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

BRIEF SUMMARY OF MAJOR PROVISIONS OF AND DETAILED COMPARISON SHOWING CHANGES MADE IN EXISTING LAW BY H.R. 6675 AS PASSED BY THE HOUSE OF REPRESENTATIVES

(Compiled by Education and Public Welfare Division, Legislative Reference Service, Library of Congress, at the Direction of the Chairman and Printed for the Use of the Committee on Finance)

46—433

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1965

COMMITTEE ON FINANCE

HARRY FLOOD BYRD, Virginia, *Chairman*

RUSSELL B. LONG, Louisiana
GEORGE A. SMATHERS, Florida
CLINTON P. ANDERSON, New Mexico
PAUL H. DOUGLAS, Illinois
ALBERT GORE, Tennessee
HERMAN E. TALMADGE, Georgia
EUGENE J. McCARTHY, Minnesota
VANCE HARTKE, Indiana
J. W. FULBRIGHT, Arkansas
ABRAHAM A. RIBICOFF, Connecticut

JOHN J. WILLIAMS, Delaware
FRANK CARLSON, Kansas
WALLACE F. BENNETT, Utah
CARL T. CURTIS, Nebraska
THRUSTON B. MORTON, Kentucky
EVERETT McKINLEY DIRKSEN, Illinois

ELIZABETH B. SPRINGER, *Chief Clerk*

TABLE OF CONTENTS

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

	Page
A. Health insurance and medical care	1
B. Child health care program amendments	1
C. Public assistance	2
D. Old-age, survivors, and disability insurance	3
E. Scope and persons affected	5
F. Cost and financing	6

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

HEALTH INSURANCE AND MEDICAL CARE FOR THE AGED

I. Health insurance for the aged	10
A. Basic hospital plan	10
1. Benefits	10
2. Effective dates	11
3. Eligibility	11
4. Basis of reimbursement	11
5. Administration	12
6. Financing	12
B. Voluntary supplementary plan	12
1. Benefits	12
2. Effective date	13
3. Eligibility and payment of premium	13
4. Enrollment	13
5. Administration by carriers; basis for reimbursement	13
6. Financing	13
C. Extension of Kerr-Mills program	14
1. Brief summary	14
2. Medical assistance for the aged	15
(*a*) Eligibility for assistance	15
(*b*) Scope of benefits	15
(*c*) Matching formula	16
(*d*) State plan requirements	17
(*e*) Use of private health insurance	19
3. Effect on other public assistance programs	20
(*a*) Medical vendor program content and scope	20
(*b*) Matching formula—vendor medical payments	20

PUBLIC ASSISTANCE

I. Increase in Federal matching formula	22
A. Payments for old-age assistance, aid to the blind, and aid to the permanently and totally disabled, and combined aged, blind, and disabled program (title XVI)	22
B. Payments for aid to families with dependent children	24
C. Special formula for Puerto Rico, Virgin Islands, and Guam	24
1. Matching formula	24
2. Dollar limitation	24
D. Pass along provision	24
E. Consideration of income in determination of need	25
1. Consideration of earnings in old-age assistance and aged in combined program (title XVI)	25
2. Disregarding OASDI benefit increase, and child's benefit beyond age 18, to extent attributable to retroactive effective date	25
II. Mental and TB exclusion	25
A. Old-age assistance and aged individuals in combined program (title XVI)	25
B. Aid to the blind and disabled	25
C. Medical assistance for the aged	25
D. State plan requirements	26
E. Pass along provision	26

Page

III. Protective payments — 27
A. Protective payments under old-age assistance and combined program (title XVI) — 27
IV. Other changes — 27
A. Definition of medical assistance for the aged — 27
B. Exemption of earnings under the poverty program — 27
C. Administrative and judicial review — 27
1. Initial approval of State plan — 27, 28
2. Subsequent noncompliance — 28
3. Audit exceptions — 28
4. Effective date — 28

MATERNAL AND CHILD HEALTH SERVICES

I. Increase in authorization — 29
II. Provision for extension of services to additional parts of State — 29
III. Payment of reasonable cost of inpatient hospital services — 29

CRIPPLED CHILDREN'S SERVICES

I. Increase in authorization — 30
II. Provision for extension of services to additional parts of State — 30
III. Authorization for grants to institutions of higher learning for training of professional personnel — 30
IV. Payment of reasonable cost of inpatient hospital services — 30

SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

I. Authorization — 31

GRANTS FOR MENTAL RETARDATION PLANNING

I. Authorization — 32

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

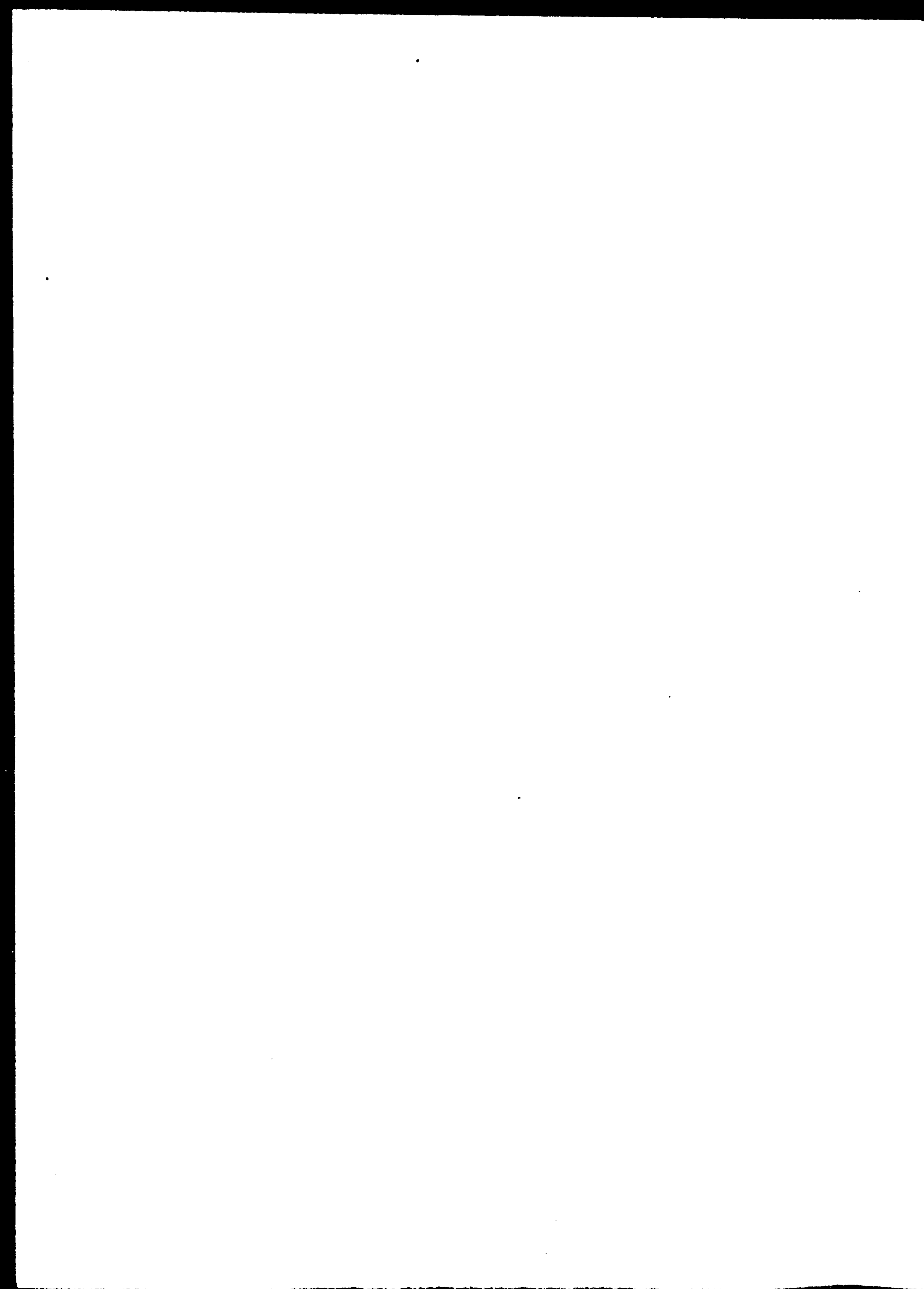
I. Coverage — 33
A. Self-employed — 33
1. Professional groups — 33
2. Ministers — 33
3. Farm operators — 33
4. Public officials — 34
5. Newspaper vendors — 34
B. Employees — 34
1. Agricultural workers — 34
2. Domestic workers — 34
3. Casual labor — 34
4. Cash tips — 35, 36
5. State and local government employees — 36–38
6. Employees of nonprofit organizations — 38
7. Federal employees — 39, 40
8. Students, interns, and nurses in schools and hospitals — 40
9. Newsboys — 40
10. Members of the Armed Forces — 40
11. Railroad employees — 41
12. Family employment — 41
13. Employees of Communist organizations — 41
II. Provisions relating to disability — 41
A. Nature of the provisions — 41
1. Benefits — 41
2. Disability "freeze" — 41
B. Eligibility requirements — 41
1. Definition — 41
2. Entitlement to other benefits — 41
3. Waiting period — 42
4. Termination of benefits — 42
5. Insured status (work requirement) — 42
6. Applications — 42
III. Benefit categories — 42
A. Worker—Old age — 42
B. Wife or dependent husband — 43
C. Widow, widower, or parent — 43
D. Children — 43, 44
E. Divorced wife, widow — 44
F. "Transitional insured status" for certain aged workers, wives, and widows aged 72 or over — 45
G. Time for filing proof of support and application for lump-sum death payment — 45

Page

IV. Benefit amounts ---- 45
A. Creditable earnings ---- 45
B. Average monthly wage ---- 45, 46
C. Recomputations ---- 46
D. Benefit formula ---- 47
E. Maximum primary insurance amount ---- 47
F. Minimum primary insurance amount ---- 47
G. Maximum family benefits ---- 47, 48
H. Lump sum death payment ---- 48
I. Illustrative monthly benefits payable under present law and H.R. 6675 based on $5,600 earnings base ---- 48
V. Fully insured status ---- 49
VI. Retirement test ---- 50
A. Scope ---- 50
B. Test of earnings ---- 50
C. Age exemptions ---- 50
VII. Financing ---- 50
A. Allocations between trust funds ---- 50
B. Maximum taxable amount ---- 50
C. Tax rate for self-employed ---- 50
D. OASDI tax rate for employees and employers ---- 50
E. Reimbursement of the trust funds for the cost of noncontributory military service credits ---- 50
F. Railroad retirement tax ---- 51
VIII. Miscellaneous ---- 51
A. Advisory Council on Social Security ---- 51
B. Board of Trustees ---- 51

MEDICAL EXPENSE DEDUCTION FOR INCOME TAX PURPOSES

I. Character of deduction ---- 52
A. General ---- 52
B. Taxpayers aged 65 or over ---- 52
II. Three-percent and one-percent limits ---- 52
III. Medical care insurance premiums ---- 52
A. Deduction ---- 52
B. Definition ---- 52
IV. Overall limit in case of disabled taxpayers ---- 52
V. Revenue impact ---- 53
VI. Effective date ---- 53



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

A. HEALTH INSURANCE AND MEDICAL CARE

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

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

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

Effective date.—Benefits would be first effective on July 1, 1966, except for services in extended care facilities which would be effective on January 1, 1967. (See p. 10.)

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

Effective date.—Benefits would be first effective beginning July 1, 1966. (See p. 12.)

The provision in the income tax law which limits medical expense deductions to amounts in excess of 3 percent of adjusted gross income (as well as the present limitation on medicine and drugs) for persons under 65 would be applied to persons 65 and over.

The bill also provides a special deduction, available to those who itemize their deductions, for one-half of any premiums paid for insurance of medical care expenses whether or not they have medical expenses in excess of the 3 percent floor, but this deduction may not exceed $250. Also treats as medical care expenses (1) the prepayment before age 65 of insurance for medical care after age 65, and (2) the $3 per month premium for supplemental health insurance under part B of title XVIII. (See p. 52.)

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

Effective date.—Matching under new title (XIX) will be available January 1, 1966. After June 30, 1967, no vendor medical care payments can be made under existing titles, and all medical payments must be under new title. (See p. 14.)

B. CHILD HEALTH CARE PROGRAM AMENDMENTS

1. *Maternal and child health and crippled children authorization.*—The amount authorized for these programs over current authorizations would be

increased by $5 million for fiscal 1966 and by $10 million in each succeeding fiscal year as follows:

Fiscal year	Existing law	Under bill
1966	$40,000,000	$45,000,000
1967	40,000,000	50,000,000
1968	45,000,000	55,000,000
1969	45,000,000	55,000,000
1970 and after	50,000,000	60,000,000
(See pp. 29–30.)		

2. *Crippled children training personnel.*—Provides grants to institutions of higher learning for training professional personnel for health and related care for crippled children, particularly children who are mentally retarded or have multiple handicaps. Authorizes $5 million for fiscal 1967, $10 million for fiscal 1968, and $17.5 million for each succeeding fiscal year. (See p. 30.)

3. *Health care for needy children.*—Authorizes the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and services for preschool or school-age children, particularly in areas with concentrations of low-income families. An appropriation of $15 million is authorized for fiscal 1966; $35 million for fiscal 1967, and an additional $5 million for each succeeding year rising to $50 million for fiscal 1970., (See p. 31.)

4. *Mental retardation planning.*—Authorizes grants totaling $2,750,000 for each of 2 fiscal years (1966 and 1967) for the purpose of assisting States to implement and follow up on planning for treatment of mental retardation authorized under section 1701 of the Social Security Act. (See p. 32.)

C. Public Assistance

1. *Increased assistance payments.*—The Federal share of payments under all State public assistance programs is increased a little more than an average of $2.50 a month for the needy aged, blind and disabled and an average of about $1.25 for needy children, effective January 1, 1966. This is brought about by revising the matching formula for the needy aged, blind, and disabled (and for the adult categories in title XVI) to provide a Federal share of $31 out of the first $37 (now twenty-nine thirty-fifths of the first $35) with matching above this amount varying according to State per capita income up to a maximum of $75 (now $70) per month per individual on an average basis. The bill revises matching formula for aid to families with dependent children so as to provide a Federal share of five-sixths of the first $18 (now fourteen-seventeenths of the first $17) with matching above this amount varying according to State per capita income up to a maximum of $32 (now $30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients. (See p. 22.)

2. *Tubercular and mental patients.*—Removes exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged indiviuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. Requires as condition of Federal participation in such payments to, or for, mental patients certain agreements and arrangements to assure that better care results from the additional Federal money. Provides that States will receive no more in Federal funds under this provision than they increase their expenditures for mental health purposes under public health and public welfare programs. Also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions. Effective January 1, 1966. (See p. 25.)

3. Adds a provision for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined title XVI program)

unable to manage their money because of physical or mental incapacity. Effective January 1, 1966. (See p. 27.)

4. Increases earnings exemption under old-age assistance programs (and aged in combined program) so that a State may, at its option, exempt the first $20 (now $10) and one-half of the next $60 (now $40) of a recipient's monthly earnings. Effective January 1, 1966. (See p. 25.)

5. Modifies definition of medical assistance for the aged so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution. Effective July 1, 1965. (See p. 27.)

Adds a provision which allows the States to disregard so much of the OASDI benefit increase and the extension of child's benefit as is attributable to its retroactive effective date. (See p. 25.)

7. Provides a grace period for action by States that have not had regular legislative sessions, whose statutes now prevent them from disregarding recipient earnings received under the Economic Opportunity Act. (See p. 27.)

8. Provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans and amendments of plans, and other of his actions because of noncompliance of State with plan conditions prescribed by Federal law. (See p. 27.)

D. Old-Age, Survivors, and Disability Insurance

1. The benefit provisions of the Federal old-age, survivors, and disability insurance system are revised to—

(a) Increase benefits by 7 percent across the board with a $4 minimum increase for a retired worker at 65. The minimum benefit would thus be $44 (now $40) and the new maximum $135.90 (now $127). Effective retroactively to January 1, 1965.

In the future, a first-step increase in the contribution and benefit base to $5,600 (now $4,800) beginning in calendar 1966 could produce a maximum worker's benefit of $149.90 (now $127); the second-step increase in the base to $6,600, beginning in calendar 1971, could produce a possible maximum for the worker of $167.90 a month.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly wage at all earnings levels. (Under present law a $254 limit applies at earnings levels of $315 or more per month.) Under the bill the family maximum would be $312 in 1966–70, increasing, beginning in 1971, to $368. (See p. 47.)

(b) Continue benefits beyond the present limit of age 18 up to age 22 for certain children in full-time attendance at a public or accredited school. No mother's or wife's benefits would be payable for this period. Effective retroactively to January 1, 1965. (See p. 43.)

(c) Widows could receive benefits at age 60 provided they choose to accept actuarially reduced benefits to take account of the longer period over which they will be paid. Under present law full widow's benefits and actuarially reduced worker's and wife's benefits are payable at age 62. Effective for the second month after the month of enactment. (See p. 43.)

2. The definition and waiting period provisions of the disability insurance program are revised by—

(a) Eliminating the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration so that an insured worker would be eligible for disability benefits if he has been totally disabled throughout a continuous period of at least 6 calendar months. Effective for the second month after the month of enactment. (See p. 41.)

(b) Entitling a person under 65 who is receiving an old-age or other benefit to become entitled to a disability benefit. (See p. 41.)

(c) Reducing by 1 month the waiting period during which an individual must be under a disability prior to entitlement to benefit. Disability

46-433—65——2

benefits would be payable beginning with the last month of the 6-month waiting period rather than the first month after the 6-month waiting period as under existing law. This change would be applicable to all cases in which the last month of the waiting period occurs after the month of enactment. (See p. 42.)

Certain changes are also made in the provision terminating disability benefits and waiving subsequent waiting periods so as to make them more restrictive when applied to shorter term disabilities. (See p. 42.)

(d) Allocating an additional one-fourth of 1 percent of taxable wages and three-sixteenths of 1 percent of taxable self-employment income to the disability insurance trust fund, bringing the total allocation to three-fourths of 1 percent and nine-sixteenths of 1 percent, respectively. Effective in calendar 1966. (See p. 50.)

3. Liberalizes the eligibility requirements to provide a basic benefit of $35 at age 72 or over to certain elderly persons with a minimum of three quarters of coverage (now six quarters) acquired at any time since 1937, using a new concept of "transitional insured" status. Certain wife's and widow's benefits would also be authorized on a similar basis. (See p. 49.)

4. Increases the amount an individual is permitted to earn without having deduction from benefits. Now, the first $1,200 of earnings is exempted and $1 deducted for each $2 of earnings between $1,200 and $1,700 and $1 for $1 above $1,700. The bill increases the $1 for $2 deduction ceiling from $1,700 to $2,400 and applies the $1 for $1 deduction to earnings above $2,400. (See p. 50.)

Also exempts certain royalties (from copyrights or patents obtained before age 65) from being counted as earnings of individuals over 65 for purposes of this test effective as to taxable years beginning after 1964. (See p. 50.)

5. Authorizes payments of wife's and widow's benefits to the divorced wife aged 62 or over, if she had been married to the entitled worker for at least 20 years before the date of the divorce and if her divorced husband was making (or was obligated by a court to make) a substantial contribution to her support when he became entitled to benefits, became disabled, or died.

Also provides that a wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years, and for the reestablishment of benefit rights for a widow or a wife who remarries and the subsequent marriage is terminated by divorce having lasted less than 20 years. Effective for the second month following enactment. (See p. 44.)

6. Changes the provisions with respect to children adopted by beneficiaries to require that as to any adoption after the worker becomes entitled to an old-age benefit (1) the child be living with the worker (or adoption proceeding has begun) in or before the month when application for old-age benefits is filed; (2) the child be receiving one-half of his support for a year before the worker's entitlement; and (3) the adoption be completed within 2 years after the worker's entitlement. (See p. 44.)

7. Extends the coverage provisions to include—

(a) Self-employed doctors of medicine. (See p. 33.)

(b) Cash tips as reported by the employee—the employer to report same and also to withhold income tax. No liability on employer for tips that are not reported, nor where he does not have or is not given funds to cover employee's share of tax. (See p. 35.)

(c) Facilitates social security coverage of additional employees of State and local governments in Alaska and Kentucky, certain hospital employees in California, and certain employees of the District of Columbia. (See p. 37.)

(d) Provides coverage for certain employees of nonprofit organizations retroactively for up to 5 years (1 year under present law); also by permitting validation of certain erroneously reported wages. (See p. 39.)

(e) Exempts, for social security coverage and tax purposes, self-employment income of members of certain religious groups which are conscientiously opposed to public or private insurance; the groups have to have

been in existence since 1950 and make provision for the needs of their members (See p. 33.)

(f) Provides that farm operators whose annual gross earnings are $2,400 or less (instead of $1,800 or less as in existing law) can report either their actual net earnings or 66⅔ percent (as in present law) of their gross earnings. Farmers whose annual gross earnings are over $2,400 would report their actual net earnings if over $1,600, but if actual net earnings are less than $1,600, they may instead report $1,600. (Present law provides that farmers whose annual gross earnings are over $1,800 report their actual net earnings if over $1,200, but if actual net earnings are less than $1,200, they may report $1,200.) Effective for taxable years beginning after December 31, 1965. (See p.33.)

8. *Miscellaneous.*—

(a) Provides that the benefits of people on the rolls would be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year that would increase his benefit amount. Existing law has various requirements, including filing of an application and earnings of over $1,200 a year after entitlement. (See p. 46.)

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

(c) Extends indefinitely the period of filing of proof of support for dependent husbands, widowers, and parent's benefits, and lump-sum death payments where good cause exists for failure to file within initial 2-year period. (See p.45.)

E. Scope and Persons Affected

The scope of the protection provided is broadly as follows:

1. Health insurance and medical care for the needy

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

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

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

2. Old-age, survivors, and disability insurance

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

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

3. Public assistance

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

F. Cost and Financing

1. Health care plans

(*a*) *Basic plan.*—Benefits and administrative expenses under the basic plan would be about $1.0 billion for the 6-month period in 1966 and about $2.3 billion in 1967. Contribution income for those years would be about $1.6 and $2.6 billion, respectively. The costs for the uninsured (paid from general funds) would be about $275 million per year for early years.

The level-premium (long-range) cost of the hospital insurance program is 1.23 percent of payroll broken down as follows:

	Percent
Hospital and extended care facility benefits	1.19
Posthospital home health	.03
Outpatient diagnostic	.01
	1.23

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

	Percent
1966	0.35
1967–72	.50
1973–75	.55
1976–79	.60
1980–86	.70
1987 and thereafter	.80

The taxable earnings base for the health insurance tax would be $5,600 a year for 1966 through 1970 and would thereafter be increased to $6,600 a year. The level-equivalent of the contribution schedule is also 1.23 percent of payroll.

Estimated progress of Hospital Insurance Trust Fund

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
1966	$1,578	$982	[1] $50	$17	$562
1967	2,601	2,192	66	20	925
1968	2,790	2,391	72	34	1,286
1969	2,879	2,607	78	45	1,525
1970	2,983	2,840	85	50	1,633
1971	3,327	3,055	92	55	1,868
1972	3,488	3,280	98	60	2,038
1973	3,929	3,516	105	68	2,414
1974	4,120	3,760	113	77	2,738
1975	4,267	4,018	121	84	2,950
1980	6,123	5,276	158	140	5,018
1985	7,038	6,823	205	236	7,681
1990	9,030	8,754	263	306	9,948

[1] Including administrative expenses incurred in 1965.

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

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

If 80 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about $195 to $260 million in the last 6 months of 1966 and about $765 million to $1.02 billion in 1967. Premium income from enrollees for those years would be about $275 and $560 million, respectively. The matching Government contribution would equal the premiums.

If 95 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about $230 to $310 million in 1966 and about $905 million to $1.22 billion in 1967. Premium income from enrollees for those

years would be about $325 and $665 million, respectively. The Government contribution would equal the premiums.

Estimated progress of Supplementary Health Insurance Benefits Trust Fund

[In millions]

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

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

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

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

2. OASDI changes

(a) *Cost in dollars in 1966 and long-range costs in percent of payroll*

Provision	Dollars	Percent of payroll
7-percent benefit increase ($4 minimum in primary benefit)	1, 430, 000, 000	−0. 64
Child's benefit to age 22 if in school	195, 000, 000	−. 12
Reduced age for widows	[1] 165, 000, 000	−. 00
Reduction in eligibility requirement for certain persons aged 72 or over	140, 000, 000	−. 01
Liberalization of disability definition	105, 000, 000	−. 05
Earnings test liberalization	65, 000, 000	−. 04
Coverage extensions		+. 03
Earnings base increases		+. 52
Revised contribution schedule		+. 22

[1] No long-range charge to system because of actuarial reduction.

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

[Percent]

Calendar year	Present law		H.R. 6675	
	Employee rate (same for employer)	Self-employed rate	Employee rate (same for employer)	Self-employed rate
1965	3.625	5.4	3.625	5.4
1966–67	4.125	6.2	4.0	6.0
1968	4.625	6.9	4.0	6.0
1969–72	4.625	6.9	4.4	6.6
1973 and after	4.625	6.9	4.8	7.0

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

Year	Combined tax rate on employer and employee			
	Old-age- survivors, and disability insurance program		Basic hospital insurance program under H.R. 6675	Total combined tax rate under H.R. 6675
	Under present law	Under H.R. 6675		
1965	7.25	7.25		7.25
1966	8.25	8.00	0.70	8.70
1967	8.25	8.00	1.00	9.00
1968	9.25	8.00	1.00	9.00
1969–70	9.25	8.80	1.00	9.80
1971–72	9.25	8.80	1.00	9.80
1973–75	9.25	9.60	1.10	10.70
1976–79	9.25	9.60	1.20	10.80
1980–86	9.25	9.60	1.40	11.00
1987 and after	9.25	9.60	1.60	11.20

4. Public assistance changes and child health changes

[In millions of dollars]

Costs	Fiscal year 1966	Annual rate
Maternal and child health, crippled children, and special project grants	25	60
Mental retardation projects	2.75	2.75
Mental and tuberculosis	38	75
Medical assistance for the aged definition	2	2
Formula changes	75	150
Protective payments	(1)	(1)
Income exemption (old-age assistance)	.5	1
Total	143.25	290.75

[1] No cost.

5. Summary of full year benefit costs, number of persons affected, and effective date of items with cost importance in H.R. 6675

Item	Trust fund	General Treasury	Number of persons affected	Effective date
HEALTH CARE PROGRAMS (1967)	*Millions*	*Millions*		
1. Basic hospital	$2,190	$275	17,000,000 insured, 2,000,000 uninsured.	July 1966.
2. Voluntary supplementary.		[1] 600	16,700,000 estimated.[1]	Do.
3. MAA liberalization		200	8,000,000	January 1966.
Health care total	2,190	1,075		
OASDI AMENDMENTS (1966)				
7 percent benefit increase	1,430		20,000,000	January 1965 (retroactive).
Child's benefit to age 22	195		295,000 children	Do.
Reduced age for widows	[2]		185,000 widows	2d month after month of enactment.
Special benefits at age 72	140		355,000 aged	Same as above.
Disability definition	105		155,000 workers and dependents.	Do.
Retirement test	65		No estimate available.	Taxable years ending after 1965.
OASDI total	1,935			
PUBLIC ASSISTANCE AND CHILD HEALTH (1966)				
Increase in formula		150	7,200,000	January 1966.
TB and mental exclusion		75	100,000 to 150,000	Do.
Maternal and child health, crippled children, special project grants.		60	No estimate available.	Fiscal 1966.
OAA income exemption		1	do	Jan. 1, 1966.
MAA definition		2	do	July 1, 1965.
Mental retardation projects.		3	do	Fiscal 1966.
Public assistance total		291		
Grand total payroll insurance.	4,125			
Grand total general revenue.		1,366		

[1] Based on an averaging of low and high cost estimates, and estimates of participation (87½ percent). Total benefit expenditure would be about $1 billion, with participants contributing $600,000,000.

[2] See note.

NOTE.—1st year benefit expenditures not reflected in cost table: $165,000,000 for widows benefit, 1st year—no long-term cost; $600,000,000 in individual contributions for voluntary supplemental health plan.

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

HEALTH INSURANCE AND MEDICAL CARE FOR THE AGED

I. Health Insurance for the Aged

The bill would add a new title XVIII to the Social Security Act establishing two related health insurance programs for persons 65 or over: (1) in part A a basic payroll tax plan providing protection against the costs of hospital and related posthospital care; and (2) in part B a voluntary supplementary plan providing physicians' services and other medical and health services financed by individual contributions and by Federal general revenues.

A. BASIC HOSPITAL PLAN

No Provision in Existing Law of the Following Nature

1. Benefits

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

(1) Inpatient hospital services for up to 60 days in each spell of illness with the patient paying initially a $40 deductible amount; hospital services would include all those ordinarily furnished by a hospital for its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians except services provided by interns or residents in training under approved teaching programs.

(2) Posthospital extended care (in a facility having an arrangement with a hospital for the timely transfer of patients and for furnishing medical information about patients) after the patient is transferred from a hospital (after at least a 3-day stay) for up to 20 days in each spell of illness; 2 additional days will be added to the 20 days for each day that the person's hospital stay was less than 60 days (up to a maximum of 80 additional days)—the overall maximum for posthospital extended care could thus be 100 days in each spell of illness,

(3) Outpatient diagnostic services with a $20 deductible for each diagnostic study (that is for diagnostic services furnished to him by the same hospital during a 20-day period); such deductible to be credited against the inpatient hospital deductible ($40) if hospitalization (in the same hospital) follows within 20 days.

(4) Posthospital home health services for up to 100 visits, after discharge from a hospital (after at least a 3-day stay) or extended care facility and before the beginning of a new spell of illness. Such a person must be in the care of a physician and under a plan established by a physician within 14 days of discharge calling for such services. These services would include intermittent nursing care, therapy, and the part-time services of a home health aide. The patient must be homebound, except that when equipment is used the individual could be taken to a hospital or extended care facility or rehabilitation center to receive some of these covered home health services in order to get the advantage of the necessary equipment.

No service would be covered as posthospital extended care or as outpatient diagnostic or posthospital home health services if it is of a

kind that could not be covered if it were furnished to a patient in a hospital.

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

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1969. Increases in the hospital deductible will be made only when a $5 change is called for and the outpatient deductible will change in $2.50 steps.

2. Effective dates

Benefits would be first effective on July 1, 1966, for all but extended care facilities, which would be effective on January 1, 1967.

3. Eligibility

(a) All persons who—

(1) are age 65 or over; and

(2) are eligible to receive (or receiving) social security or railroad retirement benefits.

(b) All persons not insured under social security or railroad retirement who either—

(1) have reached age 65 before 1968; or

(2) have reached age 65 after 1967 if they have three quarters of coverage for each year elapsing after 1965 and before the year they reach age 65.

The operation of this transitional provision is illustrated by the following table:

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

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

[1] Same as OASI.

Excluded from (b) would be nonresidents or resident aliens with less than 10 years in the United States, members of certain subversive organizations, persons convicted of certain subversive crimes, and persons eligible for benefits (whether or not they had actually elected benefits) under the Federal Employees Health Benefits Act of 1959 (Government employees who retired prior to the effective date of this legislation (July 1, 1960) would be eligible under the transitional provision).

4. Basis of reimbursement

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

5. Administration

Basic responsibility for administration would rest with the Secretary of Health, Education, and Welfare. The Secretary would use appropriate Stat agencies and private organizations (nominated by providers of service) to

assist in the administration of the program. Provision is made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration.

6. Financing

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

	Percent
1966	0.35
1967-72	.50
1973-75	.55
1976-79	.60
1980-86	.70
1987 and thereafter	.80

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

The cost of providing basic hospital and related benefits to people who are not social security or railroad retirement beneficiaries would be paid from general funds of the Treasury. An authorization of appropriation is included to place the trust fund in the same place it would have been if benefits had not been paid to the uninsured individuals.

B. VOLUNTARY SUPPLEMENTARY PLAN

No Provisions in Existing Law of the Following Nature

Individuals who enrolled initially would pay premiums of $3 a month (deducted, where possible, from social security and railroad retirement benefits). The Government would match this premium with $3 paid from general funds.

1. Benefits.—The voluntary supplementary insurance plan would cover physician's services, home health services, hospital services in psychiatric institutions, and other medical and health services in and out of medical institutions.

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

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

(2) Hospital care for 60 days in a spell of illness in a mental hospital (180-day lifetime maximum);

(3) Home health services (without regard to hospitalization) for up to 100 visits during each calendar year;

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

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

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

(c) Ambulance services (under limited conditions); and

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

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

2. Effective date

Benefits will be effective beginning July 1, 1966.

3. Eligibility and payment of premiums

All persons 65 or over (whether or not they are social security or railroad retirement beneficiaries) who are residents of the United States and either citizens or aliens admitted for permanent residence.

4. Enrollment

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

Persons attaining age 65 subsequent to December 31, 1965, will have enrollment periods of 7 months beginning 3 months before attaining 65.

In the future, general enrollment periods will be from October to December 31, of 1967, and each second year thereafter.

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

Coverage may be terminated (1) by the individual filing notice during enrollment period, or (2) by the Government, for nonpayment of premiums after a grace period. There will be only one chance to reenroll for persons who are in the plan but drop out, and it must be done within 3 years of termination of previous enrollment.

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

5. Administration by carriers: Basis for reimbursement

The Secretary of Health, Education, and Welfare shall, to the extent possible, contract with carriers to carry out the major administrative functions relating to the medical aspects of the program such as determining rates of payments under the program, holding and disbursing funds for benefits payments, and determining compliance and assisting in utilization review. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of service), the cost is reasonable cost. Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. Payment by the carrier for physicians' services will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service.

6. Financing

Aged persons who enroll in the voluntary plan would pay monthly premiums of $3 to be supplemented by an equal amount from Federal general revenues. Premium rates for enrolled persons (and correspondingly the matching Government contribution) would be increased from time to time if medical costs rise, but not more often than once every 2 years. The first such possible readjustment could be made January 1968. The premium rate for a person who enrolls after the first period when enrollment was open to him would be increased by 10 percent for each full year he stayed out of the program. It would also be increased for any period that he had terminated his coverage.

To provide an operating fund at the beginning of the plan, and to establish a temporary contingency reserve, a Government appropriation would be available (on a repayable basis) equal to $18 per aged person estimated to be eligible in July 1966 when the plan goes into effect.

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

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

C. EXTENSION OF KERR-MILLS PROGRAM

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

2. Medical assistance for the aged:		
(a) Eligibility for assistance	To be eligible an individual— (1) Must have attained age 65; (2) Must not be a recipient of old-age assistance; (3) Must have income and resources, as determined by the State, insufficient to meet all of the cost of the medical services outlined below. The State plan must provide reasonable standards, consistent with the objectives of the program, for determining eligibility and the extent of assistance.	Effective January 1, 1966. Existing medical vendor provisions expire on July 1, 1967. Medical Assistance for Aged program as such will be inoperative by June 30, 1967, or by adoption of new combined medical assistance program, but the MAA group of aged would be governed by the same eligibility standards with the following modifications: (1) Same as existing law. (2) No longer applicable to recipients of Old-Age Assistance since they will be eligible under new program. (3) Same but State must provide flexible income test which takes into account medical expenses (including health insurance premiums). (See also State plan requirements, pp. 17–18, items E(1) and E(5)).
(b) Scope of benefits	The State plan for Medical Assistance for the Aged may specify medical services of any scope and duration, provided that both institutional and noninstitutional services are included. Federal participation is restricted to vendor medical payments: i.e., payments made by the States directly to the doctor, hospital, etc., providing medical services on behalf of the recipient. The Federal Government shares in the expense of providing the following kinds of medical services: (1) Inpatient hospital services; (2) Skilled nursing home services; (3) Physicians' services; (4) Outpatient hospital or clinic services; (5) Home health care services; (6) Private duty nursing services; (7) Physical therapy and related services; (8) Dental services; (9) Laboratory and X-ray services; (10) Prescribed drugs, eyeglasses, dentures, and prosthetic devices; (11) Diagnostic, screening, and preventive services; and (12) Any other medical care or remedial care recognized under State law.	Essentially the same, except after July 1, 1967, benefits for new medical program *must* include at least following five services: (1) Inpatient hospital services; (2) Outpatient hospital services; (3) Other laboratory and x-ray services; (4) Skilled nursing home services; (5) Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere. Other services are optional and are the same as authorized under existing law with the following exceptions: (10) Modified so eyeglasses will be prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select. (12) Modifies provision so that medical care or remedial care recognized under State law, either has to be specified by the Secretary or is furnished by licensed practitioners within the scope of their practice as defined by State law.
	The Federal Government does not share in the expense of providing medical services to inmates of public institutions (other than medical institutions), to patients in mental or tuberculosis institutions or to patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis after 42 days of care.	Removes exclusion from Federal matching as to aged individuals who are patients in institutions for tuberculosis or mental diseases, or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. Requires as condition of Federal participation in such payments to, or for, mental patients certain agreements and arrangements to assure that better care results from the additional Federal money. Provides that States will receive no more in Federal funds under this provision than they increase their expenditures for mental health purposes under public health and public welfare programs.

C. EXTENSION OF KERR-MILLS PROGRAM—continued

Item	Existing law	H.R. 6675
2. Medical assistance for the aged—Con. (c) Matching formula: (1) Federal share	Federal payments reimburse the States for a portion of their expenditures under approved plans for medical assistance for the aged according to an equalization formula which ranges from 50 to 80 percent depending upon the per capita income of the States as related to the national per capita income. States at or above national average get a 50 percent Federal share. *Federal medical percentages applicable for July 1, 1963, through June 30, 1965*	Under matching formula for new medical program Federal payments reimburse the States for a portion of their expenditures according to an equalization formula ranging from 50 to 83 percent, depending upon the per capita income of the State as it is related to the national per capita income. Federal sharing for States at the national average would be 55 percent; for most States above the national average, sharing would be 50 percent. Like MAA, there is no maximum on the amount in which the Federal Government would share.

State:	Existing law *Percentage*	H.R. 6675 *Percentage*
Alabama	78.29	80.46
Alaska	50.00	50.00
Arizona	58.75	62.87
Arkansas	80.00	82.77
California	50.00	50.00
Colorado	50.00	51.44
Connecticut	50.00	50.00
Delaware	50.00	50.00
District of Columbia	50.00	50.00
Florida	60.69	64.62
Georgia	73.69	76.32
Guam	50.00	55.00
Hawaii	50.00	52.36
Idaho	67.43	70.68
Illinois	50.00	50.00
Indiana	52.06	56.85
Iowa	57.63	61.87
Kansas	56.63	60.97
Kentucky	75.27	77.74
Louisiana	73.46	76.11
Maine	65.65	69.09
Maryland	50.00	50.00
Massachusetts	50.00	50.00
Michigan	50.00	52.32
Minnesota	56.42	60.78
Mississippi	80.00	83.00
Missouri	50.45	55.41
Montana	59.69	63.72
Nebraska	55.10	59.59
Nevada	50.00	50.00
New Hampshire	56.38	60.74
New Jersey	50.00	50.00
New Mexico	66.55	69.89
New York	50.00	50.00
North Carolina	74.99	77.49

North Dakota	73.03
Ohio	50.00
Oklahoma	65.65
Oregon	50.00
Pennsylvania	50.00
Puerto Rico	50.00
Rhode Island	50.90
South Carolina	80.00
South Dakota	68.87
Tennessee	75.53
Texas	61.45
Utah	62.28
Vermont	64.75
Virgin Islands	50.00
Virginia	65.05
Washington	50.00
West Virginia	71.76
Wisconsin	52.50
Wyoming	50.00

(27 F.R. 9230)

North Dakota	75.73
Ohio	50.76
Oklahoma	69.09
Oregon	54.22
Pennsylvania	54.02
Puerto Rico	55.00
Rhode Island	55.81
South Carolina	82.54
South Dakota	71.98
Tennessee	77.97
Texas	65.31
Utah	66.05
Vermont	68.27
Virgin Islands	55.00
Virginia	68.55
Washington	50.84
West Virginia	74.58
Wisconsin	57.25
Wyoming	53.07

During the period January 1, 1966, through June 30, 1969, the Federal medical percentage shall not be less less than 105 percent of the Federal share of medical expenditures by the State during fiscal year 1965.

75 percent Federal matching is authorized for certain rehabilitation services for aged recipients and for the training of welfare personnel.

75 percent Federal matching would be available as to costs attributable to compensation of skilled professional medical personnel and staff directly supporting such personnel.

The Federal Government pays 50 percent of other administrative costs.

Same as existing law.

(2) Pass along provision

No provision in existing law to insure that public assistance recipients receive higher payments because of legislation liberalizing the Federal matching formula.

Federal matching for any State for any quarter prior to July 1, 1969, shall be reduced to the extent the excess of Federal matching for such quarter for the new medical program, old-age assistance, aid to needy families with children, aid to the blind, aid to the permanently and totally disabled, and aid under the consolidated program over the corresponding quarter or average quarterly Federal matching for these programs in fiscal year 1964 or 1965 is greater than the excess of total expenditures (Federal, State, and local) on these programs in such quarter over the corresponding quarter or of the average total quarterly expenditures on these programs in fiscal year 1964 or 1965.

(d) State plan requirements

In order to be eligible for Federal participation, the State must provide medical assistance for the aged according to a plan submitted to the Secretary of Health, Education, and Welfare, and approved by him, which meets the requirements set out in the law. The State plan provisions are generally the same as those required for the other public assistance programs with the following exceptions:

A State plan—

(a) must not require a premium, enrollment fee, or similar charge as a condition of eligibility;

The State plan requirements for the new medical program incorporate many of the plan requirements of existing programs. The following are the differences as they particularly affect the medical assistance for the aged group:

(1) Modifies provision to allow State to impose premiums, enrollment fees, on similiar charges if they are reasonably related (as determined in accordance with standards prescribed by the Secretary) to the recipient's income or to his income and resources;

C. EXTENSION OF KERR-MILLS PROGRAM—continued

Item	Existing law	H.R. 6675
2. Medical assistance for the aged—Con. (d) State plan requirements—Con.	(b) must not impose property liens during the lifetime of the individual receiving benefits (except pursuant to court judgment on account of benefits incorrectly paid) and any recovery provisions under the plan must be limited to the estate of the individual after his death and the death of his surviving spouse;	(2) Broadened so that recovery would be further postponed where there is surviving child, under 21 or blind or disabled. No recovery is permitted for medical assistance received before age 65.
	(c) must not impose a citizenship requirement which would exclude a citizen of the United States or a requirement which excludes a resident of the State;	(3) Same as existing law.
	(d) must also provide, to the extent required by the Secretary of Health, Education, and Welfare, for inclusion of residents of the State who are absent therefrom; and	(4) Same as existing law.
	(e) Include reasonable standards consistent with the objectives of this title for determining eligibility for, and the extent of assistance.	(5) Same but with addition so that standards (a) take into account only such income and resources as are (as determined in accordance with standards prescribed by the Secretary), available to the applicant or recipient; (b) must provide for reasonable evaluation of income or resources; (c) do not take into account the financial responsibility of any individual for any applicant or recipient who is not such individual's spouse or child under age 21 or blind or disabled; and (d) provide for flexibility in the application of such standards with respect to income by taking into account (except to the extent prescribed by the Secretary) the costs (whether in the form of insurance premiums or otherwise) incurred for medical care.
	(f) If a State has both a program for old-age assistance and medical assistance for the aged it must be administered by a single State agency.	(6) The medical program must be administered by the same State agency that administers old-age assistance (or title XVI) except that in certain States with separate blind agencies, the portion of the plan relating to the blind may be administered by those agencies. The following additional plan requirements pertinent to the MAA group are added: (7) Until July 1, 1970, local funds may be used for up to 60 percent of non-Federal share of expenditures under the program. After that date, the non-Federal share of expenditures must be met entirely by the State. (8) No deductible, cost sharing, or similar charge will be imposed on any individual in respect to inpatient hospital service, nor with respect to any other care or service unless it is reasonably related (as determined in accordance with standards approved by the Secretary), to the recipient's income or his income and resources. (9) In the case of aged individuals covered by either or both of the insurance programs (hospital insurance

40-483—65——4

		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 the 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. (10) If benefits are provided for the medically indigent aged similar provision must be made for the medically indigent blind, disabled, and dependent children and their parents. Benefits and eligibility standards must be comparable between groups. The benefits provided to the medically indigent cannot be greater than those provided to the cash recipients. (11) Safeguards must be provided to insure determination of eligibility and provision of services be administratively simple and in the best interest of recipients. (12) Provide for entering into cooperative arrangements with the State agencies responsible for administering of health services and vocational rehabilitation services, looking toward maximum utilization of such services in the provision of medical assistance under the plan. (13) Provides for the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan.
(e) Use of private health insurance	Includes in the amounts subject to Federal matching the expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof.	Same as existing law.
3. Effect on other public assistance programs: (a) Medical vendor program content and scope.	No uniformity required as to eligibility or as to the amount or scope of benefits between medical vendor programs for OAA (title I), Aid to Families with Dependent Children (title IV), Aid to Blind (title X), Aid to Permanently and Totally Disabled (title XIV), and the consolidated program for the aged, blind, and disabled (title XVI). Medical vendor programs for the medically indigent aged (MAA) can be greater in amount and scope than that for recipients on the cash assistance programs.	Federal participation in medical vendor payments will cease after June 30, 1967 (or upon the States implementation of the new program, if earlier), as to all existing titles (I, IV, X, XIV, and XVI). If a State program covers the medically indigent aged (MAA) it must provide similar benefits in amount and scope to comparably medically indigent individuals who would, if in financial need, be in the other categories of assistance. The amount and scope of medical assistance for recipients of cash assistance under any of the programs cannot be less than that provided for the medically indigent. The amount and scope of medical assistance available must be comparable as to recipients on all cash assistance programs.

C. EXTENSION OF KERR-MILLS PROGRAM—continued

Item	Existing law	H.R. 6675
3. Effect on other public assistance programs—Continued (a) Medical vendor program content and scope—Continued		Effective July 1, 1967, the States could not exclude any person who has not attained age 21 and who would be considered a dependent child except for the age and school attendance requirements under the State's aid to families with dependent children plan. Moreover, for matching purposes dependent children and adult care takers could be included even though they did not meet the State plan requirement for need and age, if they are otherwise qualified for cash payments under the aid to families with dependent children program. The Secretary of Health, Education, and Welfare shall not authorize matching unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care. Provides that no lien may be imposed against the property of individual prior to his death, and that as to recipients under age 65 years of age there shall be no recovery or adjustment as to any medical assistance correctly paid.
	No specific medical care benefits required as a condition of Federal participation.	After July 1, 1967, benefits for new medical program *must* include at least following five services: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere. Other services are optional. (See page 15.) The State plan must provide for the payment of reasonable costs of inpatient hospital services as is done for MAA group.
(b) Matching formula—vendor medical payments.	There are various formulas which determine the extent of Federal participation: *Aid to families with dependent children (title IV).*—Medical payments and cash assistance combined in one formula with Federal participation limited to an average monthly expenditure of $30 per child or adult recipient.	As to all categories of recipients, provides Federal participation as described on page 16 (varies from 50 to 83 percent). Like MAA, there is no maximum on the amount which the Federal Government would share in.

Aid to blind (title X) and aid to permanently and totally disabled (title XIV).—Medical payment and cash assistance combined in one formula as to each program with Federal participation limited to an average monthly expenditure of $70 per recipient.

Old-age assistance (title I).—A separate medical payments formula which is applicable to $15 of expenditures above the $70 average monthly participation limit or to $15 of expenditures within the $70 limit.

For States with average monthly payments over $70, the Federal Government participates in the expenditures in excess of that amount except that such participation is limited to the amount of the average vendor medical payment with a maximum of $15. The Federal share in the excess expenditure is the "Federal medical percentage" for the State, which ranges from 50 to 80 percent under a formula based on per capita income. (See page 16.)

For States with average monthly payments of $70 or less, the additional Federal share in average vendor medical payments up to $15 is an additional 15 percent over the "Federal percentage"* (which ranges from 50 percent to 65 percent based on per capita income).

This percentage, when added to the usual "Federal percentage," results in a total Federal share of from 65 to 80 percent. The additional Federal share of 15 percent also is available to States with average monthly payments over $70 when it is advantageous to them as an alternative to the method described in the preceding paragraph.

Combined program for aged, blind, and disabled (title XVI).—As of December 1, 1964, some 14 jurisdictions had combined programs for the adult categories. The Federal participation as to this program is the same as for OAA.

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

PUBLIC ASSISTANCE

I. INCREASE IN FEDERAL MATCHING FORMULA

Item	Existing law	H.R. 6675
A. Payments for old-age assistance, aid to the blind, and aid to the permanently and totally disabled, or the combined aged, blind, and disabled program (title XVI).	Federal matching share is $29 of the first $35 (29/35 of the first $35) with variable matching on the amount above $35 up to a maximum of $70 per recipient per month.	Effective January 1, 1966, the Federal matching share will be increased to $31 out of the first $37 (31/37 of the first $37) with variable matching on the amount above $37 up to a maximum of $75 per recipient per month.
	Matching for States whose per capita income is at or above the national average is 50 percent, while for States below the national average it varies up to 65 percent.	
	The "Federal percentages" as promulgated for the period July 1, 1963, through June 30, 1965, are as follows:	No change.

State:	*Federal percentage*
Alabama	65.00
Alaska	50.00
Arizona	58.75
Arkansas	65.00
California	50.00
Colorado	50.00
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	60.69
Georgia	65.00
Hawaii	50.00
Idaho	65.00
Illinois	50.00
Indiana	52.06
Iowa	57.63
Kansas	56.63
Kentucky	65.00
Louisiana	65.00
Maine	65.00
Maryland	50.00
Massachusetts	50.00
Michigan	50.00
Minnesota	56.42
Mississippi	65.00
Missouri	50.45
Montana	59.69
Nebraska	55.10
Nevada	50.00
New Hampshire	56.38
New Jersey	50.00
New Mexico	65.00
New York	50.00
North Carolina	65.00
North Dakota	65.00
Ohio	50.00
Oklahoma	65.00
Oregon	50.00

Pennsylvania	50.00
Rhode Island	50.00
South Carolina	65.00
South Dakota	65.00
Tennessee	65.00
Texas	61.45
Utah	62.28
Vermont	64.75
Virginia	65.00
Washington	50.00
West Virginia	65.00
Wisconsin	52.50
Wyoming	50.00

(27 F.R. 9185)

Vendor medical payments.—For old-age assistance and for the combined aged, blind, and disabled program there is additional Federal matching as to medical vendor payments (i.e., payments directly to the providers of medical services) with respect to State expenditures for medical or remedial care, the larger of the following alternatives:

"Federal medical percentage" of vendor payment expenditures that are above $70 per month, up to $15 per recipient per month.

or

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

The "Federal medical percentage" is dependent on the relationship between State per capita income and the national per capita income. The percentage ranges from 50 percent for States at or above the national average to 80 percent for States with the lowest income.

For States with average monthly payments over $70, the Federal Government participates at the rate of the "Federal medical percentage" in the expenditures over $70 except that such participation is limited to the amount of the average vendor medical payment up to $15 per recipient per month.

For States with average monthly payments of $70 per month or less, the Federal share in average vendor medical payments up to $15 per recipient per month is an additional 15 percentage points over and above the "Federal percentage" used to compute the Federal share of money payments.

Provision is also made that a State with an average payment over $70 per month can never receive less in additional Federal funds in respect to such medical service costs than if it had an average payment of $70 per month.

Permits Federal matching of State expenditures under all four public assistance programs for medical or remedial care furnished within 3 months before the month in which a person applies for assistance.

For those States which adopt the optional combined aged, blind, and disabled program the additional $15 matching for medical vendor payments is applicable to the blind and disabled recipient under the combined program.

No change but vendor medical provision will expire on July 1, 1967, and will be covered in new title XIX.

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

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

46-483-65-3

PUBLIC ASSISTANCE—Continued

I. INCREASE IN FEDERAL MATCHING FORMULA—Continued

Item	Existing law	H.R. 6675
B. Payments for aid to families with dependent children.	For money and medical vendor payments the Federal share is $14 out of the first $17 ($\frac{14}{17}$ of the first $17) per recipient per month with variable matching on the amount above $17 up to a maximum of $30 per recipient per month. Variable matching for the States is at the same percentages as old-age assistance money payment matching.	Effective January 1, 1966, the Federal matching share would be increased to $15 out of the first $18 ($\frac{5}{6}$ of the first $18) with variable matching on the amount above $18 up to a maximum of $32 per month per recipient.
C. Special formula for Puerto Rico, Virgin Islands, and Guam:		
1. Matching formula	Federal matching on a 50–50 basis on both money and vendor medical payments up to a maximum of $37.50 a month times the number of recipients on the old-age, blind, and disabled program with a maximum of $18 a month times the number of recipients on the aid to dependent children program.	No change.
	Additional matching for vendor medical expenditures is available for up to $7.50 per month per recipient on old-age assistance and combined adult program rather than the additional $15 per month per recipient which applies to the States and the District of Columbia.	Provision will expire June 30, 1967.
2. Dollar limitation	Total Federal payments for all 4 public assistance programs may not exceed— Puerto Rico .... $9,800,000 Virgin Islands .... 330,000 Guam .... 450,000 In each case a portion of these amounts is only available if used to provide additional medical vendor payments on behalf of assistance recipients: Puerto Rico .... $625,000 Virgin Islands .... 18,750 Guam 25,000	No change.
	Federal payments for programs of medical assistance for the aged are excepted from dollar limitation provision.	Deletes required earmarking for medical vendor payments.
D. Pass along provision	No provision in existing law to insure that public assistance recipients receive higher payments because of legislation liberalizing the Federal matching formula.	Federal matching for any State for any quarter shall be reduced to the extent that the excess of the Federal matching for such quarter over the corresponding quarter or the average Federal matching for quarters in fiscal 1964 or 1965 is greater than the excess of total Federal, State, and local expenditures for the quarter over the corresponding quarter or the average Federal, State, and local total expenditures for quarters in fiscal 1964 or 1965.

Provision	Present law	Proposed
E. Consideration of income in determination of need. 1. Consideration of earnings in old-age assistance and aged in combined program (title XVI).	In determining the need of an aged recipient, a State may, after Dec. 31, 1962, disregard a portion of earned income. Of the first $50 per month, the State may disregard up to the first $10 completely, plus ½ of the remainder.	In determining need of an aged recipient, a State may, after Dec. 31, 1965, disregard an additional portion of earned income. Of the first $80 per month, the State may disregard the first $20 completely, plus ½ of the remainder.
2. Disregarding OASDI benefit increase, and child's benefit beyond age 18, to extent attributable to retroactive effective date.	No provision in past legislation to exempt OASDI benefit increases from public assistance income considerations.	Would allow a State to disregard the retroactive portion (January 1965) of the 7 percent benefit increase or the child benefit for children over 18 in school in determining need of the aged, blind, disabled, or families with dependent children.

II. MENTAL AND TB EXCLUSION

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

II. Mental and TB exclusion—Continued

Item	Existing law	H.R. 6675
D. State plan requirements	No provision.	As to old-age assistance, medical assistance for the aged, combined program (title XVI) or new medical assistance program (title XIX) adds requirement that if State plan includes cash payment or vendor payments to persons in mental or tuberculosis institutions it must— (1) Provide for having in effect arrangements with the State mental health or tuberculosis authority or authorities, and, where appropriate, with such institutions, including arrangements for joint planning, development of alternate methods of care, assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, allowing access to patients and facilities, furnishing information, and making reports, as may be necessary to enable the State agency to carry out its responsibilities under the State plan; (2) Provide for an individual plan for each patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be periodic determination of his need for continued treatment in the institution; (3) Provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients who would otherwise need care in such institutions, including appropriate medical treatment and other assistance, for rehabilitation services which are appropriate for such, and for methods of administration necessary to assure that these provisions will be effectively carried out; and (4) Provide methods of determining the reasonable cost of institutional care for such patients. And, if the State elects to provide vendor or cash payments to patients in public institutions for mental diseases, it must be shown that the State is making satisfactory progress toward developing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to institutional care.
E. Pass along provision	No provision.	Federal matching for any State for any quarter which is attributable to State or local expenditures with respect to patients in institutions for tuberculosis or mental diseases shall only be paid to extent that the State makes a showing satisfactory to the Secretary that it has increased Federal, State, and local expenditures for mental health services under public health and public welfare programs in the State over the average of such expenditures for quarters in fiscal year 1965.

III. PROTECTIVE PAYMENTS

A. Protective payments under old-age assistance and the combined program (title XVI).	Federal financial participation as to money payments to needy persons or their legal guardians has been authorized since 1935. Vendor payments, made directly to the suppliers of medical services on behalf of recipients have been authorized by the 1950 amendments. Since 1958, payments have been authorized to be made to another person who is judicially appointed for the purpose of receiving and managing such assistance payments (whether or not he is such individual's legal representative for other purposes).	Authorizes protective payments to be made to a person who is interested in or concerned with the welfare of the needy person under a State plan which provides for— (1) Determination by the State agency that payments in this form are necessary because the needy person has, by reason of his physical or mental condition, such inability to manage funds that making cash payments to him would be contrary to his welfare; (2) Special efforts to protect the welfare and improve the ability of the needy individual to manage funds; (3) Periodic review of the situation to determine whether such payments to an interested person are still necessary—and seeking judicial appointment of a guardian or legal representative if and when such action will serve the interests of such needy individual; and (4) Opportunity for a fair hearing before the State agency on the determination that payments to an interested person are necessary. (5) Payments which together with other income meet the individual's need in full.

IV. OTHER CHANGES

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

IV. OTHER CHANGES—Continued

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

MATERNAL AND CHILD HEALTH SERVICES

(Title V of Social Security Act)

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

CRIPPLED CHILDREN'S SERVICES

(Title V of Social Security Act)

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

SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

(Title V of Social Security Act)

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

GRANTS FOR MENTAL RETARDATION PLANNING

(Title XVII of Social Security Act)

Item	Existing law	H.R. 6675
I. Authorization	$2,200,000 was authorized for grants during fiscal 1964 and fiscal 1965.	Authorizes $2,750,000 for fiscal 1966 and fiscal 1967. Sums appropriated during fiscal 1966 are for grants during that year and the 2 succeeding fiscal years. Sums appropriated in fiscal 1967 are also available until June 30, 1968.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

(Title II of the Social Security Act)

I. COVERAGE

Item	Existing law	H.R. 6675
A. Self-employed	*Covers* all self-employed if they have net earnings from self-employment of $400 a year except that certain types of income, including dividends, interest, sale of capital assets, and rentals from real estate (including certain rentals paid in crop shares—see item 3, "Farm operators") are not covered unless received by dealers in real estate and securities in the course of business dealings.	Permits exemption from the social security self-employment tax of individuals who have conscientious objections to insurance (including social security) by reason of their adherence to the established tenets or teachings of a religious sect (or division thereof) of which they are members. The exemption could be granted with respect to taxable years beginning after Dec. 31, 1950. The sect (or division thereof) must be one that has been in existence at all times since Dec. 31, 1950, and has for a substantial period of time been making reasonable provision for its dependent members. Before an individual could be granted exemption he would be required to waive all benefits and other payments under any insurance system established by the Social Security Act on the basis of his own earnings as well as all such benefits and other payments to him based on the earnings of any other person. The exemption could not be granted to any person who has been entitled to social security benefits, or to one whose earnings have provided the basis for entitlement to social security benefits for any other person.
1. Professional groups	*Covers* all professional groups except physicians.	Covers physicians. Effective for taxable years ending after Dec. 31, 1965.
2. Ministers	*Covers* duly ordained, commissioned or licensed ministers, Christian Science practitioners, and members of religious orders (other than those who have taken a vow of poverty) serving in the United States, and those serving outside the country who are citizens and either working for U.S. employers or serving a congregation predominantly made up of U.S. citizens. Coverage is available under the self-employment coverage provisions on an individual voluntary basis regardless of whether they are employees or self-employed.	No change.
3. Farm operators	*Covers* farm operators on the same basis as other self-employed persons except that farm operators whose annual gross earnings are $1,800 or less can report either their actual net earnings or 66⅔ percent of their gross earnings. Farmers whose annual gross earnings are over $1,800 report their actual net earnings if over $1,200, but if actual net earnings are less than $1,200, they may report $1,200.	Modifies exception so that farm operators whose annual gross earnings are $2,400 or less can report either their actual net earnings or 66⅔ percent of their gross earnings. Farmers whose gross earnings are over $2,400 report actual net earnings if over $1,600, but if actual net is less than $1,600, they may report either actual net earnings or $1,600. Effective as to taxable years beginning after Dec. 31, 1965.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

Title II of the Social Security Act—Continued

I. COVERAGE—Continued

Item	Existing law	H.R. 6675
A. Self-employed—Continued 3. Farm operators—Continued	Rentals from real estate are not creditable as self-employment earnings, but if landlord under arrangements with tenant or share farmer participates materially in the production of, or in the management of, the crops or livestock on his land, the income is covered.	No change.
4. Public officials	*Excludes* individuals performing functions of public officials.	No change.
5. Newspaper vendors	*Covers* individuals over 18 who buy newspapers and magazines at one price and sell them at another regardless of whether they are guaranteed minimum compensation or may return unsold papers and magazines.	No change.
B. Employees	*Covers* employees including certain agent or commission drivers, life insurance salesmen, homeworkers, traveling salesmen, and officers of corporations regardless of the common-law definition of employee.	No change.
1. Agricultural workers	*Covers* agricultural workers who either (1) are paid $150 or more in cash wages in a calendar year by an employer or (2) perform agricultural labor for an employer on 20 days or more during the calendar year. Workers who are recruited and paid by a crew leader shall be deemed to be employees of the crew leader if such crew leader is not, by written agreement, designated to be an employee of the owner or tenant and if such crew leader is customarily engaged in recruiting and supplying individuals to perform agricultural labor; under such circumstances the crew leader shall be deemed to be self-employed. *And excludes:* a. Mexican contract workers. b. Workers lawfully admitted to the United States from the Bahamas, Jamaica, and other islands in the British West Indies or from any other foreign country or its possessions, on a temporary basis to perform agricultural labor.	
2. Domestic workers	*Covers* persons performing domestic service in private nonfarm homes if they receive $50 or more during a calendar quarter from 1 employer. Noncash remuneration is excluded. *Excludes* students performing domestic service in clubs or fraternities if enrolled and regularly attending classes at school, college, or university.	No change.
3. Casual labor	*Covers* cash remuneration for service not in the course of the employer's trade or business if the remuneration is $50 or more from 1 employer during a calendar quarter.	No change.

4. Cash tips

Tips received by employees are generally not counted as wages. While employees' tips are not mentioned in the law, regulations exclude from wages tips paid directly to an employee, and not accounted for by the employee to the employer.

Tips covered for social security. Tips which an employee receives on his own behalf in the course of his employment for an employer, whether the tips are received directly from a customer or through the employer, are specifically covered as wages. However, cash tips of less than $20 received by an employee in a calendar month in the course of his employment for 1 employer and all noncash tips are excluded.

Employee obligation. An employee who, in a month, gets tips that are wages for social security is required to furnish to his employer a written report of his tips at least once a month. Tips are considered reported only if they are included in a written statement furnished to the employer on or before the 10th day following the month in which the tips are received, and only to the extent that the employer has in his possession within the same time limit wages or money given to him by the employee to cover the employee's social security tax. Covered tips are deemed paid to employee by employer when reported or, if not reported, when received. If an employee fails to report to the employer some or all of his covered tips, he is required to pay both the employee tax on the unreported tips and an additional amount equal to the employee tax. The additional tax is waived if the failure to report is due to reasonable cause and not due to willful neglect.

Employer obligation. The employer is responsible for the employee's social security tax, paying the employer's share of the tax, and including the tips in his quarterly social security report of wages and on his tax withholding statement to the employee only with respect to tips which an employee includes in a written statement furnished to the employer on or before the 10th day following the month the tips are received, and only to the extent that he can collect the employee tax, before the close of the 10th day following the month in which the tips are received, from unpaid wages (not including tips) or from funds turned over to the employer for that purpose.

An employer can obtain statements from the employee at other times before the 10th day following the month in which the tips are received, in accordance with regulations prescribed by the Secretary of the Treasury. An employer who is furnished a written statement of tips received in a month before the 10th day following the month in which the tips were received is authorized to deduct the employee's tax on the tips included in the statement from the employee's unpaid wages (not including tips) even though at the time the statement is furnished the total amount of the tips reported as received in the month in the course of his employment by the employer is less than $20.

The employer is permitted to withhold the employee's share of the social security tax from current wages on the basis of an estimated amount of tips and to adjust the amount withheld at the end of each quarter to conform to the amount actually due on the basis of the

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

Title II of the Social Security Act—Continued

I. COVERAGE—Continued

Item	Existing law	H.R. 6675
B. Employees—Continued 4. Cash tips—Continued		employee's written statement of his tips. (This provision permits the employer to gear the new reporting procedure into his usual payroll procedure.) *Tips subject to income tax withholding.* In general, tips that are covered as wages for social security are subject to income tax withholding. The employer is liable for withholding income tax on only those tips that are included in a written statement furnished to him by the employee on or before the 10th day following the month in which the tips are received and then only to the extent that he could collect the tax, at or after the time the statement is furnished and before the close of the calendar year in which the tips are received, from unpaid wages (not including tips), or from funds turned over to him for that purpose, remaining after the employee social security tax due on the tips is subtracted. Effective date: Applicable to tips received by employees after 1965.
5. State and local government employees.	*Covers* employees of State and local governments *provided* the individual State enters into an agreement with the Federal Government to provide such coverage, with the following special provisions:	
	a. *States have the option* of covering or excluding employees in any class of elective position, part-time position, fee-basis position, or performing emergency services.	No change.
	b. *Excludes* the services of the following persons, specifying that they cannot be included in a State agreement and cannot, therefore, be covered: (1) Employees on work relief projects; (2) Patients and inmates of institutions who are employed by such institutions; (3) Services of the types which would be excluded by the general coverage provisions of the law if they were performed for a private employer, *except* that agricultural and student services in this category may be covered at the option of the State.	No change.
	c. Employees who are in positions covered under an existing State or local retirement system may be covered under State agreements only if a referendum is held by a secret written ballot, after not less than 90 days' notice, and if the majority of eligible employees under the retirement system vote in favor of coverage. However, employees in policemen and firemen positions under a State and local	No change.

retirement system cannot be covered in the agreement. The Governor of a State or his delegate must certify that certain Social Security Act requirements under the referendum procedure have been properly carried out. In most States, all members of a retirement system (with minor exceptions) must be covered if any members are covered.

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

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

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

The 1960 amendments permit California to cover, before 1962, persons employed by a hospital in 1957, 1958, or 1959 in positions removed, after Sept. 1, 1954 and before 1960, from retirement system coverage for whom social security taxes were erroneously paid. Hospital employment before 1960 on which taxes were paid and all subsequent hospital employment of such persons could be covered.

Would modify provision so that service of persons in such positions after 1959 would also be covered. Upon modification of agreement by the end of 6 months following month of enactment, service performed on or after Jan. 1, 1962, would be covered. Services performed before Jan. 1, 1962, would be covered, if contribution in the proper amount was paid prior to date of enactment.

Exceptions to general law concerning coverage in named States:

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

Adds Kentucky and Alaska to the list. Effective upon enactment.

Those employees covered by a divided retirement system who did not elect coverage in the original agreement, may, nevertheless elect coverage until 1963, or, if later, until 2 years after the date on which coverage was approved for the group that originally elected coverage. Also provides that the coverage of persons electing under this amendment would begin on the same date as coverage became effective for the group originally covered.

Extends the time in which such employees can elect to be covered until the end of 1966 (or, if later, the expiration of 2 years after the date on which coverage was approved for the group that originally elected coverage). Effective upon enactment.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

Title II of the Social Security Act—Continued

I. COVERAGE—Continued

Item	Existing law	H.R. 6675
B. Employees—Continued 5. State and local government employees—Continued	Also provides that where an individual who has chosen not to be covered under the divided retirement system provision becomes a member of a different retirement system group which has elected coverage because of the annexation of the employing political subdivision by another political subdivision, or through some other action taken by a political subdivision, such individual will continue to be excluded from coverage.	
	(2) *Policemen and firemen.*—Allows the States of Alabama, California, Florida, Georgia, Hawaii, Kansas, Maine, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington and all interstate instrumentalities to make coverage available to policemen and firemen in those States, subject to the same conditions that apply to coverage of other employees who are under State and local retirement systems, except that where the policemen and firemen are in a retirement system with other classes of employees the policemen and firemen may, at the option of the State, hold a separate referendum and be covered as a separate group.	No change.
	(3) *Employees of unemployment compensation systems.*—Authorizes Florida, Georgia, Minnesota, North Dakota, Pennsylvania, Washington, and Hawaii, at their option, to cover their employees who are paid wholly or partly from Federal funds under the unemployment compensation provisions of the Social Security Act—either by themselves or with the other employees of the department of the State in which they are employed—after complying with the referendum provisions.	No change.
	d. Coverage on a compulsory basis is provided for employees of certain publicly owned transportation systems.	No change.
	e. *Effective date of coverage agreement.*—Allows agreements or modifications made after 1959 to begin as early as 5 years before the year in which an agreement is made, but no earlier than Jan. 1, 1956. Where a retirement system is covered as a single retirement system coverage group, permits the State to provide different beginning dates for coverage of the employees of different political subdivisions.	No change.

6. Employees of nonprofit organizations.	*Covers* employees of religious, charitable, educational, and other nonprofit organizations (which are exempt from income tax and are described in sec. 501(c)(3) of the Internal Revenue Code) *on a voluntary basis* if the employer organization certifies that it desires to extend coverage to its employees. Employees may concur by signing a list or supplemental list which is filed within 24 months after the quarter in which the certificate is filed. Employees who do not concur in the filing of the certificate are not covered *except* that all employees hired after a certificate becomes effective are covered.	No change.
	Waiver certificate may be made effective at the option of the organization on the 1st day of the quarter in which the certificate is filed, the 1st day of the succeeding quarter, on the 1st day of any of the 4 quarters preceding the quarter in which the certificate is filed.	Permits nonprofit organizations to elect coverage as early as the 1st day of the 20th calendar quarter preceding the quarter in which the certificate of waiver is filed. Permits the validation of certain erroneous wage reportings by nonprofit organizations. Effective upon enactment.
	Employees of nonprofit organizations who are in positions covered by State and local retirement systems and are members or eligible to become members of such systems must be treated apart from those not in such positions. Certificates must be filed separately for each group. All new employees who belong to a group for which a certificate has been filed are automatically covered, and new employees who belong to a group for which a certificate has not been filed are not covered.	
7. Federal employees	*Excludes* employees of the United States or its instrumentalities if— a. they are covered by a retirement system established by Federal law; or b. they perform services— (1) as the President, Vice President, or a Member of Congress; (2) in the legislative branch; (3) in a penal institution as an inmate;	No change, except—
	(4) as certain interns, student nurses, and other student employees of Federal hospitals; (5) as employees on a temporary basis in disaster situations;	Excepts from exclusion and thereby provides coverage to medical or dental interns or residents in training. Effective as to services performed after 1965.
	(6) as employees not covered by the Civil Service Retirement Act because they are subject to another retirement system (other than the retirement system of the Tennessee Valley Authority); or c. the instrumentality has been specifically exempted by statute from the employer tax; or d. the instrumentality was exempt from the employer tax on Dec. 31, 1950, and its employees are covered by its retirement system. *Covers* the following Federal employees excepted from the exclusion in 6–d unless they are excluded on the basis of one of the other provisions: a. employees of a corporation which is wholly owned by the United States; b. employees of a national farm loan association, a production credit association, a Federal Reserve bank, or a Federal credit union;	Extends coverage to employees of the District of Columbia not covered by any retirement system established by a law of the United States. Effective date: amendments apply to services performed after the quarter in which the Secretary of the Treasury receives a certification from the District of Columbia Commissioners that they desire coverage of these services.

Item	Existing law	H.R. 6675
B. Employees—Continued 7. Federal employees—Continued	c. employees (not compensated by funds appropriated by Congress) of the post exchanges of the various armed services (including the Coast Guard) and other similar organizations at military installations; d. employees of a State, county, or community committee under the Production and Marketing Administration.	
8. Students, interns, and nurses in schools and hospitals.	*Excludes*— a. Students in the employ of a school, a college, or university if enrolled and regularly attending classes; b. student nurses employed by a hospital or nurses training school if enrolled and regularly attending classes; c. interns in the employ of a hospital if they have completed a 4-year course in an approved medical school.	No change, except— Covered on the same basis as other employees of the same employer, effective as to service performed after 1965.
9. Newsboys	*Covers* individuals *18 and over* who deliver and distribute newspapers or shopping news, but covers individual *under 18* only if they deliver or distribute such publication to points for subsequent delivery or distribution.	No change.
10. Members of the Armed Forces	*Covers* members of the uniformed services, after December 1956, while on active duty (including active duty for training), with contributions and benefits computed on basic military pay. Noncontributory wage credits of $160 per month are granted, in general, for each month of active service in the Armed Forces of the United States during the World War II period (Sept. 16, 1940–July 24, 1947) and during the postwar emergency period (July 25, 1947–Dec. 31, 1956). Extends the noncontributory wage credits certain American citizens who, prior to Dec. 9, 1941, entered the active military or naval service of countries that, on Sept. 16, 1940, were at war with a country with which the United States was at war during World War II. Wage credits of $160 would be provided for each month of such service performed after Sept. 15, 1940, and before July 25, 1947. To qualify for such wage credits, an individual must either have been a U.S. citizen throughout the period of his active service or have lost his U.S. citizenship solely because of his entrance into such active service. He must have resided in the United States for at least 4 years during the 5-year period ending on the day of his entrance	No change.

	into such active service and must have been domiciled in the United States on such day.	
11. Railroad employees	Under coordination provisions contained in the Railroad Retirement Act: (1) employment under both the railroad system and the old-age and survivors insurance system is counted for purposes of survivor benefits under either system; (2) railroad employment of workers with less than 10 years of railroad service is credited under the Social Security Act and the benefits based on such employment are payable under this act; and (3) provision is made for mutual financial interchange between the 2 systems in order to place the Old-Age and Survivors Insurance and Disability Insurance Trust Funds in the same position in which they would have been if railroad service after 1936 had been counted as social security employment.	Amends section (1)(q) of the Railroad Retirement to provide that references to the Social Security Act in the Railroad Retirement Act will be considered to be references to the Social Security Act as amended in 1965, so that the present RR-OASDI coordination will continue to operate in all ways with respect to the Social Security Act as amended by the bill. Increases the amount of social security earnings that may be credited under the survivors provisions of the railroad retirement program to such an amount as to cause the combined total earnings to be as much as the new wage and tax base under social security—$5,600 a year for 1966 through 1970, and $6,600 a year after 1970.
12. Family employment	*Excludes* services rendered by— (1) One spouse for another. (2) Child under 21 for his parents. (3) Parents for their children, if such services are domestic services rendered in the home of the child, or such services are not rendered in the course of the child's trade or business.	No change.
13. Employees of Communist organizations.	*Excludes* from coverage employees of any organization which is registered, or against which there is a final order of the Subversive Activities Control Board to register, under the Internal Security Act as a Communist-action, a Communist-front, or Communist infiltrated organization.	No change.

II. PROVISIONS RELATING TO DISABILITY

A. Nature of the provisions:		
1. Benefits	Provides monthly benefits for disabled workers meeting eligibility requirements. Benefits are computed in the same way as retirement benefits and are payable from the Federal Disability Insurance Trust Fund.	No change.
. Disability "freeze"	Provides that when an individual for whom a period of disability has been established dies, or retires, on account of age or disability, his period of disability will be disregarded in determining his eligibility for benefits and his average monthly wage for benefit computation purposes.	No change.
B. Eligibility requirements:		
1. Definition	For benefits or for the freeze, an individual must be precluded from engaging in any substantial gainful activity by reason of a physical or mental impairment. (For purposes of the freeze only, a specified degree of blindness is presumed disabling.) The impairment must be medically determinable and one which can be expected to be of long-continued and indefinite duration or to result in death.	Eliminates the requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration. Provides that a worker would be eligible for disability insurance benefits if he has been totally disabled for a continuous period of 6 full calendar months.
2. Entitlement to other benefits	Entitlement to a benefit payable on account of old age precludes entitlement to a disability insurance benefit.	A person who becomes entitled before age 65 to a benefit payable on account of old age can later become entitled to disability insurance benefits. If prior benefit was a reduced benefit, disability insurance benefits would be reduced to take account of payment made for prior months.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

Title II of the Social Security Act—Continued

II. PROVISIONS RELATING TO DISABILITY—Continued

Item	Existing law	H.R. 6675
B. Eligibility requirements—Continued 3. Waiting period	An initial 6-month "waiting period" is required before disability insurance benefits will be paid. Benefits are payable for 7th month. However, benefits may be paid for the 1st full month of disability to a worker who becomes disabled within 60 months (5 years) after termination of disability insurance benefits or a period of disability.	Retains the initial 6-month "waiting period" requirement. Provides for payment of disability insurance benefits beginning with the last month of the 6-month "waiting period" rather than with the first month after the 6-month "waiting period." Provides that benefits may be paid without a "waiting period" upon subsequent disability only if applicant's prior disability lasted at least 18 calendar months, and only if the subsequent period is expected to last for at least a year or end in death.
4. Termination of Benefits	Provides that benefits shall not be paid after the 2d month following the month in which a worker's disability ceases.	Retains the termination provision in present law for cases of long-term disability (disability which lasts at least 18 months). Provides, in the case of disabilities which have lasted less than 18 months, for payment in the month of cessation and for only 1 additional month's benefits.
5. Insured status (work requirement).	To be eligible an individual must—(1) have at least 20 quarters of coverage in the 40 quarters ending with the quarter in which the period of disability begins; (2) be fully insured.	No change.
6. Applications	Provides that an individual must be under a disability when his application for a period of disability is filed.	Eliminates the requirement that an individual must be under a disability when his application for a period of disability is filed and substitutes instead the requirement that no application for a disability determination which is filed more than 12 months after the month in which a period of disability would end shall be accepted. This amendment permits payment of benefits in those cases of extended disability which terminated before an application was filed. Payment would be made only for months of disability which fall within the period of retroactivity of the application.

III. BENEFIT CATEGORIES

Item	Existing law	H.R. 6675
A. Worker—old age	Full benefit payable at age 65 to fully insured retired worker. Payable at age 62 to fully insured retired worker, but on an actuarially reduced basis. Benefit is reduced by 5/9 of 1 percent for each month worker is entitled to receive a benefit before age 65—the total reduction is 20 percent if worker begins drawing benefits at age 62. The reduced amount is permanent, continuing after worker reaches age 65.	No change.

Provision	Present law	Bill
Reduction where individual is entitled to a wife's benefit and an old-age benefit.	In the case where a woman is entitled to a reduced old-age insurance benefit and at the same time or subsequently becomes entitled to a wife's benefit, the wife's benefit would be reduced by the dollar reduction which was applicable to the old-age benefit, plus the regular reduction amount on the excess of the unreduced wife's benefit over the unreduced old-age benefit. A similar provision is applicable to men entitled to reduced benefit old-age and dependent husband's benefit.	No change.
B. Wife or dependent husband	A full benefit for a wife or dependent husband is 50 percent of spouse's primary benefit. Full benefit paid at age 65. Payable at age 62 to a wife or dependent husband, but on an actuarially reduced basis. Benefit is reduced by $\frac{25}{36}$ of 1 percent for each month prior to age 65. An individual who takes benefit at 62 receives 75 percent of full benefit.	No change.
C. Widow, widower, or parent	Full benefit payable at age 62 to widow, dependent widower, or surviving dependent mother or father of the insured worker. Full benefit is 82.5 percent of deceased worker's primary benefit (75 percent each in case of 2 parents).	Widows would be allowed to elect an actuarially reduced benefit upon attaining age 60. Benefits would be reduced by $\frac{5}{9}$ of 1 percent for each month she is entitled to receive a benefit prior to age 62. Thus the reduction for a widow who elects a benefit when she attains age 60 would be 13⅓ percent for the 24-month period—reducing her benefit from 82½ percent of her husband's benefit to 71½ percent of his benefit. In the case of a widow who is entitled to an old-age benefit in her own right, the old-age benefit will be reduced to take into account widow's benefits paid to her before age 62. Effective for benefits beginning with the 2d month after the month of enactment on the basis of applications filed in or after month of enactment. No change as to widowers and parents.
D. Children	A child's benefit is paid to child of the insured worker who has died, reached retirement age, or become disabled if the child is unmarried and either— (a) Is under age 18, or (b) Is under a disability which began before age 18.	Changes the language relating to the 2d qualifying alternative to conform it to the revised definition of disability in 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. Adds a 3d qualifying alternative: (c) Is age 18 or over and under age 22 if he is a full-time student. Permits a child whose benefits have terminated because he has attained age 18 to become reentitled upon filing a new application if he is a full-time student and has not attained 22. Provision would prevent a wife, widow, or surviving divorced mother from getting benefits if the only child in her care has attained 18 and is getting benefits solely because he is a student. *Student and institution defined:* A full-time student is defined as an individual who is in full-time attendance as a student at an educational institution; whether or not the student was in full-time attendance would be determined by the Secretary in the light of the standards and practices of the school involved. Specifically

Item	Existing law	H.R. 6675
D. Children—Continued		excluded is a person who is paid by his employer while attending school at the request of his employer. Provides for benefits for any period of 4 calendar months or less in which a person does not attend school if the person shows to the satisfaction of the Secretary that he intends to continue in full-time school attendance immediately after the end of the period, or does in fact return. An educational institution is defined so as to permit the payment of benefits to students taking vocational or academic courses and includes all public schools, colleges, and universities and all accredited private schools, colleges, or universities. An accredited school would be one approved by a State recognized or nationally recognized accrediting association. Also included are those nonaccredited schools, colleges, and universities whose credits are accepted, on transfer by 3 accredited institutions on the same basis as if transferred from an accredited institution. Effective for January 1965 on basis of applications filed in or after month of enactment. For children currently on rolls, no application will be required.
	The benefit paid to a child of a retired or disabled worker is ½ of the worker's primary benefit. The benefit to the child of a deceased worker is ¾ of the worker's primary benefit, except a sole surviving child is entitled to the minimum primary benefit.	In the case of a disabled child who becomes entitled on the basis of the revised requirements for disability, the effective date is the 2d month after the month of enactment.
	A child adopted by a worker who is already retired and getting old-age insurance benefits can become entitled to benefits without regard to whether he was dependent on the worker at the time the latter retired.	Child adopted by retired worker can get benefits if (1) at the time the worker became entitled to benefits the child was living with the worker or adoption proceedings had begun (2) the adoption was completed within 2 years of the time when the worker became entitled to benefits and (3) the child had been receiving ½ of his support from the worker for the entire year before the worker became entitled to old-age insurance benefits or, if the worker had a period of disability which continued until he became entitled to old-age insurance benefits, before the beginning of the period of disability. Effective for applications filed on or after the date of enactment.
E. Divorced wife, widow	Benefits are payable to a divorced woman only if she has a child of the deceased worker in her care and the child is getting benefits based on his deceased father's earnings, if she has not remarried, and if she had been getting at lease ½ of her support from her former husband under a court order or agreement at the time of his death.	Wife's or widow's benefits would be payable to an aged divorced woman if she (A) had been married to her former husband for 20 years before the divorce, (B) had not remarried, and (C) met the following support requirement when her former husband became disabled, entitled to benefits or died; (1) she was receiving ½ of her support from her former husband, or (2) she was

receiving substantial contributions from him pursuant to a written agreement, or (3) a court order for substantial contributions was in effect.

Payment of a wife's or widow's benefit to a divorced woman would not reduce the benefits paid to any other person on the same social security account and such wife's or widow's benefit would not be reduced because of other benefits payable on the same account.

Benefits for a divorced wife or a surviving divorced wife would not terminate on account of remarriage in those cases where widow's benefits under present law do not terminate—that is, where the remarriage is to a man getting benefits as a dependent widower or parent or as a disabled child aged 18 or over. If a divorced wife or a surviving divorced wife married an old-age insurance beneficiary, her benefits would terminate but she would immediately be eligible for wife's benefit on her new husband's account.

A wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years.

The support requirements that must be met by a former wife divorced (renamed "surviving divorced mother" in the bill) in order to qualify for mother's benefits based on the social security account of her deceased former husband would be conformed to the new support requirements for aged divorced women.

A woman whose right to benefits as a widow, divorced wife, surviving divorced wife, or surviving divorced mother were terminated because she remarried would have her right to these benefits restored if the remarriage ends in divorce after *less than 20 years.* Effective 2d month after enactment.

(See fully insured status p 49.)

F. "Transitional insured status" for certain workers, wives and widows aged 72 or more.

G. Time for filing proof of support and application for lump-sum death payment.

Proof of support for husband's, widower's, and parent's benefits, and applications for lump-sum death payments must be filed within a 2-year period specified in the law with an additional 2-year period allowed where there was good cause for failure to file on time.

If there is good cause for failure to file in the initial 2-year period an applicant would be allowed to file at any time. Effective with respect to applications for lump-sum death payments filed in or after the month of enactment, and monthly benefits based on applications filed in or after such month.

IV. BENEFIT AMOUNTS

A. Creditable earnings

Maximum amount of earnings which may be credited for benefit purposes is $4,800 a year.

Raises maximum amount to $5,600 a year beginning with 1966 and to $6,600 beginning with 1971.

B. Average monthly wage

In general, an individual's "average monthly wage" which determines his old-age insurance benefit amount (before reduction for retirement before age 65) is computed by dividing the total of his creditable earnings after the applicable starting date and up to the applicable closing date, by the number of months involved. Excluded from this computation are all months and all earnings in any year any part

No change except—

Item	Existing law	H.R. 6675
B. Average monthly wage—Continued	of which was included in a period of disability under the disability "freeze" (except that the months and earnings in the year in which the period of disability begins may be included if the resulting benefit would be higher). The average monthly wage in retirement cases is computed on the basis of a constant number of years, regardless of when, before age 22, the person started to work or when, after retirement age (62 for women, 65 for men) he files application for benefits. The number of years for a person who had at least 6 quarters of coverage after 1950 would be equal to 5 less than the number of years (excluding years in periods of disability) elapsing after 1950 or after the year in which the individual attained age 21, whichever is later, and up to the year in which the person was first eligible for old-age insurance benefits (generally the year in which he attained retirement age). In death and disability cases the number of years would be determined by the date of death or disability. In those cases where a larger benefit would result (because the individual's best earnings were in years before 1951) the number of years would be those elapsing after 1936, rather than 1950. The earnings used in the computation would be earnings in the highest years. Earnings in years prior to attainment of age 22 or after attainment of retirement age could be used if they were higher than earnings in intervening years. The span of years could never be less than 2. Generally, the span of years to be used for the benefit computation in retirement cases could not be less than 5—the number of years that would have to be used under the prior law by people who attained retirement age in 1960.	Worker may have average monthly wage computed entirely on years after 1950 regardless of whether he has 6 quarters of coverage after 1950, and his closing date would be the year of attainment of age 65 (62 for women) regardless of whether he is eligible (insured) in that year.
C. Recomputations	After a person has become entitled to benefits, he may, under certain circumstances, have his "average monthly wage" recomputed if it will increase his monthly benefit: (1) Recalculation to correct errors in original computation. (2) 1954 work recomputation: Where an individual who has 6 quarters of coverage after 1950 returns to work after becoming entitled to benefits and earns more than $1,200 in a year he may have his average monthly wage recomputed including such earnings. Survivors are also entitled to any increase in benefits which would result from such recomputation.	Provides for automatic annual recomputation; beginning with 1965, earnings in and after the year of 1st entitlement will be taken into account regardless of whether the worker has 6 quarters of coverage after 1950, or earns over $1,200, or files an application to have his benefits recomputed. Individuals eligible for a recomputation under present law would be deemed to have applied for such recomputation on Jan. 1, 1966 (so that it would be made automatically).

	(3) Dropout recomputation: Beneficiary who became entitled to benefits prior to the amendment which allowed a dropout of 5 years of lowest earnings may have a recomputation using the dropout if he has 6 quarters of coverage after June 1953. Survivors are entitled to any increases which would result from such a recomputation. (4) Current year recomputation: An individual becoming entitled to benefits after August 1954 may have a recomputation which will include earnings in the year he retires if such earnings were not included in the original calculation. Survivors are entitled to any increases which would result from such a recomputation. (5) Recomputation of benefits at age 65 (the "round up"): If a reduced benefit has been withheld (most common reason would be earnings which caused benefit withholding under the retirement test) for at least 3 months (during the period of reduced benefit) a person is entitled to a recomputation at age 65 which will readjust post-65 benefits to take into account the months in which the reduced benefit was withheld. (6) Other recomputations: Provides several recomputations of limited application.	Provision also made applicable at age 62 to reduced benefits for widows who were aged 60–61 at time of claim.
D. Benefit formula	The law provides a consolidated benefit table which is used in determining benefit amounts for both future beneficiaries and those now on the benefit rolls. Though not specifically stated in the law the formula for the primary insurance amount is, in effect, 58.85 percent of the 1st $110 of the average monthly wage, plus 21.40 percent of the next $290 of such wage (except that is some cases, for average monthly wages under $85, a slightly higher amount is payable so as to fit in with the minimum benefit).	The existing benefit table is amended so as to increase all primary insurance amounts by 7 percent, with a $4 guaranteed minimum increase. The existing benefit table is replaced by a new benefit table to reflect the annual earnings base of $5,600 effective in 1966 and a revision of the table, effective in 1971, is provided to reflect the annual earnings base of $6,600 effective in that year. For average monthly wages above $400, primary insurance amounts are derived by applying the benefit formula underlying the present table and adding $8.90, the same amount of increase provided for persons with the present maximum average monthly wage of $400. The formula underlying the new benefit tables is approximately 62.97 percent of the 1st $110 of the average monthly wage, plus 22.9 percent of the next $290, plus 21.4 percent of the next $150.
E. Maximun primary insurance amount	$127 a month ($400 average monthly wage).	Increases to $135.90 ($400 average monthly wage) and eventually to $167.90 ($550 average monthly wage).
F. Minimum primary insurance amount	$40 a month.	Increases minimum benefit to $44 per month.
G. Maximum family benefits	Family maximum monthly benefits are set by the table and range from $53 to $254. Though not specifically stated in the law, the maximum family benefit shown in the benefit table is 1⅓ times the primary insurance amount or approximately 80 percent of the average monthly wage, whichever is larger, up to an absolute maximum of $254—twice the maximum primary insurance amount of $127.	Family maximum benefits will range from $66 to a maximum of $312 under the $5,600 table, and to a maximum of $368 under the $6,600 table. Although not specifically stated in the bill, the formula used to determine the maximum family benefit shown in col. V of the new benefit tables is the larger of (*a*) 1⅓ times the primary insurance amount or (*b*) approximately 80 percent of the average monthly wage up to the point at which the average monthly wage is ⅜ of the maximum possible average monthly wage, plus 40 percent of the remainder. The maximum benefits payable to a family would be related to the worker's average monthly wage at every

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

Title II of the Social Security Act—Continued

IV. BENEFIT AMOUNTS—Continued

Item	Existing law	H.R. 6675
G. Maximum family benefits—Continued		average monthly wage bracket in the benefit table. The maximum payable to a family now on the benefit rolls would be $286.80 (based on an average monthly wage of $400). At the maximum average monthly wage levels of $466 (under the $5,600 base), and $550 (under the $6,600 base), the maximum family benefit would be about ⅘ of the average monthly wage. Effective for monthly benefits beginning with January 1965; effective for lump-sum death payment where death occurs in or after month of enactment.
H. Lump-sum death payment	3 times the primary insurance amount with a statutory maximum of $255.	No change.
I. Illustrative monthly benefits		

Illustrative benefits payable under present law and H.R. 6675 based on $5,600 earnings base

Average monthly wage	Old-age benefits [1]				Survivors benefits				
	Worker		Man and wife [2]		Widow aged 62, widower, or parent		Widow aged 60 [3]	Widow and 2 children	
	Present law	Bill	Present law	Bill	Present law	Bill	Bill	Present law	Bill [4]
$67 or less	$40.00	$44.00	$60.00	$66.00	$40.00	$44.00	$38.20	$60.00	$66.00
$100	59.00	63.20	88.50	94.80	48.70	52.20	45.30	88.50	94.80
$150	73.00	78.20	109.50	117.30	60.30	64.60	56.00	120.00	120.00
$200	84.00	89.90	126.00	134.90	69.30	74.20	64.40	161.70	161.70
$250	95.00	101.70	142.50	152.60	78.40	83.90	72.80	202.50	202.50
$300	150.00	112.40	157.50	168.60	86.70	92.80	80.50	236.40	240.00
$350	116.00	124.20	174.00	186.30	95.70	102.50	88.90	254.10	266.10
$400	127.00	135.90	190.50	203.90	104.80	112.20	97.30	254.10	286.80
$466	([5])	149.90	([5])	224.90	([5])	123.70	107.30	([5])	312.00

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

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

[3] Not applicable under present law.

[4] For families on the benefit roll in the month after the month of enactment who are affected by the maximum-benefit provisions, the amounts payable under the bill would, in some cases, be somewhat higher than those shown here (namely, for the cases where the average monthly wages are $150 through $350).

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

V. FULLY INSURED STATUS

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

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

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

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

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

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

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

VI. RETIREMENT TEST

Item	Present law	H.R. 6675
A. Scope	Applies to covered as well as noncovered work.	Excludes royalties received at or after age 65 on works copyrighted or patented before age 65. Effective for taxable years beginning after 1964.
B. Test of earnings	Provides that benefits will be withheld from a beneficiary under age 72 (and from any dependent drawing on his record) at the rate of $1 in benefits for each $2 of annual earnings between $1,200 and $1,700 and $1 in benefits for each $1 of annual earnings above $1,700. Benefits not withheld for any month during which the individual neither rendered services for wages in excess of $100 nor rendered substantial services in a trade or business.	Increases the uppermost limit of the $1-for-$2 "band" from $1,700 to $2,400 so that $1 in benefits would be withheld for each $2 of earnings between $1,200 and $2,400, with $1 for $1 reductions above $2,400. Effective for taxable years ending after 1965.
C. Age exemption	Benefits are not suspended because of work or earnings if beneficiary is age 72 or over.	

VII. FINANCING

Item	Present law	H.R. 6675
A. Allocation between trust funds	The Federal Old-Age and Survivors Insurance Trust Fund receives all tax contributions other than those allocated for the disability benefit program, from which benefits and administrative expenses are paid for the old-age and survivors insurance program. The Federal Disability Insurance Trust Fund receives an amount equal to ½ of 1 percent of taxable wages plus ⅜ of 1 percent of self-employment income, from which benefit and administrative expenses are paid for the disability insurance program. These funds are administered by a Board of Trustees consisting of the Secretary of the Treasury, as managing trustee, the Secretary of Labor and the Secretary of Health, Education, and Welfare, all ex officio (with the Commissioner of Social Security as Secretary).	Increases the allocation to the Disability Insurance Trust Fund, for years beginning after 1965, to ¾ of 1-percent of taxable wages and 9/16 of 1-percent of taxable self-employment income.
B. Maximum table amount	$4,800 a year.	$5,600 a year starting with 1966 and $6,600 starting with 1971.
C. Tax rate for self-employed	Taxable years beginning in— 1966–67 ..... 6.2 1968 and thereafter 6.9	Taxable years beginning in— 1966–68 ..... 6.0 1969–72 ..... 6.6 1973 and thereafter 7.0
D. OASDI tax rate for employees and employers (each).	Calendar years: 1966–67 ..... 4.125 1968 and thereafter 4.625	Calendar years: 1966–68 ..... 4.0 1969–72 ..... 4.4 1973 and thereafter 4.8

E. Reimbursement of the trust funds for the cost of noncontributory military service credits.	Amounts to cover the costs incurred through June 30, 1956, were to have been appropriated to the trust funds from general revenue over the 10 fiscal years ending June 30, 1969; costs incurred after June 30, 1956, were to have been appropriated to the trust funds annually.	The trust funds would be reimbursed by a level annual appropriation starting with fiscal year 1966 that would amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015, and by annual appropriations thereafter.
F. Railroad retirement tax	The Railroad Retirement Tax Act provides that the railroad tax will automatically adjust in the same amount, and at the same time, to any change in the OASDI tax rate after 1954.	No change.

VIII. MISCELLANEOUS

A. Advisory Council on Social Security	Councils are to be appointed in 1966 and every 5th year thereafter to review the financing of the program and submit reports to the Board of Trustees for inclusion in the annual Trustees' report to the Congress. Members are to represent employees and employers in equal numbers and the self-employed and the general public and can be paid up to $50 per day.	Councils would be appointed in 1968 and every 5th year thereafter to review all aspects of the program (including the new hospital and supplementary health insurance programs) and submit reports to the Secretary of Health, Education, and Welfare for transmittal to the Congress and the Board of Trustees. Members are to represent *organizations* of employees and employers in equal numbers and the self-employed and the general public and could be paid up to $100 a day.
B. Board of Trustees	The Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund are required to meet at least once every 6 months.	The Board of Trustees would be required to meet at least once every calendar year.

MEDICAL EXPENSE DEDUCTION FOR INCOME TAX PURPOSES

Item	Present law	H.R. 6675
I. Character of deduction:		
A. General	Medical expenses are deductible from adjusted gross income and thus are allowable only if the taxpayer itemizes his deductions.	No change.
B. Taxpayers age 65 or over	Different, more generous rules apply if the taxpayer or his spouse is age 65 or over.	All distinctions based on age of the taxpayer or his spouse are eliminated.
II. 3-percent and 1-percent limits	For a taxpayer under age 65 medical expenses are deductible only to the extent they exceed 3 percent of his adjusted gross income. Expenses for medicines and drugs are included in medical expenses (subject to the 3-percent limit) but only to the extent that these expenses exceed 1 percent of the taxpayer's adjusted gross income. Neither of these limits apply, however, if the taxpayer or his spouse is age 65 or over, nor do they apply with respect to a dependent parent (of the taxpayer or his spouse) who is 65 or over. Their medical expenses and the cost of drugs and medicines for them are immediately deductible.	Limits the deduction for medical expenses for taxpayers (or dependent parents) who are age 65 or over to amounts in excess of 3 percent of adjusted gross income and limits the amount of medicine and drug expenses which may be included in medical expenses (subject to the 3-percent limit) to costs in excess of 1 percent of adjusted gross income. (Conforms the treatment of those age 65 or over with the rules presently applicable to taxpayers and dependents under age 65.)
III. Medical care insurance premiums:		
A. Deduction	Premiums for "accident or health insurance" treated as a medical expense subject to the 3-percent limit (described in II above) in the case of taxpayers under age 65, or deductible immediately if taxpayer or his spouse (or a dependent parent) is 65 or over.	Premiums for "insurance which constitute medical care" are deductible as follows: (1) One-half of such premiums, but not more than $250 per year is deductible immediately, and (2) The remaining one-half is included in medical care expenses subject to the 3-percent floor.
B. Definition	The term "medical care" is defined to include amounts paid for "accident or health insurance." Although the Internal Revenue Service position is that premiums are treated as medical expenses only to the extent they relate to medical benefits, some courts have interpreted "accident or health insurance" more broadly to include in the premium amounts paid to provide indemnity for loss of life, limb, sight, or time.	The definition of "medical care" is narrowed to prevent the deduction of premiums for insurance not related to medical benefits. If the policy provides both medical and nonmedical benefits only the portion of the premium separately stated to be for medical benefits is allowable, and then only if the amount is reasonable. It is made certain that the $3 per month premium for Supplementary Health Insurance Benefits for the Aged under part B of new title XVIII is allowable as a medical care expense. It is also made clear that premiums for prepaid medical benefits to become effective at age 65 (payable on a level premium basis) are treated as medical care expenses if the period of prepayment covers at least 10 years (5 years if the taxpayer becomes age 65 during the period of prepayment).
IV. Overall limit in case of disabled taxpayers.	Deductions for medical expenses may not exceed $10,000 if the taxpayer is single or if he files a separate return. On a joint return (or return of a head of household or surviving spouse) the deduction may not exceed $20,000. But if the taxpayer or his spouse is both (a) age 65 or over, and (b) disabled, these limits are doubled to $20,000 if one spouse qualifies and $40,000 if both qualify.	The overall limit on deductions of medical care expenses is doubled in the case of disabled taxpayers (and their disabled wives), without regard to the fact that they may not have attained age 65—$20,000 if one is disabled and $40,000 if both are disabled. (Conforms the treatment of disabled taxpayers [and wives] who are under age 65 with the rules presently available for those who are 65 or over.)

V. Revenue impact		Applying the 3-percent and 1-percent limits to those age 65 or over increases revenues by about $170 million. On the other hand, the broader deduction for medical insurance premiums reduces revenues by about $88 million. The net effect of the changes is to increase revenues by about $82 million.
VI. Effective date		Taxable years beginning after December 31, 1966.