Mothers of Children Receiving Supplemental Security Income: Sharpening the Focus on Barriers to Employment

Donna Ruane Morrison, Georgetown Public Policy Institute, 3520 Prospect St., NW 4th Floor, Washington, DC 20007 (202) 687-1966 morrisod@georgetown.edu
Jean M. Mitchell, Georgetown Public Policy Institute
Darrell Gaskin, Georgetown Health Policy Institute

ABSTRACT

Raising a child with chronic health conditions or disabilities generally requires substantial investments from parents, both pecuniary and non-pecuniary, which potentially exert competing pressures on their labor supply. Although there may be a heightened need or desire for the parent's time within the household, foregone earnings income must be weighed against the significant expenditures associated with the child's condition and/or impairments (Myers, Brady and Seto, 2000). These factors are especially relevant for mothers, whose employment patterns are more strongly affected by care-giving responsibilities (Heymann 2000). Indeed, a number of recent studies suggest that the impact of child disability on maternal employment can be notable, but the evidence is mixed as to whether the effects vary according to the mother's marital status (Powers 2003; Lee, et al. 2004; Breslau et, al. 1982; Salkever, 1982), For example, Corman, Reichman and Noonan (2004) report that compared to unmarried mothers of comparatively healthy children, unwed mothers of children with severe health conditions or impairments are 8 percentage points less likely to be employed, on average, and are likely to work roughly three fewer hours per week if they are employed. The labor supply of economically disadvantaged mothers has received particular attention in this literature (e.g., Lee et al. 2004; Corman et al. 2004), in part because of the over-representation of

children with disabilities in poor, mother-only families (Hogan, Rogers & Msall 2000; Birenbaum 2002).

Understanding the barriers to employment among poor mothers with children with exceptional health issues is compelling for several reasons. First, these mothers, other family members, and/or their children may be eligible for public transfers. In the current post-welfare reform context within which employment and self-sufficiency are key policy goals, there is a press to better understand how entitlement programs along with other factors, influence the cost-benefit calculus of mothers' employment decisions. Mothers of children receiving Supplemental Security Income (SSI) are disproportionately more likely to enter the welfare system than other single mothers, and they have lengthier periods of dependency, on average, than typical welfare recipients (Meyers, Brady, and Seto 2000; Brandon & Hogan, 2002). In addition, Earle and Heymann (2002) report that former welfare recipients are 33 percent more likely to lose a job if they have a child with limitations affecting their ability to attend school or perform activities. Beyond the implications for welfare-related time limits and work requirements, however, pin-pointing the specific employment constraints faced by these mothers may hold promise for the families themselves. Child-SSI benefits alone are generally insufficient to protect families from poverty, so earned income may give struggling families a significant advantage. Although the study is now dated, Kearney, Grundmann and Gallicchio (1995) used matched records from the second wave of the 1990 SIPP panel and the Social Security Administration's master beneficiary record to examine, among other things, why some families with SSI-recipient child remained poor over time. They showed that the

absence of an employed family member explained the inability of these families to climb above the poverty threshold.[1]

The experience of raising a child with serious health problems and/or impairments varies widely in terms of the psycho-sociological, physical, and economic challenges that are entailed. For example, substantial differences exist across these families in terms of the associated expenditures; need for specialized equipment and accommodations; necessary parental time investments; requirements for therapeutic interventions; and disruptions to family routines. Beyond these are striking geographic variations in the market availability of medical care; compensatory programs; specialized schools and teachers; and appropriate and affordable daycare (e.g., Guralnick 2003; Schoelnick and Phillips 2002). Finally, children with disabilities themselves differ markedly, for example in terms of personal and social competencies and self-regulatory behavior (e.g., neediness, adaptability, and sociability). Therefore, to get better leverage on the impact of having a disabled child on mother's employment requires careful attention to the considerable heterogeneity within this population of families. Due partly to inadequacies in the information contained in available data sets, however, older studies commonly relied upon somewhat generic measures of childhood disabilities. Recent studies using SIPP data (e.g., Lee et al. 2004; Powers 2001) have the advantage of being able to identify sensitivity in estimates based on alternative definitions of disability. The recent analysis by Gould (2004) is an exemplar for making finer-grained distinctions across children's health conditions and impairments. Based on the assumption that the processes by which a sick child influences women's labor supply is complex, Gould decomposes

[1] At the time of the study, the average child-SSI payment among the families that remained below the poverty line was $304. The comparable figure for all families with child beneficiaries was $337.

the individual effects of both time requirements and large expenditures to explain the variance in maternal labor force activity.

The aim of the present study is to extend existing research by further disentangling the principal means by which children's health conditions and impairments influence maternal labor supply in poor families. Our intent is to illuminate how mothers make trade-offs associated with paid employment versus reliance on government transfers or other income sources. We utilize two waves of a survey of children with special health care needs (CSHCN) administered to a sample of minority mothers in the District of Columbia who have at least one child receiving SSI for one or more disabilities and enrolled in the DC Medicaid program.[2] Both the baseline and follow-up surveys were conducted by telephone in 2002, roughly 8 months apart. Caregivers were asked to identify the child's major and secondary health conditions, to rate the child's psycho-social functioning across six domains, and to assess the degree of limitations faced by the child with activities of daily living using a battery of several items. Along with their scores on these indices, we draw from Gould's (2004) typology to classify the children in terms of the severity of their condition(s) -- individually and in combination; as well as the associated degree of unpredictability; and parental time requirement. An important yet under-investigated correlate of both labor market participation and raising a child with disabilities is maternal depression, which we account for directly.

We estimate multinomial logit models in which *mothers' labor force status* at the time of the follow-up [where 0= not employed/out of labor force; 1=not employed and looking for a job; 2=not employed and in job training; and 3=employed] is predicted as a

[2] In the majority of States (including the District of Columbia), SSI-recipient children are also automatically enrolled in Medicaid.

function of an instrumental variable for TANF participation at the first interview, multiple dimensions of child's health status and limitations, mother's characteristics, and other factors. To uniquely identify the equation for receipt of TANF at baseline, we use a measure of the distance of the mother's residence to the nearest TANF office [i.e., Income Maintenance Administration Service Centers]. We maintain that while proximity to a TANF service center may increase both the mother's knowledge of cash assistance programs as well as facilitate the TANF application process, the location of the service center would not directly influence her labor market activity. Our TANF model also includes other controls for child, mother, and family characteristics also correlated with welfare receipt.

The explanatory variables in our labor force participation models include the mother's physical and mental health status, living arrangements, the presence of other young children including whether the focal child has a sibling with a disability, along with other standard measures of human capital. Additionally, we include dummy measures of whether mothers reporting receiving food stamps, disability insurance or SSI; unemployment insurance and child support.

The present analysis has a number of significant strengths. We are able to take advantage of a rich array of measures of the child's limitations and functioning available in the CSHCN survey to develop alternative classification schemes. Using this diverse set of measures will help us to isolate more precisely the dimensions of children's health conditions and limitations that pose the most significant barriers to maternal employment. Also of particular note, is our ability to address the endogeneity of TANF receipt in predicting employment behavior for our sample of mothers of children with exceptional

health problems. A further strength is that our sample is restricted to children receiving SSI benefits, a means-tested program with stringent requirements for determining eligibility[3]. Thus, we are unlikely to have children who were misclassified as disabled. Another strong point of our study lies in the of a direct measure of maternal depression. Controlling for a mother's depressive symptomology in our employment models not only allows us to assess the relative importance of parental mental health as a mechanism of the effect of child disability, but it also helps mitigate the potential for bias in mothers' subjective ratings of child functioning. Finally, in this study we recognize the potential for important variations across the life course of children in the demands associated with the care of a child with special needs. To detect whether there are age differentials in our estimated effects we interact our measures of child disability with the age of the child.

The aims of our analysis have even greater saliency when one considers current projections that the number of children diagnosed with chronic conditions, such as acquired immunodeficiency syndrome, asthma, and attention deficit/hyperactivity disorder will continue to rise (Kulthau and Perrin 2001; Cadman, Rosenbaum, Boyle and Offord 1991). With a strong association between family poverty and childhood disability, it is therefore reasonable to expect that the number of children at risk for SSI support is likely to increase as well (Fujiura and Yamaki 2000). The questions posed here are also timely. Given that escalating medical costs create mounting pressures to keep per-child SSI expenditures in check, we may see marked increases over time in the opportunity

[3] Eligibility criteria, benefit levels, and the disability determination process for SSI are all established at the federal level. The definition of disability, especially pertaining to certain mental and behavior problems, was made more stringent with welfare reform. To qualify a child must have a medically verifiable physical or mental condition(s) that results in marked and severe functional limitations and can be expected to last at least 12 months or be expected to result in death. In certain instances, a determination of disability will depend on whether a child's mental problems are causing severe problems with functioning both at home and at school.

costs of remaining out of the workforce to care for a disabled child (Lukemeyer et al. 2000; Kuhlthau et al., 1998).

Status of Paper:

A working draft of the full paper is already complete (August 2, 2005). However, we were not satisfied with our initial approach to handling the endogeneity of TANF and subsequently devised the instrumental variable strategy described in this Abstract.

We have spent the last several weeks translating respondent's addresses into geo-codes and mapping them against the geo-coded locations of the District of Columbia TANF service centers. We will use these distance measures to identify our model predicting TANF receipt at baseline.

We anticipate that the paper will be completed by the end of October and would be happy to send the full version for your consideration at that time, if it would be helpful to your review process.