Social Security

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Chapter 11
Public Assistance Programs

The social security program examined in Parts Two and Three does not satisfy all the economics-security needs of persons in the United States. Additional programs designed to fulfill specific security needs have been adopted.

Part Four looks at the importance of and changing patterns of economic security provided by public assistance programs. Part Four also includes a description of the separate Railroad Retirement system.

This chapter describes various public assistance programs in the United States as they exist currently, along with a brief discussion of their development over the years and some statistics of their operation (to indicate their magnitude). The chapter concludes with a discussion of the relationship between public assistance and social insurance programs.

The term *public assistance* will be used in a narrow sense to involve only cash payments and reimbursements for medical care with respect to groups categorized by demographic characteristics, such as those aged 65 or over. Thus, not covered are certain socially and economically significant programs of a welfare nature, such as food stamps, subsidized housing for low-income persons, and various counseling services, which in some instances supply additional income to many low-income persons. The programs that are dealt with are Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC), Medicaid, and General Assistance.

More details on the public assistance program are given in two appendixes. The status of such programs before the enactment of the Social Security Act is described in Appendix 11-1. Appendix 11-2

presents information on the history and provisions of the federal-state public assistance programs for adults, which have now been superseded by SSI.

The social security programs in the United States that deal with long-range risks have been shaped by long-standing traditions and developments. As a young country with abundant natural resources, the United States offered rich opportunities to most of the millions of immigrants and their descendants. In such a pioneer country, there was naturally a widespread general belief that all people—no matter how poor their start—could get full security and even wealth for themselves and their children through their own efforts.

Before the enactment of the Social Security Act in 1935, there was no social insurance covering the general risks of old-age, disability, and survivor protection, nor were there many private pension plans to provide protection against these risks. The various workers' compensation systems, established under state legislation, covered the risks of disability and survivorship, but only for occupational injury and, in some cases, disease. Retirement and disability pensions under organized, definite plans were provided by government action only for most federal employees and many state and local government employees; these plans provided only limited survivor benefits in the form of lump-sum refunds of contributions or elective, actuarially equivalent joint-and-survivor pensions. On the other hand, a number of public assistance programs had been developed under state and local auspices before 1935.

A widespread fallacy is that, when the old-age insurance provisions were enacted, it was believed that this would mean the eventual elimination of old-age assistance. Because this has not occurred, it is alleged that the OASDI program has failed. However, it was never the belief of the original planners of these two programs that this would occur (see Robert J. Myers, "Long-Range Trends in Old-Age Assistance," *Social Security Bulletin*, February 1953).

Cash-Assistance Programs for Adults

The Social Security Act of 1935 authorized federal grants to states to pay part of the costs of aid in the form of cash to aged persons, blind people, and needy children. In 1950, a fourth program was added for the permanently and totally disabled. However, in 1974, the character of the three programs for adults was considerably changed when they were federalized, being then termed the Supplemental Security Income (SSI) program.

Supplemental Security Income Program

On the surface, this new program appears to be only an equitable and logical revamping of the previous public assistance programs and a shift in the administration from the states to the federal government. However, SSI introduces a new philosophy, because it can quite properly be considered a guaranteed-annual-income plan for certain categories of the population, which some might argue should be extended to everybody. SSI could, in some ways, be classified as a demogrant program, rather than a social assistance one, as were the predecessor public assistance programs. The reason for that is that SSI is universally available, and the payments are mathematically determined essentially only on the basis of the individual's income. Nonetheless, SSI is properly classified as a social assistance program, because the payments are based on the individual's means, being reduced generally for other income.

Before going into detail about what SSI is and how it may possibly develop and affect other public and private economic security programs, it is important to note that it results in more federal responsibilities and diminished state and local responsibilities. Although President Nixon supported the resulting increased federalization, this change was in contrast to his frequently stated philosophy of moving power down from the federal level to the state and local level.

The SSI program replaced the federal-state public assistance programs of aid to the aged, blind, and disabled, except in Guam, Puerto Rico, and the Virgin Islands. The social services for these adult categories continued as federal-state programs, as did the cash-assistance and social service programs for families with dependent children.

SSI payments are available to all residents of the 50 states and the District of Columbia and of the Commonwealth of the Northern Mariana Islands, but not for Guam, Puerto Rico, and the Virgin Islands. The latter three jurisdictions were omitted because it was believed that SSI payment guarantees were too high relative to prevailing incomes there (yet, quite anomalously, the Marianas, with the lowest per capita income of all, were included!). Aliens not legally admitted for residence are excluded.

Qualification Definitions

What consistutes disability and blindness, which was formerly at the discretion of each state, is standardized to be essentially the same as under Old-Age, Survivors, and Disability Insurance (OASDI). A sav-

ings clause applied to existing recipients when SSI began for those who had previously qualified under public assistance with a less strict definition. Unlike OASDI, no waiting period is required under SSI for disabled persons. As a result, a person with insured status under OASDI who becomes disabled and who can meet the income and assets requirements of SSI will qualify for SSI initially and then later shift over to OASDI.

Payment Amounts

SSI initially provided a guaranteed minimum income for these adult categories of $140 per month for an individual and 50 percent more ($210) for a couple.[1] Beginning in July 1974, these amounts were increased to $146 and $219, as a result of legislation enacted in 1973. There was thus some indication of congressional intent to keep SSI payments up to date with changes in the cost of living.

Legislation enacted in 1974, which was initially proposed by President Nixon, introduced an automatic-adjustment provision into SSI closely paralleling that used under OASDI. Specifically, whenever OASDI benefits were automatically adjusted for June of a given year (first possible for 1975), the SSI payment amounts for July were increased by the same percentage, with the monthly amounts resulting being rounded to the next even 10 cents.[2] However, unlike the situation under OASDI, an ad hoc increase in the SSI payment amounts will not prevent the automatics for SSI from being operative. Subsequently, the rounding rules and the six-month deferral of the COLA date (to Januarys) as revised for OASDI were made applicable to SSI. However, the SSI standard was increased by $20/$30 for July 1983 in order to recognize that the COLA was delayed for six months. If the "lesser of wage increase or CPI increase" provision becomes applicable for OASDI (as a result of a low fund ratio), it will not apply for SSI, which will continue to use the CPI basis.

As a result of these automatic-adjustment provisions, the SSI payment level rose for Julys by the amounts of the OASDI COLAs (see Chapter 2), until it was $284.30/$426.40 for July 1982. The ad hoc increase for July 1983 brought it to $304.30/$456.40, and the regular

1. Actually, the 1972 legislation provided for a basic amount of $130, but, before the program went into operation, legislation in July 1973 increased this amount to $140.

2. Because SSI payments are made at the beginning of the month (rather than at the end, as is the case for OASDI), the increases were for July originally—but now January.

COLA increase for January 1984 resulted in a level of $314/$472. For January 1992, the level is $422/$633.

In 1991, the basic SSI monthly payment of $407 for a single aged person represented about 74 percent of the poverty standard. When the $20 "other income" disregard (as discussed later) and the value of food stamps are also considered, this proportion rises to 85 percent. The corresponding figures for an aged couple are 88 percent for SSI payments alone and 100 percent for SSI, plus the "other income" disregard, plus food stamps.

Income and Assets Disregards

A number of "income disregards" are contained in the program, none of which are subject to the foregoing automatic-adjustment provision. Perhaps the most important is the disregard of $20 of income per month per family from such sources as OASDI, Railroad Retirement (RR), other pensions, earnings, and investment—in fact, any income except payments based on need.[3] Since virtually the entire population aged 65 and over has some such non-need-related income, this really means a guaranteed monthly income of $442 for an individual and $653 for a couple as of 1992.

A special exception to this guaranteed-income feature is that individuals in an institution more than 50 percent of whose care is being paid for by Medicaid are eligible under SSI for only $30 per month, less any other income that is countable. As a result, almost all OASDI beneficiaries who are so institutionalized will not receive any SSI payment, because the OASDI benefit will almost always be large enough to eliminate it (by being in excess of $50). Another important exception is that persons who live in someone else's home (such as a child's) will have a one-third reduction in their SSI payment.

Another important income disregard is with respect to earned income, which has not already been disregarded under the general $20 disregard. The first $65 per month is disregarded, plus 50 percent of the remainder of the earnings (actually, administered on a quarterly basis). Blind persons have a further disregard of income equal to the reasonable expenses of earning income and of the income necessary

3. As regards OASDI and other programs where actuarially reduced benefits are available for early retirement (before age 65 currently), SSI considers only the actual amount of the payment. Accordingly, there is every incentive for persons who will receive SSI at age 65 to take the early-retirement benefit, because the total income from OASDI and SSI after age 65 will be the same as if they had waited until age 65 to claim OASDI. Also, SSI considers only OASDI benefits payable directly for the SSI recipient; thus, DI benefits for auxiliaries are not charged against the SSI disability payment.

for the fulfillment of a plan for achieving self-support. Also disregarded is nominal nonearned income received on an irregular basis (if at a rate of $20 or less per month).

In addition to the income disregards, SSI has certain resource exemptions. Until legislation in 1984, in order to receive SSI, resources could not exceed $1,500 for an individual and $2,250 for a couple. In 1985, these amounts increased to $1,600/$2,400, and then successively by $100/$150 increments to $2,000/$3,000 in 1989 and after. However, in determining resources, certain items are excluded—the home, household goods, personal effects, an automobile, and property needed for self-support—if these are found to be reasonable. Also, for life insurance policies with a face amount of $1,500 or less for an individual, their cash values are not counted as assets. Currently, the value of automobiles in excess of $4,500 and of household goods and personal effects in excess of $2,000 is counted in measuring assets.

It is significant to note that, except where otherwise stated, the various dollar amounts for income disregards and resource exemptions have remained unchanged since SSI was initiated. Thus, with the price inflation which has occurred in the past two decades, the real value of these elements has decreased considerably, and the program has, in essence, been deliberalized.

State Supplements

A state may pay supplements to SSI and have the federal government administer such payment if it so desires. Then, the federal government pays the administrative expenses—a great attraction to hand this responsibility over to the federal government. For persons who had been on the public assistance rolls in December 1973, states were required to supplement SSI so that no decrease in payments occurred; if a state did not do so, it would have been cut off from federal Medicaid matching funds. The state is permitted to require a residence period for these supplementary payments. A state can, of course, have a supplementary program under its own administration and with its own rules (except for the mandatory cases mentioned above).

The income-guarantee level of SSI is supplemented by state payments in all states. In mid-1990 69 percent of those receiving SSI (federal) received state supplements. In some states, these had a relatively high average (such as $237 in California and $229 in Alaska), while the average was as low as $25 (or even less) in other states.

Effect of Food Stamps

In the initial 1972 legislation, SSI recipients were not to be eligible for food stamps, so that there would be no overlap between these two programs. It was anticipated that, in many states, the new SSI payment level would exceed the former public assistance level plus the bonus value of the food stamps. In the other states where this would not be the case, it was hoped that the loss of the food stamps would be compensated for by state supplements, as described previously. As an incentive for states to take such action, the bonus value of the food stamps would be included in determining the federal payments toward the cost of the supplements.

Currently, the receipt of food stamps has no effect on the amount of the SSI payment.

Role of SSI

The SSI program clearly has certain attractive features. SSI provides desirable equitable treatment of adult public assistance recipients in the few states where payments previously were inadequate. The Social Security Administration administers SSI, with certain safeguards to keep it separate from the OASDI system. The result should be a reduction in administrative expenses, particularly because much of the investigation of individual income, resources, and needs will not be necessary as before. SSI eliminates much of the stigma that is now attached to receiving public assistance. This may be considered either good or bad, depending upon one's philosophy. Certainly, too much stigma is undesirable, but nonetheless it does seem best if individuals take more pride in receiving benefits based on their own direct efforts than on means-test payments.

Significantly, in making the adult public assistance programs more equitable and adequate, SSI was estimated to almost double the number of persons on the roll—from 3.2 million to 6.2 million (the latter figure excluding about 500,000 institutionalized persons who were eligible for at most $25 a month and 125,000 "essential persons" whose presence results in an increase in the SSI payment). The additional cost for SSI compared with the previous program was estimated at $2.0 billion a year at the $140/$210 payment rates—a 77 percent increase.

In actual practice, the SSI program did not expand to the levels originally estimated. At the end of 1990, a total of 4.8 million persons were receiving federal SSI payments (1.5 million aged, 3.3 million

disabled, and 84,000 blind). Of these 4.8 million recipients, 3.3 million received state supplementation, and an additional 0.4 million persons received state supplementation but not federal SSI. Since 1974, the number of aged recipients has been slowly decreasing—from 2.3 million at the end of 1974 to 1.5 million at the end of 1990 (despite the rise in the total aged population). The number of disabled recipients increased during the same period, from 1.6 million to 3.3 million (as did also the blind—from 72,000 to 84,000). At the end of 1990, about 70 percent of the aged recipients were also receiving OASDI benefits. The corresponding proportions for the disabled and the blind were 36 percent and 38 percent respectively. Federal SSI payments totaled about $16.5 billion in 1990, while state supplementation was about $3.8 billion.

Despite the initial belief that administration of SSI by the Social Security Administration would result in operating efficiencies, this did not turn out to be the case. Vast amounts of mispayments and computer errors occurred. Obviously, there are significant differences between administering a social insurance program (with its quite precise provisions) and administering a public assistance program based on varying needs (as measured by income and assets).

One thing that may result from SSI is that individuals will often dispose of their excess income and assets in order to qualify for SSI, because these will really not do them any good. For example, in 1991, if a man aged 65 or over had $4,000 in a savings account producing $20 of monthly income, and if he had an OASDI benefit of $350, he would not be eligible for SSI, even though his monthly income was less than $427 (the $407 SSI payment amount, plus the $20 "other income" disregard). He could become eligible for SSI, however, by spending or giving away $2,000 of his bank account, and thereby satisfying the maximum asset requirement for eligibility. Thus, SSI can have a serious effect on private savings for persons at the lower and middle economic levels.

Persons with moderate or low OASDI benefits in 1991—say, $427 per month or less (the average benefit for single persons aged 65 or over is about $590)—and no other income might well wonder whether it is worthwhile to be covered by OASDI (and pay its taxes) when this produces extra income of at most $20 per month over what SSI would have paid anyhow. As a result, many low-income workers—such as domestic employees, migrant farm workers, and subsistence farmers—might wish to avoid coverage (which is not too difficult to do).

On the other hand, one good feature of SSI is that economic-

security protection will be provided in all cases for low-income workers. Many such workers are not now covered by OASDI in all their employment, and therefore qualify for relatively low benefits. SSI will increase the incomes for these individuals.

The real danger of SSI lies in what it could potentially do if its benefit level were substantially increased. One excellent control on the reasonableness of the level of OASDI benefits in the past has been that this program is fully financed by the taxes of workers and employers. As a result, any proposals to increase the benefit level must carry with them concomitant increases in payroll taxes. Under SSI, however, with its general-revenues financing, proposals can easily (and painlessly) be made to raise what some would consider its "grossly inadequate" level. For example, it might be difficult for Congress to vote down a proposal to raise SSI payments to, say, $600 per month for an individual and $900 for a couple. If this were done, and if only a $20 OASDI disregard were continued, the majority of prospective OASDI beneficiaries would see little reason to continue OASDI with its heavy payroll taxes. They would argue that SSI itself would do almost as well and would apparently be "paid for by somebody else."

It is significant to note that, even now, many persons who are eligible for SSI do not receive it. This occurs because the amounts involved seem too small to be worth bothering about (after the reduction for OASDI benefits) or because of lack of knowledge of the availability of SSI payments.

Only the future will tell what the SSI program will do. Will it result in desirable equity and adequacy in dealing with the low-income aged, blind, and disabled? Or will it be a sleeping giant which, when aroused, will produce undesirable results by destroying or diminishing both the OASDI program and private economic security measures?

Energy Assistance

In late 1979, as a result of soaring energy prices (especially for home heating), emergency legislation of a "temporary" nature continuing for several years was enacted to establish the Low-Income Energy Assistance program. The states administer the program insofar as making payments to recipients is concerned (and provide additional funds).

Payments may be made only to households with incomes under 150 percent of the poverty income guidelines or, if higher, under 60 per-

cent of the state's median income and also to any household with members receiving SSI, AFDC, food stamps, or needs-tested veterans' benefits. These payments are made with respect to either heating or cooling costs (predominantly the former). The payments are made to all recipients, regardless of whether they pay for energy costs directly (on the theory that, in other cases, such costs are paid indirectly through rent payments).

Housing Assistance

A rent subsidy for low-income persons was started at a low level in 1976, but it has since grown significantly. This program replaced the direct building of low-cost housing by government entities (with federal subsidy). The federal subsidy amounts to the difference between the market rental rate of the housing and what the occupants are required to pay (normally no more than 25 percent of their incomes).

Aid to Families with Dependent Children

Although the cash public assistance programs for adults (the aged, the blind, and the disabled) were supplanted by SSI, the Aid to Families with Dependent Children (AFDC) program established by the 1935 Social Security Act was not. President Nixon had proposed its replacement by the Family Assistance Plan, but this was not done.

The state public assistance programs had a number of common characteristics, which are still applicable to AFDC. The persons aided must be needy according to the definition established by the state. Each state is free to decide whether it wishes to take part in the program, but if it does, it must have its plan approved by the federal government as meeting certain general requirements set forth in the law.

Among the general requirements that must be met for the AFDC program are the following:

1. The plan must operate throughout the entire state.
2. The states must at least share the costs with the local government (many states pay the entire amount).
3. A single state agency must administer the program or supervise its administration.
4. The assistance must be paid in cash except for vendor medical service payments.
5. Opportunity for fair hearing and appeal must be provided.

6. All income and resources must be taken into consideration, other than for certain small exceptions.
7. Administration must be proper and efficient (and with employees hired under a merit-system basis), subject to federal review.

The state can make payments, with federal participation, for children up to but not including age 18 and, as a result of amendments in the mid-1960s, also for ages 18–20 if they are regularly attending school.

The law provided that states might have a residence requirement of as long as one year under AFDC (except for infants) and also a citizenship requirement. The Supreme Court, however, ruled that these requirements were unconstitutional but that aliens who had not been admitted for residence were not eligible.

Originally, AFDC focused primarily on the problem of child support in families where the father had died. Over the years, however, as the social insurance systems met most of the problems in this area, this program expanded to caring for needy families where the father was otherwise absent from the home (divorce or desertion, including absence of the father in cases of illegitimate children) or disabled. In 1950 the law was changed so that one adult caretaker in the family could be included as a recipient; in 1962 a further change made both parents eligible to be recipients. Legislation in 1961 permitted payments to be made when the father was present but was unemployed and could not find work. This was to be effective only for the 14-month period beginning in May 1961, but it was made effective for another five years by legislation in 1962. Later the provision applicable to unemployed fathers was made permanent.

Legislation in 1967 inaugurated a new public assistance program with federal financial participation—emergency assistance for needy families with children. Temporary emergency assistance is available for a maximum of 30 days in a 12-month period for children under age 21 and their families. This assistance can be in any form—money, medical aid, clothing, food, and payment of rent or utilities. The federal government pays half the cost in all states.

States must consider other income and resources in determining the extent of need for public assistance. For example, with regard to the earnings of a child, states are permitted to disregard the total earned income of any such recipient who is attending school and does not have a full-time job; for any other child, there can be disregarded the first $30 of monthly earnings, plus one third of any additional earnings. States are also allowed to disregard small amounts of other income in determining the need of recipients—$5 per month per

family. States are permitted to place liens on the assets of recipients (such as homes) to recover later the amounts spent for cash assistance.

State participation in the AFDC program developed rapidly, and virtually all states had such programs within a few years after 1935. For some years, all states have had AFDC. Somewhat more than half of the states were participating in the emergency assistance program for needy families with children in 1991.

Financing of AFDC

The federal government originally participated in the financing of AFDC by paying for one third of the cost, up to a specified maximum on individual payments of $18 per month for the first child in the family and $12 for each additional child. Over the years, the federal share was increased a number of times. The federal payments, as a result of 1958 legislation, are based on the overall average payment, rather than with a maximum applying to each recipient's payment. Also in 1958, the principle was introduced of varying part of the grant with respect to payments to recipients, depending upon the average per capita income of the state.[4]

Ever since 1965, the matchable portion of payments to AFDC recipients (children, plus up to two adult caretakers in a family) has been based on the smaller of the total payments in the month or $32 times the number of recipients. If the average payment per recipient is $18 or less, the federal government pays five sixths of the cost. If the average payment exceeds $18, the federal government pays $15 (5/6 of $18) per recipient, plus the federal matching ratio applicable to that state, times the excess of the average payment per recipient over $18 (but with such excess not allowed to be larger than $14), times the number of recipients.

The federal matching ratios for AFDC are derived by the following formula, where P is the federal grant percentage applicable to the upper portion of the average payment in the state, and N and S are the national and state per capita incomes respectively:

$$P = 100 - 50 \cdot \frac{S^2}{N^2} \quad \text{and} \quad 50 \leq P \leq 65.$$

Some illustrative examples of how the federal matching formula works may be helpful. First, consider the variable-grant factor P. If a

4. The three outlying jurisdictions (Guam, Puerto Rico, and the Virgin Islands) do not have this basis, but rather the federal government reimbursed them for 50 percent of their payments (up to a maximum based on an $18 average payment). In addition, an overall annual dollar limit applies to the reimbursement to each jurisdiction.

state has the same per capita income as the national average (i.e., $S = N$), P will be 50 percent. Similarly, if the average per capita income of the state is higher than the national average, then P will also be 50 percent because of the minimum provision. On the other hand, if a state has a per capita income that is 80 percent of the national average, then P will be reduced to 65 percent (because of the maximum provision), since the formula produces 68 percent ($100 - 50 \cdot 0.64$).

The matching formula for the cash payments has been, over the years, of a weighted nature. States with low average payments receive a relatively larger federal matching ratio than do states with high average payments. Generally, but not always, the size of the average payment is correlated with the per capita income in the state, so that the poorer states tend to be given relatively larger federal financial participation. Thus, under the present formula for AFDC, if the average monthly payment is $18 or less, the federal financial share is 83.3 percent of the total cost. As the average payment increases beyond $18, this proportion decreases, more for high-income states than for low-income ones. For example, for a state with an average payment of $32 (the highest on which full federal matching occurs), the federal share is 68.7 percent for above-average-income states and 75.3 percent for the lowest-income states (those with per capita incomes of less than 83.6 percent of the national average).

As an alternative to the above federal matching basis for AFDC, a state can choose to have the federal financing apply on a unified basis to all payments under both AFDC and Medicaid. Under these circumstances, the generally more liberal formula for vendor medical payments (described later) is applied to the total payments. This unified basis was used by all but a few states in 1991, especially by the ones that had larger average payments and generally higher-than-average per capita incomes.

The alternative unified basis was advantageous to such states because the maximum on the average payment above which no federal matching occurs was not applicable and because the matching ratio under the regular formula was only 50 percent in the second step. For example, considering AFDC, for a state with above-average per capita income, the aggregate federal matching ratio under the regular basis is 68.7 percent if the average grant is $32, only 50 percent if such average grant is $44, and 40 percent if it is $55 (because no federal matching applies beyond the $32 point). On the other hand, under the alternative unified basis, the federal matching ratio would always be 50 percent for the highest-income states (and 55 percent even for a state with a per capita income equal to the national average).

Under the federal matching formula for cash payments, as it ap-

plies for the period from October 1990 through September 1991, 20 of the 51 jurisdictions (the 50 states and the District of Columbia) have a federal matching proportion of 50 percent (as, by law, do Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands), while 13 have the maximum proportion of 65 percent, leaving only 18 falling between 50 and 65 percent. It should be noted, however, that many states do not use this formula for their matching for cash assistance, but instead use the Medicaid formula.

The federal share of the administrative cost of AFDC is 50 percent, except that the matching proportion is 75 percent with respect to social services that will help recipients achieve greater self-support and family stability (90 percent for family planning services).

Statistics of Operation

In a typical month of 1990, about 7.5 million children and 3.6 million adult caretakers in 3.8 million families were receiving AFDC. The average payment was about $370 per month per family, or $125 per recipient. The annual rate of payments was about $17 billion. At the same time, about 60,000 families received emergency assistance, with an average payment of about $375.

It may be noted that the average AFDC payment has not increased as rapidly as inflation in recent years. For example, the average payment per family was $190 in December 1970; if this were adjusted by the CPI increase up to 1990, it would have been about $625 then (as against the actual average of $370). At least part of this failure to keep the AFDC payments up to date in purchasing power was made up by the new availability of additional types of assistance, such as food stamps and housing assistance.

Medicaid[5]

Medical Assistance for the Aged

In the 1960s, considerable efforts were made for the enactment of a social insurance system to provide health benefits for persons aged 65 and over. In lieu of this, and through the efforts of Senator Robert S. Kerr and Representative Wilbur D. Mills, a public assistance measure was enacted in this area—namely, Medical Assistance for the Aged (MAA). This program was intended both for persons aged 65 and over not receiving Old-Age Assistance (OAA) who have sufficient fi-

5. For more details on the history and provisions of the Medicaid program, see Robert J. Myers, *Medicare* (Homewood, Ill.: Richard D. Irwin, 1970).

nancial resources to meet their usual needs, but not to meet any heavy expenses, and for OAA recipients.

Enactment of Medicaid

In 1965, MAA and the federal matching for medical vendor payments for public assistance categories other than OAA were combined into the new Medical Assistance program (popularly referred to as Medicaid), which is Title XIX of the Social Security Act. Medically indigent persons in the blind, disabled, and AFDC categories (and also children up to age 21) were included for Medicaid coverage. The general basis of Medicaid as to characteristics and requirements to be met by the state plans in order to have federal financial participation are the same as for AFDC (as discussed earlier). Generally, Medicaid payments are made directly to the provider of services, rather than to the individual receiving medical care.

Characteristics of Medicaid

Medicaid covers, insofar as federal financial matching is concerned, all categorical assistance recipients (SSI and AFDC) and all other persons who are medically needy and who, except for the amount of their income and assets, could qualify for categorical public assistance. States are not required to cover the medically indigent.[6] The age limit for children is age 21 even if a lower age applies for cash assistance. The so-called essential persons under the SSI program (usually spouses) may also be eligible for Medicaid. All other medically needy children may also, at the option of the state, be included. The program is also applicable (and in operation) in Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands.

In conjunction with SSI, the state can have the federal government make eligibility determinations for Medicaid benefits with respect to all persons receiving SSI. Such procedure has the "advantage" to the state that then the federal government pays the administrative costs—another move away from the "new federalism" philosophy of shifting power from the federal government to the states. At the inception of the SSI program, 25 states accepted this "offer."

6. The state plans are almost equally divided into three categories—covering all SSI recipients and the medically needy, covering all SSI recipients, and covering some, but not all, SSI recipients (in the last case, any SSI recipient not meeting the income/assets test must be allowed to qualify for Medicaid through the "spend-down" provision). Most of the states which cover all SSI recipients do so for those who are "state supplement only" cases as well as for "federal SSI" cases.

Medicaid programs are required to furnish certain services—physician, inpatient hospital, outpatient hospital, laboratory, X-ray, and home health services, as well as nursing home care for those over age 21 and early and periodic screening and diagnostic treatment for those under age 21. Most other medical services (such as drugs, dental care, and eye-glasses) can be included, for federal matching purposes, at the option of the state. Initially, a state could also buy into SMI under Medicare (as described in Chapter 8).

Legislation in 1988 (the Medicare Catastrophic Coverage Act, most of whose provisions were repealed in 1989—but not the following ones) required state Medicaid programs, on a phased-in basis, to pay the Medicare monthly SMI (and, where applicable, HI) premiums, the deductibles, and the coinsurance for certain persons. These persons—who are designated as Qualified Medicare Beneficiaries (QMB)—are Medicare eligibles with incomes below the federal poverty level and with resources of no more than twice the standard under SSI (i.e., not more than $4,000 for single persons and $6,000 for couples, not counting the value of the home, personal effects, an automobile, property needed for self-support, and life insurance of $1,500). For all but five states, the "100 percent of poverty" standard was to be effective in 1992 (85 percent in 1989, 90 percent in 1990, and 95 percent in 1991). For the five other states, the phasing-in begins at 80 percent and is fully effective in 1993. However, legislation in 1990 advanced the effective date of the 100-percent basis by one year, so that it was effective in 1991. Thus expenditures under the voluntary HI program rose sharply in 1991 (see page 566).

The 1990 legislation also provided that, beginning in 1993, the Medicaid programs will pay the SMI premium (but not any of the cost-sharing payments) for persons with incomes at the poverty level and up to (but not including) 110 percent of such level (and who also meet the aforementioned resources test). Beginning in 1995, the 110 percent limit will be increased to 120 percent.

This praiseworthy provision to assist people whose income is just above the poverty level is very difficult to administer, because it operates on a month-by-month basis. Also, it is difficult to locate those who are eligible. Further, a serious "notch" problem occurs, whereby a small additional amount of income or assets can mean a very large monetary loss as to Medicare premium payment and benefits.

In 1991, the poverty standard was an annual income of $6,620 for a single person and $8,880 for a couple. If the income is just slightly more than this, the individual (or couple) loses a large amount of money—$358.80 per person for the SMI premiums, plus all of the HI and SMI cost-sharing payments if qualifying health-care costs are

incurred. This is a horrendous example of a poorly conceived benefit design. There should have been phasing-in provisions—just as occurs between SSI and OASDI—so that a person is not worse off financially by having slightly more income! (The resources situation as to the "all-or-none" borderline involved is not serious, because one can always dispose of a small amount of disqualifying assets; however, this can often not be done for income—e.g., one cannot have one's OASDI benefit be reduced on request by, say, a dollar or two.)

Originally, certain provisions were contained in Medicaid that required the states to expand them continually. Due to the very sharply increasing costs of the program, these were eliminated. For example, the 1972 amendments struck out the requirements that the states must make efforts to broaden the scope of services and liberalize eligibility requirements and that states could not reduce aggregate expenditures for their share of the program's cost from one year to the next. Also, this legislation permitted the states to introduce cost-sharing provisions for optional services for cash-assistance recipients and for all services for the medically indigent. Furthermore, the states were required to charge premiums, graded by income of the recipient, for the medically indigent, if they are included in the plan. In 1974, this requirement was removed, because of the administrative difficulties it had caused, although the states may charge such premiums.

No length-of-residence, citizenship, or lien provisions are contained in the Medicaid program (other than that aliens not legally admitted for residence are excluded).

The aforementioned 1988 legislation also added provisions to prevent spousal impoverishment when one spouse is institutionalized (e.g., in a custodial nursing home). The home of the couple had always been protected from being considered as an asset which had to be used first.

Now, the noninstitutionalized spouse is protected in certain complex ways as to her or his income and assets. In particular, after June 1992, such spouse is entitled to enough of their joint income to raise her or his own income to 150 percent of the federal poverty line for a 2-person household (122 percent in September 1979 through June 1991 and 133 percent in July 1991 through June 1992). Further, such spouse can have additional amounts of the joint income if her or his shelter expenses (rent or mortgage payment, property taxes, utilities at a prescribed rate, etc.) exceed 30 percent of the foregoing amounts determined from the federal poverty line. Still further additional amounts of the joint income are made available if certain family members reside with the spouse (e.g., minor children, dependent parents, or dependent siblings). However, the resulting protected income can-

not exceed $1,500 per month for 1989, indexed for inflation (using the CPI[U], on a September-to-September basis), unless a higher limit is set through a fair hearing or a court order.

Financing of Medicaid

The federal matching ratios for Medicaid (and for the combined expenditures for Medicaid and AFDC when the state chooses this procedure) are derived from the following formula, where P is the federal grant percentage, and N and S are the national and state per capita incomes respectively:

$$P = 100 - 45 \cdot \frac{S^2}{N^2} \quad \text{and} \quad 50 \leq P \leq 83.$$

Thus the federal matching ratio for a state with the same average per capita income as the nation as a whole is 55 percent. For most above-average-income states, the 50 percent minimum applies. For October 1991 through September 1992, no state is affected by the 83 percent maximum; Mississippi has the highest ratio, 79.99 percent. The four outlying jurisdictions (Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands) have a 75-percent ratio. Only 12 states are affected by the 50-percent minimum.

The federal share of the administrative expenses of Medicaid is 50 percent generally. However, it is 75 percent for the compensation of professional medical personnel, 90 percent for the cost of designing, developing, and installing mechanized claims-processing and information-retrieval systems (75 percent for the cost of their subsequent operation), and 100 percent for the survey and inspection costs of skilled nursing facilities (SNF) and intermediate-care facilities.

Total expenditures under the Medicaid program have risen rapidly over the years—from $6 billion in fiscal year 1972 to $54 billion in 1989 and $65 billion in 1990. About half of the 1990 expenditures were for persons who were also receiving cash-assistance payments. Also, about 33 percent of the expenditures were for persons aged 65 and over, and another 38 percent was for disabled and blind persons, and the remainder was for children and their caretakers. By type of service, the expenditures were divided as follows: hospitals, 28 percent; SNFs, 12 percent; intermediate-care facilities, 26 percent; physicians' services, 6 percent; drugs, 7 percent; outpatient hospital services, 5 percent; and all other services, 16 percent. A total of 25.3 million persons received some services during the year (3.2 million persons aged 65 or over, 3.7 million disabled persons, 11.2

million children under age 21, 6.0 million caretakers of such children, 0.1 million blind persons, and 1.0 million other persons).

General Assistance

In addition to AFDC and SSI, most states have general assistance programs that are financed wholly by state and/or local funds. These plans provide assistance for cases that do not fall within the scope of AFDC or SSI (e.g., families without children whose members are under age 65, without a disabled member, and in need). The plans vary greatly in scope and adequacy (many states have less than 2,000 recipients).

In September 1989, there were about 1.1 million general assistance recipients in the nation (in about 900,000 families). Six states (California, Illinois, Michigan, New York, Ohio, and Pennsylvania) accounted for about 80 percent of the case load.

Proposed Family Assistance Plan

For a number of years, there has been considerable public dissatisfaction with the AFDC program. The criticisms come from all sides of the spectrum of political views. Conservatives criticize the growing recipient roll and the high costs. They assert that many persons avoid work and have children in order to receive public assistance, which becomes a way of life for them. Liberals, on the other hand, criticize the program as not being at a high enough level. Thereby, the children involved are penalized because they are not properly cared for and educated and will thus continue in the vicious circle of poverty and relief. Still others criticize AFDC because it is inequitable to the so-called working poor, who could frequently have a lower total income by working than if their family were on welfare. In other words, some people assert that fathers often do better economically for their families by deserting the home and thus making the mother and children eligible for AFDC.

In an attempt to solve this very serious problem, President Nixon in 1969 proposed an entirely new, unique approach—the so-called Family Assistance Plan (FAP). This program, like SSI, had some of the characteristics of a demogrant plan, although it was basically a public assistance program. It can also properly be called a guaranteed-income plan, although its sponsors vigorously denied this.

FAP would eliminate AFDC and instead provide a basic payment to families with children amounting to $500 per year for each of the first

two members, plus $300 per year for each additional member. Thus, for a family of four, the basic annual payment would be $1,600. In order to be eligible, the family could not have more than $1,500 in resources, not counting the home, household goods, and personal effects.

The FAP payment would be reduced, at least partially, for most income. No reduction would be made for 50 percent of unearned income (including OASDI survivor benefits) and for the first $720 of annual earned income, plus 50 percent of the remainder of earned income. Other exceptions included the earnings of a student, inconsequential or irregular income, income offsetting child-care costs while training or working, public assistance or private charity, and the value of food stamps, which represent a significant net benefit because they were sold to eligible low-income persons at only a fraction of their store value.

The earned-income exclusion, of course, was intended to encourage individuals receiving FAP to become employed and to increase their earning capacity to go off the roll. At least, it would provide more equitable treatment for the working poor.

Although the proposal did pass the House of Representatives in 1970 and again in 1971, it was not considered favorably by the Senate. As a result of these unsuccessful efforts to enact FAP legislation in 1969–72, many of its supporters lost enthusiasm. Thereafter, neither the Nixon nor any later administration nor any members of Congress made significant proposals in this area.

Relationship between Public Assistance and Social Insurance Programs

General Relationship Principles

The descriptions of the public assistance and social insurance provisions of the Social Security Act indicate that, although these programs are completely separate in content, there is a certain close relationship between them, in that they cover generally the same risks, except that AFDC protects a wide variety of children besides orphans. The general theory has been that it is desirable to have social insurance programs instead of public assistance programs. The reasons for this are, on the whole, based on their different natures.

Social insurance programs have benefits payable as a matter of right on the basis of a specific earnings record and in amounts that are precisely calculated according to the earnings record. On the other

hand, public assistance programs have the basis of needs which are individually determined after consideration of the individual's income, assets, and possible financial support from relatives, with the amount of the payment possibly varying from time to time due to changes in the individual's financial condition and in general economic conditions (and, in some instances, due to changes in the state's financial position). Nonetheless, there has been the belief that public assistance programs are necessary for individuals who do not qualify for social insurance benefits or whose benefits are insufficient to meet their needs.

The view has been expressed that the dividing line between social insurance and public assistance is not so definite as it would seem at first glance. In connection with pension benefits, the eligibility conditions under OASDI are quite liberal as to the required length of participation in the system (and these conditions have been significantly liberalized over the years). As a result, the proportion of the OASDI benefit that has been "actuarially purchased" by the direct contributions or taxes of those retiring in the early decades of operation has been relatively low—from less than 1 percent in some instances to at most about 30 percent. Accordingly, it has been argued from this standpoint that there is really relatively little difference between those who have barely met the OASDI eligibility requirements and receive "insurance benefits" and those who have not met these conditions and receive public assistance payments (or nothing). Following this argument further, it has accordingly been proposed that all retired aged persons should be eligible for at least minimum OASDI benefits.

Because the Social Security Act of 1935 provided social insurance benefits only for the risk of old-age retirement, and because it provided for immediate public assistance provisions for the aged, for children, and for the blind, it was only natural that the public assistance programs began rather full-scale operations more or less immediately. The vast majority of the states that did not already have public assistance programs proceeded to establish them in the first few years after 1935, particularly for OAA. At the same time, the effectiveness of the social insurance program was relatively slow in developing, despite the addition of benefits for auxiliaries and survivors in the 1939 Act, because of the "insured-status" requirements, because no monthly benefits were payable until 1940, and because no disability benefits were available until the 1956 Act.

There has been a rather widespread view that the social insurance program (the OASDI system) was intended to eventually replace the public assistance program, or at least the most important part of it

(from a cost standpoint)—namely, payments to persons aged 65 and over. On the basis of this belief, there have appeared, from time to time, statements of concern that so many aged persons were on the public assistance rolls. In actual fact, it was always the intention that the social insurance program should gradually assume more and more of the burden from the public assistance program, but that the latter should always have a significant, although minor, role—and such has been the case.

It may be argued that the only way by which the public assistance programs—particularly SSI—could be eliminated would be if the benefits under the social insurance program were at such a high level that the minimum needs of all persons could be satisfied. If this were done, then the OASDI benefit level would be so high that the need for private individual and group provisions in this area would be significantly reduced, if not virtually eliminated.

As a general criterion, it might be argued that there should be a public assistance system to supplement the social insurance program for the relatively small minority of cases where essential needs are not met through the social insurance benefits. The proportion of social insurance beneficiaries who receive public assistance might be considered a criterion. Correspondingly, this would also serve as an indication of the relative adequacy of the social insurance benefits. So long as this proportion of persons aged 65 and over does not exceed 10 percent, it might be considered that there is a proper balance between the two programs.

The foregoing discussion, although in general terms, has primarily focused on the relationship for the aged between SSI and OASDI. There are similar relationships, although not so close, between OASDI and the other public assistance programs providing cash payments directly to recipients for general needs. The availability of survivor benefits for orphaned children and their widowed parent under OASDI naturally has an impact on the AFDC program, although over the years the latter has become more concerned with needy children whose source of support has been missing or greatly reduced because of desertion, separation, divorce, mother being unmarried, disability, or unemployment. Part of this shift in emphasis has been due to the availability of survivor protection from OASDI, and part has been due to the decreasing number of orphans in the country (as a result of rapidly declining mortality among persons in the parenthood years). In the early years of operation of AFDC, about 40 percent of the recipients were orphans, whereas currently this proportion is less than 5 percent.

Similarly, there is a relationship between OASDI and the public

assistance programs for the blind and the disabled. Again, there is not complete correspondence because, at least in certain states, the definitions of disability and blindness are not as strict as under OASDI. Nonetheless, far more recipients would now be under public assistance programs if it were not for the existence of OASDI.

Although the foregoing discussion considered only the relationship between OASDI and the public assistance programs, it is obvious that similar relationships exist between the latter and other social insurance programs and private employer programs. For example, the existence of the Railroad Retirement system and of various pension and other fringe-benefit plans for private employees and for employees of federal, state, and local governments naturally has had a significant effect in holding down the public assistance rolls. Some individuals, of course, receive benefits both under the foregoing programs and under public assistance, although probably relatively less frequently than is the case for OASDI beneficiaries, since the benefits under these systems are generally at a higher level than OASDI. Similarly, the various programs of pensions and compensation for veterans of military service have an effect on public assistance because all such payments must be taken into account by the latter in determining need.

Data with Regard to the Relationship between Public Assistance and OASDI

The number of Old-Age Assistance (OAA) recipients was about 2.0 million at the beginning of the 1940s. Following World War II, it rose gradually to a peak of 2.8 million in 1950. At the same time, the number of OASDI beneficiaries aged 65 and over grew gradually as the roll built up during the 1940s, and it exceeded the number of OAA recipients for the first time in the early part of 1951. The number of OAA recipients began to decline slowly at the end of 1950, because of the liberalized insured-status provisions for OASDI introduced then, which brought a considerable number of individuals on the roll (and also, to some extent, because of the increase in the general benefit level as a result of that legislation).

In subsequent years, as a result of the extension of OASDI coverage and additional liberalizations in the insured-status provisions and benefit-computation procedures, OAA rolls were further decreased. Some of these declines occurred immediately after the liberalized OASDI provisions became effective, because many individuals who thereby became eligible for OASDI benefits were removed from the OAA roll. Others were not removed, although they had their OAA payment reduced in recognition of the new OASDI benefit. As a re-

sult, the OAA/SSI roll declined steadily so that, as of the end of 1988, there were 28.2 million OASDI beneficiaries aged 65 or over, or 20 times as many as the number of SSI recipients aged 65 or over (excluding the relatively small number with state supplementation only, but including those with federal SSI aged 65 or over who were classified as blind or disabled persons)—a total of 1.4 million persons.

Over the years, a growing number of individuals aged 65 and over have been receiving both OASDI benefits and OAA or SSI payments. Table 11.1 shows the estimated number of such concurrent recipients in selected past years. The number of concurrent recipients increased over the years as the OASDI roll grew and reached a peak of 1.3 million in early 1972. Following this, there was a decrease, because of the large OASDI benefit increase in mid-1972. Then an increase occurred in 1974–76, when the more liberal provisions of SSI went into operation. Following 1976, small decreases have occurred; by the end of 1988, only 1.6 million concurrent recipients were present.

The proportion of OASDI beneficiaries receiving OAA or SSI and

TABLE 11.1. Persons Aged 65 or Over Receiving Both OASDI and OAA/SSI Payments*

Year†	*Estimated Number of Concurrent Recipients (thousands)*	*Concurrent Recipients as Percentage of:*	
		OASDI Beneficiaries Aged 65 or Over	*OAA/SSI Recipients Aged 65 or Over*
1945	55	8.1%	2.6%
1950	300	12.6	9.8
1955	510	8.6	19.2
1960	670	6.6	28.5
1965	970	7.0	44.7
1970	1,260	7.4	60.4
1975	1,770	8.6	69.5
1980	1,590	6.7	70.2
1983	1,355	5.4	67.8
1988	1,583	5.6	79.0

*Data for SSI recipients do not include the small number of persons receiving state-administered supplementation only; beginning with 1980, includes persons aged 65 and over who are classified as receiving SSI because of disability or blindness. Data for OASDI beneficiaries exclude those living outside the area where OAA/SSI is available.

†As of February for 1945–70; as of June for 1975–83; as of December for 1988.

categorized as being aged has been only about 5 to 6 percent in recent years. Thus, it may be concluded that the level of OASDI benefits is adequate. When these data are examined by age, it is found that the proportion tends to be higher for the older beneficiaries. This might be expected for several reasons. First, these older persons frequently have lower OASDI benefits because their benefits are based on the lower earnings of the past; the several benefit increases that applied to existing beneficiaries, as well as to future ones, did not entirely compensate for this factor. Second, in some cases, these persons have greater needs because of medical expenses. Third, these persons are less likely to have other resources because of such factors as having used them up over the period of their retirement, having passed through the depression of the 1930s immediately before retirement (so that they had more difficulty in accumulating assets for their retirement), and the much lower availability of private pension plans in the past.

In the early 1940s few OAA recipients were also receiving OASDI, because it was difficult for most of the then-aged population to so qualify. But over the years, this proportion increased, until by the mid-1960s, about half of the OAA roll was made up of concurrent recipients. In the last few years, this proportion of persons aged 65 or over receiving SSI who also receive OASDI has increased to almost 80 percent. Eventually, almost all of those aged 65 and over receiving SSI payments will also be OASDI (or Railroad Retirement) beneficiaries.

Another important comparison between these two programs is the relationship among OASDI beneficiaries aged 65 and over, OAA/SSI recipients, and the total population aged 65 and over. Table 11.2 summarizes these relationships for certain past years.

Since 1950 the relative proportion of the aged population receiving OASDI benefits has increased by 5½ times, while the proportion receiving OAA/SSI has decreased by about 70 percent. At the same time, the proportion receiving either or both has increased by about 155 percent. In addition to the 93 percent receiving OASDI or SSI as aged recipients in 1988, about another 3 percent of the population aged 65 or over was eligible for OASDI benefits but did not receive them because of continuation of employment. Thus, virtually the entire population aged 65 or over is currently receiving OASDI or SSI or is eligible for OASDI but does not receive benefits because of substantial employment earnings. The remaining 4 percent of the aged population consists largely of persons receiving only RR, Civil Service Retirement, or state and local government-employee pensions.

TABLE 11.2. Proportion of Aged Population Receiving OASDI and OAA/SSI Payments*

	Percentage of Population Aged 65 and Over Receiving:		
Year	*OASDI*	*OAA/SSI*	*OASDI or OAA/SSI, or Both*
1940	0.7%	21.7%	22.3%
1945	6.2	19.4	25.1
1950	16.4	22.4	36.6
1955	39.4	17.9	53.9
1960	61.6	14.1	71.6
1965	75.2	11.7	81.7
1970	85.5	10.4	89.6
1975	90.4	11.1	93.8
1980	91.4	8.7	94.1
1988	91.9	6.5	93.3

*As of June, except 1988 (December).

TABLE 11.3. Concurrent Receipt of SSI and OASDI Benefits, December 1988

	Number of Persons (thousands)		*Proportion of SSI Recipients with OASDI*
*SSI Category**	*With SSI*	*With Both SSI and OASDI*	
Aged*	2,006	1,583	79%
Blind	61	10	16
Disabled	2,397	540	23
Total	4,464	2,133	48

*Includes persons aged 65 and over who are classified as receiving SSI because of disability or blindness.

Note: Data are for federally administered programs only and do not include those with state supplements only payable under state administration (a total of about 375,000 persons).

The relationship between OASDI and SSI is shown in Table 11.3 as of the end of 1988. The relatively higher proportion of concurrent recipients in relation to the assistance roll for the aged than for the other two categories reflects several factors. For the blind and disabled, the assistance rolls are made up of many persons who have been in this condition for years and possibly never could have qualified under OASDI even if its coverage had been available. In some

instances, the assistance definitions of blindness and disability are not as strict as those for OASDI.

The proportion of OASDI disability beneficiaries who are receiving SSI (as either being blind or disabled) was 15 percent as of the end of 1988—as against 5.6 percent for OASDI beneficiaries aged 65 or over.

There is relatively little overlap between OASDI and AFDC, because of the nature of the latter program (which deals, to the greatest extent, with cases where the father is alive but absent from the home).

Appendix 11-1

Public Assistance Programs before the Social Security Act

From colonial times, local communities were responsible for aiding the needy. So-called paupers sometimes received public help in the form of food and fuel. At other times, they were cared for in poorhouses. Such aid was frequently given grudgingly, with the feeling being widespread that people who needed continued help from the community were shiftless and lazy. As the country developed, however, the realization spread that certain groups of people could do relatively little to support themselves and might need help for a long period—such as the aged, widows and orphans, and those disabled to such an extent that they could not work.

Shortly after the turn of the century, a series of state commissions investigated the situation of aged persons, and a number of organizations began to urge legislation on behalf of the needy aged. Until after World War I, the only permanent provision for the needy aged in nearly all states was in so-called almshouses or poor farms. On the whole, this was an extremely unsatisfactory method of caring for the problem. Not only were conditions unsatisfactory in regard to food, physical surroundings, and intermingling of the aged with the mentally defective and the chronically ill, but the cost was relatively high due to inefficient management.

The first effective legislation for old-age assistance was enacted by Alaska in 1915. Arizona had passed an old-age assistance and aid to dependent children law earlier that year, but it was declared unconstitutional. The Alaskan law was quite restricted, since it applied only to aged persons (65 for men and 60 for women) who had been in the territory since 1906.

Then, beginning in 1923 (with Montana, Nevada, and Pennsylvania), a growing number of states enacted and put into force old-age

assistance plans, so that there were 18 by the beginning of 1931 and 30 by the beginning of 1935. Most of these plans had a minimum age of either 65 or 70, and had both residence and citizenship requirements of 10 or 15 years. Also, other requirements were rather strict, so that persons were ineligible if financially able children or near relatives were present. Liens on assets of the recipients were frequently imposed to provide repayment of any assistance furnished. Initially, the plans were usually financed and administered wholly by counties. Whether a program was established was usually optional with the county, so that the extent of the assistance varied widely within each state.

In the area of survivor protection for orphaned children, so-called mothers' pensions or mothers' aid was available by law in nearly all states by 1935. The first such laws were enacted in Illinois and Missouri (1911). In many instances, however, the financing was provided by local governments, so that it was not actually available throughout all local units. The vast majority of the recipients were cases where the father had died, although assistance was furnished in certain cases of desertion, divorce, or incapacity. In general, unlike the situation for old-age assistance, the residence requirement was relatively short (usually only one or two years at most).

The only available public assistance for disabled persons on an organized basis was in respect to the blind, a category which naturally attracts great public sympathy and recognition. In 1935, 27 states had blind pension laws that, on the whole, were similar to the old-age pension laws, although somewhat more liberal with regard to such matters as residence and other requirements. Some states also carried out extensive service programs for the blind, such as vocational training workshops and employment services. Other disabled persons were cared for by general public relief (of a rather spotty nature) and by private charity.

The Great Depression of the early 1930s swept away millions of jobs. As a result, many persons used up their accumulated savings and even lost their homes. In addition, others lost their savings in bank and business failures. Many states had great difficulty in continuing to finance both general relief and the special types of assistance discussed previously. The federal government first made loans to the states for these purposes and later made outright grants, as well as establishing direct federal emergency relief programs.

Considerable public demand developed for long-range, rather than emergency, measures in these areas. Such pressures were especially heightened by the popular appeal of the so-called Townsend Plan,

which was proposed both to help the aged and to cure the depression. Under this plan, $200 a month (which, incidentally, at that time was about twice the earnings of the average full-time worker) would be paid to all U.S. citizens aged 60 and over, regardless of whether need existed, under the condition that it would all be spent within a month. The plan would have been financed by a 2-percent general transactions tax (although most estimates indicated that such a tax would have produced totally inadequate revenue).[7] A number of similar general pension proposals were propounded in the same period—such as the "$30 every Thursday" plan. The political pressure for these plans was, to a considerable extent, responsible for the passage of the public assistance and old-age insurance provisions of the Social Security Act, because many political conservatives viewed the latter as by far the better alternative.

Despite the rejection of the Townsend Plan in this manner and the subsequent enactment of the Social Security Act, its supporters continued to urge its adoption (and thus the repeal of the old-age benefits system under the Social Security program). This was especially so before 1940, when old-age benefits first became payable (originally 1942, but changed to 1940). In 1939, the House Ways and Means Committee held hearings on a bill based on the Townsend Plan (although further modified) and reported it to the full House without recommendation (a very unusual procedure). This bill was rejected by about a three-to-one vote. It would appear that this legislative procedure was followed by a body dominated by Democrats because of the wide public pressure and support for the proposal and because many of its congressional advocates were Republicans.

Although various versions of the Townsend Plan were introduced into Congress in the next 15 years, relatively little legislative consideration was given to them. During the same period, public support waned, and the extensive grass-roots organization established by Dr. Townsend gradually eroded.

For an extensive description of the movement and the political action, see Abraham Holtzman, *The Townsend Movement* (New York: New York Bookman's Associates, 1963).

7. The plan was later modified, as a result of criticisms as to its reasonableness and cost. Under a subsequent version (the McGroarty Bill), as voted on (and rejected) by the House of Representatives on April 18, 1935, during the debate on the bill that became the Social Security Act, the benefit would not be paid to anybody who was working. Also, it would be reduced by any nonearned income. Further, the basic payment would not necessarily be $200 a month, but rather such amount as could be payable from the tax receipts.

Appendix 11-2

Development of Federal-State Public Assistance Programs

In 1934, President Roosevelt established a special committee to study all matters relating to economic security. This group recommended sweeping legislation in many areas, including public assistance and social insurance covering the risk of old-age protection. Some of these proposals were enacted by Congress as the Social Security Act of 1935. This law authorized federal grants to states to pay part of the costs of aid to aged persons, blind people, and needy children.

In 1950, a fourth program was added—aid to the permanently and totally disabled. In 1956, provision of services to promote self-support or self-care became an explicit federal legislative objective. In 1960, a fifth program was inaugurated—medical assistance for the aged (MAA), which was intended for persons aged 65 and over not on old-age assistance (OAA) who had sufficient financial resources to meet their usual needs but not any heavy medical expenses. In 1965, the MAA program and the federal matching for medical vendor payments for other public assistance categories (including OAA) were combined into the new medical assistance program (popularly referred to as Medicaid), although states were permitted either to continue the former programs until 1970 or to adopt the new program immediately.

Over the years to 1974, these public assistance programs expanded but, on the whole, maintained the same general philosophy and characteristics. But then, the character of the three adult cash-payments programs was considerably changed when they were federalized, being then termed the Supplemental Security Income (SSI) program.

This appendix is primarily devoted to the three cash-assistance programs for adults, which have been supplanted by SSI (except in Guam, Puerto Rico, and the Virgin Islands). These adult federal-state programs had the same general requirements that had to be met if federal grants were to be available for AFDC, as described in the main text.

Qualifying Requirements

Special requirements related to each of the programs. For OAA, the minimum age requirement was 65, although a state could make payments to younger persons entirely from its own funds (but, in practice, only one state did so). Similarly, both APTD and AB were

paid, with federal financial participation, only to persons aged 18 or over.

The Social Security Act provided that states may not have any "length-of-residence" requirement for the medical assistance program. It also provided that the requirement for AFDC may not exceed one year for children over a year old. For the other three programs, it could not be more than five of the nine preceding years, including continuous residence for the last year. Likewise, citizenship could be required by the state, but no duration of citizenship would be required. In the actual experience, many states had considerably less stringent residence and citizenship requirements (or none at all), and the federal government participated completely in the financing in all such cases. After some years, however, the Supreme Court, ruled that all of these residence and citizenship requirements are unconstitutional.

The states were required to consider other income and resources in determining the extent of need for public assistance. There must be considered both cash and noncash gifts from relatives, earnings from employment, pensions (including social insurance benefits), and assets (such as homeownership, savings accounts, and life insurance). Certain reserves of a reasonable nature are permitted. Thus, assistance is not refused or payments reduced because of possessing small amounts of savings or life insurance.

Blind persons were granted certain special privileges. For a number of years before 1974, when the SSI program became effective, the first $85 per month of earned income plus half of any additional earned income had to be completely disregarded in considering need. Also, then, state programs were allowed to provide for disregard of the first $20 of monthly earned income of OAA and APTD recipients and 50 percent of the next $60 of such income in considering need. In addition, states could permit APTD recipients undergoing vocational rehabilitation to have all of their earnings disregarded during the first three years thereof. Under the AFDC program, a state was permitted to provide for disregard of the total earned income of any child recipient who was attending school and did not have a full-time job; for any other child, the first $30 of monthly earnings could be disregarded, plus one third of any additional earnings.

The states were also allowed to disregard small amounts of other income in determining the need of recipients—$7.50 per month for the three adult categories and $5 per month per family for AFDC. The states were permitted to place liens on assets of recipients (such as homes) to recover later the amounts spent for cash assistance, but this cannot be done under the medical assistance program.

Extent of State Participation

State participation in the public assistance programs for which federal funds were available developed rapidly, and virtually all states had old-age assistance, aid to the blind, and aid to families with dependent children programs within a few years after 1935. Likewise, following the inception of the aid to the permanently and totally disabled program in 1950, states gradually adopted such plans. At the end of 1973, just before SSI began, all states and other jurisdictions had old-age assistance, aid to families with dependent children, and aid to the blind programs, while all except Nevada had aid to the permanently and totally disabled plans (and Nevada is now participating in the SSI disability program). The participation of the states in the medical assistance program grew rather rapidly after its inauguration in 1965, until now all states except Arizona have such programs. About half the states are now participating in the emergency-assistance program for needy families with children.

Financing Provisions

The federal government originally participated in the financing of the payments to recipients on a 50–50 basis up to a specified maximum on individual payments for OAA and AB, and on a lower basis for AFDC. Over the years, the federal matching proportion rose, as did the individual matchable maximum, which was changed in 1958 to a maximum on the overall average payment. Also in 1958, the principle was introduced of varying part of the grant, depending upon the average per capita income of the state; 50–50 matching continued to apply to three jurisdictions of the United States included in the program (Guam, Puerto Rico, and the Virgin Islands), with further limitations on the total dollar amounts of federal grants in a year.

The federal matching proportion is defined as the percentage prescribed by law that is applied to the total *matchable* assistance payments. Under the basis of individual matchable maximums that originally applied, any payments made to individuals in excess of prescribed dollar amounts were excluded from the total matchable assistance payments to which the federal matching proportion applied. For example, under OAA, initially the federally matching proportion was 50 percent and the individual matchable maximum was $30 per month. The federal grant to be paid for a month was obtained by multiplying 50 percent by the total assistance payments, excluding any amounts paid to individuals in excess of $30.

After 1958, the matchable portion of the total assistance payments under the cash-assistance programs was based on the overall average payment, which is, of course, a more liberal procedure insofar as the states are concerned. For example, for OAA under the 1958 Act, the *matchable* assistance payments were the total payments if the statewide average payment was $65 or less (regardless of the fact that some individuals might have had a payment of more than $65), or $65 times the number of recipients if the statewide average was more than $65.

In 1960, additional federal financing was provided for medical care given to OAA recipients through vendor payments made directly to the suppliers of medical care. For example, in 1964, the basis was as follows: (1) for states with average total grants (cash and medical vendor) above the maximum matchable under the regular formula, there was variable-grant matching on the smallest of (a) the excess of the average total grant over the maximum matchable, (b) the average medical vendor payment, or (c) $15; and (2) for states with average total grants *below* the maximum matchable, there was an extra 15 percent, from federal funds, on the first $15 of average medical vendor payment. If the latter method produced a more favorable result for a state whose average total grant was *above* the maximum matchable, it was used.

As a result of the 1962 Act, similar additional federal financing for medical vendor payments was made available for the AB and APTD programs if the state combined them with OAA into one unified program.

Such combining could also be advantageous in that the average payment for matching purposes was determined for all three programs combined, so that, under some circumstances, more of the total payments will be matchable for federal funds. For example, if a state's average payment for AB was in excess of $70, not all of it was matchable. But if the programs were combined, lower average payments for OAA and APTD might have brought down the overall average to $70 or less, so that all payments under all programs were matchable. At the beginning of 1973 (before SSI eliminated OAA, APTD, and AB), 19 states had made such a combination.

The federal share of the administrative cost was 50 percent, except that the matching proportion was 75 percent with respect to social services that help recipients achieve greater self-support and family stability (90 percent for family planning services). The federal share was 75 percent for compensation of professional medical personnel, 90 percent for the cost of designing, developing, and installing mech-

TABLE 11.4. Maximum Matchable Amounts and Federal Matching Proportions for Cash Payments under OAA, AB, and APTD under Various Laws*

Law	*Maximum Matchable Individual Payment*†	*Federal Matching Proportion*‡
1935 Act	$30	½
1939	40	½
1946 Act	45	⅔ of first $15 + ½ of remainder
1948 and 1950 Acts	50	¾ of first $20 + ½ of remainder
1952 and 1954 Acts	55	⅘ of first $25 + ½ of remainder
1956 Act	60	⅘ of first $30 + ½ of remainder§
1958 Act	None	⅘ of first $30 + variable grant (ranging between 50 percent and 65 percent) on next $35
1960 Act	None	Same as 1958 Act, plus, for OAA only, an additional amount on first $12 of average medical vendor payment (see text)
1961 Act	None	Maximum for average medical vendor payment raised to $15, and first bracket of formula extended to $31
1962 Act	None	29/35 of first $35 + variable grant (ranging between 50 percent and 65 percent) on next $35
1965 Act‖	None	31/37 of first $37 + variable grant (ranging between 50 percent and 65 percent) on next $38

*Not applicable to Puerto Rico and the Virgin Islands (included for the first time in the 1950 Act) and Guam (included for the first time in the 1958 Act), for which jurisdictions there is 50-50 matching, within certain dollar limits. Aid to permanently and totally disabled was introduced in the 1950 Act. All of these programs, except for AFDC, were discontinued, for the 50 states and D.C., when the SSI program went into effect in 1974.

†Per month. For aid to families with dependent children (see Table 11.5), first figure is applicable to first child (and beginning with 1950 Act, to one adult in the family, and with 1962 Act, to two such adults), while second figure is applicable to all other children.

‡Dollar figures relate to average matchable payment (for AFDC, averaged over all child recipients for 1946 and 1948 Acts, and over all child and adult caretaker recipients for later acts).

§Also, federal matching was made available for medical vendor payments up to a maximum of $6 for adults and $3 for children (averaged over all recipients). This provision was eliminated in 1958.

‖In lieu of these formulas, the state can elect to have unified matching for all the cash-payment programs and Medicaid combined (see text).

anized claims-processing and information-retrieval systems (75 percent for the cost of their subsequent operation), and 100 percent of the survey and inspection costs of skilled nursing facilities and intermediate-care facilities.

The development of the federal financing basis for cash payments under the state public assistance programs is summarized in Table 11.4 for OAA, AB, and APTD and in Table 11.5 for AFDC. The federal matching ratios under the variable-grant procedure are explained by the following formula, where P is the federal grant percentage applicable to the upper portion of the average payment in the state (i.e., above $18 for AFDC), and N and S are the national and state per capita incomes respectively:

$$P = 100 - 50 \cdot \frac{S^2}{N^2} \quad \text{and} \quad 50 \leq P \leq 65.$$

Thus the federal matching ratio for a state with the same average per capita income as the nation as a whole was 50 percent for the variable-grant portion of the cash-payment programs, and the same for states with higher per capita incomes.

The matching formulas for the cash payments have been, over the years, of a weighted nature. States with low average payments receive a relatively larger federal matching ratio than do states with high average payments. Generally, but not always, the size of the average payment is correlated with the per capita income in the state, so that the poorer states tend to be given relatively larger federal financial participation.

From the time of the beginning of the MAA program until 1970, the federal matching basis for vendor medical payments generally was on a more liberal basis than that for the cash-assistance payments. In some instances, the matching basis was very complicated, so as to assure that all states would be treated as favorably (or more favorably, generally) as if the vendor medical payments had, instead, been cash payments.

As an alternative to the federal matching basis for the cash-payment assistance programs (OAA, AB, APTD, and AFDC) shown under the "1965 Act" sections of Tables 11.4 and 11.5, a state could have chosen to have the federal financing apply on a unified basis to all payments to recipients combined (i.e., both cash and Medicaid). Under these circumstances, the generally more liberal formula for vendor medical payments is applied to the total payments. This unified basis was used by more than 30 states in 1973 (before OAA, AB, and APTD were replaced by SSI)—the ones that had the larger average payments and

TABLE 11.5. Maximum Matchable Amounts and Federal Matching Proportions for Cash Payments under AFDC under Various Laws*

Law	*Maximum Matchable Individual Payment*†	*Federal Matching Proportions*‡
1935 Act	$18 and $12	⅓
1939 Act	18 and 12	½
1946 Act	24 and 15	⅔ of first $9 + ½ of remainder
1948 and 1950 Acts	27 and 18	¼ of first $12 + ½ of remainder
1952 and 1954 Acts	30 and 21	⅘ of first $15 + ½ of remainder
1956 Act	32 and 23	14⁄17 of first $17 + ½ of remainder§
1958 Act	None	14⁄17 of first $17 + variable grant (ranging between 50 percent and 65 percent) on next $13
1965 Act‖	None	⅚ of first $18 + variable grant (ranging between 50 percent and 65 percent) on next $14

Note: Same footnotes as in Table 11.4.

generally higher-than-average per capita incomes. It may still be used for the combination of AFDC and Medicaid. The alternative unified basis is advantageous to such states because the maximum on the average payment above which no federal matching occurs is not applicable and because the matching ratio under the regular formula is only 50 percent in the second step.