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THE SOCIAL SECURITY AMENDMENTS OF 1967—PUBLIC LAW 248, 90TH CONGRESS

(Includes amendments to Social Security Act made by Public Law 90–864, enacted June 29, 1968)

BRIEF SUMMARY OF MAJOR PROVISIONS AND DETAILED COMPARISON WITH PRIOR LAW

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

JULY 15, 1968

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THE SOCIAL SECURITY AMENDMENTS OF 1967: SUMMARY OF MAJOR PROVISIONS

Old-Age, Survivors, Disability, and Health Insurance

1. BENEFIT INCREASE

The 1967 amendments provide for a 13-percent increase in benefit payments for persons currently receiving benefits. The minimum benefit (payable when benefits start at age 65) is increased from $44 a month to $55. The amount of earnings subject to tax and also used in the computation of benefits is increased from $6,600 to $7,800 in 1968.

The legislation provides for the increased benefit to be first payable for the month of February 1968 (payable in March). It is estimated that 22.9 million people received the increase in benefits and that more than $3 billion in additional benefits will be paid in the first 12 months under this provision.

2. SPECIAL BENEFITS FOR PERSONS AGE 72

The amount of the special payment which is made to persons age 72 and over who are not insured for regular cash benefits is increased from $35 to $40 a month for a single person and from $52.50 to $60 a month for a couple. The increased amount is first payable for February 1968. It is estimated that over 900,000 people will get new or increased benefits under this provision.

3. RETIREMENT TEST

There is an increase from $1,500 to $1,680 in the amount of annual earnings a beneficiary under age 72 can have without having any benefits withheld. Provision is made for an increase from $125 to $140 in the amount of monthly earnings a person can have and still get a benefit for the month regardless of his annual earnings. $1 in benefits will be withheld for each $2 in earnings between $1,680 and $2,880, and $1 in benefits for each $1 in earnings above that amount. The provision is effective for earnings in 1968. It is estimated that about 760,000 people will receive approximately $175 million in additional benefits for 1968.

The Secretary of Health, Education, and Welfare is required by the amendments to study the existing retirement test and proposals for its modification.

4. BENEFITS FOR DISABLED WIDOWS AND WIDOWERS

The amendments provide for reduced monthly benefits for certain disabled widows and widowers of deceased workers who are between the ages of 50 and 62. A widow or widower would be considered disabled only if the disability is one that would preclude any gainful activity. Benefits are first payable for February 1968. It is estimated that about 65,000 disabled people will be made eligible for benefits and about $60 million in benefits will be paid during the first 12 months under this provision.

5. ADDITIONAL DISABILITY INSURANCE PROVISIONS

The amendments provide for a more detailed definition of disability than that in prior law: they liberalize the definition of blindness; they liberalize the insured status provisions for workers who become disabled before the age of 31.

6. COVERAGE PROVISIONS

Clergymen are permitted to elect not to be covered if they are opposed to coverage on the basis of conscience or religious principle: noncontributory wage credits (in addition to present contributory coverage) of $100 a month are provided for military service after 1967; coverage is extended to some employment of a parent in the home of a son or daughter; other provisions affect the coverage of certain State and local employees.

7. MEDICARE—TITLE XVIII

The amendments provide for a lifetime reserve of 60 days of hospital care after the 90 days covered in a "spell of illness" have been exhausted, with a $20 a day coinsurance provision; payment for a physician's services to the patient based on an unpaid bill (under prior law the bill had to be paid); payment of full reasonable charges (prior law authorized only 80 percent) for radiological and pathological services to hospital inpatients; payment for diagnostic X-rays made in a patient's home or in a nursing home; payment for services in nonparticipating hospitals under certain conditions; payment for physical therapy services furnished by physical therapists under the direction of hospitals or other approved agencies; liberalizations in treatment of emergency hospital services; and the establishment of an advisory council to study the question of providing health insurance protection for the disabled under the medicare program. The Secretary of Health, Education, and Welfare is directed to study (1) a proposal which would provide coverage of prescription drugs under Medicare and a proposal to establish, through a formulary committee, quality and cost control standards for drugs provided under various programs of the Social Security Act; and (2) the feasibility of covering the services of additional types of health practitioners. The amendments provide for a number of additional miscellaneous changes in the Medicare program.

Public Welfare

1. WORK INCENTIVE PROGRAM FOR AFDC RECIPIENTS

State welfare agencies are to refer appropriate adult members of families (with certain exceptions) who are receiving Aid to Families with Dependent Children to work and training programs operated by the Department of Labor. The Department of Labor, through the U.S. employment offices, will meet the employment needs of persons referred to it by three approaches. In the first instance, all those who are immediately employable will be moved into regular employment. Secondly, those who need training will be given suitable training and will then be referred to regular employment. Thirdly, the employment office will make arrangements for special work projects to employ those for whom no jobs can be found in the regular economy or for whom training is not suitable. The projects must be arranged by the employment office with public agencies or nonprofit private agencies organized for a public service purpose. Persons working in these projects must receive at least the minimum wage if the work they perform is covered under a minimum wage statute. Workers will be guaranteed amounts at least equal to their welfare grants plus 20 percent of their wages. Day care (under standards established by the Children's Bureau) must be provided for the children of mothers who are determined by welfare agencies to be appropriate for work or training. The Federal government will pay 80 percent of the cost of training under the program, and the States will pay 20 percent in cash or in kind.

2. EARNINGS EXEMPTION

The amendments require the States to exclude the first $30 of earned income plus one-third of the remainder in computing a family's income for purposes of determining payments under the Aid to Families with Dependent Children program. Earned income of child recipients who are full-time students or who are part-time students not working full time would be totally excluded.

3. AID TO FAMILIES WITH DEPENDENT CHILDREN OF UNEMPLOYED FATHERS

The amendments provide for a Federal definition of unemployment for States which have AFDC–UF programs.

4. LIMIT ON FEDERAL MATCHING FOR AFDC

The amendments provide that for purposes of Federal matching the proportion of all children under age 18 who are receiving AFDC payments on the basis of a parent's absence from the home in each State as of January 1, 1968, cannot be exceeded after June 30, 1968—postponed to June 30, 1969, under Public Law 90-364.

5. EMERGENCY ASSISTANCE

Provision is made for Federal matching for up to 30 days of emergency assistance during a 12-month period to a child and his family. This assistance can be extended to migrant families.

6. HOME REPAIRS

Federal matching is allowed for repairs (up to $500) to homes of cash assistance recipients if such repair will assure the recipient the continued use of his home and provide housing at less cost than rent for suitable accommodations.

7. SERVICES FOR CHILDREN

Child welfare services and services to children receiving AFDC are to be provided by the same organizational unit at the State and local level with certain exceptions for existing arrangements. The authorization for child welfare services is increased from $55 million to $100 million for fiscal year 1969, and from $60 million to $110 million for later years.

8. "PASS ALONG" PROVISION

States have the option of exempting up to $7.50 a month of any type of income for the aged, blind, and the disabled in determining eligibility and the amount of assistance under the cash assistance programs.

9. MEDICAID

States are limited in setting income levels for Federal matching purposes to 133⅓ percent of the AFDC payment level. For those States with programs already in effect the percentage is 150 for the period July–December 1968 and 140 for calendar year 1969. This limit does not affect persons who are receiving or are eligible for cash welfare assistance. Other Medicaid amendments relate to the coordination of Medicaid and the supplementary medical insurance program under Medicare, free choice of medical practitioners and facilities for Medicaid recipients, choice of services which the States may provide under Medicaid, provision for deductibles or cost sharing under State programs, and other miscellaneous provisions.

10. STANDARDS FOR SKILLED NURSING HOMES UNDER MEDICAID

Effective July 1970 the States will have to place Medicaid recipients only in those licensed nursing homes which meet specified standards. The States are also required to have a professional medical audit program under which periodic medical evaluations will be made of the appropriateness of the care provided to Medicaid patients in nursing homes, mental hospitals and other institutions. Effective July 1968, no Federal matching can be made for payments to a nursing home which, even though licensed, does not meet State licensing requirements.

11. FEDERAL MATCHING FOR INTERMEDIATE CARE SERVICES

Provision is made for Federal matching for vendor payments in behalf of persons who qualify for Old Age Assistance, Aid to the Blind, or Aid to the Permanently and Totally Disabled, and who are living in facilities which provide care which is more than that of boarding houses, but less than in a skilled nursing home. The rate of Federal sharing is the same as under Medicaid.

12. LICENSING OF NURSING HOME ADMINISTRATORS UNDER MEDICAID

States must license administrators of nursing homes in order to qualify for Federal matching under Medicaid.

13. MATERNAL AND CHILD HEALTH

There is a single authorization for child health programs, increasing from $250 million in 1969 to $350 million in 1973 and thereafter. An earmarking of 6 percent is made for family planning services. Special project grants are authorized to (*a*) reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing; (*b*) promote the health of children and youth of school and preschool age; and (*c*) provide dental care and services to children. Responsibility for these projects will be transferred to the States after July 1972.

14. SOCIAL WORK MANPOWER

The amendments authorize $5 million for four years for grants to public or nonprofit private colleges and universities and accredited graduate schools of social work, or associations of such schools, to meet part of the costs of improvement or expansion of social work programs and the training of personnel.

15. OTHER PUBLIC WELFARE PROVISIONS

The amendments also have provisions relating to the AFDC program for the location of absent parents, family planning, foster home care for dependent children, protective or vendor payments, and others.

THE SOCIAL SECURITY AMENDMENTS OF 1967: DETAILED COMPARISON WITH PRIOR LAW

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

1. COVERAGE

Item	Prior law	Law as amended by Public Law 90-248
A. Self-employed	*Covers* all self-employed if they have net earnings from self-employment of $400 a year except that certain types of income, including dividends, interest, sale of capital assets and rentals from real estate are not covered unless received by dealers in real estate and securities in the course of business dealings. Permits exemption from the social security self-employment tax of individuals who have conscientious objections to insurance (including social security) by reason of their adherence to the established tenets or teachings of a religious sect (or division thereof) of which they are members. Generally, applications for exemption were required to be filed on or before Apr. 15, 1966, in the case of those taxpayers with self-employment income for 1964 or any prior year. Taxpayers first deriving self-employment income in 1965 or any subsequent year are required to file applications on or before the due date (including any extension) of the income tax return for such first year.	No change. A member of a religious sect which is opposed to social insurance may file an application for exemption from the self-employment tax by Dec. 31, 1968, if the person has self-employment income for years ending before Dec. 31, 1967. If he first receives self-employment income in later years, the application would be timely if filed by the due date for the income tax return for the year in question. However, in the latter case, valid application may be filed within 3 months following the month in which the person is notified in writing by the Internal Revenue Service that a timely application has not been filed.
1. Ministers	*Covers* duly ordained, commissioned, or licensed ministers, Christian Science practitioners, and members of religious orders (other than those who have taken a vow of poverty) serving in the United States, and those serving outside the country who are citizens and either working for U.S. employers or serving a congregation predominantly made up of U.S. citizens. Coverage is available under the self-employment coverage provisions on an individual voluntary basis regardless of whether they are employees or self-employed.	Services of a clergyman would be automatically covered unless he elects not to be covered because he is conscientiously opposed to social security coverage or because he opposes coverage on grounds of religious principle. Effective for taxable years ending after 1967.
2. Farm operators	*Covers* farm operators on the same basis as other self-employed persons except that farm operators whose annual gross earnings are $2,400 or less can report either their actual net earnings or 66⅔ percent of their gross earnings. Farmers whose annual gross earnings are over $2,400 report their actual net earnings if over $1,600, but if actual net earnings are less than $1,600, they may report either actual net earnings or $1,600.	No change.

I. COVERAGE—Continued

Item	Prior law	Law as amended by Public Law 90-248
A. Self-employed—Continued 2. Farm operators—Continued	Rentals from real estate are not creditable as self-employment earnings, but if landlord under arrangements with tenant or share farmer participates materially in the production of, or in the management of, the crops or livestock on his land, the income is covered.	No change.
3. Public officials	*Excludes* individuals performing functions of public officials.	No change.
4. Newspaper vendors	*Covers* individuals over 18 who buy newspapers and magazines at one price and sell them at another regardless of whether they are guaranteed minimum compensation or may return unsold papers and magazines.	No change.
5. Retirement payments to retired partners.	Retirement payments made to retired partners are taxed and credited for social security benefit purposes like any other self-employment income even though they are not earnings for retirement test purposes if no services are performed.	Retirement payments received by a retired partner excluded for all purposes if the retired partner had no interest in the partnership, and rendered no services to the partnership, and if his share of the capital of the partnership had been paid to him. The payments must be made under a written plan which meets requirements set up by the Secretary of the Treasury; the plan must provide that the payments must be on a periodic basis and continue until the partner's death. Effective for taxable years ending on or after Dec. 31, 1967.
B. Employees	*Covers* employees including certain agent or commission drivers, life insurance salesmen, homeworkers, traveling salesmen, and officers of corporations regardless of the common-law definition of employee.	No change.
1. Agricultural workers	*Covers* agricultural workers who either (1) are paid $150 or more in cash wages in a calendar year by an employer or (2) perform agricultural labor for an employer on 20 days or more during the calendar year. Workers who are recruited and paid by a crew leader shall be deemed to be employees of the crew leader if such crew leader is not, by written agreement, designated to be an employee of the owner or tenant and if such crew leader is customarily engaged in recruiting and supplying individuals to perform agricultural labor; under such circumstances the crew leader shall be deemed to be self-employed. *And excludes:* a. Mexican contract workers.	No change.

	b. Workers lawfully admitted to the United States from the Bahamas, Jamaica, and other islands in the British West Indies or from any other foreign country or its possessions, on a temporary basis to perform agricultural labor.	
2. Domestic workers	*Covers* persons performing domestic service in private nonfarm homes if they receive $50 or more during a calendar quarter from 1 employer. Noncash remuneration is excluded. *Excludes* students performing domestic service in clubs or fraternities if enrolled and regularly attending classes at school, college, or university.	No change.
3. Casual labor	*Covers* cash remuneration for service not in the course of the employer's trade or business if the remuneration is $50 or more from 1 employer during a calendar quarter.	No change.
4. Cash tips	Cash tips received after 1965 by an employee in the course of his employment are covered as wages for social security and income-tax withholding purposes, except that employers are not required to pay the social security employer tax on the tips. However, for tips to be subject to withholding for income tax or to be counted for social security purposes, the tips must be paid in cash and must amount to $20 or more a month in work for one employer. The tips still represent compensation for income tax purposes even though less than $20 a month or even though paid in other than cash, but are not, under either of these conditions, subject to withholding for income tax or social security tax purposes. The employee is required to give his employer a written report of his tips within 10 days after the end of the month in which the tips are received (or at such other times before the 10th day as is provided by regulations); to the extent that unpaid wages due an employee and in the possession of the employer are insufficient to pay the employee social security tax due on the tips, the employee will be permitted (but not required) to make available to the employer sufficient funds to pay the employee social security tax. To the extent that the employer does not have sufficient wage payments (or funds turned over to him by the employee) to offset the required withholding, he notifies the employee and the employee reports this amount to the Government directly. If an employee fails to report, as required by law, some or all of his covered tips to his employer, he is liable not only for the employee social security tax due on the unreported tips, but also for an additional amount equal to 50 percent of the employee tax. He pays his social security tax on these tips to the District Director of the Internal Revenue Service.	No change.

I. COVERAGE—Continued

Item	Prior law	Law as amended by Public Law 90-248
B. Employees—Continued 4. Cash tips—Continued	The employer is required to withhold the employee social security tax only on tips reported to him within the specified time and for which he has sufficient funds of the employee out of which to pay the tax. He is liable for withholding income tax on only those tips that are reported to him within 10 days after the end of the month in which the tips were received, and then in general only to the extent that he can collect the tax (at or after the time the tips are reported to him and before the close of the calendar year in which the tips were received) from unpaid wages (not including tips), or from funds turned over to him for that purpose remaining after an amount equal to the amount due for the social security tax has been subtracted.	
5. Bonus and incentive pay as deferred compensation.	Bonus and incentive pay as deferred compensation are wages even if paid after employment relationship ends.	Bonus and incentive pay is not wages if paid after employment relationship ends unless payment would have been made if the employment relationship had continued if— 1. the employment relationship ended because of death, retirement for disability, or retirement for age; and 2. the payment is made under a plan established by the employer for his employees generally or for a class or classes of employees. Effective for payments made after Jan. 2, 1968.
6. State and local government employees.	*Covers* employees of State and local governments *provided* the individual States enter into an agreement with the Federal Government to provide such coverage, with the following special provisions: a. *States have the option* of covering or excluding employees in any class of elective position, part-time position, fee-basis position, or performing emergency services.	Emergency services are excluded on a mandatory basis. Also services of election officials who are paid less than $50 in a calendar quarter would not be covered at the option of the State. Effective Jan. 1, 1968. Fees received after 1967 which are not covered under a State agreement are covered under the self-employment provisions if received by a person whose compensation consists entirely of fees. People in fee-basis positions in 1968 can elect to have their fees not covered under the self-employment provisions. States may continue to provide coverage of fee-basis employees as employees but the States are allowed to remove such employees from coverage.
	b. *Excludes* the services of the following persons, specifying that they cannot be included in a State agreement and cannot, therefore, be covered: (1) Employees on work relief projects;	No change.

(2) Patients and inmates of institutions who are employed by such institutions;

(3) Services of the types which would be excluded by the general coverage provisions of the law if they were performed for a private employer, *except* that agricultural and student services in this category may be covered at the option of the State.

c. Employees who are in positions covered under an existing State or local retirement system may be covered under State agreements only if a referendum is held by a secret written ballot, after not less than 90 days' notice, and if the majority of eligible employees under the retirement system vote in favor of coverage. However, employees in policemen and firemen positions under a State and local retirement system cannot be covered in the agreement. The Governor of a State or his delegate must certify that certain Social Security Act requirements under the referendum procedure have been properly carried out. In most States, all members of a retirement system (with minor exceptions) must be covered if any members are covered.

Employees of any institution of higher learning (including a junior college or a teachers' college and employees of a municipal or county hospital) under a retirement system can, if the State so desires, be covered as a separate coverage group, and 1 or more political subdivisions may be considered as a separate coverage group even though its employees are under a statewide retirement system.

In addition, employees whose positions are covered by a retirement system but who are not themselves eligible for membership in the system could be covered without a referendum. Employees who are members or who have an option to join more than 1 State or local retirement system cannot be covered unless all such retirement systems are covered.

Individuals in positions under retirement systems on Sept. 1, 1954, are precluded from obtaining coverage under the nonretirement system coverage provisions.

Exceptions to general law concerning coverage in named States:

(1) *Split-system provisions.*—Authorizes Alaska, California, Connecticut, Florida, Georgia, Hawaii, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin, and all interstate instrumentalities, at their option, to extend coverage to the members of a State retirement system by dividing such a system into 2 divisions, one to be composed of those persons who desire coverage and the other of those persons who do not wish coverage, provided that

No change.

Adds Illinois to the list of States entitled to split their retirement systems. Effective upon enactment.

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I. COVERAGE—Continued

Item	Prior law	Law as amended by Public Law 90-248
B. Employees—Continued 6. State and local government employees—Continued	new members of the retirement system coverage group are covered compulsorily. Also authorizes similar treatment of political subdivision retirement systems of these States. Those employees covered by a divided retirement system who did not elect coverage in the original agreement, may nevertheless elect coverage through 1966, or, if later, until 2 years after the date on which coverage was approved for the group that originally elected coverage. Also provides that the coverage of persons electing under this provision would begin on the same date as coverage became effective for the group originally covered. People who are in positions under a retirement system who are not eligible to join the system due to personal disqualifications, such as those based on age or length of service, cannot be covered under the divided retirement system procedure.	Extends time in which such employees may elect coverage through 1969, or, if later, until 2 years after the date on which coverage was approved for the group that originally elected coverage. Permits States, if coverage is extended under the divided retirement system procedure, to modify their agreement after 1967 to cover individuals who are not eligible to be members of the retirement system. Effective January 1, 1968.
	(2) *Policemen and firemen.*—Allows the States of Alabama, California, Florida, Georgia, Hawaii, Kansas, Maine, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington and all interstate instrumentalities to make coverage available to policemen and firemen in those States, subject to the same conditions that apply to coverage of other employees who are under State and local retirement systems, except that where the policemen and firemen are in a retirement system with other classes of employees the policemen and firemen may, at the option of the State, hold a separate referendum and be covered as a separate group.	Adds Puerto Rico to the list of States which may provide social security coverage for policemen and firemen. Validates social security coverage for certain firemen in Nebraska for whom social security taxes were erroneously paid. Provides for social security coverage for firemen in States not included in the list of States which may cover policemen and firemen if the Governor of the State certifies that the total benefit protection of the group of firemen would be improved as a result of social security coverage. The divided retirement system could not be used and firemen would have to be covered as a separate group and not as part of a group which includes people other than firemen. Effective on enactment.
	(3) *Employees of unemployment compensation systems.*—Authorizes Florida, Georgia, Minnesota, North Dakota, Pennsylvania, Washington, and Hawaii, at their option, to cover their employees who are paid wholly or partly from Federal funds under the unemployment compensation provisions of the Social Security Act—either by themselves or with the other employees of the department of the State in which they are employed—after complying with the referendum provisions.	No change.

	d. Coverage on a compulsory basis is provided for employees of certain publicly owned transportation systems. e. *Effective date of coverage agreement.*—Allows agreements or modifications made after 1959 to begin as early as 5 years before the year in which an agreement is made, but no earlier than Jan. 1, 1956. Where a retirement system is covered as a single retirement system coverage group, permits the State to provide different beginning dates for coverage of the employees of different political subdivisions.	No change. A modification to cover a new group may provide retroactive coverage for former employees with respect to earnings that had been erroneously reported if no refund has been made of the taxes paid on the erroneously reported earnings. Effective on enactment.
7. Employees of nonprofit organizations.	*Covers* employees of religious, charitable, educational, and other nonprofit organizations (which are exempt from income tax and are described in sec. 501(c)(3) of the Internal Revenue Code) *on a voluntary basis* if the employer organization certifies that it desires to extend coverage to its employees. Employees may concur by signing a list or supplemental list which is filed within 24 months after the quarter in which the certificate is filed. Employees who do not concur in the filing of the certificate are not covered *except* that all employees hired after a certificate becomes effective are covered. Waiver certificate may be made effective at the option of the organization on the 1st day of the quarter in which the certificate is filed, the 1st day of the succeeding quarter, or as early as the 1st day of the 20th calendar quarter preceding the quarter in which the certificate of waiver is filed. Employees of nonprofit organizations who are in positions covered by State and local retirement systems and are members or eligible to become members of such systems must be treated apart from those not in such positions. Certificates must be filed separately for each group. All new employees who belong to a group for which a certificate has been filed are automatically covered, and new employees who belong to a group for which a certificate has not been filed are not covered.	No change.
8. Federal employees	*Excludes* employees of the United States or its instrumentalities if— a. they are covered by a retirement system established by Federal law; or b. they perform services— (1) as the President, Vice President, or a Member of Congress; (2) in the legislative branch; (3) in a penal institution as an inmate; (4) as student nurses, and other student employees of Federal hospitals; (5) as employees on a temporary basis in disaster situations;	No change.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

I. COVERAGE—Continued

Item	Prior law	Law as amended by Public Law 90-248
B. Employees—Continued 8. Federal employees—Continued	(6) as employees not covered by the Civil Service Retirement Act because they are subject to another retirement system (other than the retirement system of the Tennessee Valley Authority); or c. the instrumentality has been specifically exempted by statute from the employer tax; or d. the instrumentality was exempt from the employer tax on December 31, 1950, and its employees are covered by its retirement system. *Covers* the following Federal employees excepted from the exclusion in 8–d unless they are excluded on the basis of one of the other provisions: a. employees of a corporation which is wholly owned by the United States; b. employees of a national farm loan association, a production credit association, a Federal Reserve bank, or a Federal credit union; c. employees (not compensated by funds appropriated by Congress) of the post exchanges of the various armed services (including the Coast Guard) and other similar organizations at military installations; d. employees of a State, county, or community committee under the Production and Marketing Administration. e. employees of the District of Columbia who are not covered by a retirement system.	
9. Students and nurses in schools and hospitals.	*Excludes*— a. Students in the employ of a school, a college, or university if enrolled and regularly attending classes; b. student nurses employed by a hospital or nurses training school if enrolled and regularly attending classes;	No change.
10. Newsboys	*Covers* individuals *18 and over* who deliver and distribute newspapers or shopping news, but covers individuals *under 18* only if they deliver or distribute such publication to points for subsequent delivery or distribution.	No change.

11. Members of the Armed Forces.	*Covers* members of the uniformed services after December 1956, while on active duty (including active duty for training), with contributions and benefits computed on basic military pay. Noncontributory wage credits of $160 per month are granted, in general, for each month of active service in the Armed Forces of the United States during the World War II period (Sept. 16, 1940–July 24, 1947) and during the postwar emergency period (July 25, 1947–Dec. 31, 1956). Provides noncontributory wage credits for certain American citizens who, prior to Dec. 9, 1941, entered the active military or naval service of countries that, on Sept. 16, 1940, were at war with a country with which the United States was at war during World War II. Wage credits of $160 would be provided for each month of such service performed after Sept. 15, 1940, and before July 25, 1947. To qualify for such wage credits, an individual must either have been a U.S. citizen throughout the period of his active service or have lost his U.S. citizenship solely because of his entrance into such active service.	Provides additional wage credits of $100 for each $100, or fraction thereof, of active duty basic pay up to $300 a quarter. Effective for service pay from the uniformed services paid after Dec. 31, 1967. No change. No change.
12. Railroad employees	Under coordination provisions contained in the Railroad Retirement Act: (1) employment under both the railroad system and the old-age and survivors insurance system is counted for purposes of survivor benefits under either system; (2) railroad employment of workers with less than 10 years of railroad service is credited under the Social Security Act and the benefits based on such employment are payable under this act; and (3) provision is made for mutual financial interchange between the 2 systems in order to place the old-age and survivors insurance and disability insurance trust funds in the same position in which they would have been if railroad service after 1936 had been counted as social security employment.	No change.
13. Family employment	*Excludes* services rendered by— (1) One spouse for another. (2) Child under 21 for his parents. (3) Parents for their children, if such services are domestic services rendered in the home of the child, or such services are not rendered in the course of the child's trade or business.	Extends social security coverage to employment performed in the private home of the employer by a parent in the employ of his son or daughter. The employment is covered if the son or daughter is (*a*) a widow or widower with a child under age 18 or a disabled child or (*b*) a person with such a child who either is divorced or has a disabled spouse.
14. Employees of Communist organizations.	*Excludes* from coverage employees of any organization which is registered, or against which there is a final order of the Subversive Activities Control Board to register, under the Internal Security Act, as a Communist-action, a Communist-front, or Communist-infiltrated organization.	No change. However, Public Law 90–237 deleted the requirement in the Internal Security Act of 1950 requiring the registration of Communist organizations. This provision is, therefore, inoperative.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

II. PROVISIONS RELATING TO DISABILITY

Item	Prior law	Law as amended by Public Law 90-248
A. Nature of the provisions:		
1. Benefits	Provides monthly benefits for disabled workers meeting eligibility requirements. Benefits are computed in the same way as retirement benefits. No provision for monthly benefits for disabled widows and widowers.	Monthly social security benefits are payable between ages 50 and 62 to disabled widows and widowers of covered deceased workers. If benefits are first payable at age 50, they are 50 percent of the primary insurance amount. Higher percentages are payable—depending on the age at which benefits begin—up to 82½ percent of the primary insurance amount at age 62. The reduction continues to apply to benefits payable after that time. Effective for February 1968.
2. Disability "freeze"	Provides that when an individual for whom a period of disability has been established dies, or retires, on account of age or disability, his period of disability will be disregarded in determining his eligibility for benefits and his average monthly wage for benefit computation purposes.	No change.
B. Eligibility requirements:		
1. Definition	For benefits or for the freeze, an individual must be precluded from engaging in any substantial gainful activity by reason of a physical or mental impairment. The impairment must be medically determinable and one which can be expected to exist for not less than 12 months. (For purposes of the freeze only, the following specified degree of blindness is presumed disabling: Central visual acuity of 5/200 or less in the better eye with use of correcting lens. An eye in which the visual field is reduced to 5° or less concentric contraction shall be considered as having a visual acuity of 5/200 or less.)	New guidelines are provided in the law under which a person (other than a disabled widow or widower) may be determined to be disabled only if due to a physical or mental impairment (as defined) he is unable to engage in any kind of substantial gainful work which exists in the national economy even though such work does not exist in the general area in which he lives. Effective on enactment. A widow or widower can be determined to be disabled only if she or he has a physical or mental impairment that makes it impossible for him to perform *any* gainful work rather than substantial gainful work. Effective for February 1968. Changes the degree of blindness to central visual acuity of 20/200 or less or a visual field of 20° or less Effective for February 1968.
2. Entitlement to other benefits	A person who becomes entitled before age 65 to a benefit payable on account of old age can later become entitled to disability insurance benefits. If prior benefit was a reduced benefit, disability insurance benefits are reduced to take account of payment made for prior months.	No change.
3. Waiting period	An initial 6-month "waiting period" is required before disability insurance benefits will be paid. Benefits are payable for 7th month. However, benefits may be paid for the 1st full month of disability to a worker who becomes disabled within 60 months (5 years) after	No change.

	termination of disability insurance benefits or a period of disability.	
4. Termination of benefits	Provides that benefits shall not be paid after the 2d month following the month in which a worker's disability ceases.	No change.
5. Insured status (work requirement).	To be eligible an individual must— (1) have at least 20 quarters of coverage in the 40 quarters ending with the quarter in which the period of disability begins; and (2) Be fully insured. Young workers who are blind and disabled may meet an alternative insured status requirement under which workers disabled before age 31 are insured if not less than one-half (and not less than 6) of the quarters during the period elapsing after age 21 and up to the point of disability were quarters of coverage or, in the case of those disabled before age 24, at least one-half of the 12 quarters ending with the quarter in which disability began were quarters of coverage. To qualify for this alternative the worker would have to meet the statutory definition of blindness for the disability "freeze." (See above.) Workers will, however, have to meet the other regular requirements for entitlement to disability benefits, including inability to engage in any substantial gainful activity.	No change. Extends to all young workers the alternative insured status provisions which under prior law applied to the blind only. Effective for February 1968.
6. Disability benefits offset	The social security disability benefit for any month for which a worker is receiving a periodic workmen's compensation benefit is reduced to the extent that the total benefits payable to him and his dependents under both programs exceed 80 percent of his average monthly earnings covered by social security prior to the onset of disability, but with the reduction periodically adjusted to take account of changes in earnings levels.	Provides that in determining 80 percent of average earnings, earnings in excess of the social security earnings base may be used. Effective for February 1968.
7. Applications	Provides that no application for a disability determination filed more than 12 months after the month in which a period of disability would end shall be accepted.	An application for a freeze may be filed within 36 months of the time the period of disability ended if the Secretary determines that the application was not filed within the prescribed filing period because of the disabled person's incapacity to do so. Also provides that prior to Feb. 1, 1969, a person who filed an application in the past within 36 months of the end of his disability may again file an application to establish a period of disability for the freeze.
C. Payment for rehabilitation services	Provides for reimbursement from social security trust funds to State vocational rehabilitation agencies for the cost of vocational rehabilitation services furnished to disability insurance beneficiaries. Total amount of the funds that may be made available for such reimbursement could not, in any year, exceed 1 percent of the social security disability benefits paid in the previous year.	No change.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

II. PROVISIONS RELATING TO DISABILITY—Continued

Item	Prior law	Law as amended by Pubiic Law 90-248
D. Disability determinations	Provides that disability determinations, including determinations that a disabled person had recovered, generally must be made by State agencies under agreements with the Social Security Administration.	No change.

III. BENEFIT CATEGORIES

A. Worker—old age	Full benefit payable at age 65 to fully insured retired worker. Payable at age 62 to fully insured retired worker, but on an actuarially reduced basis. Benefit is reduced by 5/9 of 1 percent for each month worker is entitled to receive a benefit before age 65—the total reduction is 20 percent if worker begins drawing benefits at age 62. The reduced amount is permanent, continuing after worker reaches age 65.	No change.
	In the case of a woman who is entitled to a reduced old-age insurance benefit and who is at the same time or subsequently becomes entitled to a wife's benefit, the wife's benefit would be reduced by the dollar reduction which was applicable to the old-age benefit, plus the regular reduction amount on the excess of the unreduced wife's benefit over the unreduced old-age benefit.	No change.
	A similar provision is applicable to men entitled to reduced old-age benefit and dependent husband's benefit.	
B. Wife or dependent husband	A full benefit for a wife or dependent husband is 50 percent of spouse's primary benefit.	Wife's and husband's benefits limited to maximum of $105 a month.
	Full benefit paid at age 65. Benefit also payable at age 62 to a wife or dependent husband, but on an actuarially reduced basis, i.e., benefit is reduced by 25/36 of 1 percent for each month prior to age 65. An individual who takes benefit at 62 receives 75 percent of full benefit.	
C. Widow, widower, or parent	Full benefit payable at age 62 to widow, dependent widower, or surviving dependent mother or father of the insured worker.	Benefits provided for disabled widows and widowers as early as age 50; benefits reduced by 43/198 of 1 percent for each month benefits are taken before age 60 and by 5/9 of 1 percent for each month between ages 60 and 62. Because widow's benefits, but not widower's
	Full benefit is 82.5 percent of deceased worker's primary benefit (75 percent each in case of 2 parents).	

	Widows may elect an actuarially reduced benefit upon attaining age 60. Benefits will be reduced by 5/9 of 1 percent for each month she is entitled to receive a benefit prior to age 62. Thus the reduction for a widow who elects a benefit when she attains age 60 is 13⅓ percent for the 24-month period—reducing her benefit from 82½ percent of her husband's benefit to 71½ percent of his benefit. In the case of a widow who is entitled to an old-age benefit in her own right, the old-age benefit is reduced to take into account widow's benefits paid to her before age 62.	benefits, are payable at the reduced rate between ages 60 and 62, the provision would have no effect on widow's benefits which begin at age 60 or later. Effective for February 1968.
D. Divorced wife, widow	Benefits are payable to a divorced woman if she has a child of the deceased worker in her care and the child is getting benefits based on the deceased father's earnings, if she has not remarried, and if she had been getting at least ½ of her support from her former husband under a court order or agreement at the time of his death. Wife's or widow's benefits are payable to an aged divorced woman on her former husband's earnings if she (A) had been married to her former husband for 20 years before the divorce; (B) is not married, regardless of intervening marriages; and (C) met the following support requirement when her former husband became disabled, entitled to benefits or died: (1) She was receiving ½ of her support from her former husband, or (2) she was receiving substantial contributions from him pursuant to a written agreement, or (3) a court order for substantial contributions was in effect. Payment of a wife's or widow's benefit to a divorced woman does not reduce the benefits paid to any other person on the same social security account and such wife's or widow's benefit is not reduced because of other benefits payable on the same account. Benefits for a divorced wife or a surviving divorced wife are not terminated on account of remarriage in those cases where the remarriage is to a man getting benefits as a dependent widower or parent or as a disabled child aged 18 or over. If a divorced wife or a surviving divorced wife marries an old-age insurance beneficiary, her benefits are terminated but she is immediately eligible for a wife's benefit on her new husband's account. A wife's benefits are not terminated when the woman and her husband are divorced if the marriage has been in effect for 20 years.	No change.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

III. BENEFIT CATEGORIES—Continued

Item	Prior law	Law as amended by Public Law 90-248
E. Children	A child's benefit is paid to child of the insured worker who has died, reached retirement age, or become disabled if the child is unmarried and either— (a) Is under age 18, or (b) Is under a disability which began before age 18. (c) Is age 18 or over and under age 22 if he is a full-time student. Permits a child whose benefits have terminated because he has attained age 18 to become reentitled upon filing a new application if he is a full-time student and has not attained age 22. A wife, widow, or surviving divorced mother will not get benefits if the only child in her care has attained age 18 and is getting benefits solely because he is a student.	No change.
	Student and institution defined: A full-time student is defined as an individual who is in full-time attendance as a student at an educational institution; whether or not the student was in full-time attendance is determined by the Secretary in the light of the standards and practices of the school involved. Specifically excluded is a person who is paid by his employer while attending school at the request of his employer. Provides for benefits for any period of 4 calendar months or less in which a person does not attend school if the person shows to the satisfaction of the Secretary that he intends to continue in full-time school attendance immediately after the end of the period, or does in fact return.	No change.
	Definition of a child based on the laws applied in determining the devolution of intestate personal property in the State in which the worker is domiciled. Since 1965 also includes in definition of child a child who cannot inherit his father's intestate personal property if the father had acknowledged him in writing, had been ordered by a court to contribute to his support, had been judicially decreed to be his father or had been shown by other satisfactory evidence to be his father and was living with or contributing to his support.	Monthly benefits payable to children who can qualify for benefits even though they cannot inherit father's intestate property (under provision of 1965 amendments) cannot exceed the difference between the total amounts payable to other people on the same account and the maximum monthly amount payable on that account. A saving provision provides that benefits payable to a person on the effective date of the 1965 amendments which were reduced because a child became entitled to benefits under the 1965 provision will not be reduced in the future nor will the benefits payable to persons on the rolls in January 1968 be reduced.
	Child adopted by retired worker can get benefits if (1) at the time the worker became entitled to benefits the child was living with the worker or adoption proceedings had begun (2) the adoption was completed	No change.

	within 2 years of the time when the worker became entitled to benefits and (3) the child had been receiving ½ of his support from the worker for the entire year before the worker filed his application for old-age insurance benefits or, if the worker had a period of disability which continued until he became entitled to old-age insurance benefits, before the beginning of the period of disability. Child adopted by the spouse of a deceased worker can get benefits only if the adoption is completed within 2 years after the worker's death.	Includes in the definition of adopted child a child who was adopted by the worker's spouse more than 2 years after the worker's death, provided that proceedings to adopt the child had been initiated before the worker died. Effective for February 1968.
	Child adopted by a disabled worker can get benefits if (1) the adoption is completed within 24 months after the worker became entitled to disability benefits and (2) either proceedings for adoption had been instituted in or before the month in which the worker's latest period of disability began or the child was living with the worker in such month.	A child adopted by a person who is getting disability benefits can become entitled to benefits if (*a*) the adoption takes place in the United States; (*b*) it was under the supervision of a public or private child-placement agency; (*c*) the disabled individual had resided in the United States for the year prior to the adoption; and (*d*) the child is under 18 at the time of adoption. Effective for February 1968.
F. Dependents benefits based on woman worker's earnings record:		
1. Children	A child is deemed dependent on his father or adopting father unless the child has been adopted by someone else or the child is neither the worker's legitimate nor adopted child. A child is dependent on his stepfather if he is living with the stepfather or the stepfather is providing at least ½ of the child's support. A child is dependent on his mother or adopting mother if she is currently insured. If she is not currently insured, the child is dependent on her only if: (A) she is contributing at least ½ of the child's support or (B) she is living with the child or is making regular contributions to the child's support and the child's father is neither living with the child nor making regular contributions to the child's support. A child is dependent on his stepmother if requirement (A) or (B) above is met.	Provides the same dependency requirements for benefits based on the earnings of a woman worker as present law requires for benefits based on the earnings of a male worker. Effective for February 1968.
2. Husbands and widowers	Husband's and widower's benefits can be paid to a husband or widower who was receiving ½ of his support from his wife at the time she became disabled, retired, or died provided she was currently insured at such time.	Eliminates the requirement that the wife be currently insured. Effective for February 1968.
G. Definitions of widow, widower, and stepchildren.	The relationship of widow, widower, or stepchild must have existed for at least 1 year. This requirement does not apply to the surviving widow or widower if the couple has a child, has adopted a child or if the surviving spouse is actually or potentially entitled to benefits on the earnings record of a previous spouse.	The duration-of-relationship requirements are reduced to 9 months. The requirement is further reduced to 3 months in the case of a worker's death by accidental means or if death occurred while he was on active duty in one of the uniformed services unless the Secretary of HEW determines that at the time the marriage occurred the worker could not reasonably have been expected to live for 9 months. Effective for February 1968.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

IV. BENEFIT AMOUNTS

Item	Prior law	Law as amended by Public Law 90–248
A. Creditable earnings	Maximum amount of earnings that may be credited for benefit purposes is $6,600 a year.	Raises maximum amount to $7,800 a year effective Jan. 1, 1968.
B. Benefit formula	The law contains a benefit table which is used to determine benefit amounts for both present and future beneficiaries. Though not stated in the law the formula is approximately 62.97 percent of the 1st $110 of average monthly earnings, plus 22.9 percent of the next $290, plus 21.4 percent of the next $150.	The table is amended to provide a 13-percent benefit increase and to take account of the increase in creditable earnings to $7,800 a year. The new formula is approximately 71.16 percent of the 1st $110 of average monthly earnings, plus 25.88 percent of the next $290, plus 24.18 percent of the next $150, plus 28.43 percent of the next $100. Effective for February 1968.
C. Maximum primary insurance amount	$168 a month ($550 average monthly wage).	Increases to $189.90 ($550 average monthly earnings) and eventually to $218 ($650 average monthly earnings). Effective for February 1968.
D. Maximum limit on wife's benefit	No provision in present law; the wife's benefit is ½ of the primary insurance amount at all levels.	Limits wife's benefit to no more than $105. Without this limit, the wife's benefit would eventually rise to $109.
E. Minimum primary insurance amount	$44 a month.	$55 a month. Effective for February 1968.
F. Maximum family benefits	Family maximum benefits are set by a table in the law and range from $66 a month to $368.	Extends table to take account of rise in creditable earnings and minimum primary insurance amount. As a result the family maximum would range from $82.50 to 434.40 a month. Effective for February 1968.
G. Computation involving 1937–50 wages	When 1937–50 wages are used to compute a benefit the actual wages shown in the social security records are used. Unlike other wages, yearly wages for this period have not been placed on magnetic tape for electronic data processing. A manual examination of the wages is therefore necessary.	To permit electronic data processing a person would be deemed to have been paid all of the wages credited to him for the period 1937–50 in 9 years before 1951 if his total wages for the period do not exceed $27,000; if the total wages in the period exceed $27,000, the wages would be deemed to have been paid at the rate of $3,000 a year. People who require 7 or more quarters of coverage to be insured would be deemed to have 1 quarter of coverage for each $400 of wages earned in the period 1937–50. Effective on enactment for benefits due after 1966.
H. Benefits for certain individuals age 72 and over.	Monthly benefits of $35 a month are provided for a single person and $52.50 a month for a couple in cases where the person has no work, or not enough to be insured, under social security.	Benefits increased to $40 a month for a single person and to $60 a month for a couple. Effective for February 1968.

Comparison of monthly cash benefits under prior law and under Public Law 90-248

Average monthly earnings after 1950	$67 or less		$150		$250		$300		$350		$400		$550		$650 [1] P.L. 90-248
	Prior law	P.L. 90-248	Prior law	P.L. 90-248	Prior law	P.L. 90-248	Prior law	P.L. 90-248	Prior law	P.L. 90-248	Prior law	P.L. 90-248	Prior law	P.L. 90-248	
1. Retirement at 65 or disability benefit	$44.00	$55.00	$78.20	$88.40	$101.70	$115.00	$112.40	$127.10	$124.20	$140.40	$135.90	$153.60	$168.00	$189.90	$218.00
2. Retirement at 62	35.20	44.00	62.60	70.80	81.40	92.00	90.00	101.70	99.40	112.40	108.80	122.90	134.40	152.00	174.40
3. Wife's benefit at 65 or with child in her care	22.00	27.50	39.10	44.20	50.90	57.50	56.20	63.60	62.10	70.20	68.00	76.80	84.00	95.00	[2]105.00
4. Wife's benefit at 62	16.50	20.70	29.40	33.20	38.20	43.20	42.20	47.70	46.60	52.70	51.00	57.60	63.00	71.30	78.80
5. 1 child of retired or disabled worker	22.00	27.50	39.10	44.20	50.90	57.50	56.20	63.60	62.10	70.20	68.00	76.80	84.00	95.00	109.00
6. Widow 62 or older	44.00	55.00	64.60	73.00	84.00	94.90	92.80	104.90	102.50	115.90	112.20	126.80	138.60	156.70	179.90
7. Widow at 60, no child	38.20	47.70	56.00	63.30	72.80	82.30	80.50	91.00	88.90	100.50	97.30	109.90	120.20	135.90	156.00
8. Disabled widow at age 50	-------	33.40	-------	44.30	-------	57.60	-------	63.70	-------	70.30	-------	76.90	-------	95.10	109.20
9. Widow under 62 and 1 child	66.00	82.50	117.40	132.60	152.60	172.60	168.60	190.80	186.40	210.60	204.00	230.40	252.00	285.00	327.00
10. Widow under 62 and 2 children	66.00	82.50	120.00	132.60	202.40	202.40	240.00	240.00	279.60	280.80	306.00	322.40	368.00	395.60	434.40
11. 1 surviving child	44.00	55.00	58.70	66.30	76.30	86.30	84.30	95.40	93.20	105.30	102.00	115.20	126.00	142.50	163.50
12. 2 surviving children	66.00	82.50	117.40	132.60	152.60	172.60	168.60	190.80	186.40	210.60	204.00	230.40	252.00	285.00	327.00
13. Maximum family benefit	66.00	82.50	120.00	132.60	202.40	202.40	240.00	240.00	280.80	280.80	309.20	322.40	368.00	395.60	434.40
14. Lump-sum death payment	132.00	165.00	234.60	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00

[1] Maximum AME under Public Law 90-248.
[2] Maximum wife's benefit.

Source: Social Security Administration.

V. FINANCING

A. Allocation between OASI and DI trust funds.	The Federal Old-Age and Survivors Insurance Trust Fund receives all OASDI tax contributions other than those allocated for the disability insurance program, from which fund benefits and administrative expenses are paid for the old-age and survivors insurance program. A separate tax and fund is established for the hospital insurance trust fund.	No change.
	The Federal Disability Insurance Trust Fund receives an amount equal to 0.70 of 1 percent of taxable wages plus 0.525 of 1 percent of self-employment income, from which benefit and administrative expenses are paid for the disability insurance program.	The allocation to the Disability Insurance Trust Fund, for years beginning after 1967, is increased to 0.95 of 1 percent of taxable wages and 0.7125 of 1 percent of taxable self-employment income.
	These funds are administered by a Board of Trustees consisting of the Secretary of the Treasury, as managing trustee, the Secretary of Labor and the Secretary of Health, Education, and Welfare, all ex officio (with the Commissioner of Social Security as Secretary).	No change.
B. Maximum taxable amount	$6,600 a year.	$7,800 a year starting with 1968.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

VI. MISCELLANEOUS

Item	Prior law	Law as amended by Public Law 90–248
A. Overpayments	When the person who has been overpaid is alive the overpayment can be recovered only by withholding subsequent benefits payable to him. If he has died the overpayment can be recovered by withholding subsequent benefits to others getting benefits on the same earnings record. A person who is liable for repayment of an overpayment to another person cannot have the overpayment waived if the overpaid person was at fault even though he himself is without fault.	An overpayment can be recovered by requiring a refund or by withholding cash benefits of the overpaid person or any other person who is getting benefits on the same account, whether or not the overpaid person is alive. A person who is liable for the repayment of an overpayment made to another person may have recovery waived if he himself is without fault. Effective on enactment.
B. Underpayments	In the case of cash benefit underpayments where an individual dies before the completion of the payment of amounts due him and such amount at the time of his death does not exceed an amount equal to 1 month's benefit, payment is to be made to his surviving spouse who was living in the same household, or, if the underpayment exceeds that amount or if there is no such spouse, to the legal representative of his estate.	Amounts due will be paid under the following order of priority: (1) Spouse living with the individual at time of his death or to the spouse not living with individual but entitled to benefits on the same earnings record. (2) Child entitled to benefits on the same earnings record. (3) Parent entitled to benefits on the same earnings record. (4) Spouse who was neither entitled to benefits on the same earnings record nor living with the individual. (5) Child not entitled to benefits on the same earnings record. (6) Parent not entitled to benefits on the same earnings record. (7) Legal representative of the individual's estate, if any. Effective on enactment.
C. Termination of benefits upon deportation.	Benefits are terminated upon the deportation of a retired or disabled worker under any 1 of 14 specified paragraphs of the Immigration and Nationality Act. Benefits of dependents and survivors who are not citizens will not be paid if they are out of the country.	No change.
D. Payments to aliens	Benefits to an alien are suspended if he is outside the United States continuously for 6 consecutive calendar months. The provision does not apply to aliens: (1) Who are citizens of countries which have effect a social insurance system of general application which would pay benefits to qualified United States citizens while they are outside of that country; (2) Whose benefits are based on the earnings of a person who has 40 quarters of social security coverage;	Once an alien has been outside the United States for 30 consecutive days he will be deemed to be outside the United States until he returns to the United States for 30 consecutive days. An alien who is a citizen of a country that has a pension system of general application which would not pay benefits to qualified citizens of the United States while they are outside of that country would generally not be paid benefits after he has been outside the United States for 6 months. A citizen of a country without such a system and to which the Treas-

	(3) Whose benefits are based on the earnings of a person who has lived in the United States for 10 years; (4) Who is serving outside the United States in the Armed Forces of the United States; (5) If the application of the provision would be contrary to a treaty obligation of the United States under the provisions of a treaty in effect on Aug. 1, 1956; (6) Who is the survivor of a person who died in the military service of the United States or of a person who died as the result of a disease or injury incurred or aggravated in line of duty during a period of military service from which he was released under conditions other than dishonorable; (7) Who had earnings from railroad employment which are counted for social security purposes; (8) Who was, or could have been entitled to benefits for December 1956. Also, the Treasury is authorized to withhold payment to beneficiaries in certain Communist-controlled countries; when the Treasury authorizes payments renewed, back payments are made to the beneficiary or his estate.	ury prohibition on payment applies, or has applied in the past 5 years, would not be paid benefits after he has been outside the United States for 6 months. Amounts that have been accumulated through June 1968 as due an alien who is living in a Communist-controlled country where the Treasury is withholding benefits would be limited to 12-month's benefits and would be paid only to the beneficiary or to a survivor who is entitled to benefits on the same earnings record. Amounts that would be withheld by the Treasury for months after June 1968 would not be paid.
E. Loss of benefits upon conviction of certain subversive crimes.	If an individual is convicted of treason, espionage, or certain other offenses of a subversive nature including a number of offenses under the Internal Security Act, and the offense was committed after the enactment date of this provision (Aug. 1, 1956), the court in its discretion may provide as an additional penalty that none of the individual's wages or self-employment income (or the earnings of any other individual upon which his benefit is based) credited before his conviction shall be used in computing his benefit. The provision applies only to the individual convicted of the offense and does not affect the rights of his dependents or survivors.	No change.
F. Beneficiary reports:		
1. Time for filing reports of earnings.	Under the retirement test a person whose earnings in a year were large enough to cause him to lose some or all of his benefits in a year must file a report of his earnings not later than the 15th day of the 4th month following the close of the taxable year in which he had the earnings.	Where a valid reason exists the Secretary may extend the period for filing the report. The extension may not be for more than 3 months.
2. Penalty for late filing	For the 1st failure to report earnings which are large enough to cause a loss of benefits a penalty of 1 month's benefits is authorized. For failure to report work on 7 or more days in a month outside the United States or that a woman receiving mother's benefits does not have a child in her care a penalty of 1 month's benefits for the first offense is made and for the second and subsequent offenses a penalty of 1 month's benefits for each month for which benefits are to be withheld is authorized.	Where the amount to be withheld because of earnings is less than 1 month's benefit, penalty is reduced to actual amount payable for the month but to not less than $10. The penalty for second and subsequent offenses is reduced to 2 months' benefits for the second offense and to 3 months' benefits for the third and subsequent offenses. In no event, however, will the penalty exceed the actual amount of benefits which are withheld.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

VI. MISCELLANEOUS—Continued

Item	Prior law	Law as amended by Public Law 90-248
G. Advisory Council on Social Security	The Commissioner of Social Security is chairman and 12 other persons appointed by the Secretary are members of the Council. The Councils are to be appointed in 1968 and every 5th year thereafter.	The Secretary will appoint the Chairman as well as the other 12 members of the Council. The Councils will be appointed after January 1969 and after January of every 4th year thereafter.
H. Trustees reports	The reports of the trustees of the social security trust funds are to be sent to the Congress by Mar. 1 of each year.	The reports of the trustees will be sent to the Congress by Apr. 1 of each year. Also, the report of the Trustees on the OASI fund will contain a separate actuarial analysis of all disability expenditures.
I. Disclosure of information—deserting parents.	Disclosure must be authorized by regulation. Under regulation disclosure of parent's or his employer's address is authorised to the agency administering the AFDC program if the child is getting AFDC. The law requires disclosure, at the request of a State or local agency participating in any State or local public assistance program, of the most recent address in the social security records of a parent (or his most recent employer or both) who has failed to provide support for his or her destitute child or children under age 16 who are recipients of or applicants for assistance under such public assistance program where there is a court order for the support of the children and the information requested is to be used by the welfare agency or the court on behalf of the children.	Adds provision for disclosure of address of deserting parent or his employer, on request of an appropriate court, if the information is for the use of the court in issuing a support order against the parent. (The child need not have applied for AFDC.)
J. Attorney's fees	Permits a court which renders a decision favorable to a claimant for social security benefits to set a reasonable fee for the attorney who represented the claimant before the court. The fee cannot exceed 25 percent of the past-due benefits which result from the court's decision. The Secretary may certify for payment to the attorney, out of the total of the past-due benefits, the amount of the fee set by the court. Any attorney charging or receiving more than the fee set by the court is subject to a fine of up to $500, imprisonment up to one year, or both. Under regulations, the Secretary must approve attorneys' fees for services provided before the Social Security Administration.	No change. Adds a provision to authorize the Secretary of HEW to fix a reasonable fee for the services provided before the Social Security Administration for an applicant for social security benefits by an attorney and to pay such attorney's fee out of the applicant's past-due benefits. The amount that can be paid out of past-due benefits is limited to the smaller of (*a*) 25 percent of the past-due benefits; (*b*) the fee fixed by the Secretary; or (*c*) an amount agreed to by the applicant and the attorney.

K. Death in military service	No provision.	Provide that all benefits paid on the basis of official reports of death in military service issued by the Department of Defense will be considered lawful payments even though it is later determined that the person who was reported dead is still alive. *Effective date.*—The provision will apply to all payments made to payees who get benefits for January 1968 or later.
L. Expedited benefit payments	No provision.	Establish special procedures to expedite the payment of benefits. The new procedures would go into effect after June 30, 1968, but would not apply to disability benefits or negotiated checks.

HEALTH INSURANCE

(Title XVIII of the Social Security Act)

Item	Prior law	Law as amended by Public Law 90-248
I. Hospital insurance:		
A. Eligibility:		
1. Permanent provision	Eligibility to hospital insurance benefits begins with the first day of the first month in which an individual is both age 65 and eligible for cash benefits under social security or the railroad retirement system and ends with the last day of the month with which his eligibility to cash benefits ends (except that eligibility continues to the day of death even though cash benefits are not payable for the month of death).	No change.
2. Transitional provision	In addition, all those who attained 65 before 1968 are eligible for hospital insurance even though not eligible for such cash benefits and people who attain 65 in 1968 or later need quarters of coverage under a transitional provision as indicated in the following table: *Year attains age 65:* — *Required quarters* 1968 — 6 1969 — 9 1970 — 12 1971 — 15 1972 — 18 1973 — 21 1974 — 23 Women who attain age 65 in 1972 need the same number of quarters of coverage—18—for regular insured status and men who attain 65 in 1974 need the same number—23—so the transitional provision washes out in those years.	Modifies prior provision so that 3 quarters rather than 6 would be required for people attaining age 65 in 1968, with the requirements for later years also reduced by 3 as follows: *Year attains age 65:* — *Required quarters* 1968 — 3 1969 — 6 1970 — 9 1971 — 12 1972 — 15 1973 — 18 1974 — 21 1975 — 24 For women the provision washes out in 1974; for men in 1975.

HEALTH INSURANCE—Continued

(Title XVIII of the Social Security Act)—Continued

Item	Prior law	Law as amended by Public Law 90-248
I. Hospital insurance—Continued B. Benefits: 1. Hospital benefits	Eligible individuals are entitled to have payment made for up to 90 days of hospital care, subject to a deductible of $40 and to copay of $10 a day for the 61st through the 90th day during each spell of illness.	Each medicare beneficiary will be entitled to a lifetime reserve of 60 days of hospital care after the 90 days in a spell of illness are exhausted. Coinsurance of $20 a day would apply to such added days of coverage. Effective: For services furnished after Dec. 31, 1967.
2. Spell of illness	A "spell of illness" begins with the 1st day of hospitalization and ends with the end of the 1st 60-day period during all of which the individual is not a patient of either a hospital or nursing home.	No change.
3. Mental or TB hospital credit.	If an individual is an inpatient of a mental or TB hospital when he becomes eligible for hospital insurance the number of days he was such an inpatient prior to his eligibility are counted against the 90 days of coverage. Hospital inpatient coverage in a mental hospital is further limited by a 190-day lifetime maximum. (Days in such a hospital just before eligibility do not count against the lifetime maximum.)	Tuberculosis hospitals are removed from the provision and the provision will no longer apply in the case of an individual who is treated in a general hospital for a condition not related to mental illness. The number of days counted against days of coverage is increased from 90 to 150. Effective: For services furnished after Dec. 31, 1967.
4. Posthospital extended care.	Beneficiaries are also eligible for post-hospital extended care (in a qualified facility having an arrangement with a hospital for the timely transfer of patients and for the furnishing of medical information about patients) if the patient is transferred to the hospital within 14 days of discharge (after at least a 3-day stay) for up to 100 days in each spell of illness. Patients pay $5 a day for each day after 20 days of extended care in a spell of illness.	No change.
5. Posthospital home health services.	Benefits also include posthospital home health services for up to 100 visits, after discharge from a hospital (after at least a 3-day stay) or, if later, after a covered stay in an extended care facility, and before the beginning of a new spell of illness. The patient must be in the care of a physician and under a plan established by a physician within 14 days of discharge from the hospital or extended care facility. The covered services include intermittent nursing care, therapy, and, to the extent provided in regulations, the part-time services of a home health aide. For the services to be covered, the patient must be homebound, except that, when certain equipment is used, the individual may be taken to a hospital or extended care facility or rehabilitation center to receive services involving nontransportable equipment.	No change.

6. Outpatient hospital diagnostic services.	Outpatient hospital diagnostic services are covered subject to a $20 deductible amount and 20-percent coinsurance for each diagnostic study (that is, for diagnostic services furnished to an individual by the same hospital during a 20-day period). (Amounts credited toward the $20 deductible are treated as covered expenses under the pt. B supplementary medical insurance program.)	Transfers hospital outpatient diagnostic services from the hospital insurance program to the supplementary medical insurance program. The effect of the change is that all hospital outpatient services will be covered under the supplementary medical insurance program and thus subject to the pt. B deductible ($50 a year) and coinsurance (20 percent). Effective: For services furnished after Mar. 31, 1968.
7. Changes in deductible.	The deductible amounts for inpatient hospital and outpatient hospital diagnostic services will be increased if necessary to keep pace with increases in hospital costs, but no such increase will occur before 1969. The coinsurance amounts for long-stay hospital and extended care facility benefits will be correspondingly adjusted. Increases in the hospital deductible will be made only when a $4 change is called for and the outpatient deductible will change in $2 steps.	As indicated above, the separate outpatient deductible will be eliminated.
8. Blood deductible	In addition to the $40 deductible for inpatient hospital services there is a deductible in an amount equal to the cost of the first 3 pints of blood furnished for an individual during a spell of illness. When the blood is not replaced, the difference between the cost of the blood to the hospital and the charge to the beneficiary is deducted from the payments the program would otherwise make to the hospital.	The definition of "blood" is broadened to include units of packed red blood cells and the 3-pint deductible is also applied to the supplementary medical insurance program. Effective: For blood or packed red cells furnished after Dec. 31, 1967.
C. Definition of providers of services:		
1. Hospital	In general, the term "hospital" means an institution which (1) is primarily engaged in providing diagnostic and therapeutic services for medical diagnosis, treatment, and care, or rehabilitation services for injured, disabled, or sick persons; (2) maintains clinical records on all patients; (3) has bylaws in effect with respect to its staff of physicians; (4) requires that every patient be under the care of a physician; (5) provides 24-hour nursing service rendered by or under the supervision of a registered nurse; (6) has in effect a hospital utilization review plan; (7) in the case of an institution in any State which provides for licensing of hospitals, is licensed (or approved) by the licensing agency pursuant to State or local law; and (8) meets such other requirements as the Secretary finds necessary in the interest of health and safety (except that these requirements may not be higher than the comparable requirements prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals). A hospital which is accredited by the Joint Commission is deemed to meet all of the above qualifications except the utilization review requirement. For the specific purpose of determining how long an individual is out of a hospital in order to establish when a spell of illness ends, an institution satisfying item (1) of the definition is a "hospital."	No change.

HEALTH INSURANCE—Continued

(Title XVIII of the Social Security Act)—Continued

Item	Prior law	Law as amended by Public Law 90-248
I. Hospital insurance—Continued C. Definition of providers of services—Continued 2. Emergency hospital	In determining whether emergency hospital services are covered and for purposes of describing the institution from which an individual must be transferred in order to be eligible for posthospital extended care or posthospital home health services, an institution satisfying items (1), (2), (3), (4), (5), and (7) of the definition is a "hospital." The term "hospital" does not (except for purposes of determining when a spell of illness ends) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis, unless it is a tuberculosis hospital or a psychiatric hospital as defined below. The term "hospital" also includes a Christian Science sanatorium operated or listed and certified by the First Church of Christ Scientist, Boston, Mass., but payment may be made with respect to services provided by or in such a sanatorium only to such extent and under such limitations and requirements as may be provided in regulations.	The definition of hospital for emergency purposes is changed to mean an institution which: (1) Is licensed as a hospital; (2) Has full-time nursing service; and (3) Is primarily engaged in providing medical care under the supervision of a doctor of medicine or osteopathy. (See p. 32 for description of other changes affecting coverage of emergency hospital care.) Effective: As of July 1, 1966.
3. Psychiatric hospital	The term "psychiatric hospital" means an institution which (1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons; (2) satisfies the requirements prescribed for hospitals under items (3) through (8) in 1, above; (3) maintains clinical records on all patients and maintains such records as the Secretary of Health, Education, and Welfare finds necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits; (4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and (5) is accredited by the Joint Commission on Accreditation of Hospitals. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.	No change.

4. Tuberculosis hospital...	The term "tuberculosis hospital" means an institution which (1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis; (2) satisfies the requirements prescribed for hospitals under items (3) through (8) in 1, above; (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment; (4) meets such staffing requirements as the Secretary may find necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and (5) is accredited by the Joint Commission on Accreditation of Hospitals. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.	No change
5. Extended care facility...	The term "extended care facility" means an institution (or a distinct part thereof) which has an agreement with one or more participating hospitals for the timely transfer of patients and their medical records and which (1) is primarily engaged in providing to inpatients skilled nursing care and related services, or rehabilitation services; (2) has policies which are developed with the advice of and periodically reviewed by a professional group (including at least 1 physician and at least 1 registered nurse) to govern the services it provides; (3) has a physician, registered nurse, or medical staff responsible for the execution of such policies; (4) requires that the health care of each patient be under the supervision of a physician and provides for having a physician available to furnish necessary emergency medical care; (5) maintains clinical records on all patients; (6) provides 24-hour nursing services sufficient to meet needs in accordance with facility policies and has at least 1 registered professional nurse employed full time; (7) provides appropriate methods for dispensing and administering drugs and biologicals; (8) has in effect a utilization review plan as defined below; (9) is licensed (or meets the standards for licensing) pursuant to State or local law; and (10) meets such other conditions relating to health and safety or physical facilities as the Secretary may find necessary. The term "extended care facility" does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For the specific purpose of determining when a spell of illness ends the term includes any institution which satisfies item (1).	No change.

HEALTH INSURANCE—Continued

(Title XVIII of the Social Security Act)—Continued

Item	Prior law	Law as amended by Public Law 90-248
I. Hospital insurance—Continued C. Definition of providers of services—Continued 6. Utilization review	A utilization review plan of a hospital or extended care facility will be considered sufficient if it is applicable to services furnished to individuals entitled to benefits under title XVIII and if it provides (1) for the review, on a sample or other basis, of admissions, duration of stays, and professional services from the standpoint of medical necessity and for the purpose of promoting the most efficient use of available health facilities and services; (2) for such review to be made by a staff committee of the institution which includes two or more physicians, or by a similarly composed group outside the institution which is established either by the local medical society and some or all of the hospitals and extended care facilities in the locality or in some other manner which may be approved by the Secretary; (3) for such review (in each case of a continuous stay of extended duration in a hospital or extended care facility) as of such days of such stay (which may be different for different classes of cases) as may be specified in regulations, with such review being made as promptly as possible after each day specified in the regulations but no later than 1 week following that day; and (4) for prompt notification to the institution, the individual, and his physician of any finding (which shall be made only after opportunity for consultation has been provided the physician) that further stay in the institution is not medically necessary. The utilization review plan must provide for review by a group outside the institution where, because of its small size (or, in the case of an extended care facility, because of lack of an organized medical staff), or for such other reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee.	No change.
7. Home health agency	The term "home health agency" means a public agency or private organization (or a part of such agency or organization) which (1) primarily provides skilled nursing and other therapeutic services; (2) has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered nurse) to govern services it provides, and provides for supervision of such services by a physician or a registered nurse; (3) maintains clinical records on all patients; (4) is licensed (or meets standards for licensing) pursuant to State or local law;	No change.

	and (5) meets other conditions found by the Secretary to be necessary for health and safety. The term does not include a private organization which is not a nonprofit organization exempt from Federal income taxation unless it is licensed pursuant to State law and meets such additional standards and requirements as may be prescribed by regulations. For purposes of hospital insurance, the term does not include any agency or organization which is primarily for the care and treatment of mental diseases.	
D. Conditions of payment: 1. Physician certifications.	A physician must certify (and recertify, in such cases and as often and with such supporting material as may be provided in regulations, but in any event by the 20th day of hospitalization) that—	
	(A) in the case of inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services), the services were required to be given on an inpatient basis for medical treatment, or inpatient diagnostic study was medically required;	The (A) provision is deleted except with respect to recertifications. Effective: For services furnished after date of enactment (Jan. 2, 1968).
	(B) in the case of inpatient psychiatric hospital services, the services were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual, and such treatment could reasonably be expected to improve the condition, or inpatient diagnostic study was medically required;	No change.
	(C) in the case of inpatient tuberculosis hospital services, the services were required to be given on an inpatient basis by or under supervision of a physician for the treatment of tuberculosis, and the treatment can be reasonably expected to improve the condition or render it noncommunicable;	No change.
	(D) in the case of posthospital extended care services, the services were required to be given on an inpatient basis because the individual needed skilled nursing care on a continuing basis for a condition for which he was hospitalized prior to transfer to the extended care facility, or which arose while receiving care for such a condition;	No change.
	(E) in the case of posthospital home health services, the services were required because the individual was confined to his home and needed intermittent skilled nursing care, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services or posthospital extended care services, and the services were furnished while the individual was under the care of a physician and under a plan established and reviewed periodically by a physician; or	No change.
	(F) in the case of outpatient hospital diagnostic services, the services were required for diagnostic study.	The (F) provision is deleted. Effective: For services furnished after date of enactment (Jan. 2, 1968).

HEALTH INSURANCE—Continued

(Title XVIII of the Social Security Act)—Continued

Item	Prior law	Law as amended by Public Law 90-248
I. Hospital insurance—Continued D. Conditions of payment—Con. 2. Review of long-stay cases.	Payment may not be made for inpatient hospital services furnished an individual after the 20th day of a continuous stay or for posthospital extended care services furnished continuously after a period of time prescribed in regulations if the Secretary, before such individual's admission to the hospital or extended care facility, has rendered an adverse decision that the hospital or extended care facility is not making the necessary utilization reviews of long-stay cases. Payment may not be made for inpatient hospital services or posthospital extended care services furnished an individual after a finding by the physician members of the appropriate utilization review committee that further inpatient hospital services or posthospital extended care services are medically unnecessary. If such a finding has been made, payment may not be made for services furnished after the third day after the day the notice of such finding is received by the hospital or extended care facility.	No change.
3. Emergency hospital services.	Payment may be made for emergency hospital services, in the absence of an agreement of the kind otherwise required between the Secretary and the hospital, to the extent that the Secretary would be required to make payment if the hospital had such an agreement in effect and otherwise met the conditions of payment. (See definition of hospital, above, for special definition of hospital for purposes of this provision.) The hospital must agree, as a condition of payment under this provision, not to charge the patient for the covered emergency services.	Provides that if the hospital does not bill for emergency hospital services, the patient could be paid 60 percent of the room and board charges and 80 percent of the hospital ancillary charges (of, if the hospital does not make separate charges for routine and ancillary services, ⅘ of the hospital's reasonable charges), subject to deductible and other existing limitations. (See above for change in definition of hospital for emergency purposes.) Effective: For admissions after Dec. 31, 1967. For outpatient services furnished between Jan. 1, 1968, and Apr. 1, 1968 (when all outpatient services become covered under SMI). Change in definition of hospital for emergency purposes is effective July 1, 1966, with the result that prior law payment procedures apply for admissions between that date and Dec. 31, 1967, in hospitals made newly eligible.
4. Services outside United States.	The preceding provisions for payments for emergency hospital services are applicable to emergency inpatient hospital services furnished by a hospital located outside the United States if the individual was present in the United States at the time the emergency which necessi-	No change.

	tated inpatient hospital services occurred and the hospital outside the United States was closer to, or substantially more accessible from, the place where the emergency arose than the nearest hospital within the United States which was adequately equipped to deal with the individual's illness or injury and available for the treatment of the illness or injury.	
5. Temporary coverage of nonparticipating hospitals.	No provision.	Provides that payment may be made, on the basis of an itemized bill, to an individual entitled to hospital insurance benefits for inpatient hospital services furnished after June 30, 1966, in certain nonparticipating hospitals as a result of admissions occurring before January 1, 1968. The hospital must be licensed as a hospital, have full-time nursing services, and be primarily engaged in providing medical care under the supervision of a doctor of medicine or osteopathy. Application for reimbursement under this provision would have to be filed before Jan. 1, 1969, and payment would be limited to 60 percent of room and board charges and 80 percent of hospital ancillary charges for up to 90 days in each spell of illness (subject to cost-sharing provisions in present law) if the hospital formally participates in the hospital insurance program before Jan. 1, 1969, and applies its utilization review plan to the services furnished such individual. If the hospital does not participate before Jan. 1, 1969, payment under this provision would be limited to 20 days in each spell of illness.
E. Reasonable cost reimbursement.	Providers of services under the program are to be paid on the basis of reasonable costs (regardless of whether the service is covered under hospital or supplementary medical insurance). The reasonable cost of any service is determined under regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services. In prescribing these regulations the Secretary must consider, among other things, the principles developed and generally applied by national organizations or established prepayment organizations in computing the amount of payment to be made by third parties to providers of services. Such regulations may provide for determination of the cost of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations must take into account both direct and indirect costs of providers in order that the costs with respect to individuals covered by medicare will not be borne by individuals not so covered and the costs with respect to individuals not	The Secretary of Health, Education, and Welfare is authorized to experiment with various methods of reimbursement to organizations, institutions, and physicians, participating in medicare, medicaid, or the child health program which offer incentives for keeping costs down while maintaining quality.

HEALTH INSURANCE—Continued

(Title XVIII of the Social Security Act)—Continued

Item	Prior law	Law as amended by Public Law 90-248
I. Hospital insurance—Continued E. Reasonable cost reimbursement—continued	covered will not be borne by medicare. The regulations must also provide for making retroactive corrective adjustments where, for any provider of services for any fiscal period, the total reimbursement produced by methods of determining costs proves to be either inadequate or excessive.	Hospitals will be permitted, as an alternative to the present procedure, to collect small charges (if not more than $50) for outpatient hospital services from the beneficiary without submitting a cost-reimbursement bill to medicare. (The amounts collected would be counted as expenses reimbursable to the beneficiary under the medical insurance plan.) The payments due the hospitals would be computed at intervals to assure that the hospital received its final reimbursement on a cost basis. Effective: Services furnished after Mar. 31, 1968.
	Regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed 1½ times the average of the rates of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. (By regulation these last two sentences also apply to proprietary hospitals.)	No change.
	If a patient receives inpatient services in accomodations which are more expensive than semiprivate accommodations, but which are not medically necessary, the amount of payment may not exceed an amount equal to the reasonable cost of such services if furnished in semiprivate aecommodations. If a patient receives other items or services which are more expensive than those for which payment can be made, the Secretary will take into account for purposes of payment no more than the reasonable cost of the services that can be paid for.	No change.
	If a patient is placed in accommodations less expensive than semiprivate accommodations for a reason the Secretary determines is not consistent with the program's purpose (and not at the patient's request), payment will be limited to the reasonable cost of semiprivate accommodations minus the difference between the customary charges for semiprivate accommodations and the accomodations furnished.	No change.

	The term "semiprivate accommodations" means 2-bed, 3-bed, or 4-bed accommodations.	
F. Administration:		
1. State agencies	The Secretary is required to make an agreement with any State which is able and willing to enter into an agreement to utilize the services of the State health agency or other appropriate State agencies for the purpose of determining which institutions and agencies qualify to participate in the programs under medicare and whether independent laboratories meet the requirements of law and regulation. The Secretary may accept a State (or local) agency's findings as to the qualifications of an institution or agency to participate. The Secretary may also, pursuant to agreement, use State and local agencies to do any of the following: (1) provide consultative services to institutions or agencies to assist them in establishing and maintaining fiscal records or otherwise qualifying for participation, or in providing information necessary to determine what benefits are payable; and (2) provide consultative services to institutions, agencies, or organizations to assist them in establishing and evaluating the effectiveness of utilization review procedures. The Secretary is to pay the State for the reasonable costs of the administrative activities performed under its agreement and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those covered under medicare or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.	This provision is repealed effective July 1, 1969. (See p. 78 for substitute provision in the medicaid (title XIX) program.)
2. Intermediaries	If any group or association of providers of services wishes to have payments under pt. A made through a National, State, or other public or private agency or organization, and nominates such an agency or organization for this purpose, the Secretary may enter into an agreement with the agency or organization providing for the determination of the amount to be paid under pt. A to such providers, and for the payment to such providers of the amounts so determined. The agreement may also include provision for the agency or organization to do all or any part of the following: (1) provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records and otherwise to qualify as participants in the program; and (2) serve as a center for communications between the providers covered under the agreement and the Secretary, and make such audits of the records of such providers as may be necessary to assure proper payment.	No change

HEALTH INSURANCE—Continued

(Title XVIII of the Social Security Act)—Continued

Item	Prior law	Law as amended by Public Law 90-248
I. Hospital insurance—Continued F. Administration—Continued	The Secretary may not enter into an agreement with an agency or organization unless (1) he finds that (A) to do so is consistent with effective and efficient administration, (B) the agency or organization is willing and able to assist the providers in the application of safeguards against unnecessary utilization of services (and the agreement provides for such assistance), and (2) the agency or organization agrees to furnish to the Secretary such information acquired by it in carrying out its agreement as the Secretary may find necessary to perform his functions under pt. A.	No change.
	An agreement may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the agency or organization for making payments to providers of services. Such an agreement may also provide for payment to the agency or organization of the necessary and proper costs of carrying out its functions performed or to be performed under the terms of the agreement.	No change.
	If the nomination of an agency or organization is made by a group or association of providers of services, it will not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon notice, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination (and any provider which has not made a nomination) may elect to receive payments either directly from the Secretary or from any agency or organization which has entered into an agreement with the Secretary if the Secretary and such agency or organization agree to it.	No change.
G. Financing	Taxes pursuant to the schedule below are deposited in the Federal Hospital Insurance Trust Fund from which all benefits and administrative expenses are disbursed. The Trust Fund also receives the general revenues to meet the expenses arising from those who qualify under the transitional insured provision. The hospital insurance taxes under the railroad retirement system are also deposited in the fund.	

	Hospital Insurance Tax Schedule: *Percent* 1968–72 ..... 0.5 1973–75 ..... .55 1976–79 ..... .6 1980–86 ..... .7 1987 and after 8	Hospital Insurance Tax Schedule: *Percent* 1968–72 ..... 0.6 1973–75 ..... .65 1976–79 ..... .7 1980–86 ..... .8 1987 and after 9
H. Hospital insurance taxes paid by railroad employees.	People employed under both railroad retirement and social security pay hospital insurance taxes on wages covered under both systems. If taxes are paid on more than the maximum amount of wages taxable under 1 program no provision for refund of excess taxes.	An employee's hospital insurance taxes in excess of the maximum may be refunded.
II. Supplementary medical insurance—pt. B:		
A. Eligibility	Each individual who has attained age 65 and who is a resident of the United States and is either a citizen, or an alien who has been a lawful resident for 5 years or more, is eligible to enroll under pt. B. Any person eligible for hospital insurance benefits is eligible regardless of the preceding requirement.	No change.
B. Enrollment and disenrollment.	An eligible individual may enroll during the 7-month period beginning with the 3d month before the month he reaches age 65 and ending with the 3d month after the month in which he reaches age 65. In addition, an individual who fails to enroll in the 7-month period may enroll in a general enrollment period. The 1st general enrollment period began Oct. 1, 1967, and ran through Mar. 31, 1968. General enrollment periods running from Oct. 1 through Dec. 31 begin in 1969 and every odd year thereafter. An individual may not enroll more than 3 years after the close of his 1st enrollment period. A person who disenrolls may enroll only once after that.	A person over 65 who believes, on the basis of documentary evidence, that he has just reached age 65 will be allowed to enroll in the program as if he had attained age 65 on the date shown in the evidence. Effective: for enrollments beginning in February 1968. General enrollment periods run from Jan. 1 through Mar. 31 beginning in 1969 and *every* year thereaftert An individual may enroll within a general enrollmene period which begins within 3 years after the close of his first enrollment period.
	Coverage may be terminated by an individual receiving social security, railroad retirement, or civil service benefits (whose premiums must be deducted from their benefits) only during a general enrollment period. Persons not receiving those benefits can terminate coverage by notice during a general enrollment period or by nonpayment of premiums (subject to a grace period of up to 90 days).	Persons receiving social security, railroad retirement, or civil service retirement benefits can file a notice to disenroll at any time and coverage will terminate with the close of the calendar quarter following the quarter in which the notice is filed. Effective: Apr. 1, 1968.
C. Coverage period	An individual who enrolls in a month before the month in which he reaches age 65 will be eligible for benefits beginning with the first day of the month he reaches age 65. If he enrolls in the month in which he reaches age 65, coverage is effective with the next month. If he enrolls in the month after he reaches 65 coverage is effective with the 2d month following the month in which he enrolls. If he enrolls in the 2d month	

HEALTH INSURANCE—Continued

(Title XVIII of the Social Security Act)—Continued

Item	Prior law	Law as amended by Public Law 90-248
II. Supplementary medical insurance—pt. B—Continued C. Coverage period—Continued	or 3d month after the month in which he reaches age 65 coverage is effective with the 3d month following the month in which he enrolls. If an individual enrolls during a general enrollment period coverage is effective with the July 1 following. If an individual disenrolls during a general enrollment period his coverage ends with Dec. 31 of the period (except that, if an individual disenrolls during January, February, or March of the general enrollment period running from Oct. 1, 1967, to Mar. 31, 1968, coverage will end with Mar. 31, 1968).	If an individual disenrolls during a general enrollment period beginning in 1969 or later, coverage ends with Apr. 1 of that year.
D. Premiums	The monthly premium for each month before April 1968 is $3.00. The Secretary was required to announce before Jan. 1, 1968, the premium amount to be effective for April 1968—$4.00. The Secretary must announce during the period July 1 to Oct. 1, 1969, the premium amount to be in effect from January 1970 through December 1971. The Secretary is required to make similar announcements in each odd-numbered year thereafter.	The Secretary is to announce by Jan. 1, 1969, and each year thereafter, the premium amount which is to be in effect for the 12-month period beginning the following July 1. The $4.00 premium announced by the Secretary in December 1967 will apply from April 1968 through June 1969. At the time the premium amount is announced, the Secretary must issue a public statement setting forth the actuarial bases and assumptions used in arriving at the premium amount. The latter provision is effective after Dec. 1, 1968.
	If an individual 1st enrolls more than 12 months after he could have enrolled, his premium is increased by 10 percent for each full 12 months the individual could have been but was not enrolled.	No change.
E. Financing	Premiums paid by enrollees with matching amounts appropriated from general revenues are deposited in a Federal Supplementary Medical Insurance Trust Fund from which all benefits and administrative expenses of the program are paid.	Adds provisions authorizing payment from general revenues to the Federal Supplementary Medical Insurance Trust Fund to put the Trust Fund in the same fiscal position it would have been had the matching general revenues been deposited in the Fund at the same time the premiums were deposited. Effective: For fiscal years occurring after June 30, 1967.
	General revenue appropriation can also include a contingency fund available during 1966 and 1967.	Contingency fund would be made available through 1969.
F. Benefits	The supplementary medical insurance plan covers physicians' services, home health services, and numerous other medical and health services in and out of medical institutions as set forth below; however, they are not covered if they would constitute items which could be paid for under pt. A without regard to deductibles, coinsurance, or time-limit provisions:	Removes exclusion of services which are covered under pt. A. (Another provision of law avoids duplicate payment.) Effective: For services furnished after Mar. 31, 1968.

	There is an annual deductible of $50 (but expenses counted toward a deductible in the last 3 months of a year count also in the following year). Then the plan covers 80 percent of the reasonable charges (above the deductible) for the following services: (1) physicians' and surgeons' services, whether furnished in a hospital, clinic, office, home, or elsewhere; (2) home health services (with no requirement of prior hospitalization) for up to 100 visits during each calendar year; (3) diagnostic X-ray, diagnostic laboratory tests, and other diagnostic tests; (4) X-ray, radium, and radioactive isotope therapy; (5) ambulance services; and (6) surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home, prosthetic devices (other than dental) which replace all or part of an internal body organ; braces and artificial legs, arms, eyes, etc. There is a special limitation on outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year is limited, in effect, to $250 or 50 percent of the expenses, whichever is smaller.	Adds deductible of 3 pints of blood with a unit of packed red cells equivalent to a pint of blood. Effective: With blood furnished after Dec. 31, 1967. Provides that 100 percent of the reasonable charges will be reimbursed for pathology and radiology services furnished to hospital inpatients. Effective: For services after Mar. 31, 1968. Covers the services of licensed podiatrists (but excludes routine foot care). Effective: For services after Dec. 31, 1967. Permits payment to be made for durable medical equipment needed by an individual whether rented or purchased. If purchased, payment would be made periodically in the same amount as if equipment were rented, up to the purchase price. Effective: For items purchased after Dec. 31, 1967. Permits payment for diagnostic X-rays taken in a patient's home or in a nursing home. These services will be covered only if they are provided under the supervision of a physician and are performed under health and safety regulations of the Secretary. Effective: For services furnished after Dec. 31, 1967.
G. Physical therapy services	Covered where furnished as part of inpatient hospital services, outpatient hospital services, and home health services. Not covered if performed in physical therapist's office.	Covers outpatient physical therapy services no matter where performed, furnished by physical therapists employed by or under an agreement with and under the supervision of hospitals and other providers of services as well as approved clinics, rehabilitation centers, and local public health agencies. Effective: For services furnished after June 30, 1968.
H. Administration: 1. Carriers	The Secretary of Health, Education, and Welfare is required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the voluntary supplementary medical insurance plan such as determining rates of payments under the program and holding and disbursing funds for benefit payments. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of services), the cost is a reasonable cost.	1. No change.

HEALTH INSURANCE—Continued

(Title XVIII of the Social Security Act)—Continued

Item	Prior law	Law as amended by Public Law 90-248
II. Supplementary medical insurance—pt. B—Continued H. Administration—Continued 2. Reasonable charges	Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that the charges are reasonable and not higher than the charges applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. In determining reasonable charges, the carriers will consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.	2. No change.
3. Physician payment method.	Payment by the carrier for physicians' services can be made only on the basis of a receipted bill, or on the basis of an assignment under the terms of which the physician agrees to accept the reasonable charge as determined by the carriers as the full charge for the service.	3. Permits payment either to the patient on the basis of an itemized bill (paid or unpaid) or to the physician under the assignment method. Effective: For claims not completed by Jan. 2, 1968.
4. Time limit on filing SMI claims.	No provision.	4. Claims must be filed no later than the close of the calendar year following the year (and the last 3 months of the previous year) in which the services are furnished Effective: For bills submitted after March 1968.
I. Reimbursement for civil service annuitants for premium payments.	No provision.	Federal employee health benefit plans would be permitted to reimburse civil service retirement annuitants for the premium payments they make to the supplementary medical insurance program, provided such reimbursement is financed from funds other than contributions made by the Federal Government and the Federal employees toward the health benefit plan. Effective: On enactment, Jan. 2, 1968.
III. Exclusions from both Medicare programs.	The following are excluded from both pt. A and pt. B of medicare: Items or services— (1) which are not necessary for medical diagnosis or treatment or improved functioning of a malformed body member; (2) for which the individual is not obligated to pay (a free chest X-ray, for example); (3) which are paid for by some other governmental entity except where specified by the Secretary; (4) which are furnished outside the United States (except for emergency hospitalization as described above);	

	(5) which are required as a result of war; (6) which are personal comfort items; (7) which are routine physical checkups, eyeglasses or eye examination for the purpose of prescribing, fitting, or changing eyeglasses, hearing aids or examinations therefor, or immunizations; (8) for orthopedic shoes or other supportive devices for the feet; (9) are for custodial care; (10) which are for cosmetic surgery, except for prompt repair of accidental injury; (11) furnished by immediate relatives or members of the same household; (12) in connection with the care, treatment, filling, removal, or replacement of teeth or structure directly supporting teeth; or (13) which are, or can be expected to be, paid for under workmen's compensation.	Adds exclusion of refractive procedures on the eye performed for any purpose. Effective: On enactment, Jan. 2, 1968. Adds exclusion of routine foot care. Effective: For services furnished after Dec. 31, 1967.
IV. Advisory groups:		
A. Health Insurance Benefits Advisory Council.	A Health Insurance Benefits Advisory Council is established for the purpose of advising the Secretary of Health, Education, and Welfare on matters of general policy in the administration of the medicare program and in the formulation of regulations under medicare. The Council is composed of 16 members, one of them designated Chairman, selected by the Secretary. Members hold office for 4 years with the initial appointments varied so that 1 quarter of the membership is appointed each year.	The Health Insurance Benefits Advisory Council assumes the duties of the National Medical Review Committee (which was never formed). The Council's membership is increased from 16 to 19 persons. Effective: On enactment, Jan. 2, 1968.
B. National Medical Review Committee.	A National Medical Review Committee is required to be established for the purpose of studying the utilization of hospital and other medical care and services "with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized or in the administration of the programs established by this title, or in the provisions of this title." The Committee is composed of 9 persons, a majority of which shall be physicians, representative of organizations of professional personnel in the field of health or outstanding in that field. 1 member shall represent the general public. Appointments are for 3 years with initial appointments set at intervals so that 3 members are appointed or reappointed every year. Committee was never appointed.	Repealed: See above.
C. Other groups and studies: 1. Health practitioners---	No provision.	The Secretary of Health, Education, and Welfare is required to study the need for, and make recommendations concerning, the extension of coverage under the supplementary medical insurance program to the services of additional types of personnel who engage in the independent practice of furnishing health services. Report due Jan. 1, 1969.

HEALTH INSURANCE—Continued

(Title XVIII of the Social Security Act)—Continued

Item	Prior law	Law as amended by Public Law 90-248
IV. Advisory group—Continued C. Other groups and studies—Con. 2. Disabled under medicare.	No provision.	The Secretary of Health, Education, and Welfare is required to establish an Advisory Council to study the problems relative to including the disabled under the health insurance program, and also any special problems with regard to the costs which would be involved in such coverage. The Council is to make its report by Jan. 1, 1969.
3. Drug study	No provision.	The Secretary of HEW is required to study and report to the Congress, prior to Jan. 1, 1969, the savings which might accrue to the Government and the effects on the health professions and on all elements of the drug industry which might result from enactment of two proposals relating to drugs: (1) a proposal to cover prescription drugs under medicare; and (2) a proposal to establish, through a formulary committee, quality and cost control standards for drugs provided under the various programs of the Social Security Act.
V. Overpayments and underpayments	Where more than the correct amount is paid for a service or item under medicare, the overpayment can be recouped by withholding regular cash social security or railroad retirement benefits. No special provision for handling underpayments under pt. B program.	Provides that amounts due under the supplementary medical insurance program after the beneficiary's death be paid to the person who paid for the services, either before or after the beneficiary's death, or to the person who provided the services. (If the person who paid for the services is the decedent, the payment would be made to the legal representative of his estate if there is one.) Otherwise the benefits will be paid under the following order of payment: 1. Spouse living with the individual at time of his death or to the spouse not living with individual but entitled to benefits on the same earnings record. 2. Child entitled to benefits on the same earnings record. 3. Parent entitled to benefits on the same earnings record. 4. Spouse who was neither entitled to benefits on the same earnings record nor living with the individual. 5. Child not entitled to benefits on the same earnings record. 6. Parent not entitled to benefits on the same earnings record. 7. Legal representative of the individual's estate, if any. Effective: Underpayments outstanding arising after enactment, Jan. 2, 1968.

DATA ON OASDHI

TABLE 1.—*Maximum contribution amounts under Public Law 90–248—Old-age, survivors, disability, and hospital insurance*

Calendar year	OASDI		Hospital insurance		Total	
	Previous law	(Public Law 90–248)	Previous law	(Public Law 90–248)	Previous law	(Public Law 90–248)
	Employee					
1967	$257.40	$257.40	$33.00	$33.00	$290.40	$290.40
1968	257.40	296.40	33.00	46.80	290.40	343.20
1969–70	290.40	327.60	33.00	46.80	323.40	374.40
1971–72	290.40	358.80	33.00	46.80	323.40	405.60
1973–75	320.10	390.00	36.30	50.70	356.40	440.70
1976–79	320.10	390.00	39.60	54.60	359.70	444.60
1980–86	320.10	390.00	46.20	62.40	366.30	452.40
1987 and after	320.10	390.00	52.80	70.20	372.90	460.20
	Self-employed					
1967	$389.40	$389.40	$33.00	$33.00	$422.40	$422.40
1968	389.40	452.40	33.00	46.80	422.40	499.20
1969–70	435.60	491.40	33.00	46.80	468.60	538.20
1971–72	435.60	538.20	33.00	46.80	468.60	585.00
1973–75	462.00	546.00	36.30	50.70	498.30	596.70
1976–79	462.00	546.00	39.60	54.60	501.60	600.60
1980–86	462.00	546.00	46.20	62.40	508.20	608.40
1987 and after	462.00	546.00	52.80	70.20	514.80	616.20

Source: Chief Actuary, Social Security Administration.

DATA ON OASDHI—Continued

TABLE 2.—*Progress of old-age and survivors insurance trust fund, short-range estimate*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year [3]
	Actual data					
1951	$3,367	$1,885	$81		$417	$15,540
1952	3,819	2,194	88		365	17,442
1953	3,945	3,006	88		414	18,707
1954	5,163	3,670	92	−$21	447	20,576
1955	5,713	4,968	119	−7	454	21,663
1956	6,172	5,715	132	−5	526	22,519
1957	6,825	7,347	[4] 162	−2	556	22,393
1958	7,566	8,327	[4] 194	124	552	21,864
1959	8,052	9,842	184	282	532	20,141
1960	10,866	10,677	203	318	516	20,324
1961	11,285	11,862	239	332	548	19,725
1962	12,059	13,356	256	361	526	18,337
1963	14,541	14,217	281	423	521	18,480
1964	15,689	14,914	296	403	569	19,125
1965	16,017	16,737	328	436	593	18,235
1966	20,658	18,267	256	444	644	20,570
	Estimated data, Public Law 90-248					
1967	$23,210	$19,486	$393	$508	$797	$24,190
1968	23,794	22,664	488	459	904	25,277
1969	27,454	24,166	435	530	986	28,586
1970	28,811	25,126	448	619	1,136	32,340
1971	32,478	26,145	463	601	1,386	38,995
1972	33,905	27,161	478	582	1,735	46,414

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

[2] An interest rate of 3.75 percent is used in determining the level-costs under the intermediate-cost long-range estimates, but in developing the progress of the trust fund a varying rate in the early years has been used.

[3] Not including amounts in the railroad retirement account to the credit of the old-age and survivors insurance trust fund. In millions of dollars, these amounted to $377 for 1953, $284 for 1954, $163 for 1955, $60 for 1956, and nothing for 1957 and thereafter.

[4] These figures are artificially high because of the method of reimbursements between this trust fund and the disability insurance trust fund (and, likewise, the figure for 1959 is too low).

NOTE.—Contributions include reimbursement for additional cost of noncontributory credit for military service and for the special benefits payable to certain noninsured persons aged 72 and over.

TABLE 3.—*Progress of disability insurance trust fund, short-range cost estimate*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
	Actual data					
1957	$702	$57	[3] $3	----------	$7	$649
1958	966	249	[3] 12	----------	25	1,379
1959	891	457	50	—$22	40	1,825
1960	1,010	568	36	—5	53	2,289
1961	1,038	887	64	5	66	2,437
1962	1,046	1,105	66	11	68	2,368
1963	1,099	1,210	68	20	66	2,235
1964	1,154	1,309	79	19	64	2,047
1965	1,188	1,573	90	24	59	1,606
1966	2,022	1,784	137	25	58	1,739
	Estimated data, Public Law 90–248					
1967	$2,313	$1,956	$107	$31	$72	$2,030
1968	3,236	2,390	129	44	95	2,798
1969	3,517	2,608	121	22	131	3,695
1970	3,629	2,740	123	22	171	4,610
1971	3,759	2,867	127	25	212	5,562
1972	3,880	2,985	133	29	253	6,548

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

[2] An interest rate of 3.75 percent is used in determining the level-costs under the intermediate-cost long-range estimates, but in developing the progress of the trust fund a varying rate in the early years has been used.

[3] These figures are artificially low because of the method of reimbursements between this trust fund and the old-age and survivors insurance trust fund (and, likewise, the figure for 1959 is too high).

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

DATA ON OASDHI—Continued

TABLE 4.—*Progress of hospital insurance trust fund, short range estimate*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund [1]	Balance in fund at end of year
	Actual data				
1966	$1,911	$767	[2] $57	$34	$1,121
	Estimated data, Public Law 90–248				
1967	$2,943	$2,683	$94	$45	$1,332
1968	3,972	3,190	112	64	2,066
1969	4,223	3,636	127	90	2,616
1970	4,391	3,982	139	108	2,994
1971	4,564	4,292	150	117	3,233
1972	4,732	4,602	161	121	3,323

[1] An interest rate of 3.75 percent is used in determining the level-costs, but in developing the progress of the trust fund a varying rate in the early years has been used, ranging down from 5 percent initially to 4 percent after 1975.

[2] Including administrative expenses incurred in 1965.

NOTE. The transactions relating to the noninsured persons, the costs for whom is borne out of the general funds of the Treasury, are not included in the above figures. The actual disbursements in 1966, and the balance in the trust fund by the end of the year, have been adjusted by an estimated $174,000,000 on this account.

TABLE 5.—*Comparison of contribution income and benefit outgo under prior law and under Public Law 90-248, old-age, survivors, disability, and hospital insurance*

[In billions of dollars]

Calendar year	Contribution income	Benefit outgo	Excess of contributions over benefits
	Prior law		
1967	28.5	24.2	4.3
1968	29.6	25.5	4.1
1969	33.7	26.9	6.8
1970	35.2	28.2	7.0
1971	36.2	29.4	6.8
1972	37.2	30.8	6.4
	Public Law 90-248		
1968	31.0	28.3	2.7
1969	35.2	30.4	4.8
1970	36.8	31.8	5.0
1971	40.8	33.3	7.5
1972	42.5	34.7	7.8

Source: Chief Actuary, Social Security Administration.

TABLE 6.—*Tax rates under prior law and under Public Law 90-248, employer-employee, each, and self-employed*

[In percent]

Period	OASDI		HI		Total	
	Prior law	Amendments	Prior law	Amendments	Prior law	Amendments
	Employee-employer, each					
1968	3.9	3.8	0.5	0.6	4.4	4.4
1969–70	4.4	4.2	.5	.6	4.9	4.8
1971–72	4.4	4.6	.5	.6	4.9	5.2
1973–75	4.85	5.0	.55	.65	5.4	5.65
1976–79	4.85	5.0	.6	.7	5.45	5.7
1980–86	4.85	5.0	.7	.8	5.55	5.8
1987 and after	4.85	5.0	.8	.9	5.65	5.9
	Self-employed					
1968	5.9	5.8	0.5	0.6	6.4	6.4
1969–70	6.6	6.3	.5	.6	7.1	6.9
1971–72	6.6	6.9	.5	.6	7.1	7.5
1973–75	7.0	7.0	.55	.65	7.55	7.65
1976–79	7.0	7.0	.6	.7	7.6	7.7
1980–86	7.0	7.0	.7	.8	7.7	7.8
1987 and after	7.0	7.0	.8	.9	7.8	7.9

NOTE.—The maximum taxable earnings base under prior law, $6,600, is increased to $7,800 effective Jan. 1, 1968.

TABLE 7.—*Tax rates for old-age, survivors, and disability insurance under Public Law 90-248, subdivided by trust fund*

[In percent]

Calendar years	Combined employer-employee rate			Self-employed rate		
	OASI	DI	Total	OASI	DI	Total
1967	7.10	0.70	7.8	5.3750	0.5250	5.9
1968	6.65	.95	7.6	5.0875	.7125	5.8
1969–70	7.45	.95	8.4	5.5875	.7125	6.3
1971–72	8.25	.95	9.2	6.1875	.7125	6.9
1973 and after	9.05	.95	10.0	6.2875	.7125	7.0

TABLE 8.—*Changes in actuarial balance of old-age, survivors, and disability insurance system expressed in terms of estimated level cost as percent of taxable payroll by type of change, intermediate-cost estimate, previous law and Public Law 90–248, based on 3.75 percent interest*

[In percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of previous law	+0.89	−0.15	+0.74
Increase in earnings base	+.25	+.02	+.27
Earnings test liberalization	−.06	[1]	−.06
Disabled widow's benefits at age 50	−.03	[2]	−.03
Special disability insured status under age 31	[2]	−.02	−.02
Liberalized benefits with respect to women workers	−.07	[1]	−.07
Benefit formula change	−.95	−.10	−1.05
Revised contribution schedule	−.02	+.25	+.23
Total effect of changes in 1967 amendments	−.88	+.15	−.73
Actuarial balance under 1967 amendments	+.01	.00	+.01

[1] Less than 0.005 percent.
[2] Not applicable to this program.

TABLE 9.—*Estimated additional OASDI benefit payments in calendar years 1968, 1969, and 1972 under Public Law 90–248*

[In millions]

Item	1968	1969	1972
General benefit increase	$2,529	$3,190	$3,604
Benefit increase for transitional insured	6	7	5
Benefit increase for transitional noninsured	43	43	25
Liberalized benefits with respect to women workers	73	90	101
Special disability insured status under age 31	60	72	77
Disabled widow's benefits at age 50	50	63	73
Earnings test liberalization	140	221	244
Total	2,901	3,686	4,129

TABLE 10.—*Level-cost analysis for hospital insurance trust fund, intermediate-cost estimate*

Bill	Level cost of benefits [1]	Level equivalent of contributions	Actuarial balance
Previous law, original estimate	1.23	1.23	0
Previous law, revised estimate	1.54	1.23	−.31
1967 amendments	[2] 1.38	1.41	+.03

[1] Including administrative expenses.

[2] Decrease due to earning base increase.

TABLE 11.—*Changes in actuarial balance of hospital insurance system, expressed in terms of level cost as percent of taxable payroll, by type of change, intermediate-cost estimate, prior law and 1967 amendments, based on 3.75-percent interest*

[In percent]

Item	Level cost
Actuarial balance of present system	−0.31
Increase in taxable earnings base	+.15
Revised contribution schedule	+.18
Transfer of outpatient diagnostic benefits to SMI	+.01
Further hospital benefits beyond 90 days	(1)
Total effect of changes in 1967 amendments	+.34
Actuarial balance under 1967 amendments	+.03

[1] Less than 0.005 percent.

TABLE 12.—*Actual experience, supplementary medical insurance program*

[In millions]

Item	Calendar year	
	1966 [1]	1967
Premiums from participants	$322	$636
Government contributions		[2] 937
Benefit payments	218	1,217
Administrative expenses	[3] 74	118
Interest on fund	2	22
Balance in fund at end of year	122	382

[1] Program operative (insofar as premium collection and benefit payments) only after June 1966.

[2] Includes matching payments for 1966. Based on actual data for period up through June 1967, and thereafter on assumption that premiums paid by participants are matched.

[3] Includes small amount of administrative expenses incurred in 1965.

TABLE 13.—*Comparison of annual increase in hospital costs and in earnings*

[In percent]

Year	Increase over previous year	
	Average wages in covered employment [1]	Average daily hospitalization costs [2]
1955	3.8	6.3
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
Average for 1954–63 [3]	4.0	6.7
1964	3.1	6.9
1965	1.6	7.0
1966	4.4	8.3

[1] Data are for calendar years (based on experience in 1st quarter of year).
[2] Data are for fiscal years ending in September of year shown. When the data are adjusted on a calendar-year basis, the increase from 1965 to 1966 was determined to be 11.0 percent.
[3] Rate of increase compounded annually that is equivalent to total relative increase from 1954 to 1963.

TABLE 14.—*Assumptions as to future rates of increase in hospital costs*

[In percent]

Calendar year	Low cost	Intermediate cost	High cost
1967	12.0	15.0	15.0
1968	10.0	15.0	15.0
1969	8.0	10.0	15.0
1970	6.0	6.0	15.0
1971	5.2	5.2	15.0
1972	4.6	4.6	10.0
1973	4.1	4.1	4.1
1974	3.6	3.6	3.6
1975 and after	3.0	3.0	3.0

PUBLIC ASSISTANCE AMENDMENTS

I. AID TO THE AGED, BLIND, AND PERMANENTLY AND TOTALLY DISABLED

(Titles I, X, XIV, and XVI of the Social Security Act)

Item	Prior law	Public Law 90–248
A. State plan requirements	Provides several requirements common to all 3 separate categorical programs in titles I, X and XIV and combined adult program in title XVI; plan must (1) be in effect throughout the State; (2) provide for financial participation by the State; (3) provide for a single State agency to administer or supervise the plan; (4) provide an opportunity for fair hearing; (5) provide methods of administration (including a merit system) as found necessary by the Secretary of Health, Education, and Welfare for proper and efficient administration; (6) provide for submitting reports to the Secretary; (7) provide safeguards which restrict the disclosure of information about recipients; (8) provide a description of the services made available to recipients to help them attain self-care; (9) provide that all people wishing to apply for assistance can do so and that assistance will be furnished with reasonable promptness; and (10) provide for the designation of a State [agency] authority or authorities responsible for standards in private or public institutions in which recipients reside. In addition, State plan must meet following additional requirements for each program as indicated:	Adds a new plan requirement to all 3 programs to provide for the training and use of paid subprofessional staff as community aides in the administration of the plans, and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to recipients and assisting advisory committees.
	(a) *Old-age assistance and aid to the disabled.*—Plan must (1) provide that the State take into account all income (including expenses incurred to earn the income) and resources except that at the option of State $5 per month may be disregarded and, in the case of earnings, $20 plus ½ of the next $60 per month may be disregarded (for aid to the disabled State may disregard additional amounts for up to 36 months while getting vocational rehabilitation) (2) with respect to old-age assistance and the combined adult program in title XVI only: provide for reasonable eligibility standards and extent of aid; and (3) provide, if assistance is provided to individuals who are patients in institutions for mental diseases:	Changes $5 to $7.50.
	(a) for having in effect arrangements with the State mental health authority or authorities, and, where appropriate, with such institutions, including arrangements for joint planning, development of	

alternate methods of care, assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, allowing access to patients and facilities, furnishing information, and making reports, as may be necessary to enable the State agency to carry out its responsibilities under the State plan;

(b) for an individual plan for each patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be periodic determination of his need for continued treatment in the institution;

(c) for the development of alternate plans of care, making maximum utilization of available resources, for recipients who would otherwise need care in such institutions, including appropriate medical treatment and other assistance, for rehabilitation services which are appropriate, and for methods of administration necessary to assure that these provisions will be effectively carried out; and

(d) methods of determining the reasonable cost of institutional care for such patients.

And, if the State elects to provide vendor or cash payments to patients in public institutions for mental diseases, it must be shown that the State is making satisfactory progress toward developing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to institutional care.

(*b*) *Aid to the blind.*—Plan must (1) provide that the State take into account all income and resources except State must disregard the first $85 per month of earned income and, for up to a 12-month period, any other income and resources needed to accomplish an approved plan for self-support, with option to State to extend up to additional 24 months. State can also disregard $5 of any type of income.

Changes $5 to $7.50.

Individuals must be at least age 65 to be eligible for old-age assistance; definitions of "blind" and "disabled" are left to the States. In the case of aid to the blind and the disabled, cannot include individuals in a mental or tuberculosis institution. Moreover, no individual can be included who is an inmate in a public institution of a nonmedical nature.

No change.

PUBLIC ASSISTANCE AMENDMENTS—Continued

I. AID TO THE AGED, BLIND, AND PERMANENTLY AND TOTALLY DISABLED—Continued

(Titles I, X, XIV, and XVI of the Social Security Act)

Item	Prior law	Public Law 90–248
B. Payments to the States—Old-age assistance, aid to the blind, and aid to the disabled:		
1. Formula	Federal matching share is $31 of the 1st $37 (31/37 of the 1st $37) with variable matching on the amount above $37 up to a maximum of $75 per recipient per month. Matching for States whose per capita income is at or above the national average is 50 percent, while for States below the national average it varies up to 65 percent.	No change.
2. Federal percentage	The "Federal percentages" as promulgated for the period July 1, 1967, through June 30, 1969, are as follows:	

State	*Percent*
Alabama	65.00
Alaska	50.00
Arizona	61.10
Arkansas	65.00
California	50.00
Colorado	50.35
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	61.21
Georgia	65.00
Hawaii	50.00
Idaho	64.30
Illinois	50.00
Indiana	50.00
Iowa	55.11
Kansas	53.22
Kentucky	65.00
Louisiana	65.00
Maine	65.00
Maryland	50.00
Massachusetts	50.00
Michigan	50.00
Minnesota	53.78
Mississippi	65.00
Missouri	53.78
Montana	60.01
Nebraska	56.09
Nevada	50.00

	New Hampshire ..... 55.69 New Jersey ..... 50.00 New Mexico ..... 65.00 New York ..... 50.00 North Carolina ..... 65.00 North Dakota ..... 65.00 Ohio ..... 50.00 Oklahoma ..... 65.00 Oregon ..... 50.00 Pennsylvania ..... 50.04 Rhode Island ..... 50.00 South Carolina ..... 65.00 South Dakota ..... 65.00 Tennessee ..... 65.00 Texas ..... 63.45 Utah ..... 61.38 Vermont ..... 65.00 Virginia ..... 62.05 Washington ..... 50.00 West Virginia ..... 65.00 Wisconsin ..... 51.87 Wyoming 54.67	
3. Partial payments to States	Provides that if a State fails to comply with its State plan under titles I, IV, X and XIV of the Social Security Act, the penalty, after hearing, is suspension of Federal funds for entire title.	Provides that Federal funds may be withheld for only that part of the plan which is not being complied with.
4. Home repairs	No provision.	Provides that States may, under all federally financed assistance programs (except medical assistance under title XIX), make payments for home repair or capital improvements for an owned home up to a total of $500 with 50 percent Federal matching when to do so would be more economical than paying rent in other quarters.
C. Medical vendor payments	For old-age assistance and for the combined aged, blind, and disabled program there is additional Federal matching as to medical vendor payments (i.e., payments directly to the providers of medical services) with respect to State expenditures for medical or remedial care, the larger of the following alternatives: "Federal medical percentage" of vendor payment expenditures that are above $75 per month, up to $15 per recipient per month, or 15 percent of vendor payment expenditures, up to $15 per recipient per month. Vendor medical provisions expire with Dec. 31, 1969, for all public assistance titles except title XIX—Medicaid. The "Federal medical percentage" is dependent on the relationship between State per capita income and the national per capita income. The percentage ranges from 50 percent for States at or above the national average to 80 percent for States with the lowest income.	No change.

PUBLIC ASSISTANCE AMENDMENTS—Continued

I. AID TO THE AGED, BLIND, AND PERMANENTLY AND TOTALLY DISABLED—Continued

(Titles I, X, XIV, and XVI of the Social Security Act)

Item	Prior law	Public Law 90-248
C. Medical vendor payments—Continued	For States with average monthly payments over $75, the Federal Government participates at the rate of the "Federal medical percentage" in the expenditures over $75 except that such participation is limited to the amount of the average vendor medical payment up to $15 per recipient per month. For States with average monthly payments of $75 per month or less, the Federal share in average vendor medical payments up to $15 per recipient per month is an additional 15 percent over and above the "Federal percentage" used to compute the Federal share of money payments. Provision is also made that a State with an average payment over $75 per month can never receive less in additional Federal funds in respect to such medical service costs than if it had an average payment of $75 per month. Permits Federal matching of State expenditures under all four public assistance programs for medical or remedial care furnished within 3 months before the month in which a person applies for assistance. For those States which adopt the optional combined aged, blind, and disabled program the additional $15 matching for medical vendor payments is applicable to the blind and disabled recipient under the combined program. The "Federal medical percentage" as promulgated for the period July 1, 1967, through June 30, 1969, for each of the States is as follows:	

State	*Percent*
Alabama	76.23
Alaska	50.00
Arizona	61.10
Arkansas	77.56
California	50.00
Colorado	50.35
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	61.21
Georgia	69.84
Hawaii	50.00

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	Idaho	64.30
	Illinois	50.00
	Indiana	50.00
	Iowa	55.11
	Kansas	53.22
	Kentucky	72.50
	Louisiana	71.75
	Maine	66.58
	Maryland	50.00
	Massachusetts	50.00
	Michigan	50.00
	Minnesota	53.78
	Mississippi	80.00
	Missouri	53.78
	Montana	60.01
	Nebraska	56.09
	Nevada	50.00
	New Hampshire	55.69
	New Jersey	50.00
	New Mexico	66.83
	New York	50.00
	North Carolina	72.50
	North Dakota	67.49
	Ohio	50.00
	Oklahoma	66.23
	Oregon	50.00
	Pennsylvania	50.04
	Rhode Island	50.00
	Sout'i Carolina	78.33
	South Dakota	70.28
	Tennessee	73.49
	Texas	63.45
	Utah	61.38
	Vermont	65.56
	Virginia	62.05
	Washington	50.00
	West Virginia	73.15
	Wisconsin	51.87
	Wyoming	54.67
D. Special formula for Puerto Rico, Virgin Islands, and Guam: 1. Matching formula	Federal matching on a 50-50 basis on both money and vendor medical payments up to a maximum of $37.50 a month times the number of recipients on the old-age, blind, and disabled program with a maximum of $18 a month times the number of recipients on the aid to dependent children program. Additional matching for vendor medical expenditures is available for up to $7.50 per month per recipient on old-age assistance and combined adult program rather than the additional $15 per month per recipient which applies to the States and the District of Columbia.	No change.

PUBLIC ASSISTANCE AMENDMENTS—Continued

I. AID TO THE AGED, BLIND, AND PERMANENTLY AND TOTALLY DISABLED—Continued

(Titles I, X, XIV, and XVI of the Social Security Act)

Item	Prior law	Public Law 90–248
D. Special formula for Puerto Rico, Virgin Islands, and Guam—Continued 2. Dollar limitation	Total Federal payments for all 4 public assistance programs may not exceed— Puerto Rico ..... $9,800,000 Virgin Islands ..... 330,000 Guam 450,000	Establishes new dollar limits as follows: Fiscal year / Puerto Rico / Virgin Islands / Guam 1968 ..... $12,500,000 / $425,000 / $575,000 1969 ..... 15,000,000 / 500,000 / 690,000 1970 ..... 18,000,000 / 600,000 / 825,000 1971 ..... 21,000,000 / 700,000 / 960,000 1972 and thereafter ..... 24,000,000 / 800,000 / 1,100,000 In addition to these amounts, the Secretary is authorized to certify additional payments to be used for services related to the work incentive program under pt. C of title IV, aid to families with dependent children, and for family planning services in the following amounts: Puerto Rico ..... $2,000,000 Virgin Islands ..... 35,000 Guam ..... 90,000 Federal matching percentage would be 60 percent rather than 75 percent as for the States.
E. Protective payments	Authorizes protective payments to be made to a person who is interested in or concerned with the welfare of the needy person under a State plan which provides for— (1) Determination by the State agency that payments in this form are necessary because the needy person has, by reason of his physical or mental condition, such inability to manage funds that making cash payments to him would be contrary to his welfare; (2) Special efforts to protect the welfare and improve the ability of the needy individual to manage funds; (3) Periodic review of the situation to determine whether such payments to an interested person are still necessary—and seeking judicial appointment of a guardian or legal representative if and when such action will serve the interests of such needy individual;	No change.

	(4) Opportunity for a fair hearing before the State agency on the determination that payments to an interested person are necessary; and (5) Payments which together with other income meet the individual's need in full.	
F. Federal matching for administrative expenses.	The Federal Government pays 75 percent of the cost of— (1) certain services, to be prescribed by the Secretary of Health, Education, and Welfare: In the case of aged applicants and recipients, "to help them attain or retain capability for self-care"; in the case of applicants and recipients on the blind and disabled program, "to help them attain or retain capability for self-support or self-care"; (2) other services provided to applicants or recipients specified by the Secretary as likely to prevent or reduce dependency; (3) services described in (1) and (2) specified by the Secretary as appropriate for individuals who, within the periods prescribed by the Secretary, have been or are likely to become applicants for or recipients of public assistance and who request such services; and (4) training of personnel employed or preparing for employment with a State or local public assistance agency. Federal Government pays 50 percent of all other administrative costs.	No change.

II. AID TO FAMILIES WITH DEPENDENT CHILDREN

	In addition to State plan requirements which are common to all public assistance programs (see p. 52), States are required to—	
A. Social and other services: 1. Plan requirement	(a) provide a description of services which the State agency makes available to maintain and strengthen family life for children, including a description of the steps taken to assure maximum utilization of other agencies providing similar or related services, and (b) provide for a program of services for each child as may be necessary in the light of home conditions ando ther needs of such child, a nd provide for coordination with child-welfare services under pt. 3 of title V.	(a) No change. (b) Provide for the development and application of a program for family services (as defined below) and chlid welfare services (as defined on p. 109) for each child, relative, and appropriate "household member" (an individual living in the same house whose needs are taken into account in determining eligibility for and the amount of aid) as may be necessary in the light of the home conditions in order to assist the members of the family to attain or retain capacity for self-support and care and in order to maintain and strengthen family life.

II. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Prior law	Public Law 90–248
A. Social and other services—Continued	No provision.	(c) Provide for the development of a program for each child, relative, and essential person with the objective of (1) assuring that each such individual will enter the labor force and accept employment when appropriate; (2) preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life; and for the implementation of such programs by assuring that child care arrangements are made for each individual who is referred to the work incentive program and that family planning services are offered in all appropriate cases. Family planning services are completely voluntary. Each program developed must be reviewed at least annually and the Secretary of HEW must be furnished reports on such programs;
	No provision.	(d) Provide that where the State agency has reason to believe that the home is unsuitable for a recipient child because of neglect, abuse, or exploitation, that this be brought to the attention of the appropriate court or law enforcement agency;
	No provision.	(e) Development of a program for establishing the paternity of illegitimate children receiving assistance and for securing support for these children as well as those who have been deserted or abandoned by their parents, utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support. A single organizational unit in the State or local agency administering the plan must carry out this provision.
	No provision.	(f) Provide for entering into cooperative arrangements with appropriate courts and law enforcement agencies to assist in securing support for children, including entering into financial arrangements with such courts and agencies in order to obtain optimum results for the program. "Family services" for purposes of paragraph (a) means services to a family for the purpose of preserving, rehabilitating, reuniting, or strengthening the family and of assisting members of the family to attain or retain capability for maximum self-support and personal independence.
2. Federal matching	The Federal Government shares with the States on a dollar-for-dollar basis (50 percent) in the administrative costs of carrying out the program. However, the Federal Government will pay 75 percent of the cost of—	Retains the 50 percent processing. However, the Federal Government will pay 75 percent of the cost of—

	(a) certain services prescribed by the Secretary of Health, Education, and Welfare "to maintain and strengthen family life for children, and to help relatives specified in the act with whom children * * * are living to attain to retain capability for self-support or self-care." (b) other services provided to applicants or recipients specified by the Secretary as likely to prevent or reduce dependency; (c) services described in (a) and (b) specified by the Secretary as appropriate for individuals who, within the periods prescribed by the Secretary, have been or are likely to become applicants for or recipients of public assistance and who request such services; and (d) training of personnel employed or preparing for employment with a State or local public assistance agency.	(a) Services under the new plan requirements set forth above at A1(a) and A1(b) which are provided to a child or relative receiving assistance or to a "household member." (b) No change. (c) Any of the services in (a) or (b) above under the plan requirements to children, relatives, or "essential persons" who are applicants for assistance or who, within such period as the Secretary may prescribe, have been or are likely to become applicants for or recipients of assistance. (d) No change. The Federal 75-percent matching for services within (a), (b), and (c) is contingent on the establishment of a single organizational unit in the State or local agency responsible for furnishing services. The Federal matching under this provision shall be 85 percent rather than 75 percent for services provided under these programs during the period July 1, 1968, to July 1, 1969, pursuant to pars. (a) and (b) under the plan requirements.
3. Providers of welfare services	Services are to be provided by the staff of the State welfare agency but, in the provision of these services, there must be maximum utilization of other agencies providing similar or related services. Services may also be furnished, pursuant to agreement with the State welfare agency, by a State health or vocational rehabilitation agency or by other State agencies which the Secretary deems appropriate (whether provided by its staff or by contract with nonprofit private or local public agencies). The provision of services by other agencies are subject to limitations by the Secretary and must be services which in the judgment of the State welfare agency, cannot be as economically or effectively provided by its staff and are not otherwise reasonably available to individuals in need of such services.	Provides an exception to the requirement of obtaining services from public agencies for child-welfare services, family planning services, and family services, to the extent specified by the Secretary, so that they may be provided from other sources.
4. Report to Congress	No provision.	The Secretary of Health, Education, and Welfare, on the basis of a review of the reports from the States, shall report his findings on the effectiveness of programs of services developed by the States under A1(b). The Secretary shall annually report to the Congress (beginning July 1, 1970) on the programs developed by each State.
5. Effective date	----------	The State plan requirements are effective July 1, 1968. The Federal matching for services implementing the new State plan requirement will be available on or after the modification of the State plan.

PUBLIC ASSISTANCE AMENDMENTS—Continued

II. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Prior law	Public Law 90-248
B. Income exemptions	The State agency in determining need, upon which eligibility for and the amount of assistance is based, must take into account any other income (including expenses reasonably attributable to the earning of income) and resources of any child or relative claiming assistance. The States, at their option, may disregard not more than $50 per month of earned income of each dependent child under age 18 but not more than $150 per month in the same home. The States also have the option of disregarding up to $5 of any income before disregarding child's earned income as noted above. Finally, States have the option of permitting all or part of earned or other income to be set aside for future identifiable needs of a child.	Establishes the following exemption of earnings: All earned income of each child recipient who is a full-time student attending a school, college, or university, or a course of vocational or technical training to fit him for gainful employment, or a student attending school less than full time but not working full time, is exempt. In the case of a child not in school, a relative, or "household member" the first $30 of earned income of the group in a month plus ⅓ of the remainder would be exempt. The optional provision for setting aside a portion of income for future identifiable needs is continued, as well as the option of the States to disregard $5 a month of any type of income. The provision exempting $50 a month of a child's income is superseded by these provisions. The earnings exemption will not be available in any month for a person who voluntarily terminated his employment or reduced his earned income within such period preceding the month assistance is applied for as may be prescribed by the Secretary (but such period must not be less than 30 days), or to persons who refused without good cause to accept employment in which they were able to engage, offered by or through the public employment office or by a private employer, which is determined to be bona fide by the State or local agency. The earnings exemption will also not be available to persons whose income in the month of application was in excess of their need as determined by the State agency, unless in any of the 4 preceding months they were receiving assistance. Makes specific reference to "household member" so his income and resources can be taken into account in determining the need of the child or relative claiming aid. Effective date: The earnings exemption must be in effect in the States by July 1, 1969, but will be optional with the States from January 1968 on.
	There are a number of income exemptions applicable to the AFDC program in other legislation. For instance, title VII of the Economic Opportunity Act provides that until June 30, 1969, the first $85 a month and ½ of the remainder of payments under titles I, II and of grants under title III of that act must be disregarded. Sec. 109 of the Elementary and Secondary School Act	The new provisions override any other provisions of any other law disregarding earned income.

	of 1965 provide that, for a period of 1 year, the first $85 a month earned in any month for services under that act shall be disregarded for purposes of determining need under the AFDC program.	
C. Families with unemployed fathers	For period ending June 30, 1968, Federal participation is authorized in payments to children who are deprived of parental support or care "by reason of the unemployment of a parent" as defined by a State. Program is optional with the States, and 22 have such programs.	Limits the program to children who need support or care on the basis of the unemployment of the father. Unemployment will be defined by the Secretary of Health, Education, and Welfare. Program made permanent but still optional with the States.
	Permanent provisions of law limit Federal matching to needy dependent children under 18 (and specified relative with whom they are living) who have been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent. (Specified relatives include grandmother, grandfather, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, 1st cousin, nephew, or niece.)	
	No provision.	Adds new plan requirement relating to when aid to dependent children assistance will be paid on the basis of an unemployed father: The plan must require the payment of aid with respect to a child within such definition when his father has been unemployed for a minimum period of 30 days before receipt of aid, has not without good cause within such period refused a bona fide offer of employment or training, and has at least 6 quarters of work in a 13-calendar-quarter period ending within 1 year before the application for aid or within such 1-year period received unemployment compensation under any State or Federal program or was "qualified for unemployment compensation." The bill defines a "quarter of work" as a calendar quarter in which the father received at least $50 of earned income (or which is a "quarter of coverage" for purposes of the old-age, survivors, and disability insurance program under title II of the act), or in which he participated in a community work and training program or the work incentive program. The father shall be deemed "qualified for unemployment compensation" under the State's unemployment compensation law if he would have been eligible therefor upon application, or if he had been in uncovered work which, had it been covered, would (with his covered work) have made him eligible for such compensation upon application. The bill provides that persons who have fulfilled the requirements at any time after April 1961 (related to the date of enactment of the original unemployed parent legislation) will be considered to be eligible with respect to the quarters of work provision for up to 6 months after a State plan under these provisions becomes operative.

PUBLIC ASSISTANCE AMENDMENTS—Continued

II. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Prior law	Public Law 90–248 and Public Law 90–364
C. Families with unemployed fathers—Con.		Fathers who are now on the rolls, and who met the work requirements at any time after April 1961, would continue to be eligible if other requirements are met.
	The State plan must— (1) no provision;	The State plan must— (1) provide for assurances that fathers of children within the above definition are referred to the work incentive program within 30 days after receiving aid; and
	(2) give assurance that assistance will not be granted if, and for as long as, the unemployed parent refuses, without good cause, to accept employment in which he is able to engage, and which is offered through either a public employment office or by an employer if the offer is determined by the State agency to be a bona fide offer of such employment;	(2) Repealed. However, unemployed fathers, as with appropriate other relatives, must take work or training unless there is good cause for not doing so. (See D. Work incentive program below.)
	(3) provide for entering into cooperative arrangements with the system of public employment offices in the State looking toward the employment of unemployed parents, including appropriate provision for periodic registration of the unemployed parent and for the maximum utilization of the job placement and other services and facilities of such offices;	(3) Repealed. However, failure to maintain current registration with public employment office bars assistance.
	(4) provide for entering into cooperative arrangements with the State vocational education agency looking toward maximum utilization of its services and facilities to encourage retraining of such unemployed parent; and	(4) No change.
	(5) Any State, *at its option*, may provide for the denial of all (or any part) of aid under the plan to which any child or relative might be entitled for any month if the unemployed parent receives compensation under an unemployment compensation law of a State or of the United States for any week, any part of which is included in such month.	(5) Assistance barred for any month during any part of which unemployment compensation is paid. Public Law 90–364 modifies by not allowing assistance to be paid during any period (of less than a month) when unemployment insurance is paid.
		Effective date; Jan. 1, 1968, but no State with an unemployed parent program on October 1, 1967, shall be required to include any additional recipients by reason of this amendment before July 1, 1969.
D. Work incentive program.—Community work and training.	Federal matching is authorized, for the period July 1, 1961, to June 30, 1968, for assistance payments made for work performed by a relative (18 years of age or older) with whom the child is living. Twelve States make such payments. Federal participation in these	Establishes a new work incentive program for families receiving AFDC payments to be administered by the Department of Labor which replaces the community work and training program. The State welfare agencies would determine who was appropriate for such referral

payments may be made only under limited conditions designed to assure protection of the health and welfare of the children and their relatives;

(1) The work must be performed for the State public assistance agency or another public agency under a program (which need not be in effect throughout the State) administered by or under the supervision of the State public assistance agency.

(2) There must be State financial participation in these expenditures.

(3) The State plan must include provisions which give reasonable assurance that—

(a) appropriate health, safety, and other conditions of work will be maintained;

(b) the rates of pay will be not less than the applicable minimum rate under State law for the same type of work, if there is any such rate, and not less than the prevailing wage rates on similar work in the community;

(c) the work projects will serve a useful public purpose; will not displace regular workers or be a substitute for work that would otherwise be performed by employees of public or private agencies, institutions, or organizations; and (except in the case of emergency or nonrecurring projects) will be of a type not normally undertaken by the State or community in the past;

(d) the additional expenses of going to work will be considered in determining the worker's needs;

(e) the worker will have reasonable opportunities to seek regular employment and to secure appropriate training or retraining and will be provided with protection under the State workmen's compensation law or similar protection; and

(f) aid will not be denied because of a relative's refusal with good cause to perform work under the program.

but would not include (1) children who are under age 16 or going to school; (2) any person with illness, incapacity, advanced age or remoteness from a project that precludes effective participation in work or training; or (3) persons whose substantially continuous presence in the home is required because of the illness or incapacity of another member of the household. For all those referred the welfare agency will assure necessary child care arrangements for the children involved. An individual who desires to participate in work or training would be considered for assignment and, unless specifically disapproved, would be referred to the program.

People referred by the State welfare agency to the Department of Labor would be handled under 3 priorities. Under priority I, the Secretary of Labor, through the U.S. employment offices, would make arrangements for as many as possible to move into regular employment and would establish an employability plan for each other person.

Under priority II all those found suitable would receive training appropriate to their needs and up to $30 a month as an incentive payment. After training, as many as possible would be referred to regular employment.

Under priority III, the employment office would make arrangements for special work projects to employ those who are found to be unsuitable for the training and those for whom no jobs in the regular economy can be found at the time. These special projects would be set up by agreement between the employment office and public agencies or nonprofit private agencies organized for a public service purpose (including Indian tribes). It would be required that workers receive at least the minimum wage (but not necessarily the prevailing wage) if the work they perform is covered under a minimum wage statute (and in applying the minimum wage law, their welfare grants would be counted). Moreover, the work performed under special projects must not result in the displacement of regularly employed workers and would have to be of a type which, under the circumstances in the local situation, would not otherwise be performed by regular employees.

The special work projects would work like this: The State welfare agency would make payments to the employment office equal to (1) the welfare benefit the family would have been entitled to, or, if smaller, (2) a portion of the welfare benefit equal to 80 percent of the rates which the individual receives on the special project.

The Secretary of Labor would arrange for the participants to work in a special work project. The amount of the funds paid by him into the project would depend on the terms he negotiates with the agency sponsoring the project. The amount of funds put into the projects by the employment office could not be larger than the funds sent to the Secretary of Labor by the State welfare agency.

II. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Prior law	Public Law 90-248
D. Work incentive program.—Community work and training—Continued		The extent to which the State welfare expenditures might be reduced would depend upon the negotiating efforts of the Secretary of Labor. If he is successful in placing workers in work projects where the pay is relatively good, the contribution the State must make into the employment pool would be less and there would be a savings to both Federal and State Governments. Employees who work under these agreements would have their situations reevaluated by the employment office at regular intervals (at least every 6 months) for the purpose of making it possible for as many such employees as possible to move into regular employment. In most instances the recipient would not receive a check from the welfare agency. Instead, he would receive a payment from an employer for services performed. The entire check would be subject to income, social security, and unemployment compensation taxes. In those cases where an employee receives wages which are insufficient to raise his income to a level equal to the grant he would have received had he not been in the project plus 20 percent of his wages, a welfare check equal to the difference would be paid. In these instances the supplemental check would be issued by the welfare agency and sent to the worker. During fiscal year 1969, the Federal government is authorized to meet the employer's share in these special projects on behalf of public agencies and Indian tribes.
	(4) The State plan must also include provision for— (a) cooperative arrangements with the public employment offices and with the State vocational education and adult education agency or agencies looking toward employment and occupational training of the relatives and maximum use of public vocational or adult education services and facilities in their training or retraining; (b) assuring appropriate arrangements for the care and protection of the child during the relative's absence from the home in order to perform the work under the program; (c) such other provisions as the Secretary finds necessary to assure that the operation of the program will not interfere with the objectives of the aid to dependent children program.	The State could set up a review panel or panels, composed of no more than 5 members with 1 member representing labor, 1 member representing industry, and the remainder the general public, to give final approval to special projects. A refusal to accept work or undertake training without good cause by a person who has been referred would be reported back to the State agency by the Labor Department; and, unless such person returns to the program within 60 days (during which he would receive counseling), his welfare payment would be terminated. Protective and vendor payments would be continued, however, for the dependent children, beginning with the time of refusal to accept work or training without good cause. The appropriate State agencies or private organi-

	(5) A State participating in such a program must also provide (in its State plan) that there will be no adjustment or recovery by the State or any locality on account of any payments which are correctly made for the work. The cost of administration of a State plan for which Federal funds are paid may not include the cost of making or acquiring materials or equipment in connection with work under a community work and training program or the cost of supervision of that work, and may only include those other costs attributable to the programs which are permitted by the Secretary.	zations would have to meet 20 percent, in cash or in kind, of the total cost of the program (excluding amounts paid on special work projects, priority III, which would come from the employer and the transferred welfare payments). In the event that the 20-percent, non-Federal contribution is not made in any State, the Secretary of HEW may withhold amounts due to the State under the various public assistance programs until the amount so withheld equals the required non-Federal share. The Secretary of Labor can assist individuals to relocate their residence when required in order to enable them to become permanently employable and self-supporting. The Secretary of Labor is required to report annually to the Congress on the work incentive program with the 1st report due by July 1, 1970. The Secretary is authorized to enter into an agreement with any "State" which has a program of aid to families with unemployed parents which is financed by federally appropriated funds but not through the Social Security or Economic Opportunity Acts under which the work incentive program will be available to recipients under the State program. States must agree to follow the same rules regarding the furnishing of necessary services, including child care, and those regarding the effects of a refusal to accept work or training without good cause. (The only "State" which qualified at the time of enactment was the District of Columbia.) Effective date: Referral of appropriate AFDC recipients to the Department of Labor is mandatory by the States beginning July 1, 1968, unless State law needs to be changed in which case the mandatory date is July 1, 1969. At the option of the States it can be effective on Apr. 1, 1968.
E. Program of Federal payments for foster care of dependent children: 1. Eligibility	Allows Federal payments with respect to any child otherwise not eligible who— (1) is removed, after Apr. 30, 1961, from home of specified relative as a result of a judicial determination that continuation therein would be contrary to his welfare; (2) is placed in a foster family home (approved by the State as a result of such determination); or (for the period through June 30, 1968) in a nonprofit private child-care institution, subject to limitations prescribed by the Secretary to include within Federal participation only cost items which are included in foster family home care. Provision is made for payments by the State or local agency for foster care in a	(1) No change. (2) Makes permanent the inclusion of child care in stitutions.

II. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Prior law	Public Law 90-248
E. Program of Federal payments for foster care of dependent children—Con.	foster family home or a child-care institution either directly or through a public or nonprofit private child-placement or child-care agency. (3) was receiving aid to dependent children in the month when court proceedings were started, and for whose placement and care the State agency administering the program is responsible.	(3) Modifies provisions to cover children: (a) who were not receiving payments in the month court proceeding started but would have received such aid if they had applied for it, or (b) who had been living with one of the relatives specified in the law within 6 months of the start of the court proceedings and if in the month they were removed from home of the relative they would have been eligible for assistance if they had applied for it. Makes provision permanent.
	For the period through June 30, 1968, responsibility for the placement and care of dependent children placed in foster care homes may rest either with the State or local agency administering the program under title IV or with any other public agency with whom the administering agency has an agreement. Such agreement must include provision for assuring development of a plan for each child which is satisfactory to the State public assistance agency and such other provisions as may be necessary to assure that the objectives of the State plan approved under title IV are met.	
2. Federal matching for foster care	The Federal share is ⅔ of the 1st $18 per recipient per month with variable grant matching on the amount up to $32 per recipient per month. Variable grant matching above first $18 has a Federal share which varies from 50 to 65 percent depending on per capita income of State.	Provides Federal matching maximum of $100 a month for children in foster care. Effective after December 1967.
F. Emergency assistance for certain needs: 1. Definition of assistance	No provision.	Emergency assistance to needy families with children is defined to mean, (1) money payments, payments in kind, or such other payments as the State agency may specify, or medical or remedial care recognized under State law on behalf of an eligible child or any other member of the household in which such child is living, and (2) such services as the Secretary may specify. Emergency assistance may be provided only where such child and his family are without available resources and the payments, care, or services involved are necessary to avoid destitution of the child or to provide suitable living arrangements in a home for such a child. This provision would not be available to a family where necessity arose because the parent or caretaker refused without good cause to accept employment or training.

		In addition, emergency assistance may be provided to migrant workers with families in the State or parts thereof as designated by the State.
2. Duration of assistance	No provision.	Emergency assistance may be given for a period not in excess of 30 days in any 12-month period in the case of a needy child under age 21 who is (or, within a period specified by the Secretary, has been) living with any of the relatives specified in the act in a place of residence maintained by such a relative as his home.
3. Federal matching	No provision.	The Federal share will be 50 percent of the total expenditures under such plan for such assistance in the form of payments or medical care and 75 percent of the total expenditures for such assistance in the form of welfare services. Effective: Upon enactment.
G. Protective and vendor payments and other State action to protect interests of AFDC children.	Authorizes protective payments to be made, in a limited number of recipients (limited in number to 5 percent of other recipients), to a person who is interested in or concerned with the welfare of the dependent child and relative, under a State plan which provides for—	Limitation on number of recipients who can be aided under this method of payment is changed to 10 percent, excluding those cases where such payments are made because a relative refused work or training without good cause. Adds authority for vendor payments under same conditions for protective payments as outlined below. (Vendor payments are made on behalf of family or child directly to a person furnishing food, living accommodations, or other goods, services, or items to or for such family.)
	(1) determination by the State agency that payments in this form are necessary because the relative is so unable to manage funds that it would be contrary to the child's welfare to make payments to such relative;	(1) In the case of an individual who refuses work or training, vendor or protective payments must be provided without regard to any of these requirements.
	(2) meeting all the need of individuals (in conjunction with other income and resources), with respect to whom they are made, under rules otherwise applicable under the State plan for determining need and the amount of assistance to be paid;	(2) Deletes requirement of meeting full need.
	(3) special efforts to improve the ability of the relative to manage funds, and periodic review of the situation to determine whether such payments are still necessary—and with provision for judicial appointment of a guardian or legal representative if the need for payments to another interested person continues beyond a period specified by the Secretary;	(3) No change.
	(4) opportunity for a fair hearing before the State agency on the determination that payments to another interested person on behalf of the child and relative are necessary; and	(4) No change.
	(5) aid in the form of foster family care, as provided for in the Social Security Act.	(5) No change.
	Effective until June 30, 1968.	Provision made permanent.
	Authorizes the State agency to take the following steps, without losing Federal matching funds, whenever it has reason to believe that payments to a relative for the benefit of a child are not being or may not be used in the best interests of the child—	No change.

II. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Prior law	Public Law 90-248 and Public Law 90-364
G. Protective and vendor payments and other State action to protect interests of AFDC children—Continued	(1) To provide the relative with counseling and guidance concerning the use of payments and management of other funds to assure their use in the best interests of the child; or (2) To advise the relative that continued misuse of payments will result in substitution of protective payments (described above), or in seeking appointment of a guardian or legal representative. Moreover, the imposition of criminal or civil penalties, under State law, upon determination by a court of competent jurisdiction that the relative is not using, or has not used, payments for the benefit of the child shall not be the basis for withholding of Federal matching funds.	
H. Limitation on number of children with respect to which the Federal Government will make matching payments.	For money and medical vendor payments the Federal share is $15 out of the 1st $18 (⅚ of the 1st $18) per recipient per month with variable matching on amounts above $18 up to a maximum of $32 per recipient per month. There is no specific limit of Federal participation in expenditures other than the $32 a month average maximum. Variable matching is at the same percentage as the other cash assistance programs. (See p 54.)	Provides that, for purposes of Federal matching, the number of dependent children, deprived of parental support or care by reason of a parent's continued absence from the home, for any calendar quarter beginning after June 30, 1968 (postponed to June 30, 1969, by Public Law 90-364), shall not exceed the number bearing the same ratio to the total population of such State under age 18 on Jan. 1 of the year in which such quarter falls as the number of such dependent children with respect to whom such payments were made to such State for the calendar quarter beginning Jan. 1, 1968, bore to the total population of such State under age 18 on that date. No limit is imposed on Federal matching for children qualifying for AFDC based upon the death, incapacity, or unemployment of the parent.
I. Disclosure of information—deserting parents.	Under regulation, disclosure of parent's or his employer's address from social security records is authorized to the agency administering the AFDC program if the child is getting AFDC. The law requires disclosure at the request of a State or local agency participating in any State or local public assistance program, of the most recent address in the social security records for a parent (or his most recent employer or both) who has failed to provide support for his or her destitute child or children under age 16 who are recipients of or applicants for assistance where there is a court order for the support of the children and the information requested is to be used by the welfare agency or the court on behalf of the children.	Adds provision for disclosure of address of deserting parent or his employer from social security records, on request of an appropriate court, if the information is for the use of the court in issuing a support order against the parent. (The child need not have applied for AFDC.) Also, the Internal Revenue Service will make available any information about the location of an absent parent in its records if the social security records do not have the information.

III. MISCELLANEOUS PROVISIONS

A. Private grantees under demonstration projects.	Provides that grants and contracts for demonstration projects under sec. 1110 of the Social Security Act can be made only with respect to public and nonprofit agencies.	Would allow contracts with private profit agencies.
B. Social work manpower	No provision specifically to train social workers	Authorizes $5,000,000 for fiscal year 1969 and the 3 following years to meet the cost of expanding educational programs in social work. At least ⅓ of the funds appropriated each year must be used to support undergraduate training.
C. Assistance for repatriated citizens	Authorizes until June 30, 1968, a Federal program of "temporary assistance" to certain U.S citizens who have returned from foreign countries and are without available resources. U.S. citizens and their dependents would be eligible if— (1) Such individuals are identified by the Department of State as having returned, or been brought, from a foreign country to the United States; (2) The cause of such return is any of the following: (a) The destitution of the U.S. citizen; (b) The illness of the U.S. citizen; (c) The illness of any of his dependents; or (d) War, threat of war, invasion, or similar crisis; and (3) Such individuals are without available resources. "Temporary assistance" includes the following: (1) Money payments; (2) Medical care; (3) Temporary billeting; (4) Transportation; and (5) Other goods and services necessary for the health or welfare of individuals (including guidance, counseling, and other welfare services). All assistance must be rendered within the United States, and must be furnished to individuals after their return from foreign countries. The Secretary of Health, Education, and Welfare is authorized to provide such assistance either directly, or through public or private agencies according to agreements entered into by the Secretary and the agencies. Provision must be made for the reimbursement of the United States by recipients of assistance. However, the Secretary is authorized to exempt certain classes of individuals from this requirement. The Secretary of Health, Education, and Welfare is authorized to make plans for the carrying out of the program, but he is required to make such plans after consultation with the Secretaries of State and Defense, and the Attorney General.	Extends program to June 30, 1969.

Item	Prior law	Public Law 90-248
I. Purpose and appropriation	The purposes of title XIX are to enable each State to furnish medical assistance on behalf of aged, blind, or permanently and totally disabled individuals and families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and rehabilitation and other services to help such individuals and families attain or retain capability for independence or self-care. Appropriations for each year in amounts necessary to carry out the purposes of the program are authorized.	No change.
II. State plan requirements	A State plan must meet certain requirements in order to be approved and thus eligible for Federal assistance. The State plan must—	
A. Where effective	(1) provide that it will be in effect in all political subdivisions of the State and, if the plan is administered by the subdivisions, that it be mandatory upon them;	(1) No change.
B. Financial participation	(2) provide for financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan with respect to which Federal financial participation under sec. 1903 is authorized and, effective July 1, 1970, provide for State financial participation equal to all of such non-Federal share or provide for distributing funds on an equalization or other basis which will assure that lack of funds on a local level will not adversely affect the program;	(2) Changes effective date to July 1, 1969.
C. Fair hearing	(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or not acted upon with reasonable promptness;	(3) No change.
D. Methods of administration	(4) provide methods of administration of the plan as found necessary by the Secretary for its proper and efficient operation; these would include (A) methods relating to the establishment and maintenance of personnel standards on a merit basis, with the Secretary being precluded from exercising any authority in connection with the selection, tenure, or compensation of any individual employed in accordance with these methods, and (B) provision for utilization of professional medical personnel in the administration of the plan, and in supervision of such administration where the plan is administered locally;	(4) No change.

E. Single State agency	(5) provide that there be a single State agency to administer, or to supervise the administration of, the plan, except that eligibility for medical assistance under the plan shall be determined by the State or local agency administering the approved plan of the State for old-age assistance or for aid to the aged, blind, or disabled;	(5) No change. (See p. 82 for change in Federal matching affecting employers of more than 1 State agency.)
F. Required reports	(6) provide that the State agency will make reports as required by the Secretary, and will comply with provisions found necessary by the Secretary to assure their correctness and verification;	(6) No change.
G. Disclosure of information	(7) provide safeguards which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the plan's administration;	(7) No change.
H. Application for assistance	(8) provide for affording all individuals who wish to do so an opportunity to apply for medical assistance under the plan and for furnishing such assistance with reasonable promptness to all applicants who are eligible for assistance under the plan;	(8) No change.
I. Institutional standards	(9) provide for a State authority or authorities with responsibility to establish and maintain standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services;	(9) No change in this plan requirement but see. A.A. (requirement No. 26) below.
J. Comparability	(10) provide for making medical assistance available to all individuals receiving old-age assistance, aid to families with dependent children, aid to the blind, and aid to the permanently and totally disabled, and aid to the aged, blind, and disabled and— (A) provide that the medical assistance made available to individuals receiving aid or assistance under any one of such plans— (i) will not be less in amount, duration, or scope than the medical assistance made available to individuals receiving aid or assistance under any other such plan; and (ii) will not be less in amount, duration, or scope than the medical or remedial care and services made available to individuals not receiving aid or assistance under any such plan; and (B) if the plan includes medical or remedial care and services for any group of individuals who are not recipients under any such plan and do not meet the State's income and resource requirements under the one of such plans which, as determined in accordance with standards prescribed by the Secretary, is appropriate, provide (except for nursing home services and mental or TB hospital service for the aged)—	(10) Provides that the fact that the State (1) makes available to individuals age 65 or older the benefits of the supplementary medical insurance program under pt. B of title XVIII (Medicare) of the act (either pursuant to a "buy-in" agreement or by State payment of the premiums due under such pt. B on their behalf); or (2) provides for meeting part or all of the cost of the deductibles, cost sharing, or similar charges under such pt. B for individuals eligible for supplementary medical insurance benefits, does not require the State to make available any such benefits, or services of the same amount, duration, and scope, to any other individuals. Effective: After June 30, 1967.

Item	Prior law	Public Law 90-248
II. State plan requirements—Con. J. Comparability—Continued	(i) for making medical or remedial care and services available to all individuals who if needy would be eligible for aid or assistance under any such plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the cost of necessary medical or remedial care and services, and (ii) that the medical or remedial care and services made available to all individuals who are not recipients under any such State plan will be equal in amount, duration, and scope;	
K. Cooperative arrangements with health and vocational agencies.	(11) provide for entering into cooperative arrangements with the State agencies responsible for health and vocational rehabilitation services looking toward maximum utilization of these services in providing medical assistance under the plan;	(11) No change.
L. Use of optometrist or physician.	(12) provide that in determining blindness an examination will be made either by a physician skilled in diseases of the eye or by an optometrist, as the individual may select;	(12) No change.
M. Required services and reasonable cost.	(13) provide for inclusion of some institutional and some noninstitutional care and services and, as of July 1, 1967, for the inclusion of at least the items of care and services listed in clauses (1) through (5) of sec. IV on benefits (see p.85); and for the payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan;	(13) Makes this requirement (other than the requirement related to reasonable cost) applicable only in the case of recipients of cash assistance under another of the State's approved public assistance plans. The State would have the option, in the case of individuals who are not recipients of cash assistance to make available at least (1) such 1st 5 items; or (2) any 7 of the 1st 14 items listed in sec. IV on benefits (see p. 85) and, if hospital or skilled nursing home services are included in the plan, physicians' services to an individual in a hospital or skilled nursing home during any period he is receiving hospital services or skilled nursing home services. Effective Jan. 1, 1968. Effective with July 1, 1970, the State plan must provide for the inclusion of home health services for any individual who, under such plan, is entitled to skilled nursing home services.
N. Deductibles	(14) provide that— (A) no deduction, cost sharing, or similar charge will be imposed on any individual with respect to in-patient hospital services furnished him under the plan; and (B) any deduction, cost sharing, or similar charge imposed for any other care or services furnished him, and any enrollment fee, premium,	(14) (A) This requirement would apply only in the case of individuals receiving cash assistance under a plan of the State approved under the other public assistance titles. (B) Also, the law makes clear that any deduction, cost sharing, or similar charge imposed under the plan with respect to inpatient hospital services, as well as

	or similar charge imposed under the plan, will be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or to his income and resources;	other medical assistance, furnished under the plan to any individual, whether or not he is a recipient of assistance under another approved public assistance plan of the State, must be reasonably related to his income or his income and resources. Effective: Jan. 1, 1968.
O. Meeting cost of medicare deductibles.	(15) in the case of eligible individuals 65 years of age or older covered by either or both of the insurance programs (hospital insurance benefits for the aged, and supplementary medical insurance benefits for the aged), provides— (A) for meeting the full cost of any deductible imposed with respect to any such individual under such hospital insurance benefits program; and (B) where, under the plan, all of a deductible, cost sharing, or similar charge imposed with respect to any such individual under such supplementary medical insurance benefits program is not met, the portion which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or to his income and resources;	(15) Would no longer require that a State plan meet the cost of deductibles imposed under pt. A of title XVIII and that the plan relate any deductibles imposed under the hospital insurance program, as well as the supplementary medical insurance program, of title XVIII to the income of the individuals covered under the plan. Effective: Jan. 1, 1968.
P. Absentees	(16) include, to the extent required by regulations of the Secretary, provisions (conforming to such regulations) regarding the furnishing of medical assistance to eligible residents who are absent from the State;	(16) No change.
Q. Income standards	(17) include reasonable standards, comparable for all groups, for determining eligibility for and the extent of medical assistance under the plan, which standards— (A) are consistent with the objectives of title XIX; (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who if he met the State's need requirements would be eligible for aid or assistance in the form of money payments under the State's plan approved under title I, IV, X, XIV, or XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for and the amount of aid or assistance under such plan; (C) provide for reasonable evaluation of any such income or resources; and (D) do not take into account the financial responsibility of any individual for any applicant or recipient unless such applicant or recipient is the individual's spouse or is his child who is under	(17) Income levels may differ but only for the medically indigent based on variations between housing costs in urban areas and rural areas. No other change in this provision but see p. 83 for limitations on Federal matching for individuals with incomes above certain amounts.

Item	Prior law	Public Law 90-248
II. State plan requirements—Con. Q. Income standards—Con.	age 21 or, if the child is age 21 or over, is blind or permanently and totally disabled; and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or any other type of remedial care recognized under State law;	
R. Property liens	(18) provide that property liens will not be imposed during a recipient's lifetime (except pursuant to a judgment of a court on account of benefits incorrectly paid), and preclude adjustments or recovery of medical assistance correctly paid except from the estate of a recipient who was at least age 65 when he received such assistance, and then only after the death of his surviving spouse and at a time when he has no surviving child who is under 21, blind, or permanently and totally disabled;	(18) No change.
S. Simplicity of administration	(19) provide safeguards necessary to assure that eligibility for care and services under the plan will be determined and such care and services will be provided in a manner consistent with simplicity of administration and in the best interests of the recipients;	(19) No change.
T. Mental institutions	(20) if the State plan includes medical assistance in behalf of individuals 65 years or older who are patients in institutions for mental diseases— (A) provide for agreements or other arrangements with State authorities concerned with mental diseases. These will include arrangements for joint planning and for development of alternate methods of care, for assuring immediate readmittance to institutions where needed for individuals under alternate plans of care, for providing for access to patients and facilities, and for submitting information and reports; (B) provide for an individual plan for each such patient to assure that the institutional care provided is in his best interests, including assurances of initial and periodic review of his medical and other needs, of his receiving appropriate medical treatment within the institution, and of periodic determination of his need for continued institutional care;	(20) No change.

	(C) provide for the development of alternate plans of care with maximum utilization of available resources for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services to help such recipients and patients attain or retain capability for self-care or other services to prevent or reduce dependency which are appropriate; and for methods of administration necessary to assure that the State plan with respect to these recipients and patients will be effectively carried out; and (D) provide methods of determining the reasonable cost of institutional care for such patients;	
U. State mental institutions	(21) if the State plan includes medical assistance in behalf of individuals 65 years or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward a comprehensive mental health program; and	(21) No change.
V. Professional staff	(22) describe (A) the kinds, numbers, and responsibilities of professional medical personnel and supporting staff used in the administration of the plan, (B) the standards used by State standard-setting authorities for institutions in which medical assistance recipients may receive care or services, (C) cooperative arrangements with State health and vocational rehabilitation agencies for maximum utilization and coordination of medical assistance with their services, and (D) other State standards and methods used to assure that medical or remedial care and services to medical assistance recipients are of high quality.	(22) No change.
W. Free choice	No provision.	Adds new State plan requirement (23) under which any individual eligible for medical assistance is free to choose to obtain the services he requires from any institution, agency, or person qualified to perform the required services (including a prepayment plan which provides such services or arranges for their availability) and which undertakes to provide such services to him. Effective July 1, 1969, except July 1, 1972, in the case of Puerto Rico, the Virgin Islands, and Guam.
X. Conditions of eligibility	Secretary cannot approve a plan which has any of the following conditions of eligibility: (1) an age requirement of more than 65 years; or (2) any age requirement which excludes any individual who has not attained the age of 21 and who meets the definition of a dependent child under title IV of the act regardless of age; or (3) any residence requirement which excludes any individual residing in the State; or (4) any citizenship requirement which excludes any citizen of the United States.	No change.

Item	Prior law	Public Law 90–248
II. State plan requirements—Continued Y. Consultative services to providers of services.	No provision in title XIX.	Establishes a new plan requirement (24) under which a State plan for medical assistance must, effective July 1, 1969, provide for consultative services by health agencies and other appropriate State agencies to hospitals, nursing homes, home health agencies, clinics, laboratories, and other institutions specified by the Secretary in order to assist them with respect to (1) qualifying for payments under the act, (2) establishing and maintaining fiscal records necessary for the proper and efficient administration of the act, and (3) providing information needed to determine payments due under the act on account of care and services furnished to individuals. (Under another provision (see p. 82) the State could receive 75 percent Federal matching toward the cost of providing these consultative services.) A provision similar to this provision in title XVIII of the act (medicare) is repealed effective July 1, 1969.
Z. Payments from a 3d party	No provision.	Establishes a plan requirement (25) under which a State must provide (1) that the State or local agency will take all reasonable measures to ascertain whether 3d parties are legally liable to pay for care and services available under the plan arising out of injury, disease, or disability; (2) that where the agency knows that a 3d party has such legal liability it will treat such legal liability as a resource of the individual for whom care and services are made available in its consideration of whether income and resources are available to him; and (3) that in any case where it is found that such legal liability exists after medical assistance has been provided to the individual, the agency will seek reimbursement for such medical assistance to the extent of such legal liability. Effective: For legal liabilities arising after Mar. 31, 1968.
A.A. Nursing home standards	No specific provision.	Adds 3 new plan requirements related to standards for nursing homes as follows: New paragraph (26) requires such a plan, effective July 1, 1969, to provide for— (1) A regular program of medical review (including evaluation of each patient's need for skilled nursing home care or need for mental hospital care) a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing home;

(2) Periodic inspections of all skilled nursing homes and mental institutions within the State by at least 1 medical review team (composed of physicians and other appropriate health and social service personnel) of (*a*) the care provided in such homes and such institutions, to recipients under the plan; (*b*) with respect to each patient receiving such care, the adequacy of services available in particular nursing homes (or mental institutions) to meet the current health needs and promote the maximum physical well-being of patients; (*c*) the necessity and desirability of their continued placement in such homes (or mental institutions); and (*d*) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and

(3) The making by such a team of full and complete reports of the findings resulting from its inspections and any recommendations to the State agency.

Paragraph (27) requires the plan to provide for agreements with every supplier of services under the plan under which such supplier agrees to keep full records of the services provided to recipients under the plan, and to furnish the State agency such information about any payments it claimed for providing services under the plan as the agency may request.

Paragraph (28) requires the plan to provide that any skilled nursing home receiving payments under the plan must—

(1) Supply the State licensing agency with full and complete information as to the identity of each person having a direct or indirect ownership interest of at least 10 percent in such home, and if it is a corporation or partnership the names of the officers and directors, or partners; and report promptly any changes which would affect the current accuracy of the required information;

(2) Have and maintain an organized nursing service for its patients, which is directed by a professional registered nurse employed full time by such home and composed of sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services during all hours of each day and all days of each week;

(3) Provide for professional planning and supervision of menus and meal service for patients for whom special diets or dietary restrictions are medically prescribed;

(4) Have satisfactory policies and procedures for maintenance of medical records on each of its patients, for dispensing and administering drugs and biologicals, and for assuring that each patient is under a physician's care and is provided medical attention during emergencies;

Item	Prior law	Public Law 90-248
II. State plan requirements—Continued A.A. Nursing home standards—Continued		(5) Have arrangements with at least 1 general hospital under which the hospital will provide needed diagnostic and other services to patients of such home and agree to timely admission of acutely ill patients of the home who need hospital care; except that the State agency may waive this requirement in whole or in part with respect to any nursing home meeting all the other requirements and which, because of its remote location or other good and sufficient reason, is unable to make such an arrangement with a hospital; and (6)(*a*) Meet (after Dec. 31, 1969), provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) applicable to nursing homes; except that the State agency may waive, for periods it deems appropriate, specific provisions of such code which, if rigidly applied, would cause unreasonable hardship to a nursing home, where the agency makes a determination (and keeps a written record of the basis thereof) that such waiver will not adversely affect the health and safety of the patients of such home; and except that the requirements described in this item (6)(*a*) shall not apply in any State if the Secretary finds that such State has in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing homes; and (*b*) meet conditions relating to environment and sanitation applicable to extended care facilities under title XVIII of the act; except that any requirement described in this item (6)(*b*) may be waived by the State agency in situations and under conditions comparable to those described in item (6)(*a*), above. Effective: Jan. 1, 1969, except when indicated differently.
B.B. Licensing of nursing home administrators.	No provision.	Establishes a plan requirement under which a State must have a program which meets the requirements set forth below for the licensing of administrators of nursing homes. For purposes of the requirement a State licensing program is one which provides that no nursing home within the State may operate except under the supervision of an administrator who is licensed as provided pursuant to the following requirements. Licensing of nursing home administrators must be carried out by the State agency responsible for licensing under the State's Healing Arts Licensing Act or, if there is no such act or

agency, a board representative of the professions and and institutions concerned with care of chronically ill and infirm aged patients.

It shall be the function of the agency or board to—

(1) Develop, impose, and enforce standards to be met as a condition of receiving a license as a nursing home administrator, designed to insure that such an administrator will be of good character and otherwise suitable, and, by training or experience in the field of institutional administration, will be qualified to serve as such an administrator;

(2) Develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

(3) Issue licenses to individuals who meet such standards, and revoke or suspend licenses in any case of substantial failure to conform to such standards;

(4) Establish and carry out procedures designed to insure that such licenses will, during any period that they serve as such administrators, comply with such standards;

(5) Receive, investigate, and take appropriate action with respect to any charge or complaint filed with the agency or board to the effect that any such licensee has failed to comply with such standards; and

(6) Conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of such licensing standards and of procedures and methods for the enforcement of such standards.

A waiver may be granted to any individual who has served as a nursing home administrator, during the full year before the State sets up its licensing agency, with respect to standards except those which relate to good character or suitability if—

(1) such waiver is for a period which ends after being in effect for 2 years or on Dec. 31, 1971, whichever is earlier, and

(2) there is provided in the State (during all of the period for which waiver is in effect), a program of training and instruction designed to enable all individuals, with respect to whom any such waiver is granted, to attain the qualifications necessary to meet such standards.

Authorizes appropriations as necessary for fiscal years 1968–72 to make grants to the States to help carry out these training programs.

Creates a National Advisory Council on Nursing Home Administration of nine persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The purpose of the council is to advise the Secretary and the States in carrying out these provisions. The members shall include, but not be limited to, representatives of State health officers, State welfare directors, nursing home administrators, and university programs in public health or medical care administration.

MEDICAL ASSISTANCE—TITLE XIX (MEDICAID)—Continued

Item	Prior law	Public Law 90-248
II. State plan requirements—Continued B.B. Licensing, etc.—Continued		The Council must be appointed before July 1, 1968, shall make a report on certain functions by July 1, 1969, and shall go out of existence on Dec. 31, 1971.
C.C. Utilization review and control	No provision.	Provides that the State plan must include methods and procedures relating to the utilization and payment for covered services as may be necessary to safeguard against unnecessary utilization and to assure that payments (including payment for drugs) are reasonable and consistent with efficiency, economy, and quality of care.
III. Payments to States: A. Amounts paid to States	Each State with an approved plan for medical assistance receives— (1) an amount equal to the Federal medical assistance percentage, as defined below, of the total medical assistance expenditures during the quarter, including in such expenditures premiums under pt. B of title XVIII for recipients of money payments under title I, IV, X, XIV, or XVI, and other insurance premiums for medical or remedial care or the cost of such care; plus (2) an amount equal to 75 percent of the amounts expended for administrative costs attributable to compensation or training of skilled professional medical personnel and directly supporting staff of the State agency or local agency administering the plan; plus (3) ½ of the remaining administrative expenses. However, the amount of the Federal payment attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for mental diseases is to be paid only to the extent that total expenditures from Federal, State, and local funds for mental health services under State and local public health and public welfare programs for the quarter are shown to the satisfaction of the Secretary to exceed the average of the total expenditures for these services for each quarter of the fiscal year ending June 30, 1965. The expenditures for these services for each quarter in the fiscal year ending June 30, 1965, are determined on the basis of the latest data available to the Secretary at the time of the 1st determination, and expenditures for quarters beginning after Dec. 31, 1965, are deter-	(1) No change. (2) Authorizes 75-percent Federal financial participation in expenses attributable to the compensation or training of skilled medical personnel and directly supporting staff engaged in the administration of an approved title XIX plan without regard to whether such personnel are employees of the single State agency responsible for administration of the plan or of some other public agency participating in the administration of the plan. Effective: For expenditures made after Dec. 1967. (3) No change.

	mined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination for such State for such quarter.	
B. Definition of Federal medical assistance percentage.	The term "Federal medical assistance percentage" for a State is 100 percent minus the percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the 50 States and the District of Columbia. Such percentage is in no case less than 50 percent or more than 83 percent, except that for Puerto Rico, the Virgin Islands, and Guam it is set at 55 percent.	"Federal medical assistance percentage" for Puerto Rico, Guam, and the Virgin Islands is changed to 50 percent effective with 1968.
C. Guarantee of higher percentage than under prior law.	If the Secretary finds, on the basis of satisfactory information submitted by a State, that its Federal medical assistance percentage applicable to any quarter during the period Jan. 1, 1966, through June 30, 1969, is less than 105 percent of the Federal share of the State's medical expenditures during the fiscal year ending June 30, 1965, then its Federal medical assistance percentage will be 105 percent of such Federal share instead of the percentage. Such adjusted percentage will be applicable for such quarter and each subsequent quarter in such period prior to the first quarter as to which such finding is not applicable. For the above purposes, such Federal share means the percentage which the excess of— (A) the total of the amounts of the Federal shares (determined under the applicable formulas of the public assistance titles of the act) of the State's expenditures for aid or assistance in any form during fiscal year 1965 under its plans approved under titles I, IV, X, XIV, and XVI over (B) the total of the Federal shares determined under such formulas with respect to its expenditures of aid or assistance during such year, excluding aid or assistance in the form of medical or remedial care, is of the total of aid or assistance expenditures in the form of medical or remedial care under such plans during such year.	No change.
D. Federal medical assistance percentage for the States.	The following are the Federal medical assistance percentages for the States for the period July 1, 1967, to June 30, 1969:	States would be limited in setting income levels for eligibility for which Federal matching funds would be available. The family income level could not be higher than 133⅓ percent of the highest amount ordinarily paid to a family of the same size without income or resources under the program of aid to families with dependent children. Needy persons receiving or eligible for aid or assistance under the cash assistance titles of the act would be exempt from this provision. The 133⅓ proportion would go into effect on July 1, 1968, except that for States which had a title XIX program approved

Item	Prior law	Public Law 90–248
III. Payments to States—Continued D. Federal medical assistance percentage for the State—Con.	*State* — *Percent* Alabama — 78.60 Alaska — 50.00 Arizona — 64.99 Arkansas — 79.81 California — 50.00 Colorado — 55.31 Connecticut — 50.00 Delaware — 50.00 District of Columbia — 50.00 Florida — 65.09 Georgia — 72.85 Hawaii — 50.00 Idaho — 67.87 Illinois — 50.00 Indiana — 53.39 Iowa — 59.60 Kansas — 57.90 Kentucky — 75.25 Louisiana — 74.58 Maine — 69.92 Maryland — 50.00 Massachusetts — 50.00 Michigan — 50.00 Minnesota — 58.40 Mississippi — 83.00 Missouri — 58.40 Montana — 64.01 Nebraska — 60.48 Nevada — 50.00 New Hampshire — 60.12 New Jersey — 50.00 New Mexico — 70.15 New York — 50.00 North Carolina — 75.30 North Dakota — 70.74 Ohio — 52.64 Oklahoma — 69.61	before July 26, 1967, for the period from July 1, 1968, to Jan. 1, 1969, the proportion would be 150 rather than 133⅓ percent and for that period from Jan 1, 1969, to Jan. 1, 1970, the proportion would be 140 percent. Puerto Rico, the Virgin Islands, and Guam would be exempt from these provisions and would instead be limited by dollar ceilings as follows: Puerto Rico — $20,000,000 Virgin Islands — 650,000 Guam — 900,000 Federal matching would be reduced to 50 percent.

	Oregon 54.37 Pennsylvania 55.03 Rhode Island 52.61 South Carolina 80.50 South Dakota 73.26 Tennessee 76.14 Texas 67.10 Utah 65.24 Vermont 69.00 Virginia 65.85 Washington 50.00 West Virginia 75.84 Wisconsin 56.68 Wyoming 59.20	
E. Comprehensive care by 1975	No provision The Secretary of Health, Education, and Welfare is not allowed to make any payments to a State unless the State shows that it is making efforts to broaden the scope of the care and services and to liberalize the eligibility requirements with a view to furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's income and resources test.	No change.
IV. Benefits:		
A. Direct payment to recipient	Vendor payments (payments made directly to the supplier of the services) can be made on behalf of individuals who are under the age of 21, dependent children under title IV, or relatives with whom such children are living, or who are 65 years of age or older, are blind, or are 18 years of age or older and permanently and totally disabled, but whose income and resources are insufficient to meet all of such cost can be covered by a State—	At the option of the State, payments for physicians' and dentists' services can be made directly to the medically needy. All payments to cash recipients must continue to be made to the vendor of medical services as will those for the medically needy other than those involving physicans and dentists.
B. Essential persons	(1) in-patient hospital services (other than services in an institution for tuberculosis or mental diseases); (2) out-patient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services (other than services in an institution for tuberculosis or mental diseases) for individuals age 21 or over. (5) physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law; (7) home health care services; (8) private duty nursing services; (9) clinic services; (10) dental services; (11) physical therapy and related services;	Provides that States may also include a person essential to the welfare of a cash assistance recipient. An "essential person" for this purpose is the spouse of the recipient and living with him and she must have her needs taken into account in deciding the size of the grant and be essential to his well-being.

MEDICAL ASSISTANCE—TITLE XIX (MEDICAID)—Continued

Item	Prior law	Public Law 90-248
IV. Benefits—Continued B. Essential persons—Continued	(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (13) other diagnostic, screening, preventive, and rehabilitative services; (14) in-patient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases; and (15) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary. The benefits can not include— (A) payments with respect to care or services for an individual who is an inmate of a public institution (except as a patient in a medical institution); or (B) payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.	
V. Maintenance of State effort	Federal matching for any State for any quarter prior to July 1, 1969, shall be reduced to the extent the excess of Federal matching for such quarter for the new medical program, old-age assistance, aid to needy families with children, aid to the blind, aid to the permanently and totally disabled, and aid under the consolidated program over the corresponding quarter in fiscal year 1964 or 1965 or average quarterly Federal matching for these programs in fiscal year 1964 or 1965 is greater than the excess of total expenditures (Federal, State, and local) on these programs in such quarter over the corresponding quarter or of the average total quarterly expenditures on these programs in fiscal year 1964 or 1965.	Maintenance of effort could be determined on the basis of money payments alone. Also, current expenditures could be measured on the basis of a full fiscal year (rather than a quarter). In addition, child welfare expenditures could be included in the determination either with money payments alone or with money payments and medical assistance. The provision would be effective July 1, 1966, rather than Jan. 1, 1966, and would be repealed effective July 1, 1968.
VI. Advisory Council	No provision.	Requires Secretary of HEW to appoint an Advisory Council on Medical Assistance to advise the Secretary on administration of the medicaid (title XIX) program. The Council would consist of 21 members with one of the members acting, upon appointment of the Secretary. as Chairman. The members are to include representatives of State and local agencies and nongovernmental groups concerned with health, and consumers of health services, with a majority to consist of consumer representatives. Members are to hold office for 4 years with the 1st offices staggered.

VII. Observance of religious beliefs	No provision.	Provides that no person may be compelled to undergo medical screening, examination, diagnosis, or treatment, except for the purpose of discovering and preventing the spread of infection or contagious disease or to protect environmental health, if the person objects on religious grounds.
VIII. Intermediate care facilities	No provision.	The law provides for vendor payments in behalf of persons who qualify for OAA, AB or APTD (or the combined program) and who are living in facilities (including a Christian Science sanitarium) which are more than boarding houses but which are less than skilled nursing homes. The rate of Federal sharing for payments for care in those institutions is at the same rate as for medical assistance under title XIX. Such homes will have to meet safety and sanitation standards comparable to those required for nursing homes in a given State.

DATA ON PUBLIC ASSISTANCE PROGRAMS

TABLE 1.—*Special types of public assistance and general assistance: Expenditures for assistance to recipients, by program and source of funds, fiscal year ended June 30, 1967* [1]

[Includes vendor payments for medical care]

Program	Expenditures from—			
	Total	Federal funds	State funds	Local funds
	Amount (in thousands)			
Total	$6,981,511	$3,814,859	$2,319,760	$846,892
Special types of public assistance	6,624,753	3,814,859	2,129,912	679,982
Old-age assistance	1,861,143	1,253,834	533,471	73,838
Aid to the blind	89,172	51,782	31,950	5,441
Aid to the permanently and totally disabled	570,129	336,442	190,339	43,348
Aid to families with dependent children	2,065,156	1,170,461	643,546	251,149
Medical assistance [2]	1,944,161	952,068	697,115	294,978
Medical assistance for the aged	94,991	50,271	33,492	11,227
General assistance	356,758	----------	189,848	166,910

TABLE 1.—*Special types of public assistance and general assistance: Expenditures for assistance to recipients, by program and source of funds, fiscal year ended June 30, 1967* [1]—Continued

[Includes vendor payments for medical care]

Program	Expenditures from—			
	Total	Federal funds	State funds	Local funds
	Percentage distribution by program			
Total	100.0	100.0	100.0	100.0
Special types of public assistance	94.9	100.0	91.8	80.3
Old-age assistance	26.7	32.9	23.0	8.7
Aid to the blind	1.3	1.4	1.4	.6
Aid to the permanently and totally disabled	8.2	8.8	8.2	5.1
Aid to familes with dependent children	29.6	30.7	27.7	29.7
Medical assistance [2]	27.8	25.0	30.1	34.8
Medical assistance for the aged	1.4	1.3	1.4	1.3
General assistance	5.1	----------	8.2	19.7
	Percentage distribution by source of funds			
Total	100.0	54.6	33.2	12.1
Special types of public assistance	100.0	57.6	32.2	10.3
Old-age assistance	100.0	67.4	28.7	4.0
Aid to the blind	100.0	58.1	35.8	6.1
Aid to the permanently and totally disabled	100.0	59.0	33.4	7.6
Aid to familes with dependent children	100.0	56.7	31.2	12.2
Medical assistance [2]	100.0	49.0	35.9	15.2
Medical assistance for the aged	100.0	52.9	35.3	11.8
General assistance	100.0	----------	53.2	46.8

[1] Expenditures for assistance include all money payments to recipients, vendor payments for medical care and assistance in kind to, and vendor payments on behalf of recipients for goods and services to meet their maintenance needs. Vendor payments for burial are excluded. Amounts cannot be compared with annual data based on monthly series or with amount of Federal grants to the States.

[2] Program initiated January 1966 under Public Law 89–97.

TABLE 2.—*Expenditures for assistance and for administration, services, and training, by program and source of funds, fiscal year ended June 30, 1967*

[Amounts in thousands]

Program	Total	Federal funds		State funds		Local funds	
		Amount	Percent	Amount	Percent	Amount	Percent
Total	$7, 825, 800	$4, 259, 176	54. 4	$2, 752, 937	32. 9	$993, 686	12. 7
Special types of public assistance	7, 384, 970	4, 259, 176	57. 7	2, 336, 961	31. 6	788, 833	10. 7
Old-age assistance	2, 034, 131	1, 348, 942	66. 3	587, 998	28. 9	97, 191	4. 8
Aid to the blind	100, 519	57, 849	57. 6	35, 866	35. 7	6, 804	6. 8
Aid to the permanently and totally disabled	659, 721	385, 729	58. 5	215, 304	32. 6	58, 688	8. 9
Aid to families with dependent children	2, 451, 503	1, 412, 586	57. 6	731, 816	29. 9	307, 101	12. 5
Medical as istance [1]	2, 036, 556	999, 832	49. 1	730, 319	35. 9	306, 404	15. 0
Medical assistance for the aged	102, 541	54, 238	52. 9	35, 657	34. 8	12, 646	12. 3
General assistance	440, 830	----------	----------	235, 976	53. 5	204, 853	46. 5

[1] Program initiated January 1966 under Public Law 89–97.

NOTE.—Expenditures for administration include those for determining initial and continuing eligibility to receive financial assistance and for providing welfare services to people applying for or receiving financial assistance or welfare services only.

TABLE 3.—*Special types of public assistance and general assistance: Payments for vendor medical bills—Total amount, amount for which type of service was not reported, and amount in all States reporting for specified type of service, by program, fiscal year ended June 30, 1967*

[Amounts in thousands]

Program	Total	Type of service not reported [1]	In all States reporting for specified type of service [2]							
			Total for specified types of services	In-patient hospital care	Nursing home care	Physicians' services	Other practitioners' services	Dental care	Prescribed drugs	Other
	Amount of vendor payments for medical care [3]									
Total	$2,345,372	$11,582	$2,333,791	$955,075	$772,620	$230,299	$18,039	$72,804	$182,584	$102,371
Special types of public assistance	2,270,996	740	2,270,256	912,662	766,120	224,543	17,923	72,246	179,424	97,338
Old-age assistance	160,089	54	160,035	24,846	101,581	10,119	268	1,044	20,900	1,277
Aid to the blind	3,081	-------	3,081	922	1,361	204	8	43	480	64
Aid to the permanently and totally disabled	42,305	3	42,302	15,831	16,280	1,604	85	399	7,200	902
Aid to families with dependent children	33,969	18	33,951	16,394	68	6,179	462	2,880	6,018	1,949
Medical assistance	1,936,753	589	1,936,164	830,314	587,286	203,679	16,978	67,698	138,187	92,021
Medical assistance for the aged	94,798	76	94,722	24,354	59,544	2,758	122	181	6,638	1,124
General assistance	74,376	10,842	63,535	42,413	6,500	5,756	116	558	3,160	5,033
	Percentage distribution									
Total	100.0	0.5	99.5	40.7	32.9	9.8	0.8	3.1	7.8	4.4
Special types of public assistance	100.0	(4)	100.0	40.2	33.7	9.9	.8	3.2	7.9	4.3
Old-age assistance	100.0	(4)	100.0	15.5	63.5	6.3	.2	.7	13.1	.8
Aid to the blind	100.0	-------	100.0	29.9	44.2	6.6	.2	1.4	15.6	2.1
Aid to the permanently and totally disabled	100.0	(4)	100.0	37.4	38.5	3.8	.2	.9	17.0	2.1
Aid to families with dependent children	100.0	.1	99.9	48.3	.2	18.2	1.4	8.5	17.7	5.7
Medical assistance	100.0	(4)	100.0	42.9	30.3	10.5	.9	3.5	7.1	4.8
Medical assistance for the aged	100.0	.1	99.9	25.7	62.8	2.9	.1	.2	7.0	1.2
General assistance	100.0	14.6	85.4	57.0	8.7	7.7	.2	.7	4.2	6.8

[1] These amounts cannot be distributed in the same way as the amounts shown for the various types of service because (1) some States may not provide through the vendor payment all the specified services; and (2) amounts for the types of service include data for State reporting a partial distribution of vendor payments.

[2] Includes amounts in States that reported a partial distribution of vendor payments by type of service.

[3] For States operating pooled funds or other prepayment plans, data represent payments out of these funds to specified type of vendor.

[4] Less than 0.05 percent.

TABLE 4.—*Recipients of public assistance money payments and/or nonmedical vendor payments and average monthly payment per recipient by program, December of calendar years 1936–66* [1]

Year and month	Recipients [2] (in thousands)							Average monthly payment per recipient [2]				
	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled [3]	Aid to families with dependent children			General assistance [5]	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled [3]	Aid to families with dependent children	General assistance [5]
				Families	Total recipients [4]	Children						
1936	1,108	45	----------	162	546	404	4,545	$18.80	$26.10	----------	$8.80	$8.00
1937	1,579	56	----------	229	769	568	4,840	19.45	27.20	----------	9.35	8.50
1938	1,779	67	----------	281	935	688	5,177	19.55	25.20	----------	9.60	7.90
1939	1,912	70	----------	316	1,042	764	4,675	19.30	25.45	----------	9.65	8.30
1940	2,070	73	----------	372	1,222	895	3,618	20.25	25.35	----------	9.85	8.30
1941	2,238	77	----------	391	1,288	944	2,068	21.25	25.80	----------	10.20	9.40
1942	2,230	79	----------	349	1,158	851	1,000	23.35	28.55	----------	10.95	11.65
1943	2,149	76	----------	272	916	676	558	26.65	27.95	----------	12.35	14.55
1944	2,066	72	----------	254	862	639	477	28.45	29.30	----------	13.40	15.60
1945	2,056	71	----------	274	943	701	507	30.90	33.50	----------	15.15	16.55
1946	2,196	77	----------	346	1,190	885	673	35.30	36.65	----------	18.10	18.45
1947	2,332	81	----------	416	1,426	1,060	739	37.40	39.60	----------	18.40	20.60
1948	2,498	86	----------	475	1,632	1,214	842	42.00	43.55	----------	20.90	22.40
1949	2,736	93	----------	599	2,048	1,521	1,337	44.75	46.10	----------	21.70	21.25
1950	2,786	97	69	651	2,233	1,661	866	43.05	46.00	$44.10	20.85	22.25
1951	2,701	97	124	592	2,041	1,523	664	44.55	48.05	46.45	22.00	22.90
1952	2,635	98	161	596	1,991	1,495	587	48.80	53.50	48.40	23.45	23.30
1953	2,582	100	192	547	1,941	1,464	618	48.90	54.05	47.90	23.20	22.05
1954	2,553	102	222	604	2,173	1,639	880	48.70	54.35	48.35	23.25	22.85
1955	2,538	104	241	602	2,192	1,661	743	50.05	55.55	48.75	23.50	23.30
1956	2,499	107	266	615	2,270	1,731	731	53.25	60.00	50.70	24.80	23.45
1957	2,480	108	290	667	2,497	1,912	907	55.50	62.20	52.35	25.40	22.70
1958	2,438	110	325	755	2,486	2,181	1,246	56.95	63.55	53.80	26.65	24.05
1959	2,370	108	346	776	2,946	2,265	1,107	56.70	65.60	54.15	27.30	25.05
1960	2,305	107	369	803	3,073	2,370	1,244	58.90	67.45	56.15	28.35	24.85
1961	2,229	103	389	916	3,566	2,753	1,069	57.60	68.05	57.05	29.45	26.15
1962	2,183	99	428	932	3,789	2,844	900	61.55	71.95	58.50	29.30	26.30
1963	2,152	97	464	954	3,930	2,951	872	62.80	73.95	59.85	29.70	27.45
1964	2,120	95	509	1,012	4,219	3,170	779	63.65	76.15	62.25	31.50	30.50
1965	2,087	85	557	1,054	4,396	3,316	677	63.10	81.35	66.50	32.85	31.65
1966	2,073	84	588	1,127	4,666	3,526	663	68.05	86.85	74.75	36.25	36.20

See footnotes at end of table, p. 92

TABLE 4.—*Recipients of public assistance money payments and/or nonmedical vendor payments and average monthly payment per recipient, by program, December of calendar years 1936–66* [1]—Continued

Year and month	Recipients [2] (in thousands)							Average monthly payment per recipient [3]				
	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled [3]	Aid to families with dependent children			General assistance [5]	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled [3]	Aid to families with dependent children	General assistance [5]
				Families	Total recipients [4]	Children						
1966												
January	2,074	85	556	1,063	4,439	3,346	714	$64.15	$82.50	$67.95	$33.10	$30.40
February	2,071	85	560	1,073	4,487	3,382	714	64.05	82.25	68.05	33.25	30.90
March	2,074	85	563	1,082	4,524	3,409	712	63.70	83.55	68.60	33.60	31.90
April	2,073	85	566	1,086	4,527	3,418	647	63.95	83.20	68.95	33.30	33.10
May	2,078	85	570	1,084	4,505	3,405	609	64.20	83.45	69.50	33.45	34.00
June	2,076	85	573	1,079	4,472	3,382	592	64.45	83.95	69.75	33.65	35.05
July	2,078	84	570	1,076	4,457	3,381	574	65.55	85.05	71.65	34.30	36.05
August	2,078	84	574	1,084	4,480	3,390	597	66.35	85.55	72.40	34.65	36.85
September	2,084	84	580	1,091	4,508	3,414	597	67.30	86.30	72.70	35.70	37.95
October	2,089	84	583	1,097	4,528	3,428	600	67.25	86.15	72.95	35.60	37.90
November	2,079	84	585	1,108	4,568	3,460	611	67.45	86.05	73.65	36.05	37.20
December	2,073	84	588	1,127	4,666	3,526	663	68.05	86.85	74.75	36.25	36.20

[1] Includes Puerto Rico and the Virgin Islands, beginning October 1950 (under the 1950 Amendments to the Social Security Act) and Guam, beginning July 1959 (under the 1958 amendments). See also footnotes 3 and 4.

[2] December of each year.

[3] Program initiated October 1950 under the 1950 amendments.

[4] Children and 1 or both parents or 1 adult caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance; before December 1950 partly estimated.

[5] Partly estimated. Excludes Idaho beginning September 1957, Nebraska, September 1952–December 1953 and beginning November 1963, Indiana beginning January 1962; data not available.

TABLE 5.—*Amount of public assistance money payments and amount expended per inhabitant, by program, calendar years 1936–66* [1]

Year	Amount of money payments (in thousands)							Amount of money payment per inhabitant [3]						
	Total	Federally aided programs					General assistance	Total	Federally aided programs					General assistance
		Total	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled [2]	Aid to families with dependent children			Total	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled [2]	Aid to families with dependent children	
1936	$655,086	$217,951	$155,484	$12,814	----------	$49,653	$437,134	$5.10	$1.70	$1.20	$0.10	----------	$0.40	$3.40
1937	802,937	396,217	309,550	16,173	----------	70,494	406,720	6.25	3.10	2.40	.15	----------	.55	3.15
1938	987,025	511,419	394,874	18,953	----------	97,592	475,606	7.60	3.95	3.05	.15	----------	.75	3.65
1939	1,050,790	568,670	433,507	20,372	----------	114,791	482,120	8.05	4.35	3.30	.15	----------	.90	3.70
1940	1,020,115	627,906	472,778	21,735	----------	133,393	392,209	7.75	4.75	3.60	.15	----------	1.00	2.95
1941	989,397	716,231	540,074	22,856	----------	153,301	273,166	7.45	5.40	4.05	.15	----------	1.15	2.05
1942	956,846	776,408	593,400	24,559	----------	158,449	180,438	7.15	5.80	4.45	.20	----------	1.20	1.35
1943	926,325	815,414	649,970	25,045	----------	140,399	110,912	6.85	6.05	4.80	.20	----------	1.05	.80
1944	940,399	851,051	690,727	25,256	----------	135,068	89,347	7.00	6.35	5.15	.20	----------	1.00	.65
1945	987,934	901,673	725,683	26,515	----------	149,475	86,262	7.40	6.75	5.45	.20	----------	1.10	.65
1946	1,179,318	1,058,921	819,764	30,717	----------	208,440	120,398	8.40	7.55	5.85	.20	----------	1.50	.85
1947	1,480,800	1,316,574	986,366	36,193	----------	294,015	164,226	10.30	9.15	6.85	.25	----------	2.05	1.15
1948	1,730,713	1,532,262	1,128,190	41,284	----------	362,788	198,451	11.80	10.45	7.70	.30	----------	2.45	1.35
1949	2,174,974	1,893,717	1,372,898	48,448	----------	472,371	281,257	14.20	12.40	8.95	.30	----------	3.10	1.85
1950	2,354,485	2,061,700	1,453,917	52,567	$8,042	547,174	292,786	15.15	13.30	9.35	.35	$0.05	3.50	1.90
1951	2,279,612	2,085,153	1,427,603	54,473	54,312	548,765	194,459	14.45	13.25	9.05	.35	.35	3.50	1.25
1952	2,311,540	2,142,045	1,462,936	59,536	81,533	538,040	169,495	14.45	13.40	9.15	.35	.50	3.35	1.05
1953	2,374,158	2,222,891	1,513,293	63,601	102,031	543,966	151,267	14.60	13.65	9.30	.40	.65	3.35	.95
1954	2,451,785	2,255,735	1,497,578	65,238	119,791	573,128	196,050	14.75	13.60	9.00	.40	.70	3.45	1.20
1955	2,516,590	2,302,634	1,487,991	67,804	134,630	612,209	213,956	14.90	13.60	8.80	.40	.80	3.60	1.25
1956	2,584,204	2,387,003	1,529,048	72,926	150,142	634,887	197,201	15.00	13.85	8.90	.40	.85	3.70	1.15
1957	2,788,161	2,577,082	1,609,390	78,679	172,170	716,842	211,079	15.90	14.70	9.20	.45	1.00	4.10	1.20
1958	3,068,701	2,765,393	1,647,376	81,455	196,644	839,918	303,308	17.20	15.50	9.25	.45	1.10	4.70	1.70
1959	3,200,768	2,858,719	1,620,715	83,553	217,279	937,172	342,049	17.65	15.80	8.95	.45	1.20	5.15	1.90
1960	3,262,449	2,942,928	1,626,021	86,080	236,402	994,425	319,521	17.70	16.00	8.85	.45	1.30	5.40	1.75
1961	3,409,371	3,057,976	1,568,987	84,506	255,645	1,148,838	351,395	18.20	16.35	8.40	.45	1.35	6.15	1.90
1962	3,510,456	3,220,918	1,566,121	83,856	281,117	1,289,824	289,538	18.45	16.95	8.25	.45	1.50	6.80	1.50
1963	3,646,058	3,368,626	1,610,310	85,122	317,656	1,355,538	277,432	18.90	17.45	8.35	.45	1.65	7.05	1.45
1964	3,815,178	3,544,918	1,606,561	86,189	355,643	1,496,525	270,260	19.50	18.15	8.20	.45	1.80	7.65	1.40
1965	3,992,964	3,732,352	1,594,183	77,308	416,765	1,644,096	260,612	20.20	18.85	8.05	.40	2.10	8.30	1.30
1966	4,303,814	4,051,937	1,630,131	84,708	487,212	1,849,886	251,877	21.55	20.30	8.15	.40	2.45	9.25	1.25

[1] Before 1943, excludes Alaska and Hawaii.
[2] Program initiated Oct. 1950 under the 1950 amendments.
[3] Based on population as of Jan. 1, excluding Armed Forces overseas, estimated by the Bureau of the Census.

TABLE 6.—*Aid to families with dependent children: Percent that amount paid for basic needs for a family consisting of father, mother, and 2 children represents of total monthly cost standard for basic needs of such family, by State, January 1967* [1]

State	Total monthly cost standard for basic needs [2]	Amount paid for basic needs under State program is lowest of—			Percent amount paid represents of cost standards for basic needs
		Maximum on money payment [3]	Amount paid under reduction formula [4]	Amount of cost standard for basic needs	
	(1)	(2)	(3)	(4)	(5)
Alabama	$177.00	$58.00	(4)		32.8
Alaska	255.47	110.00			43.1
Arizona	232.00	107.00			46.1
Arkansas	174.00	80.00			46.0
California	220.20	191.00			86.7
Colorado	216.00		$180.90		83.8
Connecticut	257.00			$257.00	100.0
Delaware	236.00	187.00			79.2
District of Columbia	182.00			182.00	100.0
Florida	196.00	55.00			28.1
Georgia	187.60	117.00			62.4
Hawaii	219.75			219.75	100.0
Idaho	211.60			211.60	100.0
Illinois	181.12			181.12	100.0
Indiana	271.40	103.00			38.0
Iowa	192.00		144.00		75.0
Kansas	234.00			234.00	100.0
Kentucky	190.00	(5)	164.35		86.5
Louisiana	161.75	116.00			71.7
Maine	254.00	137.00			53.9
Maryland	171.50	(5)		171.50	100.0
Massachusetts	250.00			250.00	100.0
Michigan	223.00			223.00	100.0
Minnesota	215.00			215.00	100.0
Mississippi	194.09	40.00	(4)		20.6
Missouri	225.46	90.00			39.9
Montana	219.00			219.00	100.0
Nebraska	276.50	115.00			41.6
Nevada	262.25	[6] 126.85			48.4
New Hampshire	204.00			204.00	100.0
New Jersey	280.00			280.00	100.0
New Mexico	193.00	(5)	183.35		95.0
New York	262.15			262.15	100.0
North Carolina	147.75			147.75	100.0

North Dakota	251.00			251.00	100.0
Ohio	232.00		178.00		76.7
Oklahoma	163.00	(3)		163.00	100.0
Oregon	203.25		197.56		97.2
Pennsylvania	197.40			197.40	100.0
Puerto Rico	87.78		28.97		33.0
Rhode Island	225.00			225.00	100.0
South Carolina	155.80	56.00			35.9
South Dakota	248.00		198.40		80.0
Tennessee	198.00	105.00			53.0
Texas	163.95	93.00			56.7
Utah	185.00	185.00			100.0
Vermont	209.50	140.00			66.8
Virgin Islands	122.50			122.50	100.0
Virginia	195.00	(5)	183.00		93.8
Washington	209.35	(5)		209.35	100.0
West Virginia	222.60	165.00	(4)		74.1
Wisconsin	218.15			218.15	100.0
Wyoming	240.30	200.00			83.2

[1] Includes data for 53 States and other jurisdictions; data not available for Guam.

[2] The specified type of family is assumed to be living alone in rented quarters and to need amounts for rent and utilities that are at least as large as the maximum amounts allowed by the States for these items. The family is also assumed to have no income other than assistance.

[3] Some States had money payment maximums that were higher than the amount of the cost standard for basic needs or the amount paid under a reduction formula. These States and their applicable maximums were: Kentucky, $260; Maryland, $237; New Mexico, $190; Oklahoma, $175; Virginia, $215; and Washington, $325.

[4] In Alabama, Mississippi, and West Virginia the applicable amounts under reduction formulas were higher than the money payment maximums for the specified type of family.

[5] The specified type of family may receive a maximum of $93 plus 20 percent of unmet need.

DATA ON PUBLIC ASSISTANCE PROGRAMS—Continued

TABLE 7.—*Detail of public welfare costs of Public Law 90–248*

[In millions of dollars]

Item	Fiscal year 1968		Fiscal year 1969	
	Estimate in committee report	Current estimate [1]	Estimate in committee report	Current estimate [2]
Public assistance:				
AFDC costs if Public Law 90–248 not enacted	1,462	1,697.0	1,555.0	1,974.3
Title XIX (including all vendor medical payments) if Public Law 90–248 not enacted	1,391	1,634.0	1,913.0	2,193.5
All other public assistance costs if Public Law 90–248 not enacted	1,647	1,854.2	1,700.0	1,843.1
Total	4,500	5,185.2	5,168.0	6,010.9
Increase in the bill:				
Day care		5.0	35.0	35.0
Other social services		[3]	35.0	35.0
Earnings exemptions		5.0	20.0	20.0
Work training	30	35.0	129.0	100.0
Foster care		[3]	10.0	10.0
Emergency assistance		2.3	10.0	10.0
Puerto Rico, et al		[3]	7.8	7.8
Demonstration projects		2.0	2.0	2.0
Additional child health requirements in title XIX				
OAA, AB, APTD spouses under medicaid		6.7	14.0	14.0
Medical review program for nursing homes			2.5	2.5
Subtotal, increases	50	[1] 56.0	265.3	236.3
Decreases in bill:				
AFDC limitation				−126.2
AFDC reductions for persons trained			−11.0	−11.0
Restrictions on title XIX			−329.0	−122.0
Decrease in public assistance due to social security benefit increases	−15	−15.0	−65.0	−65.0
Federal participation in cost of care in intermediate care facilities			−10.0	−10.0
Subtotal, decreases	−15	−15.0	−415.0	−334.2
Net cost of changes due to public assistance amendments	−35	+41.0	−149.7	−97.0
Total public assistance as amended by bill	4,535	5,226.2	5,018.3	5,913.0

[1] Includes supplemental pending in Congress, or 1969 budget.
[2] 1969 budget request pending in Congress.
[3] A negligible increase is not distributed by item.

TABLE 8.—*Comparison of annual income level, title XIX, with level representing 133⅓ percent of highest amounts of money payments ordinarily paid as AFDC to families of specified sizes*

[Based on data as of April 1968]

State	Current income level (title XIX) [1]		133⅓ percent of AFDC money payments [2]	
	1 person	4 persons	1 person	4 persons
	(1)	(2)	(3)	(4)
	1. States currently operating medical assistance programs under title XIX that include the "medically needy"			
California	$2,028	$3,900	$1,900	$3,600
Connecticut	2,100	4,400	2,300	5,200
Delaware	1,500	3,300	1,300	3,100
Hawaii	1,440	3,000	1,900	3,400
Illinois	1,800	3,600	1,700	4,200
Iowa	1,600	3,600	1,300	4,000
Kansas	1,600	3,000	2,400	4,200
Kentucky	1,620	3,420	1,300	3,000
Maryland	1,800	3,120	1,500	3,000
Massachusetts	2,160	4,176	2,200	4,700
Michigan	1,900	3,540	2,500	4,300
Minnesota	1,620	3,036	2,500	4,800
Nebraska	1,600	3,000	1,800	3,200
New Hampshire	2,088	4,056	2,400	4,900
New York	2,900	6,000	2,200	5,000
North Dakota	1,600	3,000	2,400	4,400
Oklahoma	1,728	2,448	[3] 1,700	3,200
Pennsylvania	2,000	4,000	1,600	3,500
Rhode Island	2,500	4,300	2,000	4,400
Utah	1,200	2,640	1,500	3,000
Washington	2,040	3,480	2,800	4,800
Wisconsin	1,800	3,700	2,600	4,200

See footnotes at end of table, p. 99.

TABLE 8.—*Comparison of annual income level, title XIX, with level representing 133⅓ percent of highest amounts of money payments ordinarily paid as AFDC to families of specified sizes*—Continued

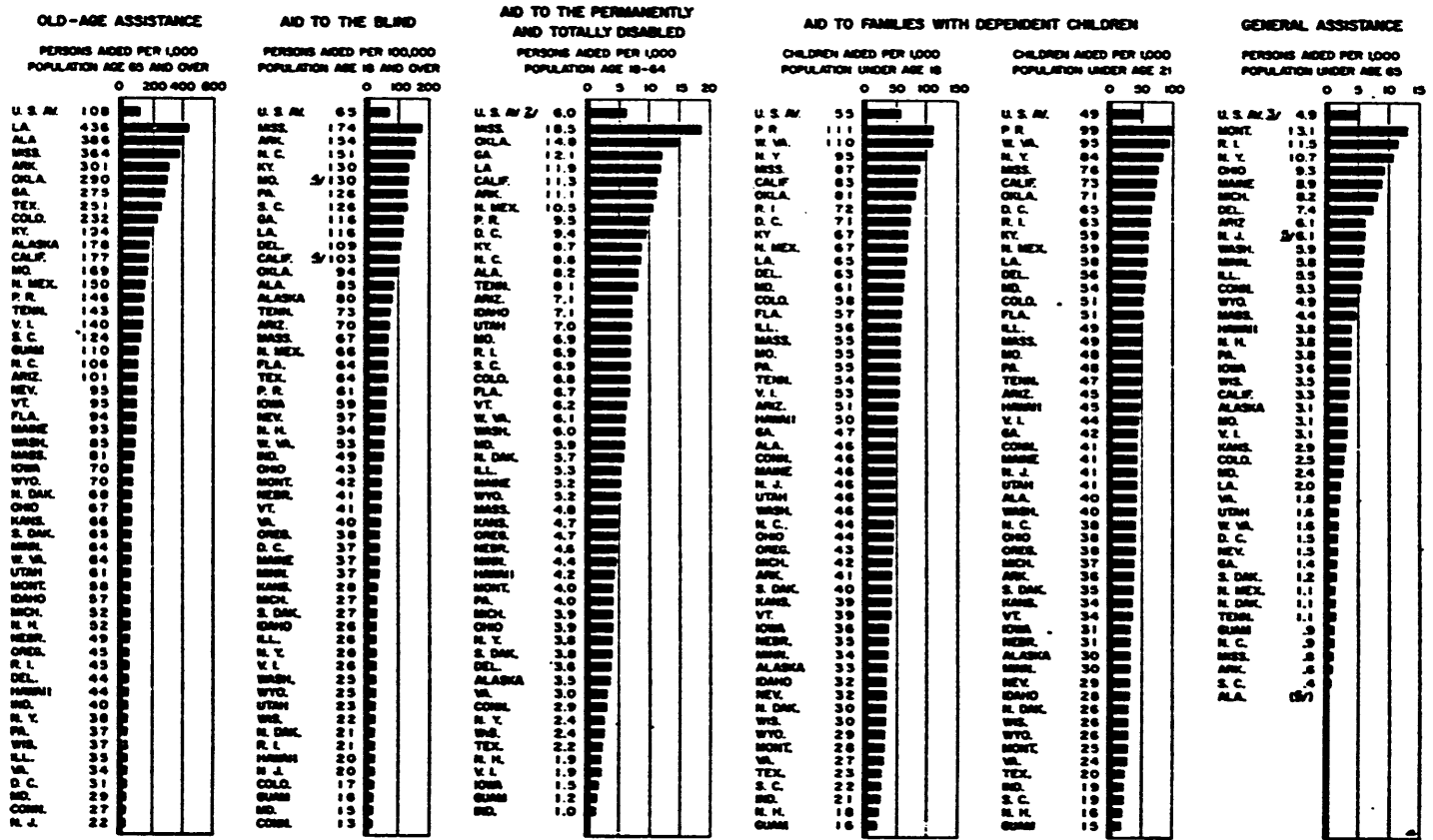
State	Current income level (title XIX) [1]		133⅓ percent of AFDC money payments [2]	
	1 person (1)	4 persons (2)	1 person (3)	4 persons (4)
	2. States currently operating medical assistance programs under title XIX that do not include the "medically needy"			
Georgia			$700	$2,000
Idaho			2,400	3,900
Louisiana			1,300	2,200
Maine			1,200	2,200
Missouri			600	1,900
Montana			900	3,300
Nevada			500	2,000
New Mexico			1,400	3,000
Ohio			1,600	3,500
Oregon			1,700	3,600
South Carolina			500	1,500
South Dakota			2,400	4,000
Texas			900	1,900
Vermont			2,400	4,600
West Virginia			1,500	2,900
Wyoming			1,600	3,200

	3. States not currently operating medical programs under title XIX			
Alabama			$700	$1,500
Alaska			800	2,300
Arizona			1,000	2,200
Arkansas			1,000	1,500
Colorado			700	2,900
District of Columbia			2,200	4,100
Florida			600	1,700
Indiana			800	2,400
Mississippi			400	900
New Jersey			2,300	5,400
North Carolina			1,700	2,600
Tennessee			800	2,000
Virginia			1,700	2,900

[1] Applicable only to "group 1" States.
[2] Computed amounts not already multiples of $100 were rounded upward to next $100.
[3] Estimated on basis of current income level.

TABLE 9.—*Proportion of population receiving public assistance money payments (recipient rates) in the United States, December 1967* [1]

(EXCLUDES RECIPIENTS RECEIVING ONLY VENDOR PAYMENTS FOR MEDICAL CARE.
CAUTION SHOULD BE USED IN MAKING COMPARISONS WITH EARLIER RATES BECAUSE OF REVISIONS IN POPULATION ESTIMATES ON WHICH RATES ARE BASED.)



1/ BASED ON CIVILIAN POPULATION AS OF JANUARY 1, 1968 ESTIMATED BY THE BUREAU OF THE CENSUS. 2/ NO PROGRAM IN NEVADA. 3/ BASED ON DATA FOR 44 STATES. NUMBER AIDED NOT AVAILABLE FOR FLORIDA, IDAHO, INDIANA, KENTUCKY, NEBRASKA, OKLAHOMA, OREGON, PUERTO RICO, TEXAS AND VERMONT. 4/ INCLUDES RECIPIENTS OF PAYMENTS MADE WITHOUT FEDERAL PARTICIPATION. RECIPIENT RATES EXCLUDING THESE RECIPIENTS ARE AS FOLLOWS: CALIFORNIA, 101 AND MISSOURI, 82. . 5/ INCLUDES UNKNOWN NUMBER OF PERSONS RECEIVING MEDICAL CARE, HOSPITALIZATION, AND BURIAL ONLY. 6/ LESS THAN 0.05.

TABLE 10.—*OAA money payment recipients also receiving OASDHI cash benefits, by State, February 1967*

State	OAA money payment recipients also receiving OASDHI cash benefits		
	Number	As percent of—	
		OAA money payment recipients	OASDHI cash beneficiaries aged 65 or over
Total [1]	1,096,000	53.1	7.0
Alabama	59,300	52.7	26.8
Alaska	750	52.9	18.0
Arizona	6,400	49.4	6.1
Arkansas	31,900	50.4	19.0
California [2]	207,000	72.3	15.5
Colorado	23,500	62.8	17.0
Connecticut	3,600	59.8	1.5
Delaware	1,000	62.9	2.9
District of Columbia	940	42.8	1.9
Florida	46,400	58.9	7.4
Georgia	40,300	42.9	16.4
Hawaii	880	54.6	2.7
Idaho	2,200	57.0	3.9
Illinois	17,400	43.7	2.0
Indiana	10,000	53.4	2.4
Iowa	13,000	53.9	4.4
Kansas	8,300	47.3	3.9
Kentucky	28,100	47.2	10.9
Louisiana	65,400	52.7	34.2
Maine	6,400	64.0	6.5
Maryland	2,800	37.0	1.3
Massachusetts	33,900	68.1	6.7
Michigan [3]	20,700	52.0	3.2
Minnesota	14,400	52.3	4.4
Mississippi	35,600	48.1	23.0
Missouri	50,900	56.5	11.7
Montana	2,300	57.2	4.1
Nebraska	5,200	48.1	3.5
Nevada	1,900	77.1	9.6
New Hampshire	2,500	59.3	3.8

See footnotes at end of table, p. 102.

TABLE 10.—*OAA money payment recipients also receiving OASDHI cash benefits, by State, February 1967*—Continued

State	OAA money payment recipients also receiving OASDHI cash benefits		
	Number	As percent of—	
		OAA money payment recipients	OASDHI cash beneficiaries aged 65 or over
New Jersey	8,000	58.9	1.4
New Mexico	3,300	35.7	7.0
New York [2]	36,100	53.7	2.3
North Carolina	14,300	36.2	4.5
North Dakota	2,100	46.2	3.7
Ohio	39,600	54.0	4.9
Oklahoma	39,600	49.1	18.9
Oregon	7,300	65.2	4.0
Pennsylvania	21,600	49.2	2.1
Puerto Rico	160	.6	.2
Rhode Island	2,600	55.4	3.0
South Carolina	4,400	19.8	3.2
South Dakota	2,800	51.8	4.2
Tennessee	15,700	34.1	5.6
Texas [2]	[1]17,000	50.9	17.2
Utah	1,900	40.3	3.3
Vermont	2,600	62.5	6.6
Virgin Islands	7	1.7	.5
Virginia	3,500	31.3	1.3
Washington	16,900	62.9	6.5
West Virginia	2,900	23.5	1.9
Wisconsin	8,800	49.8	2.2
Wyoming	1,400	60.7	5.8

[1] Excludes Guam; data not reported.
[2] March data for California; January data for New York City; December data for Texas.
[3] Estimated.

TABLE 11.—*Expenditures from public assistance funds for assistance payments and for State and local administration, services, and training, by source of funds, calendar year 1966*

[Includes vendor payments for medical care]

State	Federally aided public assistance programs and general assistance				Federally aided public assistance programs			
	Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution		
		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds
Total	$7,068,090	55.1	32.0	12.9	$6,652,052	58.6	30.7	10.8
Alabama	124,737	76.3	23.6	.1	124,710	76.3	23.6	.1
Alaska	5,651	49.2	50.8	----	4,649	59.8	40.2	----
Arizona	32,694	70.5	29.2	.2	30,736	75.0	24.8	.2
Arkansas	74,501	76.6	23.4	----	74,042	77.1	22.9	----
California	1,438,674	49.2	32.1	18.7	1,416,142	50.0	32.6	17.1
Colorado	103,010	53.5	37.1	9.4	100,197	55.0	37.8	7.2
Connecticut	86,122	46.4	49.9	3.7	79,798	50.1	49.9	----
Delaware	9,272	58.3	28.0	13.7	8,111	66.6	24.9	8.4
District of Columbia	24,767	58.1	41.9	----	23,360	61.6	38.4	----
Florida	122,282	75.1	22.5	2.4	119,378	76.9	23.1	----
Georgia	125,000	76.5	18.9	4.6	123,979	77.2	19.0	3.8
Guam	390	44.4	55.6	----	377	45.9	54.1	----
Hawaii	20,097	48.3	51.7	----	18,546	52.3	47.7	----
Idaho	16,692	69.0	29.0	2.0	16,676	69.0	29.0	2.0
Illinois	352,246	49.3	46.6	4.1	307,357	56.5	43.5	----
Indiana	58,534	59.6	24.1	16.3	58,534	59.6	24.1	16.3
Iowa	72,415	54.7	29.7	15.6	66,962	59.1	32.0	8.9
Kansas	67,195	53.6	23.1	23.3	62,596	57.6	21.1	21.4
Kentucky	104,762	75.5	24.0	.6	104,161	75.9	24.1	----
Louisiana	202,263	72.7	27.3	----	197,278	74.5	25.5	----
Maine	27,537	64.4	26.9	8.7	24,488	72.4	24.2	3.4
Maryland	87,528	53.5	39.4	7.1	78,902	59.3	34.4	6.3
Massachusetts	261,522	47.1	32.1	20.8	250,000	49.3	32.6	18.1
Michigan	244,007	48.5	38.8	12.7	209,326	56.6	38.9	4.6
Minnesota	146,679	54.3	17.7	28.0	132,324	60.2	19.3	20.5
Mississippi	63,793	78.8	20.5	.7	63,547	79.1	20.6	.3
Missouri	164,146	65.1	34.7	.2	155,728	68.6	31.3	.1
Montana	18,590	47.7	15.0	37.3	13,449	65.9	19.7	14.4
Nebraska	34,264	63.7	27.0	9.3	34,127	63.9	27.1	8.9
Nevada	9,634	50.4	27.9	21.6	8,169	59.5	32.9	7.6

See footnote at end of table p. 104.

TABLE 11.—*Expenditures from public assistance funds for assistance payments and for State and local administration, services, and training by source of funds, calendar year 1966*—Continued

[Includes vendor payments for medical care]

State	Federally aided public assistance programs and general assistance				Federally aided public assistance programs			
	Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution		
		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds
New Hampshire	$13,237	46.9	31.5	21.6	$12,317	50.4	33.9	15.7
New Jersey	147,295	43.8	26.2	30.0	129,771	49.7	24.8	25.4
New Mexico	32,437	69.9	30.1	----------	32,084	70.6	29.4	----------
New York	965,754	41.1	29.8	29.1	874,274	45.4	27.6	27.0
North Carolina	110,668	72.4	13.9	13.7	108,727	73.7	14.2	12.2
North Dakota	20,203	64.5	26.2	9.4	19,606	66.4	26.9	6.7
Ohio	250,908	48.4	47.1	4.5	209,334	58.0	39.5	2.5
Oklahoma	195,725	69.7	30.0	.3	194,879	70.0	30.0	----------
Oregon	53,887	53.6	34.7	11.7	48.516	59.6	30.0	10.4
Pennyslvania	324,381	52.3	44.7	3.1	295,042	57.5	39.2	3.4
Puerto Rico	45,624	50.9	49.1	----------	45,367	51.2	48.8	----------
Rhode Island	37,821	50.6	49.4	(1)	34,093	56.1	43.9	----------
South Carolina	35,591	75.6	23.3	1.1	34,892	77.1	22.2	.6
South Dakota	17,246	63.0	28.0	9.0	15,794	68.8	30.6	.6
Tennessee	86,362	75.4	19.7	4.9	85,796	75.9	19.8	4.2
Texas	261,142	74.3	24.5	1.2	258,086	75.2	24.8	(1)
Utah	26,985	66.2	33.8	.1	26,282	67.9	32.0	.1
Vermont	11,466	67.3	22.4	10.3	11,098	69.6	22.8	7.7
Virgin Islands	1,248	40.8	29.2	----------	1,106	46.1	53.9	----------
Virginia	45,112	68.5	15.8	15.7	42,356	73.0	13.6	13.4
Washington	114,102	53.0	47.0	----------	104,546	57.9	42.1	----------
West Virginia	57,467	74.1	24.7	1.2	56,128	75.9	24.1	----------
Wisconsin	107,018	50.2	25.9	23.9	97,941	54.9	27.8	17.3
Wyoming	7,404	50.8	22.6	26.5	6,365	59.1	15.9	25.0

[1] Less than 0.05 percent.

TABLE 12.—*Expenditures for assistance payments: Amount and percentage distribution by program and source of funds, calendar year 1966* [1]

[Includes vendor payments for medical care]

State	Old-age assistance				Aid to the blind				Aid to the permanently and totally disabled				Aid to families with dependent children			
	Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution		
		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds
Total	$1,907,897	67.5	28.6	3.8	$90,331	56.7	36.9	6.4	$565,697	58.3	33.4	8.3	$1,923,945	56.3	31.0	12.7
Alabama	95,505	77.1	22.9	(2)	1,546	75.0	25.0	(2)	9,132	78.6	21.3	.1	10,818	83.2	16.6	.1
Alaska [3]	1,512	61.7	38.3	------	108	67.2	32.8	------	412	46.2	53.8	------	2,007	62.3	37.7	------
Arizona	10,170	77.9	22.1	------	656	75.9	24.1	------	3,542	73.3	26.7	------	14,177	77.1	22.9	------
Arkansas [3]	49,753	79.7	20.3	------	1,727	73.3	26.7	------	9,612	70.1	29.9	------	7,130	83.1	16.9	------
California	342,253	49.9	43.0	7.1	19,683	43.7	42.5	13.8	118,506	46.0	46.4	7.6	344,100	48.2	34.5	17.3
Colorado	47,485	55.8	44.2	------	253	54.2	25.9	20.0	75,34	51.7	28.6	19.8	22,320	57.2	22.8	20.0
Connecticut	5,492	64.1	35.9	------	350	50.0	50.0	------	7,381	61.8	38.2	------	33,043	42.9	57.1	------
Delaware	1,365	68.4	31.6	------	343	58.4	41.6	------	565	59.1	40.9	------	4,564	70.0	15.0	15.0
District of Columbia	2,322	65.1	34.9	------	183	64.7	35.3	------	3,600	59.6	40.4	------	9,094	66.6	33.4	------
Florida [3]	62,405	78.1	21.9	------	2,165	75.5	24.5	------	16,491	74.9	25.1	------	23,995	83.3	16.7	------
Georgia [3]	66,525	80.1	16.7	3.2	2,360	77.3	19.3	3.5	20,962	76.5	20.1	3.4	24,142	78.6	17.5	3.9
Guam	100	42.7	57.3	------	2	47.7	52.3	------	24	42.5	57.5	------	176	46.4	53.6	------
Hawaii [3]	1,313	66.1	33.9	------	71	54.5	45.5	------	1,326	50.8	49.2	------	7,596	53.1	46.9	------
Idaho	3,213	73.2	26.8	------	98	72.8	27.0	.2	2,073	74.0	25.1	.8	4,866	66.1	33.9	------
Illinois [3]	29,481	76.4	23.6	------	1,758	62.2	37.8	------	26,078	59.0	41.0	------	120,802	55.1	44.9	------
Indiana	24,012	59.9	24.1	16.0	1,967	51.2	48.8	------	3,355	35.4	38.8	25.8	19,321	67.2	19.7	13.1
Iowa	29,552	63.8	36.2	------	1,347	49.3	25.4	25.4	1,913	51.0	24.5	24.5	21,906	55.6	22.2	22.2
Kansas [3]	21,732	65.4	15.1	19.5	562	59.4	21.0	19.5	7,898	49.6	30.9	19.5	19,194	52.3	22.2	25.4
Kentucky [3]	42,281	81.3	18.7	------	2,149	67.7	32.3	------	11,076	65.5	34.5	------	27,382	77.1	22.9	------
Louisiana	120,810	75.3	24.7	------	2,454	72.4	27.6	------	14,000	76.4	23.6	------	31,144	77.6	22.4	------
Maine [3]	9,089	75.9	24.1	------	232	67.2	32.8	------	2,246	65.3	34.7	------	7,090	75.8	12.6	11.6
Maryland [3]	8,593	67.2	20.9	11.9	348	63.7	23.9	12.4	8,505	61.1	26.5	12.5	39,057	61.6	35.2	3.1
Massachusetts	55,247	58.7	29.1	12.1	3,845	35.5	64.5	------	22,630	35.8	39.2	25.0	64,207	43.4	33.3	23.3
Michigan	39,739	63.2	33.8	3.0	1,655	55.2	40.6	4.2	18,254	49.0	35.3	15.8	67,823	60.1	38.6	1.3
Minnesota	20,377	74.9	16.8	8.4	796	65.1	17.6	17.3	4,626	68.5	15.9	15.6	29,874	48.1	26.1	25.8
Mississippi	36,070	82.6	17.4	------	1,394	79.7	20.3	------	11,107	80.2	19.8	------	8,404	83.3	16.7	------
Missouri	88,515	68.8	31.2	------	3,401	61.0	39.0	------	14,868	63.9	36.1	------	33,359	73.5	26.5	------
Montana	3,855	72.1	18.0	9.9	190	70.9	22.0	7.0	1,219	73.1	11.7	15.2	3,642	63.8	27.2	8.9
Nebraska [3]	8,734	71.7	21.6	6.7	511	57.8	35.5	6.7	3,123	56.6	36.5	6.9	7,031	70.9	27.4	1.6
Nevada	2,372	65.2	34.8	------	203	46.6	53.4	------					2,234	67.2	32.8	------

See footnotes at end of table, p. 108.

TABLE 12.—*Expenditures for assistance payments: Amount and percentage distribution by program and source of funds, calendar year 1966* [1]—Continued

[Includes vendor payments for medical care]

State	Old-age assistance				Aid to the blind				Aid to the permanently and totally disabled				Aid to families with dependent children			
	Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution		
		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds
New Hampshire	$5,876	51.6	21.4	27.0	$352	42.7	57.3	------	$999	41.6	23.4	35.0	$2,890	46.8	53.2	------
New Jersey	13,615	66.6	25.1	8.4	1,003	54.0	23.0	23.0	11,324	47.4	26.3	26.3	70,111	44.9	27.5	27.5
New Mexico [3]	9,411	77.1	22.9	------	384	67.9	32.1	------	4,758	66.0	34.0	------	12,930	70.2	29.8	------
New York	62,274	62.7	18.9	18.4	3,888	50.2	25.1	24.8	44,628	49.3	26.3	24.4	365,567	42.9	28.8	28.4
North Carolina	32,628	78.0	12.4	9.6	4,128	74.5	12.8	12.8	22,568	69.2	15.4	15.4	34,494	77.5	12.5	9.9
North Dakota [3]	3,975	72.7	24.6	2.8	76	62.1	37.9	------	1,469	65.2	30.6	4.2	4,129	63.3	30.0	6.8
Ohio	79,182	56.0	42.7	1.3	3,051	55.5	43.1	1.4	19,342	55.0	43.6	1.4	75,365	6.32	32.1	4.7
Oklahoma [3]	73,894	73.9	26.1	------	1,994	53.6	46.4	------	18,833	59.4	40.6	------	32,104	7.20	28.0	------
Oregon	10,478	67.4	22.8	9.8	602	51.0	34.3	14.7	7,253	61.9	26.6	11.4	17,805	55.7	31.0	13.3
Pennsylvania	37,196	67.3	32.7	------	[4] 12,302	47.0	53.0	------	18,395	62.0	38.0	------	100,829	66.2	33.8	------
Puerto Rico [3]	2,777	47.1	52.9	------	131	46.7	53.3	------	2,029	46.7	53.3	------	9,253	45.9	54.1	------
Rhode Island	4,878	62.6	37.4	------	113	60.5	39.5	------	3,095	61.5	38.5	------	12,267	52.7	47.3	------
South Carolina	16,262	80.8	19.2	------	1,473	75.6	24.4	------	6,332	77.0	23.0	------	4,949	83.3	16.7	------
South Dakota	6,642	71.7	28.3	------	100	72.0	28.0	------	1,180	67.5	32.5	------	5,042	69.4	30.6	------
Tennessee	34,931	79.0	16.8	4.2	1,498	75.8	19.4	4.8	11,258	75.9	19.3	4.8	25,861	77.7	17.8	4.5
Texas	204,044	76.0	24.0	------	3,761	73.9	26.1	------	8,294	74.9	25.1	------	28,454	78.3	21.7	------
Utah	3,390	76.1	23.9	------	130	71.8	28.2	------	3,364	71.5	28.5	------	9,833	66.1	33.9	------
Vermont	4,577	70.2	23.1	6.8	99	73.7	24.5	1.7	1,222	71.8	24.3	3.9	2,056	74.0	18.3	7.7
Virgin Islands	209	42.6	57.4	------	4	44.5	55.5	------	23	40.5	59.5	------	319	39.9	60.1	------
Virginia	11,090	77.5	14.0	8.5	1,022	73.4	16.7	10.0	6,224	73.5	16.4	10.1	15,424	76.5	13.9	9.6
Washington	24,484	67.3	32.7	------	595	60.8	39.2	------	10,720	69.2	30.8	------	28,088	55.4	44.6	------
West Virginia	8,000	80.9	19.1	------	467	78.2	21.8	------	3,429	79.0	21.0	------	31,147	77.9	22.1	------
Wisconsin	25,767	54.8	28.6	16.6	741	55.0	23.7	21.3	6,135	47.9	24.4	27.8	22,548	52.0	28.6	19.4
Wyoming	2,445	64.1	12.1	23.8	59	52.3	37.5	10.2	764	58.1	14.0	27.8	1,984	55.4	19.5	25.1

State	Medical assistance [8]				Medical assistance for the aged [8]				General assistance		
	Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution	
		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds		State funds	Local funds
Total	$1, 193, 768	49. 5	33. 0	17. 5	$295, 135	52. 2	33. 9	13. 8	$336, 361	53. 5	46. 7
Alabama					614	78. 0	22. 0		12	98. 3	1. 7
Alaska [3]									990	100. 0	
Arizona					3	60. 7	39. 3		1, 578	100. 0	
Arkansas [3]					1, 802	79. 0	21. 0		[7] 428	100. 0	
California	419, 538	50. 0	27. 4	22. 6	22, 230	50. 0	21. 9	28. 1	17, 427		100. 0
Colorado					14, 375	48. 8	51. 2		2, 448		100. 0
Connecticut	15, 588	49. 8	50. 2		9, 398	49. 0	51. 0		6, 324	50. 0	50. 0
Delaware	37	60. 9	39. 1		191	50. 0	50. 0		940	50. 0	50. 0
District of Columbia					3, 304	50. 0	50. 0		862	100. 0	
Florida [3]					2, 715	62. 4	37. 6		[8] 2, 904		100. 0
Georgia [3]									955		100. 0
Guam					22	50. 0	50. 0		13	100. 0	
Hawaii [3]	6, 532	[9] 48. 2	51. 8						1, 171	100. 0	
Idaho	2, 656	70. 7	24. 6	4. 7	2, 418	68. 2	24. 6	7. 2	[10] 6		100. 0
Illinois [3]	83, 312	[9] 49. 9	50. 1						[7] 32, 350	67. 7	32. 3
Indiana					2, 803	50. 1	30. 0	20. 0	(11)	(11)	(11)
Iowa					5, 829	56. 9	43. 1		[10] 4, 717		100. 0
Kansas [3]					6, 781	54. 9	22. 6	22. 6	4, 049	50. 0	50. 0
Kentucky [3]	10, 087	80. 9	19. 1		2, 720	73. 6	26. 4		601		100. 0
Louisiana	12, 860	76. 4	23. 6		646	74. 2	25. 8		4, 275	100. 0	
Maine [3]	2, 855	69. 6	30. 4		802	66. 1	33. 9		[7] 2, 913	45. 8	54. 2
Maryland [3]	10, 859	[4] 46. 1	46. 1	7. 9	3, 848	50. 0	50. 0		7, 849	85. 4	14. 6
Massachusetts	34, 779	50. 0	33. 4	16. 6	48, 569	49. 2	33. 8	16. 9	9, 406	23. 0	77. 0
Michigan	19, 530	50. 3	49. 7		44, 071	50. 0	40. 0	10. 0	[7] 26, 115	35. 3	64. 7
Minnesota	67, 159	60. 5	20. 0	19. 6					12, 052	2. 4	97. 6
Mississippi									246		100. 0
Missouri									8, 077	98. 2	1. 8
Montana					2, 974	59. 8	20. 7	19. 6	4, 924		100. 0
Nebraska [3]	7, 828	61. 8	18. 2	20. 0	3, 681	52. 4	32. 9	14. 7	(11)	(11)	(11)
Nevada					2, 252	47. 3	25. 1	27. 5	1, 465		100. 0
New Hampshire					1, 148	54. 9	45. 1		920		100. 0
New Jersey					19, 265	49. 8	30. 1	20. 1	14, 388	43. 5	56. 5
New Mexico [3]	670	70. 7	29. 3		233	68. 4	31. 6		271	100. 0	
New York	237, 162	[9] 34. 6	32. 7	32. 7	48, 855	49. 8	25. 1	25. 1	67, 502	50. 7	49. 3
North Carolina					3, 459	73. 3	13. 4	13. 4	1, 829		100. 0
North Dakota [3]	7, 863	66. 7	28. 5	4. 8					445	2. 5	97. 5
Ohio	12, 900	52. 3	47. 7						36, 175	85. 5	14. 5
Oklahoma [3]	57, 802	70. 3	29. 7						846	28. 9	71. 1
Oregon					4, 890	50. 0	35. 0	15. 0	4, 139	70. 0	30. 0
Pennsylvania	96, 620	[9] 46. 4	43. 7	9. 9					24, 826	100. 0	

See footnotes at end of table, p. 108.

TABLE 12.—*Expenditures for assistance payments: Amount and percentage distribution by program and source of funds, calendar year 1966* [1]—Continued

State	Medical assistance [5]				Medical assistance for the aged [6]				General assistance		
	Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution			Total (in thousands)	Percentage distribution	
		Federal funds	State funds	Local funds		Federal funds	State funds	Local funds		State funds	Local funds
Puerto Rico [3]	$24,169	55.0	45.0						$191	100.0	
Rhode Island	4,612	56.1	43.9		$5,707	50.3	49.7		3,132	100.0	(2)
South Carolina					1,938	79.3	20.7		578	71.6	28.4
South Dakota					1,408	67.2	32.8		1,452		100.0
Tennessee					4,265	74.1	20.7	5.2	566		100.0
Texas									[8] 3,055		100.0
Utah	4,133	[9] 66.1	33.9		1,756	61.9	38.1		558	100.0	
Vermont	2,066	68.4	15.3	16.3	208	62.7	37.3		[8] 368	10.0	90.0
Virgin Islands	276	55.0	45.0		13	46.3	53.7		94	100.0	
Virginia					2,693	64.2	21.5	14.3	2,204	46.0	54.0
Washington	20,526	[9] 47.0	53.0		9,107	50.0	50.0		[7] 8,186	100.0	
West Virginia	4,572	74.3	25.7		1,989	70.9	29.1		[7] 1,167	39.8	60.2
Wisconsin	26,778	57.6	25.2	17.2	5,857	52.5	47.5		7,544	6.2	93.8
Wyoming					299	50.0	50.0		829	76.3	23.7

[1] Not comparable with amount of Federal grants to the States.
[2] Less than 0.05 percent.
[3] Data for all or part of period were included in a total reported for the aged, blind, and disabled under provisions of title XVI. For purposes of this release these data are distributed to CAA, AB, and APTD on an estimated basis.
[4] Excludes State blind pension program administered under State law without Federal participation.
[5] Program initiated January 1966 under Public Law 89–97.
[6] Program initiated on October 1960 under the Social Security Amendments of 1960.
[7] Includes expenditures for medical care program administered by public assistance agency and financed from funds other than those for the federally aided public assistance programs and general assistance.
[8] Estimated.
[9] Percentage is less than the Federal medical assistance percentage, because total vendor medical payments include payments for persons not eligible for Federal funds.
[10] Incomplete.
[11] Data not available.

CHILD WELFARE SERVICES AMENDMENTS

Item	Prior law	Public Law 90–248
I. Inclusion of child welfare services in title IV.	Authorizes under pt. 3 of title V of the Social Security Act, $55,000,000 for fiscal year 1968, $55,000,000 for fiscal year 1969, and $60,000,000 for fiscal year 1970 and later years for formula grants to the States to support the provision of child welfare services. Also authorizes such sums as Congress may appropriate to support research, training, and demonstration projects in the child welfare field. "Child welfare services" are defined as public social services which supplement, or substitute for, parental care and supervision for the purpose of (1) preventing or remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children, (2) protecting and caring for homeless, dependent, or neglected children, (3) protecting and promoting the welfare of children of working mothers, and (4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible or, where needed, the provision of adequate care of children away from their homes in foster family homes or day-care or other child-care facilities.	Moves provisions to new pt. B of title IV of the Social Security Act and authorizes $100,000,000 for fiscal year 1969, and $110,000,000 for fiscal year 1970 and later years for formula grants to the States. Modifies research training, and demonstration projects provisions, to make possible dissemination of research and demonstration findings into program activity through multiple demonstrations on a regional basis and to encourage State and local agencies administering pubiic child welfare services programs to develop and staff new and innovative services and to provide contract authority to make it possible to direct research into neglected and vital areas.
	Includes standards for day care furnished through child welfare program as follows: State must provide— (1) for cooperative arrangements with State public health agency and public education agency to assure maximum utilization of the services of such agencies for children receiving day care; (2) for an advisory committee to advise State welfare agency on policies in providing day care; (3) for necessary safeguards to protect interest of child and mother, and for payment for day care services based on ability of family to pay; (4) for giving priority to low-income groups; and (5) that day care will be provided only in licensed or approved facilities and homes.	Extends same standards to day care provided under AFDC program. Requires that a plan for day-care services provide for more effective involvement of the parent or parents in the appropriate care of the child and the improvement of the health and development of the child.

DATA ON CHILD WELFARE SERVICES—Continued

TABLE 1.—*Children served by public and voluntary child welfare agencies and institutions: Number and percentage distribution by living arrangement, Mar. 31, 1966*

Living arrangement	Children served [1]					
	Total		Primarily by public agencies		Primarily by voluntary agencies	
	Number	Percentage distribution	Number	Percentage distribution	Number	Percentage distribution
U.S. estimated total	741,400	100	519,400	100	222,000	100
In homes of parents or relatives or in independent living arrangements	327,600	44	270,200	53	57,400	26
In adoptive homes	71,600	10	36,000	7	35,600	16
In foster family homes	218,100	30	171,500	34	46,600	21
In group homes	1,800	[2]	900	[2]	900	[2]
In institutions [3]	105,000	14	27,400	5	77,600	35
In temporary shelters	3,500	1	1,900	[2]	1,600	1
Elsewhere	8,000	1	5,900	1	2,100	1
Living arrangements not reported [4]	5,800	----------	5,600	----------	200	----------

[1] A child is counted only once in this table, according to his living arrangements on Mar. 31 and the auspices of the agency responsible for primary service.

[2] Less than 0.5 percent.

[3] Includes both groups of institutions shown in table 2.

[4] These are children for whom an agency makes a payment only or exercises legal custody only.

TABLE 2.—*Expenditures of State and local public welfare agencies for child welfare services: Amount and percentage distribution by purpose of expenditure, by State, fiscal year ended June 30, 1966* [1]

State	Amount						Percentage distribution				
	Total	Foster care payments	Provision of day care [2]	Personnel	Educational leave	Other	Foster care payments	Provision of day care	Personnel	Educational leave	Other
U.S. estimated total	$396,200,000	$252,300,000	$12,100,000	$108,900,000	$3,500,000	$19,400,000	63.7	3.0	27.5	0.9	4.9
Alabama	2,707,297	1,165,267	141,216	1,171,352	26,850	202,612	43.0	5.2	43.3	1.0	7.5
Alaska	859,531	683,800	2,990	161,093	4,690	6,958	79.6	.4	18.7	.5	.8
Arizona	1,972,938	1,118,536	74,296	722,812	9,687	47,607	56.7	3.8	36.6	.5	2.4
Arkansas [3]	1,173,054	570,249	89,407	432,977	38,625	41,796	48.6	7.6	36.9	3.3	3.6
California	41,710,714	[4] 25,255,129	316,773	13,524,550	76,959	2,537,303	60.5	.8	32.4	.2	6.1
Colorado	3,957,915	[4] 2,483,050	25,923	1,255,212	46,242	147,488	62.7	.7	31.7	1.2	3.7
Connecticut	10,105,384	8,444,562	----------	1,436,006	4,208	220,608	83.6	--------	14.2	(5)	2.2
Delaware	1,081,170	615,251	7,335	382,013	12,016	64,555	56.9	.7	35.3	1.1	6.0
District of Columbia	4,499,713	2,441,630	122,118	1,735,290	----------	200,675	54.3	2.7	38.6	--------	4.4
Florida	4,408,055	[4] 2,436,967	199,837	1,419,033	21,000	331,218	55.3	4.5	32.2	.5	7.5
Georgia	4,960,071	[4] 2,354,546	1,751	2,108,055	74,007	421,712	47.5	(5)	42.5	1.5	8.5
Guam	181,100	28,474	----------	27,838	10,400	114,388	15.7	--------	15.4	5.7	63.2
Hawaii	1,163,696	[4] 554,245	4,681	528,499	7,526	68,745	47.6	.4	45.4	.7	5.9
Idaho	537,327	191,498	----------	303,585	11,169	31,075	35.6	--------	56.5	2.1	5.8
Illinois	15,042,522	8,018,201	303,747	5,040,591	289,118	1,390,865	53.3	2.0	33.5	1.9	9.3
Indiana	7,599,014	5,298,134	33,008	2,105,150	24,954	137,768	69.7	.5	27.7	.3	1.8
Iowa	2,103,337	1,024,027	109,873	922,872	17,200	29,365	48.7	5.2	43.9	.8	1.4
Kansas	2,436,718	1,223,579	56,205	996,687	7,114	153,133	50.2	2.3	40.9	.3	6.3
Kentucky	3,687,344	1,213,172	85,257	1,828,470	68,067	492,378	32.9	2.3	49.6	1.8	13.4
Louisiana	6,338,815	[4] 4,058,367	236,485	1,640,589	76,971	326,403	64.0	3.7	25.9	1.2	5.2
Maine	2,980,658	2,043,756	----------	726,748	54,064	156,090	68.6	--------	24.4	1.8	5.2
Maryland	12,435,022	7,284,366	85,286	4,376,356	52,089	636,925	58.6	.7	35.2	.4	5.1
Massachusetts	11,530,504	8,213,226	----------	2,529,696	182,836	604,746	71.2	--------	21.9	1.6	5.3
Michigan	4,687,082	[4] 1,604,268	428,882	2,222,396	36,279	395,257	34.2	9.2	47.4	.8	8.4
Minnesota	12,039,493	6,835,904	91,438	3,919,339	136,672	1,056,140	56.8	.8	32.5	1.1	8.8

See footnotes at end of table, p. 112

TABLE 2.—*Expenditures of State and local public welfare agencies for child welfare services: Amount and percentage distribution by purpose of expenditure, by State, fiscal year ended June 30 1966* [1]—Continued

State	Amount						Percentage distribution				
	Total	Foster care payments	Provision of day care [2]	Personnel	Educational leave	Other	Foster care payments	Provision of day care	Personnel	Educational leave	Other
Mississippi	$1,819,501	[4] $461,597	$66,131	$938,041	$84,195	$269,537	25.4	3.6	51.6	4.6	14.8
Missouri	3,755,321	1,571,695	138,080	1,707,720	129,705	208,121	41.8	3.7	45.5	3.5	5.5
Montana	843,151	384,313	----------	351,816	29,015	78,007	45.6	--------	41.7	3.4	9.3
Nebraska	646,525	258,046	31,875	320,247	11,315	25,042	39.9	4.9	49.5	1.8	3.9
New Hampshire	1,282,328	[6] 825,609	----------	367,571	2,219	86,929	64.4	--------	28.6	.2	6.8
New Jersey	11,175,372	7,452,562	88,971	3,281,463	54,598	297,778	66.7	.8	29.3	.5	2.7
New Mexico	1,466,675	758,906	37,125	494,248	6,719	169,677	51.7	2.5	33.7	.5	11.6
New York	103,163,928	79,626,903	7,419,917	12,707,891	506,824	2,902,393	77.2	7.2	12.3	.5	2.8
North Dakota	1,478,103	655,128	3,868	673,749	19,185	126,173	44.3	.3	45.6	1.3	8.5
Ohio	20,363,789	[4] 11,870,052	531,533	6,550,464	231,379	1,180,361	58.3	2.6	32.2	1.1	5.8
Oklahoma	2,204,657	587,358	66,149	1,234,465	72,431	244,254	26.6	3.0	56.0	3.3	11.1
Oregon	4,695,852	2,974,647	779	1,334,666	56,695	329,065	63.4	[5]	28.4	1.2	7.0
Pennsylvania	26,705,210	19,843,602	736,013	5,149,989	306,716	668,890	74.3	2.8	19.3	1.1	2.5
Puerto Rico	2,290,915	[4] 703,578	110,337	1,337,906	39,047	100,047	30.7	4.8	58.4	1.7	4.4
Rhode Island	1,586,261	862,173	5,916	638,830	11,505	67,837	54.3	.4	40.3	.7	4.3
South Carolina	1,436,384	[4] 736,300	----------	653,728	----------	46,356	51.3	--------	45.5	--------	3.2
South Dakota	1,287,900	[4] 758,600	3,200	408,400	26,300	91,400	58.9	.3	31.7	2.0	7.1
Tennessee	2,989,513	882,523	20,250	1,740,924	62,552	283,264	29.5	.7	58.2	2.1	9.5
Texas	4,320,761	[6] 1,229,692	768	2,547,369	82,370	460,562	28.5	[5]	58.9	1.9	10.7
Utah	1,270,539	[4] 614,178	80,069	560,818	15,293	54,181	48.3	6.3	39.9	1.2	4.3
Vermont	1,368,649	[4] 873,586	----------	393,794	9,752	91,517	63.8	--------	28.8	.7	6.7
Virgin Islands	300,616	90,644	16,375	144,998	4,000	44,599	30.2	5.5	48.2	1.3	14.8
Virginia	7,934,995	4,419,683	37,245	3,025,252	15,000	437,815	55.7	.5	38.1	.2	5.5
Washington	7,861,838	4,536,108	33,540	2,882,681	65,097	344,412	57.7	.4	36.7	.8	4.4
West Virginia	3,409,115	1,942,162	846	1,241,668	34,388	190,051	57.0	[5]	36.4	1.0	5.6
Wisconsin	14,135,800	[4] 8,623,500	80,200	4,456,500	268,700	706,900	61.0	.6	31.5	1.9	5.0
Wyoming	462,411	200,226	637	235,295	16,258	9,995	43.3	.1	50.9	3.5	2.2

[1] Includes expenditures for day care services. State data not shown for Nevada and North Carolina, which submitted incomplete reports. Estimated expenditures for these States have been included in the U.S. estimates.

[2] "Provision of day care" covers expenditures for the establishment and operation of day care centers, and payments for family or group day care. Additional day care funds are also included in the amounts listed under "Personnel," "Educational leave," and "Other."

[3] Partly estimated.

[4] This amount is not comparable with that of the previous year because of a change in reporting procedure.

[5] Less than 0.05 percent.

[6] Includes contributions and payments from relatives, private organizations, and other sources.

TABLE 3.—*Expenditures of State and local public welfare agencies for child welfare services: Total and per capita expenditures, by source of funds, by State, fiscal year ended June 30, 1966* [1]

State	Federal, State, and local funds		State and local funds only	
	Total	Per capita [2]	Total	Per capita [2]
U.S. estimated total	$396,200,000	$4.87	$356,500,000	$4.38
Alabama	2,707,297	1.77	1,753,927	1.15
Alaska	859,531	6.61	743,010	5.72
Arizona	1,972,938	2.72	1,544,037	2.13
Arkansas	1,173,054	1.43	592,143	.72
California	41,710,714	5.52	39,087,498	5.17
Colorado	3,957,915	4.76	3,547,901	4.27
Connecticut	10,105,384	8.97	9,729,047	8.63
Delaware	1,081,170	4.96	951,297	4.36
District of Columbia	4,499,713	14.85	4,335,569	14.31
Florida	4,408,055	1.92	3,199,063	1.39
Georgia	4,960,071	2.57	3,935,263	2.04
Guam	181,100	4.32	89,426	2.13
Hawaii	1,163,696	3.65	950,689	2.98
Idaho	537,327	1.76	319,071	1.05
Illinois	15,042,522	3.52	13,302,896	3.11
Indiana	7,599,014	3.70	6,725,780	3.27
Iowa	2,103,337	1.88	1,457,877	1.30
Kansas	2,436,718	2.69	1,979,452	2.19
Kentucky	3,687,344	2.76	2,841,048	2.13
Louisiana	6,338,815	3.87	5,305,852	3.24
Maine	2,980,658	7.38	2,730,237	6.76
Maryland	12,435,022	8.20	11,856,566	7.82
Massachusetts	11,530,504	5.52	10,670,707	5.11
Michigan	4,687,082	1.30	2,977,036	.83
Minnesota	12,039,493	7.86	11,239,182	7.34

See footnotes at end of table, p. 114.

TABLE 3.—*Expenditures of State and local public welfare agencies for child welfare services: Total and per capita expenditures, by source of funds, by State, fiscal year ended June 30, 1966* [1]—Continued

State	Federal, State, and local funds		State and local funds only	
	Total	Per capita [2]	Total	Per capita [2]
Mississippi	$1,819,501	$1.70	$1,064,849	$0.99
Missouri	3,755,321	2.14	2,905,539	1.65
Montana	843,151	2.76	642,363	2.11
Nebraska	646,525	1.08	313,049	.53
New Hampshire	1,282,328	4.71	1,107,858	4.07
New Jersey	11,175,372	4.21	10,137,933	3.82
New Mexico	1,466,675	2.93	1,132,556	2.27
New York	103,163,928	15.08	100,760,877	14.73
North Dakota	1,478,103	5.19	1,268,468	4.45
Ohio	20,363,789	4.77	18,400,678	4.31
Oklahoma	2,204,657	2.29	1,601,753	1.67
Oregon	4,695,852	6.06	4,424,068	5.71
Pennsylvania	26,705,210	6.00	24,768,235	5.56
Puerto Rico	2,290,915	1.68	1,407,210	1.03
Rhode Island	1,586,261	4.64	1,362,160	3.98
South Carolina	1,436,384	1.23	707,909	.61
South Dakota	1,287,900	4.32	1,037,200	3.48
Tennessee	2,989,513	1.88	1,982,527	1.25
Texas	4,320,761	.94	2,346,792	.51
Utah	1,270,539	2.65	952,717	1.98
Vermont	1,368,649	8.10	1,228,655	7.27
Virgin Islands	300,616	12.53	229,650	9.57
Virginia	7,934,995	4.26	7,022,940	3.77
Washington	7,861,838	6.51	7,332,156	6.06
West Virginia	3,409,115	4.63	3,098,366	4.21
Wisconsin	14,135,800	8.06	13,302,200	7.58
Wyoming	462,411	3.26	328,487	2.31

[1] Includes expenditures for day care services. For scope and limitations of data, see table 31.
[2] Per capita expenditures based on child population under 21 years of age.

CHILD HEALTH AMENDMENTS

Item	Prior law	Public Law 90–248
I. Consolidation of separate programs	Provides 2 formula grant programs, 1 for maternal and child health services and another for crippled children's services. Funds authorized at $55,000,000 for fiscal year 1968 and 1969 and $60,000,000 for fiscal year 1970 and later years for each program are allocated to the States based, in part, on the proportionate share of live births of each State in the case of maternal and child health services, and the proportionate share of numbers of crippled children in the case of the crippled children's program. Also authorizes $10,000,000 for fiscal year 1968 and $17,500,000 for each later year for grants by the Secretary for training of professional personnel for health and care of crippled children (particularly mentally retarded children and children with multiple handicaps). Authorizes $30,000,000 for 1968 for special project grants for maternity and infant care. Authorizes $40,000,000 for fiscal year 1968, $45,000,000 for fiscal year 1969, and $50,000,000 for fiscal year 1970, for grants to State and local health agencies to promote health of school and preschool children. Authorizes not more than $8,000,000 each year for research projects in the field of maternal and child health and crippled children's services.	Present provisions are repealed. Provides new title V of the act (without child welfare provisions, which are moved to title IV under another provision, discussed above). New title provides for the following: Authorizes $250,000,000 for fiscal year 1969, $275,000,000 for fiscal year 1970, $300,000,000 for fiscal year 1971, $325,000,000 for fiscal year 1972 and $350,000,000 for fiscal year 1973 and later years. Fifty percent of the appropriation for fiscal years 1969 through 1972 shall be for allotments to the States for maternal and child health and crippled children's services. Forty percent shall be grants for special project grants for maternity and infant care, special project grants for health of school and preschool children, and special project grants for dental health of children. Ten percent for each such year shall be for grants for training of professional health personnel and for research projects related to maternal and child health services and crippled children's services. One-half of 1 percent of the total appropriation can be used by the Secretary for evaluation (directly or through contracts or grants) of the programs. Effective with fiscal year 1973 and for later years 90 percent of the appropriation shall be for maternal and child health services and crippled children's services, and 10 percent shall be for grants and contracts for training of professional health personnel and research in the fields of maternal and child health services and crippled children's services. The Secretary is authorized to transfer up to 5 percent of the appropriation for any year from one purpose to another purpose or purposes. The proportion of funds for family planning services shall not be less than 6 percent in any year.

TABLE 1.—*Mothers and children receiving selected direct maternal and child health services, by type of service, fiscal year 1967*

State or other area	Selected maternity services			Selected child health services		
	Medical clinic services		Number service (number of mothers)	Well child conference service		Nursing service (number of infants and other children)
	Number of mothers	Rate per 1,000 live births [1]		Number of infants	Number of other children	
Total	366,373	132	480,479	603,661	1,028,455	2,930,497
United States [2]	222,366	81	435,797	562,203	923,440	2,764,112
Alabama	22,333	325	14,795	9,530	49,642	47,189
Alaska			1,559			6,450
Arizona	5,216	157	6,463	5,889	6,289	19,456
Arkansas	2,095	59	3,150	2,426	2,812	27,360
California	23,436	68	32,632	89,754	71,116	152,322
Colorado [3]	975	28	2,245	2,251	7,071	25,128
Connecticut			100	394	1,783	489
Delaware	1,227	117	2,074	2,440	3,699	4,223
District of Columbia	7,923	455	4,686	13,310	27,688	
Florida	16,631	158	25,505	20,167	29,218	193,435
Georgia	16,861	184	32,224	34,237	54,204	88,360
Guam	1,583	598	1,583	1,668	3,953	5,966
Hawaii	484	31	3,002	3,199	8,984	20,337
Idaho			2,330	1,546	5,001	28,923
Illinois [3]	76	(4)	6,336	3,352	4,048	38,309
Indiana	5,993	62	5,490	3,075	8,485	25,872
Iowa	657	13	960	1,582	2,990	11,924
Kansas			2,035	966	2,258	32,327
Kentucky	7,731	129	12,564	4,982	24,853	46,009
Louisiana	5,223	66	8,543	11,428	8,159	86,497
Maine			606	3,676	8,159	5,208
Maryland	14,996	208	10,016	10,397	50,869	118,808
Massachusetts			7,561	19,243	40,041	106,864
Michigan	1,200	7	12,952	11,501	18,818	111,437
Minnesota	977	14	3,886	4,361	8,071	34,281
Mississippi	8,444	166	16,381	4,371	9,179	98,711
Missouri	6,320	79	11,406	37,265	46,737	48,834
Montana			1,395	697	2,334	42,375
Nebraska			674	719	1,776	11,373
Nevada	324	34	694	914	678	2,999

New Hampshire			106	260	676	391
New Jersey	95	(4)		64, 994	126, 390	
New Mexico	1, 017	44	1, 843	3, 106	5, 930	
New York [2]	5, 283	16	45, 143	23, 019	30, 321	74, 453
North Carolina	17, 659	188	21, 812	12, 833	16, 546	112, 244
North Dakota			307			7, 520
Ohio	1, 140	6	13, 287	25, 109	49, 481	141, 891
Oklahoma	471	11	2, 358	1, 442	1, 745	20, 147
Oregon			1, 474	1, 079	2, 063	16, 862
Pennsylvania	5, 365	27	8, 100	36, 652	80, 627	92, 093
Puerto Rico	141, 044	1, 916	41, 531	37, 845	99, 627	155, 829
Rhode Island			9, 087	1, 594	2, 973	14, 633
South Carolina	6, 938	133	32, 737	4, 088	5, 108	441, 268
South Dakota			166	62	311	5, 166
Tennessee	372	5	6, 862	3, 620	6, 283	64, 885
Texas	13, 303	63	17, 891	23, 827	19, 681	82, 534
Utah	444	20	1, 579	2, 080	3, 561	33, 388
Vermont			335	256	2, 202	6, 990
Virgin Islands	1, 380	706	1, 658	1, 945	1, 435	4, 590
Virginia	18, 411	213	11, 031	27, 794	13, 641	27, 646
Washington	1, 657	32	12, 901	14, 829	35, 478	37, 516
West Virginia	1, 089	35	3, 196	2, 501	6, 027	31, 844
Wisconsin			12, 921	9, 386	9, 319	113, 290
Wyoming			307		115	3, 851

[1] Live birth data are 1966 for areas other than United States; and the rate for all jurisdictions and United States excludes New York State, Colorado, and Illinois because of incomplete reporting.

[2] United States (50 States and District of Columbia).

[3] Copied from "Welfare in Review Statistical Supplement," 1966 edition.

[4] Less than 1 per thousand.

TABLE 2.—*Federal grants-in-aid to States for maternal and child health and crippled children's services, fiscal year ended June 30, 1967*

[Checks-issued basis]

State	Grants for maternal and child health services [1]	Grants for crippled children's services [2]	State	Grants for maternal and child health services [1]	Grants for crippled children's services [2]
United States	$47,652,429	$46,664,174	Montana	$192,718	$307,379
			Nebraska	239,500	368,895
Alabama	1,338,787	1,163,477	Nevada	230,000	233,000
Alaska	191,761	158,169			
Arizona	570,456	360,227	New Hampshire	205,202	202,576
Arkansas	719,500	691,739	New Jersey	748,827	501,772
California	3,154,879	2,953,647	New Mexico	551,804	349,037
			New York	2,174,952	2,216,058
Colorado	756,268	516,125	North Carolina	1,874,402	1,739,747
Connecticut	658,680	460,866			
Delaware	169,534	227,230	North Dakota	262,091	230,173
District of Columbia	418,356	735,856	Ohio	2,113,148	1,625,784
Florida	1,710,473	1,290,325	Oklahoma	573,015	650,142
			Oregon	481,152	457,674
Georgia	1,617,493	1,343,713	Pennsylvania	2,167,714	2,622,432
Guam	101,399	67,348			
Hawaii	246,388	378,024	Puerto Rico	1,504,461	1,212,059
Idaho	198,873	350,554	Rhode Island	615,735	264,650
Illinois	1,174,071	1,544,893	South Carolina	1,035,633	991,153
			South Dakota	99,161	140,966
Indiana	735,000	610,959	Tennessee	1,189,451	1,333,505
Iowa	481,830	1,147,096			
Kansas	398,463	679,190	Texas	1,999,151	2,075,577
Kentucky	1,206,694	1,092,155	Utah	419,174	274,503
Louisiana	1,209,293	1,082,857	Vermont	177,114	167,058
			Virgin Islands	140,900	137,558
Maine	339,496	311,206	Virginia	1,269,219	1,355,116
Maryland	1,162,085	1,217,479			
Massachusetts	1,210,824	771,751	Washington	827,920	668,871
Michigan	1,631,655	1,582,859	West Virginia	658,222	575,844
Minnesota	963,337	1,129,666	Wisconsin	683,636	989,826
			Wyoming	148,429	54,500
Mississippi	1,112,031	815,030			
Missouri	953,305	924,511	Institution of higher learning	638,767	1,311,367

[1] Services under title V, pt. 1, of the Social Security Act. Includes $4,750,000 earmarked for special projects for mentally retarded children.

[2] Services under title V, pt. 2, of the Social Security Act. Includes $3,750,000 earmarked for special projects for mentally retarded children.