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AMENDMENTS TO THE SOCIAL SECURITY ACT IN 1962–65

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WHEN the Kennedy Administration took office in 1961, an extensive legislative program was developed in connection with the existing social security programs—Old-Age, Survivors, and Disability Insurance; Unemployment Insurance; and Public Assistance. Most of these recommendations were enacted in 1961.[1]

In 1962 important legislation with respect to the Public Assistance program was adopted, and certain minor changes were made in the Unemployment Insurance provisions. No significant changes were made in the OASDI system in 1962–64, although the Administration (both the Kennedy and the Johnson ones) had continued to recommend strongly the enactment of hospital insurance benefits for OASDI eligibles aged 65 and over, as had been done initially in the 1961 legislative recommendations. Then, in 1965, legislation was enacted that made a number of changes in the OASDI system and in the PA program.[2]

This paper summarizes the legislative history of the several amendments during 1962–65, with emphasis on the significant 1965 ones affecting both OASDI and Public Assistance.[3] Also covered are the recommendations in the fields of OASDI and Hospital Insurance (HI) that were made by the Advisory Council on Social Security (1963–64).

RECENT EXPERIENCE

As a background for considering the legislative action in 1962–65, it is desirable first to give a broad summary of the recent operating experience of the various social security programs.

Old-Age, Survivors, and Disability Insurance

The vast impact of the OASDI system on the social and economic life of the country can be seen from the fact that, at the end of 1964, monthly

[1] See Robert J. Myers, "1961 Amendments to the Social Security Act," *TSA*, XIII, 427.

[2] These changes were made in the Social Security Amendments of 1965 (Public Law No. 89-97). Some relatively minor changes were contained in several different laws enacted in 1964 (Public Law Nos. 88-350, 382, 641, and 650); in this paper, all these laws combined will, at times, be referred to as the 1964 Amendments).

[3] See appended bibliography of the most important documents in regard to the OASDI changes enacted in 1965.

benefits were being paid to 19.8 million persons (or to more than 1 out of every 10 persons in the total population) at an annual rate of $15.9 billion. The total number of persons who had covered employment during the year was about 77 million, and their taxable earnings were about $236 billion (which represented about 73 per cent of their total earnings in covered employment, the difference of 27 per cent resulting from the effect of the $4,800 limit on earnings subject to contributions and benefit credit).

The increase in the benefit roll during 1964 was about 760,000 persons. Of the 19.8 million beneficiaries at the end of 1964, 10.7 million were retired workers aged 62 and over and 900,000 were disabled-worker beneficiaries. The remainder of the beneficiaries were distributed into a number of categories of which the following are the most important: wives of retired workers, 2.6 million; widows aged 62 and over, 2.2 million; survivor children, 1.9 million; widowed mothers with children, 0.5 million; and wives and children of disabled workers, 0.7 million.

For December, 1964, the average monthly benefit being paid to retired workers was $78 (without considering additional benefits for dependents), while for disabled workers it was $91 (new awards during the year were about $4 higher). The average benefit for a retired worker with a wife aged 62 or over was $129, while that for a widow aged 62 or over was $68 and that for a young widow with two children was $192. During 1964, lump-sum death payments, averaging $214 per worker, were made with respect to about 1.0 million deceased workers.

The total benefit payments made during 1964 amounted to $16.2 billion, as against total contribution receipts of $16.8 billion. Interest receipts amounted to $633 million (representing a rate of about 3.02 per cent on total assets, or 3.25 per cent on invested assets), while payments to the Railroad Retirement System, under the financial interchange provisions, were $422 million, and administrative expenses were $375 million (or 2¼ per cent of contribution receipts). The combined OASI and DI Trust Funds at the end of 1964 totaled $21.2 billion, of which the DI Trust Fund was $2.0 billion. During the year the OASI Trust Fund increased by $645 million, while the DI Trust Fund decreased by $188 million.

Unemployment Insurance

The number of workers covered by unemployment insurance is only about two-thirds of the number covered by OASDI—because of limitations by type of employment and size of firm. During 1963, 6.0 million persons received at least one weekly UI benefit. The average duration was 13.3 weeks, and 25 per cent of the beneficiaries exhausted their benefit

rights. The average weekly benefit was about $35, and this represented about 35 per cent of average wage (without regard to the maximum taxable wage base).

During 1964 total UI contributions amounted to $3.0 billion (at an average employer contribution rate of 2.2 per cent, after allowing for experience rating), while benefit payments were $2.5 billion. The UI Trust Fund at the end of 1964 amounted to $7.3 billion.

Public Assistance

During 1964 the number of persons receiving public assistance under the programs that involve federal financial participation did not change greatly, except for the new program of Medical Assistance for the Aged (which, by the end of 1964, was operating in thirty-nine states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands). The Old-Age Assistance roll continued the slow decline that has prevailed over recent years, decreasing by about 1½ per cent during 1964. At the end of 1964 there were 2.16 million OAA recipients, 227,000 recipients of Medical Assistance for the Aged (an increase of about 50 per cent in the year), 96,000 recipients of Aid to the Blind, 527,000 recipients of Aid to the Permanently and Totally Disabled, and 3.22 million children receiving Aid to Families with Dependent Children (with assistance also being furnished to 1.03 million adults in such families). In addition, under general assistance programs completely financed by the state and local governments, there were 778,000 recipients in 346,000 families.

The average monthly assistance payment *per recipient* at the end of 1964 was $79 for the aged, $86 for the blind, $81 for the disabled, $34 for families with dependent children, and $195 for MAA.

Data on the financing of the payments to recipients under public assistance programs involving federal participation are shown in Table 1 for the calendar year 1964. Total expenditures were $4.7 billion, of which the federal government supplied about 60 per cent. Over $1.1 billion of the total payments represented vendor payments to third parties for medical care furnished to recipients. More than 75 per cent of these medical vendor payments were made with respect to persons aged 65 and over. The federal matching share of the payments for MAA was lower than the average for all programs combined—and was only slightly more than 50 per cent—because most of the expenditures under this program were made by the larger and wealthier states, for whom the federal matching ratio was 50 per cent.

Interrelationship between OASDI and OAA

Since the OAA roll has been decreasing slowly in recent years, while at the same time the persons aged 65 and over receiving OASDI have been increasing, the ratio of the latter to the former has been increasing and was 6.3 to 1 at the end of 1964. In the middle of 1964, OAA recipients represented 12.4 per cent of the total population aged 65 and over, while the corresponding figure for OASDI beneficiaries aged 65 and over was 71.9 per cent.

TABLE 1

PAYMENTS TO RECIPIENTS UNDER PUBLIC ASSISTANCE PROGRAMS INVOLVING FEDERAL COST SHARING, 1964
(Amounts in Millions)

Program	Total Expenditures	Federal Expenditures	Federal Share
	Total Payments*		
Old-Age Assistance	$2,039	$1,324	64.9%
Medical Assistance for Aged	447	230	51.5
Aid to Blind	98	47	48.0
Aid to Disabled	473	270	57.0
Aid to Families with Children	1,634	920	56.3
Total	$4,691	$2,791	59.5%
	Vendor Medical Payments		
Old-Age Assistance	$ 432	$ 278	64.2%
Medical Assistance for Aged	445	230	51.7
Aid to Blind	12	6	48.2
Aid to Disabled	118	61	51.8
Aid to Families with Children	138	73	53.0
Total	$1,144	$ 647	56.6%

* Including vendor medical payments.

A growing number of individuals aged 65 and over receive both OAA payments and OASDI benefits. In the middle of 1964 there were 903,000 such concurrent recipients, representing 41 per cent of all OAA recipients and 6.6 per cent of all OASDI beneficiaries aged 65 and over. Since over the long range OASDI is the major program for providing basic old age security, it is to be anticipated that the proportion of OAA recipients who

will be receiving OASDI benefits will continue to increase, ultimately approaching 100 per cent. On the other hand, recent experience indicates that the proportion of OASDI beneficiaries aged 65 and over who are receiving OAA has stabilized at about 6–7 per cent and may remain at about that level in the future.

UNEMPLOYMENT INSURANCE CHANGES

The only significant legislation during the period 1962–64 was two amendments enacted in 1963. Under the first of these, the financing provision for the temporary extended unemployment benefits for persons who exhausted their regular benefits in the twenty-one-month period beginning July 1, 1960, was changed from the initial basis of an increase of 0.4 per cent in the tax rate on employers for 1962–63 to 0.4 per cent for 1962 and 0.25 per cent for 1963. This change was made because it appeared that the actual cost of the benefits paid would not be as large as the income from the 0.4 per cent tax for the two-year period, and instead there would be sufficient funds if the tax rate for the second year were reduced. The other amendment merely permitted those states that had not repaid the advances that they had received from the Federal Unemployment Insurance Trust Fund with respect to temporary additional unemployment benefits enacted under the 1958 amendments to stretch out the repayments over a longer period and to permit these repayments to be made from the state reserves rather than by increasing the federal unemployment tax on the employers in those states.

In May, 1965, the Administration recommended significant changes in the UI system. Federal unemployment adjustment benefits would be payable to workers with long-term unemployment who have exhausted their UI benefits and who have had a prescribed amount of past employment. Weekly benefits would be in the same amount as under state law and for a maximum period of twenty-six weeks in a three-year period. UI coverage would be extended to all employees in covered employment regardless of size of firm, to employees of nonprofit organizations, and to large-scale and industrial-type agricultural activities. Federal benefit standards would be established for full tax-offset credit in regard to length of employment required for eligibility purposes, duration of benefits (at least twenty-six weeks of benefits would be required for workers with twenty weeks of employment in a year), and benefit amounts (benefit must be at least 50 per cent of worker's average wage, with the state maximum weekly benefit being at least 50 per cent of the average wage in the state for July, 1967, to June, 1969, at least 60 per cent for July, 1969, to June, 1970, and at least $66\frac{2}{3}$ per cent thereafter). If a state does not meet these bene-

fit standards, the federal tax-offset credit is limited to the four-year average benefit cost, expressed in relation to taxable payroll, or to 2.7 per cent if lower.

The financing provisions would be significantly changed because there would be federal grants to states for so-called excess benefit costs. The latter term is defined as annual benefit costs in excess of 2 per cent of total payroll, and the federal grant would be two-thirds of such excess costs. In order to finance the estimated cost of the unemployment adjustment benefits and the federal grants for excess benefit costs, the contribution rate would be increased by 0.15 per cent of payroll (or to 0.10 per cent of payroll when the trust fund has built up to a specified level). In addition, there would be a matching government contribution from general revenues equal to 0.15 per cent of taxable wages (or 0.10 per cent, as the case may be). Furthermore, the maximum taxable wage base would be increased to $5,600 for 1967–70, and to $6,600 thereafter—thus paralleling the changes that would have been made in the OASDI bill passed by the House of Representatives in April, but with a one-year delay in the beginning.

PUBLIC ASSISTANCE CHANGES

The Public Welfare Amendments of 1962 made sweeping changes in the Public Assistance program. In addition to greatly increased emphasis on rehabilitative services to help recipients achieve self-support, the federal matching formula for the PA programs, other than Aid to Families with Dependent Children, was changed, and the federal proportion was further increased. The formula applicable to the programs for the aged, the blind, and the disabled was changed so that the federal share was 29/35 of the first $35 of the average assistance payment, plus a variable percentage (ranging from 50 to 65 per cent, depending upon the per capita income of the state) of the next $35—as against the former formula of 4/5 of the first $31, plus the variable matching on the next $35. The further federal matching for vendor payments for medical care for Old-Age Assistance recipients was continued unchanged.

The 1962 Amendments also made a number of other important changes,[4] such as:

1. Making it possible for states to combine their PA programs for the aged, the blind, and the disabled, as well as the Medical Assistance for the Aged program; this procedure can be financially advantageous to states because (*a*)

[4] For more details of the changes see Wilbur J. Cohen and Robert M. Ball, "Public Welfare Amendments of 1962 and Proposals for Health Insurance for the Aged," *Social Security Bulletin*, October, 1962, p. 3.

broader averaging of payments will result (which may make more of the total payments fall below the maximum matchable limit) and (*b*) special matching of vendor medical payments will be made available to the disabled and the blind (as well as to the aged).

2. Permitting states, in determining need of OAA recipients, to disregard the first $10 of monthly earned income, plus one-half of the next $40 (a provision similar to what had previously been enacted for the blind, although with smaller exemptions).
3. Extending for five years the provision for aiding dependent children of unemployed parents.
4. Having a 75 per cent federal matching for state expenditures for certain social services and training activities.

The increased federal cost resulting from the 1962 Amendments was about $300 million per year—in large part due to the new matching basis for cash assistance payments and the extension of the temporary provisions for aid to dependent children of unemployed parents.

In 1964 legislation amending the PA programs was passed by both houses, but the Conference Committee between the House and the Senate became deadlocked on the matter of hospital insurance benefits under the OASDI system. Accordingly, these provisions were not enacted.[5]

A PA amendment that was enacted during 1964 provided for federal matching of payments made under the Aid to Families with Dependent Children program with respect to children aged 18–20 who are in full-time attendance at high school or a vocational or technical training course. The limit previously was age 18, regardless of school attendance. The states, however, are not required to make payments to this new category, but, if they do so, then there will be federal funds available to help meet the cost.

The Social Security Amendments of 1965, which introduced health insurance provisions for persons aged 65 and over and made a number of significant changes in the OASDI system, also contained a number of important PA changes. Many of these changes had been in the 1964 legislation that was deadlocked in conference.

The House bill made the following important changes:

1. Federal matching at the lower end of the average-payment range would be increased for all programs (e.g., from 29/35 of the first $35 to 31/37 of the first $37 for the three "adult" programs).
2. Federal matching at the upper end of the average-payment range would be

[5] A detailed account of the legislative history of the 1964 Amendments affecting PA, OASDI, and hospital insurance that were not enacted may be obtained from the author.

increased for all PA programs (e.g., by increasing the total average payment matchable from $70 to $75 for the three "adult" programs).
3. The prohibition against federal matching of payments to aged recipients who are in mental or tuberculosis institutions would be removed.
4. OAA recipients would be permitted (if the state chooses) a larger amount of earned income that would be disregarded in determining need—namely, disregarding all of the first $20 of monthly earnings and half of the next $60.
5. In order for a state to receive additional federal funds from the new matching basis, it must pass along any increase (in the aggregate) to the recipients.
6. The program of Medical Assistance for the Aged (Kerr-Mills Law) and the vendor-medical provisions for PA recipients would be combined into a single uniform program, Medical Assistance (MA), with increased federal matching; this would be optional with the states for several years and then compulsory.
7. The new MA program would be available not only to PA recipients but also (at the option of the state) to individuals who are medically indigent and who would qualify under the PA programs if they were in sufficient financial need for other reasons than their medical care costs—just as the MAA program applies to persons aged 65 and over in addition to those on OAA; furthermore, for the purpose of this program, children would include those up to age 21 even though, because of age, they could not qualify for AFDC.

The Senate Finance Committee made the following important changes:

1. Recipients under the Aid to the Permanently and Totally Disabled program would be permitted the same earnings exemption as OAA recipients.
2. Child recipients under AFDC who are under age 18 could have (if the state law so provides) up to $50 per month of earned income disregarded in determining need, but with a maximum such exemption of $150 per family.
3. Children would be eligible under AFDC up to age 21 if attending a college or university (existing law allowed this only for attendance at high school or vocational school).

The action on the Senate floor resulted in the following changes:

1. States would be permitted to disregard up to $7 per month of any income per recipient in determining need in all PA programs.
2. Instead of the several federal matching formulas for cash and medical payments, a state that has an MA program would be able to use a single formula, involving the MA matching percentages and without limit on the average matchable payments.

The Conference Committee agreed on provisions that were the same as the Senate Bill except that, for the new MA program, adult caretakers of children could not be covered unless the family is receiving AFDC or would be eligible for AFDC if it had insufficient means for regular living costs, and except that the $7 monthly per capita exemption of any income

was reduced to $5. In regard to the first point, it might clarify the matter to list the several categories of children and their adult caretakers who could be covered by MA:

1. Children and adult caretakers receiving AFDC.
2. Children and adult caretakers who would receive AFDC if their means were insufficient for ordinary living costs.
3. Children and adult caretakers as in (2) even though the child is aged 18–20.
4. Children under age 21 in families where they would not be able to qualify for AFDC because none of the conditions as to death, absence from the home, disability, or unemployment of the father is met.

MATCHING BASIS FOR PUBLIC ASSISTANCE AFTER 1965 AMENDMENTS

The federal government finances a considerable part of the cost of the six Public Assistance programs. The federal matching for administrative expenses is 50 per cent, except that it is 75 per cent for expenses for certain social services and training activities. The federal matching basis for payments to recipients is rather complex and varies between the several programs.

Under all programs, in essence, the average payment per recipient is computed each month for each state. The federal matching payments are based on these average payments, but these average payments cannot exceed certain prescribed maximums, except for the Medical Assistance for the Aged program (MAA) and the Medical Assistance program (MA), which have no maximum.

The federal matching amounts for payments to recipients in the aged, the blind, and the disabled programs are determined for each state from the following formula, as applicable to the average matchable payment:

31/37 of first $37 + a variable grant percentage of next $38,

where the variable grant percentage, P, is determined from the following formula (in which N and S are the national and state average per capita incomes, respectively, for a three-year period):

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

For all programs except MAA, any vendor-medical payments (made directly to vendors of medical services furnished to recipients, such as doctors and hospitals) are combined with the cash payments in computing the average monthly payment and in applying the maximum averages used in computing the federal matching. For Old-Age Assistance (and for any combined single program for the aged, blind, and disabled, as men-

tioned previously), special additional federal matching is available with respect to vendor-medical payments, as follows:

1. For states with average total grants (cash and vendor-medical) above $75, the maximum matchable under the regular formula, there is variable-grant matching on a special basis on the first $15 of average vendor-medical payment (variable-grant matching on the regular basis then applies to the excess of the total grant over $37 plus the amount of average vendor-medical payment that is matched on a special basis, but such excess cannot exceed $38). The special variable-grant matching for vendor-medical payments is the same as for cash payments, except that the matching proportion has a maximum of 80 per cent rather than 65 per cent. In essence, the special matching for vendor-medical payments occurs before the second step of the regular matching for cash payments (and vendor-medical payments above a $15 average), whereas before the 1965 Amendments the reverse was the case, which was disadvantageous to a few states when the maximum matchable payment was increased.
2. For states with average total grants below $75, there is an extra 15 per cent (over and above the regular matching on the total grant) on the first $15 of average vendor-medical payment (if the latter method produces a more favorable result for a state with average total grant above $75, it is used).

The application of these matching provisions for OAA can perhaps best be understood from some examples. First, let us assume that a state with a 50 per cent variable-grant proportion has an average total grant of $85, of which $20 is vendor-medical. The average federal payment is then $31/37 \times \$37 + 0.50 \times \$15 + 0.50\ (\$85 - \$37 - \$15) = \$55$. Second, let us assume that a state with a 60 per cent variable-grant proportion has an average total grant of $50, of which $10 is vendor-medical. The average federal payment is then $31/37 \times \$37 + 0.60\ (\$50 - \$37) + 0.15 \times \$10 = \$40.30$.

The matching formula for the Aid to Families with Dependent Children program is different from that for the aged, the blind, and the disabled programs. Considering the average payment per recipient (including both children and eligible adult caretakers), the federal matching amount is determined from the following formula:

5/6 of first $18 + a variable grant percentage of next $14.

The variable-grant percentage for any state is the same as for the preceding three programs (with a 65 per cent maximum).

The federal matching basis for the MAA program is determined by multiplying the total vendor-medical payments (without maximum) by the same special variable-grant percentage that is used for vendor-medical

payments for OAA (i.e., with an 80 per cent maximum); this percentage is termed the "federal medical percentage."

The regular variable-grant percentage for the period July, 1965, through June, 1967, is 50 per cent in twenty of the fifty-one jurisdictions (the fifty States and the District of Columbia) and also for Guam, Puerto Rico, and the Virgin Islands (as prescribed by law for these three areas). The maximum proportion of 65 per cent applies to seventeen jurisdictions, so that there are fourteen falling between 50 and 65 per cent. The variable-grant percentage for MAA and vendor-medical payments can be as much as 80 per cent, but, of the seventeen jurisdictions affected by the regular 65 per cent maximum, only one is affected by the 80 per cent maximum.

The new Medical Assistance program (MA) has a different federal matching basis than either the cash PA payments or the vendor-medical and MAA payments. The MA federal matching basis is merely the multiplication of the total medical payments (without maximum) by the federal medical assistance percentage, which is determined from the following formula that is based on the same per capita income figures as in the other two formulas:

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

As will be seen, this formula has the results that a state with per capita income equal to the national average has a federal matching ratio of 55 per cent and that a state with per capita income that is at least 4.9 per cent above the national average will receive the 50 per cent minimum matching basis. The federal matching ratio for administrative expenses of the MA program is 75 per cent with respect to professional medical personnel and allied staff and 50 per cent for all other administrative expenses.

HISTORY OF OASDI CHANGES

In 1962–63 there was no specific legislative activity. The Administration concentrated its efforts on hospital-benefits proposals, and the congressional committees involved did not take any action in this direction until late 1963, when the House Ways and Means Committee held public hearings on this subject. These hearings did not relate to the cash-benefits portion of the OASDI system. However, when the Ways and Means Committee held executive sessions on social security matters during the first half of 1964, it considered all aspects of the program.

In July, 1964, the House passed H.R. 11865 making changes only in the OASDI system, and the Senate Finance Committee reported out this

bill with only a few changes. In September, on the Senate floor, hospital and related benefits provisions were added by a vote of 49 to 44. The Conference Committee became deadlocked on the latter provisions, so the legislation died when Congress adjourned on October 3 for the election campaigns.

Changes Made in 1964 Legislation

Certain changes were made by bills enacted in 1964. The most important of these were another extension of the deadline for existing ministers to elect coverage (to April 15, 1965) and the removal of the eighteen-month retroactive limitation on determination of disability. As a result of the latter, disability claimants can "establish" the beginning date of their disability with no retroactive limitation, and so the possibility of losing their insured status is eliminated. For example, consider an insured worker who was continuously in covered employment until he was disabled in January, 1955 (and had no earnings thereafter). Through lack of knowledge of the benefits available, he did not file a claim until December, 1964. Under previous law he would not be eligible, since his disability could not have been determined to have begun before June, 1963. Thus, he could not have had the necessary five years of covered work (twenty quarters of coverage) in the ten years preceding his retroactively-determined date of disability. Under present law, however, he qualifies because the date of disability is determined to be January, 1955.

Changes Recommended by Advisory Council

At the end of 1964 the Advisory Council on Social Security made its report, based on study over a period of one and a half years.[6] This Council was composed of twelve members from the general public (including R. A. Hohaus, F.S.A.) and the Commissioner of Social Security.

The Council made the following major recommendations in regard to the coverage and benefit provisions of the OASDI cash-benefits system (recommendations in the field of hospitalization benefits are described later):

1. Extend coverage to self-employed doctors, tips, and federal civilian employees who separate from service without being eligible for Civil Service Retirement benefits.
2. Increase benefit level by about 15 per cent on the average (by increasing the "bend point" in the benefit formula from $110 to $155).
3. Increase maximum lump-sum death payment from $255 to amount of maximum monthly family benefit.
4. Provide child school-attendance benefits up to age 22.

[6] See *TSA*, XVII, 99, for a review of this report.

5. Provide benefits for disabled widows, regardless of age.
6. Liberalize definition of "child" (to include cases where father was supporting child or had legal obligation to do so).
7. Provide special disability-insured status for young workers, who have difficulty in meeting "regular" requirement of twenty quarters of coverage in the last forty quarters before disablement.
8. Pay rehabilitation costs for disabled beneficiaries who are likely to be returned to gainful work (from the DI Trust Fund).

The recommendations in the area of OASDI financing were as follows:

1. Increase earnings base to $6,000 in 1966 and to $7,200 in 1968.
2. Revise the contribution schedule "to avoid the rapid increase in trust fund assets that will otherwise occur" under the early-year rates of existing law but have a long-range self-supporting schedule in the law. The combined employer-employee rates are as follows:

Year	Existing Law	Recommendation
1966–67.....	8.25%	8.6%
1968–70.....	9.25	8.6
1971–75.....	9.25	9.4
1976 and after..	9.25	10.6

Changes Made by Administration Bill, 1965

At the opening of Congress in 1965, the Administration bill, H.R. 1 by Congressman King and S. 1 by Senator Anderson, was introduced. The Administration showed its special interest in this proposal by having the bill be designated as the first one introduced in the new Congress. Besides continuing the proposal for a system of hospitalization and related benefits for persons aged 65 and over, it had the following OASDI provisions (most of which were in the 1964 legislative measures):

1. The maximum earnings base would be $5,600.
2. A 7 per cent increase would be given to all beneficiaries on the roll, and the same increase would apply in the future with respect to benefits based on the first $400 of the average monthly wage (the same factor as in the 1958 Act for the portion of the average monthly wage in excess of $110 being applied to any portion of the average monthly wage in excess of $400).
3. Child's benefits would be payable beyond age 18, and up to age 22, if the child is in full-time school attendance (with no mother's benefits payable with respect to such child).
4. Automatic recomputation of benefits to reflect earnings not used in the initial computation would be provided.
5. Coverage would be extended on a compulsory basis to self-employed doctors and to tips.

6. The contribution schedule would be the same after 1965 as in the 1964 Senate floor bill (see Table 2), except that the allocation to the DI Trust Fund would be increased to 0.67 per cent of taxable payroll with respect to the combined employer-employee rate, while the corresponding allocation to the HI Trust Fund would be 0.60 per cent for 1966, 0.76 per cent for 1967–68, and 0.90 per cent thereafter.

TABLE 2

COMBINED EMPLOYER-EMPLOYEE CONTRIBUTION SCHEDULES FOR OASDI AND HI COMBINED UNDER VARIOUS VERSIONS OF 1964 AND 1965 AMENDMENTS

CALENDAR YEARS	PREVIOUS LAW	1964 AMENDMENTS		1965 AMENDMENTS		
		House Bill*	Senate Bill	House Bill	Senate Bill	Final Bill
1965.....	7.25%	7.6%	8.5%	7.25%	7.25%	7.25%
1966.....	8.25	8.0	9.0	8.7	8.35	8.4
1967.....	8.25	8.0	9.0	9.0	8.7	8.8
1968.....	9.25	9.0	10.0	9.0	8.7	8.8
1969–70.....	9.25	9.0	10.0	9.8	10.0	9.8
1971–72.....	9.25	9.6	10.4	9.8	10.1	9.8
1973–75.....	9.25	9.6	10.4	10.7	11.2	10.8
1976–79.....	9.25	9.6	10.4	10.8	11.3	10.9
1980–86.....	9.25	9.6	10.4	11.0	11.5	11.1
1987 and after..	9.25	9.6	10.4	11.2	11.6	11.3
Earnings base...	$4,800	$5,400	$5,600	$5,600 in 1966–70; thereafter $6,600	$6,600	$6,600

* The Senate Finance Committee bill was the same as this.

NOTE.—The rate for the self-employed is 75 per cent of the combined employer-employee rate (rounded to the nearest 1/10 per cent) under the previous law and under the 1964 Amendments, but for the subsequent legislation a lower basis was adopted (see text).

7. The financing of the additional benefit costs arising from the gratuitous military service wage credits (for service before 1957) would be changed from a current-cost basis (with ten-year amortization of costs incurred before 1956) to level payments in the future spread over the next fifty years.

Changes Made by House of Representatives Bill, 1965

In the early part of 1965 the Ways and Means Committee held limited public hearings that were devoted to various health insurance and assistance proposals. These were considered in lengthy executive sessions, and a new bill, H.R. 6675 by Chairman Mills, was introduced containing health insurance provisions (discussed subsequently), OASDI changes, and public assistance changes (discussed previously). All the OASDI changes recommended by the Executive Branch in H.R. 1 and S. 1 were adopted,

and, in addition, the following provisions were included, almost all of which had been in the 1964 legislation:

1. The maximum annual earnings base would be increased to $5,600 in 1966 (the same figure as in the 1964 Senate bill and as in H.R. 1) and to $6,600 in 1971 (the same step-up basis as recommended by the Advisory Council, although lower amounts).

TABLE 3

QUARTER OF COVERAGE REQUIREMENTS FOR TRANSITIONAL INSURED STATUS

A. FOR OLD-AGE BENEFITS

Age Attained in 1965	Men	Women
71	6*	5
72	6*	4
73	6*	3
74	5	3
75	4	3
76 or over	3	3

B. FOR WIDOW'S BENEFITS†

Year of Death of Husband (or Year of Attainment of Age 65 if Earlier)	Age Attained by Widow in 1966		
	72 or Over	71	70
1956	5	5	5
1955	4	4	5
1954 or before	3	4	5

* The usual requirement of a minimum of six quarters prevails.

† A woman who attained age 70 or over in 1966 and whose husband had transitional insured status is eligible for widow's benefits at age 72 on this basis, even though the requirements below are not met (e.g., the widow of a man with three quarters of coverage who attained age 76 in 1965 and who died in 1967, at which time the wife had just attained age 71; under these circumstances, when she attains age 72 in 1968, she will be eligible for widow's benefits on this basis even though the insured worker had only three quarters of coverage, instead of the five quarters shown below).

2. Actuarially-reduced widow's benefits would be provided at age 60.
3. A special transitional insured status would be provided for persons now over or near age 72 (see Table 3), with benefits payable when age 72 or over.
4. The earnings test (or retirement test) would be liberalized by increasing the band above the $1,200 annual exempt amount for which $1 of benefits is withheld for each $2 of earnings from $500 to $1,200 (a lower-cost version of the change made on the Senate floor in 1964).
5. The definition of disability would be liberalized by requiring only total disability that has lasted for the duration of the waiting period—and not that

would be expected to be of long-continued and indefinite duration, as under existing law (a change recommended by the Executive Branch in 1961 but not in subsequent proposals or legislation).

6. The waiting period for disability benefits would be reduced by one month, so as to be a true six-month period (a change not in previous proposals or legislation).
7. Disability benefits would be made available to individuals who are receiving another type of monthly benefit, such as a reduced old-age benefit (at 62–64), whereas previous law barred this.
8. Self-employed persons belonging to religious sects whose teachings oppose insurance would be permitted to opt out (the so-called Amish amendment, added on the Senate floor in 1964).
9. The time limit on filing proof of dependency and on filing for lump-sum death payments would be removed if "good cause" is shown (added by Senate Finance Committee in 1964).
10. Benefit rights of women divorced under certain circumstances (after twenty years of marriage, or for benefits based on a previous marriage before twenty years of marriage) would be retained (completely new provision).
11. The method of determining self-employment income for farmers from gross income would be expanded to include larger amounts of such income.
12. The contribution schedule would be changed so that lower rates for OASDI would be charged in 1966–72 (a combined employer-employee rate of 8.0 per cent in 1966–68 and 8.8 per cent in 1969–71), but a higher ultimate rate thereafter (a combined employer-employee rate of 9.6 per cent, as compared with 9.25 per cent in 1968 and after in existing law). The basis for the self-employed rate for 1973 and after would be changed from the basis that has applied ever since the self-employed were first covered under the program in 1951—approximately one and a half times the employee rate—so that a maximum rate of 7.0 per cent would apply, instead of the 7.2 per cent which would result from the "one and a half times" basis.
13. The allocation to the DI Trust Fund would be increased to 0.75 per cent of taxable payroll with respect to the combined employer-employee rate. The increase takes care of the insufficiency in the financing of the existing law and the cost of the several amendments liberalizing the disability benefit provisions.

This bill was passed by the House, under a rule permitting no amendments, by considerably less than the usual overwhelming majority—namely, 313 to 115—due to the controversy over the HI provisions (as discussed later).

Changes Made by Senate Finance Committee Bill, 1965

At the end of April and in early May, the Senate Committee on Finance conducted public hearings on H.R. 6675 and then held extensive executive sessions. Most of the OASDI changes in the House bill were adopted,

but the following important changes or new provisions were included in the Senate Finance Committee bill:

1. The maximum annual earnings base would be increased to $6,600 immediately in 1966, rather than the two-step approach in the House bill.
2. The earnings test would be further liberalized by increasing the annual exempt amount from $1,200 to $1,800 (with a corresponding change in the monthly test), and the annual band for which $1 of benefits is withheld for each $2 of earnings would be retained at the $1,200 figure in the House bill.
3. The liberalization in the definition of disability was partially eliminated by requiring total disability that could be expected to last for twelve months (or earlier death); also the one-month reduction in the waiting period proposed in the House bill was eliminated.
4. The coverage of tips was changed from a "wages" basis to a "self-employment" basis, and the coverage of self-employed doctors was made retroactive for the calendar year 1965.
5. A new provision was added to prevent undue duplication of workmen's compensation and DI benefits. Under this provision the DI benefits would be reduced if the aggregate benefits exceed 80 per cent of earnings. Under these circumstances, in general, "earnings" are measured by the highest covered earnings under the OASDI system in a five-consecutive-year period but with such average earnings being adjusted periodically in accordance with changes in the general level of earnings.[7]
6. Children disabled at ages 18–21 would be eligible for child's benefits if they continue to be disabled.
7. The cost of rehabilitation services for certain disabled beneficiaries would be paid out of the trust funds, but with a maximum aggregate annual limitation of 1 per cent of the disability benefits paid in the previous year. Such rehabilitation services could be paid for only with respect to individuals for whom the savings in future benefits could be expected to offset the rehabilitation costs.
8. An unremarried widow or divorced wife would retain benefit rights acquired with respect to all previous husbands (but with the usual antiduplication provisions applying, so that only the largest benefit would be paid).
9. A widow remarrying after age 60 (or a widower after age 62) would not have the previous widow's benefit terminate, but it would be reduced to 50 per cent of her deceased husband's primary benefit (instead of remaining at the 82½ per cent rate).
10. The contribution schedule would be changed so that there would be a lower rate than in the House bill for 1966–68 (reflecting the effect of the higher earnings base in the Senate Finance Committee bill), but a higher rate

[7] The specific method for carrying out such triennial adjustments parallels a procedure described in Robert J. Myers, "A Method of Automatically Adjusting the Maximum Earnings Base under OASDI," *Journal of Risk and Insurance*, September, 1964, p. 329.

thereafter (reflecting the increase in cost that results primarily from the significant liberalization of the earnings test). The combined employer-employee rate would be 7.7 per cent in 1966–68 (as against 8.0 per cent in the House Bill), increasing to 8.9 per cent in 1969–72 (versus 8.8 per cent) and to 9.8 per cent in 1973 and after (versus 9.6 per cent).

11. The allocation to the DI Trust Fund would be increased to 0.70 per cent of taxable payroll, with respect to the combined employer-employee rate (as against 0.75 per cent in the House bill, the reduction being possible because of the elimination of most of the liberalizing features of the House bill).

Changes Made by Senate Bill, 1965

In early July the bill was debated on the Senate floor, and the following important changes were made:

1. Actuarially-reduced benefits would be provided at age 60 for all beneficiary categories who, under existing law, could obtain benefits at age 62 (thus being applicable to all and not merely to widows, as in the House bill).
2. Insured status for disability benefits for persons meeting the so-called industrial blindness definition would be based on only six quarters of coverage (acquired at any time).
3. The contribution schedule would be increased so as to finance the foregoing changes. The combined employer-employee rate would be 0.1 per cent higher than under the Senate Finance Committee bill after 1968. The allocation to the DI Trust Fund would be increased to 0.76 per cent of taxable payroll, as compared with 0.70 per cent in the Senate Finance Committee bill.

The Senate, by a record vote of 68 to 21, passed the bill on July 9.

Action of Conference Committee, 1965

The Conference Committee between the House and the Senate, on July 21, resolved the differences between the two versions of the bill by following the Senate bill, except as follows:

1. The earnings test would be liberalized only to the extent of increasing the annual exempt amount from $1,200 to $1,500 (with a corresponding change in the monthly test), but with a $1,200 band for which $1 of benefits is withheld for each $2 of earnings.
2. The actuarially-reduced benefits at age 60 would not be available for all beneficiary categories but rather only for widows.
3. The liberalized disability benefit provision for the "industrially blind" was eliminated, but in its place two liberalized provisions were introduced for the blind (namely, a special insured status provision for persons becoming blind before age 31—paralleling the Advisory Council provision in this respect that would have been applicable to all causes of disability—and an occupational disability definition for blind persons after attaining age 55).
4. The provision for paying child's benefits with respect to children disabled at ages 18–21 was eliminated.

5. The coverage of tips was changed back to a "wages" basis, but with only the employee contributing (although the employer would have to make the necessary report and transmit the taxes, if he had sufficient funds of the employee to do so).
6. The contribution schedule was decreased, since less funds would be required to finance the foregoing changes. The resulting contribution rates are shown in Table 2 and fall between those in the House bill and in the Senate bill. Table 4 shows the combined employer-employee contribution rates for OASDI and HI (the program of hospital and related benefits, to be discussed later) combined. The allocation to the DI Trust Fund was changed to 0.70 per cent—lower than in either the House bill or the Senate bill, because the provisions representing increased cost in each of these over the other one were eliminated.

TABLE 4

OASDI AND HI CONTRIBUTION SCHEDULES UNDER 1965 AMENDMENTS

YEARS	COMBINED EMPLOYER-EMPLOYEE RATE			SELF-EMPLOYED RATE		
	OASDI	HI	Total	OASDI	HI	Total
1965.....	7.25%	.....	7.25%	5.4%	.....	5.40%
1966.....	7.7	.7%	8.4	5.8	.35%	6.15
1967–68.....	7.8	1.0	8.8	5.9	.50	6.40
1969–72.....	8.8	1.0	9.8	6.6	.50	7.10
1973–75.....	9.7	1.1	10.8	7.0	.55	7.55
1976–79.....	9.7	1.2	10.9	7.0	.60	7.60
1980–86.....	9.7	1.4	11.1	7.0	.70	7.70
1987 and after.	9.7	1.6	11.3	7.0	.80	7.80

Rationale Underlying Increases in Benefit Amounts and Earnings Base

The across-the-board benefit increase of 7 per cent (with a $4 minimum increase in the primary amount) is retroactive to January, 1965. The 7 per cent increase corresponds closely to the rise in the cost of living in the six-year period between January, 1959, when the last previous general increase was made, and January, 1965. But it may be noted that persons going on the benefit roll between these two dates tended to have larger benefits than those on the roll at the beginning of the period, because of their higher earnings during the period before entry on the roll.

The $4 minimum increase produces a $6 minimum increase for a married couple when both are aged 65 or over at time of award or at the time the increase was made, and this amount will meet the cost of the premium for the new voluntary supplementary medical benefits plan. But it may be noted that this increase is payable currently and that the

premium is not to be deducted from the benefit until the check for June, 1966, payable at the beginning of the next month.

The retroactivity of the benefit increase (and also the child school-attendance benefits) to January, 1965, is the first time that this procedure has been followed. Previously, general benefit increases were made prospectively, to be effective either for a few months after enactment or for the following January. The reason given for this different course of action was that the beneficiaries would have received benefit increases at about this time under the 1964 legislation that died in conference but on which there was general agreement as to the desirability of such increases.

The $1,800 increase in the maximum taxable and creditable earnings base from $4,800 in 1965 to $6,600 in 1966 was the largest increase that has occurred to date. The previous increases were all $600 rises, but they occurred at four-year intervals in the 1950's (in 1951, 1955, and 1959), whereas in this case there was a seven-year interval. Even so, the increase seems relatively large until its effect is analyzed. The proportion of total earnings in covered employment that was covered by each of the earnings bases in the first year that they were effective and by the $4,800 base currently is as shown in the accompanying tabulation.

Year	Base	Proportion
1951.....	$3,600	81.7%
1955.....	4,200	80.9
1959.....	4,800	79.7
1965*.....	4,800	71.7
1966*.....	6,600	80.4

* Estimated on basis of 1964 experience, projected with anticipated increases in earnings levels. On the basis of 1964 earnings, the proportion would be 83.4 per cent for a base of $6,600.

Thus, the $6,600 base merely restores the relationship between taxable earnings and total earnings in covered employment that prevailed in previous years when changes were made. The 1966 proportion is estimated to be slightly higher than that which resulted when the current $4,800 base was first applicable but slightly lower than when the two previous increases were made.

CONSIDERATION OF HOSPITALIZATION AND RELATED BENEFITS UNDER OASDI

Early in 1963 the Administration submitted to Congress a revised version of its proposal to provide hospitalization and related benefits to OASDI beneficiaries aged 65 and over (including persons eligible for

monthly benefits but not receiving them because of the earnings test).[8] There was no legislative action on this measure (the King-Anderson Bill) in 1963, except that the House Ways and Means Committee held public hearings on the subject late in the year, and these were completed early in 1964. As indicated previously, both the House bill and the Senate Finance Committee bill included only OASDI benefit changes, but on the Senate floor the hospital insurance provisions were added. This caused the deadlock of the bill in conference.

Cost Estimates for King-Anderson Bill of 1963 and Similar Proposals[9]

The initial cost estimates for this proposal were made on the assumption of 1961 earnings levels and hospitalization costs. The basic assumption underlying these actuarial cost estimates was that the relationship between earnings and hospitalization costs would, on the average, continue in the future as it was in the 1961 experience. Alternatively and equivalently, these assumptions will be satisfied if earnings and hospitalization costs rise, on the average, at the same rate in the future and if the taxable earnings base is adjusted proportionately with changes in the earnings level. Under these assumptions it was estimated that the financing provided in the King-Anderson Bill would be adequate to support the cost of the benefits and the administrative expenses.

The level cost of the bill, under these assumptions, was estimated at 0.68 per cent of taxable payroll. This cost was financed by the 0.5 per cent increase in the combined employer-employee contribution rate and the 0.18 per cent savings to the cash-benefits portion of the program that results from raising the earnings base from $4,800 to $5,200. At the same time, however, it should be remembered that the underlying assumption that the earnings base will be kept up to date means that the $5,200 base would have to be increased to about $5,800 on the basis of the likely 1965 earnings level.

In considering the hospitalization-benefit costs in conjunction with a level-earnings assumption for the future, it is necessary for the purposes of long-range cost estimates to analyze possible future trends in hospital-

[8] For a description of the 1961 version of the King-Anderson Bill and legislative developments in connection with it, see Robert J. Myers, "1961 Amendments to the Social Security Act," *TSA*, XIII, 427. For a similar description of the 1963 bill and its legislative development, see Robert J. Myers, *Social Insurance and Allied Government Programs* (Homewood Ill.: Richard D. Irwin, Inc., 1965), p. 97.

[9] For more details as to the assumptions and results of the initial cost estimates, see Robert J. Myers, "Actuarial Cost Estimates for Hospital Insurance Bill," *Actuarial Study No. 57* (Washington, D.C.: Social Security Administration, July, 1963).

ization costs relative to covered earnings. Accordingly, any study of past experience of hospitalization costs should be made on this relative basis. The actual experience in recent years has indicated, in general, that hospitalization costs have risen more rapidly than the general earnings level, with the differential being about 2.7 per cent per year in the last decade.

One of the uncertainties in making cost estimates for hospitalization benefits, then, is how long and to what extent this tendency of hospitalization costs to rise more rapidly than the general earnings level will continue in the future—and whether or not it may in the long run be counterbalanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly "catching up" with the general level of wages and obviously may be expected to "catch up" completely at some future date rather than to increase indefinitely at a more rapid rate) and the development of new medical techniques and procedures, with resultant increased expense. In connection with the latter factor, there are possible counterbalancing factors, in that the higher costs involved for more refined and extensive treatments may be offset by better general health conditions, further development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also it is possible that, at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, hospitalization prices might increase less rapidly than the wages of hospital employees.

Perhaps the major difficulty in making, and in presenting, these actuarial cost estimates for hospitalization benefits is that—unlike the situation in regard to cost estimates for the OASDI monthly benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base and the dollar amounts of any deductibles are concerned). The reason for this is that there is the fundamental assumption that hospitalization costs will rise at the same rate over the long run as the total earnings level. The contribution income would rise less rapidly than the *total* earnings level unless the earnings base is kept up to date, since contributions depend on the *covered* earnings level, which is dampened if the earnings base is not raised as earnings go up. Accordingly, it seemed necessary in the actuarial cost estimates for hospitalization benefits to assume either that earnings levels will be unchanged in the future or that, if wages continue to rise, the sys-

tem will be kept up to date insofar as the earnings base and the deductibles are concerned.

An alternative assumption that is more conservative than that used in the initial cost estimates is that the relationship between hospitalization costs and wages, as it can reasonably be anticipated for 1965, should be considered and that hospitalization costs should then be assumed to rise more rapidly than wages only for five or six years (with the aggregate differential after 1965 being 10 per cent). From then on, it is assumed that, over the long run, covered earnings levels and hospitalization prices will rise at the same rate. This assumption was adopted for the cost estimates used at the time the 1964 legislation was considered.

Some of the 1964 legislation contained cost-sharing provisions such that, if the earnings base would not increase as rapidly as wages, the increased relative cost of the program would be borne by the beneficiaries through coinsurance of a flat amount per day. When considering proposals that did not contain a cost-sharing provision to offset future rises in hospitalization costs, it was assumed that the maximum earnings base will be increased from time to time in the event that earnings do rise as they have in the past. If, however, by any chance the earnings base were not increased for a few years in the future, even though earnings rose, then the financial status of the system as a whole would still be satisfactory, since the savings to the OASDI cash-benefits portion, under any set of realistic assumptions, would more than offset the "loss" to the hospital benefits portion. The latter taken alone would also be soundly financed if later on the earnings base were raised sufficiently to preserve the prior relationship to wages.

HI Provisions Recommended by Advisory Council

The Advisory Council on Social Security recommended the adoption of a Hospital Insurance program, along with the changes in the OASDI system discussed previously. The recommendation was unanimous except for Mr. Hohaus, who opposed it on the grounds that this would be a considerably different type of program from cash benefits, that the cost aspects are uncertain, that the interrelationship with other medical services is unclear, and that insufficient attention had been given to the effect on the rapidly developing private insurance efforts in this field.

The Advisory Council plan, in general, was similar to the King-Anderson Bill of 1963. The basic differences were as follows:

1. Hospitalization benefits would be available on only one basis—not three options—namely, a 45-day maximum per benefit period, with $20 deductible, which would be automatically adjusted in the future with changes in hospitalization costs.

2. Extended care facility benefits would be available for a maximum of about 120 days, on the basis of 2 days for each "unused" day of hospitalization benefits, in addition to 30 days in any event.
3. Benefits would be available for disability beneficiaries (insured worker only), as well as for persons aged 65 and over.
4. The financing basis would be significantly changed, both as to allocation of costs and as to the underlying cost assumptions, which resulted in higher contribution rates being required. The combined employer-employee rate would be 0.4 per cent of taxable payroll in all future years (using the same earnings bases as proposed for OASDI), while the self-employed rate would be 0.5 per cent. In addition, a contribution from general revenues equivalent to 0.15 per cent of taxable payroll would be made for the next fifty years; this would approximately meet the cost for the current noninsured aged, who would be blanketed-in for the hospital benefits, and for the current OASDI beneficiaries, who would contribute little (if at all) into the HI Trust Fund.

The Advisory Council recommended that somewhat more conservative assumptions should be adopted in regard to the future trend of hospitalization costs (making no recommendations, however, as to the utilization assumptions and concurring with the assumption previously used in the cost estimates that the earnings base would be kept up to date with future changes in the general level of wages). The specific assumption was that hospitalization costs would increase more rapidly than wages by 2.7 per cent per year (the average differential experienced during 1954–63) until 1970, that this differential would decrease to zero by 1975 and would then increase at an annual rate that is 0.5 per cent greater than the increase in hospital costs. In regard to the "ultimate" assumption, it should be recognized that, over the past history of the country, wages have risen at a significantly higher rate than the general price level.

Description of King-Anderson Bill of 1965

The 1965 Administration proposal was contained in identical bills introduced by Congressman King (H.R. 1) and Senator Anderson (S. 1). The benefits that would be provided were quite similar to those contained in the King-Anderson Bill of 1963 and the modified version thereof that was adopted by the Senate in 1964. The principal differences in the benefit provisions were that only one hospitalization benefit option would be provided (namely, sixty days of care within a benefit period, with a flat deductible equal in amount to the nationwide average daily hospital cost under the program), and with a maximum of sixty days of post-hospital extended care benefits.

The estimated level cost of this proposal was 0.84 per cent of taxable payroll on the basis of the cost assumptions used for the Advisory Council proposal, which were based on more conservative assumptions than had

been used previously in connection with the 1963–64 legislative proposals. The program would be financed by an allocation of the combined OASDI and HI contribution rates amounting to 0.60 per cent of taxable payroll as to the combined employer-employee rate for 1966, 0.76 per cent for 1967–68, and 0.90 per cent thereafter (with the allocation for the self-employed being 75 per cent thereof).

Just as in previous proposals, railroad workers would be furnished the same benefits through the Railroad Retirement System. The financial interchange provisions, in essence, would provide for the OASDI system to "reinsure" the hospitalization benefit experience of the Railroad Retirement System. Likewise, the benefit protection would be provided, on a transitional basis, to virtually all uninsured persons in the country (excluding only federal employees eligible for health benefits under their own plan, certain short-residence aliens, and members of subversive organizations).

House of Representatives Bill, 1965

Early in 1965 the Ways and Means Committee held executive hearings and sessions on both H.R. 1 and on other proposals for health benefits for persons aged 65 and over. Among the most important of the other proposals were H.R. 4351, introduced by Congressman Byrnes, the ranking Republican member of the Ways and Means Committee, and the so-called Eldercare Bill, introduced by Congressmen Herlong and Curtis (H.R. 3727 and H.R. 3728), that was sponsored by the American Medical Association.

The Byrnes Bill would provide a full range of health benefits (rather than merely hospitalization and related benefits as in H.R. 1), with certain deductibles and coinsurance. This proposal would be on a basis modeled closely after the high-option government-wide indemnity plan available for federal government employees of all ages. It would be financed by individual monthly premium payments equal to $2 plus 5 per cent of the OASDI cash benefit, with the remaining two-thirds of the cost being met from general revenues.

The Eldercare Bill, essentially, would expand the MAA program to permit the development of private health insurance that would be fully paid for under MAA for low-income persons and would be on a partial-payment basis for those above the maximum income limitation for "free" coverage. No uniform program of health benefits would be prescribed, but rather this would be left to each state to decide upon, if it so wished. This bill would also liberalize the MAA program in a number of respects by

providing increased federal financial participation and by easing the means test requirements.

As mentioned previously, the Ways and Means Committee reported out a new bill, H.R. 6675, that contained changes in OASDI and public assistance and, in addition, had provisions for health insurance for persons aged 65 and over. This bill would establish an HI program closely paralleling the benefit provisions in H.R. 1, but with different financing provisions and with the HI system being more "separate" from OASDI than was the case in previous proposals.

In addition, the bill would establish a supplementary voluntary program covering physician services and certain other medical costs. In essence, it may be said that the benefit provisions of this supplementary plan were similar to those of the Byrnes Bill, after the hospitalization and related benefits had been "carved out" by being provided in the separate HI system. The new supplementary program would be available on an individual voluntary election basis and would be financed by uniform premium rates from the beneficiaries, with a matching contribution from general revenues.

The Administration, through the testimony before the Senate Finance Committee of Secretary of Health, Education, and Welfare Celebrezze, supported this new program, although in his testimony before the House Ways and Means Committee the following statement was made about the HI proposal (see Item 7 of the Legislative Bibliography, p. 4):

> While neither private insurance nor public assistance, alone or together, can meet the pressing need the aged have for protection against the cost of expensive illness, the proposed program contemplates an important role for both. The proposed program will serve as a foundation on which people can build greater protection through private health insurance and employer retirement plans, just as the present social security cash benefit system is serving as a base on which people build additional protection through private means.

The HI benefit provisions of the House bill differed from those of H.R. 1 in the following major respects:

1. Post-hospital extended care benefits would be available for a maximum of 20 days per spell of illness, plus 2 additional days for each unused day of hospital benefits up to a maximum of 80 additional days (i.e., 100 total days). Furthermore, a 3-day stay in the hospital would be required before eligibility for these nursing home benefits.
2. The outpatient diagnostic benefits would be changed so that the period to which the deductible applied would be 20 days in the same hospital, rather than 30 days in all hospitals. Furthermore, any deductible paid for this benefit would be credited against the hospital deductible.

3. The home health services benefits would be limited to 100 visits and would be available only after hospitalization.
4. The services of certain medical specialists in hospitals (radiologists, anesthesiologists, pathologists, and physiatrists) would not be covered under HI but rather would be covered under the supplementary plan.
5. A deductible would be introduced in the hospital benefits with respect to the cost of the first three pints of whole blood furnished; this change was made so as not to discourage the voluntary blood-donor movement.

The HI program would be financed by a long-range increasing contribution schedule. The combined employer-employee rate would begin at 0.7 per cent in 1966, and would then increase to 1.0 per cent in 1967–71, 1.1 per cent in 1973–75, 1.2 per cent in 1976–79, 1.4 per cent in 1980–86, and 1.6 per cent thereafter. These rates would be levied on the same earnings base as proposed for OASDI—namely, $5,600 in 1966–70 and $6,600 thereafter. Unlike any previous proposals, the self-employed would pay only half the combined employer-employee contribution rate. The cost of the benefits for the uninsured group would be borne by general revenues.

The considerably higher contribution rates scheduled in this bill than under the previous proposals resulted from the adoption of considerably more conservative cost assumptions. In regard to the relationship between hospitalization costs and wages, the same differential basis was used as recommended by the Advisory Council, except that the negative differential after 1975 was eliminated. In addition, hospital utilization rates were assumed to be 10 per cent higher over the long run than was previously assumed (plus a further 10 per cent in the short range, so as to eliminate the assumed effect of lower utilization initially, when the insured persons might not be too familiar with the benefits available).

Finally, the cost estimates assumed that, although wages would almost certainly continue to rise in the future, there would be no further changes in the earnings base over those scheduled in the bill. In other words, it was assumed that wages (and, even more so, hospitalization costs) would rise steadily in the future but that the earnings base would not keep up to date—a set of conditions which causes increasing HI costs relative to taxable payroll and thus necessitates the long-range increasing contribution schedule contained in the bill. Because of the nature of the assumptions, and because of the particular problems inherent in long-range cost estimates for health benefits, the period which the cost estimates cover was limited to 1966–90, instead of extending to perpetuity or for 75 years.

The HI provisions of the bill covered noninsured persons in the same manner as did H.R. 1. The coverage of railroad workers was, however, changed so that they are directly under the HI program in the same man-

ner as OASDI workers; thus, both railroad workers and their employers would contribute to the HI Trust Fund in exactly the same manner as would be done for all other workers. Other elements of "separateness" from the OASDI system would be a specific tax for the HI system (rather than an allocation from a total combined tax rate) and income-tax withholding statements showing the relative subdivision of the total contribution between OASDI and HI. Not only would there be a separate trust fund for the HI program, but also there would be a separate board of trustees, although its membership would be the same as the corresponding board for the OASDI Trust Funds. Also, the contribution basis for the self-employed would be different (equal to employee rate, rather than one and a half times).

The voluntary supplementary program would cover the services of physicians, psychiatric hospital services, home health services (up to a maximum of 100 visits per year), and various other medical and health services, such as diagnostic tests, therapy treatments, ambulance services, surgical dressings, and medical equipment. There would be an annual deductible of $50, plus 20 per cent coinsurance on the part of the participant. Special limitations would be provided on outpatient psychiatric care (in essence, 50 per cent coinsurance and maximum reimbursement of $250 per year) and on psychiatric hospital benefits (maximum of 60 days in a benefit year and a lifetime maximum of 180 days). The program would be financed by premiums of $3 a month from the participants, with matching amounts from general revenues. The $3 premium rate could be adjusted in the future (after 1967) as experience indicated and would also be higher for individuals who do not enter the program when they are first eligible to do so (with strict requirements as to such late enrollments or as to re-enrollments).

When the bill was considered by the House, the usual procedure of a "closed rule" was followed, so that no amendments were permitted to be considered, except that a motion to recommit was in order. The bill was taken up on April 7 and 8, and Congressman Byrnes made a motion to recommit and substitute his health benefits proposal for the dual program in the bill (but retaining all the OASDI and Public Assistance amendments). This motion was rejected by a vote of 236 to 191, with a considerable spread by parties (63 Democrats joined 128 Republicans in voting for recommittal, while those opposed numbered 226 Democrats and 10 Republicans). In the final vote on passage of the bill, many of those who voted for recommittal voted for the bill (the 313 votes for passage included 248 Democrats and 65 Republicans, while the 115 votes against passage included 42 Democrats and 73 Republicans).

Senate Finance Committee Bill, 1965

As a result of the public hearings and executive sessions of the Senate Finance Committee, both the HI program and the voluntary supplementary plan—Supplementary Medical Insurance (SMI)—were approved in the general form of the House bill. During the proceedings, an attempt was made by Senator Long (Louisiana) to substitute income-related deductibles for the flat deductibles under these two programs, but this basis was finally rejected. At the same time, Senator Long and others had emphasized the need for more protection in the catastrophic area, and, as will be indicated subsequently, steps in this direction were taken.

The HI benefit provisions of the Senate Finance Committee bill differed from those of the House bill in the following major respects:

1. The hospital benefits would be available for an additional 60 days, with coinsurance of $10 per day (automatically adjusted in the future, with changes in hospitalization costs).
2. The outpatient diagnostic benefits would have 20 per cent coinsurance (so as to parallel the treatment of such services when covered outside of a hospital under SMI), and the initial deductible would be credited against the SMI deductible (rather than against the HI deductible).
3. The post-hospital extended care benefits would be available for a maximum of 100 days per spell of illness in all cases (rather than any days beyond 20 depending upon unused hospital days), but there would be coinsurance of $5 per day (automatically adjusted in the future, with changes in hospitalization costs) for each day beyond the twentieth one.
4. The home health services benefits would have a maximum of 175 visits per year.
5. The psychiatric hospital benefits would be covered under HI (instead of under SMI).
6. The services of certain medical specialists in hospitals (discussed previously) would be covered under HI, as in the King-Anderson bills, when such services are provided under an arrangement with a hospital and are billed through the hospital.

The HI program, as modified by the Senate Finance Committee, would be financed by a revised contribution schedule. Somewhat higher rates would be provided in the later years of operation than in the House bill, because of the increased cost involved in the benefit changes discussed previously. The HI contribution rates before 1971 would not be increased, because adequate additional income to the program would be available from the higher earnings base adopted (namely, $6,600 beginning with 1966, rather than $5,600 in 1966–70, and then $6,600). The combined employer-employee rate would begin at 0.65 per cent in 1966 and would then increase to 1.0 per cent for 1966–70, 1.1 per cent for

1971–72, 1.2 per cent for 1973–75, 1.3 per cent for 1976–79, 1.5 per cent for 1980–86, and 1.7 per cent for 1987 and after. Thus, after 1970, this contribution rate in the Senate Finance Committee bill would be 0.1 per cent higher than in the House bill.

The provision as to the coverage of railroad workers was changed so that they would be directly under the HI program in the same manner as OASDI workers only until the first time that the maximum taxable wage base under the Railroad Retirement System is equivalent to that under OASDI. From then on, the benefit provisions would be administered by the Railroad Retirement Board (as in the King-Anderson bills), and the Railroad Retirement tax rate would include the HI contributions. Then, the financial interchange provisions between the two systems would be operative for the hospital benefits, as they have been for the cash benefits.

The SMI benefit provisions of the Senate Finance Committee bill differed from those of the House bill principally only in the manner indicated in the previous discussion of the changes in the HI program—namely, by the transfer of certain items or services from one program to the other. The financing basis of SMI would remain unchanged, and, since the premium rate would be the same as in the House bill, the program would be somewhat more adequately financed because more costs were moved from SMI to HI than vice versa.

The effective dates for HI and SMI under the House bill would be July 1, 1966, except the extended-care facility benefits under HI (January 1, 1967). The Senate Finance Committee bill postponed the effective date for SMI until January 1, 1967, in order to give more time to establish the necessary administrative machinery.

Senate Bill, 1965

The SMI provisions were not changed significantly during the Senate debate, but the following important changes were made in the HI provisions:

1. There would be no limit on the number of hospital days covered (but with coinsurance after the sixtieth day).
2. The requirement of prior hospitalization for the home health service benefits would be eliminated.
3. The contribution schedule would be increased so as to finance the foregoing changes. The combined employer-employee rate would be 0.05 per cent higher than under the Senate Finance Committee bill during the period 1973–86.

Action of Conference Committee, 1965

The Conference Committee between the House and the Senate resolved the differences between the two versions of the bill for the health

insurance provisions at the same time as this was done for the OASDI provisions in the bill.

The Senate provisions for the HI system were followed, except as follows:

1. The maximum number of hospital days per spell of illness would be 90 (with coinsurance after the sixtieth day).
2. Prior hospitalization would be required for the home health service benefits.
3. The maximum number of home health service visits would be 100 in a 1-year period.
4. The services of the medical specialists would not be covered (but rather would be under the SMI system).
5. The transfer of the administration of the program as it applies to railroad workers to the Railroad Retirement System would be applicable only to the collection of contributions (and not as to payment of benefits as well, as under the Senate bill). Moreover, the transfer would only be effective while the earnings bases of the two systems are equivalent (whereas under the Senate bill, once this would occur, the transfer would be permanent).

The Senate provisions for the SMI program were followed, except that the effective date was moved back to that in the House bill (July 1, 1966).

PROVISIONS OF OASDI SYSTEM AFTER 1965 AMENDMENTS

The provisions of the OASDI system with regard to beneficiary categories, insured status conditions, benefit amounts, earnings test, and coverage will now be described as they exist following the 1965 Amendments. The financing provisions will be discussed later, in combination with those for the HI system.

Beneficiary Categories

Fully insured individuals are eligible for old age benefits upon attainment of age 62. The amount of this benefit is 100 per cent of the primary insurance amount, PIA (defined later), except in the case of a worker first claiming benefit before age 65. In the latter case, there is reduction in the benefit of $\frac{5}{9}$ per cent for each month below age 65 at time of retirement. Thus, a person retiring at exact age 62 receives a 20 per cent lifetime reduction, which closely approximates an "actuarial equivalent" basis. Benefits are paid only after an individual files a claim and is substantially retired (earnings test provision, described hereafter). Retroactive payments may be made for as many as twelve months before the individual filed claim; this is also done in respect to all other monthly benefits.

An individual is eligible for disability benefits if (*a*) he is totally disabled and has been so disabled for at least six months, and this can be expected to continue for at least another six months or result in prior

death (except that, no second waiting period is required in the case of a recovered disability beneficiary who has a relapse within five years), and (*b*) he is both fully insured and disability insured. The waiting period may be described as a "seven-plus month waiting period," since the individual does not receive a benefit payment until he has been disabled for seven full calendar months.

Total disability is statutorily defined as inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment. Special provisions apply to blind persons becoming disabled before age 31 (lower insured status requirements—coverage in about half the period since age 21 or currently insured status if this is a stricter requirement) and after attainment of age 55 (occupational definition of disability then).

A disability benefit can be awarded even though the individual was previously receiving another benefit, such as an actuarially reduced old-age benefit at ages 62–64 or a widow's benefit at ages 60–64; appropriate reduction is made in the disability benefit to reflect the period of receipt of the other benefit on a reduced basis. The determinations of disability are made by state agencies (generally the vocational rehabilitation unit) with review by the Social Security Administration (which may reverse the finding of disability but may not reverse a denial of the existence of disability except on a direct appeal of the individual). The determination of continuance of disability is made by the Social Security Administration.

The disability benefit is 100 per cent of the PIA. Generally, an individual must undertake vocational rehabilitation training, the cost of which is paid for by OASDI when it is expected that this will result in a savings in cash-benefits costs. During the first twelve months of rehabilitation or during the first twelve months of any employment, benefits will be paid regardless of earnings if the individual has not medically recovered from his disability. An individual who medically recovers from his disability continues to receive benefits for three months (but these payments, together with any "trial work" benefits, cannot exceed twelve months). There is no permitted amount of earnings as there is for other beneficiaries (earnings test). Rather, a disability beneficiary might have small earnings and still continue to receive benefits as long as he is considered not able to engage in any substantial gainful activity. The disability benefits terminate at age 65, when the beneficiary goes on the old-age benefit roll.

When both disability benefits and workmen's compensation benefits are payable, the combined benefits (including supplementary benefits for dependents) cannot exceed 80 per cent of "average current earnings." Any

reduction necessary is made in the DI benefits (although, of course, these cannot be reduced below zero). "Average current earnings" is defined as the larger of the "average monthly wage" on which the DI benefit is based or the average of the covered earnings in the highest consecutive five-year period. This average current earnings is adjusted triennially to reflect increases in the general level of earnings.[10] Any general OASDI benefit increase occurring after initial award is not affected by this coordination provision. Also, the provision is not applicable if the workmen's compensation system contains an offset provision with respect to DI benefits.

If the retired or disabled individual has a wife aged 65 or over (regardless of her age, if she has an eligible child under age 18, or regardless of age if he was permanently and totally disabled since age 18, in her care), an additional benefit of 50 per cent of the PIA is payable, with a similar addition for each eligible child. A wife between ages 62 and 65 without an eligible child can elect to receive reduced benefits. These are based on a reduction factor of 25/36 per cent for each month under age 65 at time of claiming benefit, which reduction continues during the joint lifetime of the couple. Thus, a wife claiming benefit at exact age 62 has a 25 per cent reduction—somewhat less than the approximately 30 per cent needed on an "actuarial equivalent" basis; a larger reduction than that for the worker is required because it applies during the shorter joint lifetime of the couple, as compared with the single lifetime of the worker. Husband's benefits are payable to a man if he is aged 62 or over and has been chiefly dependent on the retired or disabled female worker and she was currently insured at time of retirement or disablement; the same reductions as for wife's benefits when no eligible child is present apply for husband's benefits claimed before age 65. Also, a retired or disabled worker's child aged 18–21 can receive benefits if he is in full-time school attendance (but this has no effect on the eligibility of the wife).

Widow's benefits of 82½ per cent of the PIA are payable at age 62 if the deceased husband was fully insured. Parallel benefits are payable to dependent widowers aged 62 or over if the deceased wife was both fully and currently insured. Further, a widow between ages 60 and 62 (but not a widower) can elect to receive reduced benefits, based on the same reduction factor as is used for old-age benefits.

When a fully insured worker dies, parent's benefits are payable upon attainment of age 62 to parents who have been dependent upon such individual. The benefit is 82½ per cent of the PIA when one parent is eligible and 75 per cent each when two parents are eligible.

[10] See n. 7 above.

When a fully or currently insured individual dies leaving an eligible child, benefits are payable to such child and to the widowed mother under the same circumstances as for retired and disabled workers. In case of the death of an insured female worker, the child must be dependent on her, or the woman must have been currently insured. The survivor benefits are 75 per cent of the PIA for each eligible beneficiary.

In all cases of death of a fully or currently insured individual, there is a lump-sum death payment of three times the PIA, or $255, if less. The lump sum is payable in full to a surviving spouse; in other cases it may not exceed the actual burial costs.

Certain limitations apply to these benefits. No individual can receive the full amount of more than one monthly benefit. For instance, if a woman has her own old-age benefit as well as a wife's or widow's benefit, then only the amount of the larger benefit may be received. In addition, there are certain minimum and maximum benefit provisions (described subsequently), and there are restrictions on payment of benefits in the case of persons convicted of crimes affecting the security of the nation.

Monthly benefits and rights to deferred benefits generally terminate on divorce, marriage, or remarriage (as the case may be), but there are certain important exceptions, such as remarriage of widow at or after age 60 (or age 62 for a widower), although then the benefit rate is reduced from 82½ to 50 per cent; divorce after twenty years of marriage; and marriage of a survivor beneficiary to another such beneficiary (marriage of a survivor beneficiary to a primary beneficiary may terminate the survivor benefits, but it always gives dependents benefit rights on the new spouse). An unmarried woman retains rights to widow's benefits on all deceased husbands that she may have had.

Insured Status Conditions

There are four types of insured status, defined in terms of quarters of coverage. "Fully insured" is a complete or partial requirement for all benefits. "Currently insured" provides limited eligibility for survivor benefits and is an auxiliary requirement for certain other benefits. "Disability insured" status is an auxiliary requirement for disability benefits. "Transitional insured" status provides old-age, wife's, and widow's benefits for certain persons at age 72 or over who do not meet the fully insured status requirement.

A quarter of coverage requires $50 in nonagricultural wages paid in a calendar quarter or $100 of covered agricultural wages paid in a year. Self-employed individuals are generally credited with four quarters of coverage if their earnings meet the minimum test of $400 in a year, as are

employees if their wages are at least equal to the maximum amount subject to tax.

Fully insured status requires that the number of quarters of coverage obtained at any time must equal at least the years elapsed after 1950 (or year of attainment of age 21, if later) and before the year of death, disablement, or attainment of retirement age (65 for men and 62 for women). A minimum of six and a maximum of forty quarters are required.

Currently insured status requires that six quarters of coverage are acquired in the thirteen-quarter period ending with the quarter of death, disablement, attainment of retirement age, or subsequent retirement.

Disability insured status requires that twenty quarters of coverage are obtained in the forty-quarter period ending with the quarter of disablement, except that more liberal provisions apply for blind persons before age 31.

Transitional insured status requires the same number of quarters of coverage as fully insured status except that the minimum requirement is three quarters of coverage (rather than six) for old-age benefits and a graded number of quarters of coverage (three to five) for widow's benefits, depending upon year of death of husband and year of attainment of age 72 of the widow. These requirements are shown in Table 3.

The "disability freeze" provision permits the exclusion of established periods of disability in determining the number of elapsed quarters. Fully and disability insured status are measured to the beginning of such period of disability.

Benefit Amounts

The primary insurance amount, from which all benefits are determined, is based on the average wage of the insured individual and on a benefit formula.

a) Average monthly wage.—The concept of average monthly wage (AMW) is a "career average" computed over the entire period of potential coverage; however, certain periods of low earnings are excluded. Also, years of high earnings at and after attainment of age 65 for men (age 62 for women) can be substituted for years of low earnings previously, so an incentive exists to defer retirement when there is the possibility of high earnings in the future.

In general, the AMW is computed over a number of years equal to the years after 1955 (or year of attainment of age 26, if later) and before the year of disablement, death, or attainment of age 65 for men (age 62 for women), whichever occurs first. Allowance is thus made in the computation for the drop-out of five calendar years after 1950 (or attainment of

age 21, if later). The years equal to this number can be selected from those with highest earnings after 1950, including before attainment of age 22, in or after the year of attainment of age 65 for men (age 62 for women), and in the "five-year drop-out period." In addition, under the "disability freeze" provision, established periods of disability are excluded. The AMW may also be computed back to the beginning of the system in 1937, on the same basis, if a larger benefit will result. For retirement cases not involving a disability freeze, the AMW must be computed over at least five years. A minimum period of two years is prescribed for survivor benefits.

In summary, the average-wage method has the result that persons who reach age 65 for men (age 62 for women) in or before 1961 and have not had a period of disability have their AMW computed over the best five years following 1950. This period increases one year for every calendar year after 1961, until the maximum of thirty-eight years for men and thirty-five years for women is reached. Thus eventually, when no disability is involved, the AMW for retirement benefits for men is based on the best thirty-eight years in the entire working lifetime (and the best thirty-five years for women).

The basis for computing the AMW is particularly advantageous for individuals who work several years beyond the minimum retirement age, especially in the early years of operation of the system or when the earnings base is changed. As a specific example, consider a fully insured man who attains age 65 at the beginning of 1968. His AMW at that time is based on his best twelve years in the seventeen years, 1951–67. If he continues to work through 1970, his AMW will be based on his best twelve years in a twenty-year period and would be $462 if he had the maximum creditable earnings of $4,800 a year in 1959–65 and $6,600 in 1966–70. In order to have the maximum AMW of $550 under the 1965 Amendments, he would have to have the maximum covered earnings of $6,600 in 1966–77 (i.e., by working until he is age 75).

b) Benefit formula.—In all acts before the 1958 Amendments, a definite benefit formula for the PIA was prescribed. For example, the benefit formula under the 1954 Act applicable to earnings after 1950 was 55 per cent of the first $110 of AMW plus 20 per cent of the next $240 of AMW (reflecting the $4,200 earnings base). Under the 1958 Act and under present law, an apparently considerably different procedure is used. A benefit table gives the PIA for various ranges of AMW (e.g., for an AMW of $114–$118, the PIA is $70.70). The benefit table also shows the maximum family benefit applicable for each PIA (e.g., $106.10 where the AMW is $114–$118).

Actually, the benefit table is based on a definite formula and on definite minimum and maximum benefit provisions that are incorporated in the table. Thus, no change has been made in the basic principle that has prevailed in the past. The benefit formula is 62.97 per cent of the first $110 of AMW, plus 22.90 per cent of the next $290 of AMW, plus 21.40 per cent of the next $150 of AMW, with rounding adjustments. These benefit factors have resulted from the 55 per cent and 20 per cent ones of the 1954 Act, by two successive increases of 7 per cent (in the 1958 and 1965 Acts). When the AMW is under $85, a slightly higher amount is payable than results from the formula, so as to make a smooth junction with the minimum PIA of $44. The benefit table also provides for the determination of the PIA when it is more advantageous to the beneficiary to compute the AMW back to 1937 and to use the benefit computation method of the 1939 Act.

c) Minimum and maximum family benefits.—The minimum family benefit for survivors (applicable only to a one-survivor family) is $44. The maximum family benefit is the larger of (1) one and a half times the PIA or (2) 80 per cent of the first $\$X$ of AMW, plus 40 per cent of AMW in excess of $\$X$ (where X is two-thirds of the maximum possible AMW, rounded up so as to be the upper end of the AMW range in which X falls—in this instance, $370). In each AMW range in the benefit table, the 80 per cent and 40 per cent factors are applied to the highest AMW therein. The result of this formula is that the largest family maximum benefit is approximately two-thirds of the maximum possible AMW. This basis was developed by the 1964 Advisory Council and was incorporated in the various legislative proposals beginning with 1964.

Table 5 shows some illustrative monthly benefits, considering the minimum and maximum benefit provisions and the reductions for women workers and wives claiming benefits before age 65 and for widows claiming benefits before age 62.

Earnings Test

In general, benefits for retired workers and their dependents are not paid when the retired-worker beneficiary is engaged in substantial employment. This provision also applies to survivor beneficiaries and to dependents of a retired or disabled worker, insofar as the individual's benefit is concerned, when the beneficiary engages in substantial employment. This provision is termed the earnings test (or sometimes the retirement test—a misnomer in regard to young beneficiaries).

Benefits are payable for all months in a year if the annual earnings from all types of employment are $1,500 or less. In no event are benefits with-

TABLE 5

ILLUSTRATIVE MONTHLY BENEFITS UNDER OASDI SYSTEM FOR VARIOUS FAMILY CATEGORIES, BASED ON EARNINGS AFTER 1950*

(All Figures Rounded to Nearest Dollar)

AVERAGE MONTHLY WAGE	WORKER ALONE	WORKER WITH SPOUSE CLAIMING BENEFIT AT		WORKER, WIFE, AND ONE CHILD†
		Age 62	Age 65	
	Disabled Worker or Retired Worker Aged 65 at Time of Retirement			
$ 50	$ 44	$ 61	$ 66	$ 66
100	63	87	95	95
150	78	108	117	120
200	90	124	135	162
250	102	140	153	203
300	112	155	169	225
350	124	171	186	248
400	136	187	204	272
450	146	201	219	292
500	157	216	236	314
550	168	231	252	336
	Retired Worker Aged 62 at Time of Retirement			
$ 50	$ 35	$ 52	$ 57	$ 57
100	51	74	82	82
150	63	92	102	104
200	72	106	117	144
250	81	120	132	182
300	90	132	146	205
350	99	146	162	224
400	109	160	177	245
450	117	172	199	263
500	126	185	204	283
550	134	197	218	302

SURVIVOR BENEFITS

Average Monthly Wage	Widow Aged 60	Widow Aged 62‡	One Child	One Child and Mother§	Two Children and Mother‖	Maximum Family Benefit
$ 50	$ 38	$ 44	$ 44	$ 66	$ 66	$ 66
100	45	52	47	95	95	95
150	56	65	59	117	120	120
200	64	74	68	135	162	162
250	73	84	76	153	202	202
300	81	93	84	169	240	240
350	89	103	93	186	280	281
400	97	112	102	204	306	309
450	105	121	110	219	328	328
500	112	130	118	236	348	348
550	120	139	126	252	368	368

* In certain instances when maximum family benefit is payable, somewhat larger amounts are paid to beneficiary families on roll at effective date of 1965 Amendments.

† Also applies to worker and two children and to worker, dependent husband aged 65 or over, and one child.

‡ Also applies to widower and to parent.

§ Also applies to two children and to two parents.

‖ Also applies to three children.

NOTE.—Average monthly wages of $450, $500, and $550 are not possible until at least several years after 1965.

held for a month in which the individual has wages of $125 or less and does not render substantial self-employment services (the monthly test). Moreover, the retirement test is not applicable after the individual reaches age 72. If annual earnings exceed $1,500, benefits for months not affected by the monthly test exemption are reduced—by $1 for each $2 of the first $1,200 of "excess earnings" and by $1 for each $1 of subsequent "excess earnings." Under this basis an individual will always have more income from earnings and benefits combined by increasing his earnings beyond $1,500 than if he so limits them.

Coverage

Virtually all gainfully employed persons are covered under the program or could be covered by election. The major exceptions are most policemen and firemen with their own retirement systems, federal government employees under the Civil Service Retirement system, low-income self-employed persons, and farm and domestic workers with irregular employment. Railroad workers are, in essence, covered under OASDI as a result of the provisions for transfer of wage credits for those with less than ten years of railroad service and as a result of the financial interchange provisions applicable to all railroad employees. Certain special rules apply to employment categories other than employees in industry and commerce. Tips of $20 or more per month received by employees are covered as wages and are reported through the employer, who, however, does not make the usual matching contribution but rather submits only the employee contribution, which he deducts from money otherwise due the employee.

a) *Nonfarm self-employed.*—All nonfarm self-employed persons, nonprofessional and professional, are covered. Earnings are reported annually on the income tax return, provided that such earnings are at least $400 net.

b) *Farm operators.*—Farmers are covered on the same general basis as other self-employed persons, except for a special simplified reporting option for those with low net incomes. A farmer with gross income of $2,400 a year or less may, instead of itemizing income and expense, use two-thirds of his gross income as his earnings for OASDI purposes. Consistent with this, farmers with gross incomes of over $2,400 but net incomes of less than $1,600 may report earnings of $1,600.

c) *Employees of nonprofit organizations.*—Coverage for employees of nonprofit organizations is at the option of each employing unit. The employer may elect coverage, with each employee then having the individual option on coverage. Once coverage is obtained, however, it is compulsory for new employees.

d) Ministers.—Ministers may, by individual voluntary election, be covered. Their earnings are considered as self-employment income even if they are employees. Such elections must, in general, be made within two years after coverage is first available to the individual as a result of his having at least $400 of income from the ministry. The 1965 Amendments again extended (but not on a fully retroactive basis) the election period for ministers who could have elected coverage as early as 1955; the new deadline is April 15, 1966.

e) Employees of state and local governments.—Employees of state and local governments can be covered at the option of the state and of the employing unit. In addition, if there is an existing retirement system, a majority of the employees eligible must also vote in favor of coverage; however, policemen and firemen under an existing retirement system can be covered only in nineteen named states. There are a number of special provisions for designated states that facilitate coverage extension to employees under existing retirement systems by making certain subdivisions, with each being separately considered for coverage.

f) Employees of federal government.—Virtually all federal civilian employees not under an existing retirement system are covered on a regular contributory basis, as are members of the uniformed services. The "gratuitous" wage credits of $160 a month for military service after September 15, 1940, are not given for service after 1956, when regular contributory coverage began. The trust funds are reimbursed for benefit costs arising from such wage credits. Also, there is OASDI coverage on a co-ordinated basis for two small existing retirement systems (Tennessee Valley Authority and Board of Governors of the Federal Reserve Board).

g) Employees of foreign governments and international organizations.—American citizens employed in the United States by foreign governments (and wholly owned instrumentalities thereof) and by international organizations (such as the United Nations) are covered. This coverage is effected by considering these individuals to be self-employed, since it is not possible to levy taxes on their employers.

h) Farm workers.—Farm employment is covered if cash wages in a year from a single employer amount to at least $150. As an alternative, coverage is also applicable if there are twenty or more days of employment remunerated on a time basis (rather than a piece-rate basis). Foreign farm workers admitted on a temporary basis are not covered.

i) Domestic workers.—The coverage provisions for this group are cash wages of at least $50 in a quarter from a single employer.

j) Employment abroad.—The preceding coverage applies to employment in the United States (including Puerto Rico, the Virgin Islands, Guam, and American Samoa), or on American vessels or airplanes. In

addition, United States citizens working for American employers abroad are covered; also, at the option of the employer, United States citizens working for foreign subsidiaries of American companies are covered.

ACTUARIAL COST ANALYSIS OF OASDI CHANGES[11]

Table 6 presents the estimated level-cost computed over the next seventy-five years (in percentage of taxable payroll) of OASDI benefits

TABLE 6

ESTIMATED LEVEL-COST OF OASDI BENEFIT PAYMENTS, ADMINISTRATIVE EXPENSES, AND INTEREST EARNINGS ON EXISTING TRUST FUND AS PERCENTAGE OF TAXABLE PAYROLL* BY TYPE OF BENEFIT, INTERMEDIATE-COST ESTIMATE AT 3.5 PER CENT INTEREST

Item	Old-Age and Survivors Insurance	Disability Insurance
Primary benefits	6.27	0.53
Wife's benefits	0.51	0.04
Widow's benefits	1.11	†
Parent's benefits	0.01	†
Child's benefits	0.67	0.09
Mother's benefits	0.15	†
Lump-sum death payments	0.11	†
Total benefits	8.83	0.66
Administrative expenses	0.13	0.03
Railroad retirement financial interchange	0.04	0.00
Interest on existing trust fund‡	−0.18	−0.02
Net total-level cost	8.82	0.67

* Including adjustment to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate.

† This type of benefit is not payable under this program.

‡ This item is taken as an offset to the benefit and administrative expense cost.

by type, according to the intermediate-cost estimate, with comparable data for administrative expenses[12] and for interest on the existing trust fund. Table 7 shows the estimated cost of OASDI benefits as a percentage of taxable payroll for selected future years, as well as the level-cost under the low-cost, high-cost, and intermediate-cost estimates.

[11] For more complete details on these estimates see Item 13 of the Legislative Bibliography.

[12] Virtually all administrative expenses for collecting contributions, maintaining earnings records, and paying benefits are charged against the Trust Funds (see Robert J. Myers, "OASDI: Administrative Expenses," *Social Security Bulletin*, May–June 1960).

Table 8 gives the estimated future progress of the OASI Trust Fund. According to the intermediate-cost estimate, the Trust Fund rises steadily, reaching a maximum of about $160 billion in the year 2015 (not shown in the table), and then decreases slowly. According to the low-cost estimate, the Trust Fund grows rapidly and in the year 2000 will be $270

TABLE 7

ESTIMATED COST OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS AS PERCENTAGE OF PAYROLL*

Calendar Year	Low-Cost Estimate	High-Cost Estimate	Intermediate-Cost Estimate†
	OASI		
1975	7.47	8.10	7.78
1980	7.87	8.88	8.36
1990	8.28	10.42	9.28
2000	7.64	10.51	8.94
2025	8.77	13.97	10.91
2040	9.95	15.01	11.95
Level-cost‡	7.74	10.23	8.82
	DI		
1975	0.58	0.69	0.63
1980	.57	.71	.64
1990	.54	.72	.62
2000	.54	.74	.63
2025	.61	.81	.70
2040	0.65	0.86	0.73
Level-cost‡	0.60	0.78	0.67

* Taking into account lower contribution rate for the self-employed, as compared with combined employer-employee rate.

† Based on the average of the dollar costs under the low-cost and high-cost estimates.

‡ Level contribution rate, at interest rate, of 3½ per cent for intermediate cost, 3¾ per cent for low cost, and 3¼ per cent for high cost, for benefits after 1964 taking into account interest on the December 31, 1964, trust fund, future administrative expenses, and the lower contribution rates payable by the self-employed.

billion. On the other hand, under the high-cost estimate, it builds up to a maximum of about $40 billion in fifteen years and then decreases until it is exhausted shortly before the year 2000. It is unlikely that either of the latter two extreme situations could develop because the Congress would take appropriate action to prevent it.

Table 9 shows the estimated future progress of the DI Trust Fund.

TABLE 8

ESTIMATED PROGRESS OF OASI TRUST FUND
(In Millions)

Calendar Year	Contributions*	Benefit Payments	Administrative Expenses	Railroad Retirement Financial Interchange†	Interest on Fund‡	Fund at End of Year
	Short-Range Estimate					
1965	$16,014	$16,986	$351	$436	$ 570	$ 17,936
1966	18,848	18,520	377	445	546	17,988
1967	20,687	19,512	363	524	580	18,856
1968	21,568	20,334	369	474	634	19,881
1969	24,958	21,213	377	487	733	23,495
1970	26,328	22,101	385	478	900	27,759
1971	27,163	23,001	393	455	1,082	32,155
1972	28,041	23,908	401	454	1,271	36,704
	Long-Range Intermediate-Cost Estimate					
1975	$28,818	$24,848	$390	$313	$1,212	$ 40,044
1980	31,105	28,828	431	130	1,895	59,891
1990	35,600	36,629	510	— 23	2,689	82,433
2000	41,293	40,926	559	— 77	3,287	101,233
2025	51,238	62,118	769	— 107	4,476	132,792
	Long-Range Low-Cost Estimate					
1975	$29,426	$24,371	$361	$293	$1,633	$ 50,193
1980	32,080	27,996	398	105	2,767	81,283
1990	37,965	34,882	469	— 52	5,316	151,886
2000	45,265	38,365	515	— 112	9,525	270,603
	Long-Range High-Cost Estimate					
1975	$28,209	$25,326	$418	$333	$ 906	$ 30,989
1980	30,129	29,661	464	155	1,212	40,370
1990	33,235	38,376	550	7	537	18,064
2000	37,320	43,487	603	— 42	§	§

* Contributions include reimbursement for additional cost of noncontributory credit for military service.

† A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse. Interest-payment adjustments between the two systems are included in the "Interest" column.

‡ In determining the level-costs, an interest rate of 3.50 per cent is used for intermediate cost, 3.75 per cent for low cost, and 3.25 per cent for high cost; but, in developing the progress of the trust fund, a varying rate in the early years has been used, which is equivalent to such fixed rates.

§ Fund exhausted in 1993.

TABLE 9

ESTIMATED PROGRESS OF DI TRUST FUND
(In Millions)

Calendar Year	Contributions*	Benefit Payments	Administrative Expenses	Railroad Retirement Financial Interchange†	Interest on Fund‡	Fund at End of Year
	Short-Range Estimate					
1965	$1,187	$1,600	$ 85	$24	$ 51	$ 1,576
1966	1,821	1,734	102	25	49	1,585
1967	2,048	1,827	108	29	52	1,721
1968	2,132	1,898	112	21	58	1,880
1969	2,207	1,960	115	24	64	2,052
1970	2,282	2,013	119	26	70	2,246
1971	2,356	2,065	122	29	78	2,464
1972	2,433	2,113	125	32	87	2,714
	Long-Range Intermediate-Cost Estimate					
1975	$2,247	$2,022	$103	−$ 3	$ 121	$ 3,834
1980	2,425	2,211	106	− 11	166	5,177
1990	2,776	2,472	107	− 13	291	8,965
2000	3,220	2,907	120	− 13	509	15,443
2025	3,996	3,970	156	− 13	1,113	33,264
	Long-Range Low-Cost Estimate					
1975	$2,294	$1,886	$ 94	−$ 6	$ 201	$ 5,911
1980	2,501	2,050	95	− 15	311	8,986
1990	2,960	2,283	94	− 18	655	18,647
2000	3,529	2,723	103	− 18	1,252	35,267
	Long-Range High-Cost Estimate					
1975	$2,200	$2,157	$112	$ 0	$ 55	$ 1,824
1980	2,250	2,372	117	− 7	36	1,217
1990	2,592	2,661	120	− 8	§	§
2000	2,911	3,091	137	− 8	§	§

* Contributions include reimbursement for additional cost of noncontributory credit for military service.

† A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse. Interest payment adjustments between the two systems are included in the "Interest" column.

‡ In determining the level-costs, an interest rate of 3.50 per cent is used for intermediate cost, 3.75 per cent for low cost, and 3.25 per cent for high cost; but, in developing the progress of the trust fund, a varying rate in the early years has been used, which is equivalent to such fixed rates.

§ Fund exhausted in 1986.

This fund is shown to grow slowly, but steadily after 1966, reaching $15 billion by the year 2000. Under the low-cost estimate, the estimated growth is more rapid, and the balance is $35 billion in 2000. The high-cost estimate shows a very slow growth for the first ten years after 1965, with the trust fund balance never reaching $2.0 billion and with an eventual decline until it is exhausted in 1986.

The level-cost of the benefit changes provided by the 1965 Amendments was 0.93 per cent of taxable payroll (0.64 per cent for the 7 per cent benefit increase, 0.14 per cent for the liberalization of the earnings test, 0.12 per cent for the child school-attendance benefits, and 0.01 per cent each for the liberalized disability definition, the transitional benefits at age 72, and the broader definition of "child"). This was largely met by the increase of 0.85 per cent in the level-equivalent of the contribution income (0.29 per cent from the increase in the rates, 0.55 per cent from the net effect of the increase in the earnings base, and 0.01 per cent from the net effect of the increase in the coverage).

Congress has consistently enunciated the principle in connection with the 1950 Act and subsequent amendments that the program should be self-supporting from contributions of covered workers and their employers, according to the intermediate-cost estimates. Of course, it would only be by coincidence that an exact balance would result. Generally, there has been a small deficiency of the level-cost of the benefits over the level-equivalent of the contributions, under the intermediate-cost estimate, as indicated in the accompanying tabulation, which is on the seventy-five year basis (in percentage of taxable payroll).

Level Equivalent*	1961 Act		1965 Act	
	OASI	DI	OASI	DI
Benefit costs†	8.46	0.63	8.82	0.67
Contributions	8.60	0.50	8.72	0.70
Actuarial balance‡	+0.14	−0.13	−0.10	+0.03

* Valuation as of the beginning of 1965, based on taxable payroll adjusted to reflect the lower contribution rate for the self-employed as compared with combined employer-employee rate.

† Including adjustments to reflect interest earnings on the existing trust fund and for administrative expenses.

‡ A negative figure indicates the extent of lack of actuarial balance.

Congress has quite properly considered that the long-range actuarial cost estimates are not precise and that a reasonable range of variation may be present. Accordingly, the principle has been established that the OASDI system is considered to be actuarially sound if it is in reasonably

close actuarial balance (provided the year-by-year projections indicate that the balance in each Trust Fund will never become negative or, in other words, that there will always be money available to pay the benefits). Congress, or at least the congressional committees that deal with OASDI legislation, has used a "rule of thumb" that this condition is satisfied if the actuarial insufficiency on the basis of the seventy-five year cost estimates is not in excess of 0.10 per cent of taxable payroll. The actuarial balance of the program as it is affected by the 1965 Amendments is just within this limit.

PROVISIONS OF HI SYSTEM

As to OASDI beneficiaries, this system provides a specific program of hospitalization and related benefits for all persons who are (1) aged 65 and over and (2) "entitled" to monthly benefits. The term "entitled" means that the individual meets all the statutory provisions governing eligibility for monthly benefits (old-age, dependent, or survivor) and has filed an application therefor (which may be concurrent with application for hospitalization benefits). The term thus includes not only beneficiaries in current-payment status but also those who are not drawing monthly benefits because they are continuing in substantial employment.

The following benefits are provided:

1. Ninety days of semiprivate hospital care within a "benefit period," with a flat deductible in an amount which approximates the average daily hospital cost under the program (taken as $40 for 1966–68) and with coinsurance of 25 per cent of the deductible (i.e., $10 initially) for each day beyond the sixtieth day. In addition, there is a deductible equal to the cost of the first three pints of blood used in a spell of illness. The hospital services covered include room and board, operating room, laboratory tests and X-rays, drugs, dressings, general nursing services, and services of interns and residents in training (but no other physician services, even though the doctor is on the hospital staff, or his services are arranged for and billed through the hospital).
2. One hundred days of post-hospital extended care within a "benefit period," when such services are furnished following transfer from a hospital (after at least three days of hospitalization) and are necessary for continued treatment of a condition for which the individual was hospitalized. Such care would be furnished in an "extended care facility," which is an institution that has in effect a transfer agreement with a hospital (or is under common control with a hospital) and that is, in essence, a skilled nursing facility (as defined in detail in the law). There is coinsurance for each day beyond the twentieth day, in an amount equal to 50 per cent of the hospital coinsurance (i.e., $5 initially).
3. One hundred post-hospital home health service visits during the year following his most recent discharge from a hospital (after at least three days of

hospitalization)—or from an extended care facility after such hospitalization —if the plan for such services is established within two weeks of such discharge. These services include visiting nurses' services, therapy treatments, and medical supplies (other than drugs) and appliances.

4. Eighty per cent of the cost of outpatient hospital diagnostic services in excess of a deductible equal to 50 per cent of the hospital deductible (i.e., $20 initially) furnished during a twenty-day period by a particular hospital.

The term "benefit period" means the period beginning with the first day that an individual receives hospitalization benefits and ending with the sixtieth consecutive day thereafter during each of which he has not been a patient in a hospital or an extended-care facility. The benefits would first be available in July, 1966, except for post-hospital extended care benefits, which would first be available in January, 1967.

The hospital deductible (on which the outpatient diagnostic deductible and the hospital and extended-care facility coinsurance are based) is $40 for 1966–68. After 1968, for a given year, it is $40 times the ratio of the nation-wide average daily hospital cost under the program in the second preceding year to that for 1966, rounded to the nearest even $4 multiple.

These hospital and related benefits for OASDI beneficiaries (and the accompanying administrative expenses) would be financed, on a long-range basis, by a schedule of contribution rates that is separate from that of the OASDI system but is applied to the same maximum earnings base, as will be discussed subsequently. This income would be channelled into the Hospital Insurance Trust Fund, which would be established on a basis similar to that of the existing OASI and DI Trust Funds.

The same hospital benefit protection is available to beneficiaries under the Railroad Retirement System.[13] Persons who are beneficiaries under both systems would, of course, not receive "double" benefits. The employer and employee contribution rates would be increased by the same amount as under the HI system. If for any year the wage base under the Railroad Retirement System is the same as that under OASDI (i.e., the monthly RR base is one-twelfth of the annual OASDI base), the RR system collects the contributions and then turns them over to the HI Trust Fund through the financial interchange mechanism. Otherwise, railroad workers are covered for HI in exactly the same manner as all other workers. In either event, the HI system makes the arrangements with the providers of services and pays the benefits.

Likewise, the hospital benefit protection is provided to any person aged

[13] However, Railroad Retirement beneficiaries would have certain additional benefit protection in that, under certain circumstances, the benefits would be available in Canada.

65 and over on July 1, 1966, who is not eligible as an OASDI or RR beneficiary and who (*a*) is not a federal employee or a retired federal employee (or an eligible dependent or survivor thereof) receiving health benefits under the regular plan established by the federal government for such persons, or who could have been so covered by election in or after February, 1965; (*b*) is not a member of a subversive organization and has not been convicted of subversive activities; and (*c*) is a citizen or has had at least five years of continuous residence. Persons meeting such conditions who attain age 65 before 1968 also qualify for the hospital benefits, while those attaining age 65 after 1967 must have some OASDI or RR coverage to qualify—namely, three quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1965 and before the year of attainment of age 65 (e.g., six quarters of coverage for attainments in 1968, nine quarters for 1969, etc.). This transitional provision "washes out" for men attaining age 65 in 1974 and for women attaining age 65 in 1972, since the fully insured status requirement for monthly benefits for such categories is then no greater than the special insured status requirement. The benefits for the "noninsured" group are paid from the HI Trust Fund, but with full reimbursement therefor from the general treasury.

The providers of service may elect to deal with the HI system through fiscal intermediaries such as Blue Cross or insurance companies that are able to assist the providers in applying safeguards against overutilization of services and that enter into agreements with the Department of Health, Education, and Welfare to carry out the necessary functions. The providers of services are reimbursed on a "reasonable cost" basis rather than on a charge basis. An important requirement that hospitals and extended-care facilities must meet is the establishment of utilization review committees.

FINANCING PROVISIONS OF OASDI AND HI SYSTEMS UNDER 1965 AMENDMENTS

The OASDI contribution schedule in the 1965 Amendments is lower than under previous law for the period 1966–72 and is higher thereafter. The differentials for the combined employer-employee rate are 0.55 per cent lower for 1966, 0.45 per cent lower for 1967 and 1969–72, 1.45 per cent lower for 1968, and 0.45 per cent higher for 1973 and after. This would seem to represent a significant change in financing principles and is in line with the recommendations of the Advisory Council discussed previously and with the following statement made by Secretary of Health, Education, and Welfare Anthony J. Celebrezze before the Senate Finance Committee (see Item 3 of the Legislative Bibliography, p. 68): "Under this

schedule the contribution rates would increase more slowly and gradually than under present law, so that excessive accumulations of funds in the next several years, with possible depressing effects on the economy, would be avoided."

The OASDI and HI contribution schedules are shown in Table 4. The tax rates are applicable to an annual earnings base of $6,600.

Until the ultimate OASDI rate is reached in 1973, the self-employed pay approximately 75 per cent of the combined employer-employee rate (actually, 75 per cent rounded to the nearest 0.1 per cent). However, a maximum of 7.0 per cent is applicable to this self-employed rate, and it first applies in 1973 and after.

The OASDI contribution rate is allocated between the OASI and DI systems by giving a rate of 0.70 per cent of the combined employer-employee rate to DI (0.525 per cent for the self-employed) and the remainder to OASI.

PROVISIONS OF SMI SYSTEM

This system is to operate on a purely voluntary, individual-election basis available to any individual aged 65 or over who chooses to participate, except for aliens with less than five years of continuous residence (unless eligible for HI benefits on the basis of their earnings record) and for subversives.

After a $50 calendar-year deductible, 80 per cent of covered medical expenses are reimbursed. There is a carry-over provision for expenses that went toward meeting the deductible in the last three months of the previous year. Also, any amount paid as an outpatient diagnostic deductible under HI counts as an incurred expense under SMI. When necessary for diagnosis or treatment of a sickness or injury, the following medical services are covered:

1. Physician and surgeon services (in home, office, and hospital), except for routine physical or eye examinations, etc.
2. Outpatient psychiatric services—with 50 per cent coinsurance and maximum annual reimbursement of $250.
3. Home health service visits (regardless of hospitalization)—maximum of 100 visits per year.
4. Other medical services—diagnostic tests; X-ray and similar therapy; surgical dressings and splints; rental of iron lungs, oxygen tents, hospital beds, and similar equipment; prosthetic devices and artificial limbs and eyes; and ambulance service (under restricted conditions).

Covered physicians' services are limited to those by a licensed doctor of medicine or osteopathy and to certain oral surgical procedures if performed by a doctor of dentistry or oral surgery.

Benefits for physician services and for other services that are furnished by other persons than "institutional providers of services" (i.e. hospital, extended-care facility, or home health agency) will be payable on the basis of "reasonable charges." Benefits for services furnished by an institutional provider will be payable on the basis of "reasonable cost." If the physician charges the patient on such basis, he may receive the 80 per cent payment directly from the program, but, if he wishes to charge more, the patient will receive the 80 per cent payment on the basis of a receipted bill. Benefits will be available for services furnished after June, 1966.

The covered individual will pay a premium that is set initially at a rate of $3 per month, and the General Treasury pays an equal amount. After 1967, the premium rate may be changed biennially by the Secretary of Health, Education, and Welfare to reflect the actual past experience and that anticipated in the future. The premium rate will be increased for those who do not enroll in the earliest period in which they could enroll—by 10 per cent for each full year of delay. OASDI, Railroad Retirement, and Civil Service Retirement beneficiaries will have the premiums automatically deducted from their benefit checks.

A further appropriation from the General Treasury is available as a contingency reserve during the initial period from July 1, 1966, to December 31, 1967. This is in the amount of six months' government contributions ($18) for each of the estimated 19.08 million persons eligible to participate on July 1, 1966. Any amount used would have to be repaid from the future operations of the program.

The initial enrollment period extends to March 31, 1966. Persons attaining age 65 after 1965 can enroll in the seven-month period surrounding the month of their birthday, with the effective date of coverage being as follows:

Month of Enrollment	Effective Date of Coverage
Any of three months before month of birthday.....	Month of birthday
Month of birthday.....	Following month
Month after birthday.....	Second following month
Second and third months after birthday.....	Third following month

If an individual does not enroll at that time, he can do so only within the next three years and in a general enrollment period, which is October through December of each odd-numbered year beginning with 1967, with coverage effective beginning with the next July.

An individual can elect to withdraw from the program during a general enrollment period or, if not paying premiums by the benefit-deduction method, by failure to pay the premium. After withdrawal, the individual

can re-enroll (only once) if he does so within three years, in a general enrollment period.

The premium income and matching government contributions go into the Supplementary Medical Insurance Trust Fund, which would be established on the same basis as the OASI, DI, and HI Trust Funds. The benefit payments and administrative expenses will be paid from the SMI Trust Fund.

TABLE 10

ESTIMATED PROGRESS OF HI TRUST FUND
(In Millions)

Year	Contributions*	Benefit Payments	Administrative Expenses	Interest on Fund†	Fund at End of Year
1966.....	$1,637	$ 987	$ 50‡	$ 18	$ 618
1967.....	2,756	2,210	66	25	1,123
1968.....	3,018	2,406	72	46	1,709
1969.....	3,123	2,623	79	66	2,196
1970.....	3,229	2,860	86	82	2,561
1975.....	4,260	4,047	121	112	3,789
1980.....	6,113	5,307	159	166	5,790
1985.....	7,026	6,860	206	259	8,341
1990.....	9,015	8,797	264	323	10,426

* Contributions include reimbursement for additional cost resulting from noncontributory wage credits for military service and contributions with respect to railroad workers (whether paid directly to the trust fund or indirectly through the financial interchange provisions).

† An interest rate of 3¼ per cent is used in determining the level-costs, but, in developing the progress of the trust fund, a higher rate is used in the first ten years (4 per cent for 1966–70 and then a gradually decreasing rate).

‡ Includes administrative expenses incurred in 1965.

NOTE.—The transactions relating to the noninsured persons covered for the HI benefits, which cost is borne by the General Treasury, are not shown here. They involve benefit payments of $140 million in 1966, $278 million in 1967, and gradually decreasing amounts thereafter.

The benefits paid for physician and other services that are on a "reasonable-charge" basis are to be administered through carriers, which are to be fiscal intermediaries operating on a cost basis for their administrative expenses. Among other things, the carriers will determine the basis for "reasonable-charge" payments and will assist in developing procedures as to utilization practices and methods safeguarding against unnecessary utilization.

ACTUARIAL COST ANALYSIS OF HI AND SMI SYSTEMS[14]

Table 10 presents the estimated future progress of the HI Trust Fund on an intermediate-cost basis. The trust fund increases steadily, reaching a size of about one year's benefit outgo after about ten years.

[14] For more complete details on these estimates, see Item 13 of the Legislative Bibliography.

As described previously, in order to be conservative, this cost estimate is based on dynamic assumptions as to earnings levels and hospitalization costs, but on static assumptions as to the maximum taxable earnings-base provision. The steadily increasing contribution rates over the twenty-five-year period were developed in recognition of the assumption that the earnings base will not change in the future, even though it is assumed that wages of covered workers will rise. If Congress continues to increase the earnings base periodically to reflect current wage levels, the increases in the contribution schedule for the combined employer-employee rate beyond 1 per cent may not be needed. It will be recalled that the deductible and the per diem coinsurance provisions are on a dynamic basis, adjusted automatically to the average daily cost of hospitalization under the program.

The estimated level-cost of the benefit payments and administrative expenses over the next twenty-five years is 1.23 per cent of taxable payroll (1.19 per cent for hospital and extended-care facility benefits, 0.03 per cent for home health service benefits, and 0.01 per cent for outpatient diagnostic benefits). The estimated level-equivalent of the graded contribution schedule is also 1.23 per cent of taxable payroll, so that the system is in exact actuarial balance.

Table 11 gives the estimated progress of the SMI Trust Fund for the initial period of operations, July 1, 1966, to December 31, 1967, when the premium rate for participants is established at $3 per month with an equal amount from the General Treasury. Long-range cost projections are not necessary because the premium rate will be established for subsequent two-year periods on the basis of the emerging experience. Four sets of estimates are shown, for combinations of low-cost and high-cost assumptions and of 80 and 95 per cent participation rates.

A sizable fund accumulates in 1966 for all estimates, owing principally to the lag in accumulating claims in excess of the deductible and in filing and adjudicating claims. This lag has been assumed to be three months in the low-cost estimate and two months in the high-cost estimate. Since the premium rates are to be adequate to cover incurred claims and administrative expenses in the period to which they apply, the actual lag will not affect the level of premiums, except as a result of interest earnings on the trust fund.

Owing to the relative difficulty of accurately predicting the future costs of medical services, as opposed to cash benefits, the Congress has recommended a special actuarial sample of 0.1 per cent of all claims under each program, which will be available soon after receipt by the fiscal intermediaries administering the programs. These records will be set up and maintained in such a way as to ensure prompt analysis of any trends in

the cost of the programs and to facilitate cost estimates for the existing programs and for suggested changes therein. These sample claims will be those arising from a random sample of 0.1 per cent of those eligible for benefits, so that both claims and exposure data will be on the same basis.

TABLE 11

ESTIMATED PROGRESS OF SMI TRUST FUND
(In Millions)

CALENDAR YEAR	CONTRIBUTIONS		BENEFIT PAYMENTS	ADMINISTRATIVE EXPENSES	INTEREST ON FUND*	FUND AT END OF YEAR
	Participants	Government				
	Low-Cost Estimate, 80 Per Cent Participation					
1966.....	$275	$275	$ 220	$ 65†	$ 5	$270
1967.....	560	560	895	75	15	435
	Low-Cost Estimate, 95 Per Cent Participation					
1966.....	$325	$325	$ 260	$ 80†	$ 5	$315
1967.....	665	665	1,060	90	15	510
	High-Cost Estimate, 80 Per Cent Participation					
1966.....	$275	$275	$ 345	$ 85†	$ 5	$125
1967.....	560	560	1,065	95	5	90
	High-Cost Estimate, 95 Per Cent Participation					
1966.....	$325	$325	$ 410	$100†	$ 5	$145
1967.....	665	665	1,260	110	5	110

* At an interest rate of 4 per cent.

† Including administrative expenses incurred in 1965.

NOTE.—Not included above is the advance appropriation of approximately $345 million from the General Treasury which is to serve as a contingency reserve in 1966–67 (to be used only if needed and to be repayable).

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12. "Report of Conference Committee on H.R. 6675," July 26, 1965. House Report No. 682. (89th Congress.)
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DISCUSSION OF PRECEDING PAPER

DORRANCE C. BRONSON:

This discussion will comprise two discrete parts. The first part will set out, with as much brevity as I could muster, my various comments or questions on some dozen, mostly unrelated, areas in the paper. The second part will treat an aspect of our personal income taxes, namely, the journey through Congress of the 1965 Bill with respect to tax deductions for medical care expenses and the impingement, if any, of the new Medicare in that area. This second part is an important—though specialized and of narrow focus—ingredient of the 1965 legislation; but the matter is not mentioned at all in the paper or in other writings that I have seen reporting the "transit" of this Bill—H.R. 6675—through Congress to the passage of the final Act. The aim under my second part, therefore, is to try to fill in some information on medical expense tax status as a supplement, for a small area, to Mr. Myers' paper.

These comments or questions, comprising my *first part*, will now be given:

1. *Page 468.*—An explanation would be helpful of why the aged, getting both OASI and OAA (needs test) benefits, are apt to stabilize, as a percentage of the full OASI group, at 6–7 per cent.

2. *Page 468: Regarding U.C. changes.*—One misses any mention of activity or inactivity in 1965 concerning the federal U.C. program; the author stops "cold" with 1964.

3. *Page 483: Criterion for $6,600 pay ceiling.*—Mr. Myers' table shows *covered* wages, for certain past years, as percentages of total earnings in *covered* employment; toward the end of approximately a fifteen-year period, a drop occurred in the series of said percentages so that the 82 per cent for 1951 was only 72 per cent for 1965 (estimated). It is stated, following the table, that the $6,600 of 1965 "merely will restore" the 1951 relationship. Perhaps it is not within Mr. Myers' province to explain why this relationship—this "restoration"—is the *sine qua non* as *the* criterion for OASDI (and now, probably, for HI and SMI also; not by precedent, as none exists for these new coverages, but by a sort of osmosis).

In any event, I would like to see someone definitively rationalize this "restoration" criterion in respect to the current economic milieu of our advanced prosperity; the liberalized pension systems, for both private and public employees; greater average interests under private profit-

sharing and thrift plans; our greatly expanded life insurance in force; our increased individual savings in banks, fiduciaries, and holdings of securities; *and* our startling expansions, in being and proposed, for government largesse under the Great Society. (In my review[1] of the January, 1965, Advisory Council's Report, I made a similar query, because the Council used criteria on the "restoration" principle, citing ancient history, and similarly "explained" it, as almost tacitly obvious, by some seemingly plausible allusion to the state of affairs "back when," which allusion, while identifying "method" or "formula," supplied, in fact, no real explanation at all.)

4. *Pages 494, 495: New temporary total disability benefit.*—Mr. Myers succintly covers the changed definition of disability that will qualify for DI benefits which equal 100 per cent of the PIA computed at time of disability. However, like the language used in the new Act, found in the *Congressional Committee Reports*, that has issued from writers of HEW and from other government sources, Mr. Myers gives the reader no label which characterizes the amended (enlarged) disability area. It seems to me, however, that we now have both the DI "total and permanent" type of beneficiary, as before, and a new "temporary total disability" type of beneficiary.

If this is a correct statement, I believe that the semantics for use when talking, or writing, on this part of the Act might well be revised to the more descriptive practice of calling a spade a spade. Envisioning the immediate adoption of my suggestion, as an enlarged appropriate label for the amended disability provision, and to encompass the Medicare programs at the same time, HEW and others might now designate the whole system of "cash" and "service" benefits as "OASDITDIHISMI." This could be orally delivered, with practice, using only five syllables. For the most euphonious effect, the four of them, each of which contains the letter "I," should be pronounced, giving the English alphabet phonetic "eye" sound rather than the "ee" variant of some foreign (e.g., Italian) alphabets.

5. *Page 497: Regarding certain of the Fair Sex, a 1965 money-maker.*—The following sentence from the paper I shall hide from Mrs. Bronson, but, were I of the opposite sex, I would certainly survey my outlook and lay my plans under it:

> An unmarried woman retains rights to widow's benefits on all deceased husbands that she may have had.

6. *Page 497: Absence of 100 per cent vesting.*—Proposals for full vesting under private pension plans are rampant. I note that this fever has not

[1] *TSA*, XVII, 99.

infected Congress, since on page 498, for the 1965 Act, one finds that workers can still lose their insured status (and, hence, prospective benefits) for insufficient quarters of coverage; in fact, these "short-fallers" don't even get their money back, contrary to the practice in private (and public) employee contributory plans.

7. *Pages 508, 509: Terminology (gradualism).*—Discussing actuarial costs and taxes for the resulting 1965 OASDI program, the author cites the term "self-supporting" on page 508 (synonymous with another term he uses, viz., "being in balance") as constituting a congressional cost criterion. But in the succeeding paragraph, it is found that already we have moved up the road from a vista of the above terms to a more impressive view; to wit, that the OASDI system can be stamped with the label "*actuarially sound*" (italics supplied) if the aforesaid "self-support" (or test for "balance") is not deficient by over 0.1 per cent of taxable payroll (a mere $275 million, I roughly estimate, for 1966, the first year of the new $6,600 ceiling on pay). It is my understanding that congressional and government folk—in respect to both the OASI program and the Railroad Retirement Act—secure euphoric relief upon seeing or hearing the term "actuarially sound" used descriptively for these programs (just as they, earlier, came to like, and to adopt, the term "insurance" for them).[2]

8. *Pages 510, 511: HI protection to be 100 per cent, or nearly.*—The author, on these pages, describes the high degree of initial HI coverage attained by just plain "bringing in" the aged group who have had negligible or no covered employment. Having achieved this goal, however, it is labeled "transitional," and, after 1967, newcomers to the age 65 ranks must meet certain covered employment conditions. The author does not explain the rationale for this later "backsliding" from 100 per cent coverage to an increasingly imperfect coverage status; nor, indeed, is this a criticism of the paper, as it could hardly include background and reasons for all the new facets that now shine at us from the 1965 Act.

9. *Page 511: Tax drop.*—Here the new OASDI tax schedule is said to be in line with Secretary Celebrezze's quotation given on page 511; however, the Secretary's statement speaks only of a "slower increase" and contains no reference to the actual *reduction* in such taxes for the six years 1966–72.

10. *Page 514: "Cost basis."*—On page 514, the proposed use of "carriers" as intermediaries for administering the SMI (Supplementary Medical Insurance) on a "cost basis" is mentioned. Potential carriers are, I sup-

[2] Before leaving "terminology," has the term "floor of protection" been accorded the *coup de grâce* by HEW and others?

pose, the Blues, the private insurance companies, nonprofit medical service outfits, etc., etc. For stock companies, this "cost basis" for Medicare would not seem to "produce" for the owners. I know that many companies —stock and mutual—have joined, heretofore, in providing "social purpose" help on a "no-profit" setup, but I wonder (*a*) whether knowledgeable owners and regular policyholders have been happy over it and (*b*) what aggregate losses from the alleged "cost basis" have resulted (including incurred items).

11. *Page 514: "Safeguarding" by carriers.*—The last sentence in the next to the last paragraph on page 514 states the expectation that the administrative carriers will, *inter alia*, assist in "safeguarding" SMI from overutilization of services. I have observed, in the insurance press and other literature, that many carriers are busy developing policies, group programs, and so forth, aimed at selling them to the over-65 group (and under-65 group also, I guess), in order to "fill in the chinks" left open in both the new HI and SMI programs—"chinks" which include the deductibles and the coinsurances as well as benefits and durations over or beyond the "reach" of the federal program. I have wondered—assuming success in selling this sort of thing to the aged—whether, by thus eliminating many of these "chinks," the result might not be just the opposite from the aforesaid "safeguarding objectives" (and if the ensuing experience might not put both the private and public actuarial estimates into a less conservative posture).

The second part of this discussion deals with our system of personal income taxes (federal) in respect to the rather small segment thereof (but very important for those affected) which governs medical expenses with regard to deductibility and other aspects.

Deductible medical care expenses.—I hope to succeed in giving the reader some insight into the various proposals under this heading—very different views, ofttimes, one from another—which appeared during H.R. 6675's 1965 journey through Congress. Tax treatment was considered for those individuals, working or not, who were under age 65 and for those who were age 65 and over. Of course the latter group is the more pertinent relative to Mr. Myers' paper, since that is the area for the new Medicare features described by him. As I have implied above, a surprising number of variations of opinion on this topic showed up during the successive stages of the aforesaid "journey." I use the term "stages" rather than "progress" or "evolution," since these latter terms imply a degree of "order" or "increment," stop-by-stop along the route, which this writer was unable to identify as such. I believe that this will be self-explanatory

from certain items of the comparative outline, designated "Schedule A," accompanying this discussion.

I mentioned earlier that no "popularized history" for 1965 seems to have been written about this specialized area of medical care expense and its position relative to the personal income tax.[3] Attempts by nonexperts on taxes to follow and understand all the various 1965 proposals and changes by dint of analyzing the applicable provisions in the present tax code and then by studying the Mills Bill (H.R. 6675), plus the several succeeding Committee Reports, will surely entail a tough row to hoe and will, I feel, be such hard going as to end up in confused frustration in a number of cases.[4]

The reason for the complete absence of any treatment, or even references, to this income tax topic in Mr. Myers' paper probably does not lie in the aforesaid "potential frustration" (Mr. Myers would either understand the matter or know how to surmount it) but rather in (1) the fact that the subject is rather remote from the author's field of benefits and contributions and/or (2) the likelihood that, for this phase of the legislation, it was the experts of the Treasury Department, not of HEW, who served as advisers to Congress and the Committees in following through on this specialized subject.

As I have stated before, I have prepared the accompanying Schedule A, which gives a comparative outline of the salient points considered during the 1965 legislative journey of the Bill with respect to medical care expenses vs. the personal income tax. For the indicated items of column 1, this outline starts by summarizing, in column 2, the present law on deductions for medical care expense. It then, for comparison, shows the main contents of the original and House-passed Mills Bill (H.R. 6675). Column 4, for the Senate Finance Committee, is set up more as a format to give only the *changes*, per se, that the Committee proposed rather than as a format for showing the consolidated complete outline. Finally, after reading the schedule's footnote 3, which alludes to the role played by the Conference Committee, the content of the final Act concerning this medical care and income tax subject is set forth in the last column on Schedule A, which column, I trust, is both self-explanatory and self-sufficient.

[3] Mr. Myers made no reference to this area, as noted earlier. Another example of "no mention" is the article "The Social Security Amendments, 1965: Summary and Legislative History," by W. J. Cohen and R. M. Ball (officials at HEW), *Social Security Bulletin*, September, 1965.

[4] Having built up certain doubts myself, I was fortunate to secure a reliable "outside" check on my draft of Schedule A; this independent source resolved these doubts by confirming that said draft of Schedule A, and its applicable text, were substantially correct.

Now, what particular points of interest in Schedule A both warrant mentioning here and admit of doing so in a few brief words? Those below occurred to me upon scanning the schedule with this question in mind:

Items *a* and *b* (percentage rules re deductions for care and medicine)	Here is a "Yes," "No," "Yes," "No," sequence. Present law says "Yes" to freedom from any percentage rule for the aged group; Mills Bill removed said "freedom"; Senate restored it; Conference Committee and final Act again removed it.
Item *c* (liberality of dollar limits)	The sequence here is, "Good," "Better," "Ditto," "Perfect." Present law's limits are not miserly; Mills Bill adds increase thereto for disabled under 65; Senate concurs in Mills Bill; Conference Committee and final Act delete *all* dollar limits.
Item *d* (insurance claim payments and premiums)	The sequence is uniform as to amounts received under insurance claims, being offsets, obviously, to gross medical expenses under any column. As for premium payments, the sequence is, *inter alia*, "Liberal," "Cut back up to some 50 per cent," "About ditto," "Still further cut." The 1965 legislative route as to premiums was rather tortuous and uneven but capsule sketch above shows that premiums treatment "came out" worse than when it "went in." However, for the age 65 and over group, insurance contracts and premiums thereunder will take a far lesser role with the advent of Medicare.
Item *e* (re definition of disability)	"Disability" is a criterion as to *dollar limits* for Item *c* in columns 2, 3, and 4, but not in column 5. With respect to the point at which such a criterion applies, the provisions differ by column, but, with respect to the *definition* of disability, there is uniformity (except, of course, this element is inapplicable for column 5). An unexplained point lies in what reasons prompted the retention of the old DI definition for columns 3 and 4, in view of the *new* liberalized definition adopted elsewhere in the final Act for future DI cash benefits.

The above sets out items which I feel make some interesting comparisons between the four income tax viewpoints indicated in the respective columns of Schedule A. Over-all, between the present law and the final 1965 Act, it seems to me that the percentage rules remain about equivalent for those *under* age 65 but have become less favorable for the aged, probably under the rationale that the *service* benefits of Medicare will more than compensate for these potentially curtailed advantages in the tax deductions. Then, of course, the removal by the 1965 Act of *all* dollar limits is a big "plus" for taxpayers running into major illnesses (for self, spouse, or dependent) where large expenses beyond any service benefits of

SCHEDULE A

MEDICAL CARE EXPENSES UNDER PERSONAL INCOME TAX

Outline: Present Law; Mills Bill; Senate Changes; and Final "Social Security Amendments of 1965" (P.L. 89-97, Signed 7/30/65)*

Items under Review Certain Items Relative to Medical Care Expenses and/or Deductions (1)	*Present Law* Status of the Income Tax Items of Col. (1) Prior to 1965 Amendments (IRC Section 213) (2)	*Mills Bill—House-adopted* Mills Bill, H.R. 6675 of March 24, 1965; House Ways and Means Committee Reported Out; Passed House April 8, 1965 (3)	Action re Col. (3) by Senate Finance Committee† Relative to Items of Col. (1) (4)	Final Act of 1965 (Sec. 106); Reflecting Such Changes from Col. (3) or Col. (4) as Conference Committee Action Concluded‡ (5)
a) Percentage Rule: The applicable percentage formula is applied to adjusted gross income; if "medical care" expense for a year exceeds the above result, the excess is generally stipulated as tax-deductible (subject, however, to any special rules of (*d*) below concerning insurance premiums paid or claims received).	*Under 65 (taxpayer and spouse)*: The taxpayer may deduct (i) for under age 65 dependent parent of either of them and (ii) for taxpayer, spouse, and dependents not of (i) above, excess of medical care expense over 3% of adjusted gross income. *Age 65 (taxpayer or spouse)*: Taxpayer may deduct for them with no % rule, as well as for aged parent of either; for other aged dependents, only excess over 3% adjusted gross income is deductible.	*Uniform by Age:* Taxpayer may deduct, for self, spouse, and applicable dependent, excess of medical care expense over 3% of adjusted gross income.	Senate action rejects the "uniform by age" principle adopted by House in col. (3) and returns to the col. (2) basis of computing deductions; i.e., if taxpayer *or* spouse is age 65, without the 3% rule which *is used* at ages below 65.	*Uniform by Age:* Taxpayer may deduct for self, spouse, and applicable dependent, excess of medical care expense over 3% of adjusted gross income. (Note: Same as col. [3] and no special liberalization such as is in present law [col. (2)] for those age 65 and over.)
b) Medicine and Drugs: The applicable "inside formula" which interplays with the 3% rule of Item (*a*) above and can affect the deductible expenses for "medicine and drugs."	*Under 65 (taxpayer and spouse)*: For them both, taxpayer may use, for deduction purposes, the cost of "medicine and drugs" in excess of 1% of adjusted gross income. Ditto for dependents not 65. *Age 65 (taxpayer or spouse, and any aged parent)*: Cost of "medicine and drugs" is usable by taxpayer for deduction purposes without applying any 1% rule.	*Uniform by Age:* Taxpayer as to self, spouse, and applicable dependent may have paid for "medicine and drugs," which expense can be used by taxpayer for deduction purposes if it exceeds 1% of adjusted gross income.	Consistent with the rejection by the Senate group on Item (*a*) above, the "uniform by age" principle adopted by House in col. (3) is also rejected since taxpayer may ignore the 1% rule as to "medicine and drugs" if he, spouse, or applicable dependent is age 65, by present law of col. (2).	*Uniform by Age:* Taxpayer, as to self, spouse, and applicable dependent, may have borne expenses for "medicine and drugs," which expenses can be used by taxpayer for deduction purposes if they exceed 1% of adjusted gross income. (Note that this is same as col. [3].)
c) Dollar Limits: Items (*a*) and (*b*) above are unlimited as to upper amounts except for such control as afforded by the definition of terms. The instant Item (*c*) is to show dollar limits under the percentage formulae for said (*a*) and (*b*), if a limit is applicable.	*Any Age, Provided Taxpayer or Spouse Not Disabled:* Yearly deductible limit on taxpayer: (1) $5,000 times number of "regular" exemptions, but not to exceed (2) $10,000 if taxpayer is single or (3) $20,000 if joint return with spouse, or if a household head, or if a surviving spouse. Same, if disabled but not age 65. *Age 65 and Disabled (taxpayer or spouse)*: Where one of them meets this condition, taxpayer's limit is $20,000 a year, or $40,000 if both meet it.	*Uniform by Age (non-disabled taxpayer, spouse, and dependents):* Yearly deductible limit for taxpayer: (1) $5,000 times number of "regular" exemptions but not to exceed (2) $10,000 if taxpayer is single, or (3) $20,000 if married and joint return with spouse, or if a household head, or if a surviving spouse. *Any Age and Disabled (taxpayer or spouse)*: Where one of them meets this condition, taxpayer's limit is $20,000 a year, or $40,000 if both meet it.	Agrees with dollar limitations set out in col. (3) at left, including both the upper outline for the *nondisabled* and the lower outline in respect of a *disabled* taxpayer or spouse.	*Uniform by Age:* No dollar limits are applicable to maximize taxpayer's deductions under this Amended Act, for defined medical care expenses of taxpayer, his spouse, or applicable dependent.

SCHEDULE A—*Continued*

Items under Review Certain Items Relative to Medical Care Expenses and/or Deductions (1)	*Present Law* Status of the Income Tax Items of Col. (1) Prior to 1965 Amendments (IRC Section 213) (2)	*Mills Bill—House-adopted* Mills Bill, H.R. 6675 of March 24, 1965; House Ways and Means Committee Reported Out; Passed House April 8, 1965 (3)	Action re Col. (3) by Senate Finance Committee† Relative to Items of Col. (1) (4)	Final Act of 1965 (Sec. 106); Reflecting Such Changes from Col. (3) or Col. (4) as Conference Committee Action Concluded‡ (5)
d) Insurance and Insurance Premiums: This Item (*d*) gives the "rules," if any, in respect to deductible or nondeductible premiums for insurance of medical care and allied coverages. The instant Item is meant to indicate also any other "rules" applicable to insurance contracts in this field.	(i) As cash received under accident and health plans is excluded from gross income, they obviously are not properly a deductible as "medical care expense." Hence, cash receipts of this type must lower the net expenses paid, *pro tanto*. (ii) Obversely, premiums paid out for accident, health, hospitalization, etc., insurance; dues to co-operative or free-choice medical service groups; etc., to extent defined in Act as "medical care," are includible expense (subject to 3% rule); nondeductible item is, e.g., premium for time-loss indemnity. (N.B. above description not briefed from Sec. 213, IRC, but from Regs. [April, 1964], Sec. 1.213-1(e)(1).)	(i) Same status as col. (2)(i). (ii) Premiums under contracts for medical care insurance for taxpayer, spouse, or dependent are 50% deductible by taxpayer (max. $250/yr) ignoring the 3% rule; other 50% of premiums up to said $250, and 100% over $250 are deductible under the 3% rule. "Premiums" include those of enrollees of SMI programs. If contract covers more than "medical care" (see n. *) show amounts separately in contract. Certain premiums paid *under* 65, for deferred medical care at 65, will qualify for annual deduction on a "spread" basis.	(i) Same as previous cols. (2) and (3). (ii) Follows outline of col. (3) except that (*a*) premiums qualifying for the 50% deductibility, without regard to the 3% test, and also the balance of said premiums for which the 3% test will curtail the amount deductible, would be for insurance more rigidly adhering to the definitions of medical care than was the case for col. (3); and (*b*) the separation of premium amounts need not be in contract, per se, if presented in a special statement for that purpose.	(i) As previously. (ii) Ignore 3% rule of Item (*a*) above, in respect of 50% (up to annual $150) of premium for appropriate medical care insurance; other 50% and 100% over $150, subject to the 3% rule. Insurance not solely for defined medical care, to show split either in the contract or in a separate statement. Premium for medical care portion not to be of unreasonable size relative to the whole. // On above basis, elective SMI premiums are includible, but contributions (taxes) for HI (Part A) are not. // Premiums paid before 65 for medical care insurance after 65 is OK as current expense if spread over period to 65 or 10 years, if less (but for 5 years as minimum period).
e) Miscellaneous Points or Comments:	Above provisions enacted before any Medicare in Act. In re disability requirement for age 65 of (*c*) above (Sec. 213(g), (3)) definition has been same as that for DI cash benefits, but cols. (3), (4), and (5) depart from this conformity.	In re "disability" criterion in (*c*) above, the definition of disability remains the same as for DI at present (see col. [2]). Hence, it would not conform to Bill's other (new) definition for DI (Sec. 303 of Bill).	Same comment as in col. (3) at left, concerning definition of disability in two ways.	Definition of disability remains same as heretofore but is transferred out of IRC, Sec. 213, into Sec. 72(m) (latter deals with the "employee annuity rule"). Hence, the transferred definition does not conform to the new definition of disability of the amended DI program.

* For the Law, Bill, or Report of the applicable column herein, substantial similarity is found in the respective definitions of "medical care" or of "medical care expense"; this similarity is exclusive of that portion of the "care" or "expense" which relates to various forms of "insurance." The "insurance" matters are dealt with separately in Item (*d*) hereof. The aforesaid, rather uniform, definitions may be paraphrased to mean "payments for diagnosis, treatment, prevention, etc., of disease (note this excludes "time-loss" indemnities), and for essential transportation thereunder."//Another point of uniformity lies in the "effective dates" proposed under cols. (3), (4), and (5); each of these would make its proposed changes, as to deductions under the personal income tax, take effect for the year commencing after 12/31/66.

† Senate Finance Committee reported out the Bill, as then revised, on June 30, 1965. After a few amendments from the Senate Floor, one of which deleted the dollar limits of (c)(4), a Conference Committee took up the differing versions of the Bill.

‡ The Conference Committee proposed various changes in the two versions of the Bill (cols. [3] and [4]). Some of these initial proposals were altered upon review by the respective Conference groups. Since, however, the ultimate agreement and the Report (July 26, 1965) of this Committee represented, for practical purposes, the identical Final Act of col. (5), this outline omits a column itemizing the proposals and conclusions of the Conference Committee, per se.

the HI and SMI programs may be incurred. On the other hand, curtailed deductibility for premiums under appropriately structured insurance contracts is apt to be puzzling; that is, why is the purchase or maintenance of health insurance contracts, especially for those below age 65, given *less* encouragement by the new Act than had been the case under the old?

In Mr. Myers' paper he has given us much information on, first, the "lead-up" and, then, the "action" for the latest "round" of changes in the social security laws, especially those parts concerned with benefits as "rights" and with contributions (taxes) related thereto. Probably Mr. Myers struggled for this paper with more ramifications, complexities, and deviations from existing status than he did for any other paper in the author's long series of reporting such events for the Society (a series which started "way back yonder" in 1951 [*TSA*, Volume III]). Our gratitude to Bob Myers is patent, both for the currency of information as each paper appeared and for the collection as a historical record (aided and abetted by attendant discussions), which record stands available to us, "the present," for reference and for our successor actuaries, "the future," in *perpetuity* (provided, as I pray, no law "against" ever interposes).

RICHARD H. HOFFMAN:

My discussion of Mr. Robert Myers' fine paper will be limited to the cost estimates of the hospital insurance system established by the 1965 social security changes.

Since 1961, the insurance industry has made appearances before congressional committees for the purpose of presenting testimony on the various hospital insurance proposals of the type that passed this year. These testimonies have included cost estimates which were developed by the Actuarial and Statistical Committee of the Health Insurance Association, and they have invariably been considerably higher than the corresponding estimates prepared by Mr. Myers for the administration. However, the gap between them has narrowed with each succeeding proposal, as is demonstrated in Table 1. This has resulted from successive upward revisions in some of the administration's basic cost assumptions. Initially, the industry's figure was over $2\frac{1}{2}$ times the administration's figure, while the industry's estimate for the bill that was finally passed is about 25 per cent greater.

The primary factors which have produced the greater insurance industry estimates are the use of (1) higher hospital utilization rates; (2) higher hospital per diems; and (3) higher posthospital extended care (nursing home) costs. More details about the differences can be found

in a memorandum to the Ways and Means Committee signed jointly by Mr. Myers and the insurance industry representative, Mr. Daniel Pettengill. The memorandum, included in the discussions of Mr. Myers' paper by Mr. Gordon R. Trapnell, analyzes the cost estimates for H.R. 1, the bill sent to Congress at the beginning of 1965.

The insurance industry estimate of the cost of the final bill is 1.55 per cent of social security payroll, while Mr. Myers' estimate, as he indicates

TABLE 1

COMPARISON OF ADMINISTRATION AND INSURANCE INDUSTRY ESTIMATES OF LEVEL COST AS A PERCENTAGE OF SOCIAL SECURITY PAYROLL*

Year	Bill	Administration (1)	Insurance Industry (2)	Ratio (2)÷(1) (3)
1961.....	H.R. 4222	0.66%	1.73%	2.62
1963.....	H.R. 3920	0.68	1.71	2.51
1964.....	H.R. 11865	0.85	1.66	1.95
1965.....	H.R. 1	0.96†	1.38†	1.44
1965.....	Public Law 89-97	1.23	1.55	1.26

* Projections of social security payroll and over-65 population for insurance industry estimates were furnished by Mr. Myers.

† As shown in Myers-Pettengill memo to Ways and Means Committee.

TABLE 2

COMPARISON OF ADMINISTRATION AND INSURANCE INDUSTRY ANNUAL COST OF BENEFIT PAYMENTS PLUS ADMINISTRATIVE EXPENSES PUBLIC LAW 89-97

Year	Eligible Population* (in Thousands)	Administration† (in Millions) (1)	Insurance Industry (in Millions) (2)	Ratio (2)÷(1) (3)
1967.....	17,126	$2,276	$ 2,941	1.29
1968.....	17,352	2,478	3,147	1.27
1969.....	17,578	2,702	3,347	1.24
1970.....	17,804	2,946	3,547	1.20
1975.....	20,537	4,168	5,102	1.22
1980.....	23,467	5,466	7,057	1.29
1985.....	26,113	7,066	9,201	1.30
1990.....	28,806	9,061	11,921	1.32

* Estimated by Social Security Administration. Excludes persons not insured by social security.

† Table 10 of Mr. Myers' paper.

in his paper, is 1.23 per cent. This figure represents the level cost of the benefits over the first twenty-five years related to social security payroll under the $6,600 earnings base, with provision to accumulate one year's claims at the end of the period.

Inasmuch as the program probably will not run for the full twenty-five-year period without some changes in benefit provisions, it is unlikely that the level cost figures will lend themselves to any comparison with actual experience. However, it may be possible to compare some of the year-by-year cost estimates with actual experience. For this purpose, the insurance industry's estimates of annual costs corresponding to those shown in Table 10 of Mr. Myers' paper are presented in Table 2.

ABRAHAM M. NIESSEN:

Mr. Myers' account of the 1965 social security amendments is a masterful piece of work in every respect. It covers all aspects of this monumental legislation and presents the information in a clear, concise, and authoritative manner. The paper will serve as an invaluable reference to all students of social security in the United States.

Due to my connection with the Railroad Retirement Board (hereafter referred to as the Board), I was most interested in following the development of this legislation, because anything of importance that happens in the area of social security is bound to have a profound effect on the railroad retirement system. Mr. Myers' interest in railroad retirement problems was, naturally, only secondary, so that his references to our system are limited to the legislative deliberations about the role the Board would play in the administration of the Medicare program. The purpose of my discussion is to briefly comment on the effects of the 1965 social security amendments on the railroad retirement system in other areas. The 1965 amendments to the OASDI program proper affected the railroad retirement system in the following major respects:

1. The new OASDI contribution schedule resulted in corresponding changes in the tax schedule for the railroad retirement system. As things stood at that time, the tax rates on railroad employees and employers alike were to be 4½ percentage points above the OASDI rates which would be in effect at any particular point of time. Thus, the net changes in the rates were to be the same under both systems.

2. The railroad retirement system has a financial arrangement with OASDI under which the former pays contributions to the latter on railroad payrolls as if these payrolls were covered under the Social Security Act. In return, the railroad retirement account receives from the OASDI

trust funds amounts equal to the benefits or the additional benefits OASDI would have had to pay on the basis of railroad earnings. It is obvious that these transactions (known as the financial interchange between the two systems) will be greatly affected by the OASDI amendments.

3. The majority of auxiliary benefits payable under the Railroad Retirement Act were increased as a result of a special 110 per cent social security minimum guaranty (and a modified version thereof for wives' annuities) which applies to all monthly benefits payable under the Railroad Retirement Act. This guaranty provision affected also nearly 10 per cent of the employee annuities currently payable.

The major problem which arose immediately after the enactment of the 1965 social security legislation was that the additional cost to the railroad retirement system due to benefit increases will be much larger than the extra net income expected to be derived from the financial interchange. At that time, there was no provision for significantly increasing the tax income to the system because the earnings base was to remain at $450 a month per individual even though the OASDI base was to go up to $6,600 per year. As a result of all this, the actuarial condition of the railroad retirement system would have greatly deteriorated; in fact, the actuarial deficiency would have gone up from some $20 million a year to about $48 million a year on a level basis.

The situation was expected to deteriorate even further as a result of a then pending amendment which provided for the elimination of reductions in railroad wives' annuities on account of social security benefits to which these wives are entitled on the basis of their own employment. This change was estimated to add another $14 million a year to the net costs and thereby increase the actuarial deficiency to about $62 million a year on a level basis. To take care of this situation and for certain other reasons, the railroad retirement bill was expanded to provide for a permanent co-ordination between the railroad retirement earnings base and that of the OASDI system. Specifically, this particular amendment provides that the railroad retirement monthly earnings base will be one-twelfth of the annual OASDI base but not less than $450 per month. Since the additional benefits due to the extra creditable earnings cost substantially less than the corresponding additional taxes, a "surplus" from this source would result. This surplus was to offset the adverse effects of both the 1965 social security amendments and of the liberalization in railroad wives' annuities previously referred to.

The railroad retirement amendments referred to above were enacted into law on September 30, 1965, with one additional change which re-

duced the tax rates for the period October, 1965—December, 1967. The effect of this legislation was to increase the benefit costs but to increase the tax income to a much greater extent. The net gain from this legislation was estimated to be about $32 million a year on a level basis, so that the actuarial deficiency of the railroad retirement system stands now at about $30 million a year or 0.62 per cent of taxable payroll on a level basis.

The schedule of railroad retirement tax rates on employees and employers alike is shown in the accompanying tabulation. These rates will apply to earnings up to $450 a month during October–December, 1965, and to monthly earnings up to $550 beginning with January, 1966. It will be noted that beginning with 1968, the rates shown below are exactly 4.5 percentage points higher than the rates in the OASDI contribution schedule.

Calendar Years	Tax Rate for Employees and Employers Alike
1965:	
January–September	8.125
October–December	7.125
1966	7.600
1967	7.900
1968	8.150
1969–72	8.900
1973 and later	9.350

As for Medicare, the situation is briefly as follows. The Board has statutory authority to determine eligibility rights of individuals under its jurisdiction and to collect taxes on railroad earnings. The rates of tax are the same as for social security earnings except that in the case of railroad employees and employers, the tax will be applied against monthly earnings (up to $550) instead of annual earnings (up to $6,600). Arrangements have been made between the Board and the Social Security Administration for exchange of information and for co-ordination of administrative activities so as to avoid duplication and unnecessary expense. The Board will maintain the necessary contacts with its beneficiaries but will have no dealings with providers of services. Medicare benefits to individuals under the Board's jurisdiction will be paid directly from the health insurance trust funds, so that there will be no financial interchange transactions in the benefit area. However, a financial interchange will function in the tax area. The health insurance trust funds will receive taxes on the first $6,600 of an individual's railroad earnings in a calendar year even though the Board will be collecting these taxes on a monthly basis.

In addition to the above functions, the Board will pay for hospital and related services rendered to its beneficiaries in Canada. The payments will be limited to charges that are not covered under Canadian law. Special arrangements are being worked out to make this part of the Board's Medicare program simple and easy to administer.

As for financial implications, they are expected to be very minor. The cost of benefits will be immaterial to the railroad retirement system because, as mentioned earlier, these benefits will be paid directly from the health insurance funds. There will be a small loss of the transfer of taxes because the social security $6,600 annual limit will produce a slightly higher taxable payroll (for financial interchange purposes) than the $550 monthly limit on which the Board will be collecting taxes. The cost for services rendered in Canada will be a very small item because of the relatively few beneficiaries who reside in Canada and because of the benefit limitation mentioned in the preceding paragraph. To be more specific, the total net cost from this source is estimated at only $1.1 million a year on a level basis.

PHILIP D. SLATER:

We again owe Mr. Myers a debt of gratitude for his latest paper on the social security amendments of 1962-65. This paper continues his series of excellent papers which has appeared with each significant amendment to the social security law.

When one recognizes the almost infinite variety of changes that could have been made and considers the great complexity of the program at its present state, it becomes almost an impossible and hopeless task to analyze all the facets of this vast subject. It is with some reluctance, therefore, that this discusser makes a few random observations dealing with some of the present and future problems which we shall face. I sincerely hope that some of our more competent and experienced observers will contribute a lively discussion of the many points in question, since a fuller awareness of the scope and impact of current and future changes should aid considerably in the final solution.

In viewing the gradual change in the degree of funding of the social security program over the years, it is apparent that we will be operating under essentially a pay-as-you-go system. Tables 8, 9, and 10 appearing in the paper show that contributions will exceed benefit payments by very small margins within the next decade. Even as late as the year 2025, the accumulated funds will not exceed benefits in that year by a very significant amount. Without going into the pros and cons of such a weak funding, we should be aware of the inflexibility which it implies and the limitation which it will place on future planners of changes.

It is also recognized, I am sure, that the full impact of the significantly larger contributions required in 1966 and progressively thereafter has yet to be appraised. Most economists have been strangely silent regarding the expected effect of these decreases in take-home pay and corporate profits on the economy. This is particularly odd since the recent cuts in income taxes have been so widely praised. It is not inconceivable that tremendous pressures will be built up to defer the future increases in contributions now planned, as has been done in the past. This, of course, will not be possible without resorting to contributions from general revenues or decreases in benefits, a course which is unthinkable in the present atmosphere.

Even if planned contributions are actually collected, we should also be aware of certain inequities in the system now relating to benefit levels which may also generate pressures to increase benefits merely to remove these inequities. Let me mention just a few of these which may become a source of trouble.

It has been noted that with regard to OASI benefits, the price to the younger generation will exceed the value of benefits in many situations. The current changes have made the program more of a young man's burden than formerly. To illustrate this, I refer to *Actuarial Note No. 20*, prepared by Myers and Oppal, which was released by the Social Security Administration in June, 1965. It displays, among other things, the value of employee contributions as a percentage of the value of total postretirement benefits for illustrative maximum-earnings cases retiring in 1962 and other selected years extending to 2010. Unfortunately, this study was released before the 1965 amendments were adopted and does not reflect the most recent changes in benefits and contributions. We have taken certain values shown in Table 3 of this study and computed the corresponding values, recognizing the law as amended in 1965. My exhibit, which follows, displays selected data from Table 3 of this study and corresponding data modified to recognize the most recent amendments. It shows that whereas current retirees are enjoying retirement benefits on the average whose value is about 10 per cent of the value of their contribution, many young entrants into the system will be paying well over 100 per cent of the value of their retirement benefits when they eventually retire later in the century. This calculation, I should emphasize, includes only employee contributions; the actual cost to the employee and the employer combined is twice as large, or well over 200 per cent, of postretirement benefits. I realize that contributions in this exhibit include those allocated for preretirement disability benefits. The effect is not altered much if they are excluded. Actually, if a 4 per cent accumulation

VALUE OF EMPLOYEE CONTRIBUTIONS, EXCLUDING HEALTH INSURANCE, AS A PERCENTAGE OF THE VALUE OF TOTAL POSTRETIREMENT BENEFITS FOR ILLUSTRATIVE MAXIMUM-EARNINGS CASE

Year of Retirement	Value of Contributions with 3% Interest		Value of Benefits		Ratio, Value of Contributions to Value of Benefits	
	Law as Amended in 1965	Prior to 1965 Amendment	Law as Amended in 1965	Prior to 1965 Amendment	Law as Amended in 1965	Prior to 1965 Amendment
	Single Male					
1962....	$ 1,885	$ 1,885	$15,548	$14,764	12.1%	12.8%
1965....	2,580	2,580	16,054	15,005	16.1	17.2
1970....	4,312	4,080	17,416	15,125	24.8	27.0
1980....	9,406	8,066	18,621	15,246	50.5	52.9
1990....	15,341	12,399	19,103	15,366	80.3	80.7
2000....	22,502	17,407	19,947	15,487	112.8	112.4
2010....	28,531	20,543	20,429	15,487	139.7	132.6
	Married Male					
1962....	$ 1,885	$ 1,885	$26,234	$24,906	7.2%	7.6%
1965....	2,580	2,580	27,092	25,316	9.5	10.2
1970....	4,312	4,080	29,401	25,520	14.7	16.0
1980....	9,406	8,066	31,445	25,725	29.9	31.4
1990....	15,341	12,399	32,262	25,925	47.6	47.8
2000....	22,502	17,407	33,693	26,130	66.8	66.6
2010....	28,531	20,543	34,510	26,130	82.7	78.6
	Single Female					
1962....	$ 1,885	$ 1,885	$18,144	$17,182	10.4%	11.0%
1965....	2,580	2,580	18,966	17,735	13.6	14.5
1970....	4,312	4,080	19,395	17,735	22.2	23.0
1980....	9,406	8,066	21,055	17,735	44.7	45.5
1990....	15,341	12,399	21,746	17,735	70.5	69.9
2000....	22,502	17,407	22,853	17,735	98.5	98.2
2010....	28,531	20,543	23,406	17,735	121.9	115.8

Basic assumptions:

1. Worker is alive at age 65 and retires at that time (attaining age 65 at the beginning of the year).
2. Worker is employed (as an employee) at maximum covered earnings in all years after 1937 or after attaining age 20, if later.
3. Married worker has a wife the same age as he is.
4. Mortality basis—U.S. Life Table for White Persons, 1949–51.

Prior to 1965 amendment data from *Actuarial Note No. 20*, issued June, 1965.

rate were used, which is less than the current yield on long term Treasury Bonds, the results, excluding disability contributions, would be comparable generally to those shown here using a 3 per cent accumulation.

It is interesting to observe from this exhibit that the changes in 1965 accentuate this effect. The single males and females suffer the most, of course. I am sure that pressures will develop to minimize this inequity when the public becomes more aware of it. Voices have, in fact, been heard that contributions be reduced to a level more in accord with the value of benefits to be received.

Another inequity in the benefit structure is the one that allows females a larger retirement benefit than males because of the different wage period used in the benefit formula. Actually, this is a case of discrimination which private plans would hesitate to make. In fact, I do not think that they would be allowed to do it under the new Civil Rights Law.

In the area of hospital insurance and medical insurance, there are even more important problems of inequity of a different kind. The allowance of benefits to the over-65 group for individuals with no particular need and no wage record or contributions and the denial of such benefits to those below 65 with substantial contributions and a real need is certain to cause pressures to increase benefits to a wider group.

It is hoped that more of our creative members with the technical ability to analyze this program will take a continuing interest in this vast program since its objective is noble but the stakes are high.

GORDON R. TRAPNELL:

During the presentation of the HIAA cost estimates for H.R. 1 before an executive session of the Ways and Means Committee, actuaries representing the HIAA and Mr. Myers were asked pointed questions regarding why they disagreed concerning the cost of the proposed program. Chairman Mills suggested that the actuaries get together and agree on where they disagreed. After several meetings and much discussion, they agreed on the following letter explaining why their cost estimates were different. The letter should be of major interest to all students of the continuing controversy over the probable cost of the government's health benefit programs.

Memorandum to: Committee on Ways and Means, U.S. House of Representatives

From: Division of the Actuary, Social Security Administration and American Life Convention, Health Insurance Association of America, Life Insurance Association of America, and Life Insurers Conference

Subject: Explanation of the Differences between the Cost Estimates of the Social Security Administration and Those of the Insurance Business for the Health Care Benefits Contained in H.R. 1

During an appearance before the Ways and Means Committee on February 4, 1965, insurance business representatives pointed out that their estimate of the cost of the health care benefits contained in H.R. 1 is substantially higher than that of the Social Security Administration. In view of this difference, it was agreed that actuaries from the insurance business and from the Social Security Administration would prepare this joint memorandum outlining the principal factors used in each of the cost estimates and the resulting cost differentials. The factors, their assumed values, and pertinent comments are set forth in the attached Appendices A and B.

It should be noted that the "level-cost" estimates contained herein differ from any of those previously made public by either party, primarily because the period of time over which the cost of the benefits is measured has been changed from perpetuity to the period described in the next sentence. In accordance with your request, the "level-cost" estimate is now that percentage of taxable earnings between January 1, 1966, and December 31, 1990, which is equivalent to the total amount of benefits and administrative expenses estimated to be disbursed in that same period, plus an HI Trust Fund balance on December 31, 1990, equal to the total disbursements in 1990. The present value of both contributions and disbursements are determined at 3½% interest. These cost estimates also assume that earnings will rise 3% each year and that the 1966 taxable earnings base of $5,600 will be similarly increased.

The following table sets forth the differences between the Social Security Administration's "level-cost" estimate of 0.96% of taxable earnings and the insurance business' corresponding estimate of 1.38%. These estimates apply only to the benefits for OASDI beneficiaries aged 65 and over.

Item	Level-Cost
SSA's estimate of total cost	0.96%
Extra costs envisioned by insurance business:	
For greater hospital utilization	.16
For assumption that there is no "net saving" on Hospital benefit cost due to inclusion of Post-Hospital Extended Care and Home Health Service benefits	.03
For different interpretation of the term "reasonable costs"	.07
For higher average per diem cost of ancillary services	.07
For lower rates of projected increases in average hospital per diem cost	— .06
For higher Post-Hospital Extended Care utilization and per diem costs.	.11
For higher cost of administration	0.04
Insurance business estimate of total cost	1.38%

The Social Security Administration believes that it is unrealistic to assume that the maximum taxable earnings base will remain unchanged as earnings rise. On the other hand, the insurance business feels that Congress should

understand that based upon the taxable earnings base of $5,600 set in the bill, and if earnings rise 3% each year, the "level cost" estimate for the first 25 years would be 1.70% of taxable payroll as compared with the figure of 1.38% mentioned above.

We hope that this memorandum will supply the information that the Committee desires. If, after its review, there is any further information desired, we will be pleased to supply it either by a further appearance or otherwise.

Respectfully submitted,
[Signed]
ROBERT J. MYERS, *Chief Actuary*
Social Security Administration

[Signed]
D. W. PETTENGILL, *Vice President*
Group Division
Aetna Life Insurance Company
Representing ALC-HIAA-LIAA-LIC

APPENDIX A

ECONOMIC ASSUMPTIONS

Cost Factor	SSA	Insurance Business
OASDI Population Age 65 and Over	SSA projections (from Actuarial Study No. 58)	Same as SSA
Taxable Earnings	Short-range dynamic assumptions, extended to 1990, assumes: (1) earnings increase 3% per year (2) the maximum taxable earnings base increases each year to the equivalent of $5,600 in 1966 (i.e., average taxable earnings increase 3% each year)	Same as SSA
Interest Rate Used To Calculate Level-Costs (and Yield on HI Trust Fund)	3½%	Same as SSA

APPENDIX B

ASSUMPTIONS FOR HOSPITAL AND RELATED BENEFITS

Item	SSA	Insurance Business
	Hospital Inpatient Utilization Rate for 60-Day Plan with 1-Day Deductible (in Days Per Capita)	
Values used:	2.37 in 1967. 2.68 in 1975. 2.74 in 1990.	3.04 in 1967. 3.14 in 1975. 3.23 in 1990.
	NOTE: The aging of the covered group results in a grading of the utilization rates.	
Underlying data:	High and low rates as given on page 7 of *Actuarial Study No. 59.*	Based on a composite of actual experience on insured lives that is higher than experience on best risks and substantially lower than that under mass enrollment plans.
Assumptions and comments:	Utilization rates are based on the 1957 Survey of Beneficiaries and are adjusted upward for decedents. Rates are gradually increased from 1967 to 1975 for higher utilization by those previously uninsured, as well as by aging of the covered group. The 1963 Beneficiary Survey showed relatively little difference in hospital utilization between persons with and those without insurance.	The grading results solely from the aging of the group. The utilization rate applicable to any given age is assumed to remain unchanged even though future changes in medical care practices will probably increase utilization rates. Hospital bed ratios and utilization rates have been increasing 1½% per year.
	The utilization rates do not make any provision for possible future increases (or decreases) due to changes in medical care practices or in the supply of hospital beds relative to the population.	Data based on household interviews are inappropriate because of gross underreporting (14% to 18%, without considering deaths, according to National Health Survey). Further, the low utilization rate of the uninsured aged will rise immediately to the rate for the insured if H.R. 1 is passed.

APPENDIX B—*Continued*

Item	SSA	Insurance Business
	Effect of Post-Hospital Extended Care and Home Health Service Benefits on Cost of Hospital Benefits	
Value used:	Hospital benefits cost reduced by 33% of Extended Care benefit cost and by 40% of Home Health Service benefit cost.	None.
Assumptions and comments:	These reductions were made in anticipation that the inclusion of these benefits would reduce hospital utilization.	No reduction in hospital cost made by reason of existence of Extended Care and Home Health Service benefits because requirement of just one day of hospital confinement prior to admission to Extended Care facility will so increase hospital admissions as to offset any such savings. Of significance is the fact that case studies have shown that the addition of outpatient diagnostic X-ray and laboratory examination benefits to existing in-patient hospital benefits did not reduce the cost of the latter, despite an *a priori* assumption that there would be a savings.
	Adjustments to AHA Data To Obtain Average Per Diem Cost of Inpatient Hospital Care	
Value used:	Reduction of 13%.	No net change.
Underlying data:	1963 Value in AHA series ($38.91).	Same as SSA.
Assumptions:	(1) The term "reasonable cost of such services" in Section 1809(b) means all cost items attributable to the beneficiaries, including an appropriate proportion of research, teaching, and training.	(1) The term "reasonable cost of such services" in Section 1809(b) means not only all the cost items contemplated by SSA, but also a fair share of bad debts and losses to the hospital on welfare and charity patients of all ages, will be included in the HEW reimbursement formula. Since such losses

APPENDIX B—*Continued*

Item	SSA	Insurance Business
	Adjustments to AHA Data To Obtain Average Per Diem Cost of Inpatient Hospital Care—Continued	
Assumptions —*Continued:*		are not included in the numerator of the AHA series, and the patient days represented thereby are included in the denominator, the AHA series in this respect understates the true per diem cost that will be applicable to H.R. 1 beneficiaries.
	(2) The AHA series overstates per diem cost of an inpatient hospital day, due to inclusion of some costs that are not for inpatient care.	(2) The AHA series includes certain costs on a gross basis that should, and indeed must, be included on a net basis.
	The total effect of items (1) and (2) is a decrease of 7%.	The total effect of items (1) and (2) is that there is no net change.
	(3) The average per diem cost of an inpatient day for persons over 65 is 6% lower than that for persons of all ages.	(3) For a 60-day benefit, the difference between the average per diem cost for persons 65 and over and that for all persons is small and will be offset by the fact that many proprietary hospitals with their much lower per diem costs will probably not participate in this program because of its nonprofit nature.
Comments:	(1) The reimbursement formula should include an allowance for the cost of teaching, research, etc. The loss on charity patients over 65 will be virtually eliminated by H.R. 1 (including the loss that results from only partial reimbursement of hospitals under MAA, OAA, etc.).	(1) The reimbursement formula should include, among other things, an allowance for losses on charity and welfare patients of all ages and bad debts. Patients over 65 are currently paying on this basis. Since hospitals must recoup essentially their full costs in order to remain solvent, should they fail to be reimbursed for any one item of cost from one class of patients, they must obtain it from the remaining patients.

APPENDIX B—*Continued*

Item	SSA	Insurance Business
	Adjustments to AHA Data To Obtain Average Per Diem Cost of Inpatient Hospital Care—Continued	
Comments—*Continued:*		To the extent that certain items such as losses on charity and welfare patients and bad debts are excluded, as contemplated by SSA, under the H.R. 1 cost reimbursement formula, they must be recouped from the general public in the form of higher charges. Such a practice is unfair to the general public, particularly the patients under age 65 who will be paying the tax for the benefits under H.R. 1.
	Since the plan will result in full payment for virtually all patients age 65 or over (many of whom now are public assistance or charity cases), the net effect will be *less* added cost to "full payment" patients, on a per capita basis, for their share of losses on charity and welfare patients.	It should be noted that under H.R. 1 there will still be losses to hospitals on patients over 65 due to the one-day deductible and to hospital stays beyond the maximum benefit period.
	(2) Numerator of AHA series contains the cost of some items, without offsetting such costs by the income received therefor (e.g., outpatient department, public dining room).	(2) Same as SSA.
	(3) AHA series is an average cost per day for persons of all ages. Although persons over 65 require more days of hospital care per capita than those under 65, the average cost per day is lower, due to some fixed costs (e.g., operating room) being spread over longer	(3) Use of ancillary services is usually greatest during the early days of confinement. Hence, the SSA assumption might be valid for a plan providing 360 days of care. However, the average per diem cost for persons over 65 rapidly approaches that of all patients as the number of benefit days are reduced.

APPENDIX B—*Continued*

Item	SSA	Insurance Business
	Adjustments to AHA Data To Obtain Average Per Diem Cost of Inpatient Hospital Care—Continued	
Comments—*Continued:*	average durations. An index computed for persons over 65 alone would be lower than a similar index for all ages combined computed by the same method.	
	Annual Rate of Increase in Average Per Diem Cost of Inpatient Hospital Care	
Values used:	5.7% from 1963 to 1970. 4.35% from 1970 to 1975. 3% from 1975 on. Per diem cost for 1967 is $42.38. Per diem cost for 1990 is 2.28 times the 1967 per diem cost.	5% from 1963 to 1968. 4% from 1968 to 1978. 3% from 1978 on. Per diem cost for 1967 is $47.00. Per diem cost for 1990 is 2.22 times the 1967 per diem cost.
Underlying data:	AHA series, as adjusted (see page 538).	AHA series.
Assumptions and comments:	Earnings will rise at 3% per year. Hospital costs will rise faster than earnings through 1975 and the same thereafter.	Earnings will rise at 3% per year. Hospital costs will rise faster than earnings through 1978 and the same thereafter.
	Extended Care Facility Utilization Rate (in Days Per Capita)	
Value used:	0.16 days in 1967. 0.31 days in 1990.	1.01 days in 1967. 1.66 days in 1990.
Underlying data:	Analysis of present numbers of beds, beds that are acceptable, needed beds, and beds occupied, and of characteristics of occupants of beds.	Data for early years based on experience of insured lives under plans with a very tight definition of Extended Care Facility and with a requirement of at least 5 days of prior hospitalization.
Assumptions and comments:	That benefits will be provided in accordance with a strict interpretation of language in the bill. For later years, assumes greater availability and, hence, use of such facilities. Assumes that reimbursement to Extended	For later years, assumes greater availability and, hence, use of such facilities. Adjustment has also been made for the aging of the group. Passage of H.R. 1 will cause beneficiaries now insured for Post-Hospital Extended Care benefits to drop this protection.

APPENDIX B—*Continued*

Item	SSA	Insurance Business
Extended Care Facility Utilization Rate (in Days Per Capita—Continued		
Assumptions and comments—*Continued:*	Care Facilities will be made only for patients who *would* otherwise require hospital confinement. Such restricted utilization requires tight administration and careful review by Utilization Review Committee. (Cost of benefits for such facilities is only partially offset by reduction in hospital costs, since many confinements will be with respect to those who do not now receive proper care.)	If the program is then administered so tightly that their present actual utilization rate of 1.01 days is cut to 0.16 days, these beneficiaries will have lost valuable protection. Furthermore the heavy outlay for nursing home care under MAA will scarcely be reduced if H.R. 1 is so tightly administered.
	Assumes further that if there is greater expansion of these facilities, the increased cost will be fully offset by decreased hospital costs.	No similar assumption (see page 538).
	As in the case of hospital benefits, makes no provision for possible future increases (or decreases) due to changes in medical care practices.	
	Average Per Diem Cost of Extended Care Facility Benefits	
Value used:	$11.26 in 1967, with 3% increase per year.	$12.60 in 1967, with same percentage increases as for hospital per diem cost (see page 5).
Basic data:	Analysis of recent average daily costs.	Experience of insured lives.
	Level-Cost of Home Health Service and Out-Patient Diagnostic Benefits	
Value used:	0.07% of taxable payroll.	Same as SSA.
	Administrative Expense	
Value used:	3% of benefits.	5% of benefits.
Underlying data:	Experience under existing cash-benefits program, projected to allow for nature of new program.	Experience under Federal Employees Health Benefits Plan.

W. RULON WILLIAMSON:

Mr. Myers' paper, relating the current consequences of the curbs upon the personal independence of choice, instigated by the Social Security Act, is essential to round out the record of three decades of "welfare history." He has known the pressure within the centralized bureaucracy to further regimentation; he has witnessed the continued care in selection of members of advisory councils (a special case of discrimination); he has been present in both the closed sessions and the open sessions of congressional committees and knows the rules as to selection of the witnesses who will be heard; he knows the brevity of the time for senators and representatives to review committee reports, the drafted bills, the printed hearings; he has watched the very limited time for discussion on the floor of each House; he has observed the various kinds of pressure before voting; he observes the ironing-out of the differences between House and Senate bills. He does not report the news management, the airways' use of "equal time," the ignoring of adverse opinion polls and pertinent facts adverse to administration plans.

To better orient this discussion, I have reread early social security papers and discussions thereon, in transactions, records and proceedings of three actuarial societies—papers ranging from 1935 through 1943. To some extent this has enabled me to recapture the mood of bemused inquiry in which this profession attempted to serve its country in a time of deep bewilderment. The Metropolitan Life had run a striking series of monographs on social insurance; the Equitable Life, under Bill Graham's zealous development of group insurance, had formed ties with the Foundations, the Bureau of Economic Research, the American Management Association and many other corporations; as part of my own job with the Travelers, from the time of the Casualty Actuarial Society in 1914, I had been reviewing social insurance publications; M. A. Linton, president of the Provident Mutual, and shortly to become president of the Actuarial Society, had also formed ties that aided him in advancing his familiarity with social insurance; the American Telephone and Telegraph, in connection with its administration of a comprehensive program of employee benefits, had engaged the services of a Fellow of the Actuarial Society, Otto Richter. In October, 1934, Otto Richter and I found ourselves full-time junior actuarial consultants on the staff servicing the Committee on Economic Security, under Director Witte. Mr. Myers was there, too, as an efficient actuarial assistant. A senior actuarial advisory group—Mr. Linton (president of the Provident Mutual) and three teaching actuaries, Glover, Rietz, and Mowbray—were also servicing the Committee.

Indigence—Need

The key to the business of 1934 was the depression. Citizens had been shaken by the stock market crash of 1929, with its long period of unsettlement, in which the elections of 1932 ushered in the New Deal, and by 1933, the bank closings. "Social insurance" generally seems to appear in times of unsettlement, when risks increase and money is limited. Various expedients had been tried and found insufficient to bring back "normality." In Geneva was the International Labor Organization (ILO), one of whose objectives was world-wide "social insurance." In the United States, we had the Social Science Research Council, backed by the Rockefeller and Carnegie Foundations, Industrial Relations Councilors, Twentieth Century Fund and many other individuals and organizations, "researching." From such sources the Cabinet Committee on Economic Security located "the experts" to service the Committee on what to do in the epidemic proportions of indigence. The Richter-Williamson paper on the work of the Committee and the Social Security Act of 1935 reflect our bemused good intentions as to meeting need by formula—and national formula at that!

The states had been dealing with three forms of public assistance—for the aged, the needy children (Mothers' Pensions), and the blind. Only about 1 per cent of the population aged 65 and over seemed to be in the nation's poorhouses, generally under township, city, or county administration. A paper of mine (*C.A.S. Proceedings*, Volume XVII) had given pro and con arguments on state-operated old-age pensions. By the work of the Committee on Economic Security, it was found that some 3 per cent of those aged 65 and over were drawing this form of "out-relief." Still others were drawing emergency relief, perhaps hoped to be temporary. An unemployment rate over 20 per cent for several years argued for presumptive increase in old-age need.

Ignorance

We actuaries, who had grown up in "Constitutional America," with its Federal Republic of Sovereign States and National Government, limiting the national government to functions specified in the Constitution, with all other functions reserved to the states and/or the people by the Ninth and Tenth amendments, entered our "seminars" toward a planned economy quite unprepared for the authoritarian mood of the centralizers. We were unprepared for the substitutions of new controls for the checks and balances that the Constitution had placed upon the national government, with its separation of power between the legislative, the administrative, and the judiciary. We had viewed the Interna-

tional Labor Organization and other collectivist programs from a distance. In our sudden tolerance as to dropping the principles of the free market, and shut off from the general climate of freedom, we perhaps found ourselves eighteenth-century holdovers, in the twentieth century of "the wave of the future," "world government," "bigger checks and smaller balances." But most serious of all, we were ignorant of the rough and tumble of politics.

Insurance

"Over there" in Europe and Britain, they had called the panacea we sought "social insurance." That word *insurance* may have brought the actuaries in. Especially were we unprepared for the "New Math" that mingled "hand-outs" and some individual equity loosely tied in with personal tax paid. In the adopted program of "Old Age Benefits"—Title II and Title VIII of the Social Security Act—it was our ignorance that toyed with this program of largely deferred benefits with "untidy finance" (tidiness being the suggestion of A. D. Watson). In our traditional federal setup, national government's handling of either insurance or relief was out of order. Temporarily substituting "social security" for "social insurance" deferred examination of verbiage. The wide separation of Titles II and VIII did not blind Canadian A. D. Watson to the obvious intention to start a "Contributory Annuity Scheme." In discussing his paper, I find in this 1965 reading of the record that I tried educating him, back there in 1937. Page 533 (*Transactions*, Volume XXXVIII) tells Mr. Watson about the oral discussion before the Supreme Court earlier that year:

The Honorable Robert H. Jackson, Assistant Attorney General, in discussing Title II, said, "This plan of expenditure is complete in itself. It does not depend upon the amount of the tax that is raised. It does not have any reference to the taxes in fixing the amounts or the time when benefits shall begin. In fact it does not begin until 1942 so far as the monthly benefits are concerned, while the tax levy starts this year. It is not in any way dependent on the amount of taxes raised. There is no interdependence." The Chief Justice asked, "This entire scheme could be abolished by Congress without affecting the taxing provision?" Mr. Jackson replied, "It could. And the entire taxing scheme could be abolished without affecting this provision. All that you would need to do would be to keep your wage records for the benefit title. Both benefits and taxes require reference to the amount of wages earned for their computation, but by the keeping of the records this title can exist alone. It does not depend in any way upon the operation of a tax in the sense that the Agricultural Adjustment Act depended as Your Honors found in the Butler case." The plight of the aged was strikingly set forth in the Brief prepared for the Supreme Court.

Following Mr. Jackson's careful statement that either the tax or the benefits portion could stand alone, following the emphasis upon the need of the aged, the Supreme Court decided that the plight was one calling for treatment in the interests of the general welfare. They did not have to call it a "Contributory Annuity Scheme."

It was, then, a shock to me, when almost immediately after the Supreme Court decision that old age benefits could not be called unconstitutional, it was decided to change the name of the *Bureau of Old-Age Benefits* to the *Bureau of Old-Age Insurance. Insurance* was a word we had been avoiding. Its connotations were many, and it was sure to be misleading to those involved in its administration and to the citizens covered.

A most important part of the Act was "Reservation of Power," Sec. 1104: "The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress." Mr. Myers in the current paper reports four amending laws. A compilation of Social Security Laws of 1962, carrying the record through 1961, lists 66 earlier public laws that amended the Social Security Act. This seems to mean at least 70 amendments since the original legislation of 1935, evidencing considerable instability from the standpoint of "contract," or absence of guarantee back of the provisions. Although "social insurance" by ILO standards is much more far-flung than the Old-Age, Survivors, and Disability provisions, our phrase "social security" has come to be solely applied to OASDI over the years. The 70 amendments to the Act include much besides the OASDI part.

At about the same time that the Supreme Court accepted the brief on the non-integrated taxes and benefits under Titles II and VIII, I had selected "social budgeting" as a better phrase for such national programs. In our dealing with old age, we had not been as heartless in respect to the aged as the five-year exclusion of the aged from the monthly benefits would imply. There was also established at the same time Title I, which furnished a national subsidy to the states toward state provision of old age assistance. The OAA got into operation a year ahead of Title II. Of course, the taxpayers over the nation met all three taxes, local, state, and national portions of meeting the costs. But in the first three years Title I paid out nearly fifty times as much as did Title II. I had by this time come under the influence of Miles Menander Dawson's 1908 paper on such governmental plans. I presented a paper on social budgeting to the Casualty Actuarial Society in 1937, since, in its original program, the Casualty Actuarial and Statistical Society had included "social insurance" as one of its basic interests.

The first president, Dr. I. M. Rubinow, had very early given the first college course in America on "Social Insurance" at Columbia and pub-

lished a book on it. While Mr. Hohaus seems to have been influenced by the "non-reserve" aspects of the British example, I was influenced by the small flat benefit they had established in their old age and survivors plan. To rationalize OASI (OAB) as it had been started seemed to me impossible, since it gave much larger windfalls to the nonneedy than to the needy. As time passed, I saw that the "below-level of subsistence" that I recommended, even if adopted, would not stay that way. It was but "a lesser evil." I saw that overemphasis on personal incapacity that underlay the system was "poison," that hypocrisy and deceit damaged human dignity, that if one gave relief, it should be called just that. I have come to the conclusion that the responsibility should be local, not national, that what *is* relief should be honestly presented as such.

Intentions

I recently had the privilege of hearing Milton Friedman talk on "Intentions and Consequences," a talk covering more than social security but including it. I then acquired his paperback *Capitalism and Freedom.* Just back from the Stresa meeting of the Mont Pelerin Society, he had an important message to give in the "headquarters of lost faith." I have sent him my "Fabian Gradualism." Though I have heard many a reference to "the intent of Congress," I do not know what their intent was in their social security legislation. It seems to me that the intentions were those of a small "establishment." I agree with Dr. Friedman, that even allowing that the intentions were good, the consequences have been deplorable and that there is good authority that good intentions often are the pavement "of the road to hell."

The British, in their social insurance announcements, gave but a single illustration of cost progress anticipated. Our early duplication of that technique gave way to furnishing a low and a high, admitting our inability to forecast results of the many shaping forces—especially the moods of the Congress. But, having escaped from one misleading technique, taking the average of two plausible guesses has returned us to a misleading appearance of *knowledge.* About 1938 or 1939 I drew up a rather complex graph, called the 16 squares, for members of the Social Security Board, to indicate that the up-slope of benefits was to be unnecessarily steep, though unpredictable. In 1948 I did it over for the members of the Advisory Council, calling it the 16 rectangles. My recent story of "Fabian Gradualism in OASI" continues the tale—but this time with the actual results stemming from denial turning into affirmation.

In that essay—"Fabian Gradualism"—I took the illustrative single

cost table prepared for presentation to the congressional committees in 1935 for what was then called "The Morgenthau Amendment"—"the self-sufficient finance." The table showed year after year from 1937 through 1980 the income, the outgo, the residual trust fund, then called "the Reserve." Selecting the last completed calendar year, 1964, I compared the actual consequences in 1964 in the much-amended law. Some of those early figures on a fiscal-year basis were included in Mr. Richter's paper in *Law and Contemporary Problems* (School of Law, Duke University [April, 1936]). Although Mr. Richter warned against taking these figures as predictions of the actual progress of the fund, the end figure of a fund of $47 billion was argued about, even by actuaries, almost as though it were actually expected. I myself was to blame for part of that misleading argument. The actual tax collection of 1964 was seven times the item for 1964 in that famous illustration. The actual benefits were eight times those of the illustration. The dollars of interest income and of the residual trust fund were about half the items in the illustration. The ratio of the interest element of the income to the tax element of the income was 8 per cent of the comparable illustrative ratio. The ratio of the trust fund at the end of 1964 to 1964 benefits was 6 per cent of the comparable ratio in the illustration. The assumption of persistence in the much-amended law is solidly negated by this history. The total taxes (OAB and OASI) through 1964 totaled $131.6 billion. The residual trust fund was $19.1 billion (roughly 15 per cent of the taxes collected). I expect that $125 billion more—as based before the 1965 amendments—should yet go to existing beneficiaries and their families, if Section 1104 does not begin downward corrections. Their priority seems important. There are some 100,000,000 additional covered persons that must be "expecting" some $2 trillion more, as they examine the structure of the much-amended plan. A trust fund of $19.1 billion is but 1 per cent of the potential outlay—an insignificant start toward future requirements.

In the 28 years of activity, from 1937 through 1964, tax collection increased over 30-fold, but benefit payments increased 15,000-fold. When the need was greatest, the benefit payments were negligible, and now that we talk of "the affluent society," we also stress again the tremendous poverty, in ambivalent talk.

Because of actuarial curiosity, at the end of 1959 I carried through an estimate for the 7½ million persons who were drawing primary age benefits, after meeting the requirements of enough recorded tax payment to qualify them and their families for the awards. Counting both the apparent benefits of record to these persons and their families, and projecting their residual demands on the funds, I concluded, with obviously

some margin of error, that on the average they were expecting $2 of benefits per nickel of personal tax payment. Mr. Myers has sponsored a couple of sample studies that, in a recent Actuarial Note, seem in line with this conclusion.

With such expansion of benefits as the 1965 amendments incorporate, it seems to me that we are entering afresh into "the ignorance of 1935." My studies suggest that we "are piling Pelion on Ossa," and that Ossa indicates neither stability nor predictability. "Anything can happen!"

I also think it incumbent upon me to give belated recognition to "the contrary opinion" of Russell Reagh, Alanson Wilcox, George Buchan Robinson, and Jarvis Farley—these contributors to early discussion especially standing out for their sound intuitions as to "financial responsibility" in governmental programs.

Illusion

It might seem that citizens "getting two bucks for a nickel" were in clover. But those who were saving dollars, through war bonds or other national savings bonds, through level premium life insurance and annuities, in savings banks and building and loan funds—those thrifty, cautious souls avoiding the stock market—might find themselves with less windfall from OASI than their losses through the falling buying power of those saved dollars. There are millions "to whom security has not been delivered"—many of them "the salt of the earth." Millions have become dependent on government, in the operation of our "road to serfdom." Tamperers with the free market have much to answer for.

The comparable position of the very nominal rate of tax and dollars of tax over the first thirteen years and the rates of tax being levied against the entrant at low ages in 1965 and later years is more than "striking." I personally paid less than $400 in personal OASI taxes between the termination of my "civil service," untaxed for OASI, and the qualification for OASI benefits in 1954. The youngsters finishing their "expensive education, dollarwise" often have starting salaries high enough to pay the maximum OASI tax, and look forward to perhaps 45 years of such tax-paying, steadily increasing from the 1965 evidence. Some have said to me, "I could do better with my tax money for myself than OASDI seems apt to do." I have to tell them that for the last eight years all the taxes and all the interest have been insufficient to meet the benefits and administrative costs of OASI, by $3\frac{1}{2}$ billion dollars, and that judging from recent experience, a period that includes over half of both the taxes and benefits of the 28 years, they cannot count upon interest *accumulating* to help meet their future benefits and that most of the out-

lay can be properly classified as "charity to those not really needing it." When I tell them that the trust fund is only a sixth of what we people on the rolls can expect to get hereafter (we and our families), they are usually too polite to say, "Why should we contribute to your support?"

Millions of retired persons are seemingly ignorant of the relationship between what they, individually, have contributed and what they and their families are apt to get out of it. We cannot tell about "the individual." We do not know when he is going to die or qualify for awards—but the considerable "expected years of survival of the older persons" might seem apt to be extended by the coming "free medical care." One has to "say it with a smile" when he tells the already retired recipient that after all he has not really paid so very much yet. The limitation about all subsidy is that unless a man is "cost-minded" he is usually much misled by the veiled explanations accorded him.

I protest most vigorously, in connection with the advance talk about Medicare, the claim that the men about to contribute their tax for my hospital bill are "building up rights for themselves." They are only continued statutory rights. So long as Section 1104 remains, specific commitment is unwarranted. The accrued liability—on my definition of it—is so enormous, if we do not have interest accumulation, that I have stopped proclaiming what it is. I just say, "Level premium life insurance companies and uninsured pension funds seem to feel the need of assets of $200 billion. How, then, can $20 billion help much with the delayed cost wallop of OASDMI?"

Inquiry

I have known very few hardy individualists who, offered social security benefits for which they had contributed but a token in tax payment, turned down the windfall. The life insurance business has done a lot of growth in dollars of death protection. It has not shown growth in the ratio of life insurance premiums to disposable income. It was 4 per cent in the 1929 report. It was 4 per cent in the 1964 report. The savings element in life insurance seems to have dropped a bit. Going further into comparisons, OASDI showed benefits paid in 1964 of $16 billion. The life insurance companies, after adding to death, permanent total disability, matured endowments, and annuities, also needed surrender values and the return of premiums called dividends to bring the benefit to almost $11 billion. Comparing deaths before age 65, age payments beyond 65, annuities, and so forth, the life insurance business seems threatened by "the monopoly aspects" of government take-over of their field. Some of the queries that should be appearing today include my

query a year ago at the White Sulphur meeting's social security panel: "Who pays, when, how much, for whom and what and when, and why?" The answer there was, "Our children and grandchildren, on and on."

I have been listening to lots of talk about *interdependence* from various groups. I still believe that the tenth commandment against coveting what is one's neighbor's is steadily imperiled by OASDI! It uses the carrot more than the stick. I hear queries on every side as to "Where is it all going to end?" Frank Dickinson suggests that "a revolt of youth" may be imminent.

Independence

In the *Proceedings* of the Casualty Actuarial Society, during the war years, I wrote on "Some Backgrounds to American Social Security." In those prewar years the actuarial stance had been distrust of the capacity of the national government to handle trust funds and equal distrust of the ability of the American citizen to budget for himself. Although the ILO showed both of these distrusts, they seemed ready to use the government to start with! Both of these snap judgments seem to have been validated. The present aged seem to have accepted "metered bribes" to be silent to the unfairness to the young in the OASI system. However, the young trained men, just starting to be taxed (to be privileged to contribute to the aged) ten times as much as the starting tax of 1937, are protesting. Their protest against our early endorsement of "little-pay-little-go" should embarrass us. More power to their protests! At one of the last hearings before the Ways and Means Committee that I attended, the Young Americans for Freedom (YAF) brought a "breath of fresh air" by their testimony before the Committee. Last year it was "a younger actuary" who said at the panel discussion that payment for OASDMI was to fall on our children and grandchildren. It seems to me that most of the time the tendency has been to "exaggerate need" but to underestimate costs.

In the interest of the independence of the individual, I am turning to Britain's "principles of 1834." Over there, the overuse of the carrot was so astounding that they were hard-put to find enough rate-payers to support the almshouse population. The new doctrine had three prongs. "Pauperism is a bad thing. The status of a pauper should be lower than that of the lowest grade of self-sufficient common laborer. It is immoral to tempt productive citizens into pauperism." Upon Parliament's adopting these three principles, independence and self-support steadily gained. The poorhouse population fell. "Cash out-door relief" diminished. The rate-payers increased as the needed rates fell. The influence of the "about-

face" lasted for about a half-century, till the ganging-up of the socialists, Christian socialists, Fabian socialists, and Labor. As we realize how dependence—especially in old age—has been growing, we also should be about ready for a new *Declaration of Independence,* too.

Conclusion

We have been weak on definition and analysis. Error has gone too much unchallenged. There seems no good way to do a demoralizing thing. The substitution of facts for impressions seems to have been held back by apathy. Many of the facts are alarming. History does record reversals of wrong national policy—when the zest for living gets the national pulse recovering. Mr. Myers' paper could challenge us to "ascend" to meeting responsibilities—as free individuals.

(AUTHOR'S REVIEW OF DISCUSSION)

ROBERT J. MYERS:

First, I should like to express my appreciation to the various discussants for the valuable material that they have presented. Such discussions supplement my paper by bringing out important facts about various complementary factors, as well as about the extensive new programs as a whole.

Mr. Bronson has a number of interesting comments and questions, which may be taken up in turn:

1. Study of the concurrent recipients of OASI and OAA by sex and age groups relative to the total OASI beneficiaries seems to indicate that in the aggregate this proportion will remain at about the present level for some time to come. Such a conclusion could, of course, be considerably affected if federal or state standards of need are significantly changed.

2. As to activities in 1965 in regard to unemployment insurance, the paper indicated the significant legislative recommendations made by the administration. Supplementing this information, it may be noted that Congress took no action in 1965 on the bill that was introduced to carry out these recommendations, except that the House Ways and Means Committee held public hearings.

3. As to the proper level for the maximum taxable earnings base under OASDI, I attempted to point out that the $6,600 base adopted in the 1965 amendments is not such a drastic change from the previous $4,800 base when the actual experience in the last fifteen years is considered. I cannot say that this is the proper criterion—that is, keeping the earnings base up to date with what it was in 1951—but some social insurance students believe this to be so. Others think that the earnings base should

be at about the level that it was in the 1930's, when it covered the total earnings of almost all workers. On the contrary, still others express the view that Mr. Bronson does—that, with increasing affluence and prosperity, the earnings base should fall behind by having covered earnings be a smaller proportion of total earnings.

4. I agree that the new definition of disability can no longer be termed "total and permanent" but might be called "total and extended."

5. Although a woman who has been widowed several times and is presently unmarried retains rights to widow's benefits on all deceased husbands, this does not mean that she draws multiple benefits but only the largest of such benefits.

6. It has been a principle of OASDI ever since the 1939 amendments that there are no cash refund benefits for persons whose total lifetime employment does not produce sufficient quarters of coverage to obtain insured status. From this standpoint, there is not full vesting. On the other hand, when benefits become fully vested as a result of obtaining permanently insured status, such benefits cannot be forfeited by action of the individual in withdrawing his contributions (as is generally the possibility in contributory private pension plans). In any event, I believe that this lack of cash refunds is a desirable, essential difference between social insurance and private pension plans.

7. As to use of the term "actuarially sound" in connection with social insurance, I believe that this is a matter of definition. I recognize that Mr. Bronson has, for years, held the view that the concept of actuarial soundness is not applicable to OASDI, and no doubt many others agree with him. Yet I do not think that I am alone in my belief that the phrase "actuarially sound" can be applied to OASDI in the general manner that I have done. I think that it is desirable to have the administration and the Congress concerned about the actuarial soundness of the program, because this has strong effects in producing cost consciousness and fiscal responsibility. Further, insofar as I know, the term "floor of protection" is still a basic principle of OASDI, although here—as in many other areas—the matter of definition of what is a "floor" may be subject to considerable variation.

8. The reason for the transitional basis for blanketing-in uninsured persons for the HI benefits, so that after a few years persons attaining age 65 must have some covered employment to qualify for benefits, is that many persons believe that the compulsory-coverage provisions of OASDI would be weakened if there were "permanent" blanketing-in. Thus, according to this belief, and especially if there were also blanketing-in for the minimum cash benefits, many employment categories would

seek (either by law or by practice) to have their earnings removed from the taxation provisions because they would be satisfied with the benefit protection obtained on a "free blanketing-in" basis.

9. In describing the tax schedule under the 1965 amendments, there is a "slower increase" when comparison is made with the 1965 rate than would have been the case if the tax schedule in the former law had prevailed. Thus, the new tax schedule represents a *reduction* over the former tax schedule and yet at the same time yields a slower increase than previously scheduled.

10. The "cost basis" for payment of administrative expenses under HI and SMI for such potential carriers as stock insurance companies may well present philosophical problems to knowledgeable stockholders and regular policyholders, as Mr. Bronson suggests.

11. The role to be played by carriers in safeguarding SMI from overutilization can, as Mr. Bronson suggests, be made more difficult if private supplementary policies provide for the deductibles, the coinsurances, and the extended durations over the statutory benefits, if one believes that these features themselves lessen overutilization. Personally, I believe that such is the case, although there are those who argue otherwise. There are other ways in which carriers can safeguard SMI from overutilization even though these "chinks" are filled in.

As Mr. Bronson indicates, there has been no extensive discussion of the provisions of the 1965 amendments relating to income tax deductions for medical care expenses. I might add that one reason for these provisions, especially those relating to uniform treatment for those aged 65 and over with those under age 65, was the desire to recognize that there would be a contribution from general revenues for SMI for all persons aged 65 and over regardless of their income. Accordingly, the special advantage that persons aged 65 and over had for medical expense deductions was removed as a partial offset to the additional expenditures from the General Treasury for SMI.

Mr. Bronson believes that the treatment of insurance premiums as income tax deductions was deliberalized by the 1965 amendments. In my opinion this is not the case, although admittedly there are counteracting elements. The new basis is less liberal in that, in some instances, lesser amounts of the premiums for multipurpose health insurance policies will be considered for deduction purposes. However, more than counterbalancing this is the fact that half of the acceptable premium (within limits) will be considered as a deduction regardless of whether the 3 per cent medical-expense limit is met, and most people do not meet such limit.

Mr. Hoffman has presented an interesting historical comparison of my cost estimates for the HI program with those prepared by the insurance industry. However, more details of the basis of the various cost estimates are necessary for a valid comparison. Only part of the differences between the insurance business and my estimates is due to strictly actuarial assumptions. A major part of such differences—and a major part of the increases between my successive estimates—is due to changes in economic assumptions. Benefit provisions have also changed as between the various bills.

As Mr. Hoffman has stated, the gap between the two series of estimates has steadily narrowed. This is due only partially to my estimates successively being revised upward; despite rising hospitalization costs, which would produce higher estimated benefit costs, the insurance business estimates decreased steadily until that for the final law (the increase therefor being due primarily to changed economic assumptions).

Some further explanation of the bills to which the five estimates of each of the two series apply is desirable. The figures shown for H.R. 11865 of 1964 are with respect to the Gore Amendment and are contained on page 590 of Item 3 of my Legislative Bibliography. It should be noted that the Gore Amendment was not voted on by the Senate and differed significantly from the HI provisions that were put in the bill on the floor of the Senate.

It should also be noted that my initial estimate of the level-cost for H.R. 1 of 1965 (as contained in *Actuarial Study No. 59*) was .84 per cent of taxable payroll, rather than the .96 per cent in the joint memorandum (as shown by Mr. Hoffman). The estimate of .84 per cent was on a comparable basis with the estimate made for the Gore Amendment. The reasons for the difference in these two estimates will be discussed subsequently. Interestingly enough, under the assumptions made in *Actuarial Study No. 59*, the level-cost is .84 per cent for each of three different periods of determination—into perpetuity, for the next 75 years, and for the next 25 years with provision to accumulate a fund equal to one year's benefit payments at the end of the period. These equal .84 per cent costs for the long-range estimates as well as the medium-range estimates result from the effect of the ½ per cent negative differential between hospitalization costs and the earnings level assumed by the Advisory Council. The 25-year basis was used in the final estimates for the legislation enacted.

Now, let us review the major reasons for the increases in my series of cost estimates that are shown by Mr. Hoffman. The increase from the level of the 1961 and 1963 estimates to the 1964 estimate is primarily

the result of more conservative assumptions as to average daily hospitalization costs. In the beginning it was assumed that, over the long run, hospitalization costs would bear the same relationship to wages as in some recent past year. This assumption meant that any short-term differential of hospitalization costs over wages was assumed to be counterbalanced by subsequent trends in the opposite direction. Under the revised assumptions, an allowance was made for current and near-future differentials of hospitalization costs over wages, with identical trends thereafter.

The increase from the 1964 estimate to the first 1965 estimate shown by Mr. Hoffman resulted from several factors. First, the ½ per cent negative annual differential between hospitalization costs and earnings after 1975 assumed by the Advisory Council was eliminated (so that the same rate of increase is assumed for both). Second, increasing earnings levels and, accordingly, increasing hospitalization costs were assumed, instead of constant earnings at the 1961 level. Third, it was assumed that the earnings base would be kept up to date with the general earnings level. Fourth, it was assumed that the initial earnings base in the bill would be kept up to date with what it would represent in 1966 (rather than what it represented in 1963).

The final 1965 estimate was on a different basis than the earlier 1965 estimate for several reasons. First, higher hospital utilization rates were assumed (as described in more detail subsequently in my reply to Mr. Trapnell's discussion). Second, it was assumed that, despite rising earnings, the earnings base would remain fixed at $6,600 for the entire 25-year period.

The series of cost estimates of the insurance business shows a significant decrease from the level of the first three figures to that for the first 1965 estimate shown and then an increase to the final 1965 estimate. I am unable to account for the aforementioned decrease, but the final increase is largely due to the change in economic assumptions that was discussed previously in connection with my series of estimates. I believe that there is complete comparability as to economic assumptions between the two series of cost estimates only for the two 1965 estimates. In the previous years, the insurance business estimates were based on an earnings level and hospitalization costs of a somewhat later year than were my estimates. This difference in the economic assumptions represented part of the differences in the cost estimates.

Finally, Mr. Hoffman might have mentioned the insurance business cost estimates for the SMI program (see p. 554 of Item 9 of my Legislative Bibliography). The cost estimate of the insurance business for the initial

one and one-half-year period was $7 per month, or 27 per cent higher than my intermediate-cost estimate of about $5.50. This relative differential is thus about the same for SMI as for HI.

Mr. Niessen supplements the paper in a very useful fashion by indicating what impacts the social security amendments of 1965 had on the railroad retirement system, particularly as to the matter left open by these amendments, namely, the question of whether that system will collect the HI contributions for its covered workers. This depends on what the RR earnings base would be in the future (the result of the subsequent RR legislation being that it is tied automatically to the OASDI and HI base). His description of the other RR amendments, including the new benefit provisions and the revised financing basis, is also necessary for there to be a well-rounded picture of the social insurance situation in the United States.

Mr. Slater has discussed several isolated but important facets of the new legislation. He is quite correct that the intent seems to be to approach pay-as-you-go financing and develop only moderate funds. Although during the legislative process administration economists were concerned about the "fiscal drag" and "reduced take-home pay" aspects of the amendments, in the subsequent few months the economic thinking has completely changed (at least temporarily), and these tax increases are viewed as desirable anti-inflationary elements!

I agree that, in the future, it is possible that there will be efforts to defer some of the future increases in contributions now scheduled, although it should be recognized that in the past many such increases have actually gone into effect. Of course, if contribution rates do not rise, more money will be needed to finance the existing benefits, and this could only come from contributions from general revenues. On the other hand, some social insurance students will argue that the worker and employer contributions should continue to rise and that there should be government contributions, too, so that a much higher level of benefits would be possible.

The "inequity to younger workers" argument—that the value of their benefits is generally less than the value of the combined employer-employee contributions—can be used to promote both a higher general benefit level and a substantial government contribution. Under these circumstances, not only will the advocates of a high "floor of protection" be satisfied, but also those who argue the inequity to the younger worker will have their argument answered! Of course, there is no more reason to allocate the employer OASDI contribution to each employee any more than a similar allocation is made in private pension plans.

Mr. Slater, in extending the computations comparing individual values of benefits and contributions to the situation that prevails under the 1965 amendments, quite correctly shows that there is now a little more emphasis away from individual equity and toward social adequacy. The reason for this is that the current benefit formula is a little more heavily weighted at the bottom because a third step was introduced (for the portion of the average monthly wage in excess of $400).

Further, as to Mr. Slater's benefit and contribution comparisons, there is always the problem of how to limit the cases to be considered and at what point of time to consider them. The examples actually cited are as of age 65 of the worker, and this involves both several low-cost items and several high-cost items. An example of the latter is the assumption that retirement occurs at age 65, while an example of the former is the disregarding of disability and survivor protection that had previously been afforded. Accordingly, then, I do not believe that such comparisons can be validly used to serve as a definite basis for saying that the system is inequitable to younger workers or to women workers.

Mr. Trapnell has made an excellent suggestion to include in the record the joint letter that explains the reasons for the differences between the HIAA cost estimates and mine. It should be recognized that this memorandum was concerned with a slightly different version of the bill than was finally enacted. Moreover—and no doubt partly as a result of this joint memorandum—the hospital utilization assumptions underlying my official cost estimates were made more conservative. This was achieved by a 10 per cent increase in all utilization rates and the elimination of the lower rates during the early years of operation for lower utilization by persons unfamiliar with insurance (such differential being 10 per cent in the first year). For the sake of the record, it should be mentioned that Chairman Mills suggested this to me, and I heartily agreed. Furthermore, affecting both cost estimates, Chairman Mills suggested changing the economic assumptions, so that, despite the assumed increase in the general wage level in the next 25 years, the earnings base is assumed to remain unchanged (as against the previous assumption of its being kept up to date). Again, I concurred in using this more conservative assumption.

Mr. Williamson, out of his great depths of experience and association with the program, has brought out many significant events of the early days of the social security program, as he saw them. I cannot help but recognize publicly at this time the vast amount of assistance and encouragement that he gave me in the development of my career during the more than a decade that I worked under his supervision. Nonetheless, I cannot agree with what appear to be his present views on the

social security program—in brief, the elimination of the present system and the substitution of a strict, low-payment public assistance plan with a means test.

Disregarding the political fact of life that it would be impossible to repeal the present program, I believe that there are overwhelming reasons why such a public assistance program financed from general revenues would be undesirable as the sole economic security measure. For one thing, I think that all the cost controls that exist under a social insurance program would be lacking and that it would be impossible to maintain such a program with low levels of payments. Then, if the benefit level were relatively high, the means test would discourage incentives to save or otherwise provide retirement income, with the accompanying heavy financial burden on general revenues and the increased involvement of social workers with a steadily rising proportion of the population.

Mr. Williamson makes several comparisons of recent actual experience in terms of monetary units with the original estimates made for the 1935 Act. In my opinion, such comparisons are neither valid nor meaningful because of such factors as changes in the purchasing power of the dollar, changes in the general earnings level, expansion of the types of employment covered by the program, and expansion of the types of benefit protection provided. I think that the most meaningful comparison is to relate OASDI benefit payments to taxable payroll and to total payroll of covered workers, as shown in the accompanying tabulation.

Item	Benefit Payments as Per Cent of:	
	Taxable Payroll	Total Payroll
1965 estimate for 1935 Act, made in 1935	5.28%*	4.88%
1964 actual data	6.55	4.81
1966 estimate, 1965 amendments	7.20	5.79

* Derived from Tables 11 and 13 of *Actuarial Study No. 8.*

From this comparison, especially the relationship with total payroll, I would conclude that there has not been a large overliberalization of the cash-benefits program in the three decades of its existence.