Paragraph (2) of section 1834(a) provides that if an individual is an inpatient of a psychiatric hospital on the first day on which he is entitled to benefits under part B (which could be as early as July 1, 1966), the days on which he was an inpatient of such a hospital in the 60-day period immediately before such first day are to be included in determining the 60-day limit under paragraph (1) but not in determining the 180-day limit under such paragraph. For example, if an individual became covered under part B on July 1, 1966, and had been in a psychiatric hospital since June 1, 1966, he would be covered for only his first 30 days as an inpatient of a psychiatric hospital in his spell of illness beginning July 1. However, the 30 days in June would not be counted toward his lifetime maximum of 180 days.

Section 1834(b) provides that payment may not be made under part B for home health services furnished an individual during any calendar year after such services have been furnished to him for 100 visits during the year. The charging of visits in connection with the provision of covered home health items and services for this purpose is to be determined in accordance with regulations.

Section 1834(c) provides that inpatient psychiatric hospital services and home health services will be taken into account for purposes of the limits on duration of coverage prescribed in section 1834 (a)(1) and (b) only if payment under part B is made or would be made if the services had been furnished within such limits and the request and certification requirements described in section 1835(a) had been met for such services.

SECTION 1835. PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

Section 1835(a) provides that payment for the services described in section 1832(a)(2) (inpatient psychiatric hospital services, home health services, and medical and other health services) may be made only to providers of services which have an agreement with the Secretary under section 1866 and only if the requirements of section 1835(a) with respect to requests and certifications are satisfied.

Paragraph (1) of section 1835(a) requires that a written request (signed by the individual who received the services or by another person when it is impracticable for him to do so) be filed for such payment under regulations issued by the Secretary.

Paragraph (2) of section 1835(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 psychiatric hospital services received during a continuous period) that—

(A) in the case of inpatient psychiatric hospital services, the services were required to be given on an inpatient basis for psychiatric treatment by or under the supervision of a physician and such treatment could reasonably be expected to improve the condition, or inpatient diagnostic study was medically required;

(B) in the case of home health services, the services were required because the individual was confined to his home (except when receiving services referred to in sec. 1861(m)(7)) and needed intermittent skilled nursing care, or physical or speech therapy, and the services were furnished while the individual is

or was under the care of a physician and under a plan established and reviewed periodically by a physician; or

(C) in the case of medical and other health services, the services were medically required.

Under the last sentence of section 1835(a), to the extent provided by regulations, the certification and recertification requirements of paragraph (2) will 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 1835(a) provides that, in the case of inpatient psychiatric 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 intensive treatment services, services necessary for a diagnostic study, or equivalent services.

Paragraph (4) of section 1835(a) provides that payment may not be made for inpatient psychiatric hospital services furnished an individual after the 20th day of a continuous stay if the Secretary, before such individual's admission to the hospital, has rendered an adverse decision under section 1866(d) after finding that the hospital is not making utilization reviews of long-stay cases.

Paragraph (5) of section 1835(a) provides that payment may not be made for inpatient psychiatric hospital 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 psychiatric hospital services are medically unnecessary. If such a finding has been made, payment may be made for services furnished through the 3d day after the day the notice of such finding is received by the hospital.

Section 1835(b) provides that no payment is to be made under part B to a Federal provider of services unless the Secretary determines that the provider is furnishing services to the public generally as a community institution or agency (St. Elizabeths Hospital in Washington, D.C., for example). 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.

Section 1835(c) provides that if a psychiatric hospital has acted reasonably and in good faith in assuming that an individual was entitled to benefits under part B, the hospital can receive payment for inpatient hospital 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 in the spell of illness; and no payment may be made unless the hospital refunds any payment already received 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 1835(c) would constitute an overpayment to the individual (and could be recovered) under section 1870.

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SECTION 1836. ELIGIBLE INDIVIDUALS

Section 1836 provides that every individual who has attained the age of 65 and is a resident of the United States, and is either a citizen or an alien lawfully admitted for permanent residence, is eligible to enroll in the insurance program established by part B. (However, sec. 104(b)(2) of the bill provides that a person convicted of certain offenses related to the national security may not enroll under pt. B.)

SECTION 1837. ENROLLMENT PERIODS

Section 1837(a) provides that an individual may enroll in the insurance program established by part B only in such manner and form as may be prescribed in regulations, and only during an enrollment period described in section 1837.

Paragraph (1) of section 1837(b) provides that no individual may enroll for the first time under part B more than 3 years after the close of the first enrollment period during which he could have enrolled.

Paragraph (2) of section 1837(b) provides that an individual whose enrollment under part B has terminated may not enroll for a second time unless he does so in a general enrollment period (as provided in section 1837(e)) which begins within 3 years after the effective date of such termination. No individual may enroll under part B more than twice.

Section 1837(c) provides that the initial general enrollment period is to begin on the first day of the second month which begins after the date of enactment of the bill and is to end on March 31, 1966. This initial general enrollment period is open to individuals who meet the eligibility requirements of section 1836 before January 1, 1966.

Section 1837(d) provides that the initial enrollment period for an individual who first meets the eligibility requirements of section 1836 on or after January 1, 1966, is to begin on the first day of the third month before the month in which he first meets the eligibility requirements and is to end 7 months later. For example, if a resident citizen becomes 65 in April 1967, his enrollment period begins with January 1, 1967, and ends with July 31, 1967.

Section 1837(e) provides that there is to be a general enrollment period from October 1 to December 31 of each odd-numbered year beginning with 1967.

SECTION 1838. COVERAGE PERIOD

Section 1838(a) provides that an individual's coverage period (the period during which he is entitled to benefits under the insurance program established by part B and the period for which premiums are due) will begin on July 1, 1966, or on the first day of the third month following the month in which he enrolls in his initial enrollment period pursuant to section 1837(d), or on the July 1 following the month in which he enrolls in a general enrollment period pursuant to section 1837(e), whichever is the latest.

Section 1838(b) provides that an individual's coverage period will continue until his enrollment has been terminated (1) by the filing of notice, during a general enrollment period, that he no longer wishes to participate in the program, or (2) for nonpayment of premiums. The termination of a coverage period by the filing of such a notice will take

effect at the close of December 31 of the year in which the notice is filed; a termination for nonpayment of premiums will take effect on a date determined under regulations, which may provide a grace period of up to 90 days during which overdue premiums may be paid and the coverage period continued.

Section 1838(c) provides that payment may be made under part B only for expenses incurred by an individual during his coverage period.

SECTION 1839. AMOUNTS OF PREMIUMS

Section 1839(a) provides that the monthly premium for each individual enrolled under part B for each month before 1968 is to be $3.

Paragraph (1) of section 1839(b) provides that for each month after 1967 the amount of the monthly premium of each individual enrolled under part B will be determined under paragraph (2).

Paragraph (2) of section 1839(b) provides that the Secretary, between July 1 and October 1 of 1967 and of each odd-numbered year thereafter, will determine and promulgate the dollar amount which is to be applicable for premiums for months occurring in the 2 succeeding calendar years. Such dollar amount will be the amount the Secretary estimates to be necessary so that the aggregate premiums for such 2 succeeding calendar years will equal one-half of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Health Insurance Benefits Trust Fund for the 2 succeeding years. In estimating aggregate benefits payable for any period, the Secretary will include an appropriate amount for a contingency margin.

Section 1839(c) provides that in the case of an individual whose coverage period begins pursuant to an enrollment after his initial enrollment period (as determined by sec. 1837 (c) or (d)), the monthly premium determined under section 1839(b) will be increased by 10 percent of the monthly premium so determined for each full 12 months in which he could have been but was not enrolled. For these purposes there will be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time.

Section 1839(d) provides that if any monthly premium determined under the preceding provisions of section 1839 is not a multiple of 10 cents, it is to be rounded to the nearest multiple of 10 cents.

SECTION 1840. PAYMENT OF PREMIUMS

Paragraph (1) of section 1840(a) provides that the monthly premium of an individual who is entitled to monthly social security benefits under section 202 is to be collected (except as provided in subsec. (d)) by deducting the premium from the amount of such benefits. The deductions called for under this paragraph will be made in accordance with regulations of the Secretary.

Paragraph (2) of section 1840(a) provides that the Secretary of the Treasury is to transfer periodically from the Federal Old-Age and Survivors Insurance Trust Fund, and from the Federal Disability

Insurance Trust Fund (for example, for premiums deducted in the case of a woman aged 65 or over entitled to benefits as the wife of a disability beneficiary under age 65), to the Federal Supplementary Health Insurance Benefits Trust Fund, the total amount deducted under paragraph (1). Such transfers are to be made on the basis of certifications by the Secretary of Health, Education, and Welfare and will be adjusted to the extent that prior transfers were too great or too small.

Paragraph (1) of section 1840(b) provides that the monthly premium of an individual who is entitled to receive an annuity or pension for a month under the Railroad Retirement Act of 1937 is to be collected (except as provided in subsec. (d)) by deducting the premium from such annuity or pension. The deductions called for under this paragraph will be made in accordance with regulations of the Secretary (prescribed after consultation with the Railroad Retirement Board).

Paragraph (2) of section 1840(b) provides that the Secretary of the Treasury is to transfer periodically from the Railroad Retirement Account to the Federal Supplementary Health Insurance Benefits Trust Fund the total amount deducted under paragraph (1). Such transfers are to be made on the basis of certifications by the Railroad Retirement Board and will be adjusted to the extent that prior transfers were too great or too small.

Section 1840(c) provides that if an individual is entitled both to monthly social security benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under part B, or if he becomes simultaneously entitled both to such benefits and such annuity or pension after he enrolls, section 1840(a) will apply (i.e., the deduction for premiums will be made from his social security benefits); except that in the latter case, if the first month for which he was entitled to social security benefits was later than the first month for which he was entitled to a railroad retirement annuity or pension, then section 1840(b) will apply (i.e., the deduction for premiums will continue to be made from such annuity or pension).

Section 1840(d) provides that if an individual estimates that the amount which will be available for deduction under section 1840 (a) or (b) for any premium payment period will be less than the amount of the monthly premiums during that period, so that his premiums could not be deducted from his benefits on a month-to-month basis, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires. For example, if an individual has earnings such that under the retirement test no cash social security benefits are payable to him during a year, he can pay his premiums over the course of the year (in accordance with regulations) rather than having them collected from future benefits.

Section 1840(e) provides that for an individual who participates in the insurance program established by part B but to whom neither section 1840(a) nor 1840(b) applies (i.e., who is neither a social security nor a railroad retirement beneficiary), the premiums are to be paid to the Secretary at such times and in such manner as may be prescribed by regulations.

Section 1840(f) provides that amounts paid to the Secretary under section 1840 (d) or (e) are to be deposited in the Treasury to the credit of the Federal Supplementary Health Insurance Benefits Trust Fund.

Section 1840(g) provides that the premiums for an individual enrolled under part B will be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage period ends.

SECTION 1841. FEDERAL SUPPLEMENTARY HEALTH INSURANCE BENEFITS TRUST FUND

Section 1841(a) creates the Federal Supplementary Health Insurance Benefits Trust Fund, which will consist of amounts deposited in or appropriated to it as provided in part B.

Section 1841(b) creates the Board of Trustees of the Trust Fund, which is to meet at least once each calendar year and will be composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. 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 during 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 therein, 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 during 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 1841(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 1 percent, the rate of interest will be the multiple of one-eighth of 1 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 1841(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 1841(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.

Section 1841(f) 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 of Health, Education, and Welfare 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 1841(g) 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 to make the payments provided for by part B and the payments for administrative expenses in accordance with section 201(g)(1) of the Act.

SECTION 1842. USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

Section 1842(a) provides that in order to carry out the administration of the voluntary health insurance program established by part B, the Secretary to the extent possible will enter into contracts with carriers which will undertake to perform the functions specified in section 1842(a) or, to the extent provided in the contracts, to secure performance of such functions by other organizations.

Paragraph (1) of section 1842(a) provides that the carriers under contract (or such other organizations) will (A) make determinations of the rates and amounts of payments required pursuant to part B to be made to providers of services and other persons on a reasonable cost or reasonable charge basis, whichever applies; (B) receive, disburse, and account for funds in making such payments; and (C) make audits of the records of providers of services necessary to assure that proper payments are made to them under part B.

Paragraph (2) of section 1842(a) provides that the carriers will determine compliance with the requirements of section 1861(k) as to utilization review, and assist providers and other persons who furnish services for which payment may be made under part B in the development of procedures relating to utilization practices, make studies of the effectiveness of utilization procedures, assist in the application of safeguards against unnecessary utilization of services furnished by providers and other persons to individuals entitled to benefits under part B, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2)) to make reviews of utilization.

Paragraph (3) of section 1842(a) provides that the carriers will serve as a channel of communication of information relating to the administration of the voluntary health insurance program under part B.

Paragraph (4) of section 1842(a) provides that the carriers will assist in discharging other necessary administrative duties, as may be provided in the contract.

Paragraph (1) of section 1842(b) provides that contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

Paragraph (2) of section 1842(b) provides that the Secretary is not to enter into a contract with a carrier unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements relating to financial responsibility, legal authority, and other matters as he finds pertinent.

Paragraph (3) of section 1842(b) provides that each contract must provide that the carrier will—

(A) take necessary action to assure that, where payment under part B for a service is on a cost basis, the cost is reasonable cost (as determined under sec. 1861(v));

(B) take necessary action to assure that, where payment under part B for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will be made on the basis of a receipted bill, or on the basis of an assignment under which the reasonable charge is the full charge for the service;

(C) establish and maintain procedures under which an individual enrolled under part B will be entitled to a fair hearing by the carrier when request for payment is denied or is not acted upon with reasonable promptness or when the amount of payment is in controversy;

(D) furnish to the Secretary such timely information and reports as may be necessary for the Secretary to perform his functions under part B; and

(E) maintain and afford access to whatever records the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D), and otherwise to carry out the purposes of part B.

Each contract shall also contain such other terms and conditions consistent with section 1842 as the Secretary may find necessary or appropriate.

Paragraph (4) of section 1842(b) provides that each contract must be for the term of at least 1 year, and may be made automatically renewable unless either party provides notice of intent to terminate the contract at the end of its current term. However, the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying it out in a manner inconsistent with the efficient and effective administration of the insurance program established by part B.

Section 1842(c) provides that each contract is to provide for advances of funds to the carrier for the making of payments by it under part B, and for payment of the necessary and proper administrative costs of the carrier.

Section 1842(d) provides that any contract may require a carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

Paragraph (1) of section 1842(e) provides that no individual designated pursuant to a contract 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 1842(e) 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 1842(f) provides that, for purposes of part B, the term "carrier" means (1) with respect to providers of services and other persons, a voluntary association, corporation, or partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and (2) with respect to providers of services only, any agency or organization (not described in (1)) with which an agreement is in effect under section 1816.

SECTION 1843. STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS

Section 1843(a) provides that the Secretary, at the request of a State made before July 1, 1967, will enter into an agreement with such State to provide coverage under part B for all eligible individuals who are in a coverage group elected by the State from the two groups described in section 1843(b). (For definition of "eligible individual" see section 1836, discussed above.)

Section 1843(b) provides that the agreement entered into with any State under section 1843(a) may be applicable to either of the following groups: (1) aged recipients of money payments under a plan of the State approved under title I or XVI, or (2) aged recipients of money payments under all of the plans of the State approved under titles I, IV, X, XIV, and XVI. However, neither group may include any individual entitled to monthly OASDI benefits or entitled to receive an annuity or pension under the Railroad Retirement Act of 1937.

Section 1843(c) provides that, for purposes of section 1843, coverage under the agreement may be provided only for an individual who is an eligible individual (as described above) on the date the agreement is entered into or who becomes an eligible individual in the period between the date of the agreement and July 1, 1967. He will be

treated as a money payment recipient if he receives a money payment for the month in which the agreement is entered into or any month between such month and July 1967.

Section 1843(d) provides that in the case of any individual enrolled pursuant to an agreement under section 1843—

(1) the monthly premium to be paid by the State is to be determined under section 1839 (without any increase under subsec. (c) thereof);

(2) his coverage period will begin either on July 1, 1966, on the first day of the third month following the month in which the State agreement is entered into, on the first day of the first month in which he is both an eligible individual and a member of the coverage group specified in the agreement, or on a date (not later than July 1, 1967) specified in the agreement, whichever is the latest; and

(3) his coverage period will end on either the last day of the month in which he is determined by the State to have become ineligible for the money payments specified in the agreement, or the last day of the month before the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1937.

Section 1843(e) provides that any individual whose coverage period attributable to the State agreement is terminated (as described in sec. 1843(d)(3)) will be deemed for purposes of part B (including the continuation of his coverage period) to have enrolled under section 1837 in the initial general enrollment period (ending March 31, 1966) provided by section 1837(c).

Section 1843(f) provides that with respect to individuals receiving money payments under a State plan approved under title I, IV, X, XIV, or XVI, if the agreement so provides, the term "carrier" as defined in section 1842(f) also includes the State agency specified in the agreement which administers or supervises the administration of the State plan approved under title I, XVI, or XIX. Thus, a State agency which meets the definition of "carrier" under section 1843(f) could be considered a carrier with respect to all individuals receiving the specified money payments (including those who are not eligible to be in the coverage group as defined in sec. 1843(b) because they are entitled to monthly social security benefits or a pension or annuity under the railroad retirement system). The agreement with the State will also contain provisions to facilitate the financial transactions of the State and the carrier relating to deductions and coinsurance, in the interest of economy and efficiency of operation, with respect to individuals receiving money payments under the State's plans approved under titles I, IV, X, XIV, and XVI.

SECTION 1844. APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

Section 1844(a) authorizes the appropriation from time to time of a Government contribution, equal to the total premiums payable by individuals who have enrolled under part B, from the Treasury to the Federal Supplementary Health Insurance Benefits Trust Fund.

Section 1844(b) provides that in order to assure prompt payment of benefits and administrative expenses under part B during the early

months of the program, and to provide a contingency reserve, there is also authorized to be appropriated during the fiscal year ending June 30, 1966, for repayable advances (without interest) to the Trust Fund, an amount (to remain available through the next fiscal year) equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by part B if they had theretofore enrolled.

PART C—MISCELLANEOUS PROVISIONS

SECTION 1861. DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

Section 1861 defines, for purposes of both part A and part B, the terms used in the new title XVIII.

Spell of illness

Section 1861(a) defines the term "spell of illness" to mean a period of consecutive days (1) beginning with the first day (not included in a previous spell) on which the individual is furnished inpatient hospital or extended care services and which occurs in a month for which he is entitled to benefits under part A or B, and (2) ending with the close of the first period of 60 consecutive days thereafter throughout which he is neither an inpatient of a hospital nor an inpatient of an extended care facility. (For special definitions of "hospital" and "extended care facility" for purposes of sec. 1861(a)(2), see discussion of secs. 1861(e) and 1861(j) below.)

Inpatient hospital services

Section 1861(b) defines the term "inpatient hospital services" to mean the following items and services furnished to an inpatient of a hospital (and furnished by the hospital, except as provided in item (3)): (1) bed and board; (2) such nursing services, use of hospital facilities, medical social services, and drugs, biologicals, supplies, appliances, and equipment for use in the hospital as are ordinarily furnished by such hospital for the care and treatment of inpatients; (3) other diagnostic or therapeutic items or services ordinarily furnished by the hospital or by others under arrangements made by the hospital. Excluded from the term "inpatient hospital services" are the services of a private-duty nurse or attendant and medical or surgical services provided by a physician, resident, or intern; except that services of a resident-in-training or intern provided under a teaching program approved by the American Medical Association or the American Osteopathic Association are included in the term.

Inpatient psychiatric hospital services

Section 1861(c) defines the term "inpatient psychiatric hospital services" to mean inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Inpatient tuberculosis hospital services

Section 1861(d) defines the term "inpatient tuberculosis hospital services" to mean inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Hospital

Section 1861(e) defines the term "hospital" to mean in general an institution which (1) is primarily engaged in providing diagnostic and therapeutic services for medical diagnosis, treatment, and care, or rehabilitation services for injured, disabled, or sick persons; (2) maintains clinical records on all patients; (3) has bylaws in effect with respect to its staff of physicians; (4) requires that every patient be under the care of a physician; (5) provides 24-hour nursing service rendered by or under the supervision of a registered nurse; (6) has in effect a hospital utilization review plan satisfying section 1861(k); (7) is licensed (or meets standards of licensing) pursuant to State or local law; and (8) meets such other requirements as the Secretary finds necessary in the interest of health and safety (except that these requirements may not be higher than the comparable requirements prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals).

For the specific purpose of determining how long an individual is out of a hospital in order to establish when a spell of illness ends, an institution satisfying item (1) of the definition is a "hospital." In determining whether emergency hospital services are covered under section 1814(d), and for purposes of describing the institution from which an individual must be transferred in order to be eligible for post-hospital extended care or post-hospital home health services, an institution satisfying items (1), (2), (3), (4), (5), and (7) of the definition is a "hospital." The term "hospital" does not (except for purposes of determining when a spell of illness ends) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis, except that for purposes of part A the term includes a tuberculosis hospital as defined in section 1861(g) and for purposes of part B the term includes a psychiatric hospital as defined in section 1861(f). The term also includes a Christian Science sanatorium operated or listed and certified by the First Church of Christ Scientist, Boston, Mass., but payment may be made with respect to services provided by or in such a sanatorium only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of those otherwise applicable) as may be provided in regulations.

Psychiatric hospital

Section 1861(f) defines the term "psychiatric hospital" to mean an institution which (1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons; (2) satisfies the requirements prescribed for hospitals under items (3) through (8) of section 1861(e); (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals enrolled under the insurance program established by part B; (4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and (5) is accredited by the Joint Commission on Accreditation of Hospitals. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will

be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.

Tuberculosis hospital

Section 1861(g) defines the term "tuberculosis hospital" to mean an institution which (1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis; (2) satisfies the requirements prescribed for hospitals under items (3) through (8) of section 1861(e); (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered under the insurance program established by part A; (4) meets such staffing requirements as the Secretary may find necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and (5) is accredited by the Joint Commission on Accreditation of Hospitals. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.

Extended care services

Section 1861(h) defines the term "extended care services" to mean the following items and services furnished to an inpatient of an extended care facility (and furnished by such facility except as provided in items (3) and (6)): (1) nursing care furnished by or under the supervision of a registered nurse; (2) bed and board; (3) physical, occupational, or speech therapy furnished by the facility or others under arrangements with them; (4) medical social services; (5) such drugs, biologicals, supplies, appliances, and equipment as are ordinarily furnished by the facility for care and treatment of inpatients; (6) medical services of interns and residents-in-training under an approved teaching program of a hospital with which such facility has in effect a transfer agreement and certain other services provided by such a hospital; and (7) such other health services as are generally provided by extended care facilities. Any service which would not be covered if furnished to an inpatient of a hospital is excluded.

Post-hospital extended care services

Section 1861(i) defines the term "post-hospital extended care services" to mean extended care services (as defined in sec. 1861(h)) furnished an individual after transfer from a hospital of which he was an inpatient for not less than 3 consecutive days before his discharge. Items and services will be deemed to have been furnished to an individual after transfer from a hospital, and he will be deemed to have been an inpatient of the hospital immediately before transfer, if he is admitted to the extended care facility within 14 days after discharge from such hospital. An individual will be deemed not to have been discharged from an extended care facility if he is readmitted to such facility within 14 days after discharge therefrom.

Extended care facility

Section 1861(j) defines the term "extended care facility" to mean an institution (or a distinct part thereof) which has a transfer agreement with one or more participating hospitals (as described in sec. 1861(l)) and which (1) is primarily engaged in providing to inpatients skilled nursing care and related services, or rehabilitation services; (2) has policies which are developed with the advice of and periodically reviewed by a professional group (including at least one physician and at least one registered nurse) to govern the services it provides; (3) has a physician, registered nurse, or medical staff responsible for the execution of such policies; (4) requires that the health care of each patient be under the supervision of a physician and provides for having a physician available to furnish necessary emergency medical care; (5) maintains clinical records on all patients; (6) provides 24-hour nursing services sufficient to meet needs in accordance with facility policies and has at least one registered professional nurse employed full time; (7) provides appropriate methods for dispensing and administering drugs and biologicals; (8) has in effect a utilization review plan satisfying section 1861(k); (9) is licensed (or meets the standards for licensing) pursuant to State or local law; and (10) meets such other conditions relating to health and safety or physical facilities as the Secretary may find necessary. The term "extended care facility" does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For the specific purpose of determining when a spell of illness ends (under sec. 1861(a)(2)) the term includes any institution which satisfies item (1).

Utilization review

Section 1861(k) provides that a utilization review plan of a hospital or extended care facility will be considered sufficient if it is applicable to services furnished to individuals entitled to benefits under part A or part B and if it provides (1) for the review, on a sample or other basis, of admissions, duration of stays, and professional services from the standpoint of medical necessity and for the purpose of promoting the most efficient use of available health facilities and services; (2) for such review to be made by a staff committee of the institution which includes two or more physicians, or by a similarly composed group outside the institution which is established either by the local medical society and some or all of the hospitals and extended care facilities in the locality or in some other manner which may be approved by the Secretary; (3) for such review (in each case of a continuous stay of extended duration in a hospital or extended care facility) as of such days of such stay (which may be different for different classes of cases) as may be specified in regulations, with such review being made as promptly as possible after each day specified in the regulations but no later than 1 week following that day; and (4) for prompt notification to the institution, the individual, and his physician of any finding (which shall be made only after opportunity for consultation has been provided the physician) that further stay in the institution is not medically necessary. The utilization review plan must provide for review by a group outside the institution where, because of its small size (or, in the case of an extended care facility, because of lack of an organized medical staff), or for such other reasons

as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee.

Agreements for transfer between extended care facilities and hospitals

Section 1861(l) provides that a hospital and an extended care facility will be considered to have a transfer agreement if a written agreement between them (or a written undertaking by the person or body controlling them, in the case of institutions under common control) provides reasonable assurance that (1) there will be timely transfer of patients between the institutions whenever it is determined medically appropriate by the attending physician; and (2) there will be timely transfer between the institutions of medical and other information needed for patients' care or for determining whether patients can be adequately cared for in some other way. Any extended care facility which does not have a transfer agreement in effect, but which is found by a State agency (with which an agreement under sec. 1864 is in effect) or by the Secretary (if there is no such agreement) to have attempted in good faith to enter into such an agreement with a hospital close enough to the facility to make transfer of patients and information between them feasible, will be considered to have a transfer agreement in effect if the agency (or the Secretary) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for benefits under title XVIII.

Home health services

Section 1861(m) defines the term "home health services" to mean the following items and services furnished to an individual who is under the care of a physician, on a visiting basis in his residence (except as provided in item (7)), by a home health agency (or by others under arrangements with such agency) under a plan established and periodically reviewed by a physician: (1) part-time or intermittent nursing care provided by or under the supervision of a registered nurse; (2) physical, occupational, or speech therapy; (3) medical social services under the direction of a physician; (4) to the extent permitted in regulations, part-time or intermittent home health aide services; (5) medical supplies (other than drugs and biologicals) and the use of medical appliances; (6) medical services of interns and residents-in-training under an approved teaching program of a hospital with which the agency is affiliated; and (7) any of the foregoing items and services which (A) are provided on an outpatient basis under arrangements made by the home health agency at a hospital or extended care facility, or at a rehabilitation center meeting such standards as may be prescribed in regulations, and (B) involve the use of equipment of such nature that the items and services cannot readily be made available to the individual in his place of residence, or are furnished at such facility while he is there to receive any item or service involving the use of such equipment (but excluding transportation of the individual in connection with such items or services). Any item or service which would not be covered if furnished to an inpatient of a hospital is excluded.

Post-hospital home health services

Section 1861(n) defines the term "post-hospital home health services" to mean home health services (as defined in sec. 1861(m)) which

(1) are furnished an individual within 1 year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within 1 year after his most recent discharge from an extended care facility of which he was an inpatient entitled to benefits under part A, and (2) are covered by a plan (described above) established within 14 days after his discharge from the hospital or extended care facility.

Home health agency

Section 1861(o) defines the term "home health agency" to mean a public agency or private organization (or a part of such agency or organization) which (1) primarily provides skilled nursing or other therapeutic services; (2) has policies established by a professional group (including at least one physician and at least one registered nurse) to govern services, and provides for supervision of such services by a physician or a registered nurse; (3) maintains clinical records on all patients; (4) is licensed (or meets standards for licensing) pursuant to State or local law; and (5) meets other conditions found by the Secretary to be necessary for health and safety. The term does not include a private organization which is not a nonprofit organization exempt from Federal income taxation unless it is licensed pursuant to State law and meets such additional standards and requirements as may be prescribed by regulations. For purposes of part A, the term does not include any agency or organization which is primarily for the care and treatment of mental diseases.

Outpatient hospital diagnostic services

Section 1861(p) defines the term "outpatient hospital diagnostic services" to mean diagnostic services which are ordinarily furnished to outpatients for purposes of diagnostic study by the hospital or by others under arrangements made by the hospital, and which are furnished in facilities supervised by the hospital or its organized medical staff. The term excludes any services which would not be covered if furnished to an inpatient of a hospital.

Physicians' services

Section 1861(q) defines the term "physicians' services" to mean professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not services provided by an intern or resident-in-training under a teaching program approved as described in sec. 1861(b)).

Physician

Section 1861(r) defines the term "physician" to mean an individual legally authorized by a State to practice medicine and surgery (including osteopathy).

Medical and other health services

Section 1861(s) defines the term "medical and other health services" to mean any of the following items or services (unless such services are otherwise classified as inpatient hospital, extended care, home health, or physicians' services): (1) diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests; (2) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians; (3) surgical

dressings, and splints, casts, and other devices used for reduction of fractures and dislocations; (4) rental of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as the patient's home); (5) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition (but only to the extent provided in regulations); (6) prosthetic devices (other than dental) which replace all or part of an internal body organ (including replacement of such devices); and (7) leg, arm, back, and neck braces, and artificial legs, arms, and eyes (including replacements if required because the patient's physical condition changes).

Drugs and biologicals

Section 1861(t) defines the term "drugs" and the term "biologicals" to mean (except for purposes of the exclusion of drugs and biologicals under home health services) those drugs and biologicals which are included in the United States Pharmacopoeia or the National Formulary, or in 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 them.

Provider of services

Section 1861(u) defines the term "provider of services" to mean a hospital, extended care facility, or home health agency.

Reasonable cost

Paragraph (1) of section 1861(v) provides that the reasonable cost of any services is to be determined under regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies the amount of the payment determined under such paragraph with respect to the services involved will be considered the reasonable cost of such services. In prescribing these regulations the Secretary must consider, among other things, the principles developed and generally applied by national organizations or established prepayment organizations in computing the amount of payment to be made by third parties to providers of services on account of services furnished to individuals by such providers. Such regulations may provide for determination of the cost of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations must take into account both direct and indirect costs of providers in order that the costs with respect to individuals covered by the insurance programs established by title XVIII will not be borne by individuals not so covered and the costs with respect to individuals not covered will not be borne by the insurance programs. The regulations must also provide for making retroactive corrective adjustments where, for any provider of services for any fiscal period, the total reimbursement produced by methods of determining costs proves to be either inadequate or excessive.

Paragraph (2) of section 1861(v) provides that if a patient receives inpatient services in accommodations which are more expensive than semiprivate accommodations, but which are not medically necessary, the amount of payment may not exceed an amount equal to the reasonable cost of such services if furnished in semiprivate accommodations. If a patient receives other items or services which are more expensive than those for which payment can be made, the Secretary will take into account for purposes of payment no more than the reasonable cost of the services that can be paid for.

Paragraph (3) of section 1861(v) provides that if a patient is placed in accommodations less expensive than semiprivate accommodations for a reason the Secretary determines is not consistent with the program's purpose (and not at the patient's request), payment will be limited to the reasonable cost of semiprivate accommodations minus the difference between the customary charges for semiprivate accommodations and the accommodations furnished.

Paragraph (4) of section 1861(v) defines the term "semiprivate accommodations" to mean two-bed, three-bed, or four-bed accommodations.

Arrangements for certain services

Section 1861(w) provides that the term "arrangements" is limited to arrangements under which receipt of payment by a participating provider of services discharges all financial liability for the services.

State and United States

Section 1861(x) provides that the terms "State" and "United States" have the same meaning as when used in title II of the Social Security Act (i.e., the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa).

SECTION 1862. EXCLUSIONS FROM COVERAGE

Section 1862(a) provides that no payment may be made under part A or part B (regardless of any other provision of title XVIII) for any expenses incurred for items or services (1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; (2) for which the individual furnished such items or services has no legal obligation to pay and which no other person (because of such individual's membership in a prepayment plan or for some other reason) has a legal obligation to provide or to pay for; (3) which are paid for directly or indirectly by a governmental entity (other than under the Social Security Act), except in such cases as the Secretary may specify; (4) which are not provided within the United States; (5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part; (6) which constitute personal comfort items; (7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses (including contact lenses), hearing aids or examinations therefor, or immunizations; (8) where such expenses are for orthopedic shoes or other supportive devices for the feet; (9) where such expenses are for custodial care; (10) where such expenses are for cosmetic surgery or are incurred

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in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member; or (11) where such expenses constitute charges imposed by immediate relatives of the individual or members of his household.

Section 1862(b) provides that no payment may be made under part A or part B for any item or service for which payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State. Any payment under part A or part B with respect to any item or service must be conditioned on reimbursement being made to the appropriate Trust Fund for such payment if and when notice or other information is received that payment for such item or service has been made under such a law or plan.

SECTION 1863. CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

Section 1863 provides that the Secretary is to consult with the Health Insurance Benefits Advisory Council (established by sec. 1867), appropriate State agencies, and national listing or accrediting bodies, and may consult with local agencies, in prescribing such conditions for participation for providers of services as may be necessary for health and safety. The conditions may be varied for different areas or classes of institutions, and may be set higher for the institutions or agencies in a particular State at such State's request (but, in the case of hospitals, not higher than the accreditation requirements of the Joint Commission on Accreditation of Hospitals).

SECTION 1864. USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

Section 1864(a) provides that the Secretary is to make an agreement with any State which is able and willing to enter into an agreement to utilize the services of the State health agency or other appropriate State agencies (or the appropriate local agencies) for the purpose of determining which institutions and agencies qualify to participate in the programs under title XVIII. The Secretary may accept a State (or local) agency's findings as to the qualifications of an institution or agency to participate. The Secretary may also, pursuant to agreement, use State and local agencies to do any of the following: (1) provide consultative services to institutions or agencies to assist them in establishing and maintaining fiscal records or otherwise qualifying for participation, or in providing information necessary to determine what benefits are payable; and (2) provide consultative services to institutions, agencies, or organizations to assist them in establishing and evaluating the effectiveness of utilization review procedures.

Section 1864(b) provides that the Secretary is to pay the State for the reasonable costs of the administrative activities performed under its agreement under section 1864(a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of

services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

SECTION 1865. EFFECT OF ACCREDITATION

Section 1865 provides that any hospital accredited by the Joint Commission on Accreditation of Hospitals will be deemed to meet all the requirements in the definition of "hospital" in section 1861(e) except the utilization review requirement. If the Joint Commission requires a utilization review plan (or imposes another requirement serving the same purpose) for accreditation, the Secretary is authorized to find that accredited hospitals meet all the requirements in such definition. The Secretary may also accept the findings of the American Osteopathic Association, or any other national accrediting body, as to the eligibility of institutions and agencies to participate if he finds reasonable assurance that the pertinent requirements of section 1861 are met.

SECTION 1866. AGREEMENTS WITH PROVIDERS OF SERVICES

Paragraph (1) of section 1866(a) provides that any provider of services will be eligible to participate and eligible for payments under title XVIII if it files an agreement with the Secretary not to charge for covered services (except as provided in paragraph (2)) and to make adequate provision for refund of erroneous charges.

Paragraph (2) of section 1866(a) provides that a provider of services may charge an individual the following: (A) the amount of any deductible imposed pursuant to section 1813(a)(1) or (a)(2) or section 1833(b), and in addition an amount equal to 20 percent of the reasonable charges for the items and services furnished (not in excess of 20 percent of the amount customarily charged for such items and services by the provider) for which payment is made under part B (except that, in the case of expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital, the provider may charge the proportion which is appropriate under the limits imposed by sec. 1833(c)); (B) the excess amount of more expensive services and items furnished at the request of the individual; and (C) the cost of the first 3 pints of whole blood furnished during a spell of illness; except that a charge may not be made for the cost of the administration of such blood and no charge can be made if the blood has been replaced on the individual's behalf or arrangements have been made for its replacement. To illustrate the latter provision (taken together with the provisions of secs. 1813(a)(3) and 1833(d)): if a hospital were to charge a beneficiary $25 for a pint of blood which cost the hospital $10 (and which was 1 of the first 3 pints of blood furnished the beneficiary in the spell of illness), the program would not pay the hospital the $10 cost of the blood but there would be deducted from payments otherwise due the hospital the difference between the $10 cost and the $25 charge—i.e., $15; thus, if the hospital collected the $25 from the beneficiary, the hospital would receive no more in payments from the patient and the program than if it had charged the beneficiary only the $10 cost of the blood.

Section 1866(b) provides that an agreement with a provider of services under section 1866(a) may be terminated by the provider at such time and upon such public notice as may be prescribed by regulations. The Secretary could require the agreement to remain in effect for up to 6 months after the provider gives notice. The Secretary may terminate such an agreement if he determines that the provider (A) is not complying with the agreement or the law, (B) is no longer qualified to participate, or (C) has failed to provide data to determine whether payments are due the provider or the amount of such payments, or has refused access to its records for verification. The termination of any agreement with a provider is to be applicable with respect to (1) inpatient hospital services (including inpatient tuberculosis hospital services), inpatient psychiatric hospital services, and post-hospital extended care services furnished to an individual admitted on or after the effective date of termination, (2) home health services furnished under a plan established on or after the effective date of termination or, if the plan is established before the effective date, services furnished after the calendar year in which the termination is effective, and (3) any other items or services furnished on or after the effective date of termination.

Section 1866(c) provides that if the Secretary terminates an agreement, the provider may not file a new agreement unless the Secretary finds that the reason or reasons for termination is or are removed and that there is assurance they will not recur.

Section 1866(d) provides that if the Secretary finds that timely reviews of long-stay cases are not being made by a hospital or extended care facility he may, in lieu of terminating the agreement, deny payment for services furnished an individual after the 20th day of continuous inpatient hospital care or after stays of a prescribed length in an extended care facility. Such a decision denying payment for services may be made only after notice to the provider and the public and will be rescinded when the Secretary finds that the reviews are being made and that there is assurance they will continue to be made. The Secretary may not make any decision denying such payment except after reasonable notice and opportunity for hearing.

SECTION 1867. HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

Section 1867 provides for the creation of a Health Insurance Benefits Advisory Council to advise the Secretary on general policy in the administration of title XVIII and in the formulation of regulations thereunder. The Council is to consist of 16 persons, who are not Federal employees, to be appointed by the Secretary. The Secretary will from time to time appoint one of the members to serve as Chairman. The Council is to include people who are outstanding in fields related to hospital, medical, and other health activities, and at least one person who is representative of the general public. The members are to serve 4-year terms and may not serve continuously for more than 2 consecutive terms. The Secretary may appoint such special advisory professional or technical committees as may be useful. The Council members and members of any advisory or technical committee will be entitled to receive compensation at rates fixed by the Secretary (not exceeding $100 a day). The Council is to meet as frequently as the Secretary finds necessary, but he must call a meeting upon request of 4 members.

SECTION 1868. NATIONAL MEDICAL REVIEW COMMITTEE

Section 1868(a) provides for the creation of a National Medical Review Committee. The Committee is to consist of 9 persons, who are not Federal employees, to be appointed by the Secretary. The members are to be selected from among representatives of organizations and associations of professional personnel in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields; at least one member must be representative of the general public and a majority of the members must be physicians. The members are to hold office for 3-year terms and may not serve continuously for more than 2 terms.

Section 1868(b) provides that the Committee members will be entitled to receive compensation at rates fixed by the Secretary (not exceeding $100 a day).

Section 1868(c) provides that it is the Committee's function to study the utilization of hospital and other medical care and services for which payment can be made under part A or part B with a view to recommending any changes which may seem desirable in the utilization of care and services or the administration of the programs, or in the provisions of title XVIII. The Committee is to make to the Secretary (who is to transmit it promptly to the Congress) an annual report including any recommendations the Committee may have.

Section 1868(d) authorizes the Committee to engage any technical assistance required to carry out its functions. It also provides that the Secretary is to make available the secretarial, clerical, and other assistance and data needed by the Committee.

SECTION 1869. DETERMINATIONS; APPEALS

Section 1869(a) provides that determinations of entitlement to benefits under part A and part B, and of the amount of benefits under part A, are to be made by the Secretary in accordance with regulations.

Section 1869(b) provides that any individual dissatisfied with any determination under section 1869(a) as to entitlement under part A or part B, or as to amount of benefits under part A if the matter in controversy is $1,000 or more, will be entitled to the same hearing and appeal procedures as are now provided in sections 205(b) and 205(g) of the Act.

Section 1869(c) provides that any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination terminating an agreement under section 1866(b)(2), will be entitled to the same hearing and appeal procedures as are now provided in sections 205(b) and 205(g).

SECTION 1870. OVERPAYMENTS ON BEHALF OF INDIVIDUALS

Section 1870(a) provides that any payment under part A or part B to a provider of services for services furnished an individual will be considered as a payment to such individual.

Section 1870(b) provides that where overpayment is made to a provider of services or other person and cannot be recouped from such provider or person, or payment is made under the conditions specified in section 1814(e) or 1835(c) for an individual who is not

entitled to have such payment made, subsequent cash social security benefits or railroad retirement benefits payable to the individual (or, if such individual dies, benefits payable to others based on his earnings) will be reduced in accordance with regulations prescribed by the Secretary after consultation with the Railroad Retirement Board. As soon as practicable after any such adjustment is determined to be necessary, the Secretary (for purposes of sec. 1870 and secs. 1817(g) and 1841(f)) will certify (to the Railroad Retirement Board if adjustment is to be made by decreasing cash payments under the Railroad Retirement Act of 1937) the amount of the overpayment with respect to which the adjustment is to be made.

Section 1870(c) provides there will be no adjustment (or recovery) in any case in which the individual is without fault, or in which the adjustment (or recovery) would defeat the purposes of title II of the act or would be against equity and good conscience.

Section 1870(d) provides that no certifying or disbursing officer will be liable for overpayments where adjustment or recovery is waived or is not completed prior to the death of all persons against whose benefits the adjustment is authorized.

SECTION 1871. REGULATIONS

Section 1871 provides that the Secretary will prescribe the regulations necessary to carry out the administration of the new insurance programs under title XVIII. When used in such title the term "regulations" means (unless the context otherwise requires) regulations prescribed by the Secretary.

SECTION 1872. APPLICATION OF CERTAIN PROVISIONS OF TITLE II

Section 1872 provides that sections 206, 208, 216(j), and 205 (a), (d), (e), (f), (h), (i), (j), (k), and (l) of the act will apply to title XVIII as they do to title II.

SECTION 1873. DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

Section 1873 provides that any designation made in title XVIII, by name, of any nongovernmental organization or publication will not be affected by a change of the name of such organization or publication and will apply to any successor organization or publication which the Secretary finds serves the purpose for which the designation was made.

SECTION 1874. ADMINISTRATION

Section 1874(a) provides that, except as otherwise stated, the programs established by title XVIII are to be administered by the Secretary, who may perform any of his functions directly or by contract.

Section 1874(b) provides that the Secretary may contract with any person, agency, or institution to secure such special data and actuarial and other information as may be necessary in carrying out his functions.

SECTION 1875. STUDIES AND RECOMMENDATIONS

Section 1875(a) provides that the Secretary is to make studies and develop recommendations to be submitted to the Congress relating to the health care of the aged, including studies and recommendations concerning the adequacy of existing personnel and facilities for health care for purposes of the programs under title XVIII; methods for encouraging further development of efficient and economical alternatives to inpatient hospital care; the effect of the deductibles and coinsurance provisions upon beneficiaries, providers of health services, and the financing of the program; and the desirability of broadening or modifying the provisions which authorize payment for additional days of post-hospital extended care services where the maximum number of days of inpatient hospital services in a spell of illness has not been used.

Section 1875(b) instructs the Secretary to make a continuing study of the operation and administration of the insurance programs under title XVIII and to submit to the Congress annually a report concerning the operation of such programs.

SECTION 102. HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY HEALTH INSURANCE BENEFITS—(Continued)

Section 102(b) of the bill provides that if an individual was eligible to enroll under the supplementary health insurance program under part B of the new title XVIII before April 1, 1966, but failed to do so before such date, and it is shown to the satisfaction of the Secretary that there was good cause for such failure to enroll, such individual may enroll in the supplementary health insurance program at any time before October 1, 1966. The Secretary will by regulation determine what constitutes good cause. The coverage period (within the meaning of sec. 1838 of the Social Security Act) of an individual enrolling under this provision will begin on the first day of the 6th month after the month in which he enrolls.

SECTION 103. TRANSITIONAL PROVISION ON ELIGIBILITY OF PRESENTLY UNINSURED INDIVIDUALS FOR HOSPITAL INSURANCE BENEFITS

Section 103(a) of the bill provides that anyone who—

(1) has attained age 65 before 1968 (or has earned 3 quarters of coverage for each calendar year after 1965 and before the year of attainment of age 65);

(2) is not entitled to hospital insurance benefits (and would not be entitled to such benefits upon filing application for monthly benefits under section 202 of the Social Security Act), and is not certifiable as a qualified railroad retirement beneficiary (see sec. 105 of the bill, discussed below);

(3) is a resident of the United States, and is a citizen (or has resided in the United States continuously for at least 10 years immediately prior to the month in which he files application under section 103); and

(4) has filed an application under section 103 in accordance with regulations,

will be entitled to benefits under part A of title XVIII beginning with the first month in which he meets these requirements and ending with the month he dies or, if earlier, the month before the month in which he becomes eligible for hospital insurance benefits under section 226 or becomes certifiable as a railroad retirement beneficiary.

Any person who would have met the preceding requirements in any month if he had filed an application before the end of that month will be deemed to have met such requirements for that month if he files an application before the end of the next 12 months. No application will be accepted as a valid application under section 103 if it is filed before the first month in which the individual meets the requirements of paragraphs (1), (2), and (3) above; i.e., an application filed prematurely will not prevent the individual from obtaining benefits under section 103 if he qualifies therefor at a later time.

Section 103(b) of the bill provides that section 103(a) does not apply to any person who (as of the time of his application under such section) (1) is a member of any organization referred to in section 210(a)(17) of the Social Security Act (relating to subversive organizations); (2) has been convicted of any offense listed in section 202(u) of such act; or (3) is eligible, or could have been eligible if he or some other person had taken the appropriate action, for benefits under the Federal Employees Health Benefits Act of 1959.

Section 103(c) authorizes the appropriation to the Federal Hospital Insurance Trust Fund of such sums as the Secretary deems necessary on account of payments made under part A of title XVIII of the Social Security Act to individuals who are entitled to benefits thereunder solely by reason of section 103 of the bill and on account of the additional administrative expenses and loss of interest to the Fund resulting from such payments.

SECTION 104. SUSPENSION IN CASE OF ALIENS; PERSONS CONVICTED OF SUBVERSIVE ACTIVITIES

Paragraph (1) of section 104(a) of the bill amends section 202(t) of the Social Security Act (relating to suspension of benefits for certain aliens outside the United States) by adding a new paragraph which provides that an individual is not entitled to benefits under part A of title XVIII for any month for which his cash social security benefits are suspended under such section.

Paragraph (2) of section 104(a) of the bill amends section 202(u) of the Social Security Act so that the penalty which may be imposed thereunder upon a conviction for subversive activities (namely, the elimination of all earnings credits for the calendar quarter in which the conviction occurs and prior quarters) will apply to a determination of entitlement to benefits under part A of title XVIII, as well as to the determination of entitlement to cash benefits under title II as provided in existing law.

Paragraph (1) of section 104(b) of the bill provides that payments may not be made under part B of title XVIII for expenses incurred by an individual for any month for which he may not be paid cash benefits under title II by reason of section 202(t) (relating to suspension of benefits for certain aliens who are outside the United States).

Paragraph (2) of section 104(b) of the bill provides that an individual convicted of any of the offenses stipulated in section 202(u) of the Social Security Act may not enroll under part B of title XVIII.

SECTION 105. RAILROAD RETIREMENT AMENDMENTS

Paragraph (1) of section 105(a) of the bill adds a new section 21 to the Railroad Retirement Act of 1937 to provide that, in order to make available hospital insurance benefits under part A of title XVIII of the Social Security Act (added by sec. 102 of the bill) for annuitants, pensioners, and certain other aged individuals under the railroad retirement system, the Railroad Retirement Board is to certify to the Secretary of Health, Education, and Welfare, upon the Secretary's request, the name of any individual who has attained age 65 and—

(1) is entitled to an annuity or pension under the Railroad Retirement Act, or

(2) would be entitled to an annuity under such act if he (or, in the case of a spouse, the spouse's husband or wife) had stopped working in employment covered under such act and applied for such annuity, or

(3) bears a relationship to an employee which by reason of section 3(e) of such act (providing a minimum for the amounts of railroad retirement annuities which is based on the social security benefit formula) has been, or would be, taken into account in calculating the amount of the annuity of such employee or his survivors.

The certification made by the Board to the Secretary of Health, Education, and Welfare is to include such additional information as may be necessary to carry out the hospital insurance benefit provisions, and will be effective on the date of certification or on such earlier date (not more than 1 year prior to the date of certification) as the Board specifies as the date on which the individual first met the requirements for certification. The Board is to notify the Secretary of the date on which the individual no longer meets the requirements.

Paragraph (2) of section 105(a) of the bill provides that, for purposes of section 21 of the Railroad Retirement Act of 1937 (and secs. 1840, 1843, and 1870 of the Social Security Act), entitlement to an annuity or pension under the Railroad Retirement Act of 1937 is deemed to include entitlement under the Railroad Retirement Act of 1935.

Section 105(b) of the bill amends sections 3201, 3211, and 3221(b) of the Railroad Retirement Tax Act (ch. 22 of the Internal Revenue Code of 1954), relating to the rate of tax on employees, on employee representatives, and on employers, respectively. The amendments change the references to section 3101 of the Code in those sections to section 3101(a) to conform to the amendment to section 3101 made by section 321(b) of the bill. A clarifying change is made in each such section by adding a specific reference to the rate of tax (2¾ percent) provided under the Social Security Amendments of 1956. The amendments made by section 105(b) are effective with respect to compensation for services rendered after December 31, 1965.

Section 105(c) of the bill contains a cross reference to section 326 of the bill, which amends the Railroad Retirement Act of 1937 to preserve the existing relationship between the railroad retirement and old-age, survivors, and disability insurance systems.

SECTION 106. MEDICAL EXPENSE DEDUCTION

Allowance of deduction

Section 106(a) of the bill amends section 213(a) of the Internal Revenue Code of 1954 (relating to allowance of deduction for medical expenses).

Under existing law, the general rule is that a taxpayer may deduct expenses for the medical care of himself, his spouse, and his dependents; but only to the extent that they exceed 3 percent of adjusted gross income. The 3-percent limitation is not applicable, however, in the case of expenses paid by the taxpayer (1) for the medical care of a dependent mother or father of the taxpayer or his spouse, if such mother or father has attained the age of 65 before the close of the taxable year, or (2) for the medical care of the taxpayer or his spouse if either has attained the age of 65 before the close of the taxable year.

Section 106(a) of the bill revises section 213(a) by dividing it into two paragraphs, each of which describes a separate part of the total medical expense deduction allowable.

3-percent limitation

Under paragraph (1) of section 213(a), as amended by the bill, the taxpayer (regardless of age) may deduct expenses for the medical care of himself, his spouse, and his dependents only to the extent that such expenses exceed 3 percent of adjusted gross income. The 3-percent limitation is applicable to the expenses for the taxpayer, his spouse, and his dependents whether or not the taxpayer, his spouse, or his dependents have attained the age of 65 before the close of the taxable year. In determining the amount deductible under paragraph (1) of section 213(a) (that is, the amount subject to the 3-percent limitation), there is excluded the amount deductible under the revised paragraph (2) with respect to expenses paid for insurance which constitutes medical care.

Insurance constituting medical care

Under paragraph (2) of section 213(a), as amended by the bill, the taxpayer may deduct an amount equal to one-half of the expenses paid during the taxable year for insurance which constitutes medical care (as such term is defined in section 213(e) as amended by section 106(c) of the bill) for the taxpayer, his spouse, or a dependent. The maximum amount deductible under paragraph (2) is $250.

Example.—Assume that A has medical care expenses for the year (excluding amounts paid for medical care insurance) of $800 which are for himself and his spouse; that A has paid during the year $600 for insurance which constitutes medical care for himself and his spouse; and that A has adjusted gross income of $5,000. A's deduction under the new section 213(a)(2) is $250 (one-half of $600 but not in excess of $250). His deduction under section 213(a)(1) is $1,000 (whether or not A or his spouse is age 65) computed as follows:

Total medical care expenses (including insurance)		$1,400
Less: Expenses for insurance deductible under sec. 213(a)(2)		250
		1,150
Less: 3 percent of adjusted gross income of $5,000		150
Medical expense deduction under sec. 213(a)(1)		1,000

A's total section 213 deduction is $1,250 ($1,000 under paragraph (1), plus $250 under paragraph (2)).

Limitation with respect to medicine and drugs

Section 106(b) of the bill amends section 213(b) of the code (relating to the limitation with respect to medicine and drugs).

Section 213(b) of the code provides as a general rule that in computing his medical expense deduction, the taxpayer shall take into account only the aggregate of the amounts paid for medicine and drugs in excess of 1 percent of adjusted gross income. However, the 1-percent limitation does not apply to amounts paid during the taxable year for medicines and drugs (1) for the care of the taxpayer and his spouse if either has attained age 65 before the close of the taxable year, or (2) for the care of the mother or father of the taxpayer or his spouse if such parent is a dependent (as defined in sec. 152 of the code) of the taxpayer or his spouse and has attained age 65 before the close of the taxable year. Section 106(b) of the bill repeals the exceptions to the 1-percent limitation. Thus, under the bill, the 1-percent floor applies to all expenses for drugs and medicines without exception.

Definition of medical care

Section 106(c) of the bill strikes out paragraph (1) of section 213(e) of the code (which defines medical care to mean amounts paid (A) for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance), or (B) for transportation primarily for and essential to medical care described in (A)) and replaces it with new paragraphs (1), (2), and (3). The existing paragraph (2) is renumbered as paragraph (4). No substantive change is made in the definition of medical care except as it relates to amounts paid for insurance.

Under the new paragraph (1), subparagraphs (A) and (B) are the same as existing law except for the elimination of the phrase "including amounts paid for accident or health insurance". Under the new subparagraph (C), amounts paid for an insurance contract are included within the definition of medical care only to the extent that the premiums are attributable to insurance covering medical care (as defined in subparagraphs (A) and (B) of section 213(e)(1)). In determining whether a contract constitutes an "insurance" contract, it is irrelevant whether the benefits are payable in cash or services. Under the new paragraph (1)(C), premiums paid under part B of title XVIII of the Social Security Act (relating to supplementary health insurance for the aged) are amounts paid for insurance. Taxes paid under section 1401 (relating to tax on self-employment income) or under section 3101 (relating to tax on income of employees) of the Internal Revenue Code do not constitute amounts paid for insurance.

If amounts are payable under an insurance contract for other than medical care (such as an indemnity for loss of income or for loss of life, limb, or sight) then, under the new paragraph (2), no amount paid for such contract is to be treated as medical care unless (1) the contract specifies what part of the premium is attributable to insurance for medical care, and (2) the part of the premium specified in the contract as being so attributable is a reasonable amount in relation to the total premium under the contract. Moreover, the amount to

be treated as expenses for medical care in such a case is not to exceed the amount so specified in the contract.

Certain prepaid insurance

Under the new paragraph (3) added to section 213(e) of the code, subject to the limitations of the new paragraph (2), premiums paid during a taxable year by a taxpayer before he attains the age of 65 for insurance covering medical care for the taxpayer, his spouse, or a dependent after the taxpayer attains the age of 65 are to be treated as expenses paid during the taxable year for insurance which constitutes medical care if premiums for such insurance are payable (on a level payment basis) under the contract—

(1) for a period of 10 years or more, or

(2) until the year in which the taxpayer attains age 65 (but in no case for a period of less than 5 years).

Maximum limitation in certain cases

Section 106(d) of the bill amends section 213(g) of the code (which provides for an increased maximum limitation on the medical expense deduction allowable to a taxpayer who has attained the age of 65 and is disabled or whose spouse has attained the age of 65 and is disabled) to eliminate the requirement of attaining age 65 so that the increased maximum limitation is applicable in any case where either the taxpayer or his spouse is disabled.

Effective date

Section 106(e) of the bill provides that the amendments made by section 106 shall apply to taxable years beginning after December 31, 1966.

SECTION 107. RECEIPTS FOR EMPLOYEES MUST SHOW TAXES SEPARATELY

Section 107 of the bill amends section 6051(c) of the Internal Revenue Code of 1954 to provide that the statement (form W–2) furnished to an employee pursuant to section 6051 of the code must show the proportion of the amounts withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

SECTION 108. TECHNICAL AND ADMINISTRATIVE AMENDMENTS RELATING TO TRUST FUNDS

Paragraph (1) of section 108(a) of the bill amends section 201(a)(3) of the Social Security Act to exclude the taxes imposed on employers and employees for hospital insurance under sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954, as amended by section 321 of the bill, from the employer and employee taxes appropriated to the Federal Old-Age and Survivors Insurance Trust Fund.

Paragraph (2) of section 108(a) of the bill amends section 201(a)(4) of the act to exclude the taxes imposed on the self-employed for hospital insurance under section 1401(b) of the Code, as amended by section 321 of the bill, from the self-employment taxes appropriated to the Federal Old-Age and Survivors Insurance Trust Fund.

Paragraph (3) of section 108(a) of the bill amends section 201(g)(1) of the act, relating to payments from the trust funds to the Treasury

as reimbursement for administrative costs of title II of the act and chapters 2 and 21 of the Internal Revenue Code of 1954.

The new subparagraph (A) of section 201(g)(1) provides for payment from any or all of the Trust Funds (which include for this purpose the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Health Insurance Benefits Trust Fund) of the costs to the Department of Health, Education, and Welfare of administering titles II and XVIII of the act and for adjustments during, and after the close of, each fiscal year among the Trust Funds so that each fund bears its proportionate share of the costs of administering titles II and XVIII.

The new subparagraph (B) of section 201(g)(1) provides for payments from the Trust Funds to the Treasury to meet the estimated quarterly costs to the Treasury of the administration of titles II and XVIII of the act and of chapters 2 and 21 of the Internal Revenue Code of 1954.

Paragraph (4) of section 108(a) of the bill amends section 201(g)(2) of the act to specify that in estimating the amount of employee taxes subject to refund the Managing Trustee of the old-age, survivors, and disability insurance trust funds shall consider only the taxes imposed for the support of the old-age and survivors insurance and disability insurance programs. (This provision conforms with the provisions of the new section 1817(f) of the act for estimating amounts of employee taxes imposed for the hospital insurance program that are subject to refund because of overpayment.)

Paragraph (5) of section 108(a) of the bill amends section 201(h) of the act to specify that payments made under the new section 226 of the act (relating to entitlement to hospital insurance benefits) are not to be made from the Federal Old-Age and Survivors Insurance Trust Fund.

Section 108(b) of the bill amends section 218(h)(1) of the act (relating to the depositing in the trust funds of amounts received by the Secretary of the Treasury under agreements for coverage of State and local government employees) to provide for proportionate deposits in the Federal Hospital Insurance Trust Fund as well as in the existing trust funds.

Section 108(c) of the bill amends section 1106(b) of the act so that the two new insurance trust funds established by the bill, like the old-age, survivors, and disability insurance trust funds, may be reimbursed for costs of furnishing information (disclosure of which is authorized by regulations) or services to individuals or organizations.

SECTION 109. ADVISORY COUNCIL ON SOCIAL SECURITY

Section 109 of the bill replaces the existing provision for the appointment of Advisory Councils on Social Security Financing with a new provision for the appointment of Advisory Councils on Social Security.

Section 109(a) of the bill adds a new section 706 to title VII of the Social Security Act to provide for the appointment by the Secretary of Health, Education, and Welfare of an Advisory Council on Social Security in 1968 and every fifth year thereafter to review the status of the 4 named trust funds in relation to the long-term commitments of the old-age, survivors, and disability insurance program,

the hospital insurance program, and the supplementary health insurance benefits program and to review also the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs. Each Council is to consist of the Commissioner of Social Security, as chairman, and 12 members who will, to the extent possible, represent organizations of employers and employees in equal numbers, and represent self-employed persons and the public. The Councils are authorized to engage technical assistance, including actuarial services, and the Secretary is required to make available to the Council secretarial, clerical, and other assistance and such pertinent data prepared by the Department of Health, Education, and Welfare as the Council might require. While serving on business of the Council, the members of the Council will receive compensation at rates fixed by the Secretary but not exceeding $100 per day, and, while serving away from their homes or regular places of business, they will be allowed travel expenses, including per diem in lieu of subsistence. Each Council is to make reports of its findings and recommendations to the Secretary of Health, Education, and Welfare for transmission to the Congress and to the Board of Trustees of each of the 4 trust funds not later than January 1 of the second year after the year in which it was appointed, and then will cease to exist. Separate reports are required with respect to (1) the old-age, survivors, and disability insurance program, (2) the hospital insurance program, and (3) the supplementary health insurance benefits program.

Section 109(b) of the bill repeals section 116(e) of the Social Security Amendments of 1956 (which is the section presently providing for the appointment by the Secretary in 1966 and every fifth year thereafter of an Advisory Council on Social Security Financing with functions limited to review of the financing aspects of the program).

SECTION 110. MEANING OF TERM "SECRETARY"

Section 110 of the bill provides that, as used in the bill and in the provisions of the Social Security Act amended thereby, the term "Secretary" (unless the context otherwise requires) means the Secretary of Health, Education, and Welfare.

PART 2—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SECTION 121. ESTABLISHMENT OF PROGRAMS

Section 121(a) of the bill adds a new title XIX, providing grants to States for medical assistance programs, to the Social Security Act.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SECTION 1901. APPROPRIATION

Section 1901 authorizes the appropriation for each fiscal year of a sum sufficient to carry out the purposes of title XIX, in order to enable each State (as far as practicable under the conditions in such State) to furnish medical assistance on behalf of aged, blind, or

permanently and totally disabled individuals and families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and rehabilitation and other services to help such individuals and families attain or retain capability for independence or self-care. The sums made available under this section are to be used for making payments to States which have submitted and had approved State plans for medical assistance. (Sec. 1903(a) provides that such payments are to be made beginning with the quarter commencing January 1, 1966.)

SECTION 1902. STATE PLANS FOR MEDICAL ASSISTANCE

Section 1902(a) sets forth the requirements with which a State plan for medical assistance must comply in order to be approved by the Secretary of Health, Education, and Welfare and thereby qualify the State for payments under title XIX. To be approved, such a State plan must—

(1) provide that it will be in effect in all political subdivisions of the State and, if the plan is administered by the subdivisions, that it be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which Federal financial participation under section 1903 is authorized and, effective July 1, 1970, provide for State financial participation equal to all of such non-Federal share;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or not acted upon with reasonable promptness;

(4) provide methods of administration of the plan as found necessary by the Secretary for its proper and efficient operation; these would include (A) methods relating to the establishment and maintenance of personnel standards on a merit basis, with the Secretary being precluded from exercising any authority in connection with the selection, tenure, or compensation of any individual employed in accordance with these methods, and (B) provision for utilization of professional medical personnel in the administration of the plan, and in supervision of such administration where the plan is administered locally;

(5) provide that the State agency administering or supervising the State old-age assistance plan approved under title I, or the State plan for aid to the aged, blind, or disabled approved under title XVI (insofar as it relates to the aged), will administer the plan for medical assistance or supervise its administration; and that any local agency administering the State's plan approved under title I or under title XVI (insofar as it relates to the aged) in a political subdivision will administer the plan for medical assistance in that subdivision;

(6) provide that the State agency will make reports as required by the Secretary, and will comply with provisions found necessary by the Secretary to assure their correctness and verification;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the plan's administration;

(8) provide for affording all individuals who wish to do so an opportunity to apply for medical assistance under the plan and for furnishing such assistance with reasonable promptness to all applicants who are eligible for assistance under the plan;

(9) provide for a State authority or authorities with responsibility to establish and maintain standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services;

(10) provide for making medical assistance available to all individuals receiving old-age assistance, aid to families with dependent children, aid to the blind, aid to the permanently and totally disabled, and aid to the aged, blind, or disabled under the State's plans approved under titles I, IV, X, XIV, and XVI of the act; and—

(A) provide that the medical assistance made available to individuals receiving aid or assistance under any one of such plans—

(i) will not be less in amount, duration, or scope than the medical assistance made available to individuals receiving aid or assistance under any other such plan; and

(ii) will not be less in amount, duration, or scope than medical assistance made available to individuals not receiving aid or assistance under any such plan; and

(B) if the plan under title XIX includes medical assistance for any group of individuals who are not recipients under any such plan and do not meet the State's income and resource requirements under the one of such plans which, as determined in accordance with standards prescribed by the Secretary, is appropriate, provide—

(i) for making medical assistance available to all individuals who if needy would be eligible for aid or assistance under any such plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the cost of necessary medical care and services, and

(ii) that the medical assistance made available to all individuals who are not recipients under any such State plan will be equal in amount, duration, and scope;

(11) provide for entering into cooperative arrangements with the State agencies responsible for health and vocational rehabilitation services looking toward maximum utilization of these services in providing medical assistance under the plan;

(12) provide that in determining blindness an examination will be made either by a physician skilled in diseases of the eye or by an optometrist, as the individual may select;

(13) provide for inclusion of some institutional and some noninstitutional care and services and, as of July 1, 1967, for the inclusion of at least (1) inpatient hospital services, (2) outpatient hospital services, (3) other laboratory and X-ray services, (4) skilled nursing home services, and (5) physicians' services (as listed in section 1905(a)); and for the payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan;

(14) provide that—

(A) no deduction, cost sharing, or similar charge will be imposed on any individual with respect to inpatient hospital services furnished him under the plan, and

(B) any deduction, cost sharing, or similar charge imposed as to any other care or services furnished him thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, will be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or to his income and resources;

(15) in the case of eligible individuals 65 years of age or older covered by either or both of the insurance programs (hospital insurance benefits for the aged, and supplementary health insurance benefits for the aged) established by the bill, provide—

(A) for meeting the full cost of any deductible imposed with respect to any such individual under such hospital insurance benefits program; and

(B) where, under the plan, all of a deductible, cost sharing, or similar charge imposed with respect to any such individual under such supplementary health insurance benefits program is not met, the portion which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or to his income and resources;

(16) include, to the extent required by regulations of the Secretary, provisions (conforming to such regulations) regarding the furnishing of medical assistance to eligible residents who are absent from the State;

(17) include reasonable standards, comparable for all groups, for determining eligibility for and the extent of medical assistance under the plan, which standards—

(A) are consistent with the objectives of title XIX,

(B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or re-recipient and (in the case of any applicant or recipient who if he met the State's need requirements would be eligible for aid or assistance in the form of money payments under the State's plan approved under title I, IV, X, XIV, or XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for and the amount of aid or assistance under such plan,

(C) provide for reasonable evaluation of any such income or resources, and

(D) do not take into account the financial responsibility of any individual for any applicant or recipient unless such applicant or recipient is the individual's spouse or is his child who is under age 21 or, if the child is age 21 or over, is blind or permanently and totally disabled; and providm of flexibility in the application of such standards with ree for to income by taking into account, except to the extenspectr scribed by the Secretary, the costs (whether in the ft pre-o

insurance premiums or otherwise) incurred for medical care or any other type of remedial care recognized under State law;

(18) provide that property liens will not be imposed, on account of medical assistance provided under the plan, during a recipent's lifetime (except pursuant to a judgment of a court on account of benefits incorrectly paid), and preclude adjustments or recovery of medical assistance correctly paid except from the estate of a recipient who was at least age 65 when he received such assistance, and then only after the death of his surviving spouse and at a time when he has no surviving child who is under 21, blind, or permanently and totally disabled;

(19) provide safeguards necessary to assure that eligibility for care and services under the plan will be determined and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years or older who are patients in institutions for tuberculosis or mental diseases—

(A) provide for agreements or other arrangements, with State authorities concerned with mental diseases or tuberculosis (as the case may be) and, where appropriate, with such institutions, necessary for carrying out the State plan. These will include arrangements for joint planning and for development of alternate methods of care, for assuring immediate readmittance to institutions where needed for individuals under alternate plans of care, for providing for access to patients and facilities, and for submitting information and reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided is in his best interests, including assurances of initial and periodic review of his medical and other needs, of his receiving appropriate medical treatment within the institution, and of periodic determination of his need for continued institutional care;

(C) provide for the development of alternate plans of care with maximum utilization of available resources for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services to help such recipients and patients attain or retain capability for self-care or other services to prevent or reduce dependency which are appropriate; and for methods of administration necessary to assure that the State plan with respect to these recipients and patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients; and

(21) if the State plan includes medical assistance in behalf of individuals 65 years or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward a comprehensive mental health program.

Section 1902(a) also provides that, notwithstanding the requirement in paragraph (5) above, any State which (on January 1, 1965, and on the date it submits its plan under title XIX) administers or supervises

its program for the blind under title X (or under title XVI, insofar as it relates to the blind) through a State agency other than the State agency that administers or supervises its title I plan (or title XVI plan, insofar as it relates to the aged) will be permitted, upon coming under title XIX, to retain such separate blind program agency to administer or supervise (as a separate State plan, except for purposes of paragraph (10) above) the portion of the approved plan for medical assistance under title XIX which relates to blind individuals.

Section 1902(b) requires the Secretary of Health, Education, and Welfare to approve any plan which fulfills the conditions specified in section 1902(a), except that he is not to approve any plan which imposes as a condition of eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and who meets the definition of a dependent child under title IV of the act disregarding the provisions of section 406(a)(2); or

(3) any residence requirement which excludes any individual residing in the State; or

(4) any citizenship requirement which excludes any citizen of the United States.

Section 1902(c) requires the Secretary, notwithstanding the fact that a State plan is otherwise approvable, not to approve such plan if he determines that its approval and operation will result in a reduction in aid or assistance (other than so much as is provided under the approved title XIX plan) provided for eligible individuals under the State's plan approved under title I, IV, X, XIV, or XVI.

SECTION 1903. PAYMENT TO STATES

Section 1903(a) provides for making Federal payments to States with respect to expenditures for programs of medical assistance under approved plans. Except as otherwise provided in section 1903 and in section 1117 (as added to title XI of the Social Security Act by sec. 405 of the bill), the Secretary will pay each State with an approved plan for medical assistance, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in sec. 1905(b)) of the total medical assistance expenditures during the quarter, including in such expenditures premiums under part B of title XVIII (relating to supplementary health insurance benefits for the aged) for recipients of money payments under title I, IV, X, XIV, or XVI, and other insurance premiums for medical or remedial care or the cost of such care; plus

(2) an amount equal to 75 percent of the amounts expended during the quarter for administrative costs attributable to compensation of skilled professional medical personnel and directly-supporting staff of the State agency or local agency administering the plan; plus

(3) one-half of the remaining administrative expenses.

Section 1903(b) provides that, notwithstanding the provisions of section 1903(a), the amount of the Federal payment for any quarter

attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for tuberculosis or mental diseases is to be paid only to the extent that total expenditures from Federal, State, and local funds for mental health services under State and local public health and public welfare programs for the quarter are shown to the satisfaction of the Secretary to exceed the average of the total expenditures for these services for each quarter of the fiscal year ending June 30, 1965. The expenditures for these services for each quarter in the fiscal year ending June 30, 1965, are to be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination under section 1903(b); and expenditures for any quarter beginning after December 31, 1965, are to be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination for such State for such quarter. For the purposes of section 1903(b), such determinations will be conclusive.

Section 1903(c) provides that if the Secretary finds, on the basis of satisfactory information submitted by a State, that its Federal medical assistance percentage applicable to any quarter during the period January 1, 1966, through June 30, 1969, is less than 105 percent of the Federal share of the State's medical expenditures during the fiscal year ending June 30, 1965, then its Federal medical assistance percentage will be 105 percent of such Federal share instead of the percentage determined under section 1905(b). Such adjusted percentage will be applicable for such quarter and each subsequent quarter in such period prior to the first quarter as to which such finding is not applicable.

For the above purposes, such Federal share means the percentage which the excess of—

(A) the total of the amounts of the Federal shares (determined under the applicable formulas of the public assistance titles of the act) of the State's expenditures for aid or assistance in any form during fiscal year 1965 under its plans approved under titles I, IV, X, XIV, and XVI over

(B) the total of the Federal shares determined under such formulas with respect to its expenditures of aid or assistance during such year, excluding aid or assistance in the form of medical or remedial care,

is of the total of aid or assistance expenditures in the form of medical or remedial care under such plans during such year.

Section 1903(d) provides procedures for paying to a State the amounts to which it is entitled under the preceding provisions of section 1903. These are, with appropriate modifications, similar to those under the existing public assistance titles of the act.

Section 1903(e) provides that payments under the preceding provisions of section 1903 are not to be made unless the State makes a satisfactory showing that it is making efforts toward broadening the scope of the care and services available under its plan and toward liberalizing the eligibility requirements for medical assistance, looking toward providing, by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility requirements with respect to income and resources, including services to help such individuals to attain independence or self-care.

SECTION 1904. OPERATION OF STATE PLANS

Section 1904 provides for withholding of Federal payments to a State if the Secretary finds, after reasonable notice and opportunity for hearing to the State agency having responsibility for the plan, that the approved plan has been so changed that it no longer complies with the provisions of section 1902 or that in the administration of the plan there is failure to comply substantially with any such provision. Until the Secretary is satisfied that there is no longer any failure to comply, he will make no further payments to the State or in his discretion will limit payments to categories under or parts of the plan not affected by such failure.

SECTION 1905. DEFINITIONS

Section 1905(a) defines the term "medical assistance" to mean payment of part or all of the cost of the following care and services (if provided in or after the third month before the month the recipient makes application) for individuals who are under the age of 21 and who except for section 406(a)(2) are (or would, if needy, be) dependent children as defined under title IV, or who are relatives specified in section 406(b)(1) with whom such children are living, or who are 65 years of age or older, are blind, or are 18 years of age or older and permanently and totally disabled, but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services;
(2) outpatient hospital services;
(3) other laboratory and X-ray services;
(4) skilled nursing home services;
(5) physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere;
(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;
(7) home health care services;
(8) private duty nursing services;
(9) clinic services;
(10) dental services;
(11) physical therapy and related services;
(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
(13) other diagnostic, screening, preventive, and rehabilitative services; and
(14) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

but the term does not include—

(A) payments with respect to care or services for an individual who is an inmate of a public institution (except as a patient in a medical institution); or
(B) payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

Section 1905(b) defines the term "Federal medical assistance percentage". Such percentage for a State is 100 per centum minus the percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the 50 States and the District of Columbia. Such percentage is in no case less than 50 per centum or more than 83 per centum, except that for Puerto Rico, the Virgin Islands, and Guam it is set at 55 per centum. Determination and promulgation by the Secretary of the Federal medical assistance percentage will be in accordance with the provisions of section 1101(a)(8)(B) of the act, except that such promulgation will be made as soon as possible after enactment of the bill and it will be conclusive for each of the 6 quarters in the period January 1, 1966, through June 30, 1967.

SECTION 121. ESTABLISHMENT OF PROGRAMS—(Con.)

Section 121(b) of the bill provides that no payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act for aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX (as added to such act by sec. 121(a) of the bill), or for any period after June 30, 1967.

Paragraph (1) of section 121(c) of the bill (effective January 1, 1966) amends section 1101(a)(1) of the act to make a necessary conforming change.

Paragraph (2) of section 121(c) of the bill amends section 1109 of the act to provide that any amount which is disregarded (or set aside for future needs) in determining eligibility for and amount of the aid or assistance for an individual under a State plan approved under title I, IV, X, XIV, XVI, or XIX of the act is not to be taken into consideration in determining the eligibility for or amount of medical assistance for any other individual under a State plan approved under such title XIX.

Paragraph (3) of section 121(c) of the bill (effective January 1, 1966) amends section 1115 of the act to make necessary conforming changes.

SECTION 122. PAYMENT BY STATES OF PREMIUMS FOR SUPPLEMENTARY HEALTH INSURANCE

Section 122 of the bill amends sections 3(a), 403(a), 1003(a), 1403(a), and 1603(a) of the Social Security Act to authorize Federal financial participation in expenditures by a State under its approved plans under the respective public assistance titles of such act for premiums paid for supplementary health insurance benefits for the aged (the insurance program under part B of title XVIII of the Social Security Act, as added by the bill) for individuals who receive money payments under any such title.

TITLE II—OTHER AMENDMENTS RELATING TO HEALTH CARE

PART 1—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

SECTION 201. INCREASE IN MATERNAL AND CHILD HEALTH SERVICES

Section 201(a) of the bill amends section 501 of the Social Security Act to increase the authorization of appropriations for grants to the States for maternal and child health services under part 1 of title V of such Act 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 each fiscal year thereafter. Under existing law the authorized appropriation is $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 year thereafter.

Section 201(b) of the bill amends section 504 of the Act by adding a new subsection (d) which makes payments to States after June 30, 1966, contingent upon a satisfactory showing that the State is extending the provision of maternal and child health services in the State with a view to making such services available to children in all parts of the State by July 1, 1975.

SECTION 202. INCREASE IN CRIPPLED CHILDREN'S SERVICES

Section 202(a) of the bill amends section 511 of the Social Security Act to increase the authorization of appropriations for grants to the States for crippled children's services under part 2 of title V of such Act 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 each fiscal year thereafter. Under existing law the authorized appropriation is $40 million each for the fiscal years ending June 30, 1966 and 1967, $45 million 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.

Section 202(b) of the bill amends section 514 of the Act by adding a new subsection (d) which makes payments to States after June 30, 1966, contingent upon a satisfactory showing that the State is extending the provision of crippled children's services in the State with a view to making such services available to children in all parts of the State by July 1, 1975.

SECTION 203. TRAINING OF PROFESSIONAL PERSONNEL FOR THE CARE OF CRIPPLED CHILDREN

Section 203 of the bill amends part 2 of title V of the Social Security Act by adding a new section 516 which authorizes grants to public or other nonprofit 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. Authorizations for appropriations are $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.

SECTION 204. PAYMENT FOR INPATIENT HOSPITAL SERVICES

Section 204(a) of the bill amends section 503(a) of the Social Security Act to require a State plan, for maternal and child health services to provide, effective July 1, 1967, for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan.

Section 204(b) of the bill amends section 513(a) of the Act to require a State plan for services for crippled children to provide, effective July 1, 1967, for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan.

SECTION 205. SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

Section 205 of the bill amends part 4 of title V of the Social Security Act by inserting a new section to provide special project grants to promote the health of school and preschool children. In conforming changes the heading of part 4 is revised accordingly and section 532 is redesignated section 533.

The new section 532(a) authorizes appropriations of $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, for special project grants in order to promote the health of children and youth of school and preschool age, particularly in areas with concentrations of low income families. Section 532(b) authorizes the Secretary to make grants to a State health agency and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency administering or supervising the administration of the crippled children's program under part 2q title V of the Social Security Act, to any school of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school, to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for health care and services for children and youth of school age or for preschool children (to help them prepare to start school). Projects for children and youth of school

age must include such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary. Treatment, correction of defects, and aftercare are to be available under the projects only to children who would not otherwise receive them because they are from low income families or for other reasons beyond their control. Projects must provide for coordination of the health care and services provided under them with, and for utilization of, other State or local health, welfare, and education programs for children, and for payment of the reasonable cost of inpatient hospital services.

The new section 532(c) provides for payment of the grants under section 532 in advance or by way of reimbursement, in such installments and on such conditions as the Secretary determines.

SECTION 206. EVALUATION AND REPORT

Section 206 of the bill requires the Secretary to submit to the President for transmission to the Congress before July 1, 1969, a full report of the administration of section 532 of the Social Security Act (special project grants for health of school and preschool children) together with an evaluation of the program and recommendations as to continuation of and modifications in the program.

PART 2. IMPLEMENTATION OF MENTAL RETARDATION PLANNING

SECTION 211. AUTHORIZATION OF APPROPRIATIONS

Section 211(a) of the bill amends section 1701 of the Social Security Act to authorize appropriations for assisting States in initiating the implementation and carrying out of planning and other steps to combat mental retardation. The amounts authorized to be appropriated are $2,750,000 for the fiscal year ending June 30, 1966, and $2,750,000 for the fiscal year ending June 30, 1967.

Section 211(b) of the bill amends section 1702 of the act to provide that the sums appropriated pursuant to section 1701 for the fiscal year ending June 30, 1966, are to be available for grants during that fiscal year and the 2 immediately succeeding fiscal years, and that the sums appropriated for the fiscal year ending June 30, 1967, are to be available for such grants during that fiscal year and the immediately succeeding fiscal year.

PART 3—PUBLIC ASSISTANCE AMENDMENTS RELATING TO HEALTH CARE

SECTION 221. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASE

Paragraphs (1) and (2) of section 221(a) of the bill, and paragraphs (1) and (2) of section 221(d), amend the definitions of the terms "old-age assistance", "aid to the aged, blind, or disabled" (insofar

as it relates to the aged), and "medical assistance for the aged", as those terms appear in titles I and XVI of the Social Security Act. These amendments remove the limitations on Federal participation in aid or assistance to aged individuals who are patients in institutions for tuberculosis or mental diseases or who are patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis.

Section 221 (b) and (c) of the bill, and paragraph (1) of section 221(d), amend the definitions of the terms "aid to the blind", "aid to the permanently and totally disabled", and "aid to the aged, blind, or disabled" (insofar as it relates to the blind or disabled), as those terms appear in titles X, XIV and XVI, respectively, of the Social Security Act so as to remove the existing limitations in those titles on Federal sharing in aid to individuals who are patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis. Federal financial participation would remain unavailable with respect to payments to or care in behalf of blind or disabled individuals who are patients in an institution for tuberculosis or mental diseases under such titles X and XIV, and under such title XVI in the case of individuals under age 65.

Paragraph (3) of section 221(a) of the bill, and paragraph (3) of section 221(d), amend sections 2(a) and 1602(a), respectively, of the Social Security Act to add new plan requirements for a State which elects to include assistance in its State plan under title I (or aid or assistance in its State plan under title XVI, insofar as such aid relates to the aged) to or in behalf of individuals who are patients in tuberculosis or mental institutions. Such plan requirements are the same as those set forth in section 1902(a) (20) and (21) of title XIX as added to the Social Security Act by section 121(a) of the bill.

Paragraph (4) of section 221(a) of the bill, and paragraph (4) of section 221(d), add provisions to sections 3 and 1603, respectively, of the Social Security Act comparable to the provision set forth in section 1903(b) of title XIX (as added by section 121(a) of the bill). These provisions make the Federal share in State expenditures with respect to aged patients in institutions for tuberculosis or mental diseases contingent upon a comparable increase in total expenditures in the State for mental health services.

Section 221(e) of the bill provides that the amendments made by the preceding provisions of section 221 will apply to expenditures made after December 31, 1965, under a State plan approved under title I, X, XIV, or XVI of the Social Security Act.

SECTION 222. AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

Sections 222(a) and 222(b) of the bill amend sections 6(b) and 1605(b), respectively, of the Social Security Act, to permit Federal sharing in State expenditures for medical assistance for the aged in the case of individuals who also received old-age assistance or aid to the aged, blind, or disabled in the month of their admittance to or discharge from a medical institution.

Section 222(c) of the bill provides that these amendments will apply to expenditures under a State plan approved under title I or XVI of the act with respect to care and services provided under such plan after June 1965.

TITLE III—SOCIAL SECURITY AMENDMENTS

Section 300 of the bill provides that title III of the bill may be cited as the "Old-Age, Survivors, and Disability Insurance Amendments of 1965".

SECTION 301. INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Section 301 of the bill provides for a revised benefit table to effectuate a 7-percent benefit increase and new maximum benefit amounts.

Primary insurance amount

Section 301(a) of the bill amends section 215 of the Social Security Act to substitute for the present benefit table a new table. The new table effectuates the increase for people who were on the benefit rolls in any month after December 1964 and provides benefit amounts higher than those under present law for people who come on the benefit rolls in and after the month in which the bill is enacted. The new primary insurance amounts, shown in column IV of the table, represent an increase of 7 percent in the primary insurance amounts, with a minimum increase of $4, over the primary insurance amounts provided in present law, for average monthly wages up to and including $400 a month. (The primary insurance amount is the amount payable to a worker who retires at or after age 65 or to a disabled worker, and it is also the amount from which all other benefits are determined.)

An approximation of the benefits shown in the new benefit table can be arrived at by taking 62.97 percent of the first $110 of the average monthly wage, plus 22.9 percent of the next $290, plus 21.4 percent of the next $66. Benefits in the present table approximate 58.85 percent of the first $110 of average wage plus 21.4 percent of the next $290.

The primary insurance amounts provided by the revised table range from a minimum of $44 for people whose average monthly wage is $67 or less to a maximum of $149.90 for people who have the average monthly wage of $466 that will become possible in the future with the $5,600 contribution and benefit base which the bill (in sec. 320) provides. The primary insurance amounts of retired workers who are now on the benefit rolls is raised from $40 to $44 at the minimum and from $127 to $135.90 at the maximum.

Under the revised benefit table, the total monthly amount of benefits payable to a family on the basis of a single earnings record will be determined on the basis of a new formula. The maximum family benefit in present law (shown in column V of the benefit table) is the smaller of 80 percent of the average monthly wage or $254—twice the maximum primary insurance amount of $127—but it does not operate to reduce the family benefits to less than 1½ times the primary insurance amount. The $254 amount applies over a rather wide range of average monthly wage levels, so that the maximum family benefit is not wage-related at average monthly wage levels above $317. The formula used to determine the new maximum family benefit amounts (these amounts are shown in column V of the benefit table in the bill) is 80 percent of the average monthly wage up to the point at which the average monthly wage amount is two-thirds of the maximum possible average

monthly wage specified in the law, plus 40 percent of the remainder of the average monthly wage. This formula produces, at the maximum average monthly wage, a maximum family benefit of two-thirds of the average monthly wage. Specifically, with the $5,600 contribution and benefit base, the 40-percent part of the formula would begin to operate above the $314 average monthly wage level, which is about two-thirds of the maximum average monthly wage of $466 (more precisely, it is the top of the average-monthly-wage bracket that includes the amount that is two-thirds of $466). As under present law, the maximum will not operate to reduce family benefits below 1½ times the primary insurance amount. (Because this new formula for determining the maximum family benefits would result in lower family benefits ($253.20) than are provided under present law for average monthly wages in the range $315 to $319, the present $254 maximum is retained for this range in the new table.)

Primary insurance amount under 1958 act, as modified

Section 301(b) of the bill amends section 215(c) of the act to provide that a person who became entitled to old-age or disability insurance benefits before the date of enactment of the bill, or who died before such date, will have his primary insurance amount, as determined under the provisions of present law and appearing in column II of the revised table, converted to the higher primary insurance amount appearing on the same line in column IV of the new table. Under present law, column II shows the primary amounts in effect prior to the Social Security Amendments of 1958 and column IV of the table shows the amounts to which the primary insurance amounts in column II were converted as a result of those amendments.

Maximum benefits for people already on the rolls

Section 301(c) of the bill amends section 203(a)(2) of the act to assure an increase in the family benefits for families who were on the benefit rolls after December 1964 and whose benefits were determined under the provisions of the law in effect prior to the enactment of the bill. In the absence of such a provision some families now on the benefit rolls could receive little or no increase in benefits, since their benefits are already at or near the maximum amount that would be payable to the family. The bill provides that the maximum family benefit for each month after December 1964 will be the larger of (1) the family maximum specified in column V of the new table or (2) the sum of all family members' benefits after each such benefit has been increased by 7 percent (and rounded to the next higher 10 cents if it is not already a multiple of 10 cents). The section also repeals section 203(a)(3) of the act, which is a special saving clause for the maximum family benefits of people who became disabled before 1959. This clause is no longer needed since families whose benefits were determined under this clause are now covered by paragraph (2) of section 203(a) as amended by the bill.

Effective date

Section 301(d) of the bill provides that the benefit increases provided for by subsections (a), (b), and (c) of section 301 will be effective for monthly benefits for months after December 1964 and for lump-sum death payments where death occurs in or after the month of enactment of the bill.

Special provision for conversion of a disability insurance benefit to an old-age insurance benefit

Section 301(e) of the bill is a special transitional provision which applies to an individual who was entitled to a disability insurance benefit for December 1964 and who became entitled to old-age insurance benefits in January 1965, to make certain that his primary insurance amount is increased. The general rule, provided in section 215(a)(4) of present law, that would apply in this situation is that an individual who was entitled to a disability insurance benefit for the month before he becomes entitled to an old-age insurance benefit will have as his primary insurance amount (and therefore his old-age insurance benefit) the amount in column IV of the table that is equal to his disability insurance benefit. In the situation outlined above, the individual's disability insurance benefit, since it was derived from a primary insurance amount determined under present law, does not have any direct connection with column IV of the table, which contains the new benefit amounts; and thus the general rule cannot be applied to this individual. Therefore, section 301(e) of the bill provides that his primary insurance amount is the amount in column IV of the table on the same line as that on which, in column II, appears his present primary insurance amount. (This primary insurance amount in col. II is equal to his disability insurance benefit under present law.)

Additional primary insurance amounts effective in January 1971

Section 301(f) of the bill revises and extends the benefit table effective with monthly benefits payable for January 1971. The benefit table is extended to take account of average monthly wages up to $550, the maximum average monthly wage that will be possible under the $6,600 annual contribution and benefit base that will be effective for years after 1970. Under the extended table, additional primary insurance amounts are provided up to a maximum of $167.90, based on an average monthly wage of $550.

The maximum family benefits were revised and extended on the basis of the same formula that was used in arriving at the maximum family benefits in the table provided in section 301(a). As a result, increased family maximum amounts are provided for average monthly wages of $315 to $466 (the maximum average monthly wage under the $5,600 base), since with the increase in the base the point up to which the 80-percent part of the formula applies is raised from $314 to $370. Also, of course, higher maximum family benefits are provided for the average monthly wages above $466 that will be possible under the $6,600 base, up to a maximum of $368 for an average monthly wage of $550.

SECTION 302. COMPUTATION AND RECOMPUTATION OF BENEFITS

Section 302 of the bill provides for automatic recomputation of benefit amounts under title II of the Social Security Act to take account of earnings after entitlement to benefits, and makes technical changes in the provisions for computation of benefits to facilitate automatic recomputation.

Average monthly wage

Section 302(a)(1) of the bill amends subparagraph (C) of section 215(b)(2) of the act to exclude from an insured individual's computation base years (from which the years to be used in the benefit computation are chosen) the year in which he became entitled to benefits and to include in his computation base years (for purposes of survivors' benefits) the year in which he died. As a result of this change, an individual's computation base years are the calendar years occurring after 1950 (or after 1936, as provided in section 215(d)) and up to the year in which his first month of entitlement to a benefit occurs or the year after the year in which he dies.

Section 302(a)(2) amends section 215(b)(3) of the act to provide that the number of an individual's elapsed years (which determine the number of years to be used in the benefit computation) will be counted up to the year in which he reaches age 65 (age 62 for women) or dies whether or not he is fully insured in that year. Under present law, an individual's elapsed years are counted up to the year in which he is *both* fully insured and age 65 (62 for women). Since almost all insured individuals are now insured by the time they reach the required age, the deletion of the provision in present law results in a simplification of the computation provisions.

Section 302(a)(3) amends paragraphs (4) and (5) of section 215(b) of the act. Paragraph (4), as amended, makes the new provisions of section 215(b) applicable only in the case of an individual who dies or becomes entitled to benefits or to a benefit recomputation under section 215(f)(2), as amended by the bill, after December 1965. The requirement in present law that an individual have not less than six quarters of coverage after 1950 in order to have his average monthly wage determined entirely on his earnings after 1950 is omitted from the amended paragraph. Paragraph (5), as amended, preserves the present method of computing the average monthly wage for people who, after the bill is enacted and prior to 1966 (the effective date of automatic recomputation), become entitled to benefits or a recomputation of benefits.

Primary insurance benefit under 1939 act

Section 302(b) of the bill makes a minor conforming change and updates a reference in section 215(d) of the act, relating to computation of primary insurance benefits under the 1939 Social Security Act.

Certain wages and self-employment income not to be counted

Section 302(c) of the bill amends section 215(e) of the act by striking out paragraph (3), which provides for a recomputation, for self-employed people who operate on a fiscal-year basis, to include earnings in the year of entitlement that were not available for inclusion in the original computation. This provision will not be needed, since these earnings will be taken into account under the automatic recomputation provisions which will be provided under section 215(f) as amended by the bill.

Recomputation of benefits

Section 302(d)(1) of the bill amends section 215(f)(2) of the act by providing for annual automatic recomputation of benefits, beginning in 1966.

The recomputation will take into account any earnings the person had in or after the year in which he became entitled to benefits (under

present law, a recomputation to include earnings in a year after entitlement requires an application and is not available unless the person had earnings of more than $1,200 for the year). The bill would also delete the requirements in present law that the person have six quarters of coverage after 1950 in order to qualify for the recomputation. A recomputation under the amended section 215(f)(2) will be effective, in the case of a living beneficiary, with January of the year following the year in which the earnings were received, and in death cases it will be effective for survivors' benefits beginning with the month of death.

Section 302(d)(2) repeals paragraphs (3), (4), and (7) of section 215(f) of the act, thereby eliminating the provisions for a recomputation to include earnings in the year of entitlement to benefits or in the year in which an individual's benefits were recomputed on account of additional earnings, the provisions for a recomputation for the purpose of paying benefits to survivors of an individual who died after 1960 and who had been entitled to old-age insurance benefits, and the provision for recomputing at age 65 the benefits of an individual who became entitled to benefits before that age. All of these are replaced by the automatic recomputation provision.

Recomputation of disability insurance benefits

Section 302(e) of the bill amends section 223(a)(2) of the act so that the provisions for computing disability insurance benefits will conform with the changed provisions for computing old-age insurance benefits.

Effective dates and saving provisions

Section 302(f)(1) of the bill provides that the repeal of section 215(e)(3) of the act made by section 302(c) (pertaining to recomputations for certain self-employed people) will be effective for individuals who become entitled to benefits after 1965.

Section 302(f)(2) provides that in any case where an individual would, by filing an application prior to January 2, 1966, be entitled to have his benefit recomputed under the provisions of existing law, the individual will be deemed to have filed an application on the date of enactment of the bill or the earliest date of eligibility thereafter and prior to January 2, 1966. Thus anyone who would profit from a recomputation under the provisions of present law will have his benefit amount recomputed automatically as though he had filed an application for that recomputation. The new automatic recomputation provisions will take over for the future.

Section 302(f)(3) retains paragraphs (3) and (4) of section 215(f) of present law for the purpose of providing, for survivors' benefits, a recomputation of the primary insurance amount of an individual who was entitled to an old-age insurance benefit and who died after 1960 and before 1966 without having filed an application for a recomputation. The new recomputation provisions will apply to deaths occurring after 1965.

Section 302(f)(4) retains until 1966 section 215(f)(7) of the act, which provides for the automatic recomputation of benefits to take account of earnings a man who is receiving actuarially reduced benefits may have had after entitlement and through the year of death or attainment of age 65. After 1965, these recomputations will be made under the new automatic recomputation provisions.

Section 302(f)(5) provides that the amendments made by section 302(e) (relating to computations of disability insurance benefits) will apply to individuals who become entitled to disability insurance benefits after 1965.

Section 302(f)(6) retains the provisions for figuring the average monthly wage which were in effect prior to the Social Security Amendments of 1960 so that an individual who was eligible for old-age insurance benefits before 1961 but who became entitled to benefits or died after 1960 can have his average monthly wage figured over less than 5 years of earnings where such a computation will result in a higher primary insurance amount. (Generally, under the Social Security Amendments of 1960, at least 5 years have to be used in the computation of the average monthly wage.)

SECTION 303. DISABILITY INSURANCE BENEFITS

Under existing law, the term "disability" is defined as inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration.

Section 303(a) of the bill amends clause (A) of the first sentence of section 216(i)(1), and paragraph (2) of section 223(c), of the Social Security Act, by striking out in both provisions the requirement that the individual's impairment be one which can be expected to result in death or to be of long-continued and indefinite duration.

Paragraph (1) of section 303(b) of the bill amends (and recodifies) paragraph (2) of section 216(i) of the Social Security Act to provide that a period of disability will end with the second month after the month in which disability ceases (as under existing law) if the individual has been under a disability continuously at least 18 months, but that such period will end with the first month after such cessation where he has been under a disability for a continuous period of less than 18 months. The new paragraph (2) also eliminates the present requirement that the individual must be under a disability when his application for a period of disability is filed and substitutes instead the requirement that no application for a disability determination which is filed more than 12 months after the month in which a period of disability would end (as specified in this section) shall be accepted.

Paragraph (2) of section 303(b) of the bill makes conforming changes in section 216(i)(3) of the Act.

Paragraph (3) of section 303(b) of the bill amends paragraph (1) of section 223(a) of the Act to provide that an individual who is insured for disability insurance benefits (as determined under subsection 223(c)(1)), has not attained age 65, and has filed application for disability insurance benefits is entitled to a disability insurance benefit for each month in his disability payment period (a new term which is defined in sec. 223(d), added by sec. 303(c) of the bill). This amendment eliminates the requirement in present law that an individual must be under a disability when he files his application for disability insurance benefits. In view of the change in the definition of disability and the provision in present law granting 12 months retroactivity to applications, this amendment permits the payment of benefits in those cases of extended disability which terminated before an application was filed. Thus, benefits will be paid for months of

disability even though at the time of filing application the disability has ceased so long as such months of disability fall within the period of retroactivity of the application.

Paragraph (4) of section 303(b) of the bill amends section 223(c)(3)(A) of the Act to eliminate the requirement that the individual must be under a disability which continues until his application for disability insurance benefits is filed. This amendment conforms to the amendment made by section 303(b)(3) of the bill, which eliminates the need for the existence of disability at the time the application was filed.

Section 303(c) of the bill amends section 223 of the Social Security Act by adding a new subsection (d) which defines the term "disability payment period."

Paragraph (1) of the new subsection (d) provides that, for purposes of section 223, the term "disability payment period" means the period beginning with the last month of the individual's waiting period and ending with the month preceding whichever of the following months is the earliest: the month in which he dies, the month in which he attains age 65, or either the second month following the month in which his disability ceases if he has been under a disability for a continous period of less than 18 calendar months or the third month following the month in which his disability ceases if he has been under a disability continuously for at least 18 calendar months. Under the amendment, three substantive changes are made in existing law. One change permits entitlement to benefits to begin with the 6th month of the waiting period—1 month earlier than under present law under which entitlement to disability benefits cannot begin earlier than the first month after the waiting period. The second change is to provide for benefits only for 2 additional months (as against 3 additional months under present law)—the month in which the disability ceased and the subsequent month—where the disability lasted less than 18 months. Where the disability lasted at least 18 months present law is retained by providing an adjustment period of 3 months' benefits. The third change is to eliminate the requirement that a disability benefit terminates with the month before the first month for which the individual is entitled to old-age insurance benefits. This is a conforming change made necessary by section 304(a) of the bill under which a disability insurance benefit may be paid after the individual becomes entitled to old-age insurance benefits.

Paragraph (2) of the new subsection (d) provides that if an individual had a period of disability which lasted at least 18 calendar months and which ceased within the 60-month period preceding the first month of his waiting period and such individual applies for disability insurance benefits on the basis of a disability which, at the time of application, can be expected to last at least 12 months or to result in death, then for purposes of section 223 the term "disability payment period" includes each month in the waiting period with respect to which such application was filed.

Paragraphs (1), (2), and (3) of section 303(d) of the bill make conforming changes in sections 222(c)(5), 223(a)(2)(B), 223(b), and 202(j)(1) of the Social Security Act. Paragraph (3) further amends section 223(b) to take into account the amendment made by section 303(b)(3) of the bill, which eliminates the need for the individual to be

under a disability at the time application is filed. The paragraph also amends section 202(j)(1) of the act to make it clear that a disability benefit payable under section 223 will be reduced so as not to render erroneous benefits paid prior to the filing of an application for disability benefits. This is in conformity with the amendment made by section 304 of the bill under which a larger benefit can become payable for prior periods during which other benefits had already been paid.

Paragraph (1) of section 303(e) of the bill provides that the amendments made by subsection (a) (eliminating the requirement that the individual's impairment be one that is expected to be of long-continued and indefinite duration or to result in death), by paragraphs (3) and (4) of subsection (b) (relating to eligibility for disability insurance benefits), and by paragraph (3) of subsection (d) (relating to such eligibility after termination of a period of disability) of section 303 of the bill, and subparagraphs (B), (E), and (F) of section 216(i)(2) of the Social Security Act as amended by subsection (b)(1) of section 303 (relating to establishing periods of disability), will be effective with respect to applications under sections 223 and 216(i) of the Social Security Act filed in or after the month in which the bill is enacted, or with respect to applications filed before such month if the applicant has not died before such month and if either (1) notice of the final decision of the Secretary has not been given to the applicant before such month, or (2) such notice has been so given before such month but a civil action thereon is commenced (whether before, in, or after such month, under section 205(g) of the Social Security Act and the decision in such civil action has not become final before such month. However, no monthly insurance benefits under title II of the Social Security Act are to be payable or increased by reason of the amendments made by subsections (a) and (b) of section 303 of the bill for months before the second month after the month of enactment of the bill. Periods of disability as defined in section 216(i)(2) of the Social Security Act may be established on the basis of the modified definition of disability even though such periods commence before the enactment of the bill.

Paragraph (2) of section 303(e) of the bill provides that the new section 223(d)(1) of the Social Security Act (relating to disability payment periods) will be applicable in the case of applications for disability insurance benefits filed by individuals the last month of whose waiting period occurs after the month of enactment of the bill. Those individuals whose waiting periods begin before the enactment of the bill will obtain the benefit of this amendment if the 6th month of their waiting period comes no earlier than the month after the month of enactment. Subparagraph (C) of such section 223(d)(1) (relating to the month in which disability payment periods end) applies to individuals entitled to disability insurance benefits whose disability ceases in or after the second month after the month of enactment of the bill. Thus, the reduction from 3 months to 2 months in cases of disabilities lasting less than 18 months will not apply to any cases where the disability ceased before such second month.

Paragraph (3) of section 303(e) of the bill provides that the new section 223(d)(2) of the Social Security Act (relating to second disabilities), and the conforming amendments made by subsection (d) of the bill, will be effective with respect to applications for disability

insurance benefits and for a disability determination filed after the month of enactment of the bill.

Paragraph (4) of section 303(e) of the bill provides that section 216(i)(2)(D) of the Social Security Act as amended by subsection (b)(1) of the bill (relating to the termination of a period of disability) will be effective with respect to a disability (as defined in sec. 216(i) of the Social Security Act as amended by the bill) which ceases in or after the second month following the month of enactment of the bill.

SECTION 304. PAYMENT OF DISABILITY INSURANCE BENEFITS AFTER ENTITLEMENT TO OTHER MONTHLY INSURANCE BENEFITS

Section 304 of the bill provides that an individual under age 65 may become entitled to disability insurance benefits after having become entitled to old-age, wife's, husband's, widow's, widower's, or parent's insurance benefits; this is not possible under existing law.

Section 304(a) adds a new paragraph (4) to section 202(k) of the Social Security Act to provide that a worker who is simultaneously entitled to both an old-age insurance benefit and a disability insurance benefit for any month will be entitled to receive only the disability insurance benefit for that month.

Section 304(b) changes the heading of section 202(q) of the act (relating to actuarial reduction of benefits) to include a reference to the reduction of disability insurance benefits and widow's insurance benefits (a reference to the latter is required because of the provision for payment of reduced benefits to widows at age 60 which is added to the act by sec. 307 of the bill).

Section 304(c) of the bill adds a new paragraph (2) to section 202(q) of the act and renumbers the present paragraphs (2) through (7) as paragraphs (3) through (8). The new paragraph (2) provides that if an individual is entitled to a disability insurance benefit after having been entitled to a reduced old-age insurance benefit, the disability insurance benefit (determined under sec. 223) will be reduced by the amount by which the old-age insurance benefit would have been reduced if the worker had reached age 65 in the month in which he most recently became entitled to the disability insurance benefit. For example, if a man became entitled at exact age 62 to a reduced old-age insurance benefit of $80 (based on a primary insurance amount of $100) and became entitled at exact age 63 to a disability insurance benefit of $105 (determined under sec. 223 of the act), the disability insurance benefit would be reduced by $6.60 (one-third of $20.00), the amount by which the old-age insurance benefit would have been reduced if the man had reached age 65 at the time when he became disabled. The effect of this provision is to reduce the disability insurance benefit to take account of the number of months for which the man actually got a reduced old-age insurance benefit before he became disabled.

Section 304(d) of the bill changes section 202(q)(3)(B) of the act (which provides for reducing wife's or husband's benefits where the wife or husband is also entitled to old-age benefits) to make the provisions of subparagraph (B) inapplicable for months for which the individual is entitled to a disability insurance benefit as well as a wife's or husband's benefit.

Section 304(e) amends subparagraph (C) of paragraph (3) (as redesignated by the bill) of section 202(q) of the act to provide that where a person is entitled to both a disability insurance benefit and to a reduced wife's, husband's, or widow's insurance benefit, the wife's, husband's, or widow's benefit will be reduced by the sum of: (1) the amount by which the disability insurance benefit was reduced to take account of prior entitlement to a reduced old-age insurance benefit, and (2) the amount by which the wife's, husband's, or widow's benefit would be reduced if it were equal to the amount by which such benefit (prior to any reduction) exceeded the unreduced disability insurance benefit.

Section 304(f) of the bill adds two new subparagraphs (F) and (G) to the redesignated paragraph (3) of section 202(q) of the act to provide for reducing the disability insurance benefit of an individual who becomes entitled to the disability benefit after having become entitled to a widow's benefit which is reduced because it was taken before age 62.

Subparagraph (F) sets forth the method for reducing the disability insurance benefit of a woman who becomes entitled to that benefit *at or after attainment of age 62* and who is entitled for the same month to a reduced widow's benefit. The amount of the reduction in the disability insurance benefit is whichever of the following is larger: (1) the amount by which the disability insurance benefit had been reduced because of prior entitlement to a reduced old-age benefit at age 62 or later, or (2) a sum equal to the amount by which the widow's benefit which the woman was getting at age 62 was reduced plus the amount by which the disability insurance benefit would be reduced (because of prior entitlement to a reduced old-age insurance benefit) if the disability benefit were equal to the excess of the unreduced disability benefit over the unreduced widow's insurance benefit.

Subparagraph (G) sets forth the method for reducing the disability insurance benefit of a woman who becomes entitled to the disability benefit *before attainment of age 62* and after entitlement to a reduced widow's benefit. Her disability insurance benefit will be reduced by the amount by which her widow's benefit would have been reduced if she had attained age 62 in the first month for which she became entitled to the disability insurance benefit.

Section 304(g) of the bill makes a conforming change in section 202(q)(4)(A) (as redesignated by the bill) to apply, to a person who is entitled to a disability insurance benefit which is reduced because of prior entitlement to a reduced benefit, the present provisions which set forth the method for reducing increases in benefits which occur after the person has come on the rolls and before he reaches age 65.

Section 304(h) of the bill adds a new subparagraph (F) to paragraph (7) (as redesignated by the bill) of section 202(q) of the act to provide that, in determining the "adjusted reduction period" (that is, the number of months in the reduction period for which a reduced benefit was actually paid and for which the old-age insurance benefit will be reduced for future months) applicable to a reduced old-age insurance benefit, any month for which a disability insurance benefit was payable will be excluded.

Section 304(i) of the bill is a conforming change in the redesignated paragraph (8) of section 202(q) to apply to the reduced disability

insurance benefit the provision in existing law for reducing the amount of the reduction to the next lower multiple of 10 cents if it is not already a multiple of 10 cents.

Section 304(j) of the bill makes a technical conforming change in paragraph (2) of section 202(r) of the act (relating to the presumed filing of application by individuals eligible for old-age insurance benefits and for wife's or husband's insurance benefits).

Section 304(k) of the bill amends section 215(a)(4) of the act, which provides a method of determining the primary insurance amount of an individual entitled to a disability insurance benefit who dies, or becomes entitled to an old-age insurance benefit (in the case of a woman) or attains age 65 (in the case of a man). Under existing law the primary insurance amount in such cases is equal to the disability insurance benefit; this provision operates properly under existing law because the disability insurance benefit is never reduced and thus is always equal to the primary insurance amount. Under the bill, however, the disability insurance benefit may be reduced and therefore smaller than the primary insurance amount. Section 304(k) therefore provides that the primary insurance amount to be used in the case where a disability beneficiary dies or becomes entitled to old-age insurance benefits or attains age 65 shall be the primary insurance amount on which the disability insurance benefit was based rather than the amount of the disability insurance benefit itself.

Section 304(l) of the bill amends paragraph (2) of section 216(i) of the act to remove a reference to section 223(a)(3) which is repealed by section 304(n) of the bill.

Section 304(m) of the bill makes a conforming change in paragraph (2) of section 223(a) to take account of the reduction of the disability insurance benefit under the provisions of section 202(q) as amended by the bill.

Section 304(n) of the bill repeals paragraph (3) of section 223(a) of the act, thereby permitting an individual to become entitled to a disability insurance benefit after having become entitled to a widow's, widower's, parent's, old-age, wife's, or husband's insurance benefit.

Section 304(o) of the bill provides that the amendments made by section 304 are to apply with respect to monthly benefits for and after the second month following the month of enactment of the bill on the basis of applications in or after such month of enactment.

SECTION 305. DISABILITY INSURANCE TRUST FUND

Section 305(a) of the bill amends section 201(b)(1) of the Social Security Act to increase the percentage of taxable wages appropriated to the disability insurance trust fund (now one-half of 1 percent) to three-fourths of 1 percent, effective with respect to wages paid after 1965.

Section 305(b) of the bill amends section 201(b)(2) of the Social Security Act to increase the percentage of taxable self-employment income appropriated to the disability insurance trust fund (now three-eighths of 1 percent) to nine-sixteenths of 1 percent, effective with respect to taxable years beginning after 1965.

SECTION 306. PAYMENT OF CHILD'S INSURANCE BENEFITS AFTER ATTAINMENT OF AGE 18 IN CASE OF CHILD ATTENDING SCHOOL

Section 306(a) of the bill amends subparagraph (B) of section 202(d)(1) of the Social Security Act to provide for the payment of benefits to a child up to the age of 22 if he is attending school. The amended subparagraph (B) also contains language relating to a child who is over 18 but who is unmarried and under a disability which began before he attained age 18 which conforms to the revised definition of disability in section 223(c) of the Social Security Act as amended by section 303(a)(2) of the bill. A child will be considered to be under a disability if the disability began before he attained the age of 18 and lasted, or could be expected to last, for a continuous period of at least 6 calendar months or to result in his death.

Subsection (b)(1) of section 306 amends the first sentence of section 202(d)(1) of the Social Security Act (relating to the termination of child's benefits) by adding six new subparagraphs. The new subparagraphs (D) and (E) retain the provisions of existing law which terminate a child's benefit if he marries, dies, or is adopted (except for adoption by certain relatives) and provide in general for the termination of the child's benefits at attaining age 18 if he is no longer attending school and is not under a disability.

The new subparagraph (F) provides that benefits for a child who is not disabled and is a full-time student in the month in which he attains age 18 will terminate with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

The new subparagraph (G) provides that benefits for a child who becomes entitled to benefits after he attains age 18 and is not disabled will end with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

The new subparagraph (H) provides that if a child ceases to be under a disability which began before he attained age 18 and which lasted for a continuous period of at least 18 months, and the child either attains age 22 before the close of the third month following the month in which his disability ceases or is not a full-time student during that month, his benefits will terminate with the month before such third month. However, if the child's disability lasted less than 18 months, and he either attains age 22 before the close of the second month following the month in which his disability ceases or is not a full-time student in that month, his benefits will terminate with the month before such second month.

The new subparagraph (I) provides that if a child's disability ceases after he attains age 18 but before he attains age 22, and if he is a full-time student in the third month (or second month, if his disability lasted less than 18 months) thereafter, his benefits will terminate with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

Subsection (b)(2) of section 306 repeals a sentence which is no longer needed because it has been incorporated in the changes made by subsection (b)(1).

Subsection (b)(3) of section 306 adds two new paragraphs, (7) and (8), to section 202(d) of the act. The new paragraph (7) permits a child whose benefits are terminated after he attains age 18 to become reentitled to child's insurance benefits, on filing a new application, if he becomes a full-time student before age 22. Such reentitlement to benefits will end with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

The new paragraph (8) defines "full-time student" and "educational institution." A full-time student is an individual who is in full-time attendance at an educational institution; whether or not the student was in full-time attendance is to be determined by the Secretary in the light of the standards and practices of the school involved. Specifically excluded from the definition of "full-time student" is a person who is paid by his employer while attending school at the request (or pursuant to a requirement) of his employer. Benefits are payable for any period of 4 calendar months or less in which a person does not attend school if the person shows to the satisfaction of the Secretary that he intends to continue in full-time school attendance immediately after the end of the period, or if the person is in fact in full-time attendance immediately after the end of the period.

The definition of "educational institution" includes all public schools, colleges, and universities, and all private schools, colleges, and universities which are accredited by a State recognized or nationally recognized accrediting association. Also included are those nonaccredited schools, colleges, and universities whose credits are accepted, on transfer, by three accredited institutions on the same basis as if transferred from an accredited institution.

Subsection (c)(1) of section 306 of the bill adds a new subsection (s) to section 202 of the act. Paragraph (1) of the new subsection (s) prevents a wife, widow, or surviving divorced mother from getting benefits if the only child in her care is getting benefits solely because he is a student.

Paragraph (2) of the new subsection (s) revises the provisions of law which permit a person with a childhood disability to continue to get benefits when he marries another beneficiary, and which permit such a beneficiary to continue to get benefits when he marries a person with a childhood disability. Benefits are payable if the child was under a disability which began before he attained age 18 or had been under such a disability in the third month before the month in which such marriage occurred.

Paragraph (3) of the new subsection (s) retains the provision in existing law which permits a person entitled to benefits because of a childhood disability to become entitled to a higher spouse's benefit without meeting the generally applicable dependency requirement.

Subsections (c)(2) through (c)(13) of section 306 make conforming changes to incorporate references to the new subsection (s).

Subsections (c)(14) and (c)(15) of section 306 provide that the provisions of existing law which relate to withholding of benefits payable to a person with a childhood disability while an investigation of whether his disability still exists is being made or when he refuses to accept vocational rehabilitation services will not apply with respect to children over 18 who are attending school.

Subsection (d) of section 306 provides that the amendments made by that section will be effective for January 1965 and months thereafter on the basis of applications for benefits filed in or after the month of enactment of the bill. Where a child was already on the rolls in the month the bill is enacted no application will be required.

SECTION 307. REDUCED BENEFITS FOR WIDOWS AT AGE 60

Widow's insurance benefits payable beginning at age 60

Section 307(a)(1) of the bill amends section 202(e) of the Social Security Act to provide that a widow may become entitled at age 60 to benefits based on the earnings record of her deceased husband. Section 307(a)(2) of the bill, by providing for the application to the benefits of section 202(q), provides that the benefits payable to widows who claim them before age 62 will be reduced to take account of the longer period over which they will be paid. Under existing law, unreduced benefits equal to 82½ percent of the deceased husband's primary insurance amount are payable to a widow at or after age 62.

Reduction factors

Section 307(b)(1) of the bill amends section 202(q)(1) of the Social Security Act, governing the reduction of benefits payable to beneficiaries who elect to start getting them prior to attainment of age 65, to provide that widow's insurance benefits to which a woman is entitled for a month before she is 62 are reduced by five-ninths of 1 percent for each month in the reduction period (the months prior to attainment of age 62 for which she is entitled to a widow's benefit) and that benefits to which she is entitled for the month in which she attains age 62 and months thereafter are reduced by the same percentage for each month in the adjusted reduction period (the months prior to attainment of age 62 for which the widow has actually been paid a benefit). This is the same factor as that which applies to an old-age benefit which is payable prior to attainment of age 65. Under the amendment, the benefits provided for a widow before age 62 may be reduced for as many as 24 months. The reduction for a widow claiming her benefit at exactly age 60 would be 13⅓ percent; her benefit would be reduced from the 82½ percent of her husband's primary insurance amount which would be payable to her at age 62 to 71½ percent of such primary insurance amount. For a widow who gets reduced benefits, the amount of the reduction in benefits would be adjusted at age 62 (as it is now adjusted at age 65 for old-age, wife's, or husband's benefits) to take account of any months in which no benefit was paid.

Entitlement to benefits on own earnings record

Paragraphs (2) and (3) of section 307(b) of the bill amend section 202(q)(3) (as renumbered by the bill) of the act to provide that where a widow is entitled to a disability insurance benefit based on her own earnings when she becomes entitled to a reduced widow's benefit, the reduction in the widow's benefit applies only to the excess of the widow's benefit over the benefit payable on her own earnings record. Similar provision is made under existing law for a person who is entitled simultaneously to a reduced old-age benefit and a wife's or husband's benefit; for example, where a wife is entitled

to a benefit based on her own earnings for the month for which she first becomes entitled to a wife's benefit the reduction factor applies only to the amount by which the wife's benefit exceeds her own benefit.

Reduction in subsequent old-age insurance benefit

Section 307(b)(4) of the bill adds a new subparagraph (E) to section 202(q)(3) (as renumbered) of the act to provide a method for reducing the old-age insurance benefit of a widow who is entitled to reduced widow's benefits. The old-age benefit (whether the woman begins to get it before or after she reaches age 65) will be reduced to take account of the widow's benefits paid to her before age 62. The amount of the reduction in the old-age benefit is whichever of the following is larger: (1) the reduction which would have been made in the old-age benefit if no widow's benefit had been payable, or (2) the dollar amount of the reduction in the widow's benefit plus the amount resulting from applying to the amount by which the unreduced old-age benefit exceeds the unreduced widow's benefit the reduction factor which would have been applied to the unreduced old-age benefit if the woman had not been eligible for a reduced widow's benefit.

The operation of this provision may be illustrated by the following example: Assume that a woman upon reaching age 60 elects to start getting a widow's benefit and that the benefit is reduced from $50.40 (82½ percent of her husband's primary insurance amount) to $43.70—a $6.70 reduction (24 months times five-ninths of 1 percent, or 13⅓ percent of $50.40). Assume further that at age 64 she becomes entitled to an unreduced old-age benefit of $76. If no widow's benefit had been payable, the $76 benefit would have been reduced to $71—a $5.00 reduction (12 months times five-ninths of 1 percent, or 6⅔ percent of $76). Under the new section 202(q)(3)(E), the amount by which her unreduced old-age benefit exceeds her unreduced widow's benefit, or $25.60 (the $76 old-age benefit less the $50.40 widow's benefit), will be reduced to $23.90—a $1.70 reduction (6⅔ percent of $25.60). Since the sum of the amount of the reduction in her widow's benefit and the reduction in her excess old-age benefit—$8.40 ($6.70 plus $1.70)—is larger than the amount by which her old-age insurance benefit would have been reduced—$5.00—her old-age benefit must be reduced by the larger amount—$8.40—that is, from $76 to $67.60.

Reduction where widow has a child in her care

Section 307(b)(5) of the bill adds to section 202(q)(5) (as renumbered) of the act a new clause, (D), to provide that, regardless of the provisions for reducing the benefits of widows who claim them before age 62, in no case will a widow who had in her care a child entitled to child's benefits get less in benefits for months in which she had the child in her care than the amount of the mother's insurance benefit (75 percent of her husband's primary insurance amount). This could happen, for example, where a widow started getting widow's benefits at age 60 (71½ percent of her husband's primary insurance amount) and starting at age 61 a child entitled to benefits was placed in her care. This provision permits her benefit amount for any month in which she has a child in her care to be increased to 75 percent of her husband's primary insurance amount.

Reduction period

Section 307(b)(6) of the bill amends section 202(q)(6) (as renumbered) of the act to provide that, in the case of widow's insurance benefits, the "reduction period" will begin with the first month for which the woman is entitled to a reduced widow's benefit and will end with the month before the month in which she attains age 62. The number of months in the "reduction period" is the number that is multiplied by five-ninths of 1 percent to determine the reduction in the benefits.

Adjusted reduction period

Section 307(b)(7) of the bill amends section 202(q)(7) (as renumbered) of the act, which describes the months which will be eliminated from the "reduction period" in determining the "adjusted reduction period" for purposes of establishing the benefit amount payable for months beginning with the month after the reduction period, to provide that, in determining a widow's adjusted reduction period at age 62, months in which her reduced widow's benefit was increased because she had in her care a child of her deceased husband entitled to child's insurance benefits, months in which her benefit was withheld because she had earnings from work, and months beginning with the month the widow's benefit was terminated through the month prior to the widow's attainment of age 62, will not be counted. For example, if a widow elects to start getting benefits upon reaching age 60 her benefit amount will be reduced by five-ninths of 1 percent for each of the 24 months in the reduction period; if, starting at age 61, a child entitled to a benefit is placed in the widow's care and remains in her care for 6 months, her benefit amount will be adjusted at age 62 and, for future months, will be reduced by five-ninths of 1 percent for each of the 18 months in the adjusted reduction period.

Definitions

Section 307(b)(8) of the bill adds a new paragraph (9) to section 202(q) of the act. The new paragraph defines "retirement age", for purposes of the actuarial reduction provisions, as age 65 for old-age, wife's, or husband's insurance benefits and age 62 for widow's insurance benefits.

Effective date

Section 307(c) of the bill provides that reduced widow's insurance benefits will be payable beginning with the second month after the month of enactment of the bill on the basis of applications filed in or after the month of enactment.

SECTION 308. WIFE'S AND WIDOW'S BENEFITS FOR DIVORCED WOMEN

Section 308(a) of the bill amends section 202(b) (relating to the payment of wife's insurance benefits) of the Social Security Act to provide for the payment of wife's insurance benefits to a divorced wife who had not remarried and who met the following support requirements at the time her former husband became entitled to old-age or disability insurance benefits, or at the time his period of disability began: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions

from him (pursuant to a written agreement), or (3) there was in effect a court order for substantial contributions to her support from him. The amended section 202(b) also provides that a wife's benefits will not terminate if she has attained age 62 and is divorced after having been married for 20 years (benefits for a wife under age 62 with a child in her care would terminate if she was divorced, regardless of how long she had been married, since benefits are not provided for a young divorced wife with a child in her care until after the former husband's death). The amended section 202(b) also adds to the present provisions for terminating wife's benefits a provision for terminating a divorced wife's benefit if she marries someone other than the worker on whose earnings her benefit is based. For purposes of paying benefits to a divorced wife, a remarriage which ended in a divorce after less than 20 years would be deemed not to have occurred. (Benefits will not be payable under this provision, for deeming the marriage not to have occurred, for any month before whichever of the following is the latest: The month after the month in which the divorce occurs; the 12th month before the month in which these benefits are applied for; or the 2d month after the month of enactment of the bill.) Also, if a divorced wife married a person entitled to benefits as a widower, parent, or disabled child, her benefits (and her new husband's benefits) would not be terminated, and if she married a person getting old-age or disability insurance benefits, she would immediately become eligible for wife's benefits based on her new husband's wages and self-employment income.

Section 308(b)(1) amends section 202(e) (relating to the payment of widow's insurance benefits) of such act to provide for the payment of widow's insurance benefits to a surviving divorced wife who had not remarried and who met the following support requirements at the time her former husband died, at the time he became entitled to old-age or disability benefits, or at the beginning of a period of disability which ended with his death or entitlement to monthly benefits: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from him (pursuant to a written agreement), or (3) there was in effect a court order for substantial contributions to her support from him.

Sections 308(b)(2) and 308(b)(3) of the bill make conforming changes in the provisions for paying widow's benefits to a surviving divorced wife so that she will have the same treatment as a widow has under existing law in the event that she marries a beneficiary or a person who dies within 1 year and is not insured.

Section 308(b)(4) of the bill further amends the existing provisions of section 202(e) of the act for paying widow's insurance benefits to provide that, for purposes of paying benefits to widows and surviving divorced wives, a remarriage which ends in divorce after less than 20 years will be deemed not to have occurred. (Benefits will not be payable under this provision, for deeming the marriage not to have occurred, for any month before whichever of the following is the latest: The month after the month in which the divorce occurs; the 12th month before the month in which these benefits are applied for; or the 2d month after the month of enactment of the bill.)

Section 308(c) amends section 216(d) of the Social Security Act to define "divorced wife", "surviving divorced wife", "surviving divorced mother", and "divorce". Paragraphs (1) and (2) of the new subsection (d) define "divorced wife" and "surviving divorced wife" as a

woman divorced from an individual to whom she was married for a period of 20 years immediately before the divorce. The new paragraph (3) of section 216(d) substitutes the term "surviving divorced mother" for the term "former wife divorced" in the definition of the latter term as contained in existing law. Paragraph (4) defines "divorce" and "divorced" as meaning a divorce *a vinculo matrimonii*. Existing law uses the full term wherever divorce is mentioned.

Section 308(d)(1) of the bill deletes a reference to "divorced *a vinculo matrimonii*" which is no longer needed because of the definition of divorce included in the law by section 308(c) of the bill.

Section 308(d)(2) amends the provisions of the Social Security Act for continuing child's, widower's, and parent's benefits if the beneficiary marries a person getting dependents' or survivors' benefits so that such benefits will not terminate if the beneficiary marries a divorced wife getting wife's benefits. Section 308(d)(2) also has the effect of providing that a woman getting benefits as a divorced wife who marries an old-age or disability insurance beneficiary may become eligible for wife's or widow's benefits on the basis of her new husband's wages and self-employment income without regard to the 1-year duration-of-marriage requirement in present law. (Similar treatment is provided for individuals entitled to widow's benefits under existing law.)

Paragraphs (3), (4), and (5) of section 308(d) amend section 202(g) (relating to mother's insurance benefits). Under the amendment made by paragraph (3), the support requirement which must be met if a surviving divorced mother is to qualify for mother's insurance benefits is the same as the new support requirement provided for a "divorced wife" and a "surviving divorced wife." Under the amendment made by paragraph (4), for purposes of paying mother's insurance benefits to a widow or surviving divorced mother, a subsequent marriage which ends in divorce after less than 20 years may be deemed not to have occurred. (Benefits will not be payable under this provision, for deeming the marriage not to have occurred, for any month before whichever of the following is the latest: The month after the month in which the divorce occurs; the 12th month before the month in which these benefits are applied for; or the 2d month after the month of enactment of the bill.) This provision does not preclude payment of mother's insurance benefits on the basis of the wages and self-employment income of a person to whom she was remarried for less than 20 years and from whom she had been divorced if she could become entitled to such benefits under existing law.

Paragraph (5) would replace the present term "former wife divorced" with the term "surviving divorced mother" in section 202(g) of existing law (relating to mother's insurance benefits).

Paragraph (6) of section 308(d) amends section 203(a) (relating to maximum family benefits) to provide that the monthly benefits paid to a divorced wife or a surviving divorced wife will not be reduced because of the limit on total family benefits and will not be counted in figuring the total benefits payable to others on the basis of the wages or self-employment income of the same individual.

Paragraphs (7), (8), (9), (10), and (11) of section 308(d) make conforming changes in various sections of the Social Security Act.

Section 308(e) of the bill provides an effective date for the section. Wife's and widow's insurance benefits for a divorced wife and a surviving divorced wife will be payable beginning with the second

month after the month of enactment of the bill, but, in the case of an individual who was not entitled to benefits in the month after the month of enactment, only on the basis of an application filed in or after the month of enactment.

SECTION 309. TRANSITIONAL INSURED STATUS

Section 309(a) of the bill adds a new section 227 at the end of title II of the Social Security Act (after the new section 226 added by section 101 of the bill) to provide a special insured status for certain individuals now in their seventies or over who are not eligible for benefits under the provisions of present law because they (or their husbands) do not have 6 quarters of coverage.

Subsection (a) of the new section 227 provides that anyone who attains age 72 before 1969 and does not meet the existing insured-status requirements of section 214(a) will nevertheless be insured if he has one quarter of coverage for each year elapsing after 1950 and before the year in which he attained retirement age (65 for men, 62 for women) and if he has not less than 3 quarters of coverage. These provisions will merge gradually into the fully-insured-status provisions of the present law, so that men who attained age 65 and women who attained age 62 after 1956 will have to meet the requirements of present law in order to qualify for benefits. The following table sets forth the quarter-of-coverage requirements under this provision and shows how these requirements merge with the minimum 6 quarters of coverage required under present law:

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 (same as present law)	70 or younger	6 or more (same as present law).

The benefit payable to a person who meets only the transitional requirement will be $35. The wife of such a person, if she attains age 72 before 1969, will be eligible at age 72 for a wife's benefit of $17.50.

Subsection (b) of the new section 227 provides benefits for a widow who reaches age 72 before 1969 and whose husband died before 1957 or reached age 65 before 1957 and died before the transitional provisions go into effect. Such a widow could qualify for widow's benefits of $35 a month if the man had 3, 4, or 5 quarters of coverage, as shown in the following table (which also shows the requirements of present law):

Year of husband's death (or attainment of age 65, if earlier)	Quarters of coverage required under present law	Quarters of coverage required under the bill for a 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.

Subsection (c) of the new section 227 provides that a widow whose husband dies after the transitional provisions go into effect can become entitled to widow's benefits of $35 a month if she reaches age 72 before 1969, if her husband reached age 65 before 1957, and if he was (or, upon filing an application prior to his death, would have been) entitled to benefits under the transitional provisions.

Section 309(b) of the bill makes the transitional insured status provisions effective for monthly benefits beginning with the second month following the month of enactment of the bill on the basis of applications filed in or after the month of such enactment.

SECTION 310. INCREASE IN AMOUNT AN INDIVIDUAL IS PERMITTED TO EARN WITHOUT SUFFERING FULL DEDUCTIONS FROM BENEFITS

Section 310(a) of the bill amends paragraph (3) of section 203(f) of the Social Security Act by changing the provision in present law under which there is a $1-for-$2 reduction (i.e., a $1 reduction in benefits for each $2 of earnings) above $1,200 and up to $1,700 to provide instead for a $1-for-$2 reduction for earnings from $1,200 to $2,400. Benefits will continue to be reduced by $1 for each $1 of earnings above $2,400, as they are now for earnings above $1,700.

Section 310(b) of the bill provides that the change made by section 310(a) will be effective for taxable years ending after 1965.

SECTION 311. COVERAGE FOR DOCTORS OF MEDICINE

Amendments to Title II of the Social Security Act

Removal of exclusion for doctors of medicine

Under existing law, services performed by a self-employed person in the exercise of his profession as a doctor of medicine, or as a member of a partnership engaged in the practice of medicine, are excepted from the term "trade or business" and thus from self-employment coverage under section 211(c)(5) of the Social Security Act. Section 311(a)(1) of the bill amends section 211(c)(5) of the act by removing the exception provided for services performed as a doctor of medicine or as a member of a partnership engaged in the practice of medicine. In general, the effect of this amendment is to extend social security coverage to net earnings derived by an individual from the practice of medicine on his own account or by a partnership of which he is a member.

Section 311(a)(2) of the bill conforms the provisions of the last two sentences of section 211(c) of the act to the amendment made by section 311(a)(1) of the bill.

Removal of exclusion for interns in Federal hospitals

Section 210(a)(6)(C)(iv) of the Social Security Act excludes from the term "employment," and thus from social security coverage, services performed by certain interns, student nurses, and other student employees of hospitals of the Federal Government. Section 311(a)(3) of the bill amends section 210(a)(6)(C)(iv) of the act so as to remove the exclusion insofar as it pertains to medical or dental interns and medical or dental residents-in-training. The effect of this amendment

is to extend social security coverage to such individuals with respect to services performed by them as interns or residents-in-training in the employ of hospitals of the Federal Government.

Removal of exclusion for student interns

Section 210(a)(13) of the Social Security Act excludes from the term "employment," and thus from social security coverage, services performed as an intern in the employ of a hospital by an individual who has completed a 4-year course in a medical school chartered or approved pursuant to State law. Section 311(a)(4) of the bill amends section 210(a)(13) so as to remove this exclusion. The effect of this amendment is to extend social security coverage to such interns unless their services are excluded under provisions other than section 210(a)(13). Thus, the services of an intern are covered if he is employed by a hospital which is not exempt from income tax as an organization described in section 501(c)(3) of the code. If the intern is employed by a hospital which is exempt from income tax and which has a waiver certificate in effect under section 3121(k) of the code, he is not excluded from coverage by section 210(a)(8)(B) of the Social Security Act if coverage was effected under such certificate.

Amendments to the Internal Revenue Code of 1954

Removal of exclusion for doctors of medicine

Under existing law, services performed by a self-employed person in the exercise of his profession as a doctor of medicine, or as a member of a partnership engaged in the practice of medicine, are excepted from the term "trade or business" under section 1402(c)(5) of the Internal Revenue Code of 1954. Section 311(b)(1) of the bill amends section 1402(c)(5) of the code by removing the exception provided for services performed as a doctor of medicine or as a member of a partnership engaged in the practice of medicine. In general, the effect of this amendment is to subject the net earnings derived by an individual from the practice of medicine on his own account or by a partnership of which he is a member to the self-employment tax.

Section 311(b)(2) of the bill conforms the provisions of the last two sentences of section 1402(c) of the code to the amendment made by section 311(b)(1).

Technical amendments

Section 311(b)(3) of the bill conforms the language of sections 1402(e)(1) and 1402(e)(2) of the code to the amendment made by section 311(b)(1).

Removal of exclusion for interns in Federal hospitals

Section 3121(b)(6)(C)(iv) of the Internal Revenue Code of 1954 excludes from the term "employment," and thus from coverage under the Federal Insurance Contributions Act, services performed by certain interns, student nurses, and other student employees of hospitals of the Federal Government. Section 311(b)(4) of the bill amends section 3121(b)(6)(C)(iv) of the code so as to remove the exclusion insofar as it pertains to medical or dental interns and medical or dental residents-in-training. The effect of this amendment is to make the remuneration of such individuals for services performed by them as such interns or residents-in-training in the employ of hospitals

of the Federal Government subject to the Federal Insurance Contributions Act.

Removal of exclusion for student interns

Section 3121(b)(13) of the Internal Revenue Code of 1954 excludes from the term "employment," and thus from coverage under the Federal Insurance Contributions Act, services performed as an intern in the employ of a hospital by an individual who has completed a 4-year course in a medical school chartered or approved pursuant to State law. Section 311(b)(5) of the bill amends section 3121(b)(13) so as to remove this exclusion. The effect of this amendment is to extend coverage under the Federal Insurance Contributions Act to such interns unless their services are excluded under provisions other than section 3121 (b)(13). Thus, the services of an intern are covered if he is employed by a hospital which is not exempt from income tax as an organization described in section 501(c)(3) of the code. If the intern is employed by a hospital which is exempt from income tax and which has a waiver certificate in effect under section 3121(k) of the code, he is not excluded from coverage by section 3121(b)(8)(B) of the code if coverage was effected under such certificate.

Effective Date

Section 311(c) of the bill provides that the amendments made by paragraphs (1) and (2) of section 311(a) and by paragraphs (1), (2), and (3) of section 311(b), relating to the self-employment coverage of doctors of medicine, are effective for taxable years ending after December 31, 1965. The amendments made by paragraphs (3) and (4) of section 311(a) and by paragraphs (4) and (5) of section 311(b), relating to social security coverage of interns and residents-in-training, are effective with respect to services performed after 1965.

SECTION 312. GROSS INCOME OF FARMERS

Increasing gross income taken into account for optional method of computing net earnings from farm self-employment; amendments to title II of the Social Security Act

Section 312(a) of the bill amends section 211(a) of the Social Security Act to increase from $1,800 to $2,400 the maximum gross income from agricultural activity that a self-employed farmer may use under the optional method of computing his net earnings from self-employment as a farmer. Under present law, an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $1,800 or less may, at his option, base his self-employment coverage on two-thirds of his gross income from farming; if such individual's gross income is more than $1,800 and his net earnings from self-employment as a farmer are less than $1,200, he may report $1,200 as net earnings from self-employment; if his net earnings from self-employment as a farmer are $1,200 or more, he must report his actual net earnings from self-employment as a farmer. Under the amendments made by section 312(a) of the bill an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $2,400 or less may, at his option, base his self-employ-

ment coverage on two-thirds of his gross income from farming; if he has gross income of more than $2,400 and net earnings from self-employment of less than $1,600, he may report $1,600 as net earnings from self-employment as a farmer; if his net earnings from self-employment as a farmer are $1,600 or more, he must report his actual net earnings from self-employment as a farmer.

Same: Amendments to the Internal Revenue Code of 1954

Section 312(b) of the bill amends section 1402(a) of the Internal Revenue Code of 1954 to increase from $1,800 to $2,400 the maximum gross income from agricultural activity that a self-employed farmer may use under the optional method of computing his net earnings from self-employment as a farmer. Under present law, an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $1,800 or less may, at his option, treat as net earnings from such self-employment two-thirds of his gross income from farming; if such individual's gross income is more than $1,800 and his net earnings from self-employment as a farmer are less than $1,200, he may treat $1,200 as net earnings from self-employment; if his net earnings from self-employment as a farmer are $1,200 or more, he must report his actual net earnings from self-employment as a farmer. Under the amendments made by section 312(b), an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is $2,400 or less may, at his option, treat as net earnings from such self-employment two-thirds of his gross income from farming; if he has gross income from farming of more than $2,400 and his net earnings from self-employment as a farmer are less than $1,600, he may report $1,600 as net earnings from self-employment as a farmer; if his net earnings from self-employment as a farmer are $1,600 or more, he must report his actual net earnings from such self-employment.

Effective Date

Section 312(c) of the bill provides that the amendments made by sections 312(a) and 312(b) will apply with respect to taxable years beginning after December 31, 1965.

SECTION 313. COVERAGE OF TIPS

Section 313 of the bill provides for treating tips received by an employee in the course of his employment as wages paid by the employer for social security tax and benefit purposes and for the purpose of withholding income tax at source. The provisions of this section have no application to amounts which under existing law constitute wages.

Amendments to Title II of the Social Security Act

Section 313(a)(1) of the bill amends section 209 of the Social Security Act (defining "wages" for social security benefit purposes) by adding a new subsection (l). The new subsection provides that tips do not constitute wages if they are paid in a medium other than cash or if the cash tips received in a calendar month by the employee in the course of his employment by a single employer amount to less than $20.

Section 313(a)(2) of the bill further amends section 209 of the act by adding a new unnumbered paragraph at the end thereof. The new paragraph provides that tips received by an employee in the course of his employment (which are not excluded from wages under the new sec. 209(l) of the act) are to be considered wages for social security benefit purposes. Such tips are deemed paid to the employee by the employer and are deemed so paid at the time a written statement including such tips is furnished the employer pursuant to section 6053(a) of the Internal Revenue Code of 1954 (added by sec. 313(e) (2) of the bill). Tips not included in a written statement or included in a written statement not furnished the employer by the close of the 10th day following the month of receipt (as prescribed in sec. 6053(a) of the code) are considered to have been paid to the employee at the time the tips are received. Tips constitute wages for social security benefit purposes regardless of whether the tips are received by the employee from a person other than his employer or are paid to the employee by his employer. Only tips received by an employee on his own behalf and not on behalf of another employee constitute wages. Thus, where employees practice tip splitting, the ultimate recipient of the tip (or portion thereof) is the employee who is receiving the tip as wages.

Amendments to the Internal Revenue Code of 1954

Section 313(b) of the bill amends section 451 of the Internal Revenue Code of 1954 (relating to the general rule for determining the taxable year of inclusion of an item in gross income) by adding a new subsection (c). The new subsection provides that for purposes of determining the taxable year for which tips are to be included in gross income for income tax purposes, tips included by an employee in a written statement furnished to his employer in the manner and within the time prescribed in section 6053(a) are deemed received by the employee at the time the statement is furnished. Tips not included in a written statement or included in a written statement which is not furnished as prescribed in section 6053(a) are not affected by this subsection; such tips will continue to be treated as received when actually received but in accordance with the general rule provided in section 451(a).

Section 313(c)(1) of the bill amends section 3102 of the code (relating to deduction by the employer of the employee's social security tax from the employee's wages) by adding a new subsection (c).

Under paragraph (1) of the new subsection (c) the employer is responsible for deducting the employee's social security tax on tips, which constitute wages for social security tax purposes, but only to the extent that such tips are included in a written statement furnished the employer pursuant to section 6053(a), and only to the extent that, at or after the time the statement is furnished and before the close of the 10th day following the month in which the tips were received (the last day on which such a statement could be furnished under sec. 6053(a)), the employer can collect the employee's share of the tax by deducting it from wages (not including tips) of the employee under the employer's control, or from funds turned over to him for that purpose by the employee.

Paragraph (2) of the new subsection (c) provides that if the employee's share of social security tax due on tips included in a written

statement furnished to the employer pursuant to section 6053(a) exceeds the wages (other than tips) of the employee already under the employer's control, the employee must give the employer on or before the 10th day following the month in which the tips are received, an amount of money which when added to the wages under the employer's control will be sufficient to pay the tax.

Paragraph (3) of the new subsection (c) authorizes the Secretary of the Treasury or his delegate to prescribe regulations permitting an employer to (1) estimate the amount of tips an employee will report to him pursuant to section 6053 of the code (added by sec. 313(e)(2) of the bill) for a calendar quarter; (2) determine the amount to be deducted upon each payment of wages (other than tips) during such quarter as if the tips so estimated constituted the actual tips so reported; and (3) deduct upon any payment of wages (other than tips) to such employee during such quarter such amount as may be necessary to adjust the amount of tax withheld to conform to the amount actually due during the quarter (determined without regard to the new paragraph (3)).

Section 313(c)(2) of the bill further amends section 3102 of the code to authorize an employer who is furnished a written statement of tips to withhold the employee social security tax on the tips included in the statement even though at the time it is furnished the total amount of tips included in the statement and prior written statements for the month is less than $20.

Section 313(c)(3) of the bill amends section 3121(a) of the code (defining "wages" for social security tax purposes) by adding a new paragraph (12). The new paragraph provides that tips do not constitute wages for social security tax purposes if they are paid in a medium other than cash or if the cash tips received in a calendar month by the employee in the course of his employment by a single employer amount to less than $20.

Section 313(c)(4) of the bill further amends section 3121 of the code by adding a new subsection (q). The new subsection provides that tips received by an employee in the course of his employment (which are not excluded from wages under the new par. (12) of sec. 3121(a)) are to be considered wages, and thus subject to the social security tax. Such tips are deemed paid to the employee by the employer at the time a written statement including such tips is furnished the employer pursuant to section 6053(a). Tips not included in a written statement or included in a written statement not furnished the employer by the close of the 10th day following the month of receipt (as prescribed in sec. 6053(a)) are considered to have been paid to the employee at the time the tips are received. Tips constitute wages for social security tax purposes regardless of whether the tips are received by the employee from a person other than his employer or are paid to the employee by his employer. Only tips received by an employee on his own behalf and not on behalf of another employee constitute wages. Thus, where employees practice tip splitting, the ultimate recipient of the tip (or portion thereof) is the employee who is receiving the tips as wages.

Section 313(d)(1) of the bill amends section 3401 of the code (defining "wages" subject to income tax withholding) by adding a new subsection (f). The new subsection provides that tips received by an employee in the course of his employment, subject to the

exceptions in section 3401(a)(16) of the code (added by sec. 313(d)(2) of the bill), are to be considered wages, and thus subject to withholding of income tax at source. Such tips are deemed paid by the employer to the employee at the time a written statement including such tips is furnished the employer pursuant to section 6053(a). Tips not included in a written statement or included in a written statement furnished to the employer after the time prescribed in section 6053(a) are considered to have been paid to the employee at the time the tips are received. Tips constitute wages for income tax withholding purposes regardless of whether the tips are received by the employee from a person other than his employer or are paid to the employee by his employer. Only tips received by an employee on his own behalf and not on behalf of another employee constitute wages. Thus, where employees practice tip splitting, the ultimate recipient of the tip (or portion thereof) is the employee who is receiving the tips as wages.

Section 313(d)(2) of the bill further amends section 3401 of the code by adding a new paragraph (16) to subsection (a) thereof. The new paragraph provides that tips do not constitute wages subject to income tax withholding if they are paid in a medium other than cash or if the cash tips received in a calendar month by the employee in the course of his employment by a single employer amount to less than $20.

Section 313(d)(3) of the bill amends section 3402(a) of the code (relating to determining the amount of income taxes the employer is to withhold on wages) by making appropriate reference to new section 3402(k), relative to tips, added by section 313(d)(4) of the bill.

Section 313(d)(4) further amends section 3402 of the code by adding a new subsection (k). The new subsection specifies that the employer is responsible for withholding income tax on tips which constitutes wages for income-tax withholding purposes but only if the tips are included in a written statement furnished the employer pursuant to section 6053(a), and only to the extent that, at or after the time the statement is furnished and before the close of the calendar year in which the tips are received, the employer can collect the tax by deducting it from wages (not including tips) of the employee under the employer's control, or from funds turned over to him for that purpose by the employee, remaining after the employee social security tax has been subtracted. Also, the new subsection authorizes an employer who is furnished a written statement of tips pursuant to section 6053(a) to withhold income taxes on the tips included in such statement, even though at the time it is furnished the total amount of tips included in that statement and prior written statements for the month is less than $20.

Section 313(e)(1) of the bill amends section 6051(a) of the code (relating to amounts to be shown as "wages" on employee receipts—currently form W–2) by adding a new sentence which provides (1) that the amount to be shown on an employee's receipt as wages subject to social security tax will include tips only to the extent they are included in one or more written statements furnished the employer before the close of the 10th day following the month in which the tips are received, pursuant to section 6053(a), and only to the extent that, at or after the time the statement is furnished and before the close of the last day on which such a statement could be furnished

under section 6053(a), the employer can collect the employee's social security tax from wages (not including tips) of the employee under the employer's control or from funds turned over to the employer by the employee for that purpose; and (2) that the amount to be shown as wages subject to income tax will include tips only to the extent they are included in a timely written statement furnished the employer pursuant to section 6053(a) of the code, irrespective of whether or not the employer was able to deduct and withhold the income tax before the close of the calendar year.

Section 313(e)(2) of the bill amends subpart C of part III of subchapter A of chapter 61 of the code (relating to the information regarding wages paid employees) by adding a new section 6053.

Subsection (a) of the new section 6053 requires every employee who receives tips which constitute wages for social security tax purposes or income tax withholding purposes to furnish to his employer, in accordance with regulations prescribed by the Secretary of the Treasury or his delegate, one or more written statements of his tips before the close of the 10th day following the month in which the tips were received. The Secretary of the Treasury is authorized to prescribe regulations under which employers may require employees to furnish statements more frequently than once a month. He may also prescribe the form in which the employee statements of tips will be made to the employer.

Subsection (b) of the new section 6053 provides that the tips to be taken into consideration—

> (1) for purposes of the employer's obligation to collect the employee's share of the tax, pay the employer's share of the tax, and show the wages as being subject to social security tax on an employees' receipt (form W–2), and
>
> (2) for purposes of imposing the penalty, provided by new section 6652(c) of the code (added by sec. 313(e)(3) of the bill), on an employee for failure to report tips and make available his share of the social security tax due on such tips,

are only those tips which are included in a statement furnished the employer pursuant to subsection (a) of section 6053 and only to the extent that, at or after the time the statement is furnished and before the close of the 10th day following the month in which the tips were received, the employer can collect the employee's share of the social security tax from the employee's wages (other than tips) or from other funds turned over by the employee for this purpose pursuant to section 3102(c).

Section 313(e)(3) of the bill amends section 6652 of the code (relating to failure to file certain information returns) by adding a new subsection (c). The new subsection provides that the employee will be required to pay, with respect to tips which he failed to include in a timely written statement to his employer pursuant to section 6053(a) or which he included in a timely written statement but did not make available his share of the social security tax pursuant to section 3102(c), both the employee tax imposed by section 3101 on such tips and an additional amount equal to the employee tax, unless it is shown that the employee's failure was due to reasonable cause and not due to willful neglect.

Section 313(f) of the bill amends section 3111 of the code (relating to the imposition of the social security tax on employers) by adding a

sentence to provide that the employer is liable for paying the employer social security tax only on those tips which are included in a timely written statement furnished him pursuant to section 6053(a), and on which, pursuant to section 3102(c), the employer can collect the employee social security tax, on or after the time the statement is furnished and before the close of the last day on which such a statement could be furnished under section 6053(a), from wages (not including tips) of the employee under the employer's control or from funds turned over to the employer by the employee for that purpose.

Section 313(g) of the bill provides that the amendments made by section 313 of the bill will be effective only with respect to tips received by employees after 1965.

SECTION 314. INCLUSION OF ALASKA AND KENTUCKY AMONG STATES PERMITTED TO DIVIDE THEIR RETIREMENT SYSTEMS

Section 314 of the bill amends section 218(d)(6)(C) of the Social Security Act by adding Alaska and Kentucky to the list of States which are permitted to divide their retirement systems into two divisions for coverage purposes, one division consisting of those members desiring coverage under the act and the other consisting of those who do not, with all new members being covered on a compulsory basis.

SECTION 315. ADDITIONAL PERIOD FOR ELECTING COVERAGE UNDER DIVIDED RETIREMENT SYSTEM

Section 315 of the bill amends section 218(d)(6)(F) of the Social Security Act to grant an additional opportunity to obtain coverage to State and local employees (in a State permitted to use the divided retirement system procedure) who had not previously chosen coverage under the divided retirement system provisions. The present law allows such employees a further opportunity to elect coverage only if a modification providing for such election is mailed or otherwise delivered to the Secretary before 1963, or, if later, 2 years after the date on which coverage was approved for the group that originally elected coverage. Any coverage elected after the original division must begin on the same date as was provided when the group was originally covered. Section 315 extends the time in which such persons could elect to be covered until the end of 1966 (or, if later, the expiration of 2 years after the date on which coverage was approved for the group that originally elected coverage).

SECTION 316. EMPLOYEES OF NONPROFIT ORGANIZATIONS

Section 316 of the bill amends section 3121(k) of the Internal Revenue Code of 1954 and section 105(b) of the Social Security Amendments of 1960.

Period for which certificate shall apply

Section 316(a)(1) of the bill amends section 3121(k)(1)(B) of the code, which relates to the period for which certificates filed by certain

religious, charitable, etc., organizations for the purpose of waiving exemption from tax under chapter 21 of such code become effective. Under present law, a certificate filed pursuant to section 3121(k) is effective for the period beginning with whichever of the following is designated by the organization:

(1) The first day of the calendar quarter in which the certificate is filed,

(2) The first day of the calendar quarter succeeding such quarter, or

(3) The first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, but such period may not begin earlier than the first day of the 4th calendar quarter preceding the quarter in which such certificate is filed.

This amendment removes the limitation that the period may not begin earlier than the first day of the 4th calendar quarter preceding the quarter in which such certificate is filed (see par. (3) above) and provides, in lieu thereof, that the period may not begin earlier than the first day of the 20th calendar quarter preceding the quarter in which the certificate is filed.

Section 316(a)(2) provides that the amendment made by section 316(a)(1) will apply in the case of any certificate filed under section 3121(k)(1)(A) of the code after the date of enactment of the bill.

Amendment of certificate filed before 1966

Section 316(b) of the bill amends section 3121(k)(1) of the Internal Revenue Code of 1954 by adding a new subparagraph (H). Such subparagraph (H) provides that an organization which files a certificate pursuant to section 3121(k)(1) of the code before 1966 may amend such certificate during 1965 or 1966 to make the certificate effective with the first day of any calendar quarter preceding the quarter for which such certificate originally became effective, except that such date may not be earlier than the 20th calendar quarter preceding the quarter in which such certificate is so amended. Pursuant to the new subparagraph (H), an organization which has filed, prior to 1966, a waiver certificate (without regard to whether the certificate is filed before or after the enactment of the bill) may amend such certificate so as to make it effective with the first day of any calendar quarter preceding the first quarter for which the certificate is effective without amendment. However, such a certificate may not be made effective, through an amendment, for any calendar quarter which begins earlier than the 20th calendar quarter preceding the calendar quarter in which such organization files an amendment to its certificate.

Validation of certain remuneration erroneously reported as wages by nonprofit organizations

Section 316(c)(1) of the bill 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 social security credit for remuneration erroneously reported on his behalf by the organization in any taxable period from January 1, 1951, through June 30, 1960. Section 105(b) of the Social Security Amendments of 1960, as amended by the bill, will (where the conditions prescribed by the amendment are met) permit the validation of erroneously reported wages of workers who cannot be covered

through the filing of a waiver certificate by the organization because they are no longer in the employ of the organization when it files its certificate. Under section 105(b), as amended by the bill, remuneration paid to an individual for service before the calendar quarter in which the organization files its waiver certificate under section 3121(k)(1) of the Internal Revenue Code of 1954 may be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act, to the extent that an amount has been paid as social security taxes with respect to such remuneration on or before the due date of the tax return for the calendar quarter before the calendar quarter in which the organization files its waiver certificate. This rule applies, however, only if the service would have constituted employment as defined in section 210 of the Social Security Act if the requirements of section 3121(k)(1) of the Code were satisfied, and only if the following conditions are met:

(1) the person who performed the service (or a fiduciary acting for him or his estate, or a survivor of such individual who is or may become entitled to monthly benefits under title II of the Social Security Act on his earnings record) makes a request (in such form and manner, and with such official, as the Secretary of Health, Education, and Welfare may by regulations prescribe) that such remuneration be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act;

(2) a certificate under section 3121(k)(1) of the Internal Revenue Code of 1954 is filed by the organization not later than the date on which the request for validation is made;

(3) the individual requesting the validation is no longer employed by the organization on the date the organization files its waiver certificate; and

(4) if any part of the amount paid as social security taxes as previously described with respect to such remuneration paid to an individual is credited or refunded, the amount credited or refunded, plus any interest allowed, must be repaid before January 1, 1968, or, if later, the first day of the third year after the year in which the organization files its waiver certificate.

In addition, the so-called validation of wages is to be permitted only for remuneration received for service which is performed during the period for which an organization's waiver is effective. Thus, former employees of an organization which has made erroneous reports receive no greater retroactive social security coverage than employees who are employed by the organization on the date the organization files its waiver certificate and are covered only for the retroactive period for which the certificate is made effective.

Effective dates of validating provisions

Section 316(c)(2) of the bill provides that the provisions of section 105(b) of the Social Security Amendments of 1960, as amended by the bill, will become effective upon enactment of the bill. The provisions of the existing section 105(b) of the Social Security Amendments of 1960 will continue to apply to requests for validation filed before enactment of the bill. The filing of a request by an individual for validation under the existing provisions of section 105(b) of the Social Security Amendments of 1960 does not bar him from filing another request for validation under section 105(b) as amended by the bill.

SECTION 317. COVERAGE OF TEMPORARY EMPLOYEES OF THE DISTRICT OF COLUMBIA

Sections 317(a) and 317(b) of the bill amend the Social Security Act (sec. 210(a)(7)) and the Internal Revenue Code of 1954 (sec. 3121(b)(7)) to include in the definition of employment services performed by certain temporary employees of the District of Columbia. Under the amendments, service performed in the employ of the District of Columbia, or any wholly owned instrumentality thereof, is included as employment if such service is not covered by a retirement system established by a law of the United States, except that the extension of coverage is not to apply to service performed: (1) in a hospital or penal institution by a patient or inmate thereof, (2) in a hospital of the District of Columbia by student nurses and certain other student employees (other than as a medical or dental intern or as a medical or dental resident-in-training) included under section 2 of the Act of August 4, 1947 (5 U.S.C. 1052), (3) on a temporary basis in certain emergencies, or (4) as a member of a board, committee, or council of the District of Columbia paid on a per diem, meeting, or other fee basis.

Section 317(c) of the bill amends section 3125 of the Internal Revenue Code of 1954 (relating to returns in the case of governmental employees in Guam and American Samoa) by changing the heading thereof and adding a new subsection (c). The new subsection (c) provides that the return and payment of the employee and employer taxes imposed under chapter 21 of the code (Federal Insurance Contributions Act) with respect to services performed as employees of the District of Columbia, or of any wholly owned instrumentality of the District of Columbia, may be made by the Commissioners of the District of Columbia or by such agents as they may designate. A person making such return may, for convenience of administration, make payments of the employer tax imposed under section 3111 without regard to the dollar limitations in section 3121(a)(1) (although this subsection would not authorize such person to disregard these dollar limitations as to remuneration includible in returns made by him). The purpose is to relieve a person making a return on behalf of any department or agency of the District of Columbia or any instrumentality wholly owned thereby, of any necessity for ascertaining whether any wages have been reported for a particular employee by any other reporting unit of such government or instrumentality.

Section 317(d) of the bill amends section 6205(a) of the Internal Revenue Code of 1954 by adding a new paragraph (4). The new paragraph (4) provides that the Commissioners of the District of Columbia and each agent designated by them, pursuant to section 3125 of the code, to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act, will be deemed to be a separate employer for purposes of section 6205(a) of the code, relating to adjustments of underpayments of such taxes. Thus, adjustments of underpayments will be made by the reporting unit by which the underpayment was made.

Section 317(e) of the bill amends section 6413(a) of the Internal Revenue Code of 1954 by adding a new paragraph (4). The new paragraph (4) provides that the Commissioners of the District of Columbia and each agent designated by them, pursuant to section

3125 of the code, to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act, will be deemed to be a separate employer for purposes of section 6413(a) of the code, relating to adjustments of overpayments of such taxes. Thus, adjustments of overpayments will be made by the reporting unit by which the overpayment was made.

Section 317(f) of the bill amends paragraph (2) of section 6413(c) of the Internal Revenue Code of 1954 by redesignating the heading of such paragraph (2) and by adding to such paragraph (2) a new subparagraph (F). The new subparagraph provides that for purposes of the special credit or refund provisions contained in section 6413(c)(1) of the code, the Commissioners of the District of Columbia and each agent designated by them to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act will be deemed to be a separate employer. The effect of this amendment is to permit a claim for special credit or refund, rather than a general claim for refund under section 6402(a), in any case where an employee receives more than the maximum creditable wages in a calendar year by reason of having performed services for two or more reporting units of the District of Columbia or any instrumentality wholly owned thereby.

Section 317(g) of the bill provides that the amendments made by section 317 will apply with respect to service performed after the calendar quarter in which such section is enacted and after the calendar quarter in which the Secretary of the Treasury receives a certification from the Commissioners of the District of Columbia expressing their desire to have the insurance system established by title II (and part A of title XVIII) of the Social Security Act extended to the officers and employees coming under the provisions of such amendments.

SECTION 318. COVERAGE FOR CERTAIN ADDITIONAL HOSPITAL EMPLOYEES IN CALIFORNIA

Section 318 of the bill amends section 102(k) of the Social Security Amendments of 1960 by adding a new paragraph (2) permitting the coverage agreement with the State of California to be modified to apply to certain additional services performed for any hospital affected by any modification (in the California State coverage agreement) executed pursuant to section 102(k). The services which could thus be covered are those performed by individuals who were or are employed by such State (or any political subdivision thereof) after December 31, 1959, in any position described in section 102(k). The State will have until the end of the 6th month after the month of enactment in which to so modify its agreement. Such modification will be effective with respect to services performed on or after January 1, 1962; it will also be effective with respect to services performed before January 1, 1962, where contributions in the proper amount have been paid before the date of enactment of the bill.

SECTION 319. TAX EXEMPTION FOR RELIGIOUS GROUPS OPPOSED TO INSURANCE

Amendment to the Internal Revenue Code of 1954

Section 319(a) of the bill amends section 1402(c) of the code by adding a new paragraph (6) which excepts from the term "trade or

business" the performance of service by individuals who are members of certain religious faiths during the period for which an exemption under the new subsection (h) (as added by sec. 319(c)) of section 1402 is effective with respect to them. The effect of the amendment is to exempt from the self-employment tax an individual who is granted an exemption under section 1402(h) of the code.

Amendment to title II of the Social Security Act

Section 319(b) of the bill amends section 211(c) of the Social Security Act by adding a new paragraph (6) which excepts from the term "trade or business" the performance of service by individuals who are members of certain religious faiths during the period for which an exemption under new subsection (h) (as added by sec. 319(c)) of section 1402 of the Internal Revenue Code of 1954 is effective with respect to them. The effect of the amendment is to remove from social security coverage a self-employed individual who is granted an exemption from tax under section 1402(h) of the code.

Application for exemption from self-employment tax; amendment to the Internal Revenue Code

Section 319 (c) of the bill amends section 1402 of the code by adding a new subsection (h).

Paragraph (1) of section 1402 (h) provides that any individual may file an application (in such form and manner and with such official as may be prescribed by regulations under sec. 1402 (h)) for an exemption from the tax imposed on self-employment income if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to the 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. An individual who applies for exemption must, therefore, among other things, be opposed to all types of benefits or payments under titles II and XVIII of the Social Security Act.

In order that an individual may be granted an exemption from the tax imposed on self-employment income, subparagraph (A) of section 1402(h)(1) provides that the individual's application for exemption must contain, or be accompanied by, such evidence of such individual's membership in, and adherence to the tenets or teachings of, the religious sect or division thereof as the Secretary of the Treasury or his delegate may require for purposes of determining such individual's compliance with the requirements of the first sentence of paragraph (1) of section 1402(h), and subparagraph (B) of such section provides that such application must be accompanied by the individual's waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person.

In addition to the requirements of subparagraphs (A) and (B) relating to the individual who files application for exemption from the tax on self-employment income, subparagraphs (C), (D), and (E) of section 1402(h)(1) provide that an exemption may be granted

only if the Secretary of Health, Education, and Welfare makes the following findings with respect to the religious sect or division thereof of which such individual is a member:

1. That the sect or division thereof has the established tenets or teachings by reason of which the individual applicant is conscientiously opposed to the benefits of certain types of insurance;

2. That it is the practice, and has been for a period of time which the Secretary deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which, in the judgment of the Secretary, is reasonable in view of the general level of living of the members of the sect or division thereof;

3. That the sect or division thereof has been in existence continuously since December 31, 1950.

Section 1402(h)(1) of the code further provides that an exemption from the tax on self-employment income may not be granted to an individual if any benefit or other payment referred to in subparagraph (B) of such section became payable at or before the time of the filing of such waiver. This provision applies if any such benefit or other payment would have become payable at such time but for a reduction of or deduction from such benefit or payment in accordance with the provisions of section 203 (relating to reduction of insurance benefits) or 222(b) (relating to deduction on account of refusal to accept rehabilitation services) of the Social Security Act.

Paragraph (2) of section 1402(h) of the code provides rules relating to the time for filing the application for exemption described in section 1402(h)(1). Subparagraph (A) of section 1402(h)(2) provides that an individual who has self-employment income (determined without regard to the exception contained in sec. 1402(c)(6)) for any taxable year beginning after December 31, 1950 (see sec. 319(e) of the bill, relating to effective date), and ending before December 31, 1965, must file his application for exemption on or before April 15, 1966. Subparagraph (B) of section 1402(h)(2) provides that in any other case an individual must file his application for exemption on or before the due date of the return (including any extension thereof) for the first taxable year ending on or after December 31, 1965, in which he has self-employment income (determined without regard to sec. 1402(c)(6)). If an individual fails to file an application for exemption from the self-employment tax within the time prescribed by section 1402(h)(2) (A) or (B), whichever is applicable in his case, he will not be entitled to the exemption.

Paragraph (3) of section 1402(h) provides that an exemption granted to an individual pursuant to section 1402(h) will apply with respect to all taxable years beginning after December 31, 1950. However, subparagraph (A) of section 1402(h)(3) provides that such exemption will not apply for any taxable year which begins before the taxable year in which the individual who files an application for exemption first became a member of a recognized religious sect or division thereof and was an adherent of established tenets or teachings of such sect or division by reason of which he was conscientiously opposed to the acceptance of the benefits of certain types of insurance. Subparagraph (A) further provides that such exemption will not apply for any taxable year which begins before the date as of which the Secretary of Health, Education, and Welfare finds that the sect or division

thereof of which such individual is a member had the established tenets or teachings referred to in section 1402(h)(1), and that it was the practice of such sect or division to make reasonable provision for its dependent members. Subparagraph (B) of section 1402(h)(3) provides that an exemption granted pursuant to section 1402(h) will cease to be effective for any taxable year ending after the time the individual who files an application for exemption ceases to meet the requirements of the first sentence of section 1402(h)(1), or after the time as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof of which such individual is a member ceases to have the required tenets or teachings or ceases to make reasonable provision for its dependent members.

Paragraph (4) of section 1402(h) provides that in any case where an individual who has self-employment income dies before the expiration of the time prescribed in section 1402(h)(2) for filing an application for exemption pursuant to section 1402(h), such an application may be filed with respect to such deceased individual within the time prescribed in section 1402(h)(2) with respect to him by a fiduciary acting for such individual's estate or by such individual's survivor (within the meaning of sec. 205(c)(1)(C) of the Social Security Act).

Waiver of benefits; amendment to title II of the Social Security Act

Section 319(d) of the bill adds a new subsection (v) to section 202 of the Social Security Act. If an individual is granted a tax exemption under section 1402(h) of the Internal Revenue Code of 1954, no benefits or other payments are to be payable to him under title II of the Social Security Act, no payments are to be made on his behalf under part A of title XVIII (hospital insurance benefits for the aged), and no benefits or other payments are to be payable to him on the basis of the wages and self-employment income of any other person, after the filing of his waiver of benefits pursuant to section 1402(h) of the code. If the tax exemption ceases to be applicable, the waiver is to cease to be applicable to the extent benefits or other payments are based (1) on his self-employment income for and after the first taxable year for which the waiver ceases to be effective, and (2) on his wages for and after the calendar year which begins with or in such taxable year.

Effective date

Section 319(e) of the bill provides that the amendments made by section 319 will apply with respect to taxable years beginning after December 31, 1950. Section 319(e) of the bill also provides, for purposes of such effective date, that chapter 2 of the Internal Revenue Code of 1954 (secs. 1401 through 1403) shall be treated as applying to all taxable years beginning after December 31, 1950. Thus, an application for exemption from tax under section 1402(h) of the Internal Revenue Code of 1954 will be treated as an application for exemption from the tax on self-employment income imposed by the Internal Revenue Code of 1939.

Refund or credit of taxes

Section 319(f) of the bill provides that if refund or credit of any overpayment resulting from the enactment of such section 319 is prevented, by the operation of any law or rule of law, on the date of enactment of the bill or at any time on or before April 15, 1966, refund

or credit of such overpayment may, nevertheless, be made or allowed if claim therefor is filed on or before April 15, 1966. Section 319(f) further provides that no interest is to be allowed or paid on any overpayment resulting from the enactment of section 319.

SECTION 320. INCREASE IN EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

Section 320 of the bill raises the maximum amount of annual earnings subject to social security tax and counted toward benefits (the contribution and benefit base) from $4,800 to $5,600 for the years 1966 through 1970, and from $5,600 to $6,600 beginning with 1971.

Amendments to Title II of the Social Security Act

Definition of wages

Section 320(a)(1) of the bill amends section 209(a) of the Social Security Act (defining wages) to make the $5,600 contribution and benefit base applicable to wages paid after 1965 and before 1971 and to make the $6,600 base applicable to wages paid after 1970.

Definition of self-employment income

Section 320(a)(2) amends section 211(b)(1) of the act (defining self-employment income) to make the $5,600 contribution and benefit base applicable for taxable years ending after 1965 and before 1971 and to make the $6,600 base applicable for taxable years ending after 1970.

Quarter of coverage

Section 320(a)(3) amends clauses (ii) and (iii) of section 213(a)(2) of the act (defining quarter of coverage) to provide that an individual will be credited with a quarter of coverage for each quarter of a calendar year after 1965 and before 1971 if his wages for such year equal $5,600 (rather than $4,800 as in present law) and with a quarter of coverage for each quarter of a calendar year after 1970 if his wages for such year equal $6,600. An individual will also be credited with a quarter of coverage for each quarter of a taxable year ending after 1965 and before 1971 in which the sum of his wages and self-employment income equals $5,600 (rather than $4,800) and for each quarter of a taxable year ending after 1970 in which the sum of his wages and self-employment income equals $6,600.

Average monthly wage

Section 320(a)(4) amends section 215(e)(1) of the act (relating to the amount of annual earnings that can be counted in computing an individual's average monthly wage) so as to increase from $4,800 to $5,600, effective for calendar years after 1965 and before 1971, and from $5,600 to $6,600, effective for calendar years after 1970, the maximum amount of annual earnings that may be counted in the computation of an individual's average monthly wage for purposes of determining benefit amounts.

Amendments to the Internal Revenue Code of 1954

Definition of self-employment income

Section 320(b)(1) of the bill amends section 1402(b)(1) of the Internal Revenue Code of 1954 (defining self-employment income) by increasing the maximum annual limitation on self-employment income subject to the self-employment tax from $4,800 to $5,600 for taxable years ending after 1965 and before 1971, and from $5,600 to $6,600 for taxable years ending after 1970.

Definition of wages

Section 320(b)(2) amends section 3121(a)(1) of the code (defining wages) by increasing the maximum annual limitation on wages subject to social security tax from $4,800 to $5,600 for calendar years after 1965 and before 1971, and from $5,600 to $6,600 for calendar years after 1970.

Federal service

Section 320(b)(3) amends section 3122 of the code (relating to Federal service) so as to conform its provisions to the changes made in increasing the contribution and benefit base from $4,800 to $5,600 for calendar years after 1965 and before 1971, and to $6,600 for calendar years after 1970.

Returns in the case of governmental employees in Guam and American Samoa

Section 320(b)(4) amends section 3125 of the code (relating to governmental employees in Guam and American Samoa) so as to conform its provisions to the $5,600 contribution and benefit base for calendar years after 1965 and before 1971, and to the $6,600 base for calendar years after 1970. (These increases in the base will also apply to the temporary employees of the District of Columbia who are included in section 3125 by section 317(c) of the bill.)

Special refunds of employee tax

Sections 320(b)(5) and 320(b)(6) amend section 6413(c) of the code (relating to special refunds of social security tax paid by an employee on aggregate wages in excess of $4,800 received by him from more than one employer during a calendar year) so as to conform the special refund provisions to the $5,600 contribution and benefit base for calendar years after 1965 and before 1971, and to the $6,600 base for calendar years after 1970.

Effective Date

Section 320(c) provides effective dates for the changes made by the section. The amendments made by section 320 (a)(1) and (a)(3)(A) and by section 320(b) (except par. (1)) are applicable only with respect to remuneration paid after December 1965; the amendments made by section 320 (a)(2), (a)(3)(B), and (b)(1) are applicable only with respect to taxable years ending after 1965; and the amendments made by section 320(a)(4) are applicable only with respect to calendar years after 1965.

SECTION 321. CHANGES IN TAX SCHEDULES

Section 321 of the bill provides new schedules of social security tax rates, with the rates provided for hospital insurance being set forth in schedules which are separate from those provided for old-age, survivors, and disability insurance.

Self-employment tax

Section 321(a) of the bill amends section 1401 of the Internal Revenue Code of 1954 to provide new schedules of social security tax rates on self-employment income.

Subsection (a) of the amended section 1401 provides a schedule of tax rates on self-employment income for old-age, survivors, and disability insurance. Under present law the rates of self-employment tax for old-age, survivors, and disability insurance are as follows:

Taxable years beginning after—	*Tax rate (percent)*
1962 (and before 1966)	5.4
1965 (and before 1968)	6.2
1967	6.9

Under the bill, the rates of self-employment tax for old-age, survivors, and disability insurance will be as follows:

Taxable years beginning after—	*Tax rate (percent)*
1965 (and before 1969)	6.0
1968 (and before 1973)	6.6
1972	7.0

Subsection (b) of the amended section 1401 provides a schedule of tax rates on self-employment income for hospital insurance. The rates of self-employment tax provided for hospital insurance are as follows:

Taxable years beginning after—	*Tax rate (percent)*
1965 (and before 1967)	0.35
1966 (and before 1973)	.50
1972 (and before 1976)	.55
1975 (and before 1980)	.60
1979 (and before 1987)	.70
1986	.80

The new section 1401(b) provides that, for purposes of the tax imposed in respect of hospital insurance, the exclusion of employee representatives by section 1402(c)(3) of the code will not apply. Thus, the performance of service by an individual as an employee representative, as defined in section 3231(c) of the code (the Railroad Retirement Tax Act), is included in the term "trade or business" as defined in section 1402(c) for purposes of the tax imposed by the new section 1401(b).

Taxes on employees and employers

Section 321(b) and 321(c) of the bill amend section 3101 and section 3111, respectively, of the Internal Revenue Code of 1954 to provide new schedules of social security tax rates on wages for both employees and employers.

Subsection (a) of the amended section 3101 and subsection (a) of the amended section 3111 provide schedules of tax rates on wages

for old-age, survivors, and disability insurance. Under present law the tax rates for employees and employers are as follows:

Calendar years—	*Tax rate employer and employee, each (percent)*
1963–65, inclusive	3⅝
1966–67, inclusive	4⅛
1968 and after	4⅝

Under the bill, the rates for employees and employers for old-age, survivors, and disability insurance will be as follows:

Calendar years—	*Tax rate employer and employee, each (percent)*
1966–68, inclusive	4.0
1969–72, inclusive	4.4
1973 and after	4.8

Subsection (b) of the amended section 3101 and subsection (b) of the amended section 3111 provide schedules of tax rates on wages for hospital insurance. The employee and employer tax rates for hospital insurance are as follows:

Calendar years—	*Tax rate employer and employee, each (percent)*
1966	0.35
1967–72, inclusive	.50
1973–75, inclusive	.55
1976–79, inclusive	.60
1980–86, inclusive	.70
1987 and after	.80

For purposes of the employee tax and the employer tax imposed by the new sections 3101(b) and 3111(b), respectively, the exception from employment contained in paragraph (9) of section 3121(b) of the code is made inapplicable. Thus service performed by an employee as defined in section 3231(b) of the code (the Railroad Retirement Tax Act) constitutes employment, unless excluded under some paragraph (other than paragraph (9)) of section 3121(b), for purposes of determining wages subject to the employee and employer taxes imposed by the new sections 3101(b) and 3111(b).

Effective dates

Section 321(d) of the bill provides that the amendments made by section 321(a) will apply only with respect to taxable years which begin after December 31, 1965, and that the amendments made by sections 321(b) and 321(c) will apply with respect to remuneration paid after December 31, 1965.

SECTION 322. REIMBURSEMENT OF TRUST FUNDS FOR COST OF NONCONTRIBUTORY MILITARY SERVICE CREDITS

Section 322 of the bill amends section 217(g) of the Social Security Act to revise the provisions for the reimbursement of the trust funds for the cost of benefits based on military service in the period from September 16, 1940, through December 1956.

Paragraph (1) of the revised section 217(g) provides that in September 1965 and in every fifth September thereafter up to and in-

cluding September 2010, the Secretary of Health, Education, and Welfare will determine the amount which, if paid in equal annual installments, would be needed to place the old-age and survivors insurance, disability insurance, and hospital insurance trust funds in the same position at the end of June 2015 as they would be if benefits based on military service in the period from September 16, 1940, through December 1956 had not been provided.

Paragraph (2) of the revised section 217(g) authorizes annual appropriations to each of the trust funds in the amounts determined under paragraph (1) for each fiscal year in the 50 fiscal years, 1966–2015, as reimbursement for the costs of paying benefits based on military service in the period from September 16, 1940, through December 1956.

Paragraph (3) of the revised section 217(g) authorizes a final appropriation to each of the trust funds for the fiscal year ending June 30, 2016, to place the trust funds in the same position in which they would have been on June 30, 2015, if benefits based on military service in the period from September 16, 1940, through December 1956 had not been provided.

Paragraph (4) of the revised section 217(g) provides for annual appropriations to the old-age and survivors insurance, disability insurance, and hospital insurance trust funds to meet the costs of paying benefits after June 30, 2015, based on military service in the period from September 16, 1940, through December 1956.

SECTION 323. ADOPTION OF CHILD BY RETIRED WORKER

Section 323(a) of the bill amends section 202(d) of the Social Security Act (relating to child's insurance benefits) by striking out the last sentence in paragraph (1) (relating to adoptions by disabled workers) and by adding two new paragraphs (9) and (10). The new paragraph (9) of section 202(d) in effect retains the existing provisions relating to adoptions by disabled workers and makes such provisions applicable in the case where the worker is entitled to old-age insurance benefits and was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits. The effect of the new paragraph (10) of section 202(d) is to restrict the payment of child's insurance benefits when a child is adopted by a worker after the worker became entitled to old-age insurance benefits (without first becoming entitled to disability insurance benefits) by adding the following new requirements: (1) the child must have been living with the worker at the time the worker became entitled to old-age insurance benefits or adoption proceedings had begun at or before that time; (2) the child must have 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 before a period of disability began which continued until he became entitled to old-age insurance benefits; and (3) the adoption must have been completed within 2 years after the worker became entitled to old-age insurance benefits.

Section 323(b) of the bill provides that the new requirements (added by sec. 323(a)) will be effective with respect to applications for child's insurance benefits on or after the date of enactment of the bill. The requirement that adoption be completed within 2 years after the

worker became entitled to benefits is not to apply in any case where a child is adopted within 1 year after the month in which the bill is enacted.

SECTION 324. EXTENSION OF PERIOD FOR FILING PROOF OF SUPPORT AND APPLICATIONS FOR LUMP-SUM DEATH PAYMENT

Section 324(a) of the bill amends section 202(p) of the Social Security Act. The amended section 202(p) provides that in any case where the proof of support required in connection with an application for husband's insurance benefits, widower's insurance benefits, or parent's insurance benefits, or the application for a lump-sum death payment, is not filed within the 2-year period prescribed in the applicable sections of the law and where there was good cause for failure to file such proof or application, the application or proof may be filed at any time after the expiration of the 2-year period and will be deemed to have been filed within that period. Under existing law an extension of only 2 additional years is provided in such cases.

Section 324(b) of the bill provides that the amendment made by subsection (a) will be effective with respect to monthly benefits and lump-sum death payments based on applications filed in or after the month of enactment of the bill.

SECTION 325. TREATMENT OF CERTAIN ROYALTIES FOR RETIREMENT TEST PURPOSES

Section 325(a) of the bill amends section 203(f)(5) of the Social Security Act, relating to the determination of a person's net earnings and net loss from self-employment for retirement test purposes, by adding a new subparagraph (D). The new subparagraph provides that, in determining the net earnings from self-employment of a beneficiary who has attained age 65, there is to be excluded in computing his gross income from a trade or business any royalties received in or after the year in which he attained age 65 if he shows to the satisfaction of the Secretary of Health, Education, and Welfare that the royalties are attributable to a copyright or patent which was obtained before the taxable year in which he attained age 65 and that the property to which the copyright or patent relates was created by his own personal efforts.

Section 324(b) of the bill provides that the changes made by subsection (a) will be effective for taxable years beginning after 1964.

SECTION 326. AMENDMENTS PRESERVING RELATIONSHIP BETWEEN RAILROAD RETIREMENT AND OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEMS

Section 326(a) of the bill makes a technical amendment to section 1(q) of the Railroad Retirement Act of 1937 to preserve the existing relationship between such act and title II of the Social Security Act. Under this amendment, references to the Social Security Act in the Railroad Retirement Act of 1937 will be considered to be references to the Social Security Act as amended in 1965.

Section 326(b) of the bill amends section 5(l)(9) of the Railroad Retirement Act of 1937, relating to situations where social security credits are transferred to the railroad retirement program. Benefits to survivors of a railroad employee are payable either under the railroad retirement program or the social security program, but not both, on the basis of the employee's combined earnings under both programs. In general, benefits are payable under the railroad retirement program if the individual has a current connection with the railroad industry at the time of his death. The compensation for railroad service is creditable up to $5,400 a year for this purpose. However, under present law, where an individual has less than the maximum of $5,400 in creditable compensation for a year, only enough of his wages from employment subject to title II of the Social Security Act can be added to his compensation to increase the combined creditable earnings to $4,800, the present limit on wages for a year under title II of the Social Security Act. To take into account the increases made by section 320 of the bill in the maximum amount of annual earnings creditable under social security, section 326(b) of the bill amends section 5(l)(9) of the Railroad Retirement Act of 1937 to permit the crediting of wages for a year in such an amount as to cause the combined total earnings to be as much as the new earnings and tax base under social security—$5,600 a year for the years 1966 through 1970, and $6,600 a year for years after 1970.

SECTION 327. TECHNICAL AMENDMENT RELATING TO MEETINGS OF BOARD OF TRUSTEES OF THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE TRUST FUNDS

Section 327 of the bill amends section 201(c) of the Social Security Act to require the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund to meet at least once each calendar year, rather than once each 6 months as required under present law. (A similar provision for annual meetings of the Board of Trustees is included in the provisions of the bill (discussed above) creating the Federal Hospital Insurance Trust Fund and the Federal Supplementary Health Insurance Benefits Trust Fund.)

TITLE IV—PUBLIC ASSISTANCE AMENDMENTS

SECTION 401. INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSISTANCE TITLES OF THE SOCIAL SECURITY ACT

Section 401(a) of the bill amends section 3(a)(1) of the Social Security Act. The first step of the formula by which Federal payments to States with approved plans for old-age assistance under title I are determined is changed so as to provide Federal sharing in 31/37ths of the first $37 of the average monthly assistance payment instead of 29/35ths of the first $35 of the average monthly assistance payment. The amendment also has the effect of applying the Federal percentage in the second step of the present formula to an additional $38, instead

of the present additional $35, of the State's average payment. The additional Federal share in State expenditures for medical care, determined on the basis of the Federal medical percentage of the next $15 of a State's average payment, available under the third step of the present formula, is continued, thus giving under the formula as changed by the bill a potential Federal participation in State expenditures up to an average of $90. In addition, the formula is restated for the second and third steps, so as to give recognition to the State's expenditures for medical care before applying the Federal percentage to the remaining expenditures for which Federal participation is available. The formula, as restated by section 401 (a) of the bill, would pay States, in addition to the amount computed under section 3(a) (1) (A) of the Social Security Act, and in lieu of the amounts now computed under section 3(a)(1) (B) and (C) of such act, the larger of the following:

(i) (I) the Federal percentage (as defined in sec. 1101(a)(8)) of all expenditures for old-age assistance in excess of expenditures counted under clause (A), but not counting so much of the excess as exceeds $38 times the total number of recipients of old-age assistance; plus

(II) 15 percent of the State's expenditures in the form of medical care, up to a maximum of $15 times the total number of recipients of old-age assistance; or

(ii) (I) the Federal medical percentage (as defined in sec. 6(c)) of all expenditures in excess of expenditures counted under clause (A), but not counting expenditures that exceed (a) $52 times the total number of recipients, or (b) if smaller, the total expenditures for medical care plus $37 times the total number of recipients; plus

(II) the Federal percentage of all expenditures in excess of expenditures counted under clause (A) and the provisions of clause (B)(ii) described in these paragraphs (ii) (I) and (II), but not counting so much of the excess as exceeds $38 times the total number of recipients.

Section 401(b) of the bill makes corresponding changes in title XVI of the Social Security Act.

Section 401(c) of the bill amends section 403(a)(1) of the Social Security Act so as to change the formula by which the Federal share of aid to families with dependent children is determined. The present share of 14/17ths of the first $17 of the average monthly assistance payment is increased to 5/6ths of the first $18 of such payment. The ceiling for Federal participation is raised from $30 a month to $32 a month per recipient.

Sections 401(d) and 401(e) of the bill amend sections 1003(a)(1) and 1403(a)(1), respectively, of the Social Security Act so as to change the formula by which the Federal share of aid to the blind or aid to the permanently and totally disabled is determined. The present share of 29/35ths of the first $35 of the average monthly assistance payment is increased to 31/37ths of the first $37 of such payment, and the ceiling for Federal participation is raised from $70 a month to $75 a month per recipient.

Section 401(f) of the bill provides that the amendments made by the preceding provisions of section 401 will apply to expenditures

made after December 31, 1965, under a State plan approved under title I, IV, X, XIV, or XVI of the act.

SECTION 402. PROTECTIVE PAYMENTS

Sections 402(a) and 402(b) of the bill amend sections 6(a) and 1605(a), respectively, of the Social Security Act (as such sections are amended by section 221 of the bill), to extend the definitions of "old-age assistance" and "aid to the aged, blind, or disabled" to include protective payments—i.e., payments made on behalf of the recipient to an individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of the recipient. The State plan under which the payments are made must include provision for—

(1) determination by the State agency that protective payments are necessary because, by reason of a physical or mental condition, the recipient is so unable to manage funds that payments to him would be contrary to his welfare;

(2) making payments in this form only when they (together with other income and resources) will meet all the needs of the individuals with respect to whom they are made, under rules otherwise applicable under the State plan for determining need and the amount of aid or assistance paid;

(3) special efforts to protect the welfare of the recipient and to improve, to the extent possible, his capacity for self-care and ability to manage funds;

(4) periodic review by the State agency to determine whether payments in this form are still necessary, with provision for termination of such payments if not necessary and for seeking judicial appointment of a guardian or legal representative when such action will best serve the interests of the recipient; and

(5) opportunity for a fair hearing before the State agency on the determination that protective payments are necessary.

Section 402(c) of the bill provides that the amendments made by the preceding provisions of section 402 will apply to expenditures made after December 31, 1965, under a State plan approved under title I or XVI of the act.

SECTION 403. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED UNDER ASSISTANCE PROGRAMS FOR THE AGED

Section 403 of the bill amends sections 2(a)(10)(A) and 1602(a)(14) of the Social Security Act, effective January 1, 1966. These sections of the Social Security Act allow the States in determining need for old-age assistance or for aid to the aged, blind, or disabled (insofar as it relates to the aged) to disregard, of the first $50 per month of earned income, not more than the first $10 thereof plus one-half of the remainder. Under the amendments made by the bill, these amounts would be increased to $80 and $20, respectively; thus, in determining need for such assistance or aid, the State agency may disregard, of the first $80 of earned income for any month, not more than the first $20 thereof plus one-half of the remainder.

SECTION 404. ADMINISTRATIVE AND JUDICIAL REVIEW OF PUBLIC ASSISTANCE DETERMINATIONS

Section 404 of the bill amends title XI of the Social Security Act by adding a new section 1116 designed to provide for administrative and judicial review of certain administrative determinations made after December 31, 1965, with respect to State plans under the public assistance titles of such act (including the new title XIX added by sec. 121 of the bill).

Under the new section 1116(a)(1), the Secretary of Health, Education, and Welfare must, not later than 90 days after a State submits a plan to him for approval under one of the public assistance titles, make a determination as to whether it fulfills the conditions for approval specified in such title. Such 90-day period may be extended by written agreement of the Secretary and such State.

Section 1116(a)(2) provides that a State which is dissatisfied with such a determination may, within 60 days of notification thereof, petition the Secretary to reconsider his determination of disapproval. The Secretary must thereupon schedule a hearing and notify the State of the time and place. The hearing must be held not less than 20 days nor more than 60 days after the date the State is given notice thereof, unless the Secretary and the State agree in writing to another time. The decision of the Secretary to affirm, modify, or reverse his original determination must be made within 60 days after the hearing is concluded.

Section 1116(a)(3) provides that a State which is dissatisfied with a final determination by the Secretary on such a reconsideration or with his final determination (to withhold funds) under section 4, 404, 1004, 1404, or 1604 of the Social Security Act, or under section 1904 of such act (as added by section 121(a) of the bill), may, within 60 days of notification thereof, petition the United States court of appeals for the circuit in which the State is located to review such determination. The clerk of such court will forthwith transmit a copy of the petition to the Secretary, who will thereupon file in the court the record of the administrative proceedings as provided in 28 U.S.C. 2112.

Section 1116(a)(4) makes the Secretary's findings of fact conclusive unless they are substantially contrary to the weight of the evidence. The court is authorized, for good cause shown, to remand the case to the Secretary to take further evidence. In such case, the Secretary may make new or modified findings of fact and may modify his previous action, and he will certify to the court the record of such additional proceedings. Such findings of fact will likewise be conclusive unless substantially contrary to the weight of evidence.

Section 1116(a)(5) vests jurisdiction in the court to affirm the Secretary's action or to set it aside, in whole or in part. The judgment is reviewable by the Supreme Court upon certiorari or certification as provided in 28 U.S.C. 1254.

Section 1116(b) provides that, for purposes of obtaining the administrative and judicial reviews authorized under the new section 1116(a), any amendment of an approved State plan may, at the State's option, be treated as the submission of a new State plan.

Section 1116(c) provides that action pursuant to an initial determination of the Secretary described in section 1116(a) is not to be stayed pending reconsideration. In the event, however, that the

Secretary subsequently determines that such initial determination was incorrect, the funds incorrectly withheld or otherwise denied must be restored to the State forthwith in a lump sum.

Section 1116(d) provides that the State is entitled to and upon request must receive reconsideration of any determination by the Secretary to disallow Federal financial participation in any item or class of items for which the State claimed such participation under a public assistance title of the Social Security Act (including the new title XIX, added by the bill).

SECTION 405. MAINTENANCE OF STATE PUBLIC ASSISTANCE EXPENDITURES

Section 405 of the bill amends title XI of the Social Security Act by adding a new section 1117 designed to assure the maintenance of State effort in the financing of approved State plans under the public assistance titles of such act.

The new section 1117(a) provides that any increase in the Federal payments to a State for any quarter in the period January 1, 1966, through June 30, 1969—i.e., the increase in the total of the amounts otherwise payable for such quarter pursuant to determinations made under sections 3, 403, 1003, 1403, and 1603 of such act and under section 1903 of such act (as added by section 121(a) of the bill)—will be reduced to the extent that the State has not maintained expenditures from State and local funds of at least the same amount as was spent under its approved plans in a base period against which current quarter expenditures would be measured.

The amount of the reduction, if any, for a current quarter would be the amount by which—

(1) the excess of (A) the total of the Federal shares determined for the State under all of the sections of the act referred to above for such quarter over (B) the total of the Federal shares determined under sections 3, 403, 1003, 1403, and 1603 of the Act for the same quarter of fiscal year 1965, is greater than

(2) the excess of (A) the total expenditures for the current quarter under all of the State's approved plans (including its plan under the new title XIX) over (B) the total of the expenditures under all of its plans under titles I, IV, X, XIV, and XVI for the same quarter of fiscal year 1965.

The new section 1117(a) also gives the State the option to substitute (with respect to each of the quarters of any fiscal year) for the amount determined under paragraph (1)(B) above—

(3) the total of the Federal shares determined for the State for the same quarter in fiscal year 1964; or

(4) the average of the totals determined for each quarter in fiscal year 1964 or fiscal year 1965.

If the State elects the substitution under paragraph (3), there will be substituted for the amount determined under paragraph (2)(B) the total expenditures under its plans approved under titles I, IV, X, XIV, and XVI for the quarter referred to in paragraph (3). If the State elects the substitution under paragraph (4) for either of the years referred to therein, there will be substituted for the amount determined under paragraph (2)(B) the average of the total expenditures under such approved plans for each quarter in the same fiscal year.

Where the State has elected to substitute under paragraph (3) or (4), that election will apply with respect to all quarters in the fiscal year for which the substitution (under paragraph (3) or (4), as the case may be) has been elected.

The new section 1117(b) provides that expenditures under any or all plans of a State approved under title I, IV, X, XIV, XVI, or XIX (as added by the bill), and the reduction determined with respect thereto under such section 1117, will be determined on the basis of data in the quarterly reports of the State to the Secretary pursuant to and in accordance with his requirements under such titles; and determinations so made will be conclusive for purposes of such new section.

The new section 1117(c) provides that if a reduction is required under section 1117 (a) and (b) in the total of the Federal shares determined for a State under sections 3, 403, 1003, 1403, 1603, and 1903 (as added by the bill) for any quarter, the Secretary is to determine which of such amounts should be reduced and the extent thereof in such way as he deems will best further the purpose of maintaining State effort under the State's federally aided public assistance programs, and with the total of such reductions equalling the reduction required under section 1117 (a) and (b).

SECTION 406. DISREGARDING OASDI BENEFIT INCREASE, AND CHILD'S INSURANCE BENEFIT PAYMENTS BEYOND AGE 18, TO THE EXTENT ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE

Section 406 of the bill permits a State, notwithstanding the requirements in titles I, IV, X, XIV, and XVI of the Social Security Act for the consideration of income and resources in determining need for aid or assistance under a plan of the State approved under any such title, to disregard the amount of any OASDI monthly insurance payment to a beneficiary which is attributable to months before the month he receives such payment, but only to the extent it is also attributable (1) to the increase in such insurance benefits resulting from the enactment of section 301 of the bill, or (2) to the payment of child's insurance benefits after attainment of age 18, in the case of children attending shcool, resulting from the enactment of section 306 of the bill.

SECTION 407. EXTENSION OF GRACE PERIOD FOR DISREGARDING CERTAIN INCOME FOR STATES WHERE LEGISLATURE HAS NOT MET IN REGULAR SESSION

Section 407 of the bill provides that, notwithstanding section 701 of the Economic Opportunity Act of 1964 (enacted August 20, 1964), funds to which a State is otherwise entitled under the public assistance titles of the Social Security Act (including title XIX as added by the bill) for any period before the first month following the month of adjournment of the State's first regular legislative session adjourning after August 20, 1964, will not be withheld because of action taken pursuant to a statute of the State which prevents the State from complying with the requirements of section 701(a) of the Economic

Opportunity Act of 1964 (relating to the disregard of certain income in determining need for federally aided public assistance).

SECTION 408. TECHNICAL AMENDMENTS TO ELIMINATE PUBLIC ASSISTANCE PROVISIONS WHICH BECOME OBSOLETE IN 1967

Section 407 of the bill makes a series of technical amendments to provisions of the Social Security Act (and to section 618 of the Revenue Act of 1951). With one exception, such amendments become effective July 1, 1967. Such amendments would eliminate various provisions in present law made obsolete by the enactment of section 121(b) of the bill. Under such section 121(b), for any period after June 30, 1967, Federal financial participation in vendor medical care payments for needy individuals will no longer be available to any State under titles I, IV, X, XIV, or XVI of the Social Security Act, and can only be provided with respect to State plans approved under the new title XIX of such act (as added by sec. 121(a) of the bill); similarly, for any period after June 30, 1967, Federal financial participation in medical assistance for the aged will no longer be available under title I or XVI and can only be provided with respect to State plans approved under the new title XIX.

Section 408(i)(1) of the bill changes the limitation in section 1108 of the Social Security Act on payments to Puerto Rico, the Virgin Islands, and Guam. Under section 408(i)(2) of the bill, these changes are effective for fiscal years beginning on or after the date on which the plan of any such jurisdiction under title XIX of such Act (as added by the bill) is approved, or beginning on or after July 1, 1967, whichever is earlier.

V. SEPARATE VIEWS OF THE REPUBLICANS ON H.R. 6675

General Statement

The Republican members of the committee are unanimous in their opposition to the provisions of this bill providing for hospitalization for the aged financed through the social security tax system. For the most part, we support and favor the other amendments to the social security laws as contained in the bill, many of which were proposed by Republicans.

We also fully support the concept that adequate health insurance should be made available to the aged at a reasonable cost. Such a program, however, should be voluntary. It should reflect ability to pay. Participation on the part of the Government should be financed out of the general revenues, and not by a regressive payroll tax upon a segment of the population, many of whom may be least able to pay for health insurance for others.

We offer a substitute program of health insurance (H.R. 4351) more comprehensive in benefits than the combined program proposed in parts 1 and 2 of title I of the committee bill. Our proposal has broad Republican sponsorship (H.R. 4351, H.R. 4352, H.R. 4353, H.R. 4354, H.R. 4355, H.R. 4356, H.R. 4357, H.R. 4358, H.R. 4519, H.R. 5022, H.R. 5031, H.R. 5582, H.R. 6690). It is predicated upon the voluntary enrollment concept, a principle which the majority recognizes in the medical services program which was added to the administration's original "medicare" bill during the closing days of the committee's deliberations. If the enrollment principle is sound for the supplemental program in the committee bill, it should be applied across the board under a uniform comprehensive health insurance program such as that offered in the Republican bills. Not only are the benefits more extensive, but it also provides protection for catastrophic illness. The Republican program is described elsewhere in this report.

Republican Opposition to Hospitalization Benefits Under Social Security

PRELIMINARY STATEMENT

In opposing hospitalization for the aged under social security, the Republican members of the committee are not unmindful of the increased cost of private health insurance for those over age 65. We believe that the reliance on a payroll tax to finance a hospitalization program jeopardizes the cash benefit program under the social security system by imposing upon that system a liability to finance undetermined future service benefits. The magnitude of that liability should cause concern to anyone dedicated to the preservation of social security cash benefits.

The committee bill would impose upon today's workers a liability of approximately $35 billion for hospitalization benefits solely for those already over age 65.[1] This blanket extension of benefits to those

[1] An additional $3.3 billion will be financed out of general revenues, making a total of $38.3 billion as the cost of the hospital benefit program for those already now age 65.

over age 65 could only be justified on the basis that all of the aged are in dire need while all of those who will be required to pay the additional payroll taxes have ample means. This is a wholly unrealistic assumption. The shifting of a $35 billion liability from those presently retired to the active work force cannot be reconciled on the basis of "ability to pay."

The hospitalization program proposed in this bill, as the majority now admits, was "oversold." In an effort to avoid the disillusionment and dissatisfaction which was bound to result from the general misunderstanding with respect to the benefits in the administration's program, the committee added a supplemental voluntary insurance program.

There is an equal, or even greater, lack of understanding with respect to the taxes which may ultimately be required to finance these obligations. The so-called medicare program has been widely advanced as providing *prepaid* medical care for the aged, *at a cost of only a few cents per week.* This is equally misleading.

Benefits financed through a payroll tax carries the erroneous implication of "entitlement." The recipients have been led to believe that these benefits become a matter of right. Both cash benefits and hospital benefits under the social security program will be continued only so long as the active worker is willing to pay the taxes required to finance those benefits. By the adminission of the former Secretary of Health, Education, and Welfare before the last Congress, the combined payroll tax in the committee bill exceeds the limits of an acceptable payroll tax.

Recognizing this, the committee bill makes an obvious effort "to soften the blow" on the work force. At the outset the hospital benefits will be financed with only a fraction of the ultimate tax that must be assessed to finance the benefits. Notwithstanding the increases in cash benefits, the regular social security tax rate provided in the bill for 1966 is less than the rate called for in existing law. The taxes which will be paid on account of today's younger worker are not commensurate with the benefits provided for him at age 65. When he understands this, will the worker be willing to pay the tax? If not, both cash benefits and hospital benefits will be in jeopardy.

COMMITTEE BILL COSTS MORE FOR LESS PROTECTION THAN REPUBLICAN PROPOSAL

The majority has finally recognized, as the Republicans long contended, that the limited hospitalization benefits provided for under the administration's original bill (H.R. 1)—widely advertised as "medicare"—were woefully inadequate. In an effort to meet this criticism, the Democrats borrowed from the Republican proposal and added a voluntary program of insurance for medical services. The committee bill now provides for a mandatory hospitalization program financed by a payroll or social security tax, together with a voluntary program for medical services financed partially by contributions and partially out of the general revenues of the Treasury. Notwithstanding diverse means of enrollment and financing, the package of benefits offered under the dual approach proposed in the committee bill still does not fully meet the needs of the aged.

While the adoption of the voluntary medical insurance program partially remedies the inadequacy of the administration's original

"medicare" bill, the committee bill still fails to cover two of the basic concerns of the aged; namely (1) the high and recurrent cost of drugs, and (2) the ever-present risk of a catastrophic illness. Both were covered in the substitute proposal offered by the Republicans.

On the other hand, the cost to the taxpayer—whether he pays a payroll tax or an income tax—of the comprehensive health insurance offered by the Republicans, is less than the cost of the administration's original hospital program. In preparing its estimates, the Department of Health, Education, and Welfare has assumed 80 percent participation in the voluntary medical insurance program in H.R. 6675. On the same assumption, the relative cost of the Republican proposal would be $400 million less than the cost of the administration's hospital benefits program alone.

Comparative cost of H.R. 6675 and Republican proposal based on 80 percent participation

[In billions]

	H.R. 6675	Republican proposal
Hospital benefit	$2.30	
Medical benefit	1.12	
Total, cost of program	3.42	$2.90
Less: Premium contributions	.56	1.00
To be financed by taxpayers	2.86	1.90

Source: Department of Health, Education, and Welfare.

While the estimates assume 80 percent participation, the Republicans would hope that the participation might be much greater. In fact, the Chief Actuary for the Department estimated that as many as 95 percent of the aged would participate in the Republican program. Even if we assume 100 percent participation, the net cost to the general revenues would be less than $2 billion for the first full year of coverage. This results from the fact that as participation increases, there are offsetting reductions in other programs and the tax revenue loss due to the medical deduction of $1.2 billion presently being claimed by the aged will be practically eliminated.

Net cost of Republican comprehensive health insurance proposal, 100 percent coverage

	Billions
Benefit cost	$3.65
Less:	
Premium contributions	1.25
Tax revenue from medical deduction	.25
Reduction of Federal cost for OAA–MAA programs	.35
Total	1.85
Cost to general revenues, net	1.80

In addition, the cost to the States for medical assistance to the aged would likewise be reduced, because the health insurance fund would cover a substantial part of such costs.

ELIGIBILITY PROVISIONS HIGHLY DISCRIMINATORY IN PRINCIPLE AND IN FACT

The hospitalization provisions of the committee bill, which are predicated upon the administration's original medicare proposal (H.R. 1), provide for 60 days of hospital care and related benefits for the aged irrespective of financial need, without any financial contribution from those already over age 65, and without regard to whether the individual may already be adequately protected against such costs. The bill automatically extends these benefits to all of those *presently* over age 65, and to those who attain that age before 1968, without regard to coverage under the social security system, *except that the bill excludes certain Federal civil service employees and their families irrespective of age.* Anyone reaching age 65 after 1967 must have the specified quarters of coverage under the social security system to be eligible for hospital benefits.

The committee bill thus excludes everyone who attains age 65 after 1967 without the required quarters of social security coverage. This means that until we reach that time when everyone qualifies for cash benefits under social security, there will always be those over age 65 who will not qualify for hospitalization benefits. Yet, this same group will qualify to purchase the voluntary insurance plan to cover the other medical services which was added in the committee bill.

The administration's original bill (H.R. 1) would also have excluded *all* Federal employees. The Republicans sought to make the benefits available to *all retired* Federal employees, just as the benefits are made available to all other persons over age 65. The majority rejected this proposal for the stated reason that with enactment of the Federal Employees' Health Benefits Act of 1959, the Federal Government offered adequate health insurance to its employees. However, the majority agreed to limit exclusion to those Federal employees who retire or have retired after the enactment of the 1959 act, *and their spouses.* Some 250,000 presently retired Federal employees and their spouses, and all future retirees, are excluded from the hospital benefit program.

We know of no justification for excluding any Federal employees. With respect to the Federal employee, the Government stands in role of employer, and should be governed accordingly. The majority takes the position that the hospital benefits in the bill should be denied to the retired Federal employee where other insurance is available. The health insurance provided for in the 1959 act costs the retired Federal employee about $20 per month for a retired couple. On the other hand, the hospitalization benefits in the committee bill are extended without cost to retired employees of the automotive industry, the agricultural industry, the chemical industry, and other groups notwithstanding that their employers have already provided them with complete hospitalization coverage without cost to them. The committee ignores the role of the Federal Government as an "employer" and discriminates against its own employees.

SEPARATION OF HOSPITALIZATION PROGRAM FROM SOCIAL SECURITY ILLUSORY

The bill purports to establish a separate hospital insurance fund, financed by a payroll tax, apart from the social security system. In

financing benefits for those presently over age 65, however, the bill distinguishes between the aged who are entitled to receive social security cash benefits and the aged who do not qualify for social security cash benefits. For the former, hospital benefits are to be financed by the payroll tax. For the latter, hospital benefits are to be financed out of the general revenues. If the program is, in fact, separate from the social security system, there is no basis for financing differently hospital benefits for the retired already receiving social security cash benefits as against those not entitled to cash benefits. With respect to the hospital benefit program—if it is a program separate and distinct from the social security system—neither group has made any contribution and neither has any prior entitlement to hospital benefits.

Similarly, those reaching age 65 after 1967—ineligible for the hospitalization program because they do not have the requisite social security coverage—are in no different position with respect to the hospital benefit program than are any of those presently over age 65. Yet benefits are denied to those reaching age 65 after 1967 unless they have the requisite social security coverage. Obviously, therefore, the so-called separation of the hospital benefits from the social security system of cash benefits under social security is purely illusory. It ignores the fact that the hospitalization and social security programs are linked together by a common method of financing (the payroll tax), a common wage base to which the tax is applied, and a common test for entitlement to benefits.

HOSPITALIZATION PROGRAM REAL THREAT TO INTEGRITY OF OASDI CASH BENEFITS

Under the committee bill, the hospital benefit program will be an integral part of the social security system. There is a common method of financing, applied to a common wage base, with a common test for entitlement to benefits. The bill has already been acclaimed by the administration as a program of medical care for the aged *under social security*. A real threat to the integrity of the social security cash benefit system is inherent in the committee bill.

The central fact which must be faced on a proposal to provide hospital benefits—a form of service benefit as contrasted to a cash benefit—is that it is impossible to accurately estimate its future cost. As the chairman of the Ways and Means Committee said in a speech as recently as last September: "These difficult-to-predict future costs, *when such a program is identified with the social security system*, could well have highly dangerous ramifications on the social security cash benefit." [Italic added.]

The American people must have confidence in the continued soundness of the social security program. In the past, the basis of this assurance has been the conservative nature of the assumptions upon which the social security system is based. One of these is the so-called level earnings assumption whereby the condition of the system is measured on the basis of the most recent year for which payroll information has been recorded. It is conservative in that it does not anticipate increase in earnings level even though such increases have been the history of the American economy over the long run. This safety factor which is built into the social security system comes into play because of a cash benefit structure which pays back

less, proportionately, to higher income people than to those whose average wages are lower. Thus, if future earnings increase, as they are very likely to do, this "savings" results because more people will have their benefit computed in the less weighted part of the benefit formula.

No similar assumptions can be made with respect to the hospitalization program. In order adequately to finance the hospitalization program it must be assumed either (1) that the tax rate will be continually increased or (2) that the wage base will be continually "updated" in order to provide additional funds to meet the increase in cost of the services. No one can reasonably assure the committee, or this Congress, that the actuarial cost estimates on which the program has been predicated will be realistic or valid a few years from now. Therefore, it would be unrealistic to assume that the tax rate in the bill—up to 1.60 percent on a wage base of $6,600—will adequately finance the benefits. In fact, our experience with the estimates submitted by the Department of Health, Education, and Welfare over the past 10 years with respect to the various hospital benefit programs conclusively establishes the opposite.

In 1957, the Department of Health, Education, and Welfare made estimates with respect to the cost of the original Forand bill then pending before the committee. Within a short period of time, the Department was forced to concede that those estimates were wholly inadequate. Based upon the facts known to us today, the estimated cost of that bill should have been at least double the amount of the original estimate. A similar bill with reduced benefits was introduced in 1960. Before the committee hearings were concluded on that bill, the Department had conceded that the costs were greatly underestimated. On the basis of what we know today, the Department underestimated the cost of that bill by at least one-third.

In 1963, when the King-Anderson bill (H.R. 1) was first introduced, it called for a tax rate increase of 0.50 percent (0.25 percent each on employer and employee) with a wage base increase to $5,000. When the committee conducted hearings on this bill in 1964, only 1 year later, the Department had already readjusted its estimates of the cost to increase both the tax rate and the base.

In January 1965, the Department estimated the cost of the hospitalization program in the administration's bill (H.R. 1) as equivalent to a tax of 0.84 percent on a taxable base of $5,600. Within the past few weeks, the Department has again revised its estimates upward. This escalation in cost estimates and tax rates has continued up until final action by the committee last week. Notwithstanding that benefits have been reduced from those originally proposed in H.R. 1, the committee bill now proposes a tax up to 1.6 percent on a wage base of $6,600.

Any member of the committee who is prepared to assure the Congress that these latest and most recent estimates of cost can be relied upon is ignoring 10 years of past experience. This is not to reflect upon the integrity of the actuaries who have participated in making the estimates. Uncertainty with respect to the cost of a program of this type is unavoidable.

The Congress would be wise if, in this context, it considered seriously a statement last year of Labor Minister Gilbert Granval who is responsible for France's social security system. He said in a report to President Charles de Gaulle:

"The financial breaking point is near. The solution cannot be found in the framework of the present system." He is quoted as saying that the chief drain on the French social security system has not been the retirement and other benefits but the health insurance system.

FINANCING OF HOSPITAL BENEFITS IS MISLEADING

In the committee bill, provision is made for a payroll tax using the same wage base as the social security system. The rate of tax and the wage base is, however, escalated in subsequent years. The ultimate tax rate of 1.60 percent provided for in the bill to finance the hospital benefits at a $6,600 wage base will be more than double the initial tax rate of 0.70 percent assessed on a $5,600 wage base for 1966. This "gimmick" merely postpones the full impact of the cost. It may make the program more "palatable" today, but it does not, in fact, diminish the burden on the active work force—employees, employers, and self-employed alike—who will be called upon to provide hospital benefits for those already over age 65. The real burden is merely shifted to the future.

The Department has estimated the cost of the program on a 25-year basis—the basis used in the committee bill—is the equivalent of a tax of 1.27 percent on a wage base of $5,600. Instead, the committee bill proposes to start out with a tax of 0.70 percent. This results in underfinancing the program on a level cost basis during the initial 10-year period. It requires subsequent increases in the tax rate and the wage base to a rate of 1.6 percent on a wage base of $6,600. In adopting this method of financing, we are misleading today's worker into believing that the cost of the hospital benefit is only a few cents per week. If no one paid more than the initial top rate the program would be "broke" in a couple of years.

Comparison of tax rates in H.R. 6675 with tax rate required to finance hospital benefit program on a level cost basis [1]

Year	Wage base	Tax rate	Tax	Level cost (on fixed wage base of $5,600)	Excess or (deficiency)
1966	$5,600	$0.70	$39.20	$70.12	($30.92)
1967	5,600	1.00	56.00	70.12	(14.12)
1968	5,600	1.00	56.00	70.12	(14.12)
1969	5,600	1.00	56.00	70.12	(14.12)
1970	5,600	1.00	56.00	70.12	(14.12)
1971	6,600	1.00	66.00	70.12	(24.12)
1972	6,600	1.00	66.00	70.12	(24.12)
1973	6,600	1.10	72.60	70.12	2.48
1974	6,600	1.10	72.60	70.12	2.48
1975	6,600	1.10	72.60	70.12	2.48
1976	6,600	1.20	79.20	70.12	9.08
1977	6,600	1.20	79.20	70.12	9.08
1978	6,600	1.20	79.20	70.12	9.08
1979	6,600	1.20	79.20	70.12	9.08
1980	6,600	1.40	84.40	70.12	14.28
1981	6,600	1.40	84.40	70.12	14.28
1982	6,600	1.40	84.40	70.12	14.28
1983	6,600	1.40	84.40	70.12	14.28
1984	6,600	1.40	84.40	70.12	14.28
1985	6,600	1.40	84.40	70.12	14.28
1986	6,600	1.40	84.40	70.12	14.28
1987	6,600	1.60	105.60	70.12	35.48
1988	6,600	1.60	105.60	70.12	35.48
1989	6,600	1.60	105.60	70.12	35.48
1990	6,600	1.60	105.60	70.12	35.48
1991	6,600	1.60	105.60	70.12	35.48

[1] Source: Basic data from Department of Health, Education, and Welfare.

The Department estimates $35 billion as the cost of the hospital program for those now over age 65 alone, who will not have paid 1 cent of the tax to finance these benefits. If we add to this the cost for those approaching age 65, who will have paid only a nominal tax, the total liability will exceed $133 billion. It is wholly irresponsible and unnecessary to place this burden on the payroll tax, with the representation which has frequently been made by the proponents of medicare that prepaid health insurance can be provided at a cost of only a few cents per week.

HOSPITAL INSURANCE TAX REGRESSIVE—NO MEASURE OF ABILITY TO PAY

A payroll tax is one of the most unfair and regressive taxes in our entire tax system. It applies to the first dollar of earnings. There are no exemptions, no deduction, no exclusions, and no tax credits. No consideration is given to the taxpayer's ability to pay. The president of a large corporation pays the same tax as his worker. The justification for this type of tax rests upon the basic premise of the social security system that the benefits, for which the tax is levied, are wage related. The financing of a hospital service benefit by a payroll tax represents a basic departure from that principle.

A worker earning a $3,600 wage, with a wife and two children to support, will pay total Federal income and payroll taxes of $250 for the year 1966. Of this amount, the payroll tax accounts for $162, with $18 of that amount applying to the hospitalization program. At the outset, this worker will be paying $18 per year towards financing hospital benefits for a retired couple without regard to their financial resources. The same retired couple with an income of $3,600 will pay no income tax, no social security tax, and no hospital insurance tax. They will have two less mouths to feed, and more spendable income, yet the worker will be forced to pay for their hospitalization.

FEDERAL TAX BURDEN OF MARRIED TAXPAYERS UNDER AGE 65 AND OVER AGE 65 [1]

Under age 65—Husband and wife with 2 children who take the standard deduction and have income of—

	Income tax	OASDI	Health Insurance	Total tax
$3,600				
1967	$88.00	$144.00	$18.00	$250.00
1976	88.00	172.80	21.60	282.40
1987	88.00	172.80	28.80	289.60
$4,600				
1967	$234.00	$184.00	$23.00	$441.00
1976	234.00	220.80	27.60	482.40
1987	234.00	220.80	36.80	491.60
$5,600				
1967	$402.00	$224.00	$28.00	$654.00
1976	402.00	316.80	39.60	758.40
1987	402.00	316.80	52.80	781.60

Over age 65—Husband and wife 65 or over (assumed to receive $1,200 retirement income, social security, pensions, interest, dividends, rent) with income of—

	Income	OASDI	Health Insurance	Total tax
$3,600				
1967	0	0	0	0
1976	0	0	0	0
1987	0	0	0	0
$4,600				
1967	$89.60	0	0	$89.60
1976	89.60	0	0	89.60
1987	89.60	0	0	89.60
$5,600				
1967	$224.00	0	0	$224.00
1976	224.00	0	0	224.00
1987	224.00	0	0	224.00

[1] Source: Internal Revenue Code.

PREPAYMENT FOR HOSPITAL BENEFITS A MYTH

Under the committee bill, a worker entering the work force at age 21 today will pay a payroll tax for 44 years—matched by the same amount paid on account of his wage by his employer—to finance a benefit for others. The actual cost of the hospitalization program per worker entering the work force at age 21, with interest at 3½ percent per annum, will amount to $8,590. That is what will be paid on account of the new generation of workers to finance hospital benefits for those already retired. The same amount invested in private health insurance would provide the worker with far more extensive benefits than are provided under the hospital program contained in the bill.

Hospital insurance cost under H.R. 6675 for workers at selected ages from Jan. 1, 1966, to retirement [1]

HOSPITAL INSURANCE TAX

Age	Employee tax	Employer tax	Combined
21	$2,003	$2,003	$4,006
25	1,792	1,792	3,584
35	1,264	1,264	2,528
45	742	742	1,484

HOSPITAL INSURANCE TAX COMPOUNDED WITH INTEREST AT 3½ PERCENT PER ANNUM

21	$4,295	$4,295	$8,590
25	3,586	3,586	7,172
35	2,067	2,067	4,134
45	1,025	1,025	2,050

[1] Source: Department of Health, Education, and Welfare.

The so-called prepayment concept of the committee bill is a myth. The funding of the hospital benefit program is so meager as to be meaningless. When the 21-year-old worker reaches age 65, there will not be $8,590 in the fund to finance his hospital benefits. The money will have been used to pay benefits for those who preceded him. *It is not contemplated that the amount "prepaid," or set aside in the hospital insurance fund to pay future costs, will exceed the cost of 1 year's benefits.*

Estimated progress of hospital insurance trust fund [1]

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Fund at end of year
1966	$1,578	$982	[2] $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] Source: Department of Health, Education, and Welfare.
[2] Including administrative expenses incurred in 1965.

The 21-year-old worker, or indeed the 45-year-old worker, is not "prepaying" for his hospital benefits. He is really being taxed for the hospital benefits of those already retired and of the older workers who will retire before him. For example, the Department has estimated that a worker at age 50 who pays the full amount of the tax for the balance of his working years will have been taxed only to the extent of a fraction of the cost of his benefits.

Relative hospital benefit cost and taxes paid under H.R. 6675 by selected age groups over 50 years of age [1]

[In billions]

	Cost of providing hospital benefits to selected age group	Taxes paid by selected age group	Cost younger workers are required to pay to provide benefits to selected age group
(1) Individuals 65 or over on Jan. 1, 1966	$35		$35
(2) Individuals between 60 and 65 on Jan. 1, 1966	25	$1	24
(3) Individuals between 50 and 60 on Jan. 1, 1966	80	6	74
(4) All individuals 50 or over on Jan. 1, 1966 ((1) through (3) above)	$140	$7	$133

[1] Source: Department of Health, Education, and Welfare.

HOSPITAL COST REIMBURSEMENT FORMULA DESTROYS QUALITY OF MEDICAL CARE

The committee bill embodies a wholly new concept of payment for the hospital services which will be supplied to the aged under the hospital benefits program. The bill provides that the payment to the providers of such services (hospitals) will be limited to the "reasonable cost" of the services to be determined in accordance with regulations to be issued by the Department of Health, Education, and Welfare.

In other words, it makes no difference what the hospital might customarily charge for room and board, radiotherapy, or any other of the multitudinous services available for the treatment of the patient. It is immaterial, in fact, what Blue Cross or any health insurer might pay for the same service. The bill presupposes that it will cost less to render the services to the aged. Actuarially, the cost estimates relied upon in the bill are predicated on the assumption that the Department will be able to buy hospital services for the aged at a "discount" rate.

The bill requires that the Department shall fix a price—namely, "reasonable cost"—for each and every service rendered by the hospital or nursing home. The bill does not specifically define "reasonable cost." However, in fixing the reasonable cost of such services, it is admitted that charges for bad debts, charity patients, and certain unabsorbed overhead will not be allocated as a cost of the services financed under the hospitalization program.

The committee was advised that there are some 5,000 hospitals which will participate in the program. Add to this an undetermined number of nursing homes and other providers of services. The so-called reasonable cost in each case will vary. This means that every provider of services will be required to analyze its cost for every service which may be supplied to the aged, and to negotiate and

agree with the agency administering the program on the price to be charged to the aged for such service.

The hospitals are for the most part nonprofit institutions. There is hardly a hospital in the country which does not embark upon various money-raising programs in order to make up the deficit between the charges and the cost of running the hospital. Any cost which is shifted from the overage 65 patients in the cost formula prescribed by the Department, must necessarily be paid by someone. Many of the hospitals are already faced with inadequate revenues. If the hospitals are to continue in operation, someone will have to pay for the charity patients, the bad debt losses, and the unabsorbed overhead. If the entire burden is shifted from the overage 65 patients to the other patients, this will inevitably increase hospitalization costs for the patients under age 65.

In lieu of this formula, the Republicans suggested that the hospital program reimburse the provider of services at the customary rate charged for such services. This was rejected on the grounds that it would result in an overpayment on account of the aged. The Department claimed that the "reasonable cost" for the aged, as contemplated by the committee bill, will be less than the Blue Cross rates.

The consequences of the adoption of the "reasonable cost" formula should be apparent. If the hospitals are prevented from charging the customary rates to the patients over age 65, hospital costs for patients under age 65 will have to be increased in order to make up the difference. In order to reduce its losses, when the patients under age 65 can no longer bear such increases, the hospital will be forced to curtail the quality of its service.

The Department will undoubtedly contend that the services offered to those aged 65 cannot be reduced because the Department will see that this is not done. In other words, in the final analysis, so long as the "reasonable cost" formula remains in the bill, hospital care for those over age 65—and the operations of the hospital itself—will necessarily be subject to control by the Department. This is essential if the Department is to prevent the hospital from taking the only course open to it in reducing its losses, namely, to cut back on its services to the patients over age 65 who are the cause of such losses.

Republicans Offer Better Proposal for Comprehensive Health Insurance

OUTLINE OF REPUBLICAN COMPREHENSIVE HEALTH INSURANCE PROGRAM

We propose a program of comprehensive health insurance for everyone over age 65 equivalent to the medical insurance available to Government employees under the high option of the Government-wide indemnity plan. This plan has been described by the Department of Health, Education, and Welfare as providing the most comprehensive insurance available at this time. Our program would meet all of the medical needs of the aged, both in and out of the hospital. It will cover the catastrophic illness. It is both comprehensive in scope and comprehensive in effect.

Under this program, all persons aged 65 or over are eligible, on a uniform basis. Their participation would be voluntary; there would

be no means test. Enrollment would be during an initial enrollment period, followed by periodic enrollment periods.

For those under social security—or railroad retirement—enrollment would be exercised by an assignment of a premium contribution to be taken out of, or checked off, the individual's current social security benefit. Those not under social security would execute an application accompanying it with their initial premium contribution. State agencies would be granted an option to purchase the insurance for their old-age assistance and medical assistance for the aged recipients at a group rate.

Premium contributions by individuals would be based upon the cash benefits which they would either receive, or be entitled to receive upon reaching age 65. The premium would be 10 percent of the minimum social security benefit and 5 percent of the balance. Those receiving the lowest social security benefits would pay the least. The average premium contribution on the basis of the benefit levels in the committee bill would be about $6.50 per month per person. Persons not under social security would pay a premium equivalent to the maximum contribution of an individual under social security. The remainder of the cost of the insurance would be paid by the Federal Government out of general revenues.

Benefits would be paid out of a national health insurance fund. The fund would receive as deposits the contributions of individuals, contributions from the social security system and Railroad Retirement Board on behalf of individuals covered under those systems, State contributions for OAA and MAA recipients, and annual appropriations from the Federal Treasury. The Secretary of the Treasury would administer the fund. The insurance program would be administered by the Department of Health, Education, and Welfare, which would be charged with general administration, recordkeeping, and so forth, but would not process the claims or bills of hospitals, physicians, and the like. The Surgeon General would contract with private agencies—Blue Cross-Blue Shield, for example—which would process and pay the claims of those furnishing services and would then be reimbursed from the national health insurance fund.

Under what we propose, more medical care can be provided for those over age 65 at a savings both to the Government and to the taxpayer. For the first full year of coverage, the net cost to the Treasury for financing the Republican health insurance program, after taking into account the additional tax revenues and the savings in other Federal programs attributable to the program, will amount to less than $2 billion. While costs will increase—just as costs will increase under the programs in H.R. 6675—premium contributions will also increase under the Republican program. The taxpayer—or tomorrow's worker—does not bear the full brunt of the increases in hospital and other medical costs.

The Republican program also embodies an amendment to the Internal Revenue Code to provide for a special tax to recoup a part of the cost of the insurance from those participating who have incomes in excess of $5,000 for a single person and in excess of $10,000 for a married couple filing a joint return. In this manner, those over age 65, who are fully able to finance health insurance without Government aid, can participate in the program with the full knowledge that they are not passing on this cost to others.

REPUBLICAN PROPOSAL AVOIDS PROBLEMS INHERENT IN THE COMMITTEE BILL

The Republican proposal for a national health insurance fund, financed partially through voluntary contributions and partially through the general revenues, avoids the problems inherent in the committee bill. Health insurance for the aged is not divided into separate programs requiring separate financing and separate administration. The aged are treated just as we treat our Federal employees. Adequate insurance is provided at a cost which is well within the means of those who do not quality for State assistance.

The program provides comprehensive medical care. It is not misleading.

The insurance concept is completely voluntary. Since there is a cost to the insured, those who already have adequate programs paid for by their former employers or through associations and the like, may not elect the Government-sponsored program. To the extent that these do not participate, the cost to the Government is reduced.

The insurance concept is completely independent of the social security system. Social security benefits are used merely as a test of ability to pay in determining the amount of the premium. The assignment of a predetermined percentage of these benefits to the health insurance fund is the only relationship of the program to the social security system.

The premium contribution schedule embodies a relative needs test. For example, for a couple receiving the maximum social security benefit ($203.85), the cost of the insurance will be $13.00 per month. A couple receiving the minimum social security benefit ($66) will be able to buy the same health insurance at a cost of $5.50 per month. The amount of the Government subsidy thus varies with the economic status of the individual, as measured by social security benefits.

By including a contribution or premium charge, the cost is shared by the individual and the Government. This makes for a sounder program. This cost sharing will have a tendency to reduce excessive usage of the benefits.

The program preserves fully the role of the States in providing for those who are in need. Instead of blanketing in individuals receiving medical assistance under OAA and under MAA, as provided in the hospital benefit program of the committee bill, the States will determine the needs of these persons and are permitted to insure them as a group if the State elects to do so. It becomes possible to provide all recipients of medical care with the same type of basic protection, irrespective of their enonomic status. No distinction is made in our program between the person who participates on an individual basis, the social security recipient who elects to participate, the recipient of OAA and the recipient of MAA. All receive the same basic insurance policy.

In alternative, however, we also give the States the election under the Kerr-Mills Act, to offer alternate programs of private health insurance to the aged, which is the approach adopted in the Eldercare bills.

Republicans Support Amendments to Kerr-Mills Program

The bill expands State programs for medical assistance to the aged, blind, and the disabled, and provides grants for maternal and child health care and crippled children's services. These amendments will unquestionably bring about better medical care for those in need under the State-administered programs of medical assistance for the aged, the blind, the disabled, and for dependent children.

The Republicans supported similar amendments before the Ways and Means Committee in the last Congress. We reaffirm that position. However, the proponents of medicare would not support the medical assistance amendments at that time because they felt that such action might jeopardize—because of reducing the need for—the hospitalization program provided in H.R. 1.

Not only do the Republicans fully support these amendments to the Kerr-Mills program, but we would enlarge upon the committee bill in this respect. We would add the complete concept embodied in the Eldercare bills (H.R. 3728 and H.R. 3801) introduced by two Republican members of the committee. Under these bills, voluntary private health insurance plans may be used as the insurance intermediary. State governments, assisted by Federal funds, could offer health insurance coverage to fit the individual needs of the aged. The cost of such coverage would be paid completely out of Federal-State funds for those individuals with incomes below means established by each State. For those individuals exceeding the minimum but less than a maximum, the State could pay a part of the cost. Eligibility would be determined solely on the basis of a simple statement of annual income submitted to the appropriate State authorities.

While much of the Eldercare bills is embodied in the committee bill, we believe that the States should be specifically authorized to adopt such programs under the Kerr-Mills Act. We propose to enlarge upon the committee amendments to the Kerr-Mills Act in order to make more specific the right of the States to enter into private contracts of insurance for the aged.

OASDI Amendments Supported by Republicans

Substantially all of the amendments relating to the OASDI benefits were embodied in a bill (H.R. 288) introduced on January 4, 1965, by the ranking Republican member of the committee, and similar bills introduced by other Republicans (H.R. 3163, H.R. 3830, H.R. 3219, H.R. 4230, H.R. 4272, H.R. 4395, H.R. 4619, H.R. 4971, H.R. 5038, H.R. 5039, and H.R. 6404). These amendments could have been enacted into law long ago if considered separately from the so-called medicare program. In fact, some 20 million recipients (or their dependents) would already have been enjoying the benefits of these amendments if the proponents of medicare, at the direction of the administration, had not blocked enactment of the social security amendments in the last Congress.

Many of the amendments in the Republican bills (H.R. 288, 3161, 3219, and 3830) are now included in the committee bill. We fully support these amendments:

(1) A 7-percent increase in cash benefits, with a minimum increase of $4 for the primary insurance amount.[1]

[1] The Republican bills proposed a 7-percent increase in cash benefits with a minimum increase of $5 in the primary insurance amount.

(2) A minimum benefit of $35 for some 400,000 persons over age 72 who do not have the requisite work coverage to qualify for benefits under existing law.

(3) Liberalization of the earnings test for the aged who seek to supplement their social security benefits with part-time jobs.

(4) Extension of social security benefits for dependents attending school up to age 22 instead of age 18.

(5) Social security benefits for widows beginning at age 60, rather than at age 62.

(6) Liberalization of the gross income upon which farmers may elect to pay social security taxes.

(7) Recognition of the conscientious objection of certain long-established religious groups to the social security concept.

In addition to these amendments to the OASDI system, the Republican proposals also contained the amendments relating to the old-age assistance and other assistance programs administered by the States, which are presently included in H.R. 6675. Titles II, III, and IV of the committee bill are, for the most part, supported by the Republicans. We take satisfaction in the fact that many of these amendments—not included in the administration's bill (H.R. 1)—were contained in the bills introduced by the Republicans.

Republicans Applaud Tax Relief for Those Under Age 65 Carrying Health Insurance

Although we have made tremendous gains in public acceptance of health and accident insurance over the past decade, the taxpayer, instead of being given an incentive to enroll himself or his family in a medical plan, is penalized for doing so. Under existing law, the medical expense deduction is limited to the amount in excess of 3 percent of the taxpayer's adjusted gross income. The 3-percent limitation effectively excludes the cost of health insurance. This penalizes the taxpayer who insures himself and his family through accident and health insurance. Today, as a practical matter, a person having adequate health insurance does not get a tax deduction for either insurance costs or medical costs.

For many years, the Republicans have sought to amend the tax laws so as to treat premiums paid on account of health and accident insurance differently from other medical expense in order that a taxpayer carrying such insurance will be placed on more nearly an equal basis with a taxpayer who does not insure his medical expenses.

The committee bill partially remedies this inequity. The bill provides a separate deduction (up to a maximum $250 per year) for 50 percent of the cost of the taxpayer's expense for health insurance. The Republicans would prefer the allowance of the deduction in full. Nevertheless, we believe that "half a loaf is better than none," and we applaud the recognition, in the committee bill, of health insurance premiums as a separate deduction, not subject to the 3-percent exclusion.

John W. Byrnes.
Thomas B. Curtis.
James B. Utt.
Jackson E. Betts.
Herman T. Schneebeli.
Harold R. Collier.
Joel T. Broyhill.
James F. Battin.

ADDITIONAL SEPARATE VIEWS OF THE HONORABLE JOEL T. BROYHILL

The undersigned has joined with my Republican colleagues in the foregoing Separate Views opposing enactment of the so-called medicare program provisions of H.R. 6675, in the compulsory form in which the program was approved by the majority members of the Committee on Ways and Means.

I support the efforts to be made by the Republican minority during the House floor consideration of H.R. 6675 to delete the mandatory medicare provisions of the bill and substitute therefor a voluntary program of broader health care insurance. I file these additional separate views because I was one of the original 35 sponsors of the eldercare proposal as embodied in my bill, H.R. 3801, and I believe it appropriate to discuss the superiority of the eldercare proposal over the administration's medicare proposal in view of the broad support given the eldercare approach in the Congress.

My preference for the eldercare approach over the medicare plan is based on the fact that the eldercare proposal avoids compulsion, minimizes Federal regimentation, and allows a comprehensive range of benefits under State administered programs. Under eldercare the extent of aid to the recipient is based on his need for Government assistance in meeting his health-care requirements without requiring a "social-worker type" needs test.

The eldercare proposal would work as follows: Voluntary private health insurance plans would be used as the insuring intermediaries. State governments, assisted by Federal funds, would offer health insurance coverage to fit a variety of individual needs of the aged. The cost of such coverage would be borne completely by Government for those individuals with incomes falling below minimum limits set by each State. For those individuals with incomes exceeding the minimum but less than a maximum, the State would pay a part of the cost. For those individuals whose incomes exceed maximum limits, the State would pay nothing. Aged individuals would periodically make a simple statement of annual income to the State. On the basis of this income statement alone would eligibility be determined.

Principal reasons for opposing medicare

Medicare should not be enacted because:

(1) The so-called medicare program is a compulsory Federal plan that would impose additional regressive payroll taxes on the current working population regardless of *inability* to pay; partial health benefits are made available to the retired population regardless of individual *ability* to be self-supporting—rich and poor alike. (See tables 1 and 2 for OASDI tax rate schedules and table 3 for medicare tax rate schedule. Tables also show tax amount per individual. Tables 5 and 6 set forth data with

respect to combined OASDI and medicare tax rates and amounts. Tables follow at the end of these additional views.)

(2) Medicare would establish a massive Federal program financed by social security and administered by a central bureaucracy and would violate the established concept that the echelon of government closest to the people can be more efficient and responsive in administration of social programs.

(3) Medicare would initiate what would ultimately become a Federal monopoly in regard to the financing and rendering of health care with respect to our aged to the detriment of endeavors of the private sector; this result would impair the quality of health care, retard the advancement of medical science, and displace private insurance.

(4) Medicare would for the first time inject into our OASDI system *service* benefits as distinguished from predeterminable *cash* benefits with the consequence that unpredictable costs and overutilization would jeopardize the soundness and acceptability of the social security program as well as necessitate a vast and costly expansion of health care facilities.

(5) The consensus of nongovernmental actuaries experienced in health insurance matters holds that the medicare program is underfinanced; but even the inadequate financing provisions of the bill would mean that for many taxpayers more would be paid in social security taxes than would be paid in income taxes.

(6) The economic thrust of the higher employment taxes necessitated by the medicare programs would have immediate adverse impact on job opportunities and the problem would be further aggravated by the certain expansion of the program once started. (See table 4 for estimated aggregate payroll taxes.)

Principal reasons for introducing eldercare

The eldercare program, embodied in H.R. 3801, was introduced for committee consideration as a preferable alternative to medicare because:

(1) The eldercare proposal is a noncompulsory program permitting health care under State administered programs aimed at providing complete care for aged persons requiring help in meeting their health expenses without a "social-worker type" means test.

(2) The proposal would provide for State administration and the utilization of private insurance carriers, thereby assuring responsible and responsive administration.

(3) Eldercare would minimize the intrusion of inflexible governmental management on medical facilities and professional services.

(4) The eldercare proposal would neither interfere with nor endanger the established concept of confining OASDI benefits to cash payments and would avoid the risky adventure of service benefits—an adventure that is failing in virtually every other major country.

(5) The eldercare proposal would not require the imposition of higher regressive payroll taxes and it would not jeopardize the actuarial status of the present OASDI system.

GENERAL DISCUSSION

The biennial political issue of compulsory Federal health care under social security has been pending before the Congress for 20 years. In that interim there has been no meaningful fundamental improvement contained in the various modifications that have been advocated in the compulsory social security approach. The only variations in the different proposals advanced from time to time are: (1) Curtailments in the suggested benefits to make the alleged cost politically salable, (2) arbitrary adjustments in eligibility requirements and, more recently, (3) a new catchword title—"Medicare."

In this 20-year period during which the Congress has rejected compulsory Federal health programs, the Congress has acted to establish sound Federal-State voluntary programs capable of meeting the health needs of citizens unable to defray the financial burdens of their own health requirements. The most recent instance of responsible action in this regard occurred with the enactment of the Kerr-Mills program.

There has also occurred in this 20-year period a phenomenal growth in the proportion of our aged population covered by private health insurance protection so that today substantially more than 60 percent of persons 65 years and over have coverage. In the past 10 years the number of aged covered by private insurance has more than tripled and the percentage of those so protected is expected to surpass 75 percent by 1969. Now the Congress is being called upon to provide a compulsory political solution to a medical problem by enacting a plan that would impair State administered programs and would destroy the incentive for the financially able aged to provide for themselves through insurance.

The membership of the House of Representatives, in acting on the medicare political palliative should be cognizant of the meaningful fact that the two groups most knowledgeable of the medical and actuarial implications of the medicare proposal oppose its enactment—these groups are the physicians and the health insurance industry. The concerns expressed by these groups are sustained by events throughout the world where government health programs have reached the critical juncture of unforeseen increases in cost and declining quality of medical service. It is not by accident that the U.S. citizens have available to them the highest standard of health care in the world under our free enterprise system. The enactment of medicare will inescapably impair the quality and increase the cost of health care in this country similar to the deteriorating standards and increasing costs being experienced in such countries as Great Britain, France, and Italy.

The proponents of compulsory health care under social security have provided a separate "health" trust fund to alleviate concern over the impact the provision of medical service benefits may have on the system's ability to meet cash benefit obligations. This same "precautionary safeguard" was attempted in the establishment of the separate Federal disability insurance trust fund under social security in 1956, which will only be saved from insolvency in 1966 by a provision in the committee's bill which allocates a larger percentage of the payroll tax which supports all facets of the OASDI program.

The potential for the impairment of the solvency of the new "health" trust fund arises in part from the fact that present aged beneficiaries

would be eligible for benefits under the program without any contribution to the trust fund for health insurance benefits. Concern over this problem was expressed in September 1964 by the able chairman of the Committee on Ways and Means when he said of medicare:

> * * * a further very serious problem is the effect which the assumption of the liability for the hospital costs for all the currently retired persons will have on the social security program as a whole. I do not believe that it is generally understood that this unfunded liability would amount to at least $33 billion. It must be realized that the currently retired individuals under the social security program have not paid any taxes as such for hospital insurance benefits. This is where the prepayment argument * * * completely breaks down.

The esteemed chiarman of the Committee on Ways and Means has worked diligently and conscientiously to provide an adequate and sound social security program; and it is because of that fact that I believe his admonition should be brought to the attention of the House membership.

Thus, this unfunded liability makes it patent that to claim medicare is based on an insurance principle is to clutch at an illusion. The unfunded obligations of the present OASDI program, which currently exceed $300 billion under present law, will have many more billions of unfunded benefit commitments added by the institution of the new "medicare" program with its schedule of deferred tax increases which does not reach its ultimate effect until January 1, 1987. The first population group that will bear the full brunt of the tax burden is the group of citizens to be born 6 years from now; and that group will be called upon to pay for its benefits as well as share in defraying the benefit costs of the presently retired and of those now in the working force.

It is also to be noted that the present law limitation on earned income by beneficiaries for eligibility for cash benefits, the so-called retirement test, would not be applicable with respect to the health service benefits. The service benefits provided in this bill will create additional inequities in the OASDI program in that persons aged 65 who become sick will be eligible for benefits without paying and taxes for these added benefits, whereas a person aged 60 who is in need and has paid increased taxes will be denied benefits.

CONCLUSION

Although there are many provisions in H.R. 6675 which I believe to be meritorious, such as were referred to in the foregoing Separate Views, the compulsory health care features of the bill threaten danger to the entire social security structure. The melancholy prospect for medicare is that it will retard, not advance, the Nation's health and welfare. In opposing this medicare program for the compelling reasons presented, I pledge myself to continued endeavors to have favorable action taken on a sounder and more equitable approach to meeting the medical needs of our aged citizens. I respectfully urge my colleagues in the House to join the Republican members of the Committee on Ways and Means in this effort.

JOEL T. BROYHILL, *Member of Congress.*

TABLE 1.—*Tax rate, tax base, and tax amount applicable to employers and employees (each) under present law and under H.R. 6675* [1]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM, 1965-87 AND AFTER

Year	Tax rate, employer and employee (each)		Tax base		Tax per employee with base wage under bill [2]			
					Amount of tax		Increase under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
	Percent	*Percent*						
1965	3.625	3.625	$4,800	$4,800	$174	$174.00		
1966	4.125	4.000	4,800	5,600	198	224.00	$26.00	$50.00
1967	4.125	4.000	4,800	5,600	198	224.00	26.00	50.00
1968	4.625	4.000	4,800	5,600	222	224.00	2.00	50.00
1969-70	4.625	4.400	4,800	5,600	222	246.40	24.40	72.40
1971-72	4.625	4.400	4,800	6,600	222	290.40	68.40	116.40
1973-75	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80
1976-79	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80
1980-86	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80
1987 and after	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80

[1] As described in Ways and Means Committee press release issued on Mar. 24, 1965, which summarizes the bill.

[2] Employers pay same amount on behalf of such employees.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 2.—*Tax rate, tax base, and tax amount applicable to self-employed persons under present law and under H.R. 6675* [1]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM, 1965-87 AND AFTER

Year	Tax rate		Tax base		Tax per self-employed with base earnings under bill			
					Amount of tax		Increase under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
	Percent	*Percent*						
1965	5.4	5.4	$4,800	$4,800	$259.20	$259.20		
1966	6.2	6.0	4,800	5,600	297.60	336.00	$38.40	$76.80
1967	6.2	6.0	4,800	5,600	297.60	336.00	38.40	76.80
1968	6.9	6.0	4,800	5,600	331.20	336.00	4.80	76.80
1969-70	6.9	6.6	4,800	5,600	331.20	369.60	38.40	110.40
1971-72	6.9	6.6	4,800	6,600	331.20	435.60	104.40	176.40
1973-75	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1976-79	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1980-86	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1987 and after	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80

[1] As described in Ways and Means Committee press release, issued on Mar. 24, 1965, which summarizes the bill.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 3.—*Tax rate, tax base and tax amount, applicable to employers, employees, and self-employed persons under the basic health insurance program of H.R. 6675* [1]

1965-87 AND AFTER

Year	Tax on employer, employee, and self-employed (each)		
	Tax rate (percent)	Tax base	Tax amount [2]
1965			
1966	0.35	$5,600	$19.60
1967	.50	5,600	28.00
1968	.50	5,600	28.00
1969-70	.50	5,600	28.00
1971-72	.50	6,600	33.00
1973-75	.55	6,600	36.30
1976-79	.60	6,600	39.60
1980-86	.70	6,600	46.20
1987 and after	.80	6,600	52.80

[1] As described in Ways and Means Committee press release issued on Mar. 24, 1965, which summarizes the bill.

[2] For each self-employed person and employee with earnings or wage equal to or in excess of the tax base; employers pay same amount on behalf of such employees.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 4.—*Estimated aggregate taxes on employers, employees, and self-employed persons under present law and under H.R. 6675* [1]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM, 1965-72 AND BASIC HEALTH INSURANCE PROGRAM, 1965-75, 1980, 1985, AND 1990

[In billions of dollars]

Year	Present law			H.R. 6675			
	Old-age and survivors insurance program	Disability insurance program	Total	Old-age and survivors insurance program	Disability insurance program	Basic health insurance program	Total
1965	$16.0	$1.2	$17.2	$16.0	$1.2		$17.2
1966	18.5	1.2	19.7	18.5	1.8	$1.6	21.9
1967	19.4	1.3	20.7	19.7	2.0	2.6	24.3
1968	22.2	1.3	23.5	20.3	2.1	2.8	25.2
1969	23.3	1.3	24.6	22.9	2.2	2.9	28.0
1970	24.0	1.4	25.4	24.0	2.2	3.0	29.2
1971	24.7	1.4	26.1	25.9	2.4	3.3	31.6
1972	25.4	1.4	26.8	27.2	2.5	3.5	33.2
1973	(2)	(2)	(2)	(2)	(2)	3.9	(2)
1974	(2)	(2)	(2)	(2)	(2)	4.1	(2)
1975	(2)	(2)	(2)	(2)	(2)	4.3	(2)
1980	(2)	(2)	(2)	(2)	(2)	6.1	(2)
1985	(2)	(2)	(2)	(2)	(2)	7.0	(2)
1990	(2)	(2)	(2)	(2)	(2)	9.0	(2)

[1] As described in Ways and Means Committee press release, issued on Mar. 24, 1965, which summarizes the bill.

[2] Not available.

Source: Compiled by staff of the Joint Committee on Internal Revenue Taxation from data supplied by Social Security Administration.

TABLE 5.—*Combined tax rate on employer and employee under present law and under H.R. 6675* [1]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND BASIC HEALTH INSURANCE PROGRAM, 1965-87 AND AFTER

[In percent]

Year	Combined tax rate on employer and employee							
	Old-age, survivors, and disability insurance program		Basic health insurance program		Old-age, survivors, and disability insurance program and basic health insurance program			
							Change under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
1965	7.25	7.25			7.25	7.25		
1966	8.25	8.00		0.70	8.25	8.70	+0.45	+1.45
1967	8.25	8.00		1.00	8.25	9.00	+.75	+1.75
1968	9.25	8.00		1.00	9.25	9.00	−.25	+1.75
1969-70	9.25	8.80		1.00	9.25	9.80	+.55	+2.55
1971-72	9.25	8.80		1.00	9.25	9.80	+.55	+2.55
1973-75	9.25	9.60		1.10	9.25	10.70	+1.45	+3.45
1976-79	9.25	9.60		1.20	9.25	10.80	+1.55	+3.55
1980-86	9.25	9.60		1.40	9.25	11.00	+1.75	+3.75
1987 and after	9.25	9.60		1.60	9.25	11.20	+1.95	+3.95

[1] As introduced in the House of Representatives on Mar. 24, 1965.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 6.—*Combined tax on employer and employee under present law and under H.R. 6675* [1] [2]

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND BASIC HEALTH INSURANCE PROGRAM, 1965-87 AND AFTER

Year	Combined tax on employer and employee							
	Old-age, survivors, and disability insurance program		Basic health insurance program		Old-age, survivors, and disability insurance program and basic health insurance program			
							Increase under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
1965	$348	$348.00			$348	$348.00		
1966	396	448.00		$39.20	396	487.20	$91.20	$139.20
1967	396	448.00		56.00	396	504.00	108.00	156.00
1968	444	448.00		56.00	444	504.00	60.00	156.00
1969-70	444	492.80		56.00	444	548.80	104.80	200.80
1971-72	444	580.80		66.00	444	646.80	202.80	298.80
1973-75	444	633.60		72.60	444	706.20	262.20	358.20
1976-79	444	633.60		79.20	444	712.80	268.80	364.80
1980-86	444	633.60		92.40	444	726.00	282.00	378.00
1987 and after	444	633.60		105.60	444	739.20	295.20	391.20

[1] For employee with wage equal to or in excess of the tax base under the bill.
[2] As introduced in the House of Representatives on Mar. 24, 1965.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

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