out of World War II. Taxes would have to be raised to pay back the money borrowed to cover the cost of the war, whether the obligations were held by the trust fund or by other investors. The fact that the trust fund, rather than other possible investors, holds part of the Federal debt does not change the purpose for which these taxes must be levied. Since all the social security contributions are permanently appropriated to the trust fund, they are not available to the Treasury to redeem Federal obligations held by the trust fund.

The operation of old-age and survivors insurance trust fund investment is similar to the investment of premiums collected by a private insurance company. A private company uses part of its current premium receipts for payments to beneficiaries and for operating expenses. The balance of its receipts is invested in income producing assets. Such investments are commonly limited by State law to the safest forms of investment so that policyholders will be assured that their claims against the company will be satisfied when they become due. Government securities ordinarily represent a considerable part of these investments. The purpose of investing these receipts is, of course, to obtain earnings that will help meet the future costs of the insurance and thus reduce the premiums the policyholders would otherwise have to pay for their insurance.

Social security tax collections are handled in much the same way. Investments of the trust fund, however, are limited by law to only one type—securities issued by the Federal Government. There are two principal reasons for such a restriction. One is similar to the motivation of State legislation dealing with investments of private insurance companies: it is designed to ensure the safety of the fund. Government securities constitute the safest form of investment. The second reason is that it keeps this publicly operated program from investing reserve funds in competitive business ventures. Such investments by the trust fund would be completely out of harmony with accepted concepts of the proper scope of a governmental activity. The securities held by the trust fund perform the same function as those held by a private insurance company. They can be readily converted into cash when needed to meet disbursements, and the earnings on these investments make possible a lower rate of contributions than would otherwise be required.

In investing its receipts in Government securities the trust fund, as a separate entity, is a lender and the United States Treasury is a borrower. The trustees of the fund receive and hold securities issued by the Treasury as evidence of these loans. These Government obligations are assets of the fund and liabilities of the United States Treasury which must pay interest on the money borrowed and repay the principal when the securities mature.

In other words, the Treasury borrows from a number of sources. It borrows from individuals, mutual savings banks, insurance companies, and various other classes of investors; and it borrows from the old-age and survivors insurance trust fund. The securities held by the fund are backed by the full faith and credit of the United States, as are all public debt securities; they are just as good as the public debt securities held by other investors.

The purchase of Federal obligations by the trust fund from the Treasury does not increase the national debt. The national debt is increased only when and to the extent to which the Federal Government's expenditures exceed receipts from taxes levied to meet those expenditures. When such a deficit occurs, the Treasury must borrow sufficient money to meet the deficit by selling Federal securities. The volume of the securities sold to meet a deficit is not increased by the purchase of such obligations by the trust fund. The purchase of Federal obligations by the trust fund in a period when the Treasury has no deficit to meet would result only in a direct or indirect transfer of Federal debt from other investors to the trust fund. The total amount of the public debt would remain unchanged.

Medical Advisory Committee on the Disability Freeze*

A significant cooperative endeavor was launched in February of this year when the Commissioner of Social Security appointed a Medical Advisory Committee to assist him and the Bureau of Old-Age and Survivors Insurance in implementing the "disability freeze" provision of the 1954 amendments to the Social Security Act.[1] This Committee,[2] composed of members of the medical and related professions having a common interest in the problems of the disabled, was formed to provide consultation on medical policies involved in securing disability determinations for individuals eligible to have their old-age and survivors insurance rights preserved under the new law.

The functions of the Committee have been defined by the Bureau in cooperation with the chairman and members of the Committee. A major Committee objective is to provide technical advice in formulating medical guides and standards to promote equal consideration for disabled individuals in all parts of the Nation. State agencies and the Bureau of Old-Age and Survivors Insurance will use these guides and standards in evaluating the severity and duration of disabling conditions.

The Medical Advisory Committee is representative of experience in a variety of specialized fields of medical practice, public and private medical administration, and social welfare services. Hence, another important phase of the Committee's work is bringing viewpoints of medical and other professional groups to the attention of responsible administrative officials and helping to interpret policies and methods of operation to the public broadly.

The Committee convened with representatives of the Department of

*Prepared by Arthur E. Hess, Assistant Director, Division of Disability Operations, Bureau of Old-Age and Survivors Insurance.

[1] See the *Bulletin*, September 1954, pages 11–12.

[2] For the establishment of the Committee and its membership, see the *Bulletin*, April 1955, page 7.

Health, Education, and Welfare in Washington on February 9–10 and again on March 14, 1955, and additional meetings are expected in the future. Significant progress was made at the February and March meetings. The Committee reviewed in general the scope of the tentative administrative plans developed by the staff of the Bureau of Old-Age and Survivors Insurance. Forms, procedures, and policies of special medical interest were considered and discussed.

The Medical Advisory Committee's method of operation to date has been to use departmental staff, particularly technical and administrative staff of the Bureau of Old-Age and Survivors Insurance, to prepare analytical materials and reports. Tentative operating instructions issued to Bureau components, as well as other data for Committee review, have been furnished to all members in advance of the meetings. Reports on some matters were received from subgroups consisting of Committee members who had been designated by the chairman to review and analyze material covering specialized areas of the suggested standards.

The special problems involved and the criteria that will be required to process the large volume of "backlog" cases expected in the first 2 years of operation under the new provision were included in the Committee considerations.[3] The Department of Health, Education, and Welfare is entering into agreements with States that designate an appropriate agency for purposes of making determinations with respect to disability freeze cases. Most States have indicated that it is administratively feasible for them to make determinations for backlog cases that are perhaps no more than a year or two old, as well as for current cases in the future. The bulk of disability determinations for backlog cases, however, will probably have to be made by the Bureau of Old-Age and Survivors Insurance. Procedures for handling the heavy workload were discussed with the Committee, as well as guidelines for making determinations in these cases on the basis of the evidence submitted by the individual as to the onset, continued duration, and severity of his disability.

Under the law a disabled individual is required to furnish proof of his disability. Forms and procedures designed to assist him in furnishing such proof and for the convenience of his attending physician or other medical source in providing a report were discussed. A determination of disability will be made on the basis of all the medical, vocational, and other factors in the case. The Committee made recommendations as to acceptable sources of medical evidence and the composition of the reviewing board or team making the determinations. Among the recommendations made to the Social Security Administration are the following:

(1) The medical report must be based on an examination by a person licensed to practice medicine or surgery.

(2) It must be acted upon by a reviewing board or team, the physician member or members of which must be doctors of medicine.

(3) If the reviewing board needs further medical opinion or evidence, it should be obtained from a consultant at the specialist level.

(4) Any medical disability may be reevaluated.

(5) Remediable impairments are not to be considered as qualifying the applicant for the disability freeze if he rejects treatment that is safe and reasonable according to the usually accepted standards of medical practice.

During its deliberation the Committee studied the problem of achieving consistency of adjudication in the light of the administrative structure in which the freeze provision will operate. In contrast to the completely Federal administration of the other provisions of old-age and survivors insurance, the disability freeze provision of the program is being administered with the cooperation of State agencies under agreements entered into for the purpose of disability determinations in individual cases. The Committee recognized that, in view of the Department's need to adjudicate a large number of cases in a short period of time and the problems of interpretation potentially involved in the participation by all States in the adjudication process, guides and standards are needed to insure reasonable uniformity. A proposed set of such guides was considered for the interpretation and application of the definition of disability in the law. Standards, which set forth medical criteria for evaluation of specific impairments and combinations of impairments, were approved as a basis for initial operations during the coming months. It is expected, as experience is gained in the use of these standards, that suggestions for their revision will be considered by the Committee. The experience of the State agencies and of the Bureau will be appraised.

In addition to considering the specific medical implications of policies and procedures, the Medical Advisory Committee took cognizance of several questions of broad social importance or of special concern to the well-being of the individual applicant. The Committee included among its recommendations the following points for further consideration by the Social Security Administration and by appropriate State agencies and nongovernmental groups:

(1) State agencies responsible for the determination of disability should acquaint other State agencies with the content of the program and solicit use of combined resources whenever possible to avoid duplication and reduce administrative costs.

(2) A trained person should be available at the State level of the

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[3] An individual may be eligible if he could have met the work-history and other requirements for eligibility at the time he became disabled (even though the disability occurred some years ago) and if he has since been continuously disabled; he may file an application at any time before July 1, 1957, and have his disability retroactively established.

The backlog includes not only eligible disabled persons who have not yet reached age 65 but also individuals now over age 65 who are on the old-age insurance benefit rolls and whose monthly retirement benefits are lower than they would have been, had the individual been able to continue to work and make his contributions under the program up to age 65. Retired individuals who are beneficiaries may apply to have their benefits recomputed and increased beginning with payments for July 1955.

Table 11.—*Average payments including vendor payments for medical care, average amount of money payments, and average amount of vendor payments for assistance cases, by program and State, February 1955* [1]

State	Old-age assistance			Aid to dependent children (per family)			Aid to the blind			Aid to the permanently and totally disabled		
	All assistance	Money payments to recipients [3]	Vendor payments for medical care [2]	All assistance [2]	Money payments to recipients [3]	Vendor payments for medical care [2]	All assistance [2]	Money payments to recipients [3]	Vendor payments for medical care [2]	All assistance [2]	Money payments to recipients [3]	Vendor payments for medical care [2]
Total, 53 States [4]	$51.71	$48.41	$3.54	$86.12	$83.54	$2.65	$56.63	$54.44	$2.37	$54.60	$48.12	$7.06
Alabama	30.38	30.37	*.01*	43.07	43.05	*.02*				35.55	35.53	*.02*
Colorado							60.17	59.88	*.47*			
Connecticut	82.88	69.88	13.00	137.20	120.20	17.00	90.35	82.35	8.00	106.67	88.67	18.00
District of Columbia	53.22	53.20	*.01*	106.38	106.36	.02				60.06	60.03	*.03*
Hawaii	47.44	36.63	10.81	90.82	88.90	1.92	55.11	46.11	9.00	62.06	50.16	11.90
Illinois	59.62	41.44	19.58	131.97	120.91	11.10	65.02	50.52	15.21	80.26	41.81	40.05
Indiana	47.88	37.66	10.82	89.86	82.09	7.86	59.06	49.31	10.14	[5]	[5]	[5]
Kansas	64.52	59.43	*5.44*	112.49	103.94	*9.42*	71.14	66.11	*5.56*	66.97	59.55	*7.81*
Louisiana	50.79	50.79	[6]	64.72	64.51	.21	49.51	49.38	.13	42.43	42.32	.11
Massachusetts	76.36	56.26	20.60	126.52	117.29	9.47	93.94	93.31	*.68*	96.48	56.30	43.40
Michigan	54.94	54.27	1.79				62.68	62.34	.99	71.68	70.36	9.98
Minnesota	66.09	43.86	22.84	119.75	107.56	12.36	82.41	55.31	28.40	55.49	50.26	6.72
Nevada	57.48	55.78	2.49							[5]	[5]	[5]
New Hampshire	58.75	46.91	12.00	128.80	115.62	13.50	63.79	54.79	9.00	71.44	51.44	20.00
New Jersey				116.08	113.84	*2.24*	69.10	69.16	*.02*			
New Mexico	45.84	43.61	2.23	73.72	71.83	1.89	46.79	42.93	3.86	40.29	38.62	1.68
New York	77.08	60.92	19.21	135.73	125.00	11.78	85.75	71.89	16.99	82.91	67.46	18.02
North Carolina	31.28	30.93	.35	61.77	61.20	.57				37.12	36.50	.61
North Dakota	64.33	53.89	10.84	119.66	110.23	9.72	55.12	53.84	1.28	79.83	57.76	23.09
Ohio	57.84	55.71	2.13	91.75	90.18	*1.58*	57.19	55.24	*1.95*			
Pennsylvania	46.09	43.47	*2.63*	105.86	101.76	*4.10*	51.10	49.39	*1.71*	54.22	50.60	*3.62*
Rhode Island	58.31	53.52	6.52	112.05	105.05	7.00	71.16	65.13	7.83	73.55	65.41	11.65
Utah	59.40	59.34	*.05*	113.22	112.97	*.24*				64.26	64.23	*.03*
Virgin Islands	14.09	13.80	.29	23.79	23.43	.36	[7]	[7]	[7]	14.94	14.60	.34
Wisconsin	62.96	51.98	*11.07*	140.31	126.20	*14.16*	67.06	58.53	*8.53*	90.70	66.17	*24.71*

[1] Averages for general assistance not computed because of difference among States in policy or practice regarding use of general assistance funds to pay medical bills for recipients of the special types of public assistance. Figures in italics represent payments made without Federal participation. States not shown made no vendor payments during the month or did not report such payments.

[2] Averages based on cases receiving money payments, vendor payments for medical care, or both.

[3] Averages based on number of cases receiving payments. See tables 12–15 for average money payments for States not making vendor payments.

[4] For aid to the permanently and totally disabled represents data for the 42 States with programs in operation.

[5] No program for aid to the permanently and totally disabled.

[6] Less than 1 cent.

[7] Average payment not computed on base of less than 50 recipients.

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agency making the disability determination to explain to the applicant whose application for a disability freeze has been disallowed on medical grounds how his impairment may be corrected.

(3) Similarly, a trained person should be available so that, for those whose applications are disallowed, appropriate referral to other public agency resources for services or assistance can be made.

(4) Closer cooperation should be fostered between the health profession and the administration of tax-supported medical care programs for the indigent.

(5) State agencies responsible for the determination of disability should take the initiative in acquainting the medical societies and their members with the purposes, methods, and benefits of the disability freeze provision.