COMMITTEE ON FINANCE
UNITED STATES SENATE
Harry Flood Byrd, *Chairman*

BRIEF SUMMARY OF MAJOR PROVISIONS OF AND DETAILED COMPARISON SHOWING CHANGES MADE IN EXISTING LAW BY H.R. 6675 AS REPORTED BY THE COMMITTEE ON FINANCE

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BRIEF SUMMARY OF H.R. 6675, THE SOCIAL SECURITY AMENDMENTS OF 1965

A. Health Insurance and Medical Care

The bill provides three programs for health insurance and medical care for the aged under the Social Security Act by establishing—

1. A *basic hospital insurance plan* providing inpatient services, related posthospital care (skilled nursing home and home health visits), and outpatient diagnostic services for individuals 65 or older who are eligible for social security benefits. These benefits would be financed through a separate payroll tax and separate trust fund. Similar benefits would be provided for railroad retirement eligibles through their system, if certain financing conditions are met.

Also, benefits would be provided to currently aged people who are not social security or railroad retirement beneficiaries. They would be financed from general revenues.

Effective date.—Benefits would be first effective on July 1, 1966, except for services in extended care facilities which would be effective on January 1, 1967. (See pp. 16, 17.)

2. *A voluntary "supplementary" plan*, providing physicians' and other medical and health services financed through monthly premiums of $3 initially by individuals 65 years or older (which would be deducted from the social security benefit of beneficiaries who elect participation), matched equally by Federal Government revenue contributions.

Effective date.—Benefits would be first effective beginning January 1, 1967. (See pp. 18, 19.)

3. *An expanded Kerr-Mills medical care program*, for the needy and medically needy would, at the option of State, combine all the vendor medical provisions for the aged, blind, disabled, and families with dependent children, now in five titles of the Social Security Act, under a uniform program (with an increase in the Federal share matching formula) in a single new title with certain prescribed Federal standards.

Effective date.—Matching under new title (XIX) will be available January 1, 1966. (See pp. 19–21, 22–29.)

B. Child Health and Welfare Amendments

1. *Maternal and child health, crippled children, and child welfare authorization.*—The amount authorized for the maternal and child health and crippled children's programs over current authorizations would be increased by $5 million for fiscal 1966 and by $10 million in each succeeding fiscal year as follows:

Fiscal year	Existing law	Under bill
1966	$40,000,000	$45,000,000
1967	40,000,000	50,000,000
1968	45,000,000	55,000,000
1969	45,000,000	55,000,000
1970 and after	50,000,000	60,000,000

(See pp. 37, 38.)

A provision has been added to bring authorizations for child welfare services in line with those for the other two programs. (See p. 39.)

2. *Crippled children training personnel.*—Grants are provided to institutions of higher learning for training professional personnel for health and related care for crippled children, particularly children who are mentally retarded or have multiple handicaps. Authorizes $5 million for fiscal 1967, $10 million for fiscal 1968, and $17.5 million for each succeeding fiscal year. (See p. 38.)

3. *Health care for needy children.*—The Secretary of Health, Education, and Welfare is authorized to carry out a 5-year program of special project grants to provide comprehensive health care and services for preschool or school-age children, particularly in areas with concentrations of low-income families. An appropriation of $15 million is authorized for fiscal 1966; $35 million for fiscal 1967, and an additional $5 million for each succeeding year rising to $50 million for fiscal 1970. Also, an additional $5 million is authorized for fiscal years 1968, 1969, and 1970 to cover the cost of special grants for children who are or are in danger of becoming emotionally disturbed. An authorization of $500,000 for fiscal 1966 and 1967 is made for grants for studies as to prevention, diagnosis, and treatment of emotionally disturbed children. (See p. 41.)

4. *Mental retardation planning.*—Grants totaling $2,750,000 for each of 2 fiscal years (1966 and 1967) are authorized for the purpose of assisting States to implement and follow up on planning for treatment of mental retardation authorized under section 1701 of the Social Security Act. (See p. 42.)

C. Public Assistance

1. *Increased assistance payments.*—The Federal share of payments under all State public assistance programs is increased a little more than an average of $2.50 a month for the needy aged, blind and disabled and an average of about $1.25 for needy children, effective January 1, 1966. This is brought about by revising the matching formula for the needy aged, blind, and disabled (and for the adult categories in title XVI) to provide a Federal share of $31 out of the first $37 (now twenty-nine thirty-fifths of the first $35) with matching above this amount varying according to State per capita income up to a maximum of $75 (now $70) per month per individual on an average basis. The bill revises matching formula for aid to families with dependent children so as to provide a Federal share of five-sixths of the first $18 (now fourteen-seventeenths of the first $17) with matching above this amount varying according to State per capita income up to a maximum of $32 (now $30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients. (See pp. 30, 31.)

2. *Tubercular and mental patients.*—The exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) is removed as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. As a condition of Federal participation in such payments to, or for, mental patients it is required that certain agreements and arrangements assure that better care results from the additional Federal money. States will receive no more in Federal funds under this provision than they increase their expenditures for mental health purposes under public health and public welfare programs. Also restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions are removed. Effective January 1, 1966. (See pp. 33, 34.)

3. *Protective payments.*—A provision is added for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined title XVI program), recipients of aid to the blind, and recipients of aid to the permanently and totally disabled unable to manage their money because of physical or mental incapacity. Effective January 1, 1966. (See p. 35.)

4. *Aid to families with dependent children in school.*—The optional provision of the States to continue making payments to dependent children who have

attained age 18 but continue in school up to age 21 is extended. The provision in present law allowing such payments for children in regular attendance at a high school or vocational school is extended to include attendance at a college or university. (See p. 36.)

5. *Income exemptions under public assistance.*—The following income exemptions would be provided:

(*a*) *Old-age assistance*

The earnings exemption under the old-age assistance program (and aged in combined program) is increased so that a State may, at its option, exempt the first $20 (now $10) and one-half of the next $60 (now $40) of a recipient's monthly earnings. (See p. 32.)

(*b*) *Aid to families with dependent children*

At their option, States are allowed to disregard up to $50 per month of earned income of any three dependent children under the age of 18 in the same home. (See p. 33.)

(*c*) *Aid to the permanently and totally disabled*

States, at their option, can exempt earnings of recipients of aid to the permanently and totally disabled. As in the case of the aged, the first $20 per month of earnings and one-half of the next $60 could be exempted. In addition, any additional income and resources could be exempted as part of an approved plan to achieve self-support during the time the recipient was undergoing vocational rehabilitation. (See p. 33.)

(*d*) *Old-age and survivors insurance (retroactive increase)*

States would be allowed to disregard so much of the OASDI benefit increase (including the children in school after 18 modification) as is attributable to its retroactive effective date. (See p. 33.)

(*e*) *Economic Opportunity Act earning exemption*

A grace period is provided for action by States that have not had regular legislative sessions, whose public assistance statutes now prevent them from disregarding earnings of recipients received under titles I and II of the Economic Opportunity Act. (See p. 35.)

(*f*) *Income exempt under another assistance program*

A provision is added stipulating that any amount of income which is disregarded in determining eligibility for a person under one of the public assistance programs shall not be considered in determining the eligibility of another individual under any other public assistance program. (See p. 35.)

6. *Definition of medical assistance for aged.*—The definition of medical assistance for the aged is modified so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution. (See p. 35.)

7. *Judicial review of State plan denials.*—The bill provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans and of his action under such programs or noncompliance with State plan conditions in the Federal law. (See pp. 35, 36.)

D. Old-Age, Survivors, and Disability Insurance

1. BENEFIT CHANGES

(*a*) *7-percent across-the-board increase in old-age, survivors, and disability insurance benefits*

A 7-percent across-the-board benefit increase is provided, effective retroactively beginning with benefits for January 1965, for the 20 million social security beneficiaries on the rolls (with a guaranteed $4 a month minimum increase for retired workers who are age 65 or over in the first month for which they are paid the increased benefit).

Monthly benefits for workers who retire at or after 65 would be increased to a new minimum of $44 (now $40) and to a new maximum of $135.90

(now $127). In the future, creditable earnings under the increase in the contribution and benefit base to $6,600 a year (now $4,800) would make possible a maximum benefit of $168.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly earnings at all earnings levels. Under present law, there is a $254 limit on family benefits which operates over a wide range of average monthly earnings. Under the bill the highest family maximum would be $368. (See p. 57.)

(*b*) *Payment of child's insurance benefits to children attending school or college after attainment of age 18 and up to age 22*

A provision adopted by both House and Senate last year is included which would continue to pay a child's insurance benefit until the child reaches age 22, provided the child is attending a public or an accredited school, including a vocational school or a college, as a full-time student after he reaches age 18. Children of deceased, retired, or disabled workers would be included. No mother's or wife's benefits would be payable if the only child in the mother's care is one who has attained age 18 but is in school.

This provision will be retroactively effective to January 1, 1965. It is estimated that 295,000 children will be eligible for benefits for September 1965, when the school year begins. (See p. 53.)

(*c*) *Benefits for widows at age 60*

An option to widows of receiving benefits beginning at age 60, is provided with the benefits payable to those who claim them before age 62 being actuarially reduced to take account of the longer period over which they will be paid. Under present law, full widow's benefits and actuarially reduced worker's and wife's benefits are payable at age 62.

This provision, adopted by both Houses of Congress last year, would be effective for the second month after the month of enactment. It is estimated that 185,000 widows will claim benefits during the first year of operation under this provision. (See p. 52.)

(*d*) *Amendment of disability program*

(*i*) *Definition of disability.*—The present requirement that a worker's disability must be expected to be of long continued and indefinite duration would be eliminated and instead the bill provides that an insured worker would be eligible for disability benefits if he has been under a disability which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 calendar months. Benefits payable by reason of this change would be paid for the second month following the month of enactment. An estimated 60,000 persons—disabled workers and their dependents—will become immediately eligible for benefits as a result of this change. (See p. 51.)

(*ii*) *Disability benefits offset provision.*—The social security disability benefit for any month for which a worker is receiving a workmen's compensation benefit will be 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 prior to the onset of disability, but with the reduction periodically adjusted to take account of changes in national average earnings levels. The offset provision will be applicable with respect to benefits payable for months after December 1965 based on applications filed after December 1965. (See p. 52.)

(*iii*) *Benefits for children disabled before reaching age 22.*—A child who is disabled before reaching age 22 (rather than before age 18 as in present law) would be eligible for disabled child's benefits should his parent die, become disabled or retire. The mother of the child would also be eligible for benefits so long as she continued to have the child in her care. Effective as to benefits for the second month following the month of enactment, an estimated 20,000 persons—disabled children and their mothers—will become immediately eligible for benefits as a result of this change. (See p. 53.)

(*iv*) *Facilitating disability determinations.*—The Secretary is authorized to make determinations of disability or cessation of disability where medical and other information supplied or designated by the individual, or evidence of remunerative work activities, indicate clearly that the individual is under a disability or that the disability has ceased. (See p. 51.)

(*v*) *Rehabilitation services.*—State vocational rehabilitation agencies will be reimbursed from the social security trust funds for the cost of rehabilitation services furnished to individuals who are entitled to disability insurance benefits or to a disabled child's benefits. The total amount of the funds that could be made available from the trust funds for purposes of reimbursing State agencies for such services could not, in any year, exceed 1 percent of the social security disability benefits paid in the previous year. (See p. 51.)

(*vi*) *Entitlement to disability benefits after entitlement to benefits payable on account of age.*—A person who becomes entitled before age 65 to a benefit payable on account of old age could later, before he reaches age 65, become entitled to disability insurance benefits. (See p. 51.)

(*vii*) *Allocation of contribution income between OASI and DI trust funds.*—An additional 0.2 percent of taxable wages and 0.15 percent of taxable self-employment income would be allocated to the disability insurance trust fund, bringing the total allocation to 0.70 percent and 0.525 percent, respectively, beginning in 1966. (See p. 60.)

(*e*) *Benefits to certain persons at age 72 or over*

Eligibility requirements would be liberalized by providing a basic benefit of $35 at age 72 or over to certain persons with a minimum of three quarters of coverage acquired at any time since the beginning of the program in 1937. To accomplish this, a new concept of "transitional insured status" is provided. Present law requires a minimum of six quarters of coverage in employment or self-employment. These provisions were approved by the House and Senate last year.

They would become effective for the second month after the month of enactment, at which time an estimated 355,000 people would be able to start receiving benefits. (See p. 50.)

(*f*) *Retirement test*

The retirement test provision in present law is liberalized. Under existing law, the first $1,200 a year is fully exempted, and there is a $1 reduction in benefits for each $2 of annual earnings between $1,200 and $1,700 and of $1 for each $1 of earnings thereafter. Under the bill, the first $1,800 a year would be fully exempted and there would be a $1 reduction in benefits for each $2 of earnings between $1,800 and $3,000 and of $1 for each $1 of earnings thereafter. In addition, the amount of earnings a beneficiary may have in a month and get full benefits for that month regardless of his annual earnings would be raised from $100 to $150. These changes are effective for taxable years ending after 1965.

Certain royalties received in or after the year in which a person reaches age 65, from copyright and patents obtained before age 65, are exempted from being counted as earnings for purposes of the retirement test, effective for taxable years beginning after 1964.

For 1966, an estimated 850,000 persons—workers and dependents—either will receive more benefits under these provisions than they would receive under present law, or will receive some benefits where they would receive no benefits under present law. (See p. 60.)

(*g*) *Wife's and widow's benefits for divorced women*

Payments of wife's or widow's benefits are authorized to the divorced wife of a retired, deceased, or disabled worker if she had been married to the worker for at least 20 years before the date of the divorce and if her divorced husband was making (or was obligated by a court to make) a substantial contribution to her support when he became entitled to benefits, became disabled, or died. H.R. 6675 would also provide that a wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect

for 20 years. Provision is also made for the reestablishment of benefit rights for a divorced wife, a widow, or a surviving divorced wife who remarries and the subsequent marriage ends in divorce, annulment, or in the death of the husband. (See p. 54.)

(*h*) *Continuation of widow's and widower's insurance benefits after remarriage*

Under present law, a widow's and widower's benefits based on a deceased worker's social security earnings record generally stop when the survivor remarries, with the result that some widows who would like to remarry do not do so because if they did they would lose their social security benefits. The bill provides that benefits would be payable to widows age 60 or over and to widowers age 62 or over who remarry. The amount of the remarried widow's or widower's benefit would be equal to 50 percent of the primary insurance amount of the deceased spouse rather than 82½ percent of that amount, which is payable to widows and widowers who are not remarried. (See p. 54.)

(*i*) *Adoption of child by retired worker*

The provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries are changed to require that, where the child is adopted after the worker becomes entitled to an old-age benefit, (1) the child must be living with the worker (or adoption proceedings have begun) in or before the month when application for old-age benefits is filed; (2) the child must be receiving one-half of his support for the entire year before the worker's entitlement; and (3) the adoption must be completed within 2 years after the worker's entitlement. (See p. 54.)

(*j*) *Definition of child*

A child would be paid benefits based on his father's earnings without regard to whether he has the status of a child under State inheritance laws if the father was supporting the child or had a legal obligation to do so. Under present law, whether a child meets the definition for the purpose of getting child's insurance benefits based on his father's earnings depends on the laws applied in determining the devolution of intestate personal property in the State in which the worker is domiciled. It is estimated that 20,000 individuals (children and their mothers) will become immediately eligible for benefits under this provision. (See p. 54.)

2. COVERAGE CHANGES

The following coverage provisions were included:

(*a*) *Physicians and interns*

Self-employed physicians would be covered for taxable years ending on or after December 31, 1965. Interns would be covered beginning on January 1, 1966. (See p. 43.)

(*b*) *Farmers*

Provisions of existing law with respect to the coverage of farmers would be amended to provide that farm operators whose annual gross earnings are $2,400 or less (instead of $1,800 or less as in existing law) can report either their actual net earnings or 66⅔ percent (as in present law) of their gross earnings. Farmers whose annual gross earnings are over $2,400 would report their actual net earnings if over $1,600, but if actual net earnings are less than $1,600, they may instead report $1,600. (Present law provides that farmers whose annual gross earnings are over $1,800 report their actual net earnings if over $1,200, but if actual net earnings are less than $1,200, they may report $1,200.) (See pp. 43, 44.)

(*c*) *Cash tips*

Cash tips received by a worker would be covered as self-employment income. Effective as to taxable years beginning after December 31, 1965. (See p. 45.)

(*d*) *State and local government employees*

Several changes would facilitate social security coverage of additional employees of State and local governments. (See pp. 45–47.)

(*e*) *Exemption of certain religious sects*

Members of certain religious sects who have conscientious objections to insurance (including social security) by reason of their adherence to the established tenets or teachings of such sects could be exempt from the social security tax on self-employment income upon application accompanied by a waiver of benefit rights. (See p. 43.)

(*f*) *Nonprofit organizations*

Nonprofit organizations, and their employees who concur, could elect social security coverage effective retroactively for a period up to 5 years (rather than 1 year, as under present law). Also, wage credit could be given for the earnings of certain employees of nonprofit organizations who were erroneously reported for social security purposes. (See pp. 47, 48.)

(*g*) *District of Columbia employees*

The bill provides for social security coverage of certain employees of the District of Columbia (primarily substitute schoolteachers). (See p. 48.)

(*h*) *Ministers*

Social security credit could be obtained for the earnings of certain ministers which were reported but which cannot be credited under present law. (See p. 43.)

3. MISCELLANEOUS

(*a*) *Filing of proof*

The period of filing of proof of support for dependent husband's, widower's, and parent's benefits, and for filing application for lump-sum death payments where good cause exists for failure to file within the initial 2-year period, is extended indefinitely. (See p. 55.)

(*b*) *Automatic recomputation of benefits*

The benefits of people on the rolls would be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year and that would increase his benefit amount. Under existing law there are various requirements that must be met in order to have benefits recomputed, including filing of an application and earnings of over $1,200 a year after entitlement. (See p. 56.)

(*c*) *Military wage credits*

The present provision authorizing reimbursement of the trust funds out of general revenue for gratuitous social security wage credits for servicemen is revised so that such payments will be spread uniformly over the next 50 years. (See p. 60.)

(*d*) *Extension of life of applications*

The bill liberalizes the requirement in existing law that an application for monthly insurance benefits be valid for only 3 months after the date of filing, and for disability benefits 3 months before the beginning of the waiting period. The bill would allow an application to remain valid up until the time the Secretary makes a final decision on the application. (See p. 51.)

(*e*) *Overpayments and underpayments*

Changes in the provisions of law relating to overpayments and underpayments would be made to facilitate the recovery of overpayments and to provide specific authority, lacking in present law, for the Secretary to settle all underpayments of benefits. (See p. 61.)

(*f*) *Authorization for one spouse to cash a joint check*

The Secretary would be authorized to make a temporary overpayment so as to permit a surviving spouse to cash a benefit check issued jointly to a

husband and wife if one of them dies before the check is negotiated; any overpayment resulting from the cashing of the joint check would be recovered. (See p. 61.)

(g) *Attorney's fees*

The bill incorporates a provision which would permit a court that renders a judgment favorable to a claimant in an action arising under the social security program to set a reasonable fee (not in excess of 25 percent of past due benefits which become payable by reason of the judgment) for an attorney who successfully represented the claimant. The Secretary would be permitted to certify payment of the fee to the attorney out of such past due benefits. (See p. 61.)

(h) *Tax on certain corporations*

The bill provides that when an employee works for a corporation which is a member of an affiliated group of corporations and is then transferred to another corporation which is a member of such group, the total employer social security tax payable by the two corporations for the years in which the employee is transferred will not exceed the amount that would be paid by a single corporation. (Under present law, such treatment is provided for the employee.) (See p. 61.)

(i) *Waiver of 1-year marriage requirement*

The bill provides an exception to the 1-year duration requirement as to social security benefits for any widow, wife, husband, or widower who was, in the month before marriage, actually or potentially entitled to railroad retirement benefits as a widow, widower, parent, or disabled adult child. (See p. 54.)

E. Miscellaneous Provisions

1. OPTOMETRISTS

The bill provides that as to all titles of Social Security Act that whenever payment is authorized for services which an optometrist is licensed to perform, the beneficiary shall have the freedom to obtain the services of either a physician skilled in diseases of the eye or an optometrist, whichever he may select.

2. ADDITIONAL UNDER SECRETARY AND ASSISTANT SECRETARIES OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The bill authorizes an additional Under Secretary and two new Assistant Secretaries of the Department of Health, Education, and Welfare.

F. Scope, Benefit Payments, Costs and Financing

1. HEALTH INSURANCE AND MEDICAL CARE FOR THE NEEDY

The scope of the protection provided is broadly as follows:

(a) *Basic plan.*—It is estimated that approximately 17 million insured individuals and 2 million uninsured would qualify on July 1, 1966.

(b) *Voluntary supplementary plan.*—It is estimated that of the total eligible aged of 19 million, from 80 to 95 percent would participate, which would mean approximately 15.2 to 18 million individuals would be involved.

(c) *Medical assistance for needy.*—The expanded medical assistance (Kerr-Mills) program is estimated to provide new or increased medical assistance to about 8 million needy persons during an early year of operation. States could, in the future, provide aid to as many as twice this number who need help with medical costs.

The costs and financing are as follows:

(a) *Basic plan.*—Benefits and administrative expenses under the basic plan would be about $1.1 billion for the 6-month period in 1966 and about $2.4 billion in 1967. Contribution income for those years would be about $1.5 and $2.8 billion, respectively. The costs for the uninsured (paid from general funds) would be about $285 million per year for early years.

The level-premium (long-range) cost of the hospital insurance program is 1.31 percent of payroll broken down as follows:

	Percent
Hospital and extended care facility benefits	1.26
Posthospital home health	.04
Outpatient diagnostic	.01
	1.31

Separate payroll taxes to finance the basic plan, paid by employers, employees, and self-employed persons, would be earmarked in a separate Hospital Insurance Trust Fund established in the Treasury. The same contribution rate would apply equally to employers, employees, and self-employed persons and would be as follows:

	Percent		Percent
1966	0.325	1976–79	0.65
1967–70	.50	1980–86	.75
1971–72	.55	1987 and after	.85
1973–75	.60		

The taxable earnings base for the hospital insurance tax would be $6,600 a year for 1966 and thereafter. The level-equivalent of the contribution schedule is 1.32. percent of payroll.

Estimated progress of Hospital Insurance Trust Fund

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
1966	$1,548	$1,055	[1] $55	$15	$453
1967	2,766	2,358	71	15	805
1968	3,025	2,574	77	29	1,208
1969	3,120	2,807	84	41	1,478
1970	3,225	3,060	92	48	1,599
1971	3,609	3,293	99	53	1,869
1972	3,776	3,535	106	60	2,064
1973	4,251	3,788	114	68	2,481
1974	4,474	4,053	122	80	2,860
1975	4,655	4,330	130	88	3,143
1980	6,569	5,680	170	153	5,479
1985	7,540	7,341	220	252	8,188
1990	9,595	9,414	282	310	10,098

[1] Including administrative expenses incurred in 1965.

NOTE.—The transactions relating to the noninsured persons who would be covered for the benefits of this program, the cost for whom is borne out of the general funds of the Treasury, are not shown in the above figures. The figures in this table are based on the assumption that railroad workers will be covered directly by this program. (See following table for data on the basis that the Railroad Retirement Board will administer their benefits.)

If the Railroad Retirement Board administers the benefits for railroad workers the results are shown on the following table:

Estimated financial results if railroad workers and annuitants receive hospital and related benefits through railroad retirement account

[In millions]

Calendar year	Contributions [1]	Benefit payments and administrative expenses [1 2]	Financial interchange payment [2 3]
1966	$29	$39	$10
1967	48	84	36
1968	50	90	40
1969	50	94	44
1970	50	99	49
1971	54	103	49
1972	55	106	51
1973	59	109	50
1974	60	113	53
1975	60	115	55
1980	74	116	42
1985	75	116	41
1990	85	114	29

[1] Amounts involved in the financial interchange transactions.
[2] Based on the assumption that all dual eligibles elect to receive benefits from the railroad retirement system.
[3] Payments from the hospital insurance trust fund to the railroad retirement account (shown on an accrual basis).

The estimated cost to the general fund of the Treasury for the hospital and related benefits for the noninsured group is as follows for the first 5 calendar years of operation:

[In millions]

Calendar year:	Cost to general treasury
1966 (last 6 months)	$145
1967	285
1968	280
1969	270
1970	265

The cost to the general fund of the Treasury decreases slowly for the closed group involved. Offsetting, in large part, the decline in the number of eligibles blanketed in is the increasing hospital utilization per capita as the average age of the group rises and the increasing hospitalization costs in future years.

(b) *Voluntary supplementary plan.*—Costs of the voluntary supplementary plan would depend on how many of the aged enrolled.

If 80 percent of the eligible aged enrolled, benefit costs (and administrative expenses) of the supplementary plan would be about $665 to $800 million in 1967. Premium income from enrollees for 1967 would be about $555 million. The matching Government contribution would equal the premiums.

If 95 percent of the eligible aged enrolled, benefit costs (and administrative expenses) of the supplementary plan would be about $790 to $945 million in 1967. Premium income from enrollees for 1967 would be about $660 million. The Government contribution would equal the premiums.

Estimated progress of supplementary health insurance benefits trust fund

Calendar year	Contributions		Benefit payments	Administrative expenses [1]	Interest on fund	Balance in fund at end of year
	Participants	Government				
	Low-cost estimate, 80-percent participation					
1967	$555	$555	$590	$75	$10	$455
1968	565	565	830	80	20	695
	Low-cost estimate, 95-percent participation					
1967	$660	$660	$700	$90	$10	$540
1968	670	670	985	95	25	825
	High-cost estimate, 80-percent participation					
1967	$555	$555	$705	$95	$5	$315
1968	565	565	1,000	100	15	360
	High-cost estimate, 95-percent participation					
1967	$660	$660	$835	$110	$10	$385
1968	670	670	1,190	115	15	435

[1] Administrative expenses shown include both those for the full year 1967 and such expenses as incurred in 1965 and 1966.

NOTE.—Not included above is the advance appropriation from general revenues that is to provide a contingency reserve during 1967–68 (to be used only if needed and to be repayable).

(c) *Kerr-Mills medical assistance plan extension.*—It is estimated that the new program will increase the Federal Government's general revenue contribution about $200 million in a full year of operation over that in the programs operated under existing law.

2. Old-age, survivors and disability insurance

The following table shows the costs in dollars in 1966, the percent of payroll costs over the long run, and the number of persons immediately affected under the bill:

Provision	1966 cost	Percent of payroll (long-range)	Persons affected
7-percent benefit increase ($4 minimum in primary benefit)	$1,470,000,000	0.64	20,000,000
Child's benefit to age 22 if in school	195,000,000	.12	295,000
Reduced age for widows	165,000,000	.00	185,000
Reduction in eligibility requirement for certain persons aged 72 or over	140,000,000	.01	355,000
Liberalization of disability definition	40,000,000	.01	60,000
Earnings test liberalization	590,000,000	.28	850,000
Broader definition of child	20,000,000	.01	40,000

The following tables show the effect of the bill on the trust funds:

Progress of old-age and survivors insurance trust fund under system as modified by committee-approved bill, intermediate-cost estimate at 3.50 percent interest [1]

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [2]	Interest on fund	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
	Estimated data (short-range estimate)					
1965	$16,014	$16,987	$351	$436	$571	$17,936
1966	18,834	18,824	377	445	540	17,664
1967	20,450	19,874	363	532	556	17,901
1968	21,264	20,771	369	483	583	18,125
1969	25,164	21,666	377	499	660	21,407
1970	26,676	22,568	385	487	817	25,460
1971	27,522	23,483	393	457	991	29,640
1972	28,414	24,406	401	455	1,171	33,963
	Estimated data (long-range estimate)					
1975	$29,144	$25,144	$390	$319	$1,192	$39,485
1980	31,456	29,179	431	135	1,873	59,260
1990	36,002	37,145	510	−21	2,632	80,723
2000	41,759	41,571	559	−77	3,144	96,999
2025	51,816	63,179	769	−107	3,766	111,683

[1] An interest rate of 3.50 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, which is equivalent to such fixed rate.

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

[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.

Progress of disability insurance trust fund under system as modified by committee-approved bill, intermediate-cost estimate at 3.50-percent interest [1]

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [2]	Interest on fund [1]	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	787	64	5	66	2,437
1962	1,046	1,105	66	11	68	2,388
1963	1,099	1,210	68	20	66	2,235
1964	1,154	1,309	79	19	64	2,047
	Estimated data (short-range estimate)					
1965	$1,187	$1,599	$85	$24	$51	$1,577
1966	1,820	1,730	102	25	47	1,587
1967	2,049	1,824	108	28	50	1,726
1968	2,133	1,898	112	21	55	1,883
1969	2,208	1,959	115	24	61	2,054
1970	2,283	2,014	119	26	67	2,245
1971	2,357	2,066	122	29	75	2,460
1972	2,434	2,114	125	31	84	2,708
	Estimated data (long-range estimate)					
1975	$2,249	$2,053	$100	−$3	$117	$3,704
1980	2,427	2,244	103	−11	156	4,873
1990	2,779	2,516	104	−13	264	8,139
2000	3,223	2,962	116	−13	452	13,747
2025	4,000	4,047	151	−13	897	26,850

[1] An interest rate of 3.50 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, which is equivalent to such fixed rate.

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

[3] These figures are artificially low because of the method of reimbursements between the 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.

The benefit provisions of the bill are financed by (1) an increase in the earnings base from $4,800 to $6,600 effective January 1, 1966, and (2) a revised tax rate schedule.

The tax rate schedule under existing law and the revised schedule by the bill for the OASDI program follow:

Year	Contribution rates (in percent)			
	Employer and employee, each		Self-employed	
	Present law	Bill	Present law	Bill
1965	3.625	3.625	5.4	5.4
1966–67	4.125	3.85	6.2	5.8
1968	4.625	3.85	6.9	5.8
1969–72	4.625	4.45	6.9	6.7
1973 and after	4.625	4.9	6.9	7.0

The combined tax rates for the old-age and survivors insurance program and the basic hospital program follow:

Combined tax rate on employer and employee—Old-age, survivors, and disability insurance tax and basic hospital insurance tax

Year	Combined tax rate on employer and employee			
	Old-age-survivors, and disability insurance program		Basic hospital insurance program under bill	Total combined tax rate under bill
	Under present law	Under bill		
1965	7.25	7.25	----------	7.25
1966	8.25	7.70	0.65	8.35
1967	8.25	7.70	1.00	8.70
1968	9.25	7.70	1.00	8.70
1969–70	9.25	8.90	1.00	9.90
1971–72	9.25	8.90	1.10	10.00
1973–75	9.25	9.80	1.20	11.00
1976–79	9.25	9.80	1.30	11.10
1980–86	9.25	9.80	1.50	11.30
1987 and after	9.25	9.80	1.70	11.50

3. Public assistance, child health and child welfare

The following table shows the cost of the various provisions of the bill:

[In millions of dollars]

Costs	Fiscal year 1966	Annual rate
Maternal and child health, crippled children, child welfare, and special project grants, studies	30.5	75.0
Mental retardation projects	2.75	2.75
Mental and tuberculosis	38.0	75.0
Medical assistance for the aged definition	2.0	2.0
Formula changes	75.0	150.0
Protective payments	(1)	(1)
Income exemption (old-age assistance)	0.5	1.0
Income exemption (aid to families with dependent children)	1.3	4.0
Income exemption (aid to the permanently and totally disabled)	1.0	2.5
Total	151.05	312.25

[1] No cost.

HEALTH INSURANCE AND MEDICAL CARE FOR THE AGED

A new title XVIII to the Social Security Act would be added providing two related health insurance programs for persons 65 or over:

(1) A basic plan in part A providing protection against the costs of hospital and related care; and

(2) A voluntary supplementary plan in part B providing protection against the costs of physicians' services and other medical and health services to cover certain areas not covered by the basic plan.

The basic plan would be financed through a separate payroll tax and separate trust fund. The plan would be actuarially sound under conservative cost assumptions. Benefits for persons currently over 65 who are not insured under the social security and railroad retirement systems would be financed out of Federal general revenues.

Enrollment in the supplementary plan would be voluntary and would be financed by a small monthly premium ($3 per month initially) paid by enrollees and an equal amount supplied by the Federal Government out of general revenues. The premiums for social security, railroad retirement and civil service retirement beneficiaries who voluntarily enroll would be deducted from their monthly insurance benefits. Uninsured persons desiring the supplemental plan would make the periodic premium payments to the Government.

A new title XIX would be added to the Social Security Act which would provide a more effective Kerr-Mills program for the aged and extend its provisions to additional needy persons. It would allow the States, at their option, to combine with a single uniform category the differing medical provisions for the needy which currently are found in five titles of the Social Security Act.

A description of these three programs follows:

A. BASIC PLAN—HOSPITAL INSURANCE

1. *General description.*—Basic protection, financed through a separate payroll tax, would be provided by H.R. 6675 against the costs of inpatient hospital services, posthospital extended care services, posthospital home health services, and outpatient hospital diagnostic services for social security and railroad retirement beneficiaries when they attain age 65. Benefits for railroad retirement eligibles would be financed by the railroad retirement tax out of their trust account if certain conditions are met. The same protection, financed from general revenues, would be provided under a special transitional provision for essentially all people who are now aged 65, or who will reach 65 in the near future, but who are not eligible for social security or railroad retirement benefits.

2. *Effective date.*—Benefits would first be effective on July 1, 1966, except for services in extended care facilities which would be effective on January 1, 1967.

3. *Benefits.*—The services for which payment would be made under the basic plan include—

(*a*) inpatient hospital services for up to 120 days in each spell of illness. The patient pays a deductible amount of $40 for the first 60 days plus $10 a day for any days in excess of 60 for each spell of illness; hospital services would include all those ordinarily furnished by a hospital to its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians *except* (1) services provided by interns or residents in training under approved teaching programs; and (2) services of radiologists, anesthesiologists, pathologists, and physiatrists where these services are provided under an arrangement with the hospital and are billed through the hospital.. Inpatient psychiatric hospital service would also be included, but a lifetime limitation of 210 days would be imposed.

(*b*) posthospital extended care (in a facility having an arrangement with a hospital for the timely transfer of patients and for furnishing medical information about patients) after the patient is transferred from a hospital (after at least a 3-day stay) for up to 100 days in each spell of illness, but after the first 20 days of care patients will pay $5 a day for the remaining days of extended care in a spell of illness;

(*c*) outpatient hospital diagnostic services, with the patient paying a $20 deductible amount and a 20-percent coinsurance for each diagnostic study (that is, for diagnostic services furnished to him by the same hospital during a 20-day period); and

(*d*) posthospital home health services for up to 175 visits, after discharge from a hospital (after at least a 3-day stay) or extended care facility and before the beginning of a new spell of illness. Such a person must be in the care of a physician and under a plan established by a physician within 14 days of discharge calling for such services. These services would include intermittent nursing care, therapy, and the part-time services of a home health aid. The patient must be homebound, except that when certain equipment is used, the individual could be taken to a hospital or extended care facility or rehabilitation center to receive some of these covered home health services in order to get advantage of the necessary equipment.

No service would be covered as posthospital extended care or as outpatient diagnostic or posthospital home health services if it is of a kind that could not be covered if it were furnished to a patient in a hospital.

A spell of illness would be considered to begin when the individual enters a hospital or extended care facility and to end when he has not been an inpatient of a hospital or extended care facility for 60 consecutive days.

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1968. The coinsurance amounts for long-stay hospital and extended care facility benefits would be correspondingly adjusted. For reasons of administrative simplicity, 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.

4. *Basis of reimbursement.*—Payment of bills under the basic plan would be made to the providers of service on the basis of the "reasonable cost" incurred in providing care for beneficiaries.

5. *Administration.*—Basic responsibility for administration would rest with the Secretary of Health, Education, and Welfare; however, the administration of benefits for individuals under the railroad retirement system would be transferred to the Railroad Retirement Board if certain financing conditions are met, as explained under the next heading. The Secretary would use appropriate State agencies and private organizations (nominated by providers of services) to assist in the administration of the program. Provision is made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration.

6. *Financing.*—Separate payroll taxes to finance the basic plan, paid by employers, employees, and self-employed persons, would be earmarked in a separate hospital insurance trust fund established in the Treasury. The amount of earnings (earnings base) subject to the new payroll taxes would be the same as for purposes of financing social security cash benefits. The same contribution rate would apply equally to employers, employees, and self-employed persons and would be as follows:

	Percent
1966	0.325
1967–70	.50
1971–72	.55
1973–75	.60
1976–79	.65
1980–86	.75
1987 and after	.85

The taxable earnings base for the health insurance tax would be $6,600 a year beginning in 1966.

The schedule of contribution rates is based on estimates of cost which assume that the earnings base will not be increased above $6,600.

The benefits for railroad retirement eligibles will be financed by the railroad retirement tax which is automatically increased by the operation of this bill. However, the railroad retirement wage base (now $450 a month) is not affected by this bill and is not within the jurisdiction of the Committee on Finance. Until an amendment is adopted to the Railroad Retirement Tax Act increasing their wage base to an amount equivalent to an earnings base of $6,600 per year, the benefits of railroad eligibles will be financed by the hospital insurance tax and administered by the Secretary of Health, Education, and Welfare; after the increase in wage base the benefits for railroad eligibles will be administered by the Railroad Retirement Board.

The cost of providing basic hospital and related benefits to people who are not social security or railroad retirement beneficiaries would be paid from general funds of the Treasury.

B. VOLUNTARY SUPPLEMENTARY INSURANCE PLAN

1. *General description.*—A package of benefits supplementing those provided under the basic plan would be offered to all persons 65 and over on a voluntary basis. Individuals who elect to enroll initially would pay premiums of $3 a month (deducted, where possible, from social security or railroad retirement benefits). The Government would match this premium with $3 paid from general funds. Since the minimum increase in cash social security benefits under the bill for workers retiring or who retired at age 65 or older would be $4 a month ($6 a month for man and wife receiving benefits based on the same earnings record), the benefit increases would fully cover the amount of monthly premiums.

2. *Effective date.*—Benefits will be effective beginning January 1, 1967.

3. *Enrollment.*—Persons who have reached age 65 before July 1, 1966, will have an opportunity to enroll in an enrollment period which begins April 1, 1966, and shall end on September 30, 1966.

Persons attaining age 65 subsequent to July 1, 1966, will have enrollment periods of 7 months beginning 3 months before the month of attainment of age 65.

In the future, general enrollment periods will be from October 1 to December 31, in each even-numbered year. The first such period will be October 1 to December 31, 1968.

No person may enroll more than 3 years after the close of the first enrollment period in which he could have enrolled.

There will be only one chance to reenroll for persons who are in the plan but drop out, and the reenrollment must occur within 3 years of termination of the previous enrollment.

Coverage may be terminated (1) by the individual filing notice during an enrollment period, or (2) by the Government, for nonpayment of premiums.

A State would be able to provide the supplementary insurance benefits to its public assistance recipients who are receiving cash assistance it it chooses to do so.

4. *Benefits.*—The voluntary supplementary insurance plan would cover physicians' services, chiropractic and podiatrists services, home health services, and numerous other medical and health services in and out of medical institutions.

There would be an annual deductible of $50. Then the plan would cover 80 percent of the patient's bill (above the deductible) for the following services:

(1) Physicians' and surgeons' services, whether furnished in a hospital, clinic, office, in the home, or elsewhere.

(2) Chiropractors' services.

(3) Podiatrists' services.

(4) Home health service (with no requirement of prior hospitalization) for up to 100 visits during each calendar year.

(5) Diagnostic X-ray and laboratory tests, and other diagnostic tests.

(6) X-ray, radium, and radioactive isotope therapy.

(7) Ambulance services.

(8) 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 r part of an internal body organ; braces and artificial legs, arms, eyes, etc.

There would be a special limitation on outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year would be limited, in effect, to $250 or 50 percent of the expenses, whichever is smaller.

5. *Administration by carriers: Basis for reimbursement.*—The Secretary of Health, Education, and Welfare would be required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the voluntary supplementary plan such as determining rates of payments under the program, holding and disbursing funds for benefit payments, and determining compliance and assisting in utilization review. 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 service), the cost is reasonable cost. Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. Payment by the carrier for physicians' services will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service. In determining reasonable charges, the carriers would 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.

6. *Financing.*—Aged persons who elect to enroll in the supplemental plan would pay monthly premiums of $3. Where the individual is currently receiving monthly social security, railroad retirement, or civil service retirement benefits, the premiums would be deducted from his benefits.

The Government would help finance the supplementary plan through a payment from general revenues in an equal amount of $3 a month per enrollee. To provide an operating fund, if necessary, at the beginning of the supplementary plan, and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis) equal to $18 per aged person estimated to be eligible in January 1967 when the supplementary plan goes into effect.

The individual and Government contributions would be placed in a separate trust fund for the supplementary plan. All benefit and administrative expenses under the supplementary plan would be paid from this fund.

Premium rates for enrolled persons (and the matching Government contribution) would be increased from time to time if program costs rise, but not more often than once every 2 years. The premium rate for a person who enrolls after the first period when enrollment is open to him or who reenrolls after terminating his coverage would be increased by 10 percent for each full 12 months he stayed out of the program.

C. IMPROVEMENT AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

1. *General description.*—A single and separate medical care program could, at the option of the State, be established to consolidate and expand the differing provisions for the needy which currently are found in five titles of the Social Security Act.

The new title (XIX) would extend the advantages of an expanded medical assistance program not only to the aged who are indigent but also to needy individuals in the dependent children, blind, and permanently and totally disabled programs and to persons who would qualify under those programs if in sufficient financial need.

Medical assistance under title XIX must be made available to all individuals receiving money payments under these programs and the medical care or services available to all such individuals must be equal in amount, duration, and scope. Effective July 1, 1967, all children under age 21 must be included who would, except for age, be dependent children under title IV.

Inclusion of the medically indigent aged not on the cash assistance rolls would be optional with the States but if they are included, comparable groups of blind, disabled, and parents and children must also be included if they need help in meeting necessary medical costs. Moreover, the amount and scope of benefits for the medically indigent could not be greater than that of recipients of cash assistance.

A State would have the option of continuing under the vendor medical provisions of existing law or adopting the new program.

2. *Effective date.*—January 1, 1966.

3. *Scope of medical assistance.*—Under existing law the State must provide "some institutional and noninstitutional care" under the medical assistance for the aged program. There are no minimum benefit requirements at all under the other public assistance vendor medical programs.

The bill requires that by July 1, 1967, under the new program a State must provide (1) inpatient hospital services, (2) outpatient hospital services, (3) other laboratory and X-ray services, (4) physicians' services (whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere), (5) dental services for individuals under the age of 21, and (6) skilled nursing home services for individuals 21 years of age or older in order to receive Federal participation. Coverage of other items of medical service would be optional with the States.

4. *Eligibility.*—Improvements would be effectuated in the program for the needy elderly by requiring that the States must provide a flexible income test which takes into account medical expenses and does not provide rigid income standards which deny assistance to people with large medical bills. Similarly the bill provides that no deductible, cost sharing, or similar charge may be imposed by the State as to hospitalization under its program and that any such charge on other medical services must be reasonably related to the recipient's income or resources. Also important is the requirement that elderly needy people on the State programs be provided assistance to meet the deductibles that are imposed by the new basic program of hospital insurance. Also where a portion of any deductible or cost sharing required by the voluntary supplementary program is met by a State program, the portion covered must be reasonably related to the individual's income and resources. No income can be imputed to an individual unless actually available; and the financial responsibility of an individual for an applicant may be taken into account only if the applicant is the individual's spouse or child who is under age 21 or blind or disabled.

5. *Standards as to quality of care and safety.*—It is required that the States include in their State plans descriptions of the medical staff utilized and the standards for institutions providing medical care and that the Secretary of Health, Education, and Welfare promulgate minimum standards relating to fire and other hazards for such institutions, which must be included in the State plans.

6. *Increased Federal matching.*—The Federal share of medical assistance expenditures under the new program would be determined upon a uniform formula with no maximum on the amount of expenditures which would be subject to participation. There is no maximum under present law on similar amounts for the medical assistance for the aged program. The Federal share, which varies in relation to a State's per capita income, would be increased over current medical assistance for the aged matching so that States at the national average would receive 55 percent rather than 50 percent, and States at the lowest level could receive as much as 83 percent as contrasted with 80 percent under existing law.

In order to receive any additional Federal funds as a result of expenditures under the new program, the States would need to continue their own expenditures at their present rate. For a specified period, any State that did not reduce its own expenditures would be assured of at least a 5-percent increase in Federal participation in medical care expenditures. As to compensation and training of professional medical personnel used in the administration of the program, the bill would provide a 75-percent Federal share as compared with the 50–50 Federal-State sharing for other administrative expenses.

7. *Administration.*—The bill provides that any State agency may be designated by the State to administer the program, as long as the determination of eligibility is accomplished by the agency administering the old-age assistance program.

COMPARISON SHOWING EXISTING LAW AND CHANGES MADE BY H.R. 6675

EXTENSION OF KERR-MILLS PROGRAM

Item	Existing law	H.R. 6675
1. Brief summary	Permits States to include in their plans under title I a program of Medical Assistance for the Aged (MAA); that is, to provide medical vendor payments (payments directly to the suppliers of medical services) for aged persons who are not Old-Age Assistance recipients, but but whose income and resources are insufficient to meet the costs of necessary medical services. The State plan for medical assistance for the aged may specify medical services of broad scope and duration provided that both institutional (hospitals, etc.) and noninstitutional (outpatient clinics, physicians, etc.) services are included. There is no dollar ceiling, the overall amount of Federal participation is governed by the extent of the State programs. The Federal share varies from 50 percent (for States with per capital income equal to or above the national average) up to 80 percent for lower per capita income States. (There are various formulas for vendor medical payments on behalf of persons on Old-Age Assistance (title I), Aid to the Blind (title X), Aid to Families with Dependent Children (title IV), Aid to the Permanently and Totally Disabled (title XIV) and the consolidated program for the aged, blind, and disabled (title XVI).)	Permits States to replace MAA with a new program (title XIX) designed like MAA to give vendor payment medical assistance to the aged who are medically indigent but also covers recipients of Old-Age Assistance (OAA) as well as recipients of Aid to the Blind, the Permanently and Totally Disabled, Needy Families with Dependent Children and the consolidated program for the aged, blind, and disabled. The amount, duration, and scope of benefits (except as specified) must be the same for the different categories of cash assistance recipients who receive vendor payments, under the new combined program. Inclusion of the medically indigent aged would be optional with the States but if they are included, comparable groups of blind, disabled, and parents and needy children must also be included if they need help in meeting necessary medical costs. The amount, duration, and scope of benefits for the medically indigent (except as specified) must be the same and cannot be greater than that of recipients on the basic maintenance programs. Certain changes are made in State plan requirements relating to the evaluation of income and resources for eligibility purposes, the imposition of deductibles, the payment of deductibles under the basic hospital plan or the payment of deductibles and co-insurance under the voluntary supplementary plan, and granting the States authority to impose enrollment fees or charges on individuals if they are reasonably related to the recipient's income (or his income and resources). Six specific health services must be provided under new program by June 30, 1967. The Federal Government would continue to participate in medical vendor payments in MAA and OAA and other public assistance programs, until the new program is adopted by the State. The matching for the new program would follow that of MAA in that there would be no dollar ceiling. However, the Federal share would vary from 50 percent to 83 percent with States at the national average receiving 55 percent. For a specified period, any State that does not reduce its expenditures would be assured at least a 5-percent increase in Federal participation in medical care expenditures. Effective January 1, 1966.

2. Medical assistance for the aged:		
(a) Eligibility for assistance	To be eligible an individual— (1) Must have attained age 65; (2) Must not be a recipient of old-age assistance; (3) Must have income and resources, as determined by the State, insufficient to meet all of the cost of the medical services outlined below. The State plan must provide reasonable standards, consistent with the objectives of the program, for determining eligibility and the extent of assistance.	Medical Assistance for Aged program as such will be inoperative for States that adopt new combined medical assistance program, but the MAA group of aged would be governed by the same eligibility standards with the following modifications: (1) Same as existing law. (2) No longer applicable to recipients of Old-Age Assistance since they will be eligible under new program. (3) Same but State must provide flexible income test which takes into account medical expenses (including health insurance premiums). (See also State plan requirements. (See pp. 25–27.)
(b) Scope of benefits	The State plan for Medical Assistance for the Aged may specify medical services of any scope and duration, provided that both institutional and noninstitutional services are included. Federal participation is restricted to vendor medical payments: i.e., payments made by the States directly to the doctor, hospital, etc., providing medical services on behalf of the recipient. The Federal Government shares in the expense of providing the following kinds of medical services: (1) Inpatient hospital services; (2) Skilled nursing home services; (3) Physicians' services; (4) Outpatient hospital or clinic services; (5) Home health care services; (6) Private duty nursing services; (7) Physical therapy and related services; (8) Dental services; (9) Laboratory and X-ray services; (10) Prescribed drugs, eyeglasses, dentures, and prosthetic devices; (11) Diagnostic, screening, and preventive services; and (12) Any other medical care or remedial care recognised under State law. The Federal Government does not share in the expense of providing medical services to inmates of public institutions (other than medical institutions), to patients in mental or tuberculosis institutions or to patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis after 42 days of care.	Essentially the same, except after July 1, 1967, benefits for new medical program *must* include at least following six services: (1) Inpatient hospital services (except in institution for tuberculosis or mental diseases); (2) Outpatient hospital services; (3) Other laboratory and x-ray services; (4) Skilled nursing home services (except in institution for tuberculosis or mental diseases) for persons age 21 or older; and (5) Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere; (6) Dental services for persons under age 21. Other services are optional and are the same as authorized under existing law with the following exceptions: (10) Modified so eyeglasses will be prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select. (12) Modifies provision so that medical care or remedial care recognized under State law, either has to be specified by the Secretary or is furnished by licensed practitioners within the scope of their practice as defined by State law. Adds provision for inpatients hospital services and skilled nursing home services in institution for tuberculosis or mental diseases. Removes exclusion from Federal matching as to aged individuals who are patients in institutions for tuberculosis or mental diseases, or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. Requires as condition of Federal participation in such payments to, or for, mental patients certain agreements and arrangements to assure that better care results from the additional Federal money. Provides that States will receive no more in Federal funds under this provision than they increase their expenditures for mental health purposes under public health and public welfare programs.

COMPARISON SHOWING EXISTING LAW AND CHANGES MADE BY H.R. 6675—Continued

EXTENSION OF KERR-MILLS PROGRAM—Continued

Item	Existing law	H.R. 6675
2. Medical assistance for the aged—Con. (c) Matching formula: (1) Federal share	Federal payments reimburse the States for a portion of their expenditures under approved plans for medical assistance for the aged according to an equalization formula which ranges from 50 to 80 percent depending upon the per capita income of the States as related to the national per capita income. States at or above national average get a 50 percent Federal share. *Federal medical percentages applicable for July 1, 1965, through June 30, 1966* State: *Percentage* Alabama 78.29 Alaska 50.00 Arizona 58.75 Arkansas 80.00 California 50.00 Colorado 50.00 Connecticut 50.00 Delaware 50.00 District of Columbia 50.00 Florida 60.69 Georgia 73.69 Guam 50.00 Hawaii 50.00 Idaho 67.43 Illinois 50.00 Indiana 52.06 Iowa 57.63 Kansas 56.63 Kentucky 75.27 Louisiana 73.46 Maine 65.65 Maryland 50.00 Massachusetts 50.00 Michigan 50.00 Minnesota 56.42 Mississippi 80.00 Missouri 50.45 Montana 59.69 Nebraska 55.10 Nevada 50.00 New Hampshire 56.38 New Jersey 50.00 New Mexico 66.55 New York 50.00 North Carolina 74.99	Under matching formula for new medical program Federal payments reimburse the States for a portion of their expenditures according to an equalization formula ranging from 50 to 83 percent, depending upon the per capita income of the State as it is related to the national per capita income. Federal sharing for States at the national average would be 55 percent; for most States above the national average, sharing would be 50 percent. Like MAA, there is no maximum on the amount in which the Federal Government would share. State: *Percentage* Alabama 80.46 Alaska 50.00 Arizona 62.87 Arkansas 82.77 California 50.00 Colorado 51.44 Connecticut 50.00 Delaware 50.00 District of Columbia 50.00 Florida 64.62 Georgia 76.32 Guam 55.00 Hawaii 52.36 Idaho 70.68 Illinois 50.00 Indiana 56.85 Iowa 61.87 Kansas 60.97 Kentucky 77.74 Louisiana 76.11 Maine 69.09 Maryland 50.00 Massachusetts 50.00 Michigan 52.32 Minnesota 60.78 Mississippi 83.00 Missouri 55.41 Montana 63.72 Nebraska 59.59 Nevada 50.00 New Hampshire 60.74 New Jersey 50.00 New Mexico 69.89 New York 50.00 North Carolina 77.49

	North Dakota 73.03 Ohio 50.00 Oklahoma 65.65 Oregon 50.00 Pennsylvania 50.00 Puerto Rico 50.00 Rhode Island 50.90 South Carolina 80.00 South Dakota 68.87 Tennessee 75.53 Texas 61.45 Utah 62.28 Vermont 64.75 Virgin Islands 50.00 Virginia 65.05 Washington 50.00 West Virginia 71.76 Wisconsin 52.50 Wyoming 50.00	North Dakota 75.73 Ohio 50.76 Oklahoma 69.09 Oregon 54.22 Pennsylvania 54.02 Puerto Rico 55.00 Rhode Island 55.81 South Carolina 82.54 South Dakota 71.98 Tennessee 77.97 Texas 65.31 Utah 66.05 Vermont 68.27 Virgin Islands 55.00 Virginia 68.55 Washington 50.84 West Virginia 74.58 Wisconsin 57.25 Wyoming 53.07
	(27 F.R. 9230)	
	75 percent Federal matching is authorized for certain rehabilitation services for aged recipients and for the training of welfare personnel.	During the period January 1, 1966, through June 30, 1969, the Federal medical percentage shall not be less less than 105 percent of the Federal share of medical expenditures by the State during fiscal year 1965. 75 percent Federal matching would be available as to costs attributable to compensation or training of skilled professional medical personnel and staff directly supporting such personnel.
(2) Pass along provision	The Federal Government pays 50 percent of other administrative costs. No provision in existing law to insure that public assistance recipients receive higher payments because of legislation liberalizing the Federal matching formula.	Same as existing law. 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 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.
(d) State plan requirements	In order to be eligible for Federal participation, the State must provide medical assistance for the aged according to a plan submitted to the Secretary of Health, Education, and Welfare, and approved by him, which meets the requirements set out in the law. The State plan provisions are generally the same as those required for the other public assistance programs with the following exceptions: A State plan— (a) must not require a premium, enrollment fee, or similar charge as a condition of eligibility;	The State plan requirements for the new medical program incorporate many of the plan requirements of existing programs. The following are the differences as they particularly affect the medical assistance for the aged group: (1) Modifies provision to allow State to impose premiums, enrollment fees, on similiar charges if they are reasonably related (as determined in accordance with standards prescribed by the Secretary) to the recipient's income or to his income and resources;

EXTENSION OF KERR-MILLS PROGRAM—Continued

Item	Existing law	H.R. 6675
2. Medical assistance for the aged—Con. (d) State plan requirements—Con.	(2) must not impose property liens during the lifetime of the individual receiving benefits (except pursuant to court judgment on account of benefits incorrectly paid) and any recovery provisions under the plan must be limited to the estate of the individual after his death and the death of his surviving spouse;	(2) Broadened so that recovery would be further postponed where there is surviving child, under 21 or blind or disabled. No recovery is permitted for medical assistance received before age 65.
	(3) must not impose a citizenship requirement which would exclude a citizen of the United States or a requirement which excludes a resident of the State;	(3) Same as existing law.
	(4) must also provide, to the extent required by the Secretary of Health, Education, and Welfare, for inclusion of residents of the State who are absent therefrom; and	(4) Same as existing law.
	(5) Include reasonable standards consistent with the objectives of this title for determining eligibility for, and the extent of assistance;	(5) Same but with addition so that standards (a) take 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; (b) must provide for reasonable evaluation of income or resources; (c) do not take into account the financial responsibility of any individual for any applicant or recipient who is not such individual's spouse or child under age 21 or blind or disabled; and (d) 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.
	(6) If a State has both a program for old-age assistance and medical assistance for the aged it must be administered by a single State agency;	(6) The medical program may be administered by any single State agency except that eligibility for medical assistance must be determined by the agency that administers old-age assistance (or title XVI). In certain States with separate blind agencies, however, the portion of the plan relating to the blind may be administered by those agencies.
		The following additional plan requirements pertinent to the MAA group are added:
	(7) If payments are made to individuals in public or private institutions, must provide for a State authority or authorities to establish and maintain standards for such institutions.	(7) Broadened to require after June 30, 1967, that such standards include any requirements in standards established by the Secretary relating to protection against fire and other hazards to health and safety.
		(8) Until July 1, 1970, local funds may be used for up to 60 percent of non-Federal share of expenditures under the program. After that date, the non-Federal share of expenditures must be met entirely by the State.

(9) No deductible, cost sharing, or similar charge will be imposed on any individual in respect to inpatient hospital service, nor with respect to any other care or service unless it is reasonably related (as determined in accordance with standards approved by the Secretary), to the recipient's income or his income and resources.

(10) In the case of aged individuals covered by either or both of the insurance programs (hospital insurance benefits for the aged, and supplementary medical insurance benefits for the aged) established by the bill, provide—

(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 the 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.

(11) If benefits are provided for the medically indigent aged similar provision must be made for the medically indigent blind, disabled, and dependent children and their parents. Benefits and eligibility standards must be comparable between groups. The benefits provided to the medically indigent cannot be greater than those provided to the cash recipients.

(12) Safeguards must be provided to insure determination of eligibility and provision of services be administratively simple and in the best interest of recipients.

(13) Provide for entering into cooperative arrangements with the State agencies responsible for administering of health services and vocational rehabilitation services, looking toward maximum utilization of such services in the provision of medical assistance under the plan.

(14) Provide for 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.

(15) Include descriptions of kinds, numbers, and responsibilities of professional medical personnel, the standards to be used by standard-setting authorities for institutions, the cooperative arrangements with State health and vocational rehabilitation agencies, and other standards and methods to be used to assure provision of medical or remedial care and that services are of high quality.

(e) Use of private health insurance.	Includes in the amounts subject to Federal matching the expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof.	Same as existing law.

EXTENSION OF KERR-MILLS PROGRAM—Continued

Item	Existing law	H.R. 6675
3. Effect on other public assistance programs: (a) Medical vendor program content and scope.	No uniformity required as to eligibility or as to the amount or scope of benefits between medical vendor programs for OAA (title I), Aid to Families with Dependent Children (title IV), Aid to Blind (title X), Aid to Permanently and Totally Disabled (title XIV), and the consolidated program for the aged, blind, and disabled (title XVI). Medical vendor programs for the medically indigent aged (MAA) can be greater in amount and scope than that for recipients on the cash assistance programs. No specific medical care benefits required as a condition of Federal participation.	Federal participation in medical vendor payments will cease upon the States' implementation of the new program, as to all existing titles (I, IV, X, XIV, and XVI). If a State program covers the medically indigent aged (MAA) it must provide (except as specified) the same benefits in amount, duration, and scope to comparably medically indigent individuals who would, if in financial need, be in the other categories of assistance. The amount, duration, and scope of medical assistance for recipients of cash assistance under any of the programs cannot be less than that provided for the medically indigent. The amount, duration, and scope of medical assistance available must be (except as specified) the same as to recipients on all cash assistance programs. Effective July 1, 1967, as to the new program, the States could not exclude any person who has not attained age 21 and who would be considered a dependent child except for the age and school attendance requirements under the State's aid to families with dependent children plan. Moreover, for matching purposes dependent children and adult care takers could be included even though they did not meet the State plan requirement for need and age, if they are otherwise qualified for cash payments under the aid to families with dependent children program. The Secretary of Health, Education, and Welfare shall not authorize matching unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalising the eligibility requirements for medical assistance, with a view toward furnishing by 10 years after the plan is effective, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care. Provides that no lien may be imposed against the property of individual prior to his death, and that as to recipients under age 65 years of age there shall be no recovery or adjustment as to any medical assistance correctly paid. After July 1, 1967, benefits for new medical program *must* include at least following six services: (1) inpatient hospital services; (except in institutions for tuberculosis or mental diseases);

(b) Matching formula—vendor medical payments	There are various formulas which determine the extent of Federal participation: *Aid to families with dependent children (title IV).*—Medical payments and cash assistance combined in one formula with Federal participation limited to an average monthly expenditure of $30 per child or adult recipient. *Aid to blind (title X) and aid to permanently and totally disabled (title XIV).*—Medical payment and cash assistance combined in one formula as to each program with Federal participation limited to an average monthly expenditure of $70 per recipient. *Old-age assistance (title I).*—A separate medical payments formula which is applicable to $15 of expenditures above the $70 average monthly participation limit or to $15 of expenditures within the $70 limit. For States with average monthly payments over $70, the Federal Government participates in the expenditures in excess of that amount except that such participation is limited to the amount of the average vendor medical payment with a maximum of $15. The Federal share in the excess expenditure is the "Federal medical percentage" for the State, which ranges from 50 to 80 percent under a formula based on per capita income. (See page 16.) For States with average monthly payments of $70 or less, the additional Federal share in average vendor medical payments up to $15 is an additional 15 percent over the "Federal percentage"* (which ranges from 50 percent to 65 percent based on per capita income). This percentage, when added to the usual "Federal percentage," results in a total Federal share of from 65 to 80 percent. The additional Federal share of 15 percent also is available to States with average monthly payments over $70 when it is advantageous to them as an alternative to the method described in the preceding paragraph. *Combined program for aged, blind, and disabled (title XVI).*—As of December 1, 1964, some 14 jurisdictions had combined programs for the adult categories. The Federal participation as to this program is the same as for OAA.	(2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services (except in institutions for tuberculosis or mental diseases) for persons age 21 or older; (5) physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) dental services for persons under age 21. Other services are optional. The State plan must provide for the payment of reasonable costs of inpatient hospital services as is done for MAA group. As to all categories of recipients, provides Federal participation as described on page 16 (varies from 50 to 83 percent). Like MAA, there is no maximum on the amount which the Federal Government would share in.

*The "Federal percentage" determines the amount of Federal participation as to the amount of average payments between $35 and $70 for the adult programs ($17 to $30 for AFDC).

PUBLIC ASSISTANCE

I. INCREASE IN FEDERAL MATCHING FORMULA

Item	Existing law	H.R. 6675
A. Payments for old-age assistance, aid to the blind, and aid to the permanently and totally disabled, or the combined aged, blind, and disabled program (title XVI).	Federal matching share is $29 of the first $35 ($^{29}/_{35}$ of the first $35) with variable matching on the amount above $35 up to a maximum of $70 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. The "Federal percentages" as promulgated for the period July 1, 1963, through June 30, 1965, are as follows:	Effective January 1, 1966, the Federal matching share will be increased to $31 out of the first $37 ($^{31}/_{37}$ of the first $37) with variable matching on the amount above $37 up to a maximum of $75 per recipient per month. No change.

State:	*Federal percentage*
Alabama	65.00
Alaska	50.00
Arizona	58.75
Arkansas	65.00
California	50.00
Colorado	50.00
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	60.69
Georgia	65.00
Hawaii	50.00
Idaho	65.00
Illinois	50.00
Indiana	52.06
Iowa	57.63
Kansas	56.63
Kentucky	65.00
Louisiana	65.00
Maine	65.00
Maryland	50.00
Massachusetts	50.00
Michigan	50.00
Minnesota	56.42
Mississippi	65.00
Missouri	50.45
Montana	59.69
Nebraska	55.10
Nevada	50.00
New Hampshire	56.38
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	50.00
Rhode Island	50.00
South Carolina	65.00
South Dakota	65.00
Tennessee	65.00
Texas	61.45
Utah	62.28
Vermont	64.75
Virginia	65.00
Washington	50.00
West Virginia	65.00
Wisconsin	52.50
Wyoming	50.00

(27 F.R. 9185)

Vendor medical 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 $70 per month, up to $15 per recipient per month.

or

15 percent of vendor payment expenditures, up to $15 per recipient per month.

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.

For States with average monthly payments over $70, the Federal Government participates at the rate of the "Federal medical percentage" in the expenditures over $70 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 $70 per month or less, the Federal share in average vendor medical payments up to $15 per recipient per month is an additional 15 percentage points 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 $70 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 $70 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.

No change.

Formula also changed to reflect new matching maximum on assistance payments of $75.

Formula is restated so that amounts in which the Federal Government participates at the "Federal medical percentage" are counted before those in which participation is at this "Federal percentage."

PUBLIC ASSISTANCE—Continued

I. INCREASE IN FEDERAL MATCHING FORMULA—Continued

Item	Existing law	H.R. 6675
B. Payments for aid to families with dependent children.	For money and medical vendor payments the Federal share is $14 out of the first $17 ($^{14}/_{17}$ of the first $17) per recipient per month with variable matching on the amount above $17 up to a maximum of $30 per recipient per month. Variable matching for the States is at the same percentages as old-age assistance money payment matching.	Effective January 1, 1966, the Federal matching share would be increased to $15 out of the first $18 (⅚ of the first $18) with variable matching on the amount above $18 up to a maximum of $32 per month per recipient.
C. 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.
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 In each case a portion of these amounts is only available if used to provide additional medical vendor payments on behalf of assistance recipients: Puerto Rico ..... $625,000 Virgin Islands ..... 18,750 Guam ..... 25,000 Federal payments for programs of medical assistance for the aged are excepted from dollar limitation provision.	No change. Deletes required earmarking for medical vendor payments on approval of its plan for medical assistance under title XIX.
D. Pass along provision	No provision in existing law to insure that public assistance recipients receive higher payments because of legislation liberalizing the Federal matching formula.	Federal matching for any State for any quarter shall be reduced to the extent that the excess of the Federal matching for such quarter over the corresponding quarter or the average Federal matching for quarters in fiscal 1964 or 1965 is greater than the excess of total Federal, State, and local expenditures for the quarter over the corresponding quarter or the average Federal, State, and local total expenditures for quarters in fiscal 1964 or 1965.
E. Consideration of income in determination of need.		
1. Disregarding earnings in old-age assistance and aged in combined program (title XVI).	In determining the need of an aged recipient, a State may, after Dec. 31, 1962, disregard a portion of earned income. Of the first $50 per month, the State may disregard up to the first $10 completely, plus ½ of the remainder.	In determining need of an aged recipient, a State may, after Dec. 31, 1965, disregard an additional portion of earned income. Of the first $80 per month, the State may disregard the first $20 completely, plus ½ of the remainder.

2. Disregarding earnings of disabled individual under title XIV and under title XVI (combined program).	No provision.	In determining need of a disabled recipient under titles XIV and XVI, effective Jan. 1, 1966, of the first $80 per month of earned income, the State may disregard the first $20 completely, plus ⅓ of the remainder and may also disregard for up to 36 months such additional amounts of income and resources as may be necessary for the fulfillment of an approved plan for achieving self-support but only while he is actually undergoing vocational rehabilitation.
3. Disregarding earnings in aid to families with dependent children (title IV).	No provision.	In determining need under title IV, effective July 1, 1965, the State may disregard not more than $50 per month of earned income of each dependent child but not more than 3 in the same home.
4. Disregarding OASDI benefit increase, and child's benefit beyond age 18, to extent attributable to retroactive effective date.	No provision in past legislation to exempt OASDI benefit increases from public assistance income considerations.	Would allow a State to disregard the retroactive portion (January 1965) of the 7 percent benefit increase or the child benefit for children over 18 in school in determining need of the aged, blind, disabled, or families with dependent children.

II. MENTAL AND TB EXCLUSION

A. Old-age assistance and aged individual in combined program (title XVI).	Federal matching is available as to cash and vendor payment, but does not include— (1) Cash or vendor payments on behalf of an inmate of a public institution (except as a patient in medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases; or (2) Any cash payments to any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof; (3) Vendor payments on behalf of any individual who is a patient in a medical institution as a result of a diagnosis of tuberculosis or psychosis with respect to any period after the individual has been a patient in such an institution for 42 days.	(1) Deletes tuberculosis and mental exclusion for individuals age 65 or over; retains exclusion as to payments to inmates of a public institution (except as a patient in a mental institution). (2) Deletes tuberculosis and mental exclusion. (3) Deletes tuberculosis and mental exclusion entirely
B. Aid to blind and disabled	Federal matching is available as to cash and vendor payment, but does not include— (1) Cash or vendor payments on behalf of an inmate of a public institution (except as a patient in medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases; or (2) Any cash or vendor payments to any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof;	(1) No change. (2) Deletes tuberculosis and mental exclusion.
C. Medical assistance for the aged	Federal matching is available as to vendor payments but does not include— (1) Payments on behalf of an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases, or (2) On behalf of any individual who is a patient in a medical institution as a result of a diagnosis of tuberculosis or psychosis with respect to any period after the individual has been a patient in such an institution for 42 days.	(1) Deletes tuberculosis and mental exclusion; retains exclusion as to payments to inmates of a public institution (except as a patient in a mental institution). (2) Deletes tuberculosis and mental exclusion entirely.

PUBLIC ASSISTANCE—Continued

II. MENTAL AND TB EXCLUSION—Continued

Item	Existing law	H.R. 6675
D. State plan requirements	No provision.	As to old-age assistance, medical assistance for the aged, combined program (title XVI) or new medical assistance program (title XIX) adds requirement that if State plan includes cash payment or vendor payments to persons in mental institutions it must— (1) Provide 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; (2) Provide 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; (3) Provide 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 for such, and for methods of administration necessary to assure that these provisions will be effectively carried out; and (4) Provide 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.
E. Pass along provision	No provision.	Federal matching for any State for any quarter which is attributable to State or local expenditures with respect to patients in institutions for tuberculosis or mental diseases shall only be paid to extent that the State makes a showing satisfactory to the Secretary that it has increased Federal, State, and local expenditures for mental health services under public health and public welfare programs in the State over the average of such expenditures for quarters in fiscal year 1965.

III. PROTECTIVE PAYMENTS

A. Protective payments under old-age assistance, aid to the blind, and aid to the permanently and totally disabled, and the combined program (title XVI).	Federal financial participation as to money payments to needy persons or their legal guardians has been authorized since 1935. Vendor payments, made directly to the suppliers of medical services on behalf of recipients have been authorized by the 1950 amendments. Since 1958, payments have been authorized to be made to another person who is judicially appointed for the purpose of receiving and managing such assistance payments (whether or not he is such individual's legal representative for other purposes).	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; and (4) Opportunity for a fair hearing before the State agency on the determination that payments to an interested person are necessary. (5) Payments which together with other income meet the individual's need in full.

IV. OTHER CHANGES

A. Definition of medical assistance for the aged.	The term "medical assistance for the aged" means payments of part or all of the cost of care and services (if provided in or after the 3d month before the month in which the recipient makes application for assistance) for individuals 65 years of age or older who are not recipients of old-age assistance but whose income and resources are insufficient to meet all of the cost of medical services.	Eliminates restriction upon Federal matching for recipients of old-age assistance for month they are admitted effective July 1, 1965, or discharged from a medical institution.
B. Exemption of earnings under the poverty program.	The Economic Opportunity Act of 1964 provides that certain amounts of income derived under titles I and II of that act may not be taken into account by State public assistance programs after June 30, 1965.	Provides a further grace period for State compliance with this provision so that no funds will be withheld before the 1st month after the adjournment of a State's first regular legislative session which adjourns after the date of the enactment of the Economic Opportunity Act (Aug. 20, 1964).
C. Administrative and Judicial Review of Administrative Actions: (1) Initial approval of State plan...	No explicit authority for review of Secretary's disapproval of a plan which is submitted by a State.	Sets up specific statutory procedures for review of administrative determinations: When a State submits a new plan under one of the public assistance titles, the Secretary shall make a determination within 90 days as to whether the proposal meets the applicable requirements for approval. This period may be extended by written agreement of the Secretary and the State. If the State is dissatisfied with the Secretary's determination, it may, within 60 days, petition for a reconsideration. The Secretary shall, within 30 days after receipt of the petition, set a time and place for a hearing, to begin from 20 to 60 days after the date notice of the

IV. OTHER CHANGES—Continued

Item	Existing law	H.R. 6675
C. Administrative and Judicial Review of Administrative Actions—Continued (1) Initial approval of State plan—Continued		hearing is furnished to the State, unless the Secretary and the State agree in writing upon another time. Within 60 days of the conclusion of the hearing, the Secretary shall affirm, modify, or reverse his original determinations. If the State is dissatisfied with this final determination, it may, within 60 days, appeal to the U.S. court of appeals. In the judicial proceeding, the findings of fact, by the Secretary shall be conclusive if supported by substantial evidence; if good cause shown for taking further evidence, the court may remand the case to the Secretary for this purpose. The court may affirm the action of the Secretary or set it aside, in whole or in part. The court's judgment shall be subject to review by the Supreme Court of the United States upon certiorari or certification. The foregoing procedures are also applicable, at the option of the State, upon submittal of any amendment of an approved State plan. The bill further provides that action pursuant to an initial determination of the Secretary, as therein described, shall not be stayed pending reconsideration. If the Secretary subsequently determines that his initial determination was incorrect, he shall pay forthwith in a lump sum any amounts, not otherwise already paid, which are payable to the State in accordance with the corrected determination of the Secretary on the basis of the expenditures made by the State.
(2) Subsequent noncompliance	Under all public assistance titles the Secretary shall give reasonable notice and opportunity for hearing to a State prior to discontinuing payments under a previously approved State plan because of his finding that the plan has been so changed that it no longer complies with certain requirements of the law.	Makes final determination of the Secretary subject to judicial review in the same manner as outlined above.
(3) Audit exceptions (disallowance of specific items for Federal participation).	No specific authority for review of Secretary's disallowances.	Provides that whenever the Secretary determines that there shall be a disallowance the State shall be be entitled, on request, to an administrative reconsideration of the decision.
(4) Effective date		Effective as to determinations made after December 31, 1965.
D. Eligibility of children over age 18 for aid to families with dependent children (title IV).	States may provide aid to children 18–21 years of age who are attending a high school or a vocational or technical training course and receive federal sharing in such aid.	Amends present provision to permit federal sharing in aid to children 18–21 regularly attending a school, college, or university, or vocational or technical training course.

MATERNAL AND CHILD HEALTH SERVICES

(Title V of Social Security Act)

Item	Existing law	H.R. 6675
I. Increase in authorization	$40,000,000 for the fiscal year ending June 30, 1966. $40,000,000 for the fiscal year ending June 30, 1967. $45,000,000 for the fiscal year ending June 30, 1968 and 1969. $50,000,000 for the fiscal year ending June 30, 1970 and for each fiscal year thereafter.	$45,000,000 for the fiscal year ending June 30, 1966. $50,000,000 for the fiscal year ending June 30, 1967. $55,000,000 for the fiscal year ending June 30, 1968 and 1969. $60,000,000 for the fiscal year ending June 30, 1970.
II. Provision for extension of services to additional parts of State.	No provision.	Requirement that after June 30, 1966, a State make a satisfactory showing that it is extending the provision of maternal and child health services with a view to making services available by July 1, 1975, to children in all parts of the State.
III. Payment of reasonable cost of inpatient hospital services.	No provision.	Requires effective July 1, 1967, payment of reasonable cost (as determined in accordance with standards approved by the Secretary and included in maternal and child health services plans of inpatient hospital care).

CRIPPLED CHILDREN'S SERVICES

(Title V of Social Security Act)

Item	Existing law	H.R. 6675
I. Increase in authorisation	$40,000,000 for the fiscal year ending June 30, 1966. $40,000,000 for the fiscal year ending June 30, 1967. $45,000,000 for the fiscal year ending June 30, 1968 and 1969. $50,000,000 for the fiscal year ending June 30, 1970 and for each fiscal year thereafter.	$45,000,000 for the fiscal year ending June 30, 1966. $50,000,000 for the fiscal year ending June 30, 1967. $55,000,000 for the fiscal year ending June 30, 1968 and 1969. $60,000,000 for the fiscal year ending June 30, 1970.
II. Provision for extension of services to additional parts of State.	No provision.	Requirement that after June 30, 1966, a State make a satisfactory showing that it is extending the provision of Crippled Children's Services with a view to making services available by July 1, 1975, the children in all parts of the State.
III. Authorisation for grants to institutions of higher learning for training of professional personnel.	No explicit provision.	Authorization of $5,000,000 for fiscal year ending June 30, 1967, $10,000,000 for fiscal year ending June 30, 1968, and $17,500,000 for each fiscal year thereafter for grants to institutions of higher learning for training professional personnel for health and related care of crippled children particularly mentally retarded children and children with multiple handicaps.
IV. Payment of reasonable cost of inpatient hospital services.	No provision.	Requires effective July 1, 1967, payment of reasonable cost (as determined in accordance with standards approved by the Secretary and included in Crippled Children's Services plans of inpatient hospital care).

CHILD WELFARE SERVICES

(Title V of Social Security Act)

Item	Existing law	H.R. 6675
I. Increase in authorization	$40,000,000 for the fiscal year ending June 30, 1966. $45,000,000 for the fiscal year ending June 30, 1967. $45,000,000 for the fiscal year ending June 30, 1968. $50,000,000 for the fiscal year ending June 30, 1969, and succeeding fiscal years.	$45,000,000 for the fiscal year ending June 30, 1966. $50,000,000 for the fiscal year ending June 30, 1967. $55,000,000 for the fiscal year ending June 30, 1968. $55,000,000 for the fiscal year ending June 30, 1969. $60,000,000 for the fiscal year ending June 30, 1970, and for each year thereafter.
II. Day care	Earmarking: From annual appropriation for child welfare services, the excess over $25,000,000 is earmarked for support of day care activities in the States, but earmarked amount may not exceed $10,000,000. Allotments: The earmarked amount is allotted so that each State shall have an amount which bears the same ratio to the total amount earmarked as the product of (1) the population of each State (under the age of 21) and (2) the allotment percentage (based on relative per capita income) bears to the sum of the corresponding products of all the States. But any State allotments under $10,000 shall be increased to that amount by proportionately reducing allotments to each of the remaining States. State plan requirements: Provides the following requirements: (1) Plan must be developed jointly by the State agency and the Secretary of Health, Education, and Welfare. (2) Plan must provide, with respect to day care— (a) for arrangements with State health and public school authorities to assure maximum utilization of such agencies in the provision of health care and education to day care children; (b) for an advisory committee to advise the State agency on general policy relating to the provision of day care, representing public and private groups interested in day care; (c) for safeguards assuring that day care is provided only in cases where it is in the interest of mother and child, and where a need for it exists; and (d) for giving priority in determining the need for day care, to low income groups, other groups, and geographical areas with the greatest relative needs for such care. Effective July 1, 1963.	Deletes provision for earmarking. Deletes provision for allotments.

CHILD WELFARE SERVICES—Continued

(Title V of Social Security Act)—Continued

Item	Existing law	H.R. 6675
II. Day care—Continued	Eligible facilities: Day care which is supported under this program must be provided in facilities (including private homes) which are licensed by the State, or approved (as meeting the licensing requirements) by the State agency which is responsible for licensing this type of facility.	Made a plan requirement that day care under the plan will be provided only in facilities (including private homes) which are licensed by the State or approved as meeting standards established for licensing.

SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

(Title V of Social Security Act)

Item	Existing law	H.R. 6675
I. Authorization	No provision.	Authorization of $15,000,000 for the fiscal year ending June 30, 1966, $35,000,000 for the fiscal year ending June 30, 1967, and increases in the authorization of $10,000,000 for the fiscal year ending June 30, 1968; and $5,000,000 each fiscal year thereafter through the fiscal year ending June 30, 1970, for project grants to the State health agency or with its consent the health agency of any political subdivision of the State, to the State agency administering or supervising the administration of the State crippled children's program, to schools of medicine, and to teaching hospitals affiliated with medical schools to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for health care and services for children of school age and preschool children. To be comprehensive in nature projects for children and youth of school age must include screening, diagnosis, preventive services, treatment, correction of defects, and aftercare. Projects must provide for (1) coordination with and utilization of other State and local health, welfare, and education programs for such children; (2) payment of reasonable cost of inpatient hospital services; (3) treatment, correction of defects, or aftercare to be available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and (4) inclusion of such screening. diagnosis, preventive services, treatment, correction of defects, and aftercare, medical or dental, as required by the Secretary. Authorizes grants to a State health, mental health or public welfare agency and with the consent of the appropriate State agency to the health, mental health or public welfare agency of any political subdivision of the State, and to any public or nonprofit private agency or institution to pay not to exceed 75 percent of the cost of projects providing for the identification, care, and treatment of children who are or are in danger of becoming emotionally disturbed, including the followup of children receiving such care and treatment. A project must provide for coordination of the care and treatment provided under it with, and utilization (to the extent feasible) of, community mental health centers and other State or local agencies engaged in health, welfare, or education programs or activities for such children. The Secretary is required to make a full report before July 1, 1969, of the administration of these project grants for the health care of school and preschool children with his evaluation and recommendations as to continuation or modification of the program.

MISCELLANEOUS AMENDMENTS RELATING TO HEALTH CARE

Item	Existing law	H.R. 6675
I. Health Study of Resources Relating to Children's Emotional Illness.	No provision.	Authorizes an appropriation of $500,000 each for the fiscal year ending June 30, 1966, and the fiscal year ending June 30, 1967, for grants for research into and study of the resources, methods, and practices for diagnosing or preventing mental illness in children and of treating, caring for, and rehabilitating children with emotional illness.
II. Grants for mental retardation planning. (Title XVIII of the Social Security Act.)	$2,200,000 was authorized for grants during fiscal 1964 and fiscal 1965.	Authorizes $2,750,000 for fiscal 1966 and fiscal 1967. Sums appropr'ated during fiscal 1966 are for grants during that year and the 2 succeeding fiscal years. Sums appropriated in fiscal 1967 are also available until June 30, 1968.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

(Title II of the Social Security Act)

I. COVERAGE

Item	Existing law	H.R. 6675
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 (including certain rentals paid in crop shares—see item 3, "Farm operators") 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. The exemption could be granted with respect to taxable years beginning after Dec. 31, 1950. The sect (or division thereof) must be one that has been in existence at all times since Dec. 31, 1950, and has for a substantial period of time been making reasonable provision for its dependent members. Before an individual could be granted exemption he would be required to waive all benefits and other payments under any insurance system established by the Social Security Act on the basis of his own earnings as well as all such benefits and other payments to him based on the earnings of any other person. The exemption could not be granted to any person who has been entitled to social security benefits, or to one whose earnings have provided the basis for entitlement to social security benefits for any other person.
1. Professional groups	*Covers* all professional groups except physicians.	Covers physicians. Effective for taxable years ending on or after Dec. 31, 1965.
2. 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.	Permits social security credit to be obtained for the earnings of certain ministers who died or filed waiver certificates before April 16, 1965, where such earnings were reported for social security purposes but cannot be credited under present law.
3. Farm operators	*Covers* farm operators on the same basis as other self-employed persons except that farm operators whose annual gross earnings are $1,800 or less can report either their actual net earnings or 66⅔ percent of their gross earnings. Farmers whose annual gross earnings are over $1,800 report their actual net earnings if over $1,200, but if actual net earnings are less than $1,200, they may report $1,200.	Modifies exception so 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 gross earnings are over $2,400 report actual net earnings if over $1,600, but if actual net is less than $1,600, they may report either actual net earnings or $1,600. Effective as to taxable years beginning after Dec. 31, 1965.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

I. COVERAGE—Continued

Item	Existing law	H.R. 6675
A. Self-employed—Continued 3. 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.
4. Public officials	*Excludes* individuals performing functions of public officials.	No change.
5. 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.
(See p. 45 for cash tips.) 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. 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	Tips received by employees are generally not counted as wages. While employees' tips are not mentioned in the law, regulations exclude from wages tips paid directly to an employee, and not accounted for by the employee to the employer.	Cash tips received by an employee in the course of his employment are covered as income from self-employment for social security tax and benefit purposes, except that tips which are covered as wages under present law would continue to be covered as wages. In computing the tipped employee's net earnings from self-employment, only business expenses attributable to tips covered as income from self-employment are to be deducted. Effective for taxable years beginning after 1965.
5. State and local government employees.	*Covers* employees of State and local governments *provided* the individual State enters 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. 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; (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.	Permits Iowa and North Dakota to modify their agreements to exclude services performed by students, including services already covered, in the employ of a school, college, or university in any calendar quarter if the remuneration for such services is less than $50. The modification would specify the effective date of the exclusion, but it could not be earlier than the date of enactment.

Item	Existing law	H.R. 6675
B. Employees—Continued 5. State and local government employees—Continued	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.	
	The 1960 amendments permit California to cover, before 1962, persons employed by a hospital in 1957, 1958, or 1959 in positions removed, after Sept. 1, 1954 and before 1960, from retirement system coverage for whom social security taxes were erroneously paid. Hospital employment before 1960 on which taxes were paid and all subsequent hospital employment of such persons could be covered.	Would modify provision so that service of persons in such positions after 1959 would also be covered. Upon modification of agreement by the end of 6 months following month of enactment, service performed on or after Jan. 1, 1962, would be covered. Services performed before Jan. 1, 1962, would be covered, if contribution in the proper amount was paid prior to date of enactment.
	Exceptions to general law concerning coverage in named States: (1) *Split-system provisions.*—Authorizes 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, 1 to be composed of those persons who desire coverage and the other of those persons who do not wish coverage, provided that new members of the retirement system coverage group are covered compulsorily. Also authorize similar treatment of political subdivision retirement systems of these States.	Adds Alaska to the list. Effective upon enactment.
	Those employees covered by a divided retirement system who did not elect coverage in the original agreement, may, nevertheless elect coverage until 1963, 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 amendment would begin on the same date as coverage became effective for the group originally covered.	Extends the time in which such employees can elect to be covered until the end of 1966 (or, if later, the expiration of 2 years after the date on which coverage was approved for the group that originally elected coverage). Effective upon enactment.

	Also provides that where an individual who has chosen not to be covered under the divided retirement system provision becomes a member of a different retirement system group which has elected coverage because of the annexation of the employing political subdivision by another political subdivision, or through some other action taken by a political subdivision, such individual will continue to be excluded from coverage.	
	(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.	No change.
	(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.
	(4) Retirement systems in Maine (1958 amendments)—permits State of Maine until July 1, 1965, to treat teaching and nonteaching employees who are in the same retirement system as though they were under separate retirement systems for social security coverage purposes.	Extends cutoff date to July 1, 1970.
	d. Coverage on a compulsory basis is provided for employees of certain publicly owned transportation systems.	No change.
	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.
6. 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.	No change.
	Employees may concur by signing a list or supplemental list which is filed within 24 months after the	

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

I. COVERAGE—Continued

Item	Existing law	H.R. 6675
B. Employees—Continued 6. Employees of nonprofit organizations—Continued	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, on the 1st day of any of the 4 quarters preceding the quarter in which the certificate 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.	Permits nonprofit organizations to elect coverage as early as the 1st day of the 20th calendar quarter preceding the quarter in which the certificate of waiver is filed. Permits the validation of certain erroneous wage reportings by nonprofit organizations. Effective upon enactment. Adds provisions (1) giving those employees to whom additional retroactive coverage is made applicable an individual choice of such coverage, and (2) permitting certain employees whose wages were erroneously reported by a nonprofit organization during the period the organization's waiver certificate was in effect to validate such erroneously reported wages.
7. 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 certain interns, student nurses, and other student employees of Federal hospitals; (5) as employees on a temporary basis in disaster situations; (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 Dec. 31, 1950, and its employees are covered by its retirement system. *Covers* the following Federal employees excepted from the exclusion in 7–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;	No change, except— Excepts from exclusion and thereby provides coverage to medical or dental interns or residents in training. Effective as to services performed after 1965. Extends coverage to employees of the District of Columbia not covered by any retirement system established by a law of the United States. Effective date: amendments apply to services performed after the quarter in which the Secretary of the Treasury receives a certification from the District of Columbia Commissioners that they desire coverage of these services.

	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.	
8. Students, interns, 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; c. interns in the employ of a hospital if they have completed a 4-year course in an approved medical school.	No change, except— Covered on the same basis as other employees of the same employer, effective as to service performed after 1965.
9. Newsboys	*Covers* individuals *18 and over* who deliver and distribute newspapers or shopping news, but covers individual *under 18* only if they deliver or distribute such publication to points for subsequent delivery or distribution.	No change.
10. 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). Extends the noncontributory wage credits to 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. He must have resided in the United States for at least 4 years during the 5-year period ending on the day of his entrance into such active service and must have been domiciled in the United States on such day.	No change.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

I. COVERAGE—Continued

Item	Existing law	H.R. 6675
B. Employees—Continued		
11. 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.	Amends section (1)(q) of the Railroad Retirement Act to provide that references to the Social Security Act in the Railroad Retirement Act will be considered to be references to the Social Security Act as amended in 1965, so that the present RR–OASDI coordination will continue to operate in all ways with respect to the Social Security Act as amended by the bill. Increases the amount of social security earnings that may be credited under the survivors provisions of the railroad retirement program to such an amount as to cause the combined total earnings to be as much as the new wage and tax base under social security—$6,600 a year after 1965.
12. 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.	No change.
13. 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.

II. PROVISIONS RELATING TO DISABILITY

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 and are payable from the Federal Disability Insurance Trust Fund.	No change.
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. (For purposes of the freeze only, a specified degree of blindness is presumed disabling.) The impairment must be medically determinable and one which can be expected to be of long-continued and indefinite duration or to result in death.	Eliminates the requirement that a worker's disability must be expected to be of long-continued and indefinite duration. Provides that an insured worker would be eligible for disability benefits if he has been under a disability which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 calendar months.
2. Entitlement to other benefits	Entitlement to a benefit payable on account of old age precludes entitlement to a disability insurance benefit.	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 would be reduced to take account of payment made for prior months.
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 termination of disability insurance benefits or a period of disability.	No change.
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; (2) be fully insured.	No change.
6. Applications	a. Provides that an individual must be under a disability when his application for a period of disability is filed.	a. Eliminates the requirement that an individual must be under a disability when his application for a period of disability is filed and substitutes instead the requirement that no application for a disability determination which is filed more than 12 months after the month in which a period of disability would end shall be accepted. This amendment permits payment of benefits in those cases of extended disability which terminated before an application was filed. Payment would be made only for months of disability which fall within the period of retroactivity of the application.
	b. Provides that the life of an application for benefits is 3 months (9 months for disability benefits); i.e., an applicant has 3 months from the date of application to qualify for benefits before his application expires.	b. Extends the life of applications for social security benefits to the date of the final decision thereon by the Secretary.
C. Payment for rehabilitation services	No applicable provision.	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.
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.	Authorizes the Social Security Administration to make disability determinations in those cases which can be promptly adjudicated on the basis of readily available evidence and to terminate entitlement to benefits in cases of recovery based on such evidence or on evidence received that the beneficiary has returned to gainful work.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

II. PROVISIONS RELATING TO DISABILITY—Continued

Item	Existing law	H.R. 6675
E. Disability benefits offset	No applicable provision	Adds a disability benefits offset provision to existing law under which the social security disability benefit for any month for which a worker is receiving a periodic workmen's compensation benefit will be 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 prior to the onset of disability, but with the reduction periodically adjusted to take account of changes in earnings levels.

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.
Reduction where individual is entitled to a wife's benefit and an old-age benefit.	In the case where a woman is entitled to a reduced old-age insurance benefit and 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. A similar provision is applicable to men entitled to reduced benefit old-age and dependent husband's benefit.	No change.
B. Wife or dependent husband	A full benefit for a wife or dependent husband is 50 percent of spouse's primary benefit. Full benefit paid at age 65. Payable at age 62 to a wife or dependent husband, but on an actuarially reduced basis. 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.	No change.
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. Full benefit is 82.5 percent of deceased worker's primary benefit (75 percent each in case of 2 parents).	Widows would be allowed to elect an actuarially reduced benefit upon attaining age 60. Benefits would 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 would be 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 will be reduced to take into account widow's benefits paid to her before age 62. Effective for benefits beginning with the 2d month after the month of enactment on the basis of applications filed in or after month of enactment. No change as to widowers and parents.
D. 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.	(b) Is under a disability which began before he attained age 22. Adds a 3d qualifying alternative: (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 22. Provision would prevent a wife, widow, or surviving divorced mother from getting benefits if the only child in her care has attained 18 and is getting benefits solely because he is a student. *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 would be 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. An educational institution is defined so as to permit the payment of benefits to students taking vocational or academic courses and includes all public schools, colleges, and universities and all accredited private schools, colleges, or universities. An accredited school would be one approved by a State recognized or nationally recognized accrediting association. Also included are those nonaccredited schools, colleges, and universities whose credits are accepted, on transfer by 3 accredited institutions on the same basis as if transferred from an accredited institution. Effective for January 1965 on basis of applications filed in or after month of enactment. For children currently on rolls, no application will be required. In the case of a disabled child who becomes entitled on the basis of the revised requirements for disability, the effective date is the 2d month after the month of enactment.

OLD-AGE SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

III. BENEFIT CATAGORIES—Continued

Item	Existing law	H.R. 6675
D. Children—Continued	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.	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 judically 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.
	A child adopted by a worker who is already retired and getting old-age insurance benefits can become entitled to benefits without regard to whether he was dependent on the worker at the time the latter retired.	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 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 became entitled to 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. Effective for applications filed on or after the date of enactment.
E. Wife, husband, widow, and widower	Widow's benefits are paid without regard to remarriage to an individual who dies within one year of the remarriage and is not fully insured at his death and mother's insurance benefits are paid without regard to remarriage to an individual who dies if the widow or former wife divorced is not eligible for benefits on his earnings record. Widow's, widower's or mother's insurance benefits are not payable to a remarried spouse of a deceased worker; exception is made where the remarriage is to certain specified social security beneficiaries.	Widow's benefits would be paid to an aged widow and mother's benefits would be paid to a young widow or surviving divorced mother who is not married regardless of intervening marriages. Benefits based on a prior spouse's earnings record would be payable to widows age 60 or over and to widowers age 62 or over who remarry. The amount of the remarried widow's or widower's benefit would be 50 percent of the primary insurance amount of the deceased spouse.
	Wife, husband, widow and widower must have been married to the worker for one year to qualify for benefits; exception is made where, in the month preceding the marriage, the spouse was actually or potentially entitled to a widow's, widower's, parent's or disabled adult child's benefit under the social security program.	Exception to the one-year duration-of-marriage requirement extended to the spouse who was, in the month preceding the marriage, actually or potentially entitled to a widow's, widower's, parent's or (if over age 18) child's annuity under the Railroad Retirement Act.
F. Divorced wife, widow	Benefits are payable to a divorced woman only if she has a child of the deceased worker in her care and the child is getting benefits based on his deceased father's earnings, if she has not remarried, and if she had been getting at lease 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 would be payable to an aged divorced woman if she (A) had been married to her former husband for 20 years before the divorce; (B) who 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 would not reduce the benefits paid to any other person on the same social security account and such wife's or widow's benefit would not be reduced because of other benefits payable on the same account. Benefits for a divorced wife or a surviving divorced wife would not terminate on account of remarriage in those cases where widow's benefits under present law do not terminate—that is, 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 married an old-age insurance beneficiary, her benefits would terminate but she would immediately be eligible for wife's benefit on her new husband's account. A wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years. The support requirements that must be met by a former wife divorced (renamed "surviving divorced mother" in the bill) in order to qualify for mother's benefits based on the social security account of her deceased former husband would be conformed to the new support requirements for aged divorced women.
G. Dependency of husbands and widowers.	Wife must be currently insured and have provided ½ of husband's or widower's support; exception made where the husband or widower was, in the month preceding the marriage, actually or potentially entitled to widower's, parent's or disabled adult child's benefits under the social security program.	Provides an exception to the currently insured and ½ support requirements where the husband or widower was, in the month preceding the marriage, actually or potentially entitled to a widower's, parent's or (where over age 18) child's annuity under the Railroad Retirement Act. (See fully insured status p. 59.)
H. "Transitional insured status" for certain workers, wives and widows aged 72 or over.	No provision.	
I. Time for filing proof of support and application for lump-sum death payment.	Proof of support for husband's, widower's, and parent's benefits, and applications for lump-sum death payments must be filed within a 2-year period specified in the law with an additional 2-year period allowed where there was good cause for failure to file on time.	If there is good cause for failure to file in the initial 2-year period an applicant would be allowed to file at any time. Effective with respect to applications for lump-sum death payments filed in or after the month of enactment, and monthly benefits based on applications filed in or after such month.

IV. BENEFIT AMOUNTS

A. Creditable earnings	Maximum amount of earnings which may be credited for benefit purposes is $4,800 a year.	Raises maximum amount to $6,600 beginning with 1966.
B. Average monthly wage	In general, an individual's "average monthly wage" which determines his old-age insurance benefit amount (before reduction for retirement before age 65) is computed by dividing the total of his creditable earnings after the applicable starting date and up to the applicable closing date, by the number of months involved. Excluded from this computation are all months and all earnings in any year any part of which was included in a period of disability under the disability "freeze" (except that the months and earnings in the year in which the period of disability begins may be included if the resulting benefit would be higher). The average monthly wage in retirement cases is computed on the basis of a constant number of years, re-	No change except— Worker may have average monthly wage computed entirely on years after 1950 regardless of

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

IV. BENEFIT AMOUNTS—Continued

Item	Existing law	H.R. 6675
B. Average monthly wage—Continued	gardless of when, before age 22, the person started to work or when, after retirement age (62 for women, 65 for men) he files application for benefits. The number of years for a person who had at least 6 quarters of coverage after 1950 would be equal to 5 less than the number of years (excluding years in periods of disability) elapsing after 1950 or after the year in which the individual attained age 21, whichever is later, and up to the year in which the person was first eligible for old-age insurance benefits (generally the year in which he attained retirement age). In death and disability cases the number of years would be determined by the date of death or disability. In those cases where a larger benefit would result (because the individual's best earnings were in years before 1951) the number of years would be those elapsing after 1936, rather than 1950. The earnings used in the computation would be earnings in the highest years. Earnings in years prior to attainment of age 22 or after attainment of retirement age could be used if they were higher than earnings in intervening years. The span of years could never be less than 2. Generally, the span of years to be used for the benefit computation in retirement cases could not be less than 5—the number of years that would have to be used under the prior law by people who attained retirement age in 1961.	whether he has 6 quarters of coverage after 1950, and his closing date would be the year of attainment of age 65 (62 for women) regardless of whether he is eligible (insured) in that year.
C. Recomputations	After a person has become entitled to benefits, he may, under certain circumstances, have his "average monthly wage" recomputed if it will increase his monthly benefit: (1) Recalculation to correct errors in original computation. (2) 1954 work recomputation: Where an individual who has 6 quarters of coverage after 1950 returns to work after becoming entitled to benefits and earns more than $1,200 in a year he may have his average monthly wage recomputed including such earnings. Survivors are also entitled to any increase in benefits which would result from such recomputation. (3) Dropout recomputation: Beneficiary who became entitled to benefits prior to the amendment which allowed a dropout of 5 years of lowest earnings may have a recomputation using the dropout if he has 6 quarters of coverage after June 1953. Survivors are entitled to any increases which would result from such a recomputation. (4) Current year recomputation: An individual becoming entitled to benefits after August 1954	Provides for automatic annual recomputation; beginning with 1965, earnings in and after the year of 1st entitlement will be taken into account regardless of whether the worker has 6 quarters of coverage after 1950, or earns over $1,200, or files an application to have his benefits recomputed. Individuals eligible for a recomputation under present law would be deemed to have applied for such recomputation no later than Jan. 1, 1966 (so that it would be made automatically).

	may have a recomputation which will include earnings in the year he retires if such earnings were not included in the original calculation. Survivors are entitled to any increases which would result from such a recomputation. (5) Recomputation of benefits at age 65 (the "round up"): If a reduced benefit has been withheld (most common reason would be earnings which caused benefit withholding under the retirement test) for at least 3 months (during the period of reduced benefit) a person is entitled to a recomputation at age 65 which will readjust post-65 benefits to take into account the months in which the reduced benefit was withheld. (6) Other recomputations: Provides several recomputations of limited application.	Provision also made applicable at age 62 to reduced benefits for widows who were aged 60–61 at time of claim.
D. Benefit formula	The law provides a consolidated benefit table which is used in determining benefit amounts for both future beneficiaries and those now on the benefit rolls. Though not specifically stated in the law the formula for the primary insurance amount is, in effect, 58.85 percent of the 1st $110 of the average monthly wage, plus 21.40 percent of the next $290 of such wage (except that in some cases, for average monthly wages under $85, a slightly higher amount is payable so as to fit in with the minimum benefit).	The existing benefit table is amended so as to increase all primary insurance amounts by 7 percent, with a $4 guaranteed minimum increase. The existing benefit table is replaced by a new benefit table to reflect the annual earnings base of $6,600 effective in 1966. For average monthly wages above $400, primary insurance amounts are derived by applying the benefit formula underlying the present table and adding $9.00, the amount of increase provided for persons with the present maximum average monthly wage of $400 ($8.90) rounded to the nearest dollar. The formula underlying the new benefit table is approximately 62.97 percent of the 1st $110 of the average monthly wage, plus 22.9 percent of the next $290, plus 21.4 percent of the next $150.
E. Maximum primary insurance amount	$127 a month ($400 average monthly wage).	Increases to $135.90 ($400 average monthly wage) and eventually to $168 ($550 average monthly wage).
F. Minimum primary insurance amount	$40 a month.	Increases minimum benefit to $44 per month.
G. Maximum family benefits	Family maximum monthly benefits are set by the table and range from $53 to $254. Though not specifically stated in the law, the maximum family benefit shown in the benefit table is 1½ times the primary insurance amount or approximately 80 percent of the average monthly wage, whichever is larger, up to an absolute maximum of $254—twice the maximum primary insurance amount of $127.	Family maximum benefits will range from $66 to a maximum of $368. Although not specifically stated in the bill, the formula used to determine the maximum family benefit shown in col. V of the new benefit table is the larger of (a) 1½ times the primary insurance amount or (b) approximately 80 percent of the average monthly wage up to the point at which the average monthly wage is ⅔ of the maximum possible average monthly wage, plus 40 percent of the remainder. The maximum benefits payable to a family would be related to the worker's average monthly wage at every average monthly wage bracket in the benefit table. The maximum payable to a family now on the benefit rolls would be $309.20 (based on an average monthly wage of $400). At the maximum average monthly wage level, $550 (under the $6,600 base), the maximum family benefit would be about ⅔ of the average monthly wage.
H. Lump-sum death payment	3 times the primary insurance amount with a statutory maximum of $255.	Effective for monthly benefits beginning with January 1965; effective for lump-sum death payment where death occurs in or after month of enactment. No change.

Illustrative benefits provided under present law and in 1936 under bill

I. Illustrative monthly benefits;

Average monthly wage [1]	Old-age benefits [2]				Survivors benefits				
	Worker		Man and wife [3]		Widow aged 62, widower, or parent		Widow aged 60 [4]	Widow and 2 children [5]	
	Present law	Bill	Present law	Bill	Present law	Bill	Bill	Present law	Bill
$67 or less	$40.00	$44.00	$60.00	$66.00	$40.00	$44.00	$38.20	$60.00	$66.00
$100	59.00	63.20	88.50	94.80	48.70	52.20	45.30	88.50	94.80
$150	73.00	78.20	109.50	117.30	60.30	64.60	56.00	120.00	120.00
$200	84.00	89.90	126.00	134.90	69.30	74.20	64.40	161.70	161.70
$250	95.00	101.70	142.50	152.60	78.40	83.90	72.80	202.50	202.50
$300	105.00	112.40	157.50	168.60	86.70	92.80	80.50	236.40	240.00
$350	116.00	124.20	174.00	186.30	95.70	102.50	88.90	254.10	279.60
$400	127.00	135.90	190.50	203.90	104.80	112.20	97.30	254.10	306.00
$466	(6)	150.00	(6)	225.00	(6)	123.80	107.30	(6)	335.40
$500	(6)	157.00	(6)	235.50	(6)	129.60	112.40	(6)	348.60
$550	(6)	168.00	(6)	252.00	(6)	138.60	120.20	(6)	368.00

[1] As defined in the law.

[2] Worker aged 65 or over at time of retirement, and wife age 65 or over at the time when she comes on the rolls.

[3] Survivor benefit amounts for a widow and 1 child or for 2 parents would be the same as for a man and wife.

[4] Not applicable under present law.

[5] Survivor benefit amounts for 3 children would be the same as for a widow and 2 children

[6] Not applicable since maximum average monthly wage possible is $400.

V. FULLY INSURED STATUS

Item	Present law	H.R. 6675
	To be fully insured an individual must have either— (1) 40 quarters of coverage; or (2) 1 quarter of coverage (acquired at any time after 1936) for every year elapsing after 1950 (or after the year in which he attained age 21, if that was later) and up to the year of disability, death, or attainment of age 65 for men (62 for women), but with a minimum of 6 quarters of coverage; or (3) 6 quarters of coverage if individual died before 1951.	No change in regular provision but adds a new concept of— *Transitional insured status worker*—Adds a provision for a special insured status for individuals who have attained 72 so that the 6-quarter minimum is reduced to 3 quarters. The following chart shows the "transitional" requirement for workers as compared with the regular requirement of existing law:

Year of attainment of retirement age 62 (for women) or age 65 (for men)	Required quarters	
	Existing law	Proposed
1954 and earlier	6	3
1955	6	4
1956	6	5
1957	6	6

A worker who meets the above requirements (including attainment of 72) will be paid a benefit of $35 a month, and his wife a benefit of $17.50 at age 72 if she has attained age 72 before 1969.

Widow's benefits would be payable at age 72 to a woman who reached age 72 before 1969 if her husband was living when the transitional provision became effective and if he met the work requirements of the provision. A widow who reached age 72 before 1969 but whose husband died before the transitional provision became effective could qualify if her husband had attained age 65 or died before 1957 and if he had a specified number of quarters of coverage as shown in the following table:

Year of husband's death (or attainment of age 65, if earlier)	Quarters of coverage required under present law	Quarters of coverage required if the widow attains age 72—		
		In 1966 or before	In 1967	In 1968
1954 or before	6	3	4	5
1955	6	4	4	5
1956	6	5	5	5

Upon attaining age 72, an eligible widow will be paid a monthly benefit of $35.

Effective for monthly benefits for and after the 2d month following the month of enactment.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

VI. RETIREMENT TEST

Item	Present law	H.R. 6675
A. Scope	Applies to covered as well as noncovered work.	Excludes royalties received at or after age 65 on works copyrighted or patented before age 65. Effective for taxable years beginning after 1964.
B. Test of earnings	Provides that benefits will be withheld from a beneficiary under age 72 (and from any dependent drawing on his record) at the rate of $1 in benefits for each $2 of annual earnings between $1,200 and $1,700 and $1 in benefits for each $1 of annual earnings above $1,700. Benefits not withheld for any month during which the individual neither rendered services for wages in excess of $100 nor rendered substantial services in a trade or business.	Increases the annual exempt amount from $1,200 to $1,800. Permits payment of full benefits to beneficiary, regardless of the amount of his annual earnings, for any month in which he does not earn wages of more than $150, instead of more than $100. Increases the uppermost limit of the $1-for-$2 "band" from $1,700 to $3,000, so that $1 in benefits would be withheld for each $2 of earnings between $1,800 and $3,000, with $1-for-$1 reductions above $3,000. Effective for taxable years ending after 1965.
C. Age exemption	Benefits are not suspended because of work or earnings if beneficiary is age 72 or over.	No change.

VII. FINANCING

Item	Present law	H.R. 6675
A. Allocation between trust funds	The Federal Old-Age and Survivors Insurance Trust Fund receives all tax contributions other than those allocated for the disability benefit program, from which benefits and administrative expenses are paid for the old-age and survivors insurance program. The Federal Disability Insurance Trust Fund receives an amount equal to ½ of 1 percent of taxable wages plus ¾ of 1 percent of self-employment income, from which benefit and administrative expenses are paid for the disability insurance program. 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).	Increases the allocation to the Disability Insurance Trust Fund, for years beginning after 1965, to 0.70 of 1-percent of taxable wages and 0.525 of 1-percent of taxable self-employment income.
B. Maximum taxable amount	$4,800 a year.	$6,600 a year starting with 1966.
C. Tax rate for self-employed	Taxable years beginning in— 1966–67 — 6.2 1968 and thereafter — 6.9	Taxable years beginning in— 1966–68 — 5.8 1969–72 — 6.7 1973 and thereafter — 7.0
D. OASDI tax rate for employees and employers (each).	Calendar years: 1966–67 — 4.125 1968 and thereafter — 4.625	Calendar years: 1966–68 — 3.85 1969–72 — 4.45 1973 and thereafter — 4.9
E. Reimbursement of the trust funds for the cost of noncontributory military service credits.	Amounts to cover the costs incurred through June 30, 1956, were to have been appropriated to the trust funds from general revenue over the 10 fiscal years ending June 30, 1969; costs incurred after June 30, 1956, were to have been appropriated to the trust funds annually.	The trust funds would be reimbursed by a level annual appropriation starting with fiscal year 1966 that would amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015, and by annual appropriations thereafter.

F. Railroad retirement tax	The Railroad Retirement Tax Act provides that the railroad tax will automatically adjust in the same amount, and at the same time, to any change in the OASDI tax rate after 1954.	No change, except for simplifying amendment.

VIII. MISCELLANEOUS

A. Advisory Council on Social Security	Councils are to be appointed in 1966 and every 5th year thereafter to review the financing of the program and submit reports to the Board of Trustees for inclusion in the annual Trustees' report to the Congress. Members are to represent employees and employers in equal numbers and the self-employed and the general public and can be paid up to $50 per day.	Councils would be appointed in 1968 and every 5th year thereafter to review all aspects of the program (including the new hospital and supplementary medical insurance programs) and submit reports to the Secretary of Health, Education, and Welfare for transmittal to the Congress and the Board of Trustees. Members are to represent *organizations* of employees and employers in equal numbers and the self-employed and the general public and could be paid up to $100 a day.
B. Board of Trustees	The Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund are required to meet at least once every 6 months.	The Board of Trustees would be required to meet at least once every calendar year.
C. Affiliated corporations	When a person works for more than 1 corporation in an affiliated group of corporations, each such corporation is considered a separate employer for purposes of determining the maximum amount of wages subject to employer taxes.	When a person works for more than 1 corporation in an affiliated group of corporations, the affiliated group would be considered as a single employer for purposes of determining the maximum amount of wages subject to employer taxes.
D. Paying two or more members of same family.	Secretary of Health, Education, and Welfare may authorize a joint payment equal to the total benefits due to any two or more members of the same family.	Adds a provision that Secretary of the Treasury may authorize the surviving payee or payees of a joint benefit check to cash any such check which was not negotiated before one of the payees died, provided that any part that is an overpayment of benefits is recovered or adjusted.
E. Overpayments and underpayments	Whenever an error is made in paying benefits, future benefits of the beneficiary are increased or decreased until proper adjustments have been made. If the beneficiary dies before adjustment is completed, subsequent benefits based on same wages and self-employment income are increased or decreased until proper adjustment has been made. Adjustment or recovery of an overpayment is waived if the overpaid person is without fault and adjustment or recovery would defeat the purpose of the program or would be against equity and good conscience.	Permits the Secretary to adjust any overpayment by decreasing the benefits of all other persons entitled on the basis of the same wages and self-employment income during the lifetime as well as after the death of the overpaid individual. Permits the Secretary to establish an order of priority for making any payment of benefits due a deceased beneficiary. Permits the Secretary to waive recovery or adjustment of an overpayment from any person who is without fault in the overpayment, even if he is not the overpaid person and the overpaid person is at fault.
F. Attorneys' fees	The Secretary may prescribe the maximum fees which an attorney or other person may charge for services performed in connection with any claim before the Secretary. Any person who charges or collects more than the permitted fee is subject to a fine of up to $500, imprisonment up to one year, or both.	Adds a provision to permit 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.

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