Old-Age, Survivors, and Disability Insurance: Early Problems and Operations of the Disability Provisions

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The disability freeze provisions of the Social Security Act became effective July 1, 1955. Their administration was still evolving when the amendments of August 1956 added provisions for cash disability benefits to insured persons aged 50–64 and for benefits to dependent children aged 18 or over who became totally disabled before they reached age 18. The experience of the Bureau of Old-Age and Survivors Insurance in administering the disability provisions is reported in the following pages.

THE Social Security Act provides three types of disability protection under the old-age, survivors, and disability insurance program: the preservation of insured status (the disability freeze), benefits for disabled workers aged 50–64, and child's benefits for persons aged 18 or older who have been continuously disabled since before they became 18.

The disability freeze has now been in operation for more than 2 years, and the cash disability benefits had their first major impact in August 1957, when more than 100,000 disability benefit checks were released. Child's benefits were first payable for January 1957. The following article describes the basic problems that had to be solved before effective operations could begin and presents a detailed picture of the present position of the Bureau of Old-Age and Survivors Insurance in administering the new provisions.

Types of Provisions

The disability freeze, enacted in 1954,[1] preserves the insurance status of workers so that absence from work because of long-term, total disability will not cause the reduction or loss of future benefit rights and payments. Before a worker can have his status frozen he must have worked in covered employment for at least 5 years out of the 10 years immediately preceding the beginning date of the disability; at least 1½ years of covered employment must be within the 3 years immediately before the beginning date of the disability. The disability must be of at least 6 months' duration. For purposes of the freeze, disability is defined as (1) "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration," or (2) "blindness." "Blindness" is defined as visual acuity of 5/200 or less in the better eye with the use of a correcting lens or as a comparable reduction in visual field.

In February 1955 a medical advisory committee was established by the Commissioner of Social Security. One of its functions is to provide the Social Security Administration with technical advice on medical problems arising in the application of this definition.[2]

A disabled person applying for a freeze before July 1958 may have his insurance status preserved as it was on the first date on which he was both disabled and had the required work record.[3] Thus, an individual applying before July 1, 1958, can establish a continuous period of disability with a beginning date as early as the last quarter of 1941, when the work requirements of the law could first be met. Starting July 1, 1958, however, the beginning of a worker's period of disability may not be established earlier than 1 year before his application is filed. Since the work requirements must be met on the beginning date of the period of disability, workers who have been disabled and have not worked for several years may no longer be eligible if they do not apply for the freeze before the end of June 1958.

Disability insurance benefits, first payable for July 1957, are provided for workers aged 50–64 who meet the same definition of disability used for the freeze, except that statutory blindness, in itself, does not automatically constitute disability.[4] The disability benefit, payable only after a 6-month waiting period, is calculated as though the worker were of retirement age. Unlike the retirement benefit, it is not accompanied by auxiliary payments to dependents. The claimant must meet the same

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[1] See Wilbur J. Cohen, Robert M. Ball, and Robert J. Myers, "Social Security Act Amendments of 1954: A Summary and Legislative History," *Social Security Bulletin*, September 1954, pages 11-12.

[2] See the *Bulletin*, April 1955, page 7, and May 1955, page 26.

[3] Under the original provisions, disability determinations could be fully retroactive only if applications were filed by June 30, 1957. Public Law No. 109 (Eighty-fifth Congress) extended the time limit to June 30, 1958.

[4] See Charles I. Schottland, "Social Security Amendments of 1956: A Summary and Legislative History," *Social Security Bulletin*, September 1956, pages 4-5, for a more detailed description of disability insurance benefits and benefits to dependent disabled children over age 18.

work requirements as for the disability freeze. He must also be fully insured at the beginning of his waiting period, but this additional requirement will not have any disqualifying effect upon applicants until 1961.[5]

Benefits to the children of insured workers have been extended by the 1956 amendments to include disabled children aged 18 or over whose disability began before they reached age 18. These benefits were first payable for January 1957. Disability under this provision is defined exactly as it is for disability insurance benefits. To qualify, the disabled person must be dependent, at the time his application is filed, upon a parent entitled to an old-age benefit, or, if the insured parent has died, he must have been dependent at the time of the parent's death. The disability must exist when the disabled son or daughter files application and must have continued since before he or she became age 18. The benefit is computed in the same manner as any other child's benefit under the program. The mother of a person receiving this type of benefit may qualify for mother's benefits if she has the disabled son or daughter in her care.

The 1956 amendments require that the amount of any disability insurance benefit or of any child's benefit payable to a disabled person aged 18 or over be reduced by the amount of any other periodic Federal disability benefit or any periodic Federal or State workmen's compensation benefit payable in whole or in part because of the claimant's physical or mental impairment. This provision was designed to reduce unwarranted duplication of disability benefits. In 1957 the law was amended to provide an exception; no reduction is made in the disability benefits payable under the Social Security Act to a veteran receiving compensation from the Veterans Administration because of a service-connected disability. The reduction provision continues to apply in all other cases, including veterans' pensions paid on account of non-service-connected disability.

[5] To be fully insured a person generally must have worked in covered employment at least half as many quarters as the number of calendar quarters elapsing between December 31, 1950 (or his 21st birthday, if that is later), and his attainment of age 65 (age 62 for women) or the date on which his period of disability begins. The 5 years of covered employment required for the disability freeze will be sufficient for fully insured status for disability benefits through 1960. Beginning in 1961 more than 5 years of employment will generally be necessary, since 5 years will then be less than half the time that has elapsed since 1950. (Anyone with 10 years of work in covered employment is fully insured for life.)

Administrative Problems

In enacting the disability freeze provisions in 1954, Congress specified that agreements should be negotiated with each State for making disability determinations and that these agreements should be made with the agency "administering the State plan approved under the Vocational Rehabilitation Act, or any other appropriate agency." The provision was implemented in late 1954 and in 1955. The Governor of each state designated the agency that he believed could best carry out the agency process prescribed by Congress. Agreements were also made with the District of Columbia, Alaska, Hawaii, and Puerto Rico. In 44 jurisdictions the agency designated was the State vocational rehabilitation agency; in four, the public welfare agency (which also administers the Federal-State program of aid to the permanently and totally disabled); and in four, both the agency administering the general vocational rehabilitation program and the agency administering rehabilitation provisions for the blind were named.

Organizing Within State Agencies

The provision for agreements to be negotiated with the States created a unique governmental relationship, under which State agencies play an integral part in the administration of a wholly Federal program. The working relationship under these agreements resembles in some respects the grants-in-aid relationship, although there are no State laws defining participation in program responsibility and no State funds involved. The relationship is voluntary. Federal funds are paid to the State agencies for their expenses, and in return the agencies make determinations of disability for applicants under the old-age, survivors, and disability insurance program.

In negotiating these agreements, legal questions with strong administrative policy considerations had to be resolved. What expenditures, for example, would be included in the reimbursable operating costs, and what would be considered joint costs of the Bureau and the State agency and how should they be shared? It was essential that each agreement allow the operation to fit as effectively as possible into each agency's existing structures and take into account the extent to which the agency could organize quickly to handle the new workload. Thus the agreements specified the classes of cases to be included or excluded from State jurisdiction at the option of the State. To alleviate the impact on State agencies of the heavy backlog of claims filed during 1955, the agreements with many State agencies initially restricted their disability determination activity to disabilities of recent origin. (Cases not covered by State agreements were handled directly by the Bureau of Old-Age and Survivors Insurance.)

The agreements cite uniformly the respective responsibilities of the Secretary of Health, Education, and Welfare (as they are to be carried out by the Bureau of Old-Age and Survivors Insurance) and of the State agencies. To ensure prompt and orderly processing and equality of treatment both within a State and among the States, the agreements require that uniform standards be applied in determining disability. All agreements provide that the States account for the Federal money paid to them by submitting for review and approval regular budgets and reports supporting their expenditures. All agreements also establish State responsibility for the employment of professionally qualified personnel to make the disability determinations, and the State agencies must follow Federal regulations and policies concerning the disclosure of information.

The agreements were flexible in such administrative areas as organization and staffing and the application of merit system requirements. Another example of flexibility is the provision permitting each agency to

pay for medical examinations in accordance with fee schedules in effect locally.

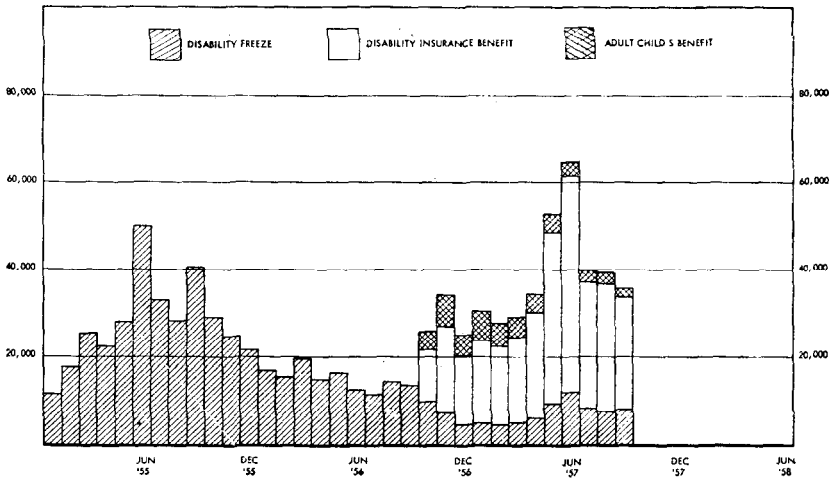
In preparing for the discussions with State agencies the Bureau of Old-Age and Survivors Insurance studied the fiscal and administrative procedures and experience of the Federal-State programs for which the Department is responsible, as well as those of the Federal-State unemployment insurance program. It also worked closely with a special committee of the Council of Vocational Rehabilitation State Directors. This committee helped considerably in developing the model agreement that was discussed with the State agencies and made recommendations for handling basic fiscal matters, such as questions that might be raised by auditors concerning specific expenditure items and the payment of administrative or overhead costs. A number of States either lacked statutory authority or required legal opinions by their attorneys general before they could enter into agreements, and a model enabling bill was prepared by the Department's Office of the General Counsel and distributed to all States by the Council of State Governments.

One difficulty encountered while the agreements were being negotiated was that all vocational rehabilitation agencies were faced with the problem of simultaneously building up their rehabilitation programs [6] and meeting the impact of the old-age, survivors, and disability insurance referrals for vocational rehabilitation services. In States where the vocational rehabilitation agency was also assuming the responsibility for making disability determinations there was the additional problem of securing and training new staff or of training existing staff for this function. Some of these agencies found it difficult to obtain the staff needed to achieve growth in both types of program activity as rapidly as necessary. Others quickly reached the point of effectiveness and asked to take on the full workload of disability applications filed in their State. In these States the original agreements were modified accordingly. The growing capacity of the State agencies to handle a large volume of cases is shown by the fact that at the beginning of the fiscal year 1955–56 only 13 of the 42 contracting agencies had accepted the entire backlog of disability cases (disabilities dating back as early as 1941) and at the end of that fiscal year 34 of the 56 contracting agencies were accepting the full backlog. The increasing acceptance of the backlog by the State agencies is also reflected in the growing proportion of cases forwarded to them by the Bureau's district offices. Cumulatively, they have been sent 52.4 percent of all cases; in the July–September 1957 quarter they received 77.5 percent.

Soon after some of the earliest agreements had been negotiated, it was clear that modifications were needed to permit the States to accept cases not covered by their original agreements when the Bureau felt that additional medical development, including medical examinations, was necessary. Extension of agreements to authorize transfer of jurisdiction in such cases was obtained gradually through further negotiations.

When the disability benefit provisions were enacted in 1956, the Bureau of Old-Age and Survivors Insurance and the State agencies were able, under the existing freeze agreements, to proceed temporarily with case processing except for cases involving benefits to dependent, disabled children aged 18 or over. The new agreements extending State jurisdiction to these cases and perfecting State authority for disability insurance benefit determinations were negotiated fairly rapidly. Only one State, Nevada, required new legislation to handle all benefit cases. For a few States, where the increased load of applications under the 1956 amendments created difficult operating situations and where it was mutually agreed that the State agency could not give as prompt attention to the cases as the Bureau could, temporary modifications were negotiated for transfer of some cases to the Bureau.

Chart 1.—*Initial disability applications received in district offices, by month, January 1955–September 1957*



Organization Within the Bureau

A corollary problem to that of organizing for State agency operations was the consideration of how best to fit into the Bureau structure the responsibility for administering the disability provisions. A Division of Disability Operations was established to pull together the special skills and resources needed for this new part of the insurance program.

Staff members with experience acquired in planning and administering the old-age and survivors insurance benefits were drawn from existing Bureau units. In addition, the

[6] The Vocational Rehabilitation Amendments of 1954 (Public Law 565, Eighty-third Congress) provided for a major expansion of the vocational rehabilitation program.

Bureau secured persons experienced in the administration of Federal-State programs. To fill out on the technical side it was necessary to employ persons skilled in evaluating disability and to blend their knowledge and abilities with those of claims adjudicative personnel. From this combination was welded a skilled group of disability examiners to review State agency disability determinations for consistent application of basic policies and procedures. These examiners were also to adjudicate the large volume of applications that the Bureau would handle until the State agencies could take on their full share of the workload.

Besides the Division of Disability Operations, the operating segments of the Bureau most affected by the disability provisions were the field organization, the district offices, and the regional staffs who supervise district office operations. These offices are the first point of contact and assistance for the disabled individual. District office staff had to learn about this new part of the program and to adapt their skills and facilities to the problems of the disabled; they also had to work with these problems in a new organizational setting, where State agencies share in the responsibilities for case processing and where rehabilitation is a closely related program. Furthermore, an entirely new area of relationships had to be developed with the medical profession. At the regional level, in particular, the negotiating and liaison functions with State agencies created significant new problems for the Bureau staff.

Coordination With Other Agencies

Organizing for disability operations required the establishment and maintenance of new relationships with agencies administering other programs. Some of these agencies—vocational rehabilitation agencies and public assistance agencies—were directly involved in the operation of the new provisions, and some, from their long experience in administering disability programs, were able to provide valuable advice and assistance.

Particularly close relations have been necessary with the Veterans Administration and the Railroad Retirement Board. Many disabled veterans filing for disability insurance benefits have as their only medical records those of the Veterans Administration. Interagency procedures were designed to make available, under proper authorization, pertinent records for use in supporting the veteran's claim for disability determinations under the social security program.

The Railroad Retirement Act guarantees to railroad employees that their annuities will not be less than the benefits that would have been payable if their railroad employment after 1936 had been creditable under the Social Security Act. Since in the calculation of the old-age, survivors, and disability insurance benefits periods of disability may be ignored, it is necessary to make disability freeze determinations even for disabled career railroad workers who may never have had work covered by the Social Security Act. At the outset, however, relatively few disabled railroad workers were aware of this "guarantee" provision, mainly because they have associated all benefits relating to their employment with the provisions administered by the Railroad Retirement Board. Accordingly, a working arrangement was reached with the Board soon after the 1954 amendments whereby it would advise disability beneficiaries under that program of the possible advantages of the freeze and accept freeze applications from those who wished to file. By June 30, 1957, the Board had received 35,000 freeze applications. Using the disability evaluation guides of the Bureau of Old-Age and Survivors Insurance, the Board is evaluating these applications and submitting disability recommendations for Bureau review. Differences of opinion are reconciled through periodic discussions between Board and Bureau disability staff.

Policies and Procedures

Development of Policy

In developing the policies essential to effective operation of these new provisions, the Bureau conducted extensive research and conferred with experts on policies and methods of operation. Study of other disability program experience proved helpful in the planning that had to be completed in the brief period between enactment of the legislation and initiation of the program.

Coordinated policies had to be rapidly prepared for use by district offices, State agencies, and the Bureau's central office. Disability applicants were to be interviewed and their case files compiled in more than 550 geographically dispersed district offices, and determinations of disability were to be made by 56 contracting agencies. It was thus essential that the basic policies for securing evidence and evaluating disability be uniformly understood.

The problem of achieving sound adjudication in the complex area of disability evaluation would have been a major one even if the decisions were to be made by a compact group of evaluators working in one central office and under uniform administrative direction. Since decisions were to be made by scattered evaluation teams representing 56 different jurisdictions, the problems of achieving uniform understanding and effective communication presented a formidable challenge.

Evaluation of Disability

Disability is defined in the Social Security Act as inability to work in any substantial gainful activity because of any medically determinable physical or mental impairment that can be expected to result in death or to last indefinitely. The definition is thus in general terms. It does not answer specifically such questions as: What is "long-continued and indefinite duration? What constitutes "substantial gainful activity?" What is "medically determinable?"

There appeared to be an implicit understanding throughout the hearings, debates, and reports on the disability legislation that Congress was concerned with impairments that could be expected to continue for so extended a period that they might well be characterized as permanent, although this term was not used in the law. As a consequence, the requirement of "long-continued and indefinite duration" has been interpreted to exclude any impairment that can be expected to improve to such an extent in the reasonably

near future that it would no longer prevent the individual from engaging in substantial work. Moreover, if by reasonable effort and with safety to himself the individual could achieve recovery or substantial reduction of the symptoms of the condition,[7] the impairment would not meet the "long-continued and indefinite" requirement.

"Inability to engage in substantial gainful activity" is the most difficult element in the definition. This phrase is not construed to mean that complete and irrevocable helplessness must be demonstrated. Congressional deliberation indicated, however, that the definition was intended to mean "total," in the sense that it refers to inability to engage in substantial gainful work of any type, not merely the kind of work the applicant has usually engaged in. Thus, an individual who has been advised to give up his particular kind of work in order to make his medical treatment more effective or who can no longer meet the physical or mental demands of his job is not necessarily disabled under the definition of disability under the Social Security Act. Although a prediction that the individual will never regain an ability to work is not required, there must be (1) a reasonable expectation that a medically determinable condition of serious proportions exists that will continue indefinitely and (2) a finding of a present inability to engage in any substantial gainful work because of such impairment.

This concept of disability differs in several respects from those underlying some of the other disability programs in this country. Industrial programs, for example, in their approach to the problem of retirement because of disability understandably tend to emphasize the employee's inability to continue at his regular job or to work satisfactorily at other jobs available in the company, rather than his inability to do any kind of substantial work. Disability determinations under the Social Security Act sometimes differ, also, from those made under private insurance contracts, which often presume extended duration of the disability if it has lasted at least 6 months, or from decisions under workmen's compensation programs and other public programs, primarily because of statutory differences.

A handicapped person may find it difficult or impossible to engage in substantial gainful work even though his condition is not so severe as to prevent him from doing many kinds of work. Social and economic factors affect the individual's ability to obtain and to retain employment in a competitive setting. Among these factors are fluctuations in the level of business activity, variations in the ability of an individual to find job openings, pre-employment physical requirements, hiring policies, and restrictions in employers' insurance contracts. Those who apply for disability benefits are usually not working and are under some employment handicap because of a physical or mental impairment. A finding of "disability" cannot be made, however, unless the impairment is found to be the *primary* cause of the individual's separation from the labor market.

Faced with the problems of evaluating disability on a large scale, the Bureau found it essential to develop and to keep refining evaluation guides —a tool that helps to get the job done with facility and uniformity. Guides that contain clinical descriptions of the most common disabling conditions have been prepared with the assistance of the Medical Advisory Committee and participating State agencies. These guides describe more than 130 impairments and show the symptoms and clinical and laboratory findings that usually exist when the condition has become so severe that most persons so afflicted would be unable to engage in substantial gainful work. Not all persons so afflicted will be equally disabled, but the impairments described are set at a level of severity that will be presumptively disabling in the absence of conflicting evidence.

Examples of some impairments that, if the claimant is not actually working, would be considered severe enough to prevent substantial gainful activity are:

1. The loss of the use of two limbs.
2. Certain progressive diseases that have resulted in the physical loss or atrophy of a limb, such as diabetes, multiple sclerosis, or Buerger's disease.
3. Disease of the heart, lungs, or blood vessels that has resulted in a major loss of heart or lung reserve as evidenced by X-ray, electrocardiogram, or other objective findings and that, despite medical treatment, produces breathlessness, pain, or fatigue on slight exertion, such as walking several blocks, using public transportation, or doing small chores.
4. Cancer that is inoperable and progressive.
5. Damage to the brain or a brain abnormality that has resulted in severe loss of judgment, intellect, orientation, or memory.
6. Mental disease (psychosis or severe psychoneurosis) requiring continued institutionalization or constant supervision of the affected individual.
7. The loss or diminution of vision to the extent that the affected individual has central visual acuity of no better than 20/200 in the better eye after best correction or has an equivalent concentric contraction of his visual fields.
8. Permanent and total loss of speech.
9. Total deafness uncorrectible by a hearing aid.

The guides greatly facilitate the handling of cases in which, from the standpoint of medical evidence alone, the impairment is clearly disabling, and there is no evidence to the contrary. The guides serve also as a training device and a standardization tool. They do not, however, represent a rating schedule, nor would an applicant be denied simply because his impairment was not severe enough to be presumptively disabling.

In determining if an individual's impairment makes him unable to engage in substantial work—whether or not the condition is presumptively disabling—primary consideration is given to the severity of the impairment as established by medical evidence, but consideration is also given in all cases to such other factors as the individual's education, training, and work experience. Thus, an im-

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[7] House Report No. 1698, Eighty-third Congress, second session; also *Social Security Amendments of 1954: Report of the Committee on Ways and Means, House of Representatives, to accompany H.R. 9366,* page 23.

pairment that approaches but does not meet the level of presumptive disability is not the basis for denial of the application. In such cases the impairment is carefully evaluated to determine whether, for the particular applicant, it so severely limits his ability to perform significant functions—such as moving about, handling objects, hearing or speaking, reasoning or understanding—that he is unable, with his training, education, and work experience, to engage in any kind of substantial gainful activity.

In only a small proportion of cases has a disabled person filed his claim while still engaged in some kind of gainful activity or returned to work after having had a period of disability established. The Bureau's experience in determining capacity for substantial gainful activity, when the disabled person is actually working, indicates that generally the work and earnings involved are either clearly substantial or clearly insignificant. In the great majority of cases, however, the individual has performed no work of any kind since his disability caused him to stop work, and one of the most difficult aspects of the disability determination is deciding if there is a capacity for substantial gainful activity even though the individual is not working.

Some individuals with seriously handicapping impairments find it possible to work in a sheltered setting or under special conditions in which the employer grants significant concessions or sets up special working conditions. Sheltered employment is generally defined as productive, remunerative work especially suited to the impairment of a handicapped individual and having as its objective his physical restoration, psychological readjustment, and subsequent participation in the regular labor force. The principal sources of such work are nonprofit voluntary agencies, organized to assist the handicapped.

Under the disability provisions of the Social Security Act, an individual in sheltered work might be found "able to engage in substantial gainful activity" if he were, in fact, actually doing substantial work on a reasonably regular basis and for substantial pay. When work under sheltered conditions ends, however, the individual often cannot find work in the competitive labor market and may not again be able to secure the advantage of special working conditions. Generally, therefore, an individual who would be found disabled if he were not working under special conditions is not considered to have demonstrated a capacity for other work.

Work on a trial basis is not considered as substantial gainful activity until there has been time to evaluate adequately the success or failure of the employment attempt. Work attempts that are of short duration and end because of the worker's health are generally considered unsuccessful and thus do not constitute substantial gainful activity. In effect, the governing factor in determining ability or inability to "engage in substantial gainful activity" is the actual capacity for gainful work as shown by the physical and mental demands of the job, the hours of work, the nature of the duties, the amount of earnings, and the continuity and duration of the effort.

Claims Process

The disabled individual usually first learns about the new disability protection through one of the many sources reached by the Bureau's district offices in their public informational activities. He may learn about it from his doctor, the newspaper or radio, his employer or union, or his friends. The individual—or, if he is unable to do so, his representative—gets in touch with the local district office.

Here he receives information as to his rights and obligations. He may decide to file an application, or he may decide not to file an application for a disability determination if he finds he did not work long enough in covered employment to meet the earnings requirements of the law or if his disability is temporary, partial, or otherwise less severe than it would have to be for him to qualify. If he decides to apply, he receives assistance from the district office in filing his application and in securing necessary proofs. The applicant supplies basic information on the nature and extent of his impairment, the medical treatment he has received, his education and work experience, and other facts needed for a sound determination of disability—his age, for example, the extent of his physical mobility, and the receipt of rehabilitation services or disability benefits under another program.

The applicant is responsible for presenting sufficient medical evidence to establish a reasonable likelihood that he has an impairment that meets the requirements of the law. This evidence includes medical and hospital reports giving the history of his condition, the diagnosis, and supporting clinical findings. Not only the nature of the impairment must be shown but also its severity. The medical evidence is handled in a way that protects the doctor-patient relationship and the individual's rights. Regulations prohibit disclosure except in specific situations, such as for use in vocational rehabilitation considerations. The district office provides the applicant with one or more report forms, which he usually takes to his physician for completion. The physician returns the form directly to the district office. Although the individual is encouraged to take the forms himself to the physician if the current status of his disability is involved, in some instances he may need medical evidence of earlier treatments or examinations; he will then be assisted in requesting information by mail from the doctor, hospital, or other source.

The medical report form, used by applicants to request information from their physicians or other medical sources, was designed with the assistance of the Medical Advisory Committee and was modeled after the standard forms used by most insurance companies to simplify doctors' reporting problems. Some special forms have been developed for use by mental hospitals where the applicant is hospitalized for a chronic mental impairment. The physician or hospital may, however, furnish the report in any convenient form—such as a narrative summary or a photocopy of records. If the records are being held by a government agency or a public or private institution, the district office may request a report directly from the source.

When the file is complete, it is forwarded by the district office to

the contracting agency in the individual's State or to the Division of Disability Operations for a determination of disability. In the State agency the case is assigned to a special disability determination unit, where the determinations are made by the State evaluation team (consisting of at least one doctor and one other person skilled in disability evaluation). All the evidence the individual has submitted is reviewed, and, if necessary, the State agency takes further steps to document the case more fully. Agency personnel may ask the applicant for additional information and may obtain, from appropriate sources, needed supplementary medical information, reports of psychological or vocational tests and studies, and information on employment and other matters.

Although the evidence in a particular case may indicate a reasonable likelihood that a claimant is disabled, more definitive clinical reports or other medical evidence is sometimes necessary to arrive at a sound decision or to resolve conflicts in the evidence. The State agency may, in such cases, authorize consultative examinations at Federal expense. Selection of consulting examiners and payment of fees are governed by State practices.

The State agency team makes its determination and fixes the date of onset (and termination, if any) of the disability. This determination is sent, with the complete file, to the Bureau's central office in Baltimore for review. Legally the State agency decisions that are unfavorable to the applicant cannot be reversed by the Bureau; his recourse in such instances is a request for reconsideration by the State agency or a hearing before a referee of the Appeals Council of the Social Security Administration. The Bureau corresponds with the State agency whenever it has a question about the handling of any individual case. All determinations are reviewed to ensure consistency of understanding of the disability requirements and reasonable uniformity in results among the State agencies; proper adjudication and equitable treatment of each applicant's rights under title II of the Social Security Act are thus assured. When State agency determinations have been examined and approved, they become by law the decisions of the Secretary of Health, Education, and Welfare. General consistency is achieved through a system for communicating policy and procedural decisions and through training and conference techniques. The same instructions, guides, and training materials governing determinations made by the Bureau are applied in the review of State agency cases.

The Bureau formally notifies the applicant of the final determination made in his case. If the application is denied, or a date different from that alleged for the onset of the disability is established and the applicant wishes to request reconsideration, he may submit supporting evidence or information. If the initial determination was made by a State agency, the Bureau returns the file to that agency for reconsideration. After reconsideration a new notice, affirming or reversing the previous action, is sent to the applicant by the Bureau. If an individual whose claim is denied chooses to request a hearing before a referee of the Appeals Council and the original decision is upheld by the referee, he may then ask that the case be reviewed by the Appeals Council. If the referee's decision is upheld by the Appeals Council, the individual may request judicial review in a United States District Court.

When a determination of disability has been made for an individual applying for a benefit on disability, his case file is sent to one of the Bureau's six payment centers in different parts of the country. There such nondisability aspects of the claim as age, insured status, and dependency are adjudicated, and benefits are certified for allowed claims.

A period of disability once allowed may be terminated in certain circumstances. Most common are the improvement of the impairment so that the individual is again able to work and the actual return of the individual to substantial gainful work. An applicant who has been found disabled is responsible for notifying the Bureau if either of these events occurs. Possible improvement in medical condition is periodically checked by means of reexaminations, scheduled in accordance with the nature of the impairment and the likelihood of significant change for the better. When a disabled individual returns to work, the Bureau may be put on notice by the individual's own report, by the employer's quarterly report showing earnings posted to his account after the disability had been established, and from other sources, such as a report of successful rehabilitation by a State agency. The continuance or termination of a period of disability is determined under the same rules as are the original determinations of disability.

To become entitled to disability insurance benefits, an application must be filed for such benefits. Thus, persons who have been allowed a period of disability under the freeze provisions do not automatically qualify for benefits upon attainment of age 50. At that time, the continuance of the disability must be affirmed or reestablished. It may be necessary to furnish additional medical evidence with the application for benefits.

Vocational Rehabilitation Services

Disability evaluation is closely associated with steps for vocational rehabilitation. Congress placed in the 1956 amendments to the Social Security Act the following statement of policy for referral for rehabilitation services:

> It is hereby declared to be the policy of the Congress . . . that disabled individuals applying for a determination of disability shall be promptly referred to the State agency or agencies administering or supervising the administration of the State plan approved under the Vocational Rehabilitation Act for necessary vocational rehabilitation services, to the end that the maximum number of such individuals may be rehabilitated into productive activity.

Following this policy the Office of Vocational Rehabilitation and the Bureau of Old-Age and Survivors Insurance, consulting with State agency officials, set up procedures so that persons inquiring about their rights under the disability provisions could be considered for rehabilitation serv-

ices by the vocational rehabilitation agency in the State in which they reside. Initially, the signed consent of disabled individuals was necessary before referral could be made. A revision of regulations in 1956, however, eliminated this requirement.

Every disabled person applying for a determination of disability receives a full and complete evaluation of the medical and nonmedical facts in his file for old-age, survivors, and disability insurance purposes. At the same time his potentialities for rehabilitation are assessed, on the basis of this evidence, under criteria furnished by the vocational rehabilitation agency. If, from the initial screening, rehabilitation seems possible, copies of pertinent medical or other evidence in the individual's disability file accompany a formal referral to a vocational rehabilitation counselor. The counselor then studies the case to determine whether services may be offered to the individual under the State rehabilitation program. For those who are identified as having vocational rehabilitation prospects, this policy of close coordination makes it possible for the vocational rehabilitation agencies to promptly consider them for services. Ability to provide the needed medical and vocational services for all the disabled persons who are referred may, of course, be limited by the agency's lack of funds, facilities, and skilled personnel.

The vocational rehabilitation agency also reports to the Bureau of Old-Age and Survivors Insurance on whether it accepts each referred case for further consideration. When an applicant is accepted, subsequent reports are also made on whether he has been offered services and, if so, on the outcome of the rehabilitation plan. Any refusal to accept services is also reported. These reports are an important factor in helping the Bureau of Old-Age and Survivors Insurance to carry out its responsibility for determining whether disability still continues after services are completed and whether the issue of refusal of services without good cause needs to be investigated.

The policies governing the development of evidence for the disability program require that full medical and nonmedical information be secured concerning each disabled individual's impairment and residual capacities. Thus the disability determination process produces information that is directly pertinent in assessing the applicant's rehabilitation potentialities and in the rehabilitative process itself. The rehabilitation activities of the agencies are, however, financed by the regular funds of the rehabilitation program. The Bureau of Old-Age and Survivors Insurance pays only the costs incurred by the contracting agencies in determining whether an applicant is and continues to be disabled for purposes of the Social Security Act.

The 1956 amendments require that disability benefit payments be suspended so long as the individual refuses, without good cause, to accept available rehabilitation services under a State plan. A State agency report that services have been declined does not, in itself, mean the loss of right to payments but does put the Bureau on notice that it may be necessary to suspend benefit payments. Each case is carefully investigated before a decision is made that an individual who has refused rehabilitation services—knowing the value of vocational rehabilitation services and the effect on his benefit rights of such refusal—has refused the services without good cause. The law, however, provides that refusal to accept rehabilitation services shall be deemed to be for "good cause" if the individual belongs to a church that teaches reliance on prayer as the sole treatment for physical or mental impairments.

Another provision in the 1956 amendments states that an individual who is receiving disability benefits and who is working under an approved State plan for his rehabilitation may still be considered as meeting the definition of disability for 12 months after he begins such work. This provision and the one imposing benefit suspensions for refusal of rehabilitation services without good cause are designed to encourage rehabilitation; the Bureau feels that their administration should be as compatible as possible with rehabilitation objectives and is developing policies to this end. State agencies have asked that policies be developed collaterally and in accordance with dual program requirements and objectives. As the Bureau moves forward in carrying out both provisions, it is taking advantage of the knowledge and advice of professional personnel from State and other rehabilitation organizations and from the Office of Vocational Rehabilitation in the Department of Health, Education, and Welfare.

Relationships With Medical Groups

The Medical Advisory Committee presents the viewpoints of medical and other professional groups on proposed policies relating to the operation of the disability provisions. One of its main functions has been to provide professional guidance in the formulation of medical criteria for evaluating disability. In addition, the Committee aids in promoting mutual understanding and working relationships among the Social Security Administration, cooperating State agencies, and physicians generally, and it interprets to the medical profession the problems and objectives of the disability determination process.

The Committee membership was drawn from all parts of the country and represents medical and related professions having a common interest in the problems of the disabled. The unbroken service of all of the original members and the Committee's continued functioning after disability insurance benefits had been established by the 1956 amendments have resulted in especially effective working relationships with Bureau staff. The Committee has met six times—three times in 1955, twice in 1956, and once in the first half of 1957. It has published one report,[8] and a second report is in preparation. Specific Committee recommendations are made directly and informally to the Bureau.

The Board of Trustees of the American Medical Association in September 1956 appointed a committee on medical rating of physical impairment. One of this committee's important functions is to provide liaison between the Association and

[8] *Medical Advisory Committee Report and Recommendations on the Administration of the OASI Disability Freeze Provision*, July 1955.

the Bureau of Old-Age and Survivors Insurance.

In administering the disability program, the Bureau and participating State agencies consider the promotion of sound and effective relationships with physicians to be a function of major importance. Informational materials prepared by Bureau and State agency staff and by the Medical Advisory Committee have been published and used by various professional medical associations, including State and county medical societies. The American Medical Association also has developed and published its own informational materials to assist physicians in cooperating in the disability program.[9]

Operations in State Agencies

Each contracting agency, although performing disability operations for the Bureau of Old-Age and Survivors Insurance, must operate within the framework of its State laws, organization, and administrative practices. Accordingly, the Bureau has had to develop management guides, policies, and procedures that permit some adaptation to individual State needs. Basic instructions to the States on administration cover such areas as accountability for funds, the propriety of expenditures, the distribution of costs when more than one program is involved, submittal of budgets and reports, and case controls. Procedures for evaluation and for case flow are also set forth, with their implications for staffing and organization. In addition, the Bureau carries on a survey program, arranges for technical and administrative training and conferences, and provides on-the-spot management assistance as requested by the State or as the need is detected in operational reviews.

The costs that the State agencies incur in making disability determinations are paid from appropriations made by Congress for the administrative expenses of the old-age, survivors, and disability insurance program. On the basis of budget estimates the Bureau advances money to the States. Any unexpended balance of these advances existing at the end of the budget period is used to finance costs in succeeding budget periods.

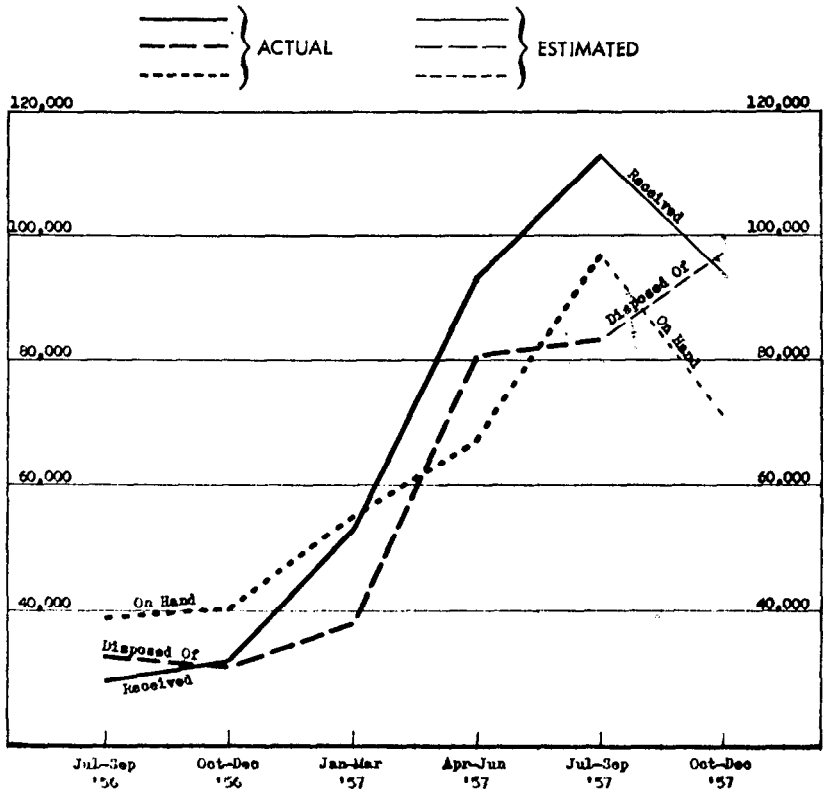
Existing State practices for handling Federal funds and the State's choice of a depository for funds are usually acceptable to the Bureau. Funds must be identifiable, however, on the State's records. Accounting records and reports and supporting documents permit verification by Federal fiscal audit and by the Bureau in its administrative review.

The Bureau works closely with the State agencies in the preparation of their budget estimates. The agencies submit budgets, item by item, for specific objects of expenditure such as personnel, equipment, and medical costs. Their expenditures are not subject, however, to control on that basis. State agencies must keep within the limitation of the total funds advanced for any period on the basis of an approved budget, although they may request and justify an increase for any period.

Although most States were able to establish an organization for handling freeze cases by the end of 1955, few achieved full operation in that year. Some agencies continued to have difficulty during 1956 because of large workloads. Inability to staff the program as fast as the workload developed resulted in heavy pending claims loads and long delays in the processing of some cases. Priority in processing was given to freeze cases that would result in immediate old-age and survivors insurance benefit increases and to claims in which disability benefits could immediately be paid.

The quality of the determinations has not, however, been a problem. In most agencies quality was achieved

Chart 2.—*State agency operations: Disability cases received, disposed of, and on hand, by quarter, July 1956–December 1957* [1]



[1] Data for July 1956-September 1957 from State agency reports, for October-December 1957 estimated.

[9] See the *Journal of the American Medical Association*, June 1, 1957, pages 566-571.

at an early point. Where difficulties have been encountered they were primarily in achieving full productivity with new personnel and with procedures and policies—Bureau as well as State—that required refinement in the light of experience. In some instances existing State laws, regulations, or practices have tended to limit the agencies' administrative flexibility—for example, in the use of overtime or in the recruitment of the necessary personnel as rapidly as workloads demanded.

In 1957, State agencies significantly increased overall production while continuing to emphasize quality. The disability staff of State agencies more than doubled in number from December 1956 through September 1957, primarily because of the added workloads created by the 1956 amendments.

Current Program Operations

By the end of September 1957, more than 900,000 initial applications for the disability protection provided by the 1954 and 1956 amendments had been filed in the district offices; of these 52,000 were for child's benefits for disabled persons aged 18 or over. The overwhelming proportion of disability applications have been filed by workers aged 50–64. Since October 1, 1956, when application could first be made for monthly disability insurance benefits, more than three-fourths of all new applications filed by disabled workers have been for cash benefits. This relationship is illustrated in chart 1, which shows, by type, the number of disability applications filed in district offices for each month since the beginning of the program.

Final determinations have been made on about 620,000 applications, including almost 34,000 for child's benefits from disabled children aged 18 or over.[10] Of the latter almost 30,000 have been found to be disabled. Of the disabled workers of all ages, approximately 324,000 or about 55 percent have been allowed periods of disability. In about three-fourths of the denials, it was found that the severity of the applicant's physical or mental condition was not great enough to prevent him from engaging in gainful work; the other applications were denied because of lack of work sufficient under the Social Security Act to meet the program requirements, failure to provide evidence or to prosecute the claim, or other technical reasons.

In about 50,000 cases—approximately 1 out of every 6 denials—the applicant has requested reconsideration. More than one-fourth of the completed reconsideration actions have resulted in a subsequent allowance. The principal reason for these reversals was the additional documentation of the case with information that was not supplied or was not available when the application was first filed; in many of these cases independent medical examinations at Government expense subsequently established that the individual's disability was more serious than the original evidence showed.

More than 12,000 applicants have carried their disagreement with the decision to a request for hearing before a referee. In more than 2,800 of these requests the Bureau has reversed the original decision before the hearing on the basis of additional evidence presented. In the approximately 2,900 cases on which the referees completed the hearings actions, about 4 percent were changed to a favorable decision. In the remaining cases awaiting a hearing, almost a third are still being developed in the Bureau or State agencies for additional or clarifying evidence.

The large number of applications filed since the enactment of the 1956 disability provisions has resulted in exceptionally high pending loads. Continued heavy workloads are anticipated for another year at least. Chart 2 depicts the progress of receipts and dispositions and shows pending loads at various dates.

At the end of September 1957 there were 120,000 disabled workers aged 50–64 receiving monthly benefits under the old-age, survivors, and disability insurance program at a monthly rate of $8.7 million. Additional disabled workers will become beneficiaries in succeeding months. The average disability insurance benefit for September 1957 was $72.24, after reductions because of the receipt of other disability pensions or benefits.

In addition to the monthly benefits payable because of disability, nearly 47,000 old-age insurance beneficiaries had increases that averaged $9.72 a month during July 1955–February 1957 as a result of the disability freeze. This increase was attributable to the exclusion of a period of disability and/or the dropout of up to 5 years of lowest earnings (when eligibility for the dropout stemmed from the disability freeze) in computing the worker's average monthly wage. In addition, about 23,000 monthly benefits payable to dependents of these retired workers, as well as to survivors of workers who had established a period of disability before death, were increased because of the freeze. For the same reason, lump-sum death benefits payable on the earnings records of about 11,000 deceased workers were increased by an average amount of $21.81 per worker.

The great majority of the disability insurance beneficiaries, as well as of applicants for a period of disability at all ages, are disabled by chronic diseases rather than by crippling injuries. Preliminary tabulations[11] show that, among applications approved so far, about one-fourth were from workers disabled by heart ailments and diseases of the blood vessels. Another one-fourth were disabled by diseases of the nervous system and impaired sight or hearing. One-eighth were suffering from mental disorders. Most of the applicants who have been turned down were suffering from similar ailments but not of the permanence or severity of those allowed.

Conclusion

The disability insurance provisions of 1954 and 1956 have added a new

[10] Data on benefit payments will not correspond with figures on disability applications filed, processed, and allowed or denied, since the payment figures do not include cases where the disability freeze is applicable but there is no immediate eligibility for benefits and since both disabled workers' and disabled children's applications may have been denied for other reasons of eligibility, such as age or dependency.

[11] See *Annual Statistical Supplement, 1955*, and *Annual Statistical Supplement, 1956* (in process).

dimension to the protection the old-age, survivors, and disability insurance program provides. The early administration of these provisions required that the Bureau establish an effective working basis for a new and unique governmental relationship with the States; that it bring into being an administrative framework and assemble the technical skills needed to handle the complex problem of disability evaluation; and that it establish policies and procedures that would lead to uniform treatment of all applicants regardless of where they filed their claims. The period ahead will be one of refinement of basic policies and processes, of operational improvements, and of continuing evaluation of the program.

Notes and Brief Reports

Selected Sources of Money Income for Aged Persons*

The slow downward trend in the labor-force participation rate of aged men appears to be continuing. In June 1957, it is estimated, fewer than 4.2 million persons aged 65 and over received cash income from employment either as earners or as wives of earners. A large proportion of the earners worked part time or intermittently, and consequently many of them were also drawing retirement benefits.

The year ending June 30, 1957, saw a net increase of more than 1.2 million in the number of persons aged 65 and over receiving old-age and survivors insurance benefits. Since the total number of aged persons in the United States is estimated to have increased during the year by only about 350,000, the proportion of the aged benefiting under the old-age, survivors, and disability insurance program increased almost one-sixth to 52 percent. In addition to the 7.8 million persons aged 65 and over with benefits in current-payment status in mid-1957, 1.8 million were eligible for but not receiving benefits. Thus, the number protected represented almost two-thirds of the entire population aged 65 and over—more than three-fourths of the men and more than half of the women.

More than 2.2 million aged persons were receiving benefits in June 1957 under the retirement programs for railroad workers and government employees, the pension and compensation programs for veterans, or the unemployment insurance programs. Certainly more than one-fifth but possibly a much larger proportion of these persons were also old-age and survivors insurance beneficiaries.

Despite the phenomenal growth in the old-age, survivors, and disability insurance program, public assistance in mid-1957 still provided the main support for nearly 2 million aged persons—two-thirds of them women—and supplemented old-age and survivors insurance benefits for about 570,000 persons whose needs, as measured by State public assistance standards, exceeded their income.

Taken together, persons receiving income under one or both of the income-maintenance programs for the aged under the Social Security Act made up almost two-thirds of all the aged. The proportion was only slightly higher for men than for women, although men were much more likely than women to receive insurance benefits.

In previous *Notes* in this series, the number of persons receiving income concurrently from both employment and social insurance programs and the number receiving benefits under more than one of the social insurance programs have been estimated. The data used were from various sources, but the primary reliance was on the findings of the 1951 nationwide sample survey of old-age and survivors insurance beneficiaries on the rolls in December 1950. Several factors relating to the old-age, survivors, and disability insurance program make it no longer feasible to make even a rough estimate of these overlaps: the total number of aged persons receiving benefits under the program has tripled since 1951; today beneficiaries include persons from almost all types of employment, whereas in December 1950 only wage and salary workers in industry and commerce were eligible; and the retirement test has been substantially modified. Consequently, it is not possible to estimate the number of aged persons supported entirely from sources other than employment or a public income-maintenance program.

Field work has just been started on a cross-section sample survey of the resources of old-age and survivors insurance beneficiaries on the

Table 1.—*Number of persons aged 65 and over receiving money income under one of the Social Security Administration programs and estimated number with income from employment, June 1957* [1]

[In thousands]

Selected sources of money income	Total	Male	Female
Total population aged 65 and over	14,870	6,830	8,040
Old-age, survivors, and disability insurance	7,810	3,980	3,830
Public assistance:[2]			
Public assistance, no old-age, survivors, and disability insurance	1,980	650	1,330
Public assistance and old-age, survivors, and disability insurance	570	320	250
Employment [3]	4,180	2,500	1,680
Earners	3,260	2,500	760
Earners' wives not themselves employed	920	----------	920

[1] Continental United States, Alaska, Hawaii, Puerto Rico, and the Virgin Islands.
[2] Old-age assistance recipients and persons aged 65 and over receiving aid to the blind. Includes 16,600 persons receiving vendor payments for medical care but no direct cash payment.
[3] Estimated in the Division of Program Research on the basis of published and unpublished data from the Bureau of the Census.

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