income families who care for children with a variety of special healthcare needs.[2] For children, a disability is a medically determinable physical or mental impairment that results in certain functional limitations, and is expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months.[3]

In 2009, almost 1.2 million children and adolescents received SSI benefits, and child health professionals provided much information in support of their patients' disability applications. The main categories of health conditions or disorders for which children received benefits were "other mental health conditions" (53.2%), mental retardation (12.7%), and all others (34.1%, mostly diseases of various body systems). The average monthly cash benefit for this population in 2009 was $593 (maximum $674) for a total SSI benefit expenditure of approximately $9 billion.[4] Almost all children receiving SSI also receive Medicaid, and estimates of associated yearly Medicaid costs for this population are $5.8 billion.[5] Table 1 presents the number of childhood SSI beneficiaries from 1983–2009.[4,6,7] Growth in this population has been described in other publications, and mainly reflects rule changes in defining children's mental health conditions in 1990; a Supreme Court decision (also in 1990) requiring more systematic assessment of functioning and disability in childhood applicants; child poverty increases; and a general rise in serious chronic health conditions among children and adolescents in general.[8]

Recently, with intense scrutiny of federal benefit programs and growing concern over waste in the US health care system,[9] the children's SSI program has drawn attention. Lawmakers and others are specifically concerned with the process of eligibility determination for benefits, reevaluation for continuing eligibility, and the incentives families experience to prove a disability exists. Although the program and its attention in the political arena have a long history dating back to the 1970s, a series of Boston Globe articles in late 2010[10] renewed attention to these issues, leading to Congressional hearings and a Government Accountability Office (GAO) investigation, which released its report in late June 2012.[11]

Because large numbers of children remain on program rolls for many years without re-evaluation of their disability, a key concern with the children's SSI program is the manner and frequency with which the agency re-evaluates children to determine whether benefits should continue. Recent work has documented the dynamics of disability among children, indicating both that increasing numbers of children and youth have disability, and that many also appear to have less disability when followed over a period of six years.[8] Children with asthma may experience a decrease in symptoms with age; some children who are obese at younger ages may no longer be overweight as they mature; children with ADHD may have less severe symptoms over time. We assume these also affect the SSI population. The Social Security Administration (SSA) refers to these re-evaluations as Continuing Disability Reviews (CDRs) (to review medical eligibility) and Redeterminations (to review income, resources, and living arrangements), and a host of laws and regulations govern how and when these are conducted for both the adult and child populations.[1,12]

Despite legislative and regulatory requirements for CDRs and redeterminations for children and adults, budget constraints have limited the ability of SSA to complete them. Recent budget limitations have particularly led SSA to focus almost entirely on evaluation of initial applications. As a result, SSA had developed an estimated 1.5 million CDR backlog by the

conclusion of FY 2010, which will lead to an estimated $556 million – $1.1 billion dollars of paid benefits yearly to beneficiaries who might no longer qualify for the program in 2011 or later.[13] The backlog estimate includes both adult and child populations, and the amount of benefits wrongly paid reflects the predicted number of beneficiaries likely determined ineligible if the 1.5 million CDRs are conducted.

Previous efforts to evaluate the cost-savings of performing CDRs focused on the timeliness of reviews and a prior backlog of CDRs (which was subsequently addressed with congressional funding in FY1996).[13] To our knowledge, no studies have examined different levels and rates of benefits of CDRs and their potential costs and savings for the children's SSI program.

The purpose of this study is to determine potential costs and savings arising from performing CDRs at various levels of beneficiaries assessed and rates of benefit cessation. We applied this approach to develop estimates for children potentially enrolled in SSI from 2012–2021.

METHODS

Data Sources

The data sources for the costs and savings analysis include publicly available reports published by the Social Security Administration (SSA). Specifically, we used the SSA Annual Report for 2011[4] to estimate the number of child participants predicted to be on SSI from 2012–2035, as well as to project benefit increases. Prior SSI Annual Reports were also used to identify the actual beneficiaries from 1998 to the present and the number of cessations from redeterminations.[6,7] With data from these documents, we established the following study parameters:

Subjects

SSA distinguishes three groups of child and adolescent recipients with respect to regularity of ongoing performance of CDRs - those receiving benefits for very low birthweight with a mandated re-evaluation at age 1 year, those turning age 18 and required for review by the adult rules for determining disability, and all others. The subjects included in this analysis include only those children outside the mandatory low-birth weight CDRs and age 18 redeterminations, insofar as SSA regularly assesses these two groups. SSA refers to this additional group of children as "other children," meaning children ages one year to their 17th birthday who are eligible for a CDR outside of the mandatory CDRs. For this analysis, we refer to this group as "children ages 1–17 years."

We initially examined the cohort of children receiving benefits in 2012 and then determined potential savings for nine additional yearly cohorts.

Study Variables

Costs of CDRs—We determined the costs of carrying out CDRs using two different estimates of redetermination rates. Table 1 shows the number of CDRs performed each year for children ages 1–17 years from 1998–2010. For our analyses, we chose 1) the number of CDRs SSA performed in 2010 (16,677) and 2) the highest number SSA has performed in any one year from 1995–2010 (183,211 in 1999). The 16,677 CDRs for children ages 1–17 in 2010 represented approximately 1% of the total SSI recipients ages 1–17 years. The 183,211 reviews in 1999 represented 22% of total children in 1999 ages 1–17.

We used SSA estimates of individual CDR costs to determine total costs for these two cohorts. Prior estimates of CDR costs are based on the adult and child population together (with no child-specific figures available). In 1994, SSA estimated that the cost of performing each full medical CDR after all appeals was $1230.[14] With the increased use of mailers and other methods to prescreen for needed CDRs, SSA changed the estimate in 2010 to $1000.[13] In 2009, SSA reported that total costs for performing its 1,101,983 million CDRs was $371 million,[15] or only approximately $336 per CDR. SSA does not however currently prescreen children for continuing disability,[16] so we chose the 2010 cost estimate of performing CDRs and multiplied the total number of CDRs by $1000.

Rates of discontinuing benefits—To establish the number of beneficiaries potentially discontinued as a result of a CDR, we used SSA data describing historical cessation rates after all appeals. From 1996–2002, despite varying rates of CDRs, the cessation percentages remained fairly stable, between 15% and 20% (Table 1). Based on the historical data, we chose three different potential cessation rates (10%, 15%, and 20%) to estimate benefits savings. Historically, 10% is a lower cessation rate than the children's SSI program has experienced, 15% is the lowest cessation rate from 1996–2002, and 20% is a typical cessation rate.

Benefit savings—To determine savings in benefits provided, we used SSA projected percentage benefit increases for years 2012–2035 to calculate the monthly benefits for children in a given year. We then used these figures to calculate decreased benefit payments that would potentially be saved if CDRs are performed.[4] To estimate benefit increases for 2036–2037, we estimated the benefit would increase by 2.8%, projecting from the SSA published estimated annual benefit percentage increase from 2020–2035.

We carried out two adjustments for yearly savings from foregone benefits. First, to calculate program savings in the first year, we adjusted the savings to reflect the different dates cessation would occur. Because SSA does not publish data on CDR timing within a calendar year, we assumed that benefits are on average ceased mid-year on July 1st. Therefore, we assumed that first year savings include only ½ of the yearly SSI payments.

Second we limited the analysis to children ages 1–17 with no estimates of savings past a child's 18th birthday and determined when they would reach age 18, based on current age distributions. For example, 2 year old children in 2012 would reach age 18 in 2028; 10 year old children in 2012 would be 18 in 2020. This process decreases the number of children in the cohort each year by the number of children who age out.

We estimated program savings both annually and as savings for each cohort through childhood (to age 18). We provide estimates for all ten cohorts. The formula used to determine annual savings is: Annual benefits saved in one year = (average monthly benefit) × (12 months) × (number of beneficiaries ceased in that year). As noted, an adjustment to the formula is made for the first year calculation. To determine total childhood savings for the cohort, we used the following: Childhood Savings = (Average monthly benefit) × (12 months) × (Estimated years before age 18) × (number of beneficiaries ceased). This amount reflects the total cumulative amount of benefit savings over succeeding years for a cohort redetermined in a single year and accounts for diminishing numbers in each year (i.e., excluding those aging out).

Analysis

For our main results, we calculated the projected costs and savings for each childhood cohort from 2012–2021 by subtracting the total cost of conducting CDRs in year 1 from the childhood benefit at the specified number of CDRs and cessation rates. By examining

different potential CDR and cessation rates, the analysis provides some determination of the bounds of changing benefit costs.

RESULTS

Table 1 indicates the growth in beneficiaries (0–18 yrs.) from <900,000 to >1.2 million from 1995–2010, as well as rates of CDRs performed (1–17 yrs.) from <5,000 to >180,000.

If SSA carries out the lower number of CDRs (16,667) for children in 2012, with an estimate of 15% determined ineligible, the one-time cost of performing the CDRs in the first year is approximately $16.7 million, with savings of $9 million, resulting in a first year cost of $7.7 million (Table 2). Over time, accounting for the savings in SSI cash benefits each year, the potential savings over the childhood of this cohort is approximately $143 million. Thus savings after costs of performing CDRs are only realized after the first year.

If SSA performs CDRs at a much higher rate (183,211 as in 1999), the agency will experience a net cost in the first year of $84.7 million and a savings over the cohort's childhood of $1.6 billion dollars (Table 3).

Table 4 provides an estimate of the childhood cohort costs and savings at the two levels of CDRs (16,677, 183,211) and three different cessation rates (10%, 15%, 20%), from 2012–2021. Table 4 includes all 10 cohorts (2012, 2013, 2014, etc.) calculated in the same manner as Table 2 and Table 3. Regardless of the cessation rate, the amount of money saved in SSI payments increases as the number of CDRs increases. If SSA continues to perform the same number of CDRs as in 2010 (16,677), savings from benefit discontinuation range from approximately $90–$252 million per cohort from 2012–2021. With higher rates of CDRs, SSA would experience a range of approximately $981 million–$3.6 billion childhood savings in SSI payments per cohort from 2012–2021.

DISCUSSION

Overall, estimates of benefit savings from performing full medical CDRs for a single cohort of children range from $90 million – $3.6 billion dollars from 2012–2021, based on different numbers of redeterminations and likely cessation rates. Our analysis is the first to specifically examine children's CDRs, and it reveals potentially significant financial benefits to the program. Other analyses completed by GAO and SSA concentrated on backlogs of CDRs and timeliness of reviews and were largely influenced by the adult SSI population.[4,17] In a 2006 Report to Congress, SSA estimated a savings of $10 for every $1 spent on full medical CDRs.[17] This figure includes the adult population and takes into account other associated benefit savings such as Medicare/Medicaid. Based on the analysis presented, for children only, we calculate a savings of $8.57 for every $1.00 spent on CDRs at the current number of CDRs and a 15% cessation rate. This figure would increase if the cessation rate and number of CDRs increased ($15.41 for every $1 at 20% cessation rate, 183,211 CDRs), and decrease if the cessation figure decreased ($5.40 for every $1 at 10% cessation rate, 16,677 CDRs). A 2003 GAO report identified significant potential savings through redeterminations, including 10 year savings of $2–5 billion for CDRs performed from 1996–2001 (when SSA had funds earmarked for CDRs to eliminate a previous backlog). The report concentrated on the backlog of CDRs and included the adult population.[18] Our study, unlike past studies, evaluates potential SSI payment savings through future CDRs and concentrates solely on the child SSI population.

This SSI administrative policy issue directly impacts pediatricians, children, and families. Increasing the number of CDRs will raise demands for clinical reports and could put pediatricians in the difficult position of submitting a report that shows clinical improvement

and excludes a child from SSI benefits despite household financial need. For children and families, increased CDRs could place new documentation burdens on low-income families with limited resources caring for a child with a disability. Filling out the clinical reports may strain the physician-patient relationship, but it could also offer an opportunity to review the child's condition in detail.

This current econometric analysis has several limitations. Some assumptions underlying our methods are based reflect SSA estimates based on the adult SSI population (who make up a much larger proportion of the total SSI population), although most come from child data. The complexity of children's health conditions often makes definitive diagnosis difficult. Thus, gathering needed data for CDRs for children may cost more than $1000 after all appeals. Using CDR mailers for initial screening has been proposed as a method to lower CDR costs for children,[16] as mailers have significantly reduced the cost of adult CDRs. SSA provides little evidence to support their estimate of $1000 per CDR. The costs described in this paper would of course vary substantially if the true cost of CDRs is much higher or lower.

Determining likely rates of cessation similarly requires several assumptions, given the limited information on co-morbidities among children on SSI. Only 34% of those children with "other mental disorders" at age 18 CDR had the same diagnosis after successful appeal or reapplication to the adult SSI program, suggesting that many beneficiaries have co-existing conditions not well-described in main SSA databases.[19] Our highest savings estimate may overstate potential savings.

Where SSA and GAO analyses of CDR effects for adults include savings beyond the cash benefit, we did not include any savings to Medicaid because current Medicaid rules would allow most children currently on SSI to qualify for Medicaid or the Children's Health Insurance Program regardless of their SSI status.

Timeliness studies published by the SSA Inspector General found that only 54% of CDRs were completed in a timely manner (completion within 1 year of initiation).[17] Our estimate assumed that the CDRs would be performed and beneficiaries would be ceased at a consistent rate throughout a calendar year. If the reviews are conducted in a less timely fashion, then the analysis overestimates the yearly savings associated with carrying out CDRs in the first year. Our estimates also do not account for children deemed ineligible at one point but who may return to the program later. This would potentially overstate savings.

The most recent backlog is not the first significant CDR backlog SSA has accrued. At the conclusion of FY 1996, SSA accumulated a 4.3 million CDR backlog (including adult and child populations). Congress authorized approximately $4 billion to eliminate that backlog within 7 years (1996–2002).[17] With this funding, SSA conducted an estimated 9.4 million CDRs within 7 years and became current with its workload.[4] Without continued supplemental funding for CDRs, 2004–2008 saw a 65% decrease in performing CDRs.[13]

The fact that cessation rates as a result of CDRs for children ages 1–17 are typically 15–20% indicates that 80–85% of children and families maintain benefits, presumably because of continuing eligibility after redetermination. Thus, even with substantial increases in CDRs, most current child beneficiaries would continue in the program and need benefits to care appropriately for their child with disability. Families of children with special healthcare needs experience severe financial burdens,[20] and any reductions in their support from SSI could adversely affect these children and their families.

Considering the dynamic nature of children's disability,[8] it seems prudent, both for providing benefits appropriately and for SSI program integrity to reassess the changes in the

status of children's disabilities consistently and equitably. The costs and savings analysis conducted here suggests an opportunity for the SSA to make positive changes within the children's SSI program. SSA could save up to $3.6 billion in childhood SSI payments for each year of increased CDRs for children ages 1–17. The program currently spends approximately $9 billion annually on direct SSI benefits for children.[4]

This analysis was not undertaken to advocate that low-income families should lose benefits, but rather to address recent concerns about the integrity of the SSI program along with the acknowledgement of waste in the US healthcare system.[9] Although typically Federal program savings do not return to the program or beneficiaries, one could advocate that savings in this case be used to strengthen SSA administration of the children's SSI program and to coordinate better with other public programs to improve support for families and outcomes for children with disabilities, especially the federal Maternal and Child Health programs.

This work uses many assumptions. Future research that might enhance the quality of these analyses could include more reliable data on CDR costs, better information regarding the disability and co-morbid conditions among children and youth receiving SSI, and better estimates of likely cessation rates (by age).

CDRs represent an avenue for savings that is in need of congressional support. Increased CDRs could help to assure fair distribution of SSI benefits from the viewpoint of beneficiaries, taxpayers, and pediatricians, and the savings accumulated as a result of the increased CDRs could be used to help improve other areas of the program including improving the CDR process, increasing the number of reviews performed in a timely manner, and strengthening the use of other federal programs to support the growth and development of children with disabilities (esp., the federal Maternal and Child Health programs). Dealing in a fair and consistent way with disability among children and youth can also help strengthen public perceptions of the value of SSI for children and its consistent association with determined need for assistance.

Acknowledgments

Preparation of this work was supported by a grant to the American Pediatric Society/Society for Pediatric Research (grant T35 HD 7446). This work is solely the responsibility of the authors and does not represent the official views of the American Pediatric Society/Society for Pediatric Research. Funders had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; and preparation, review or approval of the manuscript. Mr. Christian Pulcini had full access to all of the data in the study, and he takes responsibility for the integrity of the data and the accuracy of the data analysis.

Abbreviations

SSI	Supplemental Security Income
SSA	Social Security Administration
CDRs	Continuing Disability Reviews
DDS	Disability Determination Service
GAO	Government Accountability Office

References

1. [Accessed July 12th, 2011] The Social Security Act § 1601 et. Seq., 42 U.S.C. § 1381 et. Seq. Compilation of the Social Security Laws Web site. http://www.ssa.gov/OP_Home/ssact/title16b/1601.htm

2. Social Security Administration. Public Law 92-603. Social Security Administration; SSI: History of Provisions. Web site. http://www.ssa.gov/history/pdf/ssi.pdf
3. Social Security Administration. [Accessed March 6th, 2012] Disability Evaluation Under Social Security (Blue Book- September 2008). http://www.ssa.gov/disability/professionals/bluebook/general-info.htm
4. Social Security Administration. [Accessed July 2nd, 2011] Annual Report of the Supplemental Security Income Program. 2011. http://www.ssa.gov/oact/ssir/SSI11/ssi2011.pdf
5. Kenney GM, Ruhter J, Selden TM. Containing costs and improving care for children in Medicaid and CHIP. Health Affairs (Millwood). 2009; 28(6):w1025–36.10.1377/hlthaff.28.6.w1025
6. Social Security Administration. [Accessed July 6th, 2011] Annual Statistical Report of the Supplemental Security Income Program. 2001. http://www.ssa.gov/policy/docs/statcomps/di_asr/2001/di_asr01.pdf
7. Social Security Administration. [Accessed July 6th, 2011] Annual Statistical Report of the Supplemental Security Income Program. 2006. http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2006/ssi_asr06.pdf
8. Van Cleave J, Gortmaker SL, Perrin JM. Dynamics of obesity and chronic health conditions among children and youth. JAMA. 2010; 303(7):623–630.10.1001/jama.2010.104 [PubMed: 20159870]
9. Berwick DM, Hackbarth AD. Eliminating waste in US health care. JAMA. 2012; 307(14):1513–1516.10.1001/jama.2012.362 [PubMed: 22419800]
10. Wen, P. [Accessed August 14th, 2011] A Legacy of Unintended Side Effects. Boston Globe. Dec 12th. 2010 Available from: http://articles.boston.com/2010-12-12/news/29327138_1_ssi-supplemental-security-income-federal-disability-program
11. U. S. Government Accountability Office. Supplemental Security Income: Better management oversight needed for Children's benefits GAO-12-497. Washington, DC: General Accounting Office; Jun. 2012 Report to Congressional Requesters.
12. Sheldon, JR. Medical continuing disability reviews and related concepts: A discussion of medical CDRs and then Age 18 Redetermination. Ithaca, NY: Cornell University; Jul. 2003 Available from: http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1046&context=edicollect
13. Office of the Inspector General, Social Security Administration. [Accessed July 14th, 2011] Full Medical Continuing Disability Reviews. 2010. A-07-09-29147. http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-07-09-29147_7.pdf
14. United States General Accounting Office. Testimony Before the Subcommittee on Social Security Committee on Ways and Means. House of Representatives; 1994. Statement of Jane L. Ross. Continuing Disability Reviews Improved, But More Targeted Reviews Needed. http://www.gao.gov/new.items/d03662.pdf
15. Social Security Administration. [Accessed July 12th, 2011] Report on Continuing Disability Reviews, Fiscal Year 2009. 2011. http://www.ssa.gov/legislation/FY%202009%20CDR%20Report.pdf
16. Office of the Inspector General, Social Security Administration. [Accessed December 1st, 2011] O'Carroll J, P.P. Inspector General Response to Honorable Charles Boustany and Honorable Sam Johnson regarding August 1, 2011 correspondence asking questions for the record. 2011. http://waysandmeans.house.gov/UploadedFiles/SSA.OIG.RESPONSE.QFRs.pdf
17. Office of the Inspector General, Social Security Administration. [Accessed July 12th, 2011] Childhood Continuing Disability Reviews and Age 18 Redeterminations. 2006. A-01-06-21093. http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-01-06-21093.pdf
18. U.S. General Accounting Office. Social Security Disability: Reviews of Beneficiaries' Disability Status Require Continued Attention to Achieve Timeliness and Cost-Effectiveness. GAO-03-662. Vol. 2003. Washington, DC: General Accounting Office; Jul. 2003
19. Hemmeter J, Gilby E. The age-18 redetermination and postredetermination participation in SSI. Soc Secur Bull. 2009; 69(4):1–25. [PubMed: 20120699]
20. Kuhlthau K, Hill KS, Yucel R, Perrin JM. Financial burden for families of children with special health care needs. Matern Child Health J. 2005; 9(2):207–218.10.1007/s10995-005-4870-x [PubMed: 15965627]

WHAT'S NEW

We estimate the significant potential savings that the Social Security Administration could experience through more regular re-evaluations for children ages 1–17. Systematic redeterminations represent an opportunity for SSA to improve program integrity while consistently providing for children and families with ongoing need.

Table 1

Beneficiaries (0–18 yrs) with CDRs performed and Resulting Cessations for Children[*] (1–17 yrs.), 1995–2010.[**]

Year	Number of Beneficiaries on SSI (Ages 0–18)	Other Reviews (Ages 1–17)[***]	Cessations (After appeals)	% Cessations
1998	887,066	91157	18193	20.0%
1999	847,063	183211	41852	22.8%
2000	846,784	140699	26255	18.7%
2001	881,836	95835	17365	18.1%
2002	914,821	163768	24724	15.1%
2003	959,379	127444	19526	15.3%
2004	993,127	103437	16639	16.1%
2005	1,036,498	61387	11906	19.4%
2006	1,078,977	19384	3748	19.3%
2007	1,121,017	4440	932	21.0%
2008	1,153,844	4707	933	19.8%
2009	1,199,788	10637	1758[****]	16.5%
2010	1,238,000	16677	3612[****]	21.7%

[*] After all appeals.

[**] **Source:** Social Security Administration. Annual Report(s) of the Supplemental Security Income Program. 2011

[***] All child beneficiaries outside of the mandatory Age 1 Low-Birth-Weight CDR and Age 18 redetermination.

[****] Cessations + pending appeals (final decisions have not yet been published)

Table 2

2012 Cohort Annualized Cost and Savings; Low CDR Number (16,677) with a 15% Rate of Cessation

Year	Cost of CDRs*	Monthly Benefit**	Number of Beneficiaries Ceased***	Yearly Cost Savings****
2012	$16,677,000	$597.22	2502	−$7,711,511
2013	$0	$607.37	2502	$18,235,805
2014	$0	$618.91	2307	$17,134,025
2015	$0	$631.29	2116	$16,029,783
2016	$0	$643.92	1931	$14,920,880
2017	$0	$656.80	1748	$13,776,971
2018	$0	$671.25	1564	$12,597,953
2019	$0	$689.37	1377	$11,391,151
2020	$0	$708.67	1193	$10,145,354
2021	$0	$728.52	1009	$8,820,863
2022	$0	$748.91	835	$7,504,115
2023	$0	$769.88	675	$6,236,054
2024	$0	$791.44	527	$5,005,067
2025	$0	$813.60	393	$3,836,939
2026	$0	$836.38	270	$2,709,875
2027	$0	$859.80	161	$1,661,133
2028	$0	$883.87	72	$763,667
Total	$16,677,000			$143,058,124

* Number of CDRs × $1000

** Considering Cost-of-Living Increases in Benefits According to SSA

*** Each year beneficiaries decrease as children reach age 18 and receive a negative redetermination.

**** First year savings assumes benefits ceased on July 1st, 2012.

Table 3

2012 Cohort Annualized Cost and Savings; High CDR Number (183,211) with a 15% Cessation Rate

Year	Cost of CDRs*	Monthly Benefit**	Number of Beneficiaries Ceased***	Cost and Savings By Year***
2012	$183,211,000	$597.22	27482	−$84,733,954
2013	$0	$607.37	27482	$200,302,311
2014	$0	$618.91	25337	$188,177,200
2015	$0	$631.29	23236	$176,024,593
2016	$0	$643.92	21209	$163,882,411
2017	$0	$656.80	19199	$151,318,119
2018	$0	$671.25	17182	$138,400,269
2019	$0	$689.37	15132	$125,178,573
2020	$0	$708.67	13114	$111,522,362
2021	$0	$728.52	11097	$97,012,005
2022	$0	$748.91	9184	$82,536,279
2023	$0	$769.88	7422	$68,568,883
2024	$0	$791.44	5800	$55,084,223
2025	$0	$813.60	4323	$42,206,330
2026	$0	$836.38	2972	$29,828,696
2027	$0	$859.80	1770	$18,262,148
2028	$0	$883.87	789	$8,368,521
Total	$183,211,000.00			$1,571,938,968

*Number of CDRs × $1000

**Considering Cost-of-Living Increases in Benefits According to SSA

***Each year beneficiaries decrease as children reach age 18 and receive a negative redetermination.

****First year savings assumes benefits ceased on July 1st, 2012.

Table 4

Projected Childhood Cohort Cost* and Savings Analysis at Low and High Number of CDRs and Various Cessation Rates for Multiple Years, 2012–2021

	Number of CDRs, Cessation Rates					
	16,677			183,211		
Cohort	10%	15%	20%	10%	15%	20%
2012	$90,095,169	$143,058,124	$195,975,003	$981,309,859	$1,571,938,968	$2,822,924,820
2013	$92,328,364	$146,788,027	$200,940,025	$1,008,478,613	$1,604,323,377	$2,864,165,521
2014	$94,976,323	$150,758,316	$206,225,138	$1,037,403,553	$1,647,710,621	$2,940,043,035
2015	$97,780,035	$154,962,316	$211,821,448	$1,068,035,616	$1,693,658,582	$3,020,100,563
2016	$100,747,208	$159,411,596	$217,744,355	$1,100,459,287	$1,742,294,002	$3,104,458,768
2017	$103,892,319	$164,127,844	$224,022,768	$1,134,833,343	$1,793,855,031	$3,193,361,542
2018	$107,215,393	$169,111,067	$230,656,707	$1,171,157,816	$1,848,341,710	$3,286,744,035
2019	$110,677,662	$174,303,056	$237,568,627	$1,209,006,355	$1,921,722,374	$3,429,157,684
2020	$114,243,593	$179,650,498	$244,687,504	$1,257,154,428	$1,977,296,971	$3,525,819,373
2021	$117,909,369	$185,147,668	$252,005,710	$1,295,242,343	$2,034,427,657	$3,625,187,588

*Cost = Number of CDRs × $1000