

Social Security Amendments of 1965: Summary and Legislative History

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WITH THE SIGNING on July 30, 1965, of H.R. 6675, the Social Security Amendments of 1965 became law. The historic legislation, Public Law 89-97, establishes two coordinated health insurance programs for the aged and makes a number of substantial improvements in the existing old-age, survivors, and disability insurance (OASDI) program and other programs under the Social Security Act.

The most significant changes in the social security system are the following:

1. Establishment of two related national health insurance programs for the aged—(a) a basic plan affording protection against the costs of hospital and related care, and (b) a voluntary supplementary plan covering payments for physicians' services and other medical and health services.

2. A 7-percent increase in OASDI benefits.

3. Liberalization of the definition of disability.

4. Liberalization of the retirement test.

5. Payment of benefits to eligible children aged 18-21 who are attending school.

6. Payment of benefits to widows at age 60 on an actuarially reduced basis.

7. Coverage of self-employed physicians.

8. Coverage of tips as wages.

9. Liberalization of insured-status requirements for persons already aged 72 or over.

10. Increase to \$6,600 in the contribution and benefit base.

11. Increase in the contribution rate schedule.

The amendments include the following important changes in the public assistance titles of the Social Security Act.¹

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¹ For a brief summary of the amendments affecting public assistance and the maternal and child health and child welfare programs, see pages 18-21. *Welfare in Review* (Welfare Administration), August 1965, carries a legislative history and a fuller description of the welfare provisions of P. L. 89-97.

1. Establishment, under a new title, of a program to provide medical assistance for needy or medically needy aged, blind, or disabled persons and dependent children.

2. Increased Federal sharing in assistance payments to the aged, the blind, the disabled, and dependent children.

3. Removal of limitations on Federal participation in assistance payments with respect to aged persons in tuberculosis and mental disease hospitals under certain conditions.

4. New or increased amounts of income received by assistance recipients that may be disregarded in determining need.

The major changes in the maternal and child health and child welfare services are the following:

1. Increase in the annual authorizations of Federal funds for the three programs.

2. Authorization of special project grants to provide comprehensive health care for children of low-income families.

Background and Legislative History of the Insurance Provisions

The Social Security Amendments of 1965 embody the most far-reaching social security legislation to be enacted since the original Social Security Act was passed 30 years earlier. The law closes one of the major gaps in the economic security of the elderly by providing protection against the high costs of hospital and medical care, and it brings the existing OASDI program more in line with current economic and social conditions.

Bills to provide hospital insurance and related health benefits as part of the social security system have been introduced in every Congress since 1952. The proposals did not receive active congressional consideration, however, until 1958,

when Representative Forand (D., R.I.) introduced a bill that became the subject of testimony in public hearings before the Committee on Ways and Means of the House of Representatives on the Social Security Amendments of 1958. The Committee concluded that more information was needed before legislation could be recommended, and no further action was taken on the proposal at that time.

In 1959 and 1960 the Committee on Ways and Means held public hearings on several proposals to amend the Social Security Act, including another bill (H.R. 4700) introduced by Representative Forand to provide "insurance against the costs of hospital, nursing-home, and surgical services for persons eligible for old-age and survivors insurance benefits." The Committee, after careful review of the many proposed solutions to the problem of meeting health costs in old age, concluded that Federal action was necessary but did not recommend adoption of the proposal for hospital insurance under the social security system. Instead, the Committee recommended additional medical assistance for the needy aged through liberalizations in the Federal-State public assistance programs. This proposed medical assistance legislation was later modified by the Senate Finance Committee, and the result was a new program of medical assistance for the aged. Before its passage, Senator Clinton P. Anderson (D., N. Mex.), Senator John F. Kennedy (D., Mass.) and eight other Senators proposed adding a program of hospital insurance for persons aged 68 and over who were eligible for OASDI benefits. The amendment was defeated by a vote of 51 to 44.

The medical assistance legislation — often referred to as the "Kerr-Mills" program—won bipartisan support and was enacted on September 13, 1960, as part of H.R. 12580 (P. L. 86-778). These amendments made Federal matching grants available to the States to help finance programs of medical assistance for older persons who do not receive old-age assistance payments but who cannot afford necessary medical care. The legislation also provided increased Federal grants to help the States furnish more nearly adequate medical aid to old-age assistance recipients.

With the election of President Kennedy in 1960, the proposal for hospital insurance for the

aged under the Social Security Act became part of the Administration's legislative program. In 1961 the Administration-sponsored hospital insurance proposal was contained in bills introduced by Representative King (D., Calif.) and by Senator Anderson (D., N. Mex.) and Senator Javits (R., N.Y.).

In 1962, Senator Anderson proposed, as an amendment to the public welfare bill, hospital insurance as part of the social security system. The Senate voted 52 to 48 to table the amendments, and no further action was taken on the proposal by the Eighty-seventh Congress.

ACTION IN THE EIGHTY-EIGHTH CONGRESS

In his State of the Union Message of January 14, 1963, President Kennedy urged the new Congress to enact a program of health insurance for the aged under the Social Security Act. He elaborated on this theme in both his special Message on a Health Program, submitted to Congress on February 7, and in his special Message on Elderly Citizens of Our Nation, submitted on February 21. In the latter message, the President recommended not only the enactment of a program of hospital insurance for the elderly but also numerous improvements in the OASDI program, such as increases in benefit amounts and in the contribution and benefit base. Representative King and Senator Anderson again introduced the proposed hospital insurance legislation on behalf of the Administration; the two companion bills were introduced on February 21, 1963.

On July 7, 1964, the House Committee on Ways and Means reported out H.R. 11865, which provided for a number of major improvements in the social security program, including a 5-percent increase in cash benefits and extension of coverage to additional groups. Although proposals for a hospital insurance program for the aged were considered by the Committee, the proponents did not request that the Committee vote either on the hospital insurance measure or on any changes in medical assistance for the aged. H.R. 11865 was passed by the House by a vote of 388 to 8.

The Senate Finance Committee rejected proposals to add to H.R. 11865 hospital insurance for the aged within the framework of the social

security program. During the Senate debate on H.R. 11865, however, an amendment to provide such a program was adopted by a vote of 49 to 44, and the Senate subsequently passed the bill by a vote of 60 to 28. The Conference Committee failed to reach agreement on the hospital insurance part of the bill as passed by the Senate, and H.R. 11865 died in the Conference Committee when the Eighty-eighth Congress came to an end on October 3, 1964.

CONGRESSIONAL ACTION IN 1965

As the Eighty-ninth Congress convened on January 3, 1965, there was every indication that major social security legislation related to both health insurance and increased cash benefits would be on its agenda for early consideration. The improvements in OASDI that had failed to be enacted 3 months earlier because the Conference Committee did not agree on the hospital insurance provisions of H.R. 11865 were considered to be noncontroversial. It was also generally conceded that the November elections had ensured passage by the House of any hospital insurance legislation that the Committee on Ways and Means might report out. Finally, the House, in an unusual action, changed the composition of the Ways and Means Committee—shortly after Congress convened—to reflect the large majority that the Democrats held in the House of Representatives.

On January 4, 1965, Representative King introduced H.R. 1—the Administration's proposals for hospital insurance and improvements in the OASDI program as well as in the public assistance programs. Senator Anderson introduced the companion bill, S. 1. The King-Anderson bills contained a number of the provisions that had been considered by Congress in 1964.

The major provisions of H.R. 1 were:

1. Hospital insurance for the aged.
2. A general increase of 7 percent in cash benefits.
3. An increase to \$5,600 in the contribution and benefit base.
4. An increase in the contribution schedule.
5. Coverage of self-employed doctors.
6. Coverage of tips.
7. Extension of the period for filing proof of

support and filing application for lump-sum death payments.

8. Automatic recomputation of benefits.

Action of Ways and Means Committee

On January 27 the Committee on Ways and Means began executive sessions on the King-Anderson bill and other bills, particularly H.R. 288, which was introduced by Representative Byrnes (R., Wis.)—the ranking minority member of the Committee. The OASDI provisions of H.R. 288 were similar to those in H.R. 11865, but there was no provision for hospital insurance.

Two other bills, which would have provided health insurance benefits for the aged under a system not related to social security, also received the Committee's attention. The "Eldercare" proposal—identical bills, H.R. 3727 and H.R. 3728—was made by Representative Herlong (D., Fla.) and Representative Curtis (R., Mo.). This proposal would have modified the provisions of the Kerr-Mills program to encourage the States to provide medical assistance for the aged, the blind, and the disabled in the form of private health insurance coverage.

The second proposal, H.R. 4351, was introduced by Representative Byrnes and was supported by five of the eight Republican Committee members. It would have established a Federal health insurance program for the aged, financed from Federal general revenues and from premiums paid by participants. Enrollment would have been voluntary, and premium amounts would have been scaled to the amount of the participant's OASDI benefits.

After 2 months of deliberations, Chairman Mills introduced H.R. 6675, embodying the decisions made during the executive sessions of the Committee. The new bill provided for two related health insurance programs. The first was a basic program, under the social security system, of protection against hospital and related health costs, similar to the program proposed by the King-Anderson bill. Unlike that bill, however, the Committee's bill called for financing by an earnings tax identified separately from the present social security taxes.

The second health program for the aged proposed in the Committee's bill was a voluntary

program of protection against the cost of physicians' and certain other medical and health services not covered under the basic program. The supplementary program was to be financed by premiums from enrollees and a matching amount paid by the Federal Government from Federal tax revenues.

The Committee's reasons for recommending the health insurance programs were stated in its report² as follows:

Although your committee believes that the Kerr-Mills legislation as a whole has been very beneficial to the needy aged in our country, it has now concluded that the overall national problem of adequate medical care for the aged has not been met to the extent desired under existing legislation because of the failure of some States to implement to the extent anticipated and thus the existing program is inadequate to solve the problem. Your committee, therefore, has concluded that a more comprehensive Federal program as to both persons who can qualify and protection afforded is required.

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

In addition to the OASDI provisions of H.R. 1, the Committee adopted the following provisions of H.R. 288:

1. Payment of actuarially reduced benefits to widows at age 60.

2. Payment of child's insurance benefits after attainment of age 18 and up to the age of 22 for a full-time student.

3. Payment of benefits to certain uninsured persons already aged 72 and over who have fewer than 6 quarters of coverage under transitional provisions that would permit benefits to be paid on the basis of 3, 4, or 5 quarters of coverage.

4. Provision for members of certain religious sects to be exempt from social security self-employment taxes upon application accompanied by a waiver of all benefits and other payments under the Social Security Act.

² *Social Security Amendments of 1965: Report of the Committee on Ways and Means on H.R. 6675*, (House Report No. 213, 89th Cong., 1st sess.), 1965, page 20.

5. An increase from \$1,800 to \$2,400 in the maximum amount of gross farm income that farmers may use in computing covered farm self-employment income under the optional method of reporting such income.

6. An increase from \$1,700 to \$2,400 in the span of earnings over which \$1 in benefits is withheld for each \$2 in earnings.

The Committee also adopted the following provisions:

1. Payment of wife's or widow's benefits to a divorced wife aged 62 or over if she had been married to the worker for at least 20 years and if her divorced husband was making a substantial contribution to her support when he became entitled to benefits or died, and restoration of benefit rights that were terminated by remarriage if the marriage ended in divorce after 20 years.

2. Exclusion from gross income of a self-employed person who has attained age 65, for retirement test purposes, of royalties received in or after the year of attaining age 65 from a copyright or patent obtained before that year.

3. Elimination of the requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration, and provision instead for an insured worker to be eligible for disability benefits if totally disabled throughout a continuous period of at least 6 calendar months.

4. Payment of disability benefits beginning with the last month of the 6-month waiting period rather than after the 6-month waiting period.

H.R. 6675 was reported to the House of Representatives on March 29. On April 8, after 2 days of debate on H.R. 6675 under a closed rule, the House passed the bill, without amendment, by a vote of 313 to 115.

Action of Senate Finance Committee

The Senate Finance Committee held 15 days of public hearings (April 29 through May 19) on H.R. 6675. In testifying for the Administration the Secretary of Health, Education, and Welfare, Anthony J. Celebrezze, endorsed the proposed health insurance programs for the aged and recommended adoption with only one major change.

The Secretary recommended that physicians' services in the fields of radiology, anesthesiology, pathology, and physical medicine be covered under the hospital insurance program rather than the supplementary program, where the services are furnished through an arrangement under which the physician bills for his services through the hospital.

Throughout the public hearings of the Senate Finance Committee, testimony centered on the proposed health insurance programs. Opposition to the programs came largely from the American Medical Association and various State and local medical societies. The American Medical Association based its opposition on the belief that the programs would eventually lead to Government intervention into the practice of medicine. Some medical groups, however, testified in support of the health insurance provisions of the bill.

During executive sessions, the Senate Finance Committee adopted the Secretary's recommendation, as proposed in an amendment by Senator Douglas (D., Ill.). Under this proposal, the professional services of radiologists, anesthesiologists, pathologists, and physiatrists, when provided under arrangements with hospitals, would be covered under the hospital insurance plan rather than under the supplementary plan (as the House bill had provided). The Committee also increased the maximum duration of hospital benefits from 60 days to 120, with the last 60 days of benefits subject to coinsurance payments by the beneficiary, and adopted several changes that liberalized benefits under the two proposed health insurance programs.

In addition, the Committee adopted a number of changes in the cash benefits provisions of the bill, including the following:

1. Liberalization of the House-approved retirement test provision by increasing to \$1,800 the annual amount of earnings exempt from the test, by extending the \$1-for-\$2 adjustment span to \$3,000 with a \$1-for-\$1 adjustment on earnings above \$3,000, and by raising to \$150 the amount that a beneficiary may earn in a month and still get full benefits for that month.

2. Amendment of the definition of disability to require that a qualifying disability be one that has lasted or can be expected to last at least 12 months (instead of 6, as under the House bill).

3. Deletion of the House provision under which payment of disability benefits would have started with the sixth full month of disability rather than the seventh month, as under present law.

4. Addition of a provision under which disability benefits under the Social Security Act would be reduced to take account of workmen's compensation payments when the combined monthly benefits exceed 80 percent of the recipient's average monthly earnings before his disablement.

5. Coverage of tips as self-employment income rather than as wages.

6. Payment of benefits to a child based on his father's earnings, without regard to State law, if the father was supporting him or had a legal obligation to do so.

7. Continuation of benefit payments based on a former spouse's earnings record, at the rate of 50 percent of his or her primary insurance amount, to widows aged 60 or over and to widowers aged 62 or over who remarry.

8. Restoration of the benefit rights lost because of remarriage for divorced wives, widows, surviving divorced wives, and surviving divorced mothers who are not currently married.

9. Addition of a provision authorizing limited expenditures from social security trust funds to reimburse State agencies for vocational rehabilitation services furnished to selected disability insurance beneficiaries.

10. Addition of a provision for payment of disabled child's benefits to a child who is disabled before reaching age 22 (instead of age 18, as under present law).

11. Addition of a provision under which an affiliated group of corporations would be considered a single employer for purposes of determining the maximum amount of annual wages subject to the employer tax.

12. Addition of a provision authorizing the Secretary to make disability determinations in those cases that can be promptly adjudicated on the basis of readily available medical and other evidence.

13. Revision of the financing provisions of the House bill to provide a \$6,600 contribution and benefit base, effective for 1966, and a contribution rate schedule under which rates would be somewhat lower in the immediate future than under

the House-passed bill but higher over the long run.

The Finance Committee reported the bill on June 30.

Senate Floor Debate

A number of amendments were adopted during the Senate debate, including the following:

1. Removal of the 120-day limit on the payment of inpatient hospital benefits; benefits beyond the sixtieth day would be reduced by a coinsurance payment of \$10 a day.

2. Elimination of the requirement under the basic hospital insurance plan that a person must have been in a hospital or extended-care facility in order to be eligible for home health benefits.

3. Appointment, to be made by the Secretary, of an Advisory Council on Social Security to make a comprehensive study of nursing homes and other extended-care facilities.

4. Provision for the Secretary to study the feasibility of covering prescription drugs under the supplementary medical insurance plan.

5. Reduction in the age of eligibility for cash benefits to 60 for everyone, with the benefits reduced to take account of the longer period over which they will be paid.

6. Exclusion of the increase in benefits under the Social Security Act from income considered for purposes of determining a person's eligibility for, or the amount of, a veteran's pension.

7. Payment of disability insurance benefits to blind persons on the basis of 6 quarters of coverage, without respect to their capacity to work.

8. Requirement that the most recent addresses of husbands and parents who have deserted their families be disclosed to a State public welfare agency or a court.

9. Addition of a provision under which adoption by a brother or sister would not terminate a child's benefits.

10. Revision of the contribution schedule to provide for slightly higher rates to meet the cost of the changes made on the Senate floor.

The Senate rejected a number of amendments. They included proposals to (1) provide for an automatic 3-percent OASDI benefit increase whenever there is a 3-percent increase in the cost

of living, by a vote of 21 for and 64 against; (2) provide under the two health insurance programs for alternate variable deductible amounts related to a person's income-tax liability, by a vote of 40 for and 52 against; (3) delete the health insurance provisions, by a vote of 26 for and 64 against; (4) delete the provision for compulsory coverage of self-employed physicians and interns, by a vote of 41 for and 50 against; and (5) provide that a worker under age 31 may qualify for disability insurance benefits if he had been in covered work for at least half the period between the date he attained age 21 and the time he became disabled, by a voice vote. The Senate rejected, by a vote of 26 for and 63 against, a motion to recommit the bill to the Finance Committee, with instructions to report the bill back immediately after eliminating the health insurance provisions and report later a bill providing medical insurance for the aged patterned after the health insurance program now in effect for retired civil-service employees, with premiums paid by those covered except those unable to pay.

On July 9 the Senate passed H.R. 6675, with amendments, by a vote of 68 to 21.

CONFERENCE COMMITTEE ACTION AND ENACTMENT

On July 14 the House and Senate conferees met to settle the differences between the two versions of H.R. 6675. On July 26 the conferees filed their report.

The bill as reported by the conferees departed from the Senate version in the following significant respects:

1. Adoption of the House provisions for covering the professional services of certain hospital-based specialists under the supplementary medical insurance program rather than under the hospital insurance plan.

2. Adoption of a compromise provision under which inpatient hospital benefits can be paid for a maximum of 90 days in a spell of illness; benefits for the first 60 days would be reduced by a \$40 deductible amount, and benefits for each day beyond the sixtieth would be reduced by a coinsurance payment of \$10.

3. Adoption of the House provisions requiring

that a person must have been in a hospital or extended-care facility in order to be eligible for home health benefits under the hospital insurance program.

4. Rejection of the Senate provisions under which a study of nursing homes and other extended-care facilities would have been made by an Advisory Council on Social Security and under which the Secretary would have been required to make a study of the feasibility of covering the cost of drugs under the supplementary medical insurance plan.

5. Adoption of a compromise provision under which the amount that a beneficiary may earn in a year and get full benefits for the year is increased from \$1,200 to \$1,500, with an increase from \$100 to \$125 in the monthly measure; \$1 in benefits is withheld for each \$2 of earnings above \$1,500 and up to \$2,700 a year and for each \$1 of earnings thereafter.

6. Deletion of the Senate provision under which the eligibility age for cash benefits would have been reduced to age 60 for everyone. (The provision under which widows can elect to get benefits at age 60 was retained.)

7. Adoption of a compromise provision under which cash tips 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 tips.

8. Deletion of the Senate provision under which the increase in benefits under the Social Security Act would have been excluded from countable income in determining eligibility for and the amount of a veteran's pension.

9. Deletion of the Senate provision under which an affiliated group of corporations would have been considered a single employer in determining the maximum amount of annual wages subject to the employer tax.

10. Deletion of the Senate provision under which childhood disability benefits would have been payable to a child who became disabled before reaching age 22.

11. Deletion of the Senate provision under which the Secretary would have been authorized to make disability determinations in certain cases.

12. Adoption of a compromise providing for (a) the payment of benefits to blind workers aged 55-65 who are unable to engage in their usual occupation and who are not doing substantial

work; and (b) an alternative disability insured-status requirement, applicable to workers who become blind before reaching age 31, under which such workers are insured if they have quarters of coverage in half the quarters elapsing after age 21 up to the time of disablement or, for those becoming disabled before age 24, quarters of coverage in at least half the 12 quarters preceding the quarter in which they become disabled.

13. Adoption of a compromise provision under which the most recent address of a deserting parent would be disclosed to a State or local welfare agency if the children are applicants for or recipients of assistance, if there is a court order for the support of the children, if the agency has attempted to obtain the information from all other reasonable sources, and if the information is to be used (by the agency or court) to obtain support for the children.

On July 27 the House adopted the conference report by a vote of 307 to 116. On July 29 the Senate approved the report by a vote of 70 to 24, and the bill was cleared for the President's signature.

On July 30, 1965, H.R. 6675 was signed by President Johnson and became Public Law 89-97.

Summary of Major Provisions

HEALTH INSURANCE FOR THE AGED

Public Law 89-97 adds to the Social Security Act a new title XVIII establishing two related health insurance programs for persons aged 65 and over: (1) a hospital insurance plan providing protection against the costs of hospital and related care, and (2) a medical insurance plan covering payments for physicians' services and other medical and health services to cover certain areas not covered by the hospital insurance plan.

The hospital insurance plan is financed through a separate earnings tax and a separate trust fund. Benefits for persons who are currently aged 65 and over who are not insured under the social security or the railroad retirement systems will be financed out of Federal general revenues.

Enrollment in the medical insurance plan is voluntary, and the plan is financed by a small

monthly premium (\$6 a month initially—\$3 paid by enrollees and an equal amount paid by the Federal Government from general revenues). The premiums for social security and railroad retirement beneficiaries and for civil-service retirement annuitants who enroll will be deducted from their monthly benefits. Uninsured persons desiring the medical insurance plan will make the periodic premium payments to the Government. State welfare programs may arrange for uninsured assistance recipients to be covered.

Hospital Insurance

Protection, financed by means of an earnings tax, is provided against the costs of inpatient hospital services, posthospital extended care, posthospital home health services, and outpatient hospital diagnostic services for beneficiaries under the social security and railroad retirement systems when they attain age 65. The same protection, financed from general revenues, is provided under a special transitional provision for essentially all persons who are now aged 65 or who will reach age 65 before 1968, but who are not eligible for social security or railroad retirement benefits. Together, these two groups make up virtually the entire aged population.

The persons not protected are Federal employees who are covered under the Federal Employees Health Benefits Act of 1959 or who, if they were retired after February 15, 1965, were covered or could have been covered under that act. Others excluded are aliens who have not been residents of the United States for 5 years, aliens who have not been admitted for permanent residence, and certain subversives.

Benefits will be first available on July 1, 1966, except for services in extended-care facilities, which will become available January 1, 1967.

Benefits.—The services for which payment is to be made under the hospital insurance plan include:

a. Inpatient hospital services for a maximum of 90 days in each spell of illness. The patient will pay a deductible amount of \$40 for the first 60 days, plus a coinsurance payment of \$10 a day for each day in excess of 60 during each spell of illness. Covered hospital services include almost all those ordinarily furnished by a hospital to its

inpatients. Payment will not be made, however, for private-duty nursing or for the hospital services of physicians (including radiologists, anesthesiologists, pathologists, and physiatrists) except those provided by interns or residents in training under approved teaching programs. Inpatient psychiatric hospital services are covered, but a lifetime limitation of 190 days is imposed. Inpatient services in Christian Science sanatoriums are covered as inpatient hospital services, but only under such conditions and limitations (in lieu of or in addition to those applicable to hospitals) as are provided by regulations.

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 and meeting certain other requirements) after the patient is transferred from a hospital (after at least a 3-day stay) for a maximum of 100 days in each spell of illness. After the first 20 days of care, the patient will pay \$5 a day for the remaining 80 days of extended care in a spell of illness. Under a special provision, extended care in Christian Science sanatoriums is covered for a maximum of 30 days, with the patient paying \$5 a day.

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

d. Posthospital home health services for as many as 100 visits, after discharge from a hospital (after at least a 3-day stay) or from an extended-care facility and before the beginning of a new spell of illness. The person must be in the care of a physician and under a plan calling for such services that was established by a physician within 14 days of the patient's discharge, and the services must be provided by a qualified home health agency. These covered services include intermittent nursing care and physical therapy. The patient must be homebound except that payment may be made for services furnished at a hospital or extended-care facility or rehabilitation center that requires the use of equipment that cannot ordinarily be taken to the patient's home.

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

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services will be increased if necessary to keep pace with increases in hospital costs, but no increase will be made before 1969. For administrative simplicity, 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.

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.

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

Financing.—Contributions to finance the hospital insurance plan, paid by employers, employees, and self-employed persons, are to be placed in a separate hospital insurance trust fund established in the Treasury. The earnings base—the amount of annual earnings subject to the new tax—is the same (\$6,600) as the earnings base for purposes of financing the cash benefits. The same contribution rates apply equally to employers, employees, and self-employed persons and are as follows:

	Percent
1966 -----	0.35
1967-72 -----	.50
1973-75 -----	.55
1976-79 -----	.60
1980-96 -----	.70
1987 and thereafter -----	.80

The schedule of contribution rates is based on cost estimates that assume that the earnings base will not be increased above \$6,600. If Congress, in later years, should increase the base, the contri-

bution rates established can be reduced under the cost assumptions underlying the law. The cost of hospital insurance benefits for persons who are not beneficiaries under the social security or railroad retirement systems will be paid from general funds of the Treasury.

Medical Insurance Plan

A package of benefits supplementing those provided under the hospital insurance plan is available to all persons aged 65 and over. Individuals who enroll initially will pay \$3 a month (deducted, where possible, from social security, railroad retirement, or civil-service retirement benefits). The Government will match this amount with \$3 paid from general funds. Since the minimum increase in cash social security benefits for workers who are aged 65 or over when the benefit increase is effective for them is \$4 a month (\$6 a month for man and wife receiving benefits based on the same earnings record), the benefit increase fully covers the amount of monthly premiums.

Enrollment.—For persons aged 65 before January 1, 1966, an enrollment period will begin September 1, 1965, and end March 31, 1966. Persons attaining age 65 after December 31, 1965, will have enrollment periods of 7 months beginning 3 months before they attain age 65. In the future, general enrollment periods will be from October 1 to December 31, in each odd year, beginning in 1967. No person may enroll more than 3 years after the close of the first enrollment period in which he could have enrolled. Persons who are in the plan but drop out will have only one chance to reenroll, and reenrollment must occur within 3 years of termination of the previous enrollment. Coverage may be terminated by the individual, who must file notice during a general enrollment period, or by the Government for nonpayment of premiums. A State can provide the medical insurance protection for its public assistance recipients who are receiving cash assistance if it chooses to do so. Benefits will be available beginning July 1, 1966.

Benefits.—The medical insurance plan covers physicians’ services, home health services, and numerous other medical and health services in and out of medical institutions.

The plan covers 80 percent of the patient’s bill

(above an annual deductible of \$50) for the following services:

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

b. Home health services under an approved plan (with no requirement of earlier hospitalization) for a maximum of 100 visits during each calendar year.

c. Diagnostic X-ray and laboratory tests, and other diagnostic tests.

d. X-ray, radium, and radioactive isotope therapy.

e. Ambulance services.

f. 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) that replace all or part of an internal body organ; and 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.

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 of the medical insurance plan, such as determining rates of payments, holding and disbursing funds for benefit payments, and determining compliance and assisting in utilization review. No contract can be entered into by the Secretary unless he finds that the carrier will perform its obligations efficiently and effectively and will meet requirements, such as those relating to financial responsibility and legal authority and other matters as the Secretary finds pertinent.

The contract must provide that the carrier take necessary action to see that, where payments are made on a cost basis, the cost is reasonable. Where payments are on a charge basis 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 carrier's other policyholders

and subscribers. 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. Payment by carrier for physicians' services will be made on the basis of a receipted bill or an assignment under which the reasonable charge will be the full charge for the service.

The requirement that the reasonable charge must be the full charge where an assignment procedure is used and that otherwise a receipted bill must be submitted would (1) assure that the amount shown on the bill was the actual charge for the services and (2) provide a safeguard especially for the less well-to-do who are covered under the plan, for whom it is probable that collection would normally be made through an assignment.

Financing.—Aged persons who enroll in the medical insurance plan will pay monthly premiums of \$3. If the individual is currently receiving monthly social security, railroad retirement, or civil-service retirement benefits, the premiums will be deducted from his benefits.

The Government will help finance the medical insurance plan through a payment from general revenues of \$3 a month per enrollee. To provide an operating fund when the medical insurance plan is first effective 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 in July 1966, when the supplementary plan goes into effect. The individual and Government contributions will be placed in a separate trust fund for the medical insurance plan, and all benefit and administrative expenses will be paid from this trust fund.

The provision in the income tax law limiting medical expense deductions to amounts in excess of 3 percent of adjusted gross income for persons under age 65 will be reinstated for persons aged 65 and over. Thus, partial or full recovery of the Government contribution will be made from enrolled persons with incomes high enough to require them to pay income taxes. A special deduction (for taxpayers who itemize deductions) of half the amount of premiums for insurance covering medical care will, however, be added.

This deduction, applicable to taxpayers of all ages, cannot exceed \$150 a year.

Premium rates for enrolled persons (and the matching Government contribution) will be increased from time to time if 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 was open to him will be increased by 10 percent for each full year he stayed out of the program.

Cost of the Hospital Insurance and Medical Insurance Plans

Benefits under both plans become payable for services furnished in July 1966, except services in extended-care facilities, for which benefits become payable in January 1967. Benefits and administrative expenses under the hospital insurance plan will be about \$2.2 billion for the first year of operations. For those uninsured under the hospital insurance plan the annual cost (paid from general revenues) will be about \$290 million in the early years, with a substantial offset for public assistance savings. Benefit payments of the medical insurance plan will be about \$1.2 billion in the first year of operation.

Railroad Retirement Health Insurance Provisions

The basic administration of the health insurance benefits program will be handled by the Social Security Administration in much the same way for railroad retirement beneficiaries as for social security beneficiaries. That is, the Administration will be responsible for making payments to providers of services and carrying out related administrative functions.

The law contains provisions designed to ensure that the hospital insurance taxes paid on employment covered under the railroad retirement program will be the same as those paid on employment covered under social security. For years in which the annual earnings and tax bases of the two programs are equal, hospital insurance taxes on railroad employment will be levied under the railroad retirement taxing provisions of the law and then transferred to the Federal hospital insurance trust fund, with payments

made from that fund. In these years the Railroad Retirement Board will determine the rights of railroad retirement beneficiaries to hospital insurance benefits and provide hospital insurance protection, financed from the railroad retirement account, for railroad retirement beneficiaries in Canadian hospitals.

These provisions presumably anticipate the enactment of legislation making and keeping the railroad retirement wage and tax base equal to that under the Social Security Act. Should there be years, however, in which the tax and wage bases of the two programs are not equal, hospital insurance taxes for those years would be levied under the social security taxing provisions and hospital insurance protection for railroad beneficiaries would be provided under social security on the same basis as that for social security beneficiaries.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AMENDMENTS

Benefits

Increase in monthly cash benefits.—The law provides a 7-percent across-the-board benefit increase, effective retroactively beginning January 1965, with a minimum increase of \$4 for retired workers aged 65 and older. Benefits are increased for the 20 million social security beneficiaries on the rolls at the time of enactment and for all future beneficiaries.

The minimum monthly benefit for workers retiring at or after age 65 is now \$44. For the present, the maximum benefit will be \$135.90 (based on average monthly earnings of \$400, the highest amount possible under the \$4,800 base for contributions and benefits). In the future, the higher creditable earnings resulting from raising the base to \$6,600 a year will make possible a maximum benefit of \$168.

The maximum amount of benefits payable to a family on the basis of a single earnings record is related, at all earnings levels, to the worker's average monthly earnings with an ultimate family maximum of \$368.

The benefits of persons on the rolls will be re-computed automatically each year to take account

of any covered earnings that the worker might have had in the preceding year that can increase his benefit amount. The amendment is effective for calendar years after 1964.

Change in the retirement test.—Effective for taxable years ending after 1965, a beneficiary may have annual earnings of \$1,500 and still get all his benefits for the year; if his earnings exceed \$1,500, \$1 in benefits will be withheld for each \$2 of annual earnings up to \$2,700 and for each \$1 of earnings thereafter. He will get benefits, regardless of the amount of his annual earnings, for any month in which he earns \$125 or less in wages and does not render substantial services in self-employment.

Certain royalties that are received in or after the year in which a person reaches age 65 from copyrights and patents that were obtained before he reached that age are not counted as earnings for purposes of the test. This provision is effective for taxable years beginning after 1964.

Payment of child's insurance benefits to children aged 18-21 and attending school or college.—Child's insurance benefits are payable until the child reaches age 22, provided the child is attending a public or accredited school as a full-time student after he reaches age 18. Children of deceased, retired, and disabled workers are included. No person will be paid mother's or wife's benefits solely on the basis of having in her care a child who has attained age 18 and is in school. The change is effective for months after December 1964.

Changes in the disability program.—The law eliminates the requirement that a worker's disability must be expected to be of long-continued and indefinite duration. It provides instead that an insured worker is eligible for disability benefits (payable after the sixth month, as in the past) if he has been under a disability that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 calendar months. Benefits payable because of this change are payable beginning with benefits for September 1965.

The disability benefit under the Social Security Act 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 before the onset of disability, but with the reduction periodically adjusted to take account of changes in national average earnings levels. Under this provision, the worker's average monthly earnings are defined as the higher of (a) his average monthly wage used for purposes of computing his disability benefit under the Social Security Act or (b) his average monthly earnings in covered employment during his highest 5 consecutive years after 1950. This offset provision applies to benefits payable after December 1965 on the basis of disabilities commencing after June 1, 1965.

Reimbursement will be made from the social security trust funds to State vocational rehabilitation agencies for the cost of rehabilitation services furnished to selected individuals who are entitled to disability insurance benefits or to disabled child's benefits. The total amount that may be made available from the trust funds for purposes of reimbursing State agencies cannot, in any year, exceed 1 percent of the disability benefits paid under the Social Security Act in the preceding year. This provision is effective immediately.

The disability provisions with respect to the blind are modified in two respects. First, the definition of disability now provides that an individual is considered to be disabled for purposes of entitlement to disability benefits if he is between the ages of 55 and 65, meets the definition of "blindness" (as provided for purposes of the disability "freeze") and is unable, because of such blindness, to engage in substantial gainful activity requiring skills or abilities comparable to those required in his past occupation or occupations. He will receive no payment, however, for any month in which he engages in substantial gainful activity.

Second, an alternative insured-status requirement is provided for persons who are disabled before they reach age 31 because of "blindness" as defined. Under this provision, the blind individual would be insured if he has quarters of coverage in half the quarters elapsing after attainment of age 21 and up to the point of disability, or, for those becoming disabled before they reach age 24, for at least half the 3 years

preceding the quarter in which he becomes disabled.

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. The amendment is effective beginning with monthly benefits for September 1965 on the basis of applications filed in or after July 1965.

Benefits for widows at age 60.—Widows can elect to receive benefits at age 60. The benefits payable to those who claim them before age 62 will be actuarially reduced to take account of the longer period over which they will be paid. This provision is effective beginning September 1965.

Transitional insured status.—The law sets up a “transitional insured status” provision. Persons who reached retirement age in 1955 or 1956 can qualify for benefits if they have 1 quarter of coverage for each year that elapsed after 1950 and up to retirement age (that is, 4 or 5 quarters), and those who reached retirement age in or before 1954 can qualify if they have 3 quarters of coverage instead of 6. Benefits are not payable under this provision until age 72.

The following tabulation shows the operation of the “transitional insured status” provision for workers:

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

Wife's benefits are payable at age 72 to a woman whose husband qualifies for benefits under the transitional provision if she attains age 72 before 1969. Widow's benefit will be payable at age 72 to a woman who reaches age 72 before 1969 if her husband was living in September 1965 and if he met the work requirements of the provision. A widow who reaches age 72 before 1969 but whose husband died before September 1965 can qualify if her husband attained age 65 or died before 1957 and if he had a specified number of quarters of coverage, as shown in the following tabulation.

Year of husband's death (or attainment of age 65, if earlier)	Quarters of coverage required if the widow attains age 72 in --		
	1966 or before	1967	1968
1954 or before.....	3	4	5
1955.....	4	4	5
1956.....	5	5	5

Benefits of \$35 will be payable to retired workers and widows; wives of retired workers will receive \$17.50.

These provisions are effective for September 1965.

Dependents' benefits.—Under the new law a child can 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. Benefits will be paid to a child on his father's earnings record, even though he cannot inherit the father's intestate personal property, if the father (1) had acknowledged the child in writing; (2) had been ordered by a court to contribute to the child's support; (3) had been judicially decreed to be the child's father; or (4) is shown by other satisfactory evidence to be the child's father and was living with or contributing to the support of the child. The amendment is effective with respect to monthly benefits beginning September 1965.

Benefits are payable to widows (and widowers) even though they have remarried if the remarriage was after they reached age 60 (age 62 for widowers). The amount of their benefit equals 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 while they are not married. The change is effective with respect to monthly benefits beginning with those payable for September 1965.

The law authorizes payment of wife's or widow's benefits 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. It 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 re-establishment of benefit rights for a divorced wife, a widow, a surviving divorced mother, or a surviving divorced wife who has remarried if the subsequent marriage has ended. These changes are effective for September 1965.

The provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries are changed to require that, if the adoption occurs after the worker becomes entitled to an old-age benefit, (1) the child be living with the worker (or adoption proceedings have begun) in or before the month the application for old-age benefits is filed; (2) the child has been receiving half his support for the year before the worker's entitlement; and (3) the adoption be completed within 2 years after the worker's entitlement. The amendment is effective with respect to applications filed on or after July 30, except that the 2-year time limit will not apply to adoptions completed within the 12 months following that date.

A wife, husband, widow, or widower may get benefits without regard to the generally applicable requirement that a marriage must have lasted at least a year, if, in the month preceding the marriage he or she was actually or potentially entitled to a widow's, widower's, parent's, or (if over age 18) child's annuity under the Railroad Retirement Act. Also, a woman worker's husband or widower who was entitled to a specified railroad retirement annuity before marriage to a person insured under the Social Security Act may get benefits without regard to the generally applicable requirement that the wife be currently insured and have provided at least half her husband's support. The amendment will be effective beginning with monthly benefits payable for September 1965.

The law extends indefinitely the period for filing proof of support for dependent husband's, widower's, and parent's benefits and applications for lump-sum death payments, where good cause exists for failure to file within the initial 2-year period. The amendment is effective for lump-sum payments and monthly benefits based on applications filed in or after July 1965.

Brothers and sisters are added to the list of relatives who may adopt a child after the death of the worker on whose earnings record he is get-

TABLE 1.—Number of persons immediately affected by OASDI amendments and amount of additional cash benefit payments in 1966 ¹

Provision	Amount of payments in 1966	Number of persons immediately affected
Total additional payments.....	\$2,320,000,000	-----
7-percent benefit increase (\$4 minimum in primary benefits).....	1,470,000,000	20,000,000
Reduced benefits for widows at age 60.....	² 165,000,000	185,000
Benefits for persons aged 72 and over with limited periods in covered work.....	140,000,000	355,000
Improvements in benefits for children: Benefits for children to age 22 if in school.....	195,000,000	295,000
Broadened definition of "child".....	10,000,000	20,000
Modifications in disability provisions: Change in definition.....	40,000,000	60,000
Liberalized requirements for benefits for the blind.....	5,000,000	7,000
Modification of earnings test.....	295,000,000	³ 750,000

¹ First full year of operation.

² No long-range cost to the system because the benefits are actuarially reduced.

³ Number affected in 1966; modification does not become effective until then.

ting benefits without causing termination of the child's benefits. The amendment is effective with respect to monthly benefits beginning August 1965.

Coverage

Physicians and interns.—Coverage is extended to self-employment as a doctor of medicine, effective for taxable years ending on or after December 31, 1965. The employment of interns is covered, beginning on January 1, 1966, on the same basis as that of other employees working for the same employer.

Tips covered as wages.—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 an employer tax on the tips.

The employee must 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 unpaid wages due an employee and in his employer's possession are insufficient to pay the employee social security tax due on the tips, the employee may make available to the employer sufficient funds to pay the tax. If an employee fails to report some or all of his cov-

ered tips to his employer, he is liable not only for the employee tax but also for an additional 50 percent of that tax.

The employer must withhold the employee 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 will be 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 the amount equal to the amount due for the social security tax has been subtracted.

Exemption of Amish and other religious sects.

—Under specified conditions, members of religious sects may obtain exemption from social security self-employment taxes upon application accompanied by a waiver of benefit rights. To be eligible for exemption an individual must be found to be a member of a recognized religious sect (or a division of a sect) and to be an adherent of the established tenets or teachings of the sect by reason of which he is conscientiously opposed to accepting any private or public insurance benefits paid in the event of death, disability, old-age, or retirement, or paid toward the cost of, or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act). It must be found that the sect has such teachings and has been in existence at all times since December 31, 1950, and that it is the practice for members to make provision for their dependent members that is reasonable in view of their general level of living. The application for exemption for taxable years ending on or before December 31, 1965, must be filed by April 15, 1966. The exemption may become effective as early as the first taxable year beginning after December 31, 1950.

Farmers.—Farm operators whose annual gross earnings are \$2,400 or less may report either their actual net earnings or two-thirds of their gross earnings, for taxable years beginning after December 31, 1965. When gross earnings are more

than \$2,400 they must report their actual net earnings if \$1,600 or more; if actual net earnings are less than \$1,600, they may report either that amount or \$1,600. (For taxable years beginning before January 1, 1966, farmers whose annual gross earnings are more than \$1,800 must report their actual net earnings if \$1,200 or more, but if actual net earnings are less than \$1,200, they may report either their actual net earnings or \$1,200.)

Ministers.—For ministers who have been in the ministry for at least 2 years since 1954 the period during which they may file waiver certificates electing coverage is reopened, through April 15, 1966. Coverage for ministers whose eligibility to file waiver certificates is reopened will ordinarily begin with 1963. In addition, social security credit may be obtained for the past earnings of certain ministers who die or file waiver certificates before April 16, 1966, where such earnings were reported for social security purposes but could not be credited.

Employees of nonprofit organizations.—Nonprofit organizations may file a waiver certificate and make it retroactive up to 5 years (formerly 1 year) before the quarter in which the certificate is filed. If an organization files a waiver certificate before 1966, the certificate may be amended during 1965 or 1966 to begin coverage as early as 5 years before the quarter in which the certificate is amended. Those employees to whom additional retroactive coverage is applicable (because the organization amends its certificate) are given an individual choice of such additional coverage. Employees who were reported erroneously and who are no longer employed when an organization files or amends its waiver certificate may validate the erroneous reportings for periods during which the certificate or amended certificate is in effect. In addition, certain employees whose wages were erroneously reported by a nonprofit organization during the period its waiver certificate was in effect may validate the erroneously reported wages. These provisions are effective immediately.

District of Columbia employees.—Coverage is provided for employees of the District of Columbia who are not covered by a retirement system.

The District of Columbia Commissioners may arrange also for the coverage of temporary and intermittent employees to be shifted from the Federal civil-service retirement system to the social security system. Coverage begins after the calendar quarter in which the Secretary of the Treasury receives a certificate from the District of Columbia Commissioners expressing their desire to have coverage extended to the affected employees.

State and local coverage changes. — Another opportunity is provided, through 1966, for the election of coverage by members of State and local government retirement systems who originally did not chose coverage under the divided retirement system provision, under which current employees have a choice of coverage. Alaska is added to the list of States that may use the divided retirement system provision. These provisions are effective immediately.

Iowa and North Dakota are permitted to modify their coverage agreements with the Secretary of Health, Education, and Welfare to exclude from coverage 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 may specify the effective date of the exclusion, but it may not be earlier than July 30, 1965.

The past coverage under the social security system of employees of certain school districts in Alaska that have been included in error as separate political subdivisions under the Alaska social security coverage agreements is validated. (The employees of the school districts involved should properly have been covered as employees of the political subdivisions of which the school districts are integral parts.) The provision is effective for 1965 and earlier years; coverage for years after 1965 must be under the general provisions of the law.

California is permitted to modify its coverage agreement to extend coverage to certain hospital employees whose positions were removed from a State or local government retirement system. The State will have until the end of January 1966 to take action under this provision.

Maine is given until July 1, 1967 (rather than 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.

Miscellaneous Changes

The law also includes a number of administrative and technical changes, including provisions relating to the length of time an application for benefits is effective, treatment of underpayments and of payments to two or more members of the same family, attorney's fees, and disclosure of the whereabouts of a beneficiary.

In addition to these changes, the legislation revises the provisions authorizing reimbursement of the social security trust funds out of general revenue for gratuitous wage credits for servicemen so that reimbursement will be spread over the next 50 years, rather than 10 years.

Financing Old-Age, Survivors, and Disability Insurance Amendments

The old-age, survivors, and disability insurance 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 revised schedule is shown below:

Year	Employee	Employer	Self-employed
1966.....	3.85	3.85	5.8
1967-68.....	3.9	3.9	5.9
1969-72.....	4.4	4.4	6.6
1973 and after.....	4.85	4.85	7.0

An additional 0.20 percent of taxable wages and 0.15 percent of taxable self-employment income will be allocated to the disability insurance trust fund, bringing the total allocation to 0.70 percent of wages and 0.525 percent of self-employment income beginning in 1966.

PUBLIC ASSISTANCE AMENDMENTS

Medical Assistance Program

To provide a more effective program of medical care for needy persons, the law establishes

a program of medical assistance under a new title of the Social Security Act—title XIX.

This title is intended to replace the Kerr-Mills law—medical assistance for the aged—and the provisions for direct payments to suppliers of medical care and services under old-age assistance, aid to the blind, aid to families with dependent children, aid to the permanently and totally disabled, and the consolidated program for the aged, the blind, and the disabled. The program may be administered by a State agency designated for the purpose, but eligibility is to be determined by the State agency responsible for administering old-age assistance.

The program is to include all persons now receiving assistance for basic maintenance under the public assistance titles and also may include persons who are able to provide their maintenance but whose income and resources are not sufficient to meet their medical care costs. Services offered the former group may be no less in amount or scope than those for the latter group. If the medically needy are included, comparable eligibility provisions are to apply so that all persons similarly situated among the aged, the blind, the disabled, and dependent children would be included in the program. Other medically needy children could be included. No age requirement may be imposed that would exclude any person over age 65 or, after July 1, 1967, under age 21. A flexible income test taking medical expenses into account would be used.

The old provisions in the various public assistance titles of the Act providing vendor medical assistance terminate upon the adoption of the new program by a State but no later than December 31, 1969.

Scope of medical assistance.—Under the old provisions, the State has had to provide “some institutional and noninstitutional care” under the program of medical assistance for the aged. There have been no minimum benefit requirements with respect to vendor medical payments under the other public assistance programs. For the new program a State must, by July 1, 1967, provide inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services for individuals aged 21 and over, and physician’s services (whether furnished in the office, the patient’s home, a hospital, or a skilled nursing home) in

order to receive Federal participation in vendor medical payments. Other items of medical service are optional with the States.

Eligibility.—The law improves the program for the needy elderly by requiring that the States establish a flexible income test that takes into account medical expenses; it may not set up rigid income standards that arbitrarily deny assistance to persons with large medical bills. In the same spirit the law provides that no deductible, cost-sharing, or similar charge may be imposed by the State for hospitalization under its program and that such a charge on other medical services must be reasonably related to the recipient’s income or resources. Elderly needy recipients under the State programs must be provided assistance to meet the deductibles imposed by the new basic program of hospital insurance. Where a portion of any deductible or cost-sharing under either program is met by a State program, it must be done in a manner reasonably related to the individual’s income and resources. No income can be imputed to an individual unless it is 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 is determined by a uniform formula, with no maximum on the amount of expenditures subject to participation—the procedure followed for medical assistance for the aged. The Federal share varies in relation to a State’s per capita income; States with a national average income receive 55 percent (rather than the 50 percent formerly received for medical assistance for the aged), and States at the lowest level receive as much as 83 percent (in contrast to 80 percent).

To receive any additional Federal funds as a result of expenditures under the new program, the States must continue their own expenditures at their present rate. For a specified period, no State would receive less in Federal funds because of the new formula than it had in the past, and 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. The Federal share in the

cost of compensation and training of professional medical personnel is now 75 percent, compared with the 50-50 Federal-State sharing for other administrative expenses.

Other Public Assistance Provisions

Increased assistance payments.—The Federal share in old-age assistance, aid to the blind, and aid to the permanently and totally disabled is raised, effective January 1, 1966, to \$31 of the first \$37 of a State's average monthly payment per recipient (instead of \$29 of the first \$35) plus a proportion of the remainder up to \$75 (formerly \$70). In aid to families with dependent children the Federal share is increased to \$15 of the first \$18 of a State's average monthly payment per recipient (instead of \$14 of the first \$17), plus a proportion of the balance up to \$32 (formerly up to \$30). States receive no additional Federal funds except to the extent that they pass them on to individual recipients.

Tuberculous and mental patients.—In old-age assistance and medical assistance for the aged (and the combined program), the law removes the exclusion from Federal matching with respect to payments for 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 general medical institution. As a condition of Federal participation in such payments to, or for, mental patients, certain agreements and arrangements are required to ensure that better care results from the additional Federal money. States will receive no more in Federal funds under this provision than the increase in their expenditures for mental health purposes under public health and public welfare programs. Restrictions are removed on Federal matching in payments for the needy blind and the disabled who are tuberculous or psychotic and are in general medical institutions. The provision is effective January 1, 1966, and will cost about \$75 million a year.

Protective payments to third persons.—The law adds a provision, effective January 1, 1966, for protective payments to third persons on behalf of recipients of old-age assistance,

aid to the blind, aid to the permanently and totally disabled (and recipients under the combined title XVI program), who are unable to manage their money because of physical or mental incapacity.

Earnings and income exemptions.—The amount of earned or other income received by assistance recipients that may be disregarded by the States in determining need under various programs was increased by several provisions.

A State may, at its option, exempt the first \$20 (formerly \$10) of earned income received by persons on the old-age assistance rolls (and by the aged in a combined program) and half the next \$60 (formerly \$40) of a recipient's monthly earnings. This provision is effective October 1, 1965.

In aid to families with dependent children the States may disregard up to \$50 of earnings per child per month, but not more than \$150 in the same family may be exempted in determining need. The amendment, which is wholly permissive with the States, is effective July 1, 1965.

Recipients of aid to the permanently and totally disabled may have the same exemption of earnings that is provided under old-age assistance and the same exemption of income and resources, if they are under an approved rehabilitation plan, that is now provided for the blind. This amendment is also wholly permissive with the States and is effective October 1, 1965.

In addition to earnings, up to \$5 per recipient per month of any income may be exempted under any of the federally aided public assistance programs.

The States may disregard as much of the OASDI benefit increase as is attributable to its retroactive effective date.

The law also provides a grace period for action by States that have not had regular legislative sessions and whose public assistance statutes now prevent them from disregarding a recipient's earnings under the Economic Opportunity Act.

School attendance for child recipients.—The definition of a school in which a child aged 18-21 may receive aid to families with dependent children, at the State's option, is broadened to include colleges.

Definition of medical assistance for the aged.—The law modifies the definition of medical as-

sistance for the aged, effective July 1, 1965, to allow Federal sharing in payments in behalf of old-age assistance recipients for the month they are admitted to or discharged from a medical institution.

Judicial review.—A State dissatisfied with the Secretary's decision with respect to State public assistance plans may appeal to the courts for review.

Alternative formula.—Any State, at its option, after adopting title XIX (medical assistance) may claim Federal participation in its money payments under the formula provided under that title instead of under the different formulas in the other public assistance titles.

MATERNAL AND CHILD HEALTH AND CHILD WELFARE AMENDMENTS

Increase in Annual Authorizations

The law increases the amount authorized for maternal and child health services over current authorizations by \$5 million for fiscal year 1965-66 and by \$10 million in each succeeding fiscal year, as shown below.

Fiscal year	Old law	New law
1965-66.....	\$40,000,000	\$45,000,000
1966-67.....	40,000,000	50,000,000
1967-68.....	45,000,000	55,000,000
1968-69.....	45,000,000	55,000,000
1969-70 and after.....	50,000,000	60,000,000

The authorizations for crippled children's services and child welfare services are increased to the same amounts. Such increases will assist the States, in all these programs, to move toward the goal of extending services and making them available to children in all parts of the State by July 1, 1975.

Training Personnel For Care of Crippled Children

The law also authorizes \$5 million for the fiscal year 1966-67, \$10 million for 1967-68, and \$17.5 million for each succeeding fiscal year in grants to institutions of higher learning to be used in training professional personnel for the care of crippled children, particularly mentally retarded children with multiple handicaps.

Health Care for the Children of Low-Income Families

A new provision authorizes the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. The grants (not to exceed 75 percent of the cost of the project) will be made to State health agencies, State agencies administering the crippled children's program, any school of medicine (with appropriate participation by a school of dentistry), and any teaching hospital affiliated with such a school. Projects will provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, including dental services, for children in low-income families.

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

Mental Retardation

Grants totaling \$2,750,000 are authorized for each of 2 fiscal years—1965-66 and 1966-67. The grants will be available during the year for which the appropriation is authorized and during the succeeding fiscal year. They are for the purpose of assisting States to implement and follow up on plans and other steps to combat mental retardation, as authorized under section 1701 of the Social Security Act.

Study of Resources Relating to Children's Emotional Illness

The Secretary of Health, Education, and Welfare is authorized to make grants for carrying out a program of research into resources, methods, and practices for diagnosing or preventing emotional illness in children and of treating, caring for, and rehabilitating children with emotional illness.