

Social Security Legislation in the Eighty-sixth Congress

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The Social Security Amendments of 1960 and related legislation enacted by the Eighty-sixth Congress make a number of technical improvements and several important substantive changes in the social security programs—notably a new program of medical assistance for the aged and broader disability protection.

The most controversial provisions, dominating public interest and discussion, were those relating to medical care for the aged. The highlights of the legislative development of the medical care provisions, as well as the details of the provisions adopted, are presented in Part I of this article. Part II gives the details and legislative history of the other provisions of the 1960 amendments to the Social Security Act and of other legislation affecting the social security programs.

WITH THE SIGNING on September 13, 1960, of H. R. 12580, the Social Security Amendments of 1960 became Public Law 86-778. They make revisions—some major and some technical—in all the programs under the Social Security Act.

SUMMARY OF MAJOR PROVISIONS

Old-Age, Survivors, and Disability Insurance

The major changes made by the 1960 amendments in the old-age, survivors, and disability insurance provisions are listed below.

1. Disabled workers under age 50 and their dependents can now qualify for benefits on the same basis as workers aged 50-64 and their dependents.

2. A change in the retirement test (effective for taxable years that begin after 1960) makes the test more equitable and improves its effect on in-

centives to work. The amendment eliminates the requirement for withholding a month's benefit for each \$80 of earnings above \$1,200 and provides instead for withholding \$1 in benefits for each \$2 of earnings from \$1,200 to \$1,500 and \$1 in benefits for each \$1 of earnings above \$1,500. As under the previous act, no benefits are withheld for any month in which the beneficiary neither earns wages of more than \$100 nor renders substantial services in self-employment.

3. The requirements for fully insured status are changed to 1 quarter of coverage for every 3 calendar quarters between January 1, 1951, and the year in which the worker becomes disabled, reaches retirement age, or dies (but not less than 6 or more than 40 quarters) instead of 1 for every 2 quarters.

4. A disability insurance beneficiary or childhood disability beneficiary is allowed a period of 12 months of trial work during which his disability benefits or freeze will not be terminated solely because of such work. Benefits for the beneficiary who recovers from his disability will be continued for the month in which his disability ceases and for the 2 following months.

5. Persons who become disabled within 5 years after termination of a previous period of disability can qualify for benefits without undergoing another 6-month waiting period.

6. The benefits paid to each child of a deceased worker have been increased to three-fourths of the primary insurance amount of the deceased worker (subject to the maximum on benefits payable to a family). Under the provision previously in effect, the benefit of each child was one-half the primary insurance amount plus one-fourth divided by the number of children.

7. Benefits are provided for the survivors of workers who had acquired 6 quarters of coverage and who died before 1940.

8. Benefits are payable under certain circumstances to a person as the wife, husband, widow,

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or widower of a worker if the person had gone through a marriage ceremony in good faith in the belief that it was valid when it was not, if the marriage would have been valid had there been no impediment, and if the couple had been living together at the time of the worker's death or at the time an application for benefits was filed. The child or stepchild of a couple who have gone through such a marriage ceremony can also get benefits.

9. The duration-of-relationship requirements that apply when a worker is alive are now the same as the requirements that apply when a worker has died. Benefits are payable to a wife, husband, or stepchild on the basis of a disabled or retired worker's earnings if the necessary relationship had existed for 1 year rather than for 3 years.

10. The coverage provisions of the program are changed to (a) extend coverage to service (other than domestic service or casual labor) performed by an individual in the employ of his son or daughter; (b) facilitate coverage of additional State and local government employees; (c) extend coverage under the self-employment provisions to services performed in the United States after 1959 by United States citizens in the employ of foreign governments, instrumentalities of such governments, or international organizations; (d) extend coverage to the territories of Guam and American Samoa; (e) provide an additional opportunity, generally until April 15, 1962, for ministers and Christian Science practitioners who have been in practice at least 2 years to elect coverage; (f) eliminate the requirement that two-thirds of the employees of a nonprofit organization must concur for the organization to elect coverage for concurring employees and all employees hired in the future; (g) permit employees or their representatives or survivors to obtain credit for certain earnings reported by nonprofit organizations that failed to comply with the requirements for extending coverage to these employees.

11. The method of financing the program has been strengthened by changes designed to make the interest earnings of the trust funds more nearly equivalent to the rate of return on Government bonds bought in the open market.

12. Other changes, mostly of a technical nature, were made to simplify the law and make it

fairer and to facilitate the administration of the program.

Public Assistance

The major provisions of the Social Security Amendments of 1960 that affect the public assistance program relate to medical care for the aged and are as follows:

1. Title I of the Social Security Act is expanded to include a new program providing grants-in-aid to States for medical assistance in behalf of aged persons who are not recipients of old-age assistance but who have insufficient income and resources to meet the costs of necessary medical services. Federal sharing will range from 50 percent to 80 percent under a formula based primarily on per capita income.

2. Federal sharing in State old-age assistance expenditures for medical care in behalf of recipients is increased.

3. Provision is made for the preparation of guides or recommended standards for State use in evaluating and improving the level, content, and quality of medical care in their programs of public assistance and medical assistance for the aged, as well as the collection and publication of information on these matters.

Maternal and Child Health and Child Welfare

The major changes in the provisions of title V under the 1960 amendments to the Social Security Act are as follows:

1. The amounts authorized for annual appropriation are increased to \$25 million for each of the three programs—maternal and child health services, crippled children's services, and child welfare services.

2. A new program, and a separate appropriation, is authorized for grants to public or other nonprofit institutions of higher learning and to public or other nonprofit agencies and organizations engaged in research or child welfare activities, for special research or demonstration projects in the field of child welfare that are of regional or national significance and for special projects for the demonstration of new methods or facilities that show promise of substantial contribution to the advancement of child welfare.

I. Medical Care Provisions of the Social Security Amendments of 1960

1959 HEARINGS ON H.R. 4700

THE POSSIBLE expansion of the old-age, survivors, and disability insurance program to include hospitalization and nursing-home service benefits for aged and other beneficiaries had been discussed during the consideration of the 1958 amendments to the Social Security Act by the Eighty-fifth Congress. A bill introduced by Representative Forand, with medical care provisions almost identical with H. R. 4700 (the bill that he introduced in the Eighty-sixth Congress and that is described below), was actively under consideration and was discussed by most of the witnesses who testified at public hearings relating to the social security programs. The Committee on Ways and Means of the House of Representatives concluded, however, that more information was needed before any legislation in this field could be recommended. The Committee consequently asked the Secretary of Health, Education, and Welfare to make a study and report on possible ways of providing insurance against the cost of hospital and nursing-home care for old-age, survivors, and disability insurance beneficiaries and on the benefit costs and administrative implications of the different alternatives.

Such a report¹ was submitted to the Committee in April 1959. It brought together information on the characteristics of the aged population, their income and assets, their utilization of medical services, and the extent to which they are covered by voluntary health insurance. It also outlined and presented cost estimates for several alternative methods of providing hospital benefits for old-age, survivors, and disability insurance beneficiaries and other aged persons, including the provision of such benefits as part of the old-age, survivors, and disability insurance system, various methods of stimulating voluntary insurance, subsidies to private insurance carriers, and Federal assistance to the medically indigent. The report did not include any recommendations for specific action.

In July 1959 the Ways and Means Committee held 5 days of public hearings on H. R. 4700, a bill introduced in the Eighty-sixth Congress by Representative Forand "to provide insurance against the costs of hospital, nursing home and surgical services for persons eligible for old-age and survivors insurance benefits."

Under the bill, eligible persons aged 65 and over (62 for women), their qualified dependents, and young survivors were to be entitled to the following health benefits in a 12-month period: up to 60 days of hospital care; up to 120 days, less the number of days in hospital, of care in a skilled nursing home upon transfer from a hospital and on a physician's certification that care was medically necessary for a condition associated with that for which the person was hospitalized; and necessary surgical services. Any hospital (other than mental or tuberculosis or Federal hospitals) or qualified nursing home licensed by the State in which it was located was to be eligible to enter into an agreement to provide services under the program. Payments for these services by the insurance fund were to cover the reasonable costs incurred by the provider, who would agree to accept them as payments in full for covered services. The Secretary was to be authorized to utilize in the administration of the program nonprofit organizations representing providers of hospital, nursing-home, or surgical services or operating voluntary insurance plans covering such services.

To finance the benefits, the bill provided for an increase in old-age, survivors, and disability insurance contributions of 0.25 percent of taxable earnings each for employers and employees and 0.375 percent for self-employed persons. The cost of the program as estimated by the Social Security Administration was \$1,120 million, or 0.53 percent of taxable payrolls, in the first full year and 0.79 percent on a level-premium basis—that is, the average over the indefinite future.

(The comparable bill introduced by Representative Forand in the Eighty-fifth Congress had been fully financed according to cost estimates made at that time. In the subsequent congressional consideration of H.R. 4700, Representative Forand stated that he would amend the bill to assure that it was actuarially sound and to

¹ *Hospitalization Insurance for OASDI Beneficiaries* (Committee Print), Committee on Ways and Means of the House of Representatives, April 3, 1959.

take account of certain other technical problems resulting from the 1958 amendments to the Social Security Act.)

In testifying on the opening day of the hearings, the Secretary of Health, Education, and Welfare quoted from his report of April 3, 1959, to the Committee as follows:

There is general agreement that a problem does exist. The rising cost of medical care, and particularly of hospital care, over the past decade has been felt by persons of all ages. Older persons have larger than average medical care needs. As a group they use about two and a half times as much general hospital care as the average for persons under age 65 and they have special need for long-term institutional care. Their incomes are generally considerably lower than those of the rest of the population, and in many cases are either fixed or declining in amount. They have less opportunity than employed persons to spread the cost burden through health insurance. A larger proportion of the aged than of other persons must turn to public assistance for payment of their medical bills or rely on "free" care from hospitals and physicians. Because both the number and proportion of older persons in the population are increasing, a satisfactory solution to the problem of paying for adequate medical care for the aged will become more rather than less important.

The Secretary then stated, however, that he did not regard H. R. 4700 as a satisfactory solution to the problem, since he believed that the objective of making adequate medical care available to the aged population should, as far as possible, be achieved through reliance upon and encouragement of individual and organized voluntary action. As a proportion of all persons aged 65 and over in the population, those having voluntary health insurance had risen from 26 percent in 1952 to about 40 percent in 1959 and in view of the special efforts being made by insurance carriers would, he felt, certainly increase still further. The Secretary pointed out that "enactment of a compulsory hospital insurance law would represent an irreversible decision to abandon voluntary insurance for the aged in the hospital field and would probably mark the beginning of the end of voluntary insurance for the aged in the health field generally. The pattern of health coverage of the aged would have become frozen in a vast and uniform governmental system [involving] governmental intervention into arrangements that are on the whole better left within the framework of nongovernmental action."

The Secretary further indicated that he recognized there were problems relating to the adequacy and cost of existing health insurance for

aged persons and that the Department was continuing to study possible methods of strengthening the voluntary approach but had not yet had time to develop a definite recommendation.

During the course of the hearings, numerous witnesses testified both for and against H. R. 4700 or any similar proposal to provide health benefits for aged persons through the social security system. The American Medical Association, a number of State medical societies, the American Hospital Association, the Chamber of Commerce of the United States, the Health Insurance Association of America, the American Life Convention, the Life Insurance Association of America, and others opposed "the social security approach," and some opposed any Federal action, on a number of different grounds.

The major arguments presented by those opposed to H. R. 4700 related to the fear of Government control of hospital costs and of medical practice, the danger of overutilization of hospital facilities with an accompanying decline in the quality of care, and the fear that hospital insurance for the aged would be but the first step toward health insurance for the entire population through the social insurance system. The rapid growth of voluntary insurance and the willingness of many doctors to agree to hold down their charges for older persons were cited as evidence that the problem would solve itself, given time. Questions were also raised as to whether the aged were as badly off financially as pictured, and it was pointed out that the neediest aged were not receiving old-age and survivors insurance benefits and that they would therefore not be helped by a program geared to old-age, survivors, and disability insurance.

The use of the social insurance mechanism to provide hospital and other health benefits for aged persons was supported by the American Federation of Labor-Congress of Industrial Organizations and other representatives of organized labor, the American Public Welfare Association, the American Nurses Association, Group Health Association of America, the Physicians' Forum, the National Association of Social Workers, and others. The primary arguments presented by those supporting H. R. 4700 related to the growing need for the entire community to share in the higher-than-average medical costs of the aged, with use of the social insurance system

the most effective and logical method, assuring immediate broad coverage and a mechanism for prepayment; they reflected also the opposition to the use of a means test for medical care—suggested as an alternative to health benefits under old-age, survivors, and disability insurance. Also cited were the shortcomings of private insurance policies and protection and the question as to how much private insurance could be expected to do; the advantages that would accrue to hospitals and to private insurance carriers if the costs of the aged group were taken over by Government; and the probability that such action would strengthen rather than weaken voluntary insurance. A number of the witnesses also made suggestions for modifying the bill—by dropping surgical benefits, for example, and adding outpatient diagnostic and visiting nurse services to avoid unnecessary utilization of hospitals.

1960 PROPOSALS

There was no further congressional action on proposals for medical care for the aged in 1959. On March 14, 1960, the Ways and Means Committee went into executive session to consider possible amendments to the Social Security Act. It remained in executive session through April and May and into June. A large part of the time was devoted to the issue of medical care for the aged.

At the request of the Committee Chairman, the Secretary of Health, Education, and Welfare, as well as technical staff of the Department, sat with the Committee during most of its sessions. At the beginning of the session, the Secretary indicated that the executive branch had been exploring various alternative approaches to the problem of medical care for the aged and had conferred many times with representatives of various interested groups in an attempt to work out an acceptable solution. Up to that time, however, no agreement had been reached. The Committee asked the Secretary to push forward with his explorations and indicated an unwillingness to proceed without a definite recommendation from the Administration.

Early in 1959 the Senate Committee on Labor and Public Welfare had established a special Subcommittee on Problems of the Aged and Aging (the McNamara Subcommittee) to conduct a comprehensive study of the major problems of

the aged. The subcommittee held public hearings in seven communities throughout the country and during the first 2 weeks in April 1960 held hearings in Washington, primarily on the health needs of the aged. The lineup of groups for and against provision of medical benefits through the social insurance system was similar to that at the time of the hearings before the Committee on Ways and Means in 1959.

Some new information on the medical needs of the aged was introduced. There were additional pressures for action and additional arguments for delay. A number of persons, for instance, thought no action should be taken until after the White House Conference on Aging early in January 1961. The Secretary of Health, Education, and Welfare again testified that he was exploring various alternatives.

The Javits Bill

On April 7, Senator Javits introduced, for himself and seven other Republican Senators, S. 3350—a bill to provide Federal matching grants to States to help subsidize the cost of health insurance for persons aged 65 and over. Six identical bills were introduced in the House.

Under this proposal, a participating State would enter into contracts with private insurance carriers to provide at least one service benefit and one indemnity benefit health insurance policy that would be available to every individual in the State who was aged 65 or over or married to such an individual. The policies would be required to cover home and office physicians' calls and other ambulatory care constituting not less than one-third of the premium cost and also to permit the substitution of care in skilled nursing homes for care of equal cost in general hospitals.

The bill established a schedule of subscription charges for individual subscribers ranging from zero for those whose annual incomes were less than \$500 in the preceding year and 50 cents a month for those with incomes of \$500–\$1,000, up to \$13 a month (or such larger amount as the State might designate) for those with incomes of \$3,600 and above. No individual's subscription charge, however, was to exceed the premium cost of his policy if that cost was less than \$13 a month. The difference between the aggregate premium cost for all participants and their total

subscription payments would be made up by the Federal and State governments, with the Federal share ranging from 33 $\frac{1}{3}$ percent to 75 percent, depending on the per capita income of the State. The government costs under the bill were estimated by Senator Javits to be \$1.12 billion, of which about \$480 million would be Federal funds.

Administration Proposal

On May 4, Secretary Flemming presented to the Committee on Ways and Means and released to the press the Administration's plan. It called for Federal grants to the States to help finance a program of comprehensive medical benefits for the aged. In the States participating, the program would be open to all persons aged 65 and over who did not pay an income tax in the preceding year and to taxpayers aged 65 and over whose adjusted gross income, plus old-age and survivors insurance benefits and railroad retirement and veterans' pensions, in the preceding year did not exceed \$2,500 (\$3,800 for a couple).

The program in all participating States would provide that eligible persons could participate in the plan by paying an enrollment fee of \$24 a year (old-age assistance recipients would be covered without paying an enrollment fee). After they had incurred health and medical expenses of \$250 in a year (\$400 for a couple), the program would pay 80 percent (100 percent for old-age assistance recipients) of the cost of the following benefits in a 12-month period when the services were determined to be medically necessary: up to 180 days of hospital care, skilled nursing-home care, organized home-care services, surgical procedures, laboratory and X-ray services (up to \$200), physicians' services, dental services, prescribed drugs (up to \$350), private-duty nurses, and physical restoration services. For public assistance recipients, the initial \$250 would be paid by the assistance program.

In line with the principle enunciated by the Administration that opportunity for further development of private health insurance coverage of the aged should be maintained, the plan also provided that an eligible individual who so wished could elect to receive 50 percent, up to a maximum of \$60 a year, of the cost of a private major medical insurance policy in lieu of the specified program benefits. The States would be re-

sponsible for establishing minimum specifications for such policies.

The program would be administered by the States directly or through the use of appropriate private organizations as agents. Federal matching grants toward the government costs of the program would be 50 percent on the average, with a range from 33 $\frac{1}{3}$ percent to 66 $\frac{2}{3}$ percent, depending on the relative per capita income of the State.

On the assumption that all States would participate and that 75 percent of the 10 million persons not now receiving old-age assistance who would be eligible would enroll, the annual government cost of the program was estimated to be \$1.2 billion, and the Federal share \$600 million. Including the costs that would fall on the public assistance program (the first \$250 in a year for old-age assistance recipients), the total government cost under the proposal was estimated to be \$1.65 billion. This proposal would require new appropriations of \$688 million by the Federal Government and \$617 million from State and local revenues. Enrollment fees would amount to \$182 million a year.

The major arguments that were presented for and against this proposal are summarized below in the discussion of the Senate Finance Committee hearings.

The McNamara Bill

During the spring and early summer, a number of bills using the social insurance approach were introduced in both the House and the Senate. A few were identical with the Forand bill. Others were similar, but with variations in the scope of benefits, the groups covered, and other features. On May 6, Senator McNamara for himself and 18 other Democratic Senators introduced S. 3503, based in part on the hearings of his subcommittee.

The bill was designed to meet several of the criticisms that had been levied against the Forand bill. One criticism that had been made with increasing frequency was that 4 million of the 16 million persons aged 65 and over would be left out of any program limited to social insurance beneficiaries. The McNamara bill provided protection for this group (other than those entitled to railroad or Federal civil-service retirement

benefits), with the costs to be paid from general revenues. It also declared it to be the policy of Congress to take action as soon as possible to provide health benefits on a contributory basis for the almost 1 million railroad retirement and civil-service annuitants.

The McNamara bill restricted eligibility for health benefits to persons among those eligible for old-age and survivors insurance and the other entitled groups who met a special retirement test. It provided on an annual basis for hospital services up to 90 days, nursing-home services up to 180 days, and home health services up to 240 days but with an overall maximum of 90 units of service. One unit of service would be equal to 1 day of hospital service, 2 days of nursing-home benefits, and $2\frac{2}{3}$ days of home health services.² The bill also provided for diagnostic outpatient services and a benefit covering the cost of very expensive drugs to the extent specified by the Secretary of Health, Education, and Welfare through regulation, after consultation with an advisory council. It provided for a staggered introduction of benefits, with the hospital and diagnostic outpatient services to become effective not earlier than July 1, 1961, or later than January 1, 1962, and the remaining benefits to become effective in various 6-month periods, none ending later than July 1, 1963.

To finance these benefits, the bill provided for an increase in the scheduled old-age, survivors, and disability insurance tax rate of 0.25 percent each for employers and employees and 0.38 percent for self-employed persons beginning in 1961 and an additional increase of 0.13 percent and 0.19 percent beginning in 1972. In the first full year of operation, when all the benefits were in effect, the estimated cost of the benefits (excluding the drug benefits, for which, in the absence of precise specifications, estimates could not be made) was \$1.05 billion or 0.50 percent of taxable payroll for persons eligible for old-age and survivors insurance benefits and meeting the retirement test. It would be \$430 million for the group whose benefits would be paid for from general revenues. The long-range level premium cost for

those eligible for old-age and survivors insurance benefits was estimated at 0.89 percent of taxable payroll. (The estimated long-range level value of the increased contributions was 0.70 percent.)

ACTION OF WAYS AND MEANS COMMITTEE

In the Ways and Means Committee, discussion centered around the Forand bill and the Administration's proposal. The Committee rejected the Forand bill by a vote of 17 to 8. Several alternatives involving the social insurance approach but more limited benefits, eligibility at age 68 or age 72, the option of a cash payment in lieu of health benefits, and other proposals were considered and rejected. The Committee then began to work towards the development of a plan for medical assistance along lines similar to the existing public assistance programs, but with a less stringent test of need. According to the Chairman of the Committee a program of this kind would not be a permanent commitment for the future but would leave open the possibility of adopting either the Administration approach or the social insurance approach at a later time.

On June 13, 1960, the Ways and Means Committee reported out H. R. 12580, the Social Security Amendments of 1960. H. R. 12580 provided for a new title XVI of the Social Security Act, establishing a program of Federal grants to the States, effective July 1, 1961, to help pay the cost of medical services for aged persons who need assistance in meeting their medical expenses.

As under existing public assistance programs, each State would decide whether to participate and would determine the extent and character of its own program, including (within very broad limits) standards of eligibility and scope of benefits. Federal grants under this program could not be used for persons already receiving assistance under another federally aided public assistance program. However, a State's program under the new title could not be more liberal than its medical program under old-age assistance. The Committee indicated that the test of need for medical assistance would presumably be less stringent than that for cash assistance payments.

Federal matching grants were also conditioned on the availability under the State program of both institutional and noninstitutional services

² S. 3503 provided more limited benefits for aged persons not eligible for old-age, survivors, and disability insurance. This was changed, however, when the bill was reintroduced on June 24 as an amendment to H. R. 12580, to provide the benefits listed above for all persons covered by the bill.

and applied to any or all of the following listed services: up to 120 days a year of inpatient hospital services, skilled nursing-home services, physicians' services, outpatient hospital services, organized home-care services, private-duty nursing services, therapeutic services, major dental treatment, laboratory and X-ray services (up to \$200 a year), and prescribed drugs (up to \$200 a year).

The Federal share of the costs of medical assistance under title XVI was to be between 50 percent and 65 percent, depending on the per capita income of the State. H. R. 12580 also provided that States could get somewhat more favorable matching for vendor medical payments for old-age assistance recipients, effective October 1, 1960. Specifically, there would be an increase of 5 percentage points in the Federal share of additional expenditures up to an average of \$5 per recipient per month. The annual cost of medical services under title XVI after all States had had an opportunity to develop programs was estimated to be \$325 million, of which the Federal share would be \$165 million and the State share \$160 million. The cost of improved medical care for old-age assistance recipients was estimated to be \$10.6 million of Federal funds and \$5.4 million of State and local funds per year.

H. R. 12580 was considered in the House under a closed rule (preventing any amendments from the floor) and was passed, 381 to 23.

SENATE FINANCE COMMITTEE ACTION

The Senate Finance Committee held 2 days of public hearings on H. R. 12580 on June 29 and 30. In testifying for the Administration, the Secretary of Health, Education, and Welfare endorsed the proposed medical assistance title. He pointed out, however, that the new program would not help the aged make advance provisions for meeting the costs of illness. He reiterated the Administration's objections to use of the social insurance approach, stressing the danger of placing too heavy a load on the payroll tax. That tax, he thought, should be reserved for the cash benefits under old-age, survivors, and disability insurance. He recommended that the Federal share of any program to meet the medical care needs of the aged be financed through general revenues.

The Secretary also summarized the Adminis-

tration's proposal.³ In support of the plan he stressed the element of free choice for the individual as to whether or not to participate, the coverage of the catastrophic risks of long-term illness, the provision of a wide range of benefits without placing a premium on institutional care, the incentive for a judicious use of health services by requiring the individual to share in their costs, and the greater equity of financing the Federal share out of general revenues rather than from a payroll tax on annual earnings of \$4,800 or less. He pointed out that the test of eligibility was simple and would not subject the individual to a detailed examination of means.

The major objections raised in the Senate Finance Committee hearings to the Administration plan had to do with the reliance on State action; doubt as to the likelihood of either the States or the Federal Government raising the required amounts of money from general revenues or that many States could in fact or should be expected to raise the necessary sums; the complete determination of benefit specifications by the Federal Government in a program half of whose costs were to be financed by the States; the difficulties that many aged persons would face in paying the first \$250 of their medical expenses and 20 percent of the costs of additional expenses; the confusion and inequity that, it was argued, would result from the proposed income test; and the administrative costs and problems involved in getting such a program into operation.

Questions were also raised on the financing and State administration provisions of the Javits bill, and in addition objections were raised to the subsidy of commercial insurance companies thereunder without Federal regulations or standards on allowable profits and administrative costs. Neither the Javits bill nor the Administration plan was endorsed by any of the major groups who were opposing the Forand bill.

A resolution approved by the Governors' Conference, with 30 Governors in support and 13 opposed, was submitted to the Committee. The resolution urged Congress to adopt "a health insurance plan for persons 65 years of age and over to be financed principally through the contributory plan and framework of the old-age, survivors, and disability insurance system."

³ S. 3784, introduced by Senator Saltonstall on June 30, 1960.

Most of the witnesses who testified before the Senate Finance Committee endorsed the provisions of H. R. 12580 establishing a new program of medical assistance, whether or not they thought that the government should do more than this.

In executive session, the Senate Finance Committee made a number of changes in the medical care provisions of H. R. 12580, which it reported out on August 19, 1960. Instead of a new title for medically needy persons, it proposed amending title I of the Social Security Act, relating to Federal grants for old-age assistance. These amendments provided additional Federal matching for vendor medical payments to persons receiving old-age assistance and authorized Federal grants to the States for payment of part or all of the medical expenses of persons whose income and resources were above the assistance standard in a State but who needed help with their medical bills. These provisions, which were incorporated in Public Law 86-778, are described in detail below.

SENATE FLOOR DEBATE

On the floor of the Senate, three major amendments relating to medical care for the aged were debated. All accepted the medical assistance provisions of H. R. 12580 as reported out by the Senate Finance Committee but proposed to add other medical care programs.

Senator Javits, for himself and eight other Republican Senators, proposed an amendment that represented a combination of elements of his original bill and of the Administration's proposal. The amendment provided for Federal grants to the States to help pay for medical services for the aged. To qualify for these Federal matching grants, a State program would have to include the following provisions.

All persons aged 65 and over who did not pay an income tax or whose income including old-age and survivors insurance benefits, payments under the railroad retirement program, and veterans' pensions in the preceding year was \$3,000 (\$4,500 for couples) or less would be eligible to participate. Each State would establish a schedule of individual enrollment fees related to the participant's income, but the fee could not be less than 10 percent of the estimated full per capita cost of the medical benefits provided under the program.

States would be required to offer each participant a choice of enrolling in (1) a *diagnostic and short-term illness benefit plan* providing 21 days of hospitalization or equivalent skilled nursing-home services, 12 physician's visits in home or office, diagnostic laboratory and X-ray services costing up to \$100, and organized home health-care services for up to 24 days; or (2) a *long-term illness benefit plan* providing, after a deductible of \$250, 80 percent of the costs of 120 days of hospitalization and up to a year of skilled nursing-home services and organized home health-care services; or (3) an *optional private insurance benefit plan* providing 50 percent of the premium cost of a private health insurance policy, up to a maximum reimbursement of \$60 in a year. The Federal Government would also share in the cost of improved plans of the first two types up to a per capita cost of \$128 a year for the benefits. The average annual per capita cost (for the country as a whole) of the specified minimum plans was estimated to be \$90. A State wishing to provide more than the minimum benefits would have to make equivalent improvements both in the diagnostic and short-term illness benefit plan and in the long-term illness benefit plan. Federal sharing in costs would range among the States from 33⅓ percent (in the richest State) to 66⅔ percent (in the poorest State). State administrative expenses would be shared 50-50 by the Federal and State governments.

It was estimated that, if all States participated, some 11 million persons would be eligible to participate (about 1 million more than the number of nonrecipients of old-age assistance estimated to meet the somewhat more stringent income test under the original Administration proposal). On the assumption that 75 percent (8.25 million) of those eligible would participate, the annual government cost of the minimum benefits was estimated to be \$672 million, of which \$320 million would be Federal and \$351 million State and local cost. The annual cost of the maximum benefits in which the Federal Government would share was estimated to be \$950 million, and the Federal share would be \$463 million.

In a press conference several days following the introduction of the Javits amendment, Secretary Flemming indicated that, though he had not had an opportunity to discuss the proposal in full detail with the President, there was no question of its consistency with the basic principles favored

by the Administration. After several hours of debate on the floor of the Senate, the Javits amendment was defeated by a vote of 67 to 28.

The Senate then turned to consideration of the Anderson-Kennedy amendment, introduced by Senator Anderson and nine other Democratic Senators. This amendment proposed to add to the medical assistance provisions of H. R. 12580 a program of health benefits for persons eligible for old-age, survivors, and disability insurance benefits and aged 68 or over.

The benefits would include hospital services for up to 120 days in a year after the individual paid the first \$75 of hospital costs, up to 240 days of skilled nursing-home care on discharge from a hospital and for a condition associated with the period of hospitalization, home health services by a nonprofit or public agency for a maximum of 365 visits a year, and diagnostic outpatient hospital services, including X-ray and laboratory services. There was an overall ceiling on the first three benefits of 180 units of service in a year, with a unit of service equal to 1 day of inpatient hospital care, 2 days of skilled nursing-home care, and 3 home health visits.

Social security contribution rates would be increased beginning in 1961 by 0.25 percent each for employers and employees and 0.375 percent for self-employed persons, and the additional contributions credited to a separate account in the old-age and survivors insurance trust fund, from which all payments for medical services would be made. The level-premium or long-range cost of the plan was estimated to be 0.50 percent of taxable payroll and the cost in the first full year of operations 0.33 percent of taxable payroll or \$690 million.

The Anderson-Kennedy amendment was defeated by a vote of 51 to 44.

An amendment was introduced by Senator Long, of Louisiana, to modify the medical assistance provisions under title I of the Social Security Act to permit Federal matching of vendor payments to public mental and tuberculosis hospitals. It was estimated that this amendment would result in additional Federal grants of \$120 million a year in the first years of operation.

The amendment was opposed on the grounds that support of public mental and tuberculosis hospitals was an accepted responsibility of the States and that, if Federal funds were to be made available to the States to improve their hospital

programs, it should be done directly and not through the public assistance program. The supporters of the amendment cited the great need for additional funds for care of patients with mental illness or tuberculosis and argued that the public assistance program should not discriminate on the basis of type of illness. The amendment was adopted by a vote of 51 to 38.

CONFERENCE COMMITTEE ACTION

The Conference Committee appointed by the two Houses agreed to the medical care provisions in the Senate-passed bill, with one exception. Senator Long's amendment was dropped, but a provision that had been in the bill as approved by the House was reinstated, to provide that Federal matching grants could be used for medical care for a patient in a general hospital as the result of a diagnosis of tuberculosis or psychosis for 42 days (whether consecutive or not) after such diagnosis. Previously Federal financial participation was not available for assistance to anyone for whom a diagnosis of tuberculosis or psychosis had been made and who was in a medical institution as a result. The new provision was intended to encourage and help finance early rehabilitative treatment.

When the Conference Committee report came to the floor of the Senate, Senator Long argued against its adoption because of this and other differences from the bill as voted by the Senate. After extensive debate, the Conference report was adopted by a vote of 74 to 11. The House had adopted the report of the conferees by a vote of 368 to 17 several days earlier.

MEDICAL CARE PROVISIONS OF PUBLIC LAW 86-778

As adopted and signed by the President, Public Law 86-778 provides substantially liberalized Federal grants to the States to enable them to help pay for medical care for persons aged 65 and over who are unable to carry the cost themselves.

Under title I, as amended, Federal grants are available, effective October 1, 1960, to the States for the first time to enable them to furnish necessary medical assistance for aged persons of low

income not receiving old-age assistance for their maintenance needs. As of the same date, additional funds are made available to States to improve or to establish medical care programs in old-age assistance. The law also provides for the issuance by the Secretary of Health, Education, and Welfare of medical care guides and standards for public assistance and medical assistance for the aged and for reporting on the scope and content of the programs established by the States.

Medical Assistance for the Aged

Under this new program, States can receive Federal funds to help pay the costs of medical services for persons aged 65 and over who are not recipients of old-age assistance but whose income and resources are determined by the States to be insufficient to meet such costs. States may choose among a broad scope of medical services, but the services for which they pay the costs must include those of both an institutional and noninstitutional character.

The law specifies the scope of care and services that may be provided as follows: Inpatient hospital services; skilled nursing-home services; physicians' services; outpatient hospital or clinic services; home health-care services; private-duty nursing services; physical therapy and related services; dental services; laboratory and X-ray services; prescribed drugs, eyeglasses, dentures, and prosthetic devices; diagnostic, screening, and preventive services; and any other medical care or remedial care recognized under State law. However, as under the law before the 1960 amendments, there can be no Federal participation in payments with respect to medical services furnished an inmate in a nonmedical public institution or to a patient in a mental or tuberculosis institution. Persons with a diagnosis of tuberculosis or psychosis may be covered for 42 days of care in a general hospital.

To qualify for Federal matching grants, State plans for medical assistance must meet certain requirements already in the act and still applicable to old-age assistance as well as the new program—the requirements, for example, that the program be in effect in all political subdivisions, provide for financial participation by the State, and ensure proper and efficient administration. In addition, under a State plan for medical assist-

ance for the aged no enrollment fee or charge may be imposed as a condition of eligibility, and under regulations prescribed by the Secretary the State must furnish assistance to State residents absent from the State. Reasonable standards for determining eligibility and the extent of medical assistance are required. There must be a provision that no lien can be imposed during a recipient's lifetime on account of payments under the plan (except pursuant to a court judgment concerning incorrect payments) and that adjustment or recovery is permitted only after the death of the recipient and spouse. A State may not impose an age requirement higher than 65, and no resident of the State and no citizen of the United States may be excluded.

The Federal Government's share in the total amounts expended by the States for medical assistance for the aged under a Federal matching percentage will range from 50 percent to 80 percent, under a formula based primarily on per capita income. For Puerto Rico, the Virgin Islands, and Guam the percentage is set at 50 percent.

Medical Care in Old-Age Assistance

Under the amended title I, as formerly, there is no Federal requirement as to the scope of medical services that the States provide for old-age assistance recipients. It is expected, however, that many of the States now paying the costs of medical care for such recipients will extend their programs and that others will begin to pay for medical care by making direct payments to the suppliers.

An additional plan requirement for old-age assistance under title I is the same as one that applies to medical assistance for the aged—the State plan must include reasonable standards for determining the eligibility for and the extent of assistance. Federal matching in the cost of medical care for patients in a medical institution as the result of diagnosis of psychosis or tuberculosis for 42 days after such diagnosis is permitted for old-age assistance as well as for medical assistance. The law continues, however, to exclude from the matching provision money payments to such patients.

Before the amendments the maximum average monthly payment for old-age assistance in which

the Federal Government would participate was \$65. This amount included both money payments to the individual and vendor payments for his medical care. The Federal Government will continue as before to share in such expenditures for old-age assistance up to four-fifths of the first \$30 of the average monthly payment, with variable matching ranging from 50 percent to 65 percent in the remainder up to \$65 based on the relationship of the State's per capita income to the national per capita income.

For States with average monthly payments of more than \$65, the 1960 amendments provide for Federal participation in additional expenditures, except that such participation will be limited to the amount of the average vendor medical payments up to \$12 a month, or the amount by which the total average payment exceeds \$65, whichever is less, with the Federal share ranging from 50 percent to 80 percent based on per capita income. For States with average monthly payments of \$65 or less the Federal share in average vendor medical payments up to \$12 a month will be an additional 15 percent over the usual Federal percentage applicable to the amount of payments falling between \$30 and \$65. This percentage, when added to the usual Federal percentage for the second part of the formula for payments, will give a total Federal share of 65-80 percent. The additional Federal share of 15 percent will also be available to States with average monthly payments of more than \$65, when it is advantageous to them as an alternative to the method described above.

Comparable liberalizations of the formula for Federal participation in old-age assistance for Puerto Rico, the Virgin Islands, and Guam are included in the new law. In order to provide more adequate medical care for old-age assistance recipients, the dollar limitation on the amounts per year of Federal matching payments has been increased from \$400,000 to \$420,000 for Guam, from \$8,500,000 to \$9,000,000 for Puerto Rico, and from \$300,000 to \$315,000 for the Virgin Islands. These increases are earmarked for medical care payments in behalf of recipients of old-age assistance under title I. Medical care payments in behalf of individuals made under the new program of medical assistance for the aged under title I are not subject to the overall dollar limitation on the Federal payments to these jurisdictions.

Medical Guides and Reports

The 1960 amendments add a new section to title XI. The Secretary is directed to develop and keep current guides or recommended standards as to the level, content, and quality of medical care and services for the use of the States in evaluating and improving their public assistance programs and programs of medical assistance for the aged. The Secretary will also secure reports from the States on the scope and content of medical services under their programs and publish this information.

Estimated Costs

It was estimated during the congressional consideration of H. R. 12580 that, when all States had fairly well-developed programs, the new program of medical assistance might involve costs of about \$325 million a year—\$165 million in Federal funds and \$160 million in State and local funds. The first year's expenditures for medical assistance were estimated to be \$60 million in Federal funds and \$56 million in State and local funds.

The change in the Federal matching formula for vendor medical payments under old-age assistance makes additional Federal funds available to most States without any increase in their present expenditures for medical care. On the assumption that (1) States now spending less than \$12 a month for vendor medical payments would improve their programs as far as the additional Federal funds would permit up to that level and that (2) States with no medical care programs or very limited ones would develop plans with an average monthly cost of \$6 per recipient, it was estimated that the additional Federal grants for old-age assistance vendor medical payments in the first year would be \$142.2 million and the additional State and local expenditures \$3.9 million. These costs might increase within a few years to perhaps \$175 million in Federal funds and \$30 million in State and local funds.

Just how many persons will receive assistance under the new program is difficult to estimate. In one sense, almost all aged persons are potentially eligible for either old-age assistance or medical assistance. If all States adopted tests of need similar to the income test in the Administration plan (\$2,500 a year for an individual and \$3,800

for a couple), some 10 million persons aged 65 and over and not recipients of old-age assistance might be found in need of medical assistance.

If all States adopted fairly comprehensive programs, within a few years some 500,000-1,000,000 persons might actually receive medical assistance during a year because of substantial medical bills. This approximate number of recipients is assumed in arriving at the estimated cost of \$325 million a year when the program has been in operation for some years. All these figures could be larger in the future, as the number of persons aged 65 and over increases and if medical costs rise or all States come to have fully developed programs.

II. Other Provisions of the Social Security Amendments of 1960 and Related Legislation

BACKGROUND AND LEGISLATIVE HISTORY

Many parts of the Social Security Amendments of 1960 have their origins in actions taken by the Eighty-fifth Congress.

On June 28, 1958, the report of the House Ways and Means Committee on the Social Security Amendments of 1958 requested that the Department of Health, Education, and Welfare undertake three special studies—all relating to the old-age, survivors, and disability insurance program. The first was on the hospitalization of beneficiaries. The second was on the retirement test, with particular emphasis on situations in which individuals who had very large earnings during a single month of the year could receive benefits for other months. The third was a study to develop a practical method of including tips as wages for purposes of coverage.

The 1958 amendments (Public Law 85-840) provided for the establishment of two advisory councils, one on public assistance and one on child welfare services. Each was directed to and did file its report by January 1, 1960. The statutory language on medical care guides and reports, which was incorporated into the 1960 amendments as reported by the House and which finally

became law, was patterned on a recommendation of the Advisory Council on Public Assistance. Similarly the increase in the amount authorized to be appropriated for child welfare services and the new authorization for special research or demonstration projects in the field of child welfare services follow two of the recommendations that had been made by the Advisory Council on Child Welfare Services.

An Advisory Council on Social Security Financing, which had served during 1958 on the basis of a provision of the Social Security Amendments of 1956, made recommendations that, although modified before final enactment, formed the basis for the trust fund investment provisions contained in the 1960 amendments.

Some technical corrections in the 1958 bill, which were not made at the time the bill was passed, became the basis of a house joint resolution subsequently embodied in the 1960 amendments. On January 26, 1959, the Secretary of Health, Education, and Welfare transmitted the proposed joint resolution to the Chairman of the Committee on Ways and Means, with the request that these technical corrections be made. The proposal was subsequently introduced, as H. J. Res. 521, by Chairman Mills on September 8, 1959.

On March 13, 1959, the Committee on Ways and Means established a Subcommittee on Administration of the Social Security Laws under the chairmanship of Representative Harrison, of Virginia.

On April 2, 1959, the Department transmitted to the Committee on Ways and Means the report, *Hospitalization Insurance for OASDI Beneficiaries*.

On June 25, 1959, the Alaska Omnibus Bill, became Public Law 86-70. This law modified the public assistance and child welfare provisions of the Social Security Act so that Alaska would be treated on the same basis as other States with respect to these programs.

From July 13 to July 17, 1959, the Committee on Ways and Means held 5 days of hearings on H. R. 4700 (the Forand bill), a bill "to amend the Social Security Act and the Internal Revenue Code so as to provide insurance against the cost of hospital, nursing home, and surgical services for persons eligible for old-age and survivors insurance benefits, and for other purposes."

On August 26, 1959, the Secretary transmitted

to the President of the Senate and the Speaker of the House draft legislation to revise certain provisions of the Social Security Act relating to the management and investment of the Federal old-age and survivors insurance trust fund and the Federal disability insurance trust fund. The bill was based on recommendations made by the Advisory Council on Social Security Financing and modifications of some of these recommendations proposed by the Board of Trustees of the trust funds. This bill was subsequently introduced, as H. R. 9148, by Representative Simpson, of Pennsylvania, on September 8, 1959.

On September 16, 1959, Public Law 86-284 was enacted. The law, described in detail later in this article, modifies existing provisions governing the coverage of nonprofessional school employees under old-age, survivors, and disability insurance and makes additions to the list of States in which coverage is available to all or certain policemen and firemen on the same basis as other State and local employees under retirement systems.

During the period from November 4 to December 7, 1959, the Harrison subcommittee (the Subcommittee on Administration of Social Security Laws of the Committee on Ways and Means) held hearings on all aspects of the administration of disability insurance. Though this subcommittee did not have legislative jurisdiction, one result of the hearings was the introduction by Mr. Harrison on January 6, 1960, of H. R. 9323, a bill "to amend the provisions of Title II of the Social Security Act relating to disability freeze and disability insurance benefits so as to eliminate the age 50 requirement for such benefits, to eliminate waiting period for such benefits in certain cases, to provide a period of trial work for certain individuals receiving such benefits, and for other purposes." These three provisions, all of which were recommended in substantially the same form by the Administration, were embodied in the Social Security Amendments of 1960.

On March 14, 1960, the full Committee on Ways and Means began executive sessions, which continued almost daily for 13 weeks. During these sessions Secretary Flemming recommended, on behalf of the Administration, the extension of coverage under old-age, survivors, and disability insurance to doctors of medicine, to policemen and firemen in all States, to parents employed by adult children (except in work around the house), to the Territory of Guam, and, on a facilitated

basis, to the employees of nonprofit institutions.

The Secretary asked for the elimination of age 50 as a minimum age for receipt of disability insurance benefits, the elimination of a second waiting period for persons who had had an earlier period of disability within 5 years, and the establishment of a period of trial work for individuals who had attempted rehabilitation under other than a State-approved rehabilitation plan. (A similar provision for persons undergoing rehabilitation under a State-approved plan was already in the law.) He recommended that old-age, survivors, and disability insurance benefits for surviving children be raised to a uniform three-fourths of the primary insurance amount, subject, as before, to the family maximum, and that benefits be made payable to survivors, largely aged widows, of individuals who died fully insured before 1940.

On March 29 the Department transmitted its report, *The Retirement Test Under Old-Age, Survivors, and Disability Insurance*, and on April 5 the joint report of the Department of Health, Education, and Welfare and the Treasury Department on the question of covering tips under the old-age, survivors, and disability insurance program.

On May 4, Secretary Flemming described the Administration's proposals for medical care of the aged to the Committee.

On June 9, Chairman Mills introduced a bill, H. R. 12580, embodying the decisions made during the 3 months of executive sessions of the Ways and Means Committee. Identical bills were introduced by Representative Byrnes, of Wisconsin, and Representative Baker, of Tennessee. The bill was ordered reported the same day and was reported to the House on June 13. Its principal provisions were:

(1) Establishment of a new title of the Social Security Act, "Medical Services for the Aged," under which the Federal Government would make grants to States to assist them in providing medical care for low-income aged persons who are otherwise self-sufficient but who the States determine need help with medical expenses.

(2) Limited additional Federal matching for increased State old-age assistance expenditures for medical care.

(3) Elimination of the requirement of age 50 for disability insurance benefits and the other disability provisions described earlier.

(4) Liberalization of the insured-status requirements for old-age, survivors, and disability insurance so that a person would be fully insured if he has 1 quarter of coverage for every 4 (instead of 2) elapsed quarters.

(5) An increase in benefits payable under old-age, survivors, and disability insurance to the children of deceased workers so that, subject to the maximum on family benefits, each child would be eligible for three-fourths of the primary insurance amount.

(6) Most of the Department recommendations on old-age, survivors, and disability insurance coverage, investment of trust funds, and other matters.

(7) Increases in the amounts authorized to be appropriated for the various maternal and child health and child welfare programs and authorization for special research or demonstration projects in the field of child welfare.

(8) A number of amendments to the unemployment insurance program.

On June 22 the House of Representatives debated the bill under a closed rule and adopted it on the following day by vote of 381 to 23.

On June 23 the Senate Finance Committee, meeting in executive session, decided to hold 2 days of open hearings—June 29 and June 30. On the first day, Secretary Flemming appeared before the Committee and presented the Administration's health care proposals. These were embodied in a bill, S. 3784, which was introduced the next day by Senator Saltonstall.

On July 12, 1960, Public Law 86-624 was approved, conforming the laws applying to Hawaii with those applicable to the other States. The legislation includes changes in the public assistance and maternal and child health and child welfare provisions.

On August 10, the Finance Committee began executive sessions and on August 13 ordered H. R. 12580 reported to the Senate with the following changes:

(1) Most of the extension of old-age, survivors, and disability insurance coverage in the House bill was deleted.

(2) The insured-status liberalization to 1 out of 4 quarters was deleted.

(3) Most of the unemployment insurance provisions in the House bill were deleted.

(4) A reduction from 3 years to 1 year in the duration-of-relationship requirements for entitlement to benefits as wife, stepchild, or husband of a worker under old-age, survivors, and disability insurance was deleted.

(5) Certain modifications of the responsibilities of the Advisory Council on Financing, to be appointed in 1963, were deleted.

(6) The amount authorized to be appropriated for child welfare services was further increased.

The following additions were made:

(1) The exempt amount under the retirement test for

receipt of old-age and survivors insurance benefits was increased from \$1,200 to \$1,800.

(2) The retirement age for men under old-age and survivors insurance was lowered to 62, with benefits on a reduced basis.

(3) The present monthly exemption of \$50 in earned income under the program of aid to the blind was increased to an annual exemption of \$1,000 in earned income plus half any additional earnings.

(4) The Kerr-Frear amendment, which is essentially the same as the medical care provisions contained in the bill finally enacted, was adopted. This amendment provided for materially increasing Federal matching of expenditures for medical care under Federal-State old-age assistance programs and adopted essentially the House provisions for low-income aged persons not receiving public assistance. Instead of establishing these provisions as a new title of the Social Security Act, they were incorporated into title I.

The bill was reported in the Senate on August 19 and was debated on August 22 and 23. During the debate the Javits amendment, embodying a health care program for the aged to be financed from general revenue funds on a Federal-State basis, was defeated 67 to 28. The Anderson-Kennedy amendment that would have provided health insurance for old-age and survivors insurance beneficiaries under the old-age, survivors, and disability insurance system was defeated 51 to 44.

The following amendments were adopted:

(1) An amendment by Senator Long, permitting old-age assistance payments to aged persons in mental and tuberculosis institutions.

(2) An amendment by Senator Javits making eligible for old-age, survivors, and disability insurance benefits, under certain conditions, a child to whom the wage earner had stood "in loco parentis."

(3) An amendment by Senator Javits extending the unemployment insurance system to Puerto Rico.

(4) Other technical amendments affecting unemployment insurance.

(5) Three amendments (one by Senator Yarborough, one by Senator Engle, and the third by Senator Williams of New Jersey), which embody provisions to meet special situations related to the application of the State and local coverage provisions of old-age, survivors, and disability insurance in Texas, California, and New Jersey.

With these amendments the Senate passed the bill by a vote of 91 to 2 and requested a conference with the House.

The conferees met on August 24 and 25 and made the following significant changes:

(1) Most of the old-age, survivors, and disability insurance coverage provisions eliminated by the Senate Fi-

nance Committee were restored; however, coverage of physicians and of additional domestic and casual workers (both included in the House bill) were omitted from the final bill.

(2) The Senate provision increasing the exempt amount under the old-age and survivors insurance retirement test from \$1,200 to \$1,800 was eliminated and a test substituted under which \$1 in benefits would be withheld for each \$2 of earnings from \$1,200 to \$1,500 and for each \$1 of earnings above \$1,500. This test embodied a principle that had been described in the Department's report to the Ways and Means Committee.

(3) The Senate-approved provisions permitting payment under old-age and survivors insurance of actuarially reduced benefits to men beginning at age 62 were eliminated.

(4) The proposed insured-status requirement of 1 quarter of old-age, survivors, and disability insurance coverage for every 4 calendar quarters—approved by the House but deleted by the Senate—was replaced by a compromise requirement of 1 quarter of coverage for every 3.

(5) The Long amendment permitting payment of old-age assistance to aged patients in mental and tuberculosis hospitals was eliminated, but the House language permitting such payments in other medical institutions for up to 42 days, following a diagnosis of tuberculosis or psychosis, was restored. The amendment to pay benefits to children on the basis of an "in loco parentis" relationship was also eliminated. The provision relating to the duties of the Advisory Council on Financing, which had been deleted by the Senate, was reinstated, as was the provision relating to the duration-of-relationship requirements for a wife, husband, or stepchild.

On August 26 the House adopted the report of the conferees by a vote of 386 to 17. On August 29, after nearly 2 days of debate led by Senator Long, the Senate adopted the conference report by a vote of 74 to 11, thereby clearing the bill for the President.

On September 13, 1960, H. R. 12580 was signed by President Eisenhower and became Public Law 86-778.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

Improvements in Disability Provisions

Benefits for disabled workers under age 50.—Under the amendments, a disabled worker under age 50 and his dependents can qualify for monthly benefits, if they meet the other requirements. Previously, such benefits were payable only to disabled workers aged 50-64 and their dependents. The benefits are first payable for the month of November 1960, on the basis of applications filed in or after September 1960.

This amendment considerably strengthens the disability protection provided under old-age, survivors, and disability insurance. An estimated 125,000 disabled workers under age 50 and at least that many dependents can qualify immediately.

The age limitation of the old law was included as part of the conservative approach of the 1956 disability benefit provisions, which took into account the difficulty of predicting costs under the new program. The need of younger workers for protection in the event of disability was not seriously questioned. In 1959, the Department of Health, Education, and Welfare concluded from its experience in operating the disability insurance provisions that it would be feasible to extend the benefits to younger workers, and subsequently it recommended to Congress the elimination of the age requirement.

Trial-work period.—The amendments broaden the provision under which persons who return to work pursuant to a State-approved vocational rehabilitation plan could continue to draw benefits for as many as 12 months even though they engaged in substantial gainful activity. Under the new law, disability beneficiaries who work under any kind of rehabilitation plan or are rehabilitating themselves may perform services in each of 12 months, as long as they do not medically recover from their disability, before their benefits are terminated as a result of such services.

After 9 months of the trial period, however, the services a person has performed during the period or performs afterward will be considered in determining if he has demonstrated an ability to engage in substantial gainful activity. If he demonstrates such ability, 3 months later his benefits will be terminated. It is intended that any month in which a disabled person works for gain be counted as a month of trial work. Thus the services rendered in a month need not constitute substantial gainful activity for the month to be counted as part of a trial-work effort, but a month is not counted as part of the trial if no work is performed. No trial-work period may begin before the month in which a person becomes entitled to disability benefits or before October 1960, whichever occurs later.

The amendments also provide for the continuance of benefits for a short time after a disability ceases, whether or not the individual has tested

his ability to work. Beneficiaries who recover from their disabilities will have their benefits paid to them for the month in which their disability ceases and for the 2 succeeding months.

The Department recommended the trial-work provision as a means of relieving disabled people of anxiety concerning loss of benefits while they test their possible ability to work. Persons who are so severely disabled as to meet the statutory definition of disability need to recondition themselves to renewed work before they can carry a full workload or be certain that they can continue in gainful employment.

Modification of the waiting-period requirement.—For persons who again become disabled within 60 months of the termination of disability insurance benefits or an earlier period of disability, the amendments eliminate the requirement that the worker must be under a disability during a 6-month waiting period before qualifying for benefits.

This change had also been recommended by the Department as a means of removing a disincentive to the rehabilitation of disabled beneficiaries in doubt about their ability to work and therefore unwilling to risk termination of their disability benefits when there was the threat that they would be without benefits for 6 months after they once again became unable to work. Furthermore, persons who become disabled a second time after only a brief interval of work usually are in a less favorable position financially than when first disabled. A 6-month waiting period during which they have neither earnings nor benefits imposes needless hardship on them and their families. Restricting this change to persons who again become disabled within 5 years means that the group aided will be those for whom it is reasonable to assume that the second disability is related to the earlier disability and will be long lasting.

Benefits are payable under this provision for September 1960 and subsequent months, based on applications filed no earlier than March 1960.

Other changes in the disability provisions.—The amendments provide an alternative to the requirement that, to qualify for disability insurance benefits, the disabled worker must not only be fully insured but also must have at least 20 quarters of coverage in the 40-quarter period ending with the calendar quarter in which he meets

the definition of disability. The new alternative will affect only a few persons—those who worked long periods in employment or self-employment that is now covered by the program and had covered work in the period immediately preceding their disablement but who did not have 20 quarters of coverage within the 40 quarters preceding their disablement. The alternative requirement permits such individuals to become entitled to disability benefits if all the quarters after 1950 and before the quarter of disablement are quarters of coverage. They must have a total of 20 quarters of coverage and at least 6 quarters of coverage after 1950. The alternative is effective beginning October 1960 for applications filed in or after September 1960.

The amendments also liberalize the former provision under which a person had to be under a disability severe enough to meet the conditions of law when he filed application for disability insurance benefits or the disability freeze. Under the amendments a person who first meets the statutory requirement, generally speaking, within 3 months of filing (or 6 months in the case of a second disability) is deemed to have filed a valid application.

Changes In The Retirement Test

The amendments establish a new retirement test, effective for taxable years that begin after 1960. The former requirement that a month's benefit be withheld for each \$80 of earnings above \$1,200 is eliminated. Under the new test, if a beneficiary under age 72 earns more than \$1,200 in a year, \$1 in benefits will be withheld for each \$2 of earnings from \$1,200 to \$1,500 and for each \$1 of earnings above \$1,500. As under the previous test, regardless of the amount of annual earnings, no benefits will be withheld for any month in which the beneficiary neither earns wages of more than \$100 nor renders substantial services in self-employment. This new test follows the general approach developed and discussed by the Department in a report on the retirement test that was submitted to the Committee on Ways and Means of the House of Representatives in March of this year.

The new test reduces the deterrent to work that existed under the previous test. A beneficiary who wants to work can feel free to accept a job

at any earnings level above \$1,200, knowing that he will always have more in combined earnings and benefits than if he had limited his earnings to \$1,200 or less.

Generally speaking, under the previous test, no benefits could be paid to anyone who worked throughout the year and made more than \$2,080. Under the new test, some benefits can be paid to a single beneficiary getting the current maximum monthly benefit of \$120 if his earnings are less than \$2,790 in a year; a man and wife getting the current maximum monthly benefit of \$180 can get some benefits if his earnings are less than \$3,510.

Liberalization of the Requirements for Fully Insured Status

The amendments liberalize requirements for fully insured status so that, to be eligible for benefits, a person needs 1 quarter of coverage for every 3 calendar quarters (rather than 1 for every 2, as under the old law) elapsing after 1950 or the year of attainment of age 21 and before the year in which he reached retirement age, died, or became disabled (but not less than 6 or more than 40 quarters of coverage). Because the elapsed period used for determining the number of quarters required is now on the basis of full years, the number required will be the same in any given year regardless of when in that year the person dies or attains retirement age.

The number of additional persons—workers, dependents, and survivors—who will, as a result of the change, become eligible for monthly benefits beginning October 1960 is estimated to be about 400,000. By January 1, 1966, an estimated 1 million persons who could not qualify under the earlier provision will be eligible for monthly benefits.

Changes In Benefit Amounts

Increase in the benefits of children of deceased workers.—The amendments provide that the benefit payable to each child of a deceased worker shall be three-fourths of the worker's primary insurance amount (subject, of course, to the maximum limitation on the amount of family benefits payable on the worker's earnings record). Under

the old law the benefit payable to each such child was one-half the primary insurance amount plus one-fourth the primary insurance amount divided by the number of entitled children. If there were two surviving children, for example, even though one child went to work and got no benefits the other child still was not eligible for a benefit equal to three-fourths of the worker's primary insurance amount. Beginning with benefits for the month of December 1960, about 400,000 children will get some increase in benefits as a result of the change.

Improved method of computing the average monthly wage.—The amendments provide that the average monthly wage will now be computed on the basis of a constant number of years regardless of when the worker files application for benefits or for a benefit recomputation. The number will be five less than the number of years elapsing after 1950 (after 1936 when the use of pre-1951 earnings would raise the benefit amount) or attainment of age 21 if later, and up to the year in which the person becomes eligible for benefits, dies, or becomes disabled. The change makes the provision for computation of the average monthly wage simpler and easier to understand than it had been, and for future cases it eliminates the problem that occasionally arose under the old method when a person did not apply for benefits at the most advantageous time.

Changes In Eligibility Provisions

Benefits for survivors of certain people who died before 1951.—The amendments provide for payment of child's, widow's, mother's, and parent's insurance benefits to survivors of workers who had 6 quarters of coverage and died before 1940. Under the old law, monthly benefits were provided only for the survivors of workers who died after 1939.

The amendments provide also for the payment of benefits to the widower of a fully and currently insured woman who died before September 1950. Until now monthly benefits were provided only for the widowers of working women who died after August 1950. Provision is also made for the payment of mother's benefits to the former wife (divorced) of a man who died before September 1950 and who had at least 6 quarters of

coverage at the time he died. About 25,000 persons—most of them aged widows—have been made eligible for benefits by these changes.

Benefits in certain situations when a marriage is legally invalid.—Under the amendments, benefits are now payable to a person as the wife, husband, widow, or widower of a worker if (1) the person had gone through a marriage ceremony with the worker in good faith in the belief that it was valid, (2) the marriage would have been valid had there been no impediment, and (3) the couple had been living together at the time of the worker's death or at the time an application for benefits was filed. For the purposes of this provision, an impediment is defined as an impediment resulting from a previous marriage—its dissolution or lack of dissolution—or resulting from a defect in the procedure followed in connection with the marriage.

Benefits are also payable to a child of a person who had gone through a marriage ceremony with a worker even though an impediment prevented the ceremony from resulting in a valid marriage.

Reduction in the length of time needed to acquire the status of child, wife, or husband.—The amendments simplify the duration-of-relationship requirement by making the conditions that apply when the worker has died also applicable when the worker is alive. Wives, husbands, or stepchildren can qualify for benefits payable on a retired or disabled person's earnings if the relationship had existed for 1 year, rather than 3 years as previously required.

Benefits for a child based on his father's earnings record.—Under the amendments, benefits will be payable to a child on his father's earnings record even though the child is living with and being supported by his stepfather. Under the previous law a child was not deemed dependent upon his father, and therefore was not eligible for benefits on the father's earnings record, if the child was living with and being supported by his stepfather. In most States there is no obligation for a stepfather to support his stepchild. If a child has been denied benefits based on his father's earnings because of the support provided by his stepfather and the stepfather stops supporting him, the child could not get benefits based on the earnings of either. The change will

extend to the child living with his stepfather the protection now provided for other children, including children living with and being supported by other relatives.

Benefits for a child who is born to, becomes a stepchild of, or is adopted by a disabled worker.—Because of a defect in the 1958 amendments to the Social Security Act, benefits have not been payable to a child who is born to, becomes the stepchild of, or is adopted by a worker after the worker becomes disabled. The amendments provide for benefits to be paid to a child who is born or who becomes a worker's stepchild after the worker becomes entitled to disability insurance benefits. Provision is also made for the payment of benefits to a child who is adopted after the worker became disabled if he is adopted within 2 years after the worker becomes entitled to disability insurance benefits and if either (1) the adoption proceedings began in or before the month in which the worker's period of disability began, or (2) the child was living with the worker in the month in which the worker's period of disability began.

Because the amendment corrects a defect that arose as a result of the 1958 amendments, it is effective as though it had been enacted in the 1958 amendments and benefits may be paid retroactively to September 1958.

Changes in Coverage Provisions

Family employment.—Under the old law any services performed by a parent for his child have been excluded from coverage. This exclusion is changed to provide coverage for services performed after 1960 by parents in the employ of their adult children, if the services are those that are performed by the parent for his child in the course of a trade or business. Domestic services in or about the employer's home or other work not in the course of his trade or business continue to be excluded.

State and local government employees.—A number of new amendments are designed, in general, to facilitate coverage under the Social Security Act for employees of State and local governments. The most important is a provision, along lines recommended by the Department, that

permits coverage for groups of public employees brought under the program after 1959 to be made effective as early as the first day of the fifth year preceding the year in which the coverage is agreed to (but not before January 1, 1956). Under the old law, coverage for public employees brought under the program after 1959 could not begin earlier than the first day of the year in which the coverage was arranged.

In addition, the amendments place a time limitation on the period within which the Secretary may assess unpaid contributions based on State and local employment and on the period within which the Secretary must refund contributions that a State has erroneously paid. This provision is comparable to the statute of limitations of the Internal Revenue Code applying to non-government employment. A specific procedure was also provided for a State to use in seeking review in the United States district courts of determinations by the Secretary that result in the assessment of contributions or the denial of refund claims.

Another change permits a State to limit its liability for contributions in certain cases. It will be unnecessary for the State to pay employer contributions on more than \$4,800 when an individual is paid wages totaling more than \$4,800 in a year by two or more employing entities and when the State itself bears the cost of the employer contributions.

Several additional amendments, although applicable to all States, are designed to facilitate coverage in special situations and will affect relatively few people. Six amendments are each applicable to a single State (California, Maine, Mississippi, Nebraska, Texas, Virginia). One amendment makes the provision concerning divided retirement systems applicable to Texas, and another adds Virginia to the list of States that can cover policemen and firemen. The other amendments take care of special problems involved in the coverage of groups of employees in the other four States.

Minor changes in State and local coverage provisions were adopted by Congress during 1959. Public Law 86-284, signed September 16, 1959, reinstated until January 1, 1962, a 1956 provision under which nine States (Florida, Hawaii, Minnesota, Nevada, New Mexico, Oklahoma, Pennsylvania, Texas, and Washington) could provide coverage for nonprofessional school district em-

ployees without a referendum and as a group separate from professional employees. This law also permits coverage of policemen and firemen in positions under a retirement system in California, Kansas, North Dakota, and Vermont. The legislation also made special provision for covering certain policemen in Oklahoma.

Employees of foreign governments, instrumentalities of foreign governments, and international organizations.—Services performed within the United States by citizens of the United States in the employ of foreign governments or of international organizations entitled to privileges, exemptions, and immunities under the International Organizations Immunities Act are covered on a compulsory basis under the self-employment provisions.

The congressional committees recognized that it is generally undesirable to cover as self-employment the services of individuals who are actually employees. Since, however, a compulsory employer tax was not feasible and since some objections had been raised to allowing foreign governments to participate, even voluntarily, as employers in the United States social insurance program, the committees concluded that the only practical way to provide immediate coverage for these employees was to cover them as though they were self-employed persons. Only about 5,000 employees will be covered under this provision.

This coverage is effective for taxable years ending on or after December 31, 1960. For purposes of the retirement test, however, remuneration received by such individuals for taxable years beginning on or before September 13, 1960, is treated as wages in noncovered employment, but as net earnings in self-employment for taxable years beginning after that date.

Guam and American Samoa.—Coverage is extended to about 8,000 employees and self-employed persons in Guam and about 2,000 in American Samoa. Coverage will be effective for employees (except government employees) on January 1, 1961, and for self-employed persons for taxable years beginning after 1960. Coverage for employees of the Government of Guam will not become effective until the calendar quarter following the quarter in which the Governor of Guam certifies to the Secretary of the Treasury that the Guamanian Government has enacted legislation expressing its desire that old-age, survivors, and disability insurance be extended to these em-

ployees (in no event before January 1, 1961). A comparable effective date provision is included for employees of the Government of American Samoa. Filipino workers who come to Guam under contracts to work temporarily are excluded from coverage. Extension of coverage to Guam was recommended by the Department.

Ministers.—Legislation enacted in 1957 extended until April 15, 1959, the time within which ministers and Christian Science practitioners already in practice could file waiver certificates electing old-age, survivors, and disability insurance coverage. After that date only ministers who have not had net earnings from self-employment of \$400 or more, some part of which was from the exercise of the ministry, for as many as 2 taxable years after 1954 were still eligible to file certificates electing coverage.

The present amendments give an additional opportunity, generally until April 15, 1962, to those ministers and Christian Science practitioners who failed to file in time certificates electing coverage. In addition, the legislation permits the validation of coverage of certain clergymen who filed tax returns reporting self-employment earnings from the ministry for certain years after 1954 and before 1960 even though, through error, they had not filed waiver certificates effective for those years. These ministers, their representatives, or their survivors are given the opportunity until April 15, 1962, to file waiver certificates or supplemental certificates and make their coverage effective with the first taxable year for which they had filed such a tax return and for all succeeding years. The minister who elects such retroactive coverage must pay all taxes due for the intervening tax years by April 15, 1962.

Under another provision, ministers who have previously elected coverage effective beginning with 1957 may obtain coverage for 1956 by filing a supplemental certificate on or before April 15, 1962.

Employees of nonprofit organizations.—An amendment, which the Department recommended, eliminates the requirement that two-thirds of the employees of a nonprofit organization must consent to coverage before the organization can obtain coverage for concurring present employees and all future employees. The law retains the requirement that, in a nonprofit organization with

some employees in jobs covered by a public retirement system and some who are not, the employees must be divided into two coverage groups. The amendment also provides that certain erroneous reports of earnings by nonprofit organizations may be validated.

Employees of farm credit banks.—Another act, Public Law 86-168 (approved August 18, 1959), provides coverage for persons who first enter after December 31, 1959, the employ of Federal land banks, Federal intermediate credit banks, and banks for cooperatives. Persons who have been covered by the Federal civil-service retirement system while employed by such banks and who, after a break in service, are reemployed have an option to elect coverage under either that system or old-age, survivors, and disability insurance. Bank employees who were under the civil-service retirement system on January 1, 1960, are not covered by old-age, survivors, and disability insurance.

Financing

Investment of the trust funds.—The amendments provide for putting into effect certain recommendations made by the Advisory Council on Social Security Financing. Under these provisions the interest on future obligations issued exclusively to the trust funds is related to the average market yield of all marketable obligations of the United States that are not due or callable for 4 or more years from the time at which the special obligations are issued. Current actuarial cost estimates indicate that this change will, over the long range, provide additional income to the trust funds equivalent to 0.02 percent of payroll on a level-premium basis.

Under the old law, the interest on obligations issued exclusively to the trust funds is related to the average coupon rate on outstanding marketable obligations of the United States that are neither due nor callable until 5 years after the date of original issue. Thus the interest rate on new special obligations has been related to the coupon rate, established at some time in the past, rather than to the market yield prevailing at the time the special obligation is issued.

Advisory councils on social security financing.—The amendments provide that advisory coun-

cils on social security financing will be appointed in 1963, 1966, and every fifth year thereafter.

Under the previous law, an advisory council on social security financing was required to study and report on the status of the trust funds before each increase in the tax rates. When the law providing for advisory councils on financing was enacted in 1956, the tax increases were scheduled at 5-year intervals. The 1958 amendments accelerated the schedule of tax increases so that the tax rate is to be increased at 3-year intervals, with the next increase scheduled for 1963.

The first advisory council on financing, which made its report in January 1959, considered the present tax schedule and concluded that the 1963 tax increase should go into effect. Since the council issued its report there has been no significant change in the condition of the trust funds, nor is there any other reason to reexamine the need for the 1963 increase. It therefore was desirable to eliminate the requirement under previous law for a review of the status of the trust funds before the 1963 increase. On the other hand, it does seem desirable that the need for the increases scheduled for 1966 and 1969 be reviewed by advisory councils. Moreover, when the ultimate tax rate is reached there should continue to be periodic reviews of the financing of the program, and the amendments provide for additional councils to be appointed every 5 years after 1966.

The amendments also expand the function of the council to be appointed in 1963 so that, in addition to reviewing the status of the trust funds, it will review and report on the overall status of the old-age, survivors, and disability insurance program, including coverage, adequacy of benefits, and all other aspects.

Other Changes

The amendments made a number of changes of a technical nature. Some provisions for computing benefits that have served their purpose and generally are no longer used have been eliminated. The amendments changed the rule for crediting quarters of coverage on the basis of maximum creditable wages paid in years before 1951 to conform to the rule applied in the case of maximum creditable earnings in years after 1950. Other changes relate to the application of a penalty to the benefits paid to certain dependents of a per-

son who is employed outside the United States, the maximum benefits payable to certain families, the naming of the Secretary in legal actions, and deadlines that fall on nonwork days.

The amendments also simplify and expedite the payment of the lump-sum death payment when there is no surviving spouse who was living in the same household with the worker at the time of his death by permitting the benefit to be paid directly to the funeral home for unpaid expenses incurred through the funeral home. The payment will be made for any part of the expenses that have not been paid if the person who assumed responsibility for the expenses requests that the payment be made to the funeral home. If no one has assumed responsibility for the expenses within 90 days after the date of the worker's death, the benefit will be payable directly to the funeral home. When the expenses incurred through the funeral home have been paid in full (including payment through application of part of the lump sum), any of the lump sum that remains will be paid as a reimbursement to any person (or persons) who have paid burial expenses, in this order of priority—the funeral home expenses, the expense of opening and closing the grave, the expense of the cemetery lot, and other expenses.

PUBLIC ASSISTANCE

1960 Amendments to Social Security Act

The major impact of the amendments on public assistance—the establishment of a new program of medical assistance for the medically needy aged and the increase in Federal participation in medical payments made under the old-age assistance program—are described in part I of this article. There are, however, other changes made under the amendments and other laws passed by the Eighty-sixth Congress that make other changes in the public assistance laws.

Two of the amendments affect the program of aid to the blind under title X of the Social Security Act. Formerly the law required that a State disregard the first \$50 a month of earned income in determining need for aid to the blind. Under the new amendments, until June 30, 1962, a State may disregard either the first \$50 per month of earned income, as before, or the first \$85 per

month of earned income plus half the amount in excess of \$85. After that date a State must disregard the first \$85 per month of earned income plus half of earned income exceeding that amount.

The special legislation relating to the approval of certain State plans for aid to the blind was extended from June 30, 1961, to June 30, 1964. Only two States are affected by this legislation, which permits the approval of a State plan that does not meet title X requirements for the consideration of income and resources. Federal participation under these plans is, however, limited to expenditures that meet all requirements.

Other Legislation

Two other laws enacted by the Eighty-sixth Congress affect the public assistance provisions of the Social Security Act. Public Law 86-70, the Alaska Omnibus Act (approved June 25, 1959) and Public Law 86-624, the Hawaii Omnibus Act (approved July 12, 1960) enacted after the admission of the two new States to the Union, include provisions revising the method for computing the Federal grants to these States under titles I, IV, X, and XIV.

The 1958 amendments to the Social Security Act had set the Federal percentage to be used in the formula for computing the Federal share of public assistance expenditures for Alaska and Hawaii at 50 percent. Under these new laws, the Federal percentage for these States is to be determined, as for other States, on the basis of per capita income beginning July 1, 1960, for Hawaii and July 1, 1961, for Alaska.

MATERNAL AND CHILD HEALTH AND CHILD WELFARE

1960 Amendments to the Social Security Act

The Social Security Amendments of 1960 made several changes in the programs administered by the Children's Bureau. Other legislation enacted in 1959 and 1960 affected these programs significantly. The amounts authorized for annual appropriation were increased to \$25 million for each of the three programs under title V. The amounts formerly authorized were (1) \$21.5 mil-

lion for maternal and child health services, (2) \$20 million for crippled children's services, and (3) \$17 million for child welfare services.

The uniform amount in the apportionment to each State prescribed by the law was increased for each of the three programs from \$60,000 to \$70,000. For maternal and child health services and crippled children's services, as under the old law, the full amount of the uniform grant is to be apportioned each year, even though the appropriation may be less than the full amount authorized. The amount of the uniform grant for child welfare services continues to be based on the ratio between the amount appropriated for child welfare services and the amount authorized, except that under the new law it shall not be less than \$50,000.

The maternal and child health and crippled children's provisions are amended to provide that special project grants, up to 12½ percent of the total amount appropriated, may be made to State agencies (as is currently being done) and also directly to public or other nonprofit institutions of higher learning for special projects of regional or national significance that may contribute to the advancement of these programs. These grants may be made on such conditions as the Secretary of Health, Education, and Welfare finds necessary to carry out their purposes.

The provisions for maternal and child health and crippled children's services are also amended to make clear that the Secretary may make allotments "from time to time." He can thereby allot the funds at a time that will permit him to consider most effectively the financial need of each State.

A section was added to part 3 of title V that authorizes a new program and a separate appropriation for research or demonstration projects in the field of child welfare. Specifically, this section authorizes an appropriation for grants "to public or other nonprofit institutions of higher learning, and to public or other nonprofit agencies and organizations engaged in research or child welfare activities, for special research or demonstration projects in the field of child welfare which are of regional or national significance and for special projects for the demonstration of new methods or facilities which show promise of substantial contribution to the advancement of child welfare." Grants for these projects are to be made on such conditions as the Secretary finds

necessary to carry out the purposes of the grant.

As pointed out by the House Ways and Means Committee and the Senate Finance Committee, this new section permits implementation of a recommendation made by the Advisory Council on Child Welfare Services. The Council was established under a 1958 amendment to the act and submitted its report and recommendations to the Congress and the Secretary of Health, Education, and Welfare on December 28, 1959. One of its recommendations was that "Federal legislation provide for grants to research organizations, institutions of higher learning, and public and voluntary social agencies for demonstration and research projects in child welfare."

Other Legislation

Provisions in two new laws—the Alaska Omnibus Act (Public Law 86-70) and the Hawaii Omnibus Act (Public Law 86-264)—amend title V to enable Alaska and Hawaii to participate in the programs under that title on the same basis as other States.

Public Law 86-648 (approved July 14, 1960) extended to June 30, 1961, the provisions of Public Law 86-253 relating to the issuance of non-quota visas for certain alien orphans. This is the sixth time since 1948 that Congress has passed special, temporary legislation relating to these orphans.

The President had recommended in 1957 that the immigration laws provide for the annual admission of orphans adopted or to be adopted by American citizens. Later that year a law was enacted that provided temporary authorization (expiring June 30, 1959) for the issuance of special nonquota immigrant visas to certain eligible orphans under age 14 who were adopted by citizens abroad or who were coming to the United States to be adopted.

On May 18, 1959, the Secretary of Health, Education, and Welfare transmitted to Congress a legislative proposal to establish authority for the issuance of nonquota visas for these children on a permanent basis. This proposal also provided that assurances satisfactory to the Secretary would be given by the American citizen and spouse that the child would be well and properly cared for in a suitable home before he would be eligible for a nonquota visa. Secretary Flem-

ming stated that the effect of the proposal would be "to extend to children adopted abroad, whether by the adoptive parent in person or by proxy, safeguards similar to those which now exist in the law for children adopted after they have been brought to the United States."

Public Law 86-253 (approved September 9, 1959) continued the existing provisions on non-quota visas to June 30, 1960. It also gave the Attorney General authority to approve petitions relating to the granting of special nonquota visas, under the provisions of the law, to these alien children.

On September 7, 1959, the President approved H. J. Res. 317 to change the date of Child Health Day to the first Monday in October. The Department had transmitted a bill for this purpose on March 17, 1959, to carry out the President's recommendation made when he approved the House Joint Resolution designating May 1 as Loyalty Day.

Child Health Day had been observed on May 1 ever since 1928, in accordance with the act of May 28, 1928. Since 1956, by agreement between the United States and the United Nations, the Child Health Day Proclamation of the President has contained references to Universal Children's Day and the work of the United Nations and the United Nations Children's Fund. The new date will permit the United States to link its Child Health Day observance more closely to Universal Children's Day, which many nations observe on October 1.

The International Health Research Act of 1960 (Public Law 86-610, approved July 12, 1960) is of major significance for the programs of the Children's Bureau. This law grants new powers to the Secretary of Health, Education, and Welfare in carrying out his responsibilities under the basic act of 1912 that established the Bureau. Among these new powers are authorization for establishing and maintaining fellowships, for making grants for such fellowships, and for making grants for research in carrying out the purposes of the new law.

These purposes are (1) to advance the status of the health sciences in the United States and thereby the health of the American people through cooperative endeavor with other countries in health research and in research training; and (2) to advance the international status of the health sciences through cooperative enter-

prises in health research, research planning, and research training.

The legislative history of the law makes clear the intent of Congress that research relating to children should be an integral part of the program. The House Committee on Interstate and Foreign Commerce, in reporting on the legislation, stated:

The relationships between young children and mothers had long been recognized as fundamental to the development of stable, integrated personalities. This question can be most effectively investigated by viewing the relationship of children to mothers in different cultures. Investigations in a single culture do not provide the range of attitudes and practices that are necessary to show the consequences of different cultural patterns.

Finally, there is an array of medical problems relating to children which can be investigated most effectively through an international approach. For example, genetic effects upon the frequency of stillborn, neonatal, and infant deaths, and upon congenital malformations can be effectively studied only against a wide backdrop of investigations covering different nationalities and geographical areas. Indeed, it is almost imperative to study genetic, as well as cultural differences affecting disease and health because without such studies it is virtually impossible to disentangle the effects of heredity from those of environment. In short, a well-developed program of research relating to children in this country must encompass a well-developed set of studies involving children in other countries, and few such studies now exist.⁴

UNEMPLOYMENT INSURANCE

Title V of the Social Security Amendments of 1960 (referred to as the Employment Security Act of 1960) amends titles IX and XII of the Social Security Act and the Internal Revenue Code. It extends the coverage of unemployment insurance to certain minor groups, brings Puerto Rico into the Federal-State program, and makes some changes in the financing provisions, including those relating to the operations of the loan fund.

Coverage

The amendments extend coverage to an estimated 60,000–70,000 persons: (1) employees of certain instrumentalities of the United States that are neither wholly nor partially owned by the United States, such as Federal Reserve banks,

Federal credit unions, and Federal land banks; (2) employees serving on or in connection with American aircraft outside the United States; (3) employees of “feeder organizations,” all of whose profits are payable to a nonprofit organization, and employees of nonprofit organizations that are not exempt from income tax; and (4) various employees of certain tax-exempt organizations, including agricultural and horticultural organizations, voluntary employee beneficiary associations, and fraternal beneficiary societies (except persons earning less than \$50 a quarter and students). Coverage of the first group becomes effective January 1, 1961; the other three groups are covered beginning January 1962.

Puerto Rico, which since January 1, 1957, has had an independent unemployment insurance system, will be treated as a State for the purposes of the Federal-State system beginning January 1, 1961. Employers in Puerto Rico will be subject to the Federal unemployment tax, and Puerto Rico will be entitled to Federal grants to cover the administrative expenses of its unemployment insurance program. Benefits for Federal civilian employees and ex-servicemen in Puerto Rico will continue to be computed under the law of the District of Columbia until January 1, 1966, when they will be computed under Puerto Rican law.

Financing

Administrative expenses.—Effective January 1, 1961, the Federal unemployment tax rate becomes 3.1 percent of the first \$3,000 of an employee's covered wages instead of 3.0 percent. Instead of the present 0.3 percent of this tax, 0.4 percent will be earmarked for the Federal Government, to be used to pay the cost of administering Federal and State operations of the employment security program and to finance a loan fund, the “Federal unemployment account,” for making advances to States with depleted reserves. State tax credits are still to be computed, however, on the basis of a Federal tax rate of 3 percent. The increase in the tax rate was needed to meet rising administrative costs and to build up a larger fund for making advances to States whose unemployment reserves have been depleted because of heavy unemployment. (In the fiscal year 1958–59, the total cost of administration exceeded the proceeds of the tax for the first time, and

⁴ H. Rept. 1915, 86th Cong., 2d sess., pages 10–11.

though proceeds were greater than expenditures in 1959-60, the difference was relatively small. As of July 1960, the cash balance in the loan fund had fallen to \$3.8 million.)

Beginning with the fiscal year 1960-61, all receipts from the 0.4-percent tax will be credited to a new account—the “employment security administration account.” From this account will be paid administrative expenses, with an annual maximum of \$350 million allowed for State administrative expenses. (Actual expenditures during the fiscal year 1959-60 were \$325 million.) At the end of each fiscal year, receipts of the account in excess of administrative expenses will be transferred to the Federal unemployment account, with a view to building up and maintaining a maximum balance of \$550 million or 0.4 percent of taxable payrolls, whichever is greater, for use in making advances to States. The previous maximum for the account was fixed at \$200 million.

Any excess of receipts not required to maintain the \$550 million balance in the Federal unemployment account will be retained in the employment security administration account until that account shows a net balance of \$250 million at the close of a fiscal year. This balance is to be used to provide funds out of which administrative expenses may be paid before receipt of the bulk of Federal unemployment taxes in January and February of each year. Until the balance is built up to \$250 million, advances (to be repaid with interest) can be made from a revolving fund, which is to be financed by a continuing appropriation from the general fund of the Treasury. Any remaining excess in the employment security administration account (after repayment of Treasury advances) will be distributed to the accounts of the individual States in proportion to their respective covered payrolls, as provided under present law. Any share of surplus funds due a State that has an outstanding advance must first be used, however, to reduce this advance.

Advances from loan fund.—The law provides more stringent eligibility requirements for the States to meet in obtaining advances from the Federal unemployment account. Advances will be made only in amounts sufficient to pay unemployment benefits during the current or following month, after taking into account reserves on hand plus expected tax receipts. These requirements apply to advances made after September 13, 1960.

Under the old law, advances could be made to a State whose reserve account at the end of the quarter was less than the amount of benefits paid in the 4 preceding quarters, up to the largest amounts paid in any of the 4 quarters.

Provision is also made for speeding up the rate of repayment of advances to the States. The new law provides for a reduction of 0.3 percent a year in the employers' maximum tax credit against the Federal unemployment tax, starting with the second consecutive taxable year that the advance is outstanding. The old law provided for a reduction of 0.15 percent a year, starting with the fourth consecutive year.

Additional annual reductions in the employers' tax credit are provided for States with outstanding advances at the beginning of the third and fourth consecutive year, if the State's average contribution rate in the preceding year was less than 2.7 percent, and at the beginning of the fifth consecutive year if the State's average contribution rate in the preceding year was less than 2.7 percent or less than the State's 5-year benefit-cost rate, whichever is higher.

FEDERAL CREDIT UNIONS

Legislation signed by the President on September 22, 1959 (Public Law 86-354) completely rewrote the Federal Credit Union Act. The amendments, which were the most comprehensive in a quarter of a century, increase the scope of Federal credit union operations, placing greater powers and responsibilities on credit union officials and providing opportunities for added service to members.

Provisions increasing the maximum loan maturity from 3 years to 5 and the unsecured loan limit from \$400 to \$750 took effect with the passage of the amendments. Loans must be repaid or amortized in accordance with rules and regulations prescribed by the Director of the Bureau of Federal Credit Unions.

The board of directors of individual credit unions is given greater responsibility for internal audits. The supervisory committee, which formerly was elected by the members, must now be appointed by the board of directors for the terms of office specified in the bylaws—a change that places greater responsibility for internal control on the board.

Power is granted Federal credit unions to sell and cash checks and money orders to and for members for a fee. Rules and regulations necessary to enable credit unions to provide these services for their members were published in the *Federal Register* on October 16, 1959.

Other provisions were intended to modernize earlier legislation. Federal credit unions desiring to take advantage of these new provisions are required to amend their bylaws. They include the following:

- (1) Authority for the credit committee to appoint a loan officer empowered to approve certain loans previously requiring approval by the credit committee;
- (2) Authority to elect more than one vice president;
- (3) Authority for the board of directors to appoint an executive committee to act for the board in making investments and in approving membership applications. The board may also appoint a membership officer whose sole function is to approve applications for membership.
- (4) The board of directors given responsibility for declaring dividends rather than the members, as under the old act. The board of directors has been given added authority to declare semiannual or annual dividends. Another new provision permits a full month's dividend credit on shares paid up during the first 5 days of the month.

Another provision permits a credit union operating under a Federal charter to convert to opera-

tion under a State charter, and vice versa. In addition, the 1959 amendments permit Federal credit unions to amend their bylaws to liberalize restrictions on loans to credit union officials. Directors and committee members may now borrow up to the amount of their shareholdings plus any member's total unencumbered and unpledged shareholdings pledged as security for the loan. Still another provision, requiring no regulatory action by the Bureau or bylaw amendment by the Federal credit union, gives the board of directors the power to provide compensation for necessary clerical and auditing assistance required by the supervisory committee.

The 1960 amendments to the Social Security Act also affect the Federal credit unions. The amendments revise the Internal Revenue Code to extend unemployment insurance coverage to employees of certain Federal credit unions. Beginning January 1, 1962, any Federal credit union employing four or more persons in 20 weeks will be subject to the Federal Unemployment Tax Act. Credit unions will also be subject to the taxing provisions of State unemployment insurance laws. In addition, some Federal credit unions not subject to the Federal Unemployment Tax Act will be required to make contributions to State unemployment funds.