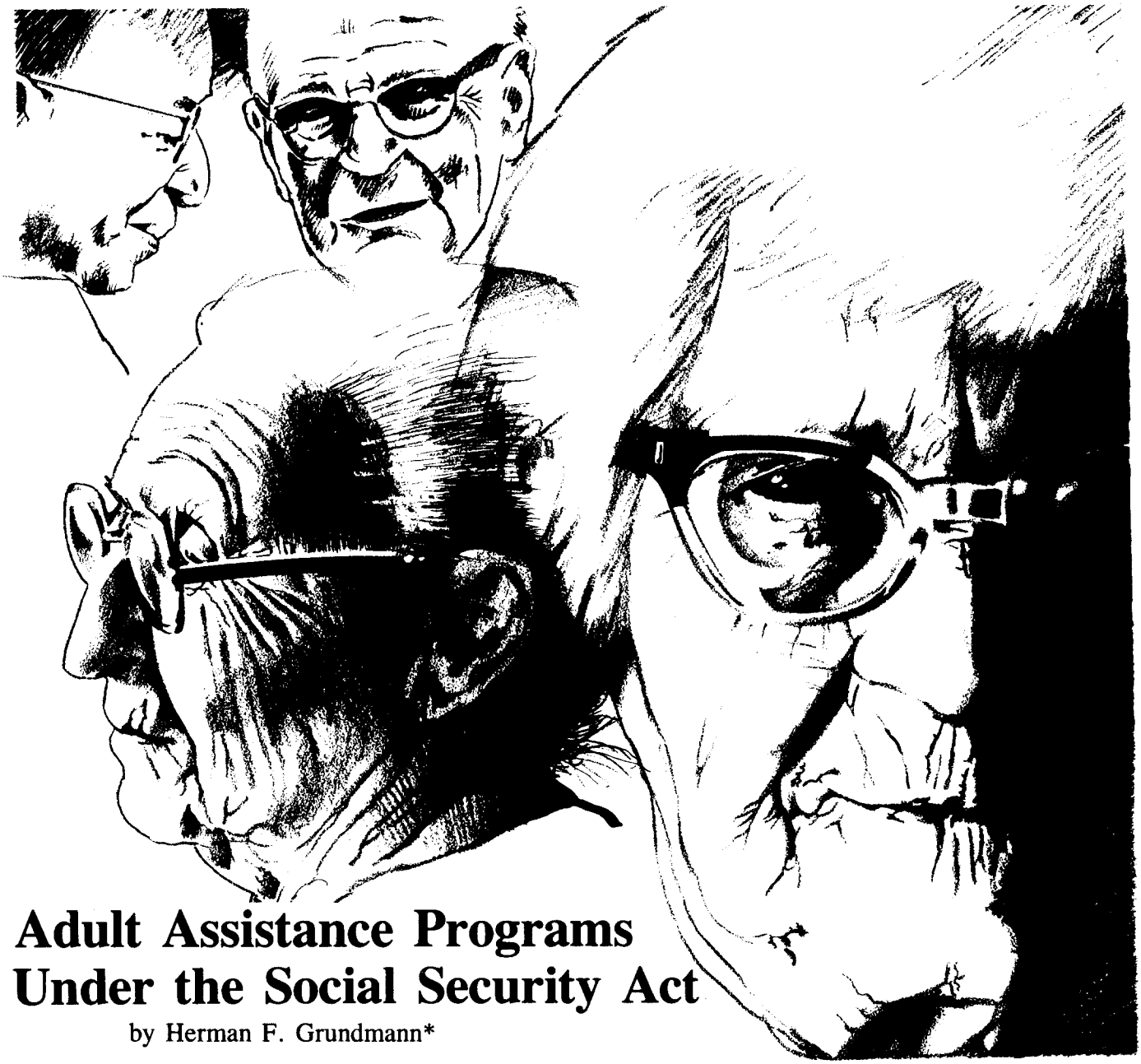

Adult Assistance Programs Under the Social Security Act

by Herman F. Grundmann*

Title I of the Social Security Act of 1935—Grants to States for Old-Age Assistance—introduced a permanent Federal commitment of financial aid to the elderly and shifted primary responsibility for public welfare from local to State welfare departments. This program of conditional grants-in-aid provided the main source of public income support for the elderly before gradually receding to its intended role as a backup to the old-age and survivors insurance program. The Act also instituted an analogous program of grants to States for aid to the blind, and the 1950 amendments added the program of grants to States for aid to the permanently and totally disabled. Through successive amendments, the formula for Federal cost-sharing in cash assistance payments under these programs was liberalized. In addition, Federal participation in payments to providers of medical care and services was permitted and gradually expanded, culminating in the enactment of the Medicaid program in 1965. In 1972, Congress replaced the three Federal-State programs of adult cash assistance with the Federal supplemental security income program for the aged, blind, and disabled, which introduced a national minimum income guarantee for these groups and provided more uniform eligibility standards and administration.

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The administrative framers of the Social Security Act envisioned a two-track approach to the problem of dependency in old age. A noncontributory, means-tested pension program would "meet the problem of millions of persons who are already superannuated or shortly will be so and are without sufficient income for a decent subsistence. A contributory annuity system, while of little or no value to people now in these older age groups, will enable younger workers, with the aid of their employers, to build up gradually their rights to annuities in their old age. Without such a contributory system the cost of pensions would, in the future, be overwhelming."[1]

This dual approach to the problem of dependency in old age ran counter to other proposals. The most salient among them, the Townsend plan, sought a single-track solution in terms of noncontributory pensions characterized by generous benefit levels and no means test. Attempts to substitute these proposals for both the old-age insurance and assistance provisions of the social security bill were easily defeated, however, because of the radical nature of these plans and doubts about their economic viability. The bill incorporating the two-track approach passed both Houses with overwhelming margins.

The social security program today bears a strong resemblance to the institutional arrangements under a mature program envisioned by the authors of the original legislation 50 years ago.

Adult Assistance Before 1935

By the 20th century, the Nation's economy had gradually shifted from a primarily agricultural base to a predominantly industrial one. This shift had profound effects on the economic situation of the elderly and necessitated major changes in institutional arrangements dealing with dependency in old age.

In the era of three-generational families on the farm or in the small town, old age in the absence of pronounced debility resulted merely in a gradual reduction of economic activity. In the urban industrial environment, older workers were at a disadvantage in competing for jobs demanding more physical exertion, skill, training, and education, and providing less flexible working conditions than many kinds of farm work. The younger urban worker, residing in cramped quarters, found it difficult in good times, and impossible in economically hard times, to provide for his family, educate his children, and also care for his aging parents.

However, perceptions and attitudes regarding the problem of dependency in old age were slow to change. Most Americans remained convinced that nearly everyone could take care of himself and his family through hard work and savings. Not until the widespread unemployment and losses in savings resulting from the Great Depression did Americans acknowledge that the vagaries of the industrial economy could inflict destitution and dependency on people through no fault of their own.

Through the 1920's, local government continued to be responsible for needy persons who were without the support of relatives, friends, or private charities. Most relief was in the form of food and shelter provided by city or county homes. As many States in the preceding decades had developed specialized institutions for certain categories of dependents, such as orphans and persons with chronic diseases or mental illness, the elderly had come to represent increasing proportions of the residents of city and county homes. Various State commissions reported frequently deplorable conditions in these homes. Many lacked adequate food, clothing, and medical care.

Following the 1920-21 recession, political pressure in the State legislatures began to build. Between 1923 and 1927, six States (Colorado, Kentucky, Maryland, Montana, Nevada, and Wisconsin) enacted legislation that permitted the counties to choose whether or not they wanted to institute programs of old-age assistance.

California (1929), and New York and Massachusetts (1930) established a new pattern by adopting laws that mandated the establishment of old-age assistance programs by the counties, provided State funds to share in the cost of such programs, and introduced a considerable degree of State supervision over county administration of the programs. A total of 20 States enacted old-age assistance laws between 1929 and 1933. Of these, 18 were of the mandatory type. Most of the States shared, and four States totally assumed, the cost of the assistance payments. By the end of 1934, programs of old-age assistance were in effect in 28 States and programs of aid to the blind in 24 States.

Provisions of the Social Security Act

The massive unemployment created by the Depression soon overwhelmed the relief capacity of private charity and local government and, not long thereafter, of the States as well. Federal relief was introduced first in the form of loans from the Reconstruction Finance Corporation, authorized by the Emergency Relief and Construction Act of 1932. The Federal Emergency Relief Act of 1933 set up the first national relief agency, the Federal Emergency Relief Administration, which provided emergency grants to the States under broad authority to distribute the money to local governments for relief purposes.

With the public assistance titles of the Social Security Act, the Federal Government for the first time extended

[1] **Report to the President of the Committee on Economic Security**, Government Printing Office, 1935, page 25.

a permanent commitment of direct financial aid to certain groups of needy persons. Grants to the States were authorized for old-age assistance under title I; aid to dependent children under title IV; and aid to the blind under title X. To qualify for Federal grants under these titles, a State was required to have an assistance plan approved by the newly established Social Security Board. The conditions for approval were specified in the Act and were essentially the same for the three programs.

The first three conditions for approval of a plan reflected characteristics of the old-age assistance programs of California, New York, and Massachusetts. The plan had to be in effect in all of the State's subdivisions; the State had to participate with its subdivisions in financing program outlays (or entirely assume the non-Federal share of outlays); and a single State agency had to administer the plan or supervise the program if administered at the local level.

Additional conditions for plan approval were that individuals whose claims had been denied be given the opportunity for an impartial review; that management methods necessary for efficient operation of the programs be introduced; and that reports to the Social Security Board be provided upon request. Also, assistance to the categorically needy—the aged, the blind, and dependent children—had to be in the form of money payments.

Further stipulations defined the kind of eligibility conditions that would be permissible. States could require that a recipient have resided in the State a specified number of years. However, this requirement could not exceed 5 out of the 9 preceding years including the year immediately preceding the application. County residence requirements were inadmissable. Although citizenship could be required, stipulations as to length of citizenship were not permitted. The minimum age requirement for eligibility for old-age assistance could be no more than 70 before 1940, and no more than age 65 effective January 1, 1940. There was no age requirement for aid to the blind.

For its part, the Federal Government obligated itself to share in the cost of the assistance expenditures under the approved State plans. Federal grants would be provided to cover 50 percent of the first $30 of monthly assistance paid to any needy recipient who was aged 65 or older, or blind, and not residing in a public institution: A less generous grant formula was applicable under the aid to dependent children program. States also could make payments in excess of $30 a month but would not receive Federal matching funds for such payments. In addition, the Federal Government would provide grants equal to 5 percent of the total Federal payment share toward the State's administrative expenditures.

The public assistance provisions of the Act did not guarantee a minimum income for eligible needy persons. For one, State participation was not required, although, in practical terms, the inducement of Federal grants was sufficient to ensure virtually uniform participation under all three programs within several years. For another, the requirement included in the original social security bill that each State "provide a reasonable subsistence compatible with decency and health" was eliminated before enactment. Thus, the Social Security Board had no authority to regulate the adequacy of payments. States were free to establish payment levels that might be considered inadequate by some absolute standard or in comparison with payment standards in other States. The Board could insist, however, under the clause mandating efficient methods of administration, that payment levels—whatever their adequacy—be equitably administered throughout a given State.

The public assistance provisions of the Act reflected an increased regard for the dignity of the indigent individual. Assistance was in the form of money payments, which gave adult recipients the right and responsibility to decide how to allocate the money to meet their needs. The higher payment levels made possible by Federal grants also contributed to the self-respect of recipients by increasing their ability to arrange their lives. Moreover, the right of applicants to a fair hearing before the State agency reinforced the dignity of recipients by strengthening the concept of assistance payments as a right.

As a result of the Social Security Act the eligibility conditions concerning minimum age, residency, and citizenship became less restrictive than they had been in most State programs. The Act did require that assistance payments be limited to needy persons. Although it did not prohibit the States from requiring financial support from relatives or liens on the recipient's home, neither did it require such provisions as a condition of Federal grants.

The public assistance provisions of the Social Security Act marked a major step in the development of public welfare institutions in the United States. These provisions did not represent a radical departure but instead built on and strengthened the assistance programs already existing in many States. Through the inducement of conditional grants-in-aid, the Act served to complete rather quickly the shift of primary responsibility for public welfare from local government to State welfare departments. Within general bounds defined by the Social Security Act, the States retained broad authority to determine the payment level, eligibility conditions, and other aspects of the assistance programs.

Legislation Through the 1940's

The use of grants-in-aid under the public assistance titles of the Social Security Act, including the requirement for approval of State plans on specified condi-

tions, was not a new development. The novel aspect of these grants was their open-ended nature.[2] The total amount of Federal grants under the public assistance provisions was not fixed under some predetermined allocation formula but depended instead on two quantities, which to a considerable extent were under State control: The number of qualified recipients, and the payment levels.

The 1939 Amendments to the Social Security Act raised from $30 to $40 the maximum monthly payment to which Federal matching grants were applicable under the programs of old-age assistance and aid to the blind. The amendments also added the stipulation that in determining an applicant's need the States were to consider all of his or her income and resources. The Social Security Board had two purposes in advocating this rule. One was to promote uniformity and equity in assistance payments among the States. The other was to emphasize that the means-tested old-age assistance program was intended to be supplementary to the old-age insurance program—in contrast to other pension proposals modeled on the Townsend plan, which did not include a means test because they were designed as primary instruments for income security in old age.[3] These proposals continued to have strong public support, especially among older people.

The 1939 amendments also strengthened the requirement for efficient management of the public assistance programs by adding the stipulation that State and local welfare department personnel must be subject to a merit system. A further requirement was added for safeguards to protect the confidentiality of records of applicants and recipients.

The Social Security Board and its successor agency from 1946 on, the Social Security Administration, were continually concerned about the disparity in payment levels among States. The disparity pointed to problems of adequacy as well as of equity. In 1940, for example, old-age assistance payments in States with the highest payment levels were on the average about four times as high as in States with the lowest payment levels; this ratio had declined to about 3-to-1 by 1950 and 2 1/2-to-1 by 1960.

Accordingly, beginning in 1939, the Board advocated a change in the grant formula to raise the rate of Federal participation to more than 50 percent for States with limited fiscal capacity. For example, States for which per capita income was equal to or above the median level among the States might continue to have Federal participation at the 50-percent rate. The remaining States would be eligible for a higher rate, up to some maximum, depending on their per capita income levels.

The purpose of such a "variable grant" formula was to provide increased financial aid and inducement for States with limited fiscal capacity to raise their payments. Congress, however, favored a formula that would increase the Federal share payable to all States, although to a greater extent for States with comparatively lower payment levels. In 1946, Congress enacted such a formula. The Federal share under the adult assistance programs became two-thirds of the first $15, plus one-half of the next $30, of the payment to qualified recipients. The Federal share was further increased in 1948 to three-fourths of the first $20, plus one-half of the next $30, of the recipient's payment.

These two-bracket formulas resulted in higher rates of Federal sharing in assistance payments for States with low payment levels—which tended to be those with limited fiscal capacity—compared with States with high payment levels. Nonetheless, the formulas were not targeted well on these States because all States with high payment levels also reaped the advantage of the higher matching rate applicable to the first bracket. Moreover, the formulas did not provide added inducement for States with low payment levels to raise their payments above the first bracket inasmuch as the rate of sharing applicable to the second bracket remained unchanged.

Legislation During the 1950's

By the late 1940's, the most serious shortcomings of the public assistance provisions were that coverage remained limited to the aged and blind, and that most State costs for medical care of recipients were excluded from Federal participation. The extreme disparity in State per capita expenditures for general assistance as well as for medical care indicated that some States did not have the fiscal capacity to provide for the whole spectrum of essential assistance needs. To a considerable extent, these States presumably were allocating their resources to those needy persons and categories of assistance expenditures for which Federal matching grants were available.

The report of the 1949 Advisory Council on Social Security endorsed earlier proposals to extend Federal financial participation, at a rate of one-third—that is, programs of assistance to needy families and individuals outside of the federally aided categories to the financing of general assistance programs. The report also endorsed proposals to permit the payment of medical costs directly to the providers of medical care, up to a total amount for each State based on its number of qualified recipients.

In 1950, Congress enacted legislation of more limited scope in both areas. A new adult assistance program of aid to the permanently and totally disabled was created under title XIV of the Social Security Act. Its provisions were entirely analogous to those of the other assistance

[2] See Martha Derthick, **The Influence of Federal Grants**, Harvard University Press, 1970, page 21.

[3] See Arthur J. Altmeyer, **The Formative Years of Social Security**, The University of Wisconsin Press, 1966, pages 80, 81, and 105.

programs. Thus, Congress singled out for Federal support, among the broad category of needy persons served by the States' general assistance programs, the group of persons considered most deserving of aid.

Extensive debates preceded enactment of this new adult assistance program. The 1949 Advisory Council recommended a disability insurance program for the permanently and totally disabled. In a forceful memorandum of dissent, however, two members of the Council argued that a public assistance program would be the more appropriate method of taking care of the disabled. They contended that the experience of private group insurance during the Depression had shown the problems arising from a medical definition of total disability when claims are pressed to the limit during economically difficult times. The House bill included provisions for both a disability insurance and a disability assistance program, while the Senate bill lacked either provision. Only the program of aid to the permanently and totally disabled was enacted.

One concomitant of the new assistance program was the need to define the eligibility condition of permanent and total disability. Although the States had the responsibility for implementing this standard—through legislative and administrative definitions, by hiring and training of medical and social work staff, and through working agreements between relevant State agencies—the Social Security Administration issued certain guidelines: Total disability did not have to mean complete incapacity but rather a substantial inability to engage in one's usual productive work, including homemaking. Permanent disability meant the likelihood rather than near-certainty that the individual would not be able to regain his or her ability to engage in productive work; medical procedures and vocational rehabilitation might be instrumental toward the latter end.

By June 30, 1951, 38 States had approved plans in operation under the new title. By the end of the decade, 45 States were participating in the program for the permanently and totally disabled.

On the issue of Federal sharing in the cost of medical care, the 1950 amendments provided a conceptual breakthrough, the practical importance of which remained limited until further legislation in 1956. The stringent requirement contained in the public assistance titles of the Act, that assistance was to be in the form of money payments to the recipients, precluded States from being reimbursed for the part of their assistance expenditures paid directly to the providers of medical care. Inasmuch as a growing proportion of expenditures for medical care by the general public was being paid through group insurance rather than directly by families and individuals, the rationale for the money payment stipulation, namely, to safeguard the individual's responsibility for his or her own affairs, was no longer convincing in regard to payments for medical care.

The 1950 amendments accordingly permitted States to receive reimbursement through Federal grants for vendor payments made directly to providers of medical (or remedial) care. However, any such payments in behalf of a recipient continued to be subject to the maximum individual payment amount for which Federal sharing was available; Congress rejected proposals for a separate State maximum for vendor payments. Since medical expenses, unlike regular maintenance costs for shelter and food, tend to vary greatly from month to month, a large proportion of the vendor payments was apt to exceed the recipient's maximum payment amount. For the most part, therefore, reimbursement for medical care costs continued to be excluded from Federal participation.

This was changed as a result of the 1956 amendments, which introduced a separate State maximum for vendor payments for purposes of Federal cost-sharing. The formula for this maximum under the adult assistance programs was $6 multiplied by the number of recipients. Under 1957 legislation, States also were given the option of including both money and vendor payments under the current maximum of $60 applicable to individual payments.

The 1958 amendments shifted the calculation of the maximum for money payments to recipients from an individual to a State basis as well. All payments to adult recipients became subject to Federal cost-sharing, provided that total State payments, including vendor payments, did not exceed $65 multiplied by the number of recipients. Thus, for example, the entire amount of an assistance payment of $100 would be subject to Federal cost-sharing as long as it was offset by a payment of $30 or less to another recipient (whose small payment amount might indicate other income sources).

The 1958 amendments also introduced variable grants into the second bracket of the matching formula. The new formula became four-fifths of all of the State's payments up to the statewide average of $30 per recipient, plus from 50 percent to 65 percent, depending on the State's per capita income, of all payments up to the State average of $65 per recipient. The formula for determining the variable grants percentage, P, was

$$P = 100 - 50(S^2/N^2) \text{ and } 50 \leqslant P \leqslant 65,$$

where S and N represent average State and national per capita income for the preceding 3 years.[4]

Other significant legislation during the 1950's cancelled the rule barring Federal participation in payments to persons in public medical institutions, except where the diagnosis was mental illness or tuberculosis (1950); encouraged the States to provide various kinds of services intended to increase the self-reliance of recipients by

[4] See Robert J. Myers, **Social Security**, Third Edition, Richard D. Irwin, Inc., 1985, page 753.

permitting Federal sharing for services on the same basis as for administrative expenditures (1956)—Federal sharing for administrative expenditures had been 50 percent for all assistance programs since 1946; and extended Federal sharing in assistance expenditures to Puerto Rico and the Virgin Islands (1950), and to Guam (1958).

Legislation During the 1960's

With the enactment of the disability insurance program in 1956, the focus in social welfare issues shifted to health care for the aged. It was generally agreed that health insurance was less available and more costly for the aged than for workers and their families. Views sharply diverged, however, regarding how to improve medical care for the aged population. The main proposals introduced in Congress in 1960 were (1) mandatory health insurance financed through social security payroll taxes (Forand bill), (2) Federal matching grants to the States for a wide range of medical benefits for low-to-moderate-income persons (administration bill), and (3) Federal matching grants to the States to subsidize the cost of private health insurance (Javits bill).

When it became apparent that adequate political support for any of these comprehensive measures was lacking, the House Ways and Means Committee agreed on a more modest plan for a medical assistance program for the needy aged. Because the plan's provisions were noncontroversial and its passage would allow for later enactment of a more comprehensive plan, the committee bill encountered little opposition in either House of Congress.

The legislation enacted resulted in title I of the Social Security Act being renamed Old-Age Assistance and Medical Assistance. The new medical assistance program provided Federal grants to the States for persons aged 65 or older who were assistance recipients or "medically needy." The medically needy were defined as categorically eligible persons whose income and resources were above the assistance level but insufficient, as determined by the States, to pay for their medical care costs. Most of the conditions for approval of a State plan were identical to those for the old-age assistance program. In addition, although the scope of medical services provided continued to be an option of the States, the plan was required to include some institutional as well as some noninstitutional care and services. No enrollment fee or premium could be imposed as a condition of an individual's eligibility.

The medical assistance program set a somewhat more liberal standard in its eligibility conditions and Federal matching formula compared with other public assistance programs: No duration-of-residence requirement was permitted, medical assistance had to be furnished to a resident of the State even when that person was absent, and no lien could be imposed against the individual's property before his or her death. Federal participation varied from 50 percent to 80 percent depending on the State's per capita income and, for the first time, was not subject to an upper limit.

Federal participation in medical vendor payments also was increased for the old-age assistance program. The State could choose one of two supplemental formulas for the increase: (1) Reimbursement at the rate of 50 percent to 80 percent, depending on per capita income, for vendor payments of up to $12 per recipient that brought expenditures above the usual State maximum amount of $65 per recipient, or (2) an additional 15 percent of reimbursement for vendor payments up to $12 per recipient. In 1961, the $12 limit on vendor payments in these supplemental formulas was raised to $15. The maximum in the main formula was also raised for all adult assistance programs (to $66 in 1961, to $70 in 1962, and to $75 in 1965), with similar increases applying to the first bracket of the formula.

As a result of the 1962 amendments, the additional Federal grants applicable to old-age assistance also became available for aid to the blind and aid to the permanently and totally disabled, provided the State combined all three programs into a single one under the newly created title XVI of the Social Security Act. In addition, the amendments increased from 50 percent to 75 percent the rate of Federal cost-sharing in services provided by the States to public assistance recipients in all categories for the purpose of increasing their self-reliance.

A long-term solution to the health care needs of the aged was attained through major legislation in 1965, which added titles XVIII and XIX, the Medicare and Medicaid programs, to the Social Security Act. Part A of Medicare, Hospital Insurance Benefits for the Aged, paid for specified periods of hospital care as well as for post-hospital extended care and home health services. All persons aged 65 or older entitled to social security or railroad retirement benefits were covered. The program was financed through a mandatory increment to the social security payroll tax.

Part B of Medicare, Supplementary Medical Insurance Benefits for the Aged, paid for services and supplies furnished by physicians. All persons entitled under Part A (except aliens) were eligible to enroll in this program by paying a monthly premium. The program was funded from these premiums and a matching Federal contribution from general revenues. Medicaid, Grants to States for Medical Assistance Programs, was designed as an improved version of both medical vendor payments for public assistance recipients and assistance for the medically needy. Federal grants were subject to the same basic conditions as under the predecessor medical assistance program. The following additional re-

quirements for Federal participation were introduced by Medicaid.

First, all public assistance recipients were to be included and, if medical assistance was provided for any category of the medically needy, the medically needy in all public assistance categories (for which the State had an approved plan) were to be included.

Second, the provision of certain medical services was mandatory—although the States continued to determine the scope of services offered. The list of medical services that generally were required included inpatient and outpatient hospital services, laboratory and X-ray services, skilled-nursing home services, and physicians' services.

Third, medical services for recipients of cash assistance were required to be no less in amount and scope than those provided for the medically needy. Eligibility conditions also had to be comparable for persons in the two groups who had similar income and resources including cash assistance.

Fourth, eligibility standards regarding income and resources were to be such as to take into account only income actually available to the individual and to consider his or her medical costs.

Finally, enrollment fees, premiums, deductions, and cost-sharing generally were prohibited with respect to those medical services that were required under the State plan. Moreover, similar charges under Part B of Medicare had to be considered in evaluating the individual's income and resources.

Federal cost-sharing in medical vendor payments for public assistance recipients formerly had been subject to a ceiling. Only cost-sharing in medical assistance for the medically needy aged had been determined by a variable grant formula free of a ceiling. Under Medicaid, Federal cost-sharing in medical assistance for both public assistance recipients and the medically needy became subject to the variable grant formula without a ceiling. This formula provided grants varying between 50 percent and 83 percent depending on the State's per capita income.

Any State with an approved Medicaid plan also was given the option to apply the Medicaid variable grant formula, in lieu of the regular two-bracket formula, to its total money expenditures under all public assistance programs. Many of the States with high money payment levels found use of this alternative formula advantageous because it did not set an upper limit to the amount of payments eligible for Federal cost-sharing.

Adult Assistance Programs in 1972

In 1972, Congress replaced the programs of grants to States for old-age assistance, aid to the blind, and aid to the permanently and totally disabled, as well as the combined program under title XVI, with a Federal program under a new title XVI called supplemental security income (SSI) for the aged, blind, and disabled. However, the programs of Federal grants-in-aid remained in effect for Puerto Rico, Guam, and the Virgin Islands.

A review of old-age assistance program experience between 1936 and 1972 indicates that the number of recipients rose (using year-end figures) from 1.1 million in 1936 to 2.2 million in 1941 and 1942, receded during the war years to 2.1 million in 1945, climbed to 2.8 million in 1950, and then gradually declined to 1.9 million in 1972 (table 1). This decline resulted from the increase in the number of aged persons receiving social security benefits as well as in the average amount of their benefits. At the end of 1940, the first year of social security benefit payments, only 147,000 persons aged 65 or older were receiving benefits. This number rose to 2.6 million in 1950, 10.9 million in 1960, and 18.7 million in 1972 (table 2). Average social security benefit amounts increased between 1940 and 1972 from $23 to $162 for retired workers, from $12 to $86 for aged wives, and from $20 to $138 for aged widows.

The number of persons receiving aid to the blind rose from 45,000 in 1936 to a peak of 110,000 in 1958 and thereafter declined gradually to 80,000 in 1972. By contrast, the number of persons receiving aid to the permanently and totally disabled climbed slowly but steadily from 69,000 in 1950, the first year of the program, to 1.2 million in 1972. The number of social security beneficiaries whose entitlement was based on disability also grew steadily from 179,000 in 1957, the first year disability benefits were payable, to reach 1.1 million in 1964, and 2.2 million in 1972.

Total money payments under the adult assistance programs amounted to $3.4 billion for fiscal year 1973. Of this amount, $2 billion represented Federal funds and $1.4 billion, State and local government funds.

The most important accomplishment of the adult assistance programs was to provide basic income support

Table 1.—Number of persons receiving adult assistance, by program, selected years, 1936–73.

[In thousands]

End of year	Total	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled
1936	1,153	1,108	45	...
1940	2,143	2,070	73	...
1945	2,127	2,056	71	...
1950	2,952	2,786	97	[1] 69
1955	2,883	2,538	104	241
1960	2,781	2,305	107	369
1965	2,729	2,087	85	557
1970	3,098	2,082	81	935
1972	3,182	1,934	80	1,168
1973	3,173	1,820	[2] 78	[3] 1,275

[1] Program initiated in October 1950 under 1950 Social Security Amendments.

[2] Includes 23,000 persons aged 65 or older.

[3] Includes 64,000 persons aged 65 or older.

Table 2.—Number of social security beneficiaries aged 65 or older and number receiving benefits based on disability, selected years, 1940–84.

[In thousands]

Type of beneficiary	End of year						
	1940	1950	1960	1970	1972	1980	1984
	Beneficiaries aged 65 or older						
Total	147	2,598	10,887	17,517	18,651	23,843	26,086
Retired workers	112	1,771	7,704	12,122	13,115	17,565	19,499
Dependents and survivors	35	827	3,183	4,861	5,126	6,185	6,547
Persons with special age-72 benefits [1]	...	...	...	534	410	93	40
	Beneficiaries with benefits based on disability						
Total	...	...	559	1,813	2,202	3,436	3,210
Disabled workers	...	...	[2] 455	1,493	1,833	2,859	2,597
Disabled children aged 18 or older	...	...	[2] 104	271	305	450	506
Disabled widows and widowers	...	...	...	[3] 49	64	128	107

[1] Authorized by 1966 legislation for persons aged 72 or older not insured under the regular or transitional provisions of the Social Security Act.

[2] Benefits to disabled workers and disabled children aged 18 or older were first payable in 1957.

[3] Benefits to disabled widows and widowers were first payable in 1968.

for the aged, blind, and disabled during the early years of the social security program. The first Federal grants under the public assistance provisions were made in February 1936, nearly 4 years before the start of social security benefit payments. From 1940 through early 1951, more aged persons received old-age assistance payments than social security benefits.

Moreover, from 1940 to 1949, average benefit amounts for retired workers rose only slightly, from $23 to $26, reflecting both the limited effect of rising earnings levels on the benefit formula and the absence of cost-of-living adjustments. During the same period, old-age assistance payments more than doubled, from $20 to $45, and payments for aid to the blind nearly doubled, from $25 to $46. These sharp increases show the responsiveness of the assistance programs to increases in the cost of living (about 70 percent) and in Federal financial participation (1946 and 1948 legislation) during this period.

The large increases in social security coverage and benefit levels enacted in 1950 marked the start of the transition for the old-age assistance program to its intended permanent role. This role was to provide income support for aged persons who either do not qualify for or qualify for only low amounts of social security benefits. The proportion of the aged population receiving social security benefits climbed rapidly from 16 percent to 86 percent between 1950 and 1970, while the proportion of the elderly receiving old-age assistance dropped from 22 percent to 10 percent. In 1950, less than 10 percent of old-age assistance recipients had been social security beneficiaries. By 1970, this proportion had grown to over 60 percent (table 3).

Similarly, aid to the permanently and totally disabled during the 1950's, and aid to the blind from 1936 on, provided income support to disabled and blind persons prior to legislation in 1956, which established the social security disability insurance program. From that time on, the primary role of these assistance programs became one of providing income support to disabled and blind persons who do not qualify for social security disability benefits or qualify for only low benefit amounts.

The number of persons receiving aid to the blind, accordingly, declined gradually after 1958. However, the number of persons receiving aid to the permanently and totally disabled continued to increase during the 1960's and into the 1970's.

Another important accomplishment of the adult assistance programs was the gradual development of methods of providing medical care and services for needy persons. The principle that all assistance should be in the form of money payments to the recipient was intended to enable him or her to retain responsibility for decisionmaking. In order to permit more effective and accepted methods of paying for medical services, this principle was gradually modified. The first change was to permit Federal cost-sharing in vendor payments. Next, the change in the cost-sharing formula from a maximum on the individual's payment to a maximum defined in terms of a statewide average payment per recipient gave the States the necessary flexibility to obtain Federal matching funds for more medical expenditures for recipients. Finally, the Medical Assistance for the Aged and Medicaid programs expanded the population of needy persons for whom cost-sharing of medical expenditures could be obtained and removed the ceiling on Federal matching funds.

Provisions of the SSI Program

The major continuing problem of the adult assistance programs was the persistence of considerable differences in cash payment levels among States. At the end of 1972, for example, the average monthly payment

Table 3.—Percent of aged population receiving social security benefits and adult assistance payments, selected years, 1940–84

End of year	Percent receiving—		Persons receiving both social security and adult assistance [1] as percent of—	
	Social security	adult assistance [1]	Social security beneficiaries	adult assistance recipients
1940	0.7	21.7	14.3	0.5
1945	6.2	19.4	8.1	2.6
1950	16.4	22.4	12.6	9.8
1955	39.4	17.9	8.6	19.2
1960	61.6	14.1	6.6	28.5
1965	75.2	11.7	7.0	44.7
1970	85.5	10.4	7.4	60.4
1972	85.6	9.6	7.1	63.3
1975	90.4	11.1	8.6	69.5
1980	91.4	8.7	6.7	70.2
1984	91.3	7.3	5.6	71.0

[1] For 1940–73, data refer to old-age assistance; data for 1975–84 refer to supplemental security income.

under old-age assistance was $80. However, this average was less than $65 in 13 States and more than $95 in 11 States. The extent of these differences could not be explained in terms of regional variations in living costs. Instead, to a considerable degree, they reflected differences among States in both fiscal capacity and the use of such capacity.

In addition, there were wide differences between States in the definitions of various eligibility factors such as the treatment of homes, the consideration of other resources, relative responsibility, and the definition of disability.

These problems were addressed by the enactment of the supplemental security income program for the aged, blind, and disabled. After a 3-year debate of comprehensive welfare reform legislation centered on the Family Assistance Plan, Congress in 1972 passed more limited reform legislation that replaced the Federal-State adult assistance programs with SSI.

As indicated by congressional reports accompanying the 1972 legislation, the SSI program was intended to achieve the following main goals: (1) To introduce a national minimum income guarantee for aged, blind, and disabled persons; (2) to institute more uniform and generally more liberal and less intrusive standards of eligibility; (3) to improve incentives and opportunities for work and rehabilitation; and (4) to provide efficient and economical delivery of this income support through the Social Security Administration.[5]

SSI Payment Levels

The monthly Federal SSI payment, which represents the national minimum income guarantee under SSI, is determined by the recipient's countable income, living arrangements, and marital status. When the program became effective in January 1974, each eligible individual living in his or her own household received a monthly SSI payment that when added to other countable income brought total monthly income up to $140. For a couple, this amount was $210. These Federal payment levels were higher than the payment standards in July 1973 in 26 States for individuals, and in 23 States for couples. Since 1975, Federal SSI payment levels have been subject to cost-of-living adjustments at the same time and by the same percentages as social security benefits. Effective in January 1985, the Federal payment levels are $325 for an individual and $488 for a couple.

Patients in public or private institutions covered under the Medicaid program are entitled to a monthly Federal SSI payment of $25.[6]

To encourage States to supplement Federal SSI payments, Congress gave them the option of having the Social Security Administration administer the supplements on their behalf and assume the administrative costs. Optional State supplementation plans vary widely as they may provide for augmented payment levels for all or selected categories of recipients.[7] State payment levels in January 1985 for aged individuals and couples living independently are shown in table 4. An amount of $325 for an individual and $488 for a couple indicates that the State does not have an optional supplement applicable to persons living independently. Alaska ($586), California ($504), and Massachusetts ($454) have the highest monthly payment levels for aged individuals.

[5] For a thorough discussion of SSI program objectives and development, see John Trout and David R. Mattson, "A 10-Year Review of the Supplemental Security Income Program," **Social Security Bulletin**, January 1984, pages 3–24.

[6] In general, inmates of public institutions are ineligible for SSI if the institution is not a Medicaid facility.

[7] For a summary of State optional supplemention programs, see **SSI: Characteristics of State Assistance Programs for SSI Recipients, January 1985**, Office of Supplemental Security Income, Social Security Administration, 1985.

Table 4.—Monthly SSI payment levels of aged individuals and couples living independently, based on combined Federal payment and optional supplement, January 1985 [2]

State	Individual [2 3]	Couple [2 3]	State	Individual [2 3]	Couple [2 3]
Alabama	$325.00	$488.00	Missouri	325.00	488.00
Alaska	586.00	859.00	Montana	325.00	488.00
Arizona	325.00	488.00	Nebraska	[8] 386.00	[8] 580.00
Arkansas	325.00	488.00	Nevada	361.40	562.46
California	504.00	936.00	New Hampshire	[9] 339.00	[9] 489.00
Colorado	383.00	766.00	New Jersey	356.25	513.36
Connecticut	[4] 465.70	[4] 574.20	New Mexico	325.00	488.00
Delaware	325.00	488.00	New York	385.91	564.03
District of Columbia	340.00	518.00	North Carolina	325.00	488.00
Florida	325.00	488.00	North Dakota	325.00	488.00
Georgia	325.00	488.00	Ohio	325.00	488.00
Hawaii	329.90	496.80	Oklahoma	385.00	608.00
Idaho	[5] 383.00	[5] 514.00	Oregon	326.70	488.00
Illinois	(6)	(6)	Pennsylvania	357.40	536.70
Indiana	325.00	488.00	Rhode Island	378.80	589.74
Iowa	325.00	488.00	South Carolina	325.00	488.00
Kansas	325.00	488.00	South Dakota	340.00	503.00
Kentucky	325.00	488.00	Tennessee	325.00	488.00
Louisiana	325.00	488.00	Texas	325.00	488.00
Maine	335.00	503.00	Utah	335.00	508.00
Maryland	325.00	488.00	Vermont	378.00	[10] 584.50
Massachusetts	453.82	689.72	Virginia	325.00	488.00
Michigan	351.70	528.00	Washington	[11] 363.30	[11] 525.40
Minnesota	[7] 360.00	[7] 554.00	West Virginia	325.00	488.00
Mississippi	325.00	488.00	Wisconsin	424.70	649.00
			Wyoming	345.00	528.00

[1] For those without countable income. These payments are reduced by the amount of countable income of the individual or couple.

[2] Effective January 1985, the Federal SSI payment level for an individual living in his or her own household and having no countable income is $325. An eligible couple living in their own household receives a monthly payment of $488. Payment levels of these amounts indicate that an optional State supplement is not payable.

[3] For recipients who live in another person's household and receive support and maintenance there, the Federal SSI payment rate is reduced by one-third.

[4] Budget process used to establish payment amounts. The amounts shown assume eligibility for the highest rental allowance in the maximum budget amount.

[5] State provides an additional income disregard of $20 per month of any income including SSI. The combined Federal and State amount excludes the disregard.

[6] Optional supplement amount is equal to the difference between monthly Federal SSI payments plus other income and the income maintenance needs based on State standards. The income maintenance needs of each case are determined individually regardless of living arrangement.

[7] Payment level for Hennepin County. State has 10 geographic payment levels.

[8] State provides an additional income disregard of $7.50 per month of unearned income including SSI. The combined Federal and State amount excludes the disregard.

[9] The combined Federal and State amount excludes the additional monthly income disregards provided by the State. The State's monthly income disregards of any income including SSI are $13 for an individual living independently and $20 for a couple.

[10] State has two geographic payment levels; higher level shown in table.

[11] Amount paid in King, Kitsap, Pierce, Snohomish, and Thurston counties.

Income and Resources

Generally, SSI provisions for the disregard of income and resources are more liberal than those under the former Federal-State programs.

In determining the countable income of an individual or couple under SSI, the first $20 per month of earned or unearned income is disregarded. In addition, earnings of $65 plus one-half of earnings in excess of $65 are also disregarded. There are also special exclusions, such as work expenses of blind persons and extraordinary impairment-related work expenses of the disabled.

The income and resources of a spouse living with an adult recipient and of a parent living with a blind or disabled child under age 18 are considered in determining the amount of the SSI payment. The Federal SSI program does not have relative responsibility requirements with respect either to adult children for their parents or to parents for their adult blind or disabled children.

The 1972 legislation provided for countable resource limits of $1,500 for an individual and $2,250 for a couple. In 1984, these limits were raised by $100 each year for an individual and $150 for a couple over a 5-year period beginning with 1985. In 1989, the resource limits will be $2,000 for individuals and $3,000 for couples.

The home of an SSI recipient, regardless of its value, is not counted as a resource nor may a lien be placed against the house. The cash surrender value of life insurance is also excluded if the face value of the policy is $1,500 or less.[8]

SSI Eligibility Requirements

As under old-age assistance, an aged person under the SSI program is defined as an individual aged 65 or older. The definitions of blindness and disability, which varied widely among the States under the former programs, are the same as for disabled workers under the social security program. However, the eligibility of a disabled child under age 18 is based on an impairment with a severity comparable to that of an adult. Special

[8] Special exclusions are also applicable to household goods and burial provisions.

provisions for continuing eligibility for cash payments and Medicaid designed to encourage employment of blind and disabled SSI recipients were enacted in 1980 and are in effect through June 1987.

Under the 1972 legislation, the SSI program was established in the 50 States and the District of Columbia. Eligibility was limited to United States citizens and to aliens permanently and lawfully residing in the United States.[9] Although there had been no age limitation under the program of aid to the blind, aid to the permanently and totally disabled had been restricted to persons aged 18 or older. Disabled children under age 18 are eligible for SSI.

Experience Under SSI

When the State assistance programs ended in 1973, they were serving 3.2 million people. Under SSI, the number of recipients increased to 4.3 million at the end of 1975 (table 5). This early growth was due to the new Federal SSI payment levels, which in many States were higher than those under the former State programs, as well as to the generally less restrictive SSI eligibility and resource requirements.

Between 1976 and 1979, the SSI population stabilized at 4.2 million and then decreased to 3.9 million in December 1983. This trend has changed recently and in June 1985, 4.1 million persons were receiving federally administered SSI payments.

Changes in the proportion of the aged population receiving SSI, after a brief reversal in 1974 and 1975, have been consistent with the long-term downward trend under old-age assistance. In 1975, 11 percent of the aged were SSI recipients, compared with 10 percent who were eligible for old-age assistance in 1972. By 1984, the proportion with SSI had declined to 7.3 percent.

The number of blind and disabled persons under age 65 increased from 1.3 million to 1.9 million between 1973 and 1975, remained approximately constant through 1983, and then rose to 2.0 million during 1984. This large increase reflects in part the extension of SSI eligibility to disabled children under age 18. At the end of 1984, 205,000 disabled children—a large proportion of whom were mentally retarded or developmentally disabled—were receiving SSI.

In 1984, expenditures for SSI payments totaled $10.4 billion, of which $2.1 billion—20 percent—represented State supplementation (table 6).

As indicated earlier, the development of medical care for needy persons was a continuing concern under the adult assistance programs. In fiscal year 1984, Medicaid expenditures on behalf of aged, blind, and disabled SSI recipients totaled $10.4 billion—equaling the amount of cash payments under the SSI program. This amount included $2.2 billion for inpatient hospital services, $2.1 billion for the care of the mentally retarded in intermediate care facilities, and $2.1 billion in payments to other intermediate care and skilled-nursing facilities.

In addition, $6.4 billion was expended under Medicaid for the care of persons who although categorically eligible for SSI were not receiving an SSI payment. Generally, these persons received institutional care covered by Medicaid. Although their income and resources were within the usual SSI program limits, their income exceeded the $25 monthly payment of an SSI recipient in a Medicaid facility. Included in the $6.4 billion total were $1.0 billion in payments to intermediate care facilities for the mentally retarded and $4.2 billion paid on behalf of patients in other intermediate care and skilled-nursing facilities.

[9] The SSI program was extended to residents of the Northern Mariana Islands in 1978.

Table 5.—Number of persons receiving federally administered SSI payments, by reason for eligibility and age, 1974–84

[In thousands]

Month and year	Total	Aged 65 or older				Under age 65		
		Total	Aged	Blind	Disabled	Total	Blind	Disabled
January 1974	3,216	1,952	1,865	23	64	1,264	49	1,214
December 1974	3,996	(1)	2,286	(1)	(1)	(1)	(1)	(1)
December 1975	4,314	2,508	2,307	22	179	1,806	52	1,754
December 1976	4,236	2,397	2,148	22	227	1,839	54	1,785
December 1977	4,238	2,353	2,051	25	277	1,885	52	1,832
December 1978	4,217	2,312	1,968	25	319	1,905	52	1,853
December 1979	4,150	2,258	1,872	25	361	1,892	52	1,840
December 1980	4,142	2,226	1,807	25	394	1,916	53	1,862
December 1981	4,019	2,121	1,687	24	419	1,898	55	1,843
December 1982	3,857	2,011	1,549	23	439	1,847	54	1,792
December 1983	3,901	2,003	1,515	23	465	1,898	56	1,842
December 1984	4,029	2,037	1,530	23	484	1,992	58	1,935

[1] Data on age distribution not available for December 1974.

Table 6.—Amount of expenditures for Federal SSI payments and State supplementation, by State, 1984

[In thousands]

State	Total	Federal SSI	State supplementation	
			Federally administered	State administered
Total	$10,371,790	$8,281,017	[1] $1,792,089	$298,684
Alabama	279,427	264,704	...	14,723
Alaska	20,804	8,095	...	[2] 12,709
Arizona	79,408	77,344	...	[2] 2,064
Arkansas	137,339	137,324	15	...
California	2,280,756	1,098,040	1,182,716	...
Colorado	112,298	64,480	...	[2] 47,818
Connecticut	92,023	59,714	...	32,309
Delaware	15,895	15,465	430	...
District of Columbia	42,727	38,676	4,051	...
Florida	430,502	423,976	(3) (4)	[4] 6,526
Georgia	313,851	313,848	3	...
Hawaii	28,200	24,653	3,547	...
Idaho	20,575	16,761	...	[2] 3,814
Illinois	340,937	306,156	(3)	34,781
Indiana	95,665	94,683	(3)	982
Iowa	51,521	50,041	1,480	(5)
Kansas	41,017	40,989	28	...
Kentucky	227,042	216,970	...	10,072
Louisiana	278,561	278,498	[4] 63	(4) (5)
Maine	40,004	34,970	5,034	...
Maryland	122,208	118,611	[4] 79	[4] 3,518
Massachusetts	280,429	172,684	107,745	...
Michigan	315,859	256,251	59,608	...
Minnesota	74,495	59,653	...	[2] 14,842
Mississippi	232,524	232,488	36	...
Missouri	177,721	171,031	...	6,690
Montana	15,545	14,765	780	...
Nebraska	32,574	26,998	...	5,576
Nevada	17,013	14,631	2,382	...
New Hampshire	20,708	12,570	...	8,138
New Jersey	240,276	196,616	43,660	...
New Mexico	57,361	57,134	...	[2] 227
New York	997,625	780,467	217,158	...
North Carolina	320,417	287,315	...	33,102
North Dakota	12,681	11,489	...	1,192
Ohio	290,815	290,807	[4] 8	(4) (5)
Oklahoma	151,774	121,505	...	30,269
Oregon	68,110	53,866	...	14,244
Pennsylvania	409,469	346,507	62,962	...
Rhode Island	35,920	27,611	8,309	...
South Carolina	177,166	173,785	(3)	3,381
South Dakota	15,901	15,428	[4] 27	[4] 446
Tennessee	271,536	271,536	(3)	...
Texas	490,707	490,707	(6)	(6)
Utah	18,584	17,806	...	778
Vermont	22,174	15,848	6,326	...
Virginia	185,282	174,986	...	10,296
Washington	118,618	99,960	18,658	...
West Virginia	100,399	100,399	(6)	(6)
Wisconsin	163,677	96,402	67,275	...
Wyoming	4,136	3,950	(3)	[2] 186
Other areas:				
Northern Mariana Islands	1,829	1,829	(6)	(6)

[1] Payments reduced by $290,000 to reflect returned checks and overpayment refunds. For fiscal year 1984, includes $7.5 million of Federal contribution to State supplementation (Wisconsin) under the "hold-harmless" provision.

[2] Data partly estimated.

[3] Data not shown; adjustment totals exceed the actual amounts paid.

[4] Mandatory payments are federally administered and optional payments are State administered.

[5] Excludes data for Iowa, Louisiana, and Ohio.

[6] State payments not made.