89th Congress, 1st Session - - - - - - House Report No. 213

SOCIAL SECURITY AMENDMENTS OF 1965

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS

ON

H.R. 6675

TO PROVIDE A HOSPITAL INSURANCE PROGRAM FOR THE AGED UNDER THE SOCIAL SECURITY ACT WITH A SUPPLEMENTARY HEALTH BENEFITS PROGRAM AND AN EXPANDED PROGRAM OF MEDICAL ASSISTANCE, TO INCREASE BENEFITS UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO IMPROVE THE FEDERAL-STATE PUBLIC ASSISTANCE PROGRAM, AND FOR OTHER PURPOSES

MARCH 29, 1965.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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MARCH 29, 1965.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MILLS, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 6675]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. OVERALL PURPOSE AND SCOPE OF THE BILL

PURPOSE

The overall purpose of H.R. 6675 is as follows:

First, to provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing—

(1) A basic plan providing protection against the costs of hospital and related care financed through a separate payroll tax and separate trust fund;

(2) A voluntary "supplementary" plan providing payments for physicians' and other medical and health services financed through small monthly premiums by individual participants matched equally by Federal Government revenue contributions; and

(3) A greatly expanded medical assistance program for the needy and medically needy which would 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 and matching formula in a single new title.

Second, to expand the services for maternal and child health, crippled children, and the mentally retarded, and to establish a 5-year program of "special project grants" to provide comprehensive health care and services for needy children of school age or preschool age.

Third, to revise and improve the benefit and coverage provisions and the financing structure of the Federal old-age, survivors', and disability insurance system by—

(1) Increasing benefits by 7 percent across the board with a $4 minimum increase for a worker retiring or who retired age 65 or older;

(2) Continuing benefits to age 22 for children attending school;

(3) Providing actuarially reduced benefits for widows at age 60;

(4) Liberalizing the definition and waiting period for disability insurance benefits;

(5) Paying benefits on a transitional basis to certain persons currently 72 or over who are now ineligible;

(6) Increasing the amount an individual is permitted to earn without losing benefits;

(7) Amending the coverage provisions by:

(*a*) Including self-employed physicians;

(*b*) Covering cash tips;

(*c*) Liberalizing the income treatment for self-employed farmers;

(*d*) Improving certain State and local coverage provisions;

(*e*) Exempting certain religious groups opposed to insurance;

(8) Revising the tax schedule and the earnings base so as to fully finance the changes made; and

(9) Making other miscellaneous improvements.

Fourth, to improve and expand the public assistance programs by—

(1) Increasing the Federal matching share for cash payments for the needy aged, blind, disabled, and families with dependent children;

(2) Eliminating limitations on Federal participation in public assistance to aged individuals in tuberculosis and mental disease hospitals under certain conditions;

(3) Affording the States broader latitude in disregarding certain earnings in determining need for aged recipients of public assistance; and

(4) Making other improvements in the public assistance titles of the Social Security Act.

SCOPE

The scope of the protection provided is broadly as follows:

Health insurance and medical care for the needy

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

(2) *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.

(3) *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.

Old-age, survivors, and disability insurance

It is estimated that the number of persons affected immediately by changes in this title would be as follows:

Provision	*Number affected*
7-percent benefit increase ($4 minimum in primary benefit)	20 million persons.
Child's benefit to age 22 if in school	295,000 children.
Reduced age for widows	185,000 widows.
Reduction in eligibility requirement for certain persons aged 72 or over	355,000 persons.
Liberalization of disability definition	155,000 workers and dependents.

Public assistance

It is estimated that some 7.2 million persons will be eligible for increased cash payments under the Federal-State matching programs. Moreover, it is estimated that 130,000 aged persons in mental and tuberculosis hospitals will potentially be eligible for payments because of the removal of the exclusion of these types of institutions from matching under the public assistance programs.

II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. Health Insurance and Medical Care for the Aged

Your committee's bill would add a new title XVIII to the Social Security Act 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 and railroad 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.

Your committee's bill would also add a new title XIX 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 replace 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:

1. BASIC PLAN—HOSPITAL INSURANCE, ETC.

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. 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.

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.

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

(1) inpatient hospital services for up to 60 days in each spell of illness with the patient paying a deductible amount of $40 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 services provided by interns or residents in training under approved teaching programs;

(2) 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 20 days in each spell of illness; 2 additional days will be added to the 20 days for each day that the person's hospital stay was less than 60 days (up to a maximum of 80 additional days)—the overall maximum for posthospital extended care could thus be 100 days in each spell of illness;

(3) outpatient hospital diagnostic services with the patient paying a $20 deductible amount for each diagnostic study (that is, for diagnostic services furnished to him by the same hospital during a 20-day period); if, within 20 days after receiving such services, the individual is hospitalized as an inpatient in the same hospital, the deductible he paid for outpatient diagnostic services (up to $20) would be credited against the inpatient hospital deductible ($40); and

(4) posthospital home health services for up to 100 visits, after discharge from a hospital (after at least a 3-day stay) or extended care facility and before the begininng 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 aide. 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. For reasons of administrative simplicity, increases in the hospital deductible will be made only when a $5 change is called for and the outpatient deductible will change in $2.50 steps.

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.

Administration.—Basic responsibility for administration would rest with the Secretary of Health, Education, and Welfare. 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.

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 (wage 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	0.35
1967–72	.50
1973–75	.55
1976–79	.60
1980–86	.70
1987 and thereafter	.80

The taxable earnings base for the health insurance tax would be $5,600 a year for 1966 through 1970 and would thereafter be increased to $6,600 a year.

The schedule of contribution rates is based on estimates of cost which assume that the earnings base will not be increased above $6,600. If Congress, in later years, should increase the base above $6,600, the tax rates established can be reduced under the cost assumptions underlying the bill.

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.

2. VOLUNTARY SUPPLEMENTARY INSURANCE PLAN

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 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 over the amount of monthly premiums.

Enrollment.—Persons who have reached age 65 before January 1, 1966, will have an opportunity to enroll in an enrollment period which begins on the first day of the second month after the month of enactment and ends March 31, 1966.

Persons attaining age 65 subsequent to December 31, 1965, 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 to December 31, in each odd numbered year. The first such period will be October 1 to December 31, 1967.

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 its public assistance recipients who are receiving cash assistance if it chooses to do so.

Effective date.—Benefits will be effective beginning July 1, 1966.

Benefits.—The voluntary supplementary insurance plan would cover physicians' services, home health services, hospital services in psychiatric institutions, 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) Hospital care for 60 days in a spell of illness in a mental hospital with a 180-day lifetime maximum;

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

(4) Additional medical and health services, whether provided in or out of a medical institution, including the following:

(*a*) Diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests;

(*b*) X-ray, radium, and radioactive isotope therapy;

(*c*) Ambulance services; and

(*d*) Surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home, prosthetic devices (other than dental) which replace all or part of an internal body organ; braces and artificial legs, arms, eyes, etc.

There 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.

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.

Financing.—Aged persons who enroll in the supplemental plan would pay monthly premiums of $3. Where the individual is currently receiving monthly social security or railroad 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 July 1966 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 medical 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 year he stayed out of the program.

Medical expense deduction.—The health care provisions of your committee's bill have a relationship to the medical expense deductions allowed under the Internal Revenue Code. In the past the 3-percent limitation in the case of medical care expenses and the 1-percent limitation applied to expenditures for medicines and drugs were waived for persons 65 or over in recognition of the fact that medical expenses generally constituted a heavy financial burden for older people. In the past, however, there was no broad-coverage health insurance plan for older persons. The health insurance provisions of your committee's bill are designed to meet these problems in a generally comprehensive manner. The historical basis for the special medical expense provisions in the tax law for the relief of older taxpayers, therefore, no longer appears to exist. For this reason the bill provides that the 3-percent floor on medical expense deductions, as

well as the 1-percent limitation on medicines and drugs, is to apply to those age 65 or over in the same manner as it presently applies to those under age 65. This will have the effect of partially or fully recovering the $3 monthly premium paid from general funds of the Treasury from those aged persons who have taxable income, depending on the amount of their taxable income.

To encourage the purchase of hospital insurance by all taxpayers, the bill provides a special deduction, available to those who itemize their deductions, for one-half of any premiums paid for insurance of medical care expenses whether or not they have medical expenses in excess of the 3-percent floor, but this deduction may not exceed $250.

Another change limits the insurance premiums which may be taken into account to those which arise from coverage of medical care expenses. Still a further change treats as current, qualifying medical care expenses (subject to limitations) the prepayment before age 65 of insurance for medical care after age 65.

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

Purpose and scope.—In order to provide a more effective Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons, the bill would establish a single and separate medical care program to replace 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.

The current provisions of law in the various public assistance titles of the act providing vendor medical assistance would terminate upon the adoption of the new program by a State and must terminate no later than June 30, 1967.

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 would require that by July 1, 1967, under the new program a State must provide inpatient hospital services, outpatient hospital

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services, other laboratory and X-ray services, skilled nursing home services, and physicians' services (whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere) in order to receive Federal participation. Coverage of other items of medical service would be optional with the States.

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 arbitrarily deny assistance to people with large medical bills. In the same spirit 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.

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 precent 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 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.

Administration.—The State agency administering the new program would have to be the same as that administering the old-age assistance program. As some States have done under existing law, such an agency could arrange for provision of medical care by or through the State health agency. The bill specifically provides as a State plan requirement that cooperative agreements be entered into with State agencies providing health services and vocational rehabilitation services looking toward maximum utilization of these services in the provision of medical assistance under the plan.

Effective date.—January 1, 1966.

4. COST OF HEALTH CARE PLANS

Basic plan.—Benefits and administrative expenses under the basic plan would be about $1 billion for the 6-month period in 1966 and about $2.3 billion in 1967. Contribution income for those years would be about $1.6 and $2.6 billion, respectively. The costs for the uninsured (paid from general funds) would be about $275 million per year for early years

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 $195 million to $260 million in the last 6 months of 1966 and about $765 million to $1.02 billion in 1967. Premium income from enrollees for those years would be about $275 and $560 million, respectively. The matching Government contribution would equal the premiums.

If 95 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about $230 to $310 million in 1966 and about $905 million to $1.22 billion in 1967. Premium income from enrollees for those years would be about $325 and $665 million, respectively. The Government contribution would equal the premiums.

Public assistance plan.—It is estimated that the new program will increase the Federal Government's contribution about $200 million in a full year of operation over that in the programs operated under existing law.

B. CHILD HEALTH AMENDMENTS

Maternal and child health and crippled children.—The bill would increase the amount authorized for maternal and child health services over current authorizations by $5 million for fiscal year 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

The authorizations for crippled children's service would be increased by the same amounts.

The increases would assist the States, in both these programs, in moving toward the goal of extending services with a view of making them available to children in all parts of the State by July 1, 1975.

Crippled children-training personnel.—The bill would also authorize $5 million for the fiscal year 1967, $10 million for fiscal 1968, and $17.5 million for each succeeding fiscal year to be 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.

Health care for needy children.—A new provision is added authorizing the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool

children, particularly in areas with concentrations of low-income families. The grants would be to State health agencies, to the State agencies administering the crippled children's program, to any school of medicine (with appropriate participation by a school of dentistry), and any teaching hospital affiliated with such school, to pay not to exceed 75 percent of the cost of the project. Projects would have to provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, including dental services, with treatment, correction of defects, and aftercare limited to children in low-income families.

An appropriation of $15 million would be authorized for the fiscal year ending June 30, 1966; $35 million for the fiscal year ending June 30, 1967; $40 million for the fiscal year ending June 30, 1968; $45 million for the fiscal year ending June 30, 1969; and $50 million for the fiscal year ending June 30, 1970.

Mental retardation planning.—Title XVII of the act would be amended to authorize grants totaling $2,750,000 for each of 2 fiscal years—the fiscal year ending June 30, 1966, and fiscal year ending June 30, 1967. The funds would be available during the 3-year period July 1, 1965, to June 30, 1968. The grants would be for the purpose of assisting States to implement and fellowup on plans and other steps to combat mental retardation authorized under this title of the Social Security Act.

C. Old-Age, Survivors, and Disability Insurance Amendments

1. BENEFIT CHANGES

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

The bill provides a 7-percent across-the-board benefit increase, effective retroactively beginning with January 1965, with a minimum increase of $4 for retired workers at age 65. These increases will be made for the 20 million social security beneficiaries now on the rolls.

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 $5,600 a year (now $4,800) would make possible a maximum benefit of $149.90.

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, until 1971, the highest family maximum would be $312.

Under the second-step increase in the wage base to $6,600 to be effective in 1971, also provided in the bill, the worker's primary benefit would range from a minimum of $44 to a future possible maximum of $167.90 a month. Maximum family benefits up to $368 would also be payable.

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

H.R. 6675 includes the provision adopted by both House and Senate last year 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 effective January 1, 1965. It is estimated that 295,000 children will be able to receive benefits for a typical school month in 1965 as a result of this provision.

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

The bill would provide the option to widows of receiving benefits beginning at age 60, 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 be able to get benefits immediately under this provision.

(*d*) *Amendment of disability program*

(i) *Definition.*—H.R. 6675 would eliminate the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration, and instead provide that an insured worker would be eligible for disability benefits if he has been totally disabled throughout a continuous period of at least 6 calendar months. Benefits payable by reason of this change would be paid for the second month following the month of enactment.

(ii) *Payment period.*—The period during which an individual must be under a disability prior to entitlement of benefits is reduced by 1 month under the bill. Disability benefits would be payable beginning with the last month of the 6-month waiting period rather than with the first month after the 6-month waiting period as under existing law. This change would be applicable to all cases in which the last month of the waiting period occurs after the month of enactment.

It is estimated some 155,000 disabled workers and dependents will be benefited by these provisions.

Certain changes are also made in the provision terminating disability benefits and waiving subsequent waiting periods so as to make them more restrictive when applied to shorter term disabilities.

(*iii*) *Entitlement to disability benefits after entitlement to benefits payable on account of age.*—Under the bill, a person who becomes entitled before age 65 to a benefit payable on account of old age could later become entitled to disability insurance benefits.

(*iv*) *Allocation of contribution income between OASI and DI trust funds.*—Under the bill, an additional one-fourth of 1 percent of taxable wages and three-sixteenths of 1 percent of taxable self-employment income would be allocated to the disability insurance trust fund, bringing the total allocation to three-fourths of 1 percent and nine-sixteenths of 1 percent, respectively, beginning in 1966.

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

Your committee's bill adopts a provision approved by the House and Senate last year, which would liberalize the eligibility requirements 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.

(i) *Men and women workers.*—The concept of "transitional insured status" which would make an individual eligible for an old-age or wife's benefit provides that the oldest workers will receive benefits with only three quarters of coverage, under the bill. These three quarters may have been acquired at any time since the inception of the program in 1937. For those who are not quite so old, the quarters of coverage requirement would increase until the requirement merges with the present minimum requirement of six quarters.

The following table illustrates the operation of the "transitional insured status" provision for workers.

Transitional insured status requirements with respect to workers benefits [1]

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965)	Quarters of coverage required
76 or over	3.	73 or over	3.
75	4.	72	4.
74	5.	71	5.
73 or younger	6 or more.	70 or younger	6 or more.

[1] Benefits will not be payable, however, until age 72.

(ii) *Widows.*—Any widow who is age 72 or over in 1966, if her husband died or reached age 65 in 1954 or earlier, could get a widow's benefit if her husband had at least three quarters of coverage. Present law requires six quarters.

If the husband died or reached 65 in 1955, the requirement would be four quarters. If he died or reached 65 in 1956, the requirement would be five quarters. If he died or reached 65 in 1957 or later, the minimum requirement would be six quarters, the same as present law.

For widows reaching age 72 in 1967 and 1968, there is a "grading-in" of the quarters of coverage requirement; which would be four or five quarters of coverage, respectively. Widows reaching age 72 in in 1969 or after would be subject to the requirements of existing law of six or more quarters of coverage.

The table below sets forth the requirements as to widows:

Transitional insured status requirements with respect to widow's benefits

Year of husband's death (or attainment of age 65, if earlier)	Present quarters required	Proposed quarters required for widow attaining age 72 in—		
		1966 or before	1967	1968
1954 or before	6	3	4	5.
1955	6	4	4	5.
1956	6	5	5	5.
1957 or after	6 or more	6 or more	6 or more	6 or more.

(*iii*) *Basic benefits.*—Men and women workers who would be eligible under the above-described provisions for workers would receive a basic benefit of $35 a month. A wife who is aged 72 or over (and who attains that age before 1969) would receive one-half of this amount, $17.50. No other dependents' basic benefits would be provided under these provisions.

Widows would receive $35 a month under the above-described provision.

These provisions 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.

(*f*) *Retirement test*

H.R. 6675 liberalizes the social security earned income limitation so that the uppermost limit of the "band" of a $1 reduction in benefits for each $2 in earnings is raised from $1,700 to $2,400. Under existing law the first $1,200 a year in earnings is wholly exempted, and there is a $1 reduction in benefits for each $2 of earnings up to $1,700 and $1 for $1 above that amount.

Your committee's bill would increase the $1 for $2 "band" so that it would apply between $1,200 and $2,400, with $1 for $1 reductions above $2,400. This change is effective as to taxable years ending after 1965.

The bill also exempts certain royalties received in or after the year in which a person reaches age 65 from copyrights and patents obtained before age 65, from being counted as earnings for purposes of this test, effective as to taxable years beginning after 1964.

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

Your committee's bill would authorize payments of wife's and widow's benefits to the divorced wife aged 62 or over 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 widow or a wife who remarries and the subsequent marriage lasts less than 20 years. These changes are effective for the second month following the month of enactment.

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

Your committee's bill would change the provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries 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 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.

2. COVERAGE CHANGES

The following coverage provisions were included:

(*a*) *Physicians and interns*

Self-employed physicians would be covered for taxable years ending after December 31, 1965. Interns would be covered beginning on January 1, 1966.

(*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.)

(*c*) *Cash tips*

Coverage of cash tips received by an employee in the course of his employment as wages would be provided, effective as to tips received after 1965.

(*i*) *Reporting of tips.*—The employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. The employee's report to his employer would include tips paid to him through the employer as well as those received directly from customers of the employer. Tips received by an employee which do not amount to a total of $20 a month in connection with his work for any one employer would not be covered and would not be reported.

(*ii*) *Tax on tips.*—The employer would be required to withhold social security taxes only on tips reported by the employee to him. Unlike the provision in last year's House bill, this provision requires the employer to withhold income tax on such reported tips.

The employer would be responsible for the social security tax on tips only if the employee reported the tips to him within 10 days after the end of the month in which the tips were received. The employer would be permitted to gear these new procedures into his usual payroll periods. The employer would pay over his own and the employee's share of the tax on these tips and would include the tips with his regular reports of wages. If at the time the employee report is due (or, in cases where the report is made earlier—if between the making of the report and the time it is due), the employer does not have unpaid wages or remuneration of the employee under his control sufficient to cover the employee's share of the social security tax applicable to the tips reported, the employee will pay his share of the tax with his report.

If the employee does not report his tips to his employer within 10 days after the end of the month involved, the employer would have no liability. In such a case the employee alone would be liable not

only for the amount of the employee tax but also an additional amount equal to the employee tax.

For purposes of withholding income tax on tips, the employer is required to deduct and withhold only on the tips reported to him and only to the extent that the tax can be deducted and withheld before the close of the calendar year from wages (excluding tips, but including funds turned over to the employer by the employee for such purpose) under the control of the employer.

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

Several changes made by the bill would facilitate social security coverage of additional employees of State and local governments.

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

Members of certain religious sects may be exempt from the tax on self-employment income and from social security coverage upon application which would be accompanied by a waiver of benefit rights.

An individual eligible for the exemption must be a member of a recognized religious sect (or a division of a sect) who is an adherent of the established teachings of such sect by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance, making payments in the event of death, disability, old-age, or retirement, or making payments toward the cost of or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act).

The Secretary of Health, Education, and Welfare must find that such sect has such teachings and has been in existence at all times since December 31, 1950, and that it is the practice for members of such sect to make provision for their dependent members which, in the Secretary's judgment, is reasonable in view of their general level of living. The exemption for previous years (taxable years ending prior to December 31, 1965) must be filed by April 15, 1966.

The exemption would be effective as early as taxable years beginning after December 31, 1950.

3. MISCELLANEOUS

(*a*) *Filing of proof*

H.R. 6675 extends indefinitely the period of filing of proof of support for dependent husbands, widowers 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.

(*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.

(*c*) *Military wage credits*

Your committee's bill revises the present provision authorizing reimbursement of the trust funds out of general revenue for gratuitous social security wage credits for servicemen so that such payments will be spread over the next 50 years.

4. FINANCING OF OASDI AMENDMENTS

The benefit provisions of H.R. 6675 are financed by (1) an increase in the earnings base from $4,800 to $5,600 (effective January 1, 1966), and $6,600 (effective 1971), and (2) a revised tax rate schedule.

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

[In percent]

Years	Employer-employee rate (each)		Self-employed rate	
	Present law	Bill	Present law	Bill
1965	3.625	3.625	5.4	5.4
1966	4.125	4.0	6.2	6.0
1967	4.125	4.0	6.2	6.0
1968	4.625	4.0	6.9	6.0
1969–72	4.625	4.4	6.9	6.6
1973 and after	4.625	4.8	6.9	7.0

5. AMOUNT OF ADDITIONAL BENEFITS IN THE FULL YEAR 1966

7 percent benefit increase ($4 minimum in primary benefit)	$1,430,000,000.
Child's benefit to age 22 if in school	$195,000,000.
Reduced age for widows	$165,000,000 (no long-range charge to system because of actuarial reduction).
Reduction in eligibility requirement for certain persons aged 72 or over	$140,000,000.
Liberalization of disability definition	$105,000,000.
Liberalization of retirement test	$65,000,000.

D. Public Assistance Amendments

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 (29/35) of the first $35) up to a maximum of $75 (now $70) per month per individual on an average basis. The matching formula is revised for aid to families with dependent children so as to provide a Federal share of five-sixths (5/6) of the first $18 (now fourteen-seventeenths (14/17) of the first $17) 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. Effective January 1, 1966. Cost About $150 million a year.

2. TUBERCULAR AND MENTAL PATIENTS

H.R. 6675 removes the exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) 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. The bill requires as condition of Federal participation in such payments to, or for, patients in mental hospitals certain agreements and arrangements to assure that better care results from the additional Federal money. The States will receive additional Federal funds under this provision only to the extent they increase their expenditures for mental health purposes under public health and public welfare programs. The bill also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions.

Effective January 1, 1966. Cost: About $75 million a year.

3. PROTECTIVE PAYMENTS TO THIRD PERSONS

A provision for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined program, title XVI program) unable to manage their money because of physical or mental incapacity is added by H.R. 6675. Effective January 1, 1966.

4. EARNINGS EXEMPTION UNDER OLD-AGE ASSISTANCE

Your committee's bill increases earnings exemption under old-age assistance program (and aged in combined program) 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. Effective January 1, 1966. Cost: About $1 million first year.

5. DEFINITION OF MEDICAL ASSISTANCE FOR AGED

H.R. 6675 modifies the definition of medical assistance for the aged 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. Effective July 1, 1965. Cost: About $2 million.

6. EXEMPTION OF RETROACTIVE OASDI BENEFIT INCREASE

The bill adds a provision which would allow the States 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.

7. ECONOMIC OPPORTUNITY ACT EARNINGS EXEMPTION

H.R. 6675 also provides a grace period 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 the Economic Opportunity Act.

8. 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.

III. GENERAL DISCUSSION OF THE BILL

A. Provisions Related to Health Care

Today, few older people are free of the fear that costly illness will exhaust their savings. In many instances the one or more episodes of hospitalization which virtually all aged people will experience can quickly dissipate whatever savings they have been able to accumulate for their later years. The frequent medical attention required by older people suffering from chronic illness can also be a serious drain on their financial resources

A large and growing proportion of the elderly applying for public assistance have had to do so only because they cannot afford needed health care. Frequently the assistance for which they must apply is very limited in scope and inadequate to meet their needs.

Your committee has been concerned about this problem for a number of years. As may be recalled, in 1960 in the 86th Congress after very careful and exhaustive review of the situation and many proposed solutions, the Committee on Ways and Means concluded that further Federal legislation was necessary. The result was the formulation and enactment of the medical assistance for the aged program, more popularly referred to as the "Kerr-Mills" program. At that time it was the view of your committee that such a program should be undertaken to determine whether it would or could adequately meet the national need. It has now been 5 years since enactment of the 1960 Social Security Amendments and there has been opportunity to evaluate the implementation of the medical assistance for the aged program and to formulate a judgment as to the extent to which this national problem is being met. The Committee on Ways and Means has conducted public hearings in the past two Congresses on this subject, the more recent of which was just last year. Although your committee believes that the Kerr-Mills legislation as a whole has been very beneficial to the needy aged in our country, it has now concluded that the overall national problem of adequate medical care for the aged has not been met to the extent desired under existing legislation because of the failure of some States to implement to the extent anticipated and thus the existing program is inadequate to solve the problem. Your committee, therefore, has concluded that a more comprehensive Federal program as to both persons who can qualify and protection afforded is required.

Therefore, a threefold approach to meet this national problem has been developed. First, since your committee believes that Government action should not be limited to measures that assist the aged only after they have become needy, your committee recommends more adequate and feasible health insurance protection under two separate but complementary programs which would contribute toward making economic security in old age more realistic, a more nearly attainable goal for most Americans. In addition, your committee recommends,

as will be discussed later in this report, a strengthening of the medical assistance provisions of the Social Security Act so that adequate medical aid may be provided for needy people.

The first of the two insurance programs consists of protection against the costs of hospital and related care. This hospital insurance plan would be financed through a new special tax separate from existing social security taxes and the contributions collected would be kept entirely separate from the funds of the existing program in a new Federal hospital insurance trust fund. The proposed hospital insurance would be financed through the new tax contributions during the individual's working lifetime with benefits available at age 65.

In past amendments to the Social Security Act, when new programs have been developed or when significant changes have been made to meet a national need, the Congress has followed the practice of extending the new or enhanced benefits not only to those who will become eligible for them in future years but also to the individuals then currently on the rolls. This has been done, of course, with the knowledge that the current beneficiaries on the rolls have not made contributions specifically for increased benefits or the new benefits then being provided. For example, every cash benefit increase which has been provided has been made equally available to the currently retired as well as to those who would retire in the future. A further example is the extension of the disability insurance benefit provisions in 1956 to both the then currently disabled individuals (who met the requirements) as well as to those would become disabled in the future (and who would meet the eligibility requirements). This, of course, does mean that the already-retired group, which has made no contributions for the hospital insurance part of the program, represents in this sense an "unfunded" liability which has to be met out of future contributions. However, the practice has always been to cover the present beneficiaries and basic to it is the recognition that the problem which such new legislation is designed to meet exists equally with regard to them as with regard to those who will become eligible in the future. It may be noted that the same practices are often followed under private pension plans—namely, to extend benefit liberalizations to existing pensioners on the rolls when doing so for future pensioners.

The second of the two insurance programs is a voluntary supplementary health insurance plan that would cover a substantial part of the cost of physicians' services and a number of other health items and services not covered under the hospital insurance program. At the beginning the voluntary supplementary plan would be financed through monthly premiums of $3, and through equal, matching contributions from Federal Government general revenues. The combined coverage of the two insurance plans would result in protection for the elderly of a quality that only a few older people can now afford. Most elderly people could be expected to have the protection of both of these insurance programs.

The provision of insurance against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged.

The bill specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or

operation of medical facilities. Further, the bill specifically provides that a beneficiary may obtain services from any participating institution, agency, or person who undertakes to provide him with the services. The responsibility for, and the control of, the care of the beneficiaries rests with the hospitals, extended care facilities, the beneficiaries' physicians, etc.

There will be no coverage of, or payment for, physicians' services under the hospital insurance program, which is financed through the separate payroll tax. Coverage of physicians' services is limited to the voluntary supplementary program which is financed by premiums of beneficiaries and from general funds of the Treasury.

In establishing the complementary plans for medical care for the aged in this bill, no special recognition is being given to the lower rate of hospital utilization which might be experienced by aged persons under comprehensive health care plans. However, it is not the intention of your committee by this action to adversely affect those organizations which provide and operate comprehensive health care services. On the other hand, it is the hope of your committee that the development of comprehensive health care plans be encouraged.

1. BASIC PLAN—HOSPITAL INSURANCE, ETC.

(a) Eligibility for protection under the basic plan.

The proposed basic hospital insurance would be provided (on the basis of a new section in title II of the act) for people aged 65 and over who are entitled to monthly social security benefits or to annuities under the Railroad Retirement Act. In addition, people who are now aged 65 or will reach age 65 within the next few years and who are not insured under the social security or railroad programs would nevertheless be covered under the basic plan. In July 1966, when the program would become effective, about 17 million people aged 65 and over who are eligible for social security or railroad retirement benefits, and about 2 million aged who would be covered under a special transitional provision, would have the proposed basic hospital insurance.

Included under the special provision would be all uninsured people who have reached 65 before 1968. As to persons reaching 65 after 1967, they would have to have the quarters of coverage that are indicated in the following table:

Quarters of coverage required for OASI cash benefits as compared to hospital insurance

Year attains age 65	Men		Women	
	OASI	Hospital insurance	OASI	Hospital insurance
1967 or before	6–16	0	6–13	0
1968	17	6	14	6
1969	18	9	15	9
1970	19	12	16	12
1971	20	15	17	15
1972	21	18	18	(1)
1973	22	21	----------	----------
1974	23	(1)	----------	----------

[1] Same as OASI.

As indicated in the table, by 1974 the quarter coverage required for cash benefits and hospitalization insurance benefits will be the same and the "transitional" provision will phase out.

Together, these two groups comprise virtually the entire aged population. The persons not protected would be Federal employees who retired after July 1, 1960, and have had the opportunity to come under the liberal provisions of the Federal Employees Health Benefits Act of 1959. Others excluded would be aliens who have not been residents of the United States for 10 years and certain subversives.

Currently, 93 percent of the people reaching age 65 are eligible for benefits under social security or railroad retirement and this percentage will rise to close to 100 percent as the program matures. Thus, over the long run virtually all older people will earn entitlement for the proposed hospital insurance.

(*b*) *Benefits*

Persons entitled to benefits under the hospital insurance plan would be eligible to have payments made for inpatient hospital care and for important additional benefits covering posthospital extended care, posthospital home health services, and certain outpatient hospital diagnostic studies.

Benefits would be payable for covered hospital and related health services furnished beginning July 1, 1966. Posthospital extended care benefits would be effective January 1, 1967.

(*1*) *Inpatient hospital benefits*

The proposed inpatient hospital benefits would, except for a deductible amount, cover the cost of services provided by (or under arrangements with) participating hospitals (including tuberculosis hospitals, but not psychiatric hospitals—the latter would be covered under the voluntary supplementary plan) for up to 60 days in any one "spell of illness." A spell of illness would normally begin with the day a beneficiary enters a hospital and end after the beneficiary has remained out of a hospital and out of an extended care facility for 60 consecutive days.

If a person is in a tuberculosis hospital at the time be becomes entitled to benefits, the days he has already been in the hospital would count toward the 60-day limit on coverage of care in such a hospital during a spell of illness. This provision is in keeping with the intent of the basic plan to cover only the active phase of treatment and not to cover 60 days of care for a person who may have been institutionalized for years previously.

The deductible amount applicable to inpatient hospital services at the beginning of the program would be $40 per spell of illness. The deductible would be changed thereafter, but not before 1969, to keep pace with increases in hospital costs. Each year, beginning in 1968, the Secretary would determine the amount of the deductible applicable for the succeeding years on the basis of the relationship between the average amount paid per day for inpatient hospital services during the preceding year and the rate for 1966. Increases in the deductible amount would be made in $5 steps so that changes of a few cents or even of a few dollars would not have to be made immediately following each such change. However, over a period of time these changes would accurately reflect the changes in hospital costs. Small annual

changes would not only be an administrative problem, but they would also increase the problems of keeping beneficiaries informed of the applicable deductible.

Covered services.—The reasonable cost of service ordinarily provided to inpatients by hospitals (other than physician's services, and certain other items), including new services and techniques as they are adopted in the future, would be paid for. Services furnished to inpatients by others under arrangements with a hospital could also be covered if the arrangements call for billing for the services to be through the hospital exclusively. Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged group, from trying to provide the best of modern care. The following are the major items and services that would be paid for.

Hospital room and board would be paid in full in accommodations containing from two to four beds. Payment would also be made for private accommodations where their use is medically indicated—ordinarily only when the patient's condition requires him to be isolated. Where private accommodations are furnished for the patient's comfort, the payments would cover only the equivalent of the reasonable cost of accommodations containing two to four beds; the patient would pay the extra charges for the private room.

Nursing services ordinarily furnished by hospitals would be paid for, but private duty nursing would not be covered.

Payments would not be made under the hospital insurance plan for the services of physicians, except services provided by interns and residents in training under approved teaching programs. Like other physicians' services, the services of radiologists, anesthesiologists, pathologists, and other physicians employed by the hospital or working through the hospital would be paid for under the voluntary supplementary plan; such services would not be covered under the hospital insurance plan. However, the services of the nonphysicians aiding such persons would be covered under the hospital insurance plan.

Drugs and biologicals furnished to hospital patients for their use while inpatients would be paid for. Payment would be provided for all drugs and biologicals which are listed in the United States Pharmacopoeia or National Formulary or New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or which are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing the drugs and biologicals. (These publications have been compiled and are maintained by the professional organizations concerned with the proper use of drugs.) The alternative requirement of approval by a committee of the medical staff of the hospital, is in line with the recommendations of the American Hospital Association, American Medical Association, American Pharmaceutical Association, and the American Society of Hospital Pharmacists. These organizations jointly have recommended that hospitals adopt a formulary system based upon the functioning of a pharmacy and drugs therapeutics committee of the medical staff of the hospital as a means of protecting the hospital's patients against drugs of poor quality. Innovation and the use of new drugs would not be discouraged because such hospital committee could adopt for use any new drugs which it approved.

The exception to the coverage of drugs and biologicals that are listed in the publications New Drugs or Accepted Dental Remedies is intended only to exclude the payment for drugs which have been unfavorably evaluated for all medicinal uses or for the medicinal use to which it is being put.

The intent of the provisions for determining which drugs and biologicals are covered is to permit payment for all drugs and biologicals which medical and medically related organizations have evaluated and selected as being proper for use in the course of good patient care.

There will be a deductible in an amount equal to the cost of the first 3 pints of blood furnished for an individual during a spell of illness. The difference between the cost of the blood to the hospital and the charge to the beneficiary would be deducted from the payments the proposed program would otherwise make to the hospital. Thus the hospital would not make a profit on the blood for which it charges a beneficiary. Your committee included this deduction provision in the interest of the voluntary blood replacement programs, which encourage donations of blood by waiving charges for blood which the patient arranges to replace. The limitation of the deduction to 3 pints of blood was made in view of the problems aged people would have in securing replacement of, or paying for, large quantities of blood.

Supplies and appliances would be paid for under the hospital insurance plan when they are a necessary part of the covered inpatient hospital services a patient receives. For example, the use of a wheelchair, crutches, or prosthetic appliances could be paid for as part of hospital services but payment for hospital services would not cover furnishing these items to the patient for use after his discharge. (However, the cost of using these items after hospitalization might be paid for if needed as part of the posthospital extended care he might receive or it might be provided under a plan for his home health services.) Items supplied at the request of the patient for his convenience, such as television rental in hospitals, would not be paid for under the program.

Conditions of participation.—Your committee's bill lists conditions that hospitals must meet in order to participate in the proposed program. These conditions for participation are included to provide assurance that participating institutions are safe, that they have facilities and organization necessary for the provision of adequate care, and that they exercise their responsibility to discourage improper and unnecessary utilization of their services and facilities. The inclusion of these conditions is designed to support the efforts of the various professional accrediting organizations sponsored by the medical and hospital associations, health insurance plans, and other interested parties to improve the quality of care in hospitals. To allow payments to institutions for services of lower quality than are now generally acceptable might reduce the incentive for establishing high-quality institutions or for maintaining high standards where they now exist.

In order to participate in the program, hospitals would be required to satisfy conditions specified in the bill relating to clinical records, medical staff bylaws, and utilization review. They would also have to meet certain other specified requirements. The bill authorizes the Secretary to prescribe such further requirements as the Secretary finds

necessary in the interest of health and safety. This authority is proposed because it would be inappropriate and unnecessary to include in the legislation all the precautions against fire hazards, contagion, etc., which should be required of institutions to make them safe. The health and safety requirements prescribed by the Secretary (including any requirements requested by a State which are higher than those prescribed for other States), cannot, however, be more strict than the comparable conditions prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals. Thus, the Secretary could, for example, require participating hospitals to maintain tissue committees which reexamine the condition of the organs removed during surgery and to meet other conditions which the health professions consider necessary to good patient care, but the Secretary could not set the hospital standards above the professionally established level.

Hospitals accredited by the Joint Commission on Accreditation of Hospitals would be conclusively presumed to meet all the conditions for participation, except for the requirement of utilization review. (If the Joint Commission adopts a requirement for utilization review, the Secretary could accept accreditation by the Joint Commission as sufficient evidence that a hospital meets all the requirements of the law.). Linking the conditions for participation to the requirements of the Joint Commission provides further assurance that only professionally established conditions would have to be met by providers of health services which seek to participate in the program.

The conditions of participation for tuberculosis hospitals would be similar to those for other hospitals, though differing in some respects due to their different purpose. To provide assurance that the program while paying for active treatment in tuberculosis hospitals would avoid paying for care that is merely custodial, the conditions of participation require that the hospital be accredited by the Joint Commission on Accreditation of Hospitals, that its clinical records be sufficient to permit the Secretary to determine the degree and intensity of treatment furnished to beneficiaries, and that it meet staffing requirements the Secretary finds necessary for carrying out an active treatment program. A distinct part of an institution can be considered a tuberculosis hospital if it meets the conditions even though the institution of which it is a part does not; and if the distinct part meets requirements equivalent to accreditation requirements, it could qualify under the program even though the institution is not accredited.

Your committee recognizes that there will be emergency situations where an individual who is eligible for hospital insurance benefits will go or be taken to a hospital that does not participate in the program. For example, an accident victim might have to be taken immediately to the nearest hospital, either for outpatient diagnosis and treatment or for admission as an inpatient. Your committee's bill would permit the payment of benefits for emergency hospital diagnostic services or inpatient care in such cases until it is no longer necessary from a medical standpoint to care for the patient in a nonparticipating institution. To be paid under the program for its services, the nonparticipating hospital, like participating hospitals, would have to agree not to charge the patient amounts (except the deductibles) in addition to the program's payments for covered services.

Christian Science sanatoriums that are operated or listed and certified by the First Church of Christ, Scientist, in Boston, could participate in the program as "hospitals." The participation of these institutions and the payment for items and services furnished by them would be subject to such conditions, limitations, and requirements as may be provided in regulations. In general, however, your committee intends that payments to Christian Science sanatoriums would cover costs of services ordinarily furnished by these sanatoriums to patients which are comparable to those for which payment could be made to hospitals and intends these sanatorium services to be a substitute for, and not an addition to, medical services that might be furnished to a person if his religious beliefs were not contrary to the use of the usual facilities. Coverages and exclusions applicable to hospital care would also apply in these institutions. For example, the services of a Christian Science nurse would be covered unless her duties are those of a private duty nurse or attendant; similarly, the services of a Christian Science practitioner, who is the Christian Science counterpart of the physician, would not be paid for since physician's services are not paid for under the hospital insurance plan. Payment would only be made for bedfast patients who, except for their religion, would have to have been admitted to a hospital.

(2) Posthospital extended care benefits

Care in an extended care facility will frequently represent the next appropriate step after the intensive care furnished in a hospital and will make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients.

The posthospital extended care benefits which would be provided under the hospital insurance plan would cover care in qualified extended care facilities in cases where the patient was hospitalized for 3 or more consecutive days and then transferred to the facility for continued care of the same illness within 14 days of his hospital discharge. A patient who meets the hospital-transfer requirement and who is then discharged from the extended facility to his home could again receive extended care benefits in the same spell of illness without being hospitalized again if he is readmitted to the facility within 14 days after discharge. The hospital-transfer requirement is intended to help limit the payment of the extended care benefits to persons for whom such care may reasonably be presumed to be required in connection with continued treatment following inpatient hospital care and makes less likely unduly long hospital stays. This requirement also helps to assure that before a patient is admitted to an extended care facility his medical condition and needs will have been adequately medically appraised. Immediate transfer from a hospital to a posthospital extended care facility is not required because, in some instances, care in such a facility might be found to be needed, for example, only after a trial at convalescent care at the patient's home proves unsuccessful. Similarly, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to the facility.

Payments could be made for 20 days of care in extended care facilities plus, at the patient's option, 2 additional days of care for each day his hospital stay in a spell of illness is less than 60 days. The payments

would be made for extended care beyond the 20th day of the patient's stay in a facility unless he elects otherwise and his election would determine how many potential hospital days would be converted into extended care coverage and how many conserved for possible future need. However, no more than a total of 100 days of extended care benefits could be paid for during any one spell of illness. (The 20 basic days plus up to an additional 80 days as a result of the 2-for-1 formula.)

The number of days of inpatient hospital care for which payments could be made during a spell of illness would be reduced by 1 day for every 2 days of extended care above 20 for which payment is made.

Covered services.—The program would cover the items and services generally furnished by posthospital extended care facilities. These include room and board in two- to four-bed accommodations, nursing care, physical, occupational and speech therapy, and such drugs as are ordinarily furnished by the facility to its inpatients. In addition, payment could be made for the medical services of interns and residents in training and other diagnostic and therapeutic services furnished inpatients of the extended care facility by a hospital with which it has an agreement for the transfer of patients and exchange of medical records. Payment would also be made for physical, occupational, and speech therapy furnished by a party other than the facility if furnished under arrangements which provide for payment for therapy to be made through the facility. In no case could payment be made for any service, drug or other item which could not be paid for under the hospital insurance program if furnished in a hospital. Neither could payment be made for services not generally provided by posthospital extended care facilities. For example, under this rule the use of an operating room would not be covered in the case of an extended care facility since operating rooms are not generally maintained as part of such facilities.

Conditions for participation.—A posthospital extended care facility could be an institution, such as a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital or a section of a facility another part of which might serve as an old-age home. To assure that there will be no unnecessary barriers to the transfer of patients between hospital and extended care facilities when the attending physician determines the transfer is medically appropriate, a participating facility would be required (except as noted in the next paragraph) have an agreement with a hospital for the transfer of patients and interchange of medical records. The requirement of a transfer arrangement does not mean that a patient would have to be transferred between a hospital and extended care facility which have such an arrangement with each other in order to qualify for extended care benefits. A transfer arrangement with any hospital would qualify the facility so that a patient's posthospital extended care would be paid for if he was admitted from any hospital.

Where an extended care facility has attempted, in good faith, to arrange a transfer agreement with nearby hospitals, but failed, the State agency could waive the requirement for a transfer agreement if the agency finds that the facility's participation is in the public interest and essential to assuring extended care to older people in the particular community.

Extended care facilities would also be required to satisfy a number of conditions necessary for an institutional setting in which high-quality convalescent and rehabilitation care can be furnished. These include conditions relating to the provision of around-the-clock nursing services with at least one registered nurse employed full time, the availability of a physician to handle emergencies, the maintenance of appropriate medical policies governing the facility's skilled nursing care and related services, methods and procedures for handling drugs, and utilization review. In addition to the conditions specified in the bill, the Secretary would be authorized to prescribe such further requirements to safeguard the health and safety of beneficiaries as he may find necessary.

(*3*) *Posthospital home health care benefits*

Payments would be made for visiting nurse services and related home health services when furnished in accordance with a plan established and periodically reviewed by a physician. The proposed payments would be made only for a patient who is under the care of a physician and confined to his own home (except when he is taken elsewhere to receive services which cannot readily be supplied at home). Since the nature and extent of the care a patient would receive would be planned by a physician, medical supervision of the home health services furnished by paramedical personnel—such as nurses or physical therapists—would be assured.

Up to 100 visits by home health personnel would be paid for during a 1-year period following the patient's discharge from a hospital or extended care facility. To be eligible for home health benefits, the beneficiary would have to have been an inpatient in a hospital for at least 3 days or in an extended care facility and a home health plan for his care would have to be developed by a physician and steps would have to be taken to implement the plan within 14 days after his discharge.

A "visit" would be defined in regulations. It is contemplated, for example, that ordinarily one visit would be charged each time home health personnel furnish a covered service to the patient. For instance, a visit would be charged each time a therapist would go to the patient's home to furnish speech therapy. If a beneficiary had a visit from a speech therapist and a visiting nurse in the same day, two visits would be charged. Similarly, if the patient were to be taken to a hospital to receive outpatient therapy that could not be furnished in his own home—hydrotherapy, for example—and also received speech therapy and other services at the hospital in the course of the same visit, two or more visits might be charged.

Covered services.—The proposed posthospital home health payments would meet the cost of part-time or intermittent nursing services, physical, occupational, and speech therapy, and other related home health services furnished by visiting nurse agencies, hospital-based home health programs and similar agencies. More or less full-time nursing care would not be paid for under the home health benefits provision. Payments could be made for services furnished by other parties under arrangements with such agencies—the services of an independent physical therapist and interns and residents in training of an affiliated hospital, for example.

To the extent permitted in regulations, the part-time or intermittent services of a home health aide would also be covered. The duties of the home health aide which would be covered are comparable to those of a nurse's aide in the hospital who would have had training and experience that is not ordinarily possessed by lay people—for example, training and experience in giving bed baths to ill and bedfast patients. Often, the home health aide's services are essential if the patient is to be cared for outside a hospital or nursing facility. Food service arrangements, such as those of meals-on-wheels programs, or the services of housekeepers would not be paid for under the home health provisions.

While the home health patient would have to be homebound to be eligible for benefits, provision is made for the payment for services furnished at a hospital or extended care facility or rehabilitation center which requires the use of equipment that cannot ordinarily be taken to the patient in his home. In some cases special transportation arrangements may have to be made to bring the homebound patient to the institution providing these special services. The transportation itself would not be paid for. If he is furnished other services at the hospital or facility at the same time, these too could be paid for, even though they are of a kind that could be furnished in the patient's home. But such services would be covered only if they are furnished under arrangements which provide for billing through the home health agency. For example, if it is necessary, because of the size of the equipment involved, to take the patient to a hospital to give him physical therapy and while at the hospital he receives speech therapy, benefits could be paid for both services, but only if the home health agency takes responsibility for arranging and billing for all the services.

Conditions for participation.—The conditions for participation of home health agencies are designed primarily to assure that participating agencies are basically suppliers of health services. The proposal would cover visiting nurse organizations as well as agencies specifically established to provide a wide range of organized home health services. It would also cover home health services provided by a community hospital. In order to participate, the home health agency or organization would, in addition to meeting certain other requirements, either have to be publicly owned or be a nonprofit organization exempt from Federal taxation or it would have to be licensed and satisfy staffing requirements and other standards and conditions prescribed by regulation. It is the understanding of your committee that organizations providing organized home care on a profit basis are presently nonexistent. However, the language of the bill permits covering such agencies if they come into being, are licensed, and meet the high standards which the present nonprofit agencies offering organized care meet.

(*4*) *Outpatient hospital diagnostic benefits*

Finally, payment could be made for tests and related services—other than those performed by physicians—that are ordinarily furnished by a participating hospital to its outpatients for the purpose of diagnostic study. Payments could also be made for such service furnished by others under arrangements with the hospital that provide for the billing to be through the hospital. Where the services are furnished outside the hospital, they would have to be furnished in facilities

operated by or under the supervision of the hospital or its organized medical staff. (Diagnostic tests performed in a physician's office would, like other physicians' services, generally be covered under the voluntary supplementary plan unless part of a routine physical checkup.)

A deductible amount equal to one-half the deductible amount applicable in the case of inpatient hospital services would be applied against payments for outpatient hospital diagnostic services furnished by the same hospital during a 20-day period. The deductible would be $20 initially (½ of $40). If, within 20 days after receiving outpatient diagnostic services, the individual is hospitalized as an inpatient in the same hospital, the amount he paid for the outpatient diagnostic services (up to the amount of the outpatient deductible) would be credited against the inpatient deductible. Crediting the outpatient deductible in this way is intended to encourage the use of outpatient diagnostic tests rather than creating a situation where a patient would be inclined to insist on going into the hospital for the tests if he saw that he might, in the absence of this provision, have to pay this $20 deductible plus the $40 hospital deductible. Through this provision for correlating the deductibles the deductible amount to be paid by a hospitalized beneficiary would be the same whether the diagnostic tests are performed on a hospital inpatient or outpatient basis.

(c) *Method of payment*

The bill provides that the payment to hospitals and other providers of services shall be equal to the reasonable cost of the services and that the methods to be used and the items to be included in determining the cost shall be developed in regulations of the Secretary in accordance with the provisions of the bill. The regulations may provide for payment of the costs of services on a per diem, per unit, per capita, or other basis, may provide for the use of estimates in different circumstances, may provide for the use of estimates of cost of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the cost.

The appropriate basis of payment for hospital services when payment is made by public or private agencies has been the subject of extended and painstaking consideration for more than a decade. Governing principles have been developed which have attained a large measure of agreement. It is the intent of the bill that in framing regulations full advantage should be taken of the experience of private agencies in order that rates of payment to hospitals may be fair both to the institutions, to the contributors to the hospital insurance trust fund, and to other patients. In framing the regulations the Secretary and his staff will consult with the organizations that have developed these principles as well as with leading associations of providers of services.

Similar principles can without undue difficulty be developed to establish fair bases of payment to extended care facilities and home health services agencies.

The cost of hospital services varies widely from one hospital to another and the variations generally reflect differences in quality and intensity of care. The same thing is true with respect to the cost of the services of other providers. The provision in the bill for

payment of the reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another, except where a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization, and other relevant factors.

Although payment may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered will not be borne by the program. The basis for the computation of the cost of beneficiaries may vary by institution. The most usual hospital cost reimbursement procedures now in use by plans that pay for inpatient services are based on the average per diem cost of the patients in the institution to which payment is made, adjusted to reflect the provisions of the plan. Some institutions, however, base their charges to the public on careful cost ascertainment or accounting and change their charges only when there is a change in the cost of the service involved. In these and other appropriate cases reimbursement would be permitted on the basis of the ratio of cost to charges for the services actually received.

In other institutions some of the charges are set according to prevailing rates in the area, or are based on other considerations and not solely on the actual costs of the particular items and services rendered. Except where a close correlation of cost and charges would be shown, other methods would have to be applied to achieve equitable reimbursement.

The concept of reasonable cost and the principles and methods for translating this concept into practice in individual circumstances are of concern to consumers, providers of service, insuring organizations, and State and Federal governmental programs.

In the determination of reasonable costs of services consideration should be given to all necessary and proper expenses incurred in rendering the services, including normal standby costs. Reasonable costs should include appropriate treatment of depreciation on buildings and equipment (taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding of depreciation) as well as necessary and proper interest on capital indebtedness.

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

Identifiable expenses for medical research, on the other hand, over and above the costs closely related to normal patient care, would not be met from the trust fund. Available research funds are generally ample to support important basic medical research.

In some cases, the charges hospital patients pay include a share of the cost of rendering services to free and part-pay patients as well as a share of uncollectible bills. Your committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The insurance system will reduce the losses of hospital income from bad debts or for care of free or part-pay aged patients which might otherwise be included in charges to other paying patients by paying the full cost, except for the deductible, for substantially all patients over 65. Under the public assistance programs now existing and even more as they would exist under the provisions of this bill, the Federal Government will make a very substantial contribution toward the medical care of the needy of all ages. Under the bill more of the needy could be aided under the Federal-State assistance programs. Further, the proposed amendments would require under the medical assistance and maternal and child health and crippled children programs of the Social Security Act the payment of the reasonable costs of covered hospital services. This will assist hospitals in reducing the income deficits arising out of providing hospital care to persons unable to pay for care.

These provisions, taken in combination with the hospital insurance system under part A of title XVIII, will appreciably reduce the need of hospitals to charge their paying and prepaying patients more than the cost of their services in order to compensate for care rendered to other patients without charge or at less than cost. The bill will thus make a contribution toward rationalizing the distribution of hospital costs and relieving voluntary insurance and prepayment systems, as well as those patients who pay for services at the time when they are rendered, of some part of the burden they now bear for indigent and charity patients.

In paying reasonable costs it is the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred.

(*d*) *Financing*

The hospital insurance program would be financed through a separate payroll tax that would be paid by employees, employers, and the self-employed. The proceeds of this tax would be earmarked in a newly established hospital insurance trust fund, which means that these funds will be kept completely separate from the taxes which support the present social security program. The earnings base of the new tax would be the same base as that for the social security tax so that the recordkeeping tasks of employers and the Government would be left largely unaffected by the establishment of a separate contribution for hospital insurance. To assure that the hospital insurance contributions are clearly identified as such to contributors, the bill requires that the withholding forms, W–2's, show what proportion of the worker's total tax payment was withheld to finance the cost of the proposed hospital insurance. Hospital insurance benefits and administrative expenses would be paid only from the hospital insurance trust fund.

The complete separation of hospital insurance financing and benefit payments is intended to assure that the hospital insurance program will in no way impinge upon the financial soundness of the old-age, survivors, and disability insurance trust funds. A separate annual re-

port will be required on the operation of the hospital insurance program. Furthermore, identifying the contribution as a hospital insurance contribution will tend to increase the contributor's sense of financial responsibility for the benefits provided.

Under the proposed schedule of contribution rates, the fund would, be sufficient to cover all the costs of the hospital insurance benefits (and administration) for persons entitled to social security or railroad retirement benefits. The schedule of contribution rates is the same for employers, employees, and self-employed persons and is as follows:

	Percent		Percent
1966	0.35	1976–79	0.60
1967–72	.50	1980–86	.70
1973–75	.55	1987 and after	.80

As will be explained in greater detail later in this report, the schedule of contribution rates is based on conservative estimates of cost. The cost estimates also use the assumption that, while earnings will continue to rise in the future as they have in the past, the annual limitation on taxable earnings will not be increased beyond the last increase provided for in your committee's bill ($6,600 in 1971 and thereafter). If the earnings base is increased after 1971, the tax rates in the contribution schedule could be revised downward. In fact, if the earnings base does rise to keep up to date with the general earnings level, the steps in the contribution schedule beyond the vate of 0.55 percent would not be needed.

The cost of providing hospital and related posthospital insurance benefits to people who are not social security or railroad retirement beneficiaries would be met from general revenues.

2. VOLUNTARY SUPPLEMENTARY PLAN

(a) *Eligibility and enrollment under the voluntary supplementary plan*

The proposed supplementary health insurance would be available to all people age 65 and over (whether or not they are social security or railroad retirement beneficiaries) who are residents of the United States and either citizens or aliens admitted for permanent residence. Enrollment in the supplementary plan would be on a voluntary basis.

In general, an eligible person could enroll during the period beginning with the third month preceding the month in which he attains age 65 and ending 7 months later. The supplementary insurance would be effective with the first day of the third month following the month in which he enrolls (but not earlier than July 1, 1966). (If an eligible person enrolled in the first month of the 7-month period, his coverage would be effective with the month in which he reaches age 65.)

A special enrollment period would be available at the beginning of the program for people who have already reached 65 by December 31, 1965. This enrollment period would begin with the first day of the second month after the month in which the bill is enacted and end on March 31, 1966. Coverage under the supplementary insurance for people who enroll during this period would begin with July 1, 1966. Individuals who are eligible to enroll during this initial general enrollment period but fail to do so could enroll at any time before October 1, 1966, if the Secretary determines that there was good cause for the individual's failure to enroll. However, if an individual en-

rolls under the latter provision, his coverage could not begin until the sixth month after he enrolls. Monthly premiums would be collected for each month during which an individual was covered under the program.

There would be a general enrollment period between October 1 and December 31 of 1967 and during the comparable period in every odd-numbered year thereafter. A person who enrolls in a general enrollment period would get protection effective with the July 1 following the general enrollment period.

No one could enroll for the first time more than 3 years after the close of the first enrollment period open to him and no one could reenroll unless he does so in a general enrollment period which begins within 3 years of the date his previous enrollment was terminated. A person could reenroll only once.

The limitations on enrollment and reenrollment such as those recommended are made in order to reduce the possibility of people enrolling in the program when their health deteriorates, thus increasing costs by covering people during periods of ill health who chose not to be covered during periods of good health.

The Secretary also is authorized to enter into an agreement with any State which, before July 1, 1967, elects to have certain of its money payment recipients covered by the supplementary plan. States would be permitted to decide whether to request enrollment of the money payment recipients of OAA or such recipients who are 65 years of age and older who are receiving money payments under the combined program, title XVI, or to decide to request coverage for all the aged among the money payment recipients under titles I, IV, X, XIV, and XVI. Excluded from coverage under this arrangement are those persons who are entitled to receive a benefit under the old-age, survivors, and disability insurance system, or the Railroad Retirement Act. The State would pay, in behalf of each individual who is to be enrolled, the premium charge that is determined by the provisions of the bill. Those recipients of public assistance money payments who become 65 years of age on or after July 1, 1967, and who are eligible to enroll individually may have their monthly premium charges paid by the public assistance agency with Federal financial participation. However, your committee believes that it is not practicable at this time to authorize States to cover recipients of medical assistance for the aged through vendor payments under an agreement or to make premium payments in their behalf.

The bill provides that under certain circumstances, the State public welfare agency may act as the carrier in the State for the administration of those provisions with respect to individuals who are receiving money payments under public assistance programs, whether such individuals are covered by the agreement or not.

The agreement may also include provisions for transfer of public assistance funds to another carrier, if the State is not serving as a carrier, so that the insurance benefits and deductibles, coinsurance, and other items met by the State under its public assistance plans can be merged for purposes of paying providers of medical care.

(*b*) *Benefits under the voluntary supplementary plan*

The voluntary supplementary plan would provide protection that builds upon the protection provided by the hospital insurance plan. It

would cover physicians' services, additional home health visits, care in psychiatric hospitals and a variety of medical and other services not covered under the hospital insurance plan. The beneficiary would pay the first $50 of expenses he incurs each year for services of the type covered under the plan. Above this deductible amount, the plan would pay 80 percent of the reasonable costs in the case of services provided by an institution or home health agency and 80 percent of reasonable charges for other covered services, with 20 percent being paid by the beneficiary.

Benefits under the supplementary plan would be provided for:

(1) Physicians' services, including surgery, consultation, and home, office, and institutional calls.

(2) Medical and other health services. These would include:

(*a*) Diagnostic X-ray and laboratory tests and other diagnostic tests;

(*b*) X-ray, radium, and radioactive isotope therapy;

(*c*) Surgical dressings, splints, casts, and other devices for reduction of fractures and dislocations;

(*d*) Rental of durable medical equipment, such as iron lungs, oxygen tents, hospital beds, and wheelchairs;

(*e*) Prosthetic devices (other than dental) which replace all or part of an internal body organ;

(*f*) Ambulance services with limitations;

(*g*) Braces and artificial legs, arms, and eyes.

(3) Inpatient psychiatric hospital services for up to 60 days during a spell of illness (subject to a lifetime maximum of 180 days).

(4) Home health services for up to 100 visits during a calendar year (without a requirement of prior hospitalization).

The $50 deductible would be applied on a calendar year basis, except that expenses the individual incurred in the last 3 months of the preceding calendar year would be counted as satisfying the deductible if they had been counted toward the deductible in that year. This special carryover provision would avoid requiring persons with substantial costs at the end of 1 year to meet the deductible perhaps early in the next year as though they had had no prior bills.

There would be a special limitation on benefits for expenses in connection with treatment of mental, psychoneurotic, and personality disorders of a person who is not a hospital inpatient. During any year, a maximum of $312.50 or 62½ percent of the expenses involved, whichever is smaller, would be considered incurred expenses—that is, expenses used in calculating benefit payments. The effect of this provision is to limit payment under the plan to a maximum of $250 (80 percent of $312.50) or half of the incurred expense (80 percent of 62½ percent of the expense), whichever is less.

Expenses for the first 3 pints of blood furnished a person in a psychiatric hospital during a spell of illness would not be considered incurred expenses (for which the program could make payment) unless the individual had already received 3 pints of blood which was not paid for under the hospital insurance plan because of the similar exclusion under that plan.

Ambulance services would be covered only where other methods of transportation are not feasible due to the individual's condition, and only to the extent provided in regulations. It is the intention of your

committee that transportation by ambulance be covered only if (*a*) normal transportation would endanger the health of the patient and (*b*) the individual is transported to the nearest hospital with appropriate facilities or to one in the same locality, and under similar restrictions, from one hospital to another, to the patient's home or to an extended care facility.

If a person is in a psychiatric hospital at the time he becomes entitled to benefits, the days he has already been in the hospital would count toward the 60-day limit on coverage of care in such a hospital during a spell of illness, but they would not count toward the 180-day lifetime limit. This provision is in keeping with the intent of the plan to cover only the active phase of treatment of mental illness and not to cover 60 days of care for a person who may have been institutionalized for years previously. The services covered under the supplementary plan as inpatient psychiatric hospital services would generally be the same as the services that are covered as inpatient hospital services under the hospital insurance plan.

The conditions of participation for psychiatric hospitals would be similar to those for other hospitals, though differing in some respects. To provide assurance that the supplementary plan, while paying for active treatment in psychiatric hospitals, would avoid paying for care that is merely custodial, the conditions of participation require that the hospital be accredited by the Joint Commission on Accreditation of Hospitals, that its clinical records be sufficient to permit the Secretary to determine the degree and intensity of treatment furnished to beneficiaries, and that it meet staffing requirements the Secretary finds necessary for carrying out an active treatment program. A distinct part of an institution can be considered a psychiatric hospital if it meets the conditions even though the institution of which it is a part does not; and if the distinct part meets requirements equivalent to accreditation requirements, it could qualify under the program even though the institution is not accredited. For inpatient psychiatric hospital services, the certification required of physicians would be appropriate to the condition being treated and somewhat different from that for inpatient hospital services under the hospital insurance program.

Covered home health services and the conditions of participation for home health agencies would be the same as under the hospital insurance plan. There would, however, be no requirement, as there is in the hospital insurance plan, that benefits be paid only when the patient was previously hospitalized.

(*c*) *Method of payment under the voluntary supplementary plan*

After the individual has incurred the $50 deductible amount, the plan would pay 80 percent of the reasonable costs of or the reasonable charges for the covered services. In the case of services (other than physicians' services) furnished by, or under arrangements made by, hospitals, extended care facilities, and home health agencies, payment would be 80 percent of reasonable costs and would be made to the provider of services by the carrier administering the benefits under the supplementary plan. In all other cases, payment would be 80 percent of reasonable charges and would be made by the carrier to the beneficiary unless the beneficiary assigned the benefits to the person or organization which furnished the covered services.

Reasonable cost, as defined for purposes of reimbursement under the supplementary plan, would be the same as under the hospital insurance plan. The carriers administering the benefits under the supplementary plan would, under the terms of their contracts with the Secretary, have to take such action as may be necessary to assure that where payment is on a cost basis, the cost is reasonable cost. In general, under the supplementary plan a provider of services (a covered hospital, extended care facility, or home health agency) could charge a beneficiary the $50 deductible and 20 percent of the reasonable charges (in excess of the $50 deductible) for the covered services.

Where payment by the program is on the basis of charges (for physicians' services and medical and other health services not furnished by providers of services), the carriers would take action to assure that the charge on which the reimbursement is based is reasonable and is not higher than the charge used for reimbursement on behalf of the carriers' own policyholders or subscribers for comparable services and under comparable circumstances. In addition, where payment is on the basis of an assignment, the reasonable charge would have to be accepted as the full payment. 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.

(*d*) *Financing*

Your committee's bill establishes a premium of $3 a month initially for individuals who enroll under the supplementary plan. Since the minimum increase in cash social security benefits provided under the bill for retired workers 65 and over would be $4 a month ($6 a month for man and wife who are both 65 and are receiving benefits based on the same earnings record), the minimum benefit increase would fully cover the amount of monthly premiums for the supplementary plan. Persons enrolling who are entitled to monthly social security or railroad retirement benefits would have the premiums deducted from their monthly benefits. (Of course, enrollment in the plan is voluntary.) Deducting the premium from monthly benefits would help keep collection costs to a minimum. The method of collecting premiums for those who are not entitled to monthly benefits would be prescribed by the Secretary. People who are entitled to monthly benefits but who, because they have not retired, may not actually receive them or those who may receive only a part of them could estimate the amount by which premiums will exceed the amount of their benefits and could pay in advance the required additional amount to the Secretary. If advance payment is not made in these cases, the annual calculation of adjustment in benefits needed where a beneficiary has worked in the prior year would take into account the premiums owed and paid in connection with the supplementary plan.

Provision is made for the Secretary to adjust the premium amounts supporting the program if medical or other costs rise, but there would be no increase in premiums before 1968, and increases would be made not more often than every 2 years after 1968. To take into account the higher cost of insuring an older individual, premiums payable by a person who enrolled later than the first period when enrollment was open to him or who reenrolled after his enrollment was terminated

would be increased by 10 percent for each full year he could have been but was not enrolled.

There would be a contribution from Federal general revenues equal to the aggregate premiums payable by enrollees. In addition, funds could be appropriated in fiscal year 1966 and remain available through the next fiscal year as repayable advances (without interest) to the trust fund in order to provide an operating fund at the beginning of the program and to provide a contingency reserve. The maximum that could be appropriated for this purpose would be $18 per person eligible to enroll at the beginning of the supplementary program, July 1, 1966.

A new separate trust fund would be established—the Federal Supplementary Health Insurance Benefits Trust Fund. All premiums and Government contributions for the supplementary program would be paid into the fund and all benefits and administrative expenses would be paid from the fund.

3. GENERAL PROVISIONS RELATING TO THE BASIC AND VOLUNTARY SUPPLEMENTARY PLANS

(a) *Conditions and limitations on payment for services*

(1) *Physicians' role*

Your committee's bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished. If services are furnished over a period of time to be specified in regulations, recertification by the physician would be necessary. Delayed physician certifications and recertifications, accompanied by medical and other evidence, to the extent provided by regulations, could be accepted in lieu of timely certifications and recertifications when, for example, the patient was unaware of his eligibility for the benefits when he was treated.

In the case of inpatient hospital services for which payment would be made, the bill would require that a physician certify that the services were required for an individual's medical treatment, or that inpatient diagnostic study was medically required and that the services were necessary for such purpose. The first physician recertification in each case of inpatient hospital services furnished over a period of time would be required no later than the 20th day of the period. In the case of outpatient hospital diagnostic services, a physician would have to certify that the services were required for diagnostic study.

In the case of posthospital extended care a physician would have to certify that the care was required because the individual needed skilled nursing care on a continuing basis for a condition with respect to which he was receiving inpatient hospital services prior to transfer to the extended care facility or for a condition which arose after such transfer and while the individual was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services.

In the case of home health services, a physician would have to certify that the services were required because the individual was confined

to his home. He would also have to certify that the individual needed (except for receipt of special treatment at a medical institution) skilled nursing care on an intermittent basis or physical or speech therapy. In the case of home health services, the intermittent nursing care or the physical or speech therapy would have to be for treatment of a condition for which the individual had received inpatient hospital services or posthospital extended care.

Your committee recognizes that there often is a significant difference between treatment provided in mental and tuberculosis hospitals and the treatment provided in other hospitals. Often the care in such institutions is purely custodial and it is the intent of the bill to cover only active care intended to cure patients in such hospitals and not to cover custodial care. Therefore, the bill would require that a physician make specific certifications before payment could be made for inpatient hospital services furnished in either a psychiatric hospital or a tuberculosis hospital. In the case of inpatient hospital services furnished in a psychiatric hospital for the psychiatric treatment of an individual, a physician would have to certify that the psychiatric services could reasonably be expected to improve the condition for which the treatment was necessary or that inpatient diagnostic study was medically required and inpatient psychiatric hospital services were necessary for such purposes. In the case of inpatient tuberculosis hospital services a physician would have to certify that the services were required to be given on an inpatient basis for the treatment of an individual for tuberculosis and that the treatment could reasonably be expected to either improve the condition for which the treatment was necessary or render the condition noncommunicable.

(2) Utilization review

The provisions of your committee's bill with respect to mechanisms for the review of utilization of services follow the kind of recommendations for utilization review that have been made by private study groups, State and national medical societies, and State agencies.

Hospitals and extended care facilities participating in the program would be required to have in effect a utilization review plan providing for a review of admissions to the institution, length of stays, and the medical necessity for services provided with the objective of promoting the efficient use of services and facilities. The review would ordinarily be carried out by a staff committee of the institution, which would have to include two or more physicians but which could also include other professional personnel such as registered nurses and medical social workers. Alternatively, the review could be conducted by a similar group outside the institution—preferably one established by the local medical society and some or all of the hospitals and extended care facilities in the locality. In some circumstances the review committee would have to be one outside the institution—for example, where the small size of the institution or, in the case of an extended care facility, the lack of an organized medical staff makes it impracticable for the institution to have a properly functioning staff committee. As mentioned previously, if and when the Joint Commission on the Accreditation of Hospitals adopts a utilization review requirement for accreditation, the Secretary could accept accreditation by the Joint Commission as sufficient evidence that a hospital meets the requirements of the law.

Under a utilization review plan, timely review would have to be made of each case in which a beneficiary stays in the institution for an extended period. Regulations would provide the institution some leeway in determining when the review would have to be carried out, and the point at which a review would be most appropriate might vary with the diagnosis and treatment involved. Where timely reviews are not being made, the Secretary could, in lieu of terminating the agreement under which the institution participates in the program, make a decision that with respect to that institution the program would make payment only for the first 20 days of a beneficiary's stay in the case of a hospital, or only for days up to a specified number (to be specified in regulations) in the case of an extended care facility.

The attending physician would have to be offered an opportunity for consultation before there could be a finding that a beneficiary's further stay in the institution is not medically necessary, by the physician members of the review group; and the individual, the institution and the attending physician would have to be promptly notified of any such finding. Where such a finding has been made, the program could not make payment for services furnished the patient after the third day following the day on which the institution received notice of the finding.

Under your committee's bill, various organizations participating in the administration of the program could have a role in facilitating utilization review. State agencies could provide consultative services to assist in the establishment of utilization review procedures and in evaluating their effectiveness. Under the hospital insurance plan, public or private organizations nominated by providers must assist in the application of safeguards against unnecessary utilization. Carriers administering benefits under the voluntary supplementary plan would determine compliance with the utilization review requirement; assist in the establishment of review groups outside hospitals; assist hospitals, extended care facilities and others who furnish covered services to develop procedures relating to utilization practices; and make studies of such procedures and methods for their improvement.

(*b*) *Exclusions from coverage*

Your committee's bill would exclude certain health items and services from coverage under both the hospital insurance and the voluntary supplementary health insurance programs in addition to any excluded through the operation of other provisions of the bill. For example, the bill would bar payment for health items or services that are not reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member. Thus, payment could be made for the rental of a special hospital bed to be used by a patient in his home only if it was a reasonable and necessary part of a sick person's treatment. Similarly, such potential personal comfort items and services as massages and heat lamp treatments would only be covered where they contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Expenses for custodial care would also be excluded.

The proposed insurance programs would not pay for any item or service furnished an individual if neither the individual nor any other person (such as a prepayment plan) has a legal obligation to pay

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for or provide the services. (Under the provision, the third-party liability statute 42 U.S.C. 2651–2653 would not apply.) Free chest X-rays provided by health organizations, for example, would not be covered. Where health expenses are charged the patient by a member of the patient's household or by an immediate relative, no payment would be made. However, a person of little means would not be barred from payment under the insurance programs because he met the test of medical indigency and was otherwise eligible to receive medical assistance under a public assistance program. Furthermore, if a person received his care on some prearranged basis toward which he prepaid, the program provided for under the title would nevertheless pay its benefits in full. Your committee expects that the patient's prepayment arrangement would be adjusted appropriately in consideration of the fact that the program met part of the patient's health costs. Except in such cases as the Secretary may specify, no payment would be made for items and services which are paid for directly or indirectly by a governmental entity.

Payments would only be made for items and services provided in the United States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. Payment would not be made for items and services required as a result of war or an act of war which occurs after the effective date of the individual's coverage under the proposed insurance.

Payments would not be made for routine physical examinations or for eyeglasses, hearing aids or the fitting expenses or other costs incurred in connection with their purchase. Thus, payment would be made under the supplementary plan for the physician's services connected with the diagnosis of a specific complaint and the treatment of the ailment, but a routine annual or semiannual checkup would not be covered. Similarly, the diagnosis and treatment by an ophthalmologist of, say, cataracts would be covered but the expenses of an eye examination to determine the need for eyeglasses and charges for prescribing and fitting eyeglasses or contact lenses would not be covered. Neither would payment be made for orthopedic shoes or other supportive devices for the feet.

Expenses for cosmetic surgery would not be covered except where incurred in connection with the prompt repair of an accidental injury or to improve the functioning of a malformed body member. For example, cosmetic surgery could be paid for when furnished in connection with the treatment of a severely burned person.

Payment would not be made for health items and services to the extent that payments have been made, or can reasonably be expected to be made, for them under a workmen's compensation law. The Secretary would prescribe regulations to govern the making of payments where a beneficiary's status under workmen's compensation has not been ascertained. Payment would be made under the insurance plans on the condition that repayment would be made if information is received that a workmen's compensation payment for the health care has been made.

(*c*) *Administration of health insurance provisions*

Overall responsibility for administration of the hospital insurance and voluntary supplementary health insurance programs would rest with the Secretary of Health, Education, and Welfare, but State

agencies and private organizations operating under agreements with the Secretary and private carriers or public organizations operating under contracts with the Secretary would have a major administrative role. In addition to using such organizations under the conditions described below, the Secretary would be authorized to purchase or contract separately for services such as auditing or cost analysis.

(1) Advisory and review groups

Your committee's bill provides for the establishment of a Health Insurance Benefits Advisory Council to advise the Secretary on general administrative policy matters and on the formulation of regulations in connection with the hospital insurance program and supplementary health insurance program, including regulations relating to conditions of participation for providers. The Advisory Council, appointed by the Secretary, would consist of a chairman and 15 members including persons outstanding in hospital, medical, and other health activities and at least one representative of the public. The members could not include regular Federal Government employees.

The bill also provides for the establishment of a National Medical Review Committee to study the utilization of hospital and other medical care and services with a view to recommending changes in the way covered care and services are used and in the administration of the basic and supplemental plans.

The committee is required to make an annual report of its recommendations to the Secretary, and he is required to transmit the report to the Congress.

The committee is to be composed of nine persons, one of whom the Secretary would designate as chairman. The members are to be selected from people who are representative of organizations and associations of professional people in the field of medicine and other people who are outstanding in the field of medicine or related fields and a majority of the committee are to be physicians and at least one member will represent the general public. Regular Federal Government employees could not be members of the committee.

(2) Conditions of participation

In formulating specific conditions of participation necessary for health and safety, the Secretary would consult with appropriate governmental agencies and private organizations. The bill specifically requires consultation with appropriate State and local agencies and national listing or accrediting bodies. Your committee would expect that the Secretary would consult with the Joint Commission on the Accreditation of Hospitals as well as with associations of providers of services. Such consultations should be helpful in the development of policies, operational procedures and administrative arrangements of mutual satisfaction to all parties interested in the basic and supplementary plans. Such consultation would provide additional assurance that varying conditions of local and national significance are taken into account.

(3) Agreements to participate

An eligible hospital, extended care facility or home health agency could participate in the programs if it filed with the Secretary an agreement not to charge any beneficiary for covered services for which

payment would be made under the program and to make adequate provision for refund of erroneous charges. Of course, a provider could bill a beneficiary for deductible and coinsurance amounts, for the first 3 pints of blood furnished him during a spell of illness, and for the portion of the charge for a private room or services supplied at the patient's request and not paid for under the program.

An agreement could be terminated by either the provider of services or the Secretary of Health, Education, and Welfare. Beneficiaries would be protected from an abrupt termination of an agreement by a provider by the requirement that notice must be given by the provider to the Secretary and to the public. The length of time between the notice and the point at which the termination becomes effective may be specified in regulations (but the length of time cannot be longer than 6 months).

The Secretary could terminate an agreement only after reasonable notice and only if the provider (*a*) does not comply with the provisions of the agreement or of the law and regulations, (*b*) is no longer eligible to participate, or (*c*) fails to provide data needed to determine what benefit amounts are payable or refuses access to financial records for verification of bills. The Secretary would be required to give reasonable notice and opportunity for hearing to a provider of services before making a final determination that the provider does not qualify to participate under the program or before terminating an agreement with the provider. The final administrative decision is subject to judicial review.

(*4*) *Role of the States*

Your committee's bill provides for State agencies, operating under an agreement with the Secretary, to determine whether a provider of services—a hospital, extended care facility or home health agency—meets the conditions for participation in the program, and having determined that the provider meets the conditions, to certify the fact to the Secretary. The Secretary would be required to use the services of State health departments or other appropriate State or local agencies in this way wherever the State agency is able and willing to perform this administrative function. In addition, the Secretary would be authorized to use such agencies for the following additional functions:

(*a*) Rendering consultative services to providers to assist them to establish and maintain necessary fiscal records and otherwise to meet the conditions for participation and to provide information necessary to derive operating costs so as to determine amounts to be paid for the providers' services;

(*b*) Rendering consultative services to providers and medical societies to assist in the establishment and testing of utilization review procedures.

To illustrate a consultative function a State agency could perform to assist providers to qualify, a State agency could assist an extended care facility to establish a transfer agreement with a participating hospital.

The Secretary could select also either public or private organizations participating in administration of the programs to perform the consultative functions mentioned in (*a*) and (*b*), above. This would enable him to select the organization which he finds can most capably carry out these functions in the specific situation.

State agencies would be reimbursed for the costs of activities they perform in the program. As in the cooperative arrangements with State agencies in the social security disability program, reimbursement to State agencies for hospital insurance benefits activities would meet the agency's related costs of administrative overhead as well as of staff. In recognition of the need for coordination of the various programs in the States that have to do with payment for health care, quality of care, and the distribution of health services and facilities, the Federal Hospital Insurance Trust Fund would pay a fair share of the State agency's costs attributable to planning and coordination of the functions to be performed under the terms of the agreements, with those other activities for which the agency is responsible which relate to public and private programs for the provision of health services similar to those for which payment may be made under the proposed program.

(5) Role of public or private organizations

Your committee's bill provides a considerable role for the participation of private organizations in the administration of both the hospital insurance plan and the supplementary plan.

Under the hospital insurance plan, groups of providers, or associations of providers on behalf of their members, could nominate a national, State, or other public or private agency or organization which they wished to have serve as a fiscal intermediary between themselves and the Federal Government. While it is expected that most providers would want to nominate a private organization, the bill would also permit nomination of a public agency (a State public health agency, for example) by providers which wished to have such an agency serve as fiscal intermediary.

A member of an association whose nominated organization or agency had been selected as a fiscal intermediary could elect to receive payment from another intermediary which had been selected (provided that the other organization or agency agrees) or could elect to deal directly with the Secretary.

The organization or agency serving as a fiscal intermediary under Part A would, under agreement with the Secetary, determine the amount of payments due upon presentation of provider bills and make the payments. The Secretary would be permitted to enter into agreement with a nominated organization only if he finds that this would be consistent with effective and efficient administration and that the organization is able and willing to assist in the application of safeguards against unnecessary utilization of covered services, and only if the organization agrees to furnish him with such of the information it gathers in carrying out the agreement as he finds necessary. The agreement may include provision for the agency or organization to perform one or more of certain administrative duties other than the payment function. These would include providing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise to qualify as providers of services, serving as a center for communicating with providers, making audits of provider records, and performing related functions. The Government would provide advances of funds to the agencies or organizations for purposes of benefit payments and as a working fund for administrative expenses, subject to account and settlement on a cost-incurred basis.

Your committee believes that benefits under the supplementary health insurance benefits program in Part B should be administered by the private sector. This form of administration is particularly appropriate for the supplementary plan because of the benefits the plan would provide in the case of physicians' services. Private insurers, group health plans, and voluntary medical insurance plans have great experience in reimbursing physicians.

The bill requires the Secretary, to the extent possible, to enter into contracts with carriers under which the carriers would perform specified administrative functions or, to the extent provided in the contracts, secure the performance of these functions by other organizations. These functions include: Determining the amount of payments due providers, and making the payments; auditing records of providers; determining whether providers meet the utilization review requirements under the program; assisting providers to develop procedures relating to utilization practices, and studying the effectiveness of such procedures; assisting in the application of safeguards against unnecessary utilization of covered services and in the establishment of review groups outside hospitals; serving as a channel of communication of information relating to the program's administration; and otherwise assisting in the administration of the supplementary plan.

The Secretary would be permitted to enter into contracts with carriers without regard to provisions of law relating to competitive bidding. However, he could enter into such a contract only if he found that the carrier would perform efficiently and effectively and if the carrier met such requirements as to financial responsibility, legal authority, and such other matters as the Secretary found pertinent. It is your committee's intent that the Secretary shall, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance. The contracts would have to provide that the carrier would take action to assure that the charges and costs of services for which the supplementary plan may make payment are reasonable. The carrier would also have to maintain such records and furnish such information and reports as the Secretary finds necessary and, in addition, would have to establish procedures for fair review of beneficiary complaints regarding disallowed requests for payment and requests where the amount of payment is in controversy.

The contracts would be for a term of at least 1 year, and could be made automatically renewable. A contract would provide for payment of the carrier's cost of administration (including advances of funds for such purposes), as the Secretary determined to be necessary and proper for carrying out the functions covered by the contract. The Secretary could terminate a contract, after reasonable notice and opportunity for a hearing, if he found that the carrier had failed to substantially carry out the contract or was carrying it out in a manner inconsistent with the efficient administration of the supplementary health insurance program.

The bill broadly defines a carrier with which the Secretary could contract as a voluntary association, corporation, partnership, or other nongovernmental organization lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance

policies or contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier. The definition would specifically include a health benefits plan duly sponsored or underwritten by an employee organization. With respect to hospitals, extended care facilities, and home health agencies, the definition also includes a public or private organization which is nominated by providers of services and which participates in administration of the hospital insurance plan. In addition, a State welfare agency which buys into the program for aged welfare recipients could act as the carrier for its recipients (if it met the other conditions of participation as a carrier).

(6) Appeals

Your committee's bill provides for the Secretary to make determinations, under both the hospital insurance plan and the supplementary plan, as to whether individuals are entitled to hospital insurance benefits or supplementary health insurance benefits and for hearings by the Secretary and judicial review where an individual is dissatisfied with the Secretary's determination. Hearings and judicial review are also provided for where an individual is dissatisfied with a determination as to the amount of benefits under the hospital insurance plan if the amount in controversy is $1,000 or more. (Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits.) Hospitals, extended care facilities, and home health agencies would be entitled to hearing and judicial review if they are dissatisfied with the Secretary's determination regarding their eligibility to participate in the program.

4. ACTUARIAL COST ESTIMATES FOR THE HOSPITAL INSURANCE SYSTEM

(a) Summary of actuarial cost estimates

The hospital insurance system established by your committee's bill has an estimated cost for benefit payments and administrative expenses that is in long-range balance with contribution income. It is recognized that the preparation of cost estimates for hospitalization and related benefits is much more difficult and is much more subject to variation than cost estimates for the cash benefits of the old-age, survivors, and disability insurance system. This is so not only because the hospital insurance program would be newly established, with no past operating experience, but also because of the greater number of variable factors involved in a service-benefit program than in a cash-benefit one. However, your committee believes that the cost estimates are made under very conservative assumptions with respect to all forseeable factors.

It is essential, in the view of your committee, that the developing operations of this new program should be carefully studied as they occur in the immediate future, so that the Congress and the executive branch can be kept as well informed as possible and as quickly as is feasible. Under these circumstances, your committee agrees with the suggestion which has been made that there should be a small continuing actuarial sample (of perhaps 0.1 percent of all eligible individuals), whose experience can be followed as promptly and as thoroughly as if the system related to only about 20,000 persons (under which circumstances, it would be possible to make many complete studies

of experience as rapidly as it develops, without the disadvantages from a time standpoint of handling the vast amount of data that arises for the millions of persons protected by the full program). In this connection, it will be essential for carriers involved in the processing and payment of claims to supply the necessary actuarial information promptly and in adequate fashion for the actuarial analyses to be made.

(*b*) *Financing policy*

(*1*) *Financing basis of committee bill*

The contribution schedule contained in your committee's bill for the hospital insurance program and the corresponding maximum earnings bases are as follows:

Calendar year	Earnings base	Employer-employee rate (percent)	Self-employed rate (percent)
1966	$5,600	0.7	0.35
1967 to 1970	5,600	1.0	.50
1971 to 1972	6,600	1.0	.50
1973 to 1975	6,600	1.1	.55
1976 to 1979	6,600	1.2	.60
1980 to 1986	6,600	1.4	.70
1987 and after	6,600	1.6	.80

The hospital insurance program would be completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base would be the same under both programs. *First*, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions). *Second*, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. *Third*, the bill provides that income tax withholding statements (forms W–2) shall show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter. *Fourth*, the hospital insurance program would cover railroad employees directly in the same manner as other covered workers, and their contributions would go directly into the hospital insurance trust fund and their benefit payments would be paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions). *Fifth*, the financing basis for the hospital insurance system would be determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one).

(2) Self-supporting nature of system

Just as has always been the case in connection with the old-age, survivors, and disability insurance system, your committee has very carefully considered the cost aspects of the proposed hospital insurance system. In the same manner, your committee believes that this program should be completely self-supporting from the contributions of covered individuals and employers (the transitional uninsured group that would be covered by this program would have their benefits, and the resulting administrative expenses, completely financed from general revenues, according to the provisions of the bill). Accordingly, your committee very strongly believes that the tax schedule in the law should make the hospital insurance system self-supporting over the long range as nearly as can be foreseen, as well as actuarially sound.

(3) Actuarial soundness of system

The concept of actuarial soundness as it applies to the hospital insurance system is somewhat similar to that concept as it applies to the old-age, survivors, and disability insurance system (see discussion of this topic in a following section), but there are important differences.

One major difference in this concept as it applies between the two different systems is that cost estimates for the hospital insurance program should desirably be made over a period of only 25 years in the future, rather than 75 years as in connection with the old-age, survivors, and disability insurance program. A shorter period for the hospital insurance program is necessary because of the greater difficulty in making forecast assumptions for a service benefit than for a cash benefit. Although there is reasonable likelihood that the number of beneficiaries aged 65 and over will tend to increase over the next 75 years when measured relative to covered population (so that a period of this length is both necessary and desirable for studying the cost of the cash benefits under the old-age, survivors, and disability insurance program), it is far more difficult to make reasonable assumptions as to the trends of medical care costs and practices for more than 25 years in the future.

In starting a new program such as hospital insurance, it seems desirable to your committee that the program should be completely in actuarial balance. In order to accomplish this result, your committee has developed a contribution schedule that will meet this requirement, according to the underlying cost estimates.

(c) Hospitalization data and assumptions

(1) Past increases in hospital costs and in earnings

Table A presents a summary comparison of the annual increases in hospital costs and the corresponding increases in wages that have occurred since 1954 and up through 1963.

TABLE I.—*Comparison of annual increases in hospitalization costs and in earnings*

[In percent]

Calendar year	Increase over previous year	
	Average wages in covered employment	Average daily hospitalization costs
1955	3.8	6.3
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
Average [1]	4.0	6.7

[1] Rate of increase compounded annually that is equivalent to total relative increase from 1954 to 1963.

The annual increases in earnings are based on those in covered employment under the old-age, survivors, and disability insurance system as indicated by first quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The data on increases in hospitalization costs are based on a series of average daily costs (including not only room and board, but also other charges), prepared by the American Hospital Association.

The annual increases in earnings have fluctuated somewhat over the 10-year period, although there have not been very large deviations from the average annual rate of 4.0 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise have fluctuated from year to year around the average annual rate of 6.7 percent; the increases in the last 2 years were relatively low as compared with previous years.

Hospital costs then have been increasing at a faster rate than earnings. The differential between these two rates of increase has fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential between the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 2.7 percent.

Your committee was advised by the Department of Health, Education, and Welfare that, in the future, earnings are estimated to increase at a rate of about 3 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be. It would appear that, at the least, hospital costs would increase about 2 percent per year more than earnings for a few years and that, at the most, this differential rate would be 3 percent per year. It is recognized, of course, that these "minimum" and "maximum" assumptions result in a relatively wide spread in the cost estimates for hospital insurance proposals if the estimates are carried out for a number of years into the future.

(2) Assumptions underlying original cost estimates for the administration's bill, H.R. 3920 and S. 880, 88th Congress (the "King-Anderson" bill)

By way of background to the development of the cost estimates for the hospital insurance system that would be established by your committee's bill, there follows a discussion of cost estimates on the administration's proposals in the 88th Congress and in this Congress.

The actuarial cost estimates for H.R. 3920 and S. 880, 88th Congress, made at the time of its introduction in 1963 were presented in detail—as to assumptions, methodology, and results—in Actuarial Study No. 57 of the Social Security Administration.

In considering the hospitalization-benefit costs in conjunction with a level-earnings assumption for the future, it is sufficient for the purposes of long-range cost estimates merely to analyze possible future trends in hospitalization costs relative to covered earnings. Accordingly, any study of past experience of hospitalization costs should be made on this relative basis. The actual experience in recent years has indicated, in general, that hospitalization costs have risen more rapidly than the general earnings level, with the differential being in the neighborhood of 3 percent per year—2.7 percent in the last 10 years.

A major consideration in making cost estimates for hospitalization benefits, then, is how long and to what extent this tendency of hospital costs to rise more rapidly than the general earnings level will continue in the future, and whether or not it may in the long run be counterbalanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly "catching up" with the general level of wages and obviously may be expected to "catch up" completely at some future date, rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased expense.

In connection with this factor, there are possible counterbalancing factors. The higher costs involved for more refined and extensive treatments may be offset by the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, the general wage level might increase more rapidly than hospitalization prices in the long run.

Perhaps the major consideration in making and in presenting these actuarial cost estimates for hospitalization benefits is that—unlike the situation in regard to cost estimates for the monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base and the dollar amounts of any deductibles are concerned). The reason for this result is that in Actuarial Study No. 59 the fundamental actuarial assumption was made that hospitalization costs would rise at the same rate over the long run as the total earnings level, whereas the contribution income would rise less rapidly than the total earnings level unless the earnings base is kept up to date. Under these condi-

tions, it is necessary that the base be kept up to date with the changes in the general level of earnings, since contributions depend on the covered earnings level, and this level is dampened if the earnings base is not raised as earnings go up. Accordingly, it was necessary in the actuarial cost estimates for hospitalization benefits in Actuarial Study No. 59 to assume either that earnings levels will be unchanged in the future or that, if wages continue to rise (as they have done in the past), the system will be kept up to date insofar as the earnings base and the deductibles are concerned.

The basic assumption underlying the actuarial cost estimates in Actuarial Study No. 57 was that the relationship between earnings and hospital costs would, on the average, be the same into the future as in the 1961 experience. Alternatively and equivalently, these assumptions meant that earnings and hospital costs will rise, on the average, at the same rate in the future and that the earnings base will be adjusted proportionately with changes in the earnings level.

(3) Alternative assumptions for hospitalization-benefits cost estimates

One alternative basis for the assumptions that have just been discussed would assume the continuation into the long-range future of recent trends in the relationship between hospitalization costs and the general wage level, while at the same time assuming that there would be no change in the maximum earnings base under the system.

In the recent past, the general earnings level has increased at a rate of about 4 percent a year, while hospital costs have risen about 7 percent a year, so that there is a differential of about 3 percent. Assuming the continuation of these trends into the *indefinite future* and assuming, at the same time, no change in the maximum earnings base would have the following effects:

(1) Eventually hospitalization costs would exceed 100 percent of the earnings of all workers in the country—let alone, of taxable earnings.

(2) Virtually everyone entitled to cash benefits under the system would have the maximum benefit prescribed under the law, since they would have their benefits figured on the maximum creditable earnings. The earnings of the lowest paid part-time workers would eventually rise to the present maximum earnings base.

(3) The cash benefits of the system would be only a very small proportion of a person's previous earnings.

(4) As a percentage of taxable payroll, the cost of the cash-benefits portion of the system would be considerably lower than it is presently estimated to be—to the extent of about 1¼ percent of taxable payroll.

Such an assumption was not used in the cost estimates because it is considered to be completely unrealistic—and could be considered an "impossible" one. It is inconceivable that hospital prices would rise indefinitely at a rate faster than earnings because eventually individuals—even currently employed workers, let alone older persons—could not afford to go to a hospital under such cost circumstances.

As a numerical example, consider a full-time male worker now earning the "typical" amount of $20 per day, or $5,200 per year. The average daily cost for hospitalization (including not only room and

board, but also other charges) for persons of all ages is about $40, currently, or twice the average daily wage. If wages increase 4 percent per year, and if hospital costs increase 7 percent per year—indefinitely into the future—then the following situation will occur:

Item	At present	In 20 years	In 50 years
Average daily wage	$20	$43.82	$142.13
Average daily hospitalization cost	$40	$154.79	$1,178.28
Ratio of hospital cost to average daily wage (percent)	200	353	829
Proportion of wage covered by $5,600 base (percent)	100	54	16

Consideration of the foregoing figures indicates that, whereas the cost of a hospital day now averages about 2 days' wages, then in 50 years if the assumed trends take place, the cost of a hospital day will be over 8 days' wages. Quite obviously, it is an untenable assumption that there can be a sizable differential between the increase in hospitalization costs and the increase in earnings levels that will continue for a longer period into the future.

(4) *Assumptions underlying original cost estimates for the administration's bill, H.R. 1 and S. 1, 89th Congress (the "King-Anderson" bill)*

The Advisory Council on Social Security Financing, which was appointed in 1963 and completed its work by the end of 1964, considered the subject of hospitalization benefits and made significant recommendations in this field that were quite similar to the corresponding provisions contained in the administration's bill, H.R. 1 and S. 1, 89th Congress, introduced in January 1965. Further details on the recommendations of the Advisory Council and on the cost assumptions that it suggested may be found in its report "The Status of the Social Security Program and Recommendations for Its Improvement" (app. V, 25th Annual Report of the Board of Trustees, H. Doc. No. 100, 89th Cong.).

The Advisory Council stressed that the assumptions used in estimating hospital insurance costs should be conservative (i.e., where judgment issues arise, they should be resolved in a direction that would yield a higher cost estimate). The assumptions suggested by the Advisory Council were that the estimated 1965 hospitalization costs should be assumed to increase in the future in relation to total earnings rates by a net differential of 2.7 percent per year for the first 5 years after 1965, with this differential then being assumed to decrease to zero over the next 5 years; during the following 5 years, the differential is assumed to reverse, and after 1980 earnings are assumed to rise at an annual rate that is 0.5 percent greater than the increase in hospitalization costs.

The cost estimates made for H.R. 1 and S. 1 (as contained in Actuarial Study No. 59 of the Social Security Administration) were on the same basis as to hospitalization-cost assumptions as recommended by the Advisory Council. The long-range cost estimates were developed on the basis that the base figure for average daily hospitalization costs would be 1963 (since the cost estimates for both the cash benefits and the hospitalization benefits are founded on this basic assumption). This, in turn, meant that there was also the

coordinate assumption that the earnings base would, in the future, keep up to date with what $5,600 represented in 1963.

(5) Assumptions as to relative trends of hospitalization costs and earnings underlying cost estimate for committee bill—H.R. 6675

As indicated previously, your committee very strongly believes that the financing basis of the new hospital insurance program should be developed on a conservative basis. For the reasons brought out previously, the cost estimates should not be developed on a level-earnings basis, but rather they should assume dynamic conditions as to both earnings levels and hospitalization costs. Accordingly, it seems appropriate to make cost projections for only 25 years in the future and to develop the financing necessary for only this period (but with a resulting trust fund balance at the end of the period equal to about 1 year's disbursements). Although the trend of beneficiaries aged 65 and over relative to the working population will undoubtedly move in an upward direction after 25 years from now, it seems impossible to predict what the trend of medical costs and what hospital-utilization and medical-practice trends will be in the distant future.

Accordingly, for the purposes of the cost estimates in this report, the assumptions as to the relative trend of hospitalization costs as compared with the general earnings level have been modified somewhat as compared with the relatively conservative assumptions recommended by the Advisory Council. The same differential of hospital costs over earnings for the first 10 years is used, but thereafter the assumption is made that these two elements increase at the same rate (rather than having a negative one-half of 1 percent annual differential, as in the Advisory Council recommendations). In other words, the basis of the hospitalization-cost trends used in the cost estimates of this report are on a more conservative basis than recommended by the Advisory Council and, in fact, are more conservative than those used by the insurance business for its estimates for proposals of this type.

(6) Assumptions as to hospital utilization rates underlying cost estimates for committee bill—H.R. 6675

It should be pointed out that the hospital utilization assumptions for the cost estimates prepared by the Social Security Administration and also those in this report have always been founded on the hypothesis that current practices in this field will not change relatively more in the future than past experience has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates for the various past proposals (H.R. 3920 and S. 880, 88th Congress; the Advisory Council plan; and H.R. 1 and S. 1, 89th Congress) were the same in all instances. In view of the fact that testimony of the insurance business and the Blue Cross stated their belief that higher utilization would develop (actually, by as much as 40 percent higher in the early years of operation), your committee has adopted higher utilization rates than those used previously by the Social Security Administration. The increase in the early-year utilization rates is about 20 percent. Half of this can be attributed to changing the

previous assumption of low-cost utilization rates in the early years to the assumption of the intermediate-cost rates then; the latter were previously used only after the program would be in operation for a few years and the beneficiaries would have better knowledge of the benefits available. The other half of the increase in the utilization rates can be said to represent a basic adjustment upward for all future years, which can be viewed as a safety factor.

In other words, the current estimates can be considered to be high-cost ones, as compared with the intermediate-cost ones formerly used by the Social Security Administration. Another factor that may be used to justify the higher utilization rates used in these cost estimates is the somewhat greater amount of hospitalization which might result from the availability of the physicians' services benefits for in-hospital cases made available under the supplementary health insurance benefits program contained in your committee's bill.

(7) Assumptions as to hospital per diem rates underlying cost estimates for committee bill—H.R. 6675

The average daily cost of hospitalization that is used in these cost estimates is computed on the same basis as the corresponding figures in Actuarial Study No. 59 of the Social Security Administration. These per diem costs were in close agreement with what the Blue Cross testimony indicated, although some 13 percent below the estimates of the insurance business. The reason for the latter differential is that the insurance business did not make as large an allowance for a lower average daily cost for persons aged 65 and over and for hospital expenses that are not related to inpatients. The only significant change in the average daily hospitalization cost figures was a reduction by about 4 percent to allow for the exclusion from the hospital insurance system that would be established by your committee's bill of the in-hospital costs arising from the professional services of radiologists, anesthesiologists, pathologists, and physiatrists (the costs for such services would be covered under the supplementary health insurance benefits plan).

(d) Results of cost estimates

(1) Summary of cost estimates for H.R. 1 and S. 1, 89th Congress, under various cost assumptions

Table B summarizes the cost estimates that would be made for H.R. 1 and S. 1, 89th Congress (the King-Anderson bill), under various cost assumptions that have been used in the past, and also under those that are being used for your committee's bill. This analysis is made, with a single plan as the base point, so as to show the effect of the various assumptions. The variations shown arise from changes in a number of the cost factors—the relative trend of hospitalization costs as compared with earnings; the period over which the cost estimates are made, and whether static or dynamic assumptions are involved; and the hospital utilization rates.

In all the previous cost estimates, it was assumed that the maximum taxable earnings base would be kept up to date, by periodic changes, with changes in the general earnings level, and also that the same would be true of any deductibles. In regard to the latter element, many of the proposals had provisions calling for increases in the deductible amounts as hospital costs increase in the future so that the condition was thus satisfied; this is the case in connection with the hospital and outpatient diagnostic deductibles in your committee's bill.

With regard to the assumption that the earnings base would be kept up to date in the future, your committee believes that this is not a conservative assumption, since it seems to bind future Congresses into taking action in order to maintain the actuarial soundness of the hospital insurance system. It should be emphasized that the actuarial soundness of the cash benefits program under the old-age, survivors, and disability insurance system does not at all depend upon an assumption of the earnings base being adjusted upward when wages rise (but rather, on the contrary, the actuarial status of the system is improved under such circumstances). Accordingly, although your committee believes that, under the likely conditions of rising wages over the next 25 years, the earnings base will be adjusted upward beyond the two increases contained in your committee's bill (from the present $4,800 to $5,600 in 1966, and to $6,600 in 1971), the conservative assumption should be made for the purposes of the actuarial cost estimates that no further increases will occur after 1971.

TABLE B.—*Summary of cost estimates for hospital insurance benefits of H.R. 1 and S. 1, 89th Congress, under various cost assumptions*

Assumptions as to earnings base	Assumptions as to relative trends of hospitalization costs and earnings	Estimated level-cost [1]
COST ESTIMATES PREPARED ON LONG-RANGE LEVEL-EARNINGS ASSUMPTIONS		
(1) Keeps up to date with what $5,600 was in 1963.	Over the long range, hospitalization costs and earnings increase at same rate from 1961 on.	0.67% (basis of Actuarial Study No. 57, 1963).
(2) Keeps up to date with what $5,600 was in 1963.	Past experience projected to 1965; in next 5 years, hospitalization costs, rise more rapidly than earnings—by a total differential of 10%; thereafter, hospitalization costs and earnings rise at same rate.	0.81% (basis of cost estimates developed for 1964 legislation).
(3) Keeps up to date with what $5,600 was in 1963.	Past experience projected to 1965; hospitalization costs rise more rapidly than wages by 2.7% for 5 years; then this differential is reduced to zero in next 5 years and after 1975 wages rise more rapidly than hospitalization costs by ½% per year.	0.84% (basis of cost estimates for Advisory Council and in Actuarial Study No. 59, 1965).
(4) Keeps up to date with what $5,600 was in 1963.	Past experience projected to 1965; hospitalization costs rise more rapidly than wages by 2.7% for 5 years; then, this differential is reduced to zero in next 5 years; after 1975, hospitalization costs and wages increase at same rate.	0.87%.
(5) Keeps up to date with what $5,600 would be in 1966.	Same as in (4)	0.90%.
COST ESTIMATES PREPARED ON LONG-RANGE RISING-EARNINGS ASSUMPTIONS		
(6) Same as in (5)	Same as in (4)	0.96%.
(7) Remains at $5,600 through 1970; brought up to date by increase to $6,600 in 1971 and increased correspondingly every 5th year thereafter.	Same as in (4)	0.98%.
(8) Remains at $5,600 through 1970; increases to $6,600 in 1971 and then remains constant.	Same as in (4)	1.09%.[2]

[1] Except for items (1) and (2), which are on a perpetuity basis, the figures are for the level-cost over a 25-year period, expressed as a percentage of taxable payroll; includes margin so that trust fund balance at end of period equals the disbursements for that year.

[2] All the cost estimates for items (1) to (8) are based on the hospital utilization rates of Actuarial Study No. 59 of the Social Security Administration. The level-cost for item (8) would be increased to 1.21% under the hospital utilization rates of the estimates of this report.

(2) Level-costs of hospitalization and related benefits

As shown in footnote 2 of table B, the level-cost of the hospital benefits that would be provided under H.R. 1 and S. 1, 89th Congress, is 1.21 percent of taxable payroll, under the assumptions that the earnings base would be the same as in your committee's bill and would not change after 1971, and that both hospitalization costs and general earnings will continue to rise during the entire 25-year period considered in the cost estimates. The corresponding level-cost of the hospital and related benefits in your committee's bill is 1.23 percent of taxable payroll. The small difference arises from several factors. A higher cost arises for your committee's bill because the self-employed contribute on a lower rate basis (i.e., at the employee rate instead of 1½ times the employee rate), because there are more insured persons (due to the transitional insured status provisions for certain persons aged 72 and over), and because of the direct coverage of railroad workers (more thorough consideration of the effect of the financial interchange provisions in the previous proposals has now been given). On the other hand, there is a lower cost under your committee's bill because of the exclusion of all in-hospital physician services and of pre-hospital home health services, but this only partially offsets the factors mentioned in the previous sentence.

The level-equivalent of the contribution schedule in your committee's bill (as described previously) is also 1.23 percent of taxable payroll. Accordingly, these estimates indicate that the hospital insurance program is in exact actuarial balance under the assumptions made (and described previously).

The estimated level-cost of the hospital and related benefits of 1.23 percent consists predominantly of the cost of the hospital benefits. It does not seem feasible to attempt to subdivide the cost for the hospital benefits and the extended care facility benefits between these two categories. In the early years, virtually all of such costs will be for hospital benefits. Perhaps only about $25 to $50 million will be expended in 1967 for extended care facility benefits. In later years, it seems quite possible that greater use of post-hospital extended care services will be made, thus tending to reduce the use of hospitals. From a cost standpoint then, it seems desirable to consider hospital benefits and extended care facility benefits in combination, and it is estimated that the level-cost therefor is 1.19 percent of taxable payroll. The level-cost of outpatient hospital diagnostic benefits is estimated at 0.01 percent of taxable payroll, with the cost in the first full year of operations being about $10 million. Finally, the estimated level-cost of the post-hospital home health benefits is 0.03 percent of taxable payroll, a figure that allows for a considerable expansion of these services in the future (with the cost in the first full year of operations being estimated at less than $10 million).

As indicated previously, one of the most important basic assumptions in the cost estimates presented herein is that the earnings base is assumed to remain unchanged after it increases to $6,600 in 1971, even though for the remainder of the period considered (up to 1990) the general earnings level is assumed to rise at a rate of 3 percent annually. If the earnings base does rise in the future to keep up to date with the general earnings level, then the contribution rates required would be lower than those scheduled in your committee's

bill. In fact, if this were to occur, the steps in the contribution schedule beyond the combined employer-employee rate of 1.1 percent would not be needed. Furthermore, under the foregoing conditions, if the hospital utilization experience followed the intermediate-cost assumptions made previously in Actuarial Study No. 59 of the Social Security Administration (increased by 10 percent for the estimates presented in this report), and if all other conditions (such as the relationship of hospitalization costs and general earnings) developed as they are set forth in the assumptions, then it is possible that the combined employer-employee contribution rate would not have to increase beyond 1.0 percent.

(3) Number of persons protected on July 1, 1966

It is estimated that on July 1, 1966, the total population of the United States (including American Samoa, Guam, Puerto Rico, and the Virgin Islands) who are aged 65 and over will be 19.10 million (after allowance for underenumeration in the census counts and in population projections based thereon).

The total number of such persons who are estimated to be eligible for the hospital and related benefits on the basis of insured status under the old-age, survivors, and disability insurance system and the railroad retirement system is 16.95 million. Of the remaining 2.15 million, about 2.00 million are estimated to be eligible for the hospital and related benefits under the transitional provision on eligibility of presently uninsured individuals, as contained in your committee's bill. The remaining 150,000 persons are not eligible for hospital and related benefits because they are active or retired employees who are eligible (or had the opportunity to be eligible) for more comprehensive benefits under the Federal Employees Health Benefits Act of 1959, because they are alien residents who do not meet the residence requirements, or because they are subversives.

The cost for the 2.00 million persons who would be blanketed in for the hospital and related benefits is met from the General Treasury (with the financial transactions involved passing through the hospital insurance trust fund). The costs so involved, along with the financial transactions, are not included in the preceding cost analysis or in the following discussions of the progress of the hospital insurance trust fund. A later portion of this section, however, discusses these costs for the blanketed-in group.

(4) Future operations of hospital insurance trust fund

Table C shows the estimated operation of the hospital insurance trust fund under your committee's bill. According to this estimate, the balance in the trust fund would grow steadily in the future, increasing from about $560 million at the end of 1966 to $1.9 billion 5 years later. Over the long range, the trust fund would build up steadily, reaching $9.9 billion in 1990 (representing the benefit outgo for 1.1 years at the level of that time).

TABLE C.—*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	$1,578	$982	[1] $50	$17	$562
1967	2,601	2,192	66	20	925
1968	2,790	2,391	72	34	1,286
1969	2,879	2,607	78	45	1,525
1970	2,983	2,840	85	50	1,633
1971	3,327	3,055	92	55	1,868
1972	3,488	3,280	98	60	2,038
1973	3,929	3,516	105	68	2,414
1974	4,120	3,760	113	77	2,738
1975	4,267	4,028	121	84	2,950
1980	6,123	5,276	158	140	5,018
1985	7,038	6,823	205	236	7,681
1990	9,030	8,754	263	306	9,948

[1] Including administrative expenses incurred in 1965.

NOTE.—The transactions relating to the noninsured persons, the costs for whom is borne out of the general funds of the Treasury, are not shown in the above figures.

(*e*) *Cost estimate for hospitalization benefits for noninsured persons paid from general funds*

Your committee's bill would provide hospitalization and related benefits not only for beneficiaries of the old-age, survivors, and disability insurance system and the railroad retirement system, but also for most persons aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. Such benefit protection would be provided to any person aged 65 and over on July 1, 1966, who is not eligible as an old-age, survivors, and disability insurance or railroad retirement beneficiary and who (*a*) is not an employee of the Federal Government or a retired Federal employee eligible (or who had the opportunity to be eligible) for health benefits under the Federal Employees Health Benefits Act of 1959, (*b*) is not a member of a subversive organization and has not been convicted of subversive activities, and (*c*) is a citizen or has had at least 10 years of continuous residence.

Persons meeting such conditions who attain age 65 before 1968 also would qualify for the hospitalization benefits, while those attaining age 65 after 1967 must have some old-age, survivors, and disability insurance or railroad retirement coverage to qualify—namely, 3 quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1965 and before the year of attainment of age 65 (e.g., 6 quarters of coverage for attainment of age 65 in 1968, 9 quarters for 1969, etc.). This transitional provision "washes out" for men attaining age 65 in 1974 and for women attaining age 65 in 1972, since the fully-insured-status requirement for monthly benefits for such categories is then no greater than the special-insured status requirement.

The benefits for the "noninsured" group would be paid from the health insurance trust fund, but with simultaneous reimbursement therefor from the general fund of the Treasury on a current basis.

The estimated cost to the general fund of the Treasury for the hospitalization 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)	$140
1967	275
1968	270
1969	260
1970	250

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.

5. ACTUARIAL COST ESTIMATES FOR THE VOLUNTARY SUPPLEMENTARY HEALTH INSURANCE BENEFITS SYSTEM

(a) Summary of actuarial cost estimates

The supplementary health insurance benefits system that would be established by your committee's bill has an estimated cost for benefit payments incurred and for administrative expenses that would adequately be met during the first 2 years of operation (1966–67) by the individual premium rates prescribed plus the equal matching contributions from the general fund of the Treasury. Both contributions and benefit payments would begin in July 1966. In subsequent years, your committee's bill provides for appropriate adjustment of the premium rates so as to assure that the program will be adequately financed, along with the establishment of sufficient contingency reserves. Although provision is made for an advance appropriation from general revenues to provide a contingency reserve during the period July 1966 through June 1967, it is believed that this will not actually have to be drawn upon, but nonetheless it serves as a desirable safeguard to the financing basis of the program.

Just as in the case of the hospital insurance system, it is essential that the operating experience of a vast new program such as this should be subject to prompt, thorough actuarial review and study. Accordingly, your committee approves of the suggestion that has been made for a small random sample of the eligibles to be maintained on a current basis, so as to permit intensive study by the actuary without the delay that would be inherent in attempting to obtain operating experience data for the entire group of persons covered under the system

(b) Financing policy

(1) Self-supporting nature of system

Your committee has recommended the establishment of a supplementary health insurance benefits program that can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and

over in the United States. This program is intended to be completely self-supporting from the contributions of covered individuals and from the equal-matching contributions from the general fund of the Treasury. Initially (for the period July 1966 through December 1967), the premium rate is established at $3 per month, so that the total income of the system per participant per month will be $6. Persons who do not elect to come into the system at as early a time as possible will generally have to pay a higher premium rate than $3. Under your committee's bill, the monthly premium rate can be adjusted for future years after 1967 so as to reflect the expected experience, including an allowance for a margin for contingencies. All financial operations for this program would be handled through a separate fund, the supplementary health insurance benefits trust fund.

Your committee's bill also provides for the establishment of an advance appropriation from the General Treasury that will serve as an initial contingency reserve in an amount equal to $18 (or 6 months' per capita contributions from the General Treasury) times the number of individuals who are estimated to be eligible for participation in July 1966. This amount, which is approximately $345 million, would be appropriated before July 1, 1966, but it would not actually be transferred to the supplementary health insurance benefits trust fund unless, and until, some of it would be needed. This contingency amount would be available only during the first year of operations (July 1966 through June 1967), and any amounts actually transferred to the trust fund would be subject to repayment of the funds of the Treasury (without interest).

(2) Actuarial soundness of system

The concept of actuarial soundness for the old-age, survivors, and disability insurance system and for the hospital insurance system is somewhat different than that for the supplementary health insurance benefits program. In essence, the last system is on a "current cost" financing basis, rather than on a "long-range cost" financing basis. The situations are essentially different because the financial support of the supplementary health insurance benefits system comes from a premium rate that is subject to change from time to time, in accordance with the experience actually developing and with the experience anticipated in the near future. The actuarial soundness of the supplementary health insurance benefits program, therefore, depends only upon the "short-term" premium rates being adequate to meet, on an accrual basis, the benefit payments and administrative expenses over the period for which they are established (including the accumulation and maintenance of a contingency fund).

(c) Results of cost estimates

(1) Cost assumptions

Only a relatively small amount of data is available in regard to the physician's services and other services that would be covered by the supplementary health insurance benefits system. The cost estimates used in determining the premium rate to be charged to individuals,

along with the matching Government contribution, have utilized data from the experience under the Federal Employees Health Benefits Act of 1959 for persons aged 65 and over, the experience under the Connecticut 65 program, and various information obtained by the National Health Survey conducted on a periodic basis by the Public Health Service of the Department of Health, Education, and Welfare.

The cost estimates have been made on a conservative basis—as seems essential in a newly established program of this type for persons aged 65 and over, most of whom have not previously had such insurance. It is believed that the $6 total per capita income of the system (from the premiums of the individuals and the matching Government contributions) will be fully adequate to meet the costs of administration and the benefit payments incurred, as well as to build up a relatively small contingency reserve. It is believed that there will be no need to draw upon the advance appropriation that is provided from general revenues.

Two cost estimates have been presented in regard to the possible per capita cost. Under the low-cost estimate, the benefits and administrative expenses will, on an accrual basis, represent about 75 percent of the contribution income, whereas under the high-cost estimate, the corresponding ratio will be almost 100 percent.

In an individual voluntary-election program such as this, it is impossible to predict accurately in advance what proportion of those eligible to participate in the program will actually do so. Accordingly, the cost estimates have been presented on two bases—an assumed 80 percent participation and an assumed 95 percent participation. Both of these estimates assume that virtually all State public assistance agencies will "buy in" for their old-age assistance recipients.

(2) Short-range operations of supplementary health insurance benefits trust fund

Table D presents estimates of the operation of the supplementary health insurance benefits trust fund for the first 2 years of operation, 1966–67. As indicated previously, four sets of estimates are given, under different assumptions as to low-cost and high-cost estimates and low and high participation. A significant balance in the trust fund develops in 1966, because of the lag involved in making benefit payments, since there are the factors of administrative processing and of the deductible that must be met first before any benefits are payable. In this respect, it will be noted that the income from premium payments by individuals will go into the trust fund beginning in the early part of July 1966, and the matching Government contributions will go into the trust fund simultaneously.

Under the low-cost estimates, the trust fund is estimated to have a balance of about $300 to $350 million at the end of 1966, and between $600 and $700 million at the end of 1967. On the other hand, under the high-cost estimates, the balance in the trust fund at the end of 1966 will be between $200 and $250 million, and will remain at substantially this level during 1967.

TABLE D.—*Estimated progress of supplementary health insurance benefits trust fund*

[In millions]

Calendar year	Contributions		Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
	Participants	Government				
	Low cost estimate, 80-percent participation					
1966 [1]	$275	$275	$195	$65	$5	$295
1967	560	560	765	75	15	590
	Low-cost estimate, 95-percent participation					
1966 [1]	$325	$325	$230	$80	$5	$345
1967	665	665	905	90	20	700
	High-cost estimate, 80-percent participation					
1966 [1]	$275	$275	$260	$85	$5	$210
1967	560	560	1,025	95	10	220
	High-cost estimate, 95-percent participation					
1966 [1]	$325	$325	$310	$100	$5	$245
1967	665	665	1,220	110	10	255

[1] Contributions would be collected only during the last 6 months of 1966, and benefit payments would likewise be payable only during that period. Administrative expenses shown include both those for the full year 1966 and such expenses as incurred in 1965.

NOTE.—Not included above is the advance appropriation from general revenues that is to provide a contingency reserve during fiscal year 1966–67 (to be used only if needed and to be repayable).

6. IMPROVEMENT AND EXTENSION OF KERR-MILLS PROGRAM

(*a*) *Background*

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments. This method of providing care has proved popular with the suppliers of medical care, the agencies administering the programs, and the recipients themselves.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who

have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and 227,000 aged were aided in December 1964. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

Your committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, your committee bill would establish, effective January 1, 1966, a new title in the Social Security Act—"Title XIX: Grants to the States for Medical Assistance Programs." After an interim period ending June 30, 1967, all vendor payments for medical care, including medical assistance for the aged, would be administered under the provisions of the new title. Until June 30, 1967, States might continue operating under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program), or if they wish, they might move as early as January 1, 1966, to the new title. Programs of vendor payments for medical care will continue, as now, to be optional with the States.

(*b*) *State plan requirements*

(*1*) *Standard provisions*

The provisions in the proposed title XIX contain a number of requirements for State plans which are either identical to the existing provisions of law or are merely conforming changes. These are:

That a plan shall be in effect in all political subdivisions of the State.

That there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.

That the State agency will make such reports as the Secretary may from time to time require.

That there shall be safeguards provided which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the administration of the plan.

That all individuals wishing to make application for assistance under the plan shall have an opportunity to do so and that such assistance shall be furnished with reasonable promptness.

That in determining whether an individual is blind there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

That medical assistance will be furnished to individuals who are residents of the State but who are absent therefrom.

(*2*) *Additions to standard provisions*

In addition to the requirements for State plans mentioned above, your committee bill contains several other plan requirements which are either new or changed over provisions currently in the law.

The bill provides that there shall be financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan and that effective July 1, 1970, the financial participation by the State shall equal all the non-Federal share. This provision was included to make certain that the lack of availability of local funds for financing of any part of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State. Prior to the 1970 date, your committee will be willing to consider other legislative alternatives to the provisions making the entire non-Federal share a responsibility of the State so long as these alternatives, in maintaining the concept of local participation, assure a consistent statewide program at a reasonable level of adequacy.

The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff.

Your committee bill provides that the State or local agency administering the State plan under title XIX shall be the same agency which is currently administering either title I (old-age assistance) or that part of title XVI (assistance for the aged, blind, and the disabled, and medical assistance for the aged) relating to the aged. Where the program relating to the aged is State-supervised, the same State agency shall supervise the administration of title XIX. This provision was included because of the need to have the same agency which is most familiar with the administration of assistance (including medical care) to various groups of needy or nearly needy people also administer the medical assistance program. This is an agency with long experience and skill in determination of eligibility. Responsibility can be arranged by a welfare agency for actual provision of medical care by or through a health agency under suitable contractual relationships as some States have done under the MAA program.

Moreover, your committee recognizes that there are other State agencies with responsibilities for the provision of medical care or for various types of rehabilitative services in the States. In order to make certain that there is no duplication of effort and that maximum utilization will be made of the resources available from such other agencies, your committee bill provides that the State's plan must include provisions for entering into cooperative arrangements with State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the States.

Your committee bill also provides that if, on January 1, 1965, and on the date a State submits its title XIX plan, the State agency administering or supervising the administration of the State plan for the blind under title X or title XVI of the Social Security Act is different from the State agency administering or supervising the administration of the plan relating to the aged under title I or title XVI, such blind agency may be designated to administer or supervise the administration of the portion of the title XIX plan which relates to blind individ-

uals. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is expected that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of your committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided. Your committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and service in order to encourage their full cooperation and participation in the provision of services under the State plan.

(*c*) *Eligibility fo medical assistance*

Under your committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. These people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people. Thus, under the provisions of the bill, these people will have the first call upon the resources of the States to provide medical care. It is only if this group is provided for that States may include medical assistance to the less needy than those who would be eligible for aid under the various other categories of public assistance.

Under your committee bill, medical assistance made available to persons receiving assistance under title I, IV, X, XIV, or XVI must not be less in amount, duration, or scope than that provided for persons receiving aid under any other of those titles. In other words, the amount, duration, and scope of medical assistance made available must be the same for all such persons. This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance and will eliminate some of the unevenness which has been apparent in the treatment of the medical needs of various groups of the needy.

The bill provides furthermore that as States extend their programs to include assistance for persons who come within the various cate-

gories of assistance except that their income and resources are sufficient to meet their needs for maintenance, the medical assistance given such individuals shall not be greater in amount, duration, or scope than that made available for persons who are recipients of money payments. This was included in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy.

Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children who, except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal.

(*d*) *Determination of need for medical assistance*

Your committee bill would make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them.

Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary) are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual. The provisions also are designed to assure that whatever is applicable under titles I, IV, X, XIV, and XVI for the disregarding of income or for setting aside of income shall also be applicable in evaluating the income of the individual who is applying for medical assistance under title XIX. Titles I and X now provide for the disregarding of certain income and title IV provides

that income may be set aside for the future needs of the children. Other pertinent provisions for the disregard of income are found in the Economic Opportunity Act and the Food Stamp Act of 1964.

Your committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. Your committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

The bill also contains a provision designed to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted programs which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the State plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed. In order that all States shall be flexible in the consideration of an individual's income, your committee bill requires that the States standards for determining eligibility for and extent of medical assistance shall take into account, except to the extent prescribed by the Secretary, the cost—whether in the form of insurance premiums or otherwise—incurred for medical care or any other type of remedial care recognized under State law. Thus, before an individual is found ineligible for all or part of the cost of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual below the test of eligibility under the State plan. If the test of eligibility should be $2,000 a year, an individual with income in excess of that amount shall not be required to use his income to the extent he has remaining less than $2,000. This action would reduce the individual below the level determined by the State as necessary for his maintenance.

The bill contains several interrelated provisions which prohibit or limit the imposition of any deduction, cost sharing, or similiar charge,

nor of any enrollment fee, premium, or similar charge, under the plan.

No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect or require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan.

For any other items of medical assistance furnished under the plan, a charge of any kind may be imposed only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services. The Secretary is given authority to issue standards under this provision, which it is expected will protect the income and resources an individual has which are necessary for his nonmedical needs.

The hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with the individual's claim for hospitalization benefits. Your committee is concerned that hospitalization be readily available to needy persons and that the necessity of their paying deductibles shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need. For this reason, your committee's bill provides that the States make provisions, for individuals 65 years or older, of the cost of any deductible imposed with respect to individuals under the program established by the hospital insurance provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards—under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance—to guide the States. Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals to share in the cost shall not be an undue burden on them.

Titles I and XVI authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments except pursuant to a court judgment concerning incorrect payments, and prohibits adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under your com-

mittee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

(*e*) *Scope and definition of medical services*

"Medical assistance" is defined under the bill to mean payment of all or part of the care and services for individuals who would if needy, be dependent under title IV, except for section 406(a)(2), and are under the age of 21, or who are relatives specified in section 406(b)(1) with whom the child is living, or who are 65 years of age and older, blind, or permanently and totally disabled, but whose income and resources are insufficient to meet all their medical care costs. The bill, as do current provisions of law, permits Federal sharing in the cost of medical care provided up to 3 months before the month in which the individual makes application for assistance. Thus, the scope of the program includes not only the aged, blind, disabled, and dependent children as defined in State plans, but also children under the age of 21 (and their caretaker relatives) who come within the scope of title IV, except for need and age, even though they may not be defined as eligible under a particular State plan.

Your committee bill contains a list of services, the first five of which the States are required to include in their plans, if they elect to implement title XIX, and the remainder of which are optional with the States. The required services are:

Inpatient hospital services.
Outpatient hospital services.
Other laboratory and X-ray services.
Skilled nursing home services.
Physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home or elsewhere.

In the opinion of your committee, these are the most essential items of service which should be included as a minimum if the medical assistance program is to be of significant help to the individual. These minimum items of service are to become effective July 1, 1967; until then, the State plan must include—as now provided in titles I and XVI—for some institutional and some noninstitutional services.

Other items of medical service which the States may, if they wish include in their plans are:

Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
Home health care services.
Clinic service.
Private duty nursing service.
Dental service.
Physical therapy and related services.
Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.
Other diagnostic, screening, preventive, and rehabilitative services.
Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

The States must pay the reasonable cost of inpatient hospital services for the number of days of care provided under the plan.

Among the items of medical services which the States may include is medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. Under this provision, a State may if it wishes, include medical and remedial services provided by osteopaths, chiropractors, optometrists and podiatrists, and Christian Science practitioners, if such practitioners and services are licensed by the State.

If a State chooses to provide eyeglasses as a service under the plan, your committee believes that the individual recipient should be free to select either a physician skilled in diseases of the eye or an optometristto provide these glasses. Many small communities do not have qualified ophthalmologists but do have optometrists who are competent to provide, fit, or change eyeglasses.

In addition to the items specifically listed, the Secretary is authorized to define any other medical care or any other type of remedial care recognized under State law which he believes might be provided by the States and in which the Federal Government will participate financially.

The State plan may not include any individual who is an inmate of a public institution, except as a patient in a medical institution; nor may it include any individual under the age of 65 who is a patient in an institution for tuberculosis or mental diseases.

Under title XIX, it will be possible for States to give medical assistance to persons 65 years of age and older who are in mental and tuberculosis institutions and to otherwise eligible persons of any age with a diagnosis of psychosis or tuberculosis and who are receiving care in other medical institutions. Under the bill, if the plan includes medical assistance for patients in institutions for mental diseases or tuberculosis, various requirements are specified for inclusion in the State plan with respect to these individuals and various other fiscal and other provisions are included. These are identical with those included in title II, part 3 of the bill and are explained elsewhere in this report.

Medical assistance provided under the bill may include payment for care and services provided at any time within the month in which an individual becomes eligible or ineligible for assistance, e.g., by attaining a specified age. This avoids the administrative inconvenience of having to segregate bills by the day of the month on which care or services were provided and is consistent with the monthly pattern of benefits under the other public assistance titles.

(f) Other conditions for plan approval

Title XIX requires that the Secretary approve any plan which fulfills the plan requirements specified and described above and which does not contain certain other conditions. Under these provisions, a State plan may not include an age requirement of more than 65 years. Effective July 1, 1967, States may not, under the provisions of your committee bill, exclude any individual who has not attained the age of 21 and is, or would, except for the provisions of section 406(a)(2) be a dependent child under title IV. Thus, States will include within the scope of their plan all children

under the age of 21—whether or not they are attending school or taking a program of vocational training—who would otherwise be within the scope of eligibility of a dependent child as defined under title IV of the Social Security Act. This provision was included in order to provide assurance that children under the age of 21 will have their medical needs met if they are either a member of a family receiving a money payment under title IV of the Social Security Act or a member of a family which has the need and other characteristics described under title IV.

The Secretary would be prohibited from approving any plan which imposed a residence or citizenship requirement that goes beyond those now in title I and title XVI as they relate to the medical assistance for the aged program. In addition, the Secretary is directed not to approve any State plan for medical assistance if he finds that the approval and operation of the plan will result in a reduction in the level of aid or assistance provided for eligible individuals under title I, IV, X, XIV, or XVI. An exception is provided allowing States to reduce such aid to the extent that assistance now provided under titles I, IV, IX, XIV, and XVI is to be provided under title XIX. The reason your committee recommends the inclusion of this provision is to make certain that States do not divert funds from the provision of basic maintenance to the provision of medical care. If the Secretary should find that his approval of a title XIX plan would result in a reduction of aid or assistance for persons receiving basic maintenance under the public assistance titles of the Social Security Act (except as specified above) he may not approve such a plan under title XIX. Your committee recognizes the need and urgency for States to maintain, if not improve, the level of basic maintenance provided for needy people under the public assistance programs. The provision is intended to prevent any unwarranted diversion of funds from basic maintenance to medical care.

(*g*) *Financing of medical assistance*

Your committee bill provides for payments under title XIX, beginning with the quarter commencing January 1, 1966. States with approved plans would receive an amount equal to the Federal medical assistance percentage of the total amount expended during a quarter as medical assistance under the State plan. This percentage is described below. The amount expended as medical assistance for purposes of Federal matching include expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under one of the Federal-State public assistance programs. This may include payment of premiums for those individuals covered under agreements between the State and the Secretary, and also for other money payment recipients who are eligible under part B of title XVIII. In addition, expenditures for other insurance premiums for medical or any other type of remedial care or the cost thereof are matchable as medical assistance. (The definitions of assistance in the public assistance titles of the Social Security Act would also be amended to include similar provisions.)

In addition, the States are to receive 75 percent of so much of the sums expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan as are attributable to the compensation of skilled professional medical person-

nel and staff directly supporting such personnel of the State agency or the local agency administering the plan in the political subdivision. This provision was included in order to provide adequate Federal financial support for the staffing of the State and local public welfare departments by such skilled professional medical personnel and staff directly supporting such personnel as may be necessary. Such staff will include physicians, medical administrators, medical social work personnel, and other specialized personnel necessary to assure an adequate number of persons to do a quality job as well as the clerical staff, directly associated with the professional staff, and the necessary travel and other closely related expenditures. It is very likely that some people in need of medical assistance will need related social services in order to receive the full benefits of the program. Under the 1962 public welfare amendments, States may receive 75 percent Federal sharing in the cost of services provided to persons receiving aid under titles I, IV, X, XIV, and XVI to former recipients of assistance under these titles and persons likely to become recipients of aid under these titles. Thus adequate provisions are already available to help the States finance the provision of social services to those receiving medical assistance or the cost of training staff to provide such services and no such provision is included in the new title.

In addition, the States are to receive one-half of all other expenditures found by the Secretary to be necessary for the proper and efficient administration of the State plan.

The Federal medical assistance percentage is determined in accordance with a formula described in the bill. It provides that a State whose per capita income is equal to the national average per capita income shall receive 55 percent Federal matching. States whose per capita income is below the national average shall receive correspondingly higher proportions of Federal funds up to a maximum of 83 percent. States whose per capita income is above the national average shall receive correspondingly lower percentages but not less than 50 percent. The medical assistance percentages for Puerto Rico, the Virgin Islands, and Guam shall be 55 percent. The method of determining the Federal medical assistance percentage and the frequency of its determination and promulgation are (after the initial promulgation for the period January 1, 1966, to June 30, 1967) already specified in the law.

There is a special provision for adjustment of the Federal medical assistance percentage for any State which might not otherwise receive full advantage from the title XIX formula. It is provided that during the period from January 1, 1966, through June 30, 1969, the Federal medical assistance percentage under title XIX for any State shall not be less than 105 percent of the Federal share of medical expenditures by the State during fiscal year 1965. The computation is made by determining the amount of Federal payments made to each State for fiscal year 1965 under all of the public assistance titles, which would not have been payable except for the making of vendor medical payments. This amount of Federal payments is compared with the total amount of vendor medical expenditures under the public assistance plans (whether below or above the matching ceilings under the Federal statutory formulas) to give the Federal share of medical expenditures by the State during fiscal year 1965. The raising of the

Federal medical assistance percentage to 105 percent of the Federal share of medical expenditures for 1965 will obviate certain inequities in the various formulas and will enable a few States which might not otherwise do so to receive some additional Federal funds as an incentive for an improved program.

Provisions relating to the availability of Federal sharing in the cost of medical assistance for persons 65 years of age or older who are patients in mental or tuberculosis hospitals specify that the States will receive additional Federal funds only to the extent that a showing is made to the satisfaction of the Secretary that the additional funds being received are being used to extend and improve the mental health program of the States. Comparable provisions appear in title II, part 3 of the bill, and are explained more fully in that part of this report relating to title II.

The provisions of title IV, section 405 of the bill, described elsewhere in this report are designed to assure that the additional Federal funds which are to accrue to the States under the operation of the formula described above, shall be used directly in the public assistance program and may not be withdrawn from the program by the States.

The bill sets forth provisions comparable to those which are in other of the public assistance titles of the Social Security Act describing the procedure by which the State submits its estimates of the funds it will need and receives payments under its approved plan, and the procedures to be followed in the event it should become necessary to question the continued receipt of Federal funds under the new title. There is also a new provision limiting payments made under the new title to States making a satisfactory showing of efforts toward broadening the scope of care and services made available under the plan. This showing must be such that the Secretary is reasonably convinced the program of medical assistance will have such liberalized eligibility requirements and comprehensive care and services, including needed social services to achieve independence or self-care that by July 1, 1975, assistance and services needed will be available to substantially all individuals who meet the State's eligibility standards with respect to income and resources. This provision was included in order to encourage the continued development in the States of a broadened and more liberalized medical assistance program so that all persons who meet the State's test of need, whose own resources, and the resources available to them under other programs for medical care, including those established for Federal matching under this bill, are insufficient, will receive the medical care which they need by 1975.

(h) Miscellaneous provisions

Title XIX would under the provisions of your committee bill become effective January 1, 1966. No payments may be made to a State under title I, IV, X, XIV, or XVI with respect to aid or assistance in the form of medical or other types of remedial care for any period for which such State receives payment under title XIX or for any period after June 30, 1967. Thus, under the provisions of your committee bill, a State is permitted to implement title XIX at any time it wishes commencing January 1, 1966, but must do so by July 1, 1967, if it wishes to receive Federal participation in vendor payments for medical care. When a title XIX plan has gone into effect pursuant to the bill, all vendor medical payments made on or after the effective date

(and administrative costs on or after the effective date, which are related to vendor medical payments) will be accounted for under title XIX, and not under the other titles.

The bill also makes technical and conforming amendments.

(*i*) *Cost of medical assistance*

As the accompanying table shows, if all States took full advantage of provisions of the proposed title XIX, the additional Federal participation would amount to $238 million. However, because all States cannot be expected to act immediately to establish programs under the new title and because of provisions in the bill which permit States to receive the additional funds only to the extent that they increase their total expenditures, the Department of Health, Education, and Welfare estimates that additional Federal costs in the first year of operation will not exceed $200 million. Since the new title would be effective only for the last 6 months of the fiscal year ending June 30, 1966, expenditures in that fiscal year are not expected to exceed $100 million.

Public assistance: Increased Federal funds available for medical payments under title XIX [1]

[In thousands of dollars]

State	Increase available under title XIX [1]	State	Increase available under title XIX [1]
Total	$238,005	Missouri	350
		Montana	27
Alabama	1,045	Nebraska	1,511
Alaska	5	Nevada	263
Arizona	19	New Hampshire	1,931
Arkansas	3,905	New Jersey	5,559
California	20,411	New Mexico	1,634
Colorado	2,689	New York	46,580
Connecticut	3,922	North Carolina	2,890
Delaware	8	North Dakota	3,809
District of Columbia	344	Ohio	2,871
Florida	684	Oklahoma	14,752
Georgia	363	Oregon	1,291
Hawaii	898	Pennsylvania	3,098
Idaho	477	Rhode Island	2,437
Illinois	18,395	South Carolina	2,133
Indiana	2,136	South Dakota	148
Iowa	5,315	Tennessee	324
Kansas	5,808	Texas	1,237
Kentucky	262	Utah	3,028
Louisiana	3,950	Vermont	330
Maine	781	Virginia	159
Maryland	141	Washington	2,290
Massachusetts	16,614	West Virginia	2,260
Michigan	3,715	Wisconsin	17,031
Minnesota	27,578	Wyoming	280
Mississippi	317		

[1] Based on expenditures for vendor medical payments from State and local funds for all programs combined in January 1964. If State and local expenditures were reduced, the Federal expenditure would be correspondingly lower, while increases in State and local expenditures would also result in increases in the Federal cost.

B. Child Health Amendments

1. SUMMARY OF COMMITTEE ACTION

Your committee believes that the proposals embodied in part 1, title II of its bill will help to improve the health care of many low-income preschool and school age children and youth.

Your committee's bill would—

(1) Increasing the amounts authorized for maternal and child health services and crippled children's services under title V of the Social Security Act in order to assist the States to move toward the goal of extending such services with a view to making them reasonably available to children in all parts of the State by July 1, 1975;

(2) Authorizing grants for the training of personnel to serve crippled children, particularly mentally retarded children and children with multiple handicaps, and;

(3) Authorizing a new 5-year program of special project grants to provide comprehensive health care and services for children of school age and for preschool children.

(*a*) *Maternal and child health services*

The amount of Federal funds going into maternal and child health services in the fiscal year 1964 was approximately $28 million. State and local funds were more than three times as much, about $92 million.

States use Federal funds, together with State and local funds, to pay the costs of conducting prenatal clinics where mothers are examined by physicians and get medical advice; for visits by public health nurses to homes before and after babies are born to help mothers care for their babies; for well-child clinics where mothers can bring their babies and young children for examination and immunizations, where they can get competent advice on how to prevent illnesses and where their many questions about the care of babies can be answered. Such measures have been instrumental in the reduction of maternal and infant mortality, especially in rural areas. Funds are used to make available doctors, dentists, and nurses to the schools for health examinations of schoolchildren. They are also used for immunizations. These funds support diagnostic, treatment and counseling services for mentally retarded children in 47 States. Practically all States use some of the funds for improving the quality of services to mothers and children by providing special training opportunities to physicians, nurses, nutritionists, medical social workers, and other professional personnel. In addition, States carry out demonstration programs of various kinds.

Your committee believes that increases in the child population and the cost of medical care, wide variations among the States in maternal and infant mortality, and the uneven distribution of basic health services indicate the need for additional Federal support in order to help States make their maternal and child health services available to children in all parts of the State by July 1, 1975.

Existing ceilings on authorizations for appropriations for maternal and child health services are:

$40 million each for the fiscal years ending June 30, 1966, and 1967;

$45 million each for the fiscal years ending June 30, 1968, and 1969; and

$50 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Your committee's bill would authorize an increase in these ceilings on appropriations to:

$45 million for the fiscal year ending June 30, 1966;

$50 million for the fiscal year ending June 30, 1967;

$55 million each for the fiscal years ending June 30, 1968, and 1969; and

$60 million for the fiscal year ending June 30, 1970, and for succeeding fiscal years.

Such increases are authorized in order to help extend maternal and child health services to additional parts of the States, thus providing preventive health services for more mothers and children and contributing to further reduction of infant mortality through greater availability of services.

(*b*) *Crippled children's services*

About $29 million of Federal funds was expended for services for crippled children in fiscal year 1964. Expenditures from State and local funds were more than twice as much—nearly $60 million.

The program now includes children for whom medical or surgical care formerly was not available or feasible. Under the committee's bill, all State crippled children's agencies could make their services increasingly available to children with all kinds of handicaps such as cystic fibrosis, congenital heart disease, neurological disorders, epilepsy, hemophilia, and other problems. Some States have programs for the diagnosis, treatment, and aftercare of children with multiple handicaps, most of whom have varying degrees of mental retardation.

In 1963 about 400,000 children under 21 years of age received physicians' services under the crippled children's programs. Approximately 293,000 children attended diagnostic clinics and close to 70,000 children received hospitalization. About 35 percent of expenditures in the crippled children's program are for hospital care.

One-half of the children diagnosed in 1963 were children with nonorthopedic defects. Deformities of a congenital nature were the largest single group of primary conditions among children served, nearly 30 percent of all children served. Roughly 20 percent of these congenital conditions consisted of malformations of the heart and circulatory system.

However, differences in rate of service among States is considerable, the highest being 165 per 10,000, the lowest 15. This unevenness is indicative of the need for considerable growth of these programs in many States. Many crippled children or children with potentially crippling conditions do not receive needed care because their conditions may not be included in the State's program. For example, a number of States do not include children with epilepsy; others do not include children with strabismus, neglect of which often results in loss of vision in the affected eye; some States do not include children with hearing impairments. The major reason for these deficiencies in State programs is inadequate funds.

Existing authorizations for crippled children's services are:

$40 million each for the fiscal years ending June 30, 1966, and 1967;

$45 million each for the fiscal years ending June 30, 1968, and 1969; and

$50 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Your committee's bill would authorize an increase in the ceiling on appropriations to:

$45 million for the fiscal year ending June 30, 1966;

$50 million for the fiscal year ending June 30, 1967;

$55 million each for the fiscal years ending June 30, 1968, and 1969; and

$60 million for the fiscal year ending June 30, 1970, and for succeeding fiscal years.

Such increases would assist the States to move toward the goal of extending crippled children's services with a view to making such services available to children in all parts of the State by July 1, 1975.

Extension of services for crippled children to areas of a State not now served will increase the number of children helped by the program, and make services more accessible in all parts of a State. The increased funds will also help States to extend their programs and further broaden their definitions of "crippling."

(*c*) *Training of professional personnel for the care of crippled children*

Your committee's bill would authorize a program of grants to institutions of higher learning for training (and related costs) of professional personnel such as physicians, psychologists, nurses, dentists, and social workers for work with crippled children and particularly mentally retarded children and those with multiple handicaps. Authorizations would be $5 million for the fiscal year ending June 30, 1967, $10 million for the fiscal year ending June 30, 1968, and $17.5 million for each fiscal year thereafter.

Of the 4.1 million children born each year about 3 percent—at birth or later—will be classified as mentally retarded. The 27,000 children in 1963 who were served by the 92 clinics in the country supported with maternal and child health and crippled children's funds represent only a small fraction of the children who need this kind of help. A large number of these children also have physical handicaps. Despite the growth in the number of clinics serving mentally retarded children, and the increase in the number of children served, waiting lists remain long. Lack of sufficient numbers of trained personnel to staff clinics is a major reason why applications for services for mentally retarded children exceed existing resources.

The growth of programs for children with various handicapping conditions including those who are mentally retarded and the construction of new university centers for clinical services and training are increasing the demands for adequate trained professional personnel. These centers will offer a complete range of services for the mentally retarded and will demonstrate programs of specialized services for the diagnosis, treatment, education, training, and care of mentally retarded children, including retarded children with physical handicaps. They will be resources for the clinical training of physicians and other specialized personnel needed for research, diagnosis, training, or care.

The program would help to reduce the severe shortage of professional personnel to serve mentally retarded children and children with multiple handicaps. The training of health personnel authorized is

not intended to, and in your committee's judgment will not, in any way duplicate other programs of training (such as those for teachers) of personnel to work with the mentally retarded.

(*d*) *Payment for inpatient hospital services*

The bill also provides for payment of the reasonable cost of inpatient hospital services provided under the State plans for maternal and child health services and crippled children's services. Reasonable costs are to be determined in accordance with standards approved by the Secretary.

(*e*) *Special project grants for low-income school and preschool children.*

The bill would authorize a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. Projects would provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare for children in low-income families.

Your committee has evidence that many of the health needs of preschool children and children of school age, particularly children from low-income families, are not being met because of the increase in the child population. This is resulting in great crowding of clinics available to low-income families and inadequate preventive health services and medical care for their children.

The maternal mortality rate in 1961-62 in low-per-capita income States was 57 percent higher than in high-per-capita income States, 50 maternal deaths per 100,000 live births as compared with 31.9.

The infant mortality rate for low-income States in 1962, 29.6 per 1,000 live births, was 17 percent above that prevailing in high-income States.

Hospitalization rates for children coming from families whose income was under $2,000 were at the rate of 42.4 per 1,000 whereas children from families with incomes of $7,000 and over were hospitalized at the rate of 67.7 per 1,000.

The average length of hospital stay for all children under 15 was 6 days. For children whose family income was under $2,000 the average hospital stay was 9.3 days contrasted with 4.8 days for children coming from families with an income of $7,000 and over.

School aged children 5 to 17 numbered 44 million in 1960 and may reach 54 million by 1970, an increase of about 24 percent. The 4,250,000 children born in 1960 will be enrolled in school in 1966. Much can be done to help preschool children to get ready for school by correcting and preventing health handicaps.

Your committee is convinced that health supervision in the preschool years is important because many childhood disabling illnesses both physical and emotional have their origin in infancy or the preschool years. Effective health supervision for children during the years before entering school would help considerably to get them ready for school and reduce the extent of the need for school health services for

children in the first year of school. Such care should also be extended through adolescence.

In school health programs, the availability of community resources to which children can be referred for diagnosis and treatment is the critical factor in the essential followup services. Without such resources, school health services have little meaning for low-income families. Communities are finding that they do not have adequate resources to which children can be referred for diagnosis and treatment when they are found to be in need of treatment through school health programs and their resources for the examination, diagnosis, and treatment of preschool children to help them prepare to enter school are also too few and too crowded.

Large numbers of our children enter school and spend their schooldays with conditions which interfere with their growth, development, and education:

About 10,200,000 schoolchildren are in need of eye care;

About 1,500,000 children have hearing impairments—about 7 percent already have hearing loss when they enter school;

One in five children under age 17 has a chronic ailment;

Four million children are emotionally disturbed;

Half the children under 15 years in the United States have never been to a dentist and the proportion is much greater in families with incomes under $2,000;

Children in families with incomes of less than $2,000 visit the doctor only half as frequently as those in families with incomes of more than $7,000;

Your committee's proposal will make possible programs organized to make maximum use of available community medical services and to bring about a better distribution of the low-income patient group among public and voluntary community clinics and hospitals.

To be eligible for a grant a project 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 in-patient hospital services;

(3) Treatment, correction of defects or after care 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 after care, medical or dental, as required by the Secretary.

Authorizations for appropriations would be:

$15 million for the fiscal year ending June 30, 1966;

$35 million for the fiscal year ending June 30, 1967;

$40 million for the fiscal year ending June 30, 1968;

$45 million for the fiscal year ending June 30, 1969, and $50 million for the fiscal year ending June 30, 1970.

A full report with evaluation and recommendations is to be submitted to the President for transmission to the Congress before July 1, 1969.

The grants would be available to the State health agency or with its consent to the health agency of any political subdivision of the State, to the State agency administering or supervising the crippled children's program, to schools of medicine (with appropriate participation by schools of dentistry) and to teaching hospitals affiliated with schools of medicine.

The grants would pay not to exceed 75 percent of the cost of projects. Your committee recognizes, however, that non-Federal funds may have to be derived from a variety of sources, particularly at the beginning of the program. These might include existing funds and activities of the grantee agency; funds, equipment, time of personnel, or space made available by other agencies; or similar items or gifts from other sources.

Your committee is aware that other committees of the Congress have before them legislative proposals dealing with school and preschool children. Your committee has studied these proposals carefully and is thoroughly satisfied that there is no duplication of the services provided in the special project health grants for school and preschool children incorporated in the proposed new section 532 of title V of the Social Security Act and no duplication is intended. Furthermore, the Appropriations Committee will have an opportunity to look at these programs at the same time and evaluate their interrelationships.

This program would enable State or local health agencies, crippled children's agencies, and medical schools and teaching hospitals to provide comprehensive health care including dental care to children in need of such care in areas where low-income families are concentrated and to improve the amount and quality of care available to children of low-income families by the organization of the necessary services to provide care. It would reduce the numbers of children of preschool and school age who are hampered by remediable handicaps and provide necessary medical and dental care for children of low-income families who would otherwise not receive care.

2. COSTS OF IMPROVEMENTS IN MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S PROGRAMS

The accompanying tables indicate by State the allotments that would be made under the maternal and child health and crippled children's programs under the existing authorization of $40 million for each of these programs for the fiscal year ending June 30, 1966, and the State allotments which would be made under the proposed authorization of $45 million. The differences by State shown in the tables reflect the amount of additional funds that States would receive under the provisions of the bill in fiscal year ending June 30, 1966. Differences for subsequent years would be approximately twice as large.

The total additional authorizations for the four types of grant authorized under title II, part 1, amount to $25 million additional Federal funds in the fiscal year ending June 30, 1966, and to approximately $60 million for the first full year of operation.

Grant-in-aid apportionments in maternal and child health program comparison of $45,000,000 appropriations with $40,000,000 appropriations [1]

State	Maternal and child health		
	$40,000,000	$45,000,000	Difference
United States	$31,437,500	$34,875,000	$3,437,500
Alabama	779,483	865,734	86,251
Alaska	149,804	159,397	9,593
Arizona	264,259	292,373	28,114
Arkansas	461,030	511,649	50,619
California	1,762,722	1,961,629	198,907
Colorado	286,293	317,624	31,331
Connecticut	340,077	378,997	38,920
Delaware	164,678	176,565	11,887
District of Columbia	198,589	215,702	17,113
Florida	1,032,535	1,147,248	114,713
Georgia	985,295	1,094,585	109,290
Guam	130,061	136,612	6,551
Hawaii	189,032	204,672	15,640
Idaho	178,101	192,056	13,955
Illinois	993,623	1,133,275	139,652
Indiana	755,822	839,872	84,050
Iowa	477,111	529,723	52,612
Kansas	345,657	383,593	37,936
Kentucky	737,641	819,161	81,520
Louisiana	824,480	915,823	91,343
Maine	242,840	269,101	26,261
Maryland	626,668	696,062	69,394
Massachusetts	586,978	652,442	65,464
Michigan	1,190,820	1,323,871	133,051
Minnesota	603,346	670,198	66,852
Mississippi	719,492	798,867	79,375
Missouri	603,268	670,248	66,980
Montana	181,665	196,169	14,504
Nebraska	258,374	286,494	28,120
Nevada	156,861	167,542	10,681
New Hampshire	174,243	187,603	13,360
New Jersey	635,288	719,709	84,421
New Mexico	243,571	269,990	26,419
New York	1,653,908	1,840,461	186,553
North Carolina	1,208,705	1,342,775	134,070
North Dakota	179,079	193,185	14,106
Ohio	1,412,888	1,570,915	158,027
Oklahoma	392,553	435,721	43,168
Oregon	304,995	338,293	33,298
Pennsylvania	1,516,164	1,685,715	169,551
Puerto Rico	972,363	1,079,920	107,557
Rhode Island	190,794	206,706	15,912
South Carolina	725,666	805,734	80,068
South Dakota	185,011	200,031	15,020
Tennessee	790,909	878,471	87,562
Texas	1,547,537	1,720,787	173,250
Utah	216,786	236,704	19,918
Vermont	154,081	164,334	10,253
Virgin Islands	125,337	131,160	5,823
Virginia	904,121	1,004,415	100,294
Washington	474,460	526,821	52,361
West Virginia	397,854	441,417	43,563
Wisconsin	655,027	727,738	72,711
Wyoming	149,555	159,111	9,556

[1] Under sec. 502(a) (fund A), from a total of $20,000,000, which is half of the appropriation, each State receives a uniform grant of $70,000 and an additional grant in proportion to the number of live births in the State. Under sec. 502(b) (fund B), from the other $20,000,000, $4,750,000 is to be used only for special projects for mentally retarded children, and $3,812,500 or 25 percent of the remaining $15,250,000 is reserved for other special projects. The remainder, $11,437,500, is apportioned so that each State receives an amount which varies directly with the number of urban and rural live births in the State and inversely with State per capita income. No State receives less than $50,000. Live births in rural areas are given twice the weight of those in urban areas.

Grants-in-aid apportionments in crippled children's program comparison of $45,000,000 appropriations with $40,000,000 appropriations [1]

State	Crippled children		
	$40,000,000	$45,000,000	Difference
United States	$32,187,500	$35,625,000	$3,437,500
Alabama	863,999	952,425	88,426
Alaska	143,592	152,228	8,636
Arizona	281,235	310,553	29,318
Arkansas	531,492	585,446	53,955
California	1,590,273	1,821,887	231,614
Colorado	289,808	320,323	30,515
Connecticut	339,915	378,811	38,896
Delaware	162,260	173,773	11,513
District of Columbia	178,877	192,951	14,074
Florida	895,936	989,710	93,774
Georgia	1,024,979	1,130,223	105,244
Guam	127,529	133,689	6,160
Hawaii	183,185	197,923	14,738
Idaho	182,774	198,310	15,536
Illinois	990,813	1,101,414	110,601
Indiana	827,619	914,137	86,518
Iowa	549,886	606,602	56,716
Kansas	391,905	432,560	40,655
Kentucky	819,461	903,031	83,570
Louisiana	810,210	893,668	83,458
Maine	223,163	245,868	22,705
Maryland	455,442	504,001	48,559
Massachusetts	538,290	607,762	69,472
Michigan	1,201,634	1,329,113	127,479
Minnesota	654,333	722,413	68,080
Mississippi	764,518	841,932	77,414
Missouri	656,958	725,952	68,994
Montana	182,364	196,976	14,612
Nebraska	284,935	314,266	29,331
Nevada	154,259	164,540	10,281
New Hampshire	172,927	186,085	13,158
New Jersey	641,273	726,617	85,344
New Mexico	236,033	260,262	24,229
New York	1,474,981	1,688,826	213,845
North Carolina	1,332,455	1,468,283	135,828
North Dakota	183,254	201,706	18,452
Ohio	1,455,230	1,609,561	154,331
Oklahoma	463,581	511,446	47,865
Oregon	315,483	348,245	32,762
Pennsylvania	1,608,841	1,778,823	169,982
Puerto Rico	964,873	1,062,703	97,830
Rhode Island	189,749	205,500	15,751
South Carolina	775,982	854,813	78,831
South Dakota	192,665	212,111	19,446
Tennessee	894,080	985,655	91,575
Texas	1,721,357	1,902,532	181,175
Utah	217,034	236,989	19,955
Vermont	154,669	165,013	10,344
Virgin Islands	123,980	129,593	5,613
Virginia	928,948	1,024,700	95,752
Washington	485,437	536,206	50,769
West Virginia	482,236	531,184	48,948
Wisconsin	720,633	795,856	75,223
Wyoming	150,156	159,804	9,648

[1] Under sec. 512(a) (fund A) each State receives a uniform grant of $70,000 and an additional grant in proportion to the number of children under 21 years in the State. Under sec. 512(b) (fund B) $3,750,000 is to be used only for special projects for services for crippled children who are mentally retarded, and $4,062,500 or 25 percent of the remaining $16,250,000 is reserved for other special projects. The remainder, $12,187,500, is apportioned so that each State receives an amount which varies directly with the number of children under 21 years in urban and rural areas in the State and varies inversely with State per capita income. No State receives less than $50,000. Children in rural areas are given twice the weight of those in urban areas.

C. Implementation of Mental Retardation Planning

Under the Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (Public Law 88–156), $2.2 million was authorized to provide small grants to States for the purpose of planning comprehensive programs in the field of mental retardation. The requirements for receipt of such grants included the involvement of all types of agencies—health, education, welfare, institutions, etc.—concerned with problems of the mentally retarded. Your committee is advised that each State has submitted an application and received a grant under this program.

In order to assure that the planning which is being done has impact on State programs, your committee believes that further limited grants for purposes of followup and implementation are warranted. The bill accordingly authorizes appropriations of $2,750,000 each for the fiscal years ending June 30, 1966, and June 30, 1967, for this purpose. Each of these appropriations would be available for expenditure for the fiscal year for which it was made and for succeeding fiscal years that end prior to July 1, 1968.

D. General Discussion of Old-Age, Survivors, and Disability Insurance Provisions

(1) SEVEN-PERCENT INCREASE IN BENEFITS

Your committee believes that a benefit increase at this time is obvious. For the overwhelming majority of the 20 million people now getting social security checks—aged and disabled people and their families and orphaned children and their widowed mothers—the benefits are the major source of support; for a great many they are the only source. The last general benefit increase was enacted in 1958 and was effective with benefits payable for January 1959. Since that date there have been changes in wages, prices, and other aspects of the economy. For the aged, who generally are the most economically disadvantaged group, the combined effect of the 7-percent increase and the hospital insurance benefits will be to provide a substantial improvement in levels of living.

Under the bill monthly benefits for retired workers now on the benefit rolls who began to draw benefits at age 65 or later would range from $44 to $135.90, as compared with $40 to $127 under present law. Because of the increases that the bill would make in the contribution and benefit base, retired workers coming on the rolls in the future with benefits based on average monthly earnings of more than $400, the highest possible under present law, would of course get benefits of more than $135.90. The increases in the base, together with the benefit increase, would result in a maximum benefit for the worker of $149.90, payable on average monthly earnings of $466 (the highest possible under the $5,600 contribution and benefit base), and ultimately in a maximum benefit of $167.90, payable on the average monthly earnings of $550 that are possible under the $6,600 contribution and benefit base. The following table is illustrative of benefit amounts for various family groups under the $5,600 contribution and benefit base and under present law.

Illustrative monthly benefits payable under present law and under the committee bill with a $5,600 contribution and benefit base[1]

Average monthly earnings	Old-age benefits[2]				Survivors benefits			
	Worker		Man and wife[2]		Widow aged 62, widower, or parent		Widow and 2 children	
	Present law	Bill	Present law	Bill	Present law	Bill	Present law	Bill[4]
$67 or less	$40	$44.00	$60.00	$66.00	$40.00	$44.00	$60.00	$66.00
$100	59	63.20	88.50	94.80	48.70	52.20	88.50	94.80
$150	73	78.20	109.50	117.30	60.30	64.60	120.00	120.00
$200	84	89.90	126.00	134.90	69.30	74.20	161.70	161.70
$250	95	101.70	142.50	152.60	78.40	83.90	202.50	202.50
$300	105	112.40	157.50	168.60	86.70	92.80	236.40	240.00
$350	116	124.20	174.00	186.30	95.70	102.50	254.10	266.10
$400	127	135.90	190.50	203.90	104.80	112.20	254.10	286.80
$466	[5]	149.90	[5]	224.90	[5]	123.70	[5]	312.00

[1] A revised and extended benefit table will become effective with January 1971, to take account of average monthly earnings up to $550, the maximum average monthly earnings that will be possible under the $6,600 contribution and benefit base that will be effective for years after 1970.
[2] For a worker age 65 or over at the time of retirement and a 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 the benefits for a man and wife.
[4] For families already on the benefit rolls who are affected by the maximum-benefit provisions, the amounts payable under the bill would in some cases be somewhat higher than those shown here.
[5] Not applicable, since the highest possible average monthly earnings amount is $400.

The family maximum.—Under the bill, the maximum amount of benefits payable to a family would be related to the worker's average monthly earnings through the entire range as it now is at the lower levels. Under present law, the highest maximum family benefit is $254, and this amount applies at all average monthly earnings levels above $314. Under the bill, a different family maximum amount would be provided at every average monthly earnings bracket in the benefit table, from a minimum of $66 to a maximum of $312 under the $5,600 contribution and benefit base and to a maximum of $368 under the $6,600 contribution and benefit base. The maximum amount payable to a family now on the benefit rolls would be $286.80, as compared with $254 under present law.

Effective date.—The 7-percent increase would be effective beginning with benefits for January 1965. The increased benefits would be paid retroactively to the 20 million beneficiaries who were on the rolls in January 1965 and to beneficiaries who came on the rolls after January 1965 and through the month of enactment of the bill whether or not they are still on the rolls at the time of enactment. Lump-sum death payments based on deaths that occurred in the retroactive period would not be increased.

This is the first time that a general increase in social security benefits has been made retroactive. The present situation may be regarded as somewhat unique. As your committee stated last July in its report on H.R. 11865, a general increase in social security benefits was needed at that time. H.R. 11865, as passed by both Houses last year, provided for a general benefit increase and, if the bill had been enacted, it would have provided increased social security benefits that would have been effective at about the beginning of 1965. For reasons not related to the question of whether benefits should be increased, H.R. 11865 failed of passage last year. Your committee therefore recommends paying

the increased benefits retroactively to January, thus putting beneficiaries in the same relative position they would have been in if H.R. 11865 had been enacted.

Because of the magnitude of the task of converting the benefit rolls to the higher amounts, the first regular monthly check reflecting the 7-percent increase generally would be the check for the third month following the month of enactment.

To avoid the possibility of confusion on the part of beneficiaries as to the exact amount of the benefit increase, the increased benefits for the retroactive months would be paid in a separate check.

In 1965, an estimated $1.2 billion in additional benefits would be paid as a result of the 7-percent increase; in 1966, $1.4 billion in additional benefits would be paid.

2. PAYMENT OF CHILD'S INSURANCE BENEFITS TO CHILDREN ATTENDING SCHOOL OR COLLEGE AFTER ATTAINMENT OF AGE 18 AND UP TO AGE 22

Under present law a child beneficiary is considered dependent, and is paid benefits, until he reaches age 18, or after that age if he was disabled before age 18 and is still disabled. The committee believes that a child over age 18 who is attending school full time is dependent just as a child under 18 or a disabled older child is dependent, and that it is not realistic to stop such a child's benefit at age 18. A child who cannot look to a father for support (because the father has died, is disabled, or is retired) is at a disadvantage in completing his education as compared with the child who can look to his father for support. Not only may the child be prevented from going to college by loss of parental support and loss of his benefits; he may even be prevented from finishing high school or going to a vocational school. With many employers requiring more than a high school education as a condition for employment, education beyond the high school level has become almost a necessity in preparing for work.

Your committee believes it is now appropriate and desirable to provide social security benefits for children between the ages of 18 and 22 who are full-time students and who have suffered a loss of parental support. Students whose benefits have already terminated at age 18, as well as children currently on the rolls, would qualify for benefits under the provision. The median age of students graduating from high school is about 18; providing benefits up to age 22 would mean that for many children benefits could continue for the time it takes to complete a 4-year college course.

The term "school" is defined broadly to permit payments to students taking vocational or academic courses. The definition of school is intended to establish that the institution the child attends is a bona fide school. It includes all public school, colleges, and universities, as well as private, accredited institutions and private nonaccredited institutions whose credits are accepted by accredited institutions. In determining full-time attendance, the Secretary of Health, Education, and Welfare would take into account the standards and practices of the school involved. Specifically excluded would be an individual paid by his employer to attend school. Benefits would be paid during normal school vacation periods as well as during the school year.

The bill would not provide for the payment of mother's benefits to a mother whose only child is over 18 and getting benefits because he is

attending school. There is less need to pay benefits to the mother in such cases than in those where the child is under 18, since she is not required to stay at home to care for the child as she may have been when he was younger.

The provision for paying benefits to children aged 18–21 who are full-time students would be effective beginning with benefits for January 1965. Benefits would be paid retroactively to children who would have been eligible in January 1965 and to those who have become eligible since that time regardless of whether they are eligible in the month in which the bill is enacted. A provision similar to this was included in H.R. 11865, 88th Congress, which failed of passage for reasons entirely unrelated to the payment of benefits to children aged 18–21 who were full-time students. Your committee recognizes that the retroactive benefit payments cannot be made immediately after this bill is enacted since there may be some delay because of administrative problems.

An estimated 295,000 children would be eligible for benefits for September 1965, when the school year begins, and in 1966 about $195 million in benefits would be paid.

3. BENEFITS FOR WIDOWS AT AGE 60

Under present law the earliest age at which a widow without eligible children can qualify for benefits based on the earnings of her deceased husband is 62. Many women are widowed years after having left the labor market to become housewives and mothers, and they lack the skills necessary to qualify for reasonably suitable employment. Women who are widowed in their late fifties and sixties are often denied employment because of their age.

The bill would provide for the payment of aged widow's benefits beginning at age 60, with the benefits actuarially reduced to take account of the longer period over which they would be paid. This provision would thus extend to these women a choice of applying for benefits at any time between age 60 and 62, with a reduced benefit, or of waiting until age 62 to receive a full widow's benefit. The amount of the reduction—five-ninths of 1 percent for each month before age 62 for which the benefit was paid—would be sufficient to assure that over the long run there will be no additional cost to the social security system as a result of the earlier payment of the benefits. If the widow chose to get her benefits starting at age 60 her benefit would be reduced by 13⅓ percent; the reduced benefit would amount to 71½ percent of the deceased husband's primary benefit (at age 62 the full benefit equals 82½ percent of the decreased husband's primary widow's benefit).

An estimated 185,000 widows aged 60–61 on the effective date of this provision are expected to claim benefits during the first year of operation. Benefit payments would be about $165 million in 1966.

4. AMENDMENTS OF DISABILITY PROGRAM

(a) Improvements in disability provisions

In 1956, Congress amended the Social Security Act to provide disability benefits for persons afflicted with disabilities of long-continued and indefinite duration and of sufficient severity to prevent a return to

any substantial gainful employment. In providing this protection against loss of earnings resulting from extended total disability, the Congress designed a conservative program. It was expected that, as experience under these provisions was gained, necessary improvements would follow. As a result, amendments enacted in 1958 and 1960 improved the disability program by, among other changes, extending benefits to wives and children of the disabled, and by providing for the payment of disability benefits to incapacitated workers under age 50 who had previously been excluded. Your committee believes that experience with the disability program since 1960 indicates that certain further improvements should be made at this time to broaden the protection provided by the program against the risk of extended total disability. The recommended improvements in the disability provisions would be adequately financed from the contributions your committee is recommending be earmarked for the disability insurance trust fund.

(1) Elimination of the long-continued and indefinite duration requirement from the definition of disability

Under present law, disability insurance benefits are payable only if the worker's disability is expected to result in death or to be of long-continued and indefinite duration. Your committee's bill would broaden the disability insurance protection afforded by the social security program by providing disability insurance benefits for an insured worker who has been totally disabled for at least 6 calendar months even though it is expected that he will recover in the foreseeable future. The modification in the definition recommended by your committee does not change, however, the requirement in existing law that an individual must by reason of his impairment be unable "to engage in any substantial gainful activity." In line with the original views expressed by your committee and since reaffirmed, to be eligible an individual must demonstrate that he is not only unable, by reason of a physical or mental impairment, to perform the type of work he previously did, but that he is also unable, taking into account his age, education, and experience, to perform any other type of substantial gainful work, regardless of whether or not such work is available to him in the locality in which he lives.

Your committee believes that the elimination of the requirement of indefinite duration from the definition of disability would help to meet the need for insurance protection of that substantially large group of disabled workers who, though totally disabled for an extended period, can be expected to eventually recover. For many of these disabled people, the payment of disability insurance benefits would mean the difference between financial independence and dependence on public assistance. Workers who contract tuberculosis, for example, can generally be expected to recover after a period of appropriate treatment. However, the period during which they may be unable to engage in any gainful work because of their condition may extend well over a year and many such workers are, during this protracted period, without the income they need to support their families. It is estimated that if benefits were payable for disabilities that are total and last more than 6 months but are not necessarily expected to last indefinitely about 155,000 additional people—workers

and their dependents—would become immediately eligible for benefits.

Your committee expects that, as now, procedures will be utilized to assure that the worker's condition will be reviewed periodically and reports of medical reexaminations obtained where appropriate so that benefits may be terminated promptly where the worker ceases to be disabled.

The elimination of the requirement that a determination be made that a disability can be expected to result in death or to be of long-continued and indefinite duration would bring the social security disability program into line with the prevailing practice in private disability insurance. Provisions much like the one which your committee is recommending, that is, providing for the payment of disability benefits on the basis of total disability throughout a continuous period of 6 months without regard to the expected duration of disability, serve as the basis for payment in the majority of private disability insurance contracts and in many other disability programs.

The elimination of the indefinite duration requirement would also clarify for beneficiaries their rights under the disability program and at the same time simplify administration and help to speed up the payment of the first benefit check to disabled workers in those cases where a medical determination about the duration of disability is difficult to make. Under present law, the need for such prognoses sometimes results in delays in filing, and occasionally in the failure to file for benefits when the applicant is uncertain about whether his disability can be expected to be permanent. In some cases, the need for a prognosis delays a determination of disability; in other cases, the application is denied initially because a favorable prognosis is made. While the prognosis may, in the latter case, ultimately prove erroneous and thus necessitate a reversal of the initial decision, payment is then made retroactively in a lump sum and not on a current basis when the benefits are most needed.

(2) Payment of a benefit for the sixth month of disability

Your committee is also recommending that entitlement to social security disability benefits begin at the end of the sixth month of continuous disability. Under the waiting period requirement in the present law, more than 7 months must pass after the onset of disability before the disabled worker can receive his first benefit check. By changing the present requirement so that the first month of entitlement to benefits would be the last month of the waiting period, the first benefit check would be payable for the sixth full month of disability. Thus, under this recommended change there would still be a wait of at least 6 months after onset of disability before the worker or his family could receive benefits, but the first disability check would be paid as quickly as possible after the 6-month waiting period.

(3) Payment of benefits for second disabilities without regard to waiting period

Your committee is also recommending a conforming modification in the provisions of present law under which disability benefits are paid without a waiting period in the case of a worker whose previous disability was terminated within 5 years before onset of his second disability. The purpose of the provision for the payment of disability benefits without regard to the waiting period in the case of a bene-

ficiary whose disability recurs within 5 years after the termination of a prior period of disability is to encourage disabled persons to return to work even though there may be a question as to whether their work attempts will be successful. Since many disability insurance beneficiaries who return to work do so despite severe impairments and are thus faced with the possibility that their work attempts may be unsuccessful, a 6-month qualifying period for reentitlement to benefits may be a real bar to any further work attempts. Under the provision recommended by your committee, benefits would be paid beginning with the first month of onset of the second or subsequent disability and without regard to the waiting period requirement only if the individual had a prior period of disability which lasted at least 18 calendar months and only if the subsequent period of disability can be expected, at the time of application, to last a continuous period of at least 12 months or to result in death. Your committee is recommending this change in order to limit the cases in which payment of benefits would be made without a waiting period to those situations where it is reasonable to presume in general that the second or subsequent disability constitutes a recurrence or aggravation of the previous disability and where the second or subsequent disability can be expected to be of extended duration.

Concern has been expressed about the payment of disability benefits concurrently with benefits payable under State workmen's compensation laws. Your committee is advised that under the present law the extent of excessive wage replacement resulting from overlapping benefits between workmen's compensation and social security disability benefits has not been significant. Moreover, a provision in the social security law for reducing disability benefits by the amount of any other benefit to which a worker was entitled under State workmen's compensation laws, which was in effect from July 1957 to July 1958, was repealed in 1958 because it was concluded that it operated in an inequitable and unsatisfactory manner. Nevertheless, your committee shares the belief of the Advisory Council on Social Security that it would be worth while to have additional information about the overlap and its effects.

We therefore request that the Social Security Administration proceed as rapidly as feasible with plans to conduct a study of the significance of overlapping benefits under the two programs. Such a study should produce information on: (1) the number and proportion of beneficiaries under each program who are receiving cash disability benefits under the other program; (2) the characteristics of persons receiving dual benefits as compared with those not receiving dual benefits; and (3) the extent to which combined payments under the two programs are effective in replacing lost earnings, both currently and for the future. Your committee requests that a report covering the results of this study and such other facts relating to the problem as are found relevant, be made to it on or before December 31, 1966. This report should also include recommendations as to whether action (and if so, what kind of action) should be taken under the Federal social security disability program or under the State workmen's compensation programs to control excessive payments in cases of dual entitlement, as well as the effect on costs to employers.

(*b*) *Payment of disability insurance benefits after entitlement to other monthly insurance benefits*

Under the hospital insurance benefit provisions of your committee's bill, a wife who is age 65 or over and whose husband is between the age of 62 and 65 and insured can qualify for hospital insurance, provided her husband files for actuarially reduced old-age insurance benefits. The husband may be working full time and not receive any of the old-age benefits. Under present law, he would be reluctant to file for old-age benefits because present law states that after a worker becomes entitled to old-age benefits he cannot subsequently qualify for disability benefits. If present law were unchanged, the worker would be faced with the choice of sacrificing either eligibility for disability protection or his wife's health insurance.

Your committee has, therefore, included in the bill a provision whereby a worker who becomes entitled to old-age benefits may subsequently, until he reaches age 65, become entitled to disability benefits. This provision would also eliminate the difficult question some beneficiaries have faced, even before the hospital insurance question arose, as to whether they should take actuarially reduced benefits or retain their rights to disability protection.

(*c*) *Increase in allocation to the disability insurance trust fund*

The bill would increase the contribution income allocated to the disability insurance trust fund from 0.50 to three-fourths of 1 percent of taxable wages and from 0.375 to nine-sixteenths of 1 percent of taxable self-employment income. This increase takes account of lower disability termination rates than were expected (disability insurance beneficiaries have been living somewhat longer than anticipated) and the increase in the cost of the disability insurance part of the program arising out of the changes made by the bill. The increase in the contribution income to the disability fund would bring the disability insurance part of the program into close actuarial balance.

5. PAYMENT OF BENEFITS TO CERTAIN PEOPLE AGED 72 OR OVER WHO ARE NOT OTHERWISE INSURED

Your committee believes that a special transitional insured status provision should be adopted so that social security benefits can be provided for those among the present aged who, though they worked in covered jobs, did not have an opportunity to work long enough to become insured under the program, and for their wives and widows. About 355,000 people would become eligible immediately for social security benefits under these provisions, with benefits payable under the provisions totaling about $140 million in 1966.

The present law requires a minimum of six quarters of coverage for insured status; as a result, although the general requirement for insured status is one quarter of coverage for each year elapsing after 1950 and up to retirement age (65 for men, 62 for women), people who reached retirement age in 1956 or earlier must have more than one quarter for each year that elapsed after 1950 to qualify for benefits.

Under the bill the minimum would be three quarters of coverage rather than six, and therefore people who reached retirement age in 1954, 1955, or 1956 could qualify for benefits if they had one quarter of coverage for each year that elapsed after 1950 and up to retirement

age, and people who reached retirement age prior to 1954 could qualify if they had three quarters of coverage instead of six.

The following table shows the operation of the "transitional insured status" provision for workers:

Men		Women	
Age in 1965	Quarters of coverage required	Age in 1965	Quarters of coverage required
76 or over	3	73 or over	3
75	4	72	4
74	5	71	5

Wife's benefits would be payable at age 72 to a woman whose husband qualified for benefits under the transitional provision if she attained age 72 before 1969.

Widow's benefits would be payable at age 72 to a woman whose husband qualified for benefits under the transitional provision if she attained age 72 before 1969. Also, a widow whose husband had attained age 65 or died before 1957 without being insured could get benefits if the husband 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 earlier	1967	1968
1954 or before	6	3	4	5
1955	6	4	4	5
1956	6	5	5	5

Under these provisions the benefit amount for a worker would be $35 per month; for his wife, $17.50 per month; for his widow, $35 per month. Benefits would be payable for and after the second month following the month of enactment.

6. LIBERALIZATION IN THE RETIREMENT TEST

The bill would change the provision in present law under which there is a $1 reduction in benefits for each $2 of earnings above $1,200 and up to $1,700 to provide for a $1-for-$2 reduction for earnings from $1,200 to $2,400. Benefits would continue to be reduced by $1 for every $1 of earnings above $2,400, as they are now on earnings above $1,700. This change would increase the incentive to work in the income range between $1,700 and $2,400 and would, in combination with the increase in benefits that the bill also provides, make possible a significant increase in annual income for many beneficiaries who are able to work and earn more than $1,700.

Under present law a self-employed person who performs substantial services but who has no income from current work, can nevertheless have benefits withheld under the retirement test because he gets royalties attributable to a copyright or patent obtained in years before he at-

tained age 65. The bill would exclude for retirement test purposes royalties received by a self-employed person in or after the year in which he attained age 65 if those royalties are attributable to a copyright or patent obtained before the year in which he attained age 65. Royalties received by a beneficiary from a copyright or patent obtained in or after the year in which he attained age 65 would continue to be counted for retirement test purposes, as under present law, in the year in which they are received.

7. WIFE'S AND WIDOW'S BENEFITS FOR DIVORCED WOMEN

It is not uncommon for a marriage to end in divorce after many years, when the wife is too old to build up a substantial social security earnings record even if she can find a job. But under present law a wife's right to zenefits on her husband's earnings record generally ends with a divorce. Under the present social security law, the only benefits provided for a divorced woman are mother's insurance benefits, and they are payable only if she has a child of the deceased worker in her care and the child is getting benefits on the basis of his deceased father's earnings, if she has not remarried, and if she had been getting at least one-half of her support from her former husband under a court order or agreement at the time of his death. A divorced wife without a child in her care cannot get benefits even though she had been dependent upon the worker for much of his working lifetime and he was contributing to her support when he retired or died.

Under the bill wife's or widow's benefits would be payable to an aged divorced woman on the basis of her former husband's earnings if the divorced woman (A) had been married to that former husband for 20 years before the divorce, (B) had not remarried, and (C) met the following support requirement at the time her former husband became disabled, became entitled to benefits or died; (1) she was receiving one-half 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 to her support from her former husband was in effect. A conforming change would be made in 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.

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.

The bill would also provide that a wife's benefit will not terminate when she and her husband are divorced if they had been married for at least 20 years before the divorce.

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.

While the provisions just described would take care of cases in which the marriage had lasted for 20 years or more, they would leave unsolved the problem of the woman who is widowed or divorced after many years and is remarried but whose second marriage ends in divorce after less than 20 years. To meet this problem, the bill would further provide that a woman whose rights to benefits as a widow, divorced wife, surviving divorced wife, or surviving divorced mother were terminated because she remarried will have her former benefit rights restored if her second marriage ends in divorce after less than 20 years. This provision would provide protection for women whose second marriages end in divorce after they are along in years. The divorced woman who was age 62 or over and getting benefits before she remarried and the divorced woman whose former husband died when she was 50 and who later remarried would be among the women protected by the provision. Young women getting mother's benefits (including surviving divorced mothers) would also have protection in case their second marriages ended in divorce. In the case of a surviving divorced mother, the provision would not preclude her possible entitlement to benefits as a surviving mother on the basis of the earnings record of a second husband to whom she was married for a period of less than 20 years prior to divorce; under present law, a woman may be entitled to benefits on a man's earnings record as his former wife divorced if she has his child in her care even if she has not been married to him for 20 years, and the bill would not change that situation.

These changes would provide protection mainly for women who have spent their lives in marriages that are dissolved when they are far along in years—especially housewives who have not been able to work and earn social security benefit protection of their own—from loss of benefit rights through divorce.

8. ADOPTION OF CHILD BY RETIRED WORKER

Under present law, a child adopted by a worker who is already retired and getting old-age insurance benefits can become entitled to benefits even though he was not dependent on the worker at the time the latter retired. In contrast, present provisions governing the payment of child's insurance benefits to a child adopted by a person getting disability insurance benefits, and to a child adopted by the surviving spouse of a worker who has died, contain requirements designed to assure that benefits will be paid to such children only when there is a basis for assuming that the child lost a source of support when the worker became disabled or died.

Your committee believes that the provisions concerning adoptions by retired workers should be made comparable to those relating to adoptions in other cases so as to provide safeguards against abuse through adoption of children solely to qualify them for benefits, and has included in the bill a provision that would accomplish this result. Under this provision benefits would be payable to a child who is adopted by an old-age insurance beneficiary after the latter becomes entitled to benefits only if the following conditions are met:

(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 at least one-half 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 be became entitled to old-age insurance benefits, before the beginning of the period of disability.

9. COVERAGE EXTENSIONS AND MODIFICATIONS

Your committee's bill would extend social security coverage to self-employment income from the practice of medicine, and to the wages of interns, cover tips as wages, facilitate coverage of additional State and local government employees, provide additional coverage for employees of certain nonprofit organizations, extend coverage to temporary employees of the District of Columbia, increase the amount of gross income which farmers may use under the optional method of computing farm self-employment income for social security purposes, and permit exemption from the social security self-employment tax for persons who follow certain teachings of a religious sect of which they are members.

(a) Coverage of self-employed physicians and interns

Self-employed doctors of medicine are the only group of significant size whose self-employment income is excluded from coverage under social security. Large numbers of doctors have requested coverage. Your committee knows of no valid reason why this single professional group should continue to be excluded. It runs counter to the general view that coverage should be as universal as possible. There are no technical or administrative barriers to the coverage of self-employed doctors of medicine.

Moreover, more than half of the physicians in private practice have obtained some social security credits through work other than their self-employment as physicians, or through their military service. As indicated, many requests for coverage have been received from those who have not obtained social security credits in this way and from physicians who have some credits but wish to obtain full social security protection.

Your committee's bill would cover the self-employment income of the approximately 170,000 self-employed doctors of medicine on the same basis as the self-employment income of other professional groups, effective for taxable years ending after December 31, 1965.

Coverage would also be extended to services performed by medical and dental interns. The coverage of services as an intern would give young doctors an earlier start in building up social security protection and would help many of them to become insured under the program at the time when they need the family survivor and disability protection it provides. This protection is important for doctors of medicine who, like members of other professions, in the early years of their practice, may not otherwise have the means to provide adequate survivorship and disability protection for themselves and their families. Interns would be covered on the same basis as other employees working for the same employers, beginning on January 1, 1966.

(*b*) *Computation of self-employment income from agriculture*

Under present law, persons with net earnings from farm self-employment have the following option in reporting for social security purposes: (*a*) If annual gross income from agricultural self-employment is not over $1,800, either actual net earnings or 66⅔ percent of gross income may be reported; (*b*) if gross income from agricultural self-employment is over $1,800 and net earnings are less than $1,200, either net earnings or $1,200 (two-thirds of $1,800) may be reported; and (*c*) if the annual gross income is more than $1,800 and net earnings are $1,200 or more, actual net earnings must be reported.

The bill approved by your committee would retain the present option in the reporting of farm self-employment income but would raise the level of income which may be reported under the gross income option by increasing the $1,800 figure to $2,400 and the $1,200 figure to $1,600.

Thus, persons with agricultural self-employment would be permitted to use the following option in reporting their earnings from agricultural self-employment for social security purposes: (*a*) If annual gross income from agricultural self-employment is not over $2,400, either actual net earnings or 66⅔ percent of gross income may be reported; (*b*) if gross income from agricultural self-employment is over $2,400 and actual net earnings are less than $1,600, either actual net earnings or $1,600 may be reported; and (*c*) if gross earnings are more than $2,400 and net earnings are more than $1,600, the actual net earnings must be reported. This change would be effective for taxable years beginning after December 31, 1965.

(*c*) *Coverage of tips*

The problem of extending social security coverage to tips has engaged the attention of your committee for many years. The principal difficulty has been to devise a fair and practical system for obtaining information on amounts of tips received by an individual which could serve as a basis for contributions and benefit credits. Another problem has been the question of whether tips should be taxed as wages or as self-employment income.

It is a matter of common knowledge that in occupations where employees customarily receive tips, the regular wages of these employees are generally far below those of other employees with comparable training and duties. It was reported to the committee, for example, that under a bargaining agreement covering hotel employees in a large city the wages of waiters and waitresses were about 30 percent under those of a dishwasher, one of the lowest paid kitchen workers, and the wages of bellhops were one-half of those of reservation clerks. On the basis of such wage and tipping practices, the committee has concluded that it would be appropriate to treat tips as wages for social security purposes.

The committee has also decided that the only equitable way of counting tips toward benefits is on the basis of actual amounts of tips received and that the only practical way to get this information is to require employees to report their tips to the employer. Other methods for determining a tax and credit base for tips were considered previously, but the agencies directly concerned with the problems concluded that no other approach would assure better coverage

or compliance. Your committee agrees with this and has adopted in this bill the reporting plan approved last year in H.R. 11865.

On the average about one-third of the work income of employees who receive tips in the course of employment is in the form of tips; for many, tips constitute the major source of earnings. Since the regular wages of employees who customarily receive tips are relatively low, the benefits based on those wages are low. For example, under the benefit provisions of the bill, a person getting regular wages of $35 a week and averaging another $35 in tips would get a monthly retirement benefit, beginning at age 65, of $79.20 if only his regular wages were counted. If his tips could also be counted, his benefit amount would be $113.50.

Coverage of tips will provide better protection under the social security program for more than a million employees and their dependents. The amount of tips received by employees who regularly receive tips is estimated at more than $1 billion a year. Under existing law, only a small fraction of this amount may now be counted toward social security. Information has been presented to indicate that only a small fraction of this amount is now reported for income tax purposes. Because the extension of social security coverage to tips should result in better reporting of all tips for income tax purposes, it seems only fair to allow employees whose earnings are principally from tips to use the pay-as-you-go (withholding) system for paying the income tax on their tips and to have employers collect this tax from the regular wages. Your committee's bill, therefore, provides for the collection of income tax from wages on tips reported to the employer.

Under the bill, tips received by an employee (on his own behalf) in the course of his employment would be covered as wages. The employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. The employee's report to his employer would include tips paid to him through the employer as well as those received directly from customers of the employer. To avoid requiring employees and employers to report small amounts of tips that might be burdensome on employers and that would not ordinarily have a significant effect on the employee's benefit amount, tips received by an employee which do not amount to a total of $20 a month in connection with his work for any one employer would not be covered and would not be reported.

The employer would be responsible for collecting the employee's share of the social security tax on tips, paying his (the employer's) share of the tax, and including the tips with his report of wages only if the employee reported the tips to him, in writing, within 10 days after the end of the month in which the tips were received, and then only to the extent that he had available unpaid cash wages of the employee, or funds the employee turned over to him for that purpose, that were sufficient to cover the employee's share of the tax. As a convenience to the employer, a provision is included under which he would be permitted to withhold the employee's share of the social security tax from current wages on the basis of an estimated amount of tips and to adjust the amount withheld at the end of each quarter to conform to the amount actually due on the basis of the employee's written statement of his tips. This provision will permit the employer

to gear these new reporting procedures into his usual payroll periods. The amount of tips reported by the employer for the employee in his quarterly report of wages paid to employees would, of course, be the amount of tips which the employee reported to his employer for the calendar quarter and on which the employer could withhold the employee's share of the social security tax. Also, provision is made authorizing an employer who is furnished a written statement of tips to deduct from the employee's wages the employee's tax on the tips included in the statement, even though at the time the statement is furnished the total amount of tips received so far in the month is less than $20.

Although the employer would have no liability with respect to tips which were not reported to him within the time specified in the bill and with respect to which he could not collect the employee tax out of unpaid wages of, or funds turned over by, the employee, such tips, nevertheless, would be covered. In such case, the employee would be liable for the employee's share of the social security tax and—unless he could show reasonable cause for failure to provide the employer with a written statement of his tips and make available to the employer the employee's share of the tax due on such tips—an additional amount equal to that tax.

The bill further provides that the employees' tips are to be subject to income tax withholding. Under present income tax law, tips are considered compensation for services and are includible in gross income. Your committee is advised that a very substantial number of tip recipients do not report all their tips, and that many report none at all. For example, in a recent survey conducted by the Internal Revenue Service covering 154 tip employees in 5 restaurants and 2 hotels of a large northern city, practically all employees had reported only their regular wages and no tips on their tax returns. One-third of these employees have since agreed to tax deficiencies averaging $450. The others have been assessed deficiencies averaging $600 per taxpayer. In the opinion of your committee, if tips are to be covered under social security as wages they should also be treated as wages for purposes of the collection of tax at source.

Under present law, employees who receive tips should be paying the income tax due on their tips on an estimated quarterly basis as do other taxpayers who receive income from sources where the income tax is not collected by the payer. It is a difficult problem for the average tip recipient to comply with this requirement in the law because of the informal manner in which he receives numerous tips. But even if compliance could be expected, the payment in one lump sum at 3-month intervals of the estimated tax due on tips received during such 3-month period would be a considerable burden on these employees, the great majority of whom are in the lower income brackets and would have difficulty in budgeting to pay these quarterly amounts. A proper, convenient and easy solution is to offer these employees the opportunity to pay their income tax on tips currently by having the employer withhold the tax from the employee's regular wages.

In general, the employer would follow the same procedures for income tax withholding as for social security purposes. The employer's liability for withholding income tax, however, would be limited to funds of the employee that are in the employer's possession before the close of the calendar year in which the tips were received and that are

in excess of the amount of social security taxes to be collected. There would be no obligation on the part of the employee to ensure that the employer had sufficient funds of the employee to be able to deduct the full amount of the income tax required to be withheld. In most instances the employee's wages would be more than adequate to cover the social security tax and the income tax withholding. A weekly wage of only $12 for a single person would be more than enough to cover the social security and income taxes due on combined tip and wage earnings of $62. This would represent tips at a rate of $1.25 an hour for a 40-hour week which are above average earnings since 60 percent of waiters and waitresses in the United States earn under $1.25 an hour in tips, according to a 1961 Bureau of Labor Statistics survey.

Tips received by self-employed people are covered under present law as income from self-employment for social security purposes. In providing this method for covering tips received by employees it is not intended that this action of the committee change the employment status of any one who receives tips or change the treatment of tips received by the self-employed.

(d) Coverage provisions applying to employees of States and localities

(1) Addition of Alaska and Kentucky to the States which may provide coverage through division of retirement systems

Under a provision of the Social Security Act which is designed to facilitate the extension of social security coverage to members of State and local government retirement systems, 18 specified States (and all interstate instrumentalities) are permitted to divide a State or local government retirement system into two parts for purposes of social security coverage, one part consisting of the positions of members who desire coverage, and the other consisting of the positions of members who do not desire coverage. Services performed by employees in the part consisting of the positions of members who desire coverage may then be covered under social security, and once those services are covered, the services of all persons who in the future become members of the retirement system must also be covered. The 18 States which are now permitted to extend coverage under this provision are California, Connecticut, Florida, Georgia, Hawaii, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin. Your committee's bill would add Alaska and Kentucky to this group of States.

(2) Facilitating coverage under the provision for division of State and local government retirement systems

The bill would provide a further opportunity for election of social security coverage by employees of States and localities who did not elect coverage when they previously had the opportunity to do so under the provision permitting specified States to cover only those members of a retirement system who desire coverage. Under the present provision, the specified States may, during the 2-year period after coverage of a group is approved, cover additional employees who request coverage. (However, employees hired after coverage of the group is originally approved are covered on a compulsory basis.) The bill would reopen, or hold open, through December 31, 1966, the opportunity for election of coverage by those employees who had not elected

coverage before the expiration of the 2-year period following approval of the coverage of their group.

Your committee recognizes that employees who initially failed to elect coverage under the divided retirement system provision were provided two subsequent opportunities for election of coverage under amendments made to the Social Security Act in 1958 and 1961. Although in general it is important that the time limits for electing coverage be maintained and that it be known they will be maintained, this situation involves special circumstances which seem to your committee to justify providing one additional opportunity. Your committee believes, however, that in the future there should be no further reopening of the opportunity for electing coverage under the divided retirement system provision beyond that which would be provided under this bill. We urge that those now contemplating participation in the program take timely action to exercise their choice.

The social security coverage of employees obtaining coverage as a result of the further opportunity provided by the proposed amendment would be required to begin on the same date as was provided when their group was originally covered.

(3) Coverage for certain additional hospital employees in California

The bill would modify a provision of the Social Security Amendments of 1960 which made coverage under the social security program available to certain hospital employees in the State of California who had performed services at some time during the period from January 1, 1957, through December 31, 1959, with respect to which contributions had been erroneously paid to the Internal Revenue Service prior to July 1, 1960. The 1960 legislation provided for crediting the remuneration which had been erroneously reported during the 1957–59 period, and for covering the services performed after 1959 by the individuals for whom the erroneous reportings had been made. Your committee's bill would make it possible for the State to provide coverage, beginning with January 1, 1962, for the services of hospital employees employed in the positions in question after 1959, and to secure the crediting of remuneration erroneously reported for them for periods prior to 1962 if contributions with respect to such remuneration have been paid before the enactment of the bill. The State would have 6 months after the month of enactment in which to provide such coverage.

The individuals who would be affected by your committee's bill could not be covered under the 1960 legislation, since they were not in the group for which erroneous reports had been filed during the 1957 through 1959 period. And, like the employees to whom the 1960 legislation applied, they cannot be covered under the generally applicable provisions of the Social Security Act providing coverage for employees of States and localities.

Generally speaking, the Social Security Act does not permit States to bring under social security coverage persons whom the States have removed from coverage under a State and local retirement system. The positions of the employees in question were removed from coverage under the California State employees retirement system effective July 1, 1957, without awareness that this section established a bar to future social security coverage. This misunderstanding led to the erroneous reports, and created the need for the 1960 amendment.

The employees to whom the bill is directed have the same need for coverage as those to whom the 1960 legislation applied, and are barred from coverage under the general provisions of law in the same way as were the employees covered by the 1960 legislation. Your committee believes that they should be given the same opportunity to obtain protection under the social security program as was given in 1960 to hospital employees in a similar situation.

(e) *Tax exemption for members of a religious group opposed to insurance*

Your committee's bill would permit 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 December 31, 1950.

The sect (or division thereof) must be one that has been in existence at all times since December 31, 1950, and has for a substantial period of time been making reasonable provision for its dependent members. To qualify as grounds for the tax exemption, the objections of the individual and the sect (or division thereof) to insurance must include objections to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act). 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 onthe 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. An individual's exemption (and the waiver of social security benefits) would be terminated if, and as of the time, the conditions under which the exemption was granted are no longer met, and the individual could not again be granted an exemption.

Your committee believes that provisions for coverage under social security on an individual voluntary basis are undesirable, and we have been reluctant to recommend an amendment which would permit an individual to elect exemption from social security coverage. Present law provides no exemption by reason of an individual's religious beliefs. The voluntary coverage provisions for ministers are applicable only to ministerial services; a minister who does other work is covered on the same basis as any other person. We believe that an exemption from social security taxes with respect to work that is generally covered would be justifiable only in cases where it is amply clear that an individual cannot accept the benefits of insurance, including social security benefits, without renouncing basic tenets of his religion. The exemption we are recommending is designed to be granted in only such cases. The proposed exemption would be limited to the self-employment tax under social security since those persons

for whom the payment of social security taxes appears to be irreconcilable with their religious convictions also, by reason of their religious beliefs, limit their work almost entirely to farming and to certain other self-employment.

We believe that the proposed exemption must be on the basis of individual choice. To exclude all members of a religious group from social security coverage would not take account of the variances in individual beliefs within any religious group, and would deny social security protection to those individuals who want it. Among the Old Order Amish, for example, there have been some indications of a change in attitude toward social security, particularly among the younger people; some members of the Old Order Amish who have become eligible for social security benefits have claimed the benefits.

Your committee believes that the recommended provision would provide relief for those individuals who sincerely believe that payment of social security taxes is irreconcilable with their religious convictions. We strongly recommend against any broadening of the proposed amendment since any such broadening could well lead to widespread individual voluntary coverage under social security, which would undermine the soundness of the social security program.

(*f*) *Additional retroactive coverage of nonprofit organizations, and validation of coverage of certain employees of such organizations*

Under present law the employees of a nonprofit organization may be covered under social security only if the employing organization files a certificate waiving its exemption from social security coverage. Your committee has learned that in some cases organizations have been reporting their employees for social security purposes without ever having filed the required waiver certificate. Such reports may be submitted for some time before the organization learns that they are erroneous. In such cases, employees who have been counting on having social security protection on the basis of their employment with such organization may in fact not have that protection.

Your committee's bill would permit a nonprofit organization to elect social security coverage to be effective for a period of up to 5 years (rather than 1 year, as under present law) before the calendar quarter in which the waiver certificate electing social security is filed. In addition, nonprofit organizations which had filed a waiver certificate in or prior to the year in which the bill is enacted would be given until the end of the year following enactment to amend their certificate to make social security coverage effective for a period of up to 5 years before the calendar quarter in which the amendment to the waiver certificate is filed.

Thus, by making its waiver certificate sufficiently retroactive, a nonprofit organization that had been erroneously reporting earnings for its employees without having filed a certificate to elect coverage could ordinarily provide complete and continuous social security coverage for the erroneously reported employees. That is, a nonprofit organization which learns of its erroneous reporting could file a certificate electing coverage and make it sufficiently retroactive to cover the period for which employee earnings already reported would otherwise be stricken from the record because the statute of limitations had not run when the erroneous reporting had been discovered. The effect of the social security statute of limitations is that in most cases correction of

an employee's social security earnings record may be made only if the error is discovered within 3 years, 3 months, and 15 days following the end of the year in which the wages were erroneously paid. Your committee's bill would, then, resolve on a permanent basis troublesome problems which have arisen under the nonprofit coverage provisions.

Your committee's bill also amends section 105(b) of the Social Security Amendments of 1960, which provided that an employee of a nonprofit organization could, under certain circumstances, receive credit for erroneously reported wages. The amendment applies to employees who are no longer in the employ of an organization when the waiver certificate is filed. These persons cannot be covered under the general provisions for retroactive coverage, as retroactive coverage is available only to persons still in the employ of an organization when the waiver certificate is filed. The amendment would permit such employees to have validated the reports of wages which had erroneously been made for them by the organization during the period of retroactive coverage. These persons have the same need for social security protection as those who are still employed by the organization when it files its waiver certificate.

(*g*) *Coverage of certain employees of the District of Columbia*

Under the present provisions of the Social Security Act, all service performed in the employ of the District of Columbia is excluded from social security coverage. Most District employees are covered under the Federal civil service retirement system or one of the two District retirement systems. Substitute teachers, however, are not covered under any government retirement system. Under your committee's bill, the District of Columbia could provide social-security coverage for them. In addition, the bill would make it possible for the District of Columbia to cover under social security temporary or intermittent employees who are not now covered under the civil service retirement system but because of the temporary nature of their employment. The earliest date on which coverage could become effective would be the first day of the calendar quarter following the calendar quarter of enactment.

(*h*) *Special study relating to Federal employees*

The Committee on Ways and Means is aware that the single largest group of our citizens whose employment by law is precluded from social security coverage are the employees of the Federal Government. Your committee has given attention to this problem from time to time over a period of several years. Extensive consideration was given in 1960 to extending some form of social security coverage to Federal employees. At that time, it was concluded, on the recommendation of the Department of Health, Education, and Welfare and the Social Security Administration, that further opportunity should be afforded to the departments and agencies of the executive branch to give further study to the matter and present a coordinated recommendation to the Congress. Therefore, in lieu of statutory action, the Committee on Ways and Means at that time, in its report on the bill which became the Social Security Amendments of 1960 (H. Rept. 1799, to accompany H.R. 12580, 86th Cong.) urged the interested departments and agencies of the executive branch to "accelerate their efforts in finding a workable and sound solution to this problem and report it to the Congress at the earliest opportunity."

The report which was requested by the committee in 1960 regrettably was not received until a few days ago. Obviously, there was inadequate time on the part of the committee to study fully the suggestions contained in the report. The committee did not include provisions in this legislation in view of the lack of adequate time to study the report just presented to it.

Your committee has been advised by the Department of Health, Education, and Welfare that the executive branch has initiated a comprehensive study of retirement provisions for Federal personnel and that this study is to include further consideration of the proper role which should be played by social security, the civil service retirement program, and other staff retirement programs in the protection afforded Federal personnel.

In the light of all the foregoing, your committee has agreed to withhold recommendations until this further study is received despite the interest of many Members in closing this gap in the protection of civil service employees compared to that of employees in private industry. Your committee was advised that this study would be completed not later than December 1, 1965. It your committee's expectation that that time table will be met.

10. EXTENSION OF PERIOD FOR FILING PROOF OF SUPPORT AND APPLICATION FOR LUMP-SUM DEATH PAYMENT

The law provides that the proof of support required for husband's, widower's and parent's insurance benefits, and applications for lump-sum death payments, must be filed within a 2-year period specified in the law. An extension of an additional 2 years is allowed where there was good cause for failure to file within the initial 2-year period. Many instances have arisen where there has been failure to file the required documents within the time allowed. A number of private bills have been proposed, and some enacted, to except specific individuals from this requirement in the law.

Believing that it is more desirable to provide for these situations by a provision of general law, your committee has included an amendment under which, if it is shown to the satisfaction of the Secretary of Health, Education, and Welfare that there was good cause for failure to file within the initial 2-year period, an applicant would be allowed to file proof of support or an application for a lump-sum death payment at any time.

11. AUTOMATIC RECOMPUTATION OF BENEFITS

Under the bill provision is made for automatic annual recomputation of benefits to take account of earnings that a beneficiary may have after he comes on the rolls and that would increase his benefit amount. Under present law, benefit recomputations to take account of additional earnings generally are available only on application, and can be made only if the worker had covered earnings of more than $1,200 in a calendar year after he became entitled to benefits.

Experience has shown that a large number of people who are eligible for benefit recomputations to take account of additional earnings, and who will profit from such recomputations, fail to apply for them. Automatic recomputation would assure the beneficiary that he will get

credit for any earnings that would increase his benefit amount. Your committee has been advised that with the improved electronic equipment that is now used to compute benefit amounts, it is both feasible and administratively advantageous to handle these recomputations on an automatic basis.

An additional effect of the change would be to assure that no one would be disadvantaged by applying for benefits at age 65 instead of waiting until a somewhat later age. Under present law, in some few cases a worker who delays the filing of his application gets a larger benefit than he would have gotten if he had applied at age 65. In certain situations, therefore, people do not know whether to apply for benefits or to defer filing. Sometimes they do apply and it turns out to have been disadvantageous. Under the provisions in the bill it will be possible to assure every claimant that he cannot lose by applying at age 65.

12. REIMBURSEMENT OF THE TRUST FUNDS FOR THE COST OF MILITARY SERVICE CREDITS

Military service was not covered under the social security program on a contributory basis until 1957. However, special benefits were provided for the survivors of World War II veterans who died within 3 years after discharge, and noncontributory wage credits were provided under the program for active military service from September 16, 1940, through December 1956. The old-age and survivors insurance trust fund has been reimbursed for the cost of the benefits paid through August 1950, in the amount of about $15 million. However, although present law provides that the costs incurred through June 30, 1956, were to have been paid into the trust funds over the 10 fiscal years ending June 30, 1969, and that the costs incurred by the payment of such benefits after June 1956 were to have been appropriated annually, no such payments have been made.

Your committee believes that it would be desirable to amortize the amounts owing over a period longer than the 10-year period provided under present law. The bill would authorize a level annual appropriation from general revenues to the trust funds starting in fiscal year 1966, that would amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015. After 2015, annual appropriations would be authorized to pay any additional costs.

13. FINANCING PROVISIONS

(a) Increase in the contribution and benefit base

The bill would raise from $4,800 to $5,600, beginning with 1966, and to $6,600, beginning with 1971, the limitation on the amount of annual earnings that is used in determining benefits and that is subject to tax for the support of the program. The increases in the contribution and benefit base will make it possible to provide, for workers at and above average earnings levels, benefits that are more reasonably related to their actual earnings, and, by taxing a larger proportion of the Nation's growing payrolls, will improve the financial base of the program.

Even though higher benefits are provided on the basis of the additional earnings that are taxed and credited for social security pur-

poses, an increase in the contribution and benefit base results in a reduction in the overall cost of the social security program as a percent of taxable payrolls.

(*b*) *Changes in the contribution rates*

Consistent with the policy of maintaining the program on a financially sound basis that has always been followed in the past, the bill makes full provision for meeting the cost of the improvements it would make in the OASDI programs. Additional income would result from increasing the earnings base to $5,600 in 1966 and $6,600 in 1971 and from the extensions of coverage provided under the bill. In addition, your committee is recommending a revised contribution rate schedule.

Your committee has paid particular attention to the effect social security taxes might have on the individual taxpayer and the economy as a whole. Therefore, the schedule of contribution rates included in the bill, while it will produce sufficient income to finance the social security program, at the same time will avoid increases in the trust funds at a time when the economic impact of trust fund increases would be uncertain. Under the schedule of rates your committee recommends, no contribution rate increase after 1966 would go into effect at the same time as a contribution base increase, and the tax rate increase for old-age, survivors, and disbility insurance scheduled to go into effect in 1966 would be somewhat lower than the one scheduled under the present law. Also, old-age, survivors, and disability insurance contributions for the self-employed person would be held at 6.0 percent of self-employment income through 1968 rather than increasing to 6.1 percent in 1966 and to 6.9 percent in 1968; after 1973 the contribution rate for the self-employed would be only one-tenth of 1 percent higher than scheduled under present law.

The present and proposed contribution rates for old-age, survivors, and disability insurance are as follows:

Year	Contribution rates (in percent)			
	Employer and employee, each		Self-employed	
	Present law	Bill	Present law	Bill
1966–67	4.125	4.0	6.2	6.0
1968	4.625	4.0	6.9	6.0
1969–72	4.625	4.4	6.9	6.6
1973 and after	4.625	4.8	6.9	7.0

14. ADVISORY COUNCIL ON SOCIAL SECURITY

The bill would repeal the present provisions for the appointment of future Advisory Councils on Social Security Financing and provide instead for the appointment of Advisory Councils of broader scope and of somewhat different representation.

The Councils provided for under present law are, in general, required to report only on the financing of the program. The Council that was appointed in 1963 and made its report on January 1 of this year was the only Council required to present its findings and recommendations with respect to all aspects of the program. That Council

urged that "every 5 years or so Advisory Councils be formed to review the substantive provisions of the program as well as its financing." Your committee agrees with this recommendation, and under the bill the scope of future Advisory Councils would be broadened so that all future Councils would report on all aspects of the program (including the new hospital insurance and supplementary health insurance programs established under the bill) and on their impact on the public assistance programs.

Present law requires that the Councils be composed of 12 members representing employers and employees in equal numbers and self-employed persons and the public. The bill provides that the Council members shall, to the extent possible, represent employer and employee organizations in equal numbers and self-employed persons and the public.

The Councils would submit their reports to the Secretary of Health, Education, and Welfare for transmission to the Congress and to the Board of Trustees. Under the time schedule for the appointment of Advisory Councils now in the law, Councils are to be appointed in 1966 and every fifth year thereafter and report on January 1 of the second year after the year of appointment. This schedule was designed so that a Council would report 1 year before each tax increase, and every fifth year after the final increase. In 1961 the final tax increase, previously scheduled for 1969, was rescheduled for 1968. As a result, the Council to be appointed in 1966 is required to make its report on the day on which the final rate increase now in the law is scheduled to go into effect. Under the bill, the next Advisory Council would be appointed in 1968 and make its report not later than January 1, 1970. Subsequent Councils would be appointed so as to report in 1975 and every fifth year thereafter.

15. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

(a) Summary of actuarial cost estimates

The old-age, survivors, and disability insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is very closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by your committee's bill has been shown to be not quite self-supporting under the intermediate-cost estimate. Nevertheless, there is close to an exact balance, especially considering that a range of variation is necessarily present in the long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by your committee's bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows a favorable actuarial balance of 0.04 percent of taxable payroll under the provisions that would be in effect after enactment of your committee's bill, because the contribution rate allocated to this fund is slightly more than the cost of the disability benefits, based on the intermediate-cost estimate. Considering the

variability of cost estimates for disability benefits, this small actuarial surplus is not significant. The disability insurance program, as it would be modified by your committee's bill, is actuarially sound.

(*b*) *Financing policy*

(*1*) *Contribution rate schedule for old-age, survivors, and disability insurance in bill*

The contribution schedule for old-age, survivors, and disability insurance contained in your committee's bill is lower than that under present law by 0.25 percent in the combined employer-employee rate in 1966–67, is lower by 1.25 percent in 1968, is lower by 0.45 percent in 1969–72, and is higher by 0.35 percent in 1973 and thereafter. The maximum earnings base to which these tax rates are applied is $5,600 per year for 1966–70 and $6,600 for 1971 and after under your committee's bill as compared with $4,800 under present law. These tax schedules are as follows:

[Percent]

Calendar year	Present law		Committee bill	
	Employee rate (same for employer)	Self-employed rate	Employee rate (same for employer)	Self-employed rate
1965	3.625	5.4	3.625	5.4
1966–67	4.125	6.2	4.0	6.0
1968	4.625	6.9	4.0	6.0
1969–72	4.625	6.9	4.4	6.6
1973 and after	4.625	6.9	4.8	7.0

The allocation rates to the two trust funds that are applicable to the combined employer-employee contribution rate for the bill, as compared with present law, are as follows:

[Percent]

Calendar year	Old-age and survivors insurance		Disability insurance	
	Present law	Committee bill	Present law	Committee bill
1965	6.75	6.75	0.50	0.50
1966–67	7.75	7.25	.50	.75
1968	8.75	7.25	.50	.75
1969–72	8.75	8.05	.50	.75
1973 and after	8.75	8.85	.50	.75

(*2*) *Self-supporting nature of system*

The Congress has always carefully considered the cost aspects of the old-age, survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments, the Congress stated the belief that the program should be completely self-supporting from the contributions of covered individuals and employers. Accordingly, in that legislation the provision permitting appropriations to the system from general revenues of the Treasury was repealed. This policy has been continued in subsequent amendments. The Congress has always very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and actuarially sound.

(3) Actuarial soundness of system

The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is not always the case for well-administered private pension plans, which may not have funded all the liability for prior service benefits.

It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs. Thus, the concept of "unfunded accrued liability" does not by any means have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group. These additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age, survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust fund investments will, over the long run, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that, according to the intermediate-cost estimate, results in the system being in balance or substantially close thereto.

Your committee believes that it is a matter for concern if the old-age, survivors, and disability insurance system shows any significant actuarial insufficiency. Traditionally, the view has been held that for the old-age and survivors insurance portion of the program, if such actuarial insufficiency has been no greater than 0.25 percent of payroll, when measured over perpetuity, it is at the point where it is within the limits of permissible variation. The corresponding point for the disability insurance portion of the system is about 0.05 percent of payroll (lower because of the relatively smaller financial magnitude of this program). Based on the recommendation of the 1963–64 Advisory Council on Social Security Financing (see app. V of the 25th Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, H. Doc. No. 100, 89th Cong.), the cost estimates are now being made on a 75-year basis, rather than on a perpetuity basis. On this approach, the margin of variation from exact balance should be smaller—no more than 0.10 percent of

taxable payroll for the combined old-age, survivors, and disability insurance program.

Furthermore, traditionally when there has been an actuarial insufficiency exceeding the limits indicated, any subsequent liberalizations in benefit provisions were fully financed by appropriate changes in the tax schedule or through raising the earnings base, and at the same time the actuarial status of the program was improved.

The changes provided in your committee's bill are in conformity with these financing principles.

(c) *Basic assumptions for cost estimates*

(1) *General basis for long-range cost estimates*

Benefit disbursements may be expected to increase continuously for at least the next 50 to 70 years because of such factors as the aging of the population of the country and the slow but steady growth of the benefit roll. Similar factors are inherent in any retirement program, public or private, that has been in operation for a relatively short period. Estimates of the future cost of the old-age, survivors and disability insurance program are affected by many elements that are difficult to determine. Accordingly, the assumptions used in the actuarial cost estimates may differ widely and yet be reasonable.

The long-range cost estimates (shown for 1975 and thereafter) are presented on a range basis so as to indicate the plausible variation in future costs depending upon the actual trends developing for the various cost factors. Both the low- and high-cost estimates are based on assumptions that are intended to represent close to full employment, with average annual earnings at about the level prevailing in 1963. The use of 1963 average earnings results in conservatism in the estimate since the trend is expected to be an increase in average earnings in future years (as will be discussed subsequently in item 5). In 1963, the aggregate amount of earnings taxable under the program was $226 billion. Of course, when new workers enter the labor force in years after 1963, the total taxable earnings increase simply because of multiplying the larger number of covered workers by the 1963 average earnings rates. In addition to the presentation of the cost estimates on a range basis, intermediate estimates developed directly from the low- and high-cost estimates (by averaging their components) are shown so as to indicate the basis for the financing provisions.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is that the number of births in the 1930's was very low as compared with subsequent experience. As a result, there will be a dip in the relative proportion of the aged from 1995 to about 2010, which would tend to result in low benefit costs for the old-age, survivors, and disability insurance system during that period. For this reason the year 2000 is by no means a typical ultimate year insofar as costs are concerned.

(2) *Measurement of costs in relation to taxable payroll*

In general, the costs are shown as percentages of covered payroll. This is the best measure of the financial cost of the program. Dollar figures taken alone are misleading. For example, a higher earnings level will increase not only the outgo of the system but also, and to

a greater extent, its income. The result is that the cost relative to payroll will decrease. As an illustration of the foregoing points, consider an individual who has covered earnings at a rate of $300 per month. Under your committee's bill such an individual would have a primary insurance amount of $112.40. If his earnings rate should increase by 50 percent (to $450), his primary insurance amount would be $145.90. Under these conditions, the contributions payable with respect to his earnings would increase by 50 percent, but his benefit rate would increase by only 30 percent. Or to put it another way, when his earnings rate was $300 per month, his primary insurance amount represented 37.5 percent of his earnings, whereas, when his earnings increased to $450 per month, his primary insurance amount relative to his earnings decreased to 32.4 percent.

(3) General basis for short-range cost estimates

The short-range cost estimates (shown for the individual years 1965–72) are not presented on a range basis since—assuming a continuation of present economic conditions—it is believed that the demographic factors involved (such as mortality, fertility, retirement rates, etc.) can be reasonably closely forecast, so that only a single estimate is necessary. A gradual rise in the earnings level in the future, paralleling that which has occurred in the past few years, is assumed. As a result of this assumption, contribution income is somewhat higher than if level earnings were assumed, while benefit outgo is only slightly affected.

The cost estimates have been prepared on the basis of the same assumptions and methodology as those contained in the 25th Annual Report of the Board of Trustees (H. Doc. No. 100, 89th Cong.).

(4) Level-cost concept

An important measure of long-range cost is the level-equivalent contribution rate required to support the system for the next 75 years (including not only meeting the benefit costs and administrative expenses, but also the maintenance of a reasonable contingency fund during the period, which at the end of the period amounts to 1 year's disbursements), based on discounting at interest. If such a level rate were adopted, relatively large accumulations in the old-age and survivors insurance trust fund would result, and in consequence there would be sizable eventual income from interest. Even though such a method of financing is not followed, this concept may be used as a convenient measure of long-range costs. This is a valuable cost concept, especially in comparing various possible alternative plans and provisions, since it takes into account the heavy deferred benefit costs.

(5) Future earnings assumptions

The long-range estimates for the old-age, survivors, and disability insurance program are based on level-earnings assumptions, under which earnings levels of covered workers by age and sex will continue over the next 75 years at the levels experienced in 1963. This, however, does not mean that covered payrolls are assumed to be the same each year; rather, they are assumed to rise steadily as the

population at the working ages is estimated to increase. If in the future the earnings level should be considerably above that which now prevails, and if the benefits are adjusted upward so that the annual costs relative to payroll will remain the same as now estimated for the present system, then the increased dollar outgo resulting will offset the increased dollar income. This is an important reason for considering costs relative to payroll rather than in dollars.

The long-range cost estimates have not taken into account the possibility of a rise in earnings levels, although such a rise has characterized the past history of this country. If such an assumption were used in the cost estimates, along with the unlikely assumption that the benefits, nevertheless, would not be changed, the cost relative to payroll would, of course, be lower.

It is important to note that the possibility that a rise in earnings levels will produce lower costs of the old-age, survivors, and disability insurance program in relation to payroll is a very important safety factor in the financial operations of this system. The financing of the system is based essentially on the intermediate-cost estimate, along with the assumption of level earnings; if experience follows the high-cost assumptions, additional financing will be necessary. However, if covered earnings increase in the future as in the past, the resulting reduction in the cost of the program (expressed as a percentage of taxable payroll) will more than offset the higher cost arising under experience following the high-cost estimate. If the latter condition prevails, the reduction in the relative cost of the program coming from rising earnings levels can be used to maintain the actuarial soundness of the system, and any remaining savings can be used to adjust benefits upward (to a lesser degree than the increase in the earnings level). The possibility of future increases in earnings levels should be considered only as a safety factor and not as a justification for adjusting benefits upward in anticipation of such increases.

If benefits are adjusted currently to keep pace with rising earnings trends as they occur, the year-by-year costs as a percentage of payroll would be unaffected. If benefits are increased in this manner, the level-cost of the program would be higher than now estimated, since, under such circumstances, the relative importance of the interest receipts of the trust funds would gradually diminish with the passage of time. If earnings and benefit levels do consistently rise, thorough consideration will need to be given to the financing basis of the system because then the interest receipts of the trust funds will not meet as large a proportion of the benefit costs as would be anticipated if the earnings level had not risen.

(6) Interrelationship with railroad retirement system

An important element affecting old-age, survivors, and disability nsurance costs arose through amendments made to the Railroad

Retirement Act in 1951. These provide for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining benefits for those with less than 10 years of railroad service (and also for all survivor cases).

Financial interchange provisions are established so that the old-age and survivors insurance trust fund and the disability insurance trust fund are to be placed in the same financial position in which they would have been if railroad employment had always been covered under the program. It is estimated that over the long range the net effect of these provisions will be a relatively small loss to the old-age, survivors, and disability insurance system since the reimbursements from the railroad retirement system will be somewhat smaller than the net additional benefits paid on the basis of railroad earnings

(7) Reimbursement for costs of military service wage credits

Another important element affecting the financing of the program arose through legislation in 1956 that provided for reimbursement from general revenues for past and future expenditures in respect to the noncontributory credits that had been granted for persons in military service before 1957. The cost estimates contained here reflect the effect of these reimbursements (which are included as contributions), based on the assumption that the required appropriations will be made in the future in accordance with the relevant provisions of your committee's bill. These reimbursements would be made on the basis of constant annual amounts (although adjusted in accordance with actual experience) over the next 50 years, rather than on the basis of the actual disbursements each year, as under present law.

(d) Actuarial balance of program in past years

(1) Status after enactment of 1952 act

The actuarial balance under the 1952 act [1] was estimated, at the time of enactment, to be virtually the same as in the estimates made at the time the 1950 act was enacted, as shown in table E. This was the case, because the estimates for the 1952 act took into consideration the rise in earnings levels in the 3 years preceding the enactment of that act. This factor virtually offset the increased cost due to the benefit liberalizations made. New cost estimates made 2 years after the enactment of the 1952 act indicated that the level-cost (i.e., the average long-range cost, based on discounting at interest, relative to taxable payroll) of the benefit disbursements and administrative expenses was somewhat more than 0.5 percent of payroll higher than the level equivalent of the scheduled taxes (including allowance for interest on the existing trust fund).

[1] The term "1952 act" (and similar terms) is used to designate the system as it existed after the enactment of the amendments of that year.

TABLE E.—*Actuarial balance of old-age, survivors, and disability insurance program under various acts for various estimates, intermediate-cost basis*

[Percent]

Legislation	Date of estimate	Level-equivalent [1]		
		Benefit costs [2]	Contributions	Actuarial balance [3]
		Old-age, survivors, and disability insurance [4]		
1935 act	1935	5.36	5.36	
1939 act	1939	5.22	5.30	+0.08
1939 act (as amended in the 1940's) [5]	1950	4.45	3.98	−.47
1950 act	1950	6.20	6.10	−.10
1950 act	1952	5.49	5.90	+.41
1952 act	1952	6.00	5.90	−.10
1952 act	1954	6.62	6.05	−.57
1954 act	1954	7.50	7.12	−.38
1954 act	1956	7.45	7.29	−.16
1956 act	1956	7.85	7.72	−.13
1956 act	1958	8.25	7.83	−.42
1958 act	1958	8.76	8.52	−.24
1958 act	1960	8.73	8.68	−.05
1960 act	1960	8.98	8.68	−.30
1961 act	1961	9.35	9.05	−.30
1961 act	1963	9.33	9.02	−.31
1961 act (perpetuity basis)	1964	9.36	9.12	−.24
1961 act (75-year basis)	1964	9.09	9.10	+.01
1965 bill (House)	1965	9.44	9.36	−.08
		Old-age and survivors insurance [4]		
1956 act	1956	7.43	7.23	−0.20
1956 act	1958	7.90	7.33	−.57
1958 act	1958	8.27	8.02	−.25
1958 act	1960	8.38	8.18	−.20
1960 act	1960	8.42	8.18	−.24
1961 act	1961	8.79	8.55	−.24
1961 act	1963	8.69	8.52	−.17
1961 act (perpetuity basis)	1964	8.72	8.62	−.10
1961 act (75-year basis)	1964	8.46	8.60	+.14
1965 bill (House)	1965	8.73	8.61	−.12
		Disability insurance [4]		
1956 act	1956	0.42	0.49	+0.07
1956 act	1958	.35	.50	+.15
1958 act	1958	.49	.50	+.01
1958 act	1960	.35	.50	+.15
1960 act	1960	.56	.50	−.06
1961 act	1961	.56	.50	−.06
1961 act	1963	.64	.50	−.14
1961 act (perpetuity basis)	1964	.64	.50	−.14
1961 act (75-year basis)	1964	.63	.50	−.13
1965 bill (House)	1965	.71	.75	+.04

[1] Expressed as a percentage of effective taxable payroll, including adjustment to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate. Estimates prepared before 1964 are on a perpetuity basis, while those prepared after 1964 are on a 75-year basis. The estimates prepared in 1964 are on both bases (see text).

[2] Including adjustments (*a*) to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate, (*b*) for the interest earnings on the existing trust fund, (*c*) for administrative expense costs, and (*d*) for the net cost of the financial interchange provisions with the railroad retirement system.

[3] A negative figure indicates the extent of lack of actuarial balance. A positive figure indicates more than sufficient financing, according to the particular estimate.

[4] The disability insurance program was inaugurated in the 1956 act so that all figures for previous legislation are for the old-age and survivors insurance program only.

[5] The major changes being in the revision of the contribution schedule; as of the beginning of 1950, the ultimate combined employer-employee rate scheduled was only 4 percent.

NOTE.—The figures for the 1950 act and for the 1952 act according to the 1952 estimates have been revised as compared with those presented previously, so as to place them on a comparable basis with the later figures.

(2) Status after enactment of 1954 act

The 1954 amendments as passed by the House of Representatives contained an adjusted contribution schedule that not only met the increased cost of the benefit changes in the bill, but also reduced the aforementioned lack of actuarial balance to the point where, for all practical purposes, it was sufficiently provided for. The bill as it passed the Senate, however, contained several additional liberalized benefit provisions without any offsetting increase in contribution income. Accordingly, although the increased cost of the new benefit provisions was met, the "actuarial insufficiency" as then estimated for the 1952 act was left substantially unchanged under the Senate-approved bill. The benefit costs for the 1954 amendments as finally enacted fell between those of the House- and Senate-approved bills. Accordingly, under the 1954 act, the increase in the contribution schedule met all the additional cost of the benefit changes and at the same time reduced substantially the actuarial insufficiency that the then-current estimates had indicated in regard to the financing of the 1952 act.

(3) Status after enactment of 1956 act

The estimates for the 1954 act were revised in 1956 to take into account the rise in the earnings level that had occurred since 1951–52, the period that had been used for the earnings assumptions for the estimates made in 1954. Taking this factor into account reduced the lack of actuarial balance under the 1954 act to the point where, for all practical purposes, it was nonexistent. The benefit changes made by the 1956 amendments were fully financed by the increased contribution income provided. Accordingly, the actuarial balance of the system was unaffected.

Following the enactment of the 1956 legislation, new cost estimates were made to take into account the developing experience; also, certain modified assumptions were made as to anticipated future trends. In 1956–57, there were very considerable numbers of retirements from among the groups newly covered by the 1954 and 1956 amendments, so that benefit expenditures ran considerably higher than had previously been estimated. Moreover, the analyzed experience for the recent years of operation indicated that retirement rates had risen or, in other words, that the average retirement age had dropped significantly. This may have been due, in large part, to the liberalizations of the retirement test that had been made in recent years—so that aged persons were better able to effectuate a smoother transition from full employment to full retirement. The cost estimates made in early 1958 indicated that the program was out of actuarial balance by somewhat more than 0.4 percent of payroll.

(4) Status after enactment of 1958 act

The 1958 amendments recognized this situation and provided additional financing for the program—both to reduce the lack of actuarial balance and also to finance certain benefit liberalizations made. In fact, one of the stated purposes of the legislation was "to improve the actuarial status of the trust funds." This was accomplished by introducing an immediate increase (in 1959)in the combined employer-employee contribution rate, amounting to 0.5 percent, and by advancing the subsequently scheduled increases so that they would occur at 3-year intervals (beginning in 1960) instead of at 5-year intervals.

The revised cost estimates made in 1958 for the disability insurance program contained certain modified assumptions that recognized the emerging experience under the new program. As a result, the moderate actuarial surplus originally estimated was increased somewhat, and most of this was used in the 1958 amendments to finance certain benefit liberalizations, such as inclusion of supplemental benefits for certain dependents and modification of the insured status requirements.

(5) Status after enactment of 1960 act

At the beginning of 1960, the cost estimates for the old-age, survivors, and disability insurance system were reexamined and were modified in certain respects. The earnings assumption had previously been based on the 1956 level, and this was changed to reflect the 1959 level. Also, data first became available on the detailed operations of the disability provisions for 1956, which was the first full year of operation that did not involve picking up "backlog" cases. It was found that the number of persons who meet the insured status conditions to be eligible for these benefits had been significantly overestimated. It was also found that the disability incidence experience for eligible women was considerably lower than had been originally estimated, although the experience for men was very close to the intermediate estimate. Accordingly, revised assumptions were made in regard to the disability insurance portion of the program. As a result, the changes made by the 1960 amendments could, according to the revised estimates, be made without modifying the financing provisions.

(6) Status after enactment of 1961 act

The changes made by the 1961 amendments involved an increased cost that was fully met by the changes in the financing provisions (namely, an increase in the combined employer-employee contribution rate of one-fourth of 1 percent, a corresponding change in the rate for the self-employed, and an advance in the year when the ultimate rates would be effective—from 1969 to 1968). As a result, the actuarial balance of the program remained unchanged.

Subsequent to 1961, the cost estimates were further reexamined in the light of developing experience. The earnings assumption was changed to reflect the 1963 level, and the interest-rate assumption used was modified upward to reflect recent experience. At the same time, the retirement-rate assumptions were increased somewhat to reflect the experience in respect to this factor. The further developing disability experience indicated that costs for this portion of the program were significantly higher than previously estimated (because benefits are not being terminated by death or recovery as rapidly as had been originally assumed). Accordingly, the actuarial balance of the disability insurance program was shown to be in an unsatisfactory position, and this has been recognized by the Board of Trustees, who recommended that the allocation to this trust fund should be increased

(while, at the same time, correspondingly decreasing the allocation to the old-age and survivors insurance trust fund, which under present law is estimated to be in satisfactory actuarial balance even after such a reallocation).

(*e*) *Intermediate-cost estimates*

(*1*) *Purposes of intermediate-cost estimates*

The long-range intermediate-cost estimates are developed from the low- and high-cost estimates by averaging them (using the dollar estimates and developing therefrom the corresponding estimates relative to payroll). The intermediate-cost estimate does not represent the most probable estimate, since it is impossible to develop any such figures. Rather, it has been set down as a convenient and readily available single set of figures to use for comparative purposes.

The Congress, in enacting the 1950 act and subsequent legislation, was of the belief that the old-age, survivors, and disability insurance program should be on a completely self-supporting basis and actuarially sound. Therefore, a single estimate is necessary in the development of a tax schedule intended to make the system self-supporting. Any specific schedule will necessarily be somewhat different from what will actually be required to obtain exact balance between contributions and benefits. This procedure, however, does make the intention specific, even though in actual practice future changes in the tax schedule might be necessary. Likewise, exact balance cannot be obtained from a specific set of integral or rounded tax rates increasing in orderly intervals, but rather this principle of self-support should be aimed at as closely as possible.

(*2*) *Interest rate used in cost estimates*

The interest rate used for computing the level-costs for your committee's bill is 3½ percent for the intermediate-cost estimate. This is somewhat above the average yield of the investments of the trust funds at the end of 1964 (about 3.13 percent), but is below the rate currently being obtained for new investments (about 4⅛ percent).

(*3*) *Actuarial balance of OASDI system*

Table E has shown that according to the latest cost estimates made for the 1961 act there is an almost exact actuarial balance for the combined old-age, survivors, and disability insurance system, but that there is a deficit of 0.13 percent of taxable payroll for the disability insurance portion, and a favorable balance of 0.14 percent of taxable payroll for the old-age and survivors insurance portion.

Under your committee's bill, the benefit changes proposed would be approximately financed by the increases in the contribution rates and the earnings base.

Table F traces through the change in the actuarial balance of the system from its situation under the 1961 act, according to the latest estimate, to that under your committee's bill, by type of major changes involved.

TABLE F.—*Changes in actuarial balance of old-age, survivors, and disability insurance system, expressed in terms of estimated level-cost as percentage of taxable payroll, by type of change, intermediate-cost estimate, present law and committee bill, based on 3.50 percent interest*

[Percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system	+0.14	−0.13	+0.01
Earnings base increase from $4,800 to $5,600–$6,600	+.48	+.04	+.52
Revised contribution schedule	−.03	+.25	+.22
Extensions of coverage	+.03		+.03
7-percent benefit increase [1]	−.59	−.05	−.64
Earnings test liberalization	−.04		−.04
Child's benefits to age 22 if in school	−.10	−.02	−.12
Reduced widow's benefits at age 60 [2]			
Disability definition revision [3]		−.05	−.05
Transitional insured status for certain persons aged 72 and over	−.01		−.01
Total effect of changes in bill	−.26	+.17	−.09
Actuarial balance under bill	−.12	+.04	−.08

[1] Includes also the effect of the minimum increase of $4 in the primary insurance amount. The 7-percent increase does not apply beyond the first $400 of average monthly wage; the same benefit factor underlying present law for average monthly wages in excess of $110 applies for that portion of the average monthly wage above $400.

[2] Includes also the cost of the provisions for paying benefits to certain divorced women.

[3] Includes the provision for permitting the payment of disability benefits after the individual has first become entitled to some other benefit.

The changes made by your committee's bill would reasonably maintain the actuarial position of the old-age, survivors, and disability insurance system. The estimated favorable actuarial balance of 0.01 percent of taxable payroll for the present system would be slightly changed—to a lack of balance of 0.08 percent, which is below the established limit within which the system is considered substantially in actuarial balance.

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the trust funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

(4) *Level-costs of benefits, by type*

The level-cost of the old-age and survivors insurance benefits (without considering administrative expenses and the effect of interest earnings on the existing trust fund) under the 1961 act, according to the latest intermediate-cost estimate, is about 8.51 percent of taxable payroll on the 75-year basis and the corresponding figure for the program as it would be modified by your committee's bill is 8.78 percent. The corresponding figures for the disability benefits are 0.62 percent for the 1961 act and 0.70 percent for your committee's bill.

Table G presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of your committee's bill, separately for each of the various types of benefits.

TABLE G.—*Estimated level-cost of benefit payments, administrative expenses, and interest earnings on existing trust fund under the old-age, survivors, and disability insurance system, after enactment of committee bill, as percentage of taxable payroll,*[1] *by type of benefit, intermediate-cost estimate at 3.50 percent interest*

[Percent]

Item	Old-age and survivors insurance	Disability insurance
Primary benefits	6.20	0.57
Wife's benefits	.50	.04
Widow's benefits	1.10	(2)
Parent's benefits	.01	(2)
Child's benefits	.67	.09
Mother's benefits	.15	(2)
Lump-sum death payments	.11	(2)
Total benefits	8.74	.70
Administrative expenses	.13	.03
Railroad retirement financial interchange	.04	.00
Interest on existing trust fund [3]	−.18	.02
Net total level-cost	8.73	.71

[1] Including adjustment to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate.
[2] This type of benefit is not payable under this program.
[3] This item includes reimbursement for additional cost of noncontributory credit for military service and is taken as an offset to the benefit and administrative expense costs.

The level contribution rate equivalent to the graded schedules in the law may be computed in the same manner as level costs of benefits. These are shown in table E, as are also figures for the net actuarial balances.

(5) OASI income and outgo in near future

Under your committee's bill, old-age and survivors insurance benefit disbursements for the calendar year 1965 will be increased by about $1.3 billion, since the effective dates for the benefit changes are January 1965 for the 7-percent benefit increase and child's benefits to age 22 while in school, and the second month after the month of enactment for most of the other changes. There will, of course, be no additional income during 1965, since the allocation rate increase and the change in the earnings base are effective on January 1, 1966.

In calendar year 1965, benefit disbursements under the old-age and survivors insurance system as modified by your committee's bill will total about $17.0 billion. At the same time, contribution income for old-age and survivors insurance in 1965 will amount to about $16.0 billion under your committee's bill, the same as under present law. Thus, benefit outgo under your committee's bill will exceed contribution income by about $1.0 billion, whereas under present law, contribution income is estimated to exceed benefit outgo by about $370 million. The size of the old-age and survivors insurance trust fund under your committee's bill will, on the basis of this estimate, decrease by about $1.2 billion in 1965 (interest receipts are somewhat less than the outgo for administrative expenses and for transfers to the railroad retirement account); under present law, it is estimated that this trust fund would increase by about $250 million as between the beginning and the end of 1965.

In 1966, benefit disbursements under the old-age and survivors insurance system as it would be modified by your committee's bill will be about $18.3 billion, or an increase of about $1.8 billion over present law. Contribution income for old-age and survivors insurance under your committee's bill for 1966 will be $18.5 billion, or about the same as present law. Accordingly, in 1966, there will be an excess of contribution income over benefit outgo of about $200 million under your committee's bill. There will be an excess of contributions over benefit outgo of about $500 million in 1967 and about $400 million in 1968.

Under the system as modified by your committee's bill, according to this estimate, the old-age and survivors insurance trust fund will be about the same size at the end of 1966 as at the beginning of the year. It will then increase by about $240 million in 1967 and $140 million in 1968, reaching $18.3 billion at the end of 1968. In the next 2 years, as a result of the scheduled increase in the contribution rate in 1969, the trust fund will increase by about $2 billion each year.

(6) DI income and outgo in near future

Under the disability insurance system, as it would be affected by your committee's bill in calendar year 1965, benefit disbursements will total about $1,620 million, and there will be an excess of benefit disbursements over contribution income of about $440 million. In 1966 and the years immediately following, contribution income will be well in excess of benefit outgo (as a result of the increased allocation to this trust fund, and the increased taxable earnings base, as provided by your committee's bill).

The disability insurance trust fund is estimated to decrease by about $490 million in 1965 under your committee's bill, as compared with a corresponding decrease of about $330 million under present law; the greater decrease results primarily from the retroactive 7-percent benefit increase. The trust fund at the end of 1966 will be about the same size as at the beginning of the year, but after 1966 it will increase in every year.

(7) Increases in benefit disbursements in 1966, by cause

The total benefit disbursements of the old-age, survivors, and disability insurance system would be increased by about $2.1 billion in 1966 as a result of the changes that your committee's bill would make. Of this amount, about $1.4 billion results from the 7-percent benefit increase, $195 million from the benefit payments to children aged 18–21 who are in full-time school attendance, $165 million from the benefit payments to widows aged 60–61, $140 million from the liberalization of the insured-status provisions for certain persons aged 72 and over, $105 million from the liberalization of the definition of disability, and $65 million from the liberalization of the earnings test (the corresponding figure for this change for subsequent years will be about twice as large).

(8) Long-range operations of OASI trust fund

Table H gives the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the

figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty—if for no reason other than the relative difficulty in predicting future birth trends—but it is desirable and necessary nonetheless to consider these long-range possibilities under a social insurance program that is intended to operate in perpetuity.

TABLE H.—*Progress of old-age and survivors insurance trust fund under system as modified by committee bill, intermediate-cost estimate at 3.50 percent interest* [3]

[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 [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	$350	$399	$565	$17,968
1966	18,472	18,250	375	411	546	17,950
1967	19,714	19,180	361	497	567	18,193
1968	20,325	19,943	367	466	592	18,334
1969	22,920	20,785	375	475	642	20,261
1970	24,011	21,634	383	452	740	22,543
1971	25,936	22,546	391	428	866	25,980
1972	27,186	23,392	399	408	1,026	29,993
	Estimated data (long-range estimate)					
1975	$28,399	$24,440	$390	$307	$1,105	$36,829
1980	30,659	28,362	431	129	1,770	56,137
1990	35,090	36,105	510	−24	2,519	77,348
2000	40,701	40,407	559	−78	3,039	93,807
2025	50,507	61,411	769	−107	3,771	111,872

[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.

In every year after 1965 for the next 20 years, contribution income under the system as it would be modified by your committee's bill is estimated to exceed old-age and survivors insurance benefit disburse-

ments. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the long-range cost estimate (with a level-earnings assumption), reaching $36 billion in 1975, $56 billion in 1980, and over $90 billion at the end of this century. In the very far distant future, namely, in about the year 2015, the trust fund is estimated to reach a maximum of about $150 billion.

(9) Long-range operations of DI trust fund

The disability insurance trust fund, under the program as it would be changed by your committee's bill, grows slowly but steadily after 1966, according to the intermediate long-range cost estimate, as shown by table I. In 1975, it is shown as being $3.5 billion, while in 1990, the corresponding figure is $9.3 billion. There is a small excess of contribution income over benefit disbursements for every year after 1965.

TABLE I.—*Progress of disability insurance trust fund under system as modified by committee 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	887	64	5	66	2,437
1962	1,046	1,105	66	11	68	2,368
1963	1,099	1,210	68	20	66	2,235
1964	1,154	1,309	79	19	64	2,047
	Estimated data (short-range estimate)					
1965	$1,187	$1,624	$85	$20	$50	$1,555
1966	1,840	1,784	110	20	46	1,527
1967	2,044	1,880	119	20	46	1,598
1968	2,109	1,959	124	15	47	1,656
1969	2,177	2,017	128	15	50	1,723
1970	2,246	2,069	132	15	53	1,806
1971	2,426	2,126	135	15	58	2,014
1972	2,543	2,174	139	15	67	2,296
	Estimated data (long-range estimate)					
1975	$2,412	$2,146	$103	—$3	$109	$3,502
1980	2,604	2,346	106	—11	159	5,014
1990	2,980	2,630	107	—14	300	9,270
2000	3,456	3,096	120	—14	541	16,442
2025	4,289	4,230	156	—14	1,237	36,958

[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 artifically 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.

(f) Cost estimates on range basis

(1) Long-range operations of trust funds

Table J shows the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for low- and high-cost estimates, while table K gives corresponding figures for the disability insurance trust fund.

Under the low-cost estimate, the old-age and survivors insurance trust fund builds up quite rapidly and in the year 2000 is shown as being about $260 billion and is then growing at a rate of about $16 billion a year. Likewise, the disability insurance trust fund grows steadily under the low-cost estimate, reaching about $9 billion in 1980 and $38 billion in the year 2000, at which time its annual rate of growth is about $2 billion. For both trust funds, under these estimates, benefit disbursements do not exceed contribution income in any year after 1965 for the foreseeable future.

TABLE J.—*Estimated progress of old-age and survivors insurance trust fund under system as modified by committee bill, low- and high-cost estimates*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
	Low-cost estimate					
1975	$29,035	$23,966	$361	$287	$1,513	$46,828
1980	31,621	27,538	398	104	2,625	77,292
1990	37,422	34,376	469	−54	5,101	145,892
2000	44,618	37,871	515	−113	9,178	260,877
	High-cost estimate					
1975	$27,789	$24,915	$418	$327	$780	$27,126
1980	29,691	29,186	464	154	1,069	35,932
1990	32,753	37,834	550	6	363	12,504
2000	36,780	42,943	603	−43	[3]	[3]

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.
[2] At interest rates of 3.75 percent for the low-cost estimate and 3.25 percent for the high-cost estimate.
[3] Fund exhausted in 1993.

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

TABLE K.—*Estimated progress of disability insurance trust fund under system as modified by committee bill, low- and high-cost estimates*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [1]	Interest on fund [2]	Balance in fund at end of year
	Low-cost estimate					
1975	$2,463	$2,001	$94	−$6	$195	$5,765
1980	2,685	2,174	95	−15	314	9,124
1990	3,177	2,428	94	−19	689	19,651
2000	3,788	2,899	103	−19	1,337	37,684
	High-cost estimate					
1975	$2,361	$2,291	$112		$37	$1,294
1980	2,522	2,517	117	−$7	28	1,054
1990	2,782	2,832	120	−9	[3]	[3]
2000	3,124	3,293	137	−9	[3]	[3]

[1] A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.
[2] At interest rates of 3.75 percent for the low-cost estimate and 3.25 percent for the high-cost estimate.
[3] Fund exhausted in 1988.

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

On the other hand, under the high-cost estimate the old-age and survivors insurance trust fund builds up to a maximum of about $36 billion in about 15 years, but decreases thereafter until it is exhausted shortly before the year 2000. Under this estimate, benefit disbursements from the old-age and survivors insurance trust fund are lower than contribution income during all years after 1965 and before 1981.

As to the disability insurance trust fund, under the high-cost estimate, in the early years of operation the contribution income is about the same as the benefit outgo. Accordingly, the disability insurance trust fund, as shown by this estimate, will be about $1.5 billion during the first few years after 1965 and will then slowly decrease until it is exhausted in 1988.

The foregoing results are consistent and reasonable, since the system on an intermediate-cost-estimate basis is intended to be approximately self-supporting, as indicated previously. Accordingly, a low-cost estimate should show that the system is more than self-supporting, whereas a high-cost estimate should show that a deficiency would arise later on. In actual practice, under the philosophy in the 1950 and subsequent acts, as set forth in the committee reports therefor, the tax schedule would be adjusted in future years so that none of the developments of the trust funds shown in tables J and K would ever eventuate. Thus, if experience followed the low-cost estimate, and if the benefit provisions were not changed, the contribution rates would probably be adjusted downward—or perhaps would not be increased in future years according to schedule. On the other hand, if the experience followed the high-cost estimate, the contribution rates would have to be raised above those scheduled. At any rate, the high-cost estimate does indicate that, under the tax schedule adopted, there will be ample funds to meet benefit disbursements for several decades, even under relatively high-cost experience.

(2) Benefit costs in future years relative to taxable payroll

Table L shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by your committee's bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs for the low-, high-, and intermediate-cost estimates (as was previously shown in tables E and G for the intermediate-cost estimate).

TABLE L.—*Estimated cost of benefits of old-age, survivors, and disability insurance system as percent of taxable payroll,*[1] *under system as modified by committee bill*

[In percent]

Calendar year	Low-cost estimate	High-cost estimate	Intermediate-cost estimate [2]
	Old-age and survivors insurance benefits		
1975	7.33	7.95	7.64
1980	7.72	8.70	8.20
1990	8.14	10.24	9.12
2000	7.52	10.35	8.80
2025	8.65	13.78	10.76
2040	9.81	14.81	11.78
Level-cost [3]	7.64	10.13	8.73
	Disability insurance benefits		
1975	0.61	0.73	0.67
1980	.61	.75	.68
1990	.57	.77	.66
2000	.57	.79	.67
2025	.65	.86	.74
2040	.70	.91	.78
Level-cost [3]	.64	.82	.71

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

[2] Based on the averages of the dollar contributions and dollar costs under the low-cost and high-cost estimates.

[3] Level contribution rate, at an interest rate of 3.25 percent for high-cost, 3.50 percent for intermediate-cost, and 3.75 percent for low-cost, for benefits after 1964, taking into account interest on the trust fund on December 31, 1964, future administrative expenses, the railroad retirement financial interchange provisions, the reimbursement of military-wage-credits cost, and the lower contribution rates payable by the self-employed.

Your committee believes that it would be desirable to amortize the amounts owing over a period longer than the 10-year period provided under present law. The bill would authorize a level annual appropriation from general revenues to the trust funds, starting in fiscal year 1966, that would amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015. After 2015, annual appropriations would be authorized to pay any additional costs.

E. GENERAL DISCUSSION OF PUBLIC ASSISTANCE AMENDMENTS

1. INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSISTANCE TITLES

Your committee's bill provides for an increase in the payments to public assistance recipients, effective January 1, 1966. The formula determining the Federal share of assistance payments is liberalized by increasing the Federal proportion of the payments in the first step of the formula and by raising the ceiling on Federal sharing in the

second step of the formula. For the adult categories—OAA, APTD, AB, and for the combined program for the aged, blind, and disabled—the formula is changed from twenty-nine thirty-fifths of the first $35 of the average assistance payment to thirty-one thirty-sevenths of the first $37 of the average assistance payment. The ceiling is raised on the average payments from $70 a month to $75 a month. The provisions in the formula under titles I and XVI adding $15 to the ceiling for vendor medical care payments in which there can be Federal participation and otherwise recognizing medical payments are not affected by this formula change, except that the steps of the statutory formula are rearranged to improve their equitable application.

For the program of AFDC, the formula change made in your committee's bill would be from fourteen-seventeenths of the first $17 of the average payment per recipient to five-sixths of the first $18 of the average assistance payment. The ceiling is raised from $30 a month to $32 a month. Under your committee's bill, there would be an increase in Federal payments averaging about $2.50 a month for the needy recipients in the adult assistance categories and an increase of about $1.25 a month for the needy children and the adults caring for them. The level of aid provided the needy justifies this modest increase.

2. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASES

Since the enactment of the Social Security Act, patients in public mental and tuberculosis hospitals have not been eligible under the public assistance titles of the Social Security Act, and only prior to 1951 were individuals eligible who were patients in private mental and tuberculosis hospitals. The reason for this exclusion was that long-term care in such hospitals had generally been accepted as a responsibility of the States. In the opinion of your committee, contemporary developments in the treatment of mental disorders and tuberculosis justify a new approach to the problem of the care of the aged who have these diseases. A partial recognition of this change in the treatment of the mentally ill and the tuberculous was made in 1960, when this committee recommended and the Congress acted to permit Federal participation in the cost of medical payments for aged persons diagnosed as psychotic or tubercular when they are in general medical hospitals because of such diagnosis, for up to 42 days. Although this amendment has proved useful, your committee believes a more fundmental change in the Federal law is needed if new treatment methods are to be more widely used in the Nation.

There have been many encouraging developments in the care and treatment of the mentally ill and the tuberculous. Most significantly progress is being made in the provision of short-term therapy in the patient's own home, in special sections of general hospitals, in specialized mental hospitals, and in community mental health centers. This latter type of facility is being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963.

With the progress in development of short-term therapy for the mentally ill and the tuberculous, your committee believes that the distinction hitherto maintained in the public assistance titles of the Social Security Act—between the aged who are ill with a diagnosis of

psychosis or tuberculosis and the aged with other diagnosed illnesses is no longer necessary or desirable. Your committee is convinced that the entire mental health program of the States can be advanced and the care of the mentally ill aged can be materially improved by the elimination of the distinction in the Federal law between disease classifications. Thus, under the provisions of your committee bill, Federal financial participation would become available effective January 1, 1966, in assistance (money payments, if appropriate, or payment for medical care) for aged persons otherwise eligible under State plans for OAA, MAA, or under the combined programs for the aged, blind or disabled who: (1) are patients in hospitals for mental diseases or for tuberculosis or (2) are patients in general hospitals without regard to the length of their stay, who are there because of a diagnosis of psychosis or tuberculosis. Federal financial participation would also become available for assistance under titles X, XIV, and XVI of the Social Security Act for blind or disabled persons of any age who are in a general hospital with a diagnosis of phychosis or tuberculosis.

Since the provisions of the bill are designed to improve the care provided by States and to assure that Federal participation is used for such improvement, it is not intended that the availability of care for the mentally ill or tubercular under other State or local programs be considered a resource in determining the eligibility of patients for public assistance with Federal participation in the payments made.

Your committee is concerned that certain safeguards and standards are maintained. These safeguards are to be included in the plans of States which wish to take advantage of these provisions for the provision of assistance to or in behalf of patients in mental or tuberculosis hospitals. Your committee believes that the closest collaboration in the planning and execution of the plans will be needed by the State welfare agencies and the State agencies responsible for the programs for the mentally ill and the tuberculous. Your committee's bill is intended to broaden the resources available to the community (including the public welfare agencies) in planning for the needy aged who have these diseases. For this reason, your committee has included in its bill a provision for a joint agreement or other arrangement between the units of State or (where appropriate) local governments, and where appropriate with institutions for mental diseases or tuberculosis. This agreement is not only intended to set forth the way of work between the agencies administering welfare and health programs, but also to set forth alternative methods of care, particularly for the aged who are mentally ill. Institutional treatment and care in the individual's own home are only two of the possible ways of caring for the aged who have mental problems. It is expected that the joint agreements will include plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others. This legislation, it is anticipated, will give further encouragement to the trend in the States for discharging from mental hospitals to the community the aged who are considered able to care for themselves, under some form of protective arrangements. Your committee is aware that not always does a discharge plan work out to the best advantage of the patient, and thus your committee's bill provides that the agreement must make provision for the prompt readmittance to the institution where needed for

the aged person who had been placed under alternate plans of care. Inasmuch as the public welfare agency will be responsible for the determination of eligibility under the State plan for all applicants for assistance in the hospital, it is important that representatives of the agency have free access to the patient in the hospital. It is equally important that the hospital give to the public welfare agency the information it needs to administer its part of the program including the provision of assistance and the related social services. Under your committee bill, the agreement must include these arrangements.

A second safeguard, under your committee's bill, is a provision that the State plan include a provision for an individual plan for each patient in the hospital to assure that the care provided to him is in his best interests and that there will be initial and periodic review of his medical and other needs. Your committee is particularly concerned that the patient receive care and treatment designed to meet his particular needs. Thus, under your committee bill, the State plan would also need to assure that the medical care needed by the patient will be provided him and that other needs considered essential will be met and that there will be periodic redetermination of the need for the individual to be in the hospital.

Your committee bill provides for the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals. This is intended to include provision for persons who no longer need care in hospitals and who can, with financial help and social services to the extent needed, make their way in the community. Under the 1962 public welfare amendments, State public welfare agencies are encouraged to provide social services for the aged and additional Federal financing is available to assist in the cost. Under your committee bill, these social services would be made available, as appropriate, for the aged who are in the hospitals or who would otherwise need care in an institution.

Your committee believes that responsibility for the treatment of persons in mental hospitals—whether or not they be assistance recipients—is that of the mental health agency of the State. Social services may be needed for members of the patient's family, and this responsibility can be carried by the local welfare agency with Federal financial help. When the patient leaves the mental hospital to receive one of the alternative methods of care, followup social services are usually essential if the discharge plan is to be successful. Such services can be given by the public welfare agency or (if provided in the agreement between the two agencies referred to earlier) could be given by the staff of the hospital. Social services to the aged who have mental health problems, your committee believes, are important as a means of preventing further deterioration and avoiding or delaying admittance or readmittance to the institution.

Your committee recognizes that the administration of these provisions will place new responsibilities upon the welfare agencies and if these responsibilities are to be carried out effectively, appropriate planning and execution will be required. Thus your committee's bill provides authority for the Secretary to establish necessary methods of administration for the States in carrying out these provisions.

Under the bill, the Federal Government will be participating in the costs of care given to the needy aged in certain institutions. In

order to assure that the rates for the care of recipients who are patients in such institutions are reasonable, the bill provides that the State must have suitable methods for the determination of the cost. Your committee expects that this determination will be made without imposing burdensome fiscal methods on the States.

Your committee believes it is important that States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963. In order to make certain that the planning required by your committee's bill will become a part of the overall State mental health planning under the Community Mental Health Centers Act of 1963, your committee's bill makes the approvability of a State's plan for assistance for individuals in mental and tuberculosis hospitals dependent upon a showing of satisfactory progress toward developing and implementing a comprehensive mental health program—including utilization of community mental health centers, nursing homes, and other alternative forms of care.

Your committee wishes to insure that the additional Federal funds to be made available to the States under the provisions of the bill will assist the overall improvement of mental health services in the State. State and local funds now being used for institutional care of the aged will be released as a result of the bill, but there is great need for increased professional services in hospitals and for development of alternate methods of care outside the hospitals. To accomplish this, States may have to reallocate their expenditures for mental health to promote new methods of treatment and care. Your committee bill provides that the States will receive additional Federal funds only to the extent that a showing is made to the satisfaction of the Secretary that total expenditures of the States or its political subdivisions from their own funds for mental health services are increased. Such expenditures may be financed under State or local public health or public welfare programs. Expenditures will be measured against a base period and will include comparable items of expenditure for mental health programs by State and local public health and welfare agencies, including expenditures for payments to or in behalf of public assistance recipients with mental health problems and expenditures for services and other administrative items under health and welfare programs.

3. PROTECTIVE PAYMENTS

Your committee has been concerned about the problems of our aged citizens who have marginal capacity to handle their own affairs. Old-age assistance recipients are among those with the most serious problems, both because of their advanced age (average age is 76) and because they have so little resources that the usual guardianship services under State law may not be available. States may now, with Federal participation, use guardians as payees for public assistance payments, or under section 1111 of the Social Security Act, enacted in 1958, may use a special legal representative as the payee. Your committee has been advised that these arrangements still do not offer enough flexibility to meet all the needs that arise and thus, the bill contains additional provisions.

Under your committee's bill, States with Federal financial participation may make a protective payment to a third party, someone with

an interest or concern for the individual recipient. This provision is similar to the protective payment provision included in the AFDC program as one part of the 1962 Public Welfare Amendments. It would be effective January 1, 1966, and would be applicable to recipients of money payments under title I or title XVI.

Your committee is aware of the serious nature of a decision not to give a needy person the money which he would ordinarily receive directly, but instead to pay it in his behalf to a third party. Your committee's bill, therefore, has several safeguards to protect the individual's rights. For Federal sharing to be claimed in such payments, the State plan, under the bill, would have to show that a determination will be made that such individual has, by reason of his physical or mental condition, such inability to manage his own money that making payments directly to him would not be in his best interests. Furthermore, States would be able to make payments with Federal sharing only when the payments meet all the need, as determined under the State plan, of the individual. This safeguard was included by your committee because some States do not meet need according to their own standards and thus it is possible that the difficulty ascribed to the individual in handling his money may be due to the inadequate assistance he is receiving.

The State plan would have to show, in addition, that the State is undertaking and continuing efforts to protect the welfare of the individual and to the extent possible, improve his capacity for self-care and to handle his money. To avoid the possibility of protective payment arrangements continuing beyond the period necessary, the bill provides, further, that the State agency will need to make periodic reviews to determine whether conditions justify the continuation of the arrangement and if they do not, for direct payments to be resumed, or if the conditions warrant, for the judicial appointment of a guardian or a legal representative as authorized by section 1111 of the Social Security Act. The bill also provides specifically that the State agency must offer to the individual affected, if he is dissatisfied, an opportunity for a fair hearing on the decision to make his payment to a third party.

4. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED UNDER OLD-AGE ASSISTANCE AND COMBNED PROGRAMS

Your committee's bill provides for a modest increase in the amount of earnings States may disregard in determining need under the program of OAA and for the aged receiving assistance under the combined program for the aged, blind, and disabled. Currently, States may disregard no more than the first $10 a month, and one-half of the remainder within a total of $50 per month of earned income. The bill would raise those amounts to $20 a month and one-half of the remainder within a total of $80 per month of earned income, effective January 1, 1966.

Your committee is convinced that it is sound for the aged to continue in employment as long as they can, and that those who work should have some incentive and special consideration. Currently 23 States have implemented the earlier legislation and are disregarding some earned income of the aged. This amendment will permit these

States, and others which have not yet acted, to implement the legislation to increase the amounts disregarded.

5. ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS

Your committee bill contains new provisions effective January 1, 1966 for administrative and judicial review of certain administrative determinations under titles I, IV, X, XIV, XVI, and XIX of the Social Security Act. These provisions are designed to assure that the States will not encounter undue delays in obtaining Federal determinations on acceptability of proposed State plan material under the public assistance programs, and that the States will be able to obtain judicial review of their plan proposals at an appropriate stage of the proceedings. These provisions are not intended to affect adversely the usual negotiation process between the Department of Health, Education, and Welfare and the States which, in nearly all instances, results in the development of a State plan or plan amendment that can be approved by the Secretary.

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 then set a time and place for a hearing, to begin from 20 to 60 days after the date notice of the 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, unless substantially contrary to the weight of the evidence; if good cause is 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 does not amend sections 4, 404, 1004, 1404, 1604, or 1904 of the Social Security Act, which provide that 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 or that in the administration of the plan there is a failure to comply substantially with certain requirements. However, the bill provides that upon any such final determination by the Secretary, the State may appeal to the U.S. court of appeals, in the same way as described above for appeals from a final determination of the Secretary in connection with submittal of a new plan.

The bill further provides that action pursuant to an initial deter-

mination 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.

In addition to questions concerning State plan proposals, or which involve discontinuance of Federal payments under part or all of a State plan, disagreements between a State and the Secretary may occur when the Secretary disallows specific State expenditures for Federal financial participation. Such disallowances usually take the form of audit exceptions. The bill provides that whenever the Secretary determines that there shall be a disallowance the State shall be entitled, on request, to an administrative reconsideration of the decision.

6. MAINTENANCE OF STATE EFFORT

Under various provisions of this bill, additional Federal funds will be available to States to improve the public assistance program. Your committee has recognized the need for such program improvement in medical care, in basic maintenance, as well as in other areas, and believes that the Federal funds designated for these purposes should be used by the States for these purposes and not as a substitute for State funds. For this reason, the bill incorporates a provision which assures that the additional Federal funds made available to States are used within the public assistance program. Additional Federal funds will, under these provisions, be granted to States only to the extent that existing State expenditures in the program are maintained. For a period beginning January 1, 1966, and ending June 30, 1969, a measurement of these expenditures will be made in the process of granting the Federal funds to the States. Your committee believes that after June 30, 1969, the new funds will be so integrated into the programs of the States that further testing of this fact will not be needed.

Under the bill, expenditures from total and Federal funds for a particular quarter are compared with total and Federal expenditures in a "base period," either the corresponding quarter or an average of the quarters in the fiscal year ending June 30, 1964, or June 30, 1965. If this comparison shows that the increase in Federal funds as computed under the revised formula exceeds the increase in total expenditures, the increase in Federal share must be reduced to the amount of the increase in total expenditures between the base period and the quarter in question. The purpose of this provision is to assure that whatever additional Federal funds are made available to the States

under the revised formulas for computing the Federal share and under provisions for program expansion will be used for program improvements and that no part of any additional Federal funds will be used to replace non-Federal funds.

7. DISREGARDNING SO MUCH OF OASDI BENEFIT INCREASE AS IS ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE

Under title III of the bill, beneficiaries of the OASDI program will receive a 7-percent increase in their benefits retroactively effective to January 1, 1965. These benefits will be payable to beneficiaries in a lump-sum check in addition to the regular monthly check. There are currently many thousands of such beneficiaries who are receiving supplementary assistance from various of the public assistance programs under provisions of the Social Security Act. Moreover, certain children over 18 and in school will receive benefits from January 1, 1965. Your committee believes that it would be appropriate for the State public assistance agencies to disregard these retroactive payments as one-time-only income, not significant in amount and not income which under various other longstanding provisions of the public assistance titles to the act must be taken into account by the State in determining the amount of assistance for the individual.

The bill adds a provision to make it clear that States need not take these sums into consideration in determining the need of the public assistance recipients who also receive an OASDI benefit.

8. AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

When the MAA program was enacted in 1960, the law prohibited Federal sharing in MAA payments made in behalf of an aged person receiving OAA in the month MAA services were received. This provision has proved to be a hardship in the planning of States for the necessary movement of ill aged persons to and from medical institutions such as nursing homes and hospitals. For the month of movement to or from such a medical facility, States are faced with a heavy expenditure of funds, only part of which, under current provisions of law, is subject to Federal sharing. A State which has made an OAA payment to a needy person to cover his expenses in his own home is unable to claim any Federal funds as MAA when the individual goes to a medical institution that month. The reverse situation arises when the individual leaves the medical institution in which services are received under MAA.

In order to meet this need, the bill would relax the prohibition on Federal sharing in OAA and MAA for the same month so as to permit such sharing effective July 1, 1965, for MAA services furnished in the month an individual enters or leaves a medical facility.

9. EXTENSION OF GRACE PERIOD FOR DISREGARDING CERTAIN INCOM FOR STATES WHERE LEGISLATURE HAS NOT MET IN REGULAR SESSION

Section 701 of the Economic Opportunity Act of 1964 provides that certain amounts of income of an individual derived from titles I and II of that act may not be taken into account by State public assistance agencies in determining the need of such individual or any other individual for public assistance under programs authorized by the Social Security Act. The purpose of this amendment was to provide an incentive for persons who are beneficiaries of programs under the Economic Opportunity Act to undertake training and employment by permitting public assistance payments to continue for them and their families, if they are otherwise eligible, and not be reduced by specified amounts of their income under such programs. The statute provides that States with a legislative impediment to putting this provision into effect shall have until July 1, 1965, to obtain the necessary legislative change. A problem has arisen in the instance of States which do not have a regular meeting of their legislature until 1966 to make the necessary changes to State law. Under this section of the bill, such States would have until the first month following the month of adjournment of a State's first regular legislative session adjourning after the date of enactment of the Economic Opportunity Act of 1964 to act.

10. TECHNICAL AMENDMENTS TO ELIMINATE PUBLIC ASSISTANCE PROVISIONS WHICH BECOME OBSOLETE IN 1967

Title XIX, to be added to the Social Security Act by title I of this bill, would, effective July 1, 1967, provide the sole statutory base for States to receive Federal funds for the provision of payments for vendor medical care in behalf of the needy. On that date, Federal financial participation in vendor payments for medical care will not be possible under other of the public assistance titles of the act. Thus, on July 1, 1967, numerous provisions of the various public assistance titles become inoperative. The bill identifies those provisions and appropriately repeals or amends them as of July 1, 1967.

11. COSTS OF INCREASES IN THE PUBLIC ASSISTANCE MATCHING FORMULAS

The accompanying table shows by State and by assistance programs the additional amounts of money that will be available to States under the changes in public assistance formulas made by title IV. These total almost $150 million for the first full year, or $75 million for the 6 months of the fiscal year ending June 30, 1966, that they would be effective. Like other increases in public assistance provided by the bill, the States would receive these amounts only to the extent that they made corresponding increases in their total expenditures.

Public assistance: Estimated annual increase in Federal funds under proposal to raise Federal participation in assistance payments to specified levels [1]

[In thousands]

States and District of Columbia	Total all programs	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to the aged, blind, and disabled (title XVI)	Aid to families with dependent children
Total	$148,520	$50,953	$2,352	$10,194	$22,117	$62,904
Alabama	3,817	2,640	42	346	----------	789
Alaska	154	(2)	(2)	(2)	69	85
Arizona	933	319	38	68	----------	508
Arkansas	2,012	1,392	47	221	----------	352
California	22,919	11,495	523	2,008	----------	8,893
Colorado	2,731	[3] 1,735	11	253	----------	732
Connecticut	1,543	321	13	172	----------	1,037
Delaware	203	32	13	18	----------	140
District of Columbia	581	100	8	130	----------	343
Florida	3,354	(2)	(2)	(2)	2,167	1,187
Georgia	3,691	2,206	76	624	----------	785
Hawaii	344	(2)	(2)	(2)	97	247
Idaho	494	220	6	67	----------	201
Illinois	8,543	(2)	(2)	(2)	3,751	4,792
Indiana	1,260	557	76	45	----------	582
Iowa	2,172	1,286	54	50	----------	782
Kansas	1,829	(2)	(2)	(2)	1,201	628
Kentucky	2,620	(2)	(2)	(2)	1,682	938
Louisiana	4,992	3,186	134	452	----------	1,220
Maine	568	(2)	(2)	(2)	329	239
Maryland	1,791	(2)	(2)	(2)	519	1,272
Massachusetts	4,497	2,295	96	494	----------	1,612
Michigan	5,308	(2)	(2)	(2)	2,481	2,827
Minnesota	2,008	[3] 988	48	82	----------	890
Mississippi	2,874	1,782	71	415	----------	606
Missouri	4,288	2,489	164	351	----------	1,284
Montana	456	249	11	58	----------	138
Nebraska	968	553	29	108	----------	278
Nevada	199	107	7	(4)	----------	85
New Hampshire	315	196	12	25	----------	82
New Jersey	2,510	335	40	349	----------	1,786
New Mexico	950	(2)	(2)	(2)	331	619
New York	12,844	(2)	(2)	(2)	3,977	8,867
North Carolina	3,099	1,047	122	523	----------	1,407
North Dakota	476	(2)	(2)	(2)	330	146
Ohio	6,860	2,873	141	786	----------	3,060
Oklahoma	6,115	(2)	(2)	(2)	4,650	1,465
Oregon	1,036	269	18	187	----------	562
Pennsylvania	6,484	1,937	216	471	----------	3,860
Rhode Island	802	(2)	(2)	(2)	374	428
South Carolina	1,228	629	43	205	----------	351
South Dakota	404	174	3	26	----------	201
Tennessee	2,373	1,099	53	301	----------	920
Texas	6,899	5,504	116	221	----------	1,058
Utah	647	122	8	114	----------	403
Vermont	224	(2)	(2)	(2)	159	65
Virginia	1,058	322	28	161	----------	547
Washington	2,540	812	28	437	----------	1,263
West Virginia	1,978	352	20	148	----------	1,458
Wisconsin	2,375	1,266	35	252	----------	822
Wyoming	154	64	2	26	----------	62

[1] For OAA, AB, APTD, and AABD (title XVI), raise 29/35 of $35 to 31/37 of $37; and for AFDC, from 14/17 of $17 to 5/6 of $18; raise maximum average monthly payment from $70 to $75; and for AFDC, from $30 to $32. Assumes that States will continue to spend the same amount per recipient from State and local funds as in May 1964, and that the increase in Federal funds will be used to raise money payments to recipients.

[2] Combined under aid to the aged, blind, and disabled.

[3] Based on State's estimate of the number of recipients and average payment for September 1964, which shows transfers from OAA to MAA, not reflected in May data.

[4] No program for APTD.

Summary—Cost of public assistance and related items

[In millions of dollars]

Costs	Fiscal year 1965	Annual rate
Title I, pt. 2: Medical assistance	100	200
Title II:		
Pt. 1: Maternal and child health, crippled children	25	60
Pt. 2: Mental retardation projects	2.75	2.75
Pt. 3: Mental and tuberculosis	38	75
Pt. 3: Medical assistance for the aged definition	2	2
Title IV:		
Formula changes	75	150
Protective payments	(1)	(1)
Income exemption (old-age assistance)	.5	1
Total	243.25	490.75

[1] No cost.

F. Medical Expense Deductions for Income Tax Purposes

1. PRESENT LAW

As a general rule under the Internal Revenue Code only that portion of the medical care expenses paid by the taxpayer for himself, his spouse, or his dependents which exceeds 3 percent of adjusted gross income may be deducted. Included in the category of deductible medical expenses subject to this 3-percent floor are premiums paid for accident and health insurance. In computing medical care expenses for the purpose of applying the 3-percent limitation, expenses for medicines and drugs are included only to the extent that they exceed 1 percent of adjusted gross income. An exception is presently made to these general rules, however, in the case of medical care expenses incurred by a taxpayer or his spouse if either is 65 or over, or for his dependent mother or father (or mother-in-law or father-in-law) if 65 years of age or more. The expenses for medical care of such persons may be deducted without regard to either the 3-percent or the 1-percent limitations.

Under present law, certain maximum limitations are also imposed with respect to medical expense deductions. With the exception of disabled persons, these maximum limitations do not vary according to age. Generally, the maximum medical expense deduction which may be taken is $5,000 multiplied by the number of exemptions claimed (other than those for age or blindness), not to exceed $10,000 in the case of a single taxpayer or $20,000 in the case of a married couple (or head of household or surviving spouse). In the case of disabled taxpayers and their spouses, however, who have attained the age of 65, the maximum $10,000 or $20,000 limitation referred to above is increased to $20,000 or $40,000, respectively.

2. GENERAL REASONS FOR PROVISION

The health care provisions of your committee's bill have a relationship to the medical expense deductions allowed under the Internal Revenue Code. The 3-percent limitation in the case of medical care expenses and the 1-percent limitation applied to expenditures for medicines and drugs were waived for persons 65 or over in recognition of the fact that medical expenses generally constituted

a heavy financial burden for older people. The limitations were waived, however, during a period when there was no broad-coverage health insurance plan for older persons. The insurance provisions of your committee's bill are designed to meet these problems. The reasons for the special medical expense provisions in the tax law for the relief of older taxpayers, therefore, no longer appear to exist.

Moreover, restoration of a uniform floor to be applied in the computation of the medical expense deduction will provide an increase in revenue which will help defray to some degree the cost of the general fund of the voluntary insurance provisions in your committee's bill. Only in the case of an older person with sufficient income to be taxable will the benefit of the Federal Government's $36-per-year contribution towards his voluntary medical insurance coverage be reduced or offset by a lesser deduction for medical care expenses.

Restoration of a uniform medical expense deduction rule also will serve to simplify the tax law. Present law necessitates a careful distinction between the medical care expenses of persons 65 or over and the similar expenses of persons under 65. A complex special form is employed for this purpose. The need for this special form will be eliminated by the establishment of a single uniform rule for those over and under age 65.

The bill also permits, for all persons regardless of age, the deduction of a portion of medical insurance premiums without regard to the 3-percent limitation in recognition of the fact that existing law may have the effect of discouraging the provision of insurance protection against future medical bills. Under present law medical insurance premiums may not be deductible because provision for medical expenses by insurance tends to even out these charges over a period of years and, therefore, makes it more likely that in any specific year the 3-percent limitation will not be exceeded. Medical expenses of those not covered by insurance tend to vary more from year to year and thus in some years are more likely to exceed the 3-percent limitation and be deductible.

3. GENERAL EXPLANATION

Your committee's bill (sec. 106), therefore, amends the Internal Revenue Code (sec. 213) to terminate present special treatment of the medical care expenses of taxpayers who are 65 or over. Thus, the provision of present law limiting medical expense deductions for a taxpayer, his spouse, or his dependents where they are under age 65 to the amount of such expenses in excess of 3 percent of adjusted gross income is extended to all taxpayers, spouses, and dependents regardless of age. This is also true of the provision under present law limiting expenditures for medicines and drugs which are taken into account for purposes of the 3-percent limitation to the amount in excess of 1 percent of adjusted gross income. These limitations, therefore, will, in the future, apply to taxpayers and their spouses who have attained age 65 as well as dependent mothers or fathers of the taxpayer (or of his spouse) who have attained the age of 65.

The bill also removes the distinction in the maximum medical expense deduction allowance between disabled taxpayers over and under age 65. This is accomplished by extending the $20,000 maximum deduction presently available to single taxpayers and the $40,000 ceiling

available to married taxpayers filing joint returns to disabled taxpayers under age 65.

The bill further provides that all taxpayers itemizing their deductions, regardless of age, are to be granted a deduction, without regard to the 3-percent floor, for one-half the cost of medical care insurance for the taxpayer, his spouse, and his dependents, but not to exceed $250. The other half of any premiums paid, plus any excess over the $250 limit for medical care insurance, will continue to be subject to the 3-percent floor and only when they plus any other allowable medical expenses exceed 3 percent of adjusted gross income will they be deductible. Included in the category of medical insurance premiums which may be deducted (one-half under, and one-half apart from, the 3-percent floor) are those for supplementary health insurance benefits for the aged but not the taxes transferred to the trust fund for hospital insurance benefits for the aged.

The bill also makes certain other amendments to the medical expense deduction provisions of the Internal Revenue Code. The definition of medical care is revised to specifically limit the deductible portion of premiums paid on multipurpose health and accident policies to the actual cost of providing insurance protection against medical care expenses, as defined in the Internal Revenue Code. The cost of insurance allocable to income continuation payments when illness or accident causes absence from work and the cost of insurance which provides indemnity in the case of the loss of a limb, etc., is not to be deductible. This revision becomes particularly important in view of the provision which permits the deduction of one-half of the premiums paid for medical care insurance without regard to the 3-percent limitation.

The bill qualifies as a current medical expense certain premiums paid during the taxable year by a taxpayer under the age of 65 for insurance for the medical care expenses of the taxpayer, his spouse, and his dependents which will be incurred after the taxpayer attains the age of 65. However, these payments, to qualify as a current expense, must be made under a contract which provides for level premium payments over a specified minimum period. This provision, which applies only to insurance for medical care expenses, is designed to remove any impediment which might otherwise exist to the voluntary provision by a person under 65 of medical care protection for his post-65 years. This is not intended, however, to foreclose the allowance of any presently available deduction for other prepayments.

4. EFFECTIVE DATE

These provisions apply to medical care expenses incurred in tax years beginning after December 31, 1966. The provisions will, therefore, not become effective until the health care provisions of the bill have been in operation for 6 months.

5. REVENUE EFFECT

The provision reinstituting the deduction floors is expected to increase revenues by $170 million but it is expected that the deduction of one-half the cost of medical insurance premiums without regard to the 3-percent limitation will decrease revenues by $88 million. Overall, it is estimated that the provisions will increase revenues by $82 million in a full year of operation. This, of course, is much more than offset by health care payments made from the general fund of the Treasury. The distribution of this total by specific provisions and adjusted gross income classes is shown below.

Distribution of tax revenue estimates under revised medical expense deduction

[In millions of dollars]

Adjusted gross income	[1] Application of 3-percent and 1-percent limitations to all taxpayers [2]	Increased medical expense deduction [3]
0 to $3,000	1	−9
$3,000 to $5,000	9	−3
$5,000 to $10,000	20	−31
$10,000 to $20,000	24	−32
$20,000 to $50 000	47	−10
$50,000 and over	69	−3
Total	170	−88

[1] This additional revenue will be derived from those age 65 and over.

[2] Assumes a reduction in hospitalization and medical expenses of 50 percent for taxpayers with incomes under $10,000 and 25 percent for those with incomes over $10,000.

[3] Includes effect of allowing a deduction of ½ cost of all medical insurance premiums without regard to the 3-percent limitation and effect of medical expense deductions for premiums paid for voluntary insurance coverage under this bill. This reduction goes to taxpayers of all age groups.

IV. SECTION-BY-SECTION ANALYSIS OF THE BILL

The first section contains the short title of the bill—the "Social Security Amendments of 1965"—and a table of contents. The remainder of the bill is divided into four titles, and titles I and II into several parts, as follows:

Title I—Health Insurance For the Aged and Medical Assistance
- Part 1—Health Insurance Benefits for the Aged
- Part 2—Grants to States for Medical Assistance Programs

Title II—Other Amendments Relating to Health Care
- Part 1—Maternal and Child Health and Crippled Children's Services
- Part 2—Implementation of Mental Retardation Planning
- Part 3—Public Assistance Amendments Relating to Health Care

Title III—Social Security Amendments

Title IV—Public Assistance Amendments

TITLE I—HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE

Section 100 of the bill provides that title I of the bill may be cited as the "Health Insurance for the Aged Act."

PART 1—HEALTH INSURANCE BENEFITS FOR THE AGED

SECTION 101. ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Section 101 of the bill adds at the end of title II of the Social Security Act a new section 226, dealing with entitlement to hospital insurance benefits (i.e., entitlement to have payment of benefits made under part A of the new title XVIII of the Social Security Act (as added by section 102 of the bill)).

Section 226(a) provides that any individual who has attained the age of 65, and who is entitled to monthly old-age and survivors insurance benefits or is a "qualified railroad retirement beneficiary", is entitled to hospital insurance benefits under part A of the new title XVIII for each month (including, if applicable, any month of retroactive entitlement to monthly OASI benefits as provided in section 202(j)(1) of the Social Security Act and any month of retroactive entitlement to benefits as provided in section 21 of the Railroad Retirement Act of 1937) in which he meets such conditions, beginning with July 1966.

Paragraph (1) of section 226(b) provides that entitlement of an individual to hospital insurance benefits consists of entitlement to have payment made on his behalf for inpatient hospital services,

post-hospital extended care services, post-hospital home health services, and outpatient hospital diagnostic services furnished him in the United States. It also provides that no payment for post-hospital extended care services may be made for services furnished before January 1967 and that payment for post-hospital extended care services or post-hospital home health services may be made only if the discharge from a hospital required to permit payment with respect to such services occurs after June 30, 1966, or on or after the first day of the month in which the individual attains age 65, whichever is later.

Paragraph (2) of section 226(b) provides that an individual entitled under section 226 is entitled to hospital insurance benefits for the month in which he dies.

Section 226(c) provides that the term "qualified railroad retirement beneficiary" means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 21 of the Railroad Retirement Act of 1937 (as added by section 105 of the bill), and that an individual will cease to be a qualified railroad retirement beneficiary at the close of the month before the month which is certified by the Board as the month in which he ceased to meet the requirements of such section 21.

Section 226(d) contains a cross-reference to section 103 of the bill which provides entitlement to hospital insurance benefits for certain individuals not eligible for benefits under section 226.

SECTION 102. HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY HEALTH INSURANCE BENEFITS

Section 102(a) of the bill amends the Social Security Act by adding after title XVII a new title XVIII providing health insurance for the aged and consisting of part A (hospital insurance for the aged), part B (supplementary health insurance benefits for the aged), and part C (miscellaneous provisions).

TITLE XVIII—HEALTH INSURANCE FOR THE AGED

SECTION 1801. PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

Section 1801 states that nothing in the new title XVIII is to be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine, the manner in which medical services are provided, the personnel policies of providers of health care, or the operation or administration of medical facilities and personnel.

SECTION 1802. FREE CHOICE BY PATIENT GUARANTEED

Section 1802 provides that any individual entitled to benefits under title XVIII may obtain health services from any institution, agency, or person which is qualified to participate under the title and which undertakes to provide the services to him.

SECTION 1803. OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH INSURANCE PROTECTION

Section 1803 provides that nothing in title XVIII is to be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against health costs.

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED

SECTION 1811. DESCRIPTION OF PROGRAM

Section 1811 describes the insurance program for which entitlement is established under section 226 of the Social Security Act as one which provides basic protection against the costs of hospital and related post-hospital services for individuals age 65 or over who are entitled to retirement benefits under title II of the Social Security Act or under the railroad retirement system.

SECTION 1812. SCOPE OF BENEFITS

Section 1812(a) provides that the benefits provided to an individual under part A of the new title XVIII consist of entitlement to have payment made on his behalf for:

(1) inpatient hospital services (including such services in a tuberculosis hospital) for up to 60 days during any spell of illness;

(2) post-hospital extended care services for up to 20 days (or up to 100 days in the circumstances described in section 1812(c)) during any spell of illness;

(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next; and

(4) outpatient hospital diagnostic services.

Section 1812(b) provides that (subject to section 1812 (c) and (d), discussed below) payment may not be made for inpatient hospital services furnished to an individual in any spell of illness after such services have been furnished to him for 60 days during the spell or for post-hospital extended care services in any spell of illness after such care has been furnished to him for 20 days during the spell.

Section 1812(c) provides that, at the individual's option, the number of days for which payment for post-hospital extended care services may be made can be increased beyond 20 (but by no more than 80 days, for a maximum of 100) by twice the number by which the days for which the individual has already been furnished inpatient hospital service in the same spell of illness are less than 60. The number of days of inpatient hospital care for which payments could be made during the same spell of illness would be reduced by one day for each full two days of extended care above 20 for which payment is made (and by an additional day if the number of days of extended care is an odd number). The individual may conserve his inpatient hospital coverage by terminating the application of section 1812(c) at any time.

To illustrate the effect of section 1812(c), if an individual transferred to an extended care facility after a 10-day hospital stay and needed 63 days of extended care facility services, payment would be made

for the entire stay in the facility, including the 43 days beyond the initial 20, unless he elects to have payment cut off for some or all of the 43 days. If payment is made for the entire period of extended care he would, after discharge from the facility, remain eligible for 28 additional days of hospital care if he should need to be hospitalized again during the same spell of illness. That is, of the 60 days of hospital benefits, he would have received 10 days of benefits in the hospital, and he would have exchanged 22 days of hospital benefits for the 43 additional days of extended care benefits, leaving him with a balance of 28 days of hospital care. However, if the individual had requested that his days in the extended care facility beyond 20 not be paid for, he would have retained a balance of 50 days of hospital care.

Section 1812(d) provides that if an individual is an inpatient of a tuberculosis hospital on the first day of the first month for which he is entitled to benefits under part A, the days on which he was an inpatient of such a hospital in the 60-day period immediately before such first day will be included in determining the 60-day limit on inpatient hospital services insofar as it applies to him.

Section 1812(e) provides that payment may be made under part A for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section. Only the first 100 visits in the one-year period can be paid for. The number of visits to be charged in connection with the provision of covered home health items or services for this purpose is to be determined in accordance with regulations.

Section 1812(f) provides that inpatient hospital services, post-hospital extended care services, and post-hospital home health services will be taken into account for purposes of the limits on duration of coverage prescribed in the preceding subsections of section 1812 only if payment under part A is made or would be made with respect to such services if they had been furnished within such limits and if the request and certification requirements described in section 1814(a) had been met for such services.

Section 1812(g) contains a cross reference to the definitions of the terms used in part A which are found in section 1861.

SECTION 1813. DEDUCTIBLES

Paragraph (1) section 1813(a) provides that payment for inpatient hospital services furnished during any spell of illness will be reduced by the inpatient hospital deductible (the amount of which is determined under section 1813(b)). However, charges for a diagnostic study, up to the amount of the deductible which applies to a diagnostic study (described in paragraph (2)), by the same hospital during the 20-day period before the individual is admitted as an inpatient to the hospital, would be applied toward the inpatient hospital deductible.

To illustrate: An individual obtains diagnostic laboratory services in a hospital outpatient department on August 1, 1966, and is charged $15 for these services. On August 15 he is admitted as an inpatient to the same hospital in which he received the diagnostic services. He is permitted to apply his payment for the diagnostic services toward the inpatient hospital deductible ($40 in 1966); thus he would have to pay an inpatient hospital deductible of $25.

Paragraph (2) of section 1813(a) provides for a deductible with respect to outpatient hospital diagnostic services (furnished during a diagnostic study) equal to one-half the amount of the inpatient hospital deductible. A "diagnostic study" is defined as outpatient hospital diagnostic services provided by (or under arrangements made by) the same hospital during the 20-day period beginning on the first day (once he is entitled to benefits under section 226) on which outpatient hospital diagnostic services are furnished to him.

Paragraph (3) of section 1813(a) provides that payment cannot be made to any provider of services under part A for the cost of the first 3 pints of whole blood furnished to an individual during a spell of illness.

Paragraph (1) of section 1813(b) provides that the inpatient hospital deductible is $40 for any spell of illness (and is therefore $20 for any diagnostic study) beginning before 1969.

Paragraph (2) of section 1813(b) provides that the Secretary shall, between July 1 and October 1 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which is to be applicable in the case of any spell of illness or diagnostic study beginning during the succeeding calendar year. The inpatient hospital deductible will be equal to $40 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the preceding calendar year, to (B) the current average per diem rate for 1966. Any amount determined by the multiplication under this paragraph which is not a multiple of $5 will be rounded to the nearest multiple of $5 (or, if it is midway between two multiples of $5, to the next higher multiple of $5).

If, for example, the cost experience reviewed for purposes of the promulgation to be made in 1970 shows that the average per diem rate for inpatient hospital services during 1969 was $45.55 as compared to $39.80 in 1966, the amount of the deductible applicable in 1971 would be $45 ($40 multipled by $\frac{45.55}{39.80}$ and then rounded to the nearest multiple of $5).

The current average per diem rate for any year will be determined by the Secretary on the basis of the best information available to him as to the amounts paid under part A for inpatient hospital services plus the amounts which would have been paid but for the inpatient hospital deductible required under section 1813(a)(1).

SECTION 1814. CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of requests and certifications

Section 1814(a) provides that, except in the case of emergency hospital services (described in section 1814(d)), payment for covered services may be made only to providers of services which have an agreement with the Secretary entered into in accordance with section 1866 and only if the requirements of section 1814(a) with respect to requests and certifications are satisfied.

Paragraph (1) of section 1814(a) requires that a written request (signed by the individual who receives the services or by another

person when it is impracticable for him to do so) be filed for such payment under regulations to be issued by the Secretary.

Paragraph (2) of section 1814(a) requires that a physician certify (and recertify, in such cases and as often and with such supporting material as may be provided in regulations, but in any event before the 21st day in the case of inpatient hospital services received during a continuous period) that—

(A) in the case of inpatient hospital services (other than inpatient tuberculosis hospital services), the services were required to be given on an inpatient basis for medical treatment, or inpatient diagnostic study was medically required;

(B) in the case of inpatient tuberculosis hospital services, the services were required to be given on an inpatient basis by or under the supervision of a physician for the treatment of tuberculosis, and the treatment can be reasonably expected to improve the condition or render it noncommunicable;

(C) in the case of post-hospital extended care services, the services were required to be given on an inpatient basis because the individual needed skilled nursing care on a continuing basis for a condition for which he was hospitalized prior to transfer to the extended care facility, or which arose while receiving such care for such a condition;

(D) in the case of post-hospital home health services, the services were required because the individual was confined to his home (except when receiving services referred to in section 1861(m)(7)) and needed intermittent skilled nursing care, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would qualify as inpatient services if the institution met certain specified requirements) or post-hospital extended care services, and the services were furnished while the individual was under the care of a physician and under a plan established and reviewed periodically by a physician; or

(E) in the case of outpatient hospital diagnostic services, the services were required for diagnostic study.

Under the last sentence of section 1814(a), to the extent provided by regulations, the certification and recertification requirements of paragraph (2) would be deemed satisfied where a physician makes the certification or recertification at a date later than the day it was required under paragraph (2), if it is accompanied by such medical or other evidence as may be required by regulations.

Paragraph (3) of section 1814(a) provides that, in the case of inpatient tuberculosis hospital services, payment may be made only if the services are those which the records of the hospital indicate were furnished during periods when the individual was receiving treatment which could reasonably be expected to improve his condition or render it noncommunicable.

Paragraph (4) of section 1814(a) provides that payment may not be made for inpatient hospital services furnished an individual after the 20th day of a continuous stay or for post-hospital extended care services furnished continuously after a period of time prescribed in regulations if the Secretary, before such individual's admission to the hospital or extended care facility, has rendered an adverse decision under section 1866(d) after a finding that the hospital or extended

care facility is not making the necessary utilization reviews of long-stay cases.

Paragraph (5) of section 1814(a) provides that payment may not be made for inpatient hospital services or post-hospital extended care services furnished an individual during a continuous period after a finding (as described in section 1861(k)(4)) by the physician members of the appropriate utilization review committee that further inpatient hospital services or post-hospital extended care services are medically unnecessary. If such a finding has been made, payment may be made for services furnished through the 3rd day after the day the notice of such finding is received by the hospital or extended care facility.

Reasonable cost of services

Section 1814(b) provides that the amount to be paid any provider for services under part A is the reasonable cost of such services (subject to the deductibles under sec. 1813), as determined under section 1861(v) (discussed below).

No payments to Federal providers of services

Section 1814(c) provides that no payment is to be made to a Federal provider of services, except for emergency services, unless the Secretary determines that the provider is furnishing services to the public generally as a community institution or agency. Payment may not be made to any provider for any item or service which it is required to render at public expense under a law of or contract with the United States.

Payments for emergency hospital services

Section 1814(d) provides that payment may be made for emergency hospital services, in the absence of an agreement of the kind otherwise required between the Secretary and the hospital, to the extent that the Secretary would be required to make payment if the hospital had such an agreement in effect and otherwise meets the conditions of payment. (See section 1861(e) for the definition of a hospital eligible under this provision.) The hospital would have to agree, as a condition of payment under this provision, not to charge the patient for the emergency services.

Payment for inpatient hospital services prior to notification of non-eligibility

Section 1814(e) provides that if a hospital has acted reasonably and in good faith in assuming that an individual was entitled to have payment made for inpatient hospital services under part A, the hospital can receive payment for such services furnished to the individual, even though he is not entitled to have such payment made, prior to notification from the Secretary that the individual is not so entitled. However, this provision would apply only if such payment is precluded solely because the individual has used up his 60 days of entitlement to inpatient hospital services in the spell of illness; and no payment may be made unless the hospital refunds any payment already obtained from the individual or on his behalf with respect to the services involved. In any event, payment may not be made under this provision for services furnished an individual after the 6th elapsed day after the day of his admission to the hospital (not counting

Saturday, Sunday, or a legal holiday as an elapsed day). Payment to the hospital under section 1814(e) would constitute an overpayment to the individual (and could be recovered) under section 1870.

SECTION 1815. PAYMENT TO PROVIDERS OF SERVICES

Section 1815 provides that the Secretary will determine the amounts to be paid to providers of services under part A (such amounts to be paid not less often than monthly) from the Federal Hospital Insurance Trust Fund. The provider must furnish such information as the Secretary may request in order to determine the amounts to be paid to the provider.

SECTION 1816. USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

Section 1816(a) provides that if any group or association of providers of services wishes to have payments under part A made through a national, State, or other public or private agency or organization and nominates an agency or organization for this purpose, the Secretary may enter into an agreement with the agency or organization providing for the determination (subject to such review by the Secretary as may be provided for in the agreement) of the amounts to be paid under part A to such providers, and for the payment to such providers of the amounts so determined. The agreement could also include provision for the agency or organization to do all or any part of the following: (1) provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records and otherwise to qualify as participants in the program; and (2) serve as a center for communications between the providers covered under the agreement and the Secretary, make such audits of the records of such providers as may be necessary to assure proper payment, and perform such other functions as are necessary to carry out section 6181(a).

Section 1816(b) provides that the Secretary is not to enter into an agreement with an agency or organization under section 1816(a) unless he finds that (1) to do so is consistent with effective and efficient administration, (2) the agency or organization is willing and able to assist the providers in the application of safeguards against unnecessary utilization of services (and the agreement provides for such assistance), and (3) the agency or organization agrees to furnish to the Secretary such information acquired by it in carrying out its agreement as the Secretary may find necessary to perform his functions under part A.

Section 1816(c) provides that an agreement with an agency or organization under section 1816(a) may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the agency or organization for making payments to providers of services. Such an agreement will also provide for payment to the agency or organization of the necessary and proper costs of carrying out its functions performed or to be performed under the terms of the agreement.

Section 1816(d) provides that if the nomination of an agency or organization is made by a group or association of providers of services, it will not be binding on members of such group or association which

notify the Secretary of their election to that effect. Any provider may, upon notice, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination (and any provider which has not made a nomination) may elect to receive payments either directly from the Secretary or from any agency or organization which has entered into an agreement with the Secretary under section 1816(a) if the Secretary and such agency or organization agree to it.

Section 1816(e) provides that an agreement with the Secretary under section 1816(a) may be terminated by the agency or organization at such time and upon such notice as may be provided in regulations. An agreement may also be terminated by the Secretary at such time and upon such notice as may be provided in regulations, but only if he finds (after reasonable notice and opportunity for hearing) that the agency or organization has failed substantially to carry out the agreement or that the continuation of the agreement is disadvantageous or is inconsistent with the efficient administration of part A.

Section 1816(f) provides that an agreement with any agency or organization under section 1816(a) may require any of its officers or employees who are participating in carrying out the agreement to give surety bond to the United States in such amount as the Secretary may deem appropriate.

Paragraph (1) of section 1816(g) provides that no individual designated pursuant to such an agreement as a certifying officer will, in the absence of gross negligence or intent to defraud the United States, be liable for any payments incorrectly certified by him.

Paragraph (2) of section 1816(g) provides a similar immunity for disbursing officers who make an incorrect payment based upon a voucher signed by a certifying officer designated as provided in paragraph (1).

SECTION 1817. FEDERAL HOSPITAL INSURANCE TRUST FUND

Section 1817(a) creates the Federal Hospital Insurance Trust Fund, which will consist of amounts deposited in or appropriated to it as provided in part A. For the fiscal year ending June 30, 1966, and for each fiscal year thereafter, there are appropriated to the Trust Fund amounts equal to (1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 on wages reported to the Secretary of the Treasury after December 31, 1965, and (2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 on self-employment income reported to the Secretary of the Treasury on tax returns. These wages and self-employment income are to be certified by the Secretary of Health, Education, and Welfare on the basis of records established and maintained by him in accordance with such reports and returns. The amounts to be appropriated, which will be determined by the Secretary of the Treasury on the basis of estimates of the taxes, are to be transferred from time to time from the general fund of the Treasury to the Trust Fund, with adjustments being made for prior estimates which were greater or lesser than the taxes.

Section 1817(b) creates the Board of Trustees of the Trust Fund, to be composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Board of

Trustees will meet at least once each calendar year. The Secretary of the Treasury will be the Managing Trustee of the Board of Trustees, and the Commissioner of Social Security will serve as the Secretary of the Board. The Board of Trustees will (1) hold the Trust Fund; (2) report to the Congress by March 1 of each year on the operation and status of the Trust Fund for the preceding fiscal year and on its expected operation and status for the current fiscal year and the next 2 fiscal years; (3) report immediately to the Congress whenever the Board believes that the amount of the Trust Fund is unduly small; and (4) review the general policies followed in managing the Trust Fund and recommend changes in those policies, including necessary changes in the provisions of the law which govern the way in which the Trust Fund is to be managed. The report on the status and operation of the Trust Fund is to include a statement of the assets of and disbursements from the Fund during the preceding year, an estimate of income and disbursements for the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund, and is to be printed as a House document of the session of the Congress to which the report is made.

Section 1817(c) provides that it is the duty of the Managing Trustee to invest the portion of the Trust Fund which, in his judgment, is not required to meet current withdrawals. These investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. They may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. The Second Liberty Bond Act is extended to authorize the issuance at par, for purchase by the Trust Fund, of public-debt obligations having maturities fixed with due regard for the needs of the Trust Fund and bearing interest at a rate equal to the average market yield on all marketable interest-bearing obligations of the United States which are a part of the public debt at the end of the calendar month preceding the date of issue and which are not due or callable until after 4 years from such month. If the average market yield is not a multiple of one-eighth of one percent, the rate of interest will be the multiple of one-eighth of one percent nearest the market yield. Other interest-bearing obligations of the United States or obligations guaranteed by the United States may be purchased by the Managing Trustee only when he determines it is in the public interest.

Section 1817(d) provides that any obligations acquired by the Trust Fund may be sold by the Managing Trustee at the market price, except public-debt obligations issued exclusively to the Trust Fund, which may be redeemed at par plus accrued interest.

Section 1817(e) provides that the interest on and proceeds from the sale of any obligations held in the Trust Fund will be credited to and form a part of the Fund.

Paragraph (1) of section 1817(f) directs the Managing Trustee to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) of the Internal Revenue Code of 1954 which are subject to refund under section 6413(c) of the Code with respect to wages paid after December 31, 1965. Such taxes are to be determined on the basis of the records of wages established and maintained by the Secretary of Health,

Education, and Welfare in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Code, and the Secretary will furnish the Managing Trustee such information as may be required for this purpose. The payments are to be covered into the Treasury as repayments to the account for refunding internal revenue collections.

Paragraph (2) of section 1817(f) provides that repayments under paragraph (1) will not be available for expenditures but will be carried to the surplus fund of the Treasury.

Section 1817(g) provides for the transfer at least once each fiscal year to the Trust Fund, from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, of amounts equal to the amounts certified by the Secretary as overpayments under section 1870(b). It also provides for the transfer at least once each fiscal year to the Trust Fund from the Railroad Retirement Account of amounts equal to the amounts certified by the Secretary as overpayments to the Railroad Retirement Board under section 1870(b). These amounts represent the overpayments which are to be collected by reducing the cash monthly benefits payable to (or on the wage record of) the individual involved under title II of the Social Security Act or under the Railroad Retirement Act of 1937.

Section 1817(h) provides that the Managing Trustee will also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the benefits provided by part A and the administrative expenses in accordance with section 201(g)(1) of the Act.

PART B—SUPPLEMENTARY HEALTH INSURANCE BENEFITS FOR THE AGED

SECTION 1831. ESTABLISHMENT OF SUPPLEMENTARY HEALTH INSURANCE PROGRAM FOR THE AGED

Section 1831 establishes a voluntary health insurance program for individuals aged 65 or over to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

SECTION 1832. SCOPE OF BENEFITS

Section 1832(a) provides that the benefits made available to an individual under the insurance program established by part B consist of—

(1) entitlement to have payment made to him or on his behalf for physicians' services, and for medical and other health services not furnished by (or under arrangements with) a provider of services (such as a hospital or home health agency); and

(2) entitlement to have payment made on his behalf for (A) inpatient psychiatric hospital services for up to 60 days during a spell of illness; (B) home health services for up to 100 visits during a calendar year (without regard to whether or not the individual has been in a hospital); and (C) medical and other health services furnished by a provider of services (or by others under arrangements with them).