Excerpts From

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS

ON

H.R. 6675

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

CONTENTS

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SOCIAL SECURITY AMENDMENTS OF 1965

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

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

REPORT

[To accompany H.R. 6675]

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

I. OVERALL PURPOSE AND SCOPE OF THE BILL

PURPOSE

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

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

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

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

(3) A greatly expanded medical assistance program for the needy and medically needy which would combine all the vendor medical provisions for the aged, blind, disabled, and families with dependent children, now in five titles of the Social Security Act, under a uniform program and matching formula in a single new title.

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

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

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

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

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

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

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

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

(7) Amending the coverage provisions by:

(*a*) Including self-employed physicians;

(*b*) Covering cash tips;

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

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

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

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

(9) Making other miscellaneous improvements.

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

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

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

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

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

SCOPE

The scope of the protection provided is broadly as follows:

Health insurance and medical care for the needy

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

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

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

Old-age, survivors, and disability insurance

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

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

Public assistance

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

II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. Health Insurance and Medical Care for the Aged

Your committee's bill would add a new title XVIII to the Social Security Act providing two related health insurance programs for persons 65 or over:

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

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

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

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

Your committee's bill would also add a new title XIX to the Social Security Act which would provide a more effective Kerr-Mills program for the aged and extend its provisions to additional needy persons. It would replace with a single uniform category the differing medical provisions for the needy which currently are found in five titles of the Social Security Act.

A description of these three programs follows:

1. BASIC PLAN—HOSPITAL INSURANCE, ETC.

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

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

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

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

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

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

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

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

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

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1968. For reasons of administrative simplicity, increases in the hospital deductible will be made only when a $5 change is called for and the outpatient deductible will change in $2.50 steps.

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

Administration.—Basic responsibility for administration would rest with the Secretary of Health, Education, and Welfare. The Secretary would use appropriate State agencies and private organizations (nominated by providers of services) to assist in the administration of the program. Provision is made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration.

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

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

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

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

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

2. VOLUNTARY SUPPLEMENTARY INSURANCE PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(*c*) Ambulance services; and

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

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

Administration by carriers: Basis for reimbursement.—The Secretary of Health, Education, and Welfare would be required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the voluntary supplementary plan such as determining rates of payments under the

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

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

The Government would help finance the supplementary plan through a payment from general revenues in an equal amount of $3 a month per enrollee. To provide an operating fund, if necessary, at the beginning of the supplementary plan, and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis) equal to $18 per aged person estimated to be eligible in July 1966 when the supplementary plan goes into effect.

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

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

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

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

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

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

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

Purpose and scope.—In order to provide a more effective Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons, the bill would establish a single and separate medical care program to replace the differing provisions for the needy which currently are found in five titles of the Social Security Act.

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

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

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

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

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

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

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

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

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

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

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

Effective date.—January 1, 1966.

4. COST OF HEALTH CARE PLANS

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

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

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

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

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

B. CHILD HEALTH AMENDMENTS

Maternal and child health and crippled children.—The bill would increase the amount authorized for maternal and child health services over current authorizations by $5 million for fiscal year 1966 and by $10 million in each succeeding fiscal year, as follows:

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

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

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

Crippled children-training personnel.—The bill would also authorize $5 million for the fiscal year 1967, $10 million for fiscal 1968, and $17.5 million for each succeeding fiscal year to be for grants to institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps.

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

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

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

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

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

1. BENEFIT CHANGES

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

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

Monthly benefits for workers who retire at or after 65 would be increased to a new minimum of $44 (now $40) and to a new maximum of $135.90 (now $127). In the future, creditable earnings under the increase in the contribution and benefit base to $5,600 a year (now $4,800) would make possible a maximum benefit of $149.90.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly earnings at all earnings levels. Under present law, there is a $254 limit on family benefits which operates over a wide range of average monthly earnings. Under the bill, until 1971, the highest family maximum would be $312.

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

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

H.R. 6675 includes the provision adopted by both House and Senate last year which would continue to pay a child's insurance benefit

until the child reaches age 22, provided the child is attending a public or an accredited school, including a vocational school or a college, as a full-time student after he reaches age 18. Children of deceased, retired, or disabled workers would be included. No mother's or wife's benefits would be payable if the only child in the mother's care is one who has attained age 18 but is in school.

This provision will be effective January 1, 1965. It is estimated that 295,000 children will be able to receive benefits for a typical school month in 1965 as a result of this provision.

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

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

This provision, adopted by both Houses of Congress last year, would be effective for the second month after the month of enactment. It is estimated that 185,000 widows will be able to get benefits immediately under this provision.

(*d*) *Amendment of disability program*

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

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

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

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

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

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

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

Your committee's bill adopts a provision approved by the House and Senate last year, which would liberalize the eligibility requirements by providing a basic benefit of $35 at age 72 or over to certain persons with a minimum of three quarters of coverage acquired at any time since the beginning of the program in 1937. To accomplish this, a new concept of "transitional insured status" is provided. Present law requires a minimum of six quarters of coverage in employment or self-employment.

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

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

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

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

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

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

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

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

The table below sets forth the requirements as to widows:

Transitional insured status requirements with respect to widow's benefits

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

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

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

These provisions would become effective for the second month after the month of enactment, at which time an estimated 355,000 people would be able to start receiving benefits.

(*f*) *Retirement test*

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

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

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

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

Your committee's bill would authorize payments of wife's and widow's benefits to the divorced wife aged 62 or over of a retired, deceased, or disabled worker if she had been married to the worker for at least 20 years before the date of the divorce and if her divorced husband was making (or was obligated by a court to make) a substantial contribution to her support when he became entitled to benefits, became disabled, or died. H.R. 6675 would also provide that a wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years. Provision is also made for the reestablishment of benefit rights for a widow or a wife who remarries and the subsequent marriage lasts less than 20 years. These changes are effective for the second month following the month of enactment.

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

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

2. COVERAGE CHANGES

The following coverage provisions were included:

(*a*) *Physicians and interns*

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

(*b*) *Farmers*

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

(*c*) *Cash tips*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. MISCELLANEOUS

(*a*) *Filing of proof*

H.R. 6675 extends indefinitely the period of filing of proof of support for dependent husbands, widowers and parent's benefits, and for filing application for lump-sum death payments where good cause exists for failure to file within the initial 2-year period.

(*b*) *Automatic recomputation of benefits*

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

(*c*) *Military wage credits*

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

4. FINANCING OF OASDI AMENDMENTS

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

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

[In percent]

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

5. AMOUNT OF ADDITIONAL BENEFITS IN THE FULL YEAR 1966

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

D. Public Assistance Amendments

1. INCREASED ASSISTANCE PAYMENTS

The Federal share of payments under all State public assistance programs is increased a little more than an average of $2.50 a month for the needy aged, blind, and disabled and an average of about $1.25 for needy children, effective January 1, 1966. This is brought about by revising the matching formula for the needy aged, blind, and disabled (and for the adult categories in title XVI) to provide a Federal share of $31 out of the first $37 (now twenty-nine thirty-fifths (29/35) of the first $35) up to a maximum of $75 (now $70) per month per individual on an average basis. The matching formula is revised for aid to families with dependent children so as to provide a Federal share of five-sixths (5/6) of the first $18 (now fourteen-seventeenths (14/17) of the first $17) up to a maximum of $32 (now $30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients. Effective January 1, 1966. Cost About $150 million a year.

2. TUBERCULAR AND MENTAL PATIENTS

H.R. 6675 removes the exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been

diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. The bill requires as condition of Federal participation in such payments to, or for, patients in mental hospitals certain agreements and arrangements to assure that better care results from the additional Federal money. The States will receive additional Federal funds under this provision only to the extent they increase their expenditures for mental health purposes under public health and public welfare programs. The bill also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions.

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

3. PROTECTIVE PAYMENTS TO THIRD PERSONS

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

4. EARNINGS EXEMPTION UNDER OLD-AGE ASSISTANCE

Your committee's bill increases earnings exemption under old-age assistance program (and aged in combined program) so that a State may, at its option, exempt the first $20 (now $10) and one-half of the next $60 (now $40) of a recipient's monthly earnings. Effective January 1, 1966. Cost: About $1 million first year.

5. DEFINITION OF MEDICAL ASSISTANCE FOR AGED

H.R. 6675 modifies the definition of medical assistance for the aged so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution. Effective July 1, 1965. Cost: About $2 million.

6. EXEMPTION OF RETROACTIVE OASDI BENEFIT INCREASE

The bill adds a provision which would allow the States to disregard so much of the OASDI benefit increase (including the children in school after 18 modification) as is attributable to its retroactive effective date.

7. ECONOMIC OPPORTUNITY ACT EARNINGS EXEMPTION

H.R. 6675 also provides a grace period for action by States that have not had regular legislative sessions, whose public assistance statutes now prevent them from disregarding earnings of recipients received under the Economic Opportunity Act.

8. JUDICIAL REVIEW OF STATE PLAN DENIALS

The bill provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans and of his action under such programs or noncompliance with State plan conditions in the Federal law.