Introduction

The largest form of publicly supported housing in Chicago are Housing Choice Vouchers (HCV's). The Chicago Housing Authority's (CHA) Mobility Program aims to provide opportunities for HCV holders to move into Mobility Areas. Mobility Areas are neighborhoods/communities that have lower levels of crime and poverty and provide access to positive economic indicators. Yet, data indicates that despite the efforts of CHA's Mobility Program, many of Chicago's HCV recipients continue to reside in high-poverty, primarily Black/ African American segregated communities in Chicago that have little access to any kind of upward mobility including, well-performing schools, reliable transit job, and healthy physical and social environments.

Geographically within the City of Chicago, there are high levels of segregable clustering of people by race/ethnicity across specific neighborhoods. Neighborhoods located in the central and north sides are dominated by the White/Non-Hispanic population. Black households predominate the south side of the city, as well as the west side neighborhoods. Neighborhoods on the west side of the city are also dominated by the Hispanic/Latino population. Federal housing programs have been synonymous with high-rise housing projects, like Cabrini Green, as well as high crime, low education, and being Black or Latinx/Hispanic.

Research Question

This research project examines how Chicago's severe and persistent problem with racial segregation inhibits those using housing vouchers to attain any kind of upward mobility by having vouchers only accepted in predominantly low-income, Black and brown neighborhoods. In tight housing markets, many landlords are unwilling to rent to people with vouchers because they can charge higher rents to unsubsidized families. (Varaday & Walker 2003). I argue that there should be laws/policies in place to protect low-income families (especially families of color) using housing vouchers in Chicago. It is illegal to discriminate against Section 8 and housing vouchers in Chicago, but little is done by way of government enforcement to protect against discrimination and refusal of vouchers in certain neighborhoods. I also propose that the Social Security Administration and other government agencies at the state level allocate funding for social awareness programs to help lift a lot of the stigma that is attached to using a housing voucher.

Data

The data used for this research was gleaned from Citywide Affordable Rental Housing Analysis which is the source used to help identify housing trends and design policies around neighborhood and community growth and investment. I used data from Citywide and Community Area Affordable Housing Charts, Data Table Used in the Analysis and Citywide Affordable Housing Maps to show the severe segregation that plagues the housing voucher program within the city of Chicago. I used the City of Chicago affordable housing data table in order to compare which neighborhoods in Chicago had the least and the most amount of Legally Restricted Affordable Housing (LRAH) - subsidized by government programs for a defined time- and compared it against the map in Figure 2 that shows the percentage of LRAH units in each spatially defined community area. I also used academic, peer-reviewed sources that look at racial segregation and poverty in public housing and how housing vouchers inhibit upward mobility for families (mostly of color) in Chicago.

Results

There are more vouchers in the majority-black communities of South Shore (3,487), on the South Side, and Austin (3,130) and on the West Side of Chicago than in all of the city's 19 majority-white communities combined (2,357), according to analysis of CHA data on the location of voucher holders in the third quarter of 2018. Figure 1, though from 2019, highlights this spacial problem with housing vouchers. The percentage of LRAH units available in predominately white, middle, and upper-class neighborhoods in Chicago is significantly less than in Black and brown neighborhoods. These housing segregations have a racist history that dates decades back in Chicago.

MPC and the Urban Institute found through the Cost of Segregation that "the housing market reacts to this inequality in ways that worsen segregation: Affluent households are more able to comfortably afford high-cost options in certain communities, while lower-income households spend higher shares of their income for lower-cost options in different communities. The result is a self-reinforcing cycle, in which income inequality creates segregation and segregation furthers income inequality." The median household income in the Chicago region for a Black household is $40,000 lower than the median household income for a White household.

Similarly, the unemployment rate for Black residents in the Chicago region is 18 percent, while the unemployment rate for White residents is 5.8 percent. These factors are reinforced when landlords in “desirable” neighborhoods do not rent to housing voucher families.

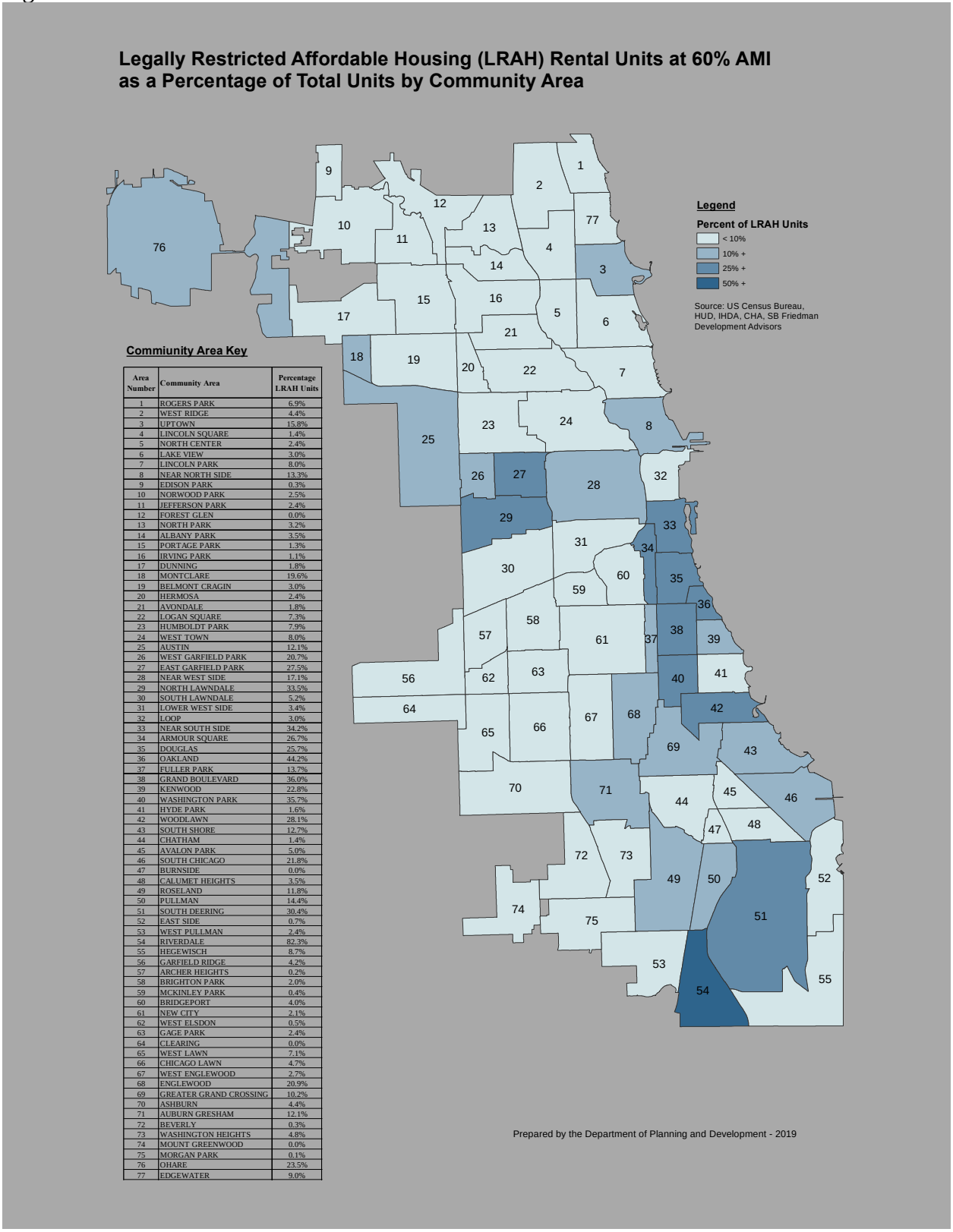
Conclusion

Despite calls to integrate housing voucher holders more widely throughout the city, the highly segregated racial composition of where voucher families live have not changed over the past decade.

Figure 2. breaks down the Area Affordability Level- availability of LRAH’s in Chicago compared to Naturally Occurring Affordable Housing - no public subsidies with market rents at 60% of AMI, and Total Higher rent - market rents above 60% of AMI, and No Rent- no information available. According to this figure, there were only 59,268 LRAH’s (all units) available in Chicago. If we reference Figure 1, mostly all options for LRAH’s in Chicago are located on the city’s south and west sides. This severely limits any type of upward mobility for families and especially youth. Without proper legislation, law, and accountability from landlords, Black and brown families will continue to be unfairly relegated to low-income communities thus stunting any chances for upward mobility, regardless of any Mobility Program.

Figures

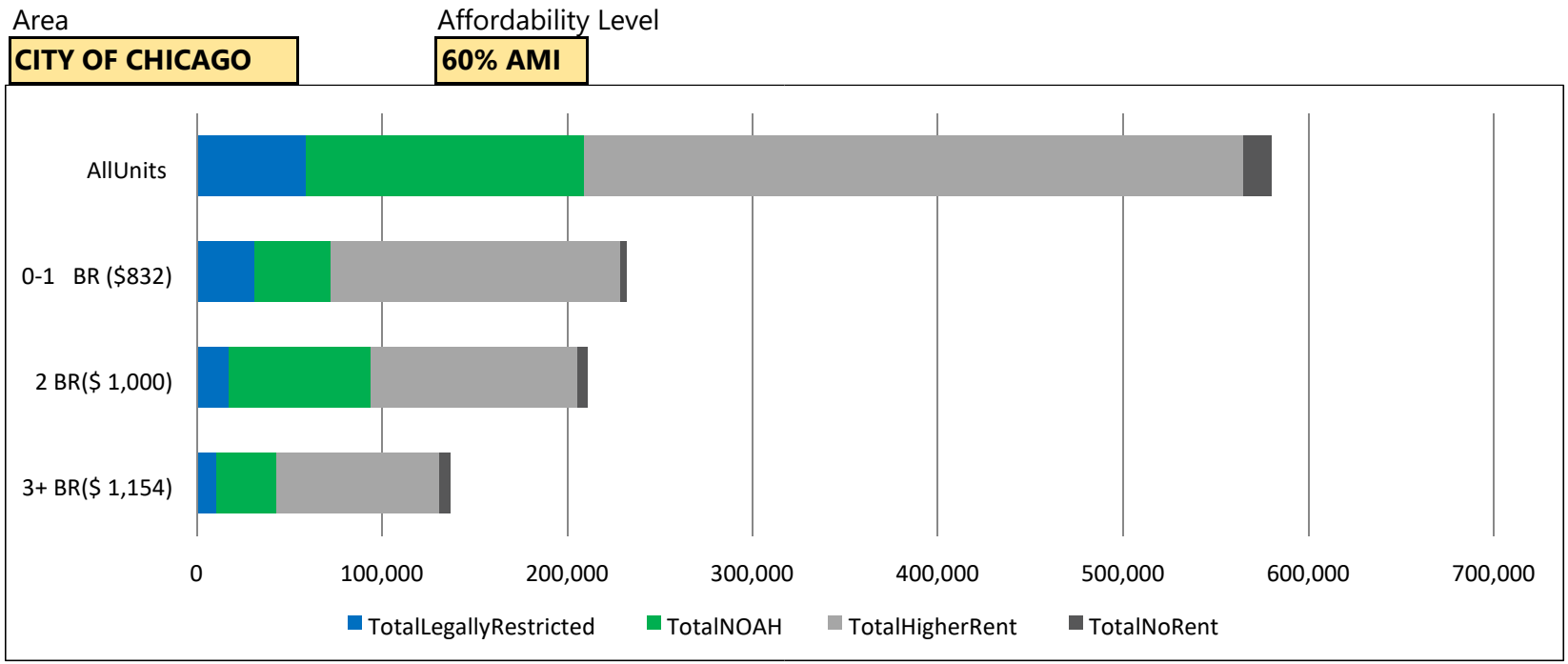
Figure 1



Area Number	Community Area	Percentage LRAH Units
1	ROGERS PARK	6.9%
2	WEST RIDGE	4.4%
3	UPTOWN	15.8%
4	LINCOLN SQUARE	1.4%
5	NORTH CENTER	2.4%
6	LAKE VIEW	3.0%
7	LINCOLN PARK	8.0%
8	NEAR NORTH SIDE	13.3%
9	EDISON PARK	0.3%
10	NORWOOD PARK	2.5%
11	JEFFERSON PARK	2.4%
12	FOREST GLEN	0.0%
13	NORTH PARK	3.2%
14	ALBANY PARK	3.5%
15	PORTAGE PARK	1.3%
16	IRVING PARK	1.1%
17	DUNNING	1.8%
18	MONTCLARE	19.6%
19	BELMONT CRAGIN	3.0%
20	HERMOSA	2.4%
21	AVONDALE	1.8%
22	LOGAN SQUARE	7.3%
23	HUMBOLDT PARK	7.9%
24	WEST TOWN	8.0%
25	AUSTIN	12.1%
26	WEST GARFIELD PARK	20.7%
27	EAST GARFIELD PARK	27.5%
28	NEAR WEST SIDE	17.1%
29	NORTH LAWNDALE	33.5%
30	SOUTH LAWNDALE	5.2%
31	LOWER WEST SIDE	3.4%
32	LOOP	3.0%
33	NEAR SOUTH SIDE	34.2%
34	ARMOUR SQUARE	26.7%
35	DOUGLAS	25.7%
36	OAKLAND	44.2%
37	FULLER PARK	13.7%
38	GRAND BOULEVARD	36.0%
39	KENWOOD	22.8%
40	WASHINGTON PARK	35.7%
41	HYDE PARK	1.6%
42	WOODLAWN	28.1%
43	SOUTH SHORE	12.7%
44	CHATHAM	1.4%
45	AVALON PARK	5.0%
46	SOUTH CHICAGO	21.8%
47	BURNSIDE	0.0%
48	CALUMET HEIGHTS	3.5%
49	ROSELAND	11.8%
50	PULLMAN	14.4%
51	SOUTH DEERING	30.4%
52	EAST SIDE	0.7%
53	WEST PULLMAN	2.4%
54	RIVERDALE	82.3%
55	HEGEWISCH	8.7%
56	GARFIELD RIDGE	4.2%
57	ARCHER HEIGHTS	0.2%
58	BRIGHTON PARK	2.0%
59	MCKINLEY PARK	0.4%
60	BRIDGEPORT	4.0%
61	NEW CITY	2.1%
62	WEST ELSDON	0.5%
63	GAGE PARK	2.4%
64	CLEARING	0.0%
65	WEST LAWN	7.1%
66	CHICAGO LAWN	4.7%
67	WEST ENGLEWOOD	2.7%
68	ENGLEWOOD	20.9%
69	GREATER GRAND CROSSING	10.2%
70	ASHBURN	4.4%
71	AUBURN GRESHAM	12.1%
72	BEVERLY	0.3%
73	WASHINGTON HEIGHTS	4.8%
74	MOUNT GREENWOOD	0.0%
75	MORGAN PARK	0.1%
76	OHARE	23.5%
77	EDGEWATER	9.0%

The data was developed by the Department of Planning and Development (DPD) in conjunction with the Department of Housing (DOH) in 2019.

Figure 2.



Number of Bedrooms (60% AMI HUD Rent Limit $)	Total Units	Total Affordable	Total Legally Restricted	Total NOAH	Total Higher Rent	Total No Rent	% Affordable	% Legally Restricted	% NOAH
3+ BR ($1,154)	136,895	43,258	10,607	32,651	87,642	5,995	32%	8%	24%
2 BR ($1,000)	210,935	93,772	17,308	76,464	111,495	5,668	44%	8%	36%
0 - 1 BR ($832)	232,372	72,397	31,354	41,043	156,601	3,374	31%	13%	18%
All Units	580,202	209,427	59,269	150,158	355,738	15,037	36%	10%	26%

Source: US Census Bureau, HUD, IHDA, CHA, SB Friedman Development Advisors

-Legally Restricted Affordable Housing (LRAH) - subsidized by government programs for a defined time

-Naturally Occurring Affordable Housing - no public subsidies with market rents at 60% of AMI
-Higher Rent - market rents above 60% of AMI
-No Rent - no information available

Introduction

While the Supplemental Security Income (SSI) program is largely funded by the US department of treasury, certain state governments supplement the benefits that individuals enrolled in the program receive. In this respect, the states can be categorized into three groups: states in which the state governments supplement SSI, states in which the Social Security Administration (SSA) supplement SSI and states in which beneficiaries receive no supplements to their SSI payments. (See table 1 for state list.)

The supplementation of SSI benefits has multiple positive effects on the participants of the program; even so, however, it is important to study the effects that it would have on the program, specifically, the number of additional participants that it would attract. Hence, this research project is dedicated to investigating the effects of supplementation on the SSI participation rate in the states. Specifically, this project looks at whether the rates of participation within states is positively affected by state government supplementation of SSI.

Research Question

A lot of factors influence the participation rates of SSI, including, but not limited to, poverty rates, costs of living, unemployment rate and availability of other welfare programs for those who are eligible for SSI. The factor that this project is dedicated to understanding is the supplementation of the SSI benefits, which is different from just the amount that participants are given.

It is rational to assume that supplementation of SSI benefits would incentivize program enrollment, because the participants would be able to earn more money than was made available by the SSA, however, this is not necessarily the case due mostly to general lack of awareness about government welfare programs. In essence, it is possible that SSI participants are not aware of the state

supplementation before application, or that, even if they were, their demand for SSI was already rather inelastic, in that they were going to enroll in the program regardless of state supplementation. So, this begs the question: does state supplementation of SSI affect the participation rates?

Data

I attempt to answer this question through the comparison to the rates of SSI participation the presence, or lack thereof, of state government supplementation in each state. However, I only made this comparison between states that have no SSI supplementation in which SSI benefits are supplemented specifically by the state, not the SSA. I obtained the data for this project from the Social Security Administration Statistics database; I made use of the table showing the number of recipients by state according to eligibility categories, age and receipt of OASDI benefits for the year 2020.

To calculate the SSI participation rate, I also needed population data, which I was able to obtain from the Unites States Census Population and Housing State Data.

Results

Figure 1 shows the relationship between the number of SSI participants and the population of the states in which the government supplements SSI benefits, and figure 2 shows the relationship between the number of SSI participants and the population of the states in which the government does not. Both graphs display strong positive correlation between population and participant number, understandably. However, figure 2 has a steeper slope than that of figure one, and this indicates a higher positive correlation.

Figure 3 is a bar graph displaying the SSI participation rate by state, and this controls for population size in a way that the scatter plots do not. From this graph, it is shown that the two states with the highest SSI participation rates, West Virginia and Mississippi, are among the six states that do not supplement SSI. In addition to this, Arkansas and Tennessee have relatively high participation rates. While Arizona and North Dakota are both closer to the lower end of participation rates, they are more of outliers compared to the rest of the states.

The low participation rates in North Dakota and Arizona can possibly be explained by the lack of supplementation; people might be discouraged towards

Table 1: Table showing states by category of SSI supplementation

State supplement	SSA supplement	State and SSA supplement	No supplement
Alabama	California	Iowa	Arizona
Florida	Michigan	Delaware	Arkansas
Indiana	New Jersey	Pennsylvania	Mississippi
Maine	Montana	Rhode Island	North Dakota
Missouri	Hawaii	District of Columbia	West Virginia
New York	Nevada		Tennessee
Oregon	Vermont		
Utah			
Wyoming			
Alaska			
Georgia			
Kansas			
Maryland			
Nebraska			
North Carolina			
South Carolina			
Virginia			
Colorado			
Idaho			
Kentucky			

Massachusetts			
New Hampshire			
Ohio			
South Dakota			
Connecticut			
Illinois			
Louisiana			
Minnesota			
New Mexico			
Oklahoma			
Texas			
Wisconsin			

Figure 1: Graph showing SSI participation in states with state supplementation of SSI benefits

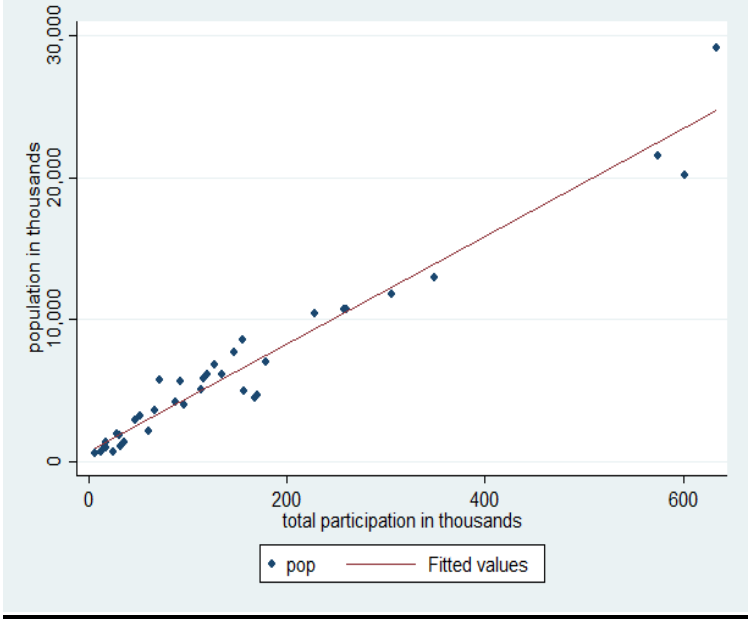


Figure 2: Graph showing SSI participation in states without state supplementation of SSI benefits

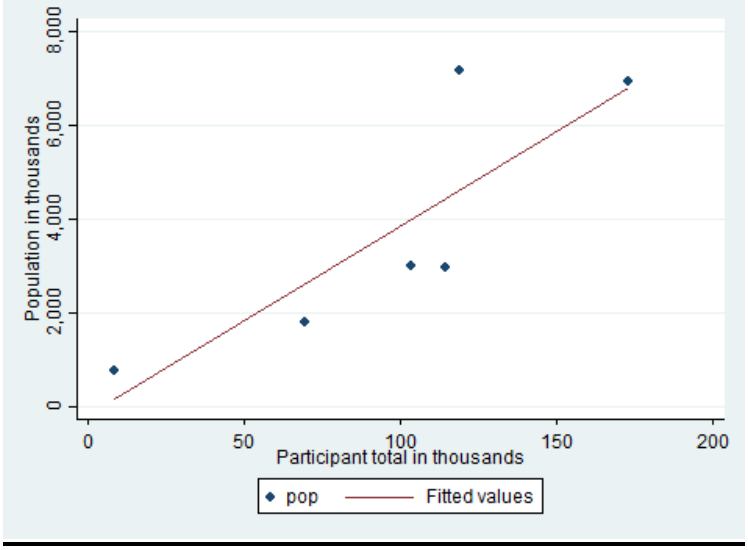
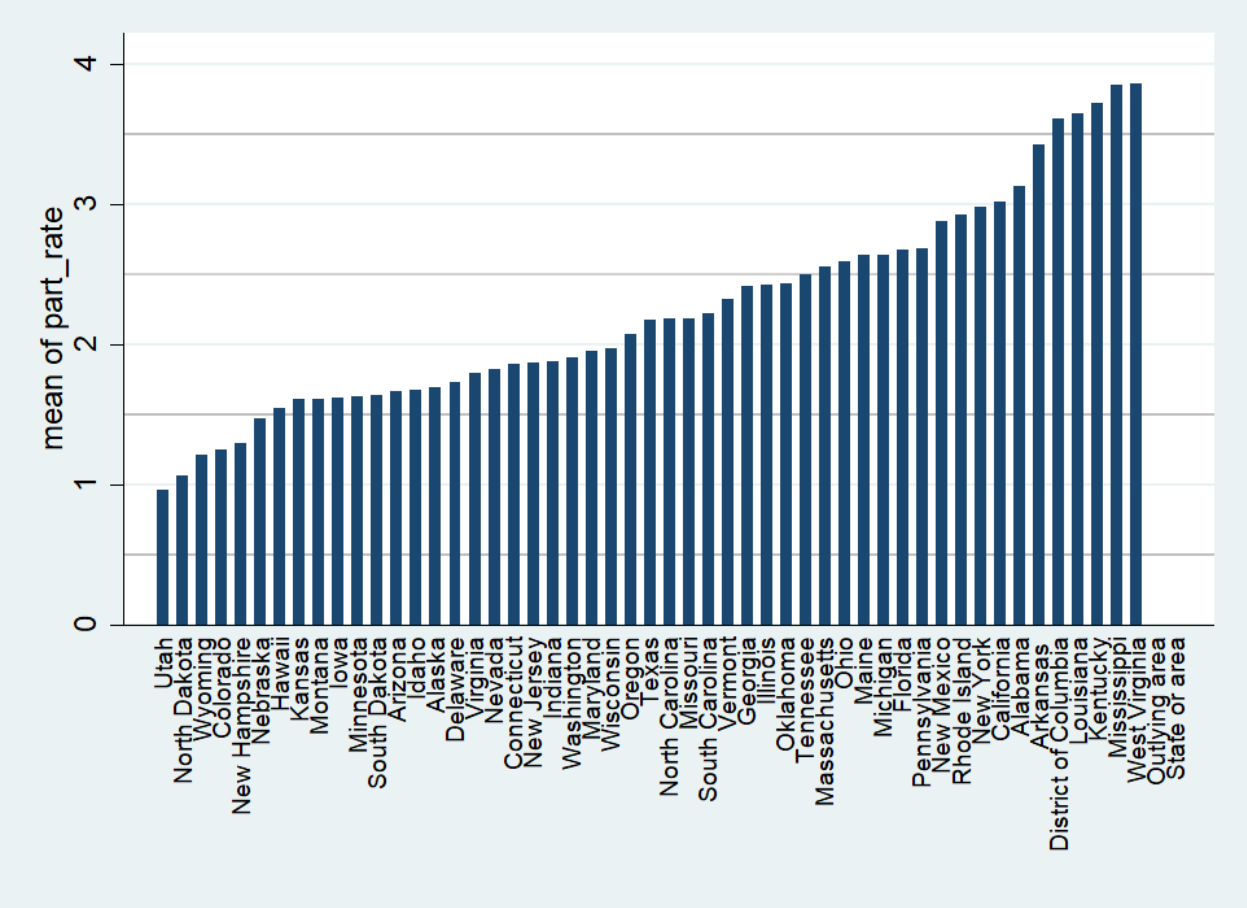


Figure 3: Bar chart showing participation rate level in states



Introduction

Supplemental Security Income (SSI) is a Means-Tested Transfer Program created in 1974 and design to provide financial help to disabled, blind, and elderly citizens of the United States. From 1990 to 2020 the number of people enrolled in the program has almost doubled in size, going from 4.8 million to 8 million recipients. The recipients are distributed differently among the 51 states and the 4 regions of the United States. Florida for example has 222 thousand recipients in 2020, while Montana has only 10 thousand. Additionally, the number of people enrolled in SSI in Idaho has almost doubles in size in the past 30 years, while in Alabama and Mississippi there was an increase of less than 2%. There is a clear variation among states and regions on the total number of recipients and the total increase of recipients since 1990.

Research Question

This research paper will indicate what regions and states have the most SSI participation; and if this pattern has changed from 1990 to 2020. There is a considerable difference in the distribution of the American population that we have to take in consideration. The South for example contains 17 states and a total of 126 million people while the Northeast contains only 9 states and a population of 57.6 million people. Besides looking at the total number of SSI recipients, this paper will also focus on the fraction of SSI recipients per region. Additionally, the paper will include the states with the most participation rate and the states with the highest increase in the total number of SSI recipients from 1990 to 2020.

Data

This research paper uses the University of Kentucky Center for Poverty Research (UKCPR) which is a nonprofit academic research center created in 2002. The center contains individual data for each of the 51 states; such as population estimates, poverty rate,

unemployment rate, federal minimum wage, and so on. UKCPR also contains a variety of variables related to the American Social Safety Net. For this research paper I will use only the data concerning population estimates and SSI recipients estimates from 1990 to 2020.

Results

Graph 1 shows the total number of SSI recipients per region from 1990 to 2020. The South is the region with the largest number of SSI recipients, followed by West, Midwest, and Northeast. All four regions showed an increase in the number of recipients from 1990 to 2020, which is somewhat expected considering the increase of 65% on the total population of the United States in this time frame. The number of recipients in the South increased from 1.9 million to 3.18 million. In the West the number went from 11.5 million to 18.6 million. The number of SSI recipients in the Midwest and Northeast regions in 1990 was close to 0.8 million, and it increased to 1.5 million in 2020 for both regions. The major difference in the total SSI recipients between the South and the other regions is fairly explained by its larger population. As shown in graph 2, the total population of the South and the rate that it has increased in the past 30 years is higher than the other three regions.

Graph 3, differently than graph 1, takes in consideration the significant difference in the total population of each region. Instead of showing the total number of recipients per region, the graph displays the percentage of the population of each region that is enrolled in SSI. The graph shows that the SSI participation rate in 1990 was higher in the South, followed by the West, Northeast, and finally Midwest. After a big gap in the number of SSI recipients in the Northeast from 1990 to 2002, the region became the one with the highest participation rate. As of 2020, Northeast is still leading with 2.55% of its population enrolled in SSI, followed by the South that

has 2.52%. However, looking at all the data from 1990 to 2020, the South has an average participation rate higher than the Northeast; 2.61% in comparison to 2.57%.

The variation on the distribution of SSI recipients is also extreme among the 51 states. Figure 4 shows the total number of recipients per state in 1990 and 2020 (in order from the highest to the lowest). California, being the state with the highest number of SSI recipients in 2020, has 1.2 million people enrolled in the program, followed by Texas that has 633 thousand, and New York with 602 thousand. In 1990 we also have California, New York, and Texas as the top 3 states with the higher number of SSI recipients. This pattern changes if we look at the percentage of people enrolled in SSI. Figure 5 shows the SSI participation rate per state in 1990 and 2020 (in order form the highest to the lowest). Mississippi, Alabama, and Arkansas - all located in the South, are the states with the highest percentage of people receiving SSI benefits in 1990, while West Virginia, Mississippi, and Kentucky – also located in the South, are the top 3 states in 2020.

Conclusion

This research paper shows that the South is by far the region with the highest number of SSI recipients. This pattern hasn't changed since 1990, which is fairly explained by the large difference in the total population of the South in comparison with the other regions. When looking at the percentage of people enrolled in SSI, the results are not so obvious. South had the most participation rate from 1990 to 2002, while Northeast had it from 2002 to 2020. Still, the South shows an average participation rate from 1990 to 2020 higher than the Northeast; 2.61% in comparison to 2.57%. Additionally, the top 3 states with the highest fraction of SSI recipients in 1990 and 2020 are all located in the South.

Figures

Figure 1

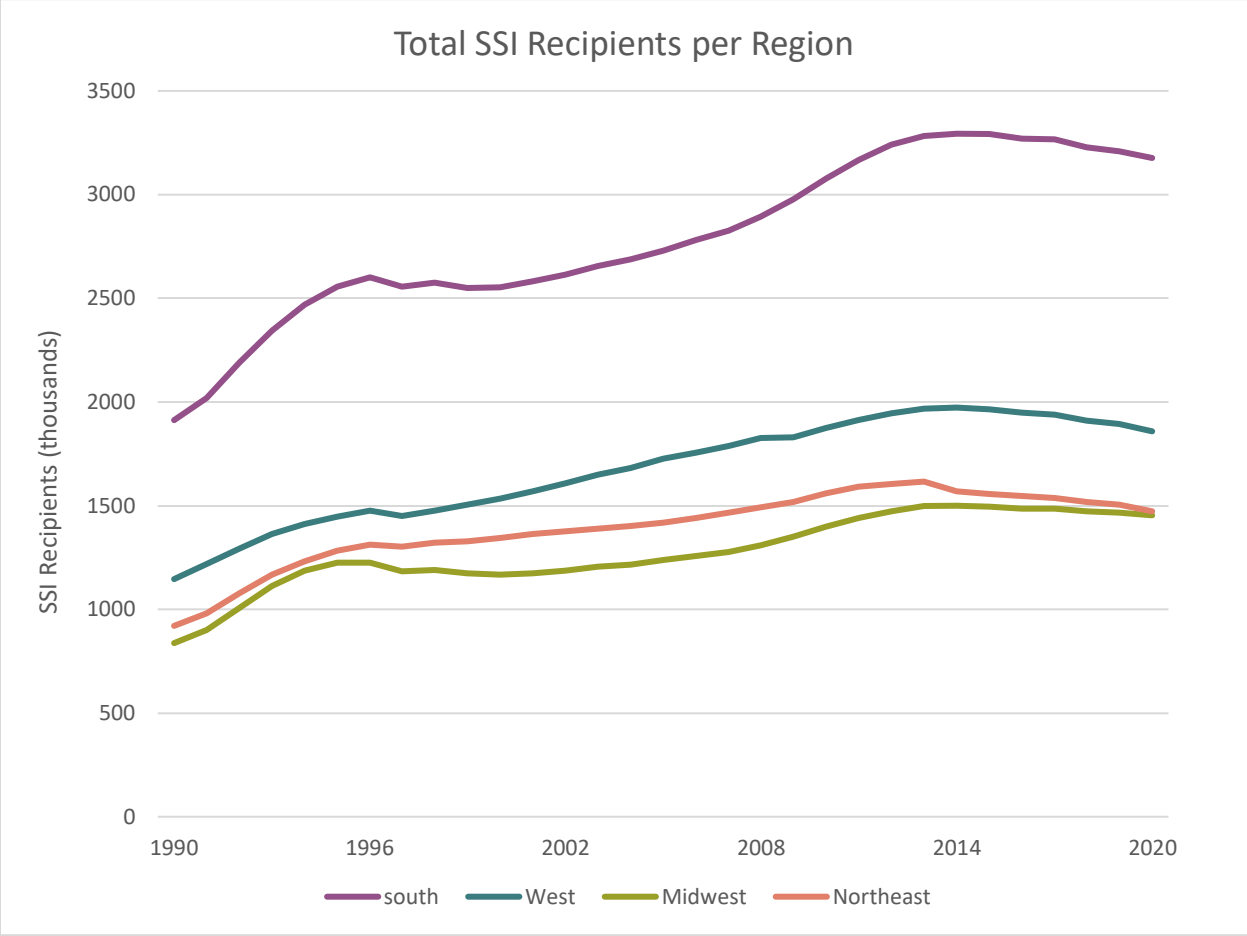


Figure 2

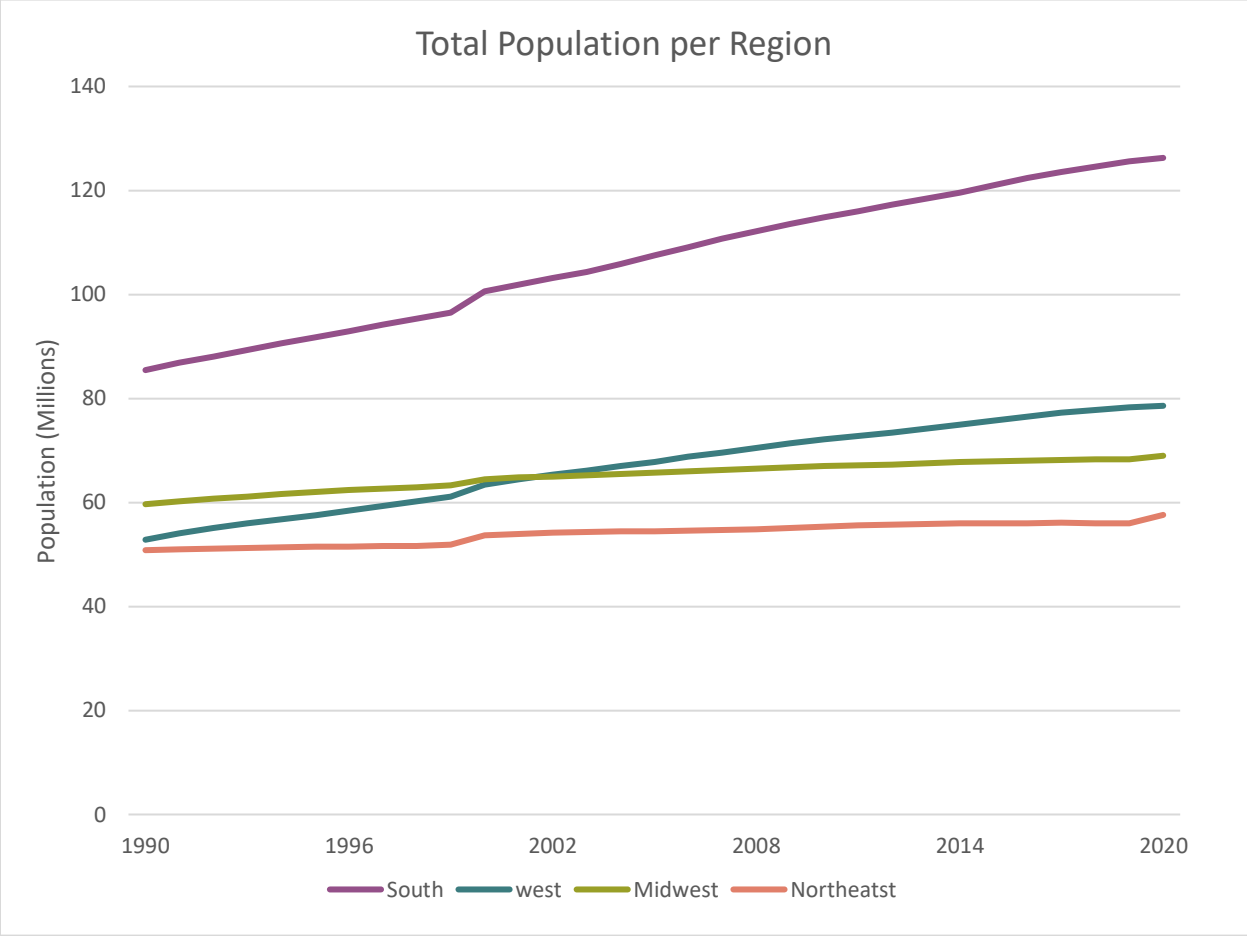

Total Population per Region
Population (Millions)
140
120
100
80
60
40
20
0
1990
1996
2002
2008
2014
2020
South
west
Midwest
Northeatst

Figure 3

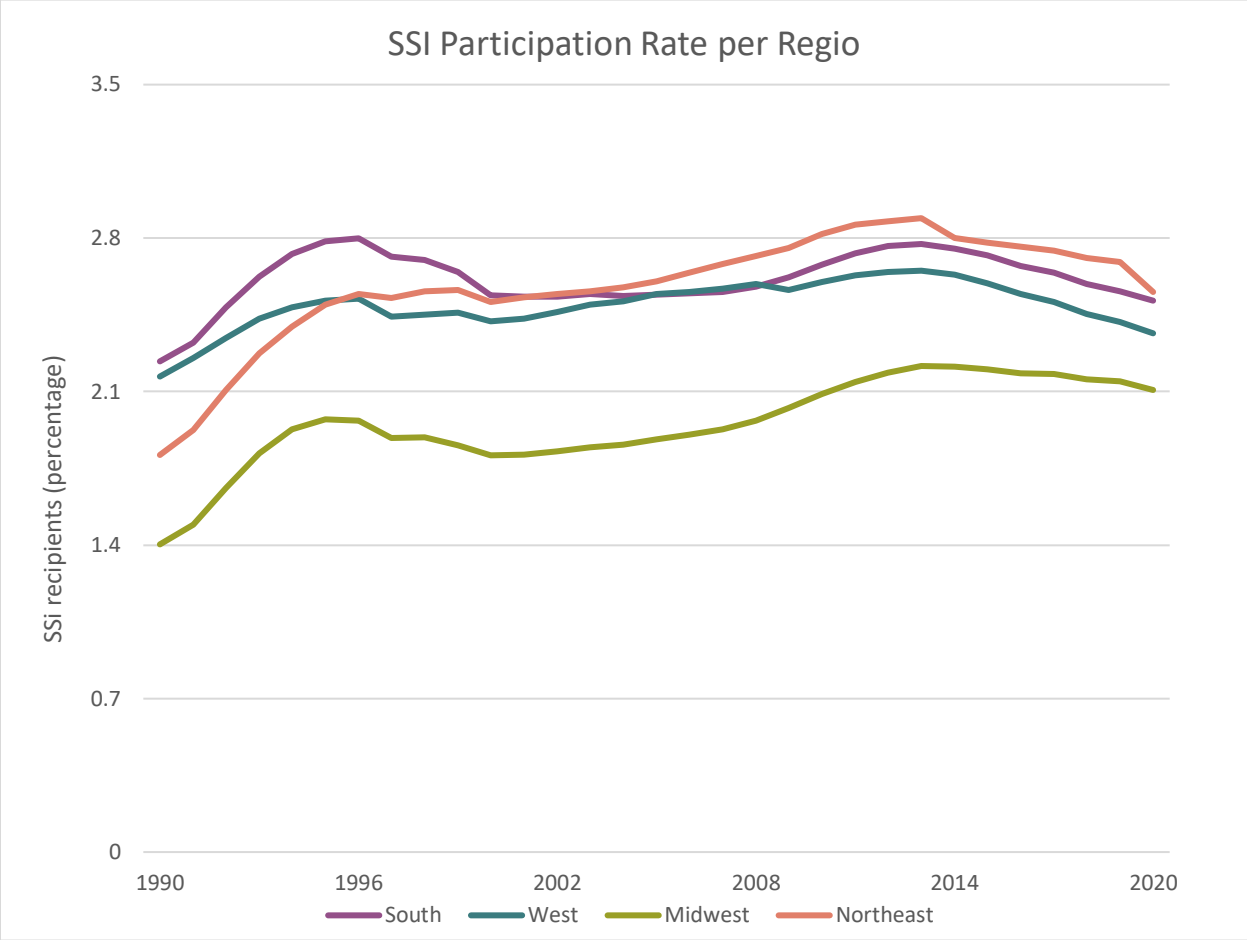

SSI Participation Rate per Regio
SSi recipients (percentage)
3.5
2.8
2.1
1.4
0.7
0
1990
1996
2002
2008
2014
2020
South
West
Midwest
Northeast

Figure 4

1990			2020		
State	Region	SSI recipients	State	Region	SSI recipients
CA	West	872772	CA	West	1193885
NY	Northeast	415270	TX	South	633119
TX	South	294740	NY	Northeast	602210
FL	South	221754	FL	South	575057
PA	Northeast	190470	PA	Northeast	348416
IL	Midwest	176690	OH	Midwest	306118
GA	South	159518	MI	Midwest	265927
OH	Midwest	155736	IL	Midwest	259848
NC	South	148666	GA	South	258228
MI	Midwest	143130	NC	South	227589
TN	South	139836	MA	Northeast	179208
LA	South	133012	NJ	Northeast	173515
AL	South	132824	TN	South	172687
MA	Northeast	119320	LA	South	170048
KY	South	114700	KY	South	167814
MS	South	113854	AL	South	157325
NJ	Northeast	105312	VA	South	155063
VA	South	95490	WA	West	146646
SC	South	90334	MO	Midwest	134572
WI	Midwest	85766	IN	Midwest	127230
MO	Midwest	84978	MD	South	120346
AR	South	75884	AZ	West	118743
WA	West	61538	WI	Midwest	116383
OK	South	60430	MS	South	114093
IN	Midwest	60148	SC	South	113810
MD	South	59774	AR	South	103134
WV	South	47214	OK	South	96421
AZ	West	44780	MN	Midwest	92748
MN	Midwest	40396	OR	West	87952
CO	West	37542	CO	West	71952
IA	Midwest	32724	WV	South	69213
CT	Northeast	32042	CT	Northeast	66886
NM	West	31550	NM	West	60950
OR	West	31522	NV	West	56406
KS	Midwest	24520	IA	Midwest	51581
ME	Northeast	23686	KS	Midwest	47245
RI	Northeast	17420	ME	Northeast	35988
DC	South	16216	RI	Northeast	32162
NE	Midwest	15560	UT	West	31465
HI	West	13776	ID	West	30742
UT	West	12616	NE	Midwest	28899
NV	West	11334	DC	South	24957
ID	West	10332	HI	West	22393
SD	Midwest	10088	NH	Northeast	17893
VT	Northeast	10068	MT	West	17494
MT	West	9958	DE	South	17162
DE	South	8080	VT	Northeast	14978
ND	Midwest	7494	SD	Midwest	14503
NH	Northeast	6870	AK	West	12434
AK	West	4634	ND	Midwest	8305
WY	West	3458	WY	West	6978

Figure

1990			2020		
State	Region	SSI participation rate	State	Region	SSI participation rate
MS	South	4.42%	WV	South	3.86%
AL	South	3.29%	MS	South	3.85%
AR	South	3.23%	KY	South	3.72%
LA	South	3.15%	LA	South	3.65%
KY	South	3.11%	DC	South	3.62%
CA	West	2.93%	AR	South	3.42%
TN	South	2.87%	AL	South	3.13%
DC	South	2.67%	CA	West	3.02%
WV	South	2.63%	NY	Northeast	2.98%
SC	South	2.59%	RI	Northeast	2.93%
GA	South	2.46%	NM	West	2.88%
NY	Northeast	2.31%	PA	Northeast	2.68%
NC	South	2.24%	FL	South	2.67%
NM	West	2.08%	ME	Northeast	2.64%
MA	Northeast	1.98%	MI	Midwest	2.64%
ME	Northeast	1.93%	OH	Midwest	2.59%
OK	South	1.92%	MA	Northeast	2.55%
VT	Northeast	1.79%	TN	South	2.50%
WI	Midwest	1.75%	OK	South	2.44%
RI	Northeast	1.74%	GA	South	2.41%
TX	South	1.74%	VT	Northeast	2.33%
FL	South	1.71%	SC	South	2.22%
MO	Midwest	1.66%	MO	Midwest	2.19%
PA	Northeast	1.60%	NC	South	2.18%
IL	Midwest	1.55%	TX	South	2.17%
VA	South	1.54%	OR	West	2.08%
MI	Midwest	1.54%	IL	Midwest	2.03%
SD	Midwest	1.45%	WI	Midwest	1.97%
OH	Midwest	1.44%	MD	South	1.95%
NJ	Northeast	1.36%	WA	West	1.90%
WA	West	1.26%	IN	Midwest	1.88%
MD	South	1.25%	NJ	Northeast	1.87%
MT	West	1.25%	CT	Northeast	1.85%
HI	West	1.24%	NV	West	1.82%
AZ	West	1.22%	VA	South	1.80%
DE	South	1.21%	DE	South	1.73%
IA	Midwest	1.18%	AK	West	1.70%
ND	Midwest	1.17%	ID	West	1.67%
CO	West	1.14%	AZ	West	1.66%
OR	West	1.11%	SD	Midwest	1.64%
IN	Midwest	1.08%	MN	Midwest	1.63%
ID	West	1.03%	IA	Midwest	1.62%
KS	Midwest	0.99%	MT	West	1.61%
NE	Midwest	0.99%	KS	Midwest	1.61%
CT	Northeast	0.97%	HI	West	1.54%
NV	West	0.94%	NE	Midwest	1.47%
MN	Midwest	0.92%	NH	Northeast	1.30%
AK	West	0.84%	CO	West	1.25%
WY	West	0.76%	WY	West	1.21%
UT	West	0.73%	ND	Midwest	1.07%
NH	Northeast	0.62%	UT	West	0.96%

The Covid-19 Pandemic: Effects on Supplemental Security Income

I. Introduction

During the Covid-19 pandemic, the United States government enacted many changes to their social security system in order to provide assistance to people who were negatively impacted by the circumstances arising from the pandemic. The recession which resulted from the pandemic led to high unemployment rates and a variety of other complications. Many individuals fell close to or below the poverty line which left them eligible for means-tested programs. Additionally, some programs saw loosened eligibility requirements and alterations which were done in order to allow more people to seek assistance during this time. One means-tested program which did not see any changes during this time was Supplemental Security Income (SSI). Unlike other programs administered by the Social Security Administration (SSA), SSI is not funded through payroll taxes or a trust fund. Instead, it is funded through personal income taxes and corporate taxes. Social Security Disability Insurance (SSDI) is a similar program which is funded by payroll taxes. Since payroll taxes were affected by the pandemic, this could have led to a decrease in financing for SSDI. A similar scenario is possible for SSI. Regarding eligibility, one is eligible for SSI if they are blind, disabled, or 65 years of age or above, a legal resident of the United States, and meet certain income and asset requirements.

II. Research Question

The research question in this memo pertains to the changes that occurred during the Covid-19 pandemic to Supplemental Security Income (SSI). As stated in the introduction, changes in funding is something that will be analyzed. SSI is financed by a variety of taxes; however, the primary ones are the personal income tax and corporate taxes. Changes to revenues in these taxes could affect SSI's funding. This would be one example of a change that occurred during the pandemic. We intend to look at tax revenues during this time to consider if there was a significant decrease in potential funding for SSI. Additionally, the factors that make up eligibility are important to consider. There have been numerous studies discussing the potential long term complications of Covid-19. This could lead to an increase in the number of those who are temporarily disabled which is one of the factors for SSI eligibility. Also, the pandemic led to high numbers of unemployment which could have increased the number of people who are eligible due to the income and asset threshold. Analyzing the effect of Covid-19 cases on the total number of SSI recipients and the effect of unemployment on the total number of SSI recipients could be useful in order to draw inferences about how SSI was affected.

variety of categories and also more detailed information about citizenship status, occupation, and award size. The Social Security Administration's Monthly Statistical Report was merged with monthly Covid-19 data from February 2020 to March 2021 in order to conduct a simple regression to measure the magnitude of the effect of Covid-19 cases on the total number of SSI recipients. Information about the unemployment rate was collected from the Bureau of Labor Statistics and information about income tax revenues was collected from the Congressional Budget Office (CBO).

IV. Results

From the SSA's latest Annual Statistical Report, we see in table two that total expenditures have consistently increased by similar margins including last year. This indicates that there has not been a major impact on funding of SSI during the pandemic. Data from the Congressional Budget Office appears to back up this claim. (Figure 1) While individual income taxes decreased in Fiscal Year 2019 to Fiscal Year 2020, they rebounded significantly in Fiscal Year 2021. Corporate income taxes saw a similar trend although smaller in magnitude. This indicates that funding to SSI was not impacted significantly during the pandemic. Payroll taxes are still down from Fiscal Year 2019; however, they are used to fund SSDI rather than SSI. As for eligibility, those who are disabled and on SSI have seen similar growth in terms of the share of total recipients. It does not appear to be the case that Covid-19 led to an increase in SSI enrollment. In order to check this, a simple regression was conducted between Covid-19 cases and SSI Recipients. We find that as Covid-19 cases increased, the number of active SSI recipients decreased. (Figure 3) This could be due to a variety of reasons. The elderly are more likely to be enrolled in SSI and they are also more likely to have serious complications, including death, from Covid-19. Some of the decrease in active recipients could be attributed to this; however, we can state with confidence that the pandemic did not lead to increased enrollments. Lastly, the unemployment rate seems relatively uncorrelated with active SSI recipients. (Figure 2) While we do know that there are certainly some individuals who qualified for SSI due to a sudden lack of employment, it is likely that most did not meet the age requirements or the disability requirements in order to be eligible. The explosion in active recipients of Unemployment Insurance (UI) during the pandemic is disconnected from the steady decline in active recipients of SSI.

V. Conclusion

The Covid-19 pandemic had significant effects on the enrollment of many social welfare programs due to the economic shock that followed. Through the analysis of data provided by the Social Security Administration, Congressional Budget Office, and Bureau of Labor Statistics, it the pandemic, potentially due to the severity of Covid-19 among the elderly. Moving forward, the Biden administration has proposed increasing the maximum SSI threshold to at least the poverty line. Additionally, they have proposed to increase the asset limits for this program. Legislation such as this could potentially increase enrollment and expenditures on SSI.

Tables & Graphs

Total Receipts

Billions of Dollars

Major Program or Category	Actual, FY 2019	Actual, FY 2020	Preliminary, FY 2021	Estimated Change From 2020 to 2021: Billions of Dollars	Estimated Change From 2020 to 2021: Percent
Individual Income Taxes	1,718	1,609	2,052	443	27.5
Payroll Taxes	1,243	1,310	1,308	−2	−0.2
Corporate Income Taxes	230	212	370	158	74.8
Other Receipts	271	289	317	27	9.4
Total	**3,462**	**3,420**	**4,047**	**627**	**18.3**
Memorandum:					
Combined Individual Income and Payroll Taxes					
Withheld taxes	2,464	2,442	2,686	244	10.0
Other, net of refunds	497	477	674	197	41.3
Total	**2,961**	**2,919**	**3,360**	**441**	**15.1**

Data sources: Congressional Budget Office; Department of the Treasury.

FY = fiscal year.

Figure 1

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2012	8.3	8.3	8.2	8.2	8.2	8.2	8.2	8.1	7.8	7.8	7.7	7.9
2013	8.0	7.7	7.5	7.6	7.5	7.5	7.3	7.2	7.2	7.2	6.9	6.7
2014	6.6	6.7	6.7	6.2	6.3	6.1	6.2	6.1	5.9	5.7	5.8	5.6
2015	5.7	5.5	5.4	5.4	5.6	5.3	5.2	5.1	5.0	5.0	5.1	5.0
2016	4.8	4.9	5.0	5.1	4.8	4.9	4.8	4.9	5.0	4.9	4.7	4.7
2017	4.7	4.6	4.4	4.4	4.4	4.3	4.3	4.4	4.3	4.2	4.2	4.1
2018	4.0	4.1	4.0	4.0	3.8	4.0	3.8	3.8	3.7	3.8	3.8	3.9
2019	4.0	3.8	3.8	3.6	3.6	3.6	3.7	3.7	3.5	3.6	3.6	3.6
2020	3.5	3.5	4.4	14.7	13.2	11.0	10.2	8.4	7.9	6.9	6.7	6.7
2021	6.4	6.2	6.0	6.0	5.8	5.9	5.4	5.2	4.7	4.6	4.2	3.9
2022	4.0	3.8	3.6	3.6	3.6							

Figure 2

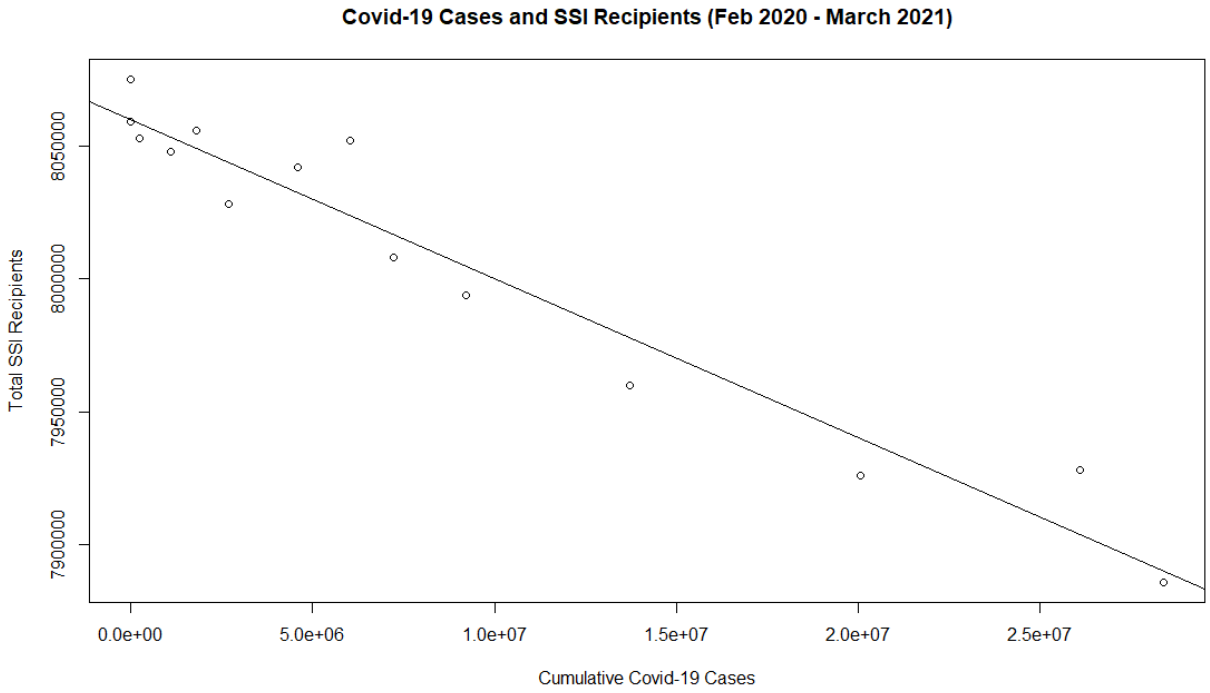

Covid-19 Cases and SSI Recipients (Feb 2020 - March 2021)
Total SSI Recipients
8050000
8000000
7950000
7900000
0.0e+00
5.0e+06
1.0e+07
1.5e+07
2.0e+07
2.5e+07
Cumulative Covid-19 Cases

Figure 3

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Introduction

Supplemental Security Income (SSI) is a federal income supplement program funded by general tax revenues. The program is designed to help aged, blind, and disabled people who have little to no income for reasons that may be related to their conditions. SSI's goal is to provide cash to meet the basic necessities of food, clothing, and shelter. Over time, the amount of people partaking in, their disabilities, and where they reside may change. Understanding how and why that is happening can be an important step towards improving the program which millions of Americans rely on to have their needs met on a daily basis.

Research Question

This research project explores what the most common disabilities are for SSI recipients and how this may vary by time or location within the US. Understanding which disabilities are becoming increasingly common and where can prove to be a vital step in allocating necessary resources and adjusting policy to help the affected groups. It is also important to understand possible explanations for why certain recipients may choose to live in a certain part of the US or why certain disabilities or disorders are more common in certain areas compared to others.

Data

This research project uses tables from the SSI Annual Statistic Report, which provides data on the size and scope of Supplemental Security Incomes Program. The SSI ASR includes variables measuring recipient demographics and participation in the Supplemental Security Income Program and covers topics such as federal benefit payments and rates, diagnoses of individuals under 65, and outcomes of the applications for disability benefits. For the purpose of this research project, we will be looking at the total number of SSI recipients per state over time, the distribution of recipient disabilities, and details regarding the award payouts for select states.

Results

Figure 1 and 2 shows the distribution of SSI recipients by diagnostic group, from the years 2012 to 2020. In figure 1, the height of each vertical line represents the total amount of recipients for a specific diagnostic group. Each color represents a different year. In figure 2, each horizontal line represents a disability/disease. Each line is divided into nine colored segments, each representing a different year. The length of each segment determines the number of recipients for a certain diagnosis expressed as a percentage of the total number of SSI recipients for that year. One thing that can be noticed after looking at the data is how mental disorders accounted for roughly over 60% of all SSI recipients for any given year. The largest diagnostic group happens to be Intellectual disorders, on average accounting for about 17% of total SSI recipients throughout the nine-year period. Some of the other large diagnostic groups include Depressive, bipolar and related disorders (13% average), Schizophrenia (7%), Musculoskeletal system and connective tissue diseases (11.5%), and diseases related to the nervous system and sense organs (8%). The diagnostic groups that accounted for the lowest percentage of SSI recipients include Infectious and parasitic diseases (1%), blood and blood forming organs (0.5%), digestive system (1%), Genitourinary system (0.9%), and diseases

related to skin and subcutaneous tissue (0.18%). In this period, some diagnostic groups have seen noticeable growth, while others have seen noticeable decline relative to the total amount of SSI recipients for a given year. Since 2012, there has been a 4% increase in the number of recipients diagnosed with autism, a 2.3% increase in recipients with musculoskeletal and connective tissue disorders, and a 4.4% increase in mental disorders labeled as "other". Among the largest decliners include a 4.3% decline in unclassified childhood and adolescent disorders, a 1.5% decline in depressive, bipolar, and related disorders, and a 1.9% decline in unknown diseases.

The SSI Annual Statistical report classifies each diagnostic groups into one of three main categories: structural/physical disabilities or ailments[1], mental disorders[2], and diseases or disorders dealing with internal systems[3]. Figures 3, 4, and 5 depict how large each state's category is relative to the rest of the total SSI recipient population for that state. When it comes to structural/physical disabilities or ailments, Utah has the largest percentage (19.13%) and Kentucky has the lowest percentage (9.09%). When it comes to mental illnesses, New Hampshire has the highest percentage (65.70%) and Georgia has the lowest (47.82%). When it comes to diseases, South Carolina has the largest percentage (38.74%) and New Hampshire has the lowest (19.97%). Surprisingly, just because a state's category takes up a larger percentage of their total SSI recipients compared to other states doesn't necessarily mean they pay higher than the states with lower percentages. When comparing the average payouts of the top 3 states for each category turned out to be less than what the bottom 3 states would payout. A possible explanation for is how some states provide supplemental payments in addition to the initial SSI award payout.

Conclusion

This research paper shows that overall, the most common category of SSI disabilities are mental disorders, and for the most part this has stayed consisted throughout the years (at least in the time period 2012-2020). The size of some diagnostic groups has seen noticeable increases, while others have seen steady declines. When it comes to individual states, mental illnesses continue to have the largest percentage of cases overall relative to that state's total SSI recipient population. There doesn't seem to be a correlation between the relative size of a disability category and the award payout. If given the opportunity to continue research related to this topic, I would look more into how each states SSI policies differ from one another and if that can be correlated with the amount of recipients they have for certain diagnostic groups. I would also investigate societal factors that may or may not make a state better suited for having certain diagnostic groups, such as care facilities, support groups, accessibility, etc.

1. Congenital anomalies, Endocrine, nutritional, and metabolic diseases, Infectious and parasitic diseases, and injuries.
2. Autism Spectrum disorders, developmental disorders, childhood, and adolescent disorders not elsewhere classified, intellectual disorders, depressive, bipolar, and related disorders, neurocognitive disorders, schizophrenia spectrum and other psychotic disorders, and other mental disorders.
3. Neoplasms, blood and blood-forming organs, circulatory system, digestive system, genitourinary system, musculoskeletal system and connective tissue, nervous system and sense organs, respiratory system, skin and subcutaneous tissue, other, and unknown.

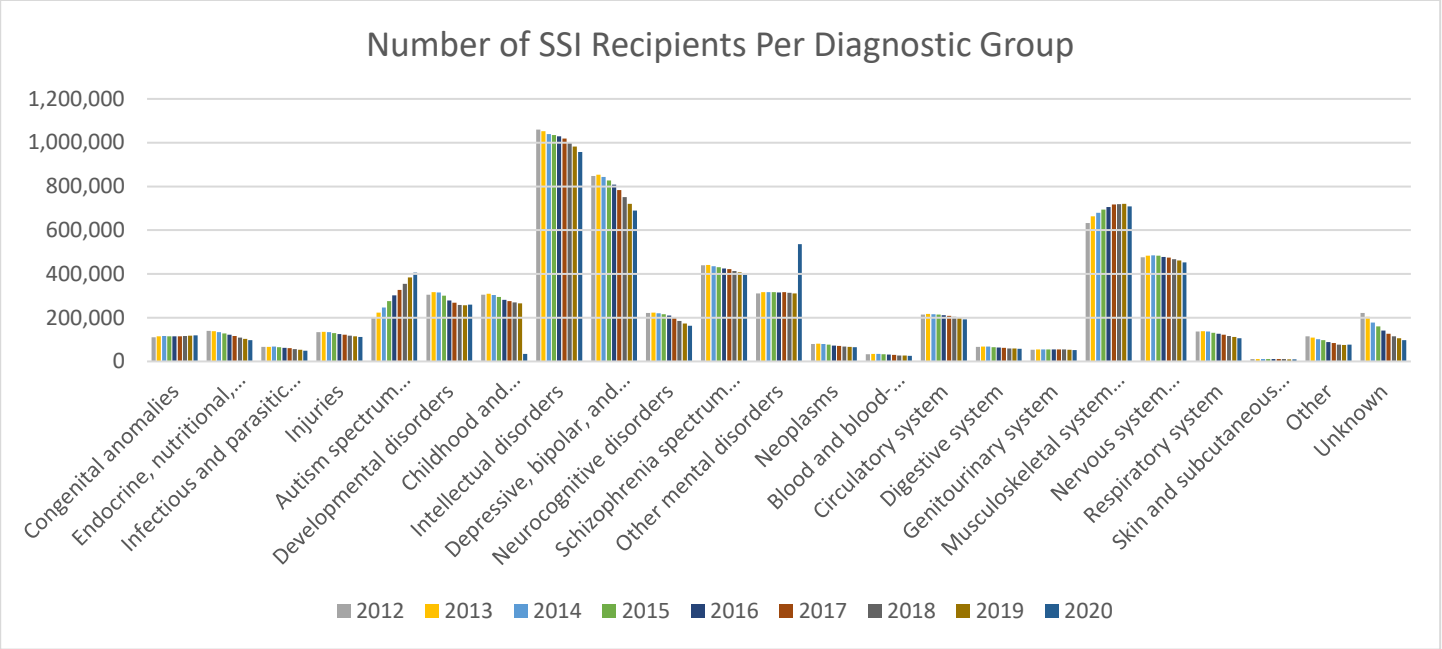

Figure 1

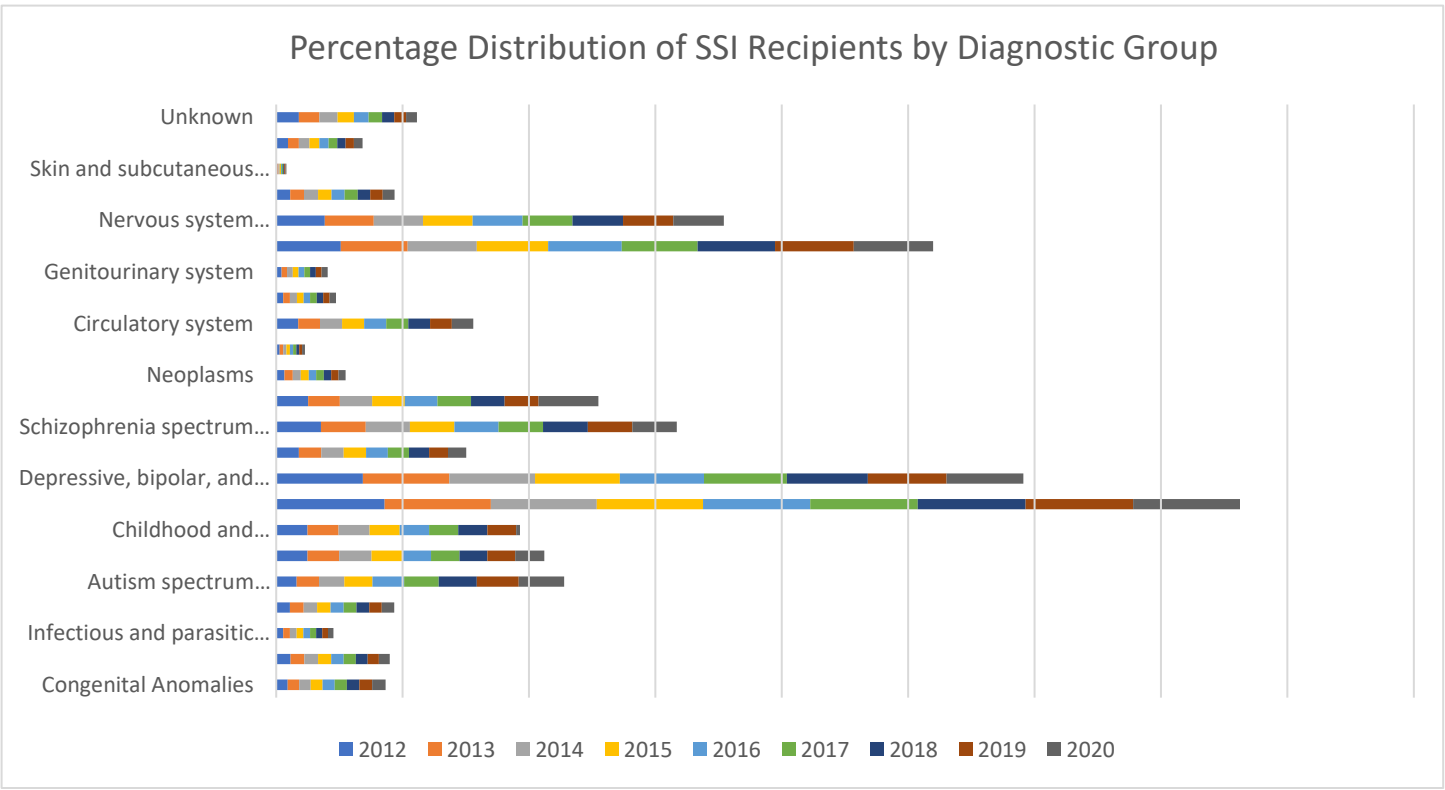

Figure 2

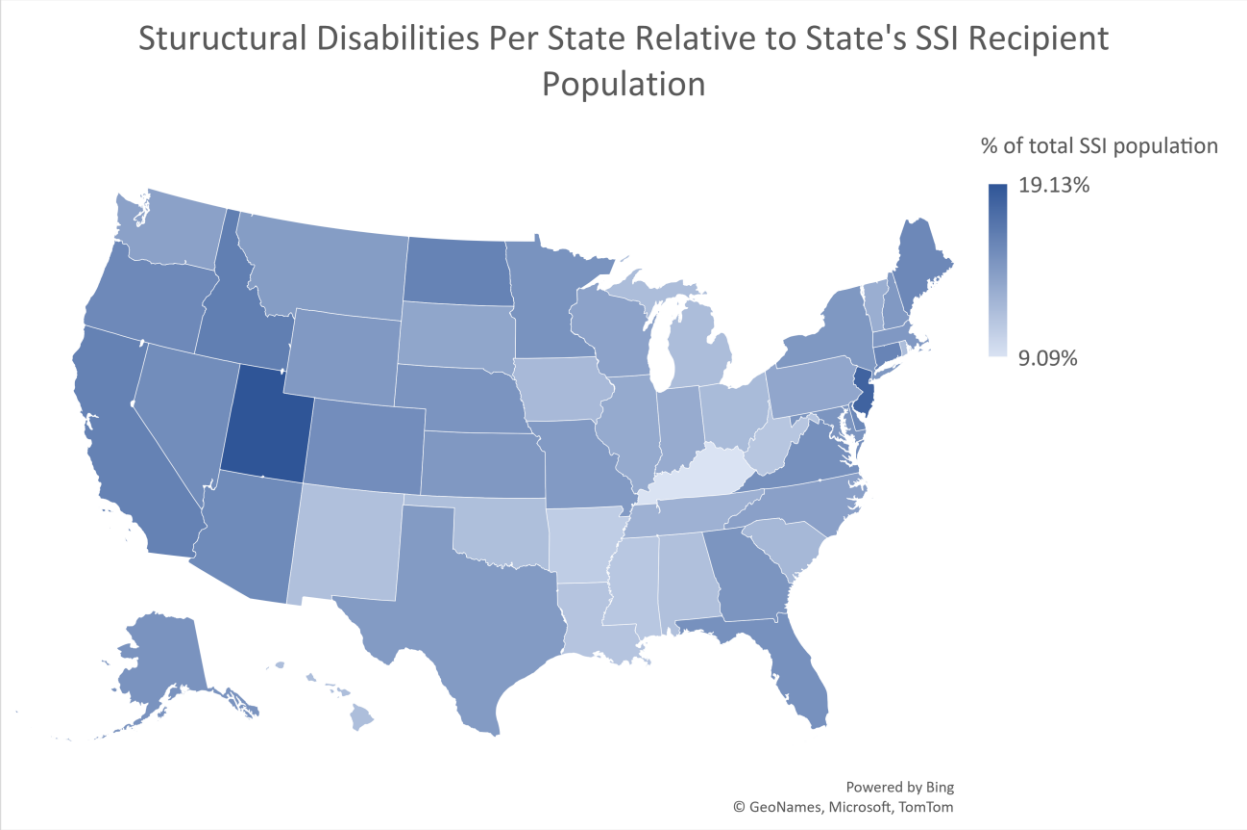

Figure 3

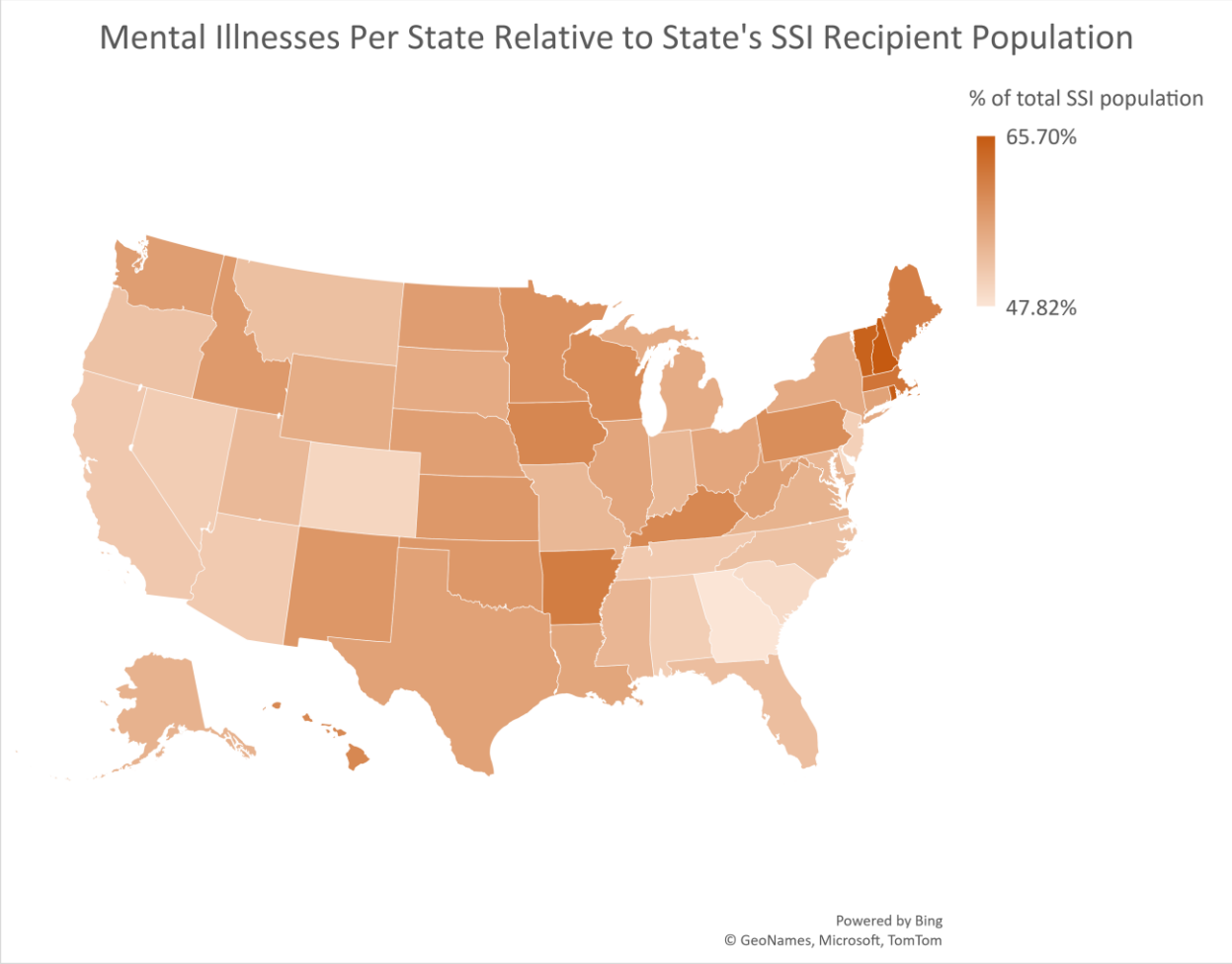

Figure 4

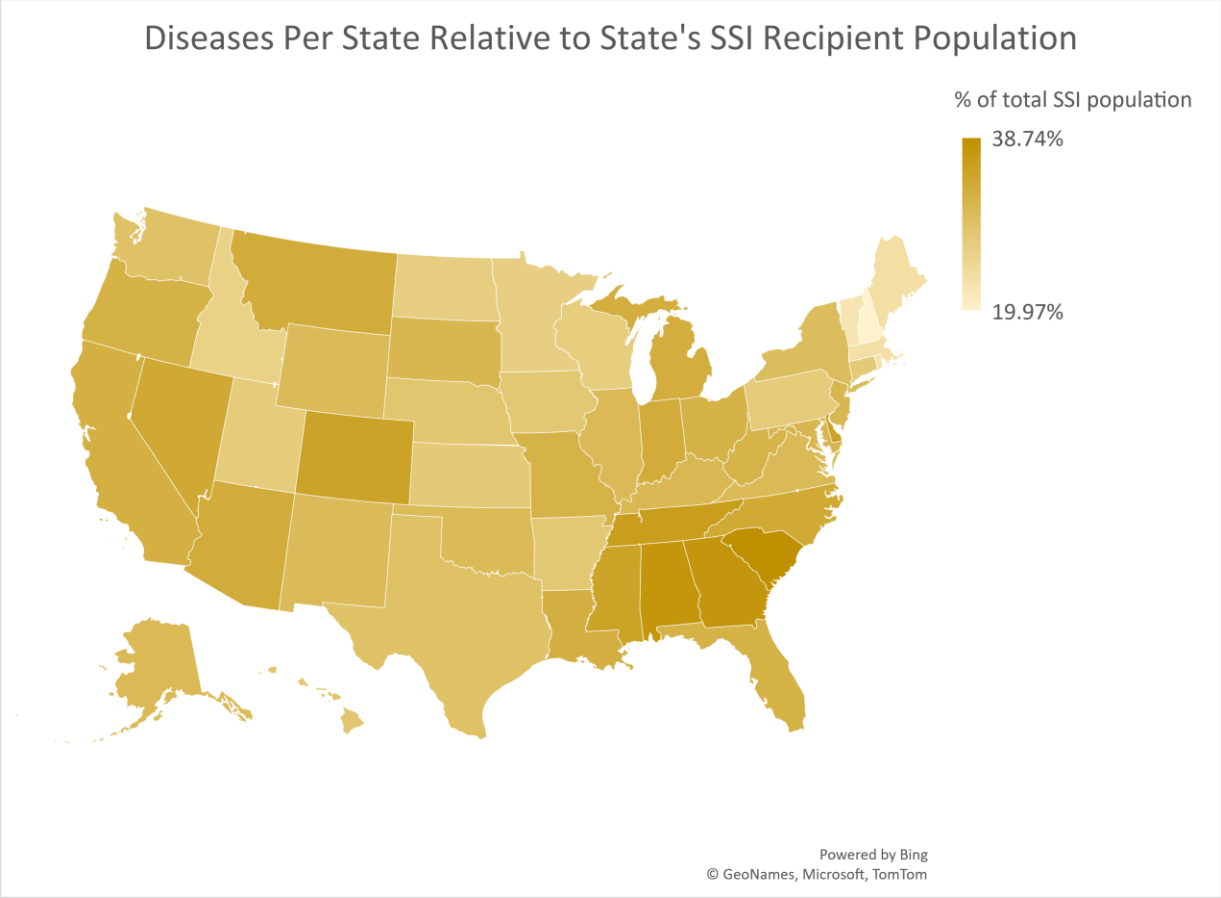
Diseases Per State Relative to State's SSI Recipient Population
% of total SSI population
38.74%
19.97%
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Figure 5