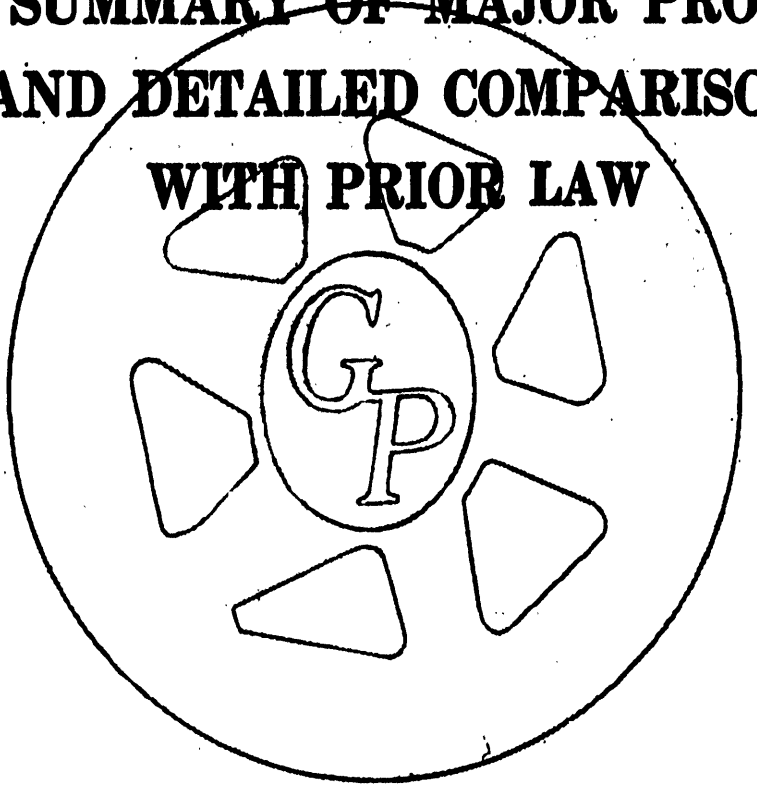
COMMITTEE ON FINANCE
UNITED STATES SENATE
Harry Flood Byrd, *Chairman*

THE SOCIAL SECURITY AMENDMENTS OF 1965—PUBLIC LAW 97, 89th CONGRESS BRIEF SUMMARY OF MAJOR PROVISIONS AND DETAILED COMPARISON WITH PRIOR LAW



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BRIEF SUMMARY OF THE SOCIAL SECURITY AMENDMENTS OF 1965

A. Health Insurance and Medical Care

The legislation 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 are financed through a separate payroll tax and separate trust fund, except that the benefits for railroad retirement eligibles will be financed through their payroll tax system, if certain financing conditions are met.

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

Effective date.—Benefits are first effective on July 1, 1966, except for skilled nursing services in extended care facilities which are effective on January 1, 1967. (See pp. 17–20.)

2. *A voluntary supplementary medical insurance plan* providing physicians' and other medical and health services financed through monthly premiums of $3 initially by individuals 65 years or older matched equally by Federal general revenue contributions.

Effective date.—Benefits are first effective July 1, 1966. (See pp. 20–22.)

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

Effective date.—Matching under new title (XIX) will be available January 1, 1966. (See pp. 22–30.)

B. Child Health and Welfare Amendments

1. Maternal and child health, crippled children, and child welfare authorization

The amount authorized for the maternal and child health and crippled children's programs over current authorizations will be increased by $5 million for each program for fiscal 1966 and by $10 million in each succeeding fiscal year as follows:

Fiscal year	Prior law	Under new law
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. 40–41.)

The somewhat different authorizations for child welfare services under prior law are revised to bring them in line with those for the other two programs, so that authorizations for all three programs are identical.

2. Training personnel for the health care of crippled children

Grants are provided to institutions of higher learning for training professional personnel for health and related care for crippled children, particularly children who are mentally retarded or have multiple handicaps. Authorizes $5 million for fiscal 1967, $10 million for fiscal 1968, and $17.5 million for each succeeding fiscal year. (See p. 41.)

3. Health care for needy children

The Secretary of Health, Education, and Welfare is authorized to carry out a 5-year program of special project grants to provide comprehensive health care and services for preschool or school-age children, particularly in areas with concentrations of low-income families. An appropriation of $15 million is authorized for fiscal 1966; $35 million for fiscal 1967, and an additional $5 million for each succeeding year rising to $50 million for fiscal 1970. An authorization of $500,000 for fiscal 1966 and 1967 is made for grants to study the prevention, diagnosis, and treatment of emotionally disturbed children. (See p. 44–45.)

4. Mental retardation planning

Grants totaling $2,750,000 for each of 2 fiscal years (1966 and 1967) are authorized for the purpose of assisting States to implement and follow up on planning for treatment of mental retardation authorized under section 1701 of the Social Security Act. (See p. 45.)

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 combined program in title XVI) to provide a Federal share of $31 out of the first $37 (formerly $29 out of the first $35) with matching above this amount varying according to State per capita income up to a maximum of $75 (formerly $70) per month per individual on an average basis. The law revises matching formula for aid to families with dependent children so as to provide a Federal share of five-sixths of the first $18 (formerly fourteen-seventeenths of the first $17) with matching above this amount varying according to State per capita income up to a maximum of $32 (formerly $30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients. Effective January 1, 1966. (See pp. 32–34.)

2. Tubercular and mental patients

The exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) is removed as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. As a condition of Federal participation in such payments to, or for, mental patients it is required that certain agreements and arrangements assure that better care results from the additional Federal money. States will receive no more in Federal funds under this provision than they increase their expenditures for mental health purposes under public health and public welfare programs. Also restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions are removed. Effective January 1, 1966. (See pp. 35–37.)

3. Protective payments

A provision is added for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined title XVI program),

recipients of aid to the blind, and recipients of aid to the permanently and totally disabled unable to manage their money because of physical or mental incapacity. Effective January 1, 1966. (See pp. 37.)

4. Aid to families with dependent children in school

The optional provision in present law allowing States to continue making payments to dependent children up to age 21 if they are in regular attendance at a high school or vocational school is extended to include attendance at a school, college or university. (See p. 39.)

5. Income exemptions under public assistance

The following income exemptions are provided:

(a) *Old-age assistance.*—The earnings exemption under the old-age assistance program (and aged in combined program) is increased so that a State may, at its option, exempt the first $20 (formerly $10) and one-half of the next $60 (formerly $40) of a recipient's monthly earnings. Effective October 1, 1965. (See p. 35.)

(b) *Aid to families with dependent children.*—At their option, States are allowed to disregard up to $50 per month of earned income of any dependent child under the age of 18 but not more than $150 of earnings may be exempted in the same home. Effective July 1, 1965. (See p. 35.)

(c) *Aid to the permanently and totally disabled.*—States, at their option, may exempt earnings of recipients of aid to the permanently and totally disabled. As in the case of the aged, the first $20 per month of earnings and one-half of the next $60 could be exempted. In addition, any additional income and resources could be exempted as part of an approved plan to achieve self-support during the time the recipient was undergoing vocational rehabilitation. Effective October 1, 1965. (See p. 35.)

(d) *Income exemption for all public assistance programs.*—States, at their option, may disregard not more than $5 per month per recipient of any income in all five public assistance programs. Effective October 1, 1965. (See p. 35.)

(e) *Old-age and survivors insurance (retroactive increase).*—States at their option, may disregard so much of the OASDI benefit increase (including the children in school after age 18 modification) as is attributable to its retroactive effective date. (See p. 35.)

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

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

6. Definition of medical assistance for aged

The definition of medical assistance for the aged is modified so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution. (See p. 37.)

7. Judicial review of State plan denials

The law provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans and of his action under such programs for noncompliance with conditions in the Federal law. (See pp. 38–39.)

8. Uniform matching

The new law permits a State that has a medical assistance program under title XIX to claim Federal sharing in total expenditures for money payments under other titles, under the same formula used for determining the Federal share for medical assistance under title XIX. (See p. 34.)

D. Old-Age, Survivors, and Disability Insurance

1. BENEFIT CHANGES

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

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

Monthly benefits for workers who retire at or after 65 are increased to a new minimum of $44 (formerly $40) and to a new maximum of $135.90 (formerly $127) on average earnings up to $4,800. In the future, creditable earnings under the increase in the contribution and benefit base to $6,600 a year would make possible a maximum benefit of $168.

The maximum amount of benefits payable to a family on the basis of a single earnings record will be related to the worker's average monthly earnings at all earnings levels. Under prior law, there was a $254 limit on family benefits which operated over a wide range of average monthly earnings. Under the legislation the highest family maximum would be $368. (See p. 62.)

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

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

This provision is effective retroactively to January 1, 1965. It is estimated that 295,000 children will be eligible for benefits for September 1965, when the school year begins. (See pp. 57–58.)

(c) Benefits for widows at age 60

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

This provision is effective beginning with monthly benefits payable for September 1965. It is estimated that 185,000 widows will claim benefits during the first year of operation. (See p. 57.)

(d) Amendment of disability program

(i) Definition of disability.—The requirement that a worker's disability must be expected to be of long continued and indefinite duration is eliminated and instead an insured worker will be eligible for disability benefits if he has been under a disability which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 calendar months. Benefits payable by reason of this change will be paid beginning with benefits for September 1965. An estimated 60,000 persons—disabled workers and their dependents—become immediately eligible for benefits as a result of this change. (See p. 55.)

(ii) Disability benefits offset provision.—The social security disability benefit for any month for which a worker is receiving a workmen's compensation benefit will be reduced to the extent that the total benefits payable to him and his dependents under both programs exceed 80 percent of his average monthly earnings covered by social security prior to the onset of disability, but with the reduction periodically adjusted to take account of changes in national average earnings levels. The offset provision will be applicable with respect to benefits payable for months after December 1965 based on disabilities commencing after June 1, 1965. (See p. 56.)

(*iii*) *Blindness as a disabling factor.*—(a) Young workers who are blind and disabled: Establishes alternative insured status requirement for workers disabled before age 31 of one-half of the quarters elapsing after age 21 up to the point of disability (with a minimum of six quarters), or, in the case of individuals disabled before age 24, at least one-half of the quarters in the 3-year period ending with the onset of the disability. To qualify for this alternative the worker will have to meet the statutory definition of blindness for the disability "freeze." Workers will, however, have to meet the other regular requirements for entitlement to disability benefits, including inability to engage in any substantial gainful activity.

(b) Older workers who are blind and disabled: Provides that those individuals age 55 or over who meet the statutory definition of blindness for the disability "freeze" could qualify for cash benefits on the basis of their inability to engage in their past occupation or occupations. However, their benefits will not be paid for any month in which they are actually engaging in any substantial gainful activity. (See p. 55.)

(*iv*) *Rehabilitation services.*—State vocational rehabilitation agencies will be reimbursed from the social security trust funds for the cost of rehabilitation services furnished to individuals who are entitled to disability insurance benefits or to a disabled child's benefits. The total amount of the funds that could be made available from the trust funds for purposes of reimbursing State agencies for such services cannot, in any year, exceed 1 percent of the social security disability benefits paid in the previous year. (See p. 56.)

(*v*) *Entitlement to disability benefits after entitlement to benefits payable on account of age.*—A person who becomes entitled before age 65 to a benefit payable on account of old age could later, before he reaches age 65, become entitled to disability insurance benefits. (See p. 55.)

(*vi*) *Allocation of contribution income between OASI and DI trust funds.*—An additional 0.20 percent of taxable wages and 0.15 percent of taxable self-employment income is allocated to the disability insurance trust fund, bringing the total allocation to 0.70 percent and 0.525 percent, respectively, beginning in 1966.

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

Eligibility requirements are liberalized by providing a basic benefit of $35 at age 72 or over to certain persons with as few as three quarters of coverage acquired at any time since the beginning of the program in 1937. To accomplish this, a new concept of "transitional insured status" is provided. Prior law required a minimum of six quarters of coverage.

Effective for monthly benefits for September 1965, at which time an estimated 355,000 people will be able to start receiving benefits. (See p. 64.)

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

Payments of wife's or widow's benefits are authorized to the divorced wife of a retired, deceased, or disabled worker if she had been married to the worker for at least 20 years before the date of the divorce and if her divorced husband was making (or was obligated by a court to make) a substantial contribution to her support when he became entitled to benefits, became disabled, or died. The legislation also provides that a wife's benefits will not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years. Provision is also made for the reestablishment of benefit rights for a divorced wife, a widow, a surviving divorced wife, or a surviving divorced mother who remarries and the subsequent marriage ends in divorce, annulment, or in the death of the husband.

Effective in September 1965. (See p. 59.)

(*f*) *Retirement test*

The amendments liberalize the retirement test so that a beneficiary under age 72 may have annual earnings of $1,500 (instead of $1,200 as in prior law) and still get full benefits for the year. If a beneficiary earnings exceed $1,500 for a year, $1 in benefits is withheld for each $2 of annual earnings between $1,500 and $2,700 and for each $1 of earnings thereafter (under prior law the $1 for $2 adjustment applied to annual earnings between $1,200 and $1,700).

A beneficiary will nevertheless get full benefits, regardless of his annual earnings, for any month in which he earns wages of $125 or less (rather than $100 as in prior law), and does not render substantial services in self-employment. These changes are effective for taxable years ending after 1965.

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

For 1966, an estimated 750,000 persons—workers and their dependents or survivors—either will get more benefits under the new law than they would have gotten under prior law, or will get some benefits where they would have gotten no benefits under prior law. (See p. 65).

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

Under prior law, a widow's and widower's benefits based on a deceased worker's social security earnings record generally terminated when the survivor remarried. The new legislation provides that benefits would be payable to widows age 60 or over and to widowers age 62 or over who remarry. The amount of the remarried widow's or widower's benefit will be equal to 50 percent of the primary insurance amount of the deceased spouse rather than 82½ percent of that amount, which is payable to widows and widowers who are not remarried. (See p. 59.)

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

The provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries are changed to require that, where the child is adopted after the worker becomes entitled to an old-age benefit, (1) the child must be living with the worker in the month when application for old-age benefits is filed or adoption proceedings have begun in or before that month; (2) the child must be receiving one-half of his support from the worker for the entire year before the worker's entitlement; and (3) the adoption must be completed within 2 years after the worker's application for benefits. (See p.58.)

(*j*) *Definition of child*

(i) A child will be paid benefits based on his father's earnings without regard to whether he has the status of a child under State inheritance laws if the father was supporting the child or had a legal obligation to do so. Under prior law, whether a child met the definition for the purpose of getting child's insurance benefits based on his father's earnings depended on the laws applied in determining the devolution of intestate personal property in the State in which the worker was domiciled. It is estimated that 20,000 individuals (children and their mothers) became immediately eligible for benefits under this provision. (See p. 58.)

(ii) Also an exception is provided so that child's benefits will not terminate if child is adopted by his brother or sister after the death of the worker on whose earnings record he is getting benefits. Under prior law benefits terminated upon adoption unless he was adopted by his stepparent, grandparent, uncle, or aunt. (See p. 59.)

2. COVERAGE CHANGES

The following coverage provisions were included:

(*a*) *Physicians and interns*

Self-employed physicians are covered for taxable years ending on or after December 31, 1965. Interns are covered beginning on January 1, 1966, on the same basis as other employees working for the same employer. (See pp. 46 and 53.)

(*b*) *Farmers*

Under the new law, farm operators whose annual gross earnings are $2,400 or less will be permitted to report either their actual net earnings or 66⅔ percent of their gross earnings, for taxable years beginning after December 31, 1965.

Farmers whose annual gross earnings are over $2,400 will be required to report their actual net earnings if $1,600 or more but if actual net earnings are less than $1,600, they will be permitted to report either their actual net earnings or $1,600. (See p. 46.)

(c) Cash tips

Cash tips received after 1965 by an employee in the course of his employment are covered as wages for social security and income-tax withholding purposes, except that employers are not required to pay the social security employer tax. The employee is required to give his employer a written report of his tips within 10 days after the end of the month in which the tips are received. To the extent that the employer does not have sufficient wage payments (or funds turned over to him by the employee) to offset the required withholding, he notifies the employee and the employee reports this amount to the Government directly. (See p. 48.)

(d) State and local government employees

Several changes would facilitate social security coverage of additional employees of State and local governments. (See pp. 49–51.)

(e) Exemption of certain religious sects

Members of certain religious sects who have conscientious objections to insurance (including social security) by reason of their adherence to the established tenets or teachings of such sects could be exempt from the social security tax on self-employment income upon application accompanied by a waiver of benefit rights. (See p. 46.)

(f) Nonprofit organizations

Nonprofit organizations, and their employees who concur, may elect social security coverage effective retroactively for a period up to 5 years (rather than 1 year, as under prior law). Also, wage credit may be given for the earnings of certain employees of nonprofit organizations who were erroneously reported for social security purposes. (See pp. 51–52.)

(g) District of Columbia employees

The legislation provides for social security coverage of certain employees of the District of Columbia (primarily substitute schoolteachers). (See p. 52.)

(h) Ministers

The dead line for electing social security coverage by ministers who have been in the ministry at least 2 years since 1954 is extended 2 years. Also, social security credit may be obtained for the earnings of certain ministers, which were reported but which cannot be credited under prior law. (See p. 46.)

3. MISCELLANEOUS

(a) Filing of proof

The period of filing of proof of support for dependent husband's, widower's, and parent's benefits, and for filing application for lump-sum death payments where good cause exists for failure to file within the initial 2-year period, is extended indefinitely. (See p. 60.)

(b) Automatic recomputation of benefits

The benefits of people on the rolls will be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year and that would increase his benefit amount. Under prior law there are various requirements that must be met in order to have benefits recomputed, including filing of an application and earnings of over $1,200 a year after entitlement. (See p. 61.)

(c) Military wage credits

The provision authorizing reimbursement of the trust funds out of general revenue for gratuitous social security wage credits for servicemen is revised so that such payments will be spread over the next 50 years. (See p. 65.)

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

The new law liberalizes the requirement that an application for monthly insurance benefits be valid for only 3 months after the date of filing, and for disability benefits 3 months before the beginning of the waiting period. The new law allows an application to remain valid up until the time the Secretary makes a final decision on the application. (See p. 56.)

(*e*) *Underpayments*

The new law provides specific authority, lacking in prior law, for the Secretary to settle certain underpayments of benefits. (See p. 66.)

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

The Secretary of the Treasury would be authorized, under a new provision, to issue regulations so as to permit a surviving spouse (or other surviving payee) to cash a benefit check issued jointly to a husband and wife if one of them dies before the check is negotiated; any overpayment resulting from the cashing of the joint check would be recovered. (See p. 66.)

(*g*) *Social security records—Deserting parents*

The new law provides that, under certain specified conditions, the address of a deserting parent of a child applying for or receiving public assistance may be given to a welfare agency or a court through a welfare agency. (See p. 66.)

(*h*) *Attorney's fees*

A provision is incorporated which permits a court that renders a judgment favorable to a claimant in an action arising under the social security program to set a reasonable fee (not in excess of 25 percent of past due benefits which become payable by reason of the judgment) for an attorney who successfully represented the claimant. The Secretary is permitted to certify payment of the fee to the attorney out of such past due benefits. (See p. 66.)

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

The legislation provides an exception to the 1-year duration of marriage requirement for social security benefits for any widow, wife, husband, or widower who was, in the month before marriage, actually or potentially entitled to railroad retirement benefits as a widow, widower, parent, or disabled adult child. (See pp. 59–60.)

E. Scope, Costs and Financing

1. HEALTH INSURANCE AND MEDICAL CARE FOR THE NEEDY

The *scope* of the protection provided is broadly as follows:

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

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

Medical assistance for needy.—The expanded medical assistance (Kerr-Mills) program is estimated to provide new or increased medical assistance

to about 8 million needy persons during an early year of operation. States could, in the future, provide aid to as many as twice this number who need help with medical costs.

The *costs and financing* are as follows:

Basic plan.—Benefits and administrative expenses under the basic plan would be about $1 billion for the 6-month period in 1966 and about $2.3 billion in 1967. Contribution income for those years would be about $1.6 and $2.8 billion, respectively. The costs for the uninsured (paid from general funds) would be about $280 million for the first full year.

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
Total	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.

The tax rate, base, and tax amount for future years is shown in the following table:

TABLE 1.—*Tax rate, tax base, and tax amount applicable to employers, employees, and self-employed persons under the basic hospital insurance program of the Social Security Amendments of 1965 (Public Law 89–97), 1965–87 and after*

Year	Tax on employer, employee, and self-employed (each)		
	Tax rate (percent)	Tax base	Tax amount [1]
1965			
1966	0.35	$6,600	$23.10
1967	.50	6,600	33.00
1968	.50	6,600	33.00
1969–72	.50	6,600	33.00
1973–75	.55	6,600	36.30
1976–79	.60	6,600	39.60
1980–86	.70	6,600	46.20
1987 and after	.80	6,600	52.80

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

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

The following table shows the estimated progress of the Hospital Insurance Trust Fund.

TABLE 2.—*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 [1]
1966	$1,637	$987	[2] $50	$18	[3] $618
1967	2,756	2,210	66	25	1,123
1968	3,018	2,406	72	46	1,709
1969	3,123	2,623	79	66	2,196
1970	3,229	2,860	86	82	2,561
1971	3,329	3,077	92	91	2,812
1972	3,433	3,303	99	95	2,938
1973	3,891	3,540	106	100	3,283
1974	4,096	3,788	114	108	3,585
1975	4,260	4,047	121	112	3,789
1980	6,113	5,307	159	166	5,790
1985	7,026	6,860	206	259	8,341
1990	9,015	8,797	264	323	10,426

[1] An interest rate of 3.50 percent is used in determining the level-costs, but in developing the progress of the trust fund, a higher rate is used in the 1st 10 years (4.0 percent for 1966–70, and then a gradually decreasing rate).

[2] Includes administrative expenses incurred in 1965.

[3] Balance as of June 30, 1965 (before payment of benefits begins), is $715,000,000.

NOTE.—The transactions relating to the noninsured persons who would be covered for the benefits of this program, the cost for whom is borne out of the general funds of the Treasury, are not shown in the above figures.

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

[In millions]

Calendar year:	*Cost to General Treasury*
1966 (last 6 months)	$140
1967	278
1968	272
1969	264
1970	256

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

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 $895 to $1,065 million in 1967. Premium income from enrollees for 1967 would be about $560 million. 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 $1,060 to $1,260 million in 1967. Premium income from enrollees for 1967 would be about $665 million. The Government contribution would equal the premiums.

The following table shows the estimated progress of the Medical Insurance Trust Fund:

TABLE 3.—*Estimated progress of Supplementary Medical Insurance Trust Fun*

[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	$220	$65	$5	$270
1967	560	560	895	75	15	435
	Low-cost estimate, 95-percent participation					
1966 [1]	$325	$325	$260	$80	$5	$315
1967	665	665	1,060	90	15	510
	High-cost estimate, 80-percent participation					
1966 [1]	$275	$275	$345	$85	$5	$125
1967	560	560	1,065	95	5	90
	High-cost estimate, 95-percent participation					
1966 [1]	$325	$325	$410	$100	$5	$145
1967	665	665	1,260	110	5	110

[1] Administrative expenses shown include those incurred in 1965 and 1966.

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

Kerr-Mills medical assistance plan extension.—It is estimated that the new program will increase the Federal Government's general revenue contribution about $240 million in a full year of operation over that in the programs currently operating.

2. OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

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

TABLE 4.—*Costs of and persons affected by OASDI amendments*

Provision	1st year costs	Percent of payroll (long-range)	Persons affected
7-percent benefit increase ($4 minimum in primary benefit)	$1,470,000,000	0.64	20,000,000
Child's benefit to age 22 if in school	195,000,000	.12	295,000
Reduced age for widows	165,000,000	.00	185,000
Reduction in eligibility requirement for certain persons aged 72 or over	140,000,000	.01	355,000
Liberalization of disability definition	45,000,000	.01	67,000
Earnings test liberalization	295,000,000	.14	750,000
Broader definition of child	10,000,000	.01	20,000

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

TABLE 5.—*Progress of Old-Age and Survivors Insurance Trust Fund*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [2]	Interest on fund [1]	Balance in fund at end of year [3]
	Actual data					
1951	$3,367	$1,885	$81	----------	$417	$15,540
1952	3,819	2,194	88	----------	365	17,442
1953	3,945	3,006	88	----------	414	18,707
1954	5,163	3,670	92	−$21	447	20,576
1955	5,713	4,968	119	−7	454	21,663
1956	6,172	5,715	132	−5	526	22,519
1957	6,825	7,347	[4] 162	−2	556	22,393
1958	7,566	8,327	[4] 194	124	552	21,864
1959	8,052	9,842	184	282	532	20,141
1960	10,866	10,677	203	318	516	20,324
1961	11,285	11,862	239	332	548	19,725
1962	12,059	13,356	256	361	526	18,337
1963	14,541	14,217	281	423	521	18,480
1964	15,689	14,914	296	403	569	19,125
	Estimated data (short-range estimate)					
1965	$16,014	$16,986	$351	$436	$570	$17,936
1966	18,848	18,520	377	445	546	17,988
1967	20,687	19,512	363	524	580	18,856
1968	21,568	20,334	369	474	634	19,881
1969	24,958	21,213	377	487	733	23,495
1970	26,328	22,101	385	478	900	27,759
1971	27,163	23,001	393	455	1,082	32,155
1972	28,041	23,908	401	454	1,271	36,704
	Estimated data (long-range estimate)					
1975	$28,818	$24,848	$390	$313	$1,212	$40,044
1980	31,105	28,828	431	130	1,895	59,891
1990	35,600	36,629	510	−23	2,689	82,433
2000	41,293	40,926	559	−77	3,287	101,233
2025	51,238	62,118	769	−107	4,476	132,792

[1] An interest rate of 3.50 percent is used in determining the level-costs, but in developing the progress of the trust fund a varying rate in the early years has been used, which is equivalent to such fixed rate.

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

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

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

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

TABLE 6.—*Progress of Disability Insurance Trust Fund* [1]

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange [2]	Interest on fund [1]	Balance in fund at end of year]
	Actual data					
1957	$702	$57	[3] $3	----------	$7	$649
1958	966	249	[3] 12	----------	25	1,379
1959	891	457	50	−$22	40	1,825
1960	1,010	568	36	−5	53	2,289
1961	1,038	887	64	5	66	2,437
1962	1,046	1,105	66	11	68	2,368
1963	1,099	1,210	68	20	66	2,235
1964	1,154	1,309	79	19	64	2,047
	Estimated data (short-range estimate)					
1965	$1,187	$1,600	$85	$24	$51	$1,576
1966	1,821	1,734	102	25	49	1,585
1967	2,048	1,827	108	29	52	1,721
1968	2,132	1,898	112	21	58	1,880
1969	2,207	1,960	115	24	64	2,052
1970	2,282	2,013	119	26	70	2,246
1971	2,356	2,065	122	29	78	2,464
1972	2,433	2,113	125	32	87	2,714
	Estimated data (long-range estimate)					
1975	$2,247	$2,022	$103	−$3	$121	$3,834
1980	2,425	2,211	106	−11	166	5,177
1990	2,776	2,472	107	−13	291	8,965
2000	3,220	2,907	120	−13	509	15,443
2025	3,996	3,970	156	−13	1,113	33,264

[1] An interest rate of 3.50 percent is used in determining the level-costs, but in developing the progress of the trust fund a varying rate in the early years has been used, which is equivalent to such fixed rate.

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

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

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

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

The tax rate schedule under prior law and the revised schedule under the new legislation for the OASDI program is shown by the two tables which follow:

TABLE 7.—*Tax rate, tax base, and tax amount applicable to employers and employees (each) under the Social Security Amendments of 1965 (Public Law 89–97) and under prior law, old-age, survivors, and disability insurance program, 1965–87 and after*

Year	Tax rate employer and employee (each)		Tax base		Tax per employee with base wage under Public Law 89–97 [1]			
					Amount of tax		Increase under Public Law 89–97	
	Under prior law	Under Public Law 89–97	Under prior law	Under Public Law 89–97	Under prior law	Under Public Law 89–97	Over prior law	Over 1965
	Percent	*Percent*						
1965	3.625	3.625	$4,800	$4,800	$174	$174.00	----	----
1966	4.125	3.850	4,800	6,600	198	254.10	$56.10	$80.10
1967	4.125	3.900	4,800	6,600	198	257.40	59.40	83.40
1968	4.625	3.900	4,800	6,600	222	257.40	35.40	83.40
1969–72	4.625	4.400	4,800	6,600	222	290.40	68.40	116.40
1973–75	4.625	4.850	4,800	6,600	222	320.10	98.10	146.10
1976–79	4.625	4.850	4,800	6,600	222	320.10	98.10	146.10
1980–86	4.625	4.850	4,800	6,600	222	320.10	98.10	146.10
1987 and after	4.625	4.850	4,800	6,600	222	320.10	98.10	146.10

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

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

TABLE 8.—*Tax rate, tax base, and tax amount applicable to self-employed persons under the Social Security Amendments of 1965 (Public Law 89–97) and under prior law, old-age, survivors, and disability insurance program, 1965–87 and after*

Year	Tax rate		Tax base		Tax per self-employed with base earnings under Public Law 89–97			
					Amount of tax		Increase under Public Law 89–97	
	Under prior law	Under Public Law 89–97	Under prior law	Under Public Law 89–97	Under prior law	Under Public Law 89–97	Over prior law	Over 1965
	Percent	*Percent*						
1965	5.4	5.4	$4,800	$4,800	$259.20	$259.20	----	----
1966	6.2	5.8	4,800	6,600	297.60	382.80	$85.20	$123.60
1967	6.2	5.9	4,800	6,600	297.60	389.40	91.80	130.20
1968	6.9	5.9	4,800	6,600	331.20	389.40	58.20	130.20
1969–72	6.9	6.6	4,800	6,600	331.20	435.60	104.40	176.40
1973–75	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1976–79	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1980–86	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1987 and after	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80

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

8. HOSPITAL INSURANCE AND OLD-AGE, DISABILITY, AND SURVIVORS INSURANCE (COMBINED)

The following three tables show the aggregate taxes, the combined tax rates, and combined tax on employer and employee under the two programs:

TABLE 9.—*Estimated aggregate taxes on employers, employees, and self-employed persons under the Social Security Amendments of 1965 (Public Law 89-97) and under prior law, old-age, survivors, and disability insurance program, 1965-72, 1975, 1980, 1985, 1990, 2000, and 2025, and basic hospital insurance program, 1965-75, 1980, 1985, and 1990*

[In billions]

Year	Prior law			Public Law 89-97			
	Old-age and survivors insurance program	Disability insurance program	Total	Old-age and survivors insurance program	Disability insurance program	Basic hospital insurance program	Total
1965	$16.0	$1.2	$17.2	$16.0	$1.2	----------	$17.2
1966	18.5	1.2	19.7	18.8	1.8	$1.6	22.2
1967	19.4	1.3	20.7	20.7	2.0	2.8	25.5
1968	22.2	1.3	23.5	21.6	2.1	3.0	26.7
1969	23.3	1.3	24.6	25.0	2.2	3.1	30.3
1970	24.0	1.4	25.4	26.3	2.3	3.2	31.8
1971	24.6	1.4	26.0	27.2	2.4	3.3	32.9
1972	25.2	1.4	26.6	28.0	2.4	3.4	33.8
1973	(1)	(1)	(1)	(1)	(1)	3.9	(1)
1974	(1)	(1)	(1)	(1)	(1)	4.1	(1)
1975	[2] 24.6	[2] 1.4	[2] 26.0	[2] 28.8	[2] 2.2	4.3	[3]
1980	[2] 26.5	[2] 1.5	[2] 28.0	[2] 31.1	[2] 2.4	6.1	[3]
1985	[2] 28.3	[2] 1.6	[2] 29.9	[2] 33.2	[2] 2.6	7.0	[3]
1990	[2] 30.3	[2] 1.7	[2] 32.0	[2] 35.6	[2] 2.8	9.0	[3]
2000	[2] 35.2	[2] 2.0	[2] 37.2	[2] 41.3	[2] 3.2	(1)	(1)
2025	[2] 43.7	[2] 2.5	[2] 46.2	[2] 51.2	[2] 4.0	(1)	(1)

[1] Not available.

[2] These are long-range estimates which assume level-earnings trends in the future; all other estimates are short-range estimates which assume increased earnings from year to year.

[3] Since the constituents of these totals represent long-range and short-range estimates they are not combined here.

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

TABLE 10.—*Combined tax rate on employer and employee under the Social Security Amendments of 1965 (Public Law 89–97) and under prior law, old-age, survivors, and disability insurance program and basic hospital insurance program, 1965–87 and after*

[In percent]

Year	Combined tax rate on employer and employee							
	Old-age, survivors, and disability insurance program		Basic hospital insurance program		Old-age, survivors, and disability insurance program and basic hospital insurance program			
							Change under Public Law 89–97	
	Under prior law	Under Public Law 89–97	Under prior law	Under Public Law 89–97	Under prior law	Under Public Law 89–97	Over prior law	Over 1965
1965	7.25	7.25	----	----	7.25	7.25	----	----
1966	8.25	7.70	----	0.70	8.25	8.40	+0.15	+1.15
1967	8.25	7.80	----	1.00	8.25	8.80	+.55	+1.55
1968	9.25	7.80	----	1.00	9.25	8.80	−.45	+1.55
1969–72	9.25	8.80	----	1.00	9.25	9.80	+.55	+2.55
1973–75	9.25	9.70	----	1.10	9.25	10.80	+1.55	+3.55
1976–79	9.25	9.70	----	1.20	9.25	10.90	+1.65	+3.65
1980–86	9.25	9.70	----	1.40	9.25	11.10	+1.85	+3.85
1987 and after	9.25	9.70	----	1.60	9.25	11.30	+2.05	+4.05

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

TABLE 11.—*Combined tax on employer and employee*[1] *under the Social Security Amendments of 1965 (Public Law 89–97) and under prior law, old-age, survivors, and disability insurance program and basic hospital insurance program, 1965–87 and after*

Year	Combined tax on employer and employee							
	Old-age, survivors, and disability insurance program		Basic hospital insurance program		Old-age, survivors, and disability insurance program and basic hospital insurance program			
							Increase under Public Law 89–97	
	Under prior law	Under Public Law 89–97	Under prior law	Under Public Law 89–97	Under prior law	Under Public Law 89–97	Over prior law	Over 1965
1965	$348	$348.00	----	----	$348	$348.00	----	----
1966	396	508.20	----	$46.20	396	554.40	$158.40	$206.40
1967	396	514.80	----	66.00	396	580.80	184.80	232.80
1968	444	514.80	----	66.00	444	580.80	136.80	232.80
1969–72	444	580.80	----	66.00	444	646.80	202.80	298.80
1973–75	444	640.20	----	72.60	444	712.80	268.80	364.80
1976–79	444	640.20	----	79.20	444	719.40	275.40	371.40
1980–86	444	640.20	----	92.40	444	732.60	288.60	384.60
1987 and after	444	640.20	----	105.60	444	745.80	301.80	397.80

[1] For employee with wage equal to or in excess of the tax base under Public Law 89–97.

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

4. PUBLIC ASSISTANCE, CHILD HEALTH AND CHILD WELFARE

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

TABLE 12.—*Cost of public assistance and child health and welfare amendment*

[In millions of dollars]

Costs	Fiscal year 1966	Annual rate
Maternal and child health, crippled children, child welfare, and special project grants, studies	30.5	75.0
Mental retardation projects	2.75	2.75
Mental and tuberculosis	38.0	75.0
Medical assistance for the aged definition	2.0	2.0
Formula changes	75.0	150.0
Protective payments	(1)	(1)
Income exemption (old-age assistance)	.5	1.0
Income exemption (aid to families with dependent children)	1.3	4.0
Income exemption (aid to the permanently and totally disabled)	1.0	2.5
Total	151.05	312.25

[1] No cost.

HEALTH INSURANCE AND MEDICAL CARE FOR THE AGED

A. BASIC PLAN—HOSPITAL INSURANCE

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

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

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

Included under the special provision will be almost all uninsured people who will have reached 65 before 1968. Persons reaching 65 after 1967 will have to have the quarters of coverage that are indicated in the following table:

TABLE 13.—*Quarters of coverage required for OASI cash benefits as compared to hospital insurance*

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

[1] Same as OASI.

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

The major group excluded under the transitional provision will be individuals afforded protection under the provisions of the Federal Employees' Health Benefits Act (FEHBA). Federal employees who retired before February 16, 1965, and who did not have coverage under FEHBA on that date will be covered under the transitional provision for the uninsured. Also included will be those Federal employees retiring after that date who cannot retain their FEHBA coverage after retiring. Excluded are aliens (unless they have been admitted for permanent residence and have been residents of the United States for 5 years) and certain people convicted of subversive crimes.

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

(*a*) inpatient hospital services for up to 90 days in each spell of illness. The patient pays a deductible amount of $40 for the first 60 days plus $10 a day for 30 days in excess of 60 for each spell of illness; hospital services include all those ordinarily furnished by a hospital to its inpatients; however, payment will not be made for private duty nursing or for the hospital services of physicians *except* services provided by medical or dental interns or residents in training under approved teaching programs. Inpatient psychiatric hospital service will also be included, but a lifetime limitation of 190 days is imposed.

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

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

(*d*) posthospital home health services for up to 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 estab-

lished by a physician within 14 days of discharge calling for such services. The covered services include intermittent nursing care, therapy, and, to the extent provided in regulations, the part-time services of a home health aide. For the services to be covered, the patient must be homebound, except that when certain equipment is used, the individual may be taken to a hospital or extended care facility or rehabilitation center to receive some of these covered home health services in order to utilize the necessary equipment. All those services are covered only if they are provided through a qualified home health agency.

Special provision is made for Christian Scientists who will have coverage of Christian Science sanatorium services for up to 60 days with $40 deductible plus 30 additional days at $10 coinsurance per day, as hospital service; plus an additional 30 days in a Christian Science sanatorium as extended care facility services with the $5 per day coinsurance feature.

No service will 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 will be considered to begin when the individual enters a hospital or extended care facility and to end when he has not been an inpatient of a hospital or extended care facility for 60 consecutive days.

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services will be increased if necessary to keep pace with increases in hospital costs, but no such increase will occur before 1969. The coinsurance amounts for long-stay hospital and extended care facility benefits will be correspondingly adjusted.

Increases in the hospital deductible will be made only when a $4 change is called for and the outpatient deductible will change in $2 steps.

5. *Basis of reimbursement.*—Payment of bills under the hospital insurance plan will be made to the providers of service on the basis of the "reasonable cost" incurred in providing care for beneficiaries.

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

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

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

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

For years in which the annual earnings and tax bases of the social security and railroad retirement programs are equal, hospital insurance taxes will be levied under the Railroad Retirement Tax Act and transferred from the Railroad Retirement Account to the Hospital Insurance Trust Fund, with benefit payments made from that fund. Should there be any years in which

the tax bases of the two programs are not equal, hospital insurance taxes for such years will be levied on railroad employment under the Federal Insurance Contributions Act (which applies to earnings covered under social security).

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

B. VOLUNTARY SUPPLEMENTARY MEDICAL INSURANCE PLAN

1. *General description.*—A package of benefits supplementing those provided under the basic plan will be offered to all persons 65 and over on a voluntary basis. Individuals who elect to enroll initially will pay premiums of $3 a month (deducted, where possible, from social security, railroad retirement, or civil service retirement benefits). The Government will match this premium with $3 paid from general funds.

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

3. *Eligibility.*—The medical insurance benefits will be available to all people age 65 and over (whether or not they are social security or railroad retirement beneficiaries) who are residents of the United States and either are citizens or aliens admitted for permanent residence who have had 5 years of continuous residence. Any person entitled to the basic hospital insurance benefits will be eligible regardless of the preceding requirements.

4. *Enrollment.*—Persons who have reached age 65 before January 1, 1966, will have an opportunity to enroll in an enrollment period which begins September 1, 1965, and ends March 31, 1966.

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

In the future, general enrollment periods will be from October to December 31 in each odd-numbered year. The first such period will be October 1 to December 31, 1967.

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

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

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

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

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

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

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

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

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

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

(5) Ambulance services.

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

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

6. *Administration by carriers: Basis for reimbursement.*—The Secretary of Health, Education, and Welfare is required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the voluntary supplementary medical insurance plan such as determining rates of payments under the program and holding and disbursing funds for benefit payments. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of service), the cost is a reasonable cost. Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that the charges are reasonable and not higher than the charges applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. Payment by the carrier for physicians' services will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service. In determining reasonable charges, the carriers will consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.

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

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

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

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

8. *Income tax provisions.*—The legislation provides that the 3-percent floor on medical expense deductions, as well as the 1-percent limitation on medicines and drugs, is to apply to those age 65 or over in the same manner as it presently applies to those under age 65. This will have the effect of partially recovering the $3 monthly premium paid from general funds of the Treasury from those aged persons who have taxable income, depending on the amount of their taxable income.

The law also provides a special deduction, available to those who itemize their deductions, of 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 $150 per year.

Another change limits the health and accident insurance premiums which may be taken into account to those which arise from coverage of medical care expenses and this must be indicated either on the insurance contract or on a separate statement supplied by the insurance company. Still a further change treats as current, qualifying medical care expenses (subject to limitations) the prepayment before age 65 of insurance for medical care after age 65. Also all maximum limitations on the medical expense deduction for all taxpayers are eliminated.

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

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

The new title (XIX) will extend the medical assistance program not only to the aged who are indigent but also to needy individuals in the dependent children, blind, and permanently and totally disabled programs and to persons who would qualify under those programs if in sufficient financial need. States may also include other medically-needy children.

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

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

Under the new legislation, the current provisions of law in the various public assistance titles of the act providing vendor medical assistance would terminate upon the adoption of the new program by a State, but in no case later than December 31, 1969.

2. *Effective date.*—January 1, 1966.

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

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

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

5. *Standards as to quality of care and safety.*—It is required that the States include in their State plans descriptions of the medical staff utilized, the standards for institutions providing medical care and other methods that will promote high quality medical care.

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

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

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

COMPARISON SHOWING PRIOR LAW AND CHANGES MADE BY SOCIAL SECURITY AMENDMENTS OF 1965

EXTENSION OF KERR-MILLS PROGRAM

Item	Prior law	Law as amended by Public Law 89-97
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 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 any 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 capita income equal to or above the national average) up to 80 percent for lower per capita income States. The Federal Government also shares in medical vendor payments for recipients of the other public assistance programs. (There are differing 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 (except as specified) must be the same for the different categories of cash assistance recipients who receive vendor payments under the new combined program. Inclusion of the medically indigent aged would be optional with the States but if they are included, comparable groups of blind, disabled, and parents and needy children must also be included if they need help in meeting necessary medical costs. Other medically needy children may be included if the States wish to do so. The amount, duration, and scope of benefits for the medically indigent (except as specified) must be the same and cannot be greater than that of recipients on the basic maintenance programs. Certain changes are made in State plan requirements relating to the evaluation of income and resources for eligibility purposes, the imposition of deductibles, the payment of deductibles under the basic hospital plan or the payment of deductibles and co-insurance under the voluntary supplementary plan, and the 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 under new program by June 30, 1967. The Federal Government will continue to participate in medical vendor payments in MAA and OAA and other public assistance programs until the new program is in operation in the States or through December 31, 1969, 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. Effective January 1, 1966. Existing medical vendor provisions will become obsolete on January 1, 1970.

2. Medical Assistance for the Aged:		
(a) Eligibility for assistance	To be eligible an individual—	Medical Assistance for Aged program as such will be inoperative by January 1, 1970, 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) Must have attained age 65;	(1) Same as existing law.
	(2) Must not be a recipient of old-age assistance;	(2) No longer applicable to recipients of Old-Age Assistance since they will be eligible under new program.
	(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.	(3) Same but State must provide flexible income test which takes into account medical expenses (including health insurance premiums). (See also State plan requirements. (See pp. 25–27.)
(b) 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.	Essentially the same, except after July 1, 1967, benefits for new medical program *must* include at least following five services:
	The Federal Government shares in the expense of providing the following kinds of medical services:	(1) Inpatient hospital services (except in institution for tuberculosis or mental diseases);
	(1) Inpatient hospital services;	(2) Outpatient hospital services;
	(2) Skilled nursing home services;	(3) Other laboratory and X-ray services;
	(3) Physicians' services;	(4) Skilled nursing home services (except in institution for tuberculosis or mental diseases) for persons age 21 or older; and
	(4) Outpatient hospital or clinic services;	(5) Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere;
	(5) Home health care services;	Other services are optional and are the same as authorized under existing law with the following exceptions:
	(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;	(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.
	(11) Diagnostic, screening, and preventive services; and	
	(12) Any other medical care or remedial care recognized under State law.	(12) Modifies provision so that medical care or remedial care recognized under State law, either has to be specified by the Secretary or is furnished by licensed practitioners within the scope of their practice as defined by State law.
		Adds provision for inpatient hospital services and skilled nursing home services for persons age 65 and over in institution for tuberculosis or mental diseases.
	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.

EXTENSION OF KERR-MILLS PROGRAM—Continued

Item	Prior law	Law as amended by Public Law 89-97
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.	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.

Federal medical percentages applicable for July 1, 1965, through June 30, 1967

State:	Percentage[1]
Alabama	78.02
Alaska	50.00
Arizona	60.10
Arkansas	79.24
California	50.00
Colorado	50.00
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	62.41
Georgia	72.49
Hawaii	50.00
Idaho	68.16
Illinois	50.00
Indiana	50.13
Iowa	56.90
Kansas	56.47
Kentucky	73.70
Louisiana	74.16
Maine	66.10
Maryland	50.00
Massachusetts	50.00
Michigan	50.00
Minnesota	55.15
Mississippi	80.00
Missouri	50.00
Montana	59.76
Nebraska	54.39
Nevada	50.00
New Hampshire	55.11
New Jersey	50.00
New Mexico	68.43
New York	50.00
North Carolina	73.27
North Dakota	66.37

Federal medical assistance percentage applicable for January 1, 1966–June 30, 1967

State:	Percentage[2]
Alabama	79.85
Alaska	50.00
Arizona	63.94
Arkansas	81.67
California	50.00
Colorado	53.08
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	65.21
Georgia	74.91
Hawaii	52.97
Idaho	70.73
Illinois	50.00
Indiana	55.77
Iowa	60.39
Kansas	61.45
Kentucky	76.70
Louisiana	76.41
Maine	69.57
Maryland	50.00
Massachusetts	50.00
Michigan	50.31
Minnesota	60.46
Mississippi	83.00
Missouri	53.90
Montana	62.86
Nebraska	60.39
Nevada	50.00
New Hampshire	61.31
New Jersey	50.00
New Mexico	70.73
New York	50.00
North Carolina	75.58
North Dakota	66.67

Ohio	50.00	52.33
Oklahoma	67.13	70.32
Oregon	50.00	54.12
Pennsylvania	50.00	54.38
Rhode Island	50.30	56.13
South Carolina	79.32	81.30
South Dakota	67.24	71.05
Tennessee	74.13	76.86
Texas	63.43	67.27
Utah	62.19	66.30
Vermont	62.70	68.44
Virginia	65.11	66.96
Washington	50.00	50.81
West Virginia	70.90	74.27
Wisconsin	52.55	57.60
Wyoming	50.00	55.47

[1] Based on average per capita income for 1961, 1962 and 1963.

[2] Based on average per capita income for 1962, 1963, and 1964.

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

The Federal Government pays 50 percent of other administrative costs.

(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.

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

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

Same as existing law.

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

(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 similar charges for certain medical assistance furnished under the plan 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;

Item	Prior law	Law as amended by Public Law 89–97
2. Medical Assistance for the Aged—Con. (d) State plan requirements—Con.	(2) must not impose property liens during the lifetime of the individual receiving benefits (except pursuant to court judgment on account of benefits incorrectly paid) and any recovery provisions under the plan must be limited to the estate of the individual after his death and the death of his surviving spouse;	(2) Broadened so that recovery would be further postponed where there is surviving child, under 21 or blind or disabled. No recovery is permitted for medical assistance received before age 65.
	(3) must not impose a citizenship requirement which would exclude a citizen of the United States or a requirement which excludes a resident of the State;	(3) Same as existing law.
	(4) must also provide, to the extent required by the Secretary of Health, Education, and Welfare, for inclusion of residents of the State who are absent therefrom; and	(4) Same as existing law.
	(5) Include reasonable standards consistent with the objectives of this title for determining eligibility for, and the extent of assistance;	(5) Same but with addition so that standards (a) take into account only such income and resources as are (as determined in accordance with standards prescribed by the Secretary), available to the applicant or recipient; (b) must provide for reasonable evaluation of income or resources; (c) do not take into account the financial responsibility of any individual for any applicant or recipient who is not such individual's spouse or child under age 21 or blind or disabled; and (d) provide for flexibility in the application of such standards with respect to income by taking into account (except to the extent prescribed by the Secretary) the costs (whether in the form of insurance premiums or otherwise) incurred for medical care.
	(6) If a State has both a program for old-age assistance and medical assistance for the aged it must be administered by a single State agency;	(6) The medical program may be administered by any single State agency except that eligibility for medical assistance must be determined by the agency that administers old-age assistance (or title XVI). In certain States with separate blind agencies, however, the portion of the plan relating to the blind may be administered by those agencies. The following additional plan requirements pertinent to the MAA group are added: (7) 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, local participation may continue if Federal and State funds are distributed on equalization or other basis that will assure that lack of adequate local funds will not lessen the services available under the plan. (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 the insurance programs (hospital insurance benefits for the aged, and supplementary medical insurance benefits for the aged) established by the Act, provide— (A) For meeting the full cost of any deductible imposed with respect to any such individual under such hospital insurance benefits program; and (B) Where, under the plan, all of a deductible, cost sharing, or similar charge imposed with respect to any such individual under the supplementary medical insurance benefits program is not met, the portion which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or to his income and resources. (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) Provide for the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan. (14) Include descriptions of kinds, numbers, and responsibilities of professional medical personnel, the standards to be used by standard-setting authorities for institutions, the cooperative arrangements with State health and vocational rehabilitation agencies, and other standards and methods to be used to assure provision of medical or remedial care and that services are of high quality.
(e) Use of private health insurance.	Includes in the amounts subject to Federal matching the expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof.	Same as existing law.
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 Old Age Assistance (title I), Aid to Families with Dependent Children (title IV), Aid to	Federal participation in medical vendor payments will cease after Dec. 31, 1969 (or upon the States' implementation of the new program if earlier) as to all existing titles (I, IV, X, XIV, and XVI). After that date

Item	Prior law	Law as amended by Public Law 89–97
3. Effect on other public assistance programs—Continued	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 vendor payments will be available solely through the new medical program. If a State program covers the medically indigent aged (MAA), it must provide (except as specified) the same benefits in amount, duration, and scope to comparably medically indigent individuals who would, if in financial need, be in the other categories of assistance. The amount, duration, and scope of medical assistance for recipients of cash assistance under any of the programs cannot be less than that provided for the medically indigent. The amount, duration, and scope of medical assistance available must be (except as specified) the same as to recipients on all cash assistance programs. Effective July 1, 1967, as to the new program, the States could not exclude any person who has not attained age 21 and who would be considered a dependent child except for the age and school attendance requirements under the State's aid to families with dependent children plan. Moreover, for matching purposes dependent children and adult care takers could be included even though they did not meet the State plan requirement for need and age, if they are otherwise qualified for cash payments under the aid to families with dependent children program. States could also receive Federal matching in medical assistance for medically needy children who did not so qualify if the State plan included such children. 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 65 years of age there shall be no recovery or adjustment as to any medical assistance correctly paid.
(b) Benefits	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 5 services: (1) inpatient hospital services; (except in institutions for tuberculosis or mental diseases);

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

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

PUBLIC ASSISTANCE

I. INCREASE IN FEDERAL MATCHING FORMULA

Item	Prior law	Law as amended by Public Law 89-97
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 (82⅞ of the first $35) with variable matching on the amount above $35 up to a maximum of $70 per recipient per month. Matching for States whose per capita income is at or above the national average is 50 percent, while for States below the national average it varies up to 65 percent. The "Federal percentages" as promulgated for the period July 1, 1965, through June 30, 1967, are as follows:	Effective January 1, 1966, the Federal matching share will be increased to $31 out of the first $37 (83⅞7 of the first $37) with variable matching on the amount above $37 up to a maximum of $75 per recipient per month. No change.

State:	*Federal percentage* [1]
Alabama	65.00
Alaska	50.00
Arizona	60.10
Arkansas	65.00
California	50.00
Colorado	50.00
Connecticut	50.00
Delaware	50.00
District of Columbia	50.00
Florida	62.41
Georgia	65.00
Hawaii	50.00
Idaho	65.00
Illinois	50.00
Indiana	50.13
Iowa	56.90
Kansas	56.47
Kentucky	65.00
Louisiana	65.00
Maine	65.00
Maryland	50.00
Massachusetts	50.00
Michigan	50.00
Minnesota	55.15
Mississippi	65.00
Missouri	50.00
Montana	59.76
Nebraska	54.39
Nevada	50.00
New Hampshire	55.11
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	50.30
South Carolina	65.00
South Dakota	65.00
Tennessee	65.00
Texas	63.43
Utah	62.19
Vermont	62.70
Virginia	65.00
Washington	50.00
West Virginia	65.00
Wisconsin	52.55
Wyoming	50.00

[1] Based on average per capita income for 1961, 1962, and 1963.

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 percent over and above the "Federal percentage" used to compute the Federal share of money payments.

Provision is also made that a State with an average payment over $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 provisions become obsolete on January 1, 1970.

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

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

PUBLIC ASSISTANCE—Continued

I. INCREASE IN FEDERAL MATCHING FORMULA—Continued

Item	Prior law	Law as amended by Public Law 89-97
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 (1⅐7 of the first $17) per recipient per month with variable matching on the amount above $17 up to a maximum of $30 per recipient per month. Variable matching for the States is at the same percentages as old-age assistance money payment matching.	Effective January 1, 1966, the Federal matching share would be increased to $15 out of the first $18 (⅚ of the first $18) with variable matching on the amount above $18 up to a maximum of $32 per month per recipient.
C. Special formula for Puerto Rico, Virgin Islands, and Guam:		
1. Matching formula	Federal matching on a 50–50 basis on both money and vendor medical payments up to a maximum of $37.50 a month times the number of recipients on the old-age, blind, and disabled program with a maximum of $18 a month times the number of recipients on the aid to dependent children program. Additional matching for vendor medical expenditures is available for up to $7.50 per month per recipient on old-age assistance and combined adult program rather than the additional $15 per month per recipient which applies to the States and the District of Columbia.	No change.
2. Dollar limitation	Total Federal payments for all 4 public assistance programs may not exceed— Puerto Rico ..... $9,800,000 Virgin Islands ..... 330,000 Guam ..... 450,000 In each case a portion of these amounts is only available if used to provide additional medical vendor payments on behalf of assistance recipients: Puerto Rico ..... $625,000 Virgin Islands ..... 18,750 Guam ..... 25,000 Federal payments for programs of medical assistance for the aged are excepted from dollar limitation provision.	No change. Deletes required earmarking for medical vendor payments on approval of its plan for medical assistance under title XIX.
D. Pass along provision	No provision in existing law to insure that public assistance recipients receive higher payments because of legislation liberalizing the Federal matching formula.	Federal matching for any State for any quarter shall be reduced to the extent that the excess of the Federal matching for such quarter over the corresponding quarter for 1964 or 1965 or the average Federal matching for quarters in fiscal 1964 or 1965 is greater than the excess of total Federal, State, and local expenditures for the quarter over the corresponding quarter or the average Federal, State, and local total expenditures for quarters in fiscal 1964 or 1965.
E. Alternative formula for computing Federal share.	No provision.	Permits any State that has an approved plan for medical assistance under title XIX to claim Federal matching for its expenditures under all of its public assistance programs under the same formula provided under title XIX instead of using the varying formulas in the other programs.

F. Consideration of income in determination of need.		
1. Disregarding earnings and other income 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 Oct. 1, 1965, disregard up to $5 per month of any income and also disregard an additional portion of earned income. Of the first $80 per month of additional income which is earned, the State may disregard the first $20 completely, plus ½ of the remainder.
2. Disregarding earnings and other income of blind individuals under title X and under title XVI (combined program).	In determining need of blind individuals, a State must disregard the first $85 per month of earned income and, for up to a 12-month period, any other income and resources needed to accomplish an approved plan for self-support, with option to State to extend up to additional 24 months.	Effective October 1, 1965, over and above present exemptions, State may disregard up to $5 per month of any income.
3. Disregarding earnings and other income of disabled individual under title XIV and under title XVI (combined program).	No provision.	In determining need of a disabled recipient under titles XIV and XVI, effective October 1, 1965, a State may disregard up to $5 of any income and of the first $80 per month of additional income which is earned, the State may disregard the first $20 completely, plus ½ of the remainder and may also disregard for up to 36 months such additional amounts of income and resources as may be necessary for the fulfillment of an approved plan for achieving self-support but only while he is actually undergoing vocational rehabilitation.
4. Disregarding earnings and other income in aid to families with dependent children (title IV).	No provision.	In determining need under title IV, effective July 1, 1965, the State may disregard not more than $50 per month of earned income of each dependent child under age 18 but not more than $150 per month in the same home. Effective October 1, 1965, the State may disregard up to $5 of any income before disregarding child's earned income as provided above.
5. 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 (back to January 1965) of the 7 percent benefit increase or the child benefit for children over 18 in school in determining need of the aged, blind, disabled, or families with dependent children.

II. MENTAL AND TB EXCLUSION

A. Old-age assistance and aged individual in combined program (title XVI).	Federal matching is available as to cash and vendor payment, but does not include— (1) Cash or vendor payments on behalf of an inmate of a public institution (except as a patient in medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases; or (2) Any cash payments to any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof; (3) Vendor payments on behalf of any individual who is a patient in a medical institution as a result of a diagnosis of tubercu osis or psychosis with respect to any period after the individual has been a patient in such an institution for 42 days.	(1) Deletes tuberculosis and mental exclusion for individuals age 65 or over; retains exclusion as to payments to inmates of a public institution (except as a patient in a mental institution). (2) Deletes tuberculosis and mental exclusion. (3) Deletes tuberculosis and mental exclusion entirely

PUBLIC ASSISTANCE—Continued

II. MENTAL AND TB EXCLUSION—Continued

Item	Prior law	Law as amended by Public Law 89–97
B. Aid to blind and disabled	Federal matching is available as to cash and vendor payment, but does not include— (1) Cash or vendor payments on behalf of an inmate of a public institution (except as a patient in medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases; or (2) Any cash or vendor payments to any individual who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof;	(1) No change. (2) Deletes tuberculosis and mental exclusion.
C. Medical assistance for the aged	Federal matching is available as to vendor payments but does not include— (1) Payments on behalf of an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases, or (2) On behalf of any individual who is a patient in a medical institution as a result of a diagnosis of tuberculosis or psychosis with respect to any period after the individual has been a patient in such an institution for 42 days.	(1) Deletes tuberculosis and mental exclusion; retains exclusion as to payments to inmates of a public institution (except as a patient in a mental institution). (2) Deletes tuberculosis and mental exclusion entirely.
D. State plan requirements	No provision.	As to old-age assistance, medical assistance for the aged, combined program (title XVI) or new medical assistance program (title XIX) adds requirement that if State plan includes cash payment or vendor payments to persons in mental institutions it must— (1) Provide for having in effect arrangements with the State mental health authority or authorities, and, where appropriate, with such institutions, including arrangements for joint planning, development of alternate methods of care, assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, allowing access to patients and facilities, furnishing information, and making reports, as may be necessary to enable the State agency to carry out its responsibilities under the State plan; (2) Provide for an individual plan for each patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be periodic determination of his need for continued treatment in the institution; (3) Provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients who would otherwise need care in such institutions, including appropriate medical treatment and other assistance, for rehabilitation

		services which are appropriate for such, and for methods of administration necessary to assure that these provisions will be effectively carried out; and (4) Provide methods of determining the reasonable cost of institutional care for such patients. And, if the State elects to provide vendor or cash payments to patients in public institutions for mental diseases, it must be shown that the State is making satisfactory progress toward developing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to institutional care. 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.
E. Pass along provision	No provision.	
III. PROTECTIVE PAYMENTS		
A. Protective payments under old-age assistance, ald to the blind, and aid to the permanently and totally disabled, and the combined program (title XVI).	Federal financial participation as to money payments to needy persons or their legal guardians has been authorized since 1935. Vendor payments, made directly to the suppliers of medical services on behalf of recipients have been authorized by the 1950 amendments. Since 1958, payments have been authorized to be made to another person who is judicially appointed for the purpose of receiving and managing such assistance payments (whether or not he is such individual's legal representative for other purposes).	Authorizes protective payments to be made to a person who is interested in or concerned with the welfare of the needy person under a State plan which provides for— (1) Determination by the State agency that payments in this form are necessary because the needy person has, by reason of his physical or mental condition, such inability to manage funds that making cash payments to him would be contrary to his welfare; (2) Special efforts to protect the welfare and improve the ability of the needy individual to manage funds; (3) Periodic review of the situation to determine whether such payments to an interested person are still necessary—and seeking judicial appointment of a guardian or legal representative if and when such action will serve the interests of such needy individual; and (4) Opportunity for a fair hearing before the State agency on the determination that payments to an interested person are necessary. (5) Payments which together with other income meet the individual's need in full.
IV. OTHER CHANGES		
A. Definition of medical assistance for the aged.	The term "medical assistance for the aged" means payments of part or all of the cost of care and services (if provided in or after the 3d month before the month in which the recipient makes application for assistance) for individuals 65 years of age or older who are not recipients of old-age assistance but whose income and resources are insufficient to meet all of the cost of medical services.	Eliminates restriction upon Federal matching for recipients of old-age assistance for month they are admitted to or discharged from a medical institution, effective July 1, 1965.

PUBLIC ASSISTANCE—Continued

IV. OTHER CHANGES—Continued

Item	Prior law	Law as amended by Public Law 89–97
B. Exemption of earnings under the poverty program.	The Economic Opportunity Act of 1964 provides that certain amounts of income derived under titles I and II of that act may not be taken into account by State public assistance programs after June 30, 1965.	Provides a further grace period for State compliance with this provision so that no funds will be withheld before the 1st month after the adjournment of a State's first regular legislative session which adjourns after the date of the enactment of the Economic Opportunity Act (Aug. 20, 1964).
C. Administrative and Judicial Review of Administrative Actions: (1) Initial approval of State plan---	No explicit authority for review of Secretary's disapproval of a plan which is submitted by a State.	Sets up specific statutory procedures for review of administrative determinations: When a State submits a new plan under one of the public assistance titles, the Secretary shall make a determination within 90 days as to whether the proposal meets the applicable requirements for approval. This period may be extended by written agreement of the Secretary and the State. If the State is dissatisfied with the Secretary's determination, it may, within 60 days, petition for a reconsideration. The Secretary shall, within 30 days after receipt of the petition, set a time and place for a hearing, to begin from 20 to 60 days after the date notice of the hearing is furnished to the State, unless the Secretary and the State agree in writing upon another time. Within 60 days of the conclusion of the hearing, the Secretary shall affirm, modify, or reverse his original determinations. If the State is dissatisfied with this final determination, it may, within 60 days, appeal to the U.S. court of appeals. In the judicial proceeding, the findings of fact, by the Secretary shall be conclusive if supported by substantial evidence; if good cause shown for taking further evidence, the court may remand the case to the Secretary for this purpose. The court may affirm the action of the Secretary or set it aside, in whole or in part. The court's judgment shall be subject to review by the Supreme Court of the United States upon certiorari or certification. The foregoing procedures are also applicable, at the option of the State, upon submittal of any amendment of an approved State plan. The bill further provides that action pursuant to an initial determination of the Secretary, as therein described, shall not be stayed pending reconsideration. If the Secretary subsequently determines that his initial determination was incorrect, he shall pay forthwith in a lump sum any amounts, not otherwise already paid, which are payable to the State in accordance with the corrected determination of the Secretary on the basis of the expenditures made by the State.

(2) Subsequent noncompliance	Under all public assistance titles the Secretary shall give reasonable notice and opportunity for hearing to a State prior to discontinuing payments under a previously approved State plan because of his finding that the plan has been so changed that it no longer complies with certain requirements of the law.	Makes final determination of the Secretary subject to judicial review in the same manner as outlined above.
(3) Audit exceptions (disallowance of specific items for Federal participation).	No specific authority for review of Secretary's disallowances.	Provides that whenever the Secretary determines that there shall be a disallowance the State shall be be entitled, on request, to an administrative reconsideration of the decision.
(4) Effective date	----------	Effective as to determinations made after December 31, 1965.
D. Eligibility of children over age 18 for aid to families with dependent children (title IV).	States may provide aid to children 18–21 years of age who are attending a high school or a vocational or technical training course and receive federal sharing in such aid.	Amends present provision to permit federal sharing in aid to children 18–21 regularly attending a school, college, or university, or vocational or technical training course.

MATERNAL AND CHILD HEALTH SERVICES

(Title V of Social Security Act)

Item	Prior law	Law as amended by Public Law 89-97
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 each for the fiscal year ending June 30, 1968 and 1969. $50,000,000 for the fiscal year ending June 30, 1970 and for each succeeding 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 each for the fiscal year ending June 30, 1968 and 1969. $60,000,000 for the fiscal year ending June 30, 1970, and each fiscal year thereafter.
II. Provision for extension of services to children in 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 services provided under the plans.

CRIPPLED CHILDREN'S SERVICES

(Title V of Social Security Act)

Item	Prior law	Law as amended by Public Law 89–97
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 each for the fiscal year ending June 30, 1968 and 1969. $50,000,000 for the fiscal year ending June 30, 1970 and for each succeeding 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 each for the fiscal year ending June 30 1968 and 1969. $60,000,000 for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.
II. Provision for extension of services to children in 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, to 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 services provided under the plan.

CHILD WELFARE SERVICES

(Title V of Social Security Act)

Item	Prior law	Law as amended by Public Law 89–97
I. Increase in authorization	$40,000,000 for the fiscal year ending June 30, 1966. $45,000,000 for the fiscal year ending June 30, 1967. $45,000,000 for the fiscal year ending June 30, 1968. $50,000,000 for the fiscal year ending June 30, 1969, and succeeding fiscal years.	$45,000,000 for the fiscal year ending June 30, 1966. $50,000,000 for the fiscal year ending June 30, 1967. $55,000,000 for the fiscal year ending June 30, 1968. $55,000,000 for the fiscal year ending June 30, 1969. $60,000,000 for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.
II. Day care	Earmarking: From annual appropriation for child welfare services, the excess over $25,000,000 is earmarked for support of day care activities in the States, but earmarked amount may not exceed $10,000,000.	Deletes provision for earmarking.
	Allotments: The earmarked amount is allotted so that each State shall have an amount which bears the same ratio to the total amount earmarked as the product of (1) the population of each State (under the age of 21) and (2) the allotment percentage (based on relative per capita income) bears to the sum of the corresponding products of all the States. But any State allotments under $10,000 shall be increased to that amount by proportionately reducing allotments to each of the remaining States.	Deletes provision for allotments.
	State plan requirements: Provides the following requirements: (1) Plan must be developed jointly by the State agency and the Secretary of Health, Education, and Welfare. (2) Plan must provide, with respect to day care— (a) for arrangements with State health and public school authorities to assure maximum utilization of such agencies in the provision of health care and education to day care children; (b) for an advisory committee to advise the State agency on general policy relating to the provision of day care, representing public and private groups interested in day care; (c) for safeguards assuring that day care is provided only in cases where it is in the interest of mother and child, and where a need for it exists; and (d) for giving priority in determining the need for day care, to low income groups, other groups, and geographical areas with the greatest relative needs for such care. Effective July 1, 1963.	No change.

	Eligible facilities: Day care which is supported under this program must be provided in facilities (including private homes) which are licensed by the State, or approved (as meeting the licensing requirements) by the State agency which is responsible for licensing this type of facility.	Made a plan requirement that day care under the plan will be provided only in facilities (including private homes) which are licensed by the State or approved as meeting standards established for licensing. Day care amendments effective January 1, 1966.

SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

(Title V of Social Security Act)

Item	Prior law	Law as amended by Public Law 89–97
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, $40,000,000 for fiscal year ending June 30, 1968, $45,000,000 for the fiscal year ending June 30, 1969 and $50,000,000 for 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.

MISCELLANEOUS AMENDMENTS RELATING TO HEALTH CARE

Item	Prior law	Law as amended by Public Law 89–97
I. Health Study of Resources Relating to Children's Emotional Illness.	No provision.	Authorizes an appropriation of $500,000 each for the fiscal year ending June 30, 1966, and the fiscal year ending June 30, 1967, for grants for research into and study of the resources, methods, and practices for diagnosing or preventing emotional illness in children and of treating, caring for, and rehabilitating children with emotional illness.
II. Grants for mental retardation planning. (Title XVIII of the Social Security Act.)	$2,200,000 was authorized for grants during each of fiscal 1964 and fiscal 1965.	Authorizes $2,750,000 each year 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	Prior law	Law as amended by Public Law 89–97
A. Self-employed	*Covers* all self-employed if they have net earnings from self-employment of $400 a year except that certain types of income, including dividends, interest, sale of capital assets, and rentals from real estate (including certain rentals paid in crop shares—see item 3, "Farm operators") are not covered unless received by dealers in real estate and securities in the course of business dealings.	Permits exemption from the social security self-employment tax of individuals who have conscientious objections to insurance (including social security) by reason of their adherence to the established tenets or teachings of a religious sect (or division thereof) of which they are members. The exemption could be granted with respect to taxable years beginning after Dec. 31, 1950. The sect (or division thereof) must be one that has been in existence at all times since Dec. 31, 1950, and has for a substantial period of time been making reasonable provision for its dependent members. Before an individual could be granted exemption he would be required to waive all benefits and other payments under any insurance system established by the Social Security Act on the basis of his own earnings as well as all such benefits and other payments to him based on the earnings of any other person. The exemption could not be granted to any person who has been entitled to social security benefits, or to one whose earnings have provided the basis for entitlement to social security benefits for any other person.
1. Professional groups	*Covers* all professional groups except physicians.	Covers physicians. Effective for taxable years ending on or after Dec. 31, 1965.
2. Ministers	*Covers* duly ordained, commissioned or licensed ministers, Christian Science practitioners, and members of religious orders (other than those who have taken a vow of poverty) serving in the United States, and those serving outside the country who are citizens and either working for U.S. employers or serving a congregation predominantly made up of U.S. citizens. Coverage is available under the self-employment coverage provisions on an individual voluntary basis regardless of whether they are employees or self-employed.	Extends through April 15, 1966, the period within which ministers who have been in practice at least 2 years since 1954 may file certificate electing social security coverage. Permits social security credit to be obtained for the earnings of certain ministers who die or file waiver certificates before April 16, 1966, where such earnings were reported for social security purposes but cannot be credited under present law.
3. Farm operators	*Covers* farm operators on the same basis as other self-employed persons except that farm operators whose annual gross earnings are $1,800 or less can report either their actual net earnings or 66⅔ percent of their gross earnings. Farmers whose annual gross earnings are over $1,800 report their actual net earnings if over $1,200, but if actual net earnings are less than $1,200, they may report $1,200.	Modifies exception so that farm operators whose annual gross earnings are $2,400 or less can report either their actual net earnings or 66⅔ percent of their gross earnings. Farmers whose gross earnings are over $2,400 report actual net earnings if over $1,600, but if actual net is less than $1,600, they may report either actual net earnings or $1,600. Effective as to taxable years beginning after Dec. 31, 1965.

	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.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

I. COVERAGE—Continued

Item	Prior law	Law as amended by Public Law 89-97
B. Employees—Continued 4. Cash tips	Tips received by employees are generally not counted as wages. While employees' tips are not mentioned in the law, regulations exclude from wages tips paid directly to an employee, and not accounted for by the employee to the employer.	Cash tips received after 1965 by an employee in the course of his employment are covered as wages for social security and income-tax withholding purposes, except that employers are not required to pay the social security employer tax on the tips. However, for tips to be subject to withholding for income tax or to be counted for social security purposes, the tips must be paid in cash and must amount to $20 or more a month in work for one employer. The tips still represent compensation for income tax purposes even though less than $20 a month or even though paid in other than cash, but are not, under either of these conditions, subject to withholding for income tax or social security tax purposes. The employee is required to give his employer a written report of his tips within 10 days after the end of the month in which the tips are received (or at such other times before the 10th day as is provided by regulations); to the extent that unpaid wages due an employee and in the possession of the employer are insufficient to pay the employee social security tax due on the tips, the employee will be permitted (but not required) to make available to the employer sufficient funds to pay the employee social security tax. To the extent that the employer does not have sufficient wage payments (or funds turned over to him by the employee) to offset the required withholding, he notifies the employee and the employee reports this amount to the Government directly. If an employee fails to report, as required by law, some or all of his covered tips to his employer, he is liable not only for the employee social security tax due on the unreported tips, but also for an additional amount equal to 50 percent of the employee tax. He pays his social security tax on these tips to the District Director of the Internal Revenue Service. The employer is required to withhold the employee social security tax only on tips reported to him within the specified time and for which he has sufficient funds of the employee out of which to pay the tax. He is liable for withholding income tax on only those tips that are reported to him within 10 days after the end of the month in which the tips were received, and then in general only to the extent that he can collect the tax (at or after the time the tips are reported to him and before the close of the calendar year in which the tips were received) from unpaid wages (not including tips), or from funds turned over to him for that purpose remaining after an amount equal to the amount due for the social security tax has been subtracted.

5. State and local government employees.	*Covers* employees of State and local governments *provided* the individual State enters into an agreement with the Federal Government to provide such coverage, with the following special provisions: a. *States have the option* of covering or excluding employees in any class of elective position, part-time position, fee-basis position, or performing emergency services. b. *Excludes* the services of the following persons, specifying that they cannot be included in a State agreement and cannot, therefore, be covered: (1) Employees on work relief projects; (2) Patients and inmates of institutions who are employed by such institutions; (3) Services of the types which would be excluded by the general coverage provisions of the law if they were performed for a private employer, *except* that agricultural and student services in this category may be covered at the option of the State. c. Employees who are in positions covered under an existing State or local retirement system may be covered under State agreements only if a referendum is held by a secret written ballot, after not less than 90 days' notice, and if the majority of eligible employees under the retirement system vote in favor of coverage. However, employees in policemen and firemen positions under a State and local retirement system cannot be covered in the agreement. The Governor of a State or his delegate must certify that certain Social Security Act requirements under the referendum procedure have been properly carried out. In most States, all members of a retirement system (with minor exceptions) must be covered if any members are covered. Employees of any institution of higher learning (including a junior college or a teachers' college and employees of a municipal or county hospital under a retirement system can, if the State so desires, be covered as a separate coverage group, and 1 or more political subdivisions may be considered as a separate coverage group even though its employees are under a statewide retirement system. 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.	Permits Iowa and North Dakota to modify their agreements to exclude services performed by students, including services already covered, in the employ of a school, college, or university in any calendar quarter if the remuneration for such services is less than $50. The modification would specify the effective date of the exclusion, but it could not be earlier than July 30, 1965.

Item	Prior law	Law as amended by Public Law 89-97
B. Employees—Continued 5. State and local government employees—Continued	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 who were first employed 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 July 30, 1965. Would validate the past coverage of employees of certain school districts in Alaska which have been included in error under the Alaska coverage agreement as separate political subdivisions. The employees of the school districts involved should have been covered as employees of the political subdivisions of which the school district are integral parts. Effective only for years prior to 1966.
	Exceptions to general law concerning coverage in named States: (1) *Split-system provisions.*—Authorizes California, Connecticut, Florida, Georgia, Hawaii, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin, and all interstate instrumentalities, at their option, to extend coverage to the members of a State retirement system by dividing such a system into 2 divisions, 1 to be composed of those persons who desire coverage and the other of those persons who do not wish coverage, provided that new members of the retirement system coverage group are covered compulsorily. Also authorize similar treatment of political subdivision retirement systems of these States.	Adds Alaska to the list. Effective July 30, 1965.
	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 July 30, 1965.

	Also provides that where an individual who has chosen not to be covered under the divided retirement system provision becomes a member of a different retirement system group which has elected coverage because of the annexation of the employing political subdivision by another political subdivision, or through some other action taken by a political subdivision, such individual will continue to be excluded from coverage.	
	(2) *Policemen and firemen.*—Allows the States of Alabama, California, Florida, Georgia, Hawaii, Kansas, Maine, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington and all interstate instrumentalities to make coverage available to policemen and firemen in those States, subject to the same conditions that apply to coverage of other employees who are under State and local retirement systems, except that where the policemen and firemen are in a retirement system with other classes of employees the policemen and firemen may, at the option of the State, hold a separate referendum and be covered as a separate group.	No change.
	(3) *Employees of unemployment compensation systems.*—Authorizes Florida, Georgia, Minnesota, North Dakota, Pennsylvania, Washington, and Hawaii, at their option, to cover their employees who are paid wholly or partly from Federal funds under the unemployment compensation provisions of the Social Security Act—either by themselves or with the other employees of the department of the State in which they are employed—after complying with the referendum provisions.	No change.
	(4) Retirement systems in Maine (1958 amendments)—permits State of Maine until July 1, 1965, to treat teaching and nonteaching employees who are in the same retirement system as though they were under separate retirement systems for social security coverage purposes.	Extends cutoff date to July 1, 1967.
	d. Coverage on a compulsory basis is provided for employees of certain publicly owned transportation systems.	No change.
	e. *Effective date of coverage agreement.*—Allows agreements or modifications made after 1959 to begin as early as 5 years before the year in which an agreement is made, but no earlier than Jan. 1, 1956. Where a retirement system is covered as a single retirement system coverage group, permits the State to provide different beginning dates for coverage of the employees of different political subdivisions.	No change.
6. Employees of nonprofit organizations.	*Covers* employees of religious, charitable, educational, and other nonprofit organizations (which are exempt from income tax and are described in sec. 501(c)(3) of the Internal Revenue Code) *on a voluntary basis* if the employer organization certifies that it desires to extend coverage to its employees.	No change.
	Employees may concur by signing a list or supplemental list which is filed within 24 months after the	

I. COVERAGE—Continued

Item	Prior law	Law as amended by Public Law 89-97
B. Employees—Continued		
6. Employees of nonprofit organizations—Continued	quarter in which the certificate is filed. Employees who do not concur in the filing of the certificate are not covered *except* that all employees hired after a certificate becomes effective are covered.	
	Waiver certificate may be made effective at the option of the organization on the 1st day of the quarter in which the certificate is filed, the 1st day of the succeeding quarter, or 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. Gives those employees to whom additional retroactive coverage is made applicable an individual choice of such coverage. Permits the validation of certain erroneous wage reportings as to employees and former employees of nonprofit organizations. Effective July 30, 1965.
	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—	No change, except—
	a. they are covered by a retirement system established by Federal law; or	
	b. they perform services—	
	(1) as the President, Vice President, or a Member of Congress;	
	(2) in the legislative branch;	
	(3) in a penal institution as an inmate;	
	(4) as certain interns, student nurses, and other student employees of Federal hospitals;	Excepts from exclusion and thereby provides coverage to medical or dental interns or residents in training. Effective as to services performed after 1965.
	(5) as employees on a temporary basis in disaster situations;	
	(6) as employees not covered by the Civil Service Retirement Act because they are subject to another retirement system (other than the retirement system of the Tennessee Valley Authority); or	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.
	c. the instrumentality has been specifically exempted by statute from the employer tax; or	
	d. the instrumentality was exempt from the employer tax on December 31, 1950, and its employees are covered by its retirement system.	
	Covers the following Federal employees excepted from the exclusion in 7-d unless they are excluded on the basis of one of the other provisions:	
	a. employees of a corporation which is wholly owned by the United States;	

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

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

I. COVERAGE—Continued

Item	Prior law	Law as amended by Public Law 89-97
B. Employees—Continued		
11. Railroad employees	Under coordination provisions contained in the Railroad Retirement Act: (1) employment under both the railroad system and the old-age and survivors insurance system is counted for purposes of survivor benefits under either system; (2) railroad employment of workers with less than 10 years of railroad service is credited under the Social Security Act and the benefits based on such employment are payable under this act; and (3) provision is made for mutual financial interchange between the 2 systems in order to place the Old-Age and Survivors Insurance and Disability Insurance Trust Funds in the same position in which they would have been if railroad service after 1936 had been counted as social security employment.	Amends section (1)(q) of the Railroad Retirement Act to provide that references to the Social Security Act in the Railroad Retirement Act will be considered to be references to the Social Security Act as amended in 1965, so that the present RR–OASDI coordination will continue to operate in all ways with respect to the Social Security Act as amended by the bill. Increases the amount of social security earnings that may be credited under the survivors provisions of the railroad retirement program to such an amount as to cause the combined total earnings to be as much as the new wage and tax base under social security—$6,600 a year after 1965.
12. Family employment	*Excludes* services rendered by— (1) One spouse for another. (2) Child under 21 for his parents. (3) Parents for their children, if such services are domestic services rendered in the home of the child, or such services are not rendered in the course of the child's trade or business.	No change.
13. Employees of Communist organizations.	*Excludes* from coverage employees of any organization which is registered, or against which there is a final order of the Subversive Activities Control Board to register, under the Internal Security Act as a Communist-action, a Communist-front, or Communist infiltrated organization.	No change.

II. PROVISIONS RELATING TO DISABILITY

A. Nature of the provisions:		
1. Benefits	Provides monthly benefits for disabled workers meeting eligibility requirements. Benefits are computed in the same way as retirement benefits and are payable from the Federal Disability Insurance Trust Fund.	No change.
2. Disability "freeze"	Provides that when an individual for whom a period of disability has been established dies, or retires, on account of age or disability, his period of disability will be disregarded in determining his eligibility for benefits and in determining 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, the following specified degree of blindness is presumed disabling: Central visual acuity of 5/200 or less in the better eye with use of correcting lens. An eye in which the visual field is reduced to 5° or less concentric contraction shall be considered as having a visual acuity of 5/200 or less.) The impairment must be medically determinable and one which can be expected to be of long-continued and indefinite duration or to result in death.	Eliminates the requirement that a worker's disability must be expected to be of long-continued and indefinite duration. Provides that an insured worker would be eligible for disability benefits if he has been under a disability which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 calendar months.
2. Entitlement to other benefits	Entitlement to a benefit payable on account of old age precludes entitlement to a disability insurance benefit.	A person who becomes entitled before age 65 to a benefit payable on account of old age can later become entitled to disability insurance benefits. If prior benefit was a reduced benefit, disability insurance benefits would be reduced to take account of payment made for prior months.
3. Waiting period	An initial 6-month "waiting period" is required before disability insurance benefits will be paid. Benefits are payable for 7th month. However, benefits may be paid for the 1st full month of disability to a worker who becomes disabled within 60 months (5 years) after termination of disability insurance benefits or a period of disability.	No change.
4. Termination of benefits	Provides that benefits shall not be paid after the 2d month following the month in which a worker's disability ceases.	No change.
5. Insured status (work requirement).	To be eligible an individual must—(1) have at least 20 quarters of coverage in the 40 quarters ending with the quarter in which the period of disability begins; (2) be fully insured.	No change except for special provision for certain blind workers. (See below.)
6. Special provision for the blind	No special provisions except disability "freeze" presumption noted above.	(a) Young workers who are blind and disabled: Establishes alternative insured status requirement under which workers disabled before age 31 are insured if not less than one-half (and not less than 6) of the quarters during the period elapsing after age 21 and up to the point of disability were quarters of coverage or, in the case of those disabled before age 24, at least one-half of the 12 quarters ending with the quarter in which disability began were quarters of coverage. To qualify for this alternative the worker would have to meet the statutory definition of blindness for the disability "freeze." (See above.) Workers will, however, have to meet the other regular requirements for entitlement to disability benefits, including inability to engage in any substantial gainful activity. (b) Older workers who are blind and disabled: Provides that those individuals aged 55 or over who meet the statutory definition of blindness in the disability "freeze" could qualify for cash benefits on the basis of their inability to engage in their past occupation or occupations. However, their benefits would not be paid for any month in which they are actually engaging in any substantial gainful activity. Effective for benefits for September 1965, based on applications filed on or after July 1965.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

II. PROVISIONS RELATING TO DISABILITY—Continued

Item	Prior law	Law as amended by Public Law 89-97
B. Eligibility requirements—Continued		
7. Applications	a. Provides that an individual must be under a disability when his application for a period of disability is filed.	a. Eliminates the requirement that an individual must be under a disability when his application for a period of disability is filed and substitutes instead the requirement that no application for a disability determination which is filed more than 12 months after the month in which a period of disability would end shall be accepted. This amendment permits payment of benefits in those cases of extended disability which terminated before an application was filed. Payment would be made only for months of disability which fall within the period of retroactivity of the application.
	b. Provides that the life of an application for benefits is 3 months (9 months for disability benefits); i.e., an applicant has 3 months from the date of application to qualify for benefits before his application expires.	b. Extends the life of applications for social security benefits to the date of the final decision thereon by the Secretary.
C. Payment for rehabilitation services	No applicable provision.	Provides for reimbursement from social security trust funds to State vocational rehabilitation agencies for the cost of vocational rehabilitation services furnished to disability insurance beneficiaries. Total amount of the funds that may be made available for such reimbursement could not, in any year, exceed 1 percent of the social security disability benefits paid in the previous year.
D. Disability determinations	Provides that disability determinations, including determinations that a disabled person had recovered, generally must be made by State agencies under agreements with the Social Security Administration.	No change.
E. Disability benefits offset	No applicable provision	Adds a disability benefits offset provision to existing law under which the social security disability benefit for any month for which a worker is receiving a periodic workmen's compensation benefit will be reduced to the extent that the total benefits payable to him and his dependents under both programs exceed 80 percent of his average monthly earnings covered by social security prior to the onset of disability, but with the reduction periodically adjusted to take account of changes in earnings levels.

III. BENEFIT CATEGORIES

A. Worker—old age	Full benefit payable at age 65 to fully insured retired worker. Payable at age 62 to fully insured retired worker, but on an actuarially reduced basis. Benefit is reduced by ⅝ of 1 percent for each month worker is entitled to receive a benefit before age 65—the total	No change.

	reduction is 20 percent if worker begins drawing benefits at age 62. The reduced amount is permanent, continuing after worker reaches age 65.	
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.	No change.
	A similar provision is applicable to men entitled to reduced benefit old-age and dependent husband's benefit.	
B. Wife or dependent husband	A full benefit for a wife or dependent husband is 50 percent of spouse's primary benefit.	No change.
	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.	
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.	Widows may elect an actuarially reduced benefit upon attaining age 60. Benefits will 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 is 13⅓ percent for the 24-month period—reducing her benefit from 82½ percent of her husband's benefit to 71½ percent of his benefit.
	Full benefit is 82.5 percent of deceased worker's primary benefit (75 percent each in case of 2 parents).	Effective for monthly benefits for and after September 1965.
		In the case of a widow who is entitled to an old-age benefit in her own right, the old-age benefit is reduced to take into account widow's benefits paid to her before age 62.
		Effective for benefits for and after September 1965 on the basis of applications filed in or after July 1965.
		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.	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 age 22.
		A wife, widow, or surviving divorced mother will not get benefits if the only child in her care has attained age 18 and is getting benefits solely because he is a student.

Item	Prior law	Law as amended by Public Law 89-97
D. Children—Continued		*Student and institution defined:* A full-time student is defined as an individual who is in full-time attendance as a student at an educational institution; whether or not the student was in full-time attendance is determined by the Secretary in the light of the standards and practices of the school involved. Specifically excluded is a person who is paid by his employer while attending school at the request of his employer. Provides for benefits for any period of 4 calendar months or less in which a person does not attend school if the person shows to the satisfaction of the Secretary that he intends to continue in full-time school attendance immediately after the end of the period, or does in fact return. 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 is 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 July 1965. For children currently on rolls, no application is required.
	Definition of a child based on the laws applied in determining the devolution of intestate personal property in the State in which the worker is domiciled.	Includes in definition of child a child who cannot inherit his father's intestate personal property if the father had acknowledged him in writing, had been ordered by a court to contribute to his support, had been judically decreed to be his father or had been shown by other satisfactory evidence to be his father and was living with or contributing to his support.
	A child adopted by a worker who is already retired and getting old-age insurance benefits can become entitled to benefits without regard to whether he was dependent on the worker at the time the latter retired.	Child adopted by retired worker can get benefits if (1) at the time the worker became entitled to benefits the child was living with the worker or adoption proceedings had begun (2) the adoption was completed within 2 years of the time when the worker became entitled to benefits and (3) the child had been receiving ½ of his support from the worker for the entire year before the worker filed his application for old-age insurance benefits or, if the worker had a period of disability which continued until he became entitled to old-age insurance benefits, before the beginning of the period of disability.

	A benefit of a child (based upon a deceased wage earner) will terminate upon adoption, except if by stepparent, grandparent, aunt, or uncle.	Effective for applications filed on or after July 30 1965. Exception broadened to include adoption by child's brother or sister. Effective as to benefits for months after July 1965.
E. Wife, husband, widow, and widower	Widow's benefits are paid without regard to remarriage to an individual who dies within one year of the remarriage and is not fully insured at his death and mother's insurance benefits are paid without regard to remarriage to an individual who dies if the widow or former wife divorced is not eligible for benefits on his earnings record. Widow's, widower's or mother's insurance benefits are not payable to a remarried spouse of a deceased worker; exception is made where the remarriage is to certain specified social security beneficiaries.	Widow's benefits are payable to an aged widow or surviving divorced wife, and mother's benefits are payable to a young widow or surviving divorced mother who is not married regardless of intervening marriages. Benefits based on a prior spouse's earnings record are payable to widows age 60 or over and to widowers age 62 or over who remarry. The amount of the remarried widow's or widower's benefit is 50 percent of the primary insurance amount of the deceased spouse.
	Wife, husband, widow and widower must have been married to the worker for one year to qualify for benefits; exception is made where, in the month preceding the marriage, the spouse was actually or potentially entitled to a widow's, widower's, parent's or disabled adult child's benefit under the social security program.	Exception to the one-year duration-of-marriage requirement extended to the spouse who was, in the month preceding the marriage, actually or potentially entitled to a widow's, widower's, parent's or (if over age 18) a disabled child's annuity under the Railroad Retirement Act.
. 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 least ½ of her support from her former husband under a court order or agreement at the time of his death.	Wife's or widow's benefits are payable to an aged divorced woman on her former husband's earnings if she (A) had been married to her former husband for 20 years before the divorce; (B) is not married, regardless of intervening marriages; and (C) met the following support requirement when her former husband became disabled, entitled to benefits or died: (1) She was receiving ½ of her support from her former husband, or (2) she was receiving substantial contributions from him pursuant to a written agreement, or (3) a court order for substantial contributions was in effect. Payment of a wife's or widow's benefit to a divorced woman does not reduce the benefits paid to any other person on the same social security account and such wife's or widow's benefit are not reduced because of other benefits payable on the same account. Benefits for a divorced wife or a surviving divorced wife are not terminated on account of remarriage in those cases where the remarriage is to a man getting benefits as a dependent widower or parent or as a disabled child aged 18 or over. If a divorced wife or a surviving divorced wife marries an old-age insurance beneficiary, her benefits are terminated but she is immediately eligible for wife's benefit on her new husband's account. A wife's benefits are not terminated when the woman and her husband are divorced if the marriage has been in effect for 20 years. The support requirements that must be met by a surviving divorced mother (termed "former wife divorced" under prior law) in order to qualify for mother's benefits based on the social security account of her deceased former husband conform to the new support requirements for aged divorced women.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

III. BENEFIT CATEGORIES—Continued

Item	Prior law	Law as amended by Public Law 89–97
G. Dependency of husbands and widowers.	Wife must be currently insured and have provided ½ of husband's or widower's support; exception made where the husband or widower was, in the month preceding the marriage, actually or potentially entitled to widower's, parent's or disabled adult child's benefits under the social security program.	Provides an exception to the currently insured and ½ support requirements where the husband or widower was, in the month preceding the marriage, actually or potentially entitled to a widower's, parent's or (where over age 18) child's annuity under the Railroad Retirement Act.
H. "Transitional insured status" for certain workers, wives and widows aged 72 or over.	No provision.	(See fully insured status, p. 64.)
I. Time for filing proof of support and application for lump-sum death payment.	Proof of support for husband's, widower's, and parent's benefits, and applications for lump-sum death payments must be filed within a 2-year period specified in the law with an additional 2-year period allowed where there was good cause for failure to file on time.	If there is good cause for failure to file in the initial 2-year period an applicant is allowed to file at any time. Effective with respect to applications for lump-sum death payments filed in or after July 1965, 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.	Maximum amount $6,600 beginning with 1966.
B. Average monthly wage	In general, an individual's "average monthly wage" which determines his old-age insurance benefit amount (before reduction for retirement before age 65) is computed by dividing the total of his creditable earnings after the applicable starting date and up to the applicable closing date, by the number of months involved. Excluded from this computation are all months and all earnings in any year any part of which was included in a period of disability under the disability "freeze" (except that the months and earnings in the year in which the period of disability begins may be included if the resulting benefit would be higher).	No change except—
	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	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 is the year of attainment of age 65 (62 for women) regardless of whether he is eligible (insured) in that year.

	and disability cases the number of years would be determined by the date of death or disability. In those cases where a larger benefit would result (because the individual's best earnings were in years before 1951) the number of years would be those elapsing after 1936, rather than 1950. The earnings used in the computation would be earnings in the highest years. Earnings in years prior to attainment of age 22 or after attainment of retirement age could be used if they were higher than earnings in intervening years. The span of years could never be less than 2. Generally, the span of years to be used for the benefit computation in retirement cases could not be less than 5—the number of years that would have to be used under the prior law by people who attained retirement age in 1961.	
C. Recomputations	After a person has become entitled to benefits, he may, under certain circumstances, have his "average monthly wage" recomputed if it will increase his monthly benefit: (1) Recalculation to correct errors in original computation. (2) 1954 work recomputation: Where an individual who has 6 quarters of coverage after 1950 returns to work after becoming entitled to benefits and earns more than $1,200 in a year he may have his average monthly wage recomputed including such earnings. Survivors are also entitled to any increase in benefits which would result from such recomputation. (3) Dropout recomputation: Beneficiary who became entitled to benefits prior to the amendment which allowed a dropout of 5 years of lowest earnings may have a recomputation using the dropout if he has 6 quarters of coverage after June 1953. Survivors are entitled to any increases which would result from such a recomputation. (4) Current year recomputation: An individual becoming entitled to benefits after August 1954 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.	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 prior law will be deemed to have applied for such recomputation in July 1965 or as soon thereafter as they are eligible but no later than Jan. 1, 1966 (so that the recomputation will be made automatically). Provision also made applicable at age 62 to reduced benefits for widows who were aged 60–61 at time of claim.

OLD-AGE SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

IV. BENEFIT AMOUNTS—Continued

Item	Prior law	Law as amended by Public Law 89–97
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 benefit table is amended so as to increase all primary insurance amounts by 7 percent, with a $4 guaranteed minimum increase. The benefit table is also extended to reflect the annual earnings base of $6,600 effective in 1966. For average monthly wages above $400, primary insurance amounts are derived by applying the benefit formula underlying the prior table and adding $9.00, the amount of increase provided for persons with the prior maximum average monthly wage of $400 ($8.90) rounded to the nearest dollar. The formula underlying the new benefit table is approximately 62.97 percent of the 1st $110 of the average monthly wage, plus 22.9 percent of the next $290, plus 21.4 percent of the next $150.
E. Maximum primary insurance amount	$127 a month ($400 average monthly wage).	$168 a month ($550 average monthly wage).
F. Minimum primary insurance amount	$40 a month.	$44 per month.
G. Maximum family benefits	Family maximum monthly benefits are set by the table and range from $53 to $254. Though not specifically stated in the law, the maximum family benefit shown in the benefit table is 1½ times the primary insurance amount or approximately 80 percent of the average monthly wage, whichever is larger, up to an absolute maximum of $254—twice the maximum primary insurance amount of $127.	Family maximum benefits range from $66 to a maximum of $368. Although not specifically stated in the law, the formula used to determine the maximum family benefit shown in col. V of the new benefit table is the larger of (*a*) 1½ times the primary insurance amount or (*b*) approximately 80 percent of the average monthly wage up to the point at which the average monthly wage is ⅔ of the maximum possible average monthly wage, plus 40 percent of the remainder. The maximum benefit payable to a family is related to the worker's average monthly wage at every average monthly wage bracket in the benefit table. The maximum payable to a family on the benefit rolls in 1965 is $309.20 (based on an average monthly wage of $400). At the maximum average monthly wage level, $550 (under the $6,600 base), the maximum family benefit is about ⅔ 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 July 1965.
H. Lump-sum death payment	3 times the primary insurance amount with a statutory maximum of $255.	No change.

Illustrative benefits provided under prior law and under Public Law 89–97

I. Illustrative monthly benefits:

Average monthly wage [1]	Old-age benefits [2]				Survivors benefits [3]				
	Worker		Man and wife		Widow aged 62, widower, or parent		Widow aged 60 [4]	Widow and 2 children [5]	
	Prior law	Public Law 89–97	Prior law	Public Law 89–97	Prior law	Public Law 89–97	Public Law 89–97	Prior law	Public Law 89–97
$67 or less	$40.00	$44.00	$60.00	$66.00	$40.00	$44.00	$38.20	$60.00	$66.00
$100	59.00	63.20	88.50	94.80	48.70	52.20	45.30	88.50	94.80
$150	73.00	78.20	109.50	117.30	60.30	64.60	56.00	120.00	120.00
$200	84.00	89.90	126.00	134.90	69.30	74.20	64.40	161.70	161.70
$250	95.00	101.70	142.50	152.60	78.40	83.90	72.80	202.50	202.50
$300	105.00	112.40	157.50	168.60	86.70	92.80	80.50	236.40	240.00
$350	116.00	124.20	174.00	186.30	95.70	102.50	88.90	254.10	279.60
$400	127.00	135.90	190.50	203.90	104.80	112.20	97.30	254.10	306.00
$450	(6)	146.00	(6)	219.00	(6)	120.50	104.50	(6)	328.00
$500	(6)	157.00	(6)	235.50	(6)	129.60	112.40	(6)	348.60
$550	(6)	168.00	(6)	252.00	(6)	138.60	120.20	(6)	368.00

[1] As defined in the law.

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

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

[4] No provision under prior law.

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

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

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued
(Title II of the Social Security Act)—Continued
V. FULLY INSURED STATUS

Item	Prior law	Law as amended by Public Law 89–97
	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 (See, however, special provision for young disabled workers who are blind), 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 the law:

Year of attainment of retirement age 62 (for women) or age 65 (for men)	Required quarters	
	Regular	Transitional
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 are payable at age 72 to a woman who reaches 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 reaches age 72 before 1969 but whose husband died before the transitional provision became effective can 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 regular provision	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 September 1965.

VI. RETIREMENT TEST		
A. Scope	Applies to covered as well as noncovered work.	Excludes royalties received at or after age 65 on works copyrighted or patented before age 65. Effective for taxable years beginning after 1964.
B. Test of earnings	Provides that benefits will be withheld from a beneficiary under age 72 (and from any dependent drawing on his record) at the rate of $1 in benefits for each $2 of annual earnings between $1,200 and $1,700 and $1 in benefits for each $1 of annual earnings above $1,700. Benefits not withheld for any month during which the individual neither rendered services for wages in excess of $100 nor rendered substantial services in a trade or business.	Increases the annual exempt amount from $1,200 to $1,500. Permits payment of full benefits to beneficiary, regardless of the amount of his annual earnings, for any month in which he does not earn wages of more than $125, instead of more than $100. Increases the uppermost limit of the $1-for-$2 "band" from $1,700 to $2,700, so that $1 in benefits would be withheld for each $2 of earnings between $1,500 and $2,700, with $1-for-$1 reductions above $2,700. Effective for taxable years ending after 1965.
C. Age exemption	Benefits are not suspended because of work or earnings if beneficiary is age 72 or over.	No change.
VII. FINANCING		
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).	The allocation to the Disability Insurance Trust Fund, for years beginning after 1965, is increased to 0.70 of 1-percent of taxable wages and 0.525 of 1-percent of taxable self-employment income.
B. Maximum taxable amount	$4,800 a year.	$6,600 a year starting with 1966.
C. Tax rate for self-employed	Taxable years beginning in— 1966–67 — 6.2 1968 and thereafter — 6.9	Taxable years beginning in— 1966 — 5.8 1967–68 — 5.9 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 — 3.85 1967–68 — 3.9 1969–72 — 4.4 1973 and thereafter — 4.85
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 are to be reimbursed by a level annual appropriation starting with fiscal year 1966 that will amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015, and by annual appropriations thereafter.
F. Railroad retirement tax	The Railroad Retirement Tax Act provides that the railroad tax will automatically adjust in the same amount, and at the same time, to any change in the OASDI tax rate after 1954.	No change, except for simplifying amendment.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—Continued

(Title II of the Social Security Act)—Continued

VIII. MISCELLANEOUS

Item	Prior law	Law as amended by Public Law 89–97
A. Advisory Council on Social Security	Councils 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 to be appointed in 1968 and every 5th year thereafter to review all aspects of the program (including the new hospital and supplementary medical insurance programs) and submit reports to the Secretary of Health, Education, and Welfare for transmittal to the Congress and the Board of Trustees. Members are to represent organizations of employees and employers in equal numbers and the self-employed and the general public and can 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 required to meet at least once every 6 months.	The Board of Trustees is required to meet at least once every calendar year.
C. Disclosure of information—Deserting parents.	No disclosure authorized except as prescribed by regulations. Under Regulation No. 1 information is furnished to agency administering AFDC program as to whereabouts of deserting parents of eligible children.	Requires the Secretary to furnish, at the request of a State or local agency participating in any State or local public assistance program, the most recent address in the social security records for a parent (or his most recent employer, or both) who has failed to provide support for his or her destitute child or children under age 16 who are recipients of or applicants for assistance under such public assistance program, where there is a court order for the support of the children and the information requested is to be used by the welfare agency or the court on behalf of the children.
D. Paying two or more members of same family.	Secretary of Health, Education, and Welfare may authorize a joint payment equal to the total benefits due to any two or more members of the same family.	Adds a provision that under regulations to be issued by the Secretary of the Treasury, the surviving payee or payees of a joint benefit check may cash any such check which was not negotiated before one of the payees died, provided that if the amount of the check exceeds the amount due the surviving payee or payees, the excess amount shall be recovered.
E. Underpayments	Where an error has been made resulting in an underpayment to a beneficiary who has since died, the underpayment is to be paid by increasing the subsequent benefits of others getting benefits on the same earnings record as the deceased. Since the law did not contain any provision for the disposition of underpayments in death cases where there are no subsequent benefits payable, administrative policies have been developed for settling such underpayments.	In the case of underpayments where an individual dies before the completion of the payment of amounts due him and such amount at the time of his death does not exceed an amount equal to 1 month's benefit, payment is to be made to his surviving spouse who was living in the same household, or, if there is no such spouse, to the legal representative of his estate. In all other cases, the amounts due the deceased person are to be paid, as under prior law.
F. Attorneys' fees	The Secretary may prescribe the maximum fees which an attorney or other person may charge for services performed in connection with any claim before the Secretary. Any person who charges or collects more than the permitted fee is subject to a fine of up to $500, imprisonment up to one year, or both.	Adds a provision to permit a court which renders a decision favorable to a claimant for social security benefits to set a reasonable fee for the attorney who represented the claimant before the court. The fee cannot exceed 25 percent of the past-due benefits which result from the court's decision. The Secretary may certify for payment to the attorney, out of the total of the past-due benefits, the amount of the fee set by the court. Any attorney charging or receiving more than the fee set by the court is subject to a fine of up to $500, imprisonment up to one year, or both.

MEDICAL EXPENSE DEDUCTION FOR INCOME TAX PURPOSES

Item	Prior law	Law as amended by Public Law 89–97
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.	Regardless of age of taxpayer, premiums for "insurance which constitutes medical care" are deductible as follows: (1) One-half of such premiums, but not more than $150 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. 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. Makes 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.	All maximum limitations are repealed.

MEDICAL EXPENSE DEDUCTION FOR INCOME TAX PURPOSES—Continued

Item	Prior Law	Law as amended by Public Law 89–97
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 $73 million. The net effect of the changes is to increase revenues by about $97 million.
VI. Effective date		Taxable years beginning after December 31, 1966.