

Report of the Advisory Council on Social Security: The Status of the Social Security Program and Recommendations for Its Improvement

*On January 1, 1965, the Commissioner of Social Security in his capacity as Chairman of the Advisory Council on Social Security submitted the Council's report to the Board of Trustees of the Federal Old-Age, Survivors, and Disability Insurance Trust Funds. Because of the far-reaching implications of the report, it is carried verbatim in this issue of the Bulletin.**

Foreword

As required by law, this Advisory Council was appointed by the Secretary of Health, Education, and Welfare in 1963. It is the second Advisory Council appointed under the Social Security Amendments of 1956. The first was appointed in 1957 and made its report on January 1, 1959. Under the law other advisory councils are to be appointed in 1966 and every fifth year thereafter.

Like the preceding Council and the councils to be appointed in the future, the present Council is required to review the status of the Federal Old-Age and Survivors Insurance Trust Fund and of the Federal Disability Insurance Trust Fund in relation to the long-term commitments of the social security program and to make a report of its findings and recommendations, including recommendations for changes in the social security tax rates. In addition, however, the law gives the present Council a special mandate; it provides that the Council "shall, in addition to the other findings and recommendations it is required to make, include in its report its findings and recommendations with respect to extensions of the coverage of the old-age, survivors, and disability in-

surance program, the adequacy of benefits under the program, and all other aspects of the program."

This Council, although only the second in the series established by the 1956 amendments, is the sixth major advisory group to consider social security in a long tradition of seeking advice and guidance from expert opinion and from those affected by the program. The first of these advisory groups played an important role in shaping the recommendations of the Executive Branch that led to the creation of the social security program in 1935. Additional groups appointed in 1938 and 1948 made broad studies of social security, and their recommendations played an important part in shaping the present program. A group appointed in 1953 dealt with extensions of coverage, and the one appointed in 1957 dealt only with financing.

The Council has studied the social security program for the last year and a half. It held its first meeting on June 10 and 11, 1963, and met frequently throughout the rest of 1963 and during 1964. Between meetings the Council continued its analysis of the program through a study of extensive materials. In addition, a subcommittee of three members, with the aid of two insurance company actuaries and one from organized labor as well as the actuarial staff of the Social Security Administration, has conducted a technical review of the practices followed in preparing the actuarial estimates for the program and reported its findings to the Council.

The Commissioner of Social Security, acting *ex officio* as Chairman of the Council in accordance with the provisions of law establishing the Council, has been presiding officer at the Council's meetings, and in other ways has helped to forward the work of the Council. As a government official, however, he has not taken a position on the recommendations of this essentially nongovernmental group.

* Advisory Council on Social Security, *The Status of the Social Security Program and Recommendations for Its Improvement*, U.S. Government Printing Office, Washington, D.C., 1965. For the actuarial cost estimates for the Council's recommendations, see Appendix B of the Report (not carried here).

The Council wishes to express its appreciation of the assistance of the staff of the Social Security Administration. The technical competence of the staff has been invaluable to the Council in conducting its review of the program.

Membership of the Council

Robert M. Ball, Commissioner of Social Security, Chairman

J. Douglas Brown, Dean of the Faculty, Princeton University

Kenneth W. Clement, M.D., Practicing Physician and Immediate Past President, National Medical Association

Nelson H. Cruikshank, Director, Department of Social Security, American Federation of Labor and Congress of Industrial Organizations

James P. Dixon, M.D., President, Antioch College

Loula F. Dunn, Director, American Public Welfare Association, 1949-1964

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Reinhard A. Hohaus, Director, Metropolitan Life Insurance Company, and Fellow, Society of Actuaries

Arthur Larson, Director, Rule of Law Research Center, Duke University

Herman M. Somers, Professor of Politics and Public Affairs, Princeton University

John C. Virden, Chairman of the Board, Eaton Manufacturing Company

Leonard Woodcock, Vice President, United Automobile, Aerospace and Agricultural Implement Workers of America

Introduction

A generation ago the United States established a system of contributory social insurance providing protection against the loss of earnings due to retirement in old age. Under this system employees, together with their employers, and self-employed persons make contributions during their working years and receive a continuing income for themselves and their families when they no longer have income from work.

As enacted in 1935 this social security program was limited to the risk of retirement in old age, and it was limited in coverage to industrial and commercial employees. Today, the program covers practically all kinds of employment and self-employment, and provides benefits for the wives and children of retired workers as well as for the retired worker himself. It provides benefits, also, for survivors of deceased workers and for totally disabled workers and their dependents when the disability is expected to be of long-continued and indefinite duration. Over the years the program has been improved and broadened in other ways as well. From time to time benefits have been increased, and other adjustments have been made, to take account of social and economic change and to improve the protection provided.

For the vast majority of Americans this Federal program of social security gives assurance that old age, total disability or death will not mean the end of a regular family income. Some 20 million men, women and children—1 out of 10 Americans—are receiving social security benefits every month. During 1964 about 77 million earners paid social security contributions. Nine out of ten children and their mothers can look to the program for a regular income if the head of the family should die. Over 85 percent of the people past 65 are either getting benefits or will be entitled to benefits when they or their husbands retire. About 53 million workers have now worked long enough in covered employment so that they and their families have disability insurance protection.

The Council strongly endorses the social insurance approach as the best way to provide, in a way that applies to all, that family income will continue when earnings stop or are greatly reduced because of retirement, total disability or death. It is a method of *preventing* destitution and poverty rather than relieving those conditions after they occur. And it is a method that operates through the individual efforts of the worker and his employer, and thus is in total harmony with general economic incentives to work and save. It can be made practically universal in application, and it is designed so as to work in ongoing partnership with voluntary insurance, individual savings, and private pension plans.

Under the social security program the right to benefits grows out of work; the individual earns

protection as he earns his living, and, up to the maximum amount of earnings covered under the program, the more he earns the greater is his protection. Since, unlike relief or assistance, social security benefits are paid without regard to the beneficiary's savings and resources, people can and do build upon their basic social security protection and they are rewarded for their planning and thrift by a higher standard of living than the benefits alone can provide.

The fact that the program is contributory—that employees and self-employed workers make contributions in the form of earmarked social security taxes to help finance the benefits—protects the rights and dignity of the recipient and at the same time helps to guard the program against unwarranted liberalization. The covered worker can expect, because he has made social security contributions out of his earnings during his working lifetime, that social security benefits will be paid in the spirit of an earned right, without undue restrictions and in a manner which safeguards his freedom of action and his privacy. Moreover, the tie between benefits and contributions fosters responsibility in financial planning; the worker knows that improved benefits mean higher contributions. In social insurance the decision on how to finance improvements is always an integral part of the decision on whether they are to be made.

Because of these characteristics of social insurance the Council believes that where it can be properly applied it is much to be preferred to the method of public assistance, with its test of individual need, and the Council therefore strongly favors the improvement of social insurance as a way of reducing the need for assistance. The Council recognizes the need for an adequate public assistance program, but it believes that assistance should play the role of a secondary and supplemental program designed to meet special needs and circumstances which cannot be dealt with satisfactorily by other means.

No matter how well designed and administered, assistance has serious inherent disadvantages in terms of human dignity and incentives to work and save. People view receipt of assistance as meaning a loss of self-support. In contrast, they view social insurance as an extension of self-support. People who have led productive lives and have supported themselves through their own

efforts do not want to see their self-reliance end with their ability to work.

Moreover, applying for assistance is at best a negative experience. Eligibility for assistance depends upon the individual's asking the community for help and proving that he is without the resources and income to support himself and his family. On the other hand, under social insurance the individual proves, not that he lacks something, but that he has worked and contributed, and has thus earned a right to a benefit.

In all its considerations a primary concern of the Council has been the financial soundness of the program. Clearly, no change in the program should be made, and no present trend should be permitted to continue, if the result were to jeopardize financial soundness in any way. In the light of this primary concern, the Council has undertaken to assure that the financing will be sufficient to meet all benefit and administrative costs as they fall due.

The Council has also considered the economic impact of the program. In important respects the program supports consumer demand and helps to prevent deflation. Because of social security, 20 million retired people, disabled people, widows and orphans now have an assured regular income which, of course, continues undiminished even when other segments of consumer income decline. Moreover, the program operates automatically to compensate in part for the loss of income arising from the higher rate of retirement that occurs when the general level of employment declines.

The Council is concerned, however, about the deflationary effect of the present contribution schedule in the years just ahead. Under that schedule there would be a shift from an approximate balance of income and outgo in 1965 to an annual rate of trust fund accumulation of about \$4 billion beginning in 1968. The Council recommends a large reduction in the size of these accumulations.

The Council is concerned also that in both the short run and the long run, the economic impact should be reasonable and should be capable of being absorbed by the economy and by the employee, employer and the self-employed without undue burden or strain. For this reason the Council is recommending that needed increases in both the contribution rate and the contribution and benefit base be put into effect gradually so that

Summary of Major Findings and Recommendations

I. FINANCING THE PRESENT PROGRAM

The Council has examined the financing of the present program apart from any changes which it is recommending and has found as follows:

1. *The Status of the Program and Allocation of Contribution Income.*—The social security program as a whole is soundly financed, its funds are properly invested, and on the basis of actuarial estimates that the Council has reviewed and found sound and appropriate, provision has been made to meet all of the costs of the program both in the short run and over the long-range future. The contribution income should be reallocated between the two trust funds, however, so that the disability insurance part of the program, like the old-age and survivors insurance part of the program and the program as a whole, will be in close actuarial balance.

2. *Adjustment in the Contribution Rate Schedule in the Short Range.*—The contribution rates now scheduled in the law should be adjusted to avoid the rapid increase in trust fund assets that will otherwise begin with the rate increases scheduled for 1966 and 1968.

3. *The Contribution Rates in the Long Range.*—There should continue to be included in the law a schedule of contribution rates which, according to the intermediate-cost estimates, will be sufficient to support the program over the long-range future. However, decisions about putting future rate increases into effect, once the rates actually being charged are high enough to cover the long-range cost of the program as shown by a reasonable minimum estimate, should be guided largely by estimates of program costs over a 15- or 20-year period.

4. *The Contribution and Benefit Base.*—The maximum amount of annual earnings that is taxable and creditable toward benefits needs to be substantially increased in order to maintain the wage-related character of the benefits, to restore a broader financial base for the program and to apportion the cost of the system among low-paid and higher-paid workers in the most desirable way.

5. *The Contribution Rate for the Self-Employed.*—Increases in the social security contribution rate for the self-employed beyond the present rate should be put into effect gradually, and only to the extent that the ultimate rate will be no more than 1 percent of earnings greater than the rate paid by employees.

6. *Maintaining the Integrity of the Trust Funds.*—To maintain the integrity of the trust funds, the reimbursement of the trust funds for the cost of paying social security benefits based on military service for which no contributions were paid should begin without further delay and the Board of Trustees should be given specific responsibility for reviewing those administrative charges against the trust funds which are based on estimates rather than on actual costs.

II. HOSPITAL INSURANCE FOR OLDER PEOPLE AND THE DISABLED

The Council proposes hospital insurance protection for those 65 or over and for disabled social security beneficiaries as follows:

1. *Inpatient Hospital Benefits.*—The proposed hospital insurance for people age 65 or over and the disabled should cover a number of days sufficient to meet the cost of inpatient hospital services for the full stay of almost all beneficiaries.

2. *Outpatient Hospital Diagnostic Services.*—Payment under the program should be made for the costs of outpatient hospital diagnostic services furnished beneficiaries.

3. *Deductibles.*—Hospitalized beneficiaries should pay a deductible equal to the cost of one-half day of care—\$20 at the program's beginning. In the case of beneficiaries who are provided outpatient diagnostic services, this deductible amount should be applied for each 30-day period during which diagnostic services are provided.

4. *Services in Extended-Care Facilities.*—The cost of post-hospitalization extended-care services in facilities which provide high-quality rehabilitative and convalescent services should be covered so as to pay for a minimum number of days after hospitalization in all cases, with additional days of extended-care services being paid for if the patient has not used all of his inpatient hospital coverage.

5. *Organized Home Nursing Services.*—Insurance coverage should be provided for organized home nursing services.

6. *Payments on the Basis of Reasonable Cost.*—The extent of hospital insurance and related protection should be specified in terms of the services covered rather than in terms of fixed dollars, and covered services should be paid for on the basis of the full reasonable cost of the services.

7. *Hospital Staff Review of Utilization.*—Hospitals should be required, as a condition of participation, to establish professional staff committees to review the services utilized.

8. *Administration.*—The proposed hospital insurance provisions should be administered by the same Federal agencies which administer the social security program but in carrying out this responsibility the Federal Government should use private and State agencies to the extent that these agencies can contribute to efficient and effective operation.

9. *The Basis of Eligibility for Benefits.*—Hospital insurance benefits should be provided for aged and disabled beneficiaries of the social security program, and special provision should be made for the next few years for those who have not met the requirements of eligibility under the program.

10. *Financing.*—The proposed hospital insurance program should be financed by a special earmarked contribution of 0.4 percent of covered earnings from employees and from employers, and 0.5 percent from the self-employed, with an 0.15 percent contribution from Federal general revenues to cover the cost of benefits for those already retired or disabled.

III. IMPROVEMENTS IN THE CASH-BENEFIT PROVISIONS

The Council has examined all aspects of the present program of cash benefits and is recommending changes as follows:

Social Security Benefit Amounts

1. *The Period for Computing Benefits for Men.*—The period for computing benefits (and insured status) for men should be based, as is now the case for women, on the period up to the year of attainment of age 62, instead of age 65 as under present law, with the result that 3 additional years of low earnings would be dropped from the computation of retirement benefits for men.

2. *A General Increase in Benefits.*—A general increase in benefit amounts, accomplished by a change in the way the benefit formula is constructed, should be provided to take into account increases in wages and prices since the last general benefit increase in 1958, and the maximum on monthly family benefits should be related to earnings throughout the benefit range.

3. *The Maximum Lump-Sum Death Payment.*—The maximum lump-sum death payment should not be set in terms of an absolute dollar limit but rather should be the same as the highest family maximum monthly benefit.

Dependents' and Survivors' Benefits

4. *Children Over Age 18 Attending School.*—Benefits should be payable to a child until he reaches age 22, provided the child is attending school between ages 18 and 22.

5. *Disabled Widows.*—The disabled widow of an insured worker, if she became disabled before her husband's death or before her youngest child became 18, or within a limited period after either of these events, should be entitled to widow's benefits regardless of her age.

6. *Definition of Child.*—A child should be paid benefits based on his father's earnings without regard to whether he has the status of a child under State inheritance laws if the father was supporting the child or had a legal obligation to do so.

Disability Benefits

7. *Young Disabled Workers.*—Young workers who become disabled should have their eligibility for benefits determined on the basis of a test of substantial and recent employment that is appropriate for such workers.

8. *Rehabilitation of Disability Beneficiaries.*—The social security program should pay the costs of rehabilitation for disability beneficiaries likely to be

returned to gainful work through such help, with the rehabilitation services being provided through State vocational rehabilitation agencies.

Eligibility for Benefits

9. *Insured Status.*—The Council recommends retention of a requirement of covered work as a test of eligibility for benefits, and has no major changes to recommend in the present provisions.

10. *Retirement Test.*—The provision in the law that prevents the payment of benefits to a person with substantial earnings from current work—the retirement test—is essential in a program designed to replace lost work income and should be retained.

Extending the Coverage of the Program

11. *Doctors of Medicine.*—Self-employed doctors of medicine should be covered on the same basis as other self-employed people now covered, and interns should be covered on the same basis as other employees working for the same employer.

12. *Tips.*—Social security contributions should be paid on tips an employee receives from a customer of his employer, and tips should be counted toward benefits.

13. *Federal Employees.*—Social security credit should be provided for the Federal employment of workers whose Federal service was covered under the civil service retirement system but who are not protected under that system at the time they retire, become disabled, or die.

14. *State and Local Government Employees.*—The coverage of additional State and local government employees should be facilitated by making available to all States the option of covering only those present members of State and local government retirement system groups who wish to be covered, with coverage of all new members of the group being compulsory. Also, policemen and firemen in all States should be provided the same opportunity for coverage as other State and local government employees.

The tax rates needed to finance the changes recommended by the Council

[The contribution rates under present law are applicable to annual earnings up to \$4,800; the proposed contribution rates would apply to annual earnings of \$4,800 in 1965, \$6,000 in 1966 and 1967 and \$7,200 in 1968 and thereafter.]

Period	Employee and employer, each			Self-employed		
	OASDI		Hos- pital insur- ance ¹	OASDI		Hos- pital insur- ance ¹
	Present law	Pro- posed		Present law	Pro- posed	
1965.....	3.625	3.625	-----	5.4	5.4	-----
1966-67.....	4.125	4.3	0.4	6.2	5.8	0.5
1968-70.....	4.625	4.3	.4	6.9	5.8	.5
1971-75.....	4.625	4.7	.4	6.9	6.0	.5
1976 and after.....	4.625	5.3	.4	6.9	6.3	.5

¹ The financing of the proposed hospital insurance program would also include a level contribution of 0.15 percent of covered payroll from Federal general revenues for the next 50 years (not shown in the table).

there will not be large changes in the level of contributions at any one time.

The Council's major recommendation in the pages that follow is for the extension of the program so that workers (and their employers) and the self-employed will make contributions during their working years in order to have protection against the cost of hospital care and related services in old age or in the event of permanent and total disability. The Council believes that the time has come to apply the method of social insurance to this pressing problem in order to assure the continuing effectiveness of retirement protection. While social security cash payments, if adequate, can assure that the older person and his family, or the disabled person and his family, will be able to meet regularly recurring, budgetable costs of food, clothing and shelter, they cannot in practice be made sufficient to replace the need for insurance protection against the large and uncertain costs of hospital care. If our social insurance system is to be truly effective in preventing both dependency and the fear of dependency, the system must be broadened to include hospital insurance for the aged and the totally disabled. Otherwise more and more of these people will have to turn for help to public assistance—with all the disadvantages that this has for them and for society as a whole.

The Council is also concerned that the social security cash payments be made more adequate and, particularly, that the system take into account increases in prices and earnings levels that have occurred since the last time major revisions were made in the benefit provisions. One of the strengths of social insurance is its ability to adjust to changing economic conditions so that retired and disabled persons and survivors can share on a reasonable basis in the increasing productivity of our economy.

Other major recommendations of the Council relate to the way in which the social security program is financed, the maximum amount of annual earnings taxable and creditable toward benefits under the program (the contribution and benefit base) and the level of benefits and extensions of coverage.

The Council's recommendations, together with the considerations which prompted them, are presented in three parts. Part I presents the Council's findings with respect to the financing of the

social security program, assuming no changes in the benefit and coverage provisions. Part II presents recommendations for an extension of the program to help meet the cost of hospital care and related services for the aged and the totally disabled. Part III of the report presents the Council's recommendations for improving the cash-benefit provisions, extending the coverage of the program and financing the recommended changes.

PART I. Financing the Present Program

In this part of the report the Council presents the results of its study of the financial status of the existing social security program and of the principles underlying the legislative provisions for social security financing. The financial implications of the Council's recommendations for program improvements as set forth in parts II and III of the report are presented in conjunction with those recommendations.

The financing provisions of present law are as follows: Employees pay contributions on their annual earnings up to a maximum of \$4,800. Each employer pays at the same rate as the employee on the first \$4,800 paid to each of his employees in the year. The self-employed pay at a rate approximately equal to $1\frac{1}{2}$ times the rate paid by employees. Contribution rates are scheduled to increase from an employer and employee rate of $3\frac{5}{8}$ percent each in 1965 to $4\frac{1}{8}$ percent each in 1966 and to an ultimate rate of $4\frac{5}{8}$ percent each in 1968. The contribution rates now scheduled are intended to provide enough income to meet all of the costs of the system, including administration, into the indefinite future.

Funds not needed for immediate benefit payments are invested in obligations of the United States Government and the interest earnings on these obligations are available to help pay the cost of the system. The scheduled contribution rates include an allocation to the separate disability insurance trust fund of one-half of one percent from the combined employer and employee contribution (three-eighths of one percent for the self-employed).

1. The Status of the Program and Allocation of Contributed Income

The social security program as a whole is soundly financed, its funds are properly invested, and on the basis of actuarial estimates that the Council has reviewed and found sound and appropriate, provision has been made to meet all of the costs of the program both in the short run and over the long-range future. The contribution income should be reallocated between the two trust funds, however, so that the disability insurance part of the program, like the old-age and survivors insurance part of the program and the program as a whole, will be in close actuarial balance.

As indicated in the latest Trustees' Report, the social security program as a whole is in actuarial balance both over the short run and for the long-range future. The review of the actuarial estimates conducted by the Council supported this conclusion of the Trustees. In the Council's opinion, based on actuarial estimates that the Council has reviewed and found sound and appropriate, the contribution rates in present law will supply income which, together with interest earnings on the funds, will be sufficient to meet all benefit costs and administrative expenses as they fall due.

While the old-age and survivors insurance part of the program and the program as a whole are in close actuarial balance, the disability insurance part of the program (which involves only a small proportion of the total cost of the system), when looked at separately, is underfinanced. It was recognized at the time of the last major disability amendments in 1960 that the income to the disability fund was likely to be about 0.06 percent of covered payroll short of what was needed for the long run. Experience since that time has indicated that disability benefit termination rates due to death and recovery of the beneficiary are lower than had been assumed in the earlier estimates, so that the expected deficit is now about 0.14 percent of covered payroll. To correct this situation, the Council endorses the recommendation of the Board of Trustees that there be a small reallocation of contribution income—the Council would favor 0.15 percent of covered payroll for present law—from the old-age and survivors insurance trust fund to the disability insurance trust fund.¹ This could be done without any increase in the over-all contribution rates now scheduled for the program and would put the disability insurance part of the program in close actuarial balance, while also leaving the old-age and survivors insurance part and the program as a whole in close balance.

In arriving at the conclusion that the system as a whole is in actuarial balance, the Council examined not only the results of the estimates but also the techniques used and the assumptions on which the estimates are based. It found that the techniques used in preparing the estimates of the cost of the program are in accordance

¹ Under the Council's recommendations discussed in Part III, the reallocation should be 0.25 percent of covered payroll rather than 0.15 percent.

with sound actuarial practice and that the assumptions on which these estimates are based are appropriate. The estimates take full and proper account of the various economic and demographic factors affecting the future cost of the program.² The Council favors the continuance of present practice under which estimating techniques and the assumptions underlying the estimates and the contribution schedule are re-examined and adjusted in the light of developing experience.

The Council believes that it is proper for a national system of compulsory social insurance to use what is known as an "open-group" technique in preparing actuarial cost estimates—that is, to take into account not only present assets, future benefits for present beneficiaries, and future contributions and benefits with respect to workers now covered, but also the contributions and benefits to be paid with respect to workers to be covered in the future as well. The Council is in agreement with the previous groups that have studied the financing of the program that it is unnecessary and would be unwise to keep on hand a huge accumulation of funds sufficient, without regard to income from new entrants, to pay all future benefits to past and present contributors. A compulsory social insurance program is correctly considered soundly financed if, on the basis of actuarial estimates, current assets plus future income are expected to be sufficient to cover all the obligations of the program; the present system meets this test. The claim sometimes made that the system is financially unsound, with an unfunded liability of some \$300 billion, grows out of a false analogy with private insurance, which because of its voluntary character cannot count on income from new entrants to meet a part of the future obligations for the present covered group.

It is important to note that the long-range cost estimates prepared for the program are based on the assumption that earnings will remain at a given level (at the 1963 level under the estimates shown in this report). If average earnings continue to rise in the future, as there is reason to expect they will, then, assuming no change in other cost factors, the income of the program relative to outgo will be considerably higher than the estimates show.³ The Council believes that making the estimates on a level-wage assumption allows for a desirable margin of safety and recommends that the practice be continued in making the long-range estimates. If the assumptions which underlie the intermediate or

² Since over the long-range future the cost of the program will be affected by many factors that do not lend themselves to precise measurement, assumptions regarding them may differ widely and yet be reasonable. For this reason, high-cost and low-cost assumptions are made for the various factors affecting the long-range cost of the program. Intermediate-cost estimates are then derived by averaging the high-cost estimates and the low-cost estimates. The Council believes that these intermediate-cost estimates provide a reasonable basis for gauging the long-range cost implications of present benefit provisions and proposals for changes.

³ The reason for this effect of rising earnings is that benefits based on low earnings are a higher percentage of the worker's average monthly wage than are benefits based on higher earnings, and therefore, as earnings go up, benefits as a percentage of earnings go down. Contributions, on the other hand, are the same percentage of covered earnings at all levels. As earnings go up, then, the benefit outgo as a percentage of covered earnings decreases while the contribution income as a percentage of covered earnings stays the same.

low-cost estimates are borne out by experience, then the use of level wages allows for benefit increases if wages rise without any increase in the contribution rates. If experience comes close to the high-cost assumptions, then the use of the level-wage assumption will result, if wages rise, in an offset to the cost consequences of the unfavorable experience and still allow for some upward adjustment in benefits without any increase in the contribution rates.

The Council suggests only one significant change in the assumptions underlying the long-range estimates. In the past an attempt has been made to present cost estimates into perpetuity. Specifically, it has been assumed for purposes of the estimates that trends for the factors affecting the cost of the program will level off at some point in the distant future (about 85 to 90 years) and continue at that level indefinitely. The Council believes that it serves no useful purpose to present estimates as if they had validity in perpetuity. A period of 75 years would span the lifetime of virtually all covered persons living on the valuation date and is as long a period as can be expected to have a realistic basis for estimating purposes. When costs are reassessed at frequent intervals, as has always been the practice, 75-year projections allow sufficient time to adjust to new and changing experience as it emerges. The long-range cost estimates shown in this report, therefore, are developed for a period of 75 years and it is our recommendation that long-range estimates in the future also be made on this assumption. The effect of this changed procedure is to make the estimated level-cost of the present program about 3 percent lower (about 0.25 percent of payroll) than when using the earlier procedure. At the same time the Council believes that the financing should be such that the actuarial status of the program will be reasonably close to an exact balance according to the intermediate-cost estimates.⁴

The Council has also examined the practices followed with respect to investment of the funds of the program. From the inception of the program in 1937, the investment of trust fund assets has been restricted by law to interest-bearing obligations of the United States or obligations guaranteed as to principal and interest by the United States. The investments can be either in special obligations issued exclusively for purchase by the trust funds or in publicly available obligations of the Federal Government. Under the present provisions of the Social Security Act relating to the investments of the trust funds, the special obligations issued exclusively to the trust funds bear interest rates equal to the average market yield at the end of the preceding month on all interest-bearing marketable obligations of the United States not due or callable for 4 or more years after that date. This market-yield formula, based on the recommendations of the Advisory Council on Social Security Financing appointed in 1957, has served as a model for determining interest rates on special obligations issued to certain other Federal trust funds. This Council believes that the present procedures for investing the trust funds

⁴Traditionally the social security program has been considered in actuarial balance when, on the basis of the long-range intermediate-cost estimates projected into perpetuity, the actuarial insufficiency was not greater than 0.30 percent of payroll for the program as a whole. The Council believes that a closer balance would be desirable when the long-range cost estimates are projected over a 75-year period.

and for setting the interest rates on the special obligations are satisfactory.

2. Adjustment in the Contribution Rate Schedule in the Short Range

The contribution rates now scheduled in the law should be adjusted to avoid the rapid increase in trust fund assets that will otherwise begin with the rate increases scheduled for 1966 and 1968.

The 1956 legislation establishing the social security advisory councils scheduled them so that each would make its report 1 year before the date when an increase in the social security contribution rates was due to go into effect, and one of the primary duties of the councils, as specified in the law, is to make recommendations with respect to the social security contribution schedule. Thus the Council recognizes a special obligation, without regard to other changes it is recommending, to report its findings and make recommendations regarding the social security contribution rates designed to support the existing program.

The benefit outgo of the program will increase for many years, mainly because of the increasing number of people eligible for benefits at age 62 or over. This increasing cost is to be met under the present law by raising the rates to 4½ percent each for employees and employers and to 6.2 percent for the self-employed in 1966, and finally to 4¾ percent each for employees and employers and 6.9 percent for the self-employed in 1968. The questions to which the Council is here addressing itself is whether changes should be made in these scheduled rate increases.

On the basis of the actuarial cost estimates the Council has examined, it is clear that some increase in income to the program over what the 3¾ percent tax rate now in effect would produce will be needed in 1966. The Council finds, however, that the increase to 4½ percent each for employers and employees now scheduled for 1966 and 1967 is higher than it believes is desirable for several years.

The Council is recommending an increase in the contribution and benefit base in order to maintain the wage-related character of the benefits, to restore a broader financial base for the program, and to apportion the cost of the program appropriately between high-paid and low-paid workers. If the increase in the base is adopted in accordance with the Council's recommendation, the increase needed in 1966 in the income of the program will be provided thereby. If the base is not increased, and if all other provisions remain unchanged, the Council would propose the contribution rate be increased in 1966 to 3.9 percent. This rate would produce a slight excess of income over outgo for about 2 years. In the Council's opinion it is highly desirable that the income to the funds exceed outgo year by year. As has been evidenced in several recent years, if this is not the situation, there is danger of public misunderstanding of the financial condition of the program. On the other hand, as nearly as can now be determined, it would seem to be desirable from the standpoint of the general economy to avoid the deflationary effect of large trust fund accumulations.

In the absence of any other changes in the law the Council would also propose revisions in the rates scheduled for 1968 and later years. The imposition of the 4½ percent rate as scheduled in 1968 would build very large trust fund accumulations—as much as \$4 billion a year—and would also involve the possibility of imposing rates higher than will ever be needed to pay for the benefits provided under present law. The rate of 4½ percent in 1968 is designed to meet long-range costs falling about halfway between the high- and low-cost estimates. If the actual experience is close to the low-cost estimates, for example, a contribution rate of 4½ percent in 1968, rather than 4½ percent, would cover the cost of the present program for 75 years.

This Council agrees with the last Advisory Council in the view that once the social security contribution rates actually in effect are high enough to cover the long-range cost of the program as shown by a reasonable minimum estimate, then decisions on whether scheduled rate increases are allowed to go into effect should be guided largely by conditions expected in the 15- or 20-year period immediately ahead. The Council recommends that if the present program continues unchanged in other respects the proposed 3.9 percent rate for 1966 be continued through 1968 and the rate scheduled for 1969–1971 be 4.1 percent of payroll. This figure is close to the 75-year level cost of the program under the low-cost estimates. The recommendations for rates to be included in the law for years after 1971—but to be allowed to go into effect only if developing conditions indicate that they will be necessary—are given [in the adjoining column].

The Council believes that reducing the scheduled rates as suggested for the 6 years after 1965 would not threaten the financial soundness of the program. Since continuing income from social security contributions is assured, the only fund balances required are those needed to meet temporary excesses of outgo over income due to relatively high benefit costs or low social security tax revenue in a particular period. In the opinion of the Council, fund balances high enough to maintain the solvency of the program in the face of recession conditions as severe as, say, those referred to in the annual report of the Board of Trustees—that is, conditions that would prevail if there were a drop of 5 million in the number of people with covered earnings in a year—would be adequate to provide protection against any contingency that might reasonably be expected, and the trust fund balances resulting from the Council's recommended rate schedule would be sufficient to do this.⁵

Holding the trust funds to reasonable contingency levels, instead of allowing them to increase as they would under the present tax schedule, will of course mean a loss of interest income to the program. However, despite the very substantial funds that would be built up under the present schedule, the interest earned on these funds is expected to supply only about 10 to 15 percent of the income of the program over the long-range future. Thus the role of the trust funds as interest-earning reserves is not very great even under the present schedule; the funds are even now to be thought of largely as a reserve to meet

unexpected contingencies rather than as funds for the purpose of earning interest. Moreover, if the system is improved as earnings levels rise in the future, as seems likely to be the case, interest earnings on a fund of any given size will meet a decreasing proportion of benefit costs. It may therefore prove to be unwise to count on interest earnings meeting even as large a part of benefit costs in the distant future as is now contemplated.

The Council does not consider the use of interest in the financing of the program to be a major issue. A reasonable contingency fund will result in interest earnings which will supply 4 to 5 percent of benefit costs. Even under the present contribution schedule interest earnings may not exceed 10 percent of costs. The Council believes that, on balance, any advantage of imposing rates that will build up large interest-earning trust funds is outweighed by the disadvantages.

3. The Contribution Rates in the Long Range

There should continue to be included in the law a schedule of contribution rates which, according to the intermediate-cost estimates, will be sufficient to support the program over the long-range future. However, decisions about putting future rate increases into effect, once the rates actually being charged are high enough to cover the long-range cost of the program as shown by a reasonable minimum estimate, should be guided largely by estimates of program costs over a 15- or 20-year period.

Like the last Advisory Council, the present Council endorses the practice of including in the law a contribution schedule that, according to the intermediate-cost estimates, places the system in actuarial balance over the long-range future. As that Council pointed out, this procedure is needed to make people conscious of the long-range costs of the program and the costs of proposals to change the program. Accordingly, this Council is recommending that for the *present* program, if the contribution rates it recommends for 1966 and 1969 are put into effect (bringing the rates about to the level needed for the next 75 years under the low-cost estimates), further contribution rate increases nevertheless should be scheduled in the law for 1972 and 1975. The 1972 rate should reflect the estimated cost for the next 3 years on the basis of the long-range intermediate-cost estimate, while the 1975 rate should represent the level-cost for the succeeding 65 years. The employee (and employer) rate for 1972–74 should be 4.3 percent. A rate of 4.7 percent effective in 1975 would be sufficient to finance the present program under the intermediate-cost estimate throughout the period covered by the estimate.

While the Council believes that the rates for 1972 and 1975 should be scheduled in the law in order to assure public appreciation of the approximate long-range cost of the program, decisions on whether these rates should be put into effect as scheduled, since they are higher than would be needed if the low-cost estimates are borne out by experience, should be made in the light of circum-

⁵ The Trustees follow a practice of including in their annual report an illustration of the effect that a sharp reduction in the level of economic activity and an increase in the rate of unemployment would have on the operations of the program. In the opinion of the Council this is a desirable practice and should be continued.

stances prevailing just before the proposed effective dates. These decisions should be made largely in the light of conditions that are expected to exist over the 15 or 20 years following the proposed effective dates.

If there are no other changes in the program, and if the contribution and benefit base is not increased, the Council would recommend that the 4.125 percent rate scheduled for employees and employers in 1966 be reduced to 3.9 percent, that the rate be held at this level through 1968, and that the rate for 1969 be set at 4.1 percent. Rates of 4.3 percent in 1972 and 4.7 percent in 1975 should be scheduled in the law, subject to future review. If the Council's recommendations for improvements in the program are adopted, the rates would of course need to be higher than those shown here; the cost of the changes and the recommended rates for the cash-benefit program as it would be improved are shown on pages 37 and 38. The financing of hospital insurance is discussed on pages 22-24.

4. The Contribution and Benefit Base

The maximum amount of annual earnings that is taxable and creditable toward benefits needs to be substantially increased in order to maintain the wage-related character of the benefits, to restore a broader financial base for the program and to apportion the cost of the system among low-paid and higher-paid workers in the most desirable way.

The Council recommends that the maximum amount of annual earnings that is taxable and creditable toward benefits—the contribution and benefit base—be increased to at least \$6,000 effective in 1966 and \$7,200 effective in 1968. These increases are needed in order to maintain the wage-related character of the benefits, to restore a broader financial base for the program, thus keeping the contribution rates lower than they would otherwise have to be, and to apportion the cost of the system appropriately.

As is discussed in Part III, failure to keep the contribution and benefit base up to date has serious effects on the benefit protection provided as more and more workers have earnings above the base and their benefits are related to a smaller and smaller part of their earnings. In addition, unless the contribution and benefit base is increased as earnings rise, the foundation of the financing of the program—the proportion of the Nation's payrolls which is subject to social security contributions—is weakened.

Moreover, if benefits were raised without increasing the contribution and benefit base, the increases in the contribution rates would have to be higher than they would have to be if the base were raised, and lower-paid workers as well as those earning at or above the maximum would have to pay these higher rates. It is much more desirable to meet the cost of increased protection for workers at average or higher earnings levels by increasing the amount of earnings on which those workers

contribute than by increasing the contribution rates that all workers pay.⁶

The contribution and benefit base is now substantially out of date because of large advances in the general wage level. When the program was enacted in 1935, the \$3,000 base provided would have covered 95 percent of total earnings in covered work in that year, and would have covered the full earnings of 98 percent of all workers and of 97 percent of regularly employed men.⁷ When the base was raised to \$3,600 in 1950, the \$3,600 base would have covered 86 percent of earnings in covered work and all of the earnings of 81 percent of all workers and of 62 percent of regularly employed men. In 1965, with the \$4,800 base, only about 72 percent of earnings in covered employment will be taxed to support the program and only 66 percent of all workers and 36 percent of regularly employed men will have all their earnings covered.

The concept embodied in the original \$3,000 base was that practically all of the Nation's covered payrolls should be subject to contributions for the support of the program and that all but the most highly paid workers should have all their earnings counted toward benefits. The Council does not think it would be practicable to attempt at this time to restore all of the ground that has been lost over the years. A base of \$14,500 would be needed now to cover 95 percent of total earnings in covered work, as was contemplated in 1935. Nor does the Council believe it necessary that the original situation with respect to the proportion of total earnings covered under the program be fully restored in order to carry out the general principles of the original Act.

The Council believes that a return to the relationship that existed in 1950, the first year the Congress increased the contribution and benefit base, is a practical goal. The Council recognizes, however, that it may not be practical to move to this level in one step, and is recommending, therefore, that the base be increased at least to \$6,000 for 1966 and 1967 and to \$7,200 in 1968. A contribution and benefit base of \$7,200, if effective in 1968, would, it is estimated, tax about 80 percent of total earnings in covered work and would result in 82 percent of all workers, and 63 percent of regularly employed men, having all their earnings counted toward benefits.⁸ The result would be comparable to the 1950 situation in respect to the last two measures and somewhat short in respect to the first measure.

⁶ If the base were restored to a figure comparable to the \$3,000 figure provided in the 1935 legislation, the ultimate contribution rate for employee and employer under the present program could be reduced for each by about 0.5 percent. If it were raised to a figure comparable to \$3,600 at the time that figure was written into the law in 1950, the ultimate rate for the present program could be reduced by about 0.3 percent each.

⁷ Measures of the effectiveness of the contribution and benefit base that have been used from time to time include the proportion of earnings taxed for the support of the program, the proportion of all workers who have all of their earnings credited toward benefits, and the proportion of regularly employed men (generally the primary earners) who have all of their earnings credited toward benefits. The first is probably most important for financing and the third for an evaluation of the adequacy of the benefit structure.

⁸ If earnings levels continue to increase at about the same rate as they increased over the last 5 years, average earnings in covered work will increase about 4 percent per year during the period January 1964—January 1968.

The members of the Council are agreed on the changes here recommended as the minimum desirable. Some members, however, think that the proposed amounts for the contribution and benefit base are not high enough and would recommend that they be substantially greater, rising in the second step to nine or ten thousand dollars. This group believes that it is important to go beyond restoring the 1950 situation and move toward the situation contemplated under the original Social Security Act.

5. The Contribution Rate for the Self-Employed

Increases in the social security contribution rate for the self-employed beyond the present rate should be put into effect gradually, and only to the extent that the ultimate rate will be no more than 1 percent of earnings greater than the rate paid by employees.

Since 1951, when self-employed people were first brought into the social security program, they have paid social security contributions at a rate $1\frac{1}{2}$ times the rate paid by employees. The policy of imposing the contribution at this $1\frac{1}{2}$ -times rate balances two opposing considerations. On the one hand, to the extent that the self-employed person does not contribute at rates as high as the combined employee-employer rate, there is a financial disadvantage to the program in covering him, as compared to covering an employee. On the other hand, looked at from the standpoint of an individual contributing toward his own protection, some self-employed people will be "overcharged" when paying over a lifetime at the ultimate rate now scheduled.

Although the policy of setting the self-employed rate at $1\frac{1}{2}$ times the employee rate seemed a reasonable compromise at the time it was adopted, the Council believes that, as the rates have gone up, the substantial difference between the employee rate and the self-employed rate has become difficult to justify. The contributions paid by self-employed people above the rates paid by employees are, like employers' contributions to the program, used in large part to help provide protection for low-paid workers, workers with large families and workers who were already on in years when their jobs were first covered.⁹ The Council believes that it is reasonable to use the contributions of an employer for general purposes, rather than for the benefit of the particular employees on whose earnings the contributions are based, as long as the employee can in general be said to get his own money's worth. On the other hand, the Council does not believe that self-employed workers should as a rule be charged rates for their own coverage beyond the rates needed to pay for the protection they are provided by the program in order to help meet the cost of the protection provided to others.

The Council recommends, therefore, that, except for

⁹ Actually, a part of the employers' contributions (about 15 to 20 percent)—and of that part of the self-employed person's contribution that exceeds the employee contribution—is used to meet the cost of benefits for the long-term better-paid worker, since the contributions of this group do not quite cover the cost of their own benefits.

the financing of new types of benefits such as hospital insurance, increases in the social security tax rate for the self-employed beyond the rate now being charged be put into effect only to the extent that the self-employed will pay no more than 1 percent of covered earnings above the rate paid by employees at the time the ultimate rate goes into effect.¹⁰ With self-employed contributors paying, ultimately, 1 percent of earnings more than employees, their contribution rate would reflect the fact that to a degree they are in the same position as an employer, that is, that they are their own employers. At the same time, they would not be overcharged when paying for a full working lifetime at the ultimate contribution rate.¹¹

6. Maintaining the Integrity of the Trust Funds

To maintain the integrity of the trust funds, the reimbursement of the trust funds for the cost of paying social security benefits based on military service for which no contributions were paid should begin without further delay and the Board of Trustees should be given specific responsibility for reviewing those administrative charges against the trust funds which are based on estimates rather than on actual costs.

The last Advisory Council called the management of the social security trust funds "the greatest financial trusteeship in history." This Council agrees, and it has reviewed the management of the funds to be sure that their integrity is maintained. As a result of its study, the Council has concluded that, in general, the trust funds are managed with due regard for their nature as funds held in trust for the contributors and beneficiaries of the program. The Council does, however, want to call attention to two respects in which improvement should be made.

Military service after 1956 is covered in the same way as is all other work in covered employment, and social security employee and employer contributions with respect to military service are paid into the trust fund by the Federal Government just as are the contributions of private employers and employees. For service prior to 1957 (and after September 16, 1940), however, noncontributory wage credits were provided, and, in addition, benefits were provided for the survivors of certain World War II veterans who died within 3 years after discharge.

¹⁰ In Part II the Council also recommends that the contribution rate for the self-employed under the hospital insurance proposal be only a little above that for employees—0.5 percent of earnings for the self-employed and 0.4 percent for employees.

¹¹ The contribution rate paid by the self-employed person in excess of that paid by the employee would roughly cover the difference between the value of the contributions paid over a lifetime at the ultimate rate by employees earning at the maximum covered amount and the value of the old-age, survivors, and disability insurance protection received by a person covered by the system over a whole working lifetime and earning at the maximum covered amount.

Social security contributions were not paid with respect to those special wage credits and benefits.

The social security system has been reimbursed from the general fund of the Treasury for the cost resulting from the special benefits paid through August 1950. The authorization for such reimbursement was repealed by the 1950 amendments. In 1956 the law authorized reimbursement of the system for the cost resulting from the payment of the special benefits from September 1950 on and for the cost resulting from the noncontributory wage credits for military service. Although the 1956 legislation authorized such reimbursement beginning in fiscal year 1960, no reimbursement has yet been made.

The Council views the reimbursement owed the trust funds by the United States Government for benefits arising from noncontributory military service credits in the same light as social security contributions payable by employers generally, and therefore urges that the Government as the employer of the servicemen discharge its obligations to the trust funds just as it requires employers generally to meet their obligations. The Council also believes that this reimbursement should begin without delay.

The Council notes also that, although the Board of Trustees is directed to review the general policies followed in managing the trust funds, there is no specific requirement in the law that it review the way in which administrative costs incurred outside of the Social Security Administration—for example, by the Internal Revenue Service in the collection of social security taxes and by the Treasury Disbursing Office in issuing benefit checks—are arrived at and charged to the funds, nor has any other agency of Government been assigned this responsibility. Many of these costs, unlike those of the Social Security Administration, are charged to the trust funds on the basis of estimates rather than of actual cost. The Council believes that there should be a review of such charges and that the Board of Trustees should do it.

The Council does not believe that the Board of Trustees should be required by law to meet every 6 months, as it now is. The Council has been informed that important financial policy issues suitable for consideration by the Trustees do not come up every 6 months. The Council recommends that the law be changed so that the Trustees would not be required to meet more than once every year.

PART II. Hospital Insurance for Older People and the Disabled

In its examination of the adequacy of social security protection for the aged and the totally disabled the Council came to the conclusion that cash benefits alone are not enough. Monthly cash benefits, if adequate, can meet regularly recurring expenses such as those for food, clothing and shelter, but monthly cash benefits are not a practical way to meet the problem that the aged and disabled face in the high and unpredictable costs of health care, costs that may run into the thou-

sands of dollars for some and amount to very little for others. Security in old age and during disability requires the combination of a cash benefit and insurance against a substantial part of the costs of expensive illness.

THE COUNCIL'S POSITION IN BRIEF

Essentially the problem is this: Incomes decrease sharply upon old-age or disability retirement, but the incidence of costly illness increases. During their working years, when ill health is less frequent, employed workers can generally meet costs of current care for themselves and their families—directly or through insurance—out of their current employment income, often through an employee-benefit plan and with the help of their employers. The situation of the aged and disabled is quite different. Not only do they have the higher health costs associated with old age and disability but their incomes are greatly reduced because they are no longer working.

The solution, the Council believes,¹² is to apply the method of contributory social insurance, which underlies the present social security program, so that people can contribute from earnings during their working years and have protection against the costs of hospital and related services after age 65 and during disability without having to pay contributions at the time when income is generally curtailed. Contributory social insurance, the Council believes, offers the only practical way of making sure that almost everyone will have hospital protection in old age and during periods of long-term total disability.

It is not proposed, however, that social insurance cover all the costs of illness during old age and long-term total disability. The American approach to income security has traditionally involved a partnership of private effort and governmental measures. For example, old-age, survivors, and disability insurance is supplemented by employer and trade union plans, private insurance, and individual savings and investments. All contribute to the common goal of personal and economic independence. Backstopping this combination of measures for individual self-support are the Federal-State public assistance programs.

¹² One member of the Council does not share in this belief; his reasons are given in Appendix A, pages 40-41.

We believe this same pluralistic approach can be used effectively in meeting the costs of illness during old age and disability. With social security meeting just about all of the costs of hospitalization, which, on the average, represent at least half the costs associated with the more expensive illnesses, the person who is old or totally disabled will be in a much better position than he is today to meet, on his own and through private insurance, the costs of physician services, drugs and the other elements of complete medical care. Also, with social security providing basic hospital protection, it should be practicable to improve the Federal-State public assistance programs to make them serve more effectively in meeting the health costs for older and disabled people whose needs are not met in other ways.

THE NEED FOR PROTECTION AGAINST THE COST OF HOSPITALIZATION

Older people and disabled people have a special need for protection against the cost of hospitalization and related services—they need more care and they have less money to pay for it.

As one would expect, health care expenditures on the average are much greater for people past 65 than for younger people. Total health care expenditures for the aged, in fact, are twice as high, and, in the case of expenditures for hospitalization, the ratio is about $2\frac{3}{4}$ to 1. Older persons go to the hospital more often and have to stay much longer than those under 65.

The cost of hospitalization affects practically all older people. Of every ten persons who reach age 65, nine will be hospitalized at least once during their remaining years and most will be hospitalized two or more times. In the case of aged couples, the chances are about even that the husband and wife will each be hospitalized two or more times.

Not only is hospitalization a virtually universal occurrence among older people but there is a high correlation between hospitalization and large total medical expenses. Older people who are hospitalized in a given year are the ones who have the big expenses. While medical care costs for all aged couples averaged about \$442 in 1962, the medical expenses of aged couples with one or both

members hospitalized averaged \$1,220; for non-married elderly people, average medical expenses for the year were \$270, whereas for those who were hospitalized, the average was \$1,038.¹³ Both the averages and the differentials would be even higher now.

Hospital expenses are a serious problem for the totally disabled too. Like the aged, they too are hospitalized frequently and in many cases their hospital stays are long. According to a survey of workers found disabled under the social security disability provisions¹⁴ (conducted by the Social Security Administration in 1960), about one out of five disability beneficiaries under social security received care in short-stay hospitals in the survey year; and, excluding hospitalizations in long-term institutions, half of those hospitalized were in the hospital for 3 weeks or more.¹⁵

The problem now faced by older people and the disabled is going to become even more serious because health costs will undoubtedly continue to rise, probably at a rate considerably in excess of any increase in other prices. From 1953 to 1963 the percentage rise in the consumer price index for medical care items was nearly three times the increase in the over-all index; and the price index for medical care items increased more than that for any other major price-index component. Among the items that compose the medical care segment of the index, hospitalization costs have risen at a much faster rate than other components—hospital daily service charges rose twice as much as medical care costs generally.

Health care has become so expensive that virtually no one, including the relatively well-off person at the height of his earning power, can afford to pay the cost of major, prolonged illness unless he has effective insurance. And the great majority of the aged and disabled are neither well-

¹³ Medical data obtained in the 1963 Survey of the Aged, a study conducted by the Social Security Administration, with the Bureau of the Census carrying out the field collection and the tabulation of the data.

¹⁴ At the time the survey was conducted, the worker had to be aged 50 or over to be eligible for disability insurance benefits. Since the time of the survey, the age requirement for disability beneficiaries has been eliminated, but beneficiaries aged 50 and over still represent about three-fourths of all disability beneficiaries. Thus, the data for this age group are representative of the major part of the disability beneficiary population.

¹⁵ Almost 90 percent of the disability beneficiaries in the survey had been totally disabled at least 6 months before the beginning of the survey year and half had been disabled 3 years or more.

THE ROLE OF PRIVATE PLANS

off nor have adequate health insurance. Older people have, on the average, only one-half as much income as younger people living in family groups of the same size.¹⁶ About half of the aged social security beneficiaries have practically nothing (less than \$12.50 a month per person) in continuing retirement income other than their social security benefits; and for all but about one-fifth of the aged beneficiaries, benefits were the major source of continuing retirement income.¹⁷ (Only 15 percent of the aged, for example, have any income from private pension plans and even for this 15 percent the amount from social security is generally larger than the private pension.)

Totally disabled people also have comparatively low incomes, although they more often depend in part upon the earnings of a spouse.¹⁸ Many older people and people with long-term total disabilities must therefore turn to their children and other relatives and to public agencies for aid in meeting the costs of illnesses that require hospitalization.

In the 1960's we have seen a large and growing proportion of those applying for public aid forced to do so only because they cannot meet their health costs. Today over one-third of public assistance expenditures for the aged are for health costs, and such costs have become the most important single reason older people apply for public assistance.

¹⁶ Bureau of the Census Current Population Survey income data for 1960 (the most recent available by age and size of family) show median annual income as \$2,530 for aged two-person families and as \$5,314 for younger two-person families; for individuals living alone the data for 1963 show median incomes of \$1,277 for the aged and of \$2,881 for the younger persons. The Social Security Administration's 1963 Survey of the Aged shows median income for all aged couples as \$2,875 in 1962; no data are available for younger couples as of that date, but Census data for 1962 and 1963 for aged and younger families of all sizes indicate that the ratios between incomes of aged and young families of comparable size have not changed significantly.

¹⁷ Retirement income as used here means all income other than earnings, assistance payments (public and private) and money income from a relative living in the same household. Data shown are derived from the Social Security Administration's 1963 Survey of the Aged.

¹⁸ According to the Social Security Administration's 1960 survey of disabled workers, one-half of the married disability beneficiary units (family units composed of disabled workers and spouses and their children, if any) had income, not counting social security benefits, of less than \$170 per month. The bulk of the income for most of these family units came from earnings of a working spouse. One-half of the nonmarried disability beneficiaries had income, not counting social security benefits, of less than \$7 per month (there being no spouse present to work).

The hospital insurance provisions we recommend would work in partnership with private plans and individual voluntary effort as social security now does in the field of cash benefits. With social security providing basic protection against the costs of hospital care and related services, and with improved cash benefits such as we recommend in Part III of this report, many people aged 65 and over or disabled who now cannot afford comprehensive private health insurance would be able to afford the less expensive supplementary protection against doctor bills and other health costs which, in combination with social security, would furnish comprehensive coverage. Employers also would find it more feasible to continue health protection for employees into retirement if, instead of having the whole job to do, they could build on the hospital insurance protection furnished under social security. These private measures would be built upon the hospital insurance base, just as the private life insurance and retirement pensions and annuities that many people have today are built upon the base of social security cash benefits.

On the other hand, it is unrealistic to expect private voluntary insurance alone to provide comprehensive protection for the great majority of elderly people and totally disabled people. To a large extent the problem of financing the cost of expensive illness among people at the younger ages, who are largely dependent on current earnings, is being met by private insurance organizations, but private insurance cannot meet this problem for most of the aged at a price they can afford to pay. Despite years of creative effort and hard work by the voluntary insurance organizations, less than half of the totally disabled and only a little over half of the elderly have any kind of health insurance coverage and most of what they do have is quite limited. The absolute number of older people without any kind of protection at all is nearly as large as it was 5 years ago.

The basic difficulty in relying exclusively on private insurance, of course, has been that the costs of insurance are necessarily high because the aged and the disabled need so much in the way of health care that they cannot pay the costs of adequate insurance from low retirement in-

comes. Then too, unlike working people, who generally get group health insurance coverage through their place of employment, the disabled and the elderly can ordinarily obtain health insurance only on an individual or nongroup basis. The marketing and administrative costs associated with the individual handling that is characteristic of nongroup commercial health insurance make individual coverage about $1\frac{1}{2}$ times as expensive, on the average, as group coverage offering the same benefits. Because of this consideration, together with the fact that hospital costs for the aged run about $2\frac{3}{4}$ times as much as those for younger people, the protection provided to an aged person by an individually purchased commercial hospital insurance policy costs about four times as much as comparable protection furnished younger people on a group basis. And relatively few disabled and retired workers have the benefit of contributions made toward health insurance by employers.

As a result of these facts, most voluntary health insurance within reach of the pocketbooks of the aged and the disabled is inadequate in the amounts and types of service covered and in the duration of benefits. In 1962 (the most recent year for which data are available) only 10 to 15 percent of the total medical costs of the aged, for example, was paid for by insurance. Moreover, as hospital costs rise, those who have health insurance policies paying fixed dollar amounts toward hospital care will find that the amounts cover an increasingly small proportion of their hospital bills; those who have policies which provide service benefits rather than fixed dollar amounts will be faced with increased premiums.

In the case of Blue Cross, which ordinarily provides service benefits without dollar limits, pressures are heavy to apply experience rating more and more to the high-risk older population in order to be able to offer the young group rates that are more competitive with those for commercial insurance policies. These pressures will continue to apply in the future and the result will be additional increases in Blue Cross premiums for the aged as they are required to pay rates closer to the true value of their protection.

It is also true that most of the aged who now have some form of health insurance are those who are still working, those in good health, and those in the higher income groups. To a very large

extent those who can be sold voluntary protection have already been sold.

For all these reasons, in the absence of social insurance taking on a part of the job, the Council believes that in all probability the great majority of older people and disabled people will, for the foreseeable future, continue to be without adequate protection against health care costs.

The Council believes that the extension of social insurance to the costs of hospitalization for the elderly and the disabled will make it possible for the private plans to perform a valuable complementary role. Since hospital insurance protection will be provided without further contributions during old age and disability, more of the retirement dollar will become available for buying current protection covering other parts of the medical bill, and, as indicated above, employers will find it more feasible to carry over health protection for their retired personnel.¹⁹

THE ROLE OF PUBLIC ASSISTANCE

There will be some disabled and elderly people who are without the means to add other protection to their basic hospital insurance or who have special needs such as the need for long-continuing custodial care. Public assistance programs will, therefore, have an important continuing role in meeting the total problem. Consequently, the Council favors the improvement of the program for medical assistance for the aged (MAA) and the medical care provisions of old-age assistance and aid to the permanently and totally disabled to provide more effectively for remaining needs after the proposed social insurance program goes into effect. The enactment of hospital insurance

¹⁹ In connection with the continuing role of private insurance in providing health insurance protection for the elderly, the Council would like to call attention to the recommendations of the National Committee on Health Care of the Aged. This was an ad hoc committee, with expert membership, which Senator Jacob K. Javits initiated and which served under the chairmanship of Arthur S. Flemming, former Secretary of Health, Education, and Welfare. In addition to proposing hospital insurance under social security, the National Committee recommended provisions designed to encourage the setting up of Federally authorized pools of insurers to offer supplementation to the social insurance plan. The Council has not taken any position on the subject of those recommended provisions because it is not within the scope of the Council's assignment. The Council believes, however, that the suggestion is worth the careful consideration of the Congress.

provisions for the aged and disabled will save the States some two-fifths of their present medical expenditures for older people and place them in a financial position to improve their medical assistance programs. When the number of those who need help is reduced and when the remainder do not need help with most of the costs of hospital care, because of hospital insurance under social security and because of the spread of effective supplementary protection, the way will be open in many States for much needed improvements in medical assistance for the smaller numbers of people who still need help.

There is abundant evidence, however, that the Federal-State programs of public assistance, without a social insurance program to meet a large part of the cost, cannot do the job of filling the gaps left by private voluntary insurance. Many States either cannot—or, in the light of other financial priorities, will not—put up enough money to meet the need. Despite the fact that the Federal Government will pay, out of general revenues, from 50 percent to 80 percent of the cost of a State program to meet the health needs of the aged, only a few States have developed adequate programs for the very poor, and none has combined both comprehensive care and liberal enough tests of income and assets to meet the health needs of more than a small portion of the retired aged in the State. Some have no medical-assistance-for-the-aged program at all.

Under a grant-in-aid system the wealthier States are the ones most likely to establish the better programs and most likely to get the major share of Federal funds. Furthermore, States vary in their willingness to apply their resources to a given purpose. As a result, an approach that depends on *State* initiative cannot reasonably be expected to lead to an adequate *nationwide* program. In October 1964, 68 percent of Federal MAA funds went to five of the wealthier States with only 31 percent of the country's aged.

For reasons explained in the introduction to this report, the Council does not, in any event, favor placing a main reliance on assistance in dealing with a problem which is faced by practically all the aged and the disabled. Even an adequate assistance program would have grave drawbacks for the recipient and for our society as a whole when compared with the method of social insurance. The Council believes that to the

extent practicable the objective should be to prevent dependency rather than alleviate it after it has occurred.

Yet in some circumstances assistance will continue to be necessary. This is why the Council recommends that the Federal Government give continuing support to improvements in the medical provisions of assistance programs so that all the aged and all the disabled may have their full medical needs met through a combination of social security, private protection and savings, and, as a last resort, for the unusual need and circumstance, through an improved and generally available assistance plan.

BASIC ELEMENTS OF THE RECOMMENDED PLAN

The Council recommends that the core of protection be coverage of the costs of hospital care, subject to a small deductible. Coverage of three additional types of services, which can frequently take the place of inpatient hospital care, is also recommended: (1) extended care, following a hospital stay, in a hospital-operated or hospital-affiliated facility capable of providing high quality convalescent and rehabilitative services; (2) organized home nursing services which are medically supervised and are provided by organizations staffed and equipped to offer coordinated services sufficient so that an individual who is confined at home, but not in need of round-the-clock services, could receive substantially the full array of nursing services and therapeutic services (not including those of a physician) needed to care for him at home; and (3) subject to a small deductible, hospital outpatient diagnostic services covering the full use of the hospital's facilities and personnel but not covering the diagnostic services of the patient's personal physicians.

A major principle that guided the Council in developing its recommendations is that health services should be tailored to the health needs of the patient. Provision for the four types of benefits—hospital care, extended care following the care given in the hospital, organized home nursing care, and hospital outpatient diagnostic services—would enable the older or disabled person, together with those who participate in planning for his care, to have available the kinds of services, and a level of care, most appropriate to his

individual need. Particularly for the aged, the next step in the care of a person who has been hospitalized for a serious illness may be a period of medically supervised treatment in an extended-care facility rather than continued occupancy of a high-cost bed normally used by acutely ill hospital patients. The benefit structure should cover a continuum of institutional and home nursing services and should provide an appropriate level of care for individuals who require convalescent care of somewhat lesser degree of intensity than that provided for hospital inpatients.

The coverage of important alternatives to hospitalization would help subordinate financial to medical considerations in decisions shared in by the doctor, patient and institution on whether inpatient hospital care or another form of care would be best for the patient. The recommended benefits would give financial support to the provision of institutional and noninstitutional services at the most appropriate level of intensity for patients who require care of extended duration. Covering each of the stages of required care is conducive to careful planning of the long-range treatment of those suffering serious illnesses.

In the course of formulating the proposed hospital insurance provisions for the aged and disabled, the Council was mindful of the increasing interest that the community as a whole has demonstrated in seeing to it that high quality health services are provided and that full value is received for the health dollar. Reflecting this community interest, many State and local hospital planning groups, private health cost prepayment organizations, and others have called attention to the effects of inadequate planning of facilities, excess capacity, inefficient operation, and unneeded services, any of which, whenever they occur, can result in an increase in health costs far beyond that attributable to medical and scientific achievements. The work of these groups shows that there is real promise for an improvement in the quality of care and at the same time improvement in the efficiency with which the services are provided.

The Council believes this matter to be of such widespread concern that it recommends the creation of a commission, its members to be appointed by the President, composed of experts in the fields of health care and hospital planning, of representatives of groups and agencies purchasing health

care on a large scale, and of the general public, for the purpose of enhancing the effectiveness of our hospitals throughout the country in the provision of high-quality health care. The recommendations of such a commission would be of benefit primarily to the population as a whole but would, of course, also be of long-run importance to the hospital insurance program for elderly and disabled people.

1. Inpatient Hospital Benefits

The proposed hospital insurance for people age 65 or over and the disabled should cover a number of days sufficient to meet the cost of inpatient hospital services for the full stay of almost all beneficiaries.

The Council believes that the number of days for which inpatient hospital benefits are paid should be enough to cover the full hospital stays required in nearly all cases. Sixty days of coverage for each spell of illness would accomplish this purpose. Sixty days would cover the full stay of all but about 3 to 5 percent of the stays of older persons. Moreover, it is quite possible that with coverage in extended-care facilities, such as we recommend, many of those who would otherwise stay in acute general hospitals for over 60 days could be transferred to extended-care facilities.

The Council holds the view, which is shared by many experts on hospital insurance, that the availability of hospital coverage for a substantially longer period may, especially among the aged, result in excessively long hospital stays and therefore unnecessary cost to the program. We therefore believe that it is desirable to place a limit on the number of covered days in the acute general hospital and, at the same time, provide for extended care in less expensive facilities.

The Council believes that the proposed hospital insurance should not include any provision under which beneficiaries would choose among various combinations of benefits of the same actuarial value but with a varying number of days and higher and lower deductibles. The Council sees little gain in such a choice and, on the contrary, believes that for most beneficiaries the need to make a choice would be confusing and upsetting and that widespread dissatisfaction could be expected among the large number who would later discover that they would have been better off with a different choice. Any attempt to meet this dissatisfaction by allowing people to change options would significantly increase the cost of the program for the whole group of contributors by giving an unfair advantage to those who could anticipate the need for a specific type of protection.

2. Outpatient Hospital Diagnostic Services

Payment under the program should be made for the costs of outpatient hospital diagnostic services furnished beneficiaries.

Recent progress in science and medicine has resulted in the development of complex services and equipment for the more accurate and more timely diagnosis of disease. Because of the cost of the equipment and the need for specialized personnel to operate it, the hospital has increasingly become a diagnostic center which is used when expensive and complex tests are required. Providing for the payment of the cost of expensive outpatient hospital diagnostic services should help to encourage early diagnosis of disease by removing financial barriers to the use of such services. Payment for outpatient hospital diagnostic services would also help to support the efficient provision of care by eliminating a financial incentive for hospital admissions to obtain diagnostic services.

3. Deductibles

Hospitalized beneficiaries should pay a deductible equal to the cost of one-half day of care—\$20 at the program's beginning. In the case of beneficiaries who are provided outpatient diagnostic services, this deductible amount should be applied for each 30-day period during which diagnostic services are provided.

The Council believes that beneficiaries who are hospitalized should be required to pay a small amount toward the cost of their hospital stay. Such a deductible amount might help to reduce unnecessary hospital admissions. On the other hand, we would not favor a deductible amount of substantial size since such a deductible might well deter many beneficiaries from seeking needed care. In the Council's judgment a deductible amount which is equal to about a half, or even three-fourths, of the national average cost per patient day of hospital care would not be so large as to represent a significant impediment to needed care. Such a deductible amount—\$20 to start—would, moreover, make it possible to provide, within the funds available to the proposed program, more extensive protection against catastrophic health costs than would otherwise be possible.

Provision for a similar deductible amount in the outpatient diagnostic benefit would limit coverage to diagnostic procedures with a significant financial impact. It should also have the effect of excluding from the coverage of the program the type of routine laboratory and other diagnostic procedures that are customarily furnished in or through the physician's office.

4. Services in Extended-Care Facilities

The cost of post-hospitalization extended-care services in facilities which provide high-quality rehabilitative and convalescent services should be covered so as to pay for a minimum number of days after hospitalization in all cases, with addi-

tional days of extended-care services being paid for if the patient has not used all of his inpatient hospital coverage.

The services that would be covered would be those furnished to patients in extended-care facilities which are under control of a hospital or affiliated with a hospital and which are designed primarily to render convalescent and rehabilitative services. Care in such a facility will frequently represent, particularly among the aged, the next appropriate step after the intensive care furnished in a hospital and will make unnecessary the continued occupancy of a high-cost bed normally used by acutely ill patients.

Services of this kind are essential in the over-all treatment of many illnesses following their acute stage and prior to the time a person can return to his home or transfer, in some instances, to an essentially custodial institution. And, of course, extended-care coverage, even for a limited duration, will also be of benefit to many older patients with chronic or terminal illness who can be transferred from intensive care in acute general hospitals.

Since the proposed program is designed primarily to support efforts to cure and rehabilitate, and since "nursing home" care, in many cases, is oriented not to curing or rehabilitating the patient but to giving him custodial care, the Council does not propose the coverage of care in nursing homes generally.

In order to provide an incentive for transferring a patient from a hospital to an extended-care facility at an early point, when such transfer is medically desirable, the Council believes that coverage should be provided for 2 additional days of extended care, if needed, for each day the patient's hospital stay is less than 60 days. A minimum of 30 days or so might be covered in all cases.

The Council recognizes that hospital-affiliated facilities which provide post-acute convalescent and rehabilitative care do not exist in many communities and that the services therefore may not be available immediately to many of the beneficiaries who might need them. The Council believes, however, that the coverage under the proposed program will encourage the development of such facilities and that, with the help of other programs designed to assist directly with construction, such extended-care services can be made generally available within a reasonable time.

5. Organized Home Nursing Services

Insurance coverage should be provided for organized home nursing services.

As a fourth element in the protection it proposes, the Council recommends the coverage of organized home nursing services—that is, services provided on a visiting basis in the patient's own home. Coverage of medically supervised home nursing services provided through qualified nonprofit or public agencies would encourage the establishment of organized home care programs. Experience has shown that such visiting programs can bring high-quality care to the patient in his own home, thus avoiding the need for hospitalization altogether in some

cases or facilitating the discharge of patients not only from hospitals but from extended-care facilities. The Council believes that a substantial number of professional visits a year—in the range of two to three hundred—should be covered in order to make organized home nursing services a real alternative to institutionalization.

Organized home care services sometimes include the services of hospital interns and residents-in-training. We believe that payment should be made for their services when furnished but only if the services provided are part of a professionally approved training program for such individuals.

6. Payments on the Basis of Reasonable Cost

The extent of hospital insurance and related protection should be specified in terms of the services covered rather than in terms of fixed dollars, and covered services should be paid for on the basis of the full reasonable cost of the services.

The Council recommends that protection should be in the form of service benefits, with payments for covered services made directly to the institution or organization furnishing the services rather than payments of fixed dollar amounts to the beneficiary receiving the services. Service benefits would provide more secure and reliable protection for the patient and enable the program to promptly adjust payment to hospitals in accordance with changes in hospital costs resulting from the acquisition of new equipment, the adoption of new health practices, and the general improvement of services. The inpatient hospital benefits should cover all hospital services and supplies ordinarily furnished by the hospital for necessary care and treatment of its patients, except that accommodations more expensive than semi-private accommodations would be paid for only if medically necessary. Luxury items would not be included.

The hospital or other provider of service should be reimbursed for the reasonable cost of services provided. Payment on a reasonable cost basis would be in line with the recommendations of many expert groups, including the American Hospital Association. The established practices of most Blue Cross plans are generally in line with this recommendation.

It is likely that no single formula for estimating the cost of services will prove best under all circumstances, and provision should be made to permit variations in hospital practices and services to be taken into account.

7. Hospital Staff Review of Utilization

Hospitals should be required, as a condition of participation, to establish professional staff committees to review the services utilized.

Procedures for medical staff review of hospital admissions, length of stays, the medical necessity for services provided, and the efficient use of services and facilities

are coming into use in many hospitals, and the experience with some of these procedures has been promising. Procedures for the recertification of the continued need for service by the attending physician have also been adopted in some hospitals.

The Council believes that all participating hospitals should be required to have staff communities to review the utilization of services and that consideration should be given to certification procedures. The structure and responsibilities of the staff committee should be left to the discretion of the hospital and its medical staff. However, such committees should be required at least to conduct sample reviews of hospital admissions among the beneficiaries of the program and to review long-stay cases. The professional judgments obtained through the use of such a staff committee would provide a safeguard against the improper use of services.

8. Administration

The proposed hospital insurance provisions should be administered by the same Federal agencies which administer the social security program but in carrying out this responsibility the Federal Government should use private and State agencies to the extent that these agencies can contribute to efficient and effective operation.

The Council recommends that the Federal Government have over-all responsibility for the operation of the proposed hospital insurance program but that it use both qualified private organizations and State agencies for the performance of certain functions where such use would contribute to the efficiency of administration.

Many of the functions necessary to the administration of the proposed hospital insurance provisions would require little, if any, additional effort since they are now being successfully performed under the social security program and would simultaneously serve the purposes of the hospital insurance provisions and the existing cash benefit provisions. These functions include the collection of contributions; the maintenance of earnings records; the establishment of age, disability, and the status of dependents; the determination of whether insured status requirements for eligibility are met; and the maintenance of current records of eligibles under the program.

The Council recommends, however, that the authority given to the Federal administrator should be flexible enough to permit him to determine whether or not to use the help of private and State agencies, and to what extent. Included among the functions which might be carried out by private agencies are those related to arranging for hospitals and other providers of health services to participate in the program and handling the payment of hospital bills covering costs insured by the program. State agencies which license health facilities could be used, for example, to assure that health facilities desiring to participate in the program meet the requirements for participation. The Government might find that functions such as these could be carried out better, or at less cost, if instead of performing them directly it arranged to have them performed by private and public agencies with experience in similar functions.

9. The Basis of Eligibility for Benefits

Hospital insurance benefits should be provided for aged and disabled beneficiaries of the social security program, and special provision should be made for the next few years for those who have not met the requirements of eligibility under the program.

In the long run all people age 65 or over and all people with long-term total disabilities who have worked long enough to become entitled to monthly social security cash benefits will have paid hospital insurance contributions as well as contributions for cash benefits and will be entitled to both types of protection on the basis of the insured status provisions of present law.

The Council believes that the hospital insurance benefits should also be available to people who are age 65 or over, or who will become 65 in the next few years, whether or not they have made significant contributions toward hospital insurance and whether or not they are entitled to social security cash benefits. Such persons have not had the opportunity to gain protection by contributing to the hospital insurance program but their need for such protection is equally great.

People who attain age 65 after a specified date should be required to have a gradually increasing number of earnings credits under social security, and the number required for eligibility for hospital insurance should ultimately be the same as that required for social security cash benefits.²⁰ The cost of the protection provided under this provision should be met from general revenues, as explained below in the recommendation on financing.

After consideration of all possible alternatives, the introduction of hospital insurance by making it part of the ongoing social insurance system seems to be highly desirable in social, economic and administrative terms.

10. Financing

The proposed hospital insurance program should be financed by a special earmarked contribution of 0.4 percent of covered earnings from employees and from employers, and 0.5 percent from the self-employed, with an 0.15 percent contribution from Federal general revenues to cover the cost of benefits for those already retired or disabled.

The contributions for hospital insurance should be an earmarked percentage of covered earnings, established as

²⁰ For example, the provision might be as follows: Uninsured people who reach age 65 in 1966 or before would need no quarters of coverage; those who reach age 65 in 1967 would be deemed to be insured for hospital insurance if they had at least 6 quarters of coverage (earned at any time). For people who reach age 65 in each of the succeeding years, the number of quarters of coverage needed to be insured for hospital insurance protection would increase by 3 years. The provision would not apply to people who reach age 65 in 1971 (or later), since, under the Council's recommendation, in that year the number of quarters that would be required under the special provision would be the same as the number required for regular insured status.

a new tax, separate from the taxes in the Federal Insurance Contributions Act that support the present social security cash benefits. The proceeds of this new tax would be kept separate from the taxes which finance the present social security program. These proceeds would be deposited in a newly created hospital insurance trust fund separate from the old-age and survivors insurance trust fund and the disability insurance trust fund. However, the employment and earnings coverage and the maximum on covered earnings to which the new tax would apply should be the same as those to which the present social security taxes apply so that the recordkeeping tasks of employers and the Government would be largely unaffected by the establishment of a separate contribution for hospital insurance.

Hospital insurance financing separate from that of old-age, survivors, and disability insurance should allay any concern that the hospital insurance program might in any way impinge upon the financial soundness of the OASDI trust funds. Furthermore, identifying the contribution as a hospital insurance contribution will tend to increase the contributor's sense of financial responsibility for the benefits provided.

Several members of the Council, however, while believing in the value of a separate trust fund, are of the opinion that it is not necessary to have a new and separate tax either to allay possible concern about the financial soundness of the social security program, to maintain the identity of the hospital insurance financing, or, in general, to accomplish the objectives of the proposal.

The contribution rates should be 0.4 percent of covered earnings each for employees and employers and 0.5 percent for the self-employed.²¹ It is assumed that these contributions for hospital insurance would go into effect at least 6 months earlier than the first hospital insurance benefits were paid. For example, if the plan were enacted in 1965, the contributions might go into effect in January 1966 and benefits might first be paid in July 1966.

In addition to the earmarked contributions there would be a contribution from Federal general revenues to meet the cost of hospital insurance benefits for those already retired or disabled. The Government contribution would be justified in terms of the health and welfare of the Nation's aged and disabled and the reduction in general revenue costs that will follow as social insurance reduces the need for public assistance. It is proposed that the cost to the Government be met by annual and automatic appropriations over a 50-year period. The Government's cost on this basis is estimated to be 0.15 percent of covered payrolls.

The recommended contribution rates are designed to be sufficient to cover the estimated costs of the proposed benefits both in the short run and over the long run. Because sound financing depends on the validity of the cost estimates used and this in turn depends on the validity of the assumptions which underlie the estimates, the Council believes it to be in order for this report to contain a statement of the assumptions it has directed be used in making the cost estimates.

²¹ For the same reasons that the Council has recommended that the contribution rate paid by the self-employed toward old-age, survivors, and disability insurance be set in the long run at no more than 1 percent of earnings higher than the employee rate, the Council recommends that the rate paid by the self-employed for hospital insurance be a comparable 0.1 percent above the rate paid by employees (see page 13).

As in the case of estimates of the cost of cash benefits under the social security program, assumptions underlying hospital insurance cost estimates can vary widely and still be reasonable. For hospital insurance the range over which cost assumptions may vary and still be reasonable is somewhat greater than for the cash benefits. For this reason, we have taken great care to assure that the assumptions used in estimating the cost err, if at all, on the conservative side.

Clearly, the cost of the proposed program, expressed in dollars, will be an increasing cost. One important factor which will tend to increase the cost of the program over time will be the rising cost per day of hospitalization. Another factor tending to increase costs will be the growing number of people who are eligible for hospital insurance. A third factor is the increasing average age of those who will be protected.

Since the income to the system will come from a percentage of covered earnings, and since over the years it can be expected that more and more people will be employed and that earnings levels will rise, the income of the system will also increase. To take into account both rising costs and rising income, the analysis of financing is done in terms of costs as a percent of covered (taxable) earnings. Thus, the Council's assumptions concerning future hospital costs are stated in terms of the expected future relationship between rising hospital costs and rising earnings—of how increases in hospital costs will compare with increases in covered earnings (and therefore with increases in contribution income).

Earnings reflect the increasing productivity of labor. Therefore, on the average and over time, the general level of earnings will increase much faster than the general price level. But in recent years the reverse has been true in the case of hospital prices; they have been increasing substantially faster than the general level of earnings. Obviously, however, hospital costs cannot continue indefinitely to rise faster than earnings; if they did, ultimately no one could afford hospital care. Nevertheless, the financing of the hospital insurance program must make allowance for the strong likelihood that hospital costs will, for a time, continue to increase faster than earnings. A reasonable assumption would be that the differential between the rate of increase in hospital costs and the rate of increase in earnings will get smaller and that eventually hospital prices will increase at a somewhat lower rate than earnings even though at a much higher rate than other prices.

Specifically, our assumption for the relatively short run is that hospital costs will rise faster than earnings for 10 years after the program begins operation, but not quite as fast thereafter. The Council has assumed that until 1970 the differential between hospital costs and earnings will continue to be the same as the average over the last 10 years (2.7 percent)²² and that in the

²² Although figures for the 10 years average 2.7 percent, the 2 most recent years for which data are available (1962-1963) show a differential between hospital cost increases and earnings increases of only a little over 2 percent for each of these years. Nevertheless we have used the 10-year average in order to make sure that the cost projections will be conservative. Also relevant is the fact that a substantial proportion of the increases in hospital costs that have occurred over the last 10 years is attributable to a catching up in wages and reduction in the hours of work of hospital employees, who as a group have been considerably underpaid. The catching-up process will, naturally, complete its course in time.

following 5 years the differential will average half as much.²³

The Council does not presume to have any firm basis for knowing just how much hospital prices or other prices will rise in the distant future. However, because of the comparatively large component of labor costs which will always be present in health services and because of the cost of increasing quality of care, the Council has assumed that hospital costs will probably rise indefinitely considerably faster than other prices. Therefore, the Council's assumption on the relation of hospital costs to earnings is that after the first 10 years of the program's operation (during which hospital costs are assumed to rise faster than earnings), hospital costs will rise slightly less than earnings but substantially more than other prices. (See *the original report*, pages 102-104, Appendix B, for further discussion of the specific assumptions.)

The conservative nature of this assumption is made plain when one considers the future price levels it implies. The over-all effect of the assumed price rises, if the past relationship between earnings and the general price level continues, is that in the next 75 years hospital prices will have risen 710 percent while other prices will have risen by about 110 percent.

Another factor that affects the financing of the system is the limitation placed on the maximum amount of annual earnings subject to contributions (the contribution base) and its relationship to increases in earnings levels. As has been noted, income to the system tends to rise as earnings rise. However, if over the long run the maximum on earnings which are taxed were fixed—that is, if the maximum did not rise as earnings rise—there would be an increasingly inhibiting effect on contribution income. More and more people would be paying contributions on the maximum earnings covered, and increases in their earnings would not be subject to the contribution rate.

The Council's assumption is that the contribution base will not remain fixed. In the short run the Council recommends an increase in the base in 1966 and 1968, primarily to take account of the past rise in earnings levels. For the longer run, one of the assumptions made in preparing cost estimates for hospital insurance is that periodically there will be increases in the contribution base if earnings rise. These increases are assumed because the base, which under the cash-benefit provisions is also the maximum amount of earnings creditable for benefits, must be kept generally in line with changes in earnings levels if cash social security benefits are to continue to have a reasonable relationship to the earnings they are intended to replace and if social security contributions are to vary with earnings.

The great bulk of the income from contribution base increases would of course be used to raise cash benefits to keep them in line with higher earnings levels. For

²³ By way of comparison, it may be noted that the major organization representing the commercial health insurance industry assumed smaller rises in hospital costs for this period in its estimates on the costs of the King-Anderson bill. Specifically, it estimated that hospital costs will rise 2 percent per year more rapidly than earnings from 1963 through 1968 and 1 percent more rapidly than earnings from 1969 through 1978. (Pages 587 and 588 of the record of hearings on H.R. 11865 before the Committee on Finance, United States Senate, August 1964—appendix to testimony on behalf of the Health Insurance Association of America.)

example, if hospital insurance contributions are about one-tenth of contributions under the old-age, survivors, and disability insurance program (as the Council recommends) a little over 90 percent of the income from any future increase in the contribution base would go toward old-age, survivors, and disability insurance and a little less than 10 percent toward hospital insurance.

The Council's assumption is, then, that legislative action will be taken from time to time to adjust the contribution base in line with rising earnings. However, the Council recognizes that over the short run the increases which it expects in the contribution base, beyond those adopted concurrently with hospital insurance, may not occur as anticipated. The Council recommends, therefore, that the contribution rates for hospital insurance be designed to provide sufficient income to cover benefit expenditures even if, for a number of years, no further increase in the base is enacted. The contribution rates proposed by the Council are so designed.

In summary, the principles which the Council has followed in making its recommendation for the contribution rates necessary to support the proposed hospital insurance program are as follows: The Council recommends that the income to the hospital insurance program be large enough each year to cover benefit outgo with a prudent allowance for increases in hospital costs as well as for the possibility that the contribution base increases may lag behind rising earnings.

A contribution rate of 0.4 percent each for employee and employer (0.5 percent for the self-employed) together with the 0.15 percent from the Government would be sufficient not only to meet benefit costs but also to build up substantial amounts in the hospital insurance trust fund. The new trust fund would have a sizeable balance from the start, since contributions toward the program would be collected 6 months or so before benefits would be paid.

The recommended maximum amount of annual earnings taxable would be \$6,000 in 1966 rising to \$7,200 in 1968, a recommendation discussed in Part I. While, as indicated above, it is contemplated that this maximum would rise in the future, the recommended contribution schedule would yield income in excess of outgo for at least the next 10 years even if the base is not increased after 1968.

The following table summarizes the cost effect of the four types of benefits proposed to be covered:

ACTUARIAL BALANCE UNDER PROPOSED PLAN OF HOSPITAL INSURANCE

(Costs expressed as percentage of taxable payroll according to intermediate-cost estimates)

<i>Item</i>	<i>Level-cost</i>
Level-cost effect of changes:	
Hospital benefits, 60-day maximum,	
½-day deductible -----	+ 0.84
Extended care service, 30-day maximum ¹ ----	+ 0.02
Outpatient diagnostic services, deductible of	
½-day hospital cost -----	+ 0.01
Home nursing services, 240-visit maximum ---	+ 0.03
Level-cost of proposed program -----	.90
Level-equivalent of contribution schedule ² ----	.90
Actuarial balance -----	.00

¹ With additional days if all of hospital benefits are not used.

² The 0.15 percent of payroll from general revenues for 50 years is equivalent to a level rate of 0.10 percent of payroll.

Conclusion: The Council finds that health costs represent the greatest remaining threat to the economic security of our aged and severely disabled citizens. The social insurance approach, the Council believes, is singularly fitted to serve in dealing with this threat. What is needed is an arrangement under which working people, together with their employers, can contribute from earnings during their working years and have insurance protection against health costs in later years, without further contribution, when their health costs will be high and their incomes low. Only social insurance, as typified by the social security program, can assure that such an arrangement will apply to practically everyone who works for a living.

The Council has developed and presented in this report a plan under which the major part of the costs incident to hospitalization and related care in old age or during periods of total disability will be paid for through the contributory social security program. The plan will pay for these costs in a way which is in keeping with the high standards of American health care. The plan will be responsive to changing methods and improvements that are likely to occur in health care in this country. The plan will accommodate the individual's freedom of choice of health care facilities and will in no way interfere with the private practice of medicine or with the independence of our voluntary hospital system. The Council has included recommendations which, if adopted, would assure that the proposed plan of hospital insurance for older people and totally disabled people will be soundly financed through its own contribution schedule and trust fund.

While neither private insurance nor public assistance, alone or together, can meet the pressing need for hospital protection on the part of the aged and disabled, the recommended plan contemplates an important role for both. The hospital protection proposed to be provided under the social security program will serve as a foundation on which individuals can build private health insurance, just as old-age, survivors, and disability insurance under social security is serving as a base on which people build additional protection through private means. With social security providing basic protection against hospital and related costs, public assistance will assume the role best suited for it—that of a program intended to help the members of the relatively small group whose special needs and circumstances are such that they are unable to meet their health costs through social security or through private insurance or other resources.

The Council is confident that the principles of social insurance underlying its recommended plan for hospital insurance for the aged and the totally disabled can be applied successfully as they have been applied to social security cash benefits. Today's social security program assures that the vast majority of older people and totally disabled people will receive a regular monthly income to help them meet the costs of day-to-day living. The proposed provisions for hospital insurance will round out this security by removing the greatest remaining obstacle to the financial independence of these groups. With such provisions in effect, millions of our older citizens will be able to look forward to their years of retirement without the dread of overwhelming costs arising from serious illness.

PART III. Improvements in the Cash-Benefit Provisions

In general the Council believes that the present program is functioning well and that its basic structure is satisfactory. The most important improvements in the cash-benefit provisions, and particularly in the benefit amounts, that the Council is recommending are designed to take into account recent wage and price changes. The effectiveness of the social security benefits has been diminishing because the benefits for the last 6 years have not even kept pace with rising prices and because the maximum amount of annual earnings that is taxable and creditable toward benefits has not been raised as the general level of wages has gone up.

The Council has also found that although the program is very broad in its coverage—about nine-tenths of the people who at any one time are in gainful employment in the United States are covered—there are some areas where its coverage should be further extended, and that while benefit payments are now provided in most cases in which support is lost when the worker retires in old age, becomes disabled, or dies, there are a few remaining gaps that should be filled.

The improvements recommended by the Council require additional financing; the cost of those improvements and the recommendations for providing the needed additional financing are discussed at the conclusion of this section.

Before the recommendations of the Council are set forth in detail, it may be helpful to summarize briefly the major provisions of the present program.

Monthly benefits are payable under the program to retired insured workers at age 65, and reduced-rate benefits may be paid to them as early as age 62. Benefits may also be paid to the following dependents: A wife or dependent husband age 65 or over (or age 62 with a reduction in the benefits); children under age 18 or disabled before age 18; and a wife of any age caring for a child entitled to benefits. Monthly benefits are payable to insured workers who have very severe and long-continued disabilities and to the dependents of such workers. Upon the death of an insured worker, monthly benefits are payable to a surviving widow or dependent widower age 62 or over; children under age 18 or disabled before age 18;

a mother who has such a child in her care; and dependent parents age 62 or over. A lump-sum death payment is also made.

Benefit amounts under the program are related to the average earnings of the insured worker in covered employment; currently, however, only the first \$4,800 of the worker's earnings in a year is included in calculating the average. The minimum benefit payable to a worker who goes on the benefit rolls at age 65 or later is \$40 a month and the maximum is \$127 a month. A man and wife both going on the rolls at 65 or later receive half again as much. Maximum benefits to a family based on a worker's earnings range up to \$254 a month.

Almost everyone who works is covered by social security. The only major groups excluded from coverage are self-employed physicians, Federal employees under the civil service retirement system, self-employed persons with annual net earnings of less than \$400, and farm and household workers with irregular employment. Employees of State and local governments and of nonprofit organizations may obtain coverage on a voluntary group basis and almost 80 percent have done so. Railroad employees, through a coordination of the railroad retirement and social security programs, are in effect covered by social security.

The program, then, furnishes basic retirement, disability, and survivor protection to practically all of the American people. The Council believes enactment of the recommendations discussed in the pages that follow will enable the program to do so more effectively.

SOCIAL SECURITY BENEFIT AMOUNTS

The social security program today is the major reliance of most of our people for income security in old age. As indicated in Part II, about one-half of the older social security beneficiaries have less than \$12.50 a month in continuing retirement income other than their social security benefits, and for all but about one-fifth of the beneficiaries, benefits are the major source of continuing retirement income.²⁴ With social security benefits the source of almost all of the regular retirement income received by so many of the older people in the country and the main reliance of so many

²⁴ See footnotes 16 and 17, page 16.

more, it is essential that the benefit structure be examined from time to time to make sure that benefits are reasonably adequate.

Benefits for a retired worker (men and women) alone average only \$74 a month; for an aged couple, \$130. Two-thirds of the couples on the benefit rolls are getting less than \$158 a month. Even for people now coming on the benefit rolls at or after age 65, the old-age benefits for men alone average \$103 a month; for couples, \$159. The Council believes that these amounts are too low.

In considering how best, within the limitations imposed by the necessities of financing, to improve benefits for both present beneficiaries and for those who become beneficiaries in the future the Council examined the several factors that determine benefit size—the contribution and benefit base, the provisions for translating the record of credited annual earnings into the “average monthly earnings” on which the benefit is based, the special provisions for reduced benefits for those who retire early, and the structure of the formula for deriving the monthly benefit from the average monthly earnings. As a result of its examination, the Council is recommending changes in three of the four factors and an intensive study of possible changes in the fourth.

The recommendation of the Council for increasing the contribution and benefit base is outlined in Part I of this report (on page 12) because of its implication for the financing of the program. Raising the base in line with rising earnings has equally important implications for the benefit structure of the program. Social security is important to average and above-average earners as well as to low-paid people. Over the years, the erosion of the base has meant that the protection for the higher earner has significantly deteriorated. For example, a man who was earning \$3,000 in 1940 had all of his earnings counted and, looking forward to retirement in 1965, could expect to get a benefit that would equal 21 percent of these earnings; in 1965 a man who was earning \$3,000 in 1940, if his earnings rose in proportion to the rise in earnings generally, will be earning about \$13,000, and under the \$4,800 base now in effect would get a benefit that would equal only 11 percent of his earnings today. Today about two-thirds of the regularly employed men have earnings above the maximum which can be

counted for benefit purposes. The Council believes that improvement of the benefits payable at earnings levels above \$4,800 for people retiring in the future through increasing the base is necessary in order to preserve the wage-related character of the program and to make it more effective for the average and above-average earner.

The other recommendations of the Council for improving the benefit structure are discussed in detail in the following pages.

1. The Period for Computing Benefits for Men

The period for computing benefits (and insured status) for men should be based, as is now the case for women, on the period up to the year of attainment of age 62, instead of age 65 as under present law, with the result that 3 additional years of low earnings would be dropped from the computation of retirement benefits for men.

The Council recommends that the period used for computing benefits for men in retirement cases should be shortened by 3 years, making it the same as for women. While retirement benefits are payable to men and women at age 62, and while the reduction rates applicable where benefits are taken before age 65 are the same for men as for women, the average monthly earnings for men are computed over a period equivalent to the number of years (less 5 years) up to attainment of age 65, whereas for women they are determined over a period equivalent to the years (less 5 years) up to age 62. If a man does not work after age 62 his average monthly earnings and the resulting benefits generally will be reduced, but a woman's failure to work past age 62 generally has little or no adverse effect on her benefits.²⁵

²⁵ The following example illustrates the effect on benefit amounts of shortening by 3 years the period over which a man's average monthly earnings are figured: A man who earned \$3,000 in each year, 1951 through 1958, became unable to continue at his regular work in 1959 and his earnings decreased to \$1,500 a year in 1959 through 1964. He reached age 62 in 1965, had no earnings in that year, and took his reduced old-age benefit. Under present law, only 5 years, including the 3 years from age 62 to 65 in which he had no earnings, could be omitted in figuring his average monthly earnings, with the result that he would get a benefit of \$68.80 at age 62 (his average monthly earnings of \$208 would yield an unreduced benefit of \$86). Under the recommendation an additional 3 years would be dropped from the computation and his benefit would be \$73.60 (based on average monthly earnings of \$236 and an unreduced benefit amount of \$92).

With the general benefit increase recommended by the Council the man would get a benefit of \$87.20 (based on an unreduced benefit of \$109) with the shorter computation period, while under the benefit increase alone and with the present age 65 closing point he would get a reduced benefit of \$82.40.

The Council is concerned about the low benefits payable to men who have been coming on the benefit rolls before age 65, especially those whose retirement has been involuntary. Almost one-half of the men awarded old-age benefits in the fiscal year 1964 get reduced benefits because they came on the rolls before age 65, and their benefits are, on the average, much lower than the benefit amounts payable to men who come on the rolls at age 65 or after—for fiscal year 1964 awards, \$75 for men who came on before 65 as compared to \$103 for men who came on at or after 65.

The reduced benefits which are now paid to men and their wives who start to get old-age benefits before age 65 are below what they can be expected to live on. As a result it may be anticipated that many will sooner or later have to apply for assistance; and the role of public assistance in providing income for people who can no longer work—a role which has diminished over the years as the social security program has grown—can be expected to expand. The proposal to end the computation period for men at 62 instead of 65 will alleviate this situation.

The Council is not certain, however, that this change will improve benefits enough for people who are forced into early retirement. It may be necessary later to consider providing for a smaller-than-actuarial reduction in benefits for people who come on the rolls before age 65. Provision for a smaller reduction, though, would be relatively expensive and could have adverse effects on private pension plans. It might also have effects on retirement policies and on the general patterns of work and retirement in the later years of life.

Because of the importance of such a change, the Council does not want to make any recommendation on the basis of the present limited experience with the age-62 actuarial-reduction provision for men. The provision permitting men to get benefits at 62 was enacted in 1961, and available data, much of which relates only to the year 1962, may not be representative of the ongoing situation. The Council recommends that the Social Security Administration continue to collect information about the people who come on the benefit rolls before age 65. The information should include data relative to both their past work experience and their current financial situation, and should provide answers to such questions as the following: how many have been regular full-time workers over the greater part of their lives, and how many have been only intermittently or casually employed; how many have been the primary earners in their families, and how many have been secondary earners; how many are unskilled workers, how many have skills that have become obsolete because of technological or economic change, and how many have skills that are still useful and in demand; and how many are retiring voluntarily, how many are being forced to retire, and how many have already been out of employment for some time.

Shortening by 3 years the period for computing benefits for men will, of course, benefit men who retire at or after age 65 as well as those who retire before age 65; it will also result in the payment of higher benefits in some cases to the dependents of retired men and to the survivors of men who die after reaching age 62. The proposal will also make payable more quickly, as far as men are concerned, the higher benefits that will become possible with the increased contribution and benefit base that is being recommended by the Council. The reason why

this happens is that with a computation period shorter by 3 years than it would be under present law, fewer years prior to the effective date of the new base would have to be included in the computation and the average monthly earnings would consequently be higher.²⁶

2. A General Increase in Benefits

A general increase in benefit amounts, accomplished by a change in the way the benefit formula is constructed, should be provided to take into account increases in wages and prices since the last general benefit increase in 1958, and the maximum on monthly family benefits should be related to earnings throughout the benefit range.

The Council recommends a general benefit increase which will average about 15 percent but which will be accomplished, not by increasing each benefit by 15 percent, but rather by a change in the way the benefit formula is constructed. About half of the 15 percent will go to restoring the purchasing power of the benefits, taking account of increases in prices since 1958, the time of the last general benefit increase. The remainder will be used to adjust in part to the increase in earnings that has taken place and so improve the real value of the benefits.

The Council believes that while the increase to make up for the increase in the cost of living, amounting to about 7 percent, should be applicable at all benefit levels, the improvement in the real value of the benefits should not be uniformly applicable at all levels.

Instead of the large increase in the percentage factor applicable to the lower part of the average monthly earnings that would arise from such a uniform application, the Council proposes to increase the amount of average monthly earnings to which the heavier weighting applies.²⁷ The purpose of having a weighted formula is to give recognition to the fact that the lower-paid worker and his family have less margin for reduction of their income and are less likely to have other re-

²⁶ For example, take the case of a man who has always earned at or above the maximum taxable level and who attains age 65 and retires on January 1, 1971. Assuming that the Council's recommendations with respect to the contribution and benefit base and the benefit formula were enacted, but the years up to 65 had to be used in computing the average monthly earnings, this man's average would be figured over his highest 15 years of earnings after 1950 and thus would be based on 3 years of earnings at \$4,200, 7 years at \$4,800, 2 years at \$6,000, and 3 years at \$7,200. His average monthly earnings would be \$443 and his benefit would be \$153. If, on the other hand, the recommendation for dropping out 3 more years in such cases is adopted, the 3 years in which his earnings were \$4,200 would be dropped from the computation, his average monthly earnings would be \$446 and his monthly benefit would be \$158.

²⁷ In order to provide a larger benefit relative to earnings for lower-paid people than for higher-paid people, social security benefit amounts have always been based on a formula that is weighted to pay a relatively larger percentage of average earnings up to a certain amount and a smaller percentage of earnings above that amount. The formula underlying the benefit table now in the law is 58.85 percent of the first \$110 of average monthly earnings and 21.4 percent of the remainder.

sources than high-paid workers; and the level of earnings that marks what can be considered a lower-paid worker goes up as earnings go up generally. In recognition of this fact, the amount of average monthly earnings to which the higher percentage applies was increased from the original level of \$50, set in 1939, to \$100 in 1950 and to \$110 in 1954. In view of the increase in wages that has occurred since 1954, when the amount was last changed, the Council believes that in effect the definition of what constitutes a low-paid worker should be changed again by an increase in the level of earnings to which the higher percentage is applied, and the Council recommends an increase from \$110 to \$155.²⁸

The reason for not applying more than a 7-percent cost-of-living increase at the lower levels of average monthly earnings is that the increase at average monthly earnings below, say, \$100 would go mostly to people who have not worked regularly under the program, and whose benefits are already almost as large for a couple as the earnings on which the benefits are based.

Although no substantial increase should be made in the percentage factor applying to the lower part of the average monthly earnings, since this would tend to increase benefits for people who work under the program only part time, such as people who spend most of their lives as Federal workers, as housewives, or in noncovered State and local government employment, the Council does favor improving the situation for the low-paid worker who is regularly covered. The Council believes that if the social security program is to do an adequate job as the basic system providing retirement income, one goal must be that such a low-paid worker will get benefits high enough so that he will not have to turn to public assistance to meet regular living expenses. Low-paid workers are not likely to have significant savings or private pensions; and in the absence of adequate social security benefits, most of them will have to turn to assistance to supplement their benefit income. In the opinion of the Council supplementation of benefits by assistance on a large scale to meet regular recurring expenses is undesirable. The goal should be to have social security benefits meet regular, ordinary living expenses and to have assistance serve as a backstop to meet special and unusual needs. The Council believes therefore that the level of benefits should be such that a regular full-time worker at low earnings levels will ordinarily not have to apply for assistance.

Under present law, if a worker has average monthly earnings of \$200 a month (the equivalent of full-time earnings at the Federal minimum wage) he and his wife will get a retirement benefit of \$126 starting at age 65. Forty-one of the fifty States have old-age assistance standards for a couple that are higher than \$126 a month (not counting any allowance made for medical care), and the median standard for a couple is \$147 a month. With the benefit increase that the Council is recommend-

²⁸ The result of the Council's recommendation for a change in the level of earnings to which the higher percentage is applied is that benefit amounts payable at average monthly earnings above \$155 (and up to the present maximum average monthly earnings of \$400) will be increased by a flat amount of about \$17 (see table on page 28). Above the present maximum average monthly earnings of \$400, of course, the increase in the contribution and benefit base will gradually produce benefits, for those who pay on the higher base and retire in the future, that will be considerably more than \$17 above the present maximum benefit of \$127.

ing, a worker earning \$200 a month and his wife would get total monthly social security benefits of \$151.50, an amount that would be more than or within a few dollars of the assistance standards of 30 of the 50 States. Workers who earn more than minimum wages would of course get higher benefits.

The following tables illustrate benefit amounts that would be payable under the Council's recommendations for changing the method of computing the benefits. The effect of the Council's recommendation for increasing the contribution and benefit base is also shown in the tables.

Benefit amounts payable to a retired worker who comes on the benefit rolls at age 65 or over under present law and under the Council's recommendations

Average monthly earnings	Primary insurance amounts		Percent replacement of average monthly earnings	
	Present law	Proposal	Present law	Proposal
\$67 ¹ -----	\$40	\$43	59.7	64.2
100-----	59	63	59.0	63.0
110 ² -----	65	70	59.1	63.6
124 ³ -----	68	73	54.8	58.9
155 ⁴ -----	74	91	47.7	58.7
200-----	84	101	42.0	50.5
300-----	105	122	35.0	40.7
400 ⁵ -----	\$ 127	144	31.8	36.0
500-----	\$ 127	165	25.4	33.0
600 ⁶ -----	\$ 127	\$ 186	21.2	31.0

¹ The highest amount of average monthly earnings on which the minimum benefit of \$40 is payable under present law.

² The highest amount of average monthly earnings to which the higher percentage in the benefit formula in present law is applied.

³ The smallest amount of average monthly earnings to which the recommended formula applies; at all lower average monthly earnings levels the 7-percent increase is larger.

⁴ The highest amount of average monthly earnings to which the higher percentage in the formula would be applied under the Council's recommendation.

⁵ The maximum under present law.

⁶ The maximum under the \$7,200 contribution and benefit base which the Council recommends go into effect in 1968.

Benefits payable to a married couple coming on the benefit rolls at age 65 or over under present law and under the Council's recommendations

Average monthly earnings	Benefit amount		Percent replacement of average monthly earnings	
	Present law	Proposal	Present law	Proposal
\$67 ¹ -----	\$60.00	\$64.50	89.6	96.3
100-----	88.50	94.50	88.5	94.5
110 ² -----	97.50	105.00	88.6	95.5
124 ³ -----	102.00	109.50	82.3	88.3
155 ⁴ -----	111.00	136.50	71.6	88.1
200-----	126.00	151.50	63.0	75.8
300-----	157.50	183.00	52.5	61.0
400 ⁵ -----	\$ 190.50	216.00	47.6	54.0
500-----	\$ 190.50	247.50	38.1	49.5
600 ⁶ -----	\$ 190.50	\$ 279.00	31.8	46.5

¹ The highest amount of average monthly earnings on which the minimum benefit of \$40 is payable under present law.

² The highest amount of average monthly earnings to which the higher percentage in the benefit formula in present law is applied.

³ The smallest amount of average monthly earnings to which the recommended formula applies; at all lower average monthly earnings levels the 7-percent increase is larger.

⁴ The highest amount of average monthly earnings to which the higher percentage in the formula would be applied under the Council's recommendation.

⁵ The maximum under present law.

⁶ The maximum under the \$7,200 contribution and benefit base which the Council recommends go into effect in 1968.

The Council recommends also that the method of determining family maximum benefits be changed. At present, over a wide range of average monthly earnings at the

higher levels, the maximum family benefit is a flat dollar amount unrelated to the average monthly earnings on which the individual benefits are based.²⁹ Under the Council's recommendation the family maximum would no longer have a flat dollar limit but would be determined by a weighted formula under which the family maximum at the higher earnings levels, as well as at the lower levels, would be related to previous average monthly earnings.³⁰ Such an approach would get away from a fixed dollar limit yet would continue to avoid the payment of excessively large family benefits at the higher earnings levels.

This new approach was embodied in the omnibus social security bill that passed both the Senate and the House of Representatives in 1964, but did not become law because the Conference Committee was unable to agree on other provisions in the bill.

The following table illustrates family maximum benefit amounts that would be payable under the Council's recommendations:

Maximum family benefits payable under present law and under the Council's recommendations

Average monthly earnings	Family maximum	
	Present law	Proposal
\$67 ¹	\$60.00	\$64.50
100	88.50	94.50
110 ²	97.50	105.00
124 ³	102.00	109.50
155 ⁴	124.00	136.50
200	161.60	161.60
300	240.00	240.00
400 ⁵	254.00	320.00
500	254.00	360.00
600 ⁶	254.00	400.00

¹ The highest amount of average monthly earnings on which the minimum benefit of \$40 is payable under present law.

² The highest amount of average monthly earnings to which the higher percentage in the benefit formula in present law is applied.

³ The smallest amount of average monthly earnings to which the recommended formula applies; at all lower average monthly earnings levels the 7-percent increase is larger.

⁴ The highest amount of average monthly earnings to which the higher percentage in the formula would be applied under the Council's recommendation.

⁵ The maximum under present law.

⁶ The maximum under the \$7,200 contribution and benefit base which the Council recommends go into effect in 1968.

²⁹ Specifically, the maximum family benefit under present law is \$254 (twice the maximum benefit payable to a retired worker) or 80 percent of the average monthly earnings (but it is not permitted to reduce the family benefits to less than 1½ times the worker's primary insurance amount). The \$254 limit applies at all levels of average monthly earnings above \$314.

³⁰ Specifically, the family maximum would be 80 percent of the average monthly earnings up to the point at which the average monthly earnings amount is two-thirds of the maximum possible average monthly earnings under the contribution and benefit base specified in the law. The family maximum at earnings levels above this breaking point would be increased by 40 percent of the amount of the average monthly earnings over the breaking point. For example, if the contribution and benefit base were \$6,000 the family maximum would be 80 percent of the average monthly earnings at earnings levels up to \$333; at earnings levels between \$333 and \$500 it would be 80 percent of the first \$333 plus 40 percent of any additional average monthly earnings, so that at the \$500 level the maximum would be \$333, or two-thirds of the average monthly earnings to which it applies.

3. The Maximum Lump-Sum Death Payment

The maximum lump-sum death payment should not be set in terms of an absolute dollar limit but rather should be the same as the highest family maximum monthly benefit.

Under present law the lump-sum death payment is equal to 3 times the primary insurance amount of the deceased worker but it may not exceed \$255. The \$255 limit on the maximum lump-sum death payment was established by the Congress in 1952 and it has not been changed since that time. This limit, which applies at all levels of primary insurance amounts above \$85 (average monthly earnings levels above \$207), is becoming increasingly outdated because it is unrelated to earnings levels or benefit amounts and has not been increased as earnings levels have risen or as monthly benefit levels have been increased.

Since 1952 the Consumer Price Index has risen by more than 16 percent. More significantly, over the same period the average cost of an adult's funeral has gone up at least 30 percent; and medical costs, much of which in the case of the last illness is likely to have to be met from the estate, or by the survivors, have increased almost 50 percent.

The Council believes that the lump sum should not be subject to a dollar limit that is allowed to remain stationary when other provisions of the law are changed, but rather that the dollar limit should be adjusted with other provisions of the law as earnings levels rise. The Council recommends specifically that the provision governing the amount of the maximum lump sum be changed from the present one prescribing an absolute dollar limit of \$255 to a provision that the maximum lump sum shall be equal to the highest family maximum monthly benefit. Lump-sum death payments up to the new maximum would continue to be equal to 3 times the primary insurance amount. And the maximum lump sum would increase whenever the maximum family benefit is increased so that it would not remain stationary in the future as it has over the past 12 years.

DEPENDENTS' AND SURVIVORS' BENEFITS

Since the decision in 1939 to provide family protection—that is, to protect those who normally depend on the worker for support as well as the worker himself—Congress has provided benefits in most situations where it is necessary and appropriate to replace the support lost by a dependent or survivor as a result of the retirement, disability, or death of the worker. The Council has concluded, however, that there are a few additional dependency situations for which protection should be provided.

4. Children Over Age 18 Attending School

Benefits should be payable to a child until he

reaches age 22, provided the child is attending school between ages 18 and 22.

Benefits under the social security program should be paid to a child as long as it is reasonable to assume that he is dependent on his family. Under the present law, child's insurance benefits (except for a disabled child) are payable only until age 18, presumably on the theory (not an unreasonable one at the time that benefits were first provided for children by the 1939 amendments) that by age 18 a child can be expected to support himself.³¹ With the growing importance of education in modern life it is becoming increasingly clear that this is not a reasonable expectation. Today at least some education beyond high school is rapidly becoming part of our general level of living and will increasingly be necessary because of rapid technological advancement and the growth in the number of professional, technical, and other jobs requiring higher levels of education. As a consequence the period of dependency of children has been lengthening.

There is precedent in other Federal programs for paying benefits to children after they reach the age of 18 while they are in school. The civil service retirement program generally pays benefits up to the end of the academic year in which the student reaches age 21. Under three veterans' programs—the dependency and indemnity compensation program, the non-service-connected death pension program, and the war orphans education assistance program—a child may get benefits after he reaches age 18 while he is attending school. Under an amendment enacted in 1964 to the program of aid to families with dependent children the Federal matching share in assistance payments may be continued up to age 21 where a child is attending a high school or a vocational school.

The Council does not recommend that mother's benefits be made payable to a mother where the only child getting benefits is age 18 or over and is getting benefits on the basis of being a student. Benefits are paid to a wife or widow under age 62 who has a child in her care if she does not have earnings from work above specified limits, in recognition of her need to stay at home to care for the child. Where the only child is age 18 or over there is not the same reason to pay mother's benefits, since there is no need for the mother to stay home to care for the child.

An amendment similar to that recommended by the Council, to continue social security benefits after a child reaches age 18 when the child is still in school, was passed by both houses of Congress in 1964 but failed to become law because the Conference Committee was unable to agree on other provisions in the omnibus bill.

5. Disabled Widows

The disabled widow of an insured worker, if she became disabled before her husband's death or before her youngest child became 18, or within a

³¹ Under the 1939 provision, benefits could not be paid to a child over 16 for any month in which he was not regularly attending school unless school attendance was not feasible; the school attendance requirement was repealed in 1946.

limited period after either of these events, should be entitled to widow's benefits regardless of her age.

The Council believes that the disabled widow, like the widow who is aged 62 or over or the widow who has a child of the deceased worker in her care, needs benefits when her husband dies. The Council therefore recommends that benefits be paid to the widow so disabled that she cannot work—provided, however, that she was disabled at the time of her husband's death or before her youngest child reached age 18, or within a limited period after either of these events.

The widows who would be protected are those who, when their husbands die, suffer a loss of support and who, because they are disabled themselves, have no opportunity to work and thus to substitute their own earnings for that loss of support. On the other hand, the Council does not believe it would be in keeping with the purpose of the program to pay widow's benefits on account of disability to a woman whose disability occurred after she could have reasonably been expected to have worked long enough to earn disability insurance benefits in her own right. For example, it would not seem of high priority to pay widow's benefits to a widow who was, say, 30 years old and childless when her husband died and who did not become disabled until many years later. Such a widow would most likely have gone to work and earned disability protection in her own right, and, if she had not worked after she was widowed, it would seem unreasonable to pay her a benefit on the grounds that a physical or mental impairment that developed later in life was preventing her from working.

A theoretical case can also be made, perhaps, for providing benefits for other disabled dependents (almost all of them would be disabled wives who are under age 62) of retired or disabled workers. However, it cannot be assumed that younger wives of older retired men and wives of disabled men look to employment for support to anywhere near the extent that widows do. Thus extending the group of disabled dependents to include wives would result in the payment of benefits in many cases where the couple had not experienced any loss of earned income as a result of the disability of the wife. Considering this fact, the Council believes that additional information is needed to determine whether it would be desirable to pay benefits to disabled wives as well as widows.

6. Definition of Child

A child should be paid benefits based on his father's earnings without regard to whether he has the status of a child under State inheritance laws if the father was supporting the child or had a legal obligation to do so.

Under present law, whether a child meets the definition of a child for the purpose of getting child's insurance benefits based on his father's earnings depends on the laws applied in determining the devolution of intestate personal property in the State in which the worker is

domiciled. The States differ considerably in the requirements that must be met in order for a child born out of wedlock to have inheritance rights. In some States a child whose parents never married can inherit property just as if they had married; in others such a child can inherit property as the child of the man only if he was acknowledged or decreed to be the man's child in accordance with requirements specified in the State law; and in several States a child whose parents never married cannot inherit his father's intestate property under any circumstances. As a result, in some cases social security benefits must be denied even where a child is living with his mother and father in a normal family relationship and where neither the child nor his friends and neighbors have any reason to think that the parents were never married.

The social security program is national in scope, covering the worker without regard to the State in which he resides, and the program is intended to pay benefits as a partial replacement of lost support to those relatives of the worker who normally look to him for support. The Council believes that in such a program whether a child gets benefits on the earnings record of a person who has been determined to be his father and who has an obligation to support him should not depend on whether he can inherit that person's intestate personal property under the laws of the State in which the person happens to live.

There is precedent in the veterans' laws for paying benefits to children who do not meet the definition of "child" under State law. Under the veterans' program the child of a veteran may get benefits regardless of State law if the veteran had acknowledged the child in writing, or had been ordered by a court to contribute to the child's support, or before his death had been judicially decreed to be the child's father, or is shown by other satisfactory evidence to be the child's father. The Council believes that a similar provision should be included in the social security program.

DISABILITY BENEFITS

Disability insurance is the newest part of the social security program, having been established by amendments enacted in 1954 and 1956. Since then, this part of the program has been improved by providing benefits for the dependents of disabled workers and by extending disability protection—as the original provisions did not—to workers at all ages. As a result it has played a growing role in meeting the needs of the disabled. The Council believes that this development should continue as experience with the program grows, and recommends that two improvements be made at this time.

The Council recognizes that there is ground for considering still other changes in the program, since there are many totally disabled people who face the prospect of having their resources de-

pleted during periods when they are not eligible to receive benefits under either private plans or the social security system. The Council is aware that such consideration will be enhanced by several studies now in progress or being planned by the Social Security Administration which will produce additional information on, for example, the characteristics of applicants who are denied social security disability benefits, the income and other financial resources of severely disabled people, and the extent to which social security disability beneficiaries are dependent upon public assistance. The Council believes that these studies may point up the need for further consideration of proposals to eliminate gaps in the protection now afforded totally disabled people.

7. Young Disabled Workers

Young workers who become disabled should have their eligibility for benefits determined on the basis of a test of substantial and recent employment that is appropriate for such workers.

Under present law, in order to be eligible for disability benefits, a worker must meet a requirement of 5 years of work in the 10-year period before he became totally disabled. This requirement assures that the benefits will be paid only to people who have both substantial and relatively recent employment. However, the effect of the 5-years-of-work requirement on a worker disabled while young is to make it difficult, or even impossible, for him to get disability benefits. For example, the worker who becomes totally disabled at age 25 and who started to work at age 21 has a total of only 4 years of covered work and therefore cannot meet the requirement.

The restriction of disability insurance protection to workers who have had substantial and recent employment can be achieved for younger workers by an alternative provision under which a worker disabled before age 31 would be eligible for benefits if he had been in covered work for at least one-half of the period between age 21 (the age from which fully insured status is figured under present law) and the point in time at which he became disabled, or, in the case of those becoming disabled before age 24, for at least one-half of the 3 years preceding disablement.³²

³² Under this proposal, a worker who becomes disabled before attaining age 24 would have to have been in covered work 1½ years in the 3-year period before he became disabled; a worker who became disabled after age 24 and before age 31 would have to have been in covered work half the time after age 21 and before becoming disabled; and a worker who becomes disabled after age 31 would, just as under present law, have to have been in covered work for 5 out of the 10 years before he became disabled.

This provision would be somewhat similar to a provision now in the law under which the survivors of a worker who died while young can qualify for benefits even though he had only a short period of covered work.

8. Rehabilitation of Disability Beneficiaries

The social security program should pay the costs of rehabilitation for disability beneficiaries likely to be returned to gainful work through such help, with the rehabilitation services being provided through State vocational rehabilitation agencies.

Disability insurance beneficiaries show less potential for rehabilitation than people who, though disabled, do not meet the strict definition of disability in the social security law. Because the beneficiaries have less potential, rehabilitation services for them may be given a relatively low priority by the State vocational rehabilitation agencies, and because of limitations on funds and therefore on the extent of services that can be offered by the agencies, some beneficiaries who could profit from rehabilitation services do not get them.

The Council believes that those disability beneficiaries who can reasonably be expected to be returned to gainful employment through rehabilitation services should get such services. Increasing the number of disabled workers who are rehabilitated would benefit not only the people involved but also society in general. For the rehabilitated person the gain would not only be increased income but also the satisfaction flowing from his restoration to a useful economic role in society.

The Council recommends, therefore, that money be made available from the social security trust funds to finance the rehabilitation of selected disability beneficiaries. The expenditure of social security funds is clearly justified so long as the savings from the amount of benefits that would otherwise have to be paid exceed, or at least equal, the money paid from the trust funds for rehabilitation costs. It is wasteful and shortsighted for the social security system to be paying benefits to disabled persons if a lesser expenditure of funds would assure their return to work.

ELIGIBILITY FOR BENEFITS

9. Insured Status

The Council recommends retention of a requirement of covered work as a test of eligibility for benefits, and has no major changes to recommend in the present provisions.³³

³³ As previously indicated, the Council is recommending a change in the disability insured status requirement as it applies to young workers and a change from age 65 to age 62 in the ending point for determining fully insured status for men.

The present requirement of a "fully insured" status—covered work for a period of time equal to about one-fourth of the time after 1950 (or age 21, if later) and up to death or retirement age—is, in the opinion of the Council, a reasonable one.³⁴ Some prescribed requirement of attachment to covered work is essential under a program which pays a substantial minimum benefit. The present requirement makes the program effective for older workers in the early years and, at the same time, gives equitable treatment to those now young, since the short-run requirement for fully insured status (1 quarter of coverage for each 4 quarters after 1950) is comparable to the long-run requirement (10 years out of a working life of 40 years or so). The alternative requirement for survivor benefits, the "currently insured"³⁵ status requirement in present law, serves well as a test of dependence upon covered earnings for support. The Council believes that both requirements for old-age and survivors insurance should be retained as they are, except that the end point for determining fully insured status for men should be changed from 65 to 62, as recommended in the section of this report on benefit amounts (page 26).

In connection with its consideration of the work requirements of the program, the Council has given attention to proposals for paying minimum benefits, financed either from social security funds or from general revenues, to older people who have not met these requirements. Whatever theoretical merit these proposals might have had at an earlier stage in the development of the program, there do not seem to be persuasive reasons for adopting any of them now. Only about 15 percent of the aged today are unprotected by social security and this figure is becoming smaller all the time. Over 90 percent of the people now reaching age 65 are eligible for benefits and, over the long run, virtually everyone who was dependent on earnings will qualify for benefits. About 50 percent of the 2.7 million aged persons not under social security or railroad retirement are getting old-age assistance, and the payment of minimum benefits to them would in effect be substituting either general revenue funds or social security funds, depending on the particular proposal, for a portion of the Federal-State payments which they are getting now, without removing very many from the assistance rolls. Another 20 to 25 percent of those not eligible for social security benefits are beneficiaries of other governmental retirement systems or of veterans' programs and additional numbers are in governmental institutions.

³⁴ More specifically, to be fully insured a person must have at least as many quarters of coverage (earned at any time after 1936) as the number of years elapsing after 1950 (or after the year in which he attains age 21, if later) and up to the year in which he reaches age 65 (62 for women), becomes disabled, or dies, whichever occurs first. (For most kinds of employment a person acquires 1 quarter of coverage for each calendar quarter in which he is paid \$50 or more in wages; generally speaking, a person acquires 4 quarters of coverage for each year in which he is covered as a self-employed person.) The minimum requirement for fully insured status is 6 quarters of coverage; the maximum is 40 quarters of coverage.

³⁵ A person is currently insured if he has approximately 1½ years of covered work out of the 3-year period immediately preceding his death or entitlement to benefits. In death cases, child's benefits, mother's benefits, and a lump-sum death payment can be paid if the worker was currently insured even though he was not fully insured.

Since the remaining problem is now so small, the Council believes it is undesirable to risk the public misunderstanding that might result from such a "blanketing-in."

10. Retirement Test

The provision in the law that prevents the payment of benefits to a person with substantial earnings from current work—the retirement test—is essential in a program designed to replace lost work income and should be retained.

The purpose of social security benefits is to furnish a partial replacement of earnings which are lost to a family because of death, disability, or retirement in old age. In line with this purpose the law provides that, generally speaking, the benefits for which a worker, his dependents, and his survivors are otherwise eligible are to be withheld if they earn substantial amounts.

If benefits were paid without a test of retirement, the cost of the program would be substantially increased and the combined additional contributions which would have to be paid by employers and employees to support the provision would amount to nearly 1 percent of covered earnings. In 1964 about \$2 billion in additional benefits would have been paid, and most of this money would have gone to those who are working full-time and generally earning as much as they ever did. The great majority of the older people who are eligible for benefits—those who are unable to work, those who can do some work but cannot earn more than \$1,200 a year, and those who are aged 72 and over and therefore no longer subject to the test—would not be helped by elimination of the test. Indeed they might be hurt; the increased cost might well stand in the way of improvements which *would* be of help to them. Thus if the concept of partially replacing work income lost through retirement were dropped and a straight annuity concept adopted, the costs would be incurred mostly to pay benefits to those fortunate older people with regular jobs at the expense of all the rest.

The test of retirement is essential to implement the purpose of the program—insurance against the loss of earned income. It is not to be confused with a test of individual need or income. The Council believes it is of the greatest importance that benefits continue to be paid without regard to the nonwork income or assets of the beneficiary. Only by paying benefits without regard to nonwork income can the program continue to sustain the motivation of the individual to save on his own and to buy private insurance. Only in this way can the partnership of social security with private pension plans be continued. Moreover, it is the absence of any test of need or income that, together with the concept of earned right, gives the program its distinctive character as a program of self-support and self-reliance.

The Council has not only considered the desirability of retaining the test of retirement, but has evaluated various alternative ways of liberalizing the test. The Council

recognizes that the present test does discourage some people who are retired from their regular jobs from earning as much as they could, or would like to, in part-time or irregular employment. Because only \$1 in benefits is withheld for each \$2 of earnings between \$1,200 and \$1,700, additional earnings always means more total income from benefits and earnings up to that point, but above \$1,700, a person loses \$1 in tax-exempt benefits for each \$1 of taxable earnings. Because his earnings are reduced by the amount of income tax he must pay, while the benefits he foregoes would not have been taxable, he may be worse off financially as he earns more. Even those who, because of extra exemptions or extraordinary medical expenses, for example, do not have any income tax liability may be worse off financially because they must pay the social security tax on their earnings and because of expenses connected with working.

If the limit on the span of earnings to which the \$1-for-\$2 adjustment applies were raised, people would not be faced with a financial deterrent to earning somewhat more than \$1,700 a year, and there would be relatively little increase in the cost of the program.

On the other hand, if the limit were extended very far and at the same time the benefit formula were liberalized and the benefit and contribution base raised as the Council recommends, people would be able to earn quite high amounts and still get some benefits. For example, if the present \$1,700 figure were extended as far as \$3,000 (and if the benefit increases recommended by the Council were adopted) a person getting benefits for himself and his wife based on average earnings of \$6,000 a year would be able to earn \$5,000 and still get some benefits. And such a substantial liberalization of the test would increase substantially the number of people who could keep on working at their regular jobs and get benefits.

On balance, while the Council does not recommend any change in the retirement test, it believes that if nevertheless a change were to be made it would be best to go a limited way in the direction of extending the \$1-for-\$2 band.

EXTENDING THE COVERAGE OF THE PROGRAM

Practically all working people are now covered by social security. At any given time the employment of nearly 9 out of 10 people in the paid labor force is covered. Of the employment which is not covered, about one-half is that of governmental employees—Federal, State and local—almost all of whom are covered under governmental staff retirement systems. Almost two-fifths of the employment not covered is that of people who work irregularly—part-time household and farm work performed by people (in many cases housewives, school children, or retired persons) who do not meet the relatively low earnings tests required for coverage in these employment areas,

or self-employment by people who earn less than \$400 in a particular year. The other major exclusion is self-employment in the practice of medicine. Approximately 170,000 doctors have their self-employment earnings in the practice of medicine excluded from coverage. In addition, a very substantial part of the work income of one group of covered workers, those who customarily receive tips in the course of their employment, is not subject to tax nor creditable toward benefits, and as a consequence, the social security protection of these workers is inadequate.

The changes in the coverage provisions of the program which the Council recommends would extend coverage to the self-employment earnings of physicians, provide social security protection for Federal employees when they are not eligible for civil service retirement benefits, facilitate the coverage of additional State and local government employees, and provide social security credit for tips.

To the extent feasible, everyone who works should be covered by the social security program. Every occupational group contains substantial numbers of people who at one time or another will need the protection of the program and it is impossible to foresee, over the course of a lifetime, who will and who will not have this need. Moreover, all Americans have an obligation to participate, since an effective social security program helps to reduce public assistance costs, and reduced public assistance costs mean lower general taxes. There is an element of unfairness in a situation where practically all contribute to social security while a few profit from the tax savings but are excused from contributing to the program.

It is essential that the coverage of the program remain on a compulsory basis. If coverage were voluntary, the program could not effectively carry out its purpose of providing basic protection for all. The improvident would not be inclined to elect coverage. Many workers who have great need for protection and limited opportunity to acquire it through private means—low-income workers, workers with large families and workers in poor health—would choose not to pay social security contributions because of pressing day-to-day needs. Moreover, permitting individual voluntary coverage would increase program costs and give those allowed such coverage an unfair

advantage over workers who are covered on a compulsory basis.

Social security was designed to operate under a benefit structure which would protect all Americans and their families regardless of the worker's age, the size of his family, or any other factor which might make the value of the protection high in relation to the worker's own contributions. Because social security is financed in part by employer contributions, it can provide in virtually all cases protection worth more than the employee contributions and still take care of the higher-cost risks, such as older workers and workers with large families (where the protection provided may be much more valuable than the contributions). This type of benefit structure, which is highly desirable from the standpoint of enabling the program to accomplish its goals, is practical only under compulsory coverage. Only through compulsory coverage can there be assurance that those covered will include not only the high-cost risks but also the lower-cost risks. And only in a system that provides for compulsory coverage of employees is it reasonable to require employer contributions to help finance the benefits. If employees could choose to be covered or not to be covered by social security, employers would have good grounds for resisting any requirement that they pay contributions on the earnings of those employees who elected not to participate. It would not be practical, on the other hand, to require an employer to contribute with respect to only those of his employees who elected coverage. Aside from the constitutional question of whether a tax can be imposed on one party as a result of a voluntary choice of another, such a provision would create an undesirable economic incentive to employ workers who chose not to be covered.

The only provision now in the program for individual election of coverage is that applying to ministers, and the general objections to voluntary coverage have been borne out in the experience with this provision. Coverage has been elected by a large proportion of those ministers who are approaching retirement age—ministers who can confidently expect a large return for their social security contributions. On the other hand, the proportion of younger ministers who have elected coverage is not nearly as large. Thus the net effect on the trust funds is unfavorable in comparison with the cost of the general com-

pulsory coverage of the program.³⁶ The Council strongly recommends against adoption of any changes that would make social security coverage voluntary for additional groups.

The Council is not recommending any changes in the minimum earnings required for coverage of work in household and farm employment and self-employment. There are difficult administrative problems in such changes and, although in general the results would be desirable, there are also some drawbacks. A large proportion of the people who would be brought into coverage by a lowering of the minimum earnings requirements would be short-term or casual workers, such as housewives and school children working as local seasonal labor in agriculture, who ordinarily are not in the labor force and are already protected as dependents of covered workers. The Council recognizes that as earnings levels rise there is an automatic increase of the coverage of people engaged in the kinds of work which are subject to the minimum-earnings requirements, and considers the additional coverage which will gradually arise in the future from this process desirable.

11. Doctors of Medicine

Self-employed doctors of medicine should be covered on the same basis as other self-employed people now covered, and interns should be covered

³⁶ There have been repeated extensions of the time limit specified in the law for ministers to elect coverage, thus increasing the original advantage ministers were given and the unfavorable effect on the trust funds, since a minister who first did not choose to be covered may later—if he marries and has a family, for example—decide that coverage would be to his advantage, while one who has no dependents may continue to stay outside of the program.

The Council is not now recommending any change in the coverage provisions for ministers. While the Council believes there are better methods of covering ministers, the improvements it has considered tend to be offset by the problems created by a drastic change from a method which has been known and used over a number of years. The Council recommends that the Social Security Administration explore further whether it would be feasible to change to a plan under which ministers employed by churches or other nonprofit organizations would be covered as employees, and to develop methods of minimizing the transitional problems. The Council believes that any coverage of ministers on this basis should be at the option of the nonprofit employer, and that the church or other employer should be able to provide social security coverage for lay employees and not for ministers if it chose to do so. If a church decides to cover its ministers, its current minister (or ministers) could choose to continue to be excluded from coverage, but any minister employed in the future would be covered.

on the same basis as other employees working for the same employer.

Self-employed physicians, numbering about 170,000, are the only professional group whose self-employment income is not covered under social security. The Council sees no reason why this discriminatory treatment should be continued. There are no technical or administrative barriers to the coverage of doctors. Nor is there any question that many doctors have a need for coverage as great as that of other professional self-employed people. A provision for covering self-employed doctors was approved by the House of Representatives in 1964.

Apparently physicians have been excluded up to now because spokesmen for the profession have indicated opposition to coverage. The Council believes that the wishes of a particular group are not a sufficient basis for the continued exclusion of the group. Social security is not only a mechanism in which a person participates because of the benefits he as an individual expects to receive. It is an institution through which all Americans together promote economic security by financing, from the contributions of all, a continuing income to families whose earnings are cut off by the old age, death, or disablement of the worker. Physicians, like all other Americans, benefit in general tax savings and in other ways from the prevention of dependency through social security. Like other Americans, they should share in its support. In fact, failure to cover the self-employment income of physicians has the effect that many of them have an unfair advantage under the program, since it is possible for them to acquire insured status through working for a time in covered employment, and then, because those who do so have low average monthly earnings under the program, they get the advantage of the weighted benefit formula that is intended for low-income people. Thus many of those who do qualify get a very large return in relation to the contributions they pay, in comparison with self-employed people who spend all of their working lifetimes in covered work.

The present exclusion from social security coverage of interns employed by hospitals is closely related to the exclusion of self-employed physicians. The Council believes that when self-employed physicians are covered, coverage should be extended to interns on the same basis as that on which coverage is now made available to other employees of hospitals.

12. Tips

Social security contributions should be paid on tips an employee receives from a customer of his employer, and tips should be counted toward benefits.

More than a million employees now covered under the social security program have an important part of their income from work excluded from coverage because it is received in the form of tips.³⁷ The Social Security

³⁷ Tips an employee receives directly from someone other than his employer are covered for social security purposes only if the employer requires an accounting of the tips. Very few tips are covered on this basis. Tips received by self-employed persons are covered in the same way as other types of self-employment income.

Administration has estimated that the amount of tips received by employees who regularly receive tips is more than \$1 billion a year. Tip income is estimated to represent, on the average, more than one-third of the work income of regularly tipped employees; in many cases, of course, tips represent a much larger part, or even all, of the employee's income. For example, a waiter in a large city may get only \$35 a week in wages and may average another \$55 a week in tips.

Under present law, with only his wages counted toward benefits, the waiter who gets \$35 a week in wages and \$55 a week in tips would receive a monthly retirement benefit, beginning at age 65, of \$74. If his tips were also covered, his benefit amount would be \$125. Because their tips are not counted toward benefits, tipped employees are not adequately protected under the social security program. Moreover, since tipped workers pay income tax on earnings they get in the form of tips, it seems particularly unfair to them that these earnings are not counted for social security purposes. This situation should be corrected.

Since tips received by an employee from a customer of his employer are given for services performed in an employment relationship, they should, to the extent possible, be credited to the employee's social security account in the same way that his wages are credited. This would mean that both the employee and the employer would pay their share of the social security taxes on tips, and the employer would report the tips along with the wages he pays the employee.

The Council recognizes that there are difficulties in requiring the employer to report and pay taxes on his employees' tips, since the amount of tips that would have to be reported may not be readily determinable by the employer. The Council believes, however, that most of the difficulties for employers can be overcome if they are not held responsible for reporting and paying taxes on tips that the employee was required to report but did not. A plan for covering tips on this basis was approved by the House of Representatives in 1964.

The Council is aware that some employers have argued that they should not be required to pay social security taxes on their employees' tips because they cannot count tips in determining whether they meet the requirements of minimum wage laws. The Council has been informed, however, that of the States in which tipping occupations are covered by operative minimum wage laws, only 14 make no allowance for tips. It does not seem reasonable to argue that the fact that tips are not counted toward the minimum wage in 14 States should preclude Federal action to count tips under the basic social security system. As a practical matter, Federal legislation requiring employees to report their tips to their employers for social security credit would help to remove a major obstacle to counting tips toward the minimum wage.

13. Federal Employees

Social security credit should be provided for the Federal employment of workers whose Federal service was covered under the civil service retirement system but who are not protected under that system at the time they retire, become disabled, or die.

Unlike almost all private pension plans and a high proportion of State and local retirement systems, the Federal civil service retirement system is not supplementary to the social security program. Thus when a person leaves Federal employment, his years of previous Federal service do not count toward social security benefits. Moreover, protection under the civil service retirement system does not start until after 5 years of Federal employment. As a result, although the civil service retirement system provides good protection for people who stay in Federal employment, Federal workers who leave, or those who die or become disabled before having worked for the Government for 5 years, may have inadequate protection or none at all under either civil service retirement or social security.

A practicable and relatively inexpensive way of filling the most serious gaps that result from this situation is to provide for social security credit for the Federal employment of those workers who are not protected under the civil service system at the time they retire, become disabled, or die. As part of the financing arrangement, the civil service retirement system would withhold, from the returns of contributions that are made from the civil service retirement system to separating employees, amounts equal to the social security employee contributions which would have been payable if their Federal work had been covered under social security. These withholdings would be transferred to the social security fund and additional financial adjustments made between the two systems to take account of the transfers of credit.

The plan includes the following principal elements, all of which the Council considers essential to its effective operation:

1. Credit would be transferred to social security for the Federal service of individuals who die, become disabled, or separate from work covered under the civil service retirement system after less than 5 years of Federal service. (At present, the only provision made where a person with less than 5 years of service dies or terminates his employment is for a refund of employee contributions.)
2. Credit would be transferred to social security for the Federal service of people who separate after 5 or more years of Federal work and obtain refunds of their contributions to the civil service retirement system. (The civil service retirement system does not provide any protection for people who separate from the civil service and take refunds.)
3. Former civil service employees who have not taken refunds of their civil service contributions and who die or who become disabled before age 62 could have credit for their Federal service transferred to social security. (Former employees do not have disability or survivorship protection under the civil service retirement system after separation.)

This transfer-of-credit approach would forego certain advantages which would be achieved by a straight extension of social security coverage. For example, an extension of social security coverage would provide superior protection for workers who become disabled or die relatively early in their careers. However, the transfer-of-credit approach the Council is suggesting would be considerably less costly for the Federal Government than a

straight extension of social security coverage. Equally important, whereas an extension of social security coverage would require substantial modification of the civil service retirement system to take account of social security benefits and contributions, no modifications would be required to carry out the Council's recommendation except for the financing of the transfer of credits.

14. State and Local Government Employees

The coverage of additional State and local government employees should be facilitated by making available to all States the option of covering only those present members of State and local government retirement system groups who wish to be covered, with coverage of all new members of the group being compulsory. Also, policemen and firemen in all States should be provided the same opportunity for coverage as other State and local government employees.

The provisions of present law which make social security coverage available to employees of States and their political subdivisions under voluntary agreements between the States and the Federal Government have proved generally effective in an area of employment where, by reason of constitutional barriers against Federal taxation of the States, compulsory coverage has not seemed feasible. About 7 out of 10 full-time State and local government employees are now covered under social security, and about three-fourths of those covered have supplemental protection under a staff retirement system.

Although the present approach to coverage of State and local government employment has been effective, the Council believes that improvements can and should be made within the existing framework. Over the years a number of special provisions, each applying only to a State or States named specifically in the law, have been enacted. Special provisions not only complicate administration but result in inequalities of treatment as between different groups in similar employment situations—inequalities which are inappropriate in a national social insurance system. In the main, these inequalities arise under provisions which permit a number of States named in the Federal law much greater latitude in bringing retirement-system members under social security than is permitted other States.

In all but 18 States, which are named in the law, coverage is available only by means of a referendum among members of any retirement-system group for which social security coverage is contemplated; if a majority of the members vote for social security coverage, all members of the group are covered. The 18 States named in the law are permitted to use either the referendum procedure or an alternative known as the "divided-retirement-system" provision. Under this alternative, the 18 States may extend social security coverage to only those current members of a retirement-system group who desire such coverage, with coverage being required for all employees who later become members of the retirement-system group. The requirement that all future

members of the group must be covered under social security protects the social security trust funds against continuing adverse selection.

Making the divided-retirement-system procedure generally available would make it possible for a State to provide in an orderly way for the protection of future members of retirement-system groups on a coordinated basis.

Under another provision all but 19 States (named in the law) are prohibited from providing social security coverage for retirement-system groups made up of policemen and firemen. The Council sees little justification for the prohibition. There are strong reasons why policemen and firemen should be covered under staff retirement systems in addition to social security because the benefits of staff retirement systems can be tailored to meet their special needs. However, their arduous and dangerous duties make the survivor and disability protection of social security particularly valuable to policemen and firemen. Their own systems are often seriously deficient in providing survivor protection, and their over-all disability and retirement protection, like that of other State and local government employees, could be improved considerably if they were covered under both the basic social security program and a supplementary staff-retirement system.

Some organizations of policemen and firemen that have opposed social security coverage for their members have expressed fear that their State or local government systems would be curtailed, or perhaps abandoned, if social security coverage were obtained. The Council is impressed, though, by the fact that the extension of social security protection to millions of State and local government workers who are under staff-retirement plans has given rise to no instances, to the knowledge of the Council, where there has been a reduction in over-all protection.

The Council supports the policy declaration of the Congress contained in the present social security law, which states that there should be no impairment of the protection of members of a State or local government retirement system by reason of the extension of social security coverage to employment covered by the system.

MEETING THE COST OF THE CHANGES RECOMMENDED

The increase in the contribution and benefit base and the extensions of coverage recommended by the Council will decrease the cost of the program relative to taxable payroll. On the other hand, the benefit liberalizations recommended by the Council will increase the cost of the program relative to taxable payroll.³⁸ On balance, the changes recommended by the Council would require a somewhat higher ultimate contribution rate than does present law. The following table summarizes the cost effects of the Council's rec-

³⁸ The supplementary views of one member on this subject appear in Appendix A, page 41.

ommendations and the actuarial status of the program under those changes, exclusive of hospital insurance.

Actuarial balance under the Council's proposals to modify the cash-benefit provisions

(Costs expressed as a percentage of taxable payroll according to intermediate-cost estimate)

	Text page	OASI	DI	Total
Level-cost of the benefits of the present program.....	--	8.46	0.63	9.09
Level-cost effect of changes:				
\$6,000-7,200 contribution and benefit base.....	12	-.55	-.04	-.59
Revised basis for the self-employed contribution rate.....	13	+.13	+.01	+.14
Extensions of coverage.....	33	-.05	----	-.05
Age-62 computation point for men.....	26	+.10	----	+.10
Benefits for disabled widows.....	30	+.05	----	+.05
Child's benefits to age 22 if in school.....	29	+.09	+.01	+.10
Liberalized definition of "child" for child's benefits.....	30	+.01	----	+.01
Special disability insured status at ages 30 and under.....	31	----	+.02	+.02
Rehabilitation of disability beneficiaries.....	32	----	----	----
Increase in the maximum lump-sum death payment.....	29	+.02	----	+.02
Revised benefit formula.....	27	+1.15	+.09	+1.24
Level-cost of proposed program.....	--	9.41	.72	10.13
Level-equivalent of contribution schedule.....	--	9.42	.75	10.17
Actuarial balance.....	--	-.01	+.03	+.04

The recommended schedule outlined below would finance the Council's recommendations discussed in Part III and would carry out the financing principles discussed in Part I. Under the proposed schedule, the rates, beginning in 1966, would increase at 5-year intervals until the full rates scheduled are reached in 1976. The 1971 rate of 4.7 percent would be about sufficient under the low-cost estimates to cover the cost of the improved cash-benefit program for the next 75 years. Whether the final scheduled rate of 5.3 percent should actually be put into effect in 1976 as scheduled should depend on conditions existing at that time and on expected conditions over the ensuing 15 to 20 years. Contribution rates for hospital insurance are discussed separately, on p. 22 in Part II.

Period	Contribution rates			
	Employee and employer, each		Self-employed	
	Present law ¹	Recommended ²	Present law ¹	Recommended ²
1965.....	3.625	3.625	5.4	5.4
1966-67.....	4.125	4.3	6.2	5.8
1968-70.....	4.625	4.3	6.9	5.8
1971-75.....	4.625	4.7	6.9	6.0
1976 and after.....	4.625	5.3	6.9	6.3

¹ Applicable to annual earnings up to \$4,800.

² Would apply to annual earnings of \$4,800 in 1965, \$6,000 in 1966 and 1967 and \$7,200 in 1968 and thereafter.

Other Findings

In accordance with its mandate to study and report its findings with respect to all aspects of the program the Council has considered a number of matters which are worthy of comment but which do not, at least at this time, call for recommendations for changes in law or policy.

SIMPLIFICATION OF THE LAW

The Council believes that it is important that complexities in the social security law be avoided to the extent that this is possible. Therefore, the Council recommends that a complete re-examination of the Act be conducted by the technical experts of the Social Security Administration and the Congress, and that considerable weight be given to simplification of the law even where this involves deliberalization for rare and special cases. The Council has been informed that much work looking toward an eventual simplification and recodification of the law has already been carried on in the Social Security Administration, and the Council urges that this work be pressed to a successful conclusion.

PUBLIC INFORMATION ACTIVITIES

The Council strongly endorses the Social Security Administration's program of wide public dissemination of information about social security. In its formal statement of operating objectives and in its day-to-day administration of the social security program, the Social Security Administration recognizes the importance of an effective public information system. People need to be informed so they can act to secure their rights under the law and discharge their obligations under the law. They need to know ahead of time what rights they have. Security is not only a matter of getting benefits when they are due but of being conscious ahead of time that the protection is there. The responsibility of safeguarding the rights of every individual covered by the program and of providing the full measure of service to which he is entitled can be discharged more economically, as well as more effectively, with the help of a good public information program.

CONFIDENTIALITY OF RECORDS

The Council has been made aware of the interest of some groups in changing the social security law, or in getting a broader application of the authority of the Commissioner to disclose information under present law, so that information from the records of the Social Security Administration would be available for a wide variety of purposes not related to the social security program. The Council believes that maintenance of the existing restrictions on the use of the personal and private information that has been furnished to the Social Security Administration with the understanding that it will be used only for administering the social security program is essential to protect the right to privacy of employers and all those covered under the program. Moreover, if all persons could not count on the information being kept confidential, some would have an incentive to obtain social security numbers under assumed names or would submit other incorrect data. The Social Security Administration must depend on public cooperation for the effective administration of the program. Inaccurate or incomplete information would threaten the integrity of the records and result in serious problems of administration, including the payment of incorrect benefits and the incurring of increased costs.

The Council endorses the restrictions on disclosure of confidential information prescribed by the social security law and the limited exceptions permitted under Regulation No. 1 of the Social Security Administration, including the special restrictions on disclosure of medical information obtained in connection with claims based on disability. While the Council recognizes that many of the purposes for which information is requested are worthwhile, it is convinced that the Social Security Administration should nevertheless maintain the strict confidentiality of the social security records.

SOCIAL SECURITY BENEFITS AND WORKMEN'S COMPENSATION

In some cases, disability benefits or survivors' benefits may be paid by both the social security

program and a State workmen's compensation program, each program's payment being made without regard to the payment being made under the other program. The Council recognizes that in these dual entitlement cases the combined benefits of the two programs may occasionally be excessive when measured against previous earnings. At present the volume of these situations is not large but the number of cases where combined payments may be excessive in relation to previous earnings can be expected to increase somewhat in the future. Moreover, the issue is not entirely a matter of volume; it would be desirable to prevent any excessive payments resulting from dual entitlement to whatever extent they may occur.

For these reasons the Council has examined various possible ways of meeting the overlap problem through Federal action. None has seemed satisfactory to the great majority of the Council members. Effective administration of a reduction of social security benefits where workmen's compensation is payable would be very difficult to achieve, and the withholding of a contributory benefit because of payment by another system would be hard to defend. The majority of the Council believe that if any adjustment is made it should be made by the workmen's compensation system in those cases where the State considers the combined benefit amount to be too high.

The Council understands that a cooperative study of dual entitlement cases is now being considered by the Social Security Administration and State workmen's compensation agencies. Such a study, the Council believes, would provide worthwhile additional information about the overlap and its effects and might suggest new and better ways of dealing with the problem.

ADMINISTRATION OF THE SOCIAL SECURITY PROGRAM

The effectiveness of any law depends, in large part, on how good a job is done by those responsible for carrying it out; a law is only as good as its administration.

From our own observations and from the evaluations of others, we believe that the huge task of administering the social security program, a task which involves the rights of many millions of

people and the payment of billions of dollars a year, is being handled effectively and efficiently.

Administrative costs have been kept down to only 2.2 percent of benefit payments, partly as a consequence of the use of the latest in methods and machinery. This low administrative cost, however, has not been achieved by sacrificing high-quality service to the public. Employees at all levels have combined efficient performance of duties with responsiveness to the public and a friendly and sympathetic concern for the aged, the disabled, and the widows and orphans who are the program's beneficiaries.

We should like to register our belief that accomplishment of the purposes of the social security program requires that this high quality of administration—nonpartisan and professional—be continued.

Conclusion

The Council believes that the adoption of the recommendations made in this report will increase markedly the effectiveness of social insurance as a method for providing security to the American family when income is cut off in old age or by total disability or death. Moreover, adoption of these recommendations will make sure that the existing social security program will continue on a financially sound basis and that the proposed extension of the social insurance principle to cover hospital insurance for the aged and the permanently and totally disabled will be soundly financed.

The Council has no thought that the changes herein recommended will be the final step in the development of the American social security program. In the opinion of the Council, the proposed changes would do no more than make improvements that are clearly indicated by experience with the social security program up to the present time. Consequently, the Council urges that every 5 years or so Advisory Councils be formed to review the substantive provisions of the program as well as its financing.

The Council believes that social insurance is an institution that is basic and vital to the economic security of almost every American family, and that because of its great importance it must be

constantly re-examined and brought up to date. The fulfillment of the promise of social security for the American worker and his family which was implicit in the original Social Security Act will depend on continuing wisdom and alertness to make sure that our use of the social insurance mechanism to combat insecurity among our people is adapted to changing needs and conditions inherent in our dynamic society.

Appendix A

Statement of Reinhard A. Hohaus on Part II, "Hospital Insurance for Older People and the Disabled"

The issues posed by this section of the Report are quite complex and far reaching in their impact. Extensive experience and studies in both private and social insurance lead me to take exception to the basic recommendation made in Part II. In short, I believe the analysis and the proposals contained in this part of the Report should be regarded as primarily a useful means of fostering discussion as to what might be the most appropriate ultimate moves. My reasons for these reservations are summarized briefly below.

This proposal to provide social insurance to pay for hospital care and certain related medical services for older people and the disabled differs profoundly from our system of paying cash benefits to beneficiaries under social security. I believe the proposal and its implications should be examined and evaluated more thoroughly before any final conclusions are reached.

The report recognizes quite correctly that more is involved here than inpatient care in hospitals. It also acknowledges that some flexibility is needed in providing medical care benefits; this need is reflected by its proposals for benefits that would help pay the cost of certain outpatient services and of home nursing care. There are many uncertainties, however, as to what collateral effects the covered services would have on other medical services.

We are not dealing with matters that are fixed or stable, but rather with conditions that have been changing rapidly and will continue to change. We know that the availability of volun-

tary insurance and prepayment plans has already had marked effect on the utilization of hospital facilities. With this have come very serious financial questions. While the matter of cost is exceedingly important, we also need to know much more clearly where any initial move is likely to lead, so we can better judge whether the direction indicated is a desirable path to take.

I have long been a strong supporter of the principles that have been incorporated in our social security program. I am also strongly inclined toward principles which advocate harmonizing voluntary efforts with Governmental measures, such as the Report endorses. Unquestionably, further evidence must be developed as to whether or not this kind of partnership can be accomplished effectively by the procedure proposed in the Report.

In the formulation of the proposals contained in the Report, not enough recognition has been given to the rapid growth and present scope of voluntary insurance for older people. Instead of supplementing existing plans which have won wide public acceptance, the proposal might lead to adverse consequences. Before moving into this area the potential economic and social consequences should be weighed at greater length than has been done. In like manner, the consequences of alternative measures must also be considered before final conclusions are reached.

Much progress has been made in better identifying the issues for objective consideration and appraisal. The Report contributes substantially toward that end, especially in its recognition that hospital care is but one, though an important, area of medical care. It also recognizes that in many cases care may be required far beyond the limited period of hospital care suggested in the proposal.

Where the range of need among the aged is so great, it is especially important to make certain that any aid provided through Government is utilized most effectively and in a manner that truly advances the health and welfare of all our citizens.

Further comments on the cost of the proposal on hospital insurance are given [in the following paragraphs].

Statement of Reinhard A. Hohaus on the Cost of Changes Recommended in Parts II and III

The Report expresses concern about the impact of the recommended financing provisions on our economy and the taxpayers, in both the short run and in the long run. It asks, in effect, that the necessary taxes be such that they can be borne "by the employee, employer and the self-employed without undue burden or strain."

One of the major findings in the Report is:

The maximum amount of annual earnings that is taxable and creditable toward benefits needs to be substantially increased in order to maintain the wage-related character of the benefits, to restore a broader financial base for the program and to apportion the cost of the system among low-paid and higher-paid workers in the most desirable way.

I agree with that recommendation.

The table on page 39 estimates the "level-cost of the benefits of the present program" at 9.09 percent of taxable payroll under a \$4,800 earnings base. The table also estimates that if this taxable base is increased from \$4,800 to the \$6,000-\$7,200 base recommended in the Report and if the present benefit formula is extended to the new base, the level-cost would be .59 percent of taxable payroll lower. Stated another way, a liberalization costing that percentage of the new taxable payroll would not change the present level-cost of 9.09 percent of taxable payroll.

However, if all the Council's proposals [Parts II and III] are enacted, the level-cost will increase to 10.13 percent of taxable payroll with respect to the recommendations of Part III, and with the level-cost of .90 percent of taxable payroll with respect to the recommendations of Part II (see page 25), there would be a total level-cost of 11.03 percent of taxable payroll. This would be an increase of about 21 percent above the level-cost of 9.09 percent of taxable payroll applicable to the present program.

An increase of this magnitude, in addition to an increase in the maximum earnings used for determining taxable payrolls, warrants serious scrutiny and public discussion. The cost of adopting all of the recommendations raises important questions as to priority in the distribution of our economic resources.